Perspective

Addressing Mental Health Needs among Physicians

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Physician burnout is a national phenomenon with far-reaching implications for health systems, patients, patient care, and clinicians.[1–5] Burnout is related to clinically significant depression[6] and anxiety[7]; doctors have overall prevalence rates of depression that are similar to the general population,[8] and in medical students and residents the rates are even higher.[9,10] The suicide incidence rate for physicians is higher than that in the general population.[8] Furthermore, even if timely and effective services were readily available, there are unique challenges and barriers to accessing and maintaining such care.[11] Ensuring that doctors receive timely and adequate mental health care is an important conduit to high-quality patient care because the well-being of the physician workforce is linked with medication errors, patient satisfaction, and the quality of communication during encounters.[12–15]

One common mechanism for providing this assistance and monitoring the health and well-being of doctors is physician health programs (PHPs). These state-run entities exhibit a wide range of policies, procedures, and practices. Some PHPs offer preventive services and coaching to help at-risk physicians to avoid potential effects on patient care and their careers, whereas others exist solely for the purpose of monitoring and ensuring compliance with board-sanctioned requirements. Little is known about the effectiveness of various models for sustaining a healthy workforce. The alarming rates of suicide among physicians and the dramatic increase in rates of professional burnout suggest, however, there may be a systemic problem with healthcare professionals' accessing timely and appropriate mental health treatment. There likely are several factors related to the way that these programs offer services that either facilitate or discourage doctors from seeking support.

Publicly available, informal data from existing PHPs across the United States were collected via Web site and telephone (47 of 50 states have PHPs, with California, Nebraska, and Georgia being exceptions). Data included services offered, cost of services to participants (including monitoring for the state medical board), and any unique aspects of the PHP. In addition, available state medical board licensing applications were reviewed for verbiage regarding mental health treatment or diagnosis (ie, the degree to which physicians are required to report seeking services from PHPs and elsewhere). From these data, several innovative approaches and restrictive approaches were evident.

Innovative Approaches

Safe Havens

One of the most innovative PHP approaches includes safe havens. This means that if a participant is enrolled in the PHP (sometimes referred to as being "known" to the PHP), they may legally answer "no" to questions on the medical board's applications inquiring about current or past mental health/substance abuse concerns/treatment. Furthermore, in this model, the event that triggers a report to the medical board is nonadherence to treatment, not merely accessing treatment. Colorado, North Carolina, Iowa, Minnesota, and Louisiana all are safe haven states.

Easy Access to Services

Several states provide services directly to clinicians themselves. Although this may be difficult to accomplish from financial and practical standpoints, it is beneficial for clinicians to be able to receive voluntary, low-cost psychotherapy/pharmacotherapy services in a manner that does not threaten their professional well-being. In addition, several states, including New Jersey, Colorado, and Idaho, have begun to offer these services to clinicians' family members.

Improved Licensing Questions

Although not a direct PHP intervention, there may be an important role for PHPs in advocacy. Specifically, North Carolina PHP has worked with the state medical board to bring a novel approach to the licensure process. Applicants now sign a statement acknowledging their responsibility to care for their own mental and physical health and any threats to patient safety. Absent are any questions about whether the physician has received or is receiving mental health treatment.

Furthermore, applicants are not asked to make a judgment about whether a condition is reportable. As such, seeking help for psychiatric reasons is implicitly encouraged and kept truly hidden from the medical board, unless functional impairment becomes evident through the workplace.

Restrictive Approaches

Access to Information

The access to information about the relation between PHPs and licensing boards and about each state's specific questions regarding mental health treatment is not always transparent. There were a number of state PHPs for which information about

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cost, referral procedures, and treatment process was not easy to ascertain. In fact, the authors encountered confusing Web sites, lack of access to required forms, unreturned telephone calls, and, in two cases, direct refusal to provide information. Although there may be an understandable initial resistance to providing cost information, this can serve as a deterrent for doctors who are considering treatment. Furthermore, many PHPs consider all of the conditions within a substance abuse treatment model (eg, urine drug screening, check-ins to monitor compliance). For several states, information about the process for physicians in mild distress but not needing the full spectrum of services was difficult to find.

Financial Concerns

The substantial financial burden associated with assessment and treatment for participants in some PHPs is another significant barrier. At least three of the PHP programs reported an annual cost of $1200 for basic program participation, excluding any treatment or other resources. Although doctors likely have health insurance, the PHP-recommended treatment often is not covered. In addition, costly private treatment programs designed specifically for physicians are not practically accessible for residents with comparatively low incomes. In fact, costs associated with PHP registration and treatment may range up to 30% of the average resident salary. In addition, the standard expectation of 5-year PHP monitoring, according to the Federation of State PHP guidelines,[16] presents a significant commitment, regardless of need for continued treatment.

Licensing Questions

A substantial number of states' licensing applications still use language that may penalize doctors for seeking help for mental health concerns, even when those conditions are not causing impairment in work functioning. For instance, some applications require applicants to disclose "any" anxiety diagnosis or treatment, rather than the presence of a condition that impairs their ability to work (eg, frequent panic attacks at work). As such, an applicant may accurately conclude that seeking care for a mild anxiety disorder would penalize him or her by having to report that treatment to the board, and potentially undergo PHP enrollment for a benign condition. As many as 40% of surveyed doctors report reluctance to seek formal care for a mental health condition as the result of licensing concerns,[12] which presents a substantial barrier to treatment. Of note, these questions also are likely out of compliance with the Americans with Disabilities Act.[17] A review found that just 53% of states ask questions limited to functional impairment, and only 14% of state applications limited their inquiries to current problems.[18]

Recommendations

Although there are challenges inherent in supporting the mental health of our medical workforce, there is room for improvement. First, we advocate for increased ease of access to information regarding the PHP process across states for potential participants. The lack of information about the potential cost, process, and barriers may serve as its own barrier to participation for those in need of potential support. PHPs should cease obscuring this information and work to make the information readily accessible to all.

Second, with respect to mental health conditions, the only question relevant to physician licensing boards is whether the symptoms of the condition affect job performance, broadly defined to include both patient care and professionalism. Requiring a higher standard of scrutiny and monitoring for mental health conditions compared with physical health conditions perpetuates fear and stigma, maintaining a culture of secrecy and unwillingness to seek help. Although many states have transitioned to a uniform license application, most still have a supplemental form for questions about mental health and substance use history. As such, including these items on the standardized license application so that all states ask the questions in a uniform manner and asking only about present conditions that affect job performance are recommended. In fact, in June 2018 the Federation of State Medical Boards and the American Medical Association House of Delegates[19] recommended the following wording, "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)."

The field of medicine is experiencing a burnout epidemic. There is increasing recognition of the importance of caring for the well-being of our doctors. Although any attempt to address this problem should be a multipronged approach, improvement of the care provided by PHPs represents a critical step toward facilitating the health and wellness of the physician workforce.

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