Health Problems and the Use of Health Services among Physicians: A Review Article with Particular Emphasis on Norwegian Studies

Reidar TYSSSEN

Department of Behavioural Sciences in Medicine, Institute of Basic Medical Sciences, Faculty of Medicine, University of Oslo, Oslo, Norway

Received May 12, 2007 and accepted July 23, 2007

Abstract: This paper provides an overview of recent Norwegian and international research into physicians' health problems and their use of health services, with a particular focus on more recent studies relating to The Norwegian Physicians' Survey. The review suggests that physicians' physical health is similar to the general population, although female physicians tend to be in better health than other women. Some mental disorders such as depression and suicide appear to be more prevalent. Mental health problems are known to be associated with low work control (autonomy), time pressure and demanding patients. There is little difference between the genders early in their career, but more female than male physicians seem to experience problems later on. Physicians seldom take sick leave, and tend to make less use of primary health care and some screening facilities. Self-treatment is common - even for mental problems. American impaired physician programmes have demonstrated high recovery rates (70–80%), and increasing emphasis is now being placed on psychiatric diagnoses. As certain mental disorders appear to be common among physicians, specialist psychiatric services should be made more accessible for this group. A low-threshold facility for seeking help with such problems has recently been developed in Norway (the Villa Sana Resource Centre).

Key words: Physicians, Health, Health Services, Mental disorders, Substance-related disorders, Physician Impairment, Health surveys, Norway

Introduction

Since 1993 an extensive research programme has been carried out in Norway on physicians’ health, sickness, working conditions and quality of life (The Norwegian Physicians’ Survey). The programme has resulted in several international publications1). However, an updated English review of our studies is still required to place them in the context of other international literature on health problems and the use of health services among physicians. This article represents the reworking and updating of a paper that was published in Norwegian in 20012).

Some studies indicate good physical health and health-related behaviour among physicians3, 4), while others point towards stress and a high frequency of depression and suicide in this occupational group5–7). In the USA, programmes have been run for some time for impaired physicians, many of whom suffer from substance abuse8, 9). Doctors’ health-related behaviour also affects the preventive advice they give to their patients and the measures they prescribe10). At its worst, physicians neglect of their own health can lead to their patients receiving the wrong medical treatment11, 12). On the other hand, seeking adequate treatment for their own disorders will put doctors in a better position to help patients with similar problems. Optimal health and the maximal use of health services on the part of physicians are therefore in the interests of society. If conditions at work can be connected to their health problems, this must be given serious consideration by both employers and politicians.

This article presents studies of physicians’ health problems,
in particular mental health problems, and focuses on recent Norwegian studies. The importance of working conditions for doctors’ health is also addressed. Some studies on doctors’ health-related behaviour, their use of the health services, and treatment programmes for physicians are also described. In conclusion information is given about the intervention programme run by the Norwegian Medical Association (NMA).

Materials and Methodology

The literature referred to has largely been found through some ten years’ research related to The Norwegian Physicians’ Survey\(^\text{13}\). To identify such studies using ordinary search strategies in e.g. Medline is complicated since several studies including both “physicians” and “health service” or “mental disorder” are not relevant—since many of them refer to physicians as health service staff or therapists. “Physician impairment” is also inadequate as a search term for the topic of this review.

Selection criteria
- Studies concerning physicians’ health problems, health-related behaviour and their use of health services, but also studies on the importance of working conditions for doctors’ health.
- Studies of medical students are not included.
- The Norwegian Physicians’ Survey has been prioritised, followed by Nordic and British studies.
- Publications from the past ten years, 1997–2007, have been given priority. (Several older key studies on physicians’ health-related behaviour and use of health services have also been included.)

Table 1 gives an overview of the selected studies between 1997 and 2007 from The Norwegian Physicians’ Survey, which internationally is a quite unique programme. We lack an updated review in English of the contribution from this Norwegian research programme.

Results

In all, 96 references were located, of which 18 (Table 1) belong to the category of selected studies from The Norwegian Physicians’ Survey (1997–2007). Only six of the 96 references\(^\text{41, 49, 67, 69, 74, 95}\) did not refer to physicians. All references were in the year range 1983–2007.

Where can knowledge of physicians’ health problems and health services for physicians be found?

Of historical importance are the programmes for impaired physicians conducted in the USA\(^\text{14}\). During the past 30–40 yr Americans have recognised the problem of seriously ill doctors\(^\text{8, 9}\). They have also made most progress in describing the programmes and studying the effect of interventions\(^\text{15–18}\). In the past few years international conferences on physicians’ health have been organised through a cooperation between the medical associations in the USA and Canada\(^\text{99}\). The first and so far the only European research conference on physicians’ health was arranged by the Research Institute of the NMA in Oslo 1996\(^\text{20}\). The first international conference on doctors’ health in Asia and Oceania is planned in Australia for 2007\(^\text{21}\), and there is an excellent overview of several international health programmes for physicians in a special edition of the Medical Journal of Australia\(^\text{22}\).

In 1990 the NMA decided to undertake a nationwide survey—The Norwegian Physicians’ Survey. The survey is unique in an international context with regard to both representativeness and scope\(^\text{23, 24}\). The large-scale cross-sectional study in 1993 encompassed all Norwegian physicians, a sample of a total of 9,000 doctors\(^\text{23}\). A representative panel of 2000 Norwegian physicians drawn from all parts of the country are also being monitored over time by the Research Institute of the NMA\(^\text{25}\). In addition we have followed two nationwide cohorts of all the 400 Norwegian medical students who began their studies in 1993\(^\text{26, 27}\) and 600 who graduated in 1993 and 1994\(^\text{28, 29}\). Together these two cohorts constitute the Longitudinal Study of Norwegian Medical Students and Physicians. In 2003 the ten-year follow-up was conducted, and a 15-year follow-up of the two cohorts is planned for 2008. An updated overview of publications (with abstracts) from this research programme can be found on the website of the Research Institute of NMA\(^\text{1}\).

Physicians’ health and use of health services has also been surveyed in England, the USA and Finland\(^\text{3, 30–32}\). Erica Frank and co-workers have conducted large-scale epidemiological studies on the health and health-related behaviour of female American physicians\(^\text{3, 10, 33}\). In Barcelona, Spain there is a special hospital for doctors and nurses\(^\text{34, 35}\), and during the past few years this programme has also arranged two meetings for European experts in this field. In Norway Modum Bad Hospital has assigned priority to treating doctors and other healthcare professionals\(^\text{36}\). The Villa Sana Resource Centre is a low-threshold facility that has come into existence through a cooperation between Modum Bad Hospital and the NMA\(^\text{37}\).
General health status and physical health

In essence physicians should have the same health problems as the rest of the population in corresponding socio-economic groups. A large-scale American study showed better general health-related behaviour (tobacco, alcohol, exercise etc.) among female doctors than among other women in the population. The conclusion was that female physicians were good health role models for American women. A nationwide Finnish study also showed better self-reported health among female doctors than among other women, while the health of male doctors was as good as that of other men. However, some chronic illnesses were more prevalent among both female
and male physicians—for example chronic eczema, stomach and intestinal disorders, back complaints and mental health problems. Male Finnish doctors suffered more often from asthma and chronic emphysema than other men. A Norwegian study showed that physicians have dietary habits quite similar to a reference population. Another study showed that male physicians had a higher level of physical functioning than other university graduates, but were at a lower level with regard to social skills and vitality. There was no difference between female doctors and other women with higher education. The Norwegian Physicians’ Survey also revealed more health complaints among female physicians than among their male counterparts. 

Table 1. (Continued) Studies on health problems and health behaviour among Norwegian physicians 1997–2007

<table>
<thead>
<tr>
<th>Study and year</th>
<th>Design</th>
<th>Sample</th>
<th>N</th>
<th>Response rate (%)</th>
<th>Main outcome</th>
<th>Important findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stavem et al. 2001</td>
<td>Cross-sectional</td>
<td>All doctors</td>
<td>1,126</td>
<td>57</td>
<td>Self-perceived health status</td>
<td>Male physicians scored better than other university graduates on physical functioning, but lower on vitality and social functioning. Female physicians scored lower than males on physical functioning, vitality and mental health. Seventy-five per cent had performed self-treatment during the preceding three years. Among those who were on prescription medication 73% had self-prescribed. Fifty-six per cent would prefer treatment for somatic illness from a doctor with whom they had no personal ties. Half of the doctors would prefer to seek help for mental health problems at facilities other than those located where they lived.</td>
</tr>
<tr>
<td>Rosvold &amp; Bjertness 2002</td>
<td>Cross-sectional</td>
<td>All doctors</td>
<td>1,476</td>
<td>70</td>
<td>Illness behaviour (self-treatment and help-seeking)</td>
<td>Most of the self-perceived health status was explained by self-reported psychiatric morbidity, but also by somatic morbidity. The number of working hours, specialty choice and position were less important.</td>
</tr>
<tr>
<td>Stavem et al. 2003</td>
<td>Cross-sectional</td>
<td>All doctors</td>
<td>1,126</td>
<td>57</td>
<td>Self-perceived health status</td>
<td>Six per cent reported suicidal planning during the first four postgraduate years. Predictors of this were personality (neuroticism), serious depressive symptoms and negative life events. The transition from thoughts to planning after graduation was predicted by personality (reality weakness) and severe depressive symptoms.</td>
</tr>
<tr>
<td>Tyssen et al. 2004</td>
<td>Longitudinal (4 yr)</td>
<td>Young doctors</td>
<td>327</td>
<td>52</td>
<td>Serious suicidal ideation/suicidal planning</td>
<td>Thirty-four per cent of all doctors reported a need for treatment in at least one of the three observation periods, whereas two-thirds of those with such need had sought help. Lack of help-seeking among those with a need for treatment was predicted by personality (reality weakness) and a lower level of perceived mental health problems.</td>
</tr>
<tr>
<td>Hem et al. 2005</td>
<td>Longitudinal (9 yr)</td>
<td>Young doctors</td>
<td>252</td>
<td>40</td>
<td>Self-prescribing</td>
<td>Fifty-four per cent of Norwegian doctors reported self-prescribing of drugs during the fourth and ninth year after graduation. Self-prescribing in the ninth year was predicted by male gender, previous self-prescribing (during internship), and not having consulted a general practitioner. This also held true in multivariate statistical models, where the levels of somatic, psychiatric and subjective health complaints were controlled for.</td>
</tr>
<tr>
<td>Rosta &amp; Aasland 2005</td>
<td>Cross-sectional</td>
<td>All doctors</td>
<td>1,120</td>
<td>69</td>
<td>Hazardous drinking</td>
<td>Female surgeons drank more alcohol (and more hazardously) than other female physicians. Among all the doctors, hazardous drinking was predicted by male gender, surgical specialty, and an age of 45 or more.</td>
</tr>
<tr>
<td>Rø et al. 2007</td>
<td>Cross-sectional</td>
<td>Villa Sana doctors/All doctors</td>
<td>226 / 6,602</td>
<td>94</td>
<td>Burnout, mental distress, and suicidal ideation</td>
<td>Among the Sana doctors (in a counselling programme) 49% were emotionally exhausted (Maslach) compared to 25% among other Norwegian doctors. Seventy-three per cent had clinically significant mental distress compared to 14–18% among other doctors. Twenty-one per cent had experienced serious suicidal ideation, in contrast to 10% among other Norwegian doctors.</td>
</tr>
</tbody>
</table>
Work and mental distress

Several studies indicate a high prevalence of stress and psychological problems among physicians, and there has recently been a focus on safe working practice, particularly in terms of working hours, especially among junior doctors. Likewise, a connection has been shown between lack of sleep and mental health problems among doctors. With regard to the connection between work-related stress and health complaints, the demand-control model of Karasek and Theorell has been widely applied in the general population and also in some studies among different groups of people. The combination of high demands and low control (autonomy) at work is critical for mental and physical health (for example coronary heart disease). An American follow-up study among physicians showed that a lack of control and social support in their work was associated with psychological problems one year later. Indirectly, the demand-control model has also been confirmed through other studies among physicians. A low degree of perceived autonomy was the factor that was most strongly linked to pressure of time among Norwegian doctors, who more often than other university graduates experienced a harassing and hectic work situation. We found that pressure of time and interruptions at work were what junior house officers with suicidal ideation perceived as generating most strain. Emotional pressure and demanding patients were also related to mental health problems during internship, regardless of previous problems, personality and other factors that were controlled for. This is in agreement with Maslach’s model for experienced burnout, in which emotional exhaustion is a significant single factor. This model has been validated among Norwegian physicians and a connection has been confirmed between emotional exhaustion and depression.

Among Norwegian junior house officers stress outside the job—for example problems in personal relationships or through not having a partner—were related to emotional problems, which agrees with a study conducted among British healthcare professionals. We have also examined more closely what can predict stress among junior house officers: as anticipated, both inadequate support from colleagues and sleep deprivation play a role as well as perceived medical recording skills. Nonetheless, such job stress is primarily connected to particular personality traits and personality types. A link has also been shown between interpersonal problems and occupational stress among Norwegian physicians. An aspect that should be investigated in more detail is the fact that although many doctors are overworked, and despite reports on a deterioration in working conditions at hospitals, Norwegian physicians report quite high and stable job satisfaction over time.

Mental health and substance abuse

Some reports indicate that self-reported mental health problems are more prevalent among doctors and other healthcare professionals than in the general population. Psychiatric morbidity rather than working conditions explains much of the self-perceived health of physicians. There is a higher incidence of depressive symptoms and depression among young doctors in particular—British and American studies show a prevalence of up to 30% in the first year after graduation. A new meta-analysis revealed a higher suicide rate among physicians—with a slight increase for male doctors and a considerable increase for female doctors—compared with the rest of the population. The increased suicide rate has also been confirmed recently among Norwegian physicians of both genders, and this also applied when we compared with other university graduates and healthcare professionals, such as dentists and nurses. However, all groups show declining rates during the last decade. Norwegian medical students and physicians show a high prevalence of serious suicidal ideation and plans (lifelong prevalence 8–10%), but a low prevalence of suicide attempts. Suicide attempts as a “cry for help” are therefore probably found to a lesser extent among physicians than among the general population, and doctors succeed in their attempts more often than others.

Despite a well-known decline in tobacco use among physicians in some developed countries, a recent and comprehensive international review found that doctors’ smoking rates vary from region to region, and they are still not uniformly low. Previous findings showing a high prevalence of alcohol abuse among British and Finnish physicians have not been replicated in the USA, and the incidence of hazardous drinking among physicians in Norway is no higher than it is among others. Nonetheless, Norwegian and other studies provide grounds for concern about problematic drinking habits (drinking to attain a state of intoxication and the use of alcohol to cope with tension) particularly among female students and physicians under the age of 40. With regard to specialty, doctors in surgical disciplines report higher levels of problematic drinking than do other specialists. Several studies, including one Norwegian study, indicate more self-treatment with addictive medicines among doctors than counterparts—mainly concerning stress-related pain.
among others\textsuperscript{60, 64}. Substance abuse is common among physicians who are admitted to psychiatric institutions\textsuperscript{66}, and self-prescribing can pose a risk for subsequent abuse\textsuperscript{66}. It is precisely the comorbidity of depression, substance abuse and suicide that is important—maybe particularly among physicians\textsuperscript{13}.

The risk of suicide increases with concurrent depression, substance dependence and previous suicidal conduct, especially in combination with feelings of loss and an emotionally unstable personality\textsuperscript{67}. Improving psychiatric treatment represents an important measure to prevent suicide\textsuperscript{68, 69}. Suicidal physicians should be monitored: their access to lethal medicines should be prevented and their premature discharge from institutions averted\textsuperscript{70}. The increased prevalence of suicide among doctors who are under disciplinary surveillance should be noted\textsuperscript{71}. Moreover, both severe depressive symptoms and deviant personality traits can aggravate suicidal ideation among young doctors\textsuperscript{72}.

Are there differences between male and female physicians?
A need for help due to mental health problems was reported by 17\% of young Norwegian doctors in the fourth year after graduation, with no gender difference in the incidence\textsuperscript{73}. The prevalence is at the same level as that in the rest of the population, but there are twice as many women than men with psychiatric disorders\textsuperscript{74}. The lack of proven difference between female and male physicians is probably due to a greater need for help (and seeking help) among young male doctors than among other young men\textsuperscript{73}. We found no such difference between young women doctors and women in general. However, when Norwegian women doctors are surveyed later in their career, they nonetheless have more stress-related pain and depressive symptoms than male physicians\textsuperscript{23, 39, 75}.

Use of preventive measures and the primary health service
An under-use of the primary health service has been shown among physicians, particularly the use of preventive screening for some illnesses\textsuperscript{76, 79}. Only 55\% of Norwegian female physicians followed recommendations on preventive cervical cancer testing every third year—significantly fewer than other Norwegian women\textsuperscript{77}. Finnish doctors also consult the health services more seldom than others\textsuperscript{78}, while one-third of young British physicians were not registered with a general practitioner\textsuperscript{80}. A large-scale British study among more than 1,100 physicians examined whether they followed the British Medical Association’s ethical guidelines for health services among doctors\textsuperscript{51}: a total of 96\% were registered with a general practitioner as recommended, but a quarter of the specialists would never consult general practitioners prior to seeking specialist advice, and a quarter of the general practitioners were registered with a colleague in their own practice. Other British studies indicate that doctors do not have adequate occupational health services\textsuperscript{30, 78}.

Self-care, sick leave and seeking help
The Finnish study showed that physicians took sick leave more seldom than others and performed extensive self-treatment—which even applied to two-thirds of those with mental disorders\textsuperscript{23}. Several other studies indicate considerable self-medication among physicians\textsuperscript{26, 30, 31, 79, 80}. The Norwegian Physicians’ Survey showed that eight out of ten doctors had prescribed medicines for themselves\textsuperscript{84}. One out of ten said they had used tranquillisers, and of these 73\% had prescribed this medication themselves. British studies have shown that physicians refrain from taking sick leave more often than others and that they more frequently work during the illness\textsuperscript{30, 81}. As many as 80\% of Norwegian physicians reported that during the preceding year they had worked during an illness for which they would have sick-listed their patients\textsuperscript{82}.

Among young Norwegian physicians there was an increase in the need for help for mental health problems, but no corresponding increase in seeking help\textsuperscript{83}. A personality trait (reality weakness) that is connected with severe personality disorders was a risk factor for lack of help-seeking. Male young doctors and those who had not consulted a general practitioner self-prescribed more often\textsuperscript{28}.

What is known about the effect of special treatment programmes for physicians?
Few evaluations have been made of special treatment programmes apart from the American programmes for impaired physicians. The aim of the programmes is twofold: to help doctors with problems and to protect patients from doctors who are unable to function adequately\textsuperscript{99}. In most American states the programmes are run by the medical societies, while in some states the medical boards are responsible for them. A couple of follow-up studies of five to ten years’ duration have shown that 75–77\% had improved and had achieved stable abstinence, but that this required frequent urine tests and surveillance\textsuperscript{17, 18}. Programmes with an Alcoholics Anonymous approach and regular checking of urine tests have been shown to have the best effect\textsuperscript{64}. After hospitalisation in an institution, at least two to three years’ monitoring is required along with monthly consultations to ensure the best possible result, and the threat
of losing their licence is a motivating factor for some physicians\textsuperscript{89}. However, the most successful initiatives separate medical treatment from disciplinary measures and emphasise self-help groups in confidential treatment programmes\textsuperscript{75}. Previously the programmes mainly treated substance addiction (over 90\%), while later studies show more dual diagnoses (substance problems and mental disorders) and psychiatric diagnoses alone\textsuperscript{15}. The conclusion is that there is a need for more varied and diverse psychiatric treatment measures rather than those that focus exclusively on substance abuse problems\textsuperscript{89, 85}. Among those with such problems, opiate misuse poses the greatest risk of relapse—a risk that is also increased by a concurrent psychiatric disorder\textsuperscript{16}.

The NMA’s programme for physicians in Norway

Surveys in the pilot phase showed that 84\% of the physicians wanted a special scheme that would provide doctors for doctors, and that such a scheme should focus on working conditions and psycho-social factors as well as the usual physical health examination\textsuperscript{86, 87}. The actual scheme is twofold:

The support-doctor scheme

Support doctors represent a low-threshold facility, and to some extent they take the initiative vis-à-vis colleagues with crises and problems. It is not intended to be physician’s work in the traditional sense, and the scheme is not funded by the National Health but is run by the local medical associations.

The doctors’ doctors’ scheme

The scheme consists of government-financed general practitioners who have been specially selected and trained to treat patients who are colleagues. Physician-patients’ denial of their own illness and the special doctor-patient relationship that is formed when they consult another physician demand very careful attention\textsuperscript{88–91}. Specialist health services (for example psychiatrists for physicians) are not formally included in the scheme. An e-mail survey in 2001 showed that psychiatrists for physicians were only found in 11 of 19 counties (58\%) and that the service was not available in some central and large counties\textsuperscript{3}. Knowledge of the scheme has recently been surveyed in a random selection of Norwegian physicians, and even though two-thirds of them had heard of both these schemes, only 11\% had consulted a doctors’ doctor\textsuperscript{92}.

The Villa Sana Resource Centre

This is a low-threshold facility that was evaluated for the first time in 2001\textsuperscript{93}. It runs both group-based one-week courses and one-day individual counselling for physicians, either alone or with their partner. During the first two-year period a total of 186 physicians had taken advantage of the services, 86 of whom participated in the one-week course (daily teaching and group discussions and at least one individual discussion during the week). Almost half of them were women, and problems related to both their job and their private life were common reasons for physicians to attend the centre. Almost all the course participants (94–99\%) assessed the personally-oriented group discussions and the individual discussions as excellent or quite good. A prospective study of the participants in the programme in the two-year period 2003–2005 has been started, and the initial description of this sample indicates severe mental health problems among the participants compared with other Norwegian physicians\textsuperscript{97}. This suggests that the service attracts those who need help.

Discussion

Physicians’ physical health appears in general to be as good as that of the general population, but there is much to suggest that female doctors have better physical health than other women. Some self-reported mental health problems, and in particular depressive symptoms and depression, seem to be more prevalent among physicians. Some of the apparent increase in psychiatric morbidity can be due to the measuring instruments that report a high general level of stress in this professional group\textsuperscript{13}. And we need more studies that compare the occurrence of valid mental disorders among physicians, as assessed by diagnostic interviews, with that among other people. Nonetheless, studies conducted in several countries show that suicide is more frequent in this occupational group, particularly among women doctors. Substance addiction is also a common problem among doctors who are admitted to psychiatric institutions, and self-treatment with addictive medicines constitutes a risk.

The increased prevalence of mental health problems among physicians and other healthcare professionals is most likely caused by both individual factors and working conditions\textsuperscript{6, 24, 51}. It should be possible to avoid such unfortunate working conditions. In a number of studies, pressure of time and emotionally-demanding patients as well as lack of sleep are related to mental health problems. In other stressful occupations where errors at work have significant consequences for others—for example
professional drivers and pilots—working hours and health are carefully monitored. The fact that there appears to be no similar preventive reasoning for physicians and other healthcare professionals provides food for thought. Factors such as pressure of time and interruptions during work are most often due to organisational factors. Hurried work among young doctors frequently reflects an unfavourable working environment in hospital departments, which also takes its toll on other employees. More minor psychiatric disorders have been found among healthcare professionals than among others. Poor teamwork in the departments leads to long-term sickness absence among hospital physicians, even when other factors are controlled for. In addition, in the USA it has been shown that a reduction in the 24-h shift for young doctors reduces the number of serious medical errors. Healthcare politicians and administrators should take note of such factors.

Why is there no gender difference in perceived mental health problems among young Norwegian physicians while among those who are somewhat older more stress and depression are evident among women doctors? Changes that only become apparent after some time indicate that work-related stress (and other forms of life stress) play a role, while early changes are to a large extent due to individual susceptibility. The increased prevalence of problems among male doctors, which is already evident at a younger age, can therefore be probably related to personality factors. A greater incidence of problems among elderly women doctors may primarily be caused by stress related to the profession (and negative life events). We have empirical data that enables us to make this claim, since neuroticism in the form of increased self-criticism is a predictor of depression among male doctors, but this is not the case for women physicians. Moreover, stressful events in life are linked more to depression among women than among men, and a connection has also been found between work-related stress and depression among US women physicians. This hypothesis must be examined in more detail in follow-up studies.

There is an under-use of general practitioner services and preventive health services among physicians. This is important since general practitioners are those who are best equipped to diagnose and treat the most common disorders and are also familiar with the local referral procedures. They can therefore ensure that physicians—in line with others in the population—receive prompt and optimal treatment.

Physicians perform extensive self-treatment, often “work themselves through” an illness and take sick leave more seldom. Much of this can be due to their denial and minimisation of their own symptoms, and also to additional difficulties they experience in taking on the role of patient. It may be claimed that self-care is not always detrimental, but a study of this among British general practitioners showed that according to a “jury” consisting of other general practitioners the self-treatment in question amounted to malpractice in almost 80% of the cases. The fact that physicians to a large extent treat themselves for mental health problems (and with psychotropic medication) as Norwegian and Finnish data show will be regarded by most people as extremely unfortunate.

American studies suggest that physicians have a great potential for improvement with regard to substance abuse and addiction and also perhaps to mental disorders in general if they can receive adequate treatment. The effect of treatment programmes among physicians should however be studied in more detail, including in other parts of the world and particularly with regard to disorders that are purely psychological.

Since stress and mental health problems are so prevalent among physicians, the mental health services assume a unique position and should be more accessible for doctors. The Villa Sana Resource Centre represents a step in this direction. It has been given positive evaluation from course participants and appears to attract the target group. In addition to a number of foreign studies, The Norwegian Physicians’ Survey has provided new and not least representative knowledge of this field. However, we need more international cooperation on physicians’ health as well as programmes aimed at improving it. In particular international research collaboration is needed to assess the effect of preventive measures and treatment programmes in different cultures.

Conclusion

Overall, this literature review shows that while doctors’ physical health appears to be good, several studies reveal a high prevalence of stress-related and mental disorders, particularly depression and suicide. The misuse of medicines is also a problem in this professional group. Physicians often show inadequate illness-related behaviour, but specially-organised treatment programmes for physicians in the USA have shown positive effects. There is a tendency towards more dual diagnoses and psychiatric morbidity in these programmes, which formerly mainly treated substance problems among physicians. Physicians should therefore be ensured psychiatric treatment, and the
Norwegian Villa Sana programme is a promising initiative towards lowering the threshold for seeking help for such problems.

Acknowledgements

The author is grateful to Ruth Johnson (Akasie, Norway) for her kind assistance during the preparation of this article in English. Erlend Hem and Olaf G Aasland also made substantial and valuable comments during manuscript revision.

References

60) Flaherty JA, Richman JA (1993) Substance use and addiction...
92) Aasland OG, Falkum E, Thaulow IS (2006) Hva vet norske leger om egne hjelpe-og støtteordninger [To what extent are Norwegian doctors familiar with their own support systems?]. Tidsskr Nor Laegeforen 126, 3256–7 (in Norwegian).

