Programs and Resources to Alleviate Concerns with Mental Health Disclosures on Physician Licensing Applications

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ABSTRACT: This article considers concerns about the presence and phrasing of questions on physician licensing applications related to mental health, substance abuse, and leave from practice. These questions may discourage physicians from seeking appropriate treatment due to fear of stigmatization, public disclosure, and career effects related to licensing or credentialing concerns. Accessible and affordable resources and programs are needed to allow physicians to seek treatment in a non-punitive, confidential manner. The authors discuss how some state medical boards have taken steps to address barriers that prevent licensees from seeking help and review the work of the Federation of State Medical Boards Workgroup on Physician Wellness and Burnout, which addressed concerns about physician wellness, burnout, and suicide prevention. Physician health programs also have begun to intervene in areas related to mental and physical health and are providing confidential and professional support. Additionally, medical schools, hospitals, and medical societies have increased their focus on mental health by implementing programs and offering resources to help students and physicians improve their overall health. Raising awareness about the importance of physician wellness has inherent value to physicians and the public and ultimately contributes to patient safety and the health of our nation.

There is widespread concern among the medical profession and the public about physician depression, burnout and suicide. Although physical and mental health care services for medical students and physicians are accessible, there is a long-standing and deeply ingrained stigma endured by students and physicians who seek care for both physical and mental health issues. Related to this stigma are data showing that up to 15% of physicians who commit suicide did not receive the mental health care they needed due to fear of losing their job, medical license, malpractice insurance, hospital privileges and patients.[1]

The Health Insurance Portability and Accountability Act (HIPAA) privacy rule related to mental and behavioral health provides important privacy rights and protections with respect to health information, including important controls over how a person's health information is used and disclosed by health plans and health care providers.[2] Ensuring strong privacy protections is critical to maintaining individuals' trust in their health care providers and willingness to obtain needed health care services. These protections are especially important where very sensitive information is concerned, such as services related to mental health.

Despite the protection afforded by HIPAA, medical students and physicians remain concerned that information related to mental health treatment may be disclosed. Although residency programs are not permitted to inquire about applicants' health status or history, and applicants are not required to disclose this information, medical students worry that they might be stigmatized or marginalized if their illness were to become known to the Dean of Students, other faculty and peers. Applicants may also face a dilemma regarding how to account for leaves of absence or academic struggles related to psychiatric illness.[3]

Resident physicians experience depression more frequently than the general public.[3] Distressed residents who do not seek treatment, especially for conditions such as depression, anxiety and burnout, may ultimately have an adverse effect on public safety because they may be less likely to identify and treat similar conditions in their patients and more prone to medical errors in daily practice.[4-5] Although medical students' access to student mental-health services is usually available,[6] well-structured mental health systems geared toward residents' needs may be harder to find.[3] Sponsoring institutions must provide residents and fellows with access to confidential counseling and behavioral health services. However, the resident may feel it is not in his or her best interest to tell the full story of their treatment to the program director.[3,7] Since previous mental health problems are a strong predictor of experiencing mental health problems as a resident, program directors would benefit from knowing this

information to provide appropriate screening and support for residents who are at risk.[8]

There is tension between balancing the right of physicians to access confidential mental health services with the need of state medical and osteopathic licensing boards to protect the public. Physicians have expressed concern that a depression diagnosis could negatively impact their ability to obtain and retain a medical license.[9] Yet the primary responsibility of the state licensing boards is to keep patients safe "from the unprofessional, improper, incompetent, unlawful, fraudulent and/or deceptive practice of medicine."[10] The boards do so in part by conducting a rigorous and thorough review of licensure applications before the practice of medicine can begin. However, once physicians are licensed the consequences of reporting stable and easily treatable conditions such as anxiety or depression to a state licensing board can range from a physician simply being required to submit a letter from their primary care provider documenting fitness to practice, to a request to appear before the board, to being required to undergo and pay for an examination by a board-appointed physician. Other consequences can include the required provision of extensive or ongoing medical records, enrollment in a physician health program (PHP), paying for inpatient or intensive outpatient treatment that may be followed by long-term monitoring, or agreeing to practice restrictions as well as exclusion from opportunities for employment and professional advancement.[11-12]

THERE IS TENSION BETWEEN BALANCING THE RIGHT OF PHYSICIANS TO ACCESS CONFIDENTIAL MENTAL HEALTH SERVICES WITH THE NEED OF BOARDS TO PROTECT THE PUBLIC.

An aging general population, large numbers of physicians approaching retirement age, acknowledged specialty shortages, and geographic maldistribution of clinicians require a full-strength U.S. physician workforce. Despite these established needs some state medical boards continue to make wide-ranging inquiries into psychiatric histories of applicants as part of the licensing process.[13] Although the passage of the Americans with Disabilities Act (ADA) in 1990 raised serious doubts about the legality of these inquiries, the state boards have been reluctant to abandon them, even though the American Bar Association and the American Psychiatric Association have since issued statements disapproving them.[13-14] In 2017, a review of questions on initial licensure applications for all 50 states and the District of Columbia showed that 32 licensing boards ask questions beyond the limits of ADA standards. Of these 32 licensing boards, 18 include complex questions with multiple components on their licensure applications that are inconsistent with ADA standards.[15]

In addition to concern related to stigma, which is linked to deterred or deferred care seeking, the distinction between impairment and illness often is not made on licensing applications. In 1993, the New Jersey State Medical Society filed an injunction against the New Jersey State Board of Medical Examiners which subsequently changed questions on the licensing application to provide clear definitions of the "ability to practice," and to focus on functional impairment rather than on diagnosis or treatment.[16-17] This ruling set a precedent, and since then several federal district courts have ruled against extensive mental health inquiries by state licensing boards.[5]

Most initial and renewal medical licensure applications include questions about mental health diagnoses or treatment, but there is substantial variation in reporting requirements among the different boards.[18-19] For example, while some applications inquire only about current (within the previous two years) impairment from a medical or mental health condition (e.g., "Do you currently have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety?"), others include questions about past diagnosis or treatment of a mental health condition (rather than current impairment from such a condition).[14-16,19]

Some states specifically inquire if the applicant has ever had a diagnosis of, or been treated for, a sexual disorder, bipolar disorder, schizophrenia, paranoia, or other psychotic disorder. Although state case laws have determined that specific questions about bipolar, psychotic, or sexual disorders are acceptable, professional organizations and court interpretations of the ADA recommend that the boards focus on current functional impairment instead of any history of diagnoses or treatment of illness;[5] indeed, no data exists showing that licensure application questions asking about diagnosis or treatment for mental illness recognize current impairment.[11] The APA recommends that questions about the health of applicants inquire only about the conditions that currently impair the applicant's capacity to function as a licensee and are relevant to present practice.[14]

Interpretation and definition of "psychiatric conditions" and "impairment"

In 2011, the House of Delegates of the Federation of State Medical Boards (FSMB) adopted policy on physician impairment based on best practices to provide guidance to boards regarding the inclusion of PHPs in their efforts to protect the public.[20] The policy states: "The diagnosis of an illness does not equate with impairment. Impairment is a functional classification which exists dynamically on a continuum of severity and can change over time rather than being a static phenomenon. Illness, per se, does not constitute impairment. When functional impairment exists, it is often the result of an illness in need of treatment. Therefore, with appropriate treatment, the issue of potential impairment may be resolved while the diagnosis of illness may remain."[20]

The Federation of State Physician Health Programs (FSPHP) also created a public policy regarding "illness vs. impairment." The policy states: "…Most physicians who become ill are able to function effectively even during the earlier stages of their illness due to their training and dedication. For most, this is the time of referral to a state PHP. Even if illness progresses to cause impairment, treatment usually results in remission and restoration of function. PHPs can then monitor clinical stability and continuing progress in recovery. Medical professionals recognize it is always preferable to identify and treat illness early. There are many potential obstacles to an ill physician seeking care, including: denial, aversion to the patient role, practice coverage, stigma, and fear of disciplinary action. Fear of disciplinary action and stigma are powerful disincentives to doctors referring their physician colleagues or themselves. When early referrals are not made, doctors afflicted by illness often remain without treatment until overt impairment is manifest in the workplace."[20]

There is some variability among the boards regarding whether and how their licensing applications request information about "psychiatric conditions (diagnosis/illness)" and "impairment." [14-16,19] Ideally, state and federal law should facilitate the effective interface between boards and PHPs in their efforts to support the rehabilitation of licensees with potentially impairing illness because it adds to public protection. The FSMB encourages the boards, with input from their PHPs, to revisit their medical practice acts routinely to ensure that they are updated in response to developments in the field. The FSMB also recommends establishing two separate PHP tracks; one for voluntary participants who enter the PHP without the board's mandate (these physicians should be afforded anonymity from the board so long as they do not pose a risk of harm to the public), and another for physicians who are mandated by the board to participate in a PHP.[20]

Why physicians may be discouraged from seeking treatment for mental health conditions

Even if physicians realize that they need help, many have reported substantial and persistent concern regarding stigma, which inhibits both treatment and disclosure of mental health conditions on licensure applications.[21-22] Those who disclose information about seeking mental health care have suffered delays in licensure and added scrutiny.[19] The stigma of mental health is so pervasive that many physicians consider mental health issues to be a sign indicating that they are unable to cope with the rigor of the medical profession and that their ability to care for patients, therefore, is inferior to that of other physicians.[22-23] A 2016 survey of female physicians with a history of actual mental health diagnosis or treatment found that more than two-thirds of respondents were reluctant to seek out the same treatments they offer their patients for fear that they may be judged, deemed incompetent, or have their privacy and autonomy violated because of seeking help; these beliefs crossed all age and specialty categories.[11] A study to identify factors preventing Canadian physicians (mostly primary care physicians and nonsurgical specialists) from accessing mental health services showed that the most important factors influencing a physician's decision to disclose their illness included career implications, professional integrity and social stigma.[24]

EVEN IF PHYSICIANS REALIZE THAT THEY NEED HELP, MANY HAVE REPORTED SUBSTANTIAL AND PERSISTENT CONCERN REGARDING STIGMA, WHICH INHIBITS BOTH TREATMENT AND DISCLOSURE OF MENTAL HEALTH CONDITIONS ON LICENSURE APPLICATIONS.

An anonymous, UK-wide online survey of physicians with and without a history of mental illness investigated physician attitudes about disclosing mental illness. This study showed that trainees and younger physicians were less likely to disclose

mental ill health than general practitioners and consultants due to concerns about labeling, confidentiality, and not understanding available support structures.[25]

A study of U.S. licensure applicants showed that nearly 40 percent of physicians would be reluctant to seek formal medical care for treatment of a mental health condition because of concerns about repercussions to their medical license.[16] These concerns are reasonable, as a study conducted in 2007 showed that one third of state medical board executive directors reported that a diagnosis of mental illness by itself was sufficient for sanctioning physicians.[26] Although providing inaccurate information on a medical license application may result in denial or revocation, acknowledging a history of mental health treatment may trigger a more in-depth inquiry by the licensing board.

The lack of distinction between diagnosis and impairment further stigmatizes physicians who seek care, and impedes their treatment.[27] As a result, broadly worded questions about mental health and psychiatric illness used by some state boards can frustrate efforts to promote physician wellness.[22] Thus, physicians frequently seek treatment only at the point when their psychological distress and suboptimal performance have gained the attention of insurance companies, police, review boards, or state boards.[23] These broadly worded questions discourage physicians from timely diagnosis and treatment that would allow them to practice safely.

FSMB Workgroup on Physician Wellness and Burnout

To address concerns about physician wellness, physician burnout and suicide prevention, the FSMB established the Workgroup on Physician Wellness and Burnout on behalf of the state medical and osteopathic boards in 2016. In evaluating licensing and license renewal application questions that ask about health conditions, the workgroup confronted the barriers physicians face in seeking treatment for symptoms of burnout related to the presence and phrasing of questions about mental health, substance use, and leave from practice. In the year that has passed since the FSMB adopted the workgroup recommendations in April 2018, nearly half of all medical boards in the United States have formally discussed physician wellness and burnout, with at least eight boards making changes to their licensing applications, and at least another eight currently implementing or considering specific changes.

The workgroup has identified and provided examples of effective and appropriate language in consideration of existing FSMB policies that draw an important distinction between physician illness and impairment.[28] The workgroup also researched this issue to determine whether it is necessary for the boards to include on licensing applications probing questions about a physician applicant's mental health and whether the information these questions are designed to elicit in the interest of patient safety may be better obtained through means less likely to discourage physician applicants from seeking treatment. The workgroup has also encouraged the state licensing boards to approach physician wellness and burnout from a non-punitive perspective, avoiding public disclosure of any information about a physician's diagnosis during licensing processes and offering "safe haven" non-reporting options to physicians who are under treatment and in good standing with a recognized PHP or other appropriate care provider.

For example, the Washington Medical Commission is updating its state licensure questions to focus on an individual's current impairment rather than a doctor's past mental health difficulties.[29] The Minnesota Board of Medical Practice revised its licensure application so that questions related to applicant health focused on impairment rather than illness.[30] The North Carolina Medical Board (NCMB) recently removed questions on its renewal application asking licensees to disclose potentially impairing medical conditions and instead asks them to acknowledge a statement of NCMB's expectation that they appropriately address personal health conditions, including mental health and substance use issues, without disclosing specific details.

Programs and Resources

PHPs were originally developed to enable physicians suffering from alcohol or other addictions to receive treatment while being protected from losing their state licenses.[31-32] Since their development, PHPs have evolved and have begun to intervene in other areas related to mental or physical health. Today, PHPs offer confidential referral, evaluation, and monitoring protocols, as well as professional support, for physicians and other health-care professionals who are at risk or who may have a potentially impairing substance use disorder, mental health condition, or other medical illness. PHPs seek to provide ongoing care and return clinicians to professional practice.[33]

The American Medical Association (AMA) and the American Osteopathic Association (AOA) advocate for protecting the privacy and confidentiality of a physician's health and treatment history, including participation in a PHP. Due to the PHP's expertise with safety sensitive professionals, including physicians who have recovered from a substance use disorder, and the long-term follow up with monitoring PHPs, physician recovery rates are higher than the general population for the same conditions.[34] In addition, one study reports that malpractice risk for those who complete a PHP is less than for other physicians practicing medicine who have not completed a PHP.[35]

PHPs currently operate in 47 states and the District of Columbia; these programs function within the parameters of state regulation and legislation and provide many different levels of service to physicians in need.[36] All state member PHPs must have compensated staff or a compensated medical director, or a voluntary committee chairperson or staff member, as well as the support of organized medicine in their state.[36]

States have agreed upon different PHP reporting requirements related to impairment in their monitoring contracts with the state licensing boards. Some PHP programs offer a safe haven to encourage physicians to proactively seek and receive the health care services that they need, confidentially.

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This approach is ideal for lessening barriers for those who require help. For example, the North Carolina Physicians Health Program (NCPHP) can provide non-disciplinary and confidential assistance to protect the physician's identity, provided that the physician's behavior has not negatively impacted patient care. The NCMB renewal question specifically states, "If you are an anonymous participant in the NCPHP and in compliance with your contract, you do not need to list any medical conditions related to that contract."[37] Thus, a licensee who reaches out to the NCPHP for help with depression or other mental health concerns is generally not required to disclose these concerns to the board. Physicians may remain anonymous so long as the NCPHP can establish that they can safely practice medicine, are not an imminent danger to the public, or have not committed sexual boundary violations.[37] Also, while a PHP will report a physician who meets the threshold of "public danger," they may not re-disclose the specifics of the physician's physical or mental health history. Due to the confidentiality requirements of the physician's health records, more than likely the reported physician will sign consents and agree to release the necessary medical information to the licensing board directly as needed and not via the PHP.

Data indicate that PHPs effectively treat physicians for a variety of reasons. A national study with collated data from 16 PHPs across the United States outlined the unique model of peer support provided to physicians with potentially impairing conditions.[38] Collecting 904 sequential admissions to these same programs and following them over five or more years resulted in 81% having zero positive drug screens. Of those who completed monitoring, 95% had a license and worked as a physician.[39]

Single state results reflect similar statistics with positive outcomes. For example, a retrospective cohort study of 292 health care professionals enrolled in the Washington PHP noted that 25% of participants had at least one relapse, 5% had two relapses, and 3% had three or more relapses during the five-year period.[40] Each relapse was managed within the respective PHPs which balanced compassionate responses with public safety.

Additional studies support the efficacy of the systematic monitoring provided by PHPs.[41-42] Although the studies are more limited, similar outcome data suggests that physicians with mental and behavioral health conditions can be successfully monitored in a similar fashion as physicians with substance use disorders—and with similarly positive outcomes.[43] A study by Brooks et al. suggests that PHPs provide a risk management benefit by reducing malpractice risk in individuals who complete a PHP monitoring program when measured at the end of the monitoring process.[35]

The attitude of participants in PHPs is well studied. In a study of the Massachusetts PHP, Knight, et al. reported that total satisfaction, as measured by the percentage of the highest possible total score, was high (median score 83%).[44] In 2017, the NCPHP provided services to 225 physicians; of these, 54 (24%) were self-referrals. An exit survey conducted by

the NCPHP showed that 90.5% of physicians who had participated in NCPHP and received services for substance related issues (66.67%), workplace stress (28.6%) and anxiety (28.6%), reported "feeling better off" than when they first presented for services.[45]

The FSPHP, with the support of key stakeholder organizations, is developing a Performance Enhancement and Effectiveness Review (PEER™) Program and a Provider Accreditation Program. The PEER™ program will create and manage an on-site review process of PHPs across the United States and Canada, validate current PHP practices, and identify areas that will benefit from improvements. As such reviews become more common, the data will enable the development of deeper insight and awareness into the importance of allowing health care professionals the dignity to be patients, as well as providers, thereby enhancing patient health and safety. The Provider Accreditation Program will accredit treatment providers and centers that care for health care professionals, ensuring that health care professionals who become ill receive the best treatment using evidence-based care.

Currently, the FSMB is involved in various projects to evaluate the impact of allowing non-reporting of potential impairment or treatment if physicians are in good standing with a recognized PHP or other appropriate care provider.[46] Several state medical and osteopathic boards also are addressing barriers that may prevent current and potential licensees from seeking help, while recognizing their responsibility to evaluate the fitness of potential licensees. For example, the Oregon Medical Board initiated a program to reduce physicians' fear of reporting

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treatment on licensing or hospital credentialing applications. The questions on the initial application and registration (renewal) forms ask about current disabilities from physical, mental, or emotional conditions rather than focusing only on the presence of a mental diagnosis and treatment. Specifically, questions focus on the presence of serious physical or mental illnesses or hospitalizations for either illness (physical or mental) within the past five years which impair (or impaired) the licensee's ability to practice medicine safely and competently.[47] The board also supports the de-stigmatization of mental illnesses in licensees by participating in the Health Professionals' Services Program, which was established in July 2010 as a statewide confidential referral resource for rehabilitation and monitoring. It prioritizes the identification of impaired physicians and encourages licensees struggling with burnout, depression, or substance abuse to seek professional treatment.[47]

...THE FSMB IS INVOLVED IN VARIOUS PROJECTS TO EVALUATE THE IMPACT OF ALLOWING NON-REPORTING OF POTENTIAL IMPAIRMENT OR TREATMENT IF PHYSICIANS ARE IN GOOD STANDING WITH A RECOGNIZED PHP OR OTHER APPROPRIATE CARE PROVIDER.

The Washington Medical Commission changed its initial medical license application in the mid-1990s to include a question that asks applicants if they have ever had a drug, alcohol, or mental health problem that is not already known to the PHP. This change encouraged physicians to seek help anonymously. Currently, applicants are simply asked to disclose if they have any medical conditions that limit their ability to practice medicine.[48]

Some hospitals have responded to the increased focus on physician mental health by implementing programs to help residents and physicians improve their overall health.[49] Health care organizations are also turning to a new professional role — the chief wellness officer — and charging these professionals with identifying problems within their specific organizations that contribute to burnout and finding solutions for the well-being of physicians.[50]

The University of California San Diego Health Education Assessment and Referral (HEAR) Program, in collaboration with the American Foundation for Suicide Prevention (AFSP), provides a program of ongoing education and outreach, which encourages medical students, residents, and faculty to engage in an online, anonymous, interactive screening program.[51] The program confidentially refers individuals who have been screened for stress, depression, and suicide risk to a mental health professional for evaluation and treatment. Many other schools of

medicine have adopted the AFSP Program model, and it is used by clinicians of all disciplines.[51]

The AMA, AOA, state, county, and specialty medical associations, and National Academy of Medicine also are positioned to help alleviate the added stress physicians, residents, and medical students may experience. The AMA and the AOA have developed online resources and continuing medical education programs focused on improving physician wellness, preventing burnout and increasing resilience.[52] The Accreditation Council for Graduate Medical Education (ACGME), in collaboration with the Mayo Clinic and the AFSP, has developed a library of online educational resources, including a toolkit for residents that serves as a guide in the immediate aftermath of a suicide.[53]

RAISING AWARENESS ABOUT THE IMPORTANCE OF PHYSICIAN WELLNESS HAS INHERENT VALUE TO PHYSICIANS AND THE PUBLIC AND IS ALSO A SIGNIFICANT CONTRIBUTOR TO PATIENT SAFETY.

The Lane County Medical Society Physician Wellness Program in Oregon is an example of how a county medical society provides confidential and private counseling.[54] The program provides complimentary sessions with an experienced psychologist and a certified physician coach as well as a 24/7 support line staffed by mental health professionals for use by physicians and their families. The program also addresses time constraints by offering physicians appointments at convenient times with a psychologist, psychiatrist, or physician coach who understands physicians' issues. There is no electronic record, and insurance is not billed.[54]

The National Academy of Medicine's Action Collaborative on Clinician Well-Being and Resilience recently launched the Clinician Well-Being Knowledge Hub, to provide resources to help organizations learn more about clinician burnout and solutions. The Knowledge Hub includes research articles, news articles, blog posts, toolkits, reports and briefs that provide further insight into the causes of clinician burnout; its consequences for health-care professionals, patients, and their families; and approaches that organizations can take to promote well-being.[55]

Conclusion

As an aspect of professionalism, physicians are expected to monitor their health, take responsibility for any psychiatric illness by adhering to appropriate treatment plans agreed upon with their own providers, and avoid any inclinations towards self-treatment or "curbside" consults.[56] They should also be aware of signs of relapse, or, if necessary, have a support system in place that will alert them to recurrence. When ill, physicians are expected to assess whether they can perform their duties efficaciously and without harm to patients. When physician health or wellness is compromised, so may be the safety and effectiveness of the medical care provided. Raising awareness about the importance of physician wellness has inherent value to physicians and the public and is also a significant contributor to patient safety.[56]

Key stakeholders must ensure that appropriate resources and programs are in place to allow physicians to seek treatment in a non-punitive, confidential manner, and that these resources and programs are accessible and affordable. In addition, research efforts should focus on the impact that different approaches have on reporting, stigma and resulting wellness.[14] ■

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