[Music 00:02 - 00:15]

Bonnie: Welcome to *Included: The Disability Equity Podcast* brought to you by the Johns Hopkins University Disability Health Research Center. This podcast challenges stereotypes of disability by sharing stories, data, and news. Each season digs deep into topics offering multiple perspectives and will expand your view of disability. We are your hosts. I'm Bonnielin Swenor, director of the Johns Hopkins Disability Health Research Center.

Nick: I'm Nick Reed, assistant professor at Johns Hopkins University Bloomberg School of Public Health. On this episode of *Included*, we are talking with Dr. Justin Bullock about the stigma of mental illness among medical professionals. Dr. Bullock is a resident physician in the Department of Internal Medicine at the University of California San Francisco. He's an advocate for disability inclusion among physicians, particularly those with mental illness, and his work *[unintelligible 01:14]* equity in medical training and assessments including bias by race, disability, and other marginalized groups.

[Music 01:22 - 01:34]

Dr. Bullock, thank you so much for making time to be our guest and advancing an important national discussion around mental health and, particularly, mental health among physicians.

Justin Bullock: Thank you.

Bonnie: We're so excited to be talking with you today. I wanna first start by discussing a powerful and really important commentary that you wrote in the *New England Journal of Medicine* back in March, 2020. It was titled, "Suicide—Rewriting My Story." In this article, you talked about and share that you have bipolar disorder and discussed your experience during internship year. What do you want to share with our audience about your journey during that internship year that you discussed in that article?

Justin Bullock: The first thing that I would say is I went into intern year and thinking that it would be challenging. I there are some things that make intern year challenging for everyone: being a new doctor, the pressures of that, not wanting to hurt people, being in the bottom of the medicine hierarchy, the very intense hours in the hospital. For me, particularly, the irregular night schedule was something that

my providers were very, very afraid of, and something they warned me of many times. I remember early on, and this is, I guess, it was an unfortunate big learning for me. I really thought that they were overblowing the impact that nights would have on me and on my mood, in particular. For me, what happens when I work a lot of night shifts, is actually I get very activated, and I can't sleep.

This particular story that I write about *[unintelligible 03:19]*, became progressively elevated and then crashed and became very depressed after. A lot of that was me not wanting to make my peers have to work more nights because I felt like anything that I didn't do, one of my friends would have to do instead. I also wanted to get the same tough medical experience that everyone else did, which also is some sort of—maybe they're not—maybe not the healthiest way of thinking about medicine. Then that's the first thing that I would say is that it's just a challenging year generally. I think the second thing that I hope people get from my piece is that mental illness is so common. I had many people who shared their experience of struggling with depression or anxiety during residency as a way to try and help me not feel so alone. I would say it definitely did help. It also showed the fact that there are so many people who are actually struggling.

Nick: Wow. You wrote in the piece, "As an intern with mental illness, I approached the starting line knowing that, at some point, my vulnerabilities would be exposed and that hitting the wall was inevitable." This statement echoes an important national and even international discussion about the burnout, health, and mental wellbeing of our medical workforce. Can you share with our audience a little bit about why these outcomes seem inevitable or seemed inevitable?

Justin Bullock: Mm-hmm. Yeah. It's also really interesting to hear those words now reflecting post-COVID or in the COVID pandemic. I think that medicine has a culture of really pushing people to their limits and past their limits. Particularly, residency is this time where it really—I personally feel that the residency system, it takes advantage of residents, that people who really want to care for people, who really wanna do good and save lives and help others, and it pushes them past where they should be pushed. It's for this reason that I compare it to a marathon, which is this as someone who—a former collegiate athlete who still likes to run competitively. The whole point of racing is basically to find the very, very, very edge of that which we are capable. Ideally, you don't go past but, sometimes, you certainly do.

I don't necessarily believe that medicine should be the same way. I think that's an important distinction. I think that we, obviously, want everyone to learn and provide exceptional care for our patients. I don't know if it's worth the cost of what happens when you go past that line. I really feel that medicine, the training as it's structured now, really pushes so many people to a place of burnout. I think that's made their mental illness to have problems with their personal lives outside of the hospital.

Bonnie: Yeah. I'm gonna take us a little bit deeper, if that's okay. In the past year, like you've discussed, or a year and a half, going on two years, in light of COVID, these discussions around burnout and mental health really have been elevated, right? This morning before we were having this conversation, I was doing some other reading about burnout and the factors that underscore that. I guess my question here to you is from this experience in the medicine, do you think part of what you just described so well in this virtue of medicine to truly burn yourself out, right? It feels like that's a value in some ways. Is it a cultural problem? Do we have a structural problem? Is it both? I don't know what your thoughts are from your perspective as an intern, in that intern year. I know you're not an intern any more, but does that make sense?

Justin Bullock: Yeah, yeah, yeah.

Bonnie: Where's it coming from? Yeah.

Justin Bullock: It makes perfect sense. Yeah. I think there are so many—I definitely think it's both. One thing that I've been particularly struck by recently, and I'm very into the Twitter world, and, also, talking with my peers. Something that I've found happens a lot in medicine is we have life happen outside of medicine. I have friends who had family members die while in residency and then be discouraged by their training program to take time away to go be with their families after their loved ones had died. For me, I'm incredulous because I don't believe that human beings can care for another human being soon after finding out that their sibling or mother or anyone else has passed and wanting to go be with them and not being able to. I would say that is the norm. I don't think that's unique to any one program.

I think that is the culture of medicine, that medicine is supposed to be above everything else. I am someone who believes that if we are allowed to be humans first, then we can actually be more amazing providers, and we can provide better care to people. I think there's that we, in our institution, spend a lot of time talking

about duty hours, and we recently made a big institution move to go from 80 hours per week to 72 hours per week, which is great, but ridiculous because that is not—that's not acceptable, not to work in any field at all. Pilots, after they work a certain period of time, they have to sleep. The flight attendants on the planes, like all these other people, so how is it safe for us to do surgery or to do procedures or to provide medical care with people, and it's not safe in any other field?

I think a lot of this, it plays to this complex that we have in medicine of being super-human. This actually relates really, really closely to this mental illness thing, which is we believe, somehow, that we as physicians are superior beings and are able to defy the normal physiologic laws that every other human being has to obey. I think because it feeds of that same, that thought, and that's why people push themselves so far 'cause, usually, if I'm gonna be a doctor, then I have to be able to work this 30-hour shift. I have to do all these things.

Nick: I've just been thinking about what you're talking about, and I've read some of your—I've read some of your academic work and I've read your writings. Given that a lot of our academic health care research is driven by clinician scientists, do you think this culture that physicians are living in has some sort of downstream effect on the way we approach research and the idea of societal and environmental factors, even, and personal responsibility in your health care and things like that?

Justin Bullock: Mm-hmm. Yeah. Definitely. The bioresearch that always really fires me up is the duty-hours research where, basically, all the studies, they say, "Oh, it's not worse if you work 24 hours versus 16 hours, so, therefore, we should work 24 hours." For me, it's like—never in these studies do we talk about the myriad of other impacts: being in the hospital for 24, 30, 36 hours has because, one, if it's a toxic work environment, because residents then wanna go to sleep, and if a resident gets paid, they're snippy to the nurses. Then it's basic toxic back and forth culture. That's never captured, the fact that people don't get to spend time with their loved ones. The teaching quality is completely different.

In the mornings, we're always trying to rush to get the resident out so that they don't break their 30-hour limit instead of having someone who's fresh that could be there for a whole day. For me, there are so many. We only focus on one, like did more people die, which is very important, and I definitely want us to help people live, but, too, would never consider the human aspect of the impact

of these decisions, in addition to I also have some disagreements with the way that they represent their statistics.

Bonnie: Yeah. I think time is back into what you were talking about, perhaps, creates a—I'm curious if you think that, perhaps, creates a culture that is also extra-exclusionary for people's disabilities?

Justin Bullock: Yeah. Do you know I absolutely think that that is true because I think, especially, people who are outsiders, who are not a part of medicine yet, they look and they see, and they're like, "I can do these." A smart—air quote—a smart person who has bipolar like me would probably not go into medicine if they actually cared about their own wellbeing. I say that sort of jokingly, sort of seriously, because if you truly prioritize yourself, you would see the ways that medicine does not. There are some people who, literally, they're not—do the things that medicine asks us to do. That is not representative of whether or not that person is a competent, skilled, amazing physician or the potential to be that, but only structural barriers that are arbitrarily enforced for the sake of tradition, and that's how we've always done things.

Bonnie: Yeah. It remains, as I always say, a radical idea that someone with a disability can be a truly exceptional physician, right, and work within the system. Perhaps, the system is not just failing that individual. It's that failure is bigger, right?

Justin Bullock: Yeah.

Bonnie: Go ahead. I don't wanna cut you off.

Justin Bullock: One thing to that is I think, and again, we often have this myopic view of what excellence is and what excellence means. I think one of the biggest things that I've seen in myself as a provider with a mental illness that is sometimes very, very disabling to me, I see the many ways that it positively impacts my ability to provide patient care, that it makes me so much of a better doctor. I think the discussion is always only framed around the things that I can't do, but never framed around the things that I can do because of my condition. I feel like that is such a huge disservice to our patients who are, ultimately, the reason why we're all in medicine.

Bonnie: Yeah. Thank you for saying that. I hope for a day where our society can be imaginative enough, and that's not even the right word, where we can think of disability in a way that isn't so deeply discriminatory, right, to think that it is—how could you possibly be an exceptional physician?

Justin Bullock: Yeah.

Bonnie: Someday. Well, I'm gonna just—I'll also ask you, I think, in alignment with this, you close out this amazing article with another really powerful statement that I've thought a lot about when I originally read it, and then last week when I read it again. You say, "My family and program director recently told me how proud they were of me for going into the hospital." I think that's pretty freaking cool. This seems like such a really important message, and I'll say, also, an important message brought at this time. Can you share with our audience more about that, what we're talking about with that quote and why, perhaps, it was important enough for you to close out your article with that.

Justin Bullock: Yeah, yeah. For those who can't see on the podcast, I'm smiling just listening to you read this again because it actually does give me so much joy to re-experience that sort of emotion, I think. I've been in so much therapy, and I've been getting treatment for so long, and, so, the stigma of not being okay is so real. It's so hard for me to accept when I'm like—when I need help, even when I'm very suicidal and really strongly wanting to kill myself. For me, that part was everyone really just giving me a lot of love for doing the thing that's right for Justin. For me, that was going into the hospital even though that's not what I wanted to do. It's like I actually love medicine so much, and I literally just wanna be. I just wanna be able to work and do my job, and I love my co-residents, and it's for me, sometimes, really devastating to have to step out.

I think I was really—I was very impressed with my program director that when she said that, that she was supporting it in a way that is like positive feedback. I'm happy that, and not just in the, yeah, if felt in a way that it felt very genuine and loving. To me, when I see it like that, those two sentences, those are full of just love, so like, "Justin, we love you, and we want you to be happy and healthy," and yeah. I was actually a little bit surprised that the last line, that's pretty freakin' cool that they were willing to keep that in. I wasn't sure if they would. I do think it's pretty freakin' cool. I wish that I had never got to the point where I needed to be in the hospital.

The reality of my bipolar is, sometimes, I get to that point, even if I'm taking my meds and going to therapy and doing everything that I can. It's just like our patients. Sometimes, they have to go into the hospital. We should be praising them for coming in whenever they do. I think that's a method that we should—yeah,

we should be happy for people that they give the care that they need, and this time, that it was before I tried to kill myself. That was a huge victory for me.

Nick: This is such an amazing conversation. My head is spinning with how this relates to so many different levels of health care. From an individual level, care point, of supporting people for actually doing preventative things and seeking care when they need it, which doesn't always happen. Even on a public health level where instead of engaging people with disdain, we engage with love and support, and this is amazing. I wanna switch a little bit, though, to another article you wrote. It'll relate a little bit back to what we've been talking about. In the *Journal of Hospital Medicine*, you wrote an article titled, "Trauma-Informed Transformation of Evaluation and Licensure for Physicians With Mental Illness." The article focuses on this concept of fitness-for-duty or FFD, evaluations of physicians. Can you just start by describing for our audience what is a fitness-of-duty or fitness-for-duty evaluation?

Justin Bullock: Yeah. I'll just connect with a little period in between for me what happened. This piece then, the first piece, the suicide I write in my story, I wrote in December, 2019. Basically, soon after that, and I actually wrote about this in the end of the piece. I revised the piece. I had a friend who killed himself, who was in medical training, who died by suicide. That was very devastating to me. I really struggled for many reasons, and that was certainly one of them. Ultimately, I attempted suicide three months later in March. This is my third time that I decided to commit suicide. It's the first time that I have called 9-1-1. I got myself to the hospital. I got to the hospital at a time where I was sick but, basically, I knew I would be okay.

Again, for me, that was actually a huge victory. Again, I wish that I didn't get to that point, but given the point that I arrived to, yeah, I don't know. It's, for me, is a positive. For me, it was unfortunate, but it was a positive. I actually got hospitalized at the institution I train at. Afterwards, I was just medically hospitalized, psychiatrically hospitalized. Then I did an outpatient program for a month to get cleared to be, basically, clear to return to work by a therapist and psychiatrist. When I returned to work, I was told that my case had to be reviewed by our institution's Physician Wellbeing Committee. Then I was told that that committee decided that I needed to do this fitness-for-duty evaluation. A fitness-for-duty evaluation is essentially an evaluation that is imposed when there is concern about impairment or potential impairment in the workplace.

Oftentimes, that fitness-for-duty means concern about substance uses, but I guess, sometimes, it's applied to people who have mental illness. I view fitness-for-duty as a profoundly invasive assessment. I am someone who I don't have substance use issues. I didn't drink alcohol until I turned 21. I've never used any drugs besides alcohol. I'm very lame. I have no like—I was drug tested, hair, blood, urine drug tested at this extensive psychiatric interview for multiple days. I had to release all of my past psychiatric records for my hospitalizations, my providers, my therapists. I had to do a personality test, like all these things. I think, for me, the big thing that was, and again, I'm speaking in terms of my unique experience, and there's varied experiences in fitness-for-duty. I think many are very negative. I have never had any workplace issues, performance and professionalism. I don't argue with people in my workplace.

I think this has been assessed many, many, many times. I always ask. I was saying, "Well, what criteria have I met to need to be assessed under fitness-for-duty?" The committee basically said that because I had bipolar, I had a condition which could impair my cognition. For that reason, it was legal for them to do this process and to say this process is a very legal process. They had a lawyer. Interestingly, this committee had—they did not have a single psychiatrist on the actual Wellbeing Committee, which I find unfortunate. Sorry. This is kind of a long run-on answer to your question, but the thing that I would argue with, well, there are many, many medical conditions which could impair one's cognition. If you had diabetes and you take insulin, if you took too much insulin, that could impair cognition. If you had lupus, you can get lupus in your brain. You can have lupus encephalitis. That can impair cognition.

Are we assessing everyone who has conditions that could? Also, I make sure when I'm not well, I call out of work. Before any of my hospitalizations happen, I do not work for multiple days before. I would argue that I had—I showed good insights by knowing my disease, by withdrawing before anything happened. I felt that I was very strongly punished for having bipolar disorder and, particularly, because I was so visible. I think this happened because everyone knew that I had bipolar disorder 'cause I had just wrote this big article about it. Then because I got hospitalized at my own institution, and they really didn't protect my privacy, so all my co-residents knew that I was hospitalized. It was very unfortunate.

Bonnie: Yeah. Wow. Thank you for sharing that. In this article, you not only share that personal experience with that fitness-for-duty evaluation process, but you also discussed the bias in these evaluations for physicians with mental illness, some of which you just discussed. Can you talk a little bit about that? I'd also just really like your thoughts around, maybe, how that bias, perhaps, is feeding into the stigma you alluded to and discussed earlier about mental illness among physicians and seeking out care and help when it's needed.

Justin Bullock: I definitely think there was some unique biases specifically because I'm bipolar. I think that the manic side or hypomanic side of bipolar disorder is—we learn a very stereotyped-like presentation of it, which is someone who spends a lot of money, is very impulsive, has a ton of sex, has a bunch of drugs, is very unsafe. That is not representative of everyone with bipolar disorder. For me, for instance, when I am—I'm bipolar too, so I only have hypomania. When I'm hypomanic, I do a ton of research, which if you look at my—you can look in the publication periods of my life, and you can tell when I was set up. For me, I felt that that—I was like, "You guys aren't actually looking at Justin the person. You're just sort of lumping me into this bipolar bucket."

Additionally, also, because I had just been in treatment for so long, I'm very, very closely watched. It's never a surprise when I'm not doing well. Everyone around me, like my care providers know for sure. Even with those people in existence, that wasn't sufficient. I think stepping back, I think the bias against mental illness is very strong. I think that it is viewed as a personal flaw and a weakness that existed within me and exists within other people, and not as a medical condition. The reason why I say that is because after I went through this process, and after they found they found that I had done nothing wrong, taken all my medications, done everything correctly, the committee still tried to dictate my specific psychiatric treatment, and, actually, they did not allow me to return to work until I agreed to their terms, which were not the recommendations of my own mental health providers.

To me, that suggests that this committee felt that psychiatry is not—is a field in which they can impose arbitrary recommendations while not being experts, which is shocking. Also, it's quite toxic. I will say I know that there's this component of fear, right, because the institution, they don't want me to hurt myself. They don't want to have someone else die. I will say I have attended multiple institutions that have had *[unintelligible*

25:59] with that problem. I think in the process of trying to fight that, the natural institution response is to squeeze tighter. I think that actually causes more harm. It doesn't feel supportive as someone who's struggling. Yeah. I think most people, I recognize that I am not special, but different in that I'm very vocal about my struggles with my mental illness. I think that some people may take that to mean that I am worse somehow where I would say that just means I'm open 'cause I think a lot of people feel—a lot of people have told me they feel the same way as I feel. I just write about it.

Bonnie: Yeah. Thank you so much for sharing. I think this is such an important conversation to have, particularly, right now at this time. When I think about these things, I often just—it strikes me that—back to, I think, some of the things we were even just talking about. What we're asking of our patients, we're not allowing our medical workforce to do. We are encouraging and asking our patients to come in for care and to seek help when needed. If we, as medical professionals, can't and don't allow that, right, we're not setting an example for patients for the rest of the population. That just strikes me as so far off base, right?

Justin Bullock: Yeah.

Bonnie: Just really does perpetuate stigma and stereotypes that we are, at the same time, are somehow trying to combat with our research and our work for the population, but we're not willing to do it within our own community, right?

Justin Bullock: Yeah.

Bonnie: It doesn't make sense. Thank you. Honestly, thank you for what you're doing and for talking about this as honestly and openly and sharing this because this is, I think, what we need to do. I just really do wanna thank you for that. I think it's so critical and important.

Justin Bullock: I think there's this huge culture of not calling ourselves out amongst the medical community. I think that really protects the status quo. There are a lot of people 'cause I was very vocal on Twitter about this as this was happening. A lot of that was because I knew what my personal record was, and I wasn't worried that it—I knew what would come up. A lot of people were really like, "Justin, you're basically committing career suicide." For me, it's like, "Well, I didn't commit actual suicide, but I don't really care about career suicide. That's go do this." Yeah. I think that I completely agree. Yeah. How could we expect our patients to do

this when we can't. We have shown as a community we are not in a place where we're able to do this. We need to challenge that and figure out how to love and how to support.

Bonnie: We're all the same.

Nick: I'm struck that I'm shy knowing this community. I'm sure it happens a lot that people reached out to you about career. That was what their focus was. Yeah.

Justin Bullock: I always believed that they were doing it. I honestly believe they were doing it out of—they thought that they were caring for me. I got to a point where I realized that, one, this is just so much bigger than me as I began to speak out. There's so many people from all across the country who are contacting me. Also, I'm very fortunate to—I have attended a lot of big name institutions, and I've been successful and have a lot of mentors who care about me and all these things. For me, it's like, if this is happening to me, then this will happen to anyone. I have a unique opportunity to actually make a difference because I have a platform that I've gained from getting to do all those things. There were definitely some periods—it was a lot. I would say it was definitely, emotionally—it's hard because, also, while this was happening, I'm recovering from a suicide attempt. I don't think that anyone—I don't think that people realize that that was also my own emotional life was still alive and my bipolar still living in my brain, and it made it that much more meaningful.

Nick: Yeah. Thank you for being so vulnerable and willing to use your platform that way. It's just amazing. I wanna ask: your paper talked about some trauma-informed approaches to combat the bias. Could you expand on that a little bit for our audience? How can we combat this? This is structural. This is cultural. This is deeply entrenched at different levels.

Justin Bullock: Yeah. This is where it's a huge tip of the hat to Dr. Leigh Kimberg who's one of the co-authors in this paper. She's an expert in this area. She was actually someone who was fighting for me as this was happening within the institution. I will say, first, before—I'll certainly talk about trauma-informed care. I really feel that the support of her—there were a few people within the institution and in the Twitter community, I really think saved my life in this period because I really was not doing well, especially as all of this was happening. For me, it's all very unfair. It's like I had done nothing but try and do right with my mental illness and help other

people and not work and all the things. I would say I think that Leigh lived a life of trauma-informed care. I think it's lifesaving.

I wish that she were here because she will do so much more justice than I actually could. Trauma-informed care is really this idea of how do we truly grasp and hold the weight of suffering, and how do we use that understanding to avoid re-inflicting further suffering upon already traumatized individuals. You think about this *[unintelligible 32:26]*. Some of the key tenets of trauma-informed care I'm thinking about like transparency, safety, cultural humility, so how can we be anti-oppressive? I think, really, the one thing that Leigh, Dr. Kimberg, once said to me when we were just sitting, talking, is—she basically—she said to me—we were talking about my past experiences and me having a lot of trauma, mental illness, and whatever. She said, basically, that I've experienced profound depth of suffering, and I've also recovered.

As a provider, one of the things that I can do for my patients is I can hold that hope of recovery for them while still acknowledging the deep suffering that they are experiencing. Yeah. It was one of those moments where like—I wish Leigh was here because she would just say it so much better than I can. Really, to me, that's a feeling that I get, like that I think about when I'm thinking about the idea of trauma-informed care. I think one of the things that I felt that was happening as I was going through this process is I didn't think that they had any idea of my personal experience. I didn't think that they knew what it was like to be, one, psychiatrically hospitalized, attempt suicide, to have all of your peers and attendings and everyone know that you were hospitalized. The trauma of having to walk through the hospital and be in the emergency room, you're like, "I don't' know who saw me there because I was altered," and all these things.

Also, I saw that the ways that I was assessed, they were way beyond the scope of what was necessary for the workplace. For instance, for me, they asked me about all my childhood trauma. They didn't ask me anything about my workplace performance or anything like that. I was really like, "This feels like you're just poking into my deep—we can talk about my sexual abuse, but I don't see how this is relevant to my job when I'm not having any workplace issues." I think that is antithetical toward a trauma-informed care approach. The psychiatrist who evaluated me, this external psychiatrist, basically, he does it in the sake of being thorough. That's his rationale for why probe through everything. For me, as someone who's been in therapy for over a decade and taken meds for a little bit less than that, eight years maybe, it didn't

feel like that was helpful to me, especially when I was not doing badly at my job. I wasn't yelling at people, being mean. Generally, people don't know when I'm not doing well when I'm actually in work. See, I guess that's my brief trauma-informed care thoughts.

Nick: I thought you said that really well. I thought that was amazing. It offers a lot of clarity for the approach you're taking and the way you're using this. It makes some really strong points, I think, that it goes back to breaking down these barriers that we talked about earlier where physicians, as a culture, viewing themselves above just being human, right, and using your humanness instead to inform your care which is that's who we are. It's amazing.

Justin Bullock: Yeah. I totally agree. Thank for saying that because I think that's so—and this is where I believe the disability community has so much to add to medicine that we just don't talk about at all. It's like there are—being a patient is not a pleasant experience at all. Most doctors—I'm not gonna say most—a lot of doctors don't know what that experience is like until later in life. Yeah. That is such a powerful thing that we could leverage that we don't' leverage.

Bonnie: Yeah. I've said on this broadcast a number of times, I'm convinced more and more every day that what we are all seeking is to be valued and understood. When you are in a care setting with someone who's caring for you who truly understands you, that is there. That is special and important. I think that what you're doing is so critical because of that. I think we are not having enough of these kinds of conversations to open up that space and start to change that paradigm, right? It's exactly what you said. People with disabilities in the medical workforce are the opportunity to shift that, right?

Justin Bullock: Yeah.

Bonnie: Yeah. You said it perfect. Thank you. At the end of this paper, you outlined some stuff, some action items, to change this process of the fitness-for-duty or that process, right? What are the steps that you think need to happen?

Justin Bullock: On there, I mentioned was this idea of limiting the scope of really—it is not necessary in all cases to take a full look over an entire person's trauma history in order to assess whether or not they are safe to return to work. I think one of the things that does not *[unintelligible 37:59]*, but I'm gonna say it anyway. One of the things that the committee, I think, was unable to do was—I think

there was a point where it was obvious that they had stepped into something that they probably shouldn't have, but they didn't have a mechanism by which you could stop and say, "We made a mistake. We're gonna stop and let you free."

I'm hopeful that they will make that better in the future. I think, certainly, calling on outside experts to create, actually, trauma-informed processes—I think there's this really, really dangerous culture in medicine where we as physicians believe that we can do everything. We don't need outside consultants because we have someone else who does this sometimes. I think that that is that. I think we miss out on the opportunity to really leverage colleagues who have the actual expertise to build these processes in healthy, safe ways. To say, no one—this piece, and I'll also give a shout out. I mentioned Dr. Leigh Kimberg and also Dr. *[Unintelligible 39:00]*. None of us, we all recognize that there are—there's a role for fitness-for-duty. There are some people who have benefitted from fitness-for duty. There are some people who will say fitness-for-duty has saved their career, who like I said, they had a substance use disorder, had a second opportunity to basically not have their license removed. There are some people who think it's positive.

I would push that and argue that I still think that the old fitness-for-duty model is really based on a shame model. I think that people who use substances, some substances—some people who use substances may more easily accept the shame model because there is shame in society, and it is—like substance use disorder, they're not viewed as medical conditions, which they certainly are. I would argue that there may be some people who didn't view stigma—who didn't view the positive stigmatizing because this stigma wasn't one that they accepted. That, I definitely think there should be external oversight, basically, the—we also talk a lot about licensing in this piece that, basically, a lot of states are violating the ADA in the way that they ask about people's mental health or substance use history.

One, we would have actually recommended not asking about those things at all or, two, the alternative is basically only asking about current impairment and whether you have a condition which currently impairs your ability to practice medicine. For instance, for me, for a current impairment question, even at my work, I would say, "No, I don't have a condition which impairs my ability to practice medicine." I would argue very strongly that that has been demonstrated by my performance. Yeah. I think those are the big picture of our recommendations.

Nick: Thank you for that. I wanna shift here a little bit to, maybe, a timely topic. When we sent you these questions, we actually framed this that, perhaps, we're at the tail end of the COVID-19 pandemic. The truth is we're on a fourth wave, it looks like now. I guess we'll just speak in general about the topic within the pandemic, but this has no doubt taxed and is still taxing our medical workforce. I think the conversation of mental health and burnout have become much more commonplace. I think we see it more. I know Twitter is a bubble, but I see it on Twitter a lot more. I also see academic papers talking about it and viewpoints in the JAMA family, for example, talking about it. Do you think that the pandemic's focus, or highlighting mental health and the mental health of the medical workforce, is impacting the views and evolving, maybe, the cultural stigma of mental health among medical professionals?

Justin Bullock: I hope so. I definitely think that it is. One of the things that I always fear with news—I don't know if flair is the right word. There are some topics that come into the news. They have spotlight for a while. Then they disappear away. I really hope that is not what happens with this. What we see now is that people—it's one of those things. Mental illness is very, I would say, special in that it respects no boundaries. There is no race, class, any—it is the great equalizer. The wealthiest, happiest-looking, *[unintelligible 42:43]* people can have profound mental illness. People who have what some people would describe as these horrible living conditions can now have mental illness. It really is, yeah—it does not discriminate.

I think what we're seeing now with the COVID pandemic is there's a collective trauma, right? Our society, in general, is being traumatized right now because people are dying. I was riding in an Uber to the hospital. Someone told me that their sister died from COVID. They moved out to San Francisco to care for their sister's kid. That's just like this massive trauma. I think trauma has a way of unsettling, unearthing mental illness. There are a lot of people who previously viewed mental illness as personal weaknesses. Now they see mental illness within themselves. They don't view themselves as weak. Now this is clashing with their ego, their sense of—I mean ego in like this is with self. It's clashing with their sense of self. I think when that happens, then you have this opportunity where people can begin to have these conversations where they can actually challenge what's those?

Maybe it's not about someone being weak. Maybe it's not you're just sad, and you can be happy. You can decide to not be depressed. I honestly do think that it, unfortunately, takes—not for everyone—but some people, it takes personal experience to understand. I think that's kind of a human—I think that's a human—it's easier to understand when you have personal experience. I'll say that. I think COVID has made it so it's impossible to not talk about because so many people are just struggling because how would you not be with so much death, with things, with us not having great medical therapies, with us being socially isolated from everyone.

Even, I think, in general, social beings, all this—the coping strategy that we normally would use, we don't have access to. Specifically, within health care, we are working very hard because there are people coming to the hospital 'cause there's just like—'cause there's all the old diseases that were happening, and now, there's COVID on top of it. For a little while, we weren't seeing the heart attacks, strokes, and now, I think, we're definitely seeing both. Yeah. I'm not sure that answered your question, but I think that—I think there's no way that you could not talk about it now. We could let this opportunity just pass us by and talk about it for a short period of time, or we could use this as a chance to really make a meaningful change.

Bonnie: Yeah. Thank you so much. I just wanna synthesize some of the things that you said. It's all so important across all the strands of our discussion. I do certainly hope that we get to continue this conversation, and our audience continues talking about all the things we talked about in this podcast episode on mental health. Also, thinking about how the environment, right, the structural aspects of life play into that. I think just from listening to this conversation with you, you really touched on that is I think so often we just hyper-focus on the individual, insult that individual, in a stigmatizing way, and just really listening to this common strand of this conversation is we need to think bigger than that, right? We need to think about the structures in place, the environment people are in that is putting people in sad spaces. That is exacerbating. That isn't healthy, and to stop shaming in this space. Thank you.

Justin Bullock: Yeah. Thank you.

Bonnie: Thank you so much for sharing. Thank you so much, Dr. Bullock, Justin, for all of what you're doing. We are so grateful that you are speaking out, sharing your story. We hope you keep doing it.

Justin Bullock: Thank you. I definitely will.

Bonnie: Thanks for being our guest.

Nick: Thank you.

[Music]

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Nick: Thank you to our *Included* podcast team and everyone that made this podcast possible, especially Prateek Gajwani, Curtis Nishimoto, and our guests. Music is by Molly Joyce. This podcast is supported by a Johns Hopkins Ten by Twenty Challenge grant.

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