REPORT 1 OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH (I-10)
Physician Health Programs
(Reference Committee K)

EXECUTIVE SUMMARY

Objective. To provide an historical overview on the development and operation of physician health programs (PHP) and briefly discuss what is known about the barriers to use of PHPs and the effectiveness of their confidentiality safeguards. Additionally, to review some key studies on the effectiveness of PHPs in order to identify best practice characteristics.

Methods. English-language reports on studies using human subjects were selected from a PubMed search of the literature from 1970 to July 2010 using the search terms "physician," or "resident," in combination with "impairment," "addiction," "treatment," "monitoring," and "state health programs." Additional articles were identified by manual review of the references cited in these publications. The Federation of State Physician Health Programs Web site also was consulted.

Results. Several AMA policies address various aspects of physician health, including the personal responsibilities of physicians to maintain their health and wellness and to seek appropriate help as necessary. Most states have active PHPs but they operate under multiple administrative structures and vary greatly with respect to their funding base. Current PHPs have common approaches, including use of a formal signed contract, referral to abstinent-based treatment, long-term support and contingency monitoring, drug testing, and reporting results to credentialing agencies. When properly implemented, such programs have a high rate of success in returning physicians to active practice.

Conclusion. The medical profession has an obligation to ensure that its members are able to provide safe and effective care. All PHPs aim to protect the public and to help physicians maintain their own health and effectiveness, while protecting physicians' same right to privacy and confidentiality of their medical records as anyone else seeking medical help or treatment. It is important that a state PHP have a strong collaborative relationship with the medical board in the state. The AMA recognizes the following as essential components of a state PHP: (1) contingency management that includes both positive and negative consequences; (2) random drug testing; (3) linkage with 12-step programs and with the abstinence standard espoused by these programs; (4) management of relapses by intensified treatment and monitoring; (5) use of a continuing care approach; (6) focus on lifelong recovery; and (7) protection of anonymity.

REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 1-I-10

Subject: Physician Health Programs

Presented by: Albert J. Osbahr, III, MD, Chair

Referred to: Reference Committee K
(Michael M. Miller, MD, Chair)

INTRODUCTION

Policy D-405.990 "Model Physician Health Program Act" (AMA Policy Database) asks that our American Medical Association (AMA): (1) affirm the importance of the AMA Office of Physician Health and Health Care Disparities and the importance of promoting physician health; (2) work with the Federation of State Physician Health Programs (FSPHP) to study barriers to effective utilization of state physician health programs (PHPs) and the effectiveness of their confidentiality safeguards and stability of funding; (3) review and update of existing AMA policy on PHPs, including Policy H-275.964; (4) review and update existing model legislation (Model Act) on PHPs; (5) review the FSPHP Physician Health Program Guidelines to determine their relevance to AMA policies and work to update and develop additional FSPHP guidelines in order to promote safe and effective utilization of PHPs; (6) work with the FSPHP to educate our members on the availability of state PHPs and services in order to create and better inform physicians and medical students about the purpose of PHPs and the relationship of such programs to licensing activities; and (7) clarify the confidentiality issues involved in communications between state PHPs and state medical licensing boards, including the applicability of 42 CFR 2 (Confidentiality of Alcohol and Drug Abuse Patient Records).

This report provides an historical overview on the development and operation of PHPs, notes relevant AMA policy, and briefly discusses what is known about the barriers to use of PHPs and the effectiveness of their confidentiality safeguards. Additionally, some key studies demonstrating the effectiveness of PHPs are reviewed in an effort to identify best practice characteristics.

METHODS

English-language reports on studies using human subjects were selected from a PubMed search of the literature from 1970 to July 2010 using the search terms "physician," or "resident," in combination with "impairment," "addiction," "treatment," "monitoring," and "state health programs." Additional articles were identified by manual review of the references cited in these publications. The FSPHP Web site also was consulted.

HISTORICAL DEVELOPMENT OF PHYSICIAN HEALTH PROGRAMS

Formal efforts to deal with physician illness and/or impairment originated more than 50 years ago when the Federation of State Medical Boards (FSMB) identified drug addiction and alcoholism among physicians as disciplinary problems. Before the 1970s, physicians were presumed to be in charge of their own health, as well as others, and largely invulnerable. In 1973, the AMA's Council on Mental Health published a landmark report entitled, "The Sick Physician: Impairment by Psychiatric Disorders, including Alcoholism and Drug Dependence."[1] This report argued that physicians also were susceptible to chronic illnesses such as heart disease, depression, and addiction, but in different ways than the general population, and that physicians needed to do a better job of helping their colleagues who were ill. Barriers included failure to recognize illness, a lack of knowledge and competence about how to best intervene and help ill physicians, and a prevailing "conspiracy of silence" among practitioners.

In response, the AMA subsequently convened physician health conferences in 1975 and 1977, with the purpose of promoting the health and appropriate treatment of physicians. Many reports published in the late 1970s increased awareness about physicians afflicted with addiction and/or mental illness. Within 10 years of the Council report, all but 3 of 54 medical societies in the United States had authorized or implemented PHPs. Additionally, in 1985 the AMA developed model state legislation addressing PHPs.[2]

The FSPHP, founded in 1990, evolved from initiatives taken by the AMA and individual state PHPs. A resolution adopted by the FSMB in April 1995 called for the development of a model program of probation and rehabilitation that could be adopted by individual state boards. The resolution also recommended that committees and programs be developed to address these issues, and that statutory provisions should enable treatment rather than disciplinary action for the sick physician.

Concerns were expressed that PHP practices were driven primarily by precedent and not evidence. In 1996, a national PHP conference was convened in Colorado with representation from the FSPHP, AMA, American Psychiatric Association, American Academy of Addiction Psychiatry, American Society of Addiction Medicine, and the FSMB. An outcome of this conference was the creation of a national database health screening questionnaire adopted by many PHPs. Individual PHPs began researching the characteristics of their respective databases. Aggregate data from multiple PHPs also was evaluated helping to shape clinical policies and procedures in the field. Individual states have developed programs that operate within the parameters of state regulation and legislation and provide many different levels of service to physicians in need.

In 2001, The Joint Commission issued a standard to require a process for addressing physician health and broadened the standard to include other practitioners in 2004. These standards reinforced the mission of state PHPs to provide assessment and monitoring services for physicians with potentially impairing illnesses.

In 2008, the AMA released the following statement with respect to physician health programs:[3]

> The AMA supports state health programs that provide medical treatment and monitoring for physicians with substance abuse or other health concerns. Patient safety is paramount, and well-run state health programs with proper treatment and monitoring for physicians are essential to ensure the safety and protection of patients. As patients, physicians are entitled to the same right to privacy and confidentiality of personal medical information as any other patient.

AMA POLICY

Several current policies address various aspects of physician health (Appendix I). Policy H-275.964 encourages states to develop effectively functioning PHPs. Physicians with major depression who seek treatment should have their status evaluated based on professional performance, and not merely routinely challenged (Policy D-275.974). Policy H-295.979 notes that medical school curricula should address the prevention of substance misuse, and urges medical schools, hospitals with graduate medical education programs, and state and county medical societies to initiate active liaison with local impaired physician committees. Policy H-275.998 outlines the responsibilities of the medical profession, individual physician, hospital review committees, state government, and state licensing boards with respect to physician competence. Physicians have an ethical obligation to report impaired, incompetent, and unethical colleagues and should be familiar with the reporting requirements of their own state (Policy H-275.952).

Finally, Policy E-9.0305 outlines the personal responsibilities of physicians to maintain their health and wellness and to seek appropriate help as necessary, including the fact that every physician should have a personal physician whose objectivity is not compromised. Physicians whose health or wellness is compromised should take measures to mitigate the problem. Overall, the medical profession has an obligation to ensure that its members are able to provide safe and effective care. This obligation is discharged by: (1) promoting health and wellness among physicians; (2) supporting peers in identifying physicians in need of help; (3) intervening promptly when the health or wellness of a colleague appears to have become compromised, including the offer of encouragement, coverage or referral to a physician health program; (4) establishing physician health programs that provide a supportive environment to maintain and restore health and wellness; (5) establishing mechanisms to assure that impaired physicians promptly cease practice; (6) assisting recovered colleagues when they resume patient care; and (7) reporting impaired physicians who continue to practice, despite reasonable offers of assistance, to appropriate bodies as required by law and/or ethical obligations.

FEDERATION OF STATE PHYSICIAN HEALTH PROGRAMS, INC.

The FSPHP is a nonprofit corporation whose purpose is to provide a forum for education and exchange of information among state programs, to develop common objectives and goals, to develop standards, to enhance awareness of issues related to physician health and impairment, to provide advocacy for physicians and their health issues at local, state, and national levels, and to assist state programs in their quest to protect the public.[4]

Goals of the FSPHP

The goals of the FSPHP are to: (1) promote early identification, treatment, documentation, and monitoring of ongoing recovery of physicians prior to the illness impacting the care rendered to patients; (2) achieve national and international recognition as a supporter of state PHPs; (3) promote the best medical care possible for all patients; (4) pursue consistent standards, language, and definitions among state PHPs; and (5) maintain an organizational structure that will help achieve its vision and mission.

FSPHP Physician Health Program Guidelines

The FSPHP Physician Health Program Guidelines were published in 2004 and further developed and re-released in 2005.[5] The Guidelines currently include three main sections: general guidelines, substance use disorders, and management of other psychiatric disorders, with appendices for

evaluations and treatment programs. The Guidelines are intended solely for use by PHPs for program development and enhancement. These Guidelines reflect the consensus of existing PHPs, are evolutionary in nature, and are intended to be modified based upon future research and experience. The Guidelines may not encompass all administrative structures and program options available to PHPs, and implementation may be impacted by applicable state legal, contractual, or regulatory requirements. Consequently, the ability of any given state PHP to implement all guideline components may be limited. Individual PHPs can modify the Guidelines, and such modifications are appropriate when based upon sound clinical judgment and/or regional or local legal considerations or systems issues. A glossary of relevant definitions and/or concepts is found in Appendix II.

CURRENT PHYSICIAN HEALTH PROGRAMS

The following discussion details the structure and mission of state PHPs and provides perspective on the challenges of appropriately revising the Model Act.

Administrative Structures

Currently multiple administrative structures exist across the country under which PHPs operate. These structures are not mutually exclusive and programs frequently meet criteria for several categories. The different types of state programs currently in existence include the following:

- Independent Not-for-Profit Corporation Programs – These operate under contract or formal agreement of understanding with a medical society and/or medical board. The independent corporation may contract for services with multiple licensing authorities and serve multiple professions within the state.

- Medical Society Affiliated or Sponsored Programs – These operate under contract or formal agreement with a medical society and are operated by the society.

- Medical Board Authorized or Medical Board Managed Programs – These operate under contract or formal agreement with the medical board, and may be operated with either independent clinical, or full board clinical oversight.

The various structures of PHPs makes it very difficult, if not impossible, to write model legislation that would apply equally to all states. Instead, a Model Act should identify common concepts and operational precepts, and seek to codify these concepts as noted below. Additionally, not all states have language in their Medical Practice Acts addressing physician health, nor would all endorse the introduction of such language.

Current Status of State Physician Health Programs

Almost all states have PHPs. The remaining states are in the process of passing legislation to establish such programs. Information on each state's PHP, including contact information, administrative structure, services offered, and funding sources can be found on the FSPHP Web site (http://www.fsphp.org/State_Programs.html). Existing programs vary greatly in their funding base, other support and structure as noted above. The average annual operating budget of PHPs is more than a half-million dollars, but ranges from just over $20,000 to $1.5 million.[6] Funding is derived in part from licensing boards, participant fees, state medical associations, hospitals, and insurance companies. Drug testing costs are covered by the participants.

Concepts Common to Physician Health Programs

All PHPs aim to protect the public and to help physicians maximize their own health and effectiveness. The fundamental nature of PHPs is that they protect the public by encouraging physicians to seek treatment for potentially impairing illness prior to the illness impacting patient care. In order to maximize the chance that physicians will seek treatment early in the course of an illness, they need assurance that their confidentiality will be protected, and that their decision to seek help will not, in and of itself, be used against them. Inherent in this principle is the distinction between illness and impairment. The former is a condition that is almost universal to human existence at some point; the latter refers to being "unable to practice medicine with reasonable skill and safety to patients because of physical or mental illness" as defined by the AMA Policy H-95.955. These conditions can overlap at times, but are not synonymous.

Effectiveness of Physician Health Programs

Reports from treatment programs on studies conducted in the 1980s and 1990s indicate that approximately 70% of health care professionals successfully return to practice after treatment in a PHP.[7-14] A retrospective analysis of 292 health care professional physicians enrolled in the Washington Physicians Health Program from January 1991 through December 2001 found that 75% of individuals successfully completed the program without relapse. In those who suffered relapses, the risk was increased in individuals who used an opioid, had a co-existing psychiatric illness, or positive family history for substance use disorder.[15]

Even better results were reported by the Medical Society of the District of Columbia's Physicians Health Program where approximately 90% of physicians successfully completed their 5-year contracts.[16] These contracts mandated random urine drug testing monitored by a member of the PHP, participation in a 12-step program, and continuing aftercare under the supervision of an addiction medicine specialist. A similar success rate has been associated with the program in Missouri.[17]

A national survey of all active physician health programs further examined their nature of treatment, support, and monitoring systems.[6] Responding PHPs had common goals (thorough assessment and evaluation, use of a formal signed contract, referral to abstinence-based treatment, long-term support and contingency monitoring, drug testing, and reporting results to credentialing agencies). More than half of PHPs were independent, nonprofit foundations, one-third were associated with the state medical association, and 13% were components of the state medical board.

In a second phase of this national survey, a sample of 904 physicians consecutively admitted to 16 states' PHPs was studied for five years or longer to characterize the outcomes of care and to also explore the elements of these programs that could possibly improve the care of other addicted populations.[18] As noted above, these programs were abstinence-based, requiring physicians to abstain from any use of alcohol or other drugs of abuse as assessed by frequent random tissue testing (i.e., urine, blood, and/or hair). The main outcome measures were completion of the program, continued alcohol and drug use determined by urine tests, and occupational status at five years.

Eighty-one percent of participants completed five years without a relapse episode. Of the 19% who did relapse, more than 75% had no evidence of a second relapse. At last contact, 72% of this physician sample were licensed without restrictions and actively practicing medicine. Based on a

deconstruction of the programs and identifying the essential ingredients to long-term recovery maintenance, the following elements comprise a model PHP:[18]

- contingency management that included both positive and negative consequences;
- random drug testing;
- linkage with 12-step (or similar) programs and with the abstinence standard espoused by these programs;
- management of relapses by intensified treatment and monitoring;
- use of a continuing care approach; and
- a focus on lifelong recovery.

Such programs also are beneficial to resident physicians.[19,20]

Other Important Elements for Physician Health Programs

Regular meetings of the physician administrators of PHPs are important. Such meetings create a unique physician leadership community that ensures both a high level of collaboration and also a spirited competition to improve the care of their physician patients. Treatment programs and other service providers are chosen by the physician leaders for excellence of their care and services so that the PHPs can communicate with each other about best practices. PHPs have continued to actively innovate as they seek to improve their performance. Innovations associated with the experimental use of hair and oral fluids testing; use of urine ethyl glucuronide testing; the presence of physician leaders who were in recovery; and treatment/monitoring that is state-of-the-art, prolonged, and intensive also are important.

ADEQUACY OF PRIVACY AND CONFIDENTIALITY SAFEGUARDS IN PHYSICIAN HEALTH PROGRAMS

In order to encourage physicians to seek treatment in the course of an illness, they need assurance that their confidentiality will be protected, and that their decision to seek help will not, in and of itself, be used against them. Physicians should expect the same protection of their medical records as anyone else seeking medical help or treatment. Peer review protections at the state level are essential for the efficacy of a PHP's operation. The ability to seek confidential help early in the course of any illness will facilitate physician well-being and patient protection. The confidentiality of alcohol and drug abuse client records maintained by a PHP must be protected by federal laws and regulations, including 42 CFR, Part 2. Generally, PHPs may not disclose that a physician is a PHP participant nor disclose any information identifying a physician as having a substance use disorder unless the:

- client consents in writing;
- disclosure is required by a court order;
- disclosure is made to medical personnel in a medical emergency; or
- client demonstrates overt dangerousness to self or others as being suicidal or homicidal.

CONCLUSION

One critical component of a state PHP is to provide services for all health-related conditions that could affect a physician's ability to practice with reasonable skill and safety, as opposed to focusing only on substance use disorders. To that end, state PHPs also should promote programs for health, wellness, and early detection of at-risk behavior, including stress and burnout. Referrals to PHPs will be confidential as long as the physician is compliant with all PHP recommendations,

including a monitoring agreement (if indicated) and the physician does not constitute a danger to the public.

Reporting requirements for state PHPs include, but are not limited to, non-compliance with a monitoring agreement, evidence of risk to patient safety, or evidence of repeated relapse. State PHPs should have a clear and transparent understanding with licensure agencies and other stakeholders as to reporting requirements and procedures. Separate from state PHPs, healthcare practitioners and others may also have statutory or other direct reporting requirements to licensure agencies. In addition, state PHPs should have immunity from criminal or civil liability for good faith operation. State peer review statutes may provide such immunity.

Adequate funding is essential to ensure that the PHP is able to conduct assessments in a timely manner, address emergencies involving participants, and maintain sufficient staffing to ensure that monitoring standards are met to ensure public safety. Underfunding of a monitoring program presents an invitation for events to occur that will increase the chances of participants becoming impaired and actively endangering patients.

State PHPs also must be able to conduct assessments using their own employees, by referral to outside consultants, or a combination of the two. With respect to referral for treatment, state PHPs generally do not provide direct treatment, but refer participants to outpatient and residential treatment resources. Monitoring is a core function of a state PHP, and is the primary means to support participants' abstinence and recovery and to assist the state medical board in the shared mission of protecting the public. The FSPHP Guidelines address all of these issues.

Finally, it is crucial that a state physician health program have a strong collaborative relationship with the medical board in that state, based on mutual respect and trust, as well as healthy channels of communication. This relationship gives the physician health program the leverage necessary to encourage participants to get early treatment for potentially impairing illnesses, and gives the medical board ongoing assurance that they are supported in protecting the public. There will often be some tension in this relationship. This is not necessarily a problem, but rather a reflection of the different approaches of the PHP and the medical board to the common goal of protecting the public.

RECOMMENDATIONS

The Council on Science and Public Health recommends that the following statements be adopted and the remainder of the report be filed.

1. That our American Medical Association (AMA) affirm the importance of physician health in its strategic plan and the need for regular and ongoing education of its members as to physician health. (Directive to Take Action)

2. That our AMA assist in furthering the informational and educational aspects of physician health across the continuum of medical education and other relevant organizations for the purpose of expanding awareness regarding the importance of enhanced physician health and awareness of programs designed to accomplish that goal. (Directive to Take Action)

3. That our AMA recognize the following as essential components of a state physician health program: (a) contingency management that includes both positive and negative consequences; (b) random drug testing; (c) linkage with 12-step or similar programs and with the abstinence standard espoused by these programs; (d) management of relapses by

intensified treatment and monitoring; (e) use of a continuing care approach; (f) focus on lifelong recovery; and (g) the protection of anonymity. (New HOD Policy)

4. That our AMA develop state legislative guidelines addressing the design and implementation of physician health programs in conjunction with the Federation of State Physician Health Programs. (Directive to Take Action)

Fiscal Note: $10,836

REFERENCES

1. Council on Mental Health. American Medical Association. The sick physician: impairment by psychiatric disorders, including alcoholism and drug dependence. *JAMA*. 1973; 223:684-687.

2. Department of State Legislation, Div of Legislative Activities. Model Impaired Physician Treatment Act. American Medical Association, Chicago, Ill. June 1985.

3. Board of Trustees. Statement on Physician Health Programs. American Medical Association, Chicago, IL. February 6, 2008.

4. Federation of State Physician Health Programs. www.fsphp.org. Accessed August 17, 2010.

5. Federation of State Physician Health Programs. *Physician Health Program Guidelines*. December 2005. www.fsphp.org/2005FSPHP_Guidelines.pdf Accessed August 17, 2010.

6. Dupont RL, McLellan T, Carr G, Gendel M, Skipper GE. How are addicated physicians treated? A national survey of physicians health programs. *J Subst Abuse Treat*. 2009;37:1-7

7. Morse RM, Martin MA, Swenson WM, Niven RG. Prognosis of physicians treated for alcoholism and drug dependence. *JAMA*. 1984;251:743-746.

8. Shore JH. The Oregon experience with impaired physicians on probation. *JAMA.* 1987;257:2931-2934.

9. Pelton C, Ikeda RM. The California Physicians Diversion Program's experience with recovering anesthesiologists. *J Psychoactive Drugs*. 1991;23:427-431.

10. Gallegos KV, Lubin BH, Bowers C, Blevins JW, Talbott GD, Wilson PO. Relapse and recovery: five to ten year follow-up study of chemically dependent physicians: the Georgia experience. *Md Med J*. 1992;41:315-319.

11. Bohigian GM, Croughan JL, Sanders K. The impaired physician, II: Missouri State Physicians Health Program. *Mo Med.* 1994;91:275-277.

12. Reading EG. Nine years experience with chemically dependent physicians: the New Jersey experience. *Md Med J*. 1992;41:325-329.

13. Smith PC, Smith JD. Treatment outcomes of impaired physicians in Oklahoma. *J Ok State Med Assoc*.1991;84:599-603.

14. Talbott G, Gallegos K, Wilson P, Porter T. The Medical Association of Georgia's impaired physicians' program: review of the first 100 physicians—Analysis of specialty. *JAMA.* 1987;257:2927-2930.

15. Domino KB, Hornbein TF, Polissar NL et al. Risk factors for relapse in health care professionals with substance use disorders. *JAMA*. 2005;293:1453-1460.

16. Cohen PJ. *Drugs, Addiction, and the Law: Policy, Politics, and Public Health*. Durham, Carolina Academic Press, 2004.

17. Bohigian GM, Bondurant R, Croughan J. The impaired and disruptive physician: the Missouri Physicians' health program—an update (1995-2002). *J Addict Dis*. 2005;24(1):13-23.

18. DuPont RL, McLellan AT, White WL, et al. Setting the standard for recovery: Physicians Health Programs. *J Subst Abuse Treat*. 2009;36:159-171.

19. Milling, T. J. Drug and alcohol use in emergency medicine residency: An impaired resident's perspective. *Ann Emerg Med*. 2005;46:148-151.

20. O'Leary, P. Three views on resident wellness. Resident's Journal Interview-CORF. November 2008; Vol 3,11:1-2.

21. 42 CFR, part 2

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APPENDIX I

AMA Policies on Physician Health

H-275.964 Impaired Physicians Practice Act
Our AMA encourages state medical societies that do not have effectively functioning impaired physicians programs to improve their programs and to urge their states to adopt the AMA 1985 Model Impaired Physician Treatment Act, as necessary. (Sub. Res. 7, A-89; Reaffirmed: BOT Action in response to referred for decision Res. 215, I-97; Reaffirmed: BOT Rep. 17, I-99; Reaffirmed: Sunset Report, A-00).

D-275.974 Depression and Physician Licensure
Our AMA will (1) recommend that physicians who have major depression and seek treatment not have their medical licenses and credentials routinely challenged but instead have decisions about their licensure and credentialing and recredentialing be based on professional performance; and (2) make this resolution known to the various state medical licensing boards and to hospitals and health plans involved in physician credentialing and recredentialing. (Res. 319, A-05).

H-275.998 Physician Competence
Our AMA urges: (1) The members of the profession of medicine to discover and rehabilitate if possible, or to exclude if necessary, the physicians whose practices are incompetent. (2) All physicians to fulfill their responsibility to the public and to their profession by reporting to the appropriate authority those physicians who, by being impaired, need help, or whose practices are incompetent. (3) The appropriate committees or boards of the medical staffs of hospitals which have the responsibility to do so, to restrict or remove the privileges of physicians whose practices are known to be incompetent, or whose capabilities are impaired, and to restore such physicians to limited or full privileges as appropriate when corrective or rehabilitative measures have been successful. (4) State governments to provide to their state medical licensing boards resources adequate to the proper discharge of their responsibilities and duties in the recognition and maintenance of competent practitioners of medicine. (5) State medical licensing boards to discipline physicians whose practices have been found to be incompetent. (6) State medical licensing boards to report all disciplinary actions promptly to the Federation of State Medical Boards and to the AMA Physician Masterfile. (Failure to do so simply allows the incompetent or impaired physician to migrate to another state, even after disciplinary action has been taken against him, and to continue to practice in a different jurisdiction but with the same hazards to the public.) (CME Rep. G, A-79; Reaffirmed: CLRPD Rep. B, I-89; Reaffirmed: Sunset Report, A-00; Reaffirmation I-03).

H-295.979 Substance Abuse
The AMA (1) reaffirms its position which recognizes the importance of preventing and treating psychiatric illness, alcoholism and substance abuse in medical students, residents and fellows; (2) urges medical schools to include substance abuse prevention programs in their curriculum; and (3) urges medical schools, hospitals with graduate medical education programs, and state and county medical societies to initiate active liaison with local impaired physician committees in order to more effectively diagnose and treat medical student and resident substance abuse. (Res. 106, I-85; Reaffirmed by CLRPD Rep. 2, I-95; Reaffirmed: CME Rep. 10, I-98; Reaffirmed: BOT Rep. 17, I-99; Reaffirmed: CME Rep. 11, A-07).

H-275.952 Reporting Impaired, Incompetent or Unethical Colleagues
Physicians have an ethical obligation to report impaired, incompetent, and unethical colleagues. Physicians should be familiar with the reporting requirements of their own state and comply

accordingly. (1) Physicians should work to assure that state laws provide immunity to those who report impaired, incompetent, or unethical colleagues. (2) Principles of due process must be observed in the conduct of all disciplinary matters involving physician participants at all levels. However, the confidentiality of the reporting physician should be maintained to the greatest extent possible within the constraints of due process, in order to minimize potential professional recriminations. (3) The medical profession as a whole must correct the misperception that physicians are not adequately protecting the public from incompetent, impaired or unethical physicians by better communicating its efforts and initiatives at maintaining high ethical standards and quality assurance. (CEJA Rep. A, I-91; Reaffirmed: BOT Rep. 17, I-99; Modified and Reaffirmed: CEJA Rep. 1, A-03; Reaffirmation I-03)

E-9.0305 Physician Health and Wellness

To preserve the quality of their performance, physicians have a responsibility to maintain their health and wellness, construed broadly as preventing or treating acute or chronic diseases, including mental illness, disabilities, and occupational stress. When health or wellness is compromised, so may the safety and effectiveness of the medical care provided. When failing physical or mental health reaches the point of interfering with a physician's ability to engage safely in professional activities, the physician is said to be impaired. In addition to maintaining healthy lifestyle habits, every physician should have a personal physician whose objectivity is not compromised. Physicians whose health or wellness is compromised should take measures to mitigate the problem, seek appropriate help as necessary, and engage in an honest self-assessment of their ability to continue practicing. Those physicians caring for colleagues should not disclose without the physician-patient's consent any aspects of their medical care, except as required by law, by ethical and professional obligation (Opinion E-9.031), or when essential to protect patients from harm. Under such circumstances, only the minimum amount of information required by law or to preserve patient safety should be disclosed. The medical profession has an obligation to ensure that its members are able to provide safe and effective care. This obligation is discharged by: - promoting health and wellness among physicians; - supporting peers in identifying physicians in need of help; - intervening promptly when the health or wellness of a colleague appears to have become compromised, including the offer of encouragement, coverage or referral to a physician health program; - establishing physician health programs that provide a supportive environment to maintain and restore health and wellness; - establishing mechanisms to assure that impaired physicians promptly cease practice; - assisting recovered colleagues when they resume patient care; - reporting impaired physicians who continue to practice, despite reasonable offers of assistance, to appropriate bodies as required by law and/or ethical obligations. This may entail reporting to the licensing authority. (I, II) Issued June 2004 based on the report "Physician Health and Wellness," adopted December 2003.

APPENDIX II
Relevant Definitions or Concepts

Board of Medical Examiners. Historical term largely supplanted by "Medical Board" or "Licensing Board." Medical Boards are composed of physician and public representatives, usually appointed by state government, to validate health professionals' credentials to determine whether or not health professionals meet criteria to practice medicine in a particular state. Medical Boards also have the authority to suspend, place on probation or revoke medical licensure in the interest of protecting the public.

Cooperative Agreement. This refers to a Memorandum of Understanding (MOU) or other contractual agreement between a PHP, Licensing Board, and/or Medical Society regarding the responsibilities and procedures of operation the PHP maintains.

Confidentiality. PHPs strive to be transparent with respect to their processes while preserving the privacy and confidentiality of physician participants, recognizing that confidentiality clauses are likely to encourage voluntary referrals and participation. Exceptions to confidentiality are dictated by the reporting requirements established in individual states.

Data Collection. PHPs routinely gather and share aggregate data concerning best treatment practices, physician health trends, available treatment programs and providers specializing in the treatment of health care professionals and other information useful in promoting excellence in the PHP field.

Disruptive behavior. Any behavior that disrupts the safe and effective delivery of healthcare by a medical team. A physician's problematic behavior often reflects significant emotional distress, reactions to negative environmental factors or both.

Diversion. This is somewhat outdated language which describes the process of "diverting" an ill physician from a disciplinary arena to a treatment and monitoring program. Most state programs use the language of referral from a board or other source to describe this process.

Intervention. The process of identifying illness in and developing a treatment plan for a practicing physician, resident physician and in some cases medical student. The PHP can be involved at any level of an intervention to ensure timely assessment and treatment.

Immunity. Many states provide PHPs protection from subpoena and liability for acts performed in good faith. This is also known as statutory peer review protection.

Impairment. A severe stage of illness that renders a physician unable to practice medicine with reasonable skill and safety to the public. Impairment can result from addiction, mental illness and/or physical illness. Impairment is a dynamic rather than static phenomenon.

Impaired Physician Program. Historical language used to describe what is currently known as Physician Health Program (PHP). A PHP provides health evaluations, referrals for treatment and monitoring of the efficacy of treatment for physicians who have medical and psychiatric conditions that have the potential to interfere with the safe practice of medicine. Primary and secondary intervention models are employed to prevent physician impairment.

Mandatory Reporting. Each state PHP is obligated to report certain information to state licensure boards in order to protect the public. For example, if a physician is impaired by illness and unwilling to cease practicing, a PHP would notify their state licensure board of this potentially endangering situation.

Medical Practice Act. Laws regulating and controlling the practice of medicine to ensure that patients are properly protected from unauthorized, unqualified and improper practices.

Monitoring. This refers to a core role of state PHPs: Monitoring a physician's recovery from illness and providing appropriate documentation of health and recovery to other entities including hospitals, licensing boards and credentialing committees. The length of monitoring ranges from

Outcomes. State PHPs and the FSPHP recognize the need for outcome data at the state and national level to inform our work.

Physician Committee. Historically, volunteer committees were formed to address physician illness and/or impairment at either the hospital, county, or state level. These are also referred to as "wellness committees". Joint Commission mandates that hospitals must establish a process for addressing physician illness and/or impairment, but does not mandate the existence of a Physician Committee. In most states, a referral to a PHP satisfies Joint Commission's standards.

Physician referral. Physicians with health problems are referred (not diverted) to PHPs. Multiple referral sources, including licensing boards, attorneys, hospitals, partners, family members and self-referrals exist. The best referrals are those that occur early in the course of an illness, usually via a true self-referral or from partners or other colleagues and before licensing board involvement.

Post treatment. Also referred to as "aftercare", PHPs find this component essential following the index episode of residential treatment. Physicians completing residential treatment are then referred to outpatient treatment in their local communities for continuity of care. PHPs communicate regularly with both inpatient and outpatient treatment providers to ensure treatment compliance and that progress is being made.

Professional incompetence. The inability to practice medicine with reasonable skill and safety due to skill or knowledge deficit(s). The presumed existence of a competence issue should not preclude an assessment by a state PHP. Underlying, unrecognized illness may contribute to professional incompetence.

Rehabilitation. A term historically used to describe the process by which an addicted physician is restored to good health and functionality. Today, rehabilitation includes restoration of health following a broad array of illnesses.

Treatment. The majority of state PHPs do not provide treatment. Following a comprehensive assessment, PHPs generally refer their physician participants to outside providers/treatment programs possessing the requisite expertise to care for physician patients. PHPs generally refer to specialty programs that are well versed in treating physicians, to include a milieu of physician peers. PHPs continually monitor the efficacy of individual treatment centers to ensure treatment quality.

Wellness. Wellness is not merely the absence of disease. It is a proactive, preventive approach to life designed to achieve optimum emotional, physical, social and vocational functioning. A wellness-oriented lifestyle encourages the adoption of habits and behaviors that promote health. Good nutrition, fitness activities, stress management skills, limiting alcohol consumption and smoking cessation promote wellness. It is important to promote de-stigmatization of help-seeking behavior by physicians.