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Reducing Barriers to Mental Health Care for Physicians
An Overview and Strategic Recommendations

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IMPORTANCE Mental health challenges among physicians represent a critical public health issue with profound implications for health care delivery and workforce sustainability. Despite the proven effectiveness of mental health treatment in improving outcomes, most physicians with mental health conditions do not seek help. This treatment gap is particularly concerning given that physicians experience elevated rates of burnout, depression, anxiety, and suicide risk compared with the general population, with resulting effects on physician well-being, patient care quality, and health care system stability.

OBSERVATIONS Barriers to accessing mental health care services among physicians stem from multiple interrelated factors. Medical culture normalizes inadequate self-care and high levels of distress while stigmatizing mental health conditions. Real and perceived professional consequences, including career limitations and increased scrutiny, further deter individuals from seeking help. Other barriers include logistical challenges to seeking help, inflexible schedules, and a profound desire for confidentiality. Addressing these barriers requires comprehensive initiatives spanning education, programming, and policy reform. Major national organizations are elevating evidence-informed solutions, including leadership-driven initiatives that normalize seeking help, organizational policies that provide structural support for accessing care, and legislative reforms that protect confidentiality and reduce discriminatory practices in licensing and credentialing.

CONCLUSIONS AND RELEVANCE Although multiple interventions are needed to address physician mental health, eliminating barriers to care represents a critical and actionable opportunity to reduce the alarming rates of untreated conditions and prevent physician suicides. The most urgent priority is closing the implementation gap by universally adopting proven strategies, such as removing intrusive licensing and credentialing questions and expanding confidential care options. A sustained commitment to this work, coupled with thoughtful exploration of future innovations, is essential to support physician well-being and optimize high-quality patient care.

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Thousands of physicians struggle with untreated mental health conditions, diminishing their quality of life and affecting care for millions of patients. Despite the proven effectiveness of mental health treatment, fewer than one-third seek help.[1-3] This reluctance to seek care is especially alarming given that female physicians have a 53% higher rate of suicide compared with women in the general population and because physicians who die by suicide are significantly more likely to have mental health challenges than nonphysician individuals who die by suicide.[4] These patterns highlight the critical importance of addressing treatment barriers, especially given robust evidence that mental health interventions effectively reduce suicide risk.[5,6]

This review focuses specifically on barriers that deter physicians from seeking mental health care, which is a critical yet singular piece of the broader physician well-being landscape. Drawing upon relevant research and the authors' expertise, it offers a framework to address barriers to seeking help, aiming to improve physician mental health, reduce physician suicide risk, and enhance patient care.

Mental Health Challenges Among Physicians

Mental health challenges are pervasive among physicians. The rates of depression (33%), anxiety (24%), and posttraumatic stress disorder (10%)[7-14] are elevated among physicians compared with the general population.[15,16] The demanding nature of medical practice (with frequent exposure to human suffering, intense work schedules, and irregular hours) combined with common physician traits like perfectionism and a strong sense of duty may create particular vulnerability.[16-18] The increasing rates of depression and anxietyamong physicians[8,19,20] may reflect

administrative burdens and productivity pressures that have eroded historical buffers, including professional autonomy, direct control over work, and a sense of community.[8,16,19] Although data on specialty-specific disparities are inconclusive,[8] certain physicians, including anesthesiologists, general practitioners, psychiatrists, and general surgeons, may face an elevated suicide risk.[21] Substance use disorders (SUDs) affect 8% to 15% of physicians,[22] and problematic alcohol use (any harmful or risky drinking) affects up to 27% of physicians, which is a rate that has increased significantly over the last 15 years.[23] Although SUD rates generally mirror the general population, higher-risk specialties include anesthesiology, emergency medicine, and psychiatry.[24,25]

These mental health challenges have profound consequences for patient care, workforce stability, and the physicians themselves, including decreased quality of life and increased suicide risk.[9,10,26-28] Among physicians and trainees, 6% to 14% have experienced suicidal ideation and 1% to 2.5% have attempted suicide.[2,11,21,29-33] Suicide is the leading cause of death among all US residents.[34] The elevated risk among physicians is likely even higher because physician deaths by suicide are more likely to be misclassified compared with other individuals.[15,21,35] Physicians generally have lower cause-specific mortality and longer life expectancy than the general population, so the rates of suicide highlight unique susceptibilities.[29]

Critically, differentiating burnout from diagnosable mental health conditions is essential for appropriately addressing physician mental health.[36] Although burnout can overlap with or increase risk for psychiatric conditions, it is not a clinical diagnosis but an occupational phenomenon resulting from chronic workplace stress. Burnout and mental health conditions can all manifest as distress, but they differ meaningfully in their etiologies, consequences, treatments, and preventive approaches. Basic science research supports this distinction: burnout displays separate microinflammation biomarkers and different gene methylation patterns from depression.[37,38] In addition, psychometric studies demonstrate divergent validity between burnout and depression for most assessed items.[39]

The differences between burnout and psychiatric conditions are also manifest in the consequences and treatments. Burnout is strongly associated with medical errors but is not a strong independent predictor of suicidal ideation, whereas depression predicts suicidal ideation but does not independently predict medical errors.[26,40] Thus, well-being programs aiming to reduce suicide risk should prioritize treating psychiatric conditions, and programs targeting patient care quality must also address burnout. Various psychological therapy modalities and psychotropic medications are proven treatments for mental health conditions and there is robust evidence demonstrating reduced symptoms, enhanced quality of life, and decreased suicide risk (by half) in randomized trials.[5,41-44] Conversely, management of burnout primarily emphasizes organizational and systemic changes.[45] Recognizing these distinctions is not just important for tailoring effective programs—it is also critical for avoiding misdiagnosis and misattribution. For example, one often overlooked consequence of the intense focus on burnout in recent years is that physicians with conditions like depression may mistakenly attribute their symptoms to burnout, leading them to delay or forgo effective individual interventions altogether.[40,46]

Barriers to Seeking Help

Despite the benefits, physicians remain markedly reluctant to seek treatment. Factors contributing to this reluctance are numerous and interrelated. Only 13% to 36% of physicians with mental health conditions seek help.[1-3,47-49] The consequences of this reluctance are severe; physicians who die by suicide commonly have untreated mood disorders.[50,51] Compared with other individuals who die by suicide, physicians have an increased odds (66%) of mental health challenges at the time of their deaths.[4] Because closing treatment gaps is a proven suicide prevention strategy for the general population, the larger gap among physicians highlights the critical role of decreasing treatment barriers in addressing this issue.

Inadequate Self-Care Has Been Normalized

Medical culture has long rewarded stoicism and stress endurance while discouraging acknowledgment of personal vulnerabilities.[52,53] Physicians minimize illness and distress, prioritizing patients or colleagues over their own health.[54] Ninety-six percent of general practitioners believe that physicians must portray a perpetually healthy image, reinforcing a hero narrative that frames distress as a normal part of work or a transient phase that will resolve.[48,55]

In addition, many physicians overestimate their ability to manage their health independently. Self-medicating behavior is common; 9% to 15% of physicians reported self-prescribing antidepressants and an additional 7% reported receiving antidepressant prescriptions from colleagues outside formal treatment channels.[2,55] Among practicing psychiatrists, more than half report that they would prefer informal advice or self-medication vs seeking professional mental health support.[56] This self-management tendency is evident early in the careers of physicians; 75% of interns expressed a preference for self-managing mental health conditions.[1]

Stigma and Fear of Professional Consequences Create Powerful Deterrents

Stigma remains a major barrier to seeking help, and many physicians equate mental health conditions with personal weakness when occurring in themselves or in other individuals.[55] Fear of this stigma intensifies during training and is reported as a primary barrier to seeking help by 30% of early-year medical students, 53% of final-year medical students, and 58% of resident physicians.[3,48,56,57] These fears drive a profound desire for confidentiality. The concern for confidentiality grows more pronounced throughout training and into practice, emerging as a primary barrier for 37% of medical students, 57% of first-year residents, and approximately two-thirds of practicing physicians.[1,3,48,56] The effects are greatest for those most affected; physicians with moderate to severe depression are 2 to 3 times more likely than their counterparts with mild depression to self-prescribe antidepressants (30% vs 10%, respectively) or forgo treatment due to confidentiality concerns (51% vs 17%).[9,48,52]

Concerns about repercussions were historically grounded in documented professional consequences[48,56]; some employers and regulatory bodies have inappropriately equated mental health conditions with professional incompetence. For example, a study of residency program directors found that identical fictitious

applications scored 12% to 14% lower in interview and acceptance ratings when they included a history of psychotherapy.[58]

The requirement to disclose mental health conditions on applications for medical licensing, credentialing, and commercial and malpractice insurance raises similar concerns. In a 2007 survey, approximately one-third of state medical licensing board directors indicated that a mental health diagnosis alone could justify sanctioning a physician.[59] Physicians disclosing mental health histories have faced demands for additional records or explanations, with some unimpaired physicians incurring legal costs or facing board appearances to defend their careers.[60] In states that pose questions about hypothetical impairment or illness unrelated to impairment, physicians are 21% more reluctant to seek help.[61,62] In the 1993 case *Medical Society of New Jersey v Jacobs*,[63] the court ruled that such questions discriminated against physicians with disabilities, violating the Americans with Disabilities Act. Notwithstanding this judicial precedent, implementation of substantive reforms remained inconsistent for decades.[61,64] A recent movement, led in large part by the Dr. Lorna Breen Heroes' Foundation (DLBHF) and other groups, has driven substantial change.[64-67] In 2023, Senators Wyden, Booker, and Merkley urged the US Department of Justice to take action on Americans with Disabilities Act compliance, and received a commitment to address discriminatory licensing practices.[68] Most state medical licensing boards now exclude intrusive mental health questions, but effective communication about these policy shifts remains crucial for genuinely influencing help-seeking behavior.[66,67]

Physicians Face Specific Logistical Challenges in Seeking Help

Lack of time is the most cited barrier to care and has been reported by 43% to 92% of physicians and trainees.[1,3,49] The challenges stem from both demanding schedules and a pervasive sense of duty.[55] An informal "shadow contract"[53] has been described in which physicians feel an expectation to work through illness to protect colleagues or patients. Access presents another hurdle. Driven by confidentiality concerns, many physicians seek help outside their usual networks, which creates logistical challenges.[3] These confidentiality-driven choices frequently lead to a third logistical barrier, increased cost, because approximately 1 in 5 physicians would opt to pay out of pocket to avoid insurance records if they were to seek mental health care.[9] Despite physicians' general financial stability, these types of expenses and barriers limit access to mental health care, especially for trainees.[3,48]

A Concise Multilevel Approach for Overcoming Barriers in Seeking Help

Addressing the physician mental health crisis requires multipronged interventions. Effective strategies for seeking help require a structured approach that recognizes behaviors are shaped across multiple levels and range from individual stigma to institutional culture and policy hurdles. Major national organizations have raised awareness, developed resources, advocated for policy, and set standards for seeking help.[35,69-71] Although vital for guiding initiatives, robust evidence directly linking these activities to increased levels of seeking help or improved outcomes remains limited.

Existing Initiatives

Educational Interventions and Leadership Modeling

Current educational approaches include awareness campaigns from the American Medical Association, the American Psychiatric Association, the American Foundation for Suicide Prevention, the DLBHF, and others. Educational initiatives emphasize the commonality of mental health conditions, the benefits of seeking help, and skills for recognizing concerns in oneself and in colleagues.[72] Resources from these organizations support extending education across all categories of health care workers and throughout the training continuum, recognizing that reduced stigma within a community has broad protective effects.[73,74] Some health care leaders have also begun sharing personal experiences with mental health challenges, demonstrating that seeking help is compatible with professional success.[75] Evidence suggests that such modeling efforts positively affect both attitudes toward mental health and willingness to seek help, directly addressing stigma-related barriers at both individual and cultural levels.[75-77]

Peer Support Programs

Many institutions have implemented peer support programs that use trained colleagues to reduce isolation and normalize struggles, particularly around work-related challenges or poor patient outcomes. Because physicians who die by suicide are more likely to have experienced recent job-related issues, and major medical errors are linked to a 3-fold increased risk of suicidal ideation, peer support programs represent a critical opportunity to promote seeking help.[2,4] These structured programs vary widely, and even though qualitative benefits, including improved connection, are frequently reported, rigorous evidence on outcomes is lacking due to heterogeneity in program design and methodological challenges in evaluation.[78,79]

Confidential Counseling

Confidential options range from employee assistance programs to a variety of external pathways. A diversity of options is critical because concerns about confidentiality deter some physicians from using employer-based programs, making external options essential for ensuring access to care. Crisis intervention services, such as the 988 Suicide and Crisis Lifeline and the Crisis Text Line (text 741741), are not specific to helping physicians but provide enhanced privacy and can be promoted throughout training programs and the health care environment.[80,81] The Emotional PPE Project, which is a national nonprofit organization that rapidly mobilized during the COVID-19 pandemic, has successfully connected thousands of health care professionals with free, confidential therapy through its volunteer mental health professional network.[82] Successfully implemented programs share the following features: confidentiality (often through external care providers or administrative firewalls), accessibility (eg, free or low cost, flexible scheduling, 24/7 availability), and convenience.

International approaches to physician mental health may offer valuable lessons for US implementation. The UK's NHS Practitioner Health program represents a particularly successful model that provides free, confidential health care to medical and dental

practitioners with mental health, addiction, or physical health concerns.[36] This program addresses key barriers through confidential service that physicians can access without fear of professional consequences. The NHS Practitioner Health program operates completely by self-referral, never stipulates workplace monitoring, and functions entirely outside regulatory or disciplinary processes. This program was established in 2008, has served more than 30 000 practitioners, and has documented evidence supporting its effectiveness.[83]

Anonymous Screening Programs

Anonymous screening using validated tools provides a critical entry point. A leading model is the American Foundation for Suicide Prevention's Interactive Screening Program (ISP), which has been adopted by more than 20 health systems and state medical boards.[70,84] The ISP maintains psychological safety by enabling physicians to have entirely anonymous dialogue with a program counselor who uses motivational interviewing. The ISP counselors answer questions and help facilitate a physician's readiness to accept a referral to mental health care, directly addressing stigma and fear of disclosure.

Opt-Out Programs

Several institutions have implemented innovative programs that shift the default from requiring physicians to seek help (opt in) to making mental health engagement a standard part of training or practice (opt out). The University of Southern California's Keck Checks program exemplifies this approach by offering confidential mental health check-ins for first-year medical students as part of their regular schedule.[85] Rather than waiting for distress to prompt seeking help, these programs normalize contact with mental health professionals. Similar models have been implemented for trainees in some residency programs by incorporating regular, prescheduled check-ins with mental health professionals. This reversal of the traditional pattern for seeking help directly addresses multiple barriers, especially the normalization of inadequate self-care and logistical challenges.

Robust evidence linking opt-out programs to sustained changes in help-seeking behavior is still developing, but early feedback suggests increased use of mental health resources and greater comfort discussing mental health concerns. Support for proactive approaches was demonstrated in a randomized clinical trial[86] with an intervention that provided web-based cognitive behavioral therapy prior to the internship. Compared with the control group that received educational emails and listings of local, confidential, and free resources, the intervention group showed significantly reduced subsequent suicidal ideation.[86]

External Oversight

External regulators can drive change through accreditation standards. For example, the Accreditation Council for Graduate Medical Education requires trainees be allowed to attend mental health appointments, even during working hours, promoting protected time for seeking help.[87] Other regulatory bodies could similarly strengthen support by mandating specific resources or removing barriers. For example, the Joint Commission could expand accreditation requirements to address physician barriers to seeking help through their Workforce Safety and Well-Being Resource Center.[88] At institutions where house staff are represented by collective bargaining units, these organizations can also negotiate for expanded mental health support and protected time for accessing care. Although such standards drive institutional attention to issues, ensuring meaningful implementation beyond checking boxes remains a key challenge.

State-Led Programs

Physician health programs (PHPs) have been associated, historically, with regulatory or disciplinary processes and a focus on SUDs, which may have discouraged physician self-referral.[36] However, the PHP landscape has evolved significantly, with most programs now offering a range of support for psychiatric and other medical conditions.[89] The transformation of PHPs[89] also includes increased structural independence from medical boards, including innovative funding models to reduce conflicts of interest alongside confidential engagement pathways to foster physician trust (C. Bundy, MD, MPH, Federation of State Physician Health Programs, written communication, May 6, 2025). Evidence confirms PHP effectiveness for both SUDs and other conditions, but more extensive recent research on outcomes is needed.[25,90]

Newer models further address historical shortcomings that may have deterred physicians with mental health concerns from seeking help. The Tennessee Medical Foundation's robust PHP-led statewide interactive screening program is one exemplar.[91] Another is Wisconsin Medical Society's partnership with Marvin Behavioral Health (a confidential telehealth platform launched in 2024) that combines quick therapist matching and flexible scheduling with culturally adept care.[92]

Licensure and Credentialing Reform

Significant efforts are underway to reform licensure and credentialing processes that deter physicians from seeking necessary care. This approach aims to protect patient safety by evaluating current impairment rather than penalizing a history of diagnosis or treatment. A driving force in this transformation is the DLBHF, which actively promotes organizational and legislative change with initiatives like the Wellbeing First Champion Challenge program that encourages and formally recognizes licensure boards, hospitals, and health systems that audit and successfully revise their applications to remove intrusive mental health inquiries. As of early 2025, the program has recognized reforms by licensure boards benefiting more than 1 million health workers, and reforms by hospitals and health systems affecting more than 200 000 health care workers.[67] To be effective, these policy shifts require ongoing communication and trust-building efforts because many physicians may be unaware of or skeptical about the changes.

Recent progress at the state legislative level includes Virginia's House Bill 1573, which requires the replacement of mental health questions in licensure, certification, and registration applications with functional assessments of fitness.[93] This approach directly addresses one of the most significant barriers to seeking help by physicians and preserves patient safety by focusing on physician impairment.

Funding and Federal Legislation

An evolution in mental health care for physicians toward more integrated frameworks represents a significant departure from past

approaches, and may require additional funding from both local governmental entities and the federal government. At the federal level, for instance, the Dr. Lorna Breen Health Care Provider Protection Act[94] allocated crucial funding for mental health programs and stigma reduction efforts for health care workers, and at the time of this writing is up for reauthorization. This legislation emerged from advocacy by the DLBHF and other national organizations, and helps drive systemic change through multiple channels, including the ALL IN program[95] to redesign workplace environments and the Impact Wellbeing Guide[96] for hospital leaders and executives, which was jointly created by the DLBHF and the US Centers for Disease Control and Prevention.

In addition to funding, federal legislation provides critical protections for physicians, chief among them being efforts to ensure mental health insurance parity. Despite mandates from the Mental Health Parity and Addiction Equity Act (2008) and the Affordable Care Act (2010), inconsistent enforcement perpetuates coverage gaps. Recent efforts, including the Consolidated Appropriations Act of 2021 and new federal rules, aim to strengthen accountability and transparency.[97] Unfortunately, implementation challenges persist as these efforts face a complex federal environment in 2025, with the new rules designed to bolster parity encountering significant legal challenges from some stakeholders regarding their scope and effects.

Future Directions

Although the bulk of collective effort should focus on universally implementing the established best practices and evidence-informed programs discussed, it is also valuable to identify and cautiously explore areas for future innovation.

Research

Despite extensive research on physician mental health, many questions regarding barriers to seeking help remain unanswered. Current studies are often limited by small sample sizes and rely on symptom-based assessments rather than diagnostic assessments, highlighting the need for larger, more comprehensive research frameworks.[98] Developing standardized tools to assess stigma and willingness to seek help is needed, both for advancing research and enabling institutions to better monitor this component of workforce well-being. Future investigations should evaluate how different policies and regulatory environments affect care utilization and how to tailor effective programs to various practice settings. More granular studies of physician suicide are critical. Such research should prioritize populations facing elevated risk, particularly female physicians and high-risk specialty physicians, and explore gender-specific barriers to care and the effectiveness of the interventions. In addition, systematic evaluation of interventions must also describe implementation costs to guide evidence-based resource allocation.

Leveraging Technology

Beyond basic telehealth, emerging technologies offer potential avenues to address concerns about confidentiality and access. Artificial intelligence–driven screening or support tools could provide 24/7 availability and potentially identify patterns of distress to promote seeking help. Notably, the benefits of such tools remain speculative, and programs would need to be designed as supportive rather than punitive tools, with clear protections against misuse of data for employment or licensing decisions.

Evolving Support Models

Future physician support innovations could explore alternative pathways to mental health care that align with physicians' preferences and practice realities. Enhanced peer support systems could implement proactive outreach with regular check-ins, tiered support options ranging from informal conversations to facilitated referrals, and specialized groups for specific challenges like error recovery. Alternatively, recognizing physicians' documented tendency toward self-management, structured self-help resources (such as web-based tools) could serve as important, initial engagement tools. These approaches require thorough evaluation because ineffective programs risk creating an illusion of adequate care that could paradoxically discourage seeking help.

Policy Recommendations

Innovative policy approaches that could further reduce barriers include creating and expanding the legally protected safe haven reporting pathways that provide absolute confidentiality guarantees (an approach increasingly adopted by PHPs), strengthening enforcement of mental health parity with particular attention to nonquantitative treatment limitations, implementing policies that require or incentivize proactive mental health check-ins for physicians in high-risk specialties or situations, and developing financial incentives for health care organizations to implement and evaluate systemic interventions aimed at reducing barriers to seeking help.

Conclusions

Although multiple interventions are needed to address physician mental health, eliminating barriers to care represents a critical and actionable opportunity to reduce the alarming rates of untreated conditions and prevent physician suicides. The most urgent priority is closing the implementation gap by universally adopting proven strategies, such as removing intrusive licensing and credentialing questions and expanding confidential care options. A sustained commitment to this work, coupled with thoughtful exploration of future innovations, is essential to support physician well-being and optimize high-quality patient care.

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