Mental illness: stigmatisation and discrimination within the medical profession

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Foreword

Medical practitioners are often in the front line when helping people with mental health problems and mental disorders. It is crucial, therefore, that their assistance is not hampered by prejudiced attitudes or by lack of knowledge and skills with regard to the nature of mental illness. Doctors strive to provide a good service, but are not perfect.

We are delighted to have been major contributors to this joint report, and believe that, as doctors, it is important for us to get our own house in order as quickly as possible.

We regard this report as one vital part of the Royal College of Psychiatrists' 5-year national campaign to combat and reduce stigmatisation of people with mental disorders.

Such prejudice is still widespread within our society, and can generate an additional and unacceptable handicap.

Executive summary

Introduction

In 1998 the Royal College of Psychiatrists launched a 5-year campaign to combat stigmatisation of people with anxiety disorders, severe depression, dementia, schizophrenia, eating disorders, and drug and alcohol dependencies. The campaign aims to raise public and professional awareness of such stigmatisation, to change public attitudes through explanation, education, encouragement, persuasion, experience and example, and thereby to improve the lot of people with such illnesses.

This report addresses the issue of stigmatisation of people with mental illnesses by doctors and makes recommendations aimed at reducing it. The working party that has produced it for the Management Committee of the Changing Minds campaign is a joint one between the Royal College of Psychiatrists, the Royal College of Physicians of London and the British Medical Association, with close collaboration and representation from the Royal College of General Practitioners. Service users and members of the Department of Health also accepted invitations to join the group and the Royal College of Nursing sent an observer.

Background

There have been significant, positive changes in services for and attitudes towards people with mental illnesses in the past century, but further change is still required.

Population surveys indicate that the public at large believe that people with some mental illnesses are dangerous and that their troubles are self-inflicted. People with mental illnesses are generally regarded as difficult to communicate with.

Mental illness is common and people with mental illnesses present to all segments of specialist medical practice.

General practitioners (GPs) provide the gateway to medical services for people with mental illnesses. They see all such patients and, together with team members, treat the majority. Psychiatrists see the most severely mentally ill. General practitioners can spend up to 30% of their time on mental health issues but feel they often need more support and training in dealing with these areas. People presenting to their GPs with mental health problems feel able to confide in them, but 40% feel stigmatised and discriminated against. Other doctors, including psychiatrists, are also sometimes experienced by patients as prejudiced. It is likely that doctors' attitudes towards people with mental illnesses mirror those of the general population.

Multiple 'jeopardy' sometimes awaits the patient who is also elderly, from a different ethnic or cultural background, and so on.

It would appear that, within the postgraduate training of some groups of doctors, there is often little further training in those generic skills which underwrite competence in the assessment of people with mental illnesses.

Good medical practice

The Education Committee of the General Medical Council (GMC) requires all student doctors to study the environmental and social as well as the biological determinants of disease, to learn the importance of good communications with patients, relatives and other professionals, and to be able to examine the mental state of a patient.

The Committee also requires that all independent medical practitioners be able to assess psychosocial and personal histories of patients and to examine the mental state of a patient.

The Committee further requires that, within the context of this diagnostic approach to illness, respect be preserved for the uniqueness, dignity and rights of the individual.

Current education and training

All but three medical Royal Colleges/Faculties responded to an inquiry about their level of further training regarding people with mental illnesses. Such training is sometimes limited and was rarely reported as addressing attitudes.

Some medical Royal Colleges have indicated that they would welcome advice on how to educate doctors so as to eliminate any stigmatisation by them of people with mental illnesses.

Recommendations

Government, National Health Service (NHS) Trusts, the GMC, medical Royal Colleges, the British Medical Association (BMA) and other health care organisations should make clear statements about the unacceptability of stigmatisation; should promote campaigns to raise awareness of and to combat stigmatisation of people with mental illnesses by doctors; and should adopt procedures to ensure that discrimination, when discovered, is challenged and acted upon.

Related specific recommendations include the early mounting of a national conference on stigmatisation of people with mental illnesses by doctors, and liaison with the media, including professional journals, to encourage relevant coverage. We also suggest using the anticipated input from the campaign working parties currently considering schizophrenia, drug and alcohol addiction and origins of stigmatisation, and the variety of campaign tools already being developed. Further research into doctors' attitudes towards people with mental illnesses is required.

Medical schools, the GMC, medical Royal Colleges and postgraduate deaneries should ensure that existing guidance about the training of doctors in relation to attitudes towards and assessment of people with mental illnesses, including competence in examining the mental state, is implemented for all medical students and doctors. Related diagnostic labelling must not be at the expense of recognition of and respect for the uniqueness of the individual.

Specific guidance should be developed to ensure that the selection of medical students and doctors is not subject to discrimination on grounds of mental health problems. As with physical illnesses and disabilities, it should be based on a realistic assessment of the applicant's health and of any likely effect on his or her patients.

Systems should continue to be developed for identifying and dealing sensitively with medical students and doctors with mental health problems. An occupational health service for all doctors is essential.

Introduction

In 1998 the Royal College of Psychiatrists launched a 5-year campaign to combat stigmatisation of people with mental illnesses. Initial surveys uncovered widespread public misconceptions. People with mental illnesses often experience consequent 'distancing' and related discrimination. That is what the campaign is tackling.

The objective: changing minds

The Royal College of Psychiatrists' campaign title is **Changing Minds** (the aim): **Every Family in the Land** (reflecting the very common occurrence of such illnesses).

At the outset, the campaign committee initiated a survey of public opinions about people with mental illness (Crisp *et al*, 2000). This revealed a variety of opinions concerning six categories of mental illness:

- anxiety disorders
- depression
- schizophrenia
- dementia
- eating disorders
- drug and alcohol dependency

These common mental illnesses can be expected, in one way or another, to affect every family in the land.

Whereas the extent to which the public perceived these conditions as 'dangerous', 'self-inflicted' and 'treatable' varied considerably across these disorders, there was a common view that people with any kind of mental illness are 'difficult to communicate with', 'feel differently from others' and are 'unpredictable'.

Some of these perceptions contain elements of reality. For instance, people with mental illnesses sometimes present special difficulties when it comes to communication with them: a process essential, for example, to the clinical consultant. However, in the main such perceptions are exaggerated and indiscriminate and may be totally inaccurate. As a result of such public attitudes, the very many people with mental illnesses are even more isolated and disadvantaged.

The campaign aims to demythologise this situation by raising public awareness and by changing public attitudes through explanation, education, encouragement, persuasion, experience and example.

In the first instance, a number of target populations for the campaign have been identified, including employers, the media, children, young adults and health care professionals. Working parties were set up to consider and report back on possible ways forward in respect of each of these groups.

In order to address the matter of stigmatisation of people with mental illness by doctors, the campaign management committee decided to seek to establish a collaborative working group involving not only psychiatrists but also other willing groups of doctors. Consequently, the working group was a joint one between the Royal College of Psychiatrists, the Royal College of Physicians of London and the British Medical Association. The Royal College of General Practitioners was represented on the group. Two service users and members of the Department of Health also accepted invitations to join the group. The Royal College of Nursing agreed to send an observer (see p. 4).

The working group began its work in early 1999 and considered its remit to cover the whole spectrum of practice – from student selection, through curriculum content, to practice of different specialities and in continuing education of doctors. It has also considered prejudice on the part of doctors against colleagues (and prospective students) who have a history of mental illness.

The working group has reviewed the literature on these topics, but it decided not to embark on a research project of its own at this stage, chiefly because of the delay this would impose, but also because of practical obstacles and difficulties in obtaining funding. But the group has been mindful of the relevance of the key findings of the population survey already performed as part of the campaign. Moreover, a survey has been undertaken of psychiatrists' attitudes to people with schizophrenia.

The working group was aware that many who suffer from mental illness are in double or even multiple jeopardy of prejudice (e.g. racist, ageist, sexist, homophobic). Above all, it has considered what should be done about such bias. The intention is that this report should not merely describe how things are, but that it should be the agent of change. Hence the report offers practical proposals for action.

Background

People with mental illnesses are less misunderstood than they used to be. But understanding of the individual patient requires time and resources as well as appropriate knowledge and skills. Moreover, doctors in general may share the same range of attitudes towards mental health service users as the rest of the population at large – not always positive ones.

Terms of reference

- To acknowledge the difficulties that can arise in consultations with and care of people, including colleagues, with mental disorders
- To alert doctors to the temptation to stigmatise such individuals, and to the professional and clinical importance of not doing so
- To demythologise mental disorders and also to equip doctors with other fundamental up-to-date knowledge and skills concerning mental disorders This includes their proper basic assessment, enabling realistic and professional approaches and specialist referral when necessary, with particular reference to six such disorders
- Thereby also to improve the quality of communication concerning mental disorders between doctors and those suffering from them, and between doctors and carer and user groups
- Thereby to improve the day-to-day lot of those suffering from mental disorders and to maximise their chances of recovery

How doctors view mental illness

Papers published over the past several years have looked into various aspects of the attitudes within different sectors of the medical profession towards mental health and the doctors who specialise in caring for it. The selection reprinted here of excerpts, comments and vignettes of personal experience, both by doctors and by their patients, aims to sketch out the background and covers the six disorders embraced by the Changing Minds campaign.

The past serves as a gauge of progress

Attitudes to people suffering from mental illness have changed significantly, and for the better, since the days when individuals suffering from psychiatric disorders or suspected of doing so were put behind doors that were kept permanently locked. Although there is still much that should be changed, it is important not to forget the progress that has been made. No longer is there talk

of the 'lunatic asylum'. Patients with psychiatric illnesses are no longer necessarily treated in hospitals separate from those where medical and surgical patients are admitted.

The past century has seen a huge growth in the resources available for treating mental illness and in the quality of the settings in which treatment takes place. Research into the causes of mental illness is better funded than ever before, and there is greater understanding of the complex interplay between the physical, psychological and social factors that underpin mental illness. Many more physical and psychological treatments are available and there is a substantial evidence base that directs effective treatment. Within medicine, the status of psychiatry and of mental health is much improved. Teaching about mental health and the recognition and treatment of mental illness across the age range is a standard part of all undergraduate medical training.

The recent White Paper *Reforming the Mental Health Act* (Department of Health, 2000) will enable people with mental disorder to be treated in the community, but the Royal College of Psychiatrists has concerns that the broad definition of mental disorder could increase the number of people compulsorily detained in hospital.

It is clear from professional experience that, like the general public, not all doctors stigmatise or discriminate against people with mental illnesses. Many doctors, especially in primary care, have major commitments to this group of patients.

Our concern is the background of stigmatisation and discrimination that also clearly exists. This propensity among doctors extends to those working within psychiatry. Within psychiatry, prejudices concerning certain groups of mentally ill people sometimes exist (Lewis & Appleby, 1988).

People with mental illnesses are not the only ones with conditions that are stigmatised. Those with some physical illnesses and disabilities also attract stigmatisation, but this campaign addresses these matters specifically in relation to mental illnesses.

Excerpt 1

Personal accounts from doctors as well as from lay patients confirm that people everywhere are afraid of the stigma that is attached to mental distress. Here, a GP tells of how he or she reacted when challenged with his or her own prejudice. S/he was advising a mother whose son, 19, was developing schizophrenia:

> "[My patient] was distraught and through her tears she exclaimed, 'And what if it was *your* son?'
>
> It was one of my worst clinical moments. Was I to identify with her to ease her sense of isolation and confess that my son was the same, and had presented in a not dissimilar way just a year before; or was I to remain at a safe clinical distance and keep my secret?

In the split-second available for reflection on an unexpected question, I decided not to share. It was too close, too painful, and I was in danger of breaking down. So I made supportive noises and the consultation ended.

I have often wondered whether, had [my son] been disabled by loss of sight or a limb, I might have been more ready to identify with [my patient]. After all, schizophrenia is as common as diabetes in the young adult age group. What's the difference?"

Source: anonymous writer in 'Personal View', *British Medical Journal* (1997), **314**, 1559–1560.

General practitioners spend much time on mental health problems

Family doctors typically spend considerable amounts of their time on mental health problems, according to a survey by the Mental Health After Care Association (MACA, 1999). The survey, prepared for MACA by MJM Healthcare Solutions and published in October 1999, offered the most up-to-date snapshot of present realities in mental health care that was available as this working group's report was being compiled. It entailed distributing a questionnaire to nearly 2000 GPs in England, using a stratified random sample. Of 1966 questionnaires sent out, 325 usable forms were returned, a poor response rate, which may reflect the problem that we are trying to address. The survey is the first of its kind carried out nationally into mental health in primary care and "As a first survey, it inevitably raises more questions than answers" (MACA, 1999).

Key findings in the survey included the conclusion that correspondent GPs spend on average 30% of their time on mental health problems: the equivalent of a day and a half each week. Their training in mental health, and involvement in it beyond primary care, is limited.

Fewer than half the GPs (42%) were satisfied with the time they spend on mental health, with 34% wanting to spend more, although 24% would like to spend less time. In terms of their total available time, the GPs said they spent 15% on anxiety and depression, 5% on psychosomatic problems and 3% on mental health in the elderly. Drug and alcohol problems take up more time among urban GPs, while psychosomatic and elderly issues are a bigger concern for rural GPs.

More than one in two practices have attached community psychiatric nurses and counsellors, and one in 10 have access within the practice to a social worker, psychologist and psychiatrist. General practitioners placed great importance on community psychiatric nurses (CPNs), followed by social workers and home support workers – suggesting a strong inclination towards more joint working.

The MACA report suggests that the mismatch between GPs' volume of health care workload and support in the field should be met by increased training. It calls for the support of colleagues for GPs with an interest in mental health:

"Creating a supportive climate towards mental health is a critical Primary Care Group role and should include a PCG-wide support network" (MACA, 1999).

General practitioners feel that mental health care takes up more time than other health care issues do: "Many GPs who want to spend more time on mental health feel held back. Largely it seems to be because of the extensive time commitment required, which has a knock-on effect on their other practice workload. A strong feeling among those wishing to spend less time was exactly the same. They were concerned that mental health problems were having a detrimental effect on their ability to manage their overall workload" (MACA, 1999).

The survey concludes: "Mental health problems will continue to increase, and many GPs have flagged this up as a serious concern. If GPs are to be properly supported in dealing with this, then an urgent agenda for training, supporting and redistributing the workload is required" (MACA, 1999).

Excerpt 2

> Control was the key to anorexia for R.S. At 15, she felt she "was just a depressed teenager who felt that I had no control over my life. It was already mapped out for me".
>
> When she cut her calorific intake to 300 a day, "The main thing was that I was in control". But it got worse: "From being desperate for help, I'd become manipulative and deceitful. In my mind, the medical profession were a threat because they were trying to take away all I had – my anorexia".
>
> Suicide can seem the only way out. R.S. reports: "It is after taking overdoses of tablets that I have received the most stigmatisation. I viewed it as part of my illness, but the medical staff seemed to view it as a waste of their valuable time and a waste of a bed".
>
> *Source:* www.stigma.org

Excerpt 3

> A psychiatrist suffering depression was forced to seek help after an incident in which he delayed, until too late, a request from a dying colleague to see him. The psychiatrist says he felt: "I had failed him like I had failed everything. I had no right to inflict my failure on anyone else. It was time to give up".
>
> A therapist gave him pills: "pills meant illness and illness meant it wasn't my fault". Lessons hard learned by the psychiatrist include: "I am no more immune than anyone else. I was depressed then and … will always remain vulnerable".

It took the psychiatrist 6 months to pluck up the courage to write his story for public reading.

Source: Shooter (1996)

Excerpt 4

For research scientist J.A., diagnosed with schizophrenia, "One of the biggest frustrations in having a mental health problem is the way it is perceived by some as making me unable to take decisions about what is best for me.

"And when I question a decision that's been made, nobody listens. While I can understand this when I've been very psychotic and deluded, I resent it in my day-to-day life".

J.A. makes those comments with particular reference to doctors.

She adds: "Now my GP and I have come to a working arrangement that, if I want to, he will let me try something new. But then I have to stay with it for at least three months before I start complaining".

Being educated and articulate has been to her advantage.

Source: www.stigma.org

Excerpt 5

R.J. has nothing but praise for the medical professionals who helped him to overcome his combination of manic depression and schizophrenia. The attitudes of society around him were another matter.

He comments: "The doctors can do so much, but they are in the front line of attack. It is up to patients like myself to demonstrate the efficacy of the treatment and, when it comes to describing the various illnesses, to chase a few cobwebs of misunderstanding away. I am living proof that the system works". Stigma nevertheless dogs R.J.'s life: "You have to be able to take a joke. Stigma is often a cruel, destructive joke. Ignorance is equally bad".

Source: www.stigma.org

What other studies indicate

There is a dearth of good-quality evidence on the attitudes of doctors and other health care professionals towards people with mental illnesses. However, in this section we have attempted to summarise what evidence there is in light of the concerns of many users about their experience of stigmatisation.

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Mind, the mental health charity, has run surveys of patients' experience of discrimination and poor treatment by the health service; most recently, the *Not Just Sticks and Stones* report (Mind, 1996). For instance, one-third of patients considered that their GP has treated them unfairly. A recent survey, *Environmentally Friendly* (Mind, 2000), of patients' experience of psychiatric wards found disturbingly that the modern psychiatric wards were untherapeutic environments which had negative effects on patients' mental health.

More recently, another extensive survey (*Pull Yourself Together*, Mental Health Foundation, 2000, and see Chadda, 2000) has revealed similar findings. Nearly half the respondents felt discriminated against by their GPs, who were considered to be insensitive, dismissive and overly reliant on drugs for treatment. Psychiatrists and other health care professionals were also reported as sometimes discriminating negatively towards people with mental health problems.

For their part, GPs were found (Docherty, 1997) to be reluctant to confer a label of depression upon patients because of its stigmatising potential. This, even though depression is the least negatively regarded by the public of the six mental illnesses studied in the 'Changing Minds' campaign's 1998 survey.

Doctors are reluctant to acknowledge their own mental health problems. A recent BMA report has emphasised this point in relation to drug and alcohol dependency (BMA, 1998). The GMC's performance procedures and the local support networks that have been created may prove helpful in such matters.

Health professionals who have a family member or a colleague with a mental disorder keep quiet about it, just like the rest of the public (Lefley, 1987; Phelan *et al*, 1988).

Other studies show that doctors' attitudes can harden after a few years in practice. According to Sivakumar *et al* (1986), twice as many doctors at the end of the investigation as at the start found psychiatric patients 'not easy to like'.

Results vary where studies have examined the popularity of psychiatry as a speciality among medical students. Few follow up their subjects beyond a year or two. However, where stigma-based questions are posed, few respondents admitted holding prejudicial attitudes (Sierles & Taylor, 1995). No British study has compared medical students' attitudes with those of the public.

Psychiatry

Fleming & Szmukler (1992) questioned 352 medical and nursing staff. They found that these professionals widely blamed patients with anorexia and bulimia for their own conditions – far more so than for schizophrenia, but less than for overdose patients, whose troubles were rated 'self-inflicted'. Medical students' attitudes towards schizophrenia improved after their clerkship, but attitudes towards eating disorders stayed the same.

Blaming patients for their conditions made no difference to whether professionals liked those patients (Albrecht *et al*, 1982; Fleming & Szmukler, 1992). Lewis & Appleby (1988) found that psychiatrists disliked people labelled

with 'personality disorder' (not covered in this report) compared with patients who showed similar symptoms but had no label. Ageist attitudes among professionals are also described (Bytheway, 1995).

Prejudices: multiple jeopardy

Some patients face multiple forms of discrimination on account of mental illness, especially when there is comorbidity such as personality disorder, but often also because of race (doctor and patient often come from different ethnic groups), age, gender or sexual orientation; or because of the nature of the illness, as when the patient may be perceived as blameworthy or dangerous; or because of social class. To such a list we might add features such as homelessness or personal appearance – mode of dress, say, or hairstyle, or tattoos or body piercing. When there is social distance between doctor and patient, prejudice very easily slips in.

People who have ever had contact with mental health services have a mean 8.8 years' shorter life expectancy than controls (Dembling *et al*, 1999). There are several possible explanations for this but the isolation from the health care system that accompanies stigmatisation of mental illnesses may be a contributory factor. Some patients with serious mental illness have been shown to have unhealthy lifestyles, but what seems to happen is that doctors, including psychiatrists, 'give up' on these individuals (Browne *et al*, 1999). For instance, relegated to second-class status, such patients can be refused heart transplants (Phipps, 1997; Byrne, 2000).

The assumptions

The Changing Minds campaign survey shows that the population at large believes people with some mental disorders are dangerous; that their troubles are often self-inflicted; and that it is difficult to communicate with sufferers.

There is no doubt that the perceived risk of violence, in addition to perceived difficulty in communication, is a major factor in maintaining social distance from the stigmatised. Violence to doctors is a real issue, and is given a high profile inside and outside professional contexts. Such violence is often mistakenly associated with schizophrenia and realistically associated with some types of drug and alcohol misuse. Such perceptions can spread to embrace the very many other people with mental health problems and thereby reinforce and perpetuate the prejudice, discrimination and distancing they experience.

Research has shown that half of all people with schizophrenia have been shown to be short of social skills, and that is probably true of several other mental illnesses. There is therefore some basis for the idea that patients are 'hard to talk to'. However, failure by doctors to communicate with psychiatric patients is a major obstacle to reducing stigma.

With doctor–patient communication also being the essential ingredient for consultation and diagnostic processes, it can be seen that professional competence

in this difficult arena can be seriously jeopardised and the seeds of distancing sown.

Negative attitudes do not necessarily depend on attributing blame (Fleming & Szmukler, 1992). Traditionally, doctors have had no difficulty in treating self-inflicted sports injury or sexually transmitted disease.

Surveys of public attitudes surprisingly showed general optimism by the public as to the outcome of mental disorders (Crisp *et al*, 2000).

Attitudes of psychiatrists towards people with mental illnesses have been patchily studied. In the past, one of the few studies undertaken (Roskin *et al*, 1988) showed North American psychiatrists to be authoritarian compared with other health care professionals. We doubt whether that finding would be replicated so emphatically in the UK today. In that respect, hypotheses that relate prejudice to authoritarian attitudes are noteworthy (Adorno *et al*, 1950). Identification with stereotypes predicts negative attitudes (Lyons & Ziviani, 1995), especially when the stereotype is based on threat or a focus on deficits.

A survey of UK psychiatrists' attitudes to people with schizophrenia, in particular, has been conducted and the data were being analysed at the time of writing this report. Meanwhile, research to date suggests that doctors at large share the public's overall stereotypical images of people with mental illnesses.

Excerpt 6

> Doctors can be inconsiderate sometimes with dementia patients, as B.P., who looks after her husband, a sufferer, explains.
>
> "All dementia patients understand more than they can say, but when my husband's ability to speak coherently began to disappear, there were numerous occasions when he became excluded from conversations, and not a single word was addressed to him personally. Or he was talked about as though he was not there, even by doctors".
>
> B.P. relates an incident that took place while her husband was having respite care in a mental hospital: "I was called to a meeting of doctors and senior nurses because one of the younger staff had made a complaint that my husband had touched her face and T-shirt. This was deemed to be sexual harassment. In disbelief I pointed out that when people are losing their speech, how else can they convey 'Thank you' except by touch?".
>
> *Source*: www.stigma.org

Footnotes

Although the focus of this report is stigmatisation by doctors of patients with mental illnesses, it is a related concern that psychiatry itself is sometimes stigmatised within medicine.

What medical students think about psychiatrists

Psychiatrists are regarded by medical students as interested in people, but as unclear thinkers and emotionally unstable (Buchanan & Bhugra, 1992). Psychiatric patients were regarded by students and doctors alike as 'not easy to like'. Psychiatry as a vocation was regarded by students as unscientific, imprecise, ineffective and low in status.

What psychiatrists think about psychiatry

Psychiatrists feel undervalued in their speciality, according to an article in *Academic Medicine*, February 1996. A survey of 5700 members of the American Psychiatric Association, which achieved a 30.5% response rate, divided its sample into junior (in practice for 15 years or fewer) and senior psychiatrists. The authors commented: "Even though most psychiatrists (80 per cent) in both groups felt that their profession was very important, a considerable number (45 per cent) felt that other medical specialists perceived psychiatry as a less-than-moderately important speciality" (Berman *et al*, 1996).

The way doctors think?

As long ago as 1966, Walton defined a typology of students and doctors: the 'physically minded', who have little tolerance of uncertainty and who yearn for 'closure', and the 'affective' or 'psychologically minded', who are able to accept and who even warm to the uncertainties and subjectivities inherent in 'human' problems. Those potentially contradictory styles accord respectively with convergent/reductionist and divergent/lateral thinking (Crisp, 1984). Good clinicians may need to develop both attributes and also sufficient insight to deploy them appropriately in the best interests of patients, especially when involved in a clinical subject as complex as psychiatry.

Good medical practice

Doctors' attitudes are important to their professional competence. They need enough self-awareness to be able to monitor their own attidues and, if needs be, correct them.

Knowledge, skills and attitudes

The training of independent medical practitioners involves both university and vocational elements and embraces the development and maintenance of high standards of relevant knowledge, skills and attitudes.

The main task of this working group has already been identified as to change attitudes of doctors to people with mental illness when these are less than properly professional, and it has generated a series of Recommendations (see pp. 25–28).

Attitudes are a component of individual personality but in medical practice they are also underwritten by appropriate professional competence and by professional expectations and requirements concerning conduct.

The GMC has a long-held statutory responsibility to the public to ensure high standards of such undergraduate and pre-registration medical training. In the Medical Act 1978, its task was redefined as "the general function of promoting high standards of medical education and co-ordinating all stages of medical education". It was now deemed to have a similar relationship to the medical Royal Colleges, Faculties and higher training committees as it has always done to the universities and other licensing bodies in respect of undergraduate medical education.

The GMC's Education Committee began to exercise its coordinating function by considering the training of specialists, with particular reference to the means by which the knowledge, skills and attitudes that are generic to the practice of medicine, and are introduced in basic medical education, might be applied to this later stage of education. It consequently published *Recommendations on the Training of Specialists* in 1987. These recommendations recognised the primary role of the specialist training bodies and were restricted to the identified generic competencies. To this end, the Committee first identified 12 basic attributes considered necessary for independent medical practice. Attribute 4 covered the realm of specialist practice (i.e. the domain of specialist postgraduate training bodies) and was not considered further. The 12 attributes are listed in Appendix 1 with those elements highlighted that bear most directly upon the concerns of this report.

The 1987 Recommendations thereafter elaborate on several key and topical aspects of this expected generic knowledge, skills and attitudes. Three especially relevant paragraphs are quoted within Appendix 2. Thus, within Appendices 1

and 2 it is recommended that all practising doctors should have a basic knowledge of the role of psychological and social factors in health and disease and of mental illness. Further, they should have insight into their own temperaments and, relatedly, possess communication skills sufficient to enable them competently to assess the psychosocial and personal histories of patients and their families, effectively examine the individual's mental state, and properly conduct themselves professionally. Such competencies enabling good communication with patients with mental illnesses, are likely to reduce prejudices, otherwise consequent on distancing.

In 1993, the GMC published its recommendations on undergraduate medical education, *Tomorrow's Doctors*. Those recommendations included a restatement of the attributes of the independent practitioner as described above. These are mostly embedded in *Good Medical Practice* (GMC, 2000), the standards which will define acceptable and unacceptable clinical practice relevant to the new process of revalidation.

They also stressed the importance of student doctors also learning about the environmental and social as well as biological determinants of disease, the importance of good communication with patients, relatives and other professionals, and the requirement that all qualifying doctors be able to assess an individual's mental state.

Audit: keeping track of doctors' skills

Audit of medical training differs between its undergraduate and postgraduate elements.

At an undergraduate level, medical schools have internal auditing systems in place and these are monitored by a system of external examiners, always appointed to the final professional examinations but also sometimes to wider aspects of the course. This process is overseen in turn by the Education Committee of the GMC with its statutory powers of general information-gathering concerning the curriculum and of inspecting medical schools and their final professional examinations.

At the immediate postgraduate level there has, until recently, been something of a grey area at what is a formative period of medical education. However, the GMC and postgraduate deaneries have recently taken a much clearer lead in ensuring appropriate training at this important stage of a young doctor's career.

At the level of specialist training and continuing professional development, the GMC's background role in respect of 'recommending' further development and maintenance of a range of generic competencies (importantly relevant to this working group's task) has already been referred to. However, the governance of this specialist education and training is the responsibility of the specialist medical Royal Colleges and their related training committees.

Extensive systems of inspection and recognition of adequate training posts are in place. In addition, higher professional qualifications and recognition of

completion of training relate to identified curricula, which will usually continue to address medical competence fully in terms of knowledge, skills and attitudes.

Recent developments, such as the GMC proposals for revalidation and, in England, the Chief Medical Officer's proposals for yearly appraisal, are indicative of current public and professional concerns to ensure maintenance of professional competence among independent medical practitioners.

Labelling: potential for stigma, distancing and bias

The medical model of disease, which is inherent in the Changing Minds campaign, carries at least two distinct meanings, both of which have potential for generating in the patient the experience of shame or of being stigmatised, not only for those with mental illnesses, but also sometimes for those with physical illnesses or disabilities.

For many, the term 'medical model' is synonymous with invasive/physical methods of treatment. So far as 'bodily' disease is concerned, such approaches, although potentially disempowering, can be greatly valued by the public or the individual if powerfully restorative or life-saving, and even when they are simply protective of health. With mental illnesses, such an exclusively physical approach can be experienced as especially disempowering and endorses a diagnostic 'label', which can reinforce stigma. More fundamentally, the medical model is identified with a classificatory (labelling) approach to disease. Hallowed by time, this enables doctors to identify a given condition and thereby attempt to predict outcome for the afflicted person, and to predict the effects of a particular treatment, which can be either physical, psychological or social.

With 'bodily' disease, the diagnosed illness is often perceived as an infliction upon the person concerned, whose autonomy and individuality remains respected. The diagnosis of mental illness, sometimes perceived in a reductionist way as 'brain' disease (despite expressing itself through the mind and, in some cases, apparently related to personality, relationships and life events), carries a special potential for losing sight of the person as a unique individual.

Some mental illnesses (as with some physical illnesses) additionally are perceived judgementally by others as self-inflicted; the terms 'drug/alcohol misuse' and 'abuse' have such judgmental connotations.

The diagnostic approach to mental illness can often be defended on the grounds of its value in management and treatment. Its potential also for stigmatising the afflicted person with a compartmentalised descriptive label that fails to acknowledge and respect his or her personal uniqueness, must be prevented. This requires – especially in respect of mental illness – professional sensitivity, clinical and philosophical skills, adequate consultation time and a perspective by the doctor that transcends any narrow approach to disease.

Current education and training

Currently, education and training is highly variable after graduation. Of the 14 specialist Colleges and Faculties contacted for information about their approach to the training of doctors concerning the stigmatisation of people with mental illnesses (Appendix 3), replies were received from all but three. On the whole, responses varied in relation to whether or not the speciality concerned was clinical.

All Colleges and Faculties reported some relevant training, sometimes restricted to the teaching of basic communication skills. There was seldom reference to whether or not the role of attitude and the ability to examine mental state was addressed in such training. Several medical Royal Colleges emphasised the importance that they attached to the education of trainees in mental health and mental illness matters, and provided details of such training.

The enquiry was generally welcomed. Some Colleges or Faculties were especially alert to the fact that the enquiry specifically concerned the matter of prejudice and stigmatisation.

Most Colleges (including the Royal College of Psychiatrists) indicated that they would welcome more advice on how best to address prejudice and stigmatisation within the constraints of their various and busy training programmes.

The Doctors' Support Network

Doctors themselves can be patients and can be stigmatised. Confidential assistance with self-help for doctors with mental health problems has been available only since the mid-1990s with the advent of the Doctors' Support Network (DSN). The DSN was set up when a doctor (anonymous), struggling with a physical illness, a mental illness and an addiction started looking for support. He found that no framework existed for a doctor in his situation – particularly with regard to mental illness. He contacted other doctors with mental health problems and DSN came into being.

The strength of DSN lies in its emphasis on peer support (thus avoiding the occupational health department) and on anonymity – many of the 200 doctors in touch with the network use only their first names. However, the DSN makes itself known through the very courageous standing-up of a few members who are public about their mental illness. Those members write for journals, occasionally newspapers and give media interviews.

The DSN has a 24-hour answerphone on: 07071 223372.

Excerpt 7

Alcohol-dependent A. has been twice successfully detoxified, but his GP is no longer willing to treat him. The GP regards his alcoholism as entrenched and self-inflicted, while A. himself regards his alcoholism as a lifetime curse. A. comments:

"I hate drink – but it's not that. What is worse is what it makes me – you look around you, and no one cares that once you were all right, you had plans, hopes, respect. But you can't respect yourself when the distaste of the work is writ large on every face you see – when your wife stays because of pity and a misplaced sense of duty, and when the only person who despises you more comes when you forget to avoid the mirror. There's nothing wrong with drinking – but there's something wrong with me".

Source: www.stigma.org

Recommendations

The task is huge – but that must not be an excuse for not beginning. Dealing with prejudice on the part of doctors against patients, medical students, juniors, and colleagues with a history of mental illness is a challenging task. Changing prejudiced attitudes is not easy and requires concerted action by the profession as a whole. In some cases, clear statements and recommendations concerning these matters have already been made by the bodies involved. However, in other areas clear guidance is lacking, and in some there is a need to ensure the implementation of existing guidance.

We present here a list of recommendations that, if implemented, we believe would enable considerable progress to be made. These recommendations aim to combat prejudice by changing minds through the process of selection and education of doctors. They also seek to promote procedures that will militate against prejudice by auditing and identifying prejudicial decisions and attitudes and preventing decision-making directed by prejudice. The working group has given some thought to the means by which these recommendations could be put into practice and some illustrations are contained in Appendix 4.

1. Creation of an 'anti-prejudice' climate

Unequivocal statements, procedures and action by:

(a) Government
- Anti-discrimination and disability legislation potentially includes mental illness as a category (the Disability Discrimination Act 1995 and the setting up of the Disability Rights Commission). This provision must be seen to operate effectively for those disabled by mental illnesses
- The Department for Education and Employment's Disability Awareness Campaign is most welcome and can usefully feature people with mental illnesses, including doctors and other health care professionals. Clear guidance to managers for addressing the professional problems of doctors with mental illnesses should be developed
- In March 2001 the Department of Health launched a major new campaign, 'MIND OUT for mental health' to stop the stigma and discrimination surrounding mental health

(b) NHS Executive
- The National Service Framework for Mental Health should help in tackling the stigma associated with mental illness. In particular, Standard One requires health and social services to promote mental health for all, working

with individuals and communities and to combat discrimination against individuals and groups with mental health problems and to promote their social inclusion

(c) NHS trusts
- should treat mental illness as they presently treat race, gender, age etc. in all policy and procedures

(d) GMC
- should include mental illness as a category that should not prejudice treatment in section 12 of *Good Medical Practice* in 'Duties of a Doctor'
- should publicly declare that promulgating or acting on stigmatising attitudes will be regarded as a form of professional misconduct

(e) Medical Royal Colleges
- should formally adopt anti-discriminatory policies and awareness campaigns
- should publicly state to their members that this is an issue they take seriously

(f) BMA
- should formally adopt anti-discriminatory policies and awareness campaigns

2. Teaching and learning

Organisations with responsibility for training and accreditation should develop clear guidance concerning the need for all doctors to acquire knowledge and skills related to recognition and management of mental illnesses, comparable to those required in respect of all other illnesses.

(a) GMC
- The GMC has statutory responsibility to coordinate all stages of medical education and should ensure that this is achieved in respect of people with mental illnesses. Specifically:

(b) Medical schools
Should ensure:
- that communication skills, including the ability to listen, are taught effectively – these will be especially tested when the doctor and patient come from different ethnic groups or cultures
- competence in examining an individual's mental state, which should be comparable to competence in examining an individual's physical state

- that respect for the uniqueness of the individual is sustained and that he or she is not regarded only as diagnostic label – the doctor should be able to recognise the person suffering from an illness at all times, and register and relate to that person
- corresponding recognition that the clinical encounter between a person with mental illness and a doctor can itself sometimes be a powerful instrument for favourable or unfavourable change in the patient's condition, and that it is the doctor's responsibility to maximise the potential for benefit. To accomplish this, student doctors need to develop insight into their temperaments such that they can guard against any tendency to reinforce patients' fears of personal disclosures and experience of stigmatisation
- the ability to carry out mental state examination as part of pre-registration house officer appraisal

Should:
- use input from people with mental illnesses

(c) Medical Royal Colleges

Should ensure that all doctors, as part of specialist training and as part of continuing professional development:
- remain able to examine the mental state, recognise mental health problems where they exist and either institute appropriate treatment or refer to the appropriate specialist, and to this end, participate in cross-speciality and multi-professional learning within training schemes (e.g. case conferences/ patient reviews and liaison psychiatry practice)
- retain respect for the uniqueness of the individual as distinct from the diagnostic label
- recognise the importance, in the clinical situation, of their own attitudes to mental illnesses and, if necessary, control these in the interests of patients with such illnesses

Should:
- ensure that people with a background of mental illness are not discriminated against in their recruitment or employment procedures
- link with mental health groups to help inform relevant policies and develop related educational strategies and audit

(d) Postgraduate deaneries

Should ensure:
- that all professional education within their remit pays similar, appropriate attention to the problem of stigmatisation of people with mental illnesses

(e) The medical press

Should:
- challenge stigmatising material

- run series' of articles on the extent and effects of prejudice against mental illness
- publish first-hand accounts by people with mental illnesses
- provide appropriate training and audit journalistic activity
- avoid using stigmatising language

(f) Medical journals
Should publish:
- research, reviews and personal views relevant to stigma
- educational packages relevant to stigma
- first-hand accounts by people with mental illnesses

3. Selection of doctors

Good practice with regard to selection of students and of junior and senior doctors should include avoidance of prejudice on grounds of mental health problems, past or present. It should be based on a realistic assessment of the applicant's health and of any likely effect on their patients.

This initiative should be targeted at medical schools, NHS trusts, medical Royal Colleges and postgraduate deaneries, health authorities/boards, etc. and general practices.

4. Identifying doctors with mental health problems

Systems should continue to be developed for identifying and dealing sensitively with medical students and junior and senior doctors with mental health problems. An occupational health service for all doctors, including general practitioners, is needed.

This initiative should be targeted at medical schools, NHS trusts, postgraduate deaneries, health authorities/boards etc. and general practices as part of the clinical governance agenda.

5. Governance of such a campaign as 'Changing Minds: Every Family in the Land'

A campaign of this kind needs an agreed central organisation and structure in order to take forward these recommendations. Its tasks include ongoing communication with the involved institutions; coordination of development and provision of more detailed professional and educational guidelines; and monitoring of progress.

> *Note: The working group recognises that some of the recommendations require additional resources for their implementation; others will not. The group was not required to identify the resources, nor was it equipped to do so. That task must fall to those carrying such recommendations forward.*

Appendix 1

Attributes of the independent practitioner (excerpted from GMC, 1987, with permission)(italic type is emphasis in original; bold is emphasis for the purposes of this report only)

15   Joint Higher Training Committees, Royal Colleges and their Faculties have identified the aims of training in their own specialties. These include the acquisition of specialised knowledge and skill in the relevant preventive, clinical, laboratory, management, administrative, teaching or other fields to the point where the doctor is competent to accept and exercise the highest level of responsibility in a particular specialty.

16   Nevertheless, all doctors share a common role in the prevention or alleviation of disease or distress through appropriate intervention. Education and training for specialties should not only include acquisition of the technical knowledge and skills of a particular specialty or its branches, but also development of the attributes set out below; together they contribute to a doctor's professional development.

(1)   *The ability to solve clinical and other problems in medical practice*, which involves or requires:
    (a)   an intellectual and temperamental ability to change, to face the unfamiliar and to adapt to change;
    (b)   a capacity for individual, self-directed learning; and
    (c)   reasoning and judgement in the application of knowledge to the analysis and interpretation of data, in defining the nature of a problem, and in planning and implementing a strategy to resolve it.

(2)   *Possession of adequate knowledge and understanding of the general structure and function of the human body and workings of the mind, in health and disease, of their interaction and of the interaction between man and his physical and social environment.* This requires:
    (a)   knowledge of the physical, **behavioural**, epidemiological and clinical sciences upon which medicine depends;
    (b)   understanding of the aetiology and natural history of diseases;
    (c)   understanding of the impact of both **psychological factors** upon illness and of illness upon the patient and the patient's family;
    (d)   understanding of the effects of childhood growth and of later ageing upon the individual, the family and the community; and
    (e)   understanding of the **social, cultural and environmental factors** which contribute to health or illness, and the **capacity of medicine to influence them**.

(3) *Possession of consultation skills*, which include:
    (a) skills in sensitive and effective communication with patients and their families, professional colleagues and local agencies, and the keeping of good medical records;
    (b) **the clinical skills necessary to examine the patient's** physical and **mental state** and to investigate appropriately;
    (c) the ability to exercise sound clinical judgement to analyse symptoms and physical signs in pathophysiological terms, to establish diagnoses, and to offer advice to the patient, taking account of physical, **psychological, social and cultural factors**; and
    (d) understanding of the special needs of terminal care.

(4) *Acquisition of a high standard of knowledge and skills in the doctor's specialty*, which include:
    (a) understanding of acute illness and of disabling and chronic diseases within that specialty, including their physical, mental and social implications, rehabilitation, pain relief, and the need for support and encouragement; and
    (b) relevant manual, biochemical, pharmacological, psychological, social and other interventions in acute and chronic illness.

(5) ***Willingness and ability to deal with*** *common medical* ***emergencies*** *and with other illness in an emergency.*

(6) *The ability to contribute appropriately to the prevention of illness and the promotion of health*, which involves:
    (a) understanding of the principles, methods and limitations of preventive medicine and health promotion;
    (b) understanding of the doctor's role in educating patients, families and communities, and in generally **promoting good health**; and
    (c) the ability to identify individuals at risk and to take appropriate action.

(7) *The ability to recognise and analyse ethical problems so as to enable such patients, their families, society and the doctor to have proper regard to such problems in reaching decisions*; this comprehends:
    (a) knowledge of the ethical standards and legal responsibilities of the medical profession;
    (b) understanding of the impact of medico-social legislation on medical practice; and
    (c) **recognition of the influence upon his or her approach to ethical problems of the doctor's own personality and values**.

(8) *The maintenance of attitudes and conduct appropriate to a high level of professional practice*, which includes:

(a) recognition that a blend of scientific and **humanitarian approaches** is required, involving a critical approach to learning, open-mindedness, compassion, and concern for **the dignity of the patient** and, where relevant, of the patient's family;

(b) recognition that good medical practice depends on partnership between doctor and patient, based upon **mutual understanding** and trust; the doctor may give advice, but the patient must decide whether or not to accept it;

(c) commitment to providing high quality care; awareness of the limitations of the doctor's own knowledge and of existing medical knowledge; recognition of the duty to keep up to date in the doctor's own specialist field and to be aware of developments in others; and

(d) **willingness to accept review**, including self-audit, of the doctor's performance.

(9) *Mastery of the skills required to work within a team and, where appropriate, assume the responsibilities of team leader*, which requires:

(a) recognition of the need for the doctor to **collaborate** in prevention, diagnosis, treatment and management **with other health care professionals** and with patients themselves;

(b) understanding and appreciation of the roles, responsibilities and skills of nurses and other health care workers; and

(c) **the ability to lead, guide and co-ordinate** the work of others.

(10) *Acquisition of experience in administration and planning*, including:

(a) efficient management of the doctor's own time and professional activities;

(b) appropriate use of diagnostic and therapeutic resources, and appreciation of the economic and practical constraints affecting the provision of health care; and

(c) willingness to participate, as required, in the work of bodies which advise, plan and assist the development and administration of medical services, such as NHS authorities, Royal Colleges and Faculties, and professional associations.

(11) *Recognition of the opportunities and acceptance of the duty to contribute, when possible, to the advancement of medical knowledge and skill*, which entails:

(a) understanding of the contribution of research methods, and interpretation and application of others' research in the doctor's own specialty; and

(b) willingness, when appropriate, to contribute to research in the doctor's specialist field, both personally and through encouraging participation by junior colleagues.

(12) *Recognition of the obligation to teach others, particularly doctors in training,* which requires:

(a) acceptance of responsibility for training junior colleagues in the specialty, and for teaching other doctors, medical students, and other health care professionals, when required;

(b) recognition that teaching skills are not necessarily innate but can be learned, and willingness to acquire them; and

(c) **recognition that the example of the teacher is the most powerful influence upon the standards of conduct and practice of every trainee**.

Appendix 2

The inclusion in specialist training of content common to training in all specialties (excerpted from GMC, 1987, with permission)

Communication skills

20   The consultation is fundamental to clinical medical practice and depends on successful communication between doctors and patients. Good communication requires time. It also calls for understanding by the doctor of his or her own temperament. It involves the capacity to take a good clinical history, to listen to the patient in a way that enables the patient to talk openly and the ability to explain concisely and sensitively, in simple language, the salient features of the patient's illness and any risks or disadvantages inherent in the treatment proposed. It also requires a capacity to assess the patient's understanding of the explanation so that he or she can, where appropriate, decide whether to proceed. Appreciation of the special needs of ethnic minorities is essential to good communication in our multi-racial society. Some aspects of communication may be non-verbal, such as the doctor's manner during the consultation. Communication is also fundamental to the counselling and psychotherapy skills in which doctors in clinical practice may often need to engage, most obviously in specialties such as general practice, psychiatry and obstetrics and gynaecology.

Problem solving

27   Problem solving is fundamental to the doctor's responsibilities. Specialty training programmes should demonstrate the variety and diversity of problems which are encountered. The trainee should be challenged, as training proceeds, with more complex problems which demand the integration of knowledge, skills and attitudes as they develop.

Knowledge and skills which cross specialty boundaries

28   Specialist training should reinforce other knowledge and skills introduced in basic medical education and in which all doctors should be proficient, regardless of specialty. They include the detection and consequences of abuse of alcohol and other drugs, the relevance of nutrition to health and disease, good prescribing practice and understanding of the hazards of iatrogenic illness. It is also important for doctors to be willing and able to examine in depth the many ethical problems now confronting medicine and society, and to have an understanding of the forensic aspects of medical practice.

Appendix 3

Medical Royal Colleges/Faculties approached with an enquiry about programmes of continuing generic education concerning mental illnesses, especially in respect of related attitudes

Royal College of Anaesthetists
Royal College of General Practitioners
Royal College of Obstetricians and Gynaecologists
Royal College of Physicians, Edinburgh
Royal College of Ophthalmologists
Royal College of Pathologists
Royal College of Physicians, London
      Faculty of Occupational Medicine
      Faculty of Public Health
Royal College of Psychiatrists
Royal College of Radiologists
Royal College of Surgeons of England
Royal College of Surgeons of Edinburgh
Royal College of Surgeons and Physicians of Glasgow

Appendix 4

Some specific methods for bringing about change

Government

The Department of Health, through its Impact Strategy, aims to work in partnership with service users and other agencies to educate the general public about mental health issues with a view to reducing discrimination, improving the lives of people with mental health problems, and contributing to a reduction in suicide rates.

The Department and its regional organisations, the political leaders and administrators of the National Health Service, have recently also reinforced their intentions to address the stigmatisation of people with mental illnesses. They can be invited to endorse the Royal College of Psychiatrists' campaign, Changing Minds: Every Family in the Land, in spirit and with financial help in relevant areas (e.g. core funding for implementing the present proposals) and in helping to get the messages across to individual doctors through factsheets and other materials.

Conference

A high-profile conference addressing issues of stigmatisation within the health care professions could be organised now in conjunction with the Department of Health and with invited participation from the Changing Minds campaign, the professions, user and carer groups, the Department for Education and Employment and the press.

Medical Royal Colleges

Medical Royal Colleges could modify specialist training and continuing professional development programmes to ensure that sufficient attention is paid to issues of stigma and mental health. Attention should be paid to the development of appropriate knowledge, skills and attitudes and, where necessary, changes could be made to assessment and audit processes.

Professional journals

Editors of medical journals, both general and specialist, could commission articles on the topic of stigmatisation of people with mental illness by doctors. The *British Medical Journal*, which probably reaches the largest segment of the medical profession, could play one key educational role, if willing.

Research

Funding could be identified for further research into issues of stigmatisation including baseline measures of doctors' attitudes and also of patients' perceptions.

'General public attitudes to mental health/illness', the recent Department of Health literature survey about the stigmatisation of people with mental illness (Department of Health, 1999), commented that despite a number of surveys concerning the public's opinions and behaviour towards people with mental illness, there was no research or apparent understanding of the mechanisms underlying people's propensities in this regard. Such fundamental research is long overdue.

Input from other campaign working parties

Working parties charged respectively with exploring 'The Origins of Stigmatisation' and with making proposals for tackling 'Stigmatisation in the Workplace' will be reporting. Such proposals may interact helpfully with this project.

Other tools

Educational videos (a 14-minute Changing Minds campaign video now exists); film trailers (a 2-minute movie for presentation in cinemas nationwide has been developed); pamphlets (specific campaign booklets have been produced and are being revised prior to reprinting and display on the Royal College of Psychiatrists website: http://www.rcpsych.ac.uk); this and other relevant internet sites, e.g. http://www.stigma.org/everyfamily and http://www.emental-health.org.

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