VIEWPOINT

Why Mental Health–Related Stigma Matters for Physician Wellbeing, Burnout, and Patient Care

Hae Lin Cho, BA and Caroline J. Huang, PhD

Department of Bioethics, National Institutes of Health Clinical Center, Bethesda, MD, USA.

J Gen Intern Med 35(5):1579–81

DOI: 10.1007/s11606-019-05173-6

© Society of General Internal Medicine (This is a U.S. government work and not under copyright protection in the U.S.; foreign copyright protection may apply) 2020

Mental illness as defined by the DSM-V criteria affects nearly one in five American adults,¹ while burnout affects over half of practicing physicians.^{2, 3} Taken together, these numbers suggest that many physicians have been, will be, or are currently affected by mental health issues. However, the impact these issues have on a physician's fitness to practice falls on a spectrum: Past or well-managed conditions may not affect a physician's fitness to practice at all, whereas acute or poorly managed conditions may significantly impact a physician's fitness. Overlooking this spectrum and treating all conditions as having equal impact likely contributes to the significant stigma against mental health conditions. Ironically, physicians with mental health conditions (PWMHC) and physicians experiencing burnout seem to face and internalize these attitudes despite being fully aware of their existence.⁴ As a result, physicians with past or well-managed conditions may choose not to disclose the care they have sought, and physicians with acute or poorly managed conditions may choose not to seek care at all.

This mental health–related stigma in healthcare leads to missed opportunities to improve physician support systems and patient care. First, accommodations considered appropriate for PWMHC could inform more inclusive environments for all physicians. Second, promoting a more open, inclusive workforce could help aspiring and early-career PWMHC enter and remain in the field. Third, drawing on the lived experiences of PWMHC could equip physicians to provide better care for patients struggling with mental health. In this paper, we provide recommendations for policies and patient care organized around these three themes.

These strategies are especially salient for general internists and hospitalists, who are integral to the medical care of patients with mental health conditions, and particularly

susceptible to burnout due to challenges such as high patient volume, lack of time, burdensome electronic health record requirements, and primary care physician shortages.^{3, 5, 6} Ultimately, we hope that challenging the culture of silence and stigma around mental health will result in better outcomes for physicians and patients alike.

PROMOTING PHYSICIAN WELLBEING

One way to promote physician wellbeing is to advocate that reasonable accommodations for PWMHC be implemented more broadly for all physicians. This idea finds support in a 2018 Association of American Medical Colleges (AAMC) report on the lived experiences of learners and physicians with disabilities, which outlined structural and cultural challenges and opportunities for inclusion.⁷ Structural accommodations include supplementing in-person/daytime mental health services with video/evening services and eliminating irrelevant questions about past mental health treatment from state licensing board forms.^{2, 7} Cultural adjustments include having senior leaders emphasize that their institutions recognize that disability is not a sign of inability, and that asking for and receiving reasonable accommodations is a legal right under the Americans with Disabilities Act of 1990 (ADA) and the ADA Amendments Act of 2008.⁷

A more comprehensive approach would make these kinds of accommodations unconditionally available to anyone who might benefit from receiving them, including physicians experiencing burnout. Asking for accommodations and proving why these accommodations are necessary (e.g., through evidence of a certain diagnosis or past history of accommodations) can be challenging barriers for people to surmount.⁷

While these accommodations will not “cure” physician burnout, taking reasonable steps to reduce barriers to accommodations could help stem the worst effects of physician burnout *before* the effects of changes like addressing the pressures of electronic health records or patient-staff ratios can manifest.³ For example, the aforementioned structural changes could encourage physicians actively struggling with severe burnout and comorbid mental health issues like depression or suicidal thoughts to seek adequate care. More importantly, normalizing the need for accommodations or mental health care signals a cultural shift away from the view that being vulnerable, asking for accommodations, or receiving mental health support is a sign of weakness rather than a form

Received May 10, 2019

Accepted June 27, 2019

Published online February 24, 2020

of balance and self-care. Without a cultural shift that explicitly supports physician work-life balance, there are no guarantees that physicians would even use services designed to promote their wellbeing.

INCREASING WORKFORCE VISIBILITY AND REPRESENTATION

A more inclusive culture—one that recognizes how mental health conditions differentially affect physicians' fitness—may also help increase workforce visibility and representation of PWMHC. The AAMC report says that by encountering physicians with disabilities, aspiring physicians with similar disabilities can gain the confidence to enter the medical field.⁷ However, because mental health conditions are invisible, the decision to disclose likely involves a tricky calculus, weighing needed accommodations against potential stigma. For this reason, there are few public examples of successful physicians disclosing their mental health conditions, as compared with other chronic health conditions.

Normalizing mental health challenges and accommodations would theoretically reduce mental health–related stigma and the downsides of disclosure. More transparency about the prevalence of PWMHC and physicians experiencing burnout—and identification of the accommodations available to students concerned about one or both issues—would be a helpful start. Additionally, if more PWMHC felt comfortable voluntarily disclosing, the disproportionately high burden of proving that PWMHC can be capable physicians might decrease. Established PWMHC who are open about their mental health histories may also fill the role-model vacuum for aspiring physicians, who may otherwise equate low visibility of PWMHC with incompatibility of medicine as a profession for people with mental health conditions.

Increasing workforce representation of PWMHC—or even visibility of PWMHC—may also help create a more inclusive culture that is helpful to both PWMHC and physicians experiencing burnout. Empirical evidence suggests that personal experiences with someone with a mental health condition, especially a peer or colleague, significantly reduce stigmatizing behaviors.⁴ Beyond providing validation and mentorship, PWMHC could also choose to help medical schools tailor their inclusion efforts to best meet students' needs. For instance, they could lend insight into what kinds of accommodations most benefit students susceptible to burnout, or volunteer to mentor medical students and residents who are also managing mental health conditions.

One important caveat is that disclosing mental health histories should always remain voluntary. However, there seem to be receptive audiences for the positive, albeit few, narratives of PWMHC. For example, family physician Dr. Suzanne Fiala explained her decision to open up about her bipolar disorder in 2004 as follows: "It is time to give mental illness a name, a face, a story. Only in doing so will the stigma of this disease lose its power."⁴

IMPROVING PATIENT CARE

Creating an environment where a broad range of PWMHC feel empowered to discuss their lived experiences may also improve patient care. Beyond encouraging physicians experiencing burnout to seek help and potentially improving their care delivery by decreasing medical errors or other issues associated with burnout, empowering PWMHC could enable them to leverage their dual identities as patients and providers and help educate their colleagues on the needs of and challenges faced by patients with mental health conditions. They may be able to help raise awareness about potential errors or implicit biases disproportionately faced by these patients, such as diagnostic overshadowing, or identify more respectful ways to ask about a patient's health history or describe patient encounters in medical records.

Primary care providers, who care for a third of American patients with mental health conditions, may be the most likely to benefit from the shared perspectives of PWMHC.⁵ Being better equipped to build rapport with patients with mental health conditions could improve care and health outcomes for their patients. In the best-case scenario, improved relationships with patients and patient outcomes could increase job satisfaction and feelings of self-efficacy for primary care providers, and help lower the disproportionately high rates of burnout in primary care. Given the increased risk that physicians struggling with burnout will leave their field, and the persistent shortage of primary care physicians, improving physician rapport with patients with mental health conditions seems especially important.⁷

This is not to say that PWMHC necessarily share or understand the lived experiences of all patients with mental health conditions. However, their added perspective may help improve how they and other physicians communicate with and accommodate this diverse patient population. On an institutional level, PWMHC could also opt to participate in conversations about how systemic practices beyond the doctor-patient relationship—such as lack of access to certain services—might affect the care of patients with mental health conditions.

CONCLUSION

Mental health–related stigma remains a serious and under-addressed issue that hinders both patient care and physician welfare, especially in frontline fields of medicine like primary care. The current attention to physician burnout provides a rare opportunity to broaden our conversations on physician mental health to consider the full range and impact of mental health conditions affecting physicians. Normalizing appropriate accommodations for PWMHC, creating opportunities for enhanced visibility and representation of PWMHC, and learning from the patient experiences of PWMHC are concrete steps we can take to help reduce mental health–related stigma for the good of patients, physicians, and other health professionals.

Corresponding Author: Hae Lin Cho, BA; Department of Bioethics, National Institutes of Health Clinical Center, Bethesda, MD, USA (e-mail: haelin.cho@gmail.com).

Compliance with Ethical Standards:

Disclaimer: The opinions in the article are the authors' own and do not represent the views of the National Institutes of Health, the Department of Health and Human Services, or the federal government.

Conflict of Interest: The authors declare that they do not have a conflict of interest.

REFERENCES

1. National Institute of Mental Health. Mental Health Information: Statistics. Available at: <https://www.nimh.nih.gov/health/statistics/mental-illness.shtml>. Published November 2017. Accessed March 20, 2019.
2. Jha AK, Iliff AR, Chaoui AA, Defossez S, Bombaugh MC, Miller YR. A Crisis in Health Care: A Call to Action on Physician Burnout. Cambridge, MA: Harvard Global Health Institute; 1–12.
3. Linzer M, Levine R, Meltzer D, Poplau S, Warde C, West CP. 10 Bold Steps to Prevent Burnout in General Internal Medicine. *J Gen Intern Med*. 2014;29(1):18–20. doi:<https://doi.org/10.1007/s11606-013-2597-8>
4. Wallace JE. Mental health and stigma in the medical profession. *Health (N Y)*. 2012;16(1):3–18. <https://doi.org/10.1177/1363459310371080>
5. Koven S. Should Mental Health Be a Primary-Care Doctor's Job? October 2013. Available at: <https://www.newyorker.com/tech/annals-of-technology/should-mental-health-be-a-primary-care-doctors-job>. Accessed May 3 2019.
6. Rabin RC, Kaiser Health News. A growing number of primary-care doctors are burning out. How does this affect patients? *Washington Post*. Available at: https://www.washingtonpost.com/national/health-science/a-growing-number-of-primary-care-doctors-are-burning-out-how-does-this-affect-patients/2014/03/31/2e8bce24-a951-11e3-b61e-8051b8b52d06_story.html. Published March 31, 2014. Accessed May 7 2019.
7. Meeks LM, Jain NR. Accessibility, Inclusion, and Action in Medical Education: Lived Experiences of Learners and Physicians With Disabilities. *Association of American Medical Colleges*; 2018:104.

Publisher's Note Springer Nature remains neutral with regard to jurisdictional claims in published maps and institutional affiliations.