Commentary

**Impaired Physicians and the New Politics of Accountability**

Daniel M. Fox, PhD

Abstract

Several recent articles, including the one by Schroeder and colleagues in this issue, document violations of the Americans with Disabilities Act (ADA) by state medical boards that ask applicants for initial licensure and relicensure whether they have any history of mental illness. The authors of these articles argue that the boards’ violation of the ADA is a disincentive for applicants to seek treatment, especially for depression. This commentary discusses the behavior of the boards, and efforts to address it, in the larger context of what organizations that educate, examine, license, certify, credential, and represent physicians are doing to improve the accountability of members of the profession and, as a result, the quality of their services.


S everal recent articles about questions asked by state medical boards on applications for licensure contribute to a broader story about the new politics of physicians’ accountability. Many of these articles,1,2 including the one by Schroeder and colleagues3 in this issue, have argued that some state licensing boards discriminate against physicians who have sought treatment for mental illness. These boards discriminate by requiring applicants to report any history of mental illness rather than only current impairment, as required by the Americans with Disabilities Act (ADA) and a growing body of case law. According to the articles, such questions are incentives for physicians to avoid screening and treatment for depression and other mental disorders in order to protect themselves against investigation and, perhaps, sanctions.

State medical boards make policy for licensing and disciplining physicians in the context of the history and current politics of physician accountability. Boards’ policies are informed by their members’ assumptions about public expectations for the safety and quality of medical services, by the values and attitudes of physicians and especially leaders of the profession, and by the accountability policies of organizations that educate, examine, certify, credential, and represent physicians.

For most of their history, state licensing boards assumed that government, on behalf of the public, had delegated responsibility for holding physicians accountable to the medical profession. The boards have been led and almost always dominated by physicians, though the influence of nonphysician members (now 25% of the total) and of their professional staff has grown in recent decades. One state (Alabama) long ago delegated responsibility for its board to the state medical society. A potent symbol of this delegation has been that all but a few boards have been financed mainly by fees paid by physicians rather than from states’ general revenue.

As a result of this history, licensing boards’ policies toward physicians who report that they have been treated for mental illness have been grounded in values, attitudes, and behaviors that are shared by most, though never all, members of the profession. The discomfort of many physicians with patients who present with symptoms of mental illness has been amply documented. So has frequent inattention to such symptoms among their patients, students, and colleagues. A 2003 consensus statement on depression and suicide among physicians concluded that the “culture of medicine accords low priority to physician mental health.”4 An expert panel convened in 2005 deplored the inadequate “mental health care that physicians receive, beginning in medical school and residency.”5 A review article in 2008 summarized evidence that "physicians are notoriously reluctant to seek treatment for any personal illness” but especially for mental illness. Many physicians who have sought treatment for mental distress, the author continued, “experienced a range of negative consequences” from “licensing boards, potential employers, hospitals, and other credentialing agencies.”6

Until quite recently, state licensing boards shared responsibility for regulating the quality and safety of physicians’ practice mainly with hospital medical staff organizations. Medical schools and training programs attested only that graduates had met their requirements. Specialty boards certified a physician as competent once in his or her career.

Government and private-sector purchasers of care reinforced the role of state boards and hospital staff in assessing and ensuring accountability. These purchasers of care and the insurance plans that acted as their agents or intermediaries invariably accepted the self-regulatory decisions of these bodies.

Every reader of this commentary knows, in some cases painfully, that policy for physician accountability has evolved. More organizations than ever before are assessing physicians’ performance. Self-regulation has been replaced, usually by what some experts call “physician-led regulation.” But the new accountability also includes measurement and assessment of physicians’ services by persons trained in statistics and other disciplines of health services research.
Contrary to the critical tone of the recent articles about questions on licensing applications, state medical boards have been at the forefront of policy making for the new accountability. In 1999, responding to a 1993 report by the inspector general of the federal Department of Health and Human Services, the Federation of State Medical Boards (FSMB) asserted that the boards “are ultimately accountable for the quality of care rendered within their jurisdictions and for the competence of those providing such care.” Physicians seeking initial licensure must now demonstrate clinical competence on a national examination. The Journal of Medical Licensure and Discipline, published by FSMB, regularly publishes articles about how boards can contribute to improving the quality and safety of practice. FSMB has led in convening a series of summits on accountability since 2005 that have been attended by leaders of the major national associations of the profession. In collaboration with its Canadian counterpart, FSMB published a report in 2008 describing innovations in how licensing bodies are working to improve the quality of practice.

Mandatory recertification of specialists will profoundly influence the work of licensing boards. All 24 member boards of the American Board of Medical Specialties agreed in 2002 on standards that, by 2010, will make their certificates time-limited and will require performance assessment. As a result, certification “will provide the public with real time information about whether a physician is keeping up with the standards set by his or her specialty.” When fully implemented, this innovation will provide this information about at least 70% of the nation’s physicians.

New policy for accountability, therefore, creates opportunities to address impairment and potential impairment among physicians more effectively than ever before. The effects of this policy on professional attitudes toward mental illness and its symptoms will, however, be gradual. Moreover, these effects will be distributed unevenly among the settings in which physicians train and practice.

Both compassion for colleagues and the public interest in safety and quality justify concerted action to accelerate changes in recognizing and treating mental illness among physicians. For example, licensing boards and leaders of organizations within the profession could consider adapting aspects of the policy and practice of the U.S. Air Force for destigmatizing mental illness. Responding in 1996 to an alarming increase in suicide rates, Air Force leadership mandated that suicide prevention had to become a community-wide Air Force responsibility and make the care of patients safer and more effective. Compliance by state licensing boards with the ADA is more effective. Compliance by state boards is associated with a community approach in which physicians train and practice.

Physicians and pilots share several professional characteristics. Members of both professions take pride in being competitively chosen and arduously trained. They develop strong loyalties to their colleagues. The cultures of both professions have traditionally equated revealing symptoms of illness, especially mental illness, with weakness. This equation has been reinforced by fear of losing the privilege of conducting each profession’s most prestigious and highly rewarded activities.

An obvious difference between the two professions is that medicine does not have a hierarchical command structure. The chief of staff of the Air Force and its surgeon general ordered the suicide prevention policy into effect. Nevertheless, Air Force leaders emphasized “marketing community awareness,” starting with commanders, because they were convinced that “decreasing suicides meant implementing a community approach in which prevention and assistance were a focus long before someone became suicidal.”

Although similar action within the medical community cannot be mandated by a single individual, the Air Force’s community approach could be adapted by the medical profession. Doing so could reduce suffering, improve the productivity of physicians, and make care of patients safer and more effective. Compliance by state licensing boards with the ADA is more likely to prevent discrimination against physicians who suffer or are at risk of mental illness and to protect the public from harm if such compliance is nested in the new accountability policy and accompanied by concerted corrective action within the profession.

References
Correction

The journal apologizes for publishing incorrect information about Dr. Prathibha Varkey, MBBS, MPH, MHPE, one of the authors of an article in the March 2009 issue. Below is the correct information:

Dr Varkey is associate professor of medicine, of preventive medicine, and of medical education, and associate chair for faculty development and staff satisfaction, Department of Medicine, Mayo Clinic, Rochester, Minnesota.

Reference