

COMMENTARY

Mental Illness and a Mandatory Drug Test: One Doc's Trouble Getting Licensed

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Lost in a Licensure Nightmare

Dr PJ recently applied for a second medical license in a nearby state, whose medical licensure board (MLB) referred him to the state's physician health program (PHP). The MLB application contained a question: "Have you ever been treated for a mental illness?" The doctor willingly reported a history of depression that had been treated and stable since diagnosed in medical school some 17 years earlier.

The PHP process started with a friendly phone interview. Dr PJ's treating primary care physician was on the call and testified as to his stable health and treatment. The PHP interviewer told them that an in-person follow-up meeting would not involve an evaluation or testing, just a peer-to-peer conversation so that the PHP could write a letter to the board. The only requirement was for the doctor to bring \$500 cash to the interview.

When Dr PJ appeared at the PHP, he met with a social worker who knew nothing about this history or the prior conversation. The social worker stated that the doctor would have to sign consent forms indicating that he would comply with any and all eventual recommendations made by the PHP (without specification), or his noncompliance would be reported to the medical board.

When Dr PJ asked about possible recommendations, the interviewer said that there was a greater than 90% chance that they would propose a 1-week inpatient evaluation, which would cost \$5000 cash. The interviewer added that usually this would be followed by 3 months of inpatient treatment (~\$40,000) and then 3-5 years of outpatient treatment and monitoring. First, though, he would need to take a drug test.

Dr PJ felt that this must be a mistake. He stated that he didn't feel comfortable signing anything until speaking with his lawyer. The social worker appeared surprised, and Dr PJ was sent back to the waiting room. Later, the medical director of the PHP came out and asked what the problem was and why the doctor was refusing to take the drug test.

Dr PJ tried to explain why he felt uncomfortable, that he had been told he was there only as a formality due to a history of depression, that he had never used drugs, and didn't feel comfortable signing the blanket consents given what he was told about the likely subsequent process. He politely asked for an explanation. Instead, the director stated that, from his perspective, Dr PJ must have something to hide if he was refusing to take a drug test. As a result, regardless of the original reason for the referral, he was now also under suspicion of having a drug addiction problem.

Not wishing to be under a cloud of suspicion, the next day Dr PJ called to ask the PHP where he could go to get a drug test and what exact test was used. The director stated that doing the test a day later would mean nothing. He further refused to tell the doctor or his PCP what lab to use or what test to order to duplicate the required information, stating that such information was proprietary. Dr PJ took the drug test anyway, which was negative.

Before going back to the PHP, Dr PJ spoke with multiple lawyers who uniformly stated that he would likely have to sign the papers, that any representation would cost at least \$30,000, and that it might not change anything. Dr PJ decided that a medical license in another state was not worth it and did not go back to the PHP.

However, Dr PJ's "noncompliance" with the PHP by not signing the blanket consent forms was reported back to the MLB. Subsequently, Dr PJ has experienced difficulty with his original licensure board due to reciprocal reporting between state MLBs.

Medical Trainees and Mental Health

Although exact prevalence rates vary among studies,^[1] it has been amply illustrated that medical trainees experience depression, burnout, and mental illness at a higher rate than the general population and that these symptoms often deteriorate over the course of their training.^[2-7] Medical students have a higher risk for suicidal ideation^[8] and suicide,^[9] higher rates of burnout,^[10] and a lower quality of life than age-matched populations.^[11] Burnout and depressive symptoms have been

associated with suicidal ideation in medical populations.^[12] However, medical students are less likely than the general population to receive appropriate treatment, despite potentially having better access to care.^[13-17]

It is not yet known with certainty why medical trainees are more susceptible to depression and other mental illness than the general population, but the fact seems ineluctable. It is also known that physicians complete suicide more often than age- and status-matched professionals, which is attributed to both their knowledge of, and better access to, lethal means.^[18-21] Medical trainees lie between these two populations, having more and higher risk factors for suicide and simultaneously a developing knowledge of, and limited but incrementally increased access to, lethal means.

Fears Prevent Seeking Treatments

Given these risk factors and the high investment made by and for students who are preparing for careers in medicine, it would seem prudent that every effort be made to encourage that they seek appropriate mental health care and obtain needed treatments and/or follow up. Within limits, most "normal" patients are given the right to obtain their own sources of medical care and follow up.

And such efforts are being made. However, it is readily apparent from both the medical literature and recent accounts in the popular media^[22-25] that doctors and medical trainees remain deterred from mental health seeking given fears of lack of confidentiality of their medical records, the substantial stigma still associated with mental illness, and the perceived and demonstrated negative ramifications of health disclosure on future training, licensing, reputation, and career options.

The study by Gold and colleagues titled, "I Would Never Want to Have a Mental Health Diagnosis on My Record,"^[26] the recent survey by the Mayo Group of the apparent chilling effect of overly intrusive MLB health-related questions,^[27] and personal histories^[28] clearly illustrate that such fears are not unfounded.

Ethical principles of beneficence and nonmaleficence require that patients be served by physicians who are physically and mentally capable of providing sound care. But ethics also mandate that health providers are themselves deserving of competent care of their own choosing. Additionally, ethics dictates that as long as a provider's medical or mental health diagnosis does not produce tangible behaviors indicative of current impairment, admitting to current or past treatment of a medical or mental condition that could "potentially" lead to impairment should not preclude or affect future training, licensure, or credentialing decisions.

Ethical and Legal Implications

In the case of a student like young PJ, evaluation and treatment were rationally sought out for a common and possibly transient mental illness during medical school. If such a student no longer needs follow up because of the condition's transient nature or maintains confidential treatment and follow up during his or her medical career, they should not ethically be subjected to limited post facto analysis by a person (such as a PHP director) who may not even be a physician or have formal mental health training or certification except in addictions medicine.

MLBs have an ethical duty to protect the public. But that duty should be discharged upon the assurance of a qualified practitioner, who intimately knows his physician patient, that a condition is either no longer in existence or is in sustained remission. And that duty should not be delegated, without solid justification, to a PHP.

MLBs also have an ethical as well as a legal duty to abide by the Americans with Disabilities Act (ADA) and related laws regarding discrimination against persons regarded as having a disability.^[29] According to the US Department of Justice (DOJ) in its settlement with the Louisiana State Supreme Court in an analogous case regarding bar admissions application questions, the (licensing agency) should refrain from inquiring into mental health diagnosis or treatment unless an applicant voluntarily discloses this information to explain conduct or behavior that may otherwise warrant denial of admission, or the agency learns from a third party source that the applicant raised a mental health diagnosis or treatment as an explanation for conduct or behavior that may otherwise warrant denial of admission.

According to the DOJ, any such inquiry should be narrowly, reasonably, and individually tailored, the applicant's treating professional should be accorded considerable weight, and any medical records requested should be by way of narrowly tailored requests and releases that provide access only to information reasonably needed to assess the applicant's fitness to practice. Furthermore, the DOJ stipulated that an independent medical examination shall not be requested, unless other means fail to resolve reasonable concerns regarding the applicant's fitness, and if requested should occur at a time and place convenient to the applicant. All personal or health-related information should be kept strictly confidential and accessed only by individuals with a legitimate need.^[30] The DOJ is currently investigating cases involving ADA discrimination in bar applications in Vermont and Florida.

A number of case studies,^[31,32] surveys,^[33-37] scholarly articles,^[38,39] and reports have indicated suicidal behaviors^[40] resulting from licensure board investigations (all in the wake of *Medical Society of New Jersey v Jacobs*^[41]). Their findings suggest that MLB applications continue to ask seemingly ADA impermissible questions regarding conditions that "could" result in

impairment without qualification as to whether or not a given condition does "currently" result in impairment. This has a clear psychological impact on physicians and disciplinary investigations of all sorts.

Given this context, is it finally time for the profession to critically examine whether asking such questions, and then subjecting those who answer positively to more intrusive questioning, examination, and in some cases inpatient evaluation, is an ethical and defensible practice or whether it is, in fact, contributing to the suicidality of a vulnerable population—medical trainees and physicians?

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