

# Physician, Heal Thy Double Stigma — Doctors with Mental Illness and Structural Barriers to Disclosure

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Despite calls for greater awareness of high rates of depression and suicide among physicians, estimates suggest that only about 1% of medical students with major depressive disorder disclose it as a disability.<sup>1</sup> Throughout the medical school admissions process, training, and licensure activities, students and physicians with histories of mental illness face structural barriers that result in discrimination and discourage disclosure and care seeking. These barriers stem from an explicit and internalized double stigma: against people with disabilities and, among those with disabilities, in particular against people with mental disabilities, including psychiatric, psychological, learning, and developmental disorders that impair functioning.

Many obstacles faced by students and physicians with mental disabilities represent violations of the Americans with Disabilities Act (ADA). Because of their personal experiences, physicians with mental disabilities can make important contributions to health care. Yet barriers to disclosure help to perpetuate high rates of depression and suicide in medicine and inhibit both entry into the medical field and long-term retention. Patients with silently sick or impaired physicians may be at risk for receiving substandard care. Practices are being implemented to reduce barriers to disclosure, but much work remains to be done.

By focusing on the needs of

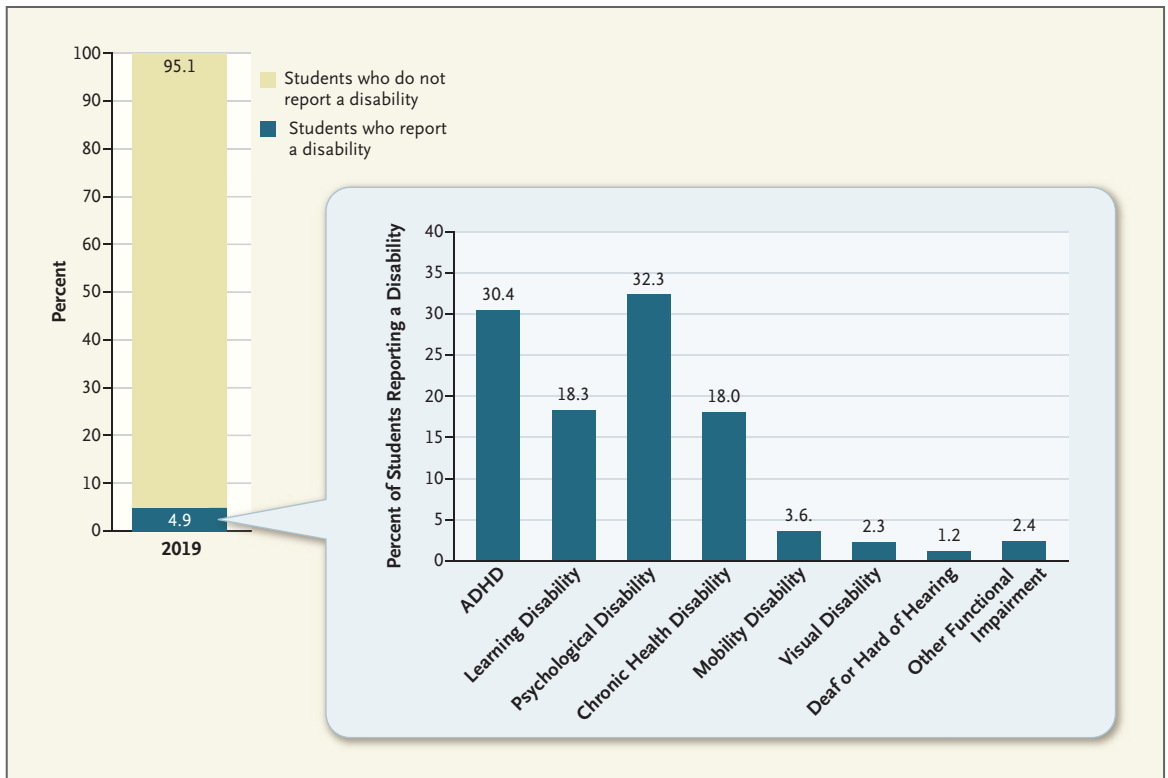
underrepresented groups, medical schools that make commitments to diversity and social justice do laudable work. Yet the disabled, and especially people with mental disabilities, often aren't featured in messaging to applicants.<sup>2</sup> When admissions offices don't provide clear, inclusive, and welcoming messaging regarding disability policies and confidentiality practices, applicants may be concerned that inquiring about disability services will penalize them in the admissions process and during training,<sup>2</sup> and prospective students with mental disabilities may be less likely to apply. Explicit messaging permits the delivery of accurate information about an applicant's chances of being admitted and successfully completing training.

Barriers during medical school are often related to confidentiality. Of medical students with disabilities, more than two thirds have psychological or learning disabilities, including attention deficit-hyperactivity disorder (see graph), which are often not apparent.<sup>3</sup> Psychological and learning disabilities probably affect functioning in different ways, and attention to the diversity of mental disabilities is crucial for ensuring personalized accommodations. Although inconspicuous, mental disabilities tend to be stigmatized more often than physical disabilities, and the decision to disclose a mental disability is therefore more dependent on the perceived confidentiality of the

disclosure process. Consequently, students often forgo help for mental disabilities, rather than risk having their confidentiality compromised.<sup>2</sup>

Perceptions about confidentiality are threatened when medical schools don't have a specific, trained disability service provider (DSP), instead leaving responsibility for coordinating disability services to a faculty member or dean, for example.<sup>2</sup> Having administrators play two distinct and potentially conflicting roles can undermine students' trust and their belief that a neutral mediator exists between students with disabilities and faculty members responsible for assigning grades. When DSPs serve an entire university, they may not understand the specific needs of medical trainees and may have difficulty customizing appropriate, timely, and confidential accommodations for mental disabilities.

When medical schools respond to acute exacerbations of mental disabilities such as major depressive disorder, too often discussions turn to the possibility of taking a medical leave. Although schools tend to be risk-averse, prioritizing this option probably makes students less likely to disclose their condition. In the minds of students accustomed to the march of professional advancement, medical leaves are easily conflated with irreversible failure, and these leaves can necessitate future disclosures on residency or job applications. Moreover, leaves



**Medical Students Reporting Various Disabilities, 2019.**

Adapted from Meeks et al.<sup>3</sup> Percentages do not sum to 100 because some schools reported more than one disability among students. ADHD denotes attention deficit–hyperactivity disorder.

aren't always necessary; levels of mental functioning exist on a spectrum, and appropriate and reasonable accommodations can often improve functioning and allow students to remain enrolled.<sup>2</sup>

Attitudes toward disclosure of mental disabilities are frequently pessimistic and stigmatizing. Medical schools and hospitals can be cultures of stoic struggle, silent competition, and vaunted productivity; seeking psychological services is often seen as a sign of weakness.<sup>2</sup> For example, academic medicine has yet to normalize requests for time away from school or work for regular psychiatric appointments.

Moving from training to full licensure brings new barriers to the disclosure of mental disabili-

ties. Because of fears about jeopardizing licensure, many physicians don't disclose disabilities or seek care for them.<sup>4</sup>

Licensing questions related to current or past diagnoses or treatment for mental disabilities that don't affect physicians' current functional abilities are irrelevant to their professional competence and therefore illegal under U.S. disability-rights laws.<sup>5</sup> A 2016 national analysis of medical licensing applications revealed that two thirds of states have application questions that violate the ADA in this manner.<sup>4</sup> Physicians in these states were more likely than physicians in states with ADA-compliant licensing procedures to be reluctant to seek formal medical care for a mental disability be-

cause of fears about repercussions.<sup>4</sup> Physicians with mental disabilities who do seek care and disclose treatment during the licensure process risk having to undergo an unmerited license investigation, in which substantial time, energy, and money for legal representation and clinical consultations are often required to demonstrate the ability to practice medicine in a safe and competent manner.

We believe that medical schools and licensing boards should take steps to bring trainees and physicians with mental disabilities into underused care networks. Our recommendations are in keeping with guidelines from the Association of American Medical Colleges,<sup>2</sup> and many of them could

be enforced during the school-accreditation process.

First, we believe that admissions offices should be facilitators of inclusion. Schools could increase the number of applications they receive from people with mental disabilities by making it clear in their materials that applicants with disabilities are specifically welcome as part of a larger commitment to diversity and social justice that includes ensuring that the student body better reflects the general population. Norms of disability inclusion should be advertised by incorporating disability-services contact information in all admissions materials.

***Amid an acute exacerbation of mental disability, administrators should first seek reasonable accommodations to help stabilize functioning, not automatically offer or require a medical leave.***

We recommend that schools make clear that people with mental disabilities can successfully be admitted and complete training and that they can receive accommodations that neither weaken professional standards nor penalize students for participating in a confidential disclosure process. Universities should hire medical school-specific DSPs who are trained in disability law, understand the curricular needs of trainees, and are committed to parity in the handling of physical and mental disabilities. As a trusted conduit between students and faculty members, DSPs should ensure students' privacy and the appropriateness of accommodations.

Schools should prevent conflicts of interest arising from having faculty members or administrators with evaluative roles double as DSPs.

Schools and hospitals should publicize their policies related to mental disabilities so that students and trainees know what to expect if they disclose a disability. Amid an acute exacerbation of a person's mental disability, administrators should first seek reasonable accommodations to help stabilize functioning, not automatically offer or require a medical leave.

Schools should promote cultures of wellness, interdependence, shared vulnerability, and

cooperation. They should encourage students with mental disabilities to see their symptoms as worthy of disclosure and accommodation and normalize care seeking and taking time for mental health appointments. Faculty members and administrators could publicly describe their own protected time for therapy. Schools could highlight examples of people with mental disabilities who confidentially disclosed their condition, found appropriate accommodations, and had professional success.

It's also important to confront stigma and enforce ADA compliance. All state licensing boards should ensure that medical licens-

ing questions are legal and address only current functional impairments that affect a physician's ability to practice medicine safely and competently. The Federation of State Medical Boards (FSMB) has recommended, but not yet enforced, this policy. We encourage the FSMB to enforce this legal standard throughout the states; students, faculty members, and administrators to advocate for such a change; and licensing applicants to take legal action if they experience discrimination. We also encourage the U.S. Department of Justice to issue guidance to ensure uniform and ADA-compliant licensing questions.

Efforts to reduce rates of depression and suicide among physicians should move beyond raising awareness of this problem and implementing stress-reduction trainings. We must actively dismantle the stigma that affects medical students and physicians with mental disabilities. From admissions to clinical training to licensure and practice, we should confront the structural sources of stigma that reduce the likelihood of disclosure of mental disabilities, the provision of legally mandated accommodations, and access to care.

Disclosure forms provided by the authors are available at [NEJM.org](https://www.nejm.org).

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