Research Article

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Canadian psychiatrists' attitudes to becoming mentally ill.

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Abstract

Aims: Doctors are at increased risk of developing a mental illness and at increased risk of suicide compared to the general population. Medical students when faced with psychological stress and are more likely to avoid help. This study attempts to assess Canadian consultant psychiatrists' attitudes to disclosure and treatment preference if they were to become mentally ill.

Method: Data was collected through a postal survey from all consultant psychiatrists registered in the province of Ontario in Canada. The survey package contained a covering letter, a 2 page questionnaire, and return stamped addressed envelope. Respondents were separated into 3 groups in order of experience as a consultant psychiatrist.

Results: 487 out of 1231 questionnaires were returned (response rate of 40%). Respondents would be most likely to disclose their mental illness to family and friends (204, 41.9%). Those who would choose to disclose to their family physician or to family/friends were more likely to cite stigma as a factor influencing their choice than those who would choose to disclose to colleagues. Nearly a third of respondents (151, 31.0%) claimed to have experienced a mental illness. There was no association between choice of whom to disclose and previous experience of mental illness (χ^2=1.22; DF=2; p=.545; Cramer's V=.05).

Conclusions: Stigma continues to play a role in how consultant psychiatrists decide the course of disclosure and treatment. Consultant psychiatrists with less than 5 years of such experience when deciding treatment for themselves are more concerned with confidentiality than their quality of care. Senior consultant psychiatrists are more likely to seek professional help than informal professional advice out the outset of a mental illness.

Keywords: psychiatrists, mental illness, stigma, disclosure, treatment, services

Introduction

One in four people in general and one in five people in Canada suffer from a mental disorder and only half of these individuals will seek help for their mental health.[1] Doctors have an increasingly demanding job with increasing expectations of excellence in clinical, academic and managerial roles. It seems surprising that with their rigorous training doctors have higher rates of suicide compared to the general population.[2] Studies have revealed that two-thirds of Canada's physicians consider their workload too heavy, and more than half say that personal and family life have suffered because of their career choice.[3] One third of Canadian physicians disagreed with a statement that their work environment encourages them to be healthy .[4]

A systematic review of mental health studies of medical students in the US and Canada found consistently higher rates of psychological distress in medical students compared with both the general population and age-matched peers .[5] Medical students were also less likely to seek help for psychological distress than their peers. [6]

A survey of psychiatrists and physicians in the UK found that most would be reluctant to disclose personal mental illness to colleagues or professional institutions. Their choices regarding disclosure and treatment would be influenced by issues of confidentiality, stigma, and career implications rather than quality of care.[7,8]

To reduce stigma and ease physician access to mental healthcare it is important to understand and address the above issues. This will facilitate psychiatrists gaining optimized mental health as well as to improve recruitment and retention of these professionals.[9] The objective of our study was to assess the understanding of Canadian psychiatrists to the incidence of mental illness amongst psychiatrists in comparison to the general population and also in comparison to their medical/surgical colleagues. The study also assessed the attitudes of psychiatrists towards preference for disclosure, and treatment should they develop a mental illness in addition to their own experience of mental illness.

Method

Ethics approval (Study code PSIY-336-11) from Queen's University in Kingston, Ontario was granted. Funding was obtained from TH's research initiation grant. A mailing list of all psychiatrists in the province of Ontario was provided by the College of Physicians and Surgeons of Ontario (CPSO) for specific use to this research project. The College of Physicians and Surgeons Ontario is a body similar to the General Medical Council (GMC) in the UK. Their role is to regulate the practice of medicine in the province of Ontario. Other provinces have their own respective College of Physicians and Surgeons. In the remainder of the text the term 'psychiatrist' refers to consultant psychiatrist.

The list obtained from the CPSO did not include approximately 10% of psychiatrists who opted out of having their postal details released for research purposes. In total 1231 psychiatrists were sent a survey package. This package included a covering letter, a 2-page questionnaire, and a stamped return addressed envelope. Consent was assumed based on taking part in the survey. The 10-item questionnaire was based on a review of the literature, previous research, and discussion with colleagues. It comprised broadly of three sections. The first

collected information on the respondents' perception of prevalence of mental illness in psychiatrists in comparison to the general population and then in comparison with other medical/surgical specialties. The second required psychiatrists to identify to whom they were most likely to disclose a mental illness and reasons for non-disclosure. The third asked psychiatrists their preference of treatment in both an outpatient and inpatient setting. The identifiable information requested was the amount of experience the respondent had as a psychiatrist and whether they had experienced mental illness in the past. A free-text box was included at the end for comments and complete anonymity was maintained. Psychiatrists were divided into 3 groups: Group 1 (less than 5 years of experience as a psychiatrist), Group 2 (5-10 years of experience) and Group 3 (greater than 10 years of experience).

Analysis

A series of two-sample chi-square tests (χ^2) were conducted to examine associations between certain categorical variables. In cases where 20% of contingency cells were <5 or where any cell=0, Fisher's Exact test was used. Phi (φ) or Cramer's V (for associations >2x2) were used as measures of effect size, these provide an association coefficient between 0 and 1. All analyses were done using SPSS 19.

Results

Of the 1231 questionnaires sent to doctors 487 were returned, a response rate of 39.6%. The respondents were placed into three groups: those in attending for <5 years (55, 11.3%), 5-10 years (53, 10.9%) and >10 years (369, 75.8%). The frequency of responses to all questions, both overall and as a function of attending group are shown in Table 1.

Perception of the incidence of mental illness

Just over half of respondents disagreed that the incidence of mental illness was higher in doctors than the general population (247, 50.7%). Just over a quarter (124, 25.5%) agreed and just under a quarter replied 'don't know' (116, 23.8%). As can be seen in Table 1, the pattern of responding was similar across all attending groups on this question (χ^2=5.92; df=4; p=.205; Cramer's V=.08). Most disagreed that psychiatric illness was greater in medical/surgical professionals than in psychiatrists (285, 58.5%), a small minority agreed (37, 7.6%). Again the attending groups responded similarly on this question (χ^2=7.06; df=4; p=.133; Cramer's V=.09). Nearly a third of respondents (151, 31.0%) claimed to have experienced a mental illness, and once more the attending groups did not differ significantly in their responses to this (χ^2=1.12; df=2; p=.57; Cramer's V =.05).

Disclosure of mental illness

Respondents would be most likely to disclose their mental illness in the first instance to family and friends (204, 41.9%) although many would instead prefer to disclose to their family physician (153, 31.4%). Relatively few would disclose to a colleague (54, 11.1%) in the first instance or to a mental health professional (32, 6.6%), very few would choose no-one (15, 3.1%) and the clergy was the least endorsed option (3, 0.6%). When considering only the three most popular response options (family/friends, family physician, and colleague) the three attending groups responded similarly (χ^2=6.63; df=4; p=.157; Cramer's V=.09). When asked about the most important factor affecting the decision *not* to disclose, the most common response was career implications (168, 34.5%). However stigma (114, 23.4%) and professional standing (80, 16.4%) were also reasonably common responses.

Again, when including only the three most popular disclosure choices in the analysis, there emerged an association between choice of whom to disclose and factor affecting disclosure (χ^2=12.52; df=6; p=.051; Cramer's V=.13) (see Table 2). Those who would choose to disclose to their family physician or to family/friends were more likely to cite stigma as a factor influencing their choice than those who would choose to disclose to colleagues. Those who would disclose to colleagues would be more likely to cite professional standing as a factor influencing their choice compared to those who would disclose to their family physician or to their family/friends. There was no association between choice of whom to disclose and previous experience of mental illness (χ^2=1.22; df=2; p=.545; Cramer's V=.05).

Treatment for mental illness

When considering out-patient treatment, the majority of respondents would opt for formal professional advice (365, 74.9%). A small proportion would choose informal professional advice (83, 17.0%) and very few would self-medicate (25, 5.1%) or have no treatment (9, 1.8%). With regard to in-patient treatment, the majority would opt for an out of area mental health facility (370, 76.0%). Only just over a quarter of respondents (130, 26.7%) claimed that quality of care would influence their choice of in-patient care, just over half would be most concerned about confidentiality (257, 52.8%) There was a strong association between in-patient preference and the factor influencing that preference (Fisher's Exact=228.25; p<.001; Cramer's V=.70). As shown in Table 3, those who would choose an out of area facility, were much more likely to cite confidentiality and stigma as factors influencing their choice, than those who would choose a local facility. Conversely, those choosing a local facility were more likely to cite quality of care and convenience as influencing factors.

There was an association between attending group and out-patient preference (Fisher's Exact=12.00; p=.042; Cramer's V=.13). As can be seen in Table 1, the >10 years group would be more likely to select informal advice than the <5 years group, but the >10 years group were less likely to self-medicate than the <5 years group.

Table 1. Responses to all questions and comparisons between attending groups. Discrepancies between the overall column and the sum of the attending group columns are due to missing cases in responses to the attending group question.

			Attending Group		
		Overall	<5 years	5-10 years	>10 years
Incidence of psychiatric illness amongst doctors is higher than general population?	Yes	124 (25.5%)	15 (27.3%)	19 (35.8%)	89 (24.1%)
	No	247 (50.7%)	30 (54.5%)	26 (49.1%)	184 (49.9%)
	Don't know	116 (23.8%)	10 (18.2%)	8 (15.1%)	96 (26.0%)
Incidence of psychiatric illness amongst medical/surgical professionals higher than that of psychiatrists?	Yes	37 (7.6%)	1 (1.8%)	8 (15.1%)	28 (7.6%)
	No	285 (58.5%)	36 (65.5%)	29 (54.7%)	214 (58.0%)
	Don't know	165 (33.9%)	18 (32.7%)	16 (30.2%)	127 (34.4%)
Have you ever experienced a mental illness, which had affected your personal, social or occupational life?	Yes	151 (31.0%)	14 (25.5%)	18 (34.0%)	118 (32.0%)
	No	336 (69.0%)	41 (74.5%)	35 (66.0%)	251 (68.0%)
If you were to develop a psychiatric illness affecting your personal, social or occupational life, to whom would you initially be most likely to disclose this?	Church/Clergy	3 (0.6%)	1 (2.0%)	0 (0.0%)	2 (0.6%)
	GP/Family physician	153 (31.4%)	18 (35.3%)	16 (32.0%)	116 (32.3%)
	Family/friends	204 (41.9%)	22 (43.1%)	27 (54.0%)	152 (42.3%)
	Colleagues	54 (11.1%)	4 (7.8%)	1 (2.0%)	46 (12.8%)
	Mental health profess.	32 (6.6%)	4 (7.8%)	5(10.0%)	22 (6.1%)
	None	15 (3.1%)	1 (2.0%)	0 (0.0%)	14 (3.9%)
	Other	9 (2.0%)	1 (2.0%)	1 (2.0%)	7 (1.9%)
What is the most important factor that would affect your decision not to disclose your mental illness?	Stigma	114 (23.4%)	12 (22.2%)	14 (26.4%)	86 (24.2%)
	Career implications	168 (34.5%)	21 (38.9%)	22 (41.5%)	121 (34.1%)
	Professional standing	80 (16.4%)	11 (20.4%)	6 (11.3%)	63 (17.7%)
	Other	109 (22.4%)	10 (18.5%)	11 (20.8%)	85 (23.9%)
If you were to suffer from a mental illness affecting your personal, social or occupational life requiring out-patient treatment, what would be your first treatment preference?	Informal profess. advice	83 (17.0%)	6 (10.9%)	7 (13.5%)	70 (19.1%)
	Formal profess. Advice	365 (74.9%)	42 (76.4%)	40 (76.9%)	275 (75.1%)
	Self-medication	25 (5.1%)	7 (12.7%)	2 (3.8%)	15 (4.1%)
	No treatment	9 (1.8%)	0 (0.0%)	3 (5.8%)	6 (1.6%)
If you were to develop a mental illness requiring in-patient treatment, where would be your first preference?	Local	109 (22.4%)	6 (10.9%)	5 (9.4%)	96 (26.5%)
	Out of area	370 (76.0%)	49 (89.1%)	48 (90.6%)	266 (73.5%)
In choosing in-patient preference, which of the following influenced your decision most?	Quality of care	130 (26.7%)	7 (12.7%)	7 (13.2%)	112 (30.5%)
	Convenience	44 (9.0%)	0 (0.0%)	5 (9.4%)	38 (10.4%)
	Confidentiality	257 (52.8%)	39 (70.9%)	34 (64.2%)	180 (49.0%)
	Stigma	32 (6.6%)	6 (10.9%)	4 (7.5%)	22 (6.0%)
	Other	21 (4.3%)	3 (5.5%)	3 (5.7%)	15 (4.1%)

Table 2. Preferences for disclosure and the factors influencing that preference.

		Factors influencing disclosure				
		Stigma	Career implications	Professional standing	Other	Total
Preference for disclosure	Family Physician	33 (22.6%)	57 (39.0%)	29 (19.9%)	27 (18.5%)	146 (100.0%)
	Family/friends	56 (28.1%)	71 (35.7%)	24 (12.1%)	48 (24.1%)	199 (100.0%)
	Colleagues	7 (13.7%)	17 (33.3%)	14 (27.5%)	13 (25.5%)	51 (100.0%)

Table 3. In-patient treatment choice and the factors influencing that choice.

		Factors influencing in-patient choice				
		Quality of Care	Convenience	Confidentiality	Stigma	Total
In-patient treatment choice	Local MH Facility	57 (56.4%)	39 (38.6%)	4 (4.0%)	1 (1.0%)	101 (100.0%)
	Out of area MH Facility	69 (19.4%)	4 (1.1%)	252 (70.8%)	31 (8.7%)	356 (100.0%)

Table 4. Previous experience of mental illness and out-patient treatment preference.

		Out-patient treatment preference				
		Informal prof. advice	Formal prof. advice	Self-medication	No treatment	Total
Previous experience of mental illness	No	69 (20.8%)	242 (72.9%)	17 (5.1%)	4 (1.2%)	332 (100.0%)
	Yes	14 (9.3%)	123 (82.0%)	8 (5.3%)	5 (3.3%)	150 (100.0%)

The >10 years group responded similarly to the 5-10 years group with regard to self-medication. There was also an association between attending group and in-patient preference (χ^2=12.66; df=2; p=.002; Cramer's V=.16). The >10 years group, although still largely in favor of out of area care, would be more likely than the other two groups to opt for local care. There was also a significant association between attending group and the factors influencing in-patient choice (Fisher's Exact =25.335; p=.001; Cramer's V=.16). As shown in Table 1, the >10 years group would be more influenced by quality of care and less influenced by confidentiality than the other two groups.

Finally, previous experience of mental illness was not associated with in-patient choice (χ^2=0.542; df=1; p=.462; φ=-.04), but it was associated with out-patient choice (χ^2=11.51; df=3; p=.009; Cramer's V=.16). As Table 4 shows, although both groups are more likely to opt for formal over informal advice, this pattern is more pronounced in the group who have had mental illness, than in the group who have not previously had mental illness.

Discussion

This is the first study to assess the attitudes of Canadian psychiatrists to becoming mentally ill themselves. As this study was carried out in one province of Canada and the results cannot be generalized across the country. There is a significantly large scope of research potential in this area especially among psychiatric residents and other healthcare professionals .[10]

Physician Impairment is any physical, mental or behavioral disorder that interferes with the ability to engage safely in professional activities.[11] Impairment among medical practitioners and psychiatrists in particular is a significant problem characterized by chronicity, under reporting and in many cases, poor outcomes.[12] However early detection, intervention and treatment programs that are more sensitive to the needs of impaired practitioners, that are more continuous, better structured, and rehabilitation and recovery focused may be more likely to produce a positive outcome. [13] It is extremely important to remember and advocate that although a physician may be mentally ill he/she is not necessarily impaired.

It is concerning that stigma continues to play a role in psychiatrists' decision making process to obtain mental healthcare. This is consistent with the findings of a survey in the USA which showed that half of all psychiatrists with a depressive illness would self-medicate rather than risk having mental illness recorded in their medical notes.[10] Both entertainment and news media provide a dramatic and distorted image of mental illness that emphasize dangerousness, criminality and unpredictability.[14] With this increased stigma doctors subsequently are concerned whether to disclose a mental health problem to their Licensing Boards for fear of being discriminated.[15] Studies of US medical licensing bodies have demonstrated a trend towards increasing stigmatizing approaches [16-19] and the concern is whether there is a similar trend in Canada.[9] Most psychiatrists in Canada are not aware what to expect from provincial colleges once their mental illness is disclosed and as a result tend to expect the worst. More work is needed by psychiatrists to inform the Provincial Colleges on physician mental health. Only then can the Provincial Licensing Colleges do more to assure physicians that the recovery model of treatment applies to them as it does other psychiatric patients.

The gap however continues to lie between 'I need help' and active psychiatric management. Psychiatrists will be well aware of the profound impact that such illnesses can have on a person's personal and professional competency. However to reflect it on oneself can at times be met with denial in the first instance. Dr. Mike Shooter (ex-President of the Royal College of Psychiatrists, UK) suffered from depression and he highlights the need to speak out and combat stigma. He points out the need to seek treatment early and how not doing so can adversely affect the doctor-patient relationship.[20] For some however the fear of stigmatization by health professionals for health professionals can lead to very tragic consequences. Dr. Suzanne Killinger-Johnson was a family physician with a psychotherapy practice in Toronto. She suffered from postpartum depression and in November of 2000 she jumped in front of a subway train cradling her son. Her son died instantly and Dr. Killinger-Johnson died 9 days later.[21]

Over the past 15 years a greater understanding has developed on the incidence, stressors and complications of physician mental illness. [22] The CPA published its first position paper on the mentally ill physician as early as 1984 with the latest version in 1997 currently under review. [22] The Canadian Medical Association should be congratulated on the most comprehensive strategy document for mentally ill physicians. Physician Health Matters - *A mental health strategy for physicians in Canada* was published by the CMA in February 2010. In addition to outlining the mental health of medical students, residents and physicians it addresses the current gaps in services and strategic direction needed to achieve 'optimal mental health for all physicians'. This sets out the necessary groundwork for institutions to implement based on current evidence. In Canada there was the inauguration of the position of 'The Bell Mental Health and Anti-Stigma Research Chair' with Queen's University in February 2012. [23] This position was offered to Dr. Heather Stuart, Professor of Community Health and Epidemiology. Stigma is a social process characterized by exclusion, rejection, blame or devaluation resulting from an adverse social judgment about a person or group. [24] There is a cultural pressure amongst physicians not to be sick so that one can provide care resulting in physicians unfortunately trying to control their own illness and treatment. [25] This concept is exacerbated for mental health issues and the stigma is

considerably attached to physicians acknowledging mental health issues or illness, as well as seeking help. [26]

Over the past decade the physician health community has been working to destigmatise physician mental health and to provide support services in this regard. All Canadian provinces have Physician Health Programs (PHPs) to help physicians with mental health difficulties. Referrals can be from physicians, families, colleagues, and self. [9] Physicians with psychiatric or drug dependence problems are referred from outside the PHP though the PHP (depending on the province) may or will be involved in monitoring the physician.

One of the most important factors influencing where a doctor is treated is the issue of confidentiality. [8] At present in Canada many hospitals are either switching or have switched to electronic patient records. Patient data in an electronic environment will be accessed from multiple portals by different professionals. This potentially poses serious concerns for psychiatrists if they have significant concerns around confidentiality of their record. A mechanism by which patients can access a list of professionals who have accessed their information may alleviate some concern regarding confidentiality.

Conclusions

Education surrounding mental illness in physicians needs to begin in medical school. Medical students require more assurance that seeking help for psychological problems will not be penalized. Junior doctors are receptive to education on physician impairment and substance misuse and this should be a mandatory component of their training. [27] Education and training of medical students and psychiatric residents to assess doctors as patients would make this scenario less taboo than it is currently perceived.

CPSO in liaison with relevant partners must develop a clear and concise document outlining steps the CPSO will take in helping the mentally ill physician. This document must be clearly advertised on the CPSO website to ease access and would reduce the catastrophizing interpretation psychiatrists (and physicians) may make to the CPSO's involvement with the mentally ill physician. By the CPSO taking a lead this will prove a stimulus for other provincial licensing colleges to follow suit.

The bridge from 'I need help' to 'I am getting help' is paved with multiple barriers. By addressing some of the concerns raised by psychiatrists will help the psychiatrist easily cross over.

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