Confronting Physician Attitudes Toward the Mentally Ill: A Challenge to Medical Educators

Medical professionals' negative attitudes toward patients with mental illness and substance abuse disorders can have negative consequences, and these attitudes are not rare. In surveys, patients have reported discrimination in mental health settings in the 16% to 44% range and 17% to 31% in physical health settings.[1] More concerning than the perceived stigma experienced by patients is the potential for bias in medical decision making. For example, health care providers are less likely to refer people with mental illnesses for a mammogram, less likely to admit them for hospitalization after a diabetic crisis, and less likely to perform a cardiac catheterization.[2] Stigmatizing beliefs also affect clinical decisions through diagnostic overshadowing, attributing physical symptoms to the mental condition and consequently not investigating or treating them.[3] Although evidence suggests that patients with mental illnesses are no less likely to be adherent to treatment recommendations than others, health care professionals who endorsed more stigmatizing attitudes about mental illness were more likely to be pessimistic about the likelihood of patients adhering to treatment, and this contributed to impaired decision making.[4]

There has been considerable effort to develop curricula to enhance trainees' competence in caring for people with mental health and substance abuse concerns. Less formal attention has been given to trainees' implicitly held attitudes toward these vulnerable populations. We believe that assessing and addressing these attitudes falls under the professionalism competency, and as such, is our responsibility as medical educators.

There are emerging resources available to assist medical educators in addressing this issue. Knaak and colleagues[5] outlined 6 key components of successful stigma-reducing interventions for health care providers. Corrigan[6] outlined a strategic stigma change model, which can be adapted for medical education. Both approaches place a high value on contact *outside of the clinical relationship* between health care providers and mental health consumers, due to the impact such contact can have on beliefs about mental illness.

Attitudes are not easily changed. However, their impact on patient care and patient outcomes for vulnerable populations requires that medical educators take active steps toward helping our trainees examine how their attitudes may influence their clinical decision making. We challenge the graduate medical education community to think creatively about augmenting trainees' rotation experiences to better allow for the examination and exploration of stigma-oriented attitudes and beliefs.

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