HOD ACTION: Council on Medical Education 6 adopted as amended and the remainder of the report filed.

REPORT 6 OF THE COUNCIL ON MEDICAL EDUCATION (A-18)
Mental Health Disclosures on Physician Licensing Applications
(Resolution 301-A-17, Resolve 3)
(Reference Committee C)

EXECUTIVE SUMMARY

Concern is growing among the profession and the public about physician and medical student depression, burnout, and suicide. Resolution 301-A-17, Resolve 3, "Mental Health Disclosures on Physician Licensing Applications," introduced by the Resident and Fellow Section and referred by the American Medical Association (AMA) House of Delegates (HOD), asks the AMA to amend Policy H-275.970, "Licensure Confidentiality," to address this concern. The AMA has expressed strong support of physical and mental health care services for medical students and physicians, but there is a long-standing and deeply ingrained stigma endured by physicians seeking care for either physical or mental health issues, partly due to concerns of career and licensure implications. In addition to concern related to stigma, which is linked to deterred or deferred care seeking, there is a lack of understanding of impairment vs. illness.

This report considers concerns that have been raised about the presence and phrasing of questions on licensing applications related to current or past impairment. These questions may be discouraging physicians from seeking appropriate treatment because of fear of stigmatization, public disclosure, and the effect on one's job due to licensing or credentialing concerns. Many medical and osteopathic licensing boards recognize that the manner in which they evaluate the fitness of potential licensees has the potential to create a barrier that prevents licensees from seeking help. Some state boards, such as the Oregon and Washington State Medical Boards, have taken steps to address these barriers. In addition, the Federation of State Medical Boards has established a Workgroup on Physician Wellness and Burnout. The workgroup is confronting the barriers physicians face in seeking treatment for symptoms of burnout related to the presence and phrasing of questions on licensing applications about mental health, substance abuse, and leave from practice. The workgroup is also seeking to draw an important distinction between physician "illness" and "impairment" as well as determine whether it is necessary for the medical boards to include probing questions about a physician applicant's mental health on licensing applications in the interests of patient safety.

This report comprises:

- A review of the current licensure application process.
- Research that describes why some physicians may be discouraged from seeking treatment for mental health conditions.
- An interpretation and definition of "psychiatric conditions" and "impairment."
- A summary of physician health programs' reporting requirements.
- A summary of actions being taken at the national and state levels to evaluate physician wellness and burnout as well as confidentiality about seeking treatment for mental health conditions.
- A review of AMA policy on this topic.
- Proposed recommendations to current AMA policy to strengthen and streamline the AMA's position on this important topic.

HOD ACTION: Council on Medical Education 6 adopted as amended and the remainder of the report filed.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 6-A-18

Subject: Mental Health Disclosures on Physician Licensing Applications (Resolution 301-A-17, Resolve 3)

Presented by: Lynne M. Kirk, MD, Chair

Referred to: Reference Committee C (Sherri S. Baker MD, Chair)

Resolution 301-A-17, Resolve 3, "Mental Health Disclosures on Physician Licensing Applications," introduced by the Resident and Fellow Section and referred by the American Medical Association (AMA) House of Delegates (HOD), asks the AMA to amend Policy H-275.970, "Licensure Confidentiality," by addition and deletion to read as follows:

> H-275.970, "Licensure Confidentiality"
> The AMA (1) encourages specialty boards, hospitals, and other organizations involved in credentialing, as well as state licensing boards, to take all necessary steps to assure the confidentiality of information contained on application forms for credentials; (2) encourages boards to include in application forms only requests for information that can reasonably be related to medical practice; (3) encourages state licensing boards to exclude from license application forms information that refers to psychoanalysis, counseling, or psychotherapy required or undertaken as part of medical training; (4) encourages state medical societies and specialty societies to join with the AMA in efforts to change statutes and regulations to provide needed confidentiality for information collected by licensing boards; and (5) encourages state licensing boards to require disclosure of physical or mental health history by physician health programs or providers only if they believe the illness of the physician they are treating is likely to impair the physician's practice of medicine or presents a public health danger. ~~that, if an applicant has had psychiatric treatment, the physician who has provided the treatment submit to the board an official statement that the applicant's current state of health does not interfere with his or her ability to practice medicine.~~ (Modify Current HOD Policy)

At the Annual 2017 Meeting of the AMA HOD, Reference Committee C heard supportive testimony on this item from a wide variety of stakeholders, reflecting growing concern among the profession and the public related to physician and medical student depression, burnout, and suicide. The AMA has expressed strong support of physical and mental health care services for medical students and physicians. Council on Medical Education Report 1-I-16, "Access to Confidential Health Services for Medical Students and Physicians,"[1] addressed the long-standing and deeply ingrained stigma endured by physicians seeking care for physical or mental health issues, partly due to concerns of career and licensure implications. Despite several existing HOD policies that support this request, testimony reflected additional concerns related to stigma, deterred or deferred care seeking, and the belief that there is a lack of understanding of impairment vs. illness. For these reasons, the HOD recommended that Resolution 301, Resolve 3, be referred for further study.

BACKGROUND

The role of state medical and osteopathic boards and patient safety

Medical and osteopathic licensing boards are state governmental agencies responsible for granting licenses to physicians to practice in the state. The primary responsibility of the boards is to determine that physicians are maintaining and advancing their knowledge and skills and providing quality patient care. Boards are also responsible for protecting the public from the unprofessional, improper, incompetent, unlawful, fraudulent and/or deceptive practice of medicine.[2] The boards do so by obtaining sufficient physician information to conduct rigorous and thorough application reviews before the practice of medicine is permitted.

The current licensure application processes

State medical licensing boards have traditionally made wide-ranging inquiries into applicants' past psychiatric histories as part of the application process.[3] Although the passage of the Americans with Disabilities Act (ADA) in 1990 raised serious doubts about the legality of these inquiries, the boards have been reluctant to abandon them, even though the American Bar Association and the American Psychiatric Association (APA) have since issued statements disapproving them.[3, 4]

Most initial and renewal medical licensure application forms include questions about mental health diagnoses or treatment, but there is substantial variation in reporting requirements among the boards.[5] For example, while some applications inquire only about current (within the previous 12 months) 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 current or past diagnosis or treatment of a mental health condition (rather than current impairment from such a condition).[6] Some states specifically inquire if the applicant has ever had a diagnosis of, or been treated for, bipolar disorder, schizophrenia, paranoia, or other psychotic disorder or for sexual disorders. 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.[7] To support this position, there are no data showing that a broad question on a licensure application that asks about diagnosis or treatment for mental illness identifies current impairment.[8]

The APA recommends that questions about the health of applicants should inquire only about the conditions that currently impair the applicant's capacity to function as a licensee and are relevant to present practice. The APA further recommends that the boards use the following language in their application form:

> "Are you currently suffering from any condition that impairs your judgment or that would otherwise adversely affect your ability to practice medicine in a competent, ethical, and professional manner? (Yes/No)"[4]

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

In 2011, the Federation of State Medical Boards (FSMB) adopted policy on physician impairment to provide guidance to boards for including physician health programs (PHPs) in their efforts to protect the public.[9] The policy represented a vision for medical boards and PHPs to effectively assist impaired licensees as well as those with potentially impairing illness based on best practices.

The FSMB policy on physician impairment 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."[9]

AMA policy states:

> "The AMA defines physician impairment as any physical, mental, or behavioral disorder that interferes with ability to engage safely in professional activities and will address all such conditions in its Physician Health Program" (Policy H-95.955, "Physician Impairment").

The FSMB defines impairment as:

> "The inability of a licensee to practice medicine with reasonable skill and safety as result of:
> a) mental disorder; or
> b) physical illness or condition, including but not limited to those illnesses or conditions that would adversely affect cognitive, motor, or perceptive skills; or
> c) substance-related disorders including abuse and dependency of drugs and alcohol as further defined."[9]

The Federation of State Physician Health Programs (FSPHP) created a public policy regarding "illness vs. impairment." The following is an excerpt from this policy:

> "…[S]ome regulatory agencies equate illness (i.e. addiction or depression) as synonymous with impairment. Physician illness and impairment exist on a continuum with illness typically predating impairment, often by many years. This is a critically important distinction. Illness is the existence of a disease. Impairment is a functional classification and implies the inability of the person affected by disease to perform specific activities.
>
> "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 are then in a position to 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."[9]

There is some variability among the boards regarding how their applications request information about "psychiatric conditions (diagnosis/illness)" and "impairment." 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 kept updated in response to developments in the field.

PHPs' reporting requirements and patient confidentiality requirements

The FSMB recommends that two separate PHP tracks be established for program participants:

- Track "A" is for voluntary participants who enter the PHP without the board's mandate. These physicians should be afforded anonymity from the board as long as they do not pose a risk of harm to the public. Cases that pose a danger of harm to the public should be reported to the board with laws or regulations in place that allow that reporting.
- Track "B" physicians are mandated by the board to participate in a PHP. As such, their identities are known to the board.[9]

In addition, the FSMB recommends that PHPs employ FSPHP Guidelines (fsphp.org/sites/default/files/pdfs/2005_fsphp_guidelines-master_0.pdf) in selecting the providers/facilities to provide treatment for physicians with addictive and/or psychiatric illness.[9]

The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule related to mental and behavioral health (hhs.gov/hipaa/for-professionals/special-topics/mental-health/index.html) provides consumers with important privacy rights and protections with respect to their health information, including important controls over how their health information is used and disclosed by health plans and health care providers. Ensuring strong privacy protections is critical to maintaining individuals' trust in their health care providers and willingness to obtain needed health care services, and these protections are especially important where very sensitive information is concerned, such as mental health information. At the same time, the Privacy Rule recognizes that circumstances arise where health information may need to be shared to ensure that the patient receives the best treatment and for other important purposes, such as for the health and safety of the patient or others.

Diagnosing depression for reimbursement can impact a physician's permanent credentials

Many physicians have expressed concern that a depression diagnosis could negatively impact their medical license.[10] The consequences of reporting to a licensing board stable and easily treatable conditions such as anxiety or depression can range from a physician simply being required to submit a letter from their primary care provider that documents fitness to practice, to being asked to appear before state board examiners, or to being required to undergo (and pay for) an examination by a board-appointed physician. Other consequences can include having to provide extensive or ongoing medical records, enrolling in a PHP, paying for inpatient or intensive outpatient treatment that is possibly followed by long-term monitoring, or agreeing to practice restrictions.[8]

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 the stigma, which inhibits both treatment and disclosure of mental health conditions on licensure applications.[8, 11] Those who disclose information about seeking mental health care have suffered delays in licensure and added scrutiny. 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.[12, 13] Several surveys have shown that physicians are reluctant to enter into such disclosure because they fear this could expose them to examinations,

potentially inappropriate treatment and monitoring, or exclusion from employment opportunities, insurance coverage, or professional advancement.[14]

A 2016 survey of female physicians with a history of actual mental health diagnosis or treatment also provided insight into why this information is not routinely disclosed on licensure applications. The most common reasons listed were the beliefs that the condition did not pose any potential safety risk to patients (75 percent), was not relevant to clinical care (70 percent), and was not the business of the state medical board (63 percent).[8] In addition, many of the survey respondents (75 percent) agreed or strongly agreed that medical board questions about whether a physician has ever had a mental health diagnosis or treatment impacts decisions about seeking treatment.[8] The study also confirmed that more than two-thirds of physicians feel 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.[8]

A similar study of 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.[6] Although providing inaccurate information on a medical license application may result in denial or revocation, acknowledging a history of mental health treatment triggers a more in-depth inquiry by the medical board.

The lack of distinction between diagnosis and impairment further stigmatizes physicians who seek care and impedes treatment.[15] As a result, the traditional role of licensing boards can frustrate efforts to promote physician wellness.[12] Thus, physicians frequently seek treatment only when their psychological distress and suboptimal performance has gained the attention of insurance companies, police, and/or review boards.[13]

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 is confronting 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.

The workgroup has been seeking to identify and highlight examples of effective and appropriate language in consideration of existing FSMB policies that draw an important distinction between physician illness and impairment.[9] The workgroup also is researching 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 interests of patient safety may be better obtained through means less likely to discourage the search for treatment among physician applicants.

The workgroup is in the process of finalizing its report and recommendations, and the FSMB will continue to update the public and the FSMB's partner organizations, including the AMA, of its progress.

FEDERATION OF STATE PHYSICIAN HEALTH PROGRAMS

The FSPHP's mission is to support PHPs in improving the health of medical professionals, thereby contributing to quality patient care. The FSPHP aims to:

- Achieve national and international recognition as a supporter of PHP programs;
- Promote early identification, treatment, documentation, and monitoring of ongoing recovery of physicians prior to the illness impacting the care rendered to patients; and
- Pursue consistent standards, language, and definitions among state physician health programs.

PHPs were originally developed to assist physicians suffering from alcohol or other addictions to receive treatment while being protected from losing their state medical licenses. In recent years, PHPs have also begun to intervene in other areas related to mental or physical health issues.

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. All state member PHPs must have compensated staff and/or a compensated medical director, and/or a voluntary committee chairperson/staff member, as well as the support of organized medicine in their state. Information about the full range of program structures and services offered by each state program is available at: fsphp.org/state-programs.

States have different reporting requirements related to impairment that have been agreed upon in their monitoring contracts with the state medical boards. Some of the programs offer a safe haven to encourage physicians to proactively seek and receive the health care services that they need, confidentially. For example, the North Carolina Physicians Health Program (NCPHP) can provide non-disciplinary and confidential assistance to ensure that the physician's identity is protected, provided that the physician's behavior has not negatively impacted patient care. The North Carolina Medical Board (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." 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 are allowed to remain anonymous so long as the NCPHP can establish that they are safe to practice, are not an imminent danger to the public, or have not committed sexual boundary violations.[16]

There are scenarios when an impaired physician is agreeable to referral to a PHP in which they may meet with safe haven or diversionary status, which does not require disclosure to a state medical board. 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 be required to release the necessary medical information to the licensing board directly as needed and not via the PHP.

AMA POLICIES

Policies related to questions on licensure applications

Policy H-295.858 (2), "Access to Confidential Health Services for Medical Students and Physicians," states that "Our AMA will urge state medical boards to refrain from asking applicants about past history of mental health or substance use disorder diagnosis or treatment, and only focus

on current impairment by mental illness or addiction, and to accept "safe haven" non-reporting for physicians seeking licensure or relicensure who are undergoing treatment for mental health or addiction issues, to help ensure confidentiality of such treatment for the individual physician while providing assurance of patient safety."

Policy H-275.945, "Self-Incriminating Questions on Applications for Licensure and Specialty Boards," directs the AMA to "(1) encourage the Federation of State Medical Boards and its constituent members to develop uniform definitions and nomenclature for use in licensing and disciplinary proceedings to better facilitate the sharing of information, (2) seek clarification of the application of the Americans with Disabilities Act to the actions of medical licensing and medical specialty boards, and (3) encourage the American Board of Medical Specialties and the Federation of State Medical Boards and their constituent members to advise physicians of the rationale behind inquiries on mental illness, substance abuse or physical disabilities in materials used in the licensure, reregistration, and certification processes when such questions are asked."

Policies related to management of psychiatric disorders

Policy H-275.970, "Licensure Confidentiality," directs the AMA "(1) to encourage specialty boards, hospitals, and other organizations involved in credentialing, as well as state licensing boards, to take all necessary steps to assure the confidentiality of information contained on application forms for credentials; (2) to encourage boards to include in application forms only requests for information that can reasonably be related to medical practice; (3) to encourage state licensing boards to exclude from license application forms information that refers to psychoanalysis, counseling, or psychotherapy required or undertaken as part of medical training; (4) to encourage state medical societies and specialty societies to join with the AMA in efforts to change statutes and regulations to provide needed confidentiality for information collected by licensing boards; and (5) to encourage state licensing boards to require that, if an applicant has had psychiatric treatment, the physician who has provided the treatment submit to the board an official statement that the applicant's current state of health does not interfere with his or her ability to practice medicine."

Policy H-95.955, "Physician Impairment," states that: "(1) The AMA defines physician impairment as any physical, mental or behavioral disorder that interferes with ability to engage safely in professional activities and will address all such conditions in its Physician Health Program. (2) The AMA encourages state medical society-sponsored physician health and assistance programs to take appropriate steps to address the entire range of impairment problems that affect physicians, to develop case finding mechanisms for all types of physician impairments, and to collect data on the prevalence of conditions affecting physician health. (3) The AMA encourages additional research in the area of physician impairment, particularly in the type and impact of external factors adversely affecting physicians, including workplace stress, litigation issues, and restructuring of the health care delivery systems."

DISCUSSION

There is growing concern that the presence and phrasing of questions related to current or past impairment on licensing applications may be discouraging physicians from seeking appropriate treatment because of fear of stigmatization, public disclosure, and the effect on one's job due to licensing or credentialing concerns.[3] Resident physicians experience higher rates of depression than the general public, and distressed physicians 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.[3, 17]

The medical and osteopathic licensing boards recognize that in their responsibility to evaluate the fitness of potential licensees, a potential barrier may exist that prevents current and potential licensees from seeking help. Some state boards have taken steps to address these barriers. The Oregon Medical Board initiated a program to reduce physicians' fear of reporting treatment on licensing or hospital credentialing applications. The board participates 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.[18] The Washington State Medical Board 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 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.[19]

Some hospitals have responded to the focus on physician mental health by implementing programs to help residents and physicians improve their overall health.[20] The AMA, American Osteopathic Association, and the state and specialty medical associations are also positioned to help alleviate the added stress physicians may experience as they interact with their respective licensing boards. The AMA has developed the following online resources focused on improving physician wellness, preventing burnout, and increasing resilience:

- Physician Wellness: Preventing Resident and Fellow Burnout (stepsforward.org/modules/physician-wellness)
- Preventing Physician Burnout (stepsforward.org/modules/physician-burnout)
- Improving Physician Resiliency (stepsforward.org/modules/improving-physician-resilience)

SUMMARY AND RECOMMENDATIONS

The Council on Medical Education is committed to ensuring that physicians seek the care they need for burnout, anxiety, depression, and substance-related disorders without fear of punitive treatment or licensure and career restrictions. The Council therefore recommends that the following recommendations be adopted in lieu of Resolution 301-A-17, Resolve 3, and the remainder of the report be filed.

1. That our American Medical Association (AMA) amend Policy H-275.970, Part 5, "Licensure Confidentiality," by addition and deletion to read as follows:

   The AMA (5) encourages state licensing boards to require disclosure of physical or mental health conditions only when a physician is suffering from any condition that currently impairs his/her judgment or that would otherwise adversely affect his/her ability to practice medicine in a competent, ethical, and professional manner, or when the physician presents a public health danger. ~~that, if an applicant has had psychiatric treatment, the physician who has provided the treatment submit to the board an official statement that the applicant's current state of health does not interfere with his or her ability to practice medicine.~~ (Modify Current HOD Policy)

2. That our AMA encourage those state medical boards that wish to retain questions about the health of applicants on medical licensing applications to use the language recommended by the Federation of State Medical Boards that reads, “Are you currently suffering from any condition for which you are not being appropriately treated that impairs your judgment or that would otherwise adversely affect your ability to practice medicine in a competent, ethical and professional manner? (Yes/No).” (Directive to Take Action)

Fiscal Note: $1,000

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