# Do State Licensing Procedures Discriminate Against Physicians Using Mental Health Services?

*One physician calls for reform.*

Steven Miles, M.D.

My experience with the Minnesota Board of Medical Practice (BMP) since disclosing on my license renewal application that I have used mental health services has led me to believe that the board's procedures need fundamental reform. Its procedures for deciding whether to renew physicians' licenses are poorly grounded, counterproductive, overly invasive, and potentially illegal. The 1996 medical license renewal form asked physicians to disclose various physical and mental conditions. The form also queried physicians about disciplinary actions, civil lawsuits, and criminal charges. The BMP can use such information to bar physicians from practice or require that they be retrained or supervised.

The 1996 renewal form clearly differentiated between physiological and mental conditions. Questions about an applicant's physiological diseases inquired whether they caused occupational disability. For example, question 1 read: "Since your last renewal, did you have any physiological disorder or conditions which impaired your cognitive, communicative or physical capability to engage in the practice of medicine with reasonable skill and safety?" By contrast, three of the four questions about mental conditions (4, 6, and 8) focused on the diagnosis or treatment of mental illness rather than on disability. These questions ask whether physicians have been diagnosed with or have been treated for bipolar disorder, schizophrenia, paranoia, any other psychotic disorder; pedophilia, exhibitionism, voyeurism, or other sexual behavior disorders; or compulsive gambling or kleptomania.

Minnesota law does not say that the BMP must or should investigate any or all physicians who have been diagnosed with or treated for mental illness. Even so, the BMP's procedure is to initiate an investigation, the first step in what it calls a disciplinary action against physicians who disclose the diagnosis or treatment of mental illness without corroborating evidence of disability such as complaints, malpractice actions, or criminal activity.

In order for the BMP to investigate a physician, it must have "probable cause"[1] to believe that the physician has the "inability to practice medicine ... [as] a result of any mental or physical condition."[2] As I interpret Minnesota law, once the BMP finds "probable cause" for an investigation, the physician is presumed disabled and bears the "burden of proof ... to demonstrate his or her qualifications."[3] A physician must also cooperate with the investigation.[4] "Failure ... to submit to a mental examination or to supply medical records constitutes an admission of the allegations (sic) against the person."[1] Thus, the self-disclosure of diagnosis or treatment allows the BMP to presume the physician is disabled, which the physician must then disprove.

## *Case*

I have type II bipolar disorder, a mainly depressive disorder with nondisabling periods of hypomania that are helpful diagnostically and that point to highly effective therapy. I have been, and am, successfully treated. I have disclosed this condition to my employers, and I pursue a successful and productive career in academic and clinical internal geriatric medicine. I have not been disciplined or sued, and no complaints have been filed regarding my professional conduct. I have noted my experience in the *Journal of the American Medical Association*. I have urged other physicians to use mental health services, discussing the issue with a large group of medical students the day after one of their classmates committed suicide.

I answered the license renewal questions honestly. On that basis, the BMP demanded copies of all notes and records from my treating physician. The BMP did not disclose that it was engaged in an investigation or that it presumed disability. Letters from the BMP merely stated that it was "required by law to assess this information." The BMP has never confirmed that I am part of an investigation or identified the statutes upon which their requests were based. I discussed the BMP's request with my physician, with mental health professional groups, and an attorney, and I reviewed the medical literature and Minnesota statutes. As a result,

I believe that the BMP's procedures probably:

- went beyond the requirements of Minnesota law by requesting additional information regarding my mental condition as a result of my disclosure;
- violated confidentiality of medical records; and
- violated the Americans with Disabilities Act (ADA).

My lawyer and I have submitted to the BMP material from the American Psychiatric Association (APA), the state chapter of the APA, legal cases, professional literature, and the name of a lawyer with the U.S. Department of Justice who has written legal briefs arguing that procedures similar to the BMP's violate the ADA. The BMP's attorney defended its policy (see the following discussion) and said the investigation would continue. As this article goes to press 11 months after completing my license renewal form, I have accumulated $8,000 in legal fees and am awaiting the BMP's next step.

### *Five Problems With the BMP's Position on Mental Illness*

I see five problems with the BMP's position on mental illness. First, the distinction between physiological conditions or disorders and mental illnesses does not comport with modern understandings of neuropsychiatry.

Second, the BMP's finding of "probable cause" or presumed disability based on diagnosis or treatment alone is discriminatory and unsupported. In a letter to my attorney dated May 10, 1996, Sarah Mulligan, assistant attorney general and counsel to the BMP, argued in support of the BMP's policy. She wrote: "The [mental] diagnoses listed can be extremely disabling illnesses and can greatly impair the ability to practice a profession. They are known to be chronic. And sufferers' insight into the illness and ability to cooperate with treatment vary, thus requiring an assessment of the individual's history of the disease as well as present manifestations."

The licensing renewal form suggests that physicians with "physical" illness have the insight to limit their practice for self-perceived disability. The form implies that physicians who use mental health services do not have this ability, a position that is

## Excerpts from American Psychiatric Association Confidentiality Statement*

It has been proposed that physicians have a special duty to the public which can only be discharged by requiring that the physician's own health record pertaining to the physician's mental health be exposed to the scrutiny of those who oversee the fitness of individuals to practice medicine.

No convincing argument has been advanced to show that a patient should be deprived of the right to the privacy of his or her medical record simply because he or she has chosen to study or practice medicine. We believe that reasonable protection of patients does not require the assumption that anyone who is now, or has been, 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. There is no evidence to suggest that the hazard is so great that normal safeguards are inadequate.

Moreover, there is a greater danger that individuals needing treatment will be barred from obtaining professional help if getting it would require them to bare their innermost secrets to public or private overseers. More likely, they would try to conceal the need and continue to practice without treatments for what might be curable ills. Far from protecting the public, it is likely that the abolition of the confidentiality of the 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 than would be the case if medical treatment were less a private matter for medical professionals than it is for others.

Licensure boards seeking to know whether a history of psychiatric disorder impairs present function should do so on a case-by-case basis and only for cause. The mandatory disclosure of the physician's confidential medical or personal history is without merit. The supposedly heightened protections for patients sought by those who would exclude physicians from the traditional safeguards of medical confidentiality are illusions.

*Position statement of confidentiality of medical records: does the physician have a right to privacy concerning his or her own medical records? Am J Psychiatr 1984;141:331-2.

# Protecting Physicians and the Public Interest

*A representative of the Minnesota Psychiatric Society argues that impairment, not diagnosis, should be the focus of Board of Medical Practice questions.*

Richard D. Lentz, M.D.

The Minnesota Psychiatric Society (MPS) is very concerned about the nature of the questions the Board of Medical Practice (BMP) asks when physicians renew their medical licenses or apply for new licenses. A task force is actively studying the issue, but a formal statement is not yet available. The MPS hopes to work with the BMP to modify the questions so that they address impairment, not diagnosis.

As chair of the Minnesota Psychiatric Society's Committee on Board of Medical Practice Relationships, I would like to address seven pertinent issues related to mood and some psychotic disorders.

1. Bipolar mood disorders are far more common than previously believed and have many presentations. Like major depressive episodes, upswings may vary from extremely mild to severe. One form, bipolar mood disorder, Type II, has brief, usually mild hypomanic, along with depressive, episodes.

2. Significant major depressive episodes occur in 10 percent to 15 percent of the entire population (including physicians), and up to 20 percent of these episodes have some psychotic components. Hence, perhaps 2 percent to 3 percent of all people, including physicians, might have experienced at least mild transient psychotic features.

3. Almost all physicians with these common mood disorders, even when severe, seek treatment appropriately, take sick leave as needed, never endanger their patients, and, therefore, are never "impaired."

4. Many medical problems such as high fever, toxic responses to medication, and transient severe organ system problems are associated with completely reversible delirium with psychotic features; however, BMP questions don't exclude these problems.

5. Current BMP questions perpetuate the myth that mental illness is equivalent to impairment, a stigma that prevents many people from seeking help. The U.S. Public Health Service is vigorously working to destroy this kind of stigma involving mental illness.

6. I assume the BMP has encountered the rare situation where a physician with psychiatric illness does become transiently impaired in practice. Questions about impairment, not diagnosis, would address such a situation.

7. Physicians should be encouraged to seek help for psychiatric disorders. Without a reasonable guarantee of privacy, many physicians, like pilots, politicians, and others who fear stigma or loss of their livelihood, will not do so. The risk of physician impairment only increases. Just as the public interest is served by protecting the privacy of quality assurance activities and peer review within medical practices and institutions, protecting the privacy of physicians seeking medical help will improve the quality of medicine.

The BMP plays a vital role in protecting the public from a physician who may be impaired. I personally endorse that role. I also believe that a policy that encourages physicians to seek help best serves the public interest. Such a policy is essential to the safe practice of medicine and is compatible with a modern understanding of mental illness. Questions that focus on psychiatric diagnosis, rather than impairment, only discourage physicians from seeking the very help they need.

*Richard Lentz is chair of the Minnesota Psychiatric Society's Committee on Board of Medical Practice Relationships, consultant in psychiatry at Park Nicollet Clinic-Health System Minnesota, staff member of the Professional Assessment Program at Abbott Northwestern Hospital, and clinical professor of psychiatry at the University of Minnesota.*

reaffirmed in the letter from Mulligan. The BMP has not offered empirical support that surgeons with Parkinson disease, for example, or family practitioners with open infected sores on their hands who do obstetric procedures have greater insight into their potential disability or danger to patients than a physician who has sought out, worked with, and been successfully treated by a psychotherapist.

Third, the BMP's list of mental health diagnoses that deserve scrutiny for presumptive disability is arbitrary. Why do kleptomania or compulsive gambling merit special inquiry for occupational disability, while the relicensing form is silent on post-traumatic stress disorder and multiple personality disorder?

Fourth, the BMP's request to independently review physicians' mental health records is both needlessly invasive and unlikely to be a useful remedy for, as Mulligan alleges, physicians' varying "insight into [their] illness and ability to cooperate with treatment." It is needlessly invasive in that the privacy of mental health records is violated to allow discussion by board members, some of whom are not qualified to render an opinion on mental health. A review of mental health records by a board culling often sketchy raw data from another practitioner's chart notes is less likely to lead to a sound psychiatric opinion than a review rendered by an independent qualified mental health professional following up on tangible evidence of occupational disability.

Fifth, mental health experts have concluded that presuming disability based on diagnosis alone and requiring a surrender and review of mental health records is counterproductive to the goal of assuring maximum mental health of health professionals (see the accompanying sidebars on pages 43 and 44).

## *The Americans with Disabilities Act*

The Americans with Disabilities Act (ADA) bars imposing discriminatory burdens on persons who are disabled or on persons who are wrongly perceived to be disabled.[5] Courts agree that the ADA applies to licensing board procedures.[6] A New Jersey court, for example, decided that the ADA applied to the state medical licensing board and that a class action against the board was permitted.[7] Before the case went to trial, the New Jersey board rescinded questions and procedures that relate to mental illness. *Minnesota Medicine* discussed the Minnesota Board of Medical Practice's procedures in light of the ADA in 1994 (see "Are Medical Licensing Questions Discriminatory? May 1994, page 27; an update to that article appears this month on page 47).

I believe that the following three elements of the BMP's policies and practices violate the ADA:

1) The BMP operates under the assumption that mental conditions fundamentally differ from physiological conditions;

2) This difference alone constitutes "probable cause" to presume medical disability without supporting evidence of disability; and

3) The BMP imposes extra procedural burdens and invasion of privacy on physicians with mental health conditions.

A key issue for an ADA ruling is whether the imposed discriminatory burden is a loss of privacy or the discriminatory loss of practice privileges. Minnesota's attorney general cites a Texas case that found no ADA violation because the physician had virtually no chance of losing the opportunity to practice.[8] However, other courts have supported ADA claims, and the implicit view of the American Psychiatric Association is that the loss of privacy is discriminatory[9, 10] (see the sidebar, page 43). Another court focused on a board's lack of empirical evidence supporting the effectiveness of the inquiries and presumed disability.[11]

This past summer, the U.S. Supreme Court rejected balancing confidentiality of mental health care records with state interests—the centerpiece of the BMP's procedures. The court ruled: "Effective psychotherapy depends on confidence and trust and therefore the mere possibility of disclosure of confidential communications may impede the development of the relationship for successful treatment. The privilege also serves the public interest since the mental health of the Nation's citizenry ... is a public good of transcendent importance. ... Making the promise of confidentiality contingent 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 privacy. ... An uncertain privilege is little better than no privilege at all."[12]

In my opinion, this ruling arguably bars the Minnesota Board of Medical Practice from demanding medical records as a part of any mental health investigation.

## *Conclusion*

The BMP provides Minnesotans protection from disabled physicians, but so do criminal proceedings, malpractice actions, peer review, and supervisory relationships. As the American Psychiatric Association and the Supreme Court point out, the destigmatization of and unthreatened access to mental health care also substantially protect the public from persons with mental illnesses, including physicians. I believe that promoting access to mental health care—without fear that such care will trigger a disciplinary investigation—protects patients at least as well as spotty board oversight of physicians who are willing to admit receiving mental health care.

The BMP's procedures must conform to state and federal law, constitutional principles, legal precedents, and to due process. I believe the BMP should retract its request for my medical records, or at least explain why it has not done so, given the Supreme Court ruling apparently bearing on the legality of that request.

The BMP's letters did not inform me that it was engaged in an investigation, of the statutory basis of the investigation, or that the investigation presumed that I was disabled. The BMP did not even provide this information in response to a written request. This lack of communication and due process (less than that printed on parking tickets) is unaccept-

able in collegial or professional relationships. It misleads and intimidates physicians who are trying to properly respond to the BMP's inquiries. Physicians who are in similar situations, who have been asked to surrender medical or psychiatric records, or who have been sanctioned or burdened on the basis of information about their medical conditions or treatment alone, should consider seeking redress.

The Minnesota Board of Medical Practice's procedures merit a challenge. The goal of such a test would be to improve the access to and climate for mental health care for every physician. That goal is in every Minnesotan's interest. MM

*Steven Miles is an associate professor of medicine in the Department of Geriatrics at St. Paul-Ramsey Medical Center and the University of Minnesota and associate faculty at the University of Minnesota Center for Biomedical Ethics.*

REFERENCES

1. Minn. Stat. § 147.091, Subd. 6 (a) (b) (1996).
2. Minn. Stat. § 147.091, Subd. 1 (l) (1996).
3. Minn. Stat. § 147.091, Subd. 1 (a) (1996).
4. Minn. Stat. § 147.131 (1996).
5. Pub L. No. 101-336 (42 U.S.C. § 12134).
6. Coleman P, Shellow R. 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(2):147-77.
7. Medical Soc'y of N.J. v. Jacobs, No. 93-3670, 1993 WL 413016 (D.N.J.)
8. Applicants v. Tex. State Bd. of Law, No. A 93 CA 740 SS, 1994 WL 776693 (W.D. Tex.).
9. Ellen S v. Fla. Bd. of Bar Examiners, 859 F. Supp. 1489 (S.D. Fla. 1994).
10. Underwood for Admission to the Bar of the State of Me., 1993 WL 649283 (Me.).
11. Clark v. Va. Bd. of Bar Examiners, 880 F. Supp. 430 (E.D. Va. 1995).
12. Jaffee for Allen deceased v. Redmun, 116 S.C. 1923 (1996).