

## Professional News

### **M.D. Prevails on Challenge to Discriminatory Relicensing Form**

*By Ken Hausman*

Steven Miles, M.D., a Minneapolis internist and gerontologist, is practicing medicine as he has done throughout much of his career, but the privilege of conducting business as usual did not come without a fight. That's because Miles has been treated for bipolar illness.

The Minnesota Board of Medical Practice, to which Miles applied for a routine renewal of his medical license, maintained that his honest answer to a question on its renewal application asking whether he had been "diagnosed with or treated for bipolar disorder, schizophrenia, paranoia, or any other psychotic disorder" warranted extensive investigation before it was willing to certify that he was fit to practice medicine.

Miles told *Psychiatric News* in a 1997 interview that when a physician acknowledges on a license renewal application that he or she has been treated for bipolar illness, it triggers "an automatic assumption of impairment based on the diagnosis" (*Psychiatric News*, September 5, 1997). Because of this policy, the medical board demanded that he turn over records of his psychiatric treatment and a list of the medications he was taking for the board to review as a condition of license renewal. It also wanted him to provide a written account of his "current practice situation" and any steps he has taken to alter his practice as a result of his illness.

The board insisted that its review procedure was an effective way to protect the public because it encouraged impaired physicians to seek treatment for their condition and to agree to be monitored if the board detected a problem in practice ability.

Miles—who had never had a complaint filed against him and whose illness was controlled by medication—was unwilling to comply and filed a complaint with the U.S. Department of Justice charging the medical board with violating the Americans With Disabilities Act (ADA). The board did not impose a similar review requirement on physicians who had been treated for physical illnesses, only investigating them when it received evidence that the physician's ability to function professionally might be compromised by a medical condition. After considerable publicity of Miles's dilemma, the board appointed a task force to review its procedures for handling inquiries of substance abuse and mental illness disorders

among Minnesota physicians who apply for license renewals. In early August the Department of Justice's Civil Rights Division responded to Miles's complaint by informing the Health and Licensing Section of the Minnesota attorney general's office that the government "generally supports the task force's recommendations," which urge shifting to a standard of proof that would investigate an applicant's ability to practice medicine instead of automatically demanding records when a psychiatric illness is involved.

The Department of Justice stated, however, that in several areas the recommendations still fall short of meeting the requirements set out in the ADA.

The medical board's task force urged, for example, that when an applicant's answers to certain questions raise concern, requests for an applicant's medical records be ordered according to a hierarchy and that the process be overseen by a medical coordinator who is also a licensed physician.

The sequence would be the following: (1) the treating physician's statement; (2) hospital summaries such as admission, discharge, and consultant reports; (3) full hospital records; and (4) outpatient treatment records.

Responding to this suggestion, attorney Sheila Foran of the Department of Justice's Disability Rights Section told the medical board that although the hierarchy idea "is sound in principle," it is "too vague to ensure implementation consistent with the ADA. In order to fully comply with the ADA, the board must devise procedures that will safeguard the integrity of the hierarchy; namely, ensuring that additional medical information will be sought only where strictly necessary to determine a licensee's fitness to practice."

Foran suggested that at the first level, the treating physician be asked specifically about the applicant's ability to "perform with reasonable skill and safety all tasks and activities required of physicians." Only when their responses are "unsatisfactory" should they be asked for information about the illness course or treatment.

"In the vast majority of cases, the treating physician's opinion that the licensee's condition does not negatively impact his or her ability to perform" professional duties should close the board's inquiry, she wrote.

Regarding level two, involving hospital summaries, the Department of Justice said that they would be requested only when "there is reasonable doubt as to the veracity or completeness of the treating physician's opinion of the licensee's ability to practice medicine," evidence of conduct that points to impairments of skill and safety procedures, or the physician's report fails to resolve the fitness issue.

At the level at which complete hospital records can be requested, the Department of Justice wants the board to show that it has reason to doubt the applicant's ability to practice, and that hospital summaries indicate that without additional information the applicant cannot be declared fit to practice.

The licensee must be informed in writing of such a finding "in ample time to permit appeal," according to Foran.

"A licensee should almost never be asked to produce outpatient medical records," she emphasized in addressing the fourth level of the hierarchy. The strict criteria for taking steps at this level are that all previous information is insufficient to draw conclusions about a physician's ability to practice and outpatient record requests are very narrowly drawn and needed "to rebut the Board's preliminary determination that the licensee is not qualified to practice medicine." The board also must give the licensee the opportunity to "demonstrate that such records are not necessary" to a determination of relicensure.

Attorney Foran also suggested that while the ADA does not require the Minnesota medical board to have an ADA coordinator and an ADA-related grievance procedure because it has fewer than 50 employees, it strongly recommended that to avoid such difficulties, it designate an individual to fill this role.

In an interview with Psychiatric News last month, Miles said that the Minnesota medical board has indicated that it plans to implement all of the Department of Justice's recommendations, except one. It plans to continue to ask whether, since his or her last license renewal, the physician has been treated for bipolar illness, schizophrenia, or other psychoses. It will continue to treat other just as disabling psychiatric disorders, such as PTSD, with a less strict standard, Miles pointed out, as it does with all physical illnesses.

Miles commented that the Department of Justice's response is "not surprising," because the board's policy was based on the "false presumption that a mental health diagnosis or use of mental health services reliably predicts occupational impairment."

His case is still open, though the board has never suspended his license. "I can't imagine [the board's] taking any action like that," he said. Whatever the medical board decides, Miles will not consider his case closed until the board compensates him for his "extraordinary legal costs," he told Psychiatric News.

Miles also stressed that he was "impressed with the degree of support" he has received from Minnesota psychiatrists, APA, and the medical community in general.