PFSP Perspectives: Alberta Doctors’ Digest

Addressing stigma: An influence and leadership opportunity for our profession

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Stigma is a problem for physicians within the house of medicine. And stigma is a problem for the patients we serve.

It refers to beliefs and attitudes towards mental health and mental illnesses that lead to negative stereotyping of people and prejudices against them and their families.

Discrimination, or enacted stigma, refers to the various ways in which people, organizations and institutions unfairly treat people living with mental health problems or illnesses, often based on acceptance of these stereotypical and prejudicial beliefs and attitudes.¹

Stigma is typically a social process.² Thus, addressing it within our medical culture, as well as for our patients in the greater culture, is an extremely important social and public health issue.

Alberta physicians who access Physician and Family Support Program (PFSP) services address, manage and cope with the stigma of mental health issues every day.

Roughly one third of calls to PFSP in 2010 were related to mental health, psychiatric disorders and addictive disorders; another third related to family and relationship issues.

These callers recognize the value personally and professionally in receiving confidential, appropriate care. These physicians realize the value of early intervention, treatment, recovery and renewed engagement with their lives.

They appreciate there is a difference between illness and occupational impairment. Generally, most callers continue to work while receiving assistance. Some take the time required to improve their individual health issue and take a medical leave-of-absence from work.

They all appreciate the mantra: Healthier physicians, healthier patients.

Potentially, this has enormous value to patients struggling with similar health issues – to appreciate that physicians are human, too, and that physicians have improved knowledge and attitudes regarding mental illness and are aware of discriminatory behavior towards those with mental illness.

Perhaps we could work together and address negative media regarding mental illness.
The negative media portrayal of those with mental illness as violent or threatening to others, as less competent or trustworthy, or in an unsympathetic manner is markedly inaccurate. And it contributes to stigma and discrimination.

Dr. Heather Stuart, a prominent Canadian researcher on stigma and mental illness and a consultant to the Mental Health Commission of Canada (MHCC), adds that negative media is profoundly distressing to people with mental illness and to their families, and has social repercussions.

For example, many individuals will not tell their employers about their illnesses or disorders lest their trustworthiness, predictability or competence be questioned. Mental illnesses sometimes are concealable. Sometimes those with depression, for example, successfully conceal symptoms to avoid what they perceive would be negative responses and consequences. In Barney et al’s 2009 qualitative study regarding the nature of stigmatizing beliefs and seeking help, some respondents agreed that depression was not apparent to others so it did not attract stigma.

However, the downside is that recognition and treatment are hampered or does not happen at all. Respondents faced considerable fears of stigmatizing responses, in anticipation and in actuality. They had greater reservations regarding work colleagues. This study reflected the general population, yet is relevant to the concerns of physicians when ill.

It also speaks to a concerning fact of medical culture. We do not always recognize when a colleague requires support. While it has been said in the past, “work is the last to go,” it behooves us to become more knowledgeable regarding symptoms or signs of mental illness or addiction. We need to continue to model proactive approaches to our health for ourselves and our colleagues.

As professionals, we must never wait until work begins to be impacted before we seek assistance. And we must never wait to support a colleague in getting assistance.

How do physicians become champions? Will some or many of us contribute to the “living library” of those with experiences of ill mental health or addiction, to share our own stories whether with colleagues or the public?

This is one of the most effective and key strategies to address stigma-discrimination – direct contact with someone who has been a patient or a consumer. Jean E. Wallace, author of Mental health and stigma in the medical profession, shares the story of a physician who had been treated for bipolar disorder for 30 years: “That only by making the mental illness personal, by connecting the illness with someone we know, will the power of stigma in the medical profession be weakened.”

The distances between colleagues need to be reduced. It is important, as health care providers, that we are aware of the impact of stigma in our workplaces, for ourselves and for our patients.
I suspect most of us have some awareness when stigma-discrimination occurs in our workplaces. Do we sometimes play a part in this? How often do we do the right thing and address a stigmatizing comment or behavior in the moment?

A 2008 survey targeting psychiatrists, by the Canadian Psychiatric Association (CPA) Working Group on Stigma, includes a multi-part question with the root:

“Do you have a personal story or experience with stigma and/or discrimination towards a patient with mental illness?”

- 79% responded in the affirmative.7

All physicians must be aware of “diagnostic overshadowing,” a term utilized in stigma-research literature and by the MHCC.5,8

That is, patients with issues of mental health and addiction should not be “diagnostically overshadowed” and receive lesser health care services than those without a mental illness diagnosis.

The literature and affected patients are clear that this happens in all services and branches of medicine.

All health care providers must change and confront vernacular and stigmatizing language use when describing patients with mental health and addiction issues.

Otherwise, it not only adversely impacts the patient, it perpetuates stigma. It may adversely impact the physician or other health care team members who may have similar conditions.

Notably, one of the priority action items arising from the 2008 CPA survey was that:

- Stigma and discrimination towards people in the emergency room must be addressed.
- 89% of respondents strongly agreed or agreed with that priority.7

Psychiatry and mental health services have tolerated multiple “structural inequities”7 in our health care system, likely contributing to illness-treatment gaps.

Is this, in part, because mental health professionals and psychiatrists are also stigmatized by our colleagues?7 Is this, in part, because as mental health professionals we have contributed to the stigmatization of our patients and their families?7

The call to action is clear. And so the stigma issue circles back to us and our culture of medicine. Is stigma alive in our culture of medicine and what is the cost?

Do we model and mentor self-care? Do we recognize the barriers to physicians, at all career stages, to becoming proactive about their health? Are we less knowledgeable than we could be?

What are our attitudes toward colleagues or trainees with mental illness or addiction?

Is there a practice of “career-prospect overshadowing”? That is, are some careers limited
because of knowledge of personal health issues? Is this based on diagnosis, rather than occupational impairment?

What are the expectations and responses of systems and organizations towards physicians suffering from mental health issues, including addiction?

PFSP case-coordination service experience continues to be positive as we work with physicians and organizations (whether a clinic, health authority, a department or university) in assisting physicians to successfully return to work following an illness episode.

While we recognize this is a relatively small group of physicians, trainees and workplaces, our aim is that there is generalization of positive knowledge, attitude and behavior in all medical workplaces. We hope patients benefit, in turn.

The mental health of physicians is a national matter. Over the last year, the Canadian Medical Association (CMA) prepared and published *Physician Health Matters: A mental health strategy for physicians in Canada* (available at cma.ca).

The report identified four strategic directions.

1. Increase knowledge and skills regarding physician mental health issues.
2. Improve access to a range of mental health services and programs for physicians.
3. Create learning and work environments that support the mental health of physicians.
4. Monitor, evaluate and research physician mental health needs, services and policies.

Additionally, a 2010 CMA and strategic collaborators workshop, *Ending stigma and achieving parity in mental health: A physician perspective*, reinforced our professional engagement in addressing stigma and discrimination as an imperative.

These reports remind us that Alberta physicians, the Alberta Medical Association and PFSP are on the right track with regard to our mission, vision and processes for physician health and, yet, there are many miles more to travel.

Whether we are medical or surgical specialists, family physicians or psychiatrists, we have a professional responsibility to all of our patients, not only to get our house of medicine in order but to address stigma wherever we find it.

This would be true influence and leadership in medicine.
References


