To Disclose or Not: Residency Application and Psychiatric Illness

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The process of applying for and being accepted into a residency program is the culmination of successfully negotiating all of the emotional, behavioral, and educational challenges accompanying medical education. Medical students usually perceive this process as very stressful because so much is at stake. Students worry about matching into a program/location of their choice in a specialty of their choice. In recent years, this process has intensified, with students applying to a much larger number of programs and accepting more interviews to increase their odds of matching successfully [1–3]. What makes matters worse is that this process comes at the tail end of a highly challenging medical education. This stress can be compounded when deciding whether or not to disclose a personal experience with psychiatric illness [4].

In the October 2020 issue of *Academic Psychiatry*, three articles examine different aspects of psychiatric illness in medical students and the residency application process. Alfayez and AlShehri [5] examine the prevalence of anxiety and depressive symptoms in medical students in Saudi Arabia and associated perceived stigma. Pheister et al. [6] examine the impact of disclosure of psychiatric illness on the residency selection process. Goldenberg and Wilkins [7] provide a glimpse of how educators think through the process of protecting the privacy of a medical student receiving inpatient

treatment from other medical students and their take on the stigma of psychiatric illness.

These issues are all the more relevant given the findings that a substantial number of medical students and residents experience depression, anxiety, or burnout. In one large systematically conducted review [8], for example, rates of depression and depressive symptoms in medical students were about 27%, and the rate of suicidal ideation about 11%. Rates increased on entry into medical school, and only a minority with depressive symptoms reportedly sought treatment. Some medical students also suffer from burnout, although prevalence varies across countries [9]. Studies indicate that only a minority of medical students experiencing high levels of burnout seek help [10, 11]. With such high rates of psychological stress, why do so many medical students decide not to seek treatment? The article by Alfayez and AlShehri [5] in this issue suggests that despite having low personal stigma, a majority of the students indicated that if they received such treatment, they would hide it from others. Around half of the students thought that program directors, supervisors, and other students would react negatively to knowledge that a student had or was receiving treatment for psychiatric illness [5]. Their findings have a striking similarity to studies examining stigma among medical students in the US [11–14]. In one such study [11], 50.3% of students felt that a residency program director would pass over their application if the program director were aware that the student had emotional or mental health problems. In one personal account, a student was advised to avoid disclosing psychiatric illness during the residency application process [15]. Mentors and educators created a dichotomy by indicating on the one hand that having a psychiatric illness and undergoing treatment is not stigmatized and on the other hand that disclosure might impact a student's residency process negatively.

Medical students tend to worry about the possibility of stigma and discrimination, which can factor in a decision to not seek help [5, 11–14]. This situation is troubling, because lack of disclosure is linked to lack of receiving help [16]. Medical student attitudes toward getting treatment for

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depression are mirrored in studies of practicing physicians. For example, in a study of female physicians [17], almost 50% reported that they believed they met the criteria for a psychiatric illness at some point in their life but had not sought treatment for reasons including that they could manage it themselves, that the diagnosis was embarrassing or shameful, fear of resulting licensing issues, and impediments to available time. In a large study of surgeons [18], around 30% reported depressive symptoms but only about one quarter of those with recent suicidal ideation sought psychiatric help, with the majority being concerned about licensure requirements. A third example concerned a survey of practicing physicians in Michigan and their views on the impact of depression on their approach to seeking mental health care [19]. In this study, roughly one quarter of respondents reported knowing a physician whose professional standing had been compromised by being depressed. In addition, physician concerns about confidentiality were associated with a higher likelihood of their avoiding care.

Are medical students correct that disclosure of a psychiatric illness puts them at a disadvantage in the application process? Pheister et al. [6] attempt to answer this question by examining the effect of disclosure of major depressive disorder (MDD) during the residency application process on the chances of being invited for an interview and the eventual ranking. The 380 program director respondents, which constituted an 11% response rate, were given vignettes with some applicants disclosing MDD, others disclosing diabetes mellitus type I, and some without either. The vignettes were further categorized into “perfect,” “good,” and “average.” The authors found that applicants with MDD were at a disadvantage compared with other applicants, including those with diabetes. However, candidates with MDD and a “perfect” application did better than the “average” or “good” applicant without any illness. Simply put, if all things are equal in an application, disclosure of depression at this stage may put an applicant at a disadvantage compared with those who disclose diabetes. The impact was not viewed as severe enough, though, to discount for other strengths in the application when compared with “weaker” applicants.

As Brenner et al. [4] point out, while bias against applicants with disclosed illness can exist, there may also be concerns about the wellbeing of the applicant as a future resident and of the possible impact of their illness on the program. A program director’s decision to not rank an applicant with a disclosed illness—psychiatric or not—might stem in part from a concern about the resident’s future performance during residency. Pheister et al. [6] found that some comments by residency directors indicated a concern about an illness causing unexpected leaves of absence and the resulting impact on the program. The authors speculated whether this concern was true only for programs with limited resources in that should training need to be extended, there may not be adequate call

coverage and monetary resources. While program directors may consider an applicant’s fitness for future practice, the question remains as to whether all psychiatric and non-psychiatric illnesses are judged by the same standards or whether psychiatric illnesses are unduly stigmatized. Although Pheister et al. [6] did not find evidence for such parity, their study cannot answer whether program directors prefer applicants with non-psychiatric illnesses over psychiatric illnesses. Moreover, in one, now dated, multi-institutional study [20], students appeared more concerned about the potential impact of illnesses such as depression, substance use, cancer, anxiety, and HIV than diabetes or arthritis, so diabetes may not be an optimal comparison.

Are the attitudes of psychiatry program directors toward applicants with mental illness different from the attitudes of non-psychiatry program directors? Studies have found that psychiatrists are not immune to stigmatizing attitudes toward those with psychiatric illnesses [21–24]. These studies measured bias in psychiatrists toward patients with psychiatric illnesses, however, not of program directors who evaluate residency candidates with mental health issues. Nevertheless, there may be some common elements in how program directors and the general population of psychiatrists perceive mental illness.

Looking ahead, educators should seek to understand how the nature and course of an illness, possible impairment, and potential to relapse might affect residency application processes and decision-making. How the size and availability of resources in a program impact decision-making also needs to be understood.

Given the studies mentioned, do we have an answer to the difficult question of whether a student should disclose a personal experience of psychiatric illness? Unfortunately, the answer is not a straight yes or no but more nuanced. When there are gaps or weaknesses in the application that are explained by an illness, then disclosure is likely not a choice. Otherwise, students might consider whether a narrative exists around disclosure. Would the applicant decide to disclose if the applicant had another type of illness? Did the illness result in a positive experience for the applicant? For example, did it lead to self-growth? Did the illness inspire the applicant to choose a particular medical specialty? Or did it lead to a change in the applicant’s attitude or behavior toward patients? Did the illness lead toward greater understanding and appreciation of the experience of a psychiatric disorder—perhaps increasing empathy and compassion for patients? Did it lead toward helping others who have similar illnesses? Personal experiences with illnesses can help foster empathy for patients [25, 26]. For example, one study found that newly qualified doctors with personal illness experiences reported more academic difficulties and higher anxiety but also reported that reflecting on these experiences improved their empathy and compassion for patients [26]. Answers to the above questions might serve

as a guidepost for the eventual decision on whether to disclose or not.

Medical students' narratives of their struggle with and successful treatment of a psychiatric condition might prove valuable in an appreciation of courage, fortitude, and dedication to helping others. In addition, it may shed light on how a particular individual navigates adversity and indicate a level of personal resilience. Residency directors might very well be disposed to applicants who self-disclose for this reason. Medical student and resident distress are, after all, commonplace, and residency programs are invested in providing support and mental health care for all residents. In addition, residents have reported that they want their program director to inquire about wellness and they may be more likely to seek help if recommended and facilitated to do so by their program director [27]. Knowing that an applicant has a medical or psychiatric condition may actually be a benefit for a program as support, information, resources, and help may be offered. Not knowing and finding out later could potentially be more devastating to a program.

Proactively and universally addressing issues of mental health, lessons learned through inevitable adversities experienced, and coping strategies that enhance resilience becomes particularly important when one considers the COVID-19 pandemic and its impact on the mental health of students, residents, and physicians. In addition, while this editorial's discussion has focused on applicants' disclosure during the application process, program directors must remember that it is not only unethical but also a legal violation to seek this information during the interview process. Decisions that are prejudiced against applicants with specific illnesses could violate the Americans with Disability Act.

As psychiatry program directors and role models, academic psychiatrists need to be responsible not to let bias or information about an applicant's medical history negatively affect their decision making, particularly if the applicant has no history of impaired performance. Separate potential concern about students' medical conditions from their talent, achievements, and goodness of fitting into one's program. Most importantly, let us all aim to recognize and correct any potential biases that may operate to the detriment of applicants in residency application processes.

Compliance with Ethical Standards

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