



Management of the Impaired Applicant

Jacob M. Appel¹

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American medical schools received applications from 53,371 unique candidates in 2019 [1]. Another 47,012 applied to residencies approved by the Association of American Medical Colleges and a smaller number to specialized fellowships [2]. Most of these applicants sought admission to multiple schools or programs: an average of 17 schools per medical school applicant and 92 programs per residency candidate [3]. One distinctive feature of assessing candidates in medicine—as distinguished from routine practice in many other fields of graduate and professional study—is an admissions interview. Until recently, these interviews were generally conducted on campus and in person, affording evaluators with an opportunity to assess interpersonal skills not readily apparent on written applications. Since the start of the COVID-19 pandemic, these interviews have largely been conducted via virtual platforms. In both situations, the vast majority of these encounters prove unproblematic. However, as is to be expected under circumstances where many individuals interact in professional settings, unforeseen difficulties occasionally arise. Anecdotal evidence suggests that a small number of applicants present each year in various states of impairment or distress. Some of these applicants may meet the formal definition of physician impairment as characterized by the Federation of State Medical Boards, namely “the inability...to provide medical care with reasonable skill and safety due to illness or injury” [4]; in other cases, whether applicants fall below such a standard may be uncertain. Still, other applicants will present in ways that may not meet such formal standards, but nevertheless raise significant concerns about their own psychological well-being. (Of note, the term “impairment” is used broadly in the following commentary to encapsulate this wide range of presentations.) Causes of such impairment may include, *inter alia*, psychiatric decompensation, acute

medical illness, unanticipated medication side effects, active use of alcohol or drugs, or neurodivergence. How to manage the impaired applicant is an uncommon but significant challenge to those engaged in the admission process.

The need to address the distinctive issues raised by impaired applicants arises within the broader context of a medical profession that is increasingly (and rightly) concerned with issues of wellness, psychiatric health, and physician burnout [5, 6]. Both medical schools and residencies have elevated the importance of improving trainee well-being over the past decade [7]. Yet while these concerns are generally dealt with *after* matriculation, the well-being and psychological health of future clinicians are matters of concern that, in some cases, may merit more attention even prior to admission or enrollment. Unfortunately, no data yet exists on the incidence with which impaired applicants present. Circumstantial indicators suggest that these instances might occur with greater frequency than would be expected in the general population, as several distinctive contributing factors potentially raise risk among applicants. First, the average medical school applicant is 24 years old, at a stage of life which overlaps significantly with the interval of the onset of frank psychosis in common mental pathologies including bipolar disorder and, to a lesser degree, schizophrenia [8–11]. Second, many students arrive at interviews from the undergraduate or medical school settings; the more limited third-party observation and supervision of these environments, as compared with the home of upbringing or workplace, may allow conditions such as psychiatric illness and addiction to persist without detection—only to become apparent in the scrutiny of the interview setting. Third, application to medical school or residency is a high-stakes endeavor, and applicants can anticipate additional stressors during their training [12]. Stress is associated with increased substance use, and both medical and psychiatric decompensation [13–15]. In addition, the COVID-19 pandemic added significantly to levels of distress among college and medical students [16, 17]. As a result, admissions officers and faculty interviewers should be prepared to encounter one or

✉ Jacob M. Appel
jacob.appel@mssm.edu

¹ Icahn School of Medicine, New York, NY, USA

more impaired applicants during the course of their careers. This paper discusses the complex medical, lethal, and ethics issues likely to arise during such an incident and offers some broad guidance regarding management. Issues common to both medical school and residency applicants are examined first, followed by a review of aspects distinct to each level of trainee.

Acute Management

Concerns about an applicant may arise prior to the interview itself. A candidate may submit an application which contains language with health or safety implications: suicidal ideation, disorganized thought processes, grandiose claims characteristic of bipolar disorder. Or the applicant may contact the admissions office or residency program via phone or email with similar signs of illness. More common is the applicant who initially raises red flags on the day of interview. In all of these situations, the first duty is to protect the applicant, fellow candidates, and the evaluating personnel. The challenge here is that while admissions interviewers and directors are often physicians, they are not *the applicant's* physician. Whether a legal duty exists to provide assistance to such applicants—which likely varies from state to state [18]—physicians and medical schools clearly have an ethical duty to keep applicants safe, as they would any other individual who either enters their premises or otherwise falls under their authority, even briefly [19]. Virtual interviews complicate these responsibilities even further. When an in-person applicant presents suicidal, violent, or floridly psychotic, emergency services should be contacted to escort the applicant to a hospital emergency room. Under rare circumstances, it may be appropriate to accompany the applicant directly, in order to reduce emotional trauma, but admissions staff must keep in mind that such situations may prove unpredictable and that they do not have the authority to physically detain such an individual should the applicant attempt to flee en route. In contrast, virtual interviewers facing an applicant who suffers from severe psychosis and/or poses a danger of harm to self or others may not even initially know the precise location of the interviewee. Under such circumstances, an interviewer should strive to ascertain the applicant's location and call-back number and then remain in contact with the applicant while summoning emergency services. Recruiting the assistance of colleagues or staff to assist with logistics may prove helpful in this process.

Less clear is how to handle an applicant who appears in apparent need of assistance, but who does not pose a direct, imminent threat to himself or others. Such cases might include those of severe depression without suicidality or an applicant who presents mildly intoxicated. The question arises whether the admissions office should address these

concerns with the applicant directly and attempt to steer him toward appropriate care or whether such a potentially invasive step is beyond the scope of the evaluating institution's responsibilities and prerogatives. Direct confrontation with applicants under these circumstances also poses risks of its own—both to the admissions staff and potentially to the applicant. Expressions of concerns by a stranger in a position of evaluation, such as an admissions officer or interviewer, may lead to further decompensation of the applicant in an unfamiliar setting (especially for out-of-town applicants who interview in person) with limited social support. Ideally, best practices might include having a mental health professional, such as committee member who works in the field or an employee of the school's health services, available for curbside advice during the course of interview season [20]. If that is not possible, having clear written guidelines for under which circumstances, and to what degree, to intervene in such cases will prove of value. Such guidelines are also essential to avoid implicit biases that may lead to different approaches to impaired applicants based upon non-pertinent demographic factors.

Disclosure and Reporting

An admissions evaluator's duty may not end once an applicant's acute condition has been satisfactorily stabilized. The question arises whether, and under what circumstances, to report the episode to the applicant's home institution or elsewhere. Choosing to do so appears to fall within the discretion of the interviewing program. As the applicant is not a patient, the Health Insurance Portability and Accountability Act of 1996 does not apply, while the Family Educational Rights and Privacy Act only applies to the sharing of educational records—not firsthand concerns arising on the interview trail. While the Americans with Disabilities Act might in theory prevent hospitals and medical schools from using specific information about applicants under certain circumstances, it does not pertain to the *sharing* of such information. Yet just because an admissions evaluator can convey information to a home institution does not necessarily mean that he or she should do so. Several arguments favor disclosure. First, an admissions office might want to prevent further decompensation on the interview trail that might ultimately lead to increased danger during future interviews at other schools. Second, these applicants may become future physicians, after all, and fellow physicians have an ethical duty to protect the public from impaired colleagues [21]. Third, reporting may serve the interest of the applicant directly by protecting him from further episodes on the interview trail, whether virtual or in person, that may foreclose long-term career opportunities in the profession.

Admissions offices might adopt one of three approaches to the issue of disclosure to home institutions: a bright line rule against disclosure, a policy that broadly prefers disclosure, or a middle ground that favors a situation-specific cost–benefit analysis. The arguments against disclosure include a concern that unnecessary entanglement that might blur the line between assessment and support. In contrast, arguments in favor of disclosure include concerns for the direct welfare of applicants that might best be served by keeping home institutions informed of any worrisome information regarding their students. In addition, evaluators might believe they have a duty to protect the public by ensuring that only fit candidates are admitted to other programs, as well as its own. The fiduciary duty that exists between physician and patient generally does not apply to applicant and evaluator, so the ethical issues surrounding dual loyalty that arise in the former setting are not applicable to the latter. Yet unlimited disclosure raises concerns of its own, such as the fear of penalizing applicants who express ill-informed views, those who are not skilled or practiced interview subjects, especially early in the interview season, etc. The consequences of this extreme approach would be information sharing between schools that would undermine the independent nature of each school’s process by adding unjust weight to earlier interviews.

Whatever decision is ultimately rendered by the admissions evaluator, any intervention employed should reflect the minimal level of entanglement and disclosure necessary to ensure the welfare of the applicant and society. For example, an admissions office might fulfill an ethical duty to protect the applicant by contacting a home institution, but barring additional justification such as an overt threat to a third party would be remiss in contacting individual evaluators directly to discuss the applicant’s condition. While calling emergency services or sending an acutely at-risk applicant to an emergency room may be appropriate, visiting that same applicant in the hospital setting would risk a boundary violation.

The decision regarding whether to report impaired applicants may be complicated even further by the question of to whom these concerns should be relayed. An increasing number of applicants do not present to medical schools from undergraduate colleges, or to post-graduate training directly from medical schools, but rather from the workforce or after one or more gap years. In essence, they have no home institution. In extreme cases, admissions offices might confront the challenge of whether to discuss concerns about such mature applicants directly with third parties such as family members or other emergency contacts. The question of whether and when this action oversteps professional boundaries is highly subjective and the literature in the field is marked by an absence of guidance.

Evaluation of Applicant

One of the goals of the medical school or residency admissions interview to detect potential factors that will impede an applicant’s ability to practice medicine effectively [22]. However, legal restrictions resulting from 1974 amendments to the Rehabilitation Act of 1973 and the American Disabilities Act prevent admissions committees from asking directly about physical or psychiatric disabilities [23, 24]. The medical community has largely embraced a medical model regarding both mental illness and addiction that rejects blame and favors rehabilitation. Impairments that appear on interview—such as depression or mania—may be treated effectively. In fact, many successful physicians suffer from significant mental illnesses that they are able to manage with appropriate clinical interventions. Of late, the medical community has placed emphasis upon the goal of helping physicians recover from impairment, if possible [25]; to some degree, the entire culture of medicine has been shifting structurally to incorporate such concerns for wellness and restoration [26]. In this context, one must ask whether an otherwise stellar applicant should be disqualified from admission based on a solitary presentation of impairment.

Alternatively, the admissions office might coordinate with the home institution to provide the applicant with a second opportunity for evaluation—during either the current cycle or a future cycle—once the applicant’s condition has stabilized. Schools might even establish a formal process for applicants to request a “reevaluation” under such circumstances. While such reevaluations should be granted sparingly, and only with evidence that the underlying impairment has been resolved, creating such a framework honors both the legal and ethical norms regarding impairment. As important, such an approach avoids penalizing the applicant who has the misfortune to suffer a medical or psychiatric decompensation concomitantly with the interview process. Justice entails treating similar candidates similarly. An applicant who suffers impairment prior to the interview process can be stabilized and shield his previous impairment from evaluators, while a matriculated student who suffers impairment is afforded numerous supports to foster a return to stability and ultimately a future career in medicine. Equity argues that the timing of an applicant’s decompensation, rather than its nature, should not be the sole factor in foreclosing a medical career. This goal inevitably competes with the limited resources of admissions offices, and the opportunity cost to other applicants of affording a previously impaired applicant a second interview. Admissions offices should recognize these tradeoffs and review each individual situation holistically with flexibility and compassion.

Level of Trainees

Many of the issues that arise related to impaired applicants will be relevant to both aspiring medical students and those applying to be house officers. A few distinctions are noted below.

Medical Students

Medical school applicants often stand at a crucial juncture in their lives: They are about to embark on extremely rigorous and stressful—although hopefully rewarding—training. Candidly, medical careers are not for everyone. An applicant who presents impaired during the admissions cycle creates an opportunity for that student, once restored to stability, to consider if and how the cause of that impairment is compatible with medical training. Doing so might help avoid future demoralization or even crushing debts. At the same time, some impaired applicants may use the experience to seek the additional supports they will need to succeed at medical careers. By working with home institutions, admissions offices can help set such candidates up for long term success—once appropriate supports or treatment are in effect, which might even require one or more years of engagement before reapplication—rather than short term failure.

House Officers

Candidates for residency positions have already devoted considerable time, and often resources, to their medical training. To some degree, they have likely proven themselves, suggesting that their current impaired state may be an aberration. Moreover, the consequences of not securing a position may have devastating impacts upon them—both psychological and financial. At the same time, society has already invested considerable resources in their training. Under such circumstances, every effort should be made to help restore them to both well-being and the ability to practice. When possible, residency programs may want to alert medical schools about impaired applicants upon detection so that those candidates may be restored to good health. A strong argument exists for reconsidering their candidacy if/when they are restored.

Conclusions

No admissions office or interviewer wants or expects to encounter an impaired applicant. However, during the course of an admissions cycle, such episodes are likely. Reflecting in advance upon the ethical and legal issues involved may

facilitate better outcomes. In addition, admissions offices and residency programs might consider taking several concrete steps in preparing for such incidents. These include (1) developing clear written guidelines with the input of diverse stake holders, including psychiatric and substance use treatment professionals, regarding how to address such situations, and (2) establishing in advance channels of communication with the medical school's or hospital's legal team, the institution's disability service office, and a psychiatric professional for real time guidance when such crises emerge.

Applicants often present at a vulnerable age under considerable stress. During in-person visits, admissions offices may be their only local form of social support and may, in essence, have to consider adopting an *in loco parentis* approach to serve the welfare of the applicants. Applicants interviewed virtually may be far from home and similarly with limited supports, and the admissions office may prove best situated to address their emergent needs. The extent of such involvement and protection will inevitably vary. However, it is unrealistic to expect admissions faculty to forget as evaluators what they know as both physicians and human beings. They will want to help. Advance preparation will help them do so.

Declarations

Conflict of Interest The author states that there is no conflict of interest.

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