A Challenge to Licensing Boards: The Stigma of Mental Illness

In August 1995, I experienced a week of anxiety and sleeplessness followed by a painful depression. Though my condition was apparent to me, my colleagues noticed nothing wrong. I sought help. A psychiatrist diagnosed type II bipolar disorder, a mainly depressive disorder, unaccompanied by life-disrupting mania. With the help of my family, psychiatrist, and medications, my depression lifted while I continued to work (though with less committee work). Two months later, a medical student at my institution committed suicide. It was rumored that he feared career stigmatization from using mental health care. The next morning, at a scheduled lecture to the stunned class, I opened by disclosing my diagnosis and telling the students that such problems were not incompatible with a successful family or professional life—but that they must seek help.

In January 1996, I disclosed my diagnosis and treatment on a routine relicensing questionnaire. I named my psychiatrist, summarized the treatment, and said that I had informed my surprised clinical supervisors. I have had a successful medical career before and since my diagnosis. I serve on national leadership posts, publish, am respected by students, enjoy clinical care, and have never been the object of a practice complaint. The Board of Medical Practice asked for all of my psychiatrist's records and notes. My psychiatrist and I did not comply. We did not see that the Board had cause to believe that I was professionally impaired. The request to review my records seemed burdensome, discriminatory, and an oblique and needlessly intrusive way to evaluate my occupational competence.[1] My psychiatrist risked a possible sanction for not complying.

The standoff has lasted more than 2 years. Minnesota's medical, mental health, professional, and consumer organizations agree that occupational impairment cannot be deduced from the diagnosis or use of mental health services. The Board's attorney cites its duty to protect the public and says that the "complaint" against me must be resolved by medical record review. The Board avoided a lawsuit by renewing my license in 1996, 1997, and 1998. The state says the Board is not accountable to a state Americans With Disabilities Act (ADA) grievance because the Board has fewer than 50 employees. The federal government has not responded to a 2-year-old ADA complaint. In 1997, the Board convened a task force to evaluate these issues. Its report was available in August 1997, and it recommended making the relicensing questionnaire impairment-focused, narrowing access to medical records, and more clearly separating disciplinary functions from oversight of impaired physicians. In September 1997, the Board tabled consideration of the task force report until January 1998. In January, it tabled it until July 1998. In July, the Board accepted the task force report and referred it to a policy committee to make recommendations to the Board in September 1998.

My legal fees are $6500 and climbing. A lawsuit would cost a formidable amount. My psychiatrist's pending retirement poses a new issue. I must search for a physician who will risk preserving the privacy of counseling me as he or she would do for others seeking similar care while working well in demanding jobs.

This type of Board policy adversely affects mental health care for physicians and the outcome of mental illness. One physician wrote, "Even though I feel I might benefit from medical care of my depression, I am loath to endanger my livelihood or invite the inquisition he [Miles] has faced by openly seeking the same."[2] Most tragically, the Minnesota Psychiatric Association and I know of physicians who have avoided treatment—perhaps because of fear of the lack of privacy afforded to other patients—and later committed suicide.

The American Psychiatric Association rejects Board review of physicians' mental health records. Paraphrased, it says protecting "patients does not require assuming that a psychiatric patient is potentially so harmful to patients that he or she cannot practice medicine without presenting his or her otherwise private medical record for public scrutiny. Far from protecting the public, it is likely that abolishing confidentiality of a physician's personal health records would simply discourage troubled people, many with treatable disorders, from finding appropriate medical help and would hamper those trying to help them. We believe that such an impaired individual is far more likely to endanger patients."[3] Board investigations should be grounded in complaints related to practice.[4] Routinely asking physicians to self-disclose diagnoses or reviewing their records does not identify impaired physicians and discourages doctors from getting needed help.

Minnesota's impaired physician monitoring program keeps clinical records confidential. However, the confidentiality of records by such a monitoring program is not the same as a private physician-patient relationship. One physician told me how she felt "raped" upon learning that her psychiatrist had detailed her relationship with a male friend to the program. This was surely a gratuitous disclosure. The Supreme Court affirms the importance of private mental health care: "Effective psychotherapy . . . depends upon . . . confidence and trust. . . . For this reason, the mere possibility of disclosure [of confidential communications] may impede development of the . . . relationship necessary for successful treatment. . . . The . . . privilege serves the public interest . . . [since t]he mental health of our citizenry . . . is a public good of transcendent importance. . . . Making the promise of confidentiality upon a . . . later evaluation of the relative importance of the patient's interest in privacy and the evidentiary need for disclosure would eviscerate the effectiveness of the privilege."[5]

The medical profession would benefit from competent colleagues who were comfortable discussing their mental health care. They would help erase the prejudices that arise when seeking such treatment is stigmatized or when mental illness is visible only after a catastrophe. I am delighted that medical school counselors say that students have cited my public challenge to the Board as they sought help. If we could speak openly with each other, physicians could teach physicians who have not experienced depression how to better diagnose and treat this disease. Though I would not wish the pain of depression on anyone, I am a better physician for my experience, more empathic with this pain, and better equipped to sustain my patients.

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1. Miles SH. Do state licensing procedures discriminate against physicians using mental health services? *Minn Med*. 1997;80:42-46.
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3. Position Statement on Confidentiality of Medical Records: does the physician have a right to privacy concerning his or her own medical records? *Am J Psychiatry*. 1984; 141:331-332.
4. Coleman R, Shellow RA. Ask about conduct, not mental illness: a proposal for bar examiners and medical boards to comply with the ADA and Constitution. *J Legislation*. 1994;20:145-177.
5. *Jaffee, Special Administrator for Allen, Deceased v Redmond et al*, 116 SC 1923 (1996).

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