

Collective Wisdom

Compiled by Louise B. Andrew MD JD FACEP

I was honored when Mark Plaster asked to publish an article of mine in one of the very first editions of this publication, and equally so when Logan Plaster approached me about starting an advice column for EPs. I'm not sure whether this means that if you stay around long enough people will WANT to hear you, or just that at a certain age it is no longer polite to ignore a wizening "maternal type unit", which I confess to being. Interestingly, the topic of that first article, Litigation Stress, is still timely; and it was my work with physicians undergoing this particular threat to our profession which led to my work with ACEP in physician wellbeing, my work through CCEMT aimed at increasing the ethicality of medical expert witnesses, and to my emerging concerns regarding depression and suicide in physicians. Although depression in professionals is by no means solely related to litigation (indeed, lawyers have an increased level of depression and suicide relative to the general population), it is still one of a number of stressors which can precipitate depression in individuals who are predisposed by virtue of genetics.

But I don't need to dwell on causes of depression. I want instead to begin to respond to questions posed by readers about anything of concern to you or to your colleagues. I don't claim to be an expert in all things, far from it. But in my years of working in a number of professional circles I have benefited from an ever widening network of amazingly gifted people who are expert in many fields. So when I can't offer anything intelligent, I will call on these colleagues liberally for advice and share their wisdom with you. Thus the column is aptly to be regarded, not as "Dear Weezy", but as "Collective Wisdom".

So I want to offer in my first column a short response to a query posed in a rhetorical way by a [respondent](#) to our December [survey](#). You may recall the anonymous comment of one reader, "I have had the pistol in my mouth and would have pulled the trigger, save for leaving my child without a parent. Does anyone honestly think that anyone in our position would report this type of thought to any

board? Go under the microscope? Lose our ability to provide for our families? For as much hype as is given to diagnosis and treatment of depression, state boards and everyone else hold their physicians to a different standard. If I were a plumber or musician, I would just go see my psychiatrist, take medication, and go on with my life, better off for having done so. We are held to an impossible double standard.”

I represent ACEP as liaison to the Federation of State **Medical Boards**, [FSMB](#), which just last month held a conjoint session with the Federation of State **Physician Health Programs** ([FSPHP](#)) on the topic of Physician Depression and Suicide. This was an educational session, not a workshop, but I was pleased that the two groups had agreed upon this topic, and to learn that the Executive Director of the FSMB, Dr. James Thompson, will sit on a Task Force organized by the American Foundation for Suicide Prevention, [AFSP](#), as part of its Physician Suicide Prevention Project.

But I want to say more about the State **Physician Health Programs**, because they are a widely underutilized and misunderstood resource which is available to physicians who are facing a variety of stressors, and they could provide lifesaving, confidential support to a physician such as our respondent above. Currently 43 states are members of the Federation, but every state has a so called “Diversion Program” or other mechanism for promotion of early identification treatment, documentation and monitoring of physicians who may be suffering from a condition which could affect patient care or result in impairment. Impairment is the inability to practice medicine with reasonable skill and safety as the result of an illness or injury, including of course mental illness (a subset of which is substance abuse). There is a mistaken tendency to equate impairment with chemical dependency, which is not accurate.

State **physician health programs** may be independent, non profit organizations, which may or may not be affiliated with the state medical society, and may or may not be administered by the licensing board. PHP’s function on an Employee Assistance Program model, meaning that they maintain a long arm relationship with the empowering authority, in this case the licensing board. Interactions between physicians and these programs are governed by several degrees of confidentiality, including therapist privilege, peer review protection, HIPAA, JCAHO and Federal Alcohol and Drug Confidentiality under 42 CFR. A physician can self refer to the PHP, or be referred by a colleague or family member, or by the state medical board. Only in the last instance is the participation mandatory, or linked necessarily with maintenance of licensure. PHPs typically provide referrals for assessment, therapy and counseling, intervention for substance abuse and dependence, including monitoring for compliance, workplace monitors, guidance for competency assessment and retraining if indicated, and some provide support meetings such as Caduceus, AA, and NA.

There are two important things to know about PHPs. One is that the physicians who administer these programs are very often in recovery themselves, and are both sympathetic to, and knowledgeable about, the various types of impairing conditions which can affect physicians. Due in part perhaps to their own experiences, many maintain a certain degree of aloofness from their associated board. It is not an adversarial relationship, but it is certainly a “circumspect” relationship. The other thing is that the services and providers to which the PHPs refer clients are both extremely knowledgeable about

physician illnesses and impairment, and genuinely concerned about maintenance of physician competence or successful return to practice if there is an absence.

As long as a physician is successfully addressing the condition for which the PHP is consulted, and there is no evidence of current impairment, a PHP will not notify the licensing board about the physician's consultation. Both parties document an understanding of this relationship early in the consultation, and there are no covert communications which would result in "exposure" or licensure review, as long as stipulated conditions are being met. Although not yet universal, there is a move afoot to make it possible for an applicant for licensure or renewal to check "NO" to the box regarding treatment for possible impairing conditions as long as the physician is addressing the condition under the supervision of a PHP. So a physician such as our respondent who understandably hesitates to report his/her depression to the state board, can (and probably should) consult his PHP immediately regarding needed intervention for depression, and can do so without fear of reporting as long as he is truly not impaired and is seeking appropriate treatment.

This is a short answer to a profoundly though provoking question on the part of our reader, but I hope it will serve to address a few of the concerns which were expressed. If you are currently experiencing depression or any potentially impairing condition, PLEASE contact your physician state health program. A list of these programs can be accessed on the home page of my website, www.physiciandepression.com, or you can find your local program by contacting your state medical society (whether or not you are a member).

I welcome your input and comments on this column. Is it helpful? Relevant? Hopeful? Questions for possible future discussion can be sent to me mail@mdmentor.com.