Self-Perceived Mental Health and Perceived Discrimination in Family Physicians and Residents: A Comparative Study Between Men and Women

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Introduction: **The present study aims to examine sex differences in demographic variables, professional activities and adversities, self-reported mental health problems, and perceived discrimination in a sample of family doctors and family medicine residents in Mexico.**

Methods: **From a larger sample of medical specialists, an analytic, cross-sectional study was conducted with 566 participants, including 317 (56%) family medicine residents and 249 (44%) family doctors in Mexico through an online survey. Demographic features, professional activities and adversities, mental health, and perceived discrimination were examined. Descriptive and comparative analyses were performed. Cramer's V for chi-square tests and Hedge's g for *t* test were conducted to determine effect sizes.**

Results: **Both sexes displayed similar percentages of professional adversities (such as attending patients with suicidal behavior or who died not by suicide under their care), and a higher number of women reported seeking specialized support to cope with these deaths (Fisher = 0.04). Men perceived greater discrimination ($P = .01$), worked more hours per day ($P < .001$) and were more verbally assaulted ($P = .04$), whereas women reported mental health problems more frequently ($P < .001$) particularly depression, anxiety, burnout and sleeping problems. Women also reported worse health status ($P < .001$) when compared with men.**

Conclusion: **Family medicine specialists constitute a vulnerable group for mental health problems and perceived discrimination. Particular attention should be paid to how men and women cope with professional adversities to determine whether additional support is required. Interventions should encourage self-care and promote the well-being of health personnel. (J Am Board Fam Med 2022;35:912–920.)**

Keywords: **Cross-Sectional Studies, Family Medicine, Gender Differences, Medical Students, Mental Health, Mexico, Perceived Discrimination, Self-Report**

Introduction

Primary care is essential for the provision of efficient and equitable health services. Family physicians are gatekeepers between the community and secondary care with a crucial role in the prevention, diagnosis, treatment, and control of pathologies with the highest incidence, morbidity, and mortality in the population[1–3]. Despite that the World Health Organization (WHO) has declared a global crisis of primary health care personnel,

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Mexico has failed to comply with recommendations regarding the number of doctors per inhabitant, especially in areas such as primary care and family medicine[3–4]. In Mexico for 14.08/100,000 inhabitants versus 76/100,000 in the US[5–6]. Since the well-being of doctors is an indicator of the quality of a health care system[7–8], research focused on mental health of family physicians, both practicing ones and those in training, constitutes a key public health parameter.

After medical school, physicians transition to a period of postgraduate training, taking their first steps into a professional environment where their daily activities expose them to multiple stressors (work overload, stigma, the work environment, educational requirements, the complexity of care, hospital culture, limited resources, high patient expectations and violence[8–14]). Physicians also witness emotionally difficult situations such as pain, suffering, and death[15–16], in addition to the difficulties of everyday life[17] (personal health, inability to satisfy personal needs, interpersonal conflicts). In addition, there is a widely held expectation that health professionals should be immune to distress and focus on patients' needs above their own. Coupled with the lack of self-recognition of the impact severe stressors have on their mental health, and the discrimination associated with some medical specialties, makes physicians prone to inaccurate self-diagnosis, self-medication, and reluctance seek care[12]. This can jeopardize personal and professional well-being, leading to mental health conditions (higher prevalence of depression, anxiety, burnout, substance use and suicidal risk[18–19]).

The role of women in medicine is increasingly important: more than 70% of medical students are women and a higher percentage of women (68%) graduate from family medicine residency programs in Mexico. As the role of women in family medicine expands, there is a need for a systematic evaluation of existing data on the gendered practice patterns of family physicians, including mental health. The prevalence of and factors contributing to mental health problems may be different for male and female physicians. Recent studies report gender differences in mental health, with higher rates of stress, burnout, depression, anxiety, posttraumatic stress disorder and insomnia among women[20–21]. Men are more likely to be seen in mandatory mental health programs, primarily for addictive disorders[22]. Depression, and deteriorating relationships are associated with physician suicide[23]. Physician suicide rates are known to be higher than those of the general population, with men being more likely to die by suicide and women more likely to attempt suicide[24].

Given that female family medicine physicians are entering the primary care workforce at higher rates than men (57%) and the broader implications of mental health problems for cost and access to health care, retention of female physicians is especially critical in light of the current and future shortage of family physicians. As the number of female physicians increases, it is imperative to understand the differences and risk factors that contribute to mental health problems. In turn, prevention strategies, intervention initiatives (individual, organizational, and structural), and the effectiveness of outcomes may be different for women. Given the important role family physicians play in primary health care services, the objective of this study was to examine sex differences in demographic variables, professional activities and adversities, self-reported mental health problems, and perceived discrimination in a sample of family physicians and family medicine residents in Mexico.

Method

Design of the Study

This study focuses on the sample of family doctors and family medicine residents, obtained from a larger sample of medical specialists from an analytic cross-sectional study performed through an online survey.

Participants

Recruitment for the larger sample was performed using a convenience sample approach with medical specialists and residents of medical specialties in the country who were willing and able to participate. A study invitation was circulated by e-mail and social media (Facebook and WhatsApp), with a link explaining the nature and procedures of the study to participants at the beginning of the online survey, first by stating the anonymity of the survey, then explaining that questions were related to physical and mental health, hobbies, and adversities related to the profession, that the study was approved by the Ethics and Research Committees, and that consent to participate could be withdrawn at any time by dropping out of the survey. A link to

an electronic information sheet and consent form was included.

Those who agreed to participate and provided electronic consent proceeded to complete the survey.

Furthermore, to increase the recruitment of family doctors, the Family Medicine Department of the National Autonomous University of Mexico (*Universidad Nacional Autónoma de México*, UNAM) helped the research team by contacting family doctors and residents in the family medicine specialty by e-mail.

Those whose medical practice or training was currently in Mexico and who were willing and able to participate were invited. The objectives and procedures of the study were explained at the beginning of the online survey. To guarantee anonymity, no identifying information was requested. Subjects who agreed to participate proceeded to complete the online survey and were also asked to invite other colleagues in Mexico to participate by sending them the online survey link. Recruitment was undertaken from November seventh, 2019 to May fifth, 2020.

Assessment Procedure

For the present study, specific sections of the complete online survey described below were used. Conducted in Spanish, it took approximately 20 to 30 minutes to answer and was divided into 4 sections:

1. Demographic information: Included the following variables: age, sex, marital status and having children.
2. Professional activities and adversities: Included the maximum hours per day spent on activities related to their profession as family doctors and the schedule for family medicine residents (the continuous 36-hour medical shift schedule was excluded). For family medicine residents, the year of the medical specialty being studied at the time of answering the survey was included. Professional adversities since the beginning of residency included receiving attacks (whether physical, verbal or psychological), the identity of the assailant (patient, patient's relative, colleague or student), being the attending physician of patients with suicidal ideation or who committed suicide, or of a patient who died (not by suicide) and whether specialized support was sought to cope with these deaths.
3. Mental health: Included questions about self-reported mental health conditions (such as major depression, anxiety disorders, burnout, sleeping problems, trauma-problems). Subjects were asked to evaluate their self-perceived health on a 100-point visual analog scale, where 0 = the worst perceived state of health and 100 = the best. Subjects were also asked to rate their current level of distress on a visual analog scale ranging from 0 to 100, where 0 = not experiencing any distress and 100 = the maximum perceived distress.
4. Perceived discrimination: Included 13 items from the King's Internalized Stigma Scale[25–26] scored on a 5-point Likert scale). Higher scores reflected higher discrimination, particularly the perception of negative reactions of other people toward their medical specialty. Examples of the items on the scale are as follows: "I have been discriminated against in my educational training because of my medical specialty," "People's reactions to my profession make me keep things to myself," "I have been discriminated against by health professionals because of my medical specialty." For the present study, we determined the internal consistency of the scale, having a Cronbach's α of 0.84.

Ethical Considerations

The Ethics and Research Committees of the Ramón de la Fuente Muñíz National Institute of Psychiatry (*Instituto Nacional de Psiquiatría Ramón de la Fuente Muñíz INPRFM*) and UNAM approved the study (CONBIOETICA-09-CEI-010_20170316, FM/DI/075) in May 2019. Those who agreed to participate took part on a voluntary basis and were not remunerated for their participation. Any participant could withdraw their consent by not completing the interview.

Statistical Analysis

Descriptive information was obtained through frequencies and percentages for categorical variables and means and standard deviations (S.D.) for continuous variables. The variables in the 4 sections in the survey were compared between men and women using chi-square tests (χ^2) for categorical variables, and independent sample Student's t test for continuous variables. To determine the effect sizes of the comparative analyses, Cramer's V for chi-square tests and Hedge's g for t test were conducted to determine the effect sizes of the

comparative analyses, with the results being interpreted as small (0.2-0.3), medium (0.4-0.7) and large (>0.8). All analyses were performed using SPSS Statistics V.21. The significance level for all tests was established at $P < .05$.

Results

Demographic Information

Of the 566 subjects included, 56.0% (n = 317) were family medicine residents and the remaining 44.0% (n = 249) family doctors. Most subjects were women (77.0%, n = 436) and the mean age of the sample was 36.5 (S.D.=7.7) years. Subjects came from all states in Mexico although most were from Mexico City (29.3%, n = 166) and Mexico State (25.8%, n = 146). Just over half the subjects were married or partnered (52.3%, n = 296) and had children (53.7%, n = 304). From the sample, 66.3% answered the survey during March-May 2020, which corresponds from the beginning to the end of the clusters of cases transmission scenario for COVID-19 in Mexico, before the community transmission phase of the epidemic.

As seen in Table 1, similar demographic features were found between men and women, except for being a family medicine resident or a family doctor. A higher percentage of men were in their first year of training.

Professional Activities and Adversities

Variables related to professional activities and adversities in the total sample and between men and women are displayed in Table 2. A similar proportion of men and women was observed in the different years of family medicine residency. The maximum number of hours worked per day was 17.9 (S.D.=5.9) and was higher in men with both groups citing approximately 7 as the ideal number of hours in a working day. Of the family medicine residents and family doctors who reported professional adversities, 56.4% (n = 319) cited attending patients with suicidal ideation while 11.1% (n = 63) mentioned attending patients who committed suicide and 46.5% (n = 263) reported being the physician in charge of a patient who died under their care. Both sexes display similar percentages of professional adversities. A higher number of women reported seeking specialized support to cope with these deaths). Out of the total sample, 68.6% (n = 388) reported having been attacked, with no differences between men and women. However, when specific aggression was examined, more men than women were verbally attacked with no differences emerging between them when the relationship of the perpetrator to the physician was analyzed.

Mental Health

Of the total sample, 47.9% (n = 271) reported mental health problems, with women being more likely to mention self-reported depression, anxiety problems, and sleeping problems (see Table 3). Even though more women reported mental health problems, as can be seen from Table 3, a similar percentage of men and women reported having received specialized treatment including psychotherapeutic interventions and/or pharmacological treatment. For those who received pharmacological treatment, over 20% of both men and women reported that it was self-prescribed. Higher perceived distress and a worse self-reported state of health were also found in women than men.

Perceived Discrimination

The total score for this internalized stigma dimension was 27.2, S.D.= 10.4. Given that the highest

Table 1. Demographics Between Men and Women

	Total (N = 566)	Men (N = 130)	Women (N = 436)	Statistics
	Demographic features n%			
Age years (mean; SD)	36.5 7.7	36.5 7.3	36.5 7.9	t = 0.1, *P = 0.91*
Marital status (Married/partnered)	296 52.3	76 58.5	220 50.5	χ^2 = 2.5, *P = 0.10*
Has children (Yes)	304 43.7	68 52.3	236 54.1	χ^2 = 0.1, *P = 0.71*
Professional role				
Family medicine resident	317 56.0	92 70.8	225 51.6	χ^2 = 14.9, *P < 0.001*;
Family doctor	249 44.0	38 29.2	211 48.4	Cramer's V = 0.16

Abbreviation: SD, standard deviation.

Table 2. Professional Activities and Adversities Between Men and Women

	Total (N = 566)	Men (N = 130)	Women (N = 436)	Statistics
	Professional activities n %			
Year of residency[a]				
1st year	102 32.2	33 35.9	69 30.7	
2nd year	124 39.1	37 40.2	87 38.7	t = 1.6, *P* = *.44*
3rd year	91 28.7	22 23.9	69 30.7	
Maximum working hours per day (mean; SD)	17.9 5.9	19.7 5.5	17.4 5.9	t = 3.9, *P* < *.001*; Hedge's *g* = 0.39
Ideal working hours per day (mean; SD)	7.1 1.8	7.2 2.1	7.0 1.7	t = 0.8, *P* = *.4*
	Professional adversities n %			
Patients with severe suicidal ideation (Yes)	319 56.4	71 54.6	248 56.9	χ^2 = 0.2, *P* = *.64*
Patients who committed suicide (Yes)	63 11.1	10 7.7	53 12.2	χ^2 = 2.0, *P* = *.15*
Attending physician of a patient who died (Yes)	263 46.5	69 53.1	194 44.5	χ^2 = 2.9, *P* = *.08*
Required specialized support (Yes)[b]	23 8.7	2 2.9	21 10.8	Fisher's exact 0.04; Cramer's V = 0.12
Attacks (Yes)	388 68.6	82 63.1	306 70.2	χ^2 = 2.3, *P* = *.12*
Physical (Yes)[c]	42 10.8	12 14.6	30 9.8	χ^2 = 1.5, *P* = *.21*
Verbal (Yes)[c]	365 94.1	81 98.8	284 92.8	χ^2 = 4.1, *P* = *.04*; Cramer's V = 0.10
Psychological (Yes)[c]	233 60.1	47 57.3	186 60.8	χ^2 = 0.3, *P* = *.56*
Assailant patients (Yes)[c]	298 76.8	57 69.5	241 78.8	χ^2 = 3.1, *P* = *.07*
Assailant patient's relative (Yes)[c]	325 83.8	65 79.3	260 85.0	χ^2 = 1.5, *P* = *.21*
Assailant colleague (Yes)[c]	132 34.0	32 39.0	100 32.7	χ^2 = 1.1, *P* = *.28*
Assailant – student (Yes)[c]	14 3.6	4 4.9	10 3.3	χ^2 = 0.4, *P* = *.48*

Abbreviation: SD, standard deviation.
[a]n = 317 from those who were residents.
[b]n = 263 from those who attend a patient who died under his/her care.
[c]n = 388 from those who reported being attacked.

possible score is 52 points, this score may reflect moderate perceived discrimination among family medicine residents and family doctors. As reported in Table 3, men experience higher discrimination than women.

Discussion

The present study compares gender differences in demographic variables, professional activities and adversities, self-reported mental health problems and perceived discrimination between men and women among a sample of family doctors and family medicine residents in Mexico. In our country, according to Heinze et al[5]., there are 16,895 family physicians and 1318 physicians graduated per year in this specialty. Our sample represents around 15 of graduated family doctors and around 6% of residents.

For those participants who answer the survey during the COVID-19 pandemic, the survey may concur with the uncertainty and initial effects of the pandemic on the health system and health care professionals. However, the survey asked physicians about their experience throughout their practice and training rather than the specific emerging period of time. Nevertheless, we cannot rule out that the emergence of the pandemic may have had an influence on some of our participants and should be analyzed.

Professional Adversities

It is likely that the exposure of family physicians to aggression events is related to, as mentioned in several studies, a dissatisfied patient with very long waiting time (to receive care or specialized interconsultation) and insufficient listening time to express their pain or suffering. Waiting time, attributable to organizational reasons and institutional processes of the health system (little known by patients and their families), is often unrelated to the physician's work and a poor understanding of the health system by patients and their families might direct their frustration toward the attending physician. Other factors could be unrealistic patient expectations of care, insufficient resources of the health institution, and

Table 3. Mental Health Problems and Perceived Discrimination

	Total (N = 566)	Men (N = 130)	Women (N = 436)	Statistics
	Mental health problems n %			
Any mental health problem (Yes)	271 47.9	36 27.7	235 53.9	$\chi^2 = 27.5$, $P < .001$; Cramer's V = 0.22
Major depression (Yes)	220 38.9	31 23.8	189 43.3	$\chi^2 = 16.0$, $P < .001$; Cramer's V = 0.16
Anxiety disorders (Yes)	229 40.5	30 23.1	199 45.6	$\chi^2 = 21.1$, $P < .001$; Cramer's V = 0.19
Burnout (Yes)	147 26.0	18 13.8	129 29.6	$\chi^2 = 12.9$, $P < .001$; Cramer's V = 0.15
Suicidal ideation (Yes)	73 12.9	11 8.5	62 14.2	$\chi^2 = 2.9$, $P = .08$
Sleeping problems (Yes)	190 33.6	22 16.9	168 38.5	$\chi^2 = 20.9$, $P < .001$; Cramer's V = 0.19
Trauma related (Yes)	45 8.0	5 3.8	40 9.2	$\chi^2 = 3.8$, $P = .06$
Received treatment (Yes)[a]	147 54.2	20 55.6	127 54.0	$\chi^2 = 0.02$, $P = .86$
Pharmacological (Yes)[b]	120 81.6	18 90.0	102 80.3	$\chi^2 = 1.0$, $P = .29$
Self-administrated (Yes)[c]	26 21.7	4 22.2	22 21.6	$\chi^2 = 0.004$, $P = .95$
Psychotherapy (Yes)[b]	121 82.3	15 75.0	106 83.5	$\chi^2 = 0.8$, $P = .35$
Perceived state of health (mean; SD)	77.2 18.2	82.6 15.9	75.5 18.5	t = 3.9, $P < .001$; Hedge's $g = 0.39$
Perceived distress (mean; SD)	59.7 28.9	53.2 30.9	61.7 28.1	t = −2.9, $P = .003$; Hedge's $g = 0.29$
	Perceived Discrimination Mean SD			
Total score	27.2 10.4	29.2 10.7	26.6 10.2	t = 2.5, $P = .01$; Hedge's $g = 0.25$

[a]n = 271 from those who reported any mental health problem.
[b]n = 147 from those who received treatment.
[c]n = 120 from those who received pharmacological treatment.
Abbreviation: SD, standard deviation.

communication problems during the consultation[27–28]. This probably explains the high number of attacks reported in our study population, particularly verbal aggression. Although we found that men were more verbally attacked than women, we need to highlight that more than 90% of them reported this kind of aggression. We hypothesize that the difference found between men and women may come from the current special attention Mexican society is paying to aggression toward women and how, in many cases, this aggression is exposed on social media. In addition, we cannot rule out that many attacks do not come to light, in men and women, because health professionals do not report them, either due to the minimization of the violent act, the normalization of violence, or even because they think filing a complaint is pointless[28]. Although violence committed by coworkers was less frequently reported, it is no less important. The culture of abuse in the family medicine workplace can be perpetuated through patterns of abuse that begin in medical school and continue through residency, and into the workplace. It can be further exacerbated by the lowly position of family medicine in the medical hierarchy and the stress caused by the shortage of family doctors[10,29–31].

In addition, caring for patients with suicidal ideation or who committed suicide or being the treating physician of a patient who died under their care, can negatively impact family physicians (graduates and/or trainees)[12,32]. Adaptive coping strategies can be decisive in protecting against the stress generated by this adversity[33] and may differ between men and women. Previous studies report that women are more likely to seek support as a strategy, while men are more likely to use avoidance strategies (such as denial, alcohol/drug use, distancing themselves and behavioral disengagement)[22,33–35]. Our results show that both men and women often fail to seek care since just over 50% of family physicians seek professional help.

Distress and Self-Reported Mental Health Problems

In the present study, family physicians reported experiencing high levels of stress, a finding consistent with other studies[36–39]. The evidence shows an increase in the prevalence of common mental disorders among physicians compared with the general population, with marked differences by sex[40–41], which was supported by our results. Women may suffer the double burden of balancing professional work and family responsibilities (such as caring for children, sick relatives and the elderly) with limited social support networks and, in many cases, with an

unequal distribution of household chores[41–42]. Workplace training programs should improve work-life balance with healthy work schedules that allow adequate time for rest or recreation.

Although a high proportion of family medicine residents and family doctors who seek professional help had received pharmacological and/or psychotherapeutic treatment for their self-reported mental problems, approximately 20% had self-prescribed their pharmacological treatment. As various studies point out, several factors contribute to self-prescription, such as lack of time to attend a consultation; difficulty finding a replacement, a backlog of work if absent, and the prevailing assumption in medicine that doctors must be resilient[12,43,44]. In addition, stigma, and the fear of being considered weak, vulnerable, or flawed by peers and supervisors may also influence self-prescription and the reluctance to seek help[12,40].

Perceived Discrimination

The levels of discrimination found, which should be taken with caution as no cutoff point of the instrument is available, may be related to the symbolic structuring in medicine, reflected in the hierarchies based on criteria such as the prestige of the specialty, the institution to which doctors are affiliated and the shift in which they work[8,9,45,46]. Professional hierarchies between other specialties and family medicine are not uncommon and seem to be multifactorial[27–28]. Some hospital-based specialists believe that family physicians are "the same" as general practitioners, that family physicians do not have their own body of knowledge and, moreover, that many of them are family physicians because they had no other professional choice or that it is a female specialty because of the possibility of a controllable pace of life. Moreover, there are institutional stigmas in medical schools against the specialty of Family Medicine such as underrating the specialty, encouraging students to choose other specialization programs or the perception that family doctors do not occupy high-profile positions[30,47].

In Mexico, there is an increased need for Family Medicine physicians. Medical education offers the opportunity to influence physicians in training to address health needs through undergraduate training in underserved areas such as family medicine. In Mexico, the aim is to counteract this problem by: 1) contact from the first year of the career with services at the first level of care, 2) mentorship with family physicians, 3) promotion of the true identity as a medical specialty, visibility and acknowledgment of specialty competencies, their scope of action, skills and abilities and how they fit into Mexican health system, 4) maintaining the family medicine residency as a 3-year course, without prerequisite of another specialty and with greater contact with the area of professional performance, 5) recovery of the prestige of the specialty in academic and professional circles, where the family physician is the center of the primary care team to identify and meet the health needs of the community, also, by improving the perception of Mexican patients about the benefits family medicine to dignify the work of this specialty; and 6) feasibility of offering the specialty as an attractive economic option, recently increasing the job offer for physicians of the specialty and offering facilities to general practitioners to specialize without losing their job.

Limitations

The limitations of our study stem from 4 main sources: (1) self-reported mental health rather than active assessment, as this is likely to include other issues that may not meet clearly defined diagnostic criteria, (2) lack of randomization of the sample, which could bias the interpretation of our results. We cannot rule out the possibility that those who answered the survey were people with clearly identified mental health problems, 3) their retrospective nature makes it impossible to determine how accurate these diagnoses are or whether the problems are currently present, and, 4) for the maintenance of confidentiality, we do not have personal data to be able to guarantee the certainty that the questionnaire was answered by family physicians and trainees, which is a common limitation found in studies using online surveys. However, in the informed consent and at the beginning of the form we asked whether they were family physicians or trainees, in case of a negative answer we did not allow them to continue with the form. Furthermore, in the process of self-diagnosis, qualitative studies have shown that physicians tend to underreact or overreact to their symptoms, going from diagnosing diseases with the worst prognosis to ruling out a disorder altogether[40,45]. Medical culture can encourage both underreporting and underrecognition of mental illness and burnout. Although the anonymous nature of the survey may encourage more accurate self-reporting, given the design of this study, it is impossible to determine the degree of underreporting[12,43–45].

Conclusion

We must question the ethical implications of ignoring physician's mental and physical health needs, normalizing violent behavior and maintaining the status quo of the current hierarchical medical culture, which are closely related to the quantity and quality of care provided and overall performance.[12,40,42] The medical world must evolve toward recognizing what it means to be a "good doctor" by acknowledging the humanity of the physician to cultivate integrity, self-reflection, and the ability to admit weaknesses and mistakes while striving to continually improve and learn. Health interventions designed to achieve the well-being of health personnel, both men and women, should be widely promoted together with a wide-ranging analysis of the need for educational and health institutions to promote the valuable work of family physicians.

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To see this article online, please go to: http://jabfm.org/content/35/5/912.full.

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