

# How clinicians expect to be judged when they access mental health care versus how they judge others

 Research brief

A research collaboration between:

Heart of Safety  
**Coalition**

Inspiring transformation for care team safety and wellbeing

**ALL IN**  
Wellbeing First for Healthcare  
a coalition led by



## Clinicians often carry an unspoken fear that seeking mental health support could invite questions about their fitness to practice or professionalism, leading to subtle, or even overt, judgment from colleagues or leaders.

In a profession where resilience is demanded and emotional strain is frequently minimized, acknowledging personal vulnerability can feel risky. Many clinicians worry that accessing mental health care might be interpreted as a sign of weakness or an inability to handle the pressures of the job, potentially affecting how peers view their clinical decision-making, reliability or professionalism. This fear of reputational harm can create a powerful barrier to accessing mental health care, leaving clinicians to struggle quietly rather than pursue the support they need and deserve.

In our 2025 report, "[Clinician perceptions of barriers to access mental health care](#)," we found that more than half of our sample, which included 750 physicians (MDs and DOs), 250 nurse practitioners (NPs), 251 physicians assistants (PAs) and 765 registered nurses (RNs), reported that negative attitudes or beliefs from their peers or direct supervisors and leaders create moderate, significant or prohibitive barriers to accessing mental health care.<sup>1</sup>

To see whether expectations of judgment about mental health care access from colleagues and supervisors aligned with respondents' professed judgment of fellow clinicians, we asked two similarly worded questions. One question asked how respondents would judge colleagues' ability to practice in a competent, ethical and professional manner if they learned that colleague accessed mental health care (expected judgment). The other asked how respondents expected colleagues' and leaders' attitudes and beliefs to be affected by the knowledge that the respondent had accessed mental health care (perceived judgment).

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## Expected judgment far outpaces professed judgment

Across all clinical roles, the expectations of a negative response if colleagues or direct supervisors were to learn that respondents accessed mental health care dramatically outpaced professed negative responses to the knowledge that colleagues accessed mental health care (see Figure 1). In fact, differences for “somewhat” and “extremely negative” ranged from five-fold (physicians) to ten-fold (nurse practitioners).

Respondents were also much more likely to express a positive response upon learning a colleague accessed mental health care than they were to expect to receive such a response. The majority of NPs, PAs and RNs and almost half of MDs/DOs reported they would expect that accessing mental health care would result in a positive impact on a colleague’s ability to practice in a competent, ethical or professional manner, while only about a quarter would expect that same positive response from colleagues or leaders.

“ [The biggest barrier to accessing mental health care is] stigma and code of silence. Concern about rumors and gossip. Concern about job security and breakdown of team trust. ”

**Emergency medicine physician**  
age 37

“ [The biggest barrier to accessing mental health care is] stigma that ‘there must be something wrong with you’ therefore I am worried that you cannot carry out your patient care safely. ”

**Neurology physician associate**  
age 64

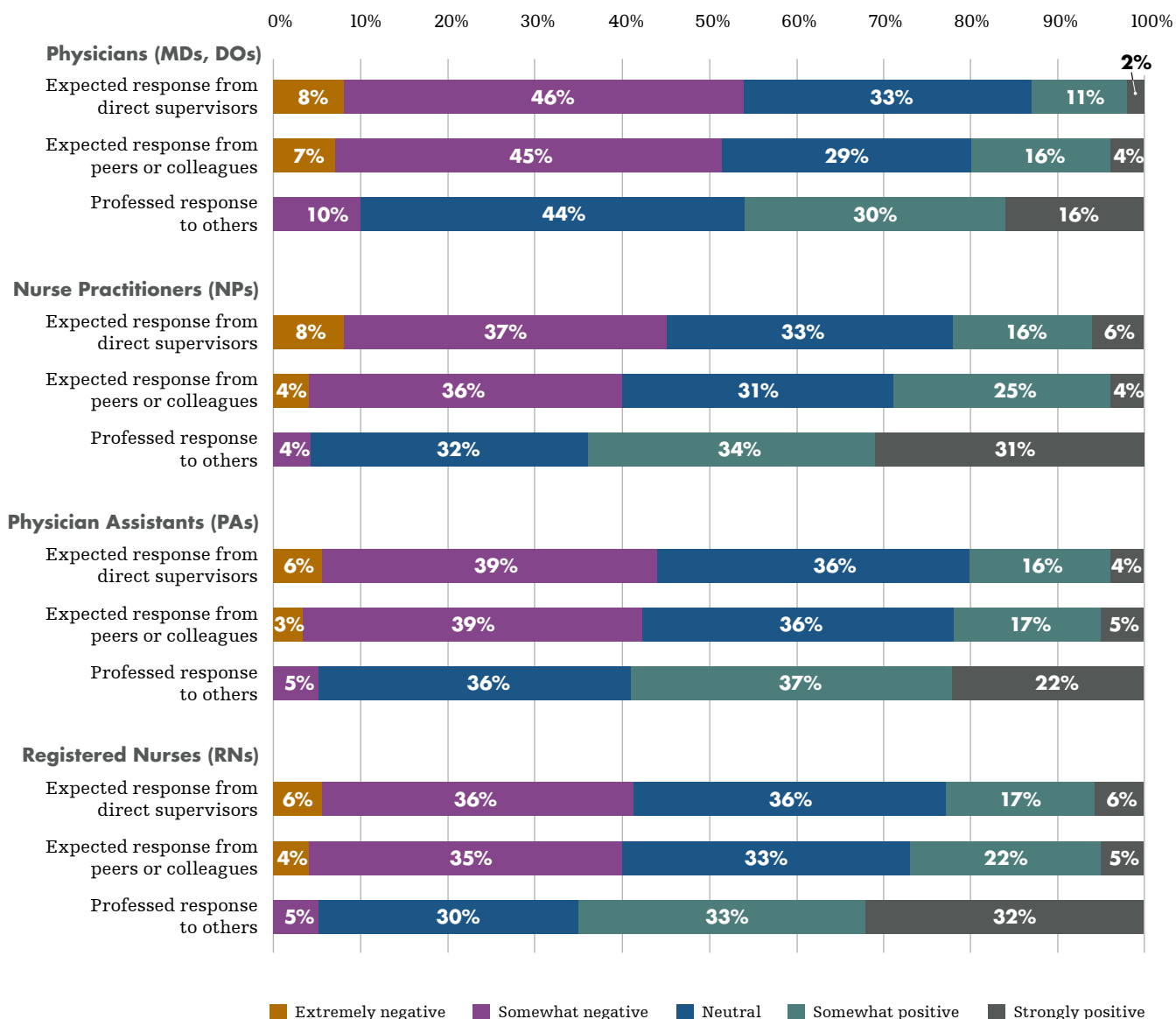
**Figure 1: Respondents were more likely to expect mental health judgment than to profess it.**

**“Expected response” based on the question:**

“Whether or not you receive mental health care, what do you believe the following people’s attitudes and beliefs would be about your ability to practice in a competent, ethical and professional manner if they knew you received mental health care?”

**“Professed response” based on the question:**

“If you learned that one of your colleagues accessed mental health care, what would your attitudes and beliefs be about their ability to practice in a competent, ethical and professional manner?”



Base: 750 MDs/DOs, 250 NPs, 251 PAs, 765 RNs

## Age is a factor in expected judgment but not professed judgment

One of the surprise findings in our report was that professed judgment of colleagues who access mental health care did not follow an age gradient, despite conventional wisdom that younger generations are more accepting (and older generations, conversely, more judgmental) of mental health conditions. Our data showed that older respondents were not significantly more likely to report a negative reaction to a colleague accessing mental health care.<sup>2</sup>

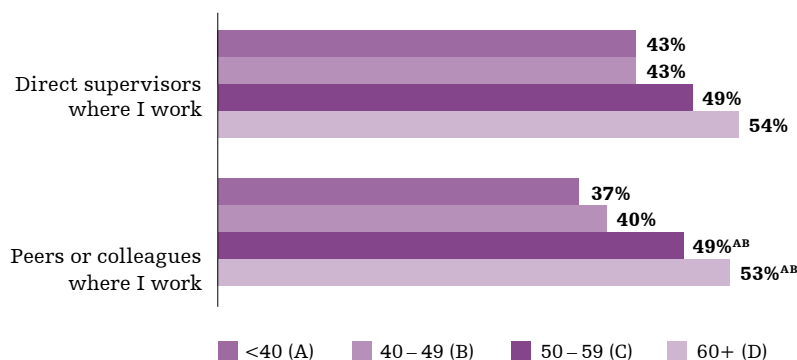
However, when we examined the data pertaining to expected judgment, we found significantly greater expectations of judgment from peers, colleagues and leaders among respondents 50 and older versus their younger counterparts (see Figure 2).

“ [The biggest barrier to accessing mental health care is] the repercussions on my practice from executive staff if engaging with mental health care providers.”

**Orthopedic surgeon**  
age 60

**Figure 2: Older clinicians are more likely to expect judgment for accessing mental health care.**

“Whether or not you receive mental health care, what do you believe the following peoples’ attitudes and beliefs would be about your ability to practice in a competent, ethical and professional manner if they knew you received mental health care?”  
(extremely/somewhat negative)



Base: 750 MDs/DOs, 250 NPs, 251 PAs, 765 RNs

Scale: Extremely negative, somewhat negative, neutral, somewhat positive, strongly positive

Capital letters indicate 95% confidence interval difference with comparison group; lowercase letters indicate 90% confidence interval

## Discussion

The good news from these data is that most clinicians do not disparage colleagues for seeking mental health care. In fact, most view it as a responsible choice that will improve a care team member's ability to practice in a competent, ethical and professional manner. And yet, many feel that seeking help will invite others to judge them and doubt their fitness to practice and professionalism. This gap between personal acceptance and anticipated social stigma contributes to underuse of mental health services by medical professionals.<sup>3,4</sup>

It is also important to note that social desirability bias may have contributed to respondents' low reporting of judgment against colleagues seeking mental health care. The fact that our survey was administered anonymously and online may have mitigated some of the social desirability effects, but more research is needed to uncover the degree to which clinicians are willing to admit mental health biases, even to themselves.<sup>5,6</sup>

Age differences in our data may also indicate a certain level of social desirability bias. Older clinicians who expressed a higher expectation of judgment nevertheless expressed equally low levels of professed judgment as their younger counterparts. This may reflect a difference between an automatic prejudiced response and a nonprejudiced controlled or deliberative response.<sup>7</sup> Even if this accounts for all of the multifold difference between expected and professed judgment, we view that as good news. This would suggest a significant culture shift where the majority of the people view seeking mental health care as a sign of strength not weakness.

“ [The biggest barrier to accessing mental health care is] knowing that other health care workers will now be always weighing and judging my decisions based on knowledge of my mental health. If I make a mistake, it might be taken as relapse or poor judgment on my part due to being mentally ill. ”

**Psychiatric nurse**  
age 34

## Actions

Given the incontrovertible facts that clinicians are human and healthcare work is stressful and at times traumatic, accessing mental health care and support resources is logical — and maybe even necessary — to grow and thrive as a clinician. Judgment and stigma still exist, but our data suggest that the tide is turning. Depending on your unique situation, attitudes and beliefs, we recommend the following actions:

- **Examine your biases.** If you are among the one in 10 MDs/DOs or one in 20 NPs, PAs or RNs who believes that accessing mental health care is a sign indicating a diminished capacity to practice in a competent, ethical or professional manner, we recommend taking a look inward to examine where these beliefs come from and whether you still believe they are fact-based, particularly in light of newer treatment modalities that often break the link between disease and disability.
- **Cautiously self-disclose.** If you are a clinician experiencing mental health stress or distress and are worried about the reputational impact of seeking mental healthcare, our data suggest you have far more allies than you may realize. Many mental health conditions are exacerbated by isolation and fear. But seeking support is a sign of strength, and disclosing your mental health needs to trusted colleagues or leaders could help you find needed resources. In addition, there are national confidential resources where clinicians can find support that takes into account the unique stresses and challenges faced by clinicians. You can find many listed at [ALL IN for Mental Health](#).
- **Express your support.** If you are part of the majority of respondents who view seeking mental health care in a positive light, first, thank you! You now have the opportunity to shape the culture of healthcare into one that celebrates help-seeking behavior and recognizes and supports the humanity of all clinicians. If you feel safe to do so, consider sharing your mental health experiences and how you found support. This helps reduce the likelihood that a

“ [The biggest barrier to accessing mental health care is] the sense of shame. Even picking up the psych meds is shameful. I have a fear of peers judging me as less reliable, competent or weak. When I did experience mental health issues, I felt my peers felt unsure as to how to approach me. ”

**Psychiatric nurse**  
age 56

clinician will think, “I’m the only one who feels this way,” and shows how support can be effective. Personal and authentic storytelling is especially powerful if you hold a leadership position because it makes it clear that success and mental health support are compatible, and that those in positions of power understand that mental health matters. In addition, expressing positive sentiments toward mental health resources available in your organization or community can help signal that you understand the value of mental health and the importance of seeking care.

““ Most nurses I know almost joke about the fact that they need therapy and anxiety meds because of hospital working environments. But should a nurse actually, theoretically speaking, become suicidal and need to go to the emergency room and receive mental healthcare in an inpatient setting, there is fear about what that would look like on their nursing license. As well as the opinion of that hospital visit to their employer. ””

**Hospital medicine nurse**

age 33

# About the survey

The survey informing this report was conducted as a collaboration between the Heart of Safety Coalition, the Dr. Lorna Breen Heroes' Foundation (LBF) and its ALL IN: Wellbeing First for Healthcare Coalition (ALL IN). Subject matter experts from the Heart of Safety Coalition and LBF drafted the survey based on market knowledge and review of published surveys and data sets focused on clinician perceptions about accessing mental health care. The proposed survey was then shared with ALL IN coalition members, which included healthcare leaders from 35 organizations at the time, who provided additional feedback based on their experience and expertise.

The survey was fielded by Medscape from January 30, 2025 through February 12, 2025. The sample included 765 registered nurses (RNs), 750 physicians, 251 physician assistants (PAs) and 250 nurse practitioners (NPs) with a response rate of 36% and an incidence rate of 93%.

Survey participants were recruited as a convenience sample from Medscape's panel of healthcare professionals. Medscape's panel is derived from healthcare professionals who have joined Medscape to access its clinical content (news, condition and drug information, journal articles, CME activities and clinical tools such as pill identifier, drug interaction tool and clinical calculators). Medscape validates physician participants via the AMA database. A representative sample was requested based on age, gender, race, ethnicity, geography and practice specialty. Survey participants were offered an honorarium according to Medscape's policies. No personally identifying information (name, practice name, date of birth, etc.) was shared with the Heart of Safety Coalition, LBF or ALL IN. To protect and respect all survey respondents' privacy, they were not asked whether or not they currently have or previously had any mental health conditions, impairing or otherwise.

For this research, we chose to use the language "mental health care" and did not use explicit language about specific types of condition treated, such as substance use disorders. We understand that medically, substance use disorders are considered mental health conditions, and we know that many respondents will have included substance use disorder treatment under the umbrella of mental health care. (We saw some evidence of this in the open-ended comments). We also know, that for people (including some clinicians) who do not fully understand the biological and psychological mechanisms that underlie substance use disorders, the levels of stigma and bias can differ between substance use disorders and other mental health conditions. Substance use can often be more stigmatized than other mental health conditions.<sup>8</sup> Additional research to understand perceptions of internal, external and

institutional stigma and discrimination that may be unique to substance use disorders among clinicians would be valuable.

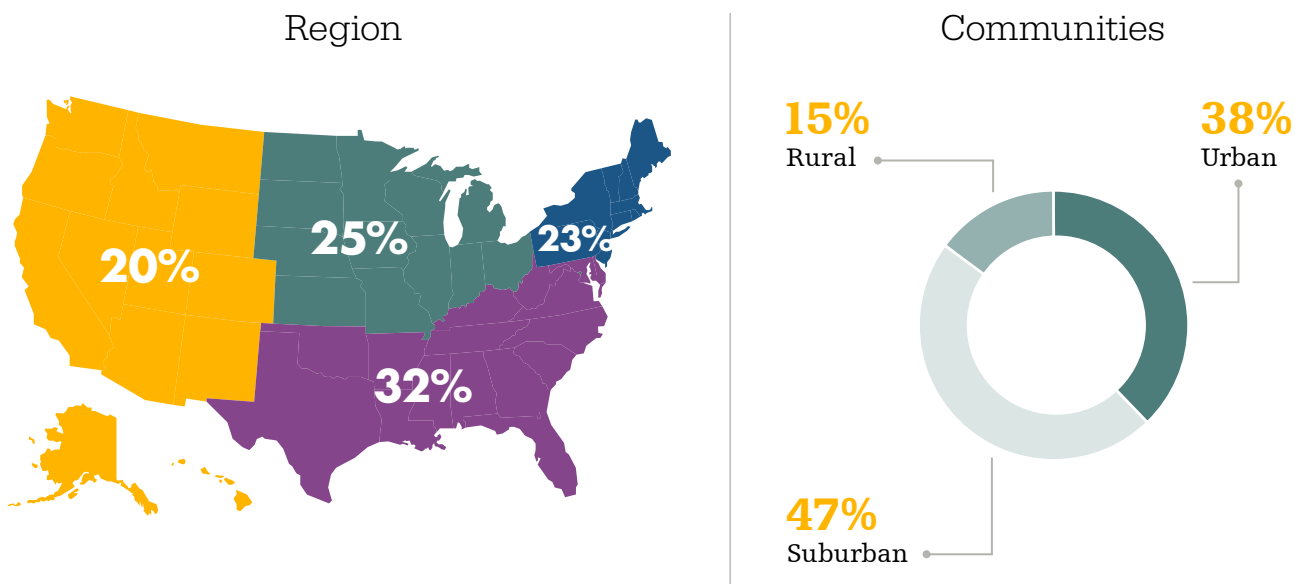
For open-ended questions, we analyzed responses using AI to identify response categories and then reviewed the categories and organized them into themes. These themes are represented in the original report, "[Clinician perceptions of barriers to access mental health care](#)".<sup>9</sup>

One intent of the original data analysis was to combine NPs and PAs into a collective group of advanced practice providers, but we found that many of the two group's attitudes, particularly around cultural barriers, diverged. In addition, the demographics were significantly different. NPs skew female within the broader healthcare profession, as does our survey sample.

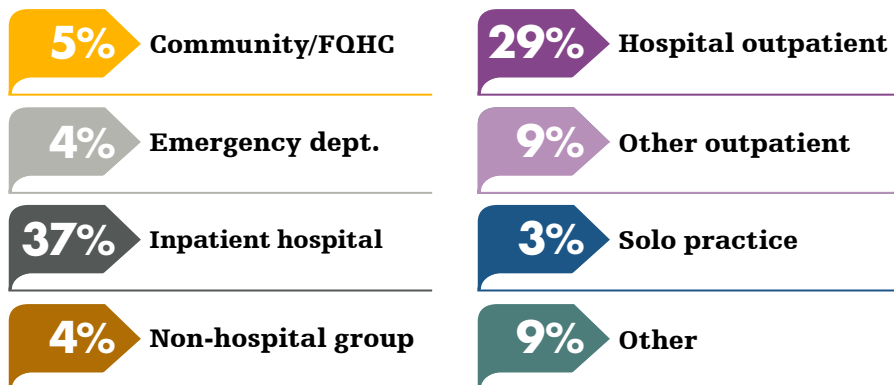
Further research is necessary to determine what drives the differences in beliefs and perceptions among certain clinician groups and what potential interventions could have the greatest impact to change both structural and cultural barriers to accessing mental health care. This survey also did not delve into the many factors of healthcare work environments that create mental stress or distress, many of which can be ameliorated to create better, safer and more supportive working environments.

We are grateful to all the healthcare professionals who shared their perspectives and insights. The following respondent characteristics are represented in the data set:

765 registered nurses



Care settings



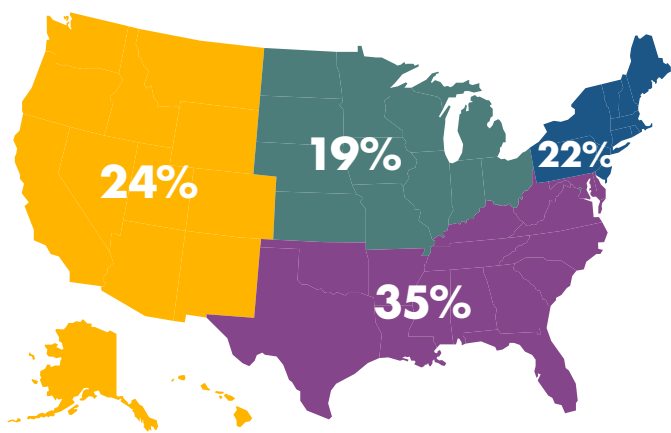
Demographics

Female	89%
Male	10%
Asian	7%
Black	4%
Hispanic	5%
White	83%
Other/ Prefer not to answer	4%
<40	21%
40 – 49	25%
50 – 59	26%
60+	28%

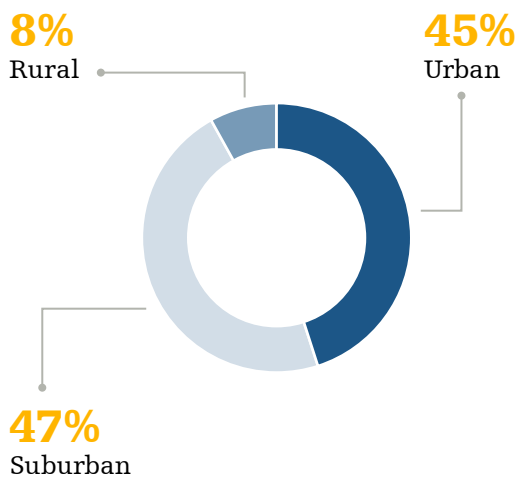
We are grateful to all the healthcare professionals who shared their perspectives and insights. The following respondent characteristics are represented in the data set:

750 physicians

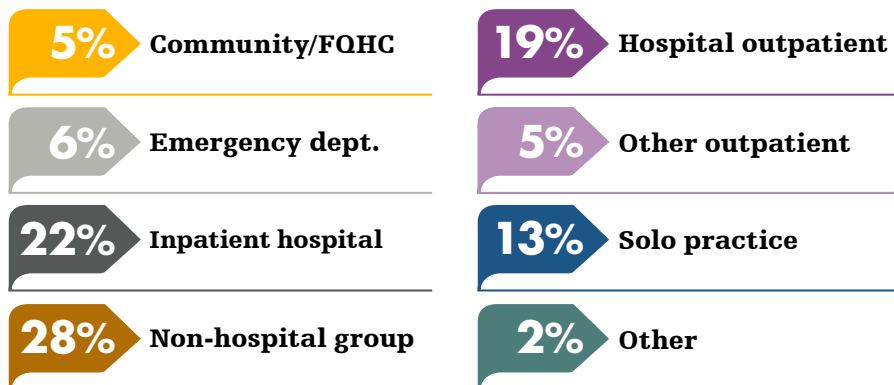
Region



Communities



Care settings



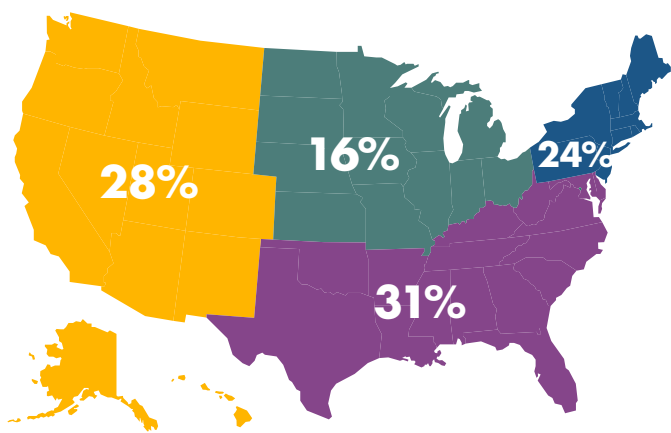
Demographics

Female	39%
Male	60%
Asian	19%
Black	7%
Hispanic	11%
White	58%
Other/ Prefer not to answer	11%
<40	24%
40 – 49	29%
50 – 59	21%
60+	27%

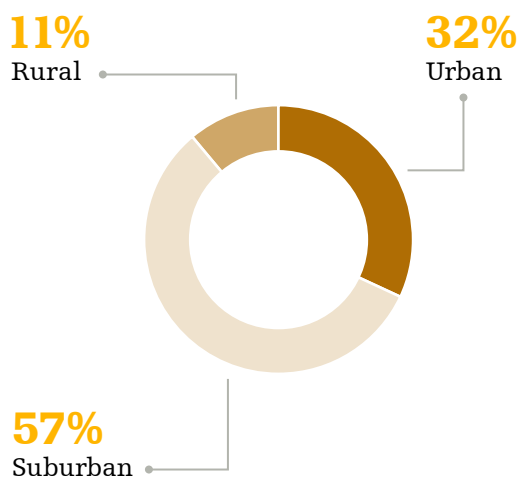
We are grateful to all the healthcare professionals who shared their perspectives and insights. The following respondent characteristics are represented in the data set:

251 physician assistants

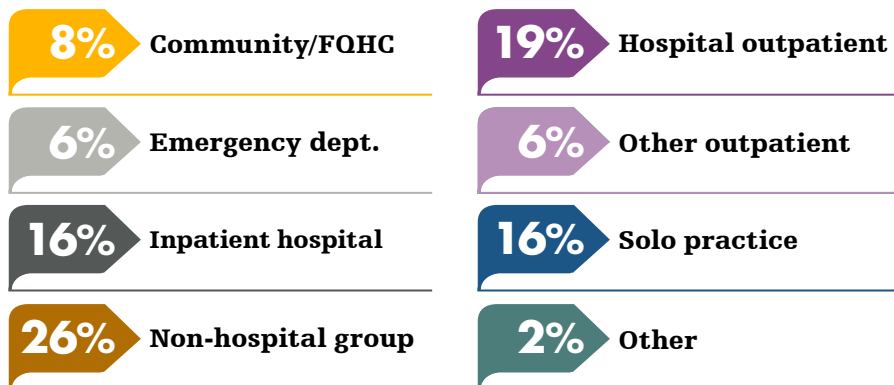
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Communities



Care settings



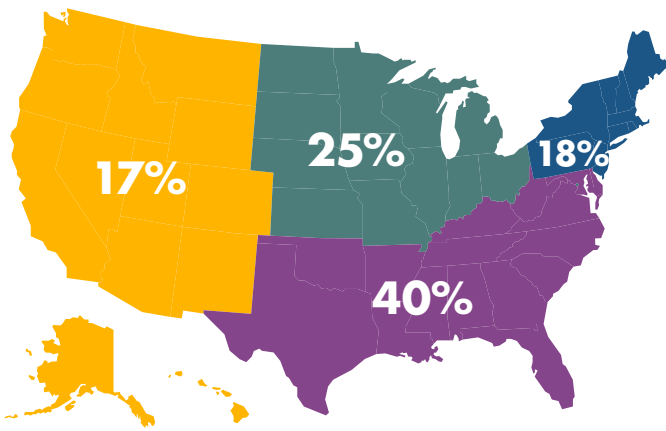
Demographics

Female	77%
Male	23%
Asian	13%
Black	5%
Hispanic	7%
White	73%
Other/ Prefer not to answer	4%
<40	41%
40 – 49	32%
50 – 59	19%
60+	8%

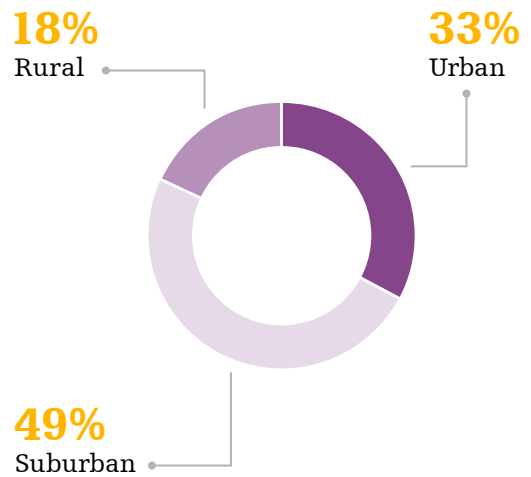
We are grateful to all the healthcare professionals who shared their perspectives and insights. The following respondent characteristics are represented in the data set:

250 nurse practitioners

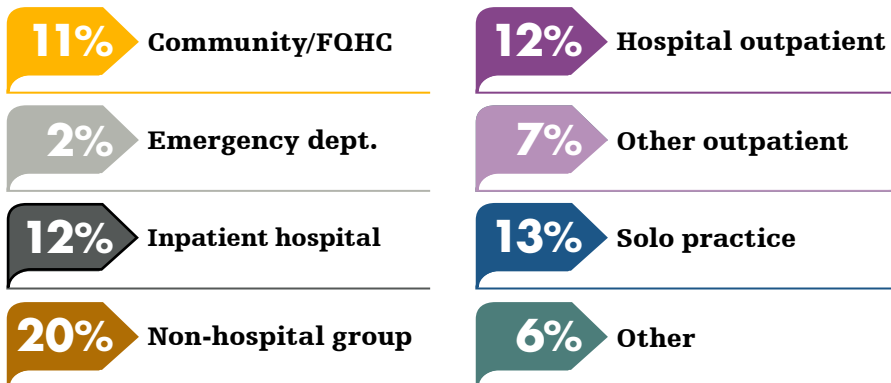
Region



Communities



Care settings



Demographics

Female	89%
Male	9%
Asian	10%
Black	7%
Hispanic	3%
White	78%
Other/ Prefer not to answer	9%
<40	33%
40 – 49	30%
50 – 59	21%
60+	16%

## References

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9. Boehm L, Simmons S. *Clinician perceptions of barriers to access mental health care*. Heart of Safety Coalition Report; September 2025 (Figure 1 and 25).

## Heart of Safety Coalition

The Heart of Safety Coalition places care team member safety at the heart of healthcare. This national community of industry leaders, learners and advocates ensures that voices are heard, connections are made, and standards are raised to inspire systemic, team and individual change that improves working and healing environments. The Coalition's three pillars of care team safety advance the Heart of Safety Declaration, which intersects the essential wellbeing principles of dignity and inclusion, physical safety, and psychological and emotional safety. Driven by its mission to make healthcare better, Stryker supports and manages the Coalition. Learn more at [www.HeartofSafetyCoalition.com](http://www.HeartofSafetyCoalition.com).

## Dr. Lorna Breen Heroes' Foundation

The Dr. Lorna Breen Heroes' Foundation's vision is a world where seeking mental health care is universally viewed as a sign of strength for health workers. We believe every health worker should have access to the mental health care and professional wellbeing support that they may need, at every moment in their career. We carry out this mission by accelerating solutions, advancing policies and making connections that put our healthcare workforce's wellbeing first. Learn more at [www.drlornabreen.org](http://www.drlornabreen.org).

## ALL IN: Wellbeing First for Healthcare Coalition

[ALL IN: Wellbeing First for Healthcare](#), led by the [Dr. Lorna Breen Heroes' Foundation](#), is a coalition of national organizations dedicated to advancing a state where the healthcare workforce's wellbeing is prioritized, and health workers feel valued and supported so they can sustain their sense of purpose and meaning in their work. Coalition members include American Academy of Physician Associates, American Association of Colleges of Nursing, American Association of Nurse Anesthesiology, American Association of Nurse Practitioners, American College of Emergency Physicians, American College of Surgeons, American Dental Association, American Foundation for Suicide Prevention, AHIP, American Hospital Association, American Medical Association, American Medical Student Association, American Nurses Association, American Nurses Credentialing Center, American Psychiatric Association Foundation, American Society of Health-System Pharmacists, American Urological Association, CAA Foundation, CHARM, Emergency Nurses Association, Epic, Federation of State Medical Boards, Federation of State Physician Health Programs, FEMinEM, FIGS, Harvard T.H. Chan School of Public Health, Heart of Safety Coalition, Institute for Healthcare Improvement, Johnson & Johnson Foundation, Medicine Forward, Moral Injury of Healthcare, National Athletic Trainers' Association, National Black Nurses Association, National Medical Association, Philippine Nurses Association of America, The Physicians Foundation, The Schwartz Center for Compassionate Healthcare, Surgeon Well-Being Coalition, and Thrive Global Foundation.