Questioning physicians about health conditions at medical licensure registration: How should policy evolve in Canada?

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Physicians report higher rates of depression, anxiety, burnout and suicidal ideation than the general population, yet are less likely to seek treatment.[1,2] Moreover, increasing numbers of medical learners report having chronic health and mental health conditions, attention-deficit/hyperactivity disorder and learning, sensory or mobility disabilities, and many face barriers to disclosure and support.[3–5] Physicians with medical conditions have been shown to forgo treatment or disclosure to avoid stigma or consequences for their medical licence.[6–9] Licensure for physicians with medical conditions must therefore strike a balance; regulators must protect the public by ensuring that physicians do not practise while impaired, yet must simultaneously encourage treatment-seeking by protecting physicians' privacy and avoiding undue scrutiny.[10,11] To strike this balance, Canadian and American regulatory bodies have published guidance for physician licensing questions and procedures to encourage self-disclosure and early intervention, as summarized in Box 1.[10–16] This guidance is largely based on consensus and was prompted by longstanding institutional concerns regarding low rates of treatment-seeking by physicians.[10] Most commonly, this guidance suggests that licensure applications focus on current impairment, rather than the mere presence of illness, past or present. A 2017 cross-sectional study of more than 5829 physicians in the United States found those physicians in jurisdictions that inquired about past impairment or illness on licensure applications were less likely to disclose and seek treatment.[7] Given this evidence and recent prioritization of physician health by Canadian policy-makers, we sought to explore variations in existing regulatory questions about medical conditions across Canadian jurisdictions, and to consider the possible downstream consequences of these variations for Canadian physicians.

Key points

- Physicians have higher rates of depression, anxiety, burnout and suicidal ideation than the general population, but are less likely to seek treatment.
- Questions on medical licensure applications may pose barriers to disclosure and help-seeking for physicians with medical conditions and can lead to negative impacts on both physician health and patient care.
- Recent Canadian and international guidance states that questions on licensure applications should focus on current functional impairment rather than the presence of diagnosis or past impairment.
- Most Canadian jurisdictions do not follow the current guidance.

What is the role of Canada's regulatory bodies in ensuring patient safety and physician well-being?

Physicians hold a legal, ethical and professional duty to safeguard patient care, which includes recognizing circumstances in which they may be unable to provide safe care.[10] Medical regulatory authorities in Canada are the provincial and territorial bodies that grant and monitor medical licences.[17] They are responsible for protecting the public and ensuring that physicians do not pose risks to patient care by working while impaired by an illness that hinders their medical judgment, competence or safety.[10,18,19] Medical regulatory authorities owe a duty to the public to assess physicians' safety to practise, to uphold public trust in the medical profession.[10] Conditions that may cause professional impairment include substance use disorders, visual impairments (e.g., cataracts) and movement disorders (e.g., tremor), which may lead to physician errors in prescribing and in interpreting diagnostic imaging or pathology, or to suboptimal interactions with patients.[10,20] However, the presence of illness does not equal impairment; a physician may be ill while continuing to function at work.[12,19,21] Medical regulatory authorities are therefore tasked with identifying, first, circumstances in which physicians will be required to disclose illness on their licence application or renewal and, second, circumstances in which an illness will require monitoring to maintain licensure.[10] In this sense, medical regulatory authorities must balance the duty to protect patients with physicians' right to privacy, with the ultimate goal of creating a nonstigmatizing environment in which physicians are encouraged to seek treatment for illness before it becomes impairing.

Box 1: Canadian and international guidance for identifying and supporting physicians with impairments in the licensure process*

Licensure applications

- Licensure applications should focus on current impairment, not mere presence of illness or treatment-seeking[10,12–16]
- Applications should not ask about past impairment[13,16]
- Applications should not distinguish between mental and physical health, or should ask about mental and physical health in the same way[10,13,16]
- Applications should define "negative impact" on work, clarifying that this involves potential harm to patients[10]
- Applications should use supportive and inclusive language that normalizes help-seeking[13]
- Licensure questions should be identical on both initial and renewal applications, with the exception that renewal questions be limited to information not previously collected[10]

Policies and procedures

- Regulatory authorities should provide safe-haven nonreporting, allowing physicians to forgo reporting diagnosis or treatment history if they are being monitored or are in good standing with a physician health program[13]
- Regulatory policies should clearly state how licensees' personal health information will be used[11,13]
- Regulatory policies should include information about confidentiality and safeguarding of information[11,15]
- Regulatory authorities should maintain a physician health program, and promote and provide information about their physician health program[11–13]
- Regulatory authorities should provide transparent information regarding current policies and processes for self-reporting, reporting and monitoring of physicians with impairments[10,11,13]
- Regulatory authorities should provide transparent information about disciplinary action[13]

*Informed by our scoping review of published and grey literature on regulation of physicians with medical conditions, conducted as outlined in Appendix 1B, available at www.cmaj.ca/lookup/doi/10.1503/cmaj.221097/tab-related-content.

What are the current models of support for physicians with health conditions?

Three primary models for monitoring physician health exist in Canada, characterized by different relationships between the medical regulatory authority, the physician health program and the local medical association, namely the co-management model, the medical association model and the independent administration model.[10] Physician health programs were originally created to provide support to physicians with medical conditions, and often hold the additional role of monitoring physicians' health conditions to ensure they are fit to practise.

In the co-management model, most of the physician health program's support services reside with the medical association, while the biological monitoring program (i.e., monitoring of substance use disorders) is managed by the medical regulatory authority. In this model, physicians seeking services from the physician health program would need to meet a specific and clearly outlined threshold for reporting before being brought to the attention of the medical regulatory authority. The medical association model houses all of the physician health program's services within the local medical association, including monitoring programs. This entails having the medical regulatory authority relinquish oversight over monitoring, while assuming the legal risks related to potential impaired physician practice. In the independent administration model, the physician health program's services are held outside of the local medical association and medical regulatory authority, where the physician health program is led by a board of directors, and a review panel may assist in the reporting of above-threshold impairment to the medical regulatory authority.

How should impairment be ascertained?

The Federation of Medical Regulatory Authorities of Canada identified licensing of impaired physicians as an organizational priority for 2022–2023, reflecting the findings of recent US research on licensing of physicians with medical conditions.[22] Several studies assessed licensure applications and their degree of adherence to current consensus-based guidance, that is, whether licensure questions were limited to current functional impairment, rather than presence of diagnosis or treatment; whether they asked about past impairment; and whether they distinguished between physical and mental health.[7–9] In 2021, 76% of US applications limited questions about medical illness to current impairment alone, in line with guidance from the Federation of State Medical Boards and American College of Physicians.[9] This represents a substantial increase from an adherence rate of 41% in 2017.[7] It is possible that increased research and prioritization of new policy guidance, released in 2018–2019 by national US bodies, has helped to drive this change. Indeed, in a 2016 US survey of more than 2000 female physicians, only 6% of respondents with a history of mental health diagnosis or treatment reported disclosing this information on a licensure application.[6] Top reasons for nondisclosure included a perceived lack of risk to patient safety, irrelevance of diagnosis to clinical care, privacy concerns and fear of licence restrictions.[6]

What are the gaps in current procedures for medical licensure in Canada?

We assessed the variations in questions on licensure applications among Canadian jurisdictions, as outlined in Appendix 1A, available at www.cmaj.ca/lookup/doi/10.1503/cmaj.221097/tab-related-content. We compared questions on licensure applications with the current consensus-based guidance, as outlined in Box 1, which emphasize that licensure applications should focus on current impairment (not presence of illness or treatment), should not ask about past impairment and should not distinguish between mental and physical health (Appendix 1B). We further considered our findings using critical policy analysis, aiming to understand foundational assumptions within existing licensure policies and potential unintended consequences for both public and physician health, as outlined in Appendix 1C.

Table 1: Examples of questions about physician health on medical licensure applications in Canada

Alignment with consensus-based guidance	Jurisdiction	Question
Aligned: questions are limited to current impairment	Newfoundland	"Do you have a physical, cognitive, and/or mental health issue which may reasonably pose a risk of harm to patients?"[23]
Not aligned: questions include past impairment, or any illness in the absence of impairment	British Columbia	"Have you ever had, or been advised by a health-care professional that you have had a physical, cognitive or mental health condition that, were it to recur, would be reasonable likely to negatively impact your medical practice in the future?"[24]
	Ontario	"Have you ever had any medical condition that has affected or could affect your ability to practise medicine?"[25]
	Nunavut	"Have you ever had, or have you ever been advised that you had, a physical, cognitive, mental and/or emotional condition which in any way may, should it reoccur, reasonably be expected to pose a risk of harm to patient or negatively impact your work as a physician?"[26]
Not aligned: questions distinguish between physical and mental health	Quebec	"Do you have or have ever had a chronic mental health problem (e.g. schizophrenia, bipolar illness)?"[27]
		"Do you have or have ever had an active mental health problem (e.g. depression) imposing a restriction or a limitation of professional activities?"[27]
		"Do you have or have ever had a problem of dependence or substance abuse (including alcoholism)?"[27]
	New Brunswick	Have you ever been treated for alcohol or drug abuse?[28]
	Yukon	"Are you now abusing, dependent on, or addicted to alcohol or a drug?"[29]
		"Are you being treated for abuse of, dependence on, or addiction to alcohol or a drug?"[29]
		"Have you ever abused, been dependent on, or addicted to alcohol or a drug?"[29]
		"Have you ever been treated for abuse of, dependence on, addiction to alcohol or a drug?"[29]

We found that, among 13 medical regulatory authorities in Canada, 10 (77%) applications were not aligned with current guidance to focus only on impairment. Five (38%) applications asked about mental health and substance use separately from physical health, in the absence of impairment (Table 1). Beyond explicit questions about health, applications also contained implicit health identifiers via questions about leaves of absence. Ten (77%) applications requested explanations of leaves of absence, with 5 requiring justifications of leaves of any duration and 5 requiring explanations for leaves of 3 months or longer (Table 2).

Notably, all applications asking about general medical conditions explicitly requested disclosure only when these conditions led to impairment. For example, many jurisdictions asked about any condition that affects or could affect the physician's ability to practise medicine (Ontario, New Brunswick, Yukon) or that would be reasonably likely to negatively affect the physician's medical practice in the future (British Columbia, Alberta, Prince Edward Island). However, 5 of the 13 applications asked about mental health and addictions without asking specifically about any associated impairment, indicating a potential implicit concern that the threshold for flagging and monitoring mental illness is lower than that of physical illness.

Across the 13 jurisdictions, 12 (92%) applications did not define impairment, which leaves physicians to self-evaluate whether their condition could affect their ability to practise medicine. If applicants selected "yes," they were prompted to provide additional details, with no further instructions on the extent of personal health information required and its impact on licensure. No application forms mentioned physician health programs for treating and monitoring medical conditions. Moreover, they did not provide statements about inclusion or cite relevant disability legislation regarding disclosure of personal information around health conditions. Among written policies, only 2 jurisdictions (Alberta, BC) provided transparent and comprehensive information about processes for disclosure, evaluation and monitoring.

These gaps carry material effects. When physicians with medical conditions answer binary questions about impairment, without transparent instructions regarding disclosure requirements and consequences, they are faced with a choice. Physicians are often unaware of the ramifications of answering "yes" on licensure applications, which could include a formal regulatory review, potentially causing licensure delays, even in the absence of current impairment. By answering "no," applicants eschew scrutiny from the medical regulatory authority. However, physicians with medical conditions that are not currently causing impairment may avoid seeking treatment or accommodations because they fear regulatory consequences. When medical conditions go untreated, in the context of the high demands of the medical working environment, they are more likely to contribute to impairment.[13]

Table 2: Characteristics of questions related to impairment, medical conditions and leaves of absence in Canadian medical licensure applications, by jurisdiction

Medical regulatory authority	Aligned (questions limited to current impairment)	Not aligned (questions ask about past impairment, or any illness or treatment-seeking)	Not aligned (questions ask about mental illness or addictions regardless of impairment)	Questions require disclosure and explanation of leaves of absence
College of Physicians and Surgeons of British Columbia		X		Leaves ≥ 3 mo
College of Physicians and Surgeons of Alberta	X			Any gaps in practice or training (any duration)
College of Physicians and Surgeons of Saskatchewan	X			NA
College of Physicians and Surgeons of Manitoba		X		NA
College of Physicians and Surgeons of Ontario		X	X	Any medical leave (of any duration); nonmedical leaves ≥ 6 mo
Collège des médecins du Québec		X	X	NA
College of Physicians and Surgeons of New Brunswick		X	X	Any premature termination or interruption of training or practice
College of Physicians and Surgeons of Nova Scotia		X		Leaves ≥ 3 mo
College of Physicians and Surgeons of Prince Edward Island		X		Leaves ≥ 3 mo
College of Physicians and Surgeons of Newfoundland and Labrador	X			Leaves ≥ 3 mo
Yukon Medical Council		X	X	Any medical leave (of any duration); nonmedical leaves ≥ 6 mo
Government of Northwest Territories		X	X	Interruptions in training (any duration)
Health Professions Department of Health, Government of Nunavut		X		Leaves ≥ 3 mo

Note: NA = not applicable.

How do other jurisdictions' regulatory bodies address this issue?

Various models for physician licensing and health monitoring exist in jurisdictions outside Canada. In the United Kingdom, the General Medical Council's licensing application involves a similar registration process that asks about medical conditions (Box 2). These questions are available publicly on the organization's website, and include a guide that instructs applicants on the information they are required and not required to disclose in the application.[30] For example, medical conditions need only be reported if these led to a formal complaint or process, and the guide defines concrete examples of these processes (e.g., formal meeting with a supervisor, manager, panel or committee). It also instructs applicants that they are not required to report disabilities, accommodations, or informal supports accessed, in the absence of a formal process. The guide states, "We believe that disabled medical students and doctors should be welcomed to the profession and valued for their contribution in healthcare. Having a disability doesn't stop you from practicing medicine safely."[30] Included in the guide are also links to guidance on good medical practice, outlining the responsibilities of registered physicians, alongside pathways for seeking support for health conditions. The UK regulatory model offers the benefits of transparency, explicit efforts to reduce stigma around disabilities and health conditions, and simultaneous reflection of physician responsibilities alongside available health supports. Limiting disclosure to health conditions that have triggered a formal process raises the

Box 2: Questions about health in licensing and registration from the United Kingdom General Medical Council[30]

- "Has a medical school, university or employer raised concerns about how you managed a health condition, that led to a formal process? The formal process could be to support you, or to investigate the concerns. Usually a senior or HR [human resources] manager, committee, hearing or similar decides what action to take after the process has finished."
- "Has a medical school, university or employer raised concerns about how a health condition affected your ability to study or work as a doctor, that led to a formal process? The formal process could be to support you, or to investigate the concerns. Usually a senior or HR [human resources] manager, committee, hearing or similar decides what action to take after the process has finished."

reporting threshold and, arguably, the system may miss identifying impaired physicians practising in independent settings or those whose impairment has not yet been ascertained by their institution. This regulatory model places the onus of identifying impairment on training and health care institutions, which do not have the same legal responsibility for protecting patient safety as medical regulatory authorities and, moreover, do not include the same support resources (such as a physician health program) integrated into their monitoring of impairment.

In the US, state licensing boards largely operate similarly to Canadian medical regulatory authorities, with initial registration and annual renewal processes for obtaining and maintaining licensure, as well as local physician health programs that are responsible for supporting or monitoring physicians with health conditions. In the private health care model of the US, the consequences of disclosing a health condition may extend beyond licensure, and into coverage of the physician's services by insurers.[31] Given concerns regarding barriers to disclosure in the licensing process, the US Federation of State Medical Boards suggests a safe-haven nonreporting clause, whereby physicians who are monitored and in good standing with their local physician health program can forgo disclosing diagnosis or treatment history on licensure applications.[13] This mechanism encourages confidential support-seeking from an arm's-length monitoring body, which allows physicians to access treatment before it becomes impairing, while avoiding unnecessary scrutiny that could discourage disclosure altogether. The physician health program, in turn, would report physicians to the licensing board only if they were deemed to pose a threat to patient safety, or were not following the program's instructions. In Colorado, one of the first jurisdictions to adopt a safe-haven agreement in 1990, applicants may respond "no" to questions on licensure applications about impairment from a medical condition, provided the applicant has undergone a voluntary assessment by the Colorado Physician Health Program.[32] Within 5 years of implementation, this policy led to an increase in voluntary referrals of 195%, where most referrals were voluntary (rather than complaint-driven), and occurred at an early stage of illness, before impairment.[32]

How should Canadian policy on medical licensure change?

In the medical licensure process, questions about personal health may cause unintended harms when processes are untransparent or intrusive. Licensure applications and policies must consider both patient safety and physician health to create effective and transparent processes that encourage disclosure and provide support. This allows medical regulatory authorities to uphold their duty of protecting patient safety, without needlessly intruding on physicians' privacy or creating a climate that discourages help-seeking. The Canadian Medical Protective Association suggests that medical regulatory authorities maintain clearly articulated and evidence-based processes for collecting, storing and sharing physicians' personal health information, as well as documented procedures to address privacy concerns.[18] Moreover, the Alberta Health Law Institute suggests several principles and standards for local physician health programs, emphasizing the need for explicit, effective, transparent, accountable and responsive mechanisms for addressing physician health; these generate trust among both physicians and the public.[10] In concrete terms, we suggest that Canadian medical regulatory authorities include in their licensure registration process transparent information about privacy, disclosure requirements, consequences of disclosure, inclusion of physicians with disabilities and support from physician health programs. We also suggest that the wording of questions about health conditions be carefully amended to include only those that cause current impairment, in line with current national and international consensus-based guidance.

Although limited evidence supports one model of physician health monitoring and regulation over another, existing evidence does suggest that mechanisms that destigmatize the reporting process and provide transparency around regulatory processes increase physician self-disclosure. The UK's approach to providing highly detailed, transparent and public guidance for completing licensure applications provides a useful model, engendering trust in both physicians and the public. Moreover, the safe-haven model adopted in some US states can be considered in Canadian jurisdictions, whereby the physician health program's services are housed entirely within the local medical association. Data from both Canadian and American physician health programs shows that use of these services is associated with improved outcomes, lowered risk of malpractice claims and improved patient care.[33–35] Moreover, in response to the rising number of physicians with disabilities entering the profession, the Association of American Medical Colleges has emphasized accommodations and the normalization of help-seeking to support inclusion, which our analysis identified as a missing ingredient in Canadian licensure policies and procedures.[3,36] Physicians with disabilities bring inherent value to the profession through their lived experience and by representing the populations they serve.[37,38]

Licensure policy for physicians with medical conditions represents a critical area of research in Canada, where physician health is an increasingly urgent priority and value for the profession.[12,33,39,40]

With this priority in mind, existing policies for physician licensure in Canada should be revised and harmonized in accordance with consensus-based guidance. The COVID-19 pandemic has prompted many to argue for pan-Canadian physician licensure to facilitate physicians' ability to move to regions of greatest need.[41] This presents the opportunity for national licensure application questions similar to the UK model. In the creation of a national standard, it will be critical to acknowledge that physicians with medical conditions can function effectively and practise safely in the profession, and that, if their illness causes impairment, treatment can lead to remission and restored function.[12,13] Institutional change is needed to encourage physician help-seeking, and we urge medical regulatory authorities in Canada to consider current guidance on medical licensure questions, while committing to transparent communication and processes regarding physician health monitoring to advance the profession's goals of patient safety and physician health.

Conclusion

Physician health policies across Canada aim to protect the public by regulating practice for physicians who may be impaired. Ideally, such policies should encourage physician self-disclosure of illness, which serves to protect patients while avoiding intrusive questions about physicians' health. In medical licensure applications across Canada, most jurisdictions do not follow national and international consensus-based guidance on questions regarding physician health, which have been shown to increase self-disclosure. In Canada, licensing processes would benefit from including transparent communications outlining privacy, procedures, requirements and consequences of disclosing a health condition during registration or renewal to address barriers to disclosure, help-seeking and treatment.

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