APA Resource Document

Resource Document on Recommended Best Practices for Physician Health Programs

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--APA Operations Manual

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I. Summary

This Resource Document aims to highlight some important safeguards and best practices for Physician Health Programs (PHPs) for physicians who seek help voluntarily from PHPs as well as those who are mandated participants. These suggestions are intended to help PHPs and their affiliates to align their practices and procedures with the goals of treatment and to minimize the risk of adverse outcomes, both for the public and for the physicians who participate in PHPs. The Council recognizes that undertreatment of psychiatric disorders and suicide risk is a

significant problem among physicians and that PHPs have an important role to play in providing effective, confidential support. This Resource Document reviews some of the potential problems that have been discussed in the literature, popular media, and litigation regarding features and practices of different PHPs. The document also provides suggestions to minimize risks related to conflicts of interest and ethical considerations. Many of the Council's recommendations are drawn from, and consistent with, guidelines promulgated by the Federation of State Physician Health Programs, the American Medical Association, and the American Psychiatric Association. Special attention is called to the important distinction between illness and impairment, procedures for enhancing confidentiality of clinical data, and due process procedures within PHPs, particularly for physicians who voluntarily self-refer to treatment.

II. Introduction and Background

Physician health is a specialized area of medical practice that recognizes that physicians are a valuable public resource. When physicians experience health problems that could affect not only the physicians themselves but also their patients, families, or colleagues, physician health programs (PHPs) are available for assessment, referral to treatment,[1] support, and advocacy. PHPs are often peer-based, confidential resources for physicians and other healthcare professionals with potentially impairing conditions, such as psychiatric illness, substance use challenges, or general medical conditions. PHPs coordinate the detection, evaluation,

[1] "Referral to treatment" is distinct from "provision of treatment." PHPs often are not viewed as treatment providers but, rather, as services that coordinate treatment and evaluation.

treatment, and monitoring of physicians and other providers, and they may be subject to local rules and regulations.[2] The Federation of State Physician Health Programs, Inc. (FSPHP) also provides some guidance to state PHPs.

Medical licensing authorities and state medical societies recognize that physicians should have the opportunity for rehabilitation, confidential support, and access to specific community resources. These are particularly important because of data that indicate a 15-20% lifetime prevalence of substance use disorders and mental health problems among physicians.[3] Fortunately, studies over the decades have also indicated a 75% success rate or more across PHPs.[4] However, concerns about stigma, discrimination, and confidentiality may prevent some physicians from seeking treatment when it is needed.[5]

[2] American Medical Association. Model Physician Health Programs Act. Chicago, IL: AMA, 2016. Accessed 10 May 2017 from http://www.fsphp.org/sites/default/files/pdfs/ama_physicians_health_programs_act_-_2016.pdf.

[3] See, e.g., Dyrbye LN, West CP, Satele D, Boone S, Tan L, Sloan J, Shanafelt TD. Burnout among U.S. medical students, residents, and early career physicians relative to the general U.S. population. *Acad Med* 2014; 89(3): 443–451. Shanafelt TD, Boone S, Tan L, et al. Burnout and satisfaction with work-life balance among US physicians relative to the general US population. *Arch Intern Med* 2012; 172(18): 1377–1385.

[4] See, e.g., Yellowlees PM, Campbell MD, Rose JS, et al. Psychiatrists with substance use disorders: positive treatment outcomes from physician health programs. *Psychiatr Serv* 2014; 65(12): 1492–1495. Knight J, Sanchez L, Sherritt L, Bresnahan LR, Fromson JA. Outcomes of a monitoring program for physicians with mental and behavioral health problems. *J Psychiatr Pract* 2007; 13(1): 25–32. Alpern F, Correnti C, Dolan T, Llufrio M, Sill A. A survey of recovering Maryland physicians. *Md Med J* 1992; 41(4): 301–303. Gallegos K, Lubin B, Bowers C, et al. Relapse and recovery: Five to ten year follow-up study of chemically dependent physicians — the Georgia experience. *Md Med J* 1992; 41(4): 315–319. Shore JH. The Oregon experience with impaired physicians on probation: An eight-year follow-up. *JAMA* 1987; 257(21): 2931–2934. Morse R, Martin M, Swenson W, Niven R. Prognosis of physicians treated for alcoholism and drug dependence. *JAMA* 1984; 251(6): 743–746.

[5] Gold KJ, Andrew LB, Goldman EB, Schwenk TL. "I would never want to have a mental health diagnosis on my record": A survey of female physicians on mental health diagnosis, treatment, and reporting. *Gen Hosp Psychiatry* 2016; 43: 51–57. Center C, Davis M, Detre T, et al. Confronting depression and suicide in physicians: A consensus statement. *JAMA* 2003; 289(23): 3161–3166. Clayton PJ, Reynolds III CF. *Struggling in Silence: Physician Depression and Suicide — A Companion Presentation*. New York, NY: American Foundation for Suicide Prevention, 2008.

Physicians may become involved with a PHP through several contexts: they may be mandated for evaluation or treatment by a board of medical licensure (BML) through investigatory or disciplinary proceedings, or a physician may self-refer to a PHP, even in the absence of functional impairment.[6] As the FSPHP and the AMA have both noted, it is problematic when jurisdictions treat illness and impairment as equivalent.[7] Not only are such policies discriminatory and prohibited by laws such as the Americans with Disabilities Act (ADA),[8] they also provide a disincentive to seeking treatment early in the course of an illness before impairment has begun.[9] Doctors should not be penalized for seeking treatment, nor for having sought treatment in the past.

Ideally, treatment should begin before illness progresses to impairment. However, a number of barriers to early treatment among physicians have been documented. These include the prevailing culture of medicine, which "accords low priority to physician mental health;"[10] discriminatory licensing practices that equate illness or treatment with impairment (e.g.,

[6] According to the FSPHP, "Rehabilitation of physicians with potentially impairing health conditions is the primary function of PHPs." (Federation of State Physician Health Programs, Inc., Physician Health Program Guidelines, December 2005 Edition. Chicago, IL: FSPHP, 2005. Available at: http://www.fsphp.org/resources/guidelines; quote from p.4)

[7] Federation of State Physician Health Programs, Inc., Physician Illness vs. Impairment (Public Policy Statement), July 30, 2008. Chicago, IL: FSPHP, 2008. Available at http://www.fsphp.org/resources/guidelines. American Medical Association. Model Physician Health Programs Act. Chicago, IL: AMA, 2016. Accessed 10 May 2017 from http://www.fsphp.org/sites/default/files/pdfs/ama_physicians_health_programs_act_-_2016.pdf.

[8] Monahan J, Bonnie RJ. License as leverage: Mandating treatment for professionals. *Int J Forensic Ment Health* 2004; 3(2): 131–138. Schroeder R, Brazeau CMLR, Zackin F, et al. Do state medical board applications violate the Americans with Disabilities Act? *Acad Med* 2009; 84(6): 776–781.

[9] Federation of State Physician Health Programs, Inc., Physician Illness vs. Impairment (Public Policy Statement), July 30, 2008. Chicago, IL: FSPHP, 2008. Available at http://www.fsphp.org/resources/guidelines. Center C, Davis M, Detre T, et al. Confronting depression and suicide in physicians: A consensus statement. *JAMA* 2003; 289(23): 3161–3166.

[10] Center C, Davis M, Detre T, et al. Confronting depression and suicide in physicians: A consensus statement. *JAMA* 2003; 289(23): 3161–3166, p.3161.

licensing board questions such as "have you ever had treatment for mental illness?" rather than "do you currently have any illness or condition that would impact your ability to practice medicine safely?");[11] and significant fears about stigma, intrusive questioning, and the risk of being reported to the medical board merely for having sought treatment.[12] While rates of depression and suicide are elevated among physicians, rates of mental health treatment remain disproportionately low. In a study of suicide deaths, for example, Gold, Sen, and Schwenk found that physicians were significantly more likely to have taken antipsychotics, benzodiazepines, or barbiturates *but not antidepressants* in around the time of their deaths.[13]

When impairment does occur, rehabilitation through treatment for substance use disorders, psychiatric illness, or other medical conditions can, in many cases, successfully restore an impaired physician's ability to practice medicine safely with the skill and professionalism

[11] Gold KJ, Shih ER, Goldman EB, Schwenk TL. Do US medical licensing applications treat mental and physical illness equivalently? *Fam Med* 2017; 49(6): 464–467. Schroeder R, Brazeau CMLR, Zackin F, et al. Do state medical board applications violate the Americans with Disabilities Act? *Acad Med* 2009; 84(6): 776–781.
[12] Gold KJ, Andrew LB, Goldman EB, Schwenk TL. "I would never want to have a mental health diagnosis on my record": A survey of female physicians on mental health diagnosis, treatment, and reporting. *Gen Hosp Psychiatry* 2016; 43: 51–57. Miller D. What stops physicians from getting mental health care? *Clin Psychiatr News*, June 29, 2017; accessed July 3, 2017 from http://www.mdedge.com/clinicalpsychiatrynews/article/141611/depression/what-stops-physicians-getting-mental-health-care.
[13] Gold KJ, Sen A, Schwenk TL. Details on suicide among US physicians: Data from the National Violent Death Reporting System. *Gen Hosp Psychiatry* 2013; 35(1): 45–49.

expected of the profession.[14] PHPs facilitate this process of rehabilitation by overseeing or coordinating treatment that protects the physician's privacy.[15]

As a career choice, medicine requires a significant commitment of time, financial investment and debt, and numerous personal sacrifices.[16] For many doctors, perhaps most, medicine is a calling and not merely a job. The potential loss of one's license or professional reputation results not only in lost income but also in significant damage to one's self-image, interpersonal relationships, and emotional wellbeing.[17] For a profession whose members face some of the highest suicide rates in the work force,[18] such concerns require serious consideration.[19] Therefore, physicians should expect that PHPs exhibit compassion, respect, and due process.[20]

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[14] However, it bears noting that an empirical study of data from the Federation of State Medical Boards (FSMB) for the period of 1994—2002 found a correlation between the severity of initial Board of Medical Licensure sanction against a physician and that physician's likelihood of subsequent recidivism. See Grant D, Alfred KC. Sanctions and recidivism: an evaluation of physician discipline by state medical boards. *J Health Politics Policy Law* 2007; 32(5): 867–885. In such cases, current methods of rehabilitation may be insufficient, and revocation of licensure may be necessary if rehabilitation is unsuccessful or impossible.

[15] American Medical Association. Model Physician Health Programs Act. Chicago, IL: AMA, 2016, p.4. Accessed 10 May 2017 from http://www.fsphp.org/sites/default/files/pdfs/ama_physicians_health_programs_act_-_2016.pdf.

[16] Monahan J, Bonnie RJ. License as leverage: Mandating treatment for professionals. *Int J Forensic Ment Health* 2004; 3(2): 131–138.

[17] Verhoef LM, Weenink JW, Winters S, Robben PBM, Westert GP, Kool RB. The disciplined healthcare professional: a qualitative interview study on the impact of the disciplinary process and imposed measures in the Netherlands. *BMJ Open* 2015; 5: e009275; doi: 10.1136/bmjopen-2015-009275. Monahan J, Bonnie RJ. License as leverage: Mandating treatment for professionals. *Int J Forensic Ment Health* 2004; 3(2): 131–138.

[18] Schernhammer ES, Colditz EA. Suicide rates among physicians: a quantitative and gender assessment (meta-analysis). *Am J Psychiatry* 2004; 161(12): 2295–2302.

[19] In the U.K., several suicides of physicians who were under investigation in recent years prompted an internal review by the General Medical Council. See Horsfall S. Doctors who commit suicide while under GMC fitness to practise investigation. General Medical Council (United Kingdom) Internal Review report, 14 December 2014. Casey D, Choong KA. Suicide whilst under GMC's fitness to practise investigation: Were those deaths preventable? *J Forensic Leg Med* 2016; 37: 22–27.

[20] Poor management of a PHP can result in a number of problems related to financial conflicts of interest and violations of the physician's due process rights. It is the Council's belief that following strong ethical guidelines in the administration of a PHP can help to protect against abuse of power and other similar problems to which PHPs may be vulnerable. In 2014, North Carolina's PHP underwent a performance audit, and among the recommendations for the state PHP was to "ensure physicians have access to objective, independent due process procedures." See State of North Carolina, Office of the State Auditor. Performance Audit: North Carolina Physicians

The American Psychiatric Association Council on Psychiatry and the Law was asked by the Association leadership to look into standards and practices among PHPs throughout the U.S. in response to allegations of improper conduct by PHPs or their affiliates. The issues surrounding these allegations include financial conflicts of interest, inadequate treatment options for non-addictive illnesses, fraudulent or erroneous interpretation of test results, failure to maintain proper chain of custody for testing samples, improperly low cutoff levels for a positive result on toxicology screens (such that occupational exposure expected among healthcare professionals (e.g., alcohol in hand sanitizers) is reported to the BML as presumed substance misuse), requiring participants to report the names or identities of other healthcare professionals they encounter in confidential treatment and recovery groups, and unreasonably expensive evaluations and treatment.[21,22] These issues have been raised in the published literature, on

Health Program, April 2014. Accessed May 8, 2017 from: http://www.ncauditor.net/EPSWeb/Reports/Performance/PER-2013-8141.pdf; quote from p.2.

[21] See, e.g., Boyd JW, Knight JR. Ethical and managerial considerations regarding state physician health programs. *J Addict Med* 2012; 6(4): 243–246. Lenzer J. Physician health programs under fire. *BMJ* 2016; 353: i3568; doi: 10.1136/bmj.i3569.

[22] Concerns have been raised about the costs of evaluation and treatment and who is responsible for bearing those costs. The FSPHP guidelines state that "[p]rogram participants [i.e., the physicians in treatment by a PHP] are personally responsible for payment for their medical costs including required evaluations, primary treatment and aftercare/monitoring costs. Participant fees should be fair and equitable with full disclosure at intake." (Federation of State Physician Health Programs, Inc., Physician Health Program Guidelines, December 2005 Edition. Chicago, IL: FSPHP, 2005. Available at: http://www.fsphp.org/resources/guidelines; quote from p.9.) There is also some indication that concerns about the costs and financial ramifications of treatment may discourage some physicians from seeking treatment when it is needed (Iannelli RJ, Finlayson AJR, Brown KP, et al. Suicidal behavior among physicians referred for fitness-for-duty evaluation. *Gen Hosp Psychiatry* 2014; 36(6): 732–736). Evaluations required by PHPs are typically expensive and not covered by insurance (Boyd JW, Knight JR. Ethical and managerial considerations regarding state physician health programs. *J Addict Med* 2012; 6(4): 243–246). Some states (e.g., Rhode Island) have a scholarship fund to help medical students cover some of the costs associated with testing and treatment.

physician blogs, in the popular media,[23] and in litigation.[24] The Council does not confirm or deny the veracity of these allegations. Rather, this Resource Document aims to highlight potential safeguards for physicians who self-refer or are mandated to participate in PHPs, so as to minimize unnecessary risks to physicians and their patients in the future, while recognizing the important public interests that PHPs are working to uphold and offering suggestions for consideration by PHPs to balance these concerns. Many of the recommendations in this Resource Document are drawn from or are otherwise consistent with the recommendations of the Federation of State Physician Health Programs (FSPHP).[25]

III. Structure and Function of PHPs

Significant differences exist between individual state PHPs in terms of referral processes, organizational structure, services available,[26] the PHP's relationship to the medical board, and other factors.[27] Although the FSPHP has published helpful guidance,[28] compliance with the FSPHP guidelines is not mandated for all PHPs.[29] PHPs may be Board-managed agencies,

[23] See, e.g., Glaser G. American doctors are killing themselves and no one is talking about it. The Daily Beast, March 23, 2015. Accessed June 22, 2017 from http://www.thedailybeast.com/american-doctors-are-killing-themselves-and-no-one-is-talking-about-it.

[24] For a listing of jurisdictions in which cases have been pursued, see: Lenzer J. Physician health programs under fire. *BMJ* 2016; 353: i3568; doi: 10.1136/bmj.i3568.

[25] The FSPHP is currently reviewing its existing guidelines, and new guidelines are expected to be released in the near future. Readers are encouraged to consult the new guidelines when they become available.

[26] Brooks E, Early SR, Gunderson DC, Shore JH, Gendel MH. Comparing substance use monitoring and treatment variations among Physician Health Programs. *Am J Addict* 2012; 21(4): 327–334.

[27] For example, the state of California does not have an official, state-sponsored PHP. However, private organizations offer similar services. See, e.g., http://www.pacificassistancegroup.net/CaliforniaPhysicianHealthProgram.en.html.

[28] Federation of State Physician Health Programs, Inc., Physician Health Program Guidelines, December 2005 Edition. Chicago, IL: FSPHP, 2005. Available at: http://www.fsphp.org/resources/guidelines.

[29] The American Medical Association has also published a Model Physician Health Programs Act, which is available through the FSPHP's website: http://www.fsphp.org/sites/default/files/pdfs/ama_physicians_health_programs_act_-_2016.pdf.

medical society affiliates, or independent non-profits.[30] Despite these differences, there are some professional, ethical, and practical commonalities among PHPs.[31] These include:

1. The provision and availability of confidential and professional support
2. Support for diversion to PHPs rather than disciplinary action by medical boards
3. Referral to PHPs in the early stages of illness or impairment
4. Limiting barriers to referral, including risks of retribution
5. Appropriate coordination of detection, evaluation, and treatment
6. Opposition to discrimination on the basis of a history of substance use, mental illness, or other medical condition

At the same time, tensions between the obligations of physician health and community safety create special conditions that are unique to the safety professions in general and particularly to physicians. Physicians who self-refer to a PHP for treatment, for example, may expect privacy within the therapy they undertake; however, different expectations may be operative when the physician is mandated to the PHP by the medical licensing board. In mandated referral cases, missing or failing a drug screen can result in reports to boards who may consequently take action against the physician's license. This may result in a misconception that boards and PHPs

[30] Federation of State Physician Health Programs, Inc., Physician Health Program Guidelines, December 2005 Edition. Chicago, IL: FSPHP, 2005. Available at: http://www.fsphp.org/resources/guidelines.
[31] American Medical Association. Model Physician Health Programs Act. Available at: http://www.fsphp.org/sites/default/files/pdfs/ama_physicians_health_programs_act_-_2016.pdf. Federation of State Physician Health Programs, Inc., Physician Health Program Guidelines, December 2005 Edition. Chicago, IL: FSPHP, 2005. Available at: http://www.fsphp.org/resources/guidelines.

coerce or collude in their respective work, when in fact they perform different functions and under different interpretations of the social contract.[32]

Standards for the safety professions, including medicine, may be higher than in other fields; fitness-for-duty evaluations of physicians may, therefore, require greater expertise. Specialized evaluations are commonly required to assess the condition of physicians who experience difficulties in their practice. Although assessments may follow established guidelines,[33] specialized assessment can involve expensive evaluations that are not covered by health insurance.

PHPs may find themselves in dual relationships; although many of their referrals originate from Boards of Medical Licensure (BMLs), they also must contend with the fact that the physicians themselves are their clients. Like all clinical service providers, PHPs have a duty to protect the public from the actions of impaired physicians. In many—perhaps most—cases, the relationship between a monitored physician and the PHP is conceptualized as a helping relationship rather than simply a forensic one,[34] but the BML may come to be viewed as the

[32] "The social contract is an agreement entered by professionals and governments (as public representatives) that secures a benefit, a right, to the public. The possibility of mandated [medical] board intervention is part of that social contract. The social contract—through licensure and credentialing agreements—confers a benefit to society: the right of individual citizens to expect safe medical practice." (Candilis PJ. Physician health programs and the social contract. *AMA J Ethics* 2016; 18(1): 77–81, p.79) See also: Monahan J & Bonnie RJ. License as leverage: mandating treatment for professionals. *Int J Forensic Mental Health* 2004; 3(2): 131–138. Bonnie RJ, Monahan J. From coercion to contract: reframing the debate on mandated community treatment for people with mental disorders. *Law and Hum Behav* 2005; 29(4): 485–503.

[33] Anfang SA, Faulkner LR, Fromson JA, Gendel MH. The American Psychiatric Association's Resource Document on Guidelines for Psychiatric Fitness-for-Duty Evaluations of Physicians. *J Am Acad Psychiatry Law* 2005; 33(1): 85–88.

[34] When the PHP relationship is mandated by a licensing board, the primary aspect is forensic, and the fiduciary duty on the part of the PHP towards the monitored physician may be secondary to the PHP's fiduciary responsibility to the BML or may even be absent.

primary client of the PHP. One reason for viewing the BML as the primary client would be that the BML has found grounds for a referral, and the physician and PHP have agreed to proceed under those conditions. Balancing responsibilities to the BML and to the physician in a treatment or monitoring program can pose complicated ethical dilemmas for the PHP.

The PHP may have a relationship to the state licensing board that formalizes its role in protecting patients and requires the reporting of impaired professionals. Such reporting requirements often result in taxing interactions for physicians who have an interest in preserving their ability to practice their chosen profession.

IV. Context for Referral

There are several ways in which a physician may interact with a PHP: self-referral, referral for evaluation by BML mandate, or treatment mandated by the BML or PHP.

(a) Self-referral.

In a case in which the physician self-refers to a PHP, a confidential relationship should be deemed to have been established between the physician and the PHP, such that no release of clinical information to third parties should take place without the prior written consent of the physician-PHP-participant unless common reporting requirements are triggered.[35] The

[35] This recommendation is consistent with the FSPHP Guidelines: "For non-board mandated participants, programs should provide confidential management. PHP participants should not be subject to investigation or disciplinary action by a licensing authority based solely upon a health diagnosis or affiliation with the PHP." (Federation of State Physician Health Programs, Inc., Physician Health Program Guidelines, December 2005 Edition. Chicago, IL: FSPHP, 2005. Available at: http://www.fsphp.org/resources/guidelines; quote from p.4)

American Medical Association's model Physician Health Programs Act stresses the importance of confidentiality:

> "The AMA believes privacy and confidentiality of a physician's health and treatment history must be paramount in the relationships between PHPs and ill physicians and other licensed health care professionals to allow those in need of help to come forward without fear of punishment, disciplinary action, embarrassment, or professional isolation. Confidentiality enhances the opportunity for recovery, [and] is an incentive to participate in early intervention."[36]

Although common mandated reporting requirements of child abuse and danger to the third parties may still hold, treatment should not necessarily be contingent upon the physician signing a release-of-information agreement. Although releases may be appropriate to set up workplace monitors and contact with treaters, it should be assumed that the physician engaging in consultation with a PHP has done so in an effort to obtain professional medical care, and the relationship should be so protected.[37] (The physician should be willing to provide appropriate release of information for obtaining past medical treatment and history

[36] American Medical Association. Model Physician Health Programs Act. Chicago, IL: AMA, 2016, p.4. Accessed 10 May 2017 from http://www.fsphp.org/sites/default/files/pdfs/ama_physicians_health_programs_act_-_2016.pdf.

[37] At least one jurisdiction has, in the past, allowed a one-time exception to the duty to report impairment to the BML, in order to encourage early self-referral to treatment: "A physician licensed by the State Medical Board who suffers from impairment of ability to practice according to acceptable and prevailing standards of care because of habitual or excessive use or abuse of drugs, alcohol, or other substances that impair ability to practice is in violation of Section 4731.22(B)(26), Ohio Revised Code, and subject to Board disciplinary action. Any Board licensee having knowledge of such a violation is required by Section 4731.224(B) to report that information to the Board. In 1987, however, the Ohio General Assembly carved out a one time 'one bite' exception, whereby an impaired physician may escape Board intervention, and the physician's colleagues may be excused from reporting the physician's impairment, so long as the physician has completed treatment with a Board approved treatment provider and maintained uninterrupted sobriety, and violated no other provisions of the Ohio Medical Practice Act. In addition, the physician must adhere to all other statutory requirements. The One Bite Rule is codified in Sections 4731.22, 4731.224 and 4731.25, Ohio Revised Code, and Rules 4731-15-01, 4731-16-04, 4731-16-07, and 4731-16-13, Ohio Administrative Code." State Medical Board of Ohio. Policy Statement: Licensure of Chemically Impaired Resident Physicians, February 14, 2001; Revised July 10, 2008.

so that the PHP can obtain the information it needs to fulfill its obligation to facilitate effective treatment.)

At the outset of treatment, self-referred physicians should be provided with an opportunity for informed consent, including disclosure of risks to confidentiality. Strong privacy and confidentiality protections should remain a high priority for PHPs in helping self-referred physicians:

> "When confidentiality is endorsed and assured by PHPs and licensure boards, the AMA believes that physicians with potentially impairing conditions are more likely to come forward and utilize PHP services earlier. This reduces the likelihood of the illness progressing to functional impairment, and promotes patient safety."[38]

For physicians who self-refer and participate voluntarily, there should be no reporting of a clinical condition or failure of a drug test to the BML without a finding of impairment in the practice of medicine or reasonable grounds to believe that the physician is impaired.

(b) Referral for evaluation by licensing board mandate.

To the extent possible, evaluations compelled by a Board of Medical Licensure (BML) mandate should occur within the boundaries of the physician's locale and the BML's own jurisdiction. In most cases, the evaluation and treatment are provided by a clinician or

[38] American Medical Association. Model Physician Health Programs Act. Chicago, IL: AMA, 2016, pp.2–3. Accessed 10 May 2017 from http://www.fsphp.org/sites/default/files/pdfs/ama_physicians_health_programs_act_-_2016.pdf.

clinicians not employed by the PHP.[39] The intensity of the evaluation, e.g., inpatient versus outpatient, should be established based upon the referred physician's medical condition. Outpatient evaluations should be considered alongside inpatient evaluations so as not to disrupt medical care for patients or the referred physician's practice and unnecessarily add to the expense of the evaluation.

Reports or records created either by the PHP or by community clinicians during the course of an evaluation or pursuant to an order for such evaluation should be treated as confidential medical information to the extent that the law or state regulations allow. Although ordinary confidentiality standards do not apply to records created for the purposes of a BML-mandated evaluation, copies of reports resulting from the evaluation should be provided simultaneously to the physician or their designee as well as to the BML or PHP.

(c) Treatment mandated by the BML or PHP.

If the evaluation concludes that treatment is necessary, the evaluator should provide recommendations for at least ***three*** (3) clinical sites appropriate for the physician's condition. Preference should be given to sites located within the jurisdiction of the

[39] Thus, in most cases, the PHP is considered a coordinator of treatment, not the treatment provider. However, the boundaries may become blurred when the PHP steps outside the coordination role (e.g., by encouraging a participant not to take medicines prescribed by the treating clinician). In such a case, the recommendations of the treating clinician should take precedence.

physician and the BML and, if possible, should be ambulatory rather than residential. However, the intensity of the treatment program should be matched to the severity of the problem, and physicians' preferences for travel outside the community that knows them should be honored. Furthermore, in addition to the traditional chemical dependency treatment track found in most PHPs, there should be treatment tracks designed specifically for the management of psychiatric disorders or other medical disorders that do not require traditional substance-abuse program elements. PHPs should, whenever possible, refer participating physicians to clinicians who are members of the panel of the participant's insurance, so as to allow maximum access to care.

V. Standards for Physician Health Programs.

PHPs should follow standards based on expert consensus in order to balance ethical responsibilities to protect the public and to help the physicians who participate in their programs.

(a) Mental health, suicide prevention, and the role of psychiatrists.

In the treatment of physicians with known or possible substance use, mental health difficulties, or other medical illnesses that may affect patient care and occupational performance, psychiatrists play a critical role. Differential diagnosis is especially important, particularly where addictions or psychiatric comorbidity are elements of the referring question. In most cases, the physician in PHP-coordinated evaluation or treatment should receive, at minimum, a comprehensive psychiatric assessment and examination, even when

the presenting problem appears on its surface to be related solely to substance use. Ideally, the leader of the team should be a psychiatrist with expertise in substance use disorders where mental health issues are among the precipitants to the referral.

Due to the high rates of suicide among physicians,[40] suicide prevention should be recognized as a central goal of the services performed by PHPs. Furthermore, there is some evidence that physicians mandated to treatment and fitness-for-duty evaluations are at an increased risk for suicide compared to their peers who are not referred for treatment or evaluation.[41] Compared with other specialists and generalist physicians, psychiatrists are uniquely qualified to perform an accurate suicide risk assessment and to formulate treatment and monitoring recommendations based on the estimated risk of suicide. The American Psychiatric Association has indicated that "[t]he psychiatric evaluation is the essential element of the suicide assessment process."[42] Furthermore, among physicians, there appears to be a correlation between suicide and the severity of both substance use

[40] Schernhammer ES, Colditz EA. Suicide rates among physicians: a quantitative and gender assessment (meta-analysis). *Am J Psychiatry* 2004; 161(12): 2295–2302

[41] Iannelli RJ, Finlayson AJR, Brown KP, et al. Suicidal behavior among physicians referred for fitness-for-duty evaluation. *Gen Hosp Psychiatry* 2014; 36(6): 732–736. Crawshaw R, Bruce JA, Eraker PL, et al. An epidemic of suicide among physicians on probation. *JAMA* 1980; 243(19): 1915–1917. Note, however, that this correlation does not imply causation; it is possible that the increased suicide risk precedes referral for a fitness-for-duty evaluation. We do not imply here that the fitness-for-duty evaluation process itself increases a physician's suicide risk. Elevated suicide risk in impaired/disciplined physicians may well precede treatment or disciplinary action on the part of the PHP or BML. Nonetheless, it bears noting that some medical bloggers have expressed the belief that actions taken by PHPs have increased the suicide risk for physicians in the PHP programs (Finlayson AJR, Iannelli RJ, Brown KP, Neufeld RE, DuPont RL, Campbell MD. Re: physician suicide and physician health programs (letter). *Gen Hosp Psychiatry* 2016; 40: 84–85).

[42] American Psychiatric Association. *Practice Guideline for the Assessment and Treatment of Patients with Suicidal Behaviors.* Arlington, VA: American Psychiatric Association, November 2003. Accessed 22 June 2017 from http://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/suicide.pdf.

disorder and comorbid mental illness,[43] further underscoring the importance of specialized assessments by well-qualified psychiatrists.

Evaluating, treating, and making treatment recommendations for physicians with suspected substance use or mental illness should be the domain of highly qualified psychiatrists with training and experience in suicide risk assessments, severe mental illness (specifically bipolar disorder and major depressive disorder), and, ideally, addictions. PHPs with sufficient resources may find specialists with added qualifications in forensic psychiatry helpful.

(b) Access to laboratory and other testing and medical records.

Where compliance with a treatment or monitoring program is mandated by the BML, all toxicology screenings should be done with a legal chain of custody, with all testing samples preserved for retesting should that be desired or indicated. The standards used for interpretation of the results of such drug testing should be those generally acceptable in the medical community with sensitivity set in such a way as to avoid unnecessary or frequent false positive findings.[44] A false positive is not a benign inconvenience for the PHP-referred

[43] Finlayson AJR, Iannelli RJ, Brown KP, Neufeld RE, DuPont RL, Campbell MD. Re: physician suicide and physician health programs (letter). *Gen Hosp Psychiatry* 2016; 40: 84–85.

[44] For example, alcohol-based hand sanitizer has been shown to produce false positives in ethyl glucuronide (EtG) tests. See Arndt T, Grüner J, Schröfel S, Stemmerich K. False-positive ethyl glucuronide immunoassay screening caused by a propyl alcohol-based hand sanitizer. *Forensic Sci Int* 2012; 223(1–3): 359–363. Similarly, positive morphine tests have occurred in persons who merely consumed small amounts of poppy seeds (Boyd JW, Knight JR. Ethical and managerial considerations regarding state physician health programs. *J Addict Med* 2012; 6(4): 243–246).

physician and their patients; such findings are often reported automatically to the BML, requiring the physician to hire an attorney and, often, refrain from working while an investigation is conducted. In the event that a physician believes that a reported test has been a false positive, appropriate confirmatory testing shall be performed, and the physician should be provided an opportunity to recommend a laboratory for such testing from an acceptable group of certified settings.[45]

Because of concerns about chain of custody and verifiability of test data and interpretation, we recommend that reports of findings from toxicology screening be provided to the physician/client directly, as well as to the monitoring authority.[46] Similarly, the raw materials that contributed to the evaluation (such as reports of psychological and/or neuropsychological testing, including the physician's raw data) should be considered to be the medical record of the physician in treatment and should be preserved and incorporated into the medical record and available to the physician promptly upon their request.

[45] The physician and the PHP may need to negotiate a compromise regarding testing laboratories if a disagreement arises. Some labs are not certified, some do not perform observed urine testing, and some otherwise fall short on security measures, such as temperature-sensitive containers that indicate a recent sample. The physician's rights and convenience and the PHP's concerns about the security and scientific integrity of the testing should all be given afforded consideration.

[46] Some have suggested that providing the physician clients with access to information about the testing could make the monitoring system and testing vulnerable to manipulation ("gaming the system") by the monitored physician. However, these concerns must be balanced against the physician's legitimate interests in liberty and due process. Appropriate confirmatory testing may be indicated where the results of a test are in dispute.

No records from the physician's treatment, held by the PHP, should be considered exempt from access by the physician/client or the physician/client's designated psychologist upon reasonable request and notice.

(c) Compliance with FSPHP Guidelines.

To the maximum extent possible, each state's PHP should be in compliance with the guidelines set forth by the Federation of State Physician Health Programs (FSPHP).[47] Some of these guidelines include:

- Separate procedures for self-referred physicians and physicians mandated into treatment and evaluation by BMLs, including additional standards for the confidentiality and privacy of self-referred physicians;
- Policies should not require PHPs to report self-referred physicians to the state's BML unless there is evidence that the physician is practicing while impaired (such that patient safety might be compromised) and is also unwilling or unable to voluntarily withdraw from practice;
- Clearly designated informed consent procedures;
- Clearly defined procedures regarding participants' confidentiality and privacy;

[47] These guidelines are freely available on the web at: http://www.fsphp.org/resources/guidelines.

- Allowing each participant physician the freedom to choose one's own treating clinician;[48]
- Adoption of recognized standards for peer review and testing;
- Explicit policies to discourage financial conflicts of interest:
    - For example, the state PHP should have independent funding and, to the extent possible, should not rely on funding from the BML or from another source that may raise concerns about a conflict of interest, e.g., a laboratory testing company;
    - Clinicians and administrators of a PHP or BML should not have a financial interest in PHP-administered treatment programs;
    - PHP-affiliated programs, clinicians, and administrators should not have a financial incentive to extend treatment or monitoring longer than what is clinically appropriate for a physician's condition,[49] nor to order unnecessary additional testing;
    - "Due diligence must be taken to avoid acceptance of funds from sources that could create a conflict of interest;"[50]

[48] The chosen treating clinician should have sufficient skill and training to effectively treat the physician's condition. For example, a physician with alcohol use disorder might best be served by a psychiatrist with additional training and experience in addictions. The PHP should honor the physician's choice of treating clinician when the chosen clinician has the appropriate professional background and qualifications.
[49] The FSPHP guidelines provide specific recommendations regarding the appropriate minimum and maximum duration of monitoring for psychiatric disorders as well as substance abuse or substance dependence.
[50] Federation of State Physician Health Programs, Inc., Physician Health Program Guidelines, December 2005 Edition. Chicago, IL: FSPHP, 2005. Available at: http://www.fsphp.org/resources/guidelines; quote from p.9.

    - PHPs "must not have any conflict of interest or business association with programs utilized for referrals;"[51]
- Fees assessed to physicians who participate as recipients of PHP services "should be fair and equitable with full disclosure at intake;"[52] and
- "PHPs should not operate for the purpose of making a profit."[53]

Although one of the FSPHP's recommendations states that PHPs should not be designed as profit-making enterprises, it bears noting that some PHPs are currently designed as for-profit businesses, and in some jurisdictions the PHP or BML may have awarded a contract to profit-making entity for the provision of services. In the interests of transparency and discouraging financial conflicts of interest, PHPs should ideally disclose (for example, in their Annual Reports) the sources of funding (e.g., percentage of operating budget derived from physician fees, the percentage obtained from medical staff at [names of specific hospitals], and so forth).

Additionally, there should be a mechanism for peer review and quality improvement in the PHP. Ideally, the peer review should be done by an independent board or outside agency on a regular basis.

[51] Federation of State Physician Health Programs, Inc., Physician Health Program Guidelines, December 2005 Edition. Chicago, IL: FSPHP, 2005. Available at: http://www.fsphp.org/resources/guidelines; quote from p.10.
[52] Federation of State Physician Health Programs, Inc., Physician Health Program Guidelines, December 2005 Edition. Chicago, IL: FSPHP, 2005. Available at: http://www.fsphp.org/resources/guidelines; quote from p.9.
[53] Federation of State Physician Health Programs, Inc., Physician Health Program Guidelines, December 2005 Edition. Chicago, IL: FSPHP, 2005. Available at: http://www.fsphp.org/resources/guidelines; quote from p.6.

There should be a process of appeal for physicians who feel aggrieved by the actions of a PHP to an independent board, agency, or ombudsperson.

When the PHP or one of its affiliates is structured as a profit-making enterprise, allegations of coercion, exploitation, or other improper conduct on the part of the PHP or its affiliate(s) should be taken seriously and promptly investigated.

Finally, the informed consent discussion for the physician who is entering into a partnership with a PHP for evaluation, treatment, or monitoring should be thorough and should not be rushed. This discussion should take place before the initiation of treatment and should address, at a minimum, limitations to confidentiality, such as the clinician's mandate to report suspected child or elder abuse or neglect and duty to warn or protect clients or third parties in the event of a serious risk of harm, including reporting to the MLB when information indicates that there is an impaired physician at risk of harming others. The physician should be afforded an opportunity to ask questions and should be fully informed of circumstances under which the jurisdiction requires reporting otherwise confidential medical information to a BML or other entity (e.g., peer-review committee).

VI. Conclusion

These recommendations attempt to address some of the current or potential problems associated with the structure and administrative standards for PHPs. PHPs vary significantly from one state to the next, but all aim to facilitate treatment for physicians whose psychiatric,

substance use, or medical condition could affect their ability to practice medicine safely. To this end, we have provided several recommendations that we hope may help PHPs to ensure that their practices and operations remain consistent with their stated missions, while assisting physician-patients who may become involved in PHP practices.