The mission of the Minnesota Board of Medical Practice is to protect the public's health and safety by assuring that the people who practice medicine or as an allied health professional are competent, ethical practitioners with the necessary knowledge and skills appropriate to their title and role.

THE POLICY & PLANNING COMMITTEE WILL MEET ELECTRONICALLY BY WEBEX:
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AGENDA FOR
THE MINNESOTA BOARD OF MEDICAL PRACTICE
POLICY & PLANNING COMMITTEE
February 1, 2021
10:00 A.M.

1. Review of application questions related to ability to practice with reasonable skill and safety
   a. Board of Medical Practice Physician Application for Licensure questions (attached)

   b. Board of Medical Practice Physician Renewal Application questions (attached)

2. Federation of State Medical Boards 2018 Policy on Physician Wellness and Burnout (attached)

3. Additional materials in support of review
   a. Minnesota Medical Association supporting documentation (attachments 1-7)

   b. Twin Cities Medical Society statement (attached)

   c. Physicians Serving Physicians statement (attached)

4. Other Business

2021 Policy & Planning Committee Meeting Dates (10:00 a.m. unless otherwise noted)
- March 1
- April 5
- May 3
- June 7
- July 12
- August 2
- September 13
- October 4
- November 1
- December 6

Attestation questions Except for questions 1-4, please answer all questions by selecting Yes or No and provide an explanation when requested. Questions 1-4 do not have "No" as an option for confidentiality reasons. If you have a condition addressed by questions 1-4 and you are NOT participating in Health Professionals Services Program (HPSP) for monitoring of the condition, you must answer "Yes" to the applicable question(s). If you do not have this condition, OR if you are participating in HPSP for monitoring of this condition, do not answer the applicable question(s). For questions 1-2, the terms "impaired" and "limited" include but are not limited to impairments or limitations related to physical, psychological, or emotional disorders or conditions, or chemical dependency or chemical abuse. The purpose and intended use of this information is to enable the Board to determine whether you meet statutory and rule requirements for licensure. This information is classified as private while your application is pending and public after your license is granted. Exception: "Yes" answers are confidential during any investigation and private thereafter. This information will NOT be included in the profiling. If responses to questions change during the time your application is pending, you must make the board aware of the new information. If additional space is necessary please attach a separate sheet.

Yes 1. Is your cognitive, communicative, or physical capability to engage in the practice of medicine or surgery with reasonable skill and safety impaired or limited in any way? Please describe.

_____

_____

Yes No 1a. If yes, are the limitations or impairments reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program? Please describe._____

_____

Yes No 1b. If yes, are the limitations or impairments reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? Please describe._____

_____

Yes 2. Does your use of alcohol or chemical substance(s), including prescription medications, in any way impair or limit your ability to practice medicine with reasonable skill and safety? Please describe.

_____

_____

Yes 3. Are you engaged in any illegal use of controlled substances including the use of illegal controlled substances (e.g. heroin, cocaine) or illegal use of legal controlled substances (i.e. not obtained pursuant to a valid prescription of a licensed health care provider)? Please describe.

_____

_____

Yes No 3a. If yes, have you taken any steps (i.e. treatment, psychotherapy, participation in a support group) to discontinue or reduce such use? Please describe.

_____

_____

Yes No 3b. If yes, are you not participating in a supervised rehabilitation program or professional assistance program which has as a component a monitoring regimen designed to assure that you are not currently engaging in the use of illegal controlled substances? Please describe._____

_____

Yes 4. Have you within the past five years been advised by your treating physician that you have a mental, physical, or emotional condition, which, if untreated, would be likely to impair your ability to practice medicine with reasonable skill and safety? I you answer this question "yes", please answer the following:

Yes No 4a. With regard to any condition referenced above, are you being treated so that such impairment is avoided?

Yes No 4b. With regard to any condition referenced above, are you in compliance with the recommended treatment?

Yes No 4c. With regard to any condition referenced above, has your treating physician advised you that you are able to practice medicine with reasonable skill and safety?

4d. Please explain_____

4e. Identify your treating physician_____

Yes No 5. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism, or other sexual behavior disorders? Please describe.

_____

_____

Yes No 6. Have you ever been the subject of an investigation by any Federal, State, or Local agency having jurisdiction over controlled substances? If so, give particulars.

_____

_____

Yes No 7. Have you ever been denied a license, or the privilege of taking an examination before any medical examining board, or has a conditioned license been issued to you by any state medical board or licensing authority? If so, give particulars.

_____

_____

Yes No 8. Has your license to practice medicine in any state or country been voluntarily or involuntarily (i.e. by medical Board Order or any other form of disciplinary action) revoked, suspended, restricted, or conditioned by a Medical Board or other licensing authority? If so, give particulars.

_____

_____

Yes No 9. Have you ever been notified of any investigation by any state medical board, medical society, or any hospital of any complaints against you relative to the practice of medicine, or have you been reprimanded or censure by any medical society or licensing board? If so, give particulars.

_____

_____

Yes No 10. Have you ever been a defendant in any malpractice lawsuits, had any malpractice settlement, or have any pending? If so, give a detailed clinical explanation of each case on the Malpractice Liability Claims Information form as well as documentation of outcome (insurance papers or court documents).

Yes No 11. Have your hospital privileges been restricted or revoked? If so, give particulars.

_____

_____

Yes No 12. Have there ever been any criminal charges filed against you? This includes charges of disorderly conduct, assault or battery, or domestic abuse, whether the charges were misdemeanor, gross misdemeanor, or felony. This also includes any offenses which have been expunged or otherwise removed from your record by executive pardon. If so, submit a personal statement regarding the date of conduct, state and local jurisdiction in which the charges were filed, date of closure, what role you played, and the outcome.

Yes No 13. Have there ever been any charges or Driving While Intoxicated (DWI) or Driving Under the Influence (DUI) or other impaired driving offenses involving alcohol or other chemical filed against you? If so, submit a detailed personal statement regarding the date of conduct, state and local jurisdiction in which the charges were filed, explaining in detail the incident and consequences including whether a CD evaluation was done (if so, submit results), and description of current drinking habits.

Yes No 14. Have you ever voluntarily or involuntarily surrendered your DEA certificate or the right to prescribe controlled substances? If so, give particulars.

_____

_____

Certificate of Ethical and Moral Character

This certificate must be signed by **two** licensed physicians who are personally acquainted with the applicant.

1.

I certify that the photograph attached is a recent one and likeness of Dr. _____

And that s/he is a person of good ethical and moral character.

_____	_____	_____	_____
SIGNATURE	DATE	LICENSE NUMBER	STATE OF ISSUE

_____
PRINT OR TYPE FULL NAME

CERTIFICATION OF IDENTIFICATION
Certification of Notary Public is required.

State:_____ County:_____

I certify that on the date set forth below, the individual named above did appear Personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document. Sworn to before me by the

applicant on this _____ day of _____ , _____.

Notary Public Signature _____

Expiration Date _____ / _____ / _____
Month Day Year

Paste a recent photo, front-view passport-type (2" square) photo in this square

SEAL
The impression of the seal must be partly upon the photo

_____
Applicant's Signature

2.

I certify that the photograph attached is a recent one and likeness of Dr. _____

And that s/he is a person of good ethical and moral character.

_____	_____	_____	_____
SIGNATURE	DATE	LICENSE NUMBER	STATE OF ISSUE

_____
PRINT OR TYPE FULL NAME

Applicant Name_____ Last 4 digits of SSN _____ Date_____

HOSPITAL STAFF PRIVILEGE REPORT

Minn. Stat. §147.162 provides that physicians shall file with the board a list of the inpatient and outpatient medical care facilities at which they have privileges. **If you have no privileges, be sure to write NONE.** Hospital staff privilege information is public and you are required to submit it for renewal purposes. **Your license will not be renewed without it**.

FACILITY	CITY AND STATE	TYPE OF PRIVILEGE

CONTINUING MEDICAL EDUCATION

All physicians (including retired or outstate) must report 75 hours of **Category 1** continuing medical education every three years. If your report is due with this renewal (see the front of the form), record CME hours below and retain documents for auditing during the year. The Board exempts physicians in residency, fellowship, or under emeritus registration from complying with the CME requirement. Physicians in residency or fellowship for a portion of the cycle can prorate; for example, if you were in residency one out of three years, you must complete two-thirds of the requirement, or 50 hours. Please indicate your status below. **Continuing medical education information is public and you are required to submit it for renewal purposes. Your license will not be renewed without it.**

HOURS	DESCRIPTION
	Courses sponsored as Category 1 of the Physician Recognition Award Program of the American Medical Association.
	Category 1 equivalent courses offered by the American Osteopathic Association Bureau of Professional Education, the Royal College of Physicians and Surgeons of Canada or by organizations which have reciprocal agreements with AMA's Accreditation Council for Continuing Medical Education (ACCME).
	TOTAL (Minimum 75 hours)

To claim exemption for a residency or fellowship program during a portion of your CME reporting cycle indicate the number of years. _____ Residency _____ Fellowship

The Board accepts certification or recertification by a member of the American Board of Medical Specialties, the American Osteopathic Association Bureau of Professional Education, the Royal College of Physicians and Surgeons of Canada, or the College of Family Physicians of Canada in lieu of compliance with the continuing education requirements during the cycle in which certification or recertification is granted. The Board also accepts Maintenance of Certification (MOC) by the American Board of Medical Specialties and Osteopathic Continuous Certification (OCC) by the American Osteopathic Association's Bureau of Osteopathic Specialists as well as the equivalent for the Royal College of Physicians and Surgeons of Canada. Were you certified by an ABMS, AOABPE, RCPSC, CFPC specialty board during your three-year cycle or are you currently participating in MOC, OCC, or the RCPSC equivalent?

___ Yes, I meet the continuing medical education requirement. ___ No, I must meet the 75 credit minimum.

Please answer all questions by selecting "Yes" or "No" and provide an explanation when requested. Questions 3-4 do not have "No" as an option for confidentiality reasons. If you have a condition addressed by questions 3-4 and you are NOT participating in the Health Professionals Services Program (HPSP) for monitoring of the condition, you must answer "Yes" to the applicable questions(s). If you do not have this condition, OR if you are participating in HPSP for monitoring of this condition, do not answer the applicable question(s). For question 4, the term "impaired" includes but is not limited to impairments or limitations related to physical, psychological, or emotional disorders or conditions, or chemical dependency or chemical abuse. The purpose and intended use of this information is to enable the Board to determine whether you meet statutory and rule requirements for licensure. This information is classified as private while your renewal application is pending, and public after your renewal is granted. Exception: "Yes" answers are confidential during any investigation and private thereafter. This information will NOT be included in the profiling.

NOTE: IF YOU ARE CURRENTLY PARTICIPATING IN HEALTH PROFESSIONALS SERVICES PROGRAM (HPSP) FOR A CONDITION COVERED BY QUESTIONS 3-4 OR IF YOU DO NOT HAVE THAT CONDITION, YOU MAY LEAVE THE QUESTION UNANSWERED AS TO THAT CONDITION.

Y N 1. Since your last renewal, have you been diagnosed with or treated for any mental, physical or cognitive condition that may affect your ability to practice with reasonable skill and safety and you have not reported the condition or illness to HPSP? If yes, please describe.

Y N 2. Since your last renewal, have you been diagnosed with or treated for any substance use disorder that may affect your ability to practice with reasonable skill and safety and you have not reported the condition or illness to HPSP? If yes, please describe.

Y 3. Since your last renewal, have you engaged in any illegal use of controlled substances including use of illegal controlled substances (e.g., heroin, cocaine) or illegal use of legal controlled substances (i.e., not obtained pursuant to a valid prescription)? If yes, please describe.

Y N 3a. If yes to question 3, have you taken any steps (i.e., treatment, psychotherapy, participation in a support group) to discontinue or reduce such use? If yes, please describe.

Y N 3b. If yes to question 3a, are you now participating in a supervised rehabilitation program or professional assistance program which has as a component a monitoring regimen designed to assure that you are not currently engaging in the use of illegal controlled substances? If yes, please describe.

Y 4. Since your last renewal, have you been advised by your treating physician that you have a mental, physical, or emotional condition, which, if untreated, would be likely to impair your ability to practice medicine with reasonable skill and safety? If yes, please answer the following:

Y N 4a. With regard to any condition referenced above, are you being treated so that such impairment is avoided?

Y N 4b. With regard to any condition referenced above, are you in compliance with the recommended treatment?

Y N 4c. With regard to any condition referenced above, has your treating physician advised you that you are able to practice medicine with reasonable skill and safety?

4d. Please explain._____

4e. Identify your treating physician._____

Y N 5. Since your last renewal, have you been diagnosed as having or have you been treated for pedophilia, exhibitionism, voyeurism, or other sexual behavior disorders? If yes, please describe.

Y N 6. Since your last renewal, have you been the subject of an investigation by any Federal, State, or Local agency having jurisdiction over controlled substances? If yes, give particulars.

Y N 7. Since your last renewal, have you been denied a license, or the privilege of taking an examination before any medical examining board, or has a conditioned license been issued to you by any state medical board or licensing authority? If yes, give particulars.

Y N 8. Since your last renewal, has your license to practice medicine in any state or country been voluntarily or involuntarily (i.e., by Medical Board Order or any other form of disciplinary action) revoked, suspended, restricted, or conditioned by a Medical Board or other licensing authority? If yes, give particulars.

Y N 9. Since your last renewal, have you been notified of any investigations by any state medical board, medical society, or any hospital of any complaints against you relative to the practice of medicine, or have you been reprimanded or censured by any medical society or licensing board? If yes, give particulars.

BE SURE TO ALSO COMPLETE THE REVERSE SIDE OF THIS APPLICATION

Y N	10. Since your last renewal, have your hospital privileges been restricted or revoked? If yes, give particulars.
Y N	11. Since your last renewal, have there been any criminal charges filed against you? This includes charges of disorderly conduct, assault or battery, or domestic abuse, whether the charges were misdemeanor, gross misdemeanor, or felony. This also includes any offenses which have been expunged or otherwise removed from your record by executive pardon or state district court judge. If yes, give particulars including the date of conduct, state and local jurisdiction in which the charges were filed.
Y N	12. Since your last renewal, have there been any charges of Driving While Intoxicated (DWI) or Driving Under the Influence (DUI) or other impaired driving offenses involving alcohol or other chemicals filed against you? If yes, give particulars, including the date of conduct, state and local jurisdiction in which the charges were filed.
Y N	13. Since your last renewal, have you voluntarily or involuntarily surrendered your DEA certificate or the right to prescribe controlled substances? If yes, give particulars.

-- NOTICE --

1. Your completed renewal application and application fee must be received or legibly postmarked on or before the current expiration date.
2. Applications are INCOMPLETE unless all required information including completion of forms, signature, and the correct fee are received or legibly postmarked on or before the current expiration date.
3. A late fee will be applied to all renewal applications if not received or legibly postmarked on or before the current expiration date.
4. Applications are INCOMPLETE when checks are not honored by your bank. Pursuant to Minn. Stat. §332.50, subd.2, issuance of a worthless (NSF) check will result in a service charge of $20.00.
5. Checks should be made payable to the Minnesota Board of Medical Practice. STATE OF MINNESOTA Taxpayer Identification Numbers are: 41-6007162 (Federal) and 9000001 (State). Foreign checks should state the fee in U.S. dollars. DO NOT SEND CASH BY MAIL.
6. Mail your completed application and proper fee in the envelope provided with your application. Be sure to apply proper postage as the postal service will not deliver parcels with inadequate postage.
7. Failure to renew will result in a lapse of your credentials. Practicing with lapsed credentials is grounds for disciplinary action under Minn. Stat. 147.091, subd. 1(x).
8. Minnesota law requires you to inform the Board of name and/or address changes within thirty days of a change. Further, the law requires that all such changes must be submitted to the Board in writing. If you have a name and/or address correction, please note the change on your application in the space provided.
9. Under the Minnesota Data Practices Act, an application accepted by the Board becomes a public record.
10. Effective March 9, 1999, infection control continuing education is no longer required. Physicians who have continuing education due March 31, 1999 or later do not need to obtain infection control continuing education.
11. A rule was promulgated in 1994 eliminating the CME Categories 2-5. The Board will only recognize courses which were formerly called Category 1 courses for physicians with 3-year cycles beginning on or after January 1, 1995. These courses are those: a) sponsored as Category 1 of the Physician Recognition Award Program of the American Medical Association; b) Category 1 equivalent courses offered by the American Osteopathic Association Bureau of Professional Education or the Royal College of Physicians and Surgeons of Canada or by organizations which have reciprocal agreements with AMA's Accreditation Council for Continuing Medical Education (ACCME). The 75-hour requirement for the three-year cycle remains unchanged.
12. Minn. Stat. §13.41, subd. 2 mandates that applicants or licensees designate a residence or business address and telephone number at which applicant or licensee can be reached regarding license matters.
13. To request a receipt, you must provide a written request and attach it to your renewal. The receipt will be mailed to the account holder at the address provided on the check.

____Yes ____No Do you dispense for profit prescription drugs in Minnesota that are to be administered orally, are ordinarily dispensed by a pharmacist, and are not a vaccine? This information is classified as public. It is unlawful to dispense these prescription drugs for profit in Minnesota after July 1, 1990 unless a statement has been filed with the Board of Medical Practice.

I certify that all information provided is accurate and correct.

X _____ _____ _____ _____

Signature | Date | *Last 4 digits Social Security # | ** Telephone #

*Your social security number is private and you are required to submit it for renewal purposes. Your license will not be renewed without it. Minn. Stat. §147.091, subd. 7(d) mandates the use of the social security number for administration of the state tax code. If your social security number has been changed since last renewal, please provide full social security number.

** Your telephone number is public and you are required to submit it for renewal purposes. Your license will not be renewed without it. Minn. Stat. §13.41, subd. 2 mandates disclosure of telephone number at which licensee can be reached regarding license matters.

Physician Wellness and Burnout

Report and Recommendations of the Workgroup on Physician Wellness and Burnout

Adopted as policy by the Federation of State Medical Boards
April 2018

Executive Summary:

The Federation of State Medical Boards (FSMB) Workgroup on Physician Wellness and Burnout was convened in April of 2016 by FSMB Chair Arthur S. Hengerer, M.D. to identify resources and strategies to address physician burnout.

While the Workgroup examined the issue of physician burnout from a broad perspective, reviewing as many facets of this complex issue as possible, including existing research, resources, and strategies for addressing it, the recommendations for state medical and osteopathic boards (hereinafter referred to collectively as "state medical boards") found in this report focus first and foremost on the licensing process. The Workgroup also saw fit to include commentary and recommendations on several other aspects of physician wellness and burnout, though some of these areas may not be under the direct purview of the FSMB or its member boards. The FSMB recognizes the importance of collaboration for effectively supporting physicians and protecting patients in the face of circumstances that lead to burnout, which is ultimately a patient safety issue. A shared accountability model that includes responsibilities to be carried out by providers from all the health professions, including physicians and physician assistants, and with organizations from across the health care community is therefore recommended as the most promising course of action to address this important issue.

Recommendations for state medical boards related to the licensing process include considering whether it is necessary to include probing questions about a physician applicant's mental health, addiction, or substance use on applications for medical licensure or their renewal, and whether the information these questions are designed to elicit, ostensibly in the interests of patient safety, may be better obtained through means less likely to discourage treatment-seeking among physician applicants.

Where member boards strongly feel that questions addressing the mental health of physician applicants must be included on medical licensing applications, several recommendations are included in this report for the appropriate phrasing of such questions, including focusing only on current impairment, which may be more meaningful in the context of a physician's ability to provide safe care to patients in the immediate future.

State medical boards are also encouraged to approach physician wellness and burnout from a non-punitive perspective, avoiding public disclosure of any information about a physician's diagnosis during licensing processes and offering "safe haven" non-reporting

options (mentioned later in this report) to physicians who are under treatment and in good standing with a recognized physician health program (PHP) or other appropriate care provider.

It is also recommended that boards take advantage of all opportunities available to them to discuss physician wellness, communicate regularly with licensees about relevant board policies and available resources, and make meaningful contributions to the ongoing national dialogue about burnout in order to advance a positive cultural change that reduces the stigma among and about physicians seeking treatment for mental, behavioral, physical or other medical needs of their own.

The Workgroup's recommendations to external organizations and stakeholders focus on increasing the awareness and availability of information and resources for addressing physician burnout and improving wellness. The value of noting and listing the availability of accessible, private, confidential counselling resources is a particular point of emphasis in this report, as is dedicating efforts to ensuring that any new regulation, technology, or initiative is implemented with due consideration to any potential for negative impact on physician wellness.

This report, which follows two years of careful study, evaluation and discussion by Workgroup members, FSMB staff, and various stakeholders, is intended to support initial steps by the medical regulatory community to begin to address the issues associated with promotion of physician wellness and mitigation of burnout, to the extent that is possible. The information and recommendations contained herein are based on principles of fairness and transparency, and grounded in the primacy of patient safety. They emphasize a responsibility among state medical boards to work to ensure physician wellness as a component of their statutory right and duty to protect patients.

Background and Charge:

In 2014, the Ethics and Professionalism Committee of the Federation of State Medical Boards (FSMB) engaged in several discussions about the risks to patient safety that may result from disruptive physician behavior. As these discussions proceeded, it became apparent from a review of the literature and discussions with state medical boards that a link exists between many instances of disruptive behavior and symptoms of professional burnout experienced by so-called "disruptive physicians." The Committee, chaired by Dr. Janelle A. Rhyne, M.D., MACP, determined that further research into physician health, self-care, and burnout should be conducted to identify resources that may be of value for state medical boards and physicians alike, and to outline possible roles for the FSMB and its partners to better promote patient safety and quality health care.

Given the complexity of the issue and the many factors contributing to physician burnout, in 2016, Dr. Arthur S. Hengerer, MD, (while serving as Chair of the FSMB), established the FSMB Workgroup on Physician Wellness and Burnout to study the issue further. The Workgroup was specifically charged with identifying resources and strategies to address

physician burnout. To accomplish its charge, the Workgroup reported that it would engage in a multi-part work program that would likely involve: 1) educating state medical boards and physicians through the creation of a compendium of research and resources on identifying, managing and preventing physician burnout; 2) raising awareness about the prevalence of burnout among physicians and other health care professionals, helping reduce the stigma sometimes associated with physicians seeking help for burnout symptoms; 3) evaluating current research on the impact of physician burnout on patient care; and 4) convening stakeholder organizations and experts to discuss physician wellness and to recommend best practices for promoting physician wellness and helping physicians identify, manage and prevent burnout throughout their career continuum (i.e. from medical school through residency training and throughout their years of licensed, unsupervised practice.)

The purpose of this report is to summarize the steps taken by the Workgroup in fulfilment of their charge, to share information gathered as part of this process, and to provide a series of recommendations for state medical boards and others to consider for addressing burnout and its symptoms. It should be noted that the Workgroup's charge does not include tasks related to defining the phenomenon of burnout or performing further analysis into the concept itself, as it was felt there is a significant amount of valuable research that has already been done in these areas and is ongoing. Much of this research, including some that is inchoate, was reviewed by the Workgroup in fulfilment of the third component of its charge. This body of research is referenced herein and informs many of the recommendations contained in this report. While burnout is a phenomenon that may impact physicians at all stages of their career, it should be noted that the recommendations specific to state medical boards in this report focus primarily on the licensing process. The Workgroup feels it is also important, however, to share information in this report related to issues beyond the licensing process. Such additional information and guidance is provided for the benefit of relevant partner organizations and stakeholders responsible for undergraduate, graduate and continuing medical education; medical school, residency training and health facility accreditation; governance, information technology, health insurance, and other activities and functions that support the provision of health care to the nation's citizens.

In developing the content and recommendations of this report, the Workgroup understands and endorses the importance of the "quadruple aim," which added a call for improvements in the quality of work lives of physicians and other health care providers[1] to the existing three aims of improving the health of populations, enhancing the patient experience of care, and reducing the per capita cost of health care.[2] As argued by proponents of the fourth aim, improved population health cannot be achieved without ensuring the health and well-being of health care providers.

[1] Bodenheimer T, Sinsky C (2014), From Triple to Quadruple Aim: Care of the Patient Requires Care of the Provider. *Ann Fam Med*, 12 (6): 573-576.
[2] Berwick DM, Nolan TW, Whittington J. (2008). The Triple Aim: care, health, and cost. *Health Aff* (Millwood), 27(3):759–69.

Several definitions have been applied to the phenomenon of physician burnout and, for the purposes of this report, it is considered a psychological response that may be experienced by doctors exposed to chronic situational stressors in the health care practice environment. This is characterized by overwhelming exhaustion, feelings of cynicism and detachment from work, and a sense of ineffectiveness and lack of accomplishment.[3] While burnout's manifestations and consequences vary widely, they could result in significant harm to patients.

It has been widely reported for more than a decade that nearly 100,000 preventable medical errors occur in the United States each year.[4] More recent findings suggest that between 210,000 and 400,000 deaths each year are associated with preventable harm.[5] Many of these errors may be attributed to physician burnout and its drivers, such as excessive caseloads, negative workplace culture, poor work-life balance, or perceived lack of autonomy in one's work.[6] Burnout affects a significant proportion of the U.S. physician workforce. A 2012 study conducted by Shanafelt and colleagues showed that 45.5% of surveyed physicians demonstrated at least one symptom of burnout.[7] When this study was repeated three years later with a different sample, the authors demonstrated that burnout and work-life dissatisfaction had increased by 9% over the three year period.[8] In addition to obvious risks to patient safety, an alarming and extreme result of physician burnout has been the disproportionate (relative to the general population) levels of suicide in recent years by physicians, medical residents and even medical students.[9,10] One is hard-pressed to find a phenomenon that negatively affects a broader array of stakeholders in health care than burnout. It impacts providers from all health professions. State medical boards' duty to protect the public, in this regard, also includes a responsibility to ensure the wellness of its licensees.

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[3] Maslach, C., Jackson, S.E. (1981). The Measurement of Experienced Burnout. *Journal of Occupational Behavior*, 2(2):99-113. See also, Maslach C, Jackson SE, Leiter MP. *(*1996). *Maslach Burnout Inventory Manual. 3rd ed*. and Maslach C, et al. (2001). Job Burnout. *Annu Rev Psychol*, 52:397–422.

[4] Kohn LT, Corrigan J, Donaldson MS. (2000). To Err Is Human: Building a Safer Health System. Washington, DC: National Academies Press (US).

[5] James JT. (2013). A New, Evidence-based Estimate of Patient Harms Associated with Hospital Care. *Journal of Patient Safety*, 9(3):122-128.

[6] Shanafelt TD, Noseworthy JH. (2016). Executive leadership and physician well-being: Nine organizational strategies to promote engagement and reduce burnout. *Mayo Clin Proc*, 92:129-146.

[7] Shanafelt TD, et al. (2012). Burnout and satisfaction with work-life balance among US physicians relative to the general US population. *Archives of Internal Medicine*, 172(18):1377-1385.

[8] Shanafelt TD, Hasan O, Dyrbye L, et al. (2015). Changes in burnout and satisfaction with work-life balance in physicians and the general US working population between 2011 and 2014. *Mayo Clin Proc,* 90:1600-1613.

[9] Rubin R. (2014). Recent Suicides Highlight Need to Address Depression in Medical Students and Residents. *JAMA,* 312(17):1725-1727.

[10] Gold KJ, Sen A, Schwenk TL. (2013). Details on suicide among US physicians: data from the National Violent Death Reporting System. *Gen Hosp Psych,* 35:45-49.

Features and Consequences of Burnout:

Physicians experiencing burnout, according to the medical literature, exhibit a wide array of signs, symptoms and related conditions, including fatigue, loss of empathy, detachment, depression, and suicidal ideation. The three principal components of burnout are widely described in the medical literature as emotional exhaustion, depersonalization, and diminished feelings of personal accomplishment.[11] Many of these symptoms are also said to be linked to low levels of career satisfaction.

Career satisfaction may be diminished by even a single influencing factor. Unreasonable increases in workload, for example, may quickly lead to dissatisfaction with one's career. Loss of job satisfaction has been noted as both a primary contributor to burnout as well as a contributor to its further progression.[12] Burnout has specifically been found to be the single greatest predictor of surgeons' satisfaction with career and choice of specialty.[13] It may also be a significant contributor to increased rates of suicidal ideation among both physicians[14] and medical students.[15]

Physicians experiencing manifestations of burnout are also reported to be more prone to engage in unprofessional behavior,[16] commit surgical or diagnostic medical errors,[17,18,19] and lose the trust[20] of their patients, while also decreasing their satisfaction.[21] At a time when there is compelling evidence of a shortage of qualified practicing physicians in many parts of the United States, losing additional physicians to early or unnecessary retirement would have a detrimental impact on patient access to care across the country. As the American Medical Association's Policy on Physician Health and Wellness states,

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[11] Maslach C, Schaufeli WB, Leiter MP. (2001). Job burnout. *Annual Review of Psychology,* 52:397-422.
[12] Mirvis DM, Graney MJ, Kilpatrick AO. (1999). Burnout among leaders of the Department of Veterans Affairs medical centers: contributing factors as determined by a longitudinal study. *J Health Hum Serv Adm,* 21:390-412, and Mirvis DM, Graney MJ, Kilpatrick AO. (1999). Trends in burnout and related measures of organizational stress among leaders of Department of Veterans Affairs medical centers. *J Healthc Manag*, 44(5):353-365. (Via Chopra SS. (2004). JAMA, 291(5):633).

[13] Shanafelt TD, et al. (2009). Burnout and Career Satisfaction among American Surgeons. *Annals of Surgery*, 250(3):463-471.
[14] Shanafelt TD, Balch CM, Dyrbye LN, et al. (2011). Suicidal ideation among American surgeons. *Arch Surg*, 146:54-62.
[15] Schwenk TL, Davis L, Wimsatt LA. (2010). Depression, stigma, and suicidal ideation in medical students. *JAMA*, 304(11): 1181-1190.
[16] Dyrbye LN, Massie FS, Jr., Eacker A, et al. (2010). Relationship between burnout and professional conduct and attitudes among US medical students. *JAMA,* 304: 1173-1180.
[17] Privitera MR, et al. (2015). Physician Burnout and Occupational Stress: An inconvenient truth with unintended consequences. *Journal of Hospital Administration*, 4(1).
[18] Shanafelt TD, Balch CM, Bechamps G, et al. (2010). Burnout and medical errors among American surgeons. *Ann Surg,* 251:995-1000.
[19] West CP, Huschka MM, Novotny PJ, et al. (2006). Association of perceived medical errors with resident distress and empathy: a prospective longitudinal study. *JAMA*, 296(9):1071-1078.
[20] Haas JS, Cook EF, Puopolo AL, Burstin HR, Cleary PD, Brennan TA. (2000). Is the professional satisfaction of general internists associated with patient satisfaction? *J Gen Intern Med*, 15(2):122-128.
[21] Anagnostopolous F, Liolios E, Persefonis G, Slater J, Kefetsios K, Niakas D. (2012). Physician burnout and patient satisfaction with consultation in primary health care settings: evidence of relationships from a one-with-many design. *J Clin Psychol Med Settings*. 19(4):401-410.

"When health or wellness is compromised, so may be the safety and effectiveness of the medical care provided."[22]

Factors Contributing to Burnout:

While a large proportion of physicians are said to experience burnout and its correlates, they do not always experience it in the same way or for the same reasons. Physicians may be predisposed to burnout because of personality traits that led them to pursue a medical career in the first place, such as perfectionism, self-denial, and compulsiveness. These are traits that are said to be common among practicing physicians. Predisposition to burnout may be stronger in instances where personal factors such as denial of personal vulnerability, tendencies to delay gratification, or excess feelings of guilt are layered onto these aforementioned personality traits. While burnout is a distinct phenomenon from mental illness and substance use disorders, the latter two issues can play a compounding role in a physician's struggle with burnout, making the identification and effective treatment of its symptoms or causes even more difficult.[23]

It is a common misconception that physicians are more susceptible to suffering from burnout at later stages in their career, presumably from fatigue and aging. In fact, research has demonstrated that physicians in the middle of their careers are at the highest risk for burnout.[24] Education and training also appear to be critical peak times for physicians, physicians-in-training or medical students to suffer from burnout.[25,26]

The environment in which physicians work, including their choice of specialty, also plays a significant role in contributing to burnout. Shanafelt and colleagues have shown substantial differences in burnout rates by specialty, although changes in the highest and lowest rates were noted between 2011[27] and 2014.[28] The control, or lack thereof, that physicians have over their work environment plays a significant role in predisposition to burnout. This may explain why emergency medicine is frequently found at or near the top of the list of medical and surgical specialties with the highest proportion of physicians experiencing burnout. Emergency physicians often work in environments that are high-demand and low-control.[29] While finding meaning in one's work has long been claimed

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[22] *Code of Medical Ethics*, (2016). American Medical Association, Opinion 9.3.1.
[23] Oreskovich M, Kaups K, Balch C, et al. (2011). The prevalence of alcohol use disorders among American surgeons. *Arch Surg*, 147:168-174.
[24] Dyrbye LN, et al. (2013). Physician satisfaction and burnout at different career stages. *Mayo Clinic Proceedings*, 88(12):1358-1367.
[25] Dyrbye LN, Shanafelt TD. (2016). A narrative review on burnout experienced by medical students and residents. Med Educ, 50:132-149.
[26] Dyrbye LN, et al. (2014). Burnout among U.S. medical students, residents, and early career physicians relative to the general U.S. population. *Academic Medicine*, 89(3):443-451.
[27] Shanafelt TD, et al. (2012). Burnout and satisfaction with work-life balance among US physicians relative to the general US population. *Archives of Internal Medicine,* 172(18):1377-1385.
[28] Shanafelt TD, Hasan O, Dyrbye L, et al. (2015). Changes in burnout and satisfaction with work-life balance in physicians and the general US working population between 2011 and 2014. *Mayo Clin Proc,* 90:1600-1613.
[29] https://www.medpagetoday.com/emergencymedicine/emergencymedicine/54916

to be the antidote to burnout,[30] it may be difficult to find such meaning absent an adequate degree of control over one's work environment.

The movement towards maximal standardization of processes, often labeled a phenomenon of "deprofessionalization," is also claimed to be a contributor to burnout among physicians. There is worry among some professionals, in medicine and other health care fields, that an expectation for rigid adherence to guidelines will replace what were formerly considered the more elegant, artistic and satisfying aspects of medical practice.[31] These movements need not be perceived as threats to physician autonomy or to the exercise of professional judgment. Rather, embracing evidence-based medicine, focusing on the value of care that is provided, and celebrating increasingly positive outcomes can contribute to great improvements in patient and population health. Professional judgment will continue to play an important role in realizing these improvements.

Frustrations have also been voiced in relation to the move in health care delivery away from paper-based records to electronic health records (EHRs). Many physicians have expressed dissatisfaction with the intrusiveness and complexity of EHR use and the limits this sometimes places on the ways in which they are able and capable of effectively documenting treatment decisions and provision of care.[32] These frustrations exist in addition to those related to the often complex, redundant, or non-intuitive methods of data entry and other elements of medical record keeping associated with EHRs,[33,34,35] as well as the fact that most systems are not yet fully interoperable. However, complaints made about particular aspects of an evolving or disruptive technology should not be interpreted as calls to abandon the important gains in patient safety, professional communication, and even efficiency that have been brought about by the introduction and implementation of EHR systems. Rather, they should be interpreted as important user feedback that may contribute to ongoing improvement of such technology.

The constantly changing and evolving nature of medicine, as well as the challenges faced by the American health care system itself, also appear to be affecting the way many physicians feel within their professional roles. A recent study reported that 65% of physicians who were surveyed predicted an ongoing deterioration in the quality of health care that they deliver, which in turn has been attributed, in part, to the erosion of

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[30] Sotile W. (2002). *The Resilient Physician*.
[31] Aasland OG. (2015). Healthy Doctors – Sick Medicine. *Professions and Professionalism*, 5(1).
[32] Friedberg MW, et al. (2013). Factors Affecting Physician Professional Satisfaction and Their Implications for Patient Care, Health Systems, and Health Policy. RAND Corporation, https://www.rand.org/pubs/research_reports/RR439.html.
[33] Arndt BG, et al. (2017). Tethered to the EHR: Primary Care Physician Workload Assessment Using EHR Event Log Data and Time-Motion Observations. *Ann Fam Med*, 15(5):419-426.
[34] Levinson J, Price BH, Saini V. (2017). Death By A Thousand Clicks: Leading Boston Doctors Decry Electronic Medical Records. Common Health, http://www.wbur.org/commonhealth/2017/05/12/boston-electronic-medical-records.
[35] Sinsky C, et al. (2016) Allocation of Physician Time in Ambulatory Practice: A Time and Motion Study in 4 Specialties. *Ann Intern Med*. 165:753-760.

physician autonomy.[36] When evolving requirements are layered onto new expectations with regard to technology, quality reporting, increased clinical volume, and numerous other initiatives required by payers, employers, and even state medical boards, it may not be surprising that physicians are experiencing burnout at alarming rates. While many of the initiatives that place additional burdens on physicians are grounded in strong rationales related to patient safety and quality care, the burnout resulting from their combined effect may actually inhibit the success of the initiatives themselves.[37] This should certainly bring pause to those charged with implementing initiatives and requirements to carefully evaluate their effectiveness, unintended consequences, and potential burden, but also to communicate their goals and perceived value. The reaction of the profession to the ongoing changes that are occurring may also indicate particular attitudes within the culture of medicine that would benefit from further discussion, as would support to integrate positive change into practice.

Burnout is not always related to stressors arising in a physician's work environment or to a physician's character traits. Family issues, personal and professional relationships, financial pressures, insufficient work-life balance, or other external stressors may also contribute to burnout. Efforts aimed at the identification, treatment, or prevention of burnout must, therefore, approach the issue from a broad enough perspective to take all of these factors into account.

Challenges and Barriers to Addressing Burnout:

While there has been a promising rise in the number of peer-reviewed research publications addressing the topic of physician burnout, in the academic medical literature, popular media and so-called gray literature (e.g., white papers, position statements, organizational reports), there seems to be a perceived lack of resources available to identify and address the issue. This perception may be misguided, however, since several academic institutions, health systems, medical specialty societies, independent physicians, physician health programs, and state medical boards make many useful, high-quality resources available (See Appendix A.). While more resources would be beneficial to physicians, and ultimately their patients, their development should be complemented with efforts aimed at highlighting best practices. Research is also needed to identify how sources of burnout might differ for male and female physicians in order that resources may be appropriately tailored. A more coordinated effort to raise awareness not only about the issue of physician burnout but also about resources for ameliorating related circumstances may also serve to reduce stigma and facilitate identification and treatment. It may also help improve systems issues that impact burnout by improving communication, team building, and collaboration within and among health care

[36] Emanuel EJ, Pearson SD. (2012). Physician autonomy and health care reform. *Journal of the American Medical Association*, *307*(4), 367-368.
[37] Dyrbye LN, Shanafelt TD. (2011). Physician Burnout: A Potential Threat to Successful Health Care Reform. *JAMA 305(19):2009-2010*.

professions. Broader awareness may also better equip physicians in their capacity as leaders to improve circumstances for those with whom they work.[38]

Many physicians are reluctant to seek help for burnout or any of its many underlying causes for fear that they will be perceived as weak or unfit to practice medicine by their colleagues or employers, or because they assume that seeking such care may have a detrimental effect on their ability to renew or retain their state medical license, arguably the most important credential a physician receives during their professional career.[39,40,41,42,43] This stigma may be felt as early as medical school,[44] a particularly dangerous cultural feature in a population where symptoms of anxiety and depression have been found to be more prevalent than in the general population.[45] In a study by Dyrbye and colleagues, it was found that only a third of the medical students experiencing features of burnout sought help and that stigma was seen as a barrier for those who chose not to seek help.[46] The same reluctance is seen with respect to help-seeking for other types of stigmatized suffering such as depression, substance use disorders, or suicidal ideation.[47] Without adequate modeling of appropriate self-care behaviors among faculty mentors, progress at stigma reduction will likely be slow. Further, while there are laudable examples of programs at academic medical centers across the country which responsibly offer accessible, complementary, private, and confidential counselling to medical students,[48] these programs are by no means widely available.

Privacy and confidentiality of a physician's health and treatment history is important to allow those in need of help to come forward without fear of punishment, disciplinary

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[38] Shanafelt TD, et al. (2015). Impact of Organizational Leadership on Physician Burnout and Satisfaction, *Mayo Clinic Proceedings*, 90(4):432-440.
[39] Chew-Graham CA, et al. (2003). 'I wouldn't want it on my CV or their records': medical students' experiences of help-seeking for mental health problems. *Medical Education*, 37(10):873–880.
[40] Federation of State Medical Boards. (2011). Policy on Physician Impairment.
[41] Guille C, et al. (2010). Utilization and Barriers to Mental Health Services Among Depressed Medical Interns: A Prospective Multisite Study, *Journal of Graduate Medical Education*, 2(2):210-214.
[42] Gold K, et al. (2016). "I would never want to have a mental health diagnosis on my record": A survey of female physicians on mental health diagnosis, treatment, and reporting. *General Hospital Psychiatry,* 43:51–57.
[43] Dyrbye LN, et al. (2017). Medical Licensure Questions and Physician Reluctance to Seek Care for Mental Health Conditions. *Mayo Clin Proc*, 92(10):1486-1493.
[44] Schwenk TL, et al. (2010). Depression, Stigma, and Suicidal Ideation in Medical Students. *JAMA,* 304(11):1181-1190.
[45] Rotenstein LS, Ramos MA, Torre M, et al. (2016). Prevalence of depression, depressive symptoms, and suicidal ideation among medical students, a systematic review and meta-analysis. *JAMA,* 316(21):2214-2236.
[46] Dyrbye LN, et al. (2015). The Impact of Stigma and Personal Experiences on the Help-Seeking Behaviors of Medical Students with Burnout. *Academic Medicine*, 90(7):961-969.
[47] Dyrbye LN, et al. (2017). Medical Licensure Questions and Physician Reluctance to Seek Care for Mental Health Conditions. *Mayo Clin Proc*, 92(10):1486-1493.
[48] Examples include the HEAR Program at UC San Diego (available to everyone at the UCSD Health System, not only medical students), the Henderson Student Counseling Center at Nova Southeastern University, the Wellness Resources offered at Oregon Health and Science University, and the Medical Student Counseling and Wellness Center at the Herbert Wertheim College of Medicine, Florida International University.

action, embarrassment or professional isolation. The use of confidential services whenever possible in lieu of regulatory awareness is preferred in order to mitigate fear of negative impacts on licensure, employment, or collegial relationships. When confidential services are not utilized, it is less likely licensees will receive early intervention and appropriate treatment, thereby foregoing opportunities for early detection of potentially impairing illness or recovery.

Funding for important programs and initiatives such as those identified above is often difficult to obtain. However, there is a growing body of research that identifies the cost savings for hospitals and employers associated with providing them, particularly when costs associated with medical errors and lower quality of care attributed to burnout are mitigated, as are high turnover rates, absenteeism, and loss of productivity.[49]

Another challenge to identifying and addressing burnout is the fact that the associated stigma may reduce the degree to which the phenomenon itself is discussed. This impacts not only a physician's own willingness to discuss or seek help for burnout, but also the willingness of fellow physicians to address or report instances of impairment among their colleagues, especially that which unduly risks the safety of patients. While the duty to report impairment or incompetence and the duty to encourage help-seeking may seem to conflict, in that a fear of being reported could cause a physician to conceal problems and avoid help, the duty to report is actually based on principles of patient safety and ethics. The duty to report also aims to assist physicians in seeking the help they need in order to continue practicing safely.

In addition to the cultural stigma associated with admitting experiences of burnout, recent research has shed light on the potential impact of licensure and license renewal processes of state medical boards that may discourage treatment-seeking among physicians.[50,51] State medical boards may inadvertently discriminate unfairly against physicians suffering from mental illness or substance use disorders, or against those who choose to take a leave of absence from practice to prevent or recover from burnout. The very presence of application questions for medical licensure or licensure renewal may stigmatize those suffering from mental and behavioral illnesses for which physicians might otherwise seek care. In fact, questions about substance abuse and mental illness on state medical licensure renewal applications have nearly doubled between 1996 and 2006.[52] While information about a physician's health status (both mental and physical) may be essential to a state medical board's solemn duty to protect the public, the FSMB has previously noted that a history of mental illness or substance use does not reliably predict future risk

[49] Shanafelt T, Goh G, Sinsky C. (2017). The Business Case for Investing in Physician Well-Being. *JAMA Intern Med*. 177(12):1826-1832.
[50] Gold K, et al. (2016). "I would never want to have a mental health diagnosis on my record": A survey of female physicians on mental health diagnosis, treatment, and reporting. *General Hospital Psychiatry,* 43:51–57.
[51] Dyrbye LN, et al. (2017). Medical Licensure Questions and Physician Reluctance to Seek Care for Mental Health Conditions. *Mayo Clin Proc*, 92(10):1486-1493.
[52] Polfliet SJ. (2008). A National Analysis of Medical Licensure Applications. *J Am Acad Psychiatry Law*, 36(3): 372.

to the public.[53] It is also very important to recognize that court interpretations of the Americans with Disabilities Act (ADA) have suggested that state medical boards should focus on current functional impairment rather than a history of diagnoses or treatment of such illness.[54]

In carrying out their duty to protect the public and ensure that only individuals who are fully qualified to practice medicine are granted licenses, state medical boards usually, and for good reasons, insist that they must have sufficient information with which to make medical licensure decisions. During the licensure granting process, state boards also work diligently to ensure that candidates for licensure (or renewal) provide a thorough assessment of their fitness to practice, balanced by protecting their rights as contained in ADA legislation. Fear among prospective and current licensees about potential limitations placed on their ability to practice medicine independently, however, or of their previous diagnoses or treatments somehow being made public despite HIPAA and other federal privacy and confidentiality laws, may cause some physicians to misrepresent personal information that is requested or not respond accurately at all to licensing application questions.[55] In such instances, paradoxically, the efforts of state medical boards to get comprehensive information may not yield the accurate information they seek about a physician's practice risks to patients. They may also discourage treatment-seeking among physicians, thereby increasing the degree of risk to patients presented by physicians experiencing conditions that remain undiagnosed or untreated.

Recommendations:

The majority of the recommendations that follow are designed for state medical boards to consider and pertain mainly to the inclusion and phrasing of questions on state medical licensing applications. Appropriately addressing the issue of physician burnout provides a unique opportunity for state medical boards to declare, directly or indirectly, that it is not only normal but anticipated and acceptable for a physician to feel overwhelmed from time to time and to seek help when appropriate. This is also an important opportunity for state medical boards to highlight and promote the benefits of physician health, both mental and physical, to help reduce stigma, to clarify related regulatory and reporting issues, promote patient safety and assure the delivery of quality health care. Physicians should feel safe about reporting burnout and be able to take appropriate measures to address it without fear of having their licensure status placed in jeopardy.

Safeguarding physician wellness and mitigating damage caused by burnout cannot be accomplished through isolated actions and initiatives by individual organizations alone. Coordinated efforts and ongoing collaboration will be essential not only for addressing

[53] Federation of State Medical Boards. (2006). Federation of State Medical Boards: Americans With Disabilities Act of 1990. License Application Questions: A Handbook for Medical Boards.
[54] Polfliet SJ. (2008). A National Analysis of Medical Licensure Applications. *J Am Acad Psychiatry Law*, 36(3):373.
[55] Gold K, et al. (2016). "I would never want to have a mental health diagnosis on my record": A survey of female physicians on mental health diagnosis, treatment, and reporting. *General Hospital Psychiatry,* 43:51–57.

the many systemic issues that contribute to burnout but also for ensuring that appropriate tools, resources, and programs are continuously in place and readily available to help physicians avoid and address burnout. As such, the FSMB also offers suggestions and recommendations to its partner organizations, many of which have been instrumental in furthering the FSMB's current understanding of burnout, its related features, and the role of the regulatory community in addressing and safeguarding physician health.

Ultimately, the Workgroup and the FSMB believe that a shared accountability model that includes several related responsibilities among regulatory, educational, systemic, organizational, and administrative stakeholders provides a promising way forward. The specific recommendations outlined below begin to address what such responsibilities should entail.

The FSMB recognizes its responsibility to help address physician burnout, not only through following its own recommendations and promoting the resources provided in this report, but also by continuing its collaborative efforts with partner organizations from across the wider health care community.

For State Medical Boards:

1. The FSMB recommends that state medical boards review their medical licensure (and renewal) applications and **evaluate whether it is necessary to include probing questions about a physician applicant's mental health, addiction, or substance use**, and whether the information these questions are designed to elicit in the interests of patient safety may be obtained through means that are less likely to discourage treatment-seeking among physician applicants. For example, some boards subscribe to notification services such as the National Practitioner Data Bank's "Continuous Query" service or other data services that provide information about arrests or convictions, including for driving under the influence, within their states which can serve as a proxy finding for physician impairment. The FSMB also recommends in its *Essentials of a State Medical and Osteopathic Practice Act* that boards require applicants to satisfactorily pass a criminal background check as a condition of licensure.[56]

2. Where state medical boards strongly feel that questions addressing the mental health of physician applicants must be included on medical licensing applications, they should **carefully review their applications to ensure that appropriate differentiation is made between the illness with which a physician has been diagnosed and the impairments that may result**. Application questions must focus only on current impairment and not on illness, diagnosis, or previous treatment in order to be compliant with the Americans with Disabilities Act (ADA).

[56] Federation of State Medical Boards. (2015). *Essentials of a State Medical and Osteopathic Practice Act.*

3. The ADA requires licensure application questions to focus on the presence or absence of current impairments that are meaningful in the context of the physician's practice, competence, and ability to provide safe medical treatment to patients. **Applications must not seek information about impairment that may have occurred in the distant past and state medical boards should limit the time window for such historical questions to two years or less, though a focus on the presence or absence of current impairment is preferred.**

   Questions that address the mental health of the applicant should be posed in the same manner as questions about physical health, as there is no distinction between impairment that might result from physical and mental illness that would be meaningful in the context of the provision of safe treatment to patients.

   Where boards wish to retain questions about the health of applicants on licensing applications, **the FSMB recommends that they use the language:** ***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)**[57,58]

4. **The FSMB recommends that state medical boards consider offering the option of "safe haven non-reporting" to applicants for licensure who are receiving appropriate treatment for mental health or addiction**. While it is up to boards to determine what constitutes appropriate treatment, the FSMB recommends that physicians who are monitored by, and in good standing with, the recommendations of a state or territorial Physician Health Program (PHP) be permitted to apply for medical licensure or license renewal without having to disclose their diagnosis or treatment to the board. The option of safe haven non-reporting should only be offered when treatment received is commensurate with the illness being treated and has a reasonable chance of avoiding any resultant impairment.

5. **State medical boards should work with their state legislatures to ensure that the personal health information of licensees related to an illness or diagnosis is not publicly disclosed as part of a board's processes**. Information disclosed must relate only to impairment of professional abilities, medical malpractice, and professional misconduct.[59]

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[57] American Psychiatric Association. (2015). Position statement on inquiries about diagnosis and treatment of mental disorders in connection with professional credentialing and licensing.
[58] The American Psychiatric Association (APA) passed an Action Paper in November 2017, resolving to query state medical boards and notify them about their compliance with APA policy and the ADA.
[59] Center C, Davis M, Detre T, et al. (2003). Confronting depression and suicide in physicians: a consensus statement. *JAMA*, 289(23):3161–3166.

6. **State medical boards should emphasize the importance of physician health, self-care, and treatment-seeking for all health conditions by including a statement to this effect on medical licensing applications, state board websites, and other official board communications**. Where appropriate, options for treatment and other resources should be made available, such as information about a state Physician Health Program (PHP), services offered through a county, state, or national medical society, and any other relevant programs. These means of communicating the importance of physician health and self-care are aimed at helping physicians with relevant information and resources but could also help raise awareness among patients of the importance of physician wellness and the threat of burnout to their doctors and their own care.

7. **State medical boards should clarify through communications, in print and online, that an investigation is not the same as a disciplinary undertaking**. Achieving an understanding of this distinction among licensees may help begin to dispel the stigma associated with reporting burnout and remove a barrier to physicians seeking help in times of need.

8. **State medical boards are encouraged to maintain or establish relationships with a PHP in their state and to support the use of data from these programs in a board's decision-making**.

9. **State medical boards should examine the policies and procedures currently in place for working with physicians who have been identified as impaired in a context that is meaningful for the provision of safe care to patients to ensure that these are fair, reasonable, and fit for the purpose of protecting patients. All such processes should be clearly explained and publicly available.**

10. **State medical boards should be aware of potential burdens placed on licensees by new or redundant regulatory requirements**. They should seek ways of facilitating compliance with existing requirements to support licensees and ensure that they are able to spend time with patients and in those areas of medicine which they find most meaningful. "Reducing the cumulative burden of rules and regulations may improve professional satisfaction and enhance physicians' ability to focus on patient care."[60]

Upon implementing some or all of the above changes to state medical board policy or processes that are meant to reduce the stigma associated with mental health issues and encourage treatment-seeking, the board should communicate these, and their rationale, to current and prospective licensees, as well as patients and the public. State medical boards should also raise the issue of physician burnout more often, emphasizing the importance

[60] Friedberg MW, et al. (2013). Factors Affecting Physician Professional Satisfaction and Their Implications for Patient Care, Health Systems, and Health Policy. RAND Corporation, https://www.rand.org/pubs/research_reports/RR439.html.

of physician wellness, help-seeking, and the availability of accessible, confidential, and private counselling programs for physicians and all health professionals.

For External Stakeholders and Partner Organizations:

Professional Medical Organizations and Societies:

11. Professional medical societies at local, state, and national levels have a key role to play in encouraging physicians to seek treatment, both preventive and curative, for the physical and mental health issues they face, as well as for features of burnout. The FSMB recognizes the many exemplary programs and initiatives of professional medical societies and encourages their continued advocacy for physician wellness and the availability of support and treatment services.

12. The FSMB recommends a sustained focus in the medical profession on the importance of self-care with an aim to reduce the stigma attached with seeking treatment for health issues, particularly ones related to mental health.

13. The FSMB recommends that attempts be made to expand the availability of accessible, private, and confidential counseling for physicians through medical societies, such as those provided by organizations like the Lane County Medical Society (Oregon), which has a program with several features identified as best practices for physician wellness by the Workgroup. Counseling via telehealth could also enhance access and provide greater assurance of privacy to those seeking care.

14. Given the prevalence of burnout, all physicians need to be educated about the resources currently available regarding burnout, including those referenced in Appendix A, for self-awareness, and for identification and referral of peer professionals who may have burnout. Medical societies are encouraged to partner with other organizations identified in this report to improve awareness of resources and their dissemination.

15. The FSMB recommends that professional medical societies and organizations representing physicians, such as the American Medical Association, the American Osteopathic Association, and the Council of Medical Specialty Societies work with state medical boards to raise awareness among the public of the importance of physician wellness not only because of its inherent value to physicians themselves but also as a significant contributor to patient safety.

Centers for Medicaid and Medicare Services:

16. The FSMB recommends careful analysis of any new requirements placed on physicians to determine their potential impact on physician wellness. Any new

requirements that could serve as a driver of burnout in physicians must be supported by evidence and accompanied by a strong rationale that is based in improving patient care to justify any new burdens imposed on physicians.

State Government, Health Departments, and Legislatures:

17. As state government, health departments, and legislatures make decisions that can impact physicians, the FSMB recommends that they weigh the potential value of proposed new regulations against potential risks to the health of physicians and other clinicians.

Vendors of Electronic Health Records (EHR) systems and standard setting organizations:

18. As a promising advancement in the provision and documentation of care, but also a key driver of frustration with medical practice, EHRs need to be improved in a way that takes the user experience into greater consideration than it does currently. This experience may be improved through facilitating greater ease of data entry into the system, as well as ease of access to data from the system. Vendors are encouraged to include end-user physicians on their builder teams to optimize input about operability and interoperability.

19. Efforts to reduce redundant or duplicative entry should be required by standard setting organizations, such as the Office of the National Coordinator for Health IT (ONC), and reflected in the EHR systems ultimately designed by vendors.

20. EHR vendors are encouraged to focus future improvements on facilitating and improving the provision of patient care. The primary purposes of an EHR relate to documentation of care received by a patient, retrieval of patient care related information and data, and patient communication.

Medical Schools and Residency Programs:

21. The FSMB encourages the Accreditation Council for Graduate Medical Education, the Association of American Medical Colleges, the American Association of Colleges of Osteopathic Medicine, the American Medical Association, the American Osteopathic Association and the institutions they represent, to continue their laudable efforts at improving the culture of medicine and facilitating open conversations about illness and wellness in order to promote positive change.

22. The FSMB recommends continued efforts to encourage medical students and residents to value self-care and understand the positive impacts that physician wellness can have on patient care.

23. The FSMB recommends that medical schools, residency programs, and their accrediting bodies consider ways of amplifying the medical student and resident voice on systemically induced pressures and support trainees by providing means for raising issues related to medical student and resident health and well-being anonymously.

Hospitals/Employers:

24. The FSMB recommends that hospitals revise, where necessary and appropriate, their questions asked as part of their credentialing process according to the recommendations made above for the medical licensing community to ensure that these are not discouraging physicians or other health professionals from seeking needed treatment.

25. The FSMB recommends that hospitals and health systems assess physician health at regular intervals using a validated instrument and act upon the results. Employers should keep results of these assessments internal to the organization or health system in order to promote workplace change, while avoiding threatening or punitive cultures.

26. Hospitals, as well as the American Hospital Association and related organizations, are encouraged to officially adopt the "Quadruple Aim" to demonstrate the importance they place in the health and wellness of the physicians and all other health professionals they employ and recognize the impact of provider health on safe patient care.

27. Hospitals should ensure that their policies and procedures are adopted with consideration given to the impact they have on the health of the hospital workforce. Decisions impacting hospital the health of hospital and health system employees should be made with adequate input from individuals representing the impacted sectors of that workforce.

28. While acknowledging the need for hospitals to acknowledge all staff in their programmatic development, employers are encouraged to make resources and programs available to physicians, including time and physical space for making connections with colleagues and pursuing personal goals that add meaning to physicians' work lives. Resources and programs should not always be developed and implemented in a "one size fits all" manner, but should incorporate consideration of the different stressors placed on male and female physicians, within and outside of the workplace, and be tailored appropriately. Resources related to EHR implementation and use should also be made available by employers, including training to optimize use and support for order-entry such as scribes or other technological solutions aimed at restoring time available to physicians.

29. Hospitals should ensure that mandatory reports related to physician competence and discipline are made available to state medical boards and other relevant authorities.

Insurers:

30. The FSMB recommends that insurance carriers revise, where necessary and appropriate, their questions on applications for professional liability insurance according to the recommendations made above for the medical licensing community to ensure that these are not discouraging physicians or other health professionals from seeking needed treatment.

31. In evaluating the quality of care provided by physicians, insurers should look beyond cost-saving measures and use metrics related to physician health and incentivize practice patterns that contribute to physician wellness.

Accrediting Organizations:

32. In its ongoing development of standards for the accreditation of undergraduate medical education programs, graduate medical education training programs, hospitals and healthcare facilities, the FSMB encourages those organizations charged with the accreditation of institutions and educational programs to include standards related to required resources and policies aimed at protecting medical student, medical resident and attending physician health.

Physicians:

33. Physician wellness is a complex issue, made up of system-wide and individual components. However, physicians have a responsibility to attend to their own health, well-being, and abilities in order to provide care of the highest standard.[61] This involves a responsibility to continually self-assess for indicators of burnout, discuss and support the identification of health issues with peers, and seek help or treatment when necessary. Physicians are encouraged to make use of services of state Physician Health Programs, which, where available, can be accessed confidentially in instances where patient harm has not occurred.

34. Physicians are encouraged to inform themselves about their ethical duty, oftentimes codified in state statutes, to report issues related to incompetence and unsafe care delivered by their peers. They are also encouraged to engage in open

[61] General Assembly of World Medical Association at Geneva Switzerland. (1948). *Declaration of Geneva,* as amended by the WMA General Assembly, October 2017.

dialogue with peers about the importance of self-care, treatment-seeking, and the threats to themselves and their patients presented by burnout.

35. Physicians are also encouraged to seek an appropriate balance between time spent on practice and related work and activities external to work, particularly ones with restorative potential.

Conclusion

The duty of state medical boards to protect the public includes a responsibility to ensure physician wellness and to work to minimize the impact of policies and procedures that impact negatively on the wellness of licensees, both prospective and current. The rationale for this duty is based on the link between physician burnout and its intendant risks to patient safety, the fact that some regulatory processes employed by state medical boards can have negative impacts on the health and wellness of physicians themselves, and the potential for regulatory change to support physician wellness and help prevent further instances of burnout.

The information and recommendations in this Report of the FSMB's Workgroup on Physician Wellness and Burnout are meant to support initial steps in the medical regulatory community and to contribute to ongoing conversation about patient safety and physician health.

FSMB WORKGROUP ON PHYSICIAN WELLNESS AND BURNOUT

Arthur S. Hengerer, MD, FACS, Chair
Immediate Past-Chair, Federation of State Medical Boards

Mohammed A. Arsiwala, MD
Vice Chair, Michigan Board of Medicine

Amy Feitelson, MD
Former Member, New Hampshire Board of Medicine

Doris C. Gundersen, MD
Federation of State Physician Health Programs

Kathleen Haley, JD
FSMB Director-at-Large
Executive Director, Oregon Medical Board

Brian J. Miller
Individual Member

Roger M. Oskvig, MD
Former Chair, New York State Board for Medicine

Michael R. Privitera Jr., MD
University of Rochester Medical Center

Jean L. Rexford
FSMB, Director-at-Large
Board Member, Connecticut Medical Examining Board

Dana C. Shaffer, DO
Secretary Treasurer, National Board of Osteopathic Medical Examiners

Scott A. Steingard, DO
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Past President, Arizona Board of Osteopathic Examiners in Medicine and Surgery

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Humayun J. Chaudhry, DO, MS, MACP, MACOI
President and CEO, FSMB

STAFF SUPPORT:

Mark L. Staz, MA
Director, Continuing Professional Development, FSMB

APPENDIX A: SAMPLE RESOURCE LIST

The following list is offered as a sample of resources available to support and facilitate the understanding, diagnosis, treatment, and prevention of symptoms of burnout or to maintain and improve physician wellness. The FSMB has not conducted an in-depth evaluation of individual resources, and inclusion herein does not indicate, nor is it to be interpreted as, an endorsement or guarantee of quality. Further, while some resources listed below are available free of charge, others are only accessible through purchase.

Federation of State Medical Boards, Policy on Physician Impairment, 2011.

Federation of State Medical Boards: Americans With Disabilities Act of 1990. License Application Questions: A Handbook for Medical Boards. Dallas, TX: Federation of State Medical Boards of the United States, Inc., 2006.

The standard tool used to evaluate rates of burnout is the Maslach Burnout Inventory, developed in the 1980s by Christina Maslach, PhD, a psychologist at the University of California Berkeley.

The HappyMD.com – in particular, the burnout prevention matrix, 117 ways to prevent burnout

Accreditation Council for Graduate Medical Education – Physician Wellbeing Resources

American Academy of Family Physicians - Physician Burnout Resources Page:

American College of Emergency Physicians (ACEP) – ACEP Wellness Resource page

American College of Physicians – Resources on Physician Well-Being and Professional Satisfaction

American Medical Association Steps Forward website:

American Osteopathic Association – AOA Physician Wellness Strategy

Association of American Medical Colleges – Wellbeing in Academic Medicine

Federation of State Physician Health Programs

Mayo Physician Well-being Program:

National Academy of Medicine Action Collaborative on Clinician Well-Being and Resilience

Remembering the Heart of Medicine

Stress Management and Resiliency Training (SMART) program

SuperSmartHealth

The Studer Group

The Well-Being Index (Mayo Clinic)

MAYO CLINIC

January 25, 2021

Minnesota Board of Medical Practice
Attn: Stuart Williams, J.D.
Policy and Planning Committee
2829 University Avenue SE
Suite 500
Minneapolis, MN 55414

Dear Mr. Williams,

We write today in appreciation of the review of questions related to mental health for medical licensure applicants and those renewing a license in Minnesota. While robust medical licensure standards are appropriate, recent review of data related to how the state's current question deters physicians from pursuit of their own care suggest that a change in wording is both appropriate and needed.

Current language issued by the Minnesota Board of Medical Practice (BMP) requires applicants to identify whether within the past five years (initial application) or since their last renewal they had/possess a mental, physical, or emotional condition which, if untreated, may affect a physician's ability to provide care to patients. What is missing from the current language is a differentiation between illness and impairment. In contrast, many other states in the country do not have any question about mental, physical, or emotional health or only inquire about current impairment on the initial medical licensure application or renewal form.

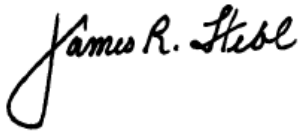
Data released by Mayo Clinic following a national study indicates that physicians who work in states that inquire broadly about mental health conditions and do not distinguish diagnosis from impairment are less likely to seek help for mental health concerns. Forgoing such care has great risk for individual physicians, as well as patients, in the long-term. Minnesota is currently a state that requires such attestation and therefore risks physicians not seeking care for mental health needs. To avoid such deferment of care and assumed risk of discrimination, we encourage the BMP to revise current language to inquire only about presence of a medical condition that currently impairs the physician. Such a change will allow Minnesota to maintain its strong licensing standards while mitigating deferment of care by physicians due to concern of licensure or risk of discrimination.

Thank you for your consideration of this important topic. Please do not hesitate to contact us, or our colleague Lotte Dyrbye, M.D., assistant dean, Mayo School of Graduate Medical Education, and co-director, Mayo Clinic Program on Physician Well-Being.

Sincerely,

Brian L. Whited, M.D.
Vice Chair
Mayo Clinic Health System

Robert C. Albright, Jr., D.O.
Regional Vice President
Mayo Clinic Health System, Southeast Minnesota



James R. Hebl, M.D.
Regional Vice President
Mayo Clinic Health System, Southwest Minnesota

January 21, 2021

Stuart Williams, JD
Chairman
Minnesota Board of Medical Practice Policy & Planning Committee
2829 University Avenue Se, Suite 500
Minneapolis, MN 55414-3246

Re: Support of Revising Initial and Renewal Licensure Application Language

Dear Mr. Williams,

On behalf of the Allina Health Systems, I am providing this letter of support for efforts to revise Minnesota's physician licensure application question inquiring on an applicant's past health conditions. Allina Health has a strong commitment to Mental Health and is actively engaged in decreasing the stigma of mental illness with our *Be the Change* program. This is critical especially now in the Covid19 pandemic, with the mental health needs of our healthcare providers increasing greatly...

The Minnesota Board of Medical Practice continues to inquire about an applicant's past mental health in their initial and renewal licensure applications. This language requires an applicant to disclose whether they have been informed or diagnosed by their physician, within the past five years, of a physical, mental, or emotional condition which impairs their ability to practice medicine.[1] This language is a deterrent to physicians and physicians in training seeking treatment.[2] In a study conducted by Mayo, 40% of physicians stated that they would be reluctant to seek formal medical care for treatment of a mental health condition because of concerns about repercussions to their licensure.

The Federation of State Medical Boards and the National Academy of Sciences, Engineering, and Medicine have acknowledged that the language used by most state licensing boards inadvertently discriminates against physicians with mental illness and is not in compliance with the ADA.[3] Both recommend that state medical boards utilize language asking only for an applicant to disclose a known current condition which impairs their ability to practice. State licensing boards have begun

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[1] Minnesota Board of Medical Practice Physician Application, *available at:* https://mn.gov/boards/assets/MNBMP%20PYAppPacketSep2019_tcm21-36587.pdf

[2] Medical Licensure Questions and Physician Reluctance to Seek Care for Mental Health Conditions, *available at:* https://www.mayoclinicproceedings.org/article/S0025-6196(17)30522-0/fulltext

[3] Physician Wellness and Burnout, *available at:* https://www.fsmb.org/siteassets/advocacy/policies/policy-on-wellness-and-burnout.pdf; To Ensure High-Quality Patient Care, the Health Care System Must Address Clinician Burnout Tied to Work and Learning Environments, Administrative Requirements, *available at:* https://www.nationalacademies.org/news/2019/10/to-ensure-high-quality-patient-care-the-health-care-system-must-address-clinician-burnout-tied-to-work-and-learning-environments-administrative-requirements

to follow the lead of the Federation of State Medical Boards, with 11 states revising their application language to ask only about an applicant's current health conditions.[4]

Allina Health supports revising Minnesota's physician licensure application health conditions question language to "do you currently have 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)." By supporting these efforts, the Policy & Planning Committee will be supporting the ability of physicians and physicians in training to seek treatment when needed. Please support our Minnesota physicians by removing this barrier.

Sincerely,

Mary Beth Lardizabal, DO, DFAPA

Interim Vice President, Mental Health & Addiction Clinical Service Line

Allina Health Systems

[4] Medical Licensure Questions and Physician Reluctance to Seek Care for Mental Health Conditions.

Minnesota Psychiatric Society

A District Branch of the American Psychiatric Association

January 22, 2021

Stuart Williams, JD
Chairman
Minnesota Board of Medical Practice Policy & Planning Committee
2829 University Avenue Se, Suite 500
Minneapolis, MN 55414-3246

Re: Support of Revising Initial and Renewal Licensure Application Language

Dear Mr. Williams,

On behalf of the Minnesota Psychiatric Society, we are pleased to provide this letter of support for efforts to revise Minnesota's physician licensure application question inquiring on an applicant's past health conditions. The Minnesota Psychiatric Society and its over 450 psychiatrist members deeply appreciate your attention to this important issue.

The Minnesota Board of Medical Practice continues to inquire about an applicant's past mental health in their initial and renewal licensure applications. This language requires an applicant to disclose whether they have been informed or diagnosed by their physician, within the past five years, of a physical, mental, or emotional condition which impairs their ability to practice medicine.[1] This language is a deterrent to physicians and physicians in training seeking treatment.[2] In a study conducted by Mayo, 40% of physicians stated that they would be reluctant to seek formal medical care for treatment of a mental health condition because of concerns about repercussions to their licensure.

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[3] Physician Wellness and Burnout, *available at:* https://www.fsmb.org/siteassets/advocacy/policies/policy-on-wellness-and-burnout.pdf; To Ensure High-Quality Patient Care, the Health Care System Must Address Clinician Burnout Tied to Work and Learning Environments, Administrative Requirements, *available at:* https://www.nationalacademies.org/news/2019/10/to-ensure-high-quality-patient-care-the-health-care-system-must-address-clinician-burnout-tied-to-work-and-learning-environments-administrative-requirements

known current condition which impairs their ability to practice. State licensing boards have begun to follow the lead of the Federation of State Medical Boards, with 11 states revising their application language to ask only about an applicant's current health conditions.[4]

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Sincerely,

Sheila Specker, MD, DFAPA
Past President

Allison Holt, MD, FAPA
President

Mary Beth Lardizabal, DO, DFAPA
Chair, MPS Ethics Committee

[4] Medical Licensure Questions and Physician Reluctance to Seek Care for Mental Health Conditions.

Minnesota Medical Association

Minnesota Physician Licensure Application Revision Proposal

Minnesota Medical Association

February 1, 2021

Current Licensure Application Language:

Initial Application:

Have you within the past five years been advised by your treating physician that you have a mental, physical, or emotional condition, which, if untreated, would be likely to impair your ability to practice medicine with reasonable skill and safety?

https://mn.gov/boards/assets/MNBMP%20PYAppPacketSep2019_tcm21-36587.pdf (page 14)
https://www.fsmb.org/siteassets/ua/states/024/instructions.pdf (page 13)

Renewal:

Since your last renewal, have you been advised by your treating physician that you have a mental, physical, or emotional condition, which, if untreated, would be likely to impair your ability to practice with reasonable skill and safety?

Concerns with current language

- Deterrent to physicians and physicians in training seeking help
- Past medical conditions are not relevant to a physician's current ability to practice
- Advances discrimination by asking for mental health history
- Encourages untruthful answers

Proposed Language

"Do you **currently** have **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)"

Federation of State Medical Boards recommended language: "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)"

MN Medical License Application

L. Dyrbye, MD MHPE
Professor of Medicine and Medical Education
Mayo Clinic

PRE-COVID 19

BURNOUT

37-44%

DEPRESSION

28-32%

Physicians

Physician Assistants

Adv. Practice Nurses

Nurses

Pharmacists

Residents

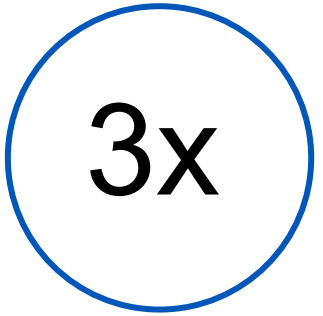
Medical Students

Dyrbye et al JAMA. 2018;320(11):1114
Rotenstein JAMA 2016; Mata et al. JAMA 314(22): 2373-2383; Shanafelt et al. Mayo Clin Proc. 94 (9):1681-1694; West et al. J Intern Med 283(6): 516-529; Dyrbye et al. Med Educ 50(1): 132-149.

US MENTAL HEALTH

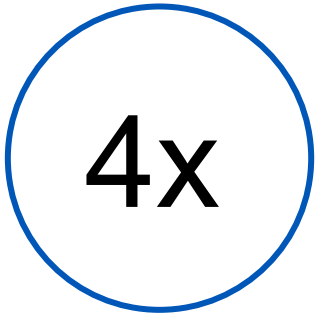
Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic — United States, June 24–30, 2020

2020 vs 2019



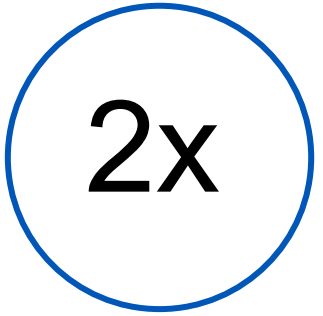
ANXIETY

25.5% vs. 8.1%



DEPRESSIVE DISORDER

24.3% vs 6.5%



SUICIDAL IDEATION

10.7% vs 4.5%

Czeisler et al. Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic — United States, June 24–30, 2020. MMWR Morb Mortal Wkly Rep 2020;69:1049–1057. http://dx.doi.org/10.15585/mmwr.mm6932a1external icon.

HEALTHCARE WORKERS

Early data suggest clinicians working on the frontline of COVID-19 are experiencing very high rates of depression, anxiety, and distress.

Emerg Infect Dis 2006;12:1924-32;CMAJ 2004;170:793-8; Compr Psychiatry 2012;53:15-23; 2005;43:676-82; JAMA Netw Open 2020;3:e203976

HEALTHCARE WORKERS

Mood disorders often go untreated, contributing to a higher prevalence of suicide among physicians in comparison to other US workers.

National study of US Surgeons

6% had recent thoughts of suicide, 40% of these individuals had not sought care due to concerns that doing so could affect their licensure to practice.

Center et al. JAMA 289; Schernhammer N Engl J Med 352; Shanafelt et al. Arch Surg 146

Medical Licensure Questions

- 2016, 51 initial and 48 renewal medical licensure applications forms
- Coded questions based on policies and recommendations from the Federation of State Medical Boards, American Psychiatric Association, American Medical Association, and the ADA of 1990.

- Applications considered “consistent” if:
  - Inquired about current (<12 months) impairment from a physical or mental health condition

  Or

  - Did not ask about mental health conditions

Dyrbye et al. Mayo Clin Proc 92(10):1486

Did not ask about mental health conditions

Initial Application	Renewal Application
Connecticut	Connecticut
Idaho	Indiana
New York	Mississippi
Rhode Island	Nebraska
Wyoming	New York
	Utah
	Washington
	Wisconsin

Dyrbye et al. Mayo Clin Proc 92(10):1486

Current Impairment Only

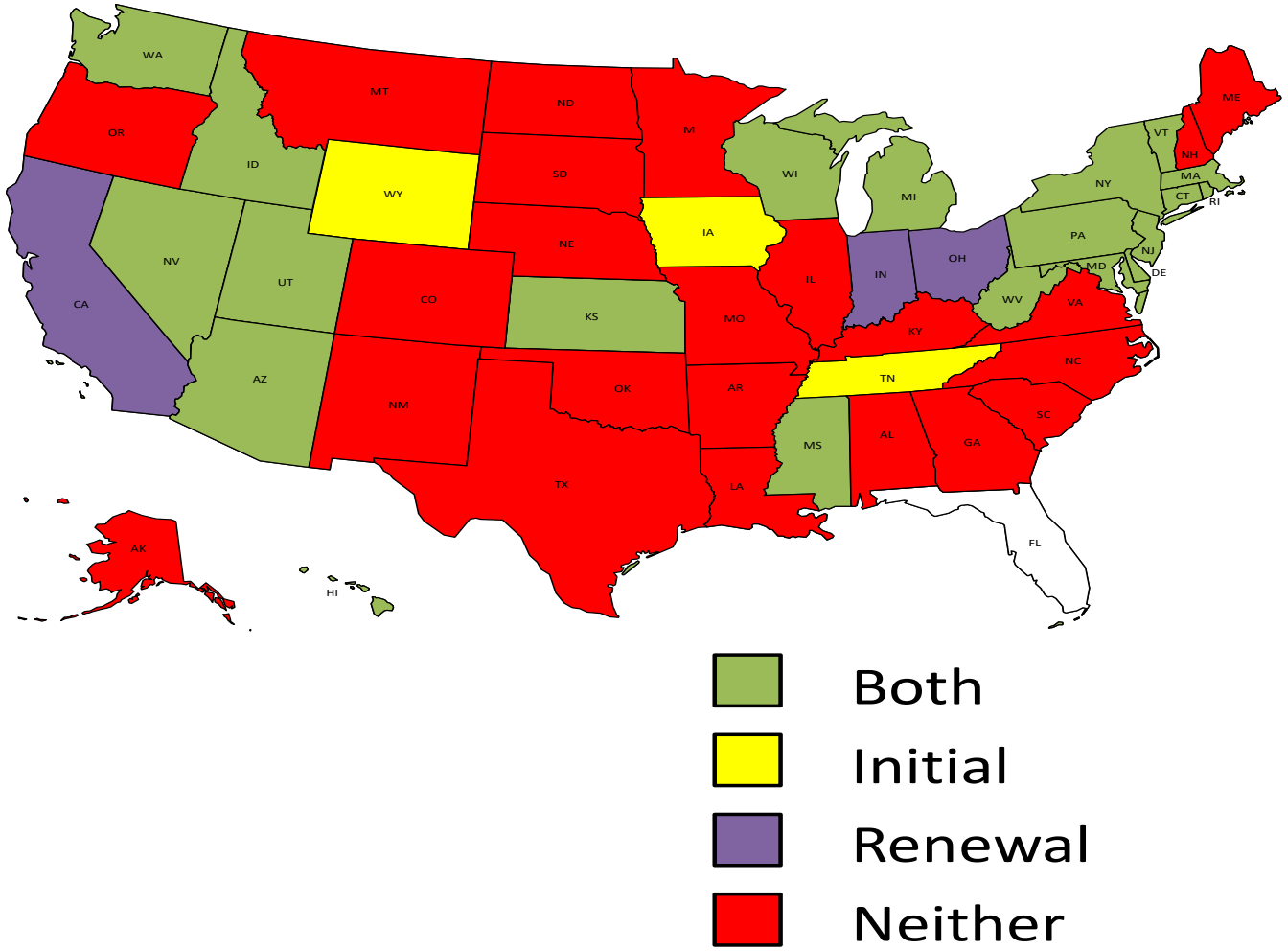
Initial Application	Renewal Application
Arizona	Arizona
Delaware	Delaware
Iowa	Maryland
Maryland	Massachusetts
Massachusetts	Nevada
Nevada	New Jersey
New Jersey	Washington
Tennessee	
Vermont	
Washington	
Wisconsin	

Dyrbye et al. Mayo Clin Proc 92(10):1486

Examples

- Washington, Wisconsin, and New Jersey: Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety?
- Nevada: Do you currently have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety?
- Massachusetts: Do you have a medical or physical condition that currently impairs your ability to practice medicine?

MEDICAL LICENSURE APPLICATION QUESTIONS



2016

2/3 SMBs asked inappropriate questions

Dyrbye et al. Mayo Clin Proc 92(10):1486

Medical Licensure Questions and Physicians Reluctance to Seek Care for Mental Health Conditions

- National sample of >5800 physicians
- 40% reluctant to seek help for mental health concern

- Physicians who worked in states in which neither the initial nor the renewal application was consistent had **21%** increased odds of reluctance to seek help for a mental health concern.

- Physicians who worked in states where only the initial application was not consistent had a **22%** increase in odds of reluctance to seek help for a mental health concern, suggesting initial application may leave a lasting impression

Dyrbye et al. Mayo Clin Proc 92(10):1486

Medical License Application Questions

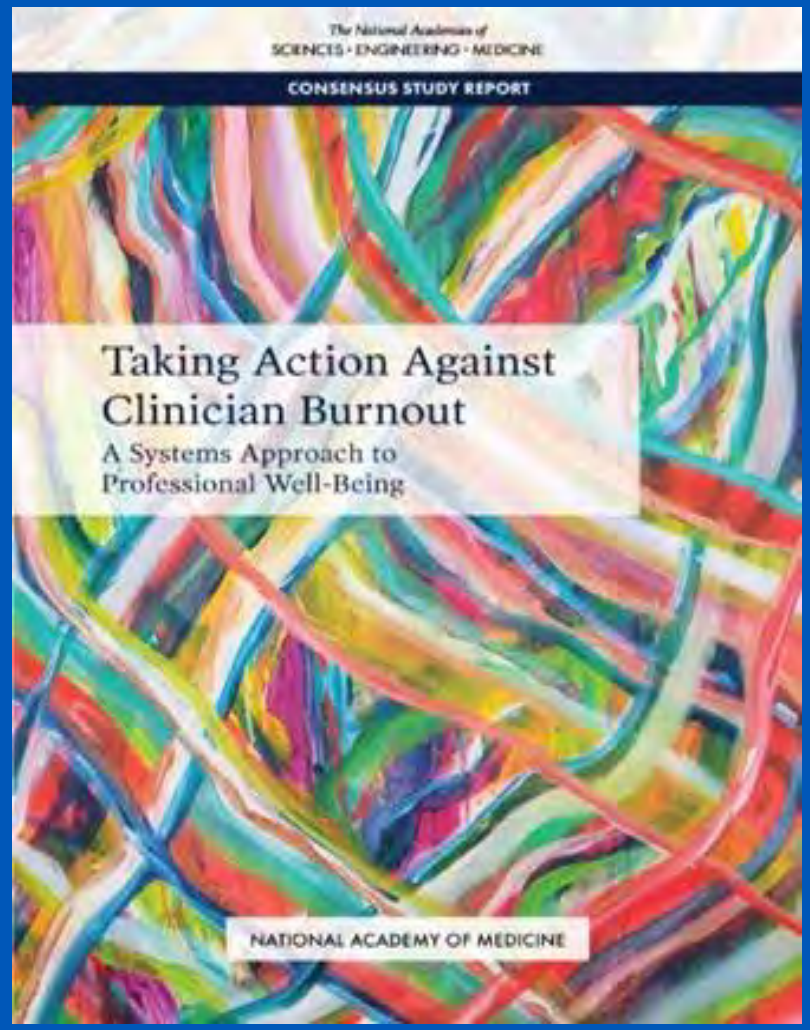
- **No** evidence that impairment or potential risk of harm to patients can be deferred from a diagnosis or treatment alone
- **No** evidence that states with consistent initial and renewal medical license application questions
  - Have more impaired physicians
  - Have higher malpractice rates
  - Deliver lower quality of care

WA, ID, NV, UT, AZ, WI, MI, MS, NY, VT, MA, CT, PA, NJ, MD, & WV

- **Is** evidence that physicians are more willing to seek help for mental health concerns in states that have consistent initial and renewal questions

NATIONAL ACADEMY OF SCIENCES, ENGINEERING, AND MEDICINE

"Recommendation 5A. **State licensing boards**, health system credentialing bodies, disability insurance carriers, and malpractice insurance carriers **should either not ask about clinicians' personal health information or else inquire only about clinicians' current impairments** due to any health condition rather than including past or current diagnosis or treatment for a mental health condition."

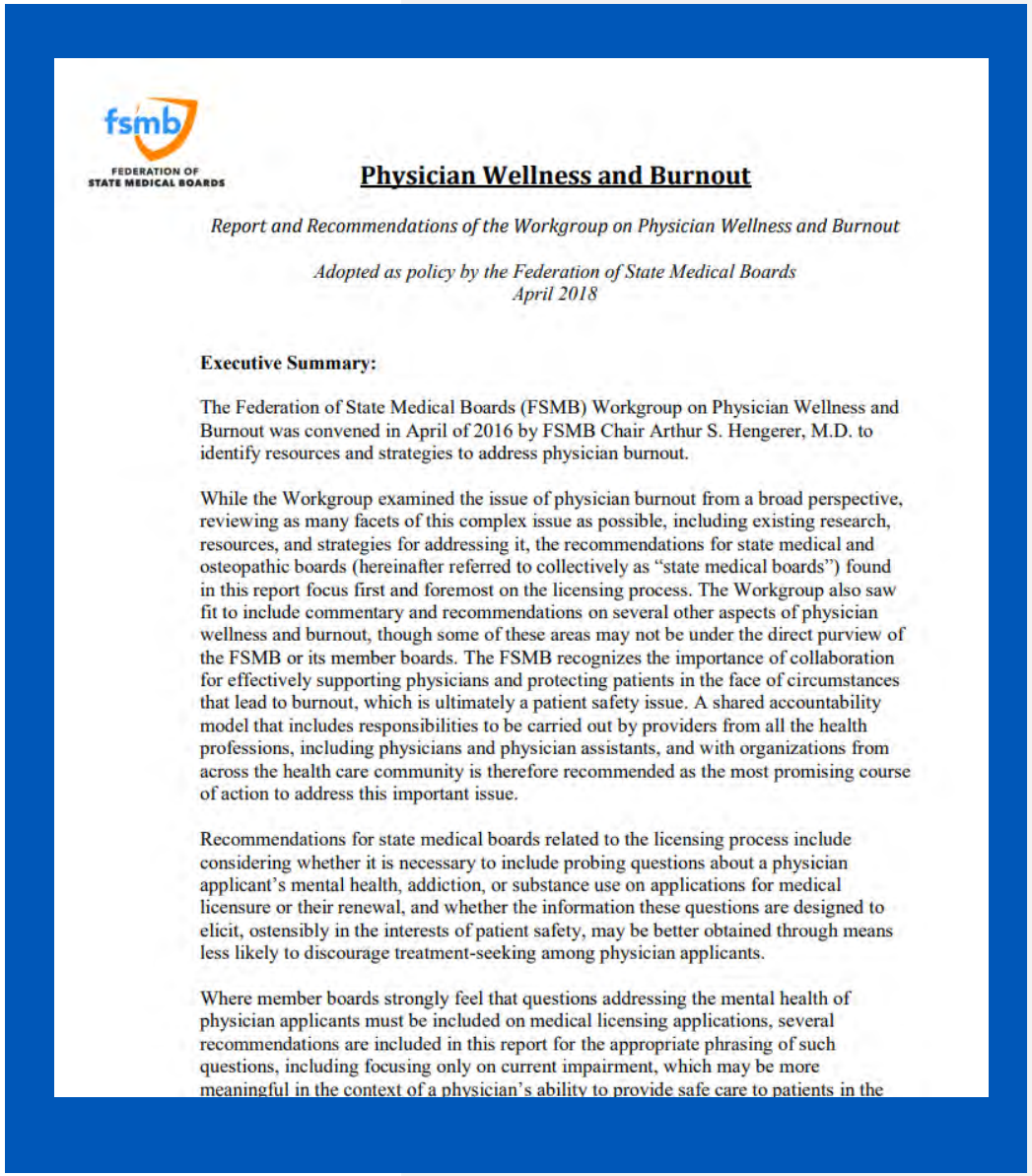


National Academies of Sciences, Engineering, and Medicine, (2019). Taking Action Against Clinician Burnout: A Systems Approach to Professional Well-Being. Washington, DC, The National Academies Press.

FEDERATION OF STATE MEDICAL BOARDS

Physician Wellness

- State boards are inadvertently discriminating against physicians with mental illness
- Court interpretations of the ADA of 1990 suggest state medical boards should focus on current functional impairment
- Application questions discourage treatment seeking



fsmb
FEDERATION OF STATE MEDICAL BOARDS

Physician Wellness and Burnout

Report and Recommendations of the Workgroup on Physician Wellness and Burnout

Adopted as policy by the Federation of State Medical Boards
April 2018

Executive Summary:

The Federation of State Medical Boards (FSMB) Workgroup on Physician Wellness and Burnout was convened in April of 2016 by FSMB Chair Arthur S. Hengerer, M.D. to identify resources and strategies to address physician burnout.

While the Workgroup examined the issue of physician burnout from a broad perspective, reviewing as many facets of this complex issue as possible, including existing research, resources, and strategies for addressing it, the recommendations for state medical and osteopathic boards (hereinafter referred to collectively as "state medical boards") found in this report focus first and foremost on the licensing process. The Workgroup also saw fit to include commentary and recommendations on several other aspects of physician wellness and burnout, though some of these areas may not be under the direct purview of the FSMB or its member boards. The FSMB recognizes the importance of collaboration for effectively supporting physicians and protecting patients in the face of circumstances that lead to burnout, which is ultimately a patient safety issue. A shared accountability model that includes responsibilities to be carried out by providers from all the health professions, including physicians and physician assistants, and with organizations from across the health care community is therefore recommended as the most promising course of action to address this important issue.

Recommendations for state medical boards related to the licensing process include considering whether it is necessary to include probing questions about a physician applicant's mental health, addiction, or substance use on applications for medical licensure or their renewal, and whether the information these questions are designed to elicit, ostensibly in the interests of patient safety, may be better obtained through means less likely to discourage treatment-seeking among physician applicants.

Where member boards strongly feel that questions addressing the mental health of physician applicants must be included on medical licensing applications, several recommendations are included in this report for the appropriate phrasing of such questions, including focusing only on current impairment, which may be more meaningful in the context of a physician's ability to provide safe care to patients in the

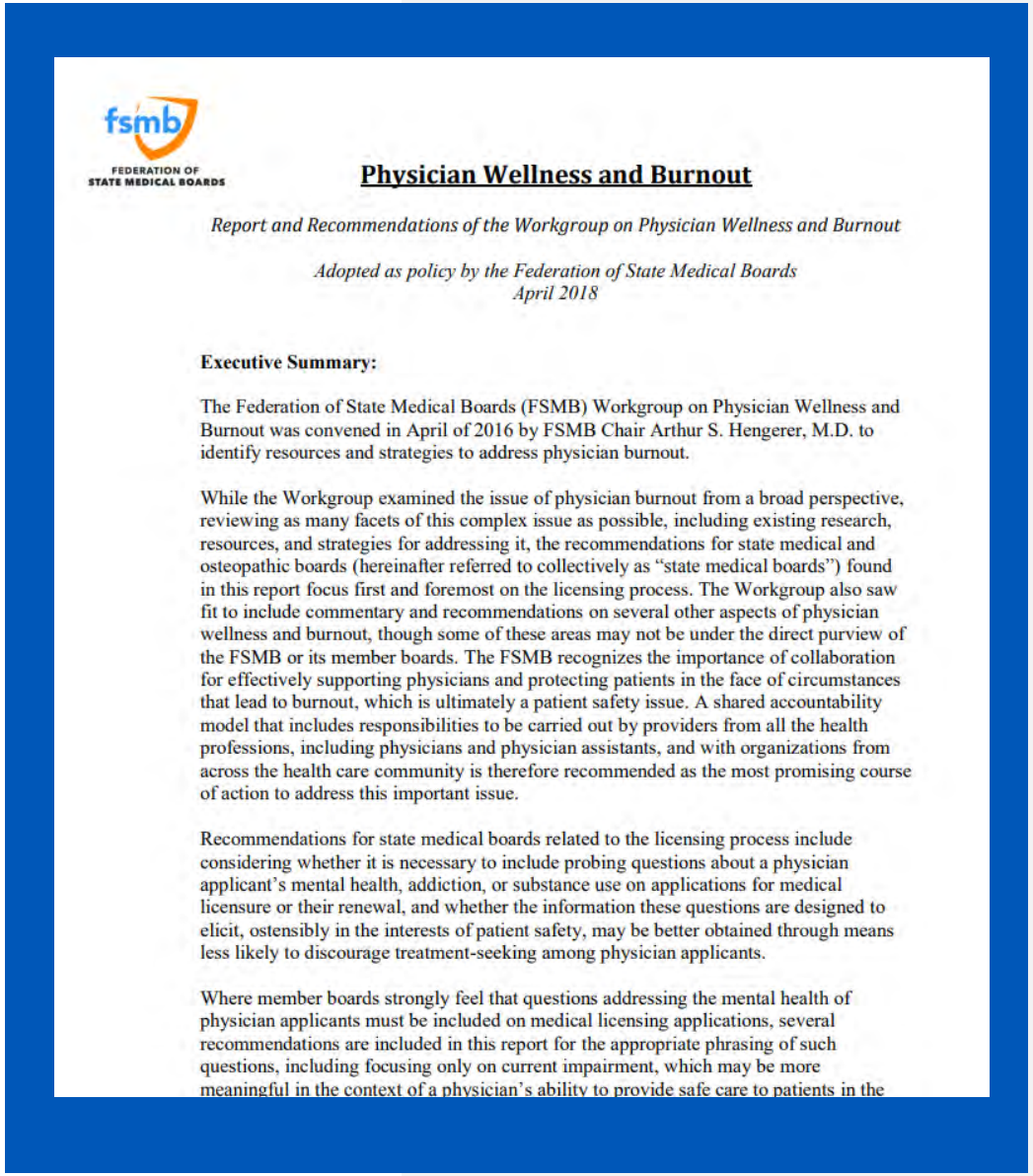
https://www.fsmb.org/siteassets/advocacy/policies/policy-on-wellness-and-burnout.pdf

FEDERATION OF STATE MEDICAL BOARDS

Physician Wellness

Evaluate whether it is necessary to include probing questions about mental health, esp. as information can be obtained through other means (National Practitioner Data Bank query regarding arrests, convictions, DUI, etc.)

Application questions must focus only on current impairment



fsmb
FEDERATION OF STATE MEDICAL BOARDS

Physician Wellness and Burnout

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https://www.fsmb.org/siteassets/advocacy/policies/policy-on-wellness-and-burnout.pdf

FSMB Recommendations

"Where boards wish to retain questions about the health of applicants on licensing applications, the FSMB recommends that they use the language:

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)"

https://www.fsmb.org/siteassets/advocacy/policies/policy-on-wellness-and-burnout.pdf

NEW MEXICO

"Galvanized by a physician colleague's suicide, a multispecialty physician coalition worked with the New Medico Medical Board.."

FINAL LANGUAGE

"Do you have or have you been diagnosed with an illness or condition which impairs your judgment or affects your ongoing ability to practice medicine in a competent, ethical and professional manner?"

Annals of Internal Medicine IDEAS AND OPINIONS

Improving How State Medical Boards Ask Physicians About Mental Health Diagnoses: A Case Study From New Mexico

Eileen Barrett, MD, MPH; Elizabeth Lawrence, MD; Daniel Waldman, MD; and Heather Brislen, MD

State-based medical license applications often ask about mental health diagnoses and treatment in terms that stigmatize mental illness, inadvertently discouraging physicians from seeking care (1–3). Physicians cite the potential impact on their ability to obtain a medical license as a reason for not seeking care for mental health conditions (4, 5). Galvanized by a physician colleague's suicide, a multispecialty physician coalition worked with the New Mexico Medical Board in a successful collaboration that resulted in updated and destigmatized language on the state medical license application. We hope that our process might inspire and inform others in similar circumstances.

Most state medical boards require applicants to answer questions about mental health diagnoses, and many require additional investigation when an applicant indicates a past or present mental health diagnosis of any kind. A 2017 study found that two thirds of state medical license applications included questions that reflected stigma around mental health diagnoses. The same study found that physicians are less likely to be willing to seek mental health care in states that differentiate mental health from other health (4). Further, medical students and residents who might avail themselves of mental health resources are deterred from doing so because of the additional scrutiny that follows (6–8).

Medical organizations' positions around this issue are evolving, and several new policies have been released. The Federation of State Medical Boards, for example, has recommended that boards evaluate whether they need to ask specific questions about mental health diagnoses and, if so, that such questions focus on current impairment only (2).

Until recently, the language on New Mexico's license application equated mental illness with impairment and included a daunting 5-year "lookback" period:

> In the five (5) years prior to this application, have you had any physical injury or disease, or mental illness or impairment, which you are currently under treatment for or could reasonably be expected to affect your ongoing ability to practice medicine safely and competently? If yes, please have your treating physician send the NM Medical Board a letter regarding your diagnosis and treatment.

Our core team of 4 physicians included a residency

physician advocates, we leveraged our networks in academia and organized medicine for the broadest possible support. The first few weeks of this project were spent on strategic, sequential recruitment of allies, including our local chapters of the American College of Physicians, American Academy of Family Physicians, American College of Emergency Physicians, and American Psychiatric Association. These chapters and a university department chair submitted letters to the medical board that requested updating of the license application language. As a second step, we sought support from our county and state medical societies via a typical resolution process, in this case listing our growing coalition of supporters as sponsors of a resolution to update our state's license application. The resolution was debated at the earliest possible county society meeting. The state medical society subsequently invited members of our coalition and members of the medical board to speak at the final hearing of the resolution. At every juncture, the initiative was supported. Support from the state medical society ultimately served as the platform for direct work with the medical board.

A months-long period of negotiation and collaboration with the medical board followed, facilitated by the state medical society and led by the core team of our coalition. The leaders of our team presented at 2 formal medical board meetings and were in frequent contact with board leadership via e-mail and telephone to stay on top of new issues, developing national recommendations, and relevant medical literature. Recognizing a need for an improved standing among trainees, medical board members met with medical students to discuss perceived bias against people with mental health diagnoses. In a telling exchange, students reported having declined recommended antidepressant medications and other treatment because of concerns about obtaining a future license. Although the infrequency of the business meetings of our stakeholder groups slowed our process, it also provided ample time for informal relationship building that strengthened our collaboration. In the end, a language change was adopted approximately a year after our coalition first came together.

State medical boards are charged with protecting the health of the public, and we share that commitment. As physicians, we also have a duty to communicate that mental health diagnoses are medical conditions that should be treated no differently from other

Barrett et al. Ann Intern Med 2020;172(9)

RECOMMENDATION

Initial and renewal application:

- "Do you currently have 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)"
- [alternative] "Do you currently have any condition that impairs your ability to practice medicine in a competent, ethical and professional manner? (Yes/No)"

FSMB suggestion:

"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)"

Pursue all opportunities to inform physicians of available resources

Additional Comments

- Mayo
- Physicians Serving Physicians/Physicians Wellness Collaborative
- Minnesota Psychiatric Society
- NAMI

Minnesota Physician Licensure Application Revision Proposal

Minnesota Medical Association

February 1, 2021

1

Current Licensure Application Language:

Initial Application:

Have you within the past five years been advised by your treating physician that you have a mental, physical, or emotional condition, which, if untreated, would be likely to impair your ability to practice medicine with reasonable skill and safety?

https://mn.gov/boards/assets/MNBMP%20PYAppPacketSep2019_tcm21-36587.pdf (page 14)
https://www.fsmb.org/siteassets/ua/states/024/instructions.pdf (page 13)

Renewal:

Since your last renewal, have you been advised by your treating physician that you have a mental, physical, or emotional condition, which, if untreated, would be likely to impair your ability to practice with reasonable skill and safety?

2

Concerns with current language

- Deterrent to physicians and physicians in training seeking help
- Past medical conditions are not relevant to a physician's current ability to practice
- Advances discrimination by asking for mental health history
- Encourages untruthful answers

3

Proposed Language

"Do you **currently** have **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)"

Federation of State Medical Boards recommended language: "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)"

4

MN Medical License Application

L. Dyrbye, MD MHPE
Professor of Medicine and Medical Education
Mayo Clinic

5

PRE-COVID 19

BURNOUT
37-44%

DEPRESSION
28-32%

- Physicians
- Physician Assistants
- Adv. Practice Nurses
- Nurses
- Pharmacists
- Residents
- Medical Students

Dyrbye et al JAMA. 2018;320(11):1114
Rotenstein JAMA 2016; Mata et al. JAMA 314(22): 2373-2383; Shanafelt et al. Mayo Clin Proc. 94 (9):1681-1694; West et al. J Intern Med 283(6): 516-529; Dyrbye et al. Med Educ 50(1): 132-149

6

US MENTAL HEALTH

Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic — United States, June 24–30, 2020

2020 vs 2019

3x **ANXIETY**
25.5% vs. 8.1%

4x **DEPRESSIVE DISORDER**
24.3% vs 6.5%

2x **SUICIDAL IDEATION**
10.7% vs 4.5%

Czeisler et al. Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic — United States, June 24–30, 2020. MMWR Morb Mortal Wkly Rep 2020;69:1049–1057. http://dx.doi.org/10.15585/mmwr.mm6932a1external icon.

7

HEALTHCARE WORKERS

Early data suggest clinicians working on the frontline of COVID-19 are experiencing very high rates of depression, anxiety, and distress.

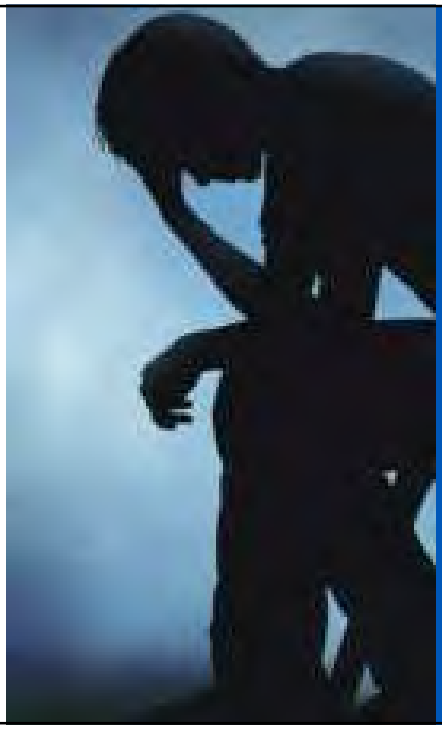
Emerg Infect Dis 2006;12:1924-32;CMAJ 2004;170:793-8; Compr Psychiatry 2012;53:15-23; 2005;43:676-82; JAMA Netw Open 2020;3:e203976

8

HEALTHCARE WORKERS

Mood disorders often go untreated, contributing to a higher prevalence of suicide among physicians in comparison to other US workers.

Center et al. JAMA 289; Schernhammer N Engl J Med 352; Shanafelt et al. Arch Surg 146



National study of US Surgeons

6% had recent thoughts of suicide, 40% of these individuals had not sought care due to concerns that doing so could affect their licensure to practice.

9

Medical Licensure Questions

- 2016, 51 initial and 48 renewal medical licensure applications forms
- Coded questions based on policies and recommendations from the Federation of State Medical Boards, American Psychiatric Association, American Medical Association, and the ADA of 1990.

- Applications considered “consistent” if:
  - Inquired about current (<12 months) impairment from a physical or mental health condition

  Or
  - Did not ask about mental health conditions

Dyrbye et al. Mayo Clin Proc 92(10):1486

10

Did not ask about mental health conditions

Initial Application	Renewal Application
Connecticut	Connecticut
Idaho	Indiana
New York	Mississippi
Rhode Island	Nebraska
Wyoming	New York
	Utah
	Washington
	Wisconsin

Dyrbye et al. Mayo Clin Proc 92(10):1486

11

Current Impairment Only

Initial Application	Renewal Application
Arizona	Arizona
Delaware	Delaware
Iowa	Maryland
Maryland	Massachusetts
Massachusetts	Nevada
Nevada	New Jersey
New Jersey	Washington
Tennessee	
Vermont	
Washington	
Wisconsin	

Dyrbye et al. Mayo Clin Proc 92(10):1486

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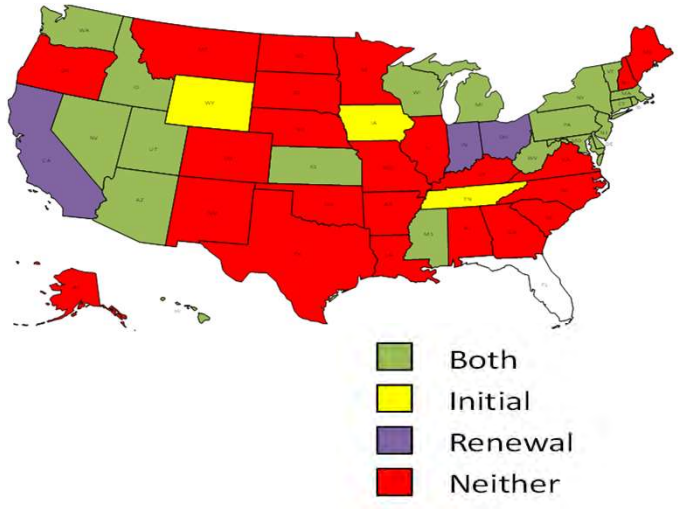
Examples

- Washington, Wisconsin, and New Jersey: Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety?
- Nevada: Do you currently have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety?
- Massachusetts: Do you have a medical or physical condition that currently impairs your ability to practice medicine?

13



MEDICAL LICENSURE APPLICATION QUESTIONS

2016

2/3 SMBs asked inappropriate questions

Dyrbye et al. Mayo Clin Proc 92(10):1486

14

Medical Licensure Questions and Physicians Reluctance to Seek Care for Mental Health Conditions

- National sample of >5800 physicians
- 40% reluctant to seek help for mental health concern

- Physicians who worked in states in which neither the initial nor the renewal application was consistent had **21%** increased odds of reluctance to seek help for a mental health concern.

- Physicians who worked in states where only the initial application was not consistent had a **22%** increase in odds of reluctance to seek help for a mental health concern, suggesting initial application may leave a lasting impression

Dyrbye et al. Mayo Clin Proc 92(10):1486

15

Medical License Application Questions

- **No** evidence that impairment or potential risk of harm to patients can be deferred from a diagnosis or treatment alone
- **No** evidence that states with consistent initial and renewal medical license application questions
  - Have more impaired physicians
  - Have higher malpractice rates
  - Deliver lower quality of care

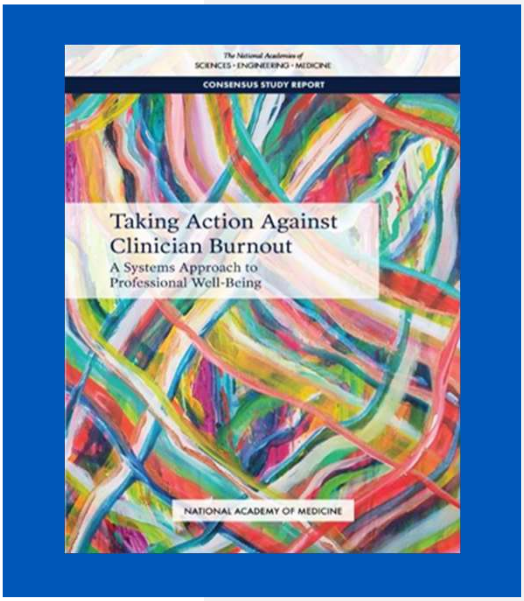
WA, ID, NV, UT, AZ, WI, MI, MS, NY, VT, MA, CT, PA, NJ, MD, & WV

- **Is** evidence that physicians are more willing to seek help for mental health concerns in states that have consistent initial and renewal questions

16

NATIONAL ACADEMY OF SCIENCES, ENGINEERING, AND MEDICINE

"Recommendation 5A. **State licensing boards**, health system credentialing bodies, disability insurance carriers, and malpractice insurance carriers **should either not ask about clinicians' personal health information or else inquire only about clinicians' current impairments** due to any health condition rather than including past or current diagnosis or treatment for a mental health condition."



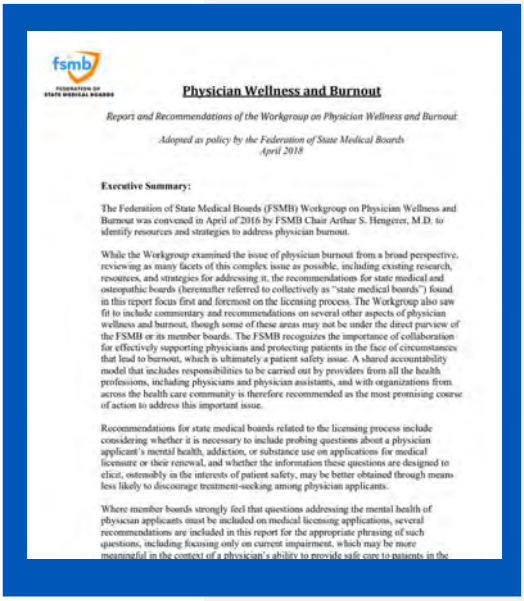
National Academies of Sciences, Engineering, and Medicine, (2019). Taking Action Against Clinician Burnout: A Systems Approach to Professional Well-Being. Washington, DC, The National Academies Press.

17

FEDERATION OF STATE MEDICAL BOARDS

Physician Wellness

- State boards are inadvertently discriminating against physicians with mental illness
- Court interpretations of the ADA of 1990 suggest state medical boards should focus on current functional impairment
- Application questions discourage treatment seeking



fsmb

Physician Wellness and Burnout

Report and Recommendations of the Workgroup on Physician Wellness and Burnout

Adopted as policy by the Federation of State Medical Boards
April 2018

Executive Summary:

The Federation of State Medical Boards (FSMB) Workgroup on Physician Wellness and Burnout was convened in April of 2016 by FSMB Chair Arthur S. Hengerer, M.D. to identify resources and strategies to address physician burnout.

While the Workgroup examined the issue of physician burnout from a broad perspective, reviewing as many facets of this complex issue as possible, including existing research, resources, and strategies for addressing it, the recommendations for state medical and osteopathic boards (hereinafter referred to collectively as "state medical boards") found in this report focus first and foremost on the licensing process. The Workgroup also saw fit to include commentary and recommendations on several other aspects of physician wellness and burnout, though some of these areas may not be under the direct purview of the FSMB or its member boards. The FSMB recognizes the importance of collaboration for effectively supporting physicians and protecting patients in the face of circumstances that lead to burnout, which is ultimately a patient safety issue. A shared accountability model that includes responsibilities to be carried out by providers from all the health professions, including physicians and physician assistants, and with organizations from across the health care community is therefore recommended as the most promising course of action to address this important issue.

Recommendations for state medical boards related to the licensing process include considering whether it is necessary to include probing questions about a physician applicant's mental health, addiction, or substance use on applications for medical licensure or their renewal, and whether the information these questions are designed to elicit, ostensibly in the interests of patient safety, may be better obtained through means less likely to discourage treatment-seeking among physician applicants.

Where member boards strongly feel that questions addressing the mental health of physician applicants must be included on medical licensing applications, several recommendations are included in this report for the appropriate phrasing of such questions, including focusing only on current impairment, which may be more meaningful in the context of a physician's ability to provide safe care to patients in the

https://www.fsmb.org/siteassets/advocacy/policies/policy-on-wellness-and-burnout.pdf

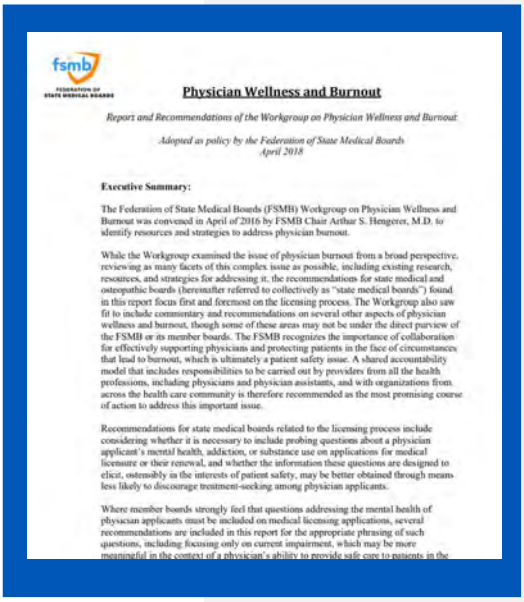
18

FEDERATION OF STATE MEDICAL BOARDS

Physician Wellness

Evaluate whether it is necessary to include probing questions about mental health, esp. as information can be obtained through other means (National Practitioner Data Bank query regarding arrests, convictions, DUI, etc.)

Application questions must focus only on current impairment



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19

FSMB Recommendations

"Where boards wish to retain questions about the health of applicants on licensing applications, the FSMB recommends that they use the language:

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)"

https://www.fsmb.org/siteassets/advocacy/policies/policy-on-wellness-and-burnout.pdf

MAYO CLINIC

20

NEW MEXICO

"Galvanized by a physician colleague's suicide, a multispecialty physician coalition worked with the New Medico Medical Board.."

FINAL LANGUAGE

"Do you have or have you been diagnosed with an illness or condition which impairs your judgment or affects your ongoing ability to practice medicine in a competent, ethical and professional manner?"

Annals of Internal Medicine — IDEAS AND OPINIONS

Improving How State Medical Boards Ask Physicians About Mental Health Diagnoses: A Case Study From New Mexico

Eileen Barrett, MD, MPH; Elizabeth Lawrence, MD; Daniel Waldman, MD; and Heather Brislen, MD

State-based medical license applications often ask about mental health diagnoses and treatment in terms that stigmatize mental illness, inadvertently discouraging physicians from seeking care [1–3]. Physicians cite the potential impact on their ability to obtain a medical license as a reason for not seeking care for mental health conditions [4, 5]. Galvanized by a physician colleague's suicide, a multispecialty physician coalition worked with the New Mexico Medical Board in a successful collaboration that resulted in updated and destigmatized language on the state medical license application. We hope that our process might inspire and inform others in similar circumstances.

Most state medical boards require applicants to answer questions about mental health diagnoses, and many require additional investigation when an applicant indicates a past or present mental health diagnosis of any kind. A 2017 study found that two thirds of state medical license applications included questions that reflected stigma around mental health diagnoses. The same study found that physicians are less likely to be willing to seek mental health care in states that differentiate mental health from other health [4]. Further, medical students and residents who might avail themselves of mental health resources are deterred from doing so because of the additional scrutiny that follows [6–8].

Medical organizations' positions around this issue are evolving, and several new policies have been released. The Federation of State Medical Boards, for example, has recommended that boards evaluate whether they need to ask specific questions about mental health diagnoses and, if so, that such questions focus on current impairment only [2].

Until recently, the language on New Mexico's license application equated mental illness with impairment and included a daunting 5-year "lookback" period:

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Barrett et al. Ann Intern Med 2020;172(9)

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RECOMMENDATION

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FSMB suggestion:

"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)"

Pursue all opportunities to inform physicians of available resources

MAYO CLINIC

22

Additional Comments

- Mayo
- Physicians Serving Physicians/Physicians Wellness Collaborative
- Minnesota Psychiatric Society
- NAMI

23

MAYO CLINIC

Medical Licensure Questions and Physician Reluctance to Seek Care for Mental Health Conditions

Liselotte N. Dyrbye, MD, MHPE; Colin P. West, MD, PhD; Christine A. Sinsky, MD; Lindsey E. Goeders, MBA; Daniel V. Satele, BS; and Tait D. Shanafelt, MD

Abstract

Objective: To determine whether state medical licensure application questions (MLAQs) about mental health are related to physicians' reluctance to seek help for a mental health condition because of concerns about repercussions to their medical licensure.

Methods: In 2016, we collected initial and renewal medical licensure application forms from 50 states and the District of Columbia. We coded MLAQs related to physicians' mental health as "consistent" if they inquired *only* about current impairment from a mental health condition or did not ask about mental health conditions. We obtained data on care-seeking attitudes for a mental health problem from a nationally representative convenience sample of 5829 physicians who completed a survey between August 28, 2014, and October 6, 2014. Analyses explored relationships between state of employment, MLAQs, and physicians' reluctance to seek formal medical care for treatment of a mental health condition because of concerns about repercussions to their medical licensure.

Results: We obtained initial licensure applications from 51 of 51 (100%) and renewal applications from 48 of 51 (94.1%) medical licensing boards. Only one-third of states currently have MLAQs about mental health on their initial and renewal application forms that are considered consistent. Nearly 40% of physicians (2325 of 5829) reported that they would be reluctant to seek formal medical care for treatment of a mental health condition because of concerns about repercussions to their medical licensure. Physicians working in a state in which neither the initial nor the renewal application was consistent were more likely to be reluctant to seek help (odds ratio, 1.21; 95% CI, 1.07-1.37; P=.002 vs both applications consistent).

Conclusion: Our findings support that MLAQs regarding mental health conditions present a barrier to physicians seeking help.

 ■ Mayo Clin Proc. 2017;92(10):1486-1493

From the Mayo Clinic Program on Physician Well-Being, Department of Medicine (L.N.D., C.P.W., T.D.S.) and Department of Health Sciences Research (D.V.S.), Mayo Clinic, Rochester, MN; and American Medical Association, Chicago, IL (C.A.S., L.E.G.). T.D.S. is currently affiliated with Department of Medicine, Division of Hematology, Stanford University, Stanford, CA.

The prevalence of psychological distress among physicians is high.[1,2] Unfortunately, their mood disorders often go untreated,[1,3,4] contributing to a higher prevalence of suicide among physicians in comparison to other US workers.[1,5] A third to half of physicians do not have a personal physician or regular source of health care,[6-8] and physicians are less likely to have seen their personal physician in the past year than other US adults.[9] Information regarding physicians' use of mental health services is limited, although data suggest that physicians frequently self-treat for depression and avoid seeking care for mental health conditions because of concerns that a mental health condition may affect their license to practice.[1,3,4] For example, in a 2008 national study of 7905 US surgeons, 6.3% reported suicidal ideation during the previous 12 months.[4] Among those with recent suicidal ideation, 26% had sought care, 16% had self-prescribed their antidepressant, and 60% reported that they were reluctant to seek care because of concerns that doing so could affect their licensure to practice.[4]

Many state licensing boards ask questions about mental health diagnoses or treatment. The fact that licensing boards inquire about these dimensions is believed to be a major deterrent to help seeking among troubled physicians, many of whom have treatable

Mayo Clin Proc. ■ October 2017;92(10):1486-1493 ■ http://dx.doi.org/10.1016/j.mayocp.2017.06.020
www.mayoclinicproceedings.org ■

disorders.[1,3,10-12] Such a concern is reasonable because a study published in 2007 found that greater than one-third of state licensure board executive directors reported that a diagnosis of mental illness was itself sufficient to sanction physicians.[13] In addition, there are reports of disclosure of mental health conditions resulting in overt and covert discrimination (eg, restrictions on clinical practice, mandatory clinical proctoring, and mandatory psychiatric evaluation for the purpose of determining competence).[1,3,10,13-15] There is also a real possibility of public disclosure of physicians' personal health information.[1,14,16]

State medical licensure boards serve to protect the public through licensure, surveillance, misconduct investigations, and disciplinary actions.[17] The Federation of State Medical Boards advises that medical licensure boards not ask physicians about history of mental illness[18] and indicates that doing so could violate the Americans with Disabilities Act of 1990.[19,20] The American Psychiatric Association has also specifically stated that impairment and potential risk of harm to patients cannot be inferred from a diagnosis or treatment alone.[10,21] Indeed, many have called for medical licensure applications to include only questions about current functional impairment of professional performance[1,19,21-25] and for decisions regarding licensure to be based solely on professional performance.[22,26] In response, some state licensing boards have modified their questions in regard to mental health[14]; however, many may remain in violation of the Americans with Disabilities Act,[19,21] and the prevalence of licensure questions about physicians' history of mental illness appears to be increasing.[20]

It remains unknown whether physicians who are licensed by medical boards that inquire about current or past diagnosis or treatment of a mental health condition are more reluctant to seek care for a mental health concern than those who are licensed by medical boards that inquire only about current impairment. In this study, we evaluated the relationship between state medical licensure application questions about mental health and whether physicians endorse reluctance to seek help for a mental health condition because of concerns about repercussions to their medical licensure.

METHODS

In 2016, we requested the initial and renewal medical licensure application forms from all 50 states and the District of Columbia (referred to henceforth as "states"). Application questions related to physicians' mental health, physical health, and substance abuse were extracted, reviewed, and independently coded by 2 of the authors (L.N.D. and T.D.S.) using an evidence-based approach informed by the American Medical Association,[25] American Psychiatric Association,[21] and Federation of State Medical Boards[18] polices and recommendations and the Americans with Disabilities Act of 1990.[19,20] Applications were classified as "consistent" if they inquired *only* about current (within a time period of 12 months or less) impairment from a medical condition or mental health condition (eg, "Do you currently have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety?") or did not ask about mental health conditions.[1,19,21-24] Applications that asked about history (ever) of impairment or whether the applicant had a mental health condition that *could* affect competency, *could* possibly impair ability to practice medicine, or *could* lead to impairment if left untreated were not considered consistent. Similarly, applications that asked about current or past diagnosis or treatment of a mental health condition (rather than impairment from such a condition) were not considered consistent. If both the initial licensure and renewal applications were designated as consistent from a given state, the medical licensure board for that state was coded as "both applications consistent." If the initial but not the renewal application was classified as consistent, the medical licensure board for that state was coded as "initial application consistent." If the renewal application but not the initial application for a given state was classified as consistent, the medical licensure board for that state was coded as "renewal application consistent." If neither the initial nor the renewal application from a given state was considered

consistent, the medical licensure board for that state was coded as "neither application consistent."

Convenience Sample of US Physicians

We obtained data on care-seeking attitudes for a mental health problem from a nationally representative convenience sample of 5829 nonretired US physicians who participated in a previously reported national survey from August 28, 2014, to October 6, 2014.[2] The survey included questions about personal (sex, age, relationship status) and professional (degree [allopathic or osteopathic], work hours, specialty, practice setting, currently practicing) characteristics as well as the physician's state of employment. In addition, physicians were asked, "If you were to need medical help for treatment of depression, alcohol/substance use, or other mental health problem would concerns about the repercussions on your medical licensure make you reluctant to seek formal medical care?" (response options "yes" or "no"). Those who indicated "yes" were considered to be reluctant to seek formal medical care for treatment of a mental health condition because of concerns about repercussions to their medical licensure. Respondents were included in this analysis if they were (1) allopathic physicians who answered the question about reluctance to seek care or (2) osteopathic physicians who worked in one of the 36 states that have a conjoined medical board (ie, one medical board licensured both allopathic and osteopathic physicians) and who answered the question about reluctance to seek care.

Statistical Analyses

Standard descriptive summary statistics were calculated. Using the physician's reported state of employment, along with our independently obtained data on state licensure questionnaire, each physician was classified as practicing in a "both application consistent," "initial application consistent," "renewal application consistent," or "neither application consistent" state. We explored the relationship between medical licensure application categories of the state in which physicians practiced and whether physicians reported that they would be reluctant to seek formal medical care for treatment of a mental health condition because of concerns about repercussions to their medical licensure using χ^2 tests. Multivariate logistic regression analysis was performed to identify personal (age, sex, relationship status) and professional (practice setting, state licensure category, specialty) characteristics associated with reluctance to seek formal medical care because of concerns about repercussions to their medical licensure. All tests were 2-sided with type I error rates of 0.05. All analyses were performed using SAS statistical software, version 9 (SAS Institute).

RESULTS

We obtained 51 of 51 (100%) initial and 48 of 51 (94.1%) renewal medical licensure application forms, resulting in a final sample of 48 medical licensing boards with complete information on both initial and renewal licensure applications. Twenty-one initial and 21 renewal applications were considered consistent. These applications included 11 initial and 8 renewal applications that asked *only* about current impairment from a mental health condition as well as 10 initial and 13 renewal applications that included no questions related to mental health. Overall, 16 of 48 medical licensing boards (33.3%) were classified as both applications consistent, 3 (6.2%) as initial applications consistent, 5 (10.4%) as renewal applications consistent, and the remaining 24 (50.0%) as neither applications consistent. Classification by state is presented in the Figure.

Demographic characteristics of the 5829 physicians in the convenience sample are presented in Table 1. Overall, 3867 physicians (66.3%) were male, the mean (SD) age was 54.5 (12) years, 5087 (87.3%) were married or partnered (single, 627 [10.8%]; widowed, 87 [1.5%]), and 3089 (53.0%) were in private practice (academic medical center, 1451 [24.9%]; veterans hospital, 89 [1.5%]; active military practice, 42 [0.7%]; other, 1158 [19.9%]).[2] Of the 5829 physicians, 1387 (23.8%) worked in the primary care setting, 1100 (18.9%) in a surgical specialty, 948 in a medical specialty (16.3%), 1786 (30.6%) in another direct patient care discipline (eg, emergency medicine, neurology, dermatology), 371 (6.4%) in a non–direct patient care discipline (eg, radiology, pathology), and 192 (3.3%) in other disciplines (data on

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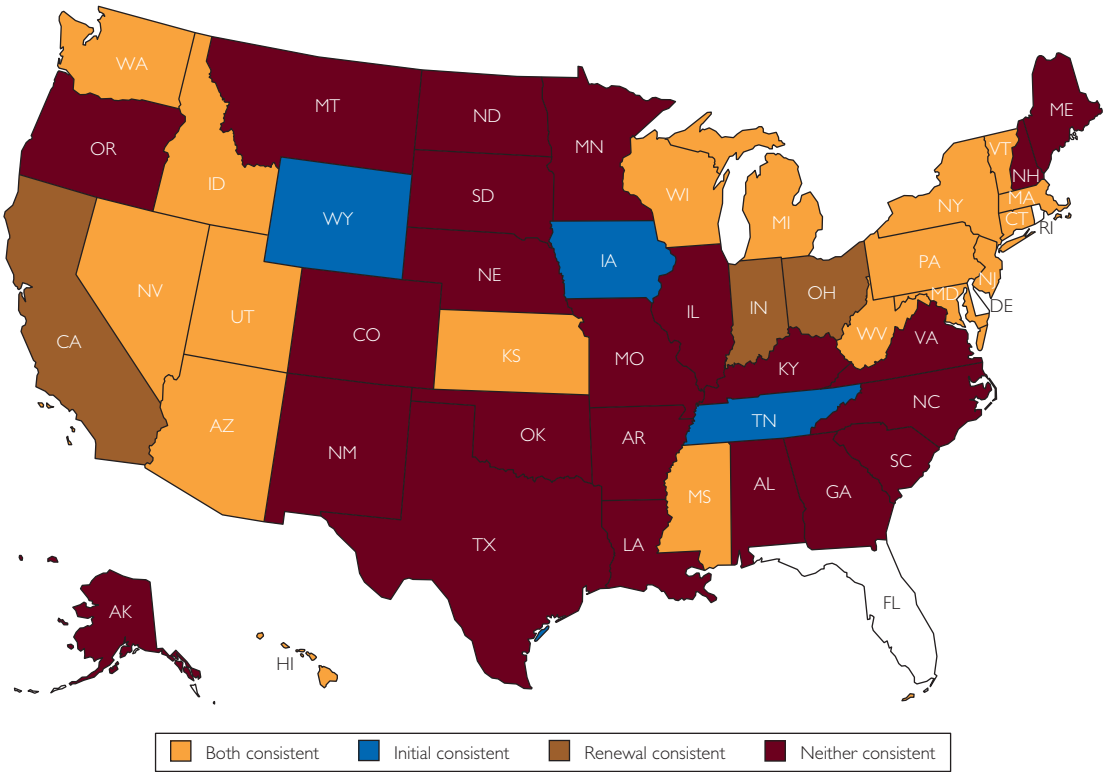

FIGURE. Medical license applications by state. Applications were classified as "consistent" if they inquired only about current impairment from a medical condition (globally) or mental health condition. Data were not available for Florida, Rhode Island, and Delaware (indicated in white).

specialty were missing in 45 physicians [0.8%]). Demographic characteristics of responders were relatively similar to those of all US physicians and to those of previous national samples of US physicians.[2,27]

Overall, nearly 40% of physicians (2325 of 5829 [39.9%]) reported that they would be reluctant to seek formal medical care for treatment of a mental health condition because of concerns about repercussions to their medical licensure. Reluctance to seek care was least prevalent among physicians practicing in states in which both applications were designated consistent (775 of 2117 [36.6%]) compared with those practicing in states classified as initial application consistent (89 of 206 [43.2%]; $P=.06$), renewal application consistent (443 of 1080, [41.0%]; $P=.02$), and neither application consistent (1018 of 2426 [42.0%], $P<.001$) (overall, $P=.002$ across categories). These data suggest that classification of state licensing board applications was related to physicians' reported reluctance to seek help for a mental health condition because of its potential effect on their license to practice.

In multivariate analysis to explore factors independently associated with whether physicians reported that they would be reluctant to seek formal medical care for treatment of a mental health condition because of concerns about repercussions to their medical licensure, physicians who were younger, male, and worked in private practice were more reluctant to seek help (Table 2). Physicians working in a state in which neither application was consistent were more likely to be reluctant to seek help (odds ratio, 1.21 [95% CI, 1.07-1.37]; $P=.002$ vs both applications consistent), as were those who worked in states in which only the renewal application was consistent (odds ratio, 1.22 [95% CI, 1.05-1.43];

TABLE 1. Demographic Characteristics of 5829 Physicians

Characteristic	No. (%) of physicians[a]
Sex	
Male	3867 (66.3)
Female	1927 (33.1)
Missing	35 (0.6)
Age (y), mean (SD) (N=5787)	54.5 (12.0)
Relationship status	
Single	627 (10.8)
Married	4854 (83.3)
Partnered	233 (4.0)
Widowed	87 (1.5)
Missing	28 (0.5)
Degree	
Allopathic physician (MD)	5634 (96.7)
Osteopathic physician (DO)	195 (3.3)
Practice setting	
Private practice	3089 (53.0)
Academic medical center	1451 (24.9)
Veterans hospital	89 (1.5)
Active military practice	42 (0.7)
Other	1158 (19.9)
Years in practice, mean (SD)	22.2 (12.6)
Specialty	
Primary care	1387 (23.8)
Surgical specialty	1100 (18.9)
Medical specialty	948 (16.3)
Other direct patient care discipline[b]	1786 (30.6)
Other non–direct patient care discipline[c]	371 (6.4)
Other	192 (3.3)
Missing	45 (0.8)

[a]Percentages may not total 100 because of rounding.
[b]For example, emergency medicine, neurology, dermatology.
[c]For example, radiology, pathology.

P=.011 vs both applications consistent). These findings persisted when specialty was included in the model (data not shown).

DISCUSSION

In this national study of nearly all (94.1%) medical licensure board applications, only one-third of states (16 of 48 [33.3%]) had questions on their initial and renewal application forms that were congruent with the American Medical Association,[25] American Psychiatric Association,[21] and Federation of State Medical Boards[18] polices and recommendations or in clear compliance with the Americans with Disabilities Act of 1990.[19,20] Nearly 40% of physicians reported they would be reluctant to seek formal medical care for treatment of a mental health condition because of concerns about repercussions to their medical licensure, and physicians working in a state in which neither the initial nor the renewal application was consistent were more likely to be reluctant to seek help.

Large population studies have found attitudes toward mental health help-seeking are associated with actual mental health care service use.[28,29] If, as observed in large previous national studies,[4] 6% of the more than 800,000 US physicians have experienced suicidal thoughts in the past 12 months and 40% of those with such suicidal ideation do not seek care because of concerns that it may have repercussions for their medical licensure, this would imply that licensure concerns may be a factor in 20,000 US physicians not receiving the professional help they need for mental health concerns.

Because the lack of seeking professional help is thought to contribute to the elevated risk of suicide among physicians in comparison to the general US population,[1] barriers to help-seeking should be removed when identified. In this regard, it is notable that physicians who worked in states with medical licensure questions consistent with national recommendations[18,19,21,25] were less likely to report that they would be reluctant to seek formal medical care for treatment of a mental health conditions because of concerns about repercussions to their medical licensure than physicians who worked in states not classified as consistent. This relationship between the way state medical licensure boards inquired about mental health conditions was independently related to whether the physicians in that state reported a reluctance to seek mental health care after adjusting for sex, age, relationship status, practice settings, and specialty. Physicians working in states in which neither the initial nor the renewal application was consistent had a 21% increase in the odds of reluctance to seek help for a mental health concern. Even physicians working in states/territories in which only the initial licensure application was not consistent had a 22% increase in the odds of reluctance to seek help for a mental health concern independent of age. This observation suggests that the questions on the initial licensure application may leave a lasting impression on physicians.

The finding that male and younger physicians were more reluctant to seek help is

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consistent with findings from studies of the general US population reporting that younger individuals and men are disproportionately deterred by stigma about mental illness, which is associated with reduced help-seeking.[28] The observation that physicians in private practice had 25% to 50% greater odds of being reluctant to seek help for a mental health concern on multi-variate analysis warrants further study but may be due to greater concern over public disclosure resulting in current or future patients judging them negatively[28] and choosing to go elsewhere for care.

Our study has several limitations. First, some medical licensure applications may have asked different questions about mental health in 2014 (the year the cohort of physicians were surveyed) than at the time we collected licensure questions in 2016. Second, although analysis of early responders vs later responders (a standard approach to response bias) suggests that the sample was representative with respect to age, sex, and specialty, it is possible that the sample may not be representative with respect to attitudes about seeking care for mental health conditions. The rate of reluctance to seek formal medical care because of concerns about repercussions to medical licensure in our study, however, was similar to what has been previously reported in the literature.[4,30]

Our study has several important strengths. First, we were able to obtain the initial and renewal licensure application forms from all but 3 states. Second, the designation of medical licensure application question category (both consistent, initial consistent, renewal consistent, or neither consistent) was determined independent of the data on physicians' self-reported attitudes about whether concerns for licensure impacted whether they would seek help for mental health conditions. Third, 2 investigators independently coded each medical licensure application question pertaining to mental health using an evidence-based approach.[18,19,21,25]

The results of this study suggest that the way in which medical licensure questions regarding mental health conditions are asked may impact whether physicians are reluctant to seek help for a mental health condition. Physicians working in states in which medical licensure application questions inquire broadly about current or past diagnosis or treatment of a mental health condition, past impairment from a mental health condition, or presence of a mental health condition that *could* affect competency were 21% to 22% more likely to be reluctant to seek help. In contrast, physicians who worked in states in which questions on medical licensure applications asked only about current impairment from a mental health condition or included no question pertaining to mental health were less likely to endorse such reluctance and thus may be more likely to seek and receive care if the need arose.[28,29] These findings support continued efforts to develop regulations and policies that encourage physicians to seek help, as suggested by others.[1,19] They also support universal use of consistent licensure questions across the US states. In this regard, the American Psychiatric Association has already developed and recommended the following language for state licensing boards to use on licensure applications: "Are you

TABLE 2. Multivariate Analysis of Factors Associated With Reluctance to Seek Formal Medical Care Because of Concerns About Repercussions to Medical Licensure[a,b]

Independent variable	OR (95% CI)[c]	*P* value	Overall *P* value
Age (for each 1 year older)	0.97 (0.97-0.98)	<.001	<.001
Female (reference, male)	0.74 (0.66-0.84)	<.001	<.001
Relationship status (reference, married)			.22
Partnered	0.98 (0.74-1.29)	0.88	
Single	1.17 (0.98-1.39)	0.08	
Widowed	0.77 (0.47-1.27)	0.3	
Practice location (reference, private practice)			<.001
Academic medical center	0.74 (0.64-0.84)	<.001	
Veterans hospital	0.51 (0.31-0.81)	.005	
Other practice setting	0.82 (0.71-0.95)	.007	
Medical licensure application questions (reference, both applications consistent)			.007
Neither application consistent	1.21 (1.07-1.37)	.002	
Renewal application consistent	1.22 (1.05-1.43)	.011	
Initial application consistent	1.29 (0.96-1.74)	.09	

[a]OR = odds ratio.

[b]Factors in the multivariate analysis included sex, age, relationship status, practice setting, state medical licensure application questions category (both optimal [reference], initial consistent, renewal consistent, neither consistent). Physicians considered reluctant to seek help if they answered "yes" to the question, "If you were to need medical help for treatment of depression, alcohol/substance use, or other mental health problem, would concerns about the repercussions on your medical license make you reluctant to seek formal medical care?"

[c]OR >1 indicates greater reluctance to seek care for mental health condition because of its potential effect on physicians' license to practice; OR <1 indicates less reluctance.

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)."[21] Such a question encourages physicians to consider any physical or mental health issue that could impair their performance and helps to destigmatize mental illness. In addition, it also enables state medical boards and their members to protect the public while being consistent with the Americans with Disabilities Act of 1990. Although there are concerns that the very nature of some illnesses could impede physicians' abilities to recognize their own limitations, a history of a medical or psychiatric disorder has little predictive value for present impairment of functioning, and there is no evidence that the risk to patients is sufficiently great to require disclosure of private medical records for public scrutiny.[10,21]

CONCLUSION

Changing medical licensure application questions, as well as similar items asked by hospitals and group practices in the credentialing process, so that they inquire about *current* functional impairment appears to be a simple but potentially meaningful step to reduce barriers to physicians seeking help for mental health conditions. Such a change, although potentially cumbersome because state medical boards may need to work with their legislators for changes to the state medical practice acts, could be implemented at minimal cost.

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January 21, 2021

Stuart Williams, JD
Chairman
Minnesota Board of Medical Practice Policy & Planning Committee
2829 University Avenue Se, Suite 500
Minneapolis, MN 55414-3246

Re: Support of Revising Initial and Renewal Licensure Application Language

Dear Mr. Williams,

We are pleased to provide this letter of support on behalf of MMIC | Constellation® for efforts to revise Minnesota's physician licensure application question inquiring on an applicant's past health conditions. Constellation and its growing portfolio of medical professional liability (MPL) insurance partners, which includes MMIC, is deeply appreciative of your attention to this important issue.

The Minnesota Board of Medical Practice continues to inquire about an applicant's past mental health in their initial and renewal licensure applications. This language requires an applicant to disclose whether they have been informed or diagnosed by their physician, within the past five years, of a physical, mental, or emotional condition which impairs their ability to practice medicine.[1] This language is a known deterrent to physicians, and physicians in training, who are seeking treatment.[2] In a study conducted by Mayo, 40% of physicians stated that they would be reluctant to seek formal medical care for treatment of a mental health condition because of concerns about repercussions to their licensure.

The Federation of State Medical Boards and the National Academy of Sciences, Engineering, and Medicine have acknowledged that the language used by most state licensing boards inadvertently discriminates against physicians with mental illness and is not in compliance with the ADA.[3] Both recommend that state medical boards utilize language asking for an applicant to only disclose a known current condition which impairs their ability to practice. State licensing boards have begun to follow the lead of the Federation of State Medical Boards, with 11 states revising their application language to only ask about an applicant's current health conditions.[4]

[1] Minnesota Board of Medical Practice Physician Application, *available at:* https://mn.gov/boards/assets/MNBMP%20PYAppPacketSep2019_tcm21-36587.pdf
[2] Medical Licensure Questions and Physician Reluctance to Seek Care for Mental Health Conditions, *available at:* https://www.mayoclinicproceedings.org/article/S0025-6196(17)30522-0/fulltext
[3] Physician Wellness and Burnout, *available at:* https://www.fsmb.org/siteassets/advocacy/policies/policy-on-wellness-and-burnout.pdf; To Ensure High-Quality Patient Care, the Health Care System Must Address Clinician Burnout Tied to Work and Learning Environments, Administrative Requirements, *available at:* https://www.nationalacademies.org/news/2019/10/to-ensure-high-quality-patient-care-the-health-care-system-must-address-clinician-burnout-tied-to-work-and-learning-environments-administrative-requirements
[4] Medical Licensure Questions and Physician Reluctance to Seek Care for Mental Health Conditions.

MMIC | Constellation supports the effort to revise the physician licensure application to "do you currently have 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)" and are in the process, ourselves, of changing this language on our MPL insurance applications.

By supporting these efforts, the Policy & Planning Committee will be supporting the ability of physicians and physicians in training to seek treatment when needed, something that will ultimately benefit us all.

Sincerely,

Laurie C. Drill-Mellum, MD

William J. McDonough

Laurie C. Drill-Mellum, MD, MPH
Chief Medical Officer, Constellation

William J. McDonough
CEO, Constellation

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The mission of the Twin Cities Medical Society is to connect, represent, and engage physicians in improving the practice of medicine, policy development and public health initiatives.

January 21, 2021

Stuart Williams, JD
Chairman
Minnesota Board of Medical Practice Policy & Planning Committee
2829 University Avenue Se, Suite 500
Minneapolis, MN 55414-3246

Re: Support of Revising Initial and Renewal Licensure Application Language

Dear Mr. Williams,

I am pleased to provide this letter of support on behalf of Twin Cities Medical Society for efforts to revise Minnesota's physician licensure application question inquiring on an applicant's past health conditions. Twin Cities Medical Society is deeply appreciative of your attention to this important issue.

The Minnesota Board of Medical Practice continues to inquire about an applicant's past mental health in their initial and renewal licensure applications. This language requires an applicant to disclose whether they have been informed or diagnosed by their physician, within the past five years, of a physical, mental, or emotional condition which impairs their ability to practice medicine.[1] This language is a deterrent to physicians and physicians in training seeking treatment.[2] In a study conducted by Mayo, 40% of physicians stated that they would be reluctant to seek formal medical care for treatment of a mental health condition because of concerns about repercussions to their licensure.

The Federation of State Medical Boards and the National Academy of Sciences, Engineering, and Medicine have acknowledged that the language used by most state licensing boards inadvertently discriminates against physicians with mental illness and is not in compliance with the ADA.[3] Both recommend that state medical boards utilize language asking only for an applicant to disclose a

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known current condition which impairs their ability to practice. State licensing boards have begun to follow the lead of the Federation of State Medical Boards, with 11 states revising their application language to ask only about an applicant's current health conditions.[4]

Twin Cities Medical Society supports the effort to revise Minnesota's physician licensure application health conditions question language to "do you currently have 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)." By supporting these efforts, the Policy & Planning Committee will be supporting the ability of physicians and physicians in training to seek treatment when needed.

Sincerely,

Sarah Traxler, MD
President

[4] Medical Licensure Questions and Physician Reluctance to Seek Care for Mental Health Conditions.

Physicians Serving Physicians

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January 21, 2021

Stuart Williams, JD
Chairman
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2829 University Avenue Se, Suite 500
Minneapolis, MN 55414-3246

Re: Support of Revising Initial and Renewal Licensure Application Language

Dear Mr. Williams,

I am pleased to provide this letter of support on behalf of Physicians Serving Physicians for efforts to revise Minnesota's physician licensure application question inquiring on an applicant's past health conditions. Physicians Serving Physicians is deeply appreciative of your attention to this important issue.

The Minnesota Board of Medical Practice continues to inquire about an applicant's past mental health in their initial and renewal licensure applications. This language requires an applicant to disclose whether they have been informed or diagnosed by their physician, within the past five years, of a physical, mental, or emotional condition which impairs their ability to practice medicine.[1] This language is a deterrent to physicians and physicians in training seeking treatment.[2] In a study conducted by Mayo, 40% of physicians stated that they would be reluctant to seek formal medical care for treatment of a mental health condition because of concerns about repercussions to their licensure.

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[4] Medical Licensure Questions and Physician Reluctance to Seek Care for Mental Health Conditions.

Physicians Serving Physicians supports the effort to revise Minnesota's physician licensure application health conditions question language to "do you currently have 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)." By supporting these efforts, the Policy & Planning Committee will be supporting the ability of physicians and physicians in training to seek treatment when needed.

Sincerely,

Michael B Koopmeiners M.D.

Michael B. Koopmeiners, MD
Medical Director