Policy on Physician Impairment from the Federation of State Medical Boards of the United States, Inc.

ABSTRACT: At the 2011 FSMB Annual Meeting, the FSMB House of Delegates adopted an updated Policy on Physician Impairment that provides guidance to state medical and osteopathic boards for including physician health programs (PHPs) as part of their efforts to protect the public. Based on current best practices, the policy offers a vision for boards and PHPs to effectively assist impaired licensees and licensees with potentially impairing illnesses. The policy offers a discussion of the terms "functional impairment" and "potentially impairing illness," defines other key terms and provides a model for implementing a successful physician health program. It also provides criteria for determining when physicians should be referred for professional evaluation/assessment and guidelines to help in the selection of providers or facilities to assist in the evaluation/assessment of physicians with addictive and/or psychiatric illness. The policy offers guidance and criteria for treatment, discharge planning, continuing care and relapse management and monitoring, and concludes with sections on physical impairment in physicians and the application of the PHP model for allied health practitioners. The newly adopted policy is being published in this issue of the *Journal of Medical Regulation* as a service to our readers. Please note that the policy makes reference to two sources of additional information from the Federation of State Physician Health Programs (FSPHP): the organization's public policy on Physician Illness vs. Impairment and its Physician Health Program Guidelines. Both documents can be accessed at FSPHP's website, at www.fsphp.org.

Keywords: physician impairment, physician health programs

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This 2011 Federation of State Medical Boards (FSMB) **Policy on Physician Impairment** supersedes the 1995 FSMB Report of the Ad Hoc Committee on Physician Impairment.

Section I: Introduction

In June 2010, FSMB Chair, Freda McKissic Bush, M.D., established a workgroup to review the FSMB's 1995 Report of the Ad Hoc Committee on Physician Impairment and to determine areas in need of revision, which include the following:

- Definition of terms.
- Description of the types of impairment.
- List elements of an effective physician health program (PHP).
- Define the value of physician health programs (PHPs).
- Develop criteria for the evaluation of a quality PHP.
- Identify regulatory issues involved in effectively utilizing a PHP.
- Enhance the protection of the public by providing education about physician impairment and illness that are potentially impairing.

This new document provides guidance to state medical and osteopathic boards for including PHPs in their efforts to protect the public. There is a need to educate the medical profession and the public about physician impairment and illness that can lead to impairment. This document represents a vision for medical boards and PHPs to effectively assist impaired licensees as well as those with potentially impairing illness based on best practices at this point in time. Future modifications may be warranted as new data becomes available.

The goals and missions of key stakeholders, including the FSMB,[1] the Federation of State Physician Health Programs (FSPHP), the American Medical Association (AMA), the American Society of Addiction Medicine (ASAM) and the American Academy of Addiction Psychiatry (AAAP), align in many ways. This is especially true with respect to a desire to see healthy physicians providing excellent care to the patients they serve. PHPs have developed knowledge and expertise in matters of physician health. They coordinate and monitor intervention, evaluation, treatment and continuing

1. According to the FSMB mission: "FSMB leads by promoting excellence in medical practice, licensure, and regulation as the national resource and voice on behalf of state medical boards in their protection of the public."

care of the impaired physician as well as those with potentially impairing illness.

These efforts require that PHPs have a primary commitment to uphold the mission of their state medical and osteopathic boards in order to protect the public. To gain the confidence of the regulatory boards, PHPs must develop audits of their programs that demonstrate an ongoing track record of ensuring safety to the public and reveal deficiencies if they occur. Such transparency and accountability to the medical and osteopathic boards is necessary to the existence of a viable PHP.

PHPs and regulatory agencies agree that public protection is paramount. Safe reintegration of the recovering physician back into the workforce constitutes the ideal scenario. At times, tension may arise among stakeholders regarding an appropriate balance between the goals of protecting the public, on the one hand, and assisting the physician in recovery on the other hand. This 2011 document is intended to promote better collaboration among all stakeholders in addressing issues of physicians with potentially impairing illness.

Section II: Discussion of "Functional Impairment" and "Potentially Impairing Illness"

It is important to draw a distinction between "impairment" and "illness." The diagnosis of an illness does not equate with impairment. Addiction, as an example, is a potentially impairing illness. Impairment is a functional classification. Individuals with an illness may or may not evidence impairment. Typically, addiction that is untreated progresses to impairment over time. Hence, in addressing physician impairment, it makes sense to identify addiction early and offer treatment and recovery prior to the illness becoming impairment.

The Federation of State Physician Health Programs (FSPHP) created a public policy regarding "Illness vs. Impairment." (To view the policy, visit www.fsphp.org.) The following is a quote from that policy:

According to the FSPHP:

> …[S]ome regulatory agencies equate "illness" (i.e. addiction or depression) as synonymous with "impairment." Physician illness and impairment exist on a continuum with illness typically predating impairment, often by many years. This is a critically important distinction. Illness is the existence of a disease. Impairment is a functional classification and implies the inability of the person affected by disease to perform specific activities.
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> Most physicians who become ill are able to function effectively even during the earlier stages of their illness due to their training and dedication. For most, this is the time of referral to a state PHP. Even if illness progresses to cause impairment, treatment usually results in remission and restoration of function. PHPs are then in a position to monitor clinical stability and continuing progress in recovery…
>
> Medical professionals recognize it is always preferable to identify and treat illness early. There are many potential obstacles to an ill physician seeking care, including denial, aversion to the patient role, practice coverage, stigma and fear of disciplinary action. Fear of disciplinary action and stigma are powerful disincentives to doctors referring their physician colleagues or themselves. When early referrals are not made, doctors afflicted by illness often remain without treatment until overt impairment is manifest in the workplace.

It is in the nature of illness and physician identity that many physicians are not motivated for assistance. Providing a voluntary track for participation in a PHP offers a physician an opportunity to obtain assistance. And as long as the physician is willing to abide by contracted agreements struck by the PHP and the physician does not pose a risk of harm to the public, the physician participant can maintain confidentiality. By maintaining confidentiality and avoiding physician discipline, hospitals and medical staffs are incentivized to refer physicians into a PHP early rather than wait for frank impairment and referral to the board for discipline.

Section III: Definition of Terms

1. Impairment

   Impairment is the inability of a licensee[2] to practice medicine with reasonable skill and safety as result of:

   a. mental disorder (as defined below).

   b. physical illness or condition, including but not limited to those illnesses or

2. For the purpose of this document, "physician" and "licensee" are sometimes used interchangeably.

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conditions that would adversely affect cognitive, motor, or perceptive skills.

c. substance-related disorders including abuse and dependency of drugs and alcohol as further defined.

Note: The above definition is in keeping with the definition offered by the American Medical Association in 1973.

Disruptive behavior and process addictions represent significant issues for boards and PHPs and are discussed briefly in items 2 and 3 below.

Impairment is a functional classification which exists dynamically on a continuum of severity and can change over time rather than being a static phenomenon. Illness, per se, does not constitute impairment. When functional impairment exists, it is often the result of an illness in need of treatment. Therefore with appropriate treatment, the issue of potential impairment may be resolved while the diagnosis of illness may remain.

2. Disruptive physician behavior

The AMA defines disruptive behavior as "a style of interaction with physicians, hospital personnel, patients, family members or others that interferes with patient care." Behavior is exhibited as a pattern of being unable or unwilling to function well with others to such an extent that his/her behavior, by words, attitude or action, has the potential to interfere with quality healthcare. The physician's behavior (attitudes, words or actions) intimidate and demean others, potentially resulting in a negative impact on patient care.

Disruptive behavior is a descriptive label, not a diagnosis. Diagnostic evaluation should be performed by professionals with expertise in the differential diagnosis of illness that can manifest as disruptive behavior, e.g., personality disorders, substance-related disorders and psychiatric clinical illnesses.

Disruptive behavior is a serious problem and a full discussion is beyond the scope of this policy. Disruptive behavior impairs the ability of the healthcare team to function effectively, thereby placing patients at risk. The majority of PHPs address disruptive behavior. The committee recommends PHPs and their boards work cooperatively to devise contractual language and agreed-upon strategies ensuring that this important issue affecting patient safety is carefully addressed in each state.

3. Process addiction

A process addiction is compulsive activity or process of psychological dependence on a behavioral activity. The process consumes the attention of the individual to the exclusion of other aspects of the individual's life and it thereby creates problems. The following are some examples of activities — if they are compulsive and excessive activities — that fall into the category of process addictions: compulsive gambling, compulsive spending, compulsive video gaming and workaholism.

The presence of a process addiction can be problematic or even impairing in itself, and it can contribute to relapse of a physician in recovery. As such, process addictions should be identified and treated.

4. Substance

a. mind- and mood-altering substances defined in law as controlled substances.

b. alcohol or other legal or illegal substances that are mood altering and can potentially impact the ability to practice.

5. Substance-use disorder (according to DSM-IV)

- Substance abuse

"The essential feature of substance abuse is a maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to the repeated use of substances…"

- Substance dependence

"The essential feature of substance dependence is a cluster of cognitive behaviors and physiological symptoms indicating that the individual continues use of the substance despite significant substance-related problems…"

According to ASAM, these disorders can be referred to as "addictive illness."

6. Addictive illness

According to ASAM, an addictive illness is "a biochemical, psychosocial, genetically-influenced primary illness hallmarked by loss of control or continued use of mind- and/or

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mood-altering substances regardless of negative consequences, frequently accompanied by a powerful denial of the existence and effects of the illness."

7. Physician health program (PHP)[3]

   Historically, PHPs were referred to as "Impaired Physician Programs." A PHP is a program of prevention, detection, intervention, rehabilitation and monitoring of licensees with potentially impairing illnesses, approved and/or recognized by the state medical board. PHPs are charged with oversight of licensees who are in need of evaluation and/or treatment. In addition, the PHP monitors licensees with illnesses that have the potential to interfere with the safe practice of medicine. Through a formalized contract, each state medical board should have available to it a PHP that meets the standards set by this document and the FSPHP Guidelines.

8. Recovering physician

   A recovering physician who has been impaired or who has been diagnosed with a potentially impairing illness, such as addictive or mental illness, is one who is receiving or has received appropriate evaluation and/or treatment.

9. Relapse

   Addictive illness relapse is the recurrence of behavior or other substantive indicators of active disease after a period of remission, i.e., abstinence from proscribed substances. It is important to note that appropriate treatment of some participants may involve the use of prescription medications known to the PHP. Relapse can involve return to the drug of choice or use of some other substance.

   There are three levels of relapse behavior having the potential to impact public safety:

   Level 1 Relapse: Behavior without chemical use that is suggestive of impending relapse

   Level 2 Relapse: Relapse, with chemical use, that is not in the context of active medical practice

   Level 3 Relapse**:** Relapse, with chemical use, in the context of active medical practice

10. Substantive non-compliance

    Substantive non-compliance is a pattern of non-compliance or dishonesty in PHP continuing care monitoring or an episode of non-compliance which could place patients at risk.

11. Tracks of referral

    a. Voluntary track

       A confidential process of seeking assistance and guidance through a PHP without required personal identification to the state licensure board whereby the potentially impairing illness is addressed. A voluntary track promotes earlier detection of potentially impairing illness before it becomes functionally impairing. The voluntary track participants are in a safe system whereby substantive non-compliance or relapse, depending on each state's non-compliance reporting requirements, will be promptly reported to the licensure board by name.

    b. Mandated track

       Mandated licensees are those required by the state medical board to participate in a PHP. A mandated referral can be via an informal referral or via a formal disciplinary process that is public. In either instance the board may require quarterly progress reports. It is recommended that boards have a non-disciplinary process for referral to PHPs to encourage early detection and intervention.

12. Mental disorder

    In the DSM-IV nomenclature, the term "mental disorder" has a specific meaning. It includes substance-related disorders, Axis I psychiatric disorders/illnesses and Axis II behavioral personality disorders.

    According to the DSM-IV, each of the "mental disorders" is conceptualized as a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and is associated with the following core characteristics:

    - Present distress (e.g., a painful symptom).
    - Disability (i.e., impairment in one or more important areas of functioning).
    - Significantly increased risk of suffering, death, pain, disability or an important loss of freedom.

3. Physician health programs are often referred to as professionals health programs. They often have responsibility for different types of healthcare professionals in addition to or other than physicians.

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Also, the syndrome or pattern must not be merely an expectable and culturally sanctioned response to a particular event — for example, the death of a loved one.

13. Psychiatric illness

    Axis I psychiatric illnesses or clinical conditions include symptom disorders such as mood disorders (for example, bipolar disorders and depressive disorders), anxiety disorders, adjustment disorders, eating disorders, psychotic disorders and certain other disorders.

    According to DSM-IV, Axis I psychiatric disorders/illnesses are considered separate and distinct from Axis II personality disorders that involve lifelong maladaptive patterns of behaving.

14. Intervention

    An intervention is a strategy orchestrated by an individual or group, in an attempt to persuade a physician to seek professional evaluation and assistance.

15. Treatment

    Treatment involves the delivery of care and rehabilitation to licensees experiencing a potentially impairing illness.

16. Continuing care

    Care that follows the acute phase of intervention and initial treatment is referred to as continuing care, oftentimes referred to as aftercare. PHPs oversee and monitor the continuity of care to ensure progress and continued compliance. Continuing care includes PHP guidance, support, toxicology collection and accountability through a formal monitoring contract[4] concurrent with or following an evaluation and treatment process.

17. Participant

    A participant is a licensee enrolled in a PHP pursuant to an executed contract.[4]

18. Licensee

    A licensed physician or other healthcare provider whose practice falls under the regulatory authority of the medical board in that state.[5]

Section IV: Model Physician Health Program (PHP)

Boards are referred to the FSPHP Guidelines for the development and enhancement of PHPs. (To view the policy, visit www.fsphp.org.) A PHP should seek membership within the FSPHP and follow FSPHP Guidelines. Implementation of these guidelines will necessarily vary from state to state in accordance with state legal, contractual and/or regulatory requirements.

Whenever possible, the medical boards and PHPs should work collaboratively in the development of effective laws and regulations in the promotion of PHPs for the benefit of the public. The effectiveness of PHPs are enhanced when they follow principles of accountability, communication and collaboration with their boards and other stakeholders.

The purpose of a PHP is to guide the rehabilitation of physicians consistent with the needs of public safety. This involves the early identification, evaluation, treatment, monitoring, and earned advocacy, when appropriate, of licensees with potentially impairing illness(es), ideally prior to functional impairment. PHPs should provide services to both voluntary and board-mandated referrals without bias and should not provide assistance or guidance for illness outside their expertise. The provision of confidentiality offers an incentive for the medical community and others to contact the PHP before a physician's illness becomes functionally impairing. Addressing illness before it becomes impairing adds to public protection.

The decision of the licensee to seek or accept PHP assistance and guidance should not, in of itself, be used against the physician in disciplinary matters before the board. However, PHPs should report substantive non-compliance and make periodic reports of compliance based on ongoing recovery documentation to appropriate individuals, committees, boards or organizations on behalf of compliant licensees in PHP continuing care.

Ideally, PHPs services should include the following:

- Wellness programs that address physician health, stress management, burn-out and early detection of "at-risk behavior."
- Educational programs on topics, including but not limited to, the recognition, evaluation, treatment and continuing care of potentially impairing conditions. These conditions may include, but are not limited to, addiction, psychiatric illness, behavioral problems,

4. Depending on the state participant, "contracts" can also be referred to as participant "agreements." For the purposes of this document, the term used is "contract."

5. Depending on state laws and regulations, PHPs may permit program participation of students and residents of medicine or other healthcare disciplines.

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physical and cognitive disorders in physicians and other licensed professionals.

- Evidence-based research opportunities when available.
- Resources for the profession, the public and the boards.

The dual role of protecting the public through licensing and discipline as well as the provision of a mechanism for the successful rehabilitation of impaired physicians is the board's or boards' statutory public protection mandate. Furthermore, early detection, evaluation, treatment and monitoring of a physician with a potentially impairing illness enhances a board's mandate to protect the public. PHPs must be dedicated to excellence in medicine and should not compromise patient care by supporting the practice of medicine during a period of licensee's functional impairment.

It is important that the PHPs are organized and structured in a manner to ensure their stability and optimal functioning. Nationally, the majority are structured as independent 501c3 corporations. Currently, various state PHP organizational/corporate structures exist as follows:

- Board-authorized or board-managed PHPs.
- Medical society affiliated or sponsored PHPs.
- Independent, not-for-profit corporations.
- Independent, for-profit corporations.

It is necessary that PHPs function in a stable environment, insulated as much as possible from changing political pressures. PHPs must also have a clearly defined mission and avoid any potential negative impact resulting from leadership and/or philosophical changes within the state medical association, state medical boards or others. Consequently, the committee optimally recommends that state boards contract with PHPs that have an independent organizational structure. Endorsement by organized medicine adds to PHP status. PHPs and their board of directors, medical associations and state boards should avoid conflicts of interest and dual roles. They should maintain appropriate boundaries between the medical association, the PHP and the state board.

A PHP should be empowered to conduct an intervention based on clinical reasons suggestive of potential impairment. Unlike the board, which must build a case capable of withstanding legal challenge, a PHP can quickly intervene based on a reasonable concern. The PHP can, therefore, be a significant benefit to public safety and a cost savings to licensure boards. Since 1995, FSMB policy has supported physician remediation via an effective PHP as an alternative to, or in conjunction with, discipline.

The FSPHP has adopted guidelines that, along with this document, serve as a resource in selecting and evaluating any particular PHP. Furthermore, it is recommended that PHPs comply with FSPHP Guidelines. A formal contract should be executed between the board and PHP, setting forth the relationship. Ideally, such a contract will be based on the principles of mutual trust, respect, accountability, collaboration, and communication. Transparency of program policies and procedures while maintaining the appropriate confidentiality of individual participants is important.

A PHP should comport with FSPHP Guidelines, including the following functional elements:

1. Administration/Personnel: To adequately and appropriately manage and administer the PHP clinical and administrative functions, PHP staff should include:

    a) Physician medical director: PHPs should employ a medical director with qualifications in addressing addictive, mental and behavioral illness. If possible, the PHP should be adequately funded for the employment of a full-time physician medical director. A full-time physician as medical director can offer clinical knowledge necessary to effectively evaluate physician impairment issues.

    b) Executive director: The PHP executive director has responsibility to oversee the administrative and operational aspects of the PHP as well as its corporate responsibilities. Some state PHPs may wish to combine the functions of the physician medical director with the executive director into the position of executive medical director.

    c) Support staff: The PHP should include adequate clerical, case management and other appropriate staff to support the physician medical director and executive director.

    There are instances noted in this report in which PHP personnel report information about identified participants to the board. Otherwise, with regard to the identities of participants, PHP directors and all PHP staff

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should follow professional standards to protect confidentiality and not disclose information about participants without appropriate releases to do so. Such releases may be in the form of language included in the PHP participant contracts/agreements.

2. Legislation

   Medical boards in consultation with PHPs should periodically review laws and regulations and recommend changes in order to ensure that the PHPs function effectively and are legally able to keep abreast of evolving best practices.

3. Organized medicine support

   PHPs should seek the support of organized medicine and others, including but not limited to, professional associations, hospitals, medical groups, legislatures, licensing authorities, malpractice insurers, medical schools and residency programs, consumer groups and the general public.

4. Intervention

   PHPs should have a process for intervening when information indicates a reasonable concern that a physician may have a potentially impairing illness. The individuals conducting the intervention should be experienced and appropriately trained for the specific type of intervention, particularly in the areas of addictive and psychiatric illness.

   Historically, this technique has been utilized with chemically dependent licensees who are in denial. However, it is effective with other illnesses such as process addictions and psychiatric illnesses. Intervention is typically carried out in person by PHP staff. Any combination of family members, colleagues, or office staff may be included depending on the specifics and needs of each case. The goal of intervention is to effect formal evaluation and treatment if needed.

5. Evaluation/assessment

   PHPs should have authority to conduct an initial screening assessment and coordinate a referral for professional evaluation in order to determine the nature and extent of functional impairment and underlying illness. Whenever possible, the evaluation of the physician should be conducted by a PHP-approved independent clinician or by an independent multidisciplinary evaluator(s) to avoid the appearance of conflict of interest. Ideally, the PHP should have a panel of expert evaluators that have been vetted and found to be acceptable for referrals. Whenever possible, the physician should be offered more than one name or facility from which to select an evaluator(s). The PHP should use the criteria set forth in "Criteria for Referral for referral for Professional Evaluation," Section VI, and FSPHP Guidelines to determine if a physician should be referred for an evaluation.

6. Treatment

   Treatment, or secondary prevention, strategies attempt to diagnose and treat an illness, especially in its early stages with the goal of preventing worsening of the illness. For example, typical treatments for addictive illness include inpatient hospitalization for detoxification, residential treatment or outpatient treatment. Treatment modalities may include medications, twelve-step mutual self-help meetings, professionally led group therapy and individual counseling, as well as other types of treatment.

   The PHP should insist the criteria set forth in Treatment Program Criteria, Section VIII and FSPHP Guidelines are followed, particularly to determine if a facility or practitioner is acceptable for referrals.

7. Discharge and continuing care

   PHPs must possess the ability to develop and implement discharge, continuing care and monitoring plan(s). Continuing Care contracts should be designed to ensure that the physician participant can practice with reasonable skill and safety based on recovery or remission of underlying illness. The PHP should also have the authority to ensure compliance with continuing care contracts and have authority to remove physician participants from practice who pose a risk to patient safety.

8. Relapse management

   Methods should be designed for the early recognition of relapse and the PHP should have the ability to respond in a timely and effective fashion. This response will include a report to the board when consistent with agreed-upon reporting requirements. For addictive illness, the PHP should meet the criteria set forth in Relapse Management and Monitoring, Section X, and FSPHP Guidelines for addressing relapse. PHPs should develop a track record that supports board confidence in their judgment to manage relapse issues.

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9. Confidentiality

   A voluntary track allows an option for the physician to maintain confidentiality. It is, however, critical that the PHP medical director communicate with the state medical board the identification of previously anonymous participants in the event of either substantive non-compliance or Level III relapse. In order to facilitate voluntary track referrals, boards should develop a mechanism to protect the confidentiality of PHP voluntary participants.

10. Reporting of PHP data to medical boards

    Aggregate PHP data (statistics) should be disclosed to the board and should be considered public information. Such data are useful for quality control purposes. Program data can suggest areas of strength in the PHP, areas of needed improvement, and need for adequate program funding.

11. Recovery monitoring

    Recovery monitoring should provide documented evidence as to whether or not the participant is able to safely practice medicine. Documentation can be in the form of reports from worksite or behavioral monitoring reports assessing stability and reliability from worksite monitors, treatment providers, PHP consultants and appropriate others.

12. Forensic monitoring

    Random, routine utilization of appropriate frequency chain of custody forensic testing is critical. Witnessed collections are preferred. In other instances a "dry room" collection procedure may be utilized. Selection of drugs/substances to be included in the screening panels should be carefully considered and varied as needed to include not only the drug of choice but also other drugs of abuse including alcohol. Case specific testing of appropriate biological specimens may include, but may not be limited to, urine, blood, saliva, hair, nails, etc., as deemed appropriate by the PHP medical director. Certified laboratory testing facilities should be utilized to perform and confirm specimen results. Certified Medical Review Officers (MROs) should be utilized when necessary. Costs for forensic testing are typically the responsibility of the program participant.

13. Advocacy

    With appropriate documentation of objective recovery/illness stability and associated physician health status, PHPs should advocate for the participant. The PHP can play an important role in assisting the participant in maintaining or returning to professional practice and avoiding discrimination, and also can assist with the administrative process of the board. Appearances before the board, hospital committees, malpractice carriers, and other bodies are an important role of the PHP as part of advocacy for the licensee.

14. Education

    PHPs should promote physician wellness and support the treatment and continuing care of physicians who have illnesses such as addictive, psychiatric, cognitive and physical illness. This can be accomplished by PHPs making presentations to students, professional associations, medical groups, hospitals, licensing authorities, treatment providers, family members, consumer groups, and the general public.

15. Recordkeeping

    The PHP should maintain documentation of PHP participant records as required by law, contracts with the board, or other record retention policies. With respect to voluntary track participants, it is of paramount importance that PHP records, names, addresses, e-mail addresses, etc. remain within the PHP and be accessible only by PHP staff and not divulged to other sources without proper legal consent and authorization.

16. Accountability

    The PHP should utilize both internal and external quality assurance measures reflecting PHP activities and performance and program participant results. (See FSPHP Guidelines.)

17. Funding

    Adequate resources are required to maintain competent case management and participant monitoring through the provision of qualified professional support services. Funding sources can include, but are not limited to, medical boards, healthcare organizations, professional societies, hospitals, malpractice carriers and participant fees. Conflicts of interest should be avoided in acceptance of funds from all sources.

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18. Participant contracts

    PHP and participant contracts should include contractual components consistent with FSPHP Guidelines for both voluntary and/or mandated participants.

19. Portability

    In the event of relocation of a participant, the PHP should have a mechanism to facilitate the transfer of monitoring to the appropriate state PHP or, in the absence of a PHP or equivalent entity, the licensing board. When a physician is licensed and working in more than one state, either the state of residence or the state in which most professional activities are occurring should agree to assume primary responsibility for monitoring with regular reports to the other state(s). Whenever possible, monitoring should not be duplicated.

20. Informed consent

    PHP participants should execute an informed consent statement or informed consent should be articulated in the monitoring contract. The written consent should outline the following:

    - The appropriate statement of confidentiality and limitations, and
    - The reporting of substantive non-compliance as defined by contract — including notification to the board(s), case management modifications, contract duration and any PHP-determined practice limitations.

21. Return to work

    The PHP should determine suitability to return to work from the standpoint of disease stability or remission as applicable. PHPs should monitor, modify worksite situations and limit or restrict work hours when appropriate. If indicated, the participant may have PHP-restricted workplace access to mind- or mood-altering substances. If concerns of potential impairment arise, participants should be voluntarily withdrawn from practice pending further evaluation. In all cases, the PHP must assume responsibility for removing participants from practice if they pose a danger to the public.

22. Anonymity

    Monitoring contracts should clearly state the conditions in which anonymity is maintained. Anonymity must be broken in the event the PHP determines a potential risk of harm to patients, Level III relapse, or substantive non-compliance exists. Any substantive event(s) should be reported to the board and appropriate others.

Ideally, there should be:

1. Mutual effective interface between the state medical board and the PHP. There must be a commitment between both parties in regard to open lines of communication.
2. The PHP and board must be aware of and understand each organization's responsibility to program participants and the public.
3. The PHP should not discriminate nor deny services based on a physician's race, creed, color, religion, sexual orientation, specialty, type of medical degree, or membership affiliations.
4. The PHP should accept indigent physician participants who otherwise meet program eligibility criteria and be available for referrals by boards and other individuals or entities in need of services.
5. Boards should endorse a PHP only if the PHP has adequate staff and funding to meet its expected mission and goals.
6. The PHP must provide arrangements for emergency interventions and evaluations.
7. The PHP must have a continuing care contract template consistent with optimal physician rehabilitation and patient safety. Details of each contract should be individualized and subject to change based on clinical needs.
8. Medical boards in consultation with PHPs should periodically review laws and regulations to ensure that the PHPs are legally able to keep abreast of evolving best practices.

Section V: Tracks for Referral to PHP

Two separate PHP tracks should be established for program participants:

- Track A is for voluntary participants who enter the PHP without the board's mandate. These physicians should be afforded anonymity from the board as long as they do not pose a risk of harm to the public. Cases that pose a danger of harm to the public should be reported to the board with laws or regulations in place that allow that reporting.

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- Track B physicians are mandated by the board to participate in a PHP. As such, their identities are known to the board.

Section VI: Criteria for Referral for Professional Evaluation

In cases where an intervention uncovers one or more of the following, a physician should be referred for professional evaluation/assessment:

1. Information or documentation of excessive or habitual alcohol or other drugs of abuse.
2. Sufficient indications of current alcohol or other drug abuse that may include positive body fluid analysis for unexplained mood-altering chemicals.
3. Behavioral, affective, cognitive, or other mental problems that raise reasonable concern for the public safety.
4. Information or documentation of psychiatric illness or substance use disorder that is not being treated or that impairs the ability to practice.

Section VII: Evaluation/Assessment Program Criteria

Addictive and Psychiatric Illness

PHPs should employ FSPHP Guideline criteria in selecting providers/evaluation facilities for evaluations/assessments of physicians with addictive and/or psychiatric illness. Factors to consider include, but are not limited to, the following:

1. Providers performing evaluations/assessments should have demonstrable expertise in the recognition of the unique characteristics of health professionals with addictive and/or psychiatric illness. The psychiatric history and mental status examination should be performed by a clinician knowledgeable in addictive and/or psychiatric illness.

   The selection of evaluator(s), whether an individual clinician or a multidisciplinary center, should be the responsibility of the PHP. Whenever possible, the licensee should be allowed to select an evaluator(s) from a PHP-approved list of evaluators or facilities. The licensee should not be allowed to select an evaluator not approved by the PHP.
2. To avoid the appearance of conflict of interest, no member of a PHP, its committees or its board of directors and no member of the licensure board should have financial or other conflicts of interest in the provision of assessment or any recommended treatment.
3. The evaluation of addictive and/or psychiatric illness requires that the licensee agree to the release of any and all records regarding diagnosis, indicated treatment, prognosis, and continuing care recommendations of such licensee.
4. When evaluation for addictive and/or psychiatric illness requires any level of care (residential, hospital inpatient or outpatient care), it should be for an appropriate period of time as defined by the PHP in consultation with evaluation and treating professionals.
5. The licensee should undergo a complete medical evaluation, including appropriate laboratory and physical examinations. Laboratory examinations should include appropriate toxicology screens.
6. The PHP may refer a licensee for comprehensive psychological evaluation. Evaluation by a clinical psychologist can be useful to evaluate personality dynamics and to screen for cognitive deficits.

   For in-depth evaluation of memory and other cognitive functions, referral should be made to a certified neuropsychologist. The psychological evaluation report should specify the instruments utilized. The report should indicate whether or not there is impairment and to what degree.
7. Upon completion of the evaluation, release of all applicable evaluation results should be made to the PHP.
8. The PHP should report to the board any physician who refuses a recommendation for treatment who has any of the following:
   a) A serious psychiatric illness (e.g., bipolar disorder).
   b) Drug or alcohol dependence.
   c) Any other potentially impairing condition which, in the opinion of the medical director places the public at risk.

Section VIII: Treatment Program Criteria

PHPs should employ FSPHP Guidelines in selecting the providers/facilities to provide treatment of physicians with addictive and/or psychiatric illness.

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Factors to consider include, but are not limited to, the following:

Addictive and Psychiatric Illness

1. The treatment provider(s) should have demonstrable expertise in the recognition of the unique characteristics of health professionals with addictive, or psychiatric illness, or Axis II personality disorder. Providers should have the ability and resources to offer the level of care indicated in each particular case. To avoid the appearance of a conflict of interest, no member of the PHP, its committees or its board of directors as well as no member of the licensure board should have a financial or other conflict of interest in the provision of treatment.
2. Admission for treatment of addictive and/or psychiatric illness requires that the licensee agree to the release of any and all records to the PHP regarding diagnosis, prognosis and continuing care recommendations.
3. When the treatment for addictive and/or psychiatric illness requires any level of care (residential, hospital inpatient or outpatient care), it should be for an appropriate period of time as determined by the treatment professionals who are approved by the PHP. Participants undergoing treatment should adhere to the recommendations of the treatment provider.
4. Upon completion of treatment, release of all applicable treatment documents should be made to the PHP.
5. A licensee who refuses to enter recommended treatment or leaves treatment prior to its successful conclusion will be subject to board notification by the PHP medical director. With regard to voluntary participants, some states may require that such reporting be contingent on the physician posing a danger to the public.

Section IX: Addictive and Mental Illness Discharge Planning and PHP Continuing Care

Continuing care of the program participant is crucial to the successful recovery, the safe return to the practice of medicine and ultimately the completion of PHP participation. FSPHP Guidelines should be followed. After the initial phases of intervention, evaluation and acute treatment have been successfully completed, FSPHP Guidelines including the following elements should be included in the participant's PHP continuing care:

1. Executed PHP Participant Contract: All participants, regardless of whether the participant is board-referred or voluntarily contracted, should be required to sign a written contract in order to participate in the PHP. The PHP, and board when applicable, should review in person the contractual elements and invite and answer questions.
2. Portability: In event of relocation, the continuing care contract must have a provision allowing the PHP to notify the applicable state PHP or, in the absence of a PHP, the board(s) in other states of the physician's pending relocation, history of potentially impairing illness and current status.
3. Referrals: The PHPs should have the expertise and ability to individualize continuing care and make the appropriate referrals.
4. Return to Work: PHPs should make determinations about a licensee's suitability to work based on the licensee's safety to practice, stability in recovery, and health-related readiness to resume professional duties.
5. Reporting: Reporting requirements may vary from state to state based on state laws and program regulations, as well as the relationship and level of trust between the PHP and the board. The PHP should report to the board on the status of program participants in accordance with the contract between the board and the PHP. Some boards require periodic reports on participants they have referred. Others ask for reports on all participants; in that case, board-mandated participants are identified by name while confidential participants are identified by number to maintain their confidentiality. Confidential PHP participants forfeit their anonymity should they experience substantive contract compliance issues or pose a risk to the public. PHPs reporting on those physicians who are board-mandated may report to the board on a periodic basis and include detailed reports on continuing care compliance and forensic monitoring results.
6. If deemed necessary or appropriate, periodic in-person conferences between the participant and the PHP staff may be warranted. Some boards may elect to have face-to-face meetings with participants they have referred to the PHP at that board's discretion.

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Addictive and Mental Illnesses:

Addictive and mental illnesses should be evaluated, treated and monitored in accordance with FSPHP Guidelines. Some specific requirements include, but are not limited to, the following:

1. Length of monitoring: The PHP must have continuing care contracts consistent with physician rehabilitation and patient safety.

   Physicians in a PHP to support recovery from addictive illness should be monitored for a minimum of five years. Substance abuse may be monitored for a shorter period of time, typically one to two years.

   Physicians in a PHP to support recovery from mental illness should be monitored for a period of time commensurate with the mental illness as determined by the treatment providers who are approved by the PHP, typically between one and five years.

2. Follow-up criteria for monitoring

   a. Role of the PHP: The PHP should be familiar with the addiction and mental illness process, coordinate with treatment providers, and be the central repository of all records/reports pertaining to continuing care.

      PHP evaluation of the status of a physician's recovery and status of disease remission should be ongoing. It should take into account a number of factors including but not limited to workplace reports, treatment reports and records, forensic screening, contract compliance, meeting attendance, and results of any face-to-face meetings.

   b. Role of worksite monitor: PHP recovering participants should have a worksite monitor(s). If the participant has a supervising physician in the workplace, the supervising physician can fulfill the role of a worksite monitor. In cases where there is no supervising physician, a worksite monitor should be assigned who meets with the approval of the PHP. Worksite monitors should provide regular status reports to the PHP regarding any performance problems. PHP staff may visit the worksite and may review records of patients treated by the participant physician to monitor safety to patients.

   c. The board should be kept apprised of all developments in the continuing care of the board-mandated physician.

   d. Forensic monitoring for addictive illness and some mental illnesses:

      i. Same-sex, witnessed random specimens are the ideal collection method.

      ii. Use of a certified laboratory ensures the availability of a toxicologist and medical review officer (MRO) for screening samples and confirming sample results. In some cases the PHP may elect to utilize its own MRO or the medical director may be MRO certified.

      iii. Chain-of-custody handling of all forensic specimens.

      iv. Drug panels, which may vary at the discretion of the PHP medical director, should include the participant's drug of choice as well as other substances of abuse including alcohol. Screens should be performed at an appropriate frequency based on individual case specifics.

3. Continuing care treatment:

   a. The recovering physician with addiction and/or mental illness should have a personal primary-care physician (PCP) who sees the physician shortly following PHP enrollment to establish a relationship and screen for any potential health issues. The participant must agree to inform the PCP of PHP enrollment and the basis for it. The participant must arrange for the PCP to make periodic reports to the PHP and share treatment records if requested by the PHP. Self-treatment is prohibited. The PCP shall not have significant conflicts of interest such as being related to the physician by blood or marriage or working within the same practice, nor shall they have a business or a fiduciary relationship.

   b. Regular attendance at mutual-help program meetings such as AA, NA or other equivalent programs is required in those individuals with addictive illness.

   c. All PHP participants are required to attend at least weekly meetings of a peer support group such as Caduceus meetings if such groups are appropriate to the illness addressed and are available.

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d. The PHP should support and encourage involvement of a physician's personal and family support system in the recovery process. The PHP may be required to intercede on the part of the recovering physician to ensure they have sufficient free time to attend required meetings.

e. Continuing medical education may be warranted in the area of addictive or mental illness.

f. A therapist, psychiatrist or psychologist should be utilized as clinically indicated.

g. Consents for release of information should be executed, maintained and shared between the various healthcare providers, PHPs and boards as appropriate.

h. The physician recovering from mental illness should agree to abstain from all substances of abuse and, if clinically indicated, should abstain from the use of alcohol. Periodic forensic testing may be warranted based on individual case specifics.

Disruptive Behavior

Disruptive behavior, as previously defined, is an ongoing issue that continues to challenge all involved. A full discussion of the issue is beyond the scope of this report.

Cases of disruptive behavior are often highly complex. In all such cases, careful documentation of the behavior is critical. PHPs or boards should refer such cases to select individuals or evaluation/treatment facilities with extensive knowledge and expertise regarding the problem.

Once any indicated evaluation and initial treatment is complete, PHP monitoring should consider the following elements:

1. Length of monitoring

   The PHP must have a continuing care contract consistent with physician rehabilitation and patient safety. The committee recommends that all physicians involved in a PHP for remediation of disruptive/abusive behavior should be monitored for one to five years, depending on individual case specifics. The PHP medical director should make this decision based on input from approved evaluation/treatment professionals.

2. Follow-up criteria for monitoring

   a. The PHP should maintain a central repository of monitoring/compliance records.

   b. Role of worksite monitor: PHP recovering participants should have a worksite monitor(s). If the participant has a supervising physician in the workplace, the supervising physician can fulfill the role of a worksite monitor. In cases where there is no supervising physician, a worksite monitor should be assigned that meets with the approval of the PHP. Worksite monitors should provide regular status reports to the PHP regarding any performance problems. PHP staff may visit the worksite and may review records of patients treated by the participant physician to monitor safety to patients.

   c. The PHP may elect to institute multiple monitors with different professional statuses to evaluate the participant's behavior. The individuals selected may include representatives from administration, physician colleagues, nursing staff, and subordinates.

3. Continuing care treatment:

   a. The licensee participant should have a personal primary-care physician (PCP) who sees the participant shortly following PHP enrollment to establish a relationship and screen for any potential health issues. The participant must agree to inform the PCP of PHP enrollment and the basis for it. The participant must arrange for the PCP to make periodic reports to the PHP and share treatment records if requested by the PHP. Self-treatment is prohibited. The PCP shall not have significant conflicts of interest such as being related to the physician by blood or marriage or working within the same practice, nor shall they have a business or a fiduciary relationship.

   b. A therapist, psychiatrist or psychologist should be utilized as clinically indicated.

   c. As part of remediation, individualized continuing medical education may be warranted in areas determined by the PHP and treatment professionals.

   d. When appropriate resources are available, support group attendance may be indicated.

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e. The PHP should support and encourage inclusion of a physician's personal and family support system in the rehabilitation process. The PHP may be required to intercede on the part of the licensee to ensure they have sufficient free time to attend required meetings.

f. Ongoing PHP evaluation of the licensee's compliance with contractual elements and especially the absence of the problematic target behaviors must occur. Timely feedback, both positive and negative, to the licensee in terms of their behavior is important.

g. The board should be kept apprised of all developments in the continuing care of the board-mandated physicians with behavioral issues.

h. Consents for release of information should be executed, maintained and shared between the various healthcare providers, PHPs and boards as appropriate.

i. The physician monitored for disruptive behavior should agree to abstain from all substances of abuse and, if clinically indicated, should abstain from the use of alcohol. Periodic forensic testing may be warranted based on individual case specifics.

Cognitive Decline

A complete review of the issue of cognitive decline is beyond the scope of this report. When such concerns arise, PHPs and boards are encouraged to utilize individual clinicians or multidisciplinary facilities with knowledge and experience regarding physicians with cognition issues. Physicians with evidence of cognitive decline should be thoroughly evaluated and receive any indicated treatment. The evaluation should screen for underlying medical conditions, mental illness, substance use disorders, and other known causes of cognitive deterioration. In some instances, cognitive decline may have reached such a stage that the practice of medicine has to be modified or even discontinued. Less severe cases of cognitive decline may allow the physician to continue practice with or without formal or informal practice restrictions. When continued duties warrant ongoing monitoring/care, the following are considerations:

1. Length of monitoring

   The PHP must have a continuing care contract consistent with physician stabilization and rehabilitation as well as patient safety. The committee recommends that all physicians involved in a PHP for monitoring of cognitive decline should be supervised for a period of time as warranted by the individual case specifics and based upon the PHP's expertise and opinions of experts involved in the case.

2. Follow-up criteria for monitoring

   a. Role of PHP: The PHP should serve as the central repository of monitoring/compliance records.

   b. Role of worksite monitor: The participant should have a worksite monitor(s). If the participant has a supervising physician in the workplace, the supervising physician can fulfill the role of a worksite monitor. In cases where there is no supervising physician, a worksite monitor should be assigned who meets with the approval of the PHP. Worksite monitor should provide regular status reports to the PHP regarding any performance problems. PHP staff may visit the worksite and may review records of patients treated by the participant physician to monitor safety to patients.

3. Follow-up criteria for treatment

   a. The cognitively challenged licensee should have a personal primary-care physician (PCP) who sees him/her shortly following enrollment in the PHP to establish a relationship and screen for any potential health issues. The participant must agree to inform the PCP of PHP enrollment and the basis for it. The participant must arrange for the PCP to make periodic reports to the PHP and share treatment records if requested by the PHP. Self-treatment is prohibited. The PCP shall not have significant conflicts of interest such as being related to the physician by blood or marriage or working within the same practice, nor shall they have a business or a fiduciary relationship.

   b. PHP evaluations of the cognitively impaired physician's health and job performance should be conducted on an ongoing basis and in a fashion determined by the PHP

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medical director, treatment providers, and others involved with the licensee as may be indicated.

c. When appropriate resources are available, support group attendance may be helpful. A support group with peers or others may prove beneficial on a case-by-case basis.

d. The board should be kept appraised of all developments in the continuing care of the board-mandated physician.

e. Consents for release of information should be executed, maintained, and shared between the various healthcare providers, PHPs and boards as appropriate.

f. The physician monitored for cognitive decline should agree to abstain from all substances of abuse and, if clinically indicated, should abstain from the use of alcohol. Periodic forensic testing may be warranted based on individual case specifics.

Section X: Relapse Management and Monitoring
PHP relapse management and monitoring should be consistent with FSPHP Guidelines.

Addictive Illness

The SMB's response to relapse may vary, depending upon the physician's recovery program and the circumstances surrounding the relapse. Relapse may involve a mind- or mood-altering substance other than the initial or primary substance of choice. Monitoring behavior, treatment, recovery groups and random forensic screening provide the opportunity for early detection of relapse.

1. There are three levels of relapse behavior having the potential to impact public safety:

   Level 1 Relapse: Behavior without chemical use that might suggest impending relapse should be reviewed by the PHP medical director or designated representative who may make treatment recommendations that potentially include individual counseling, further treatment, or a more intensive level of monitoring.

   Level 2 Relapse: Relapse with chemical use that is not in the context of active medical practice may be reported to the medical board. Relapse in any context is serious, and the PHP should carefully review the circumstances of the relapse and arrange any additional evaluation and/or treatment as may be clinically indicated to enhance sustained remission from active illness and protection of patients.

   Level 3 Relapse: Relapse with chemical use in the context of active medical practice, should be immediately reported to the state medical board. The PHP report should offer corrective action which includes the participant's amenability to further evaluation and treatment.

2. The board should underscore the need for prompt management of relapse to ensure public safety. Furthermore, it is important that management of a physician in relapse remain within the PHP.

   Relapse management and monitoring should be consistent with FSPHP Guidelines and include, but not be limited to, the following:

   a. The PHP medical director should re-evaluate the licensee, conduct an immediate intervention if indicated, and provide any notifications as specified in the PHP-board contract.

   b. PHP recommendations should depend on the circumstances and the behavior surrounding relapse in consultation with the appropriate, qualified evaluation/treatment professionals when appropriate.

   c. If the PHP instructs the physician to withdraw from practice, the physician in relapse must fully and immediately comply. If the physician is non-compliant, an emergency suspension of the physician's license to practice medicine may be indicated if there is a danger to the public.

   d. Substantive non-compliance with the continuing care contract should result in a report to the state medical board.

Psychiatric Illness

PHP relapse management should be consistent with FSPHP Guidelines. Relapse management should include, but not be limited to, the following:

1. Re-evaluation by the PHP medical director, with immediate intervention, notification to the state medical board as appropriate to the level of relapse and dictated by each individual case.

2. PHP recommendations regarding relapse should take into consideration the circumstances and behavior surrounding relapse. There may be value in consulting with providers and making a referral for professional evaluation.

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3. The physician in relapse must fully and immediately comply with PHP instructions to withdraw from practice when indicated. If the physician is non-compliant with intervention, an emergency suspension of the physician's license to practice medicine may be indicated if there is a danger to the public.
4. Substantive non-compliance with the continuing care contract will result in a report to the state medical board.

Section XI: Physical Impairment

Many competent physicians have a physical disability prior to their medical education and training and have appropriately adapted their medical practice to accommodate their disability. A practicing physician may experience the onset of a physical disability and should be presumed to self-limit or suspend practice in accordance with his/her ability to safely practice medicine. However, for some physicians who are unwilling or unable to recognize limitations due to a physical illness, the PHP or board must be able to intervene on the disabled physician in order to protect the public and assist the physician. Boards should have the capacity to respond to such physicians with a physical condition that is potentially impairing.

The committee recommends the following:

1. Boards should have the authority to refer physicians with potentially impairing physical illnesses to their state PHP for initial assessment. The PHP should arrange any indicated further evaluation by appropriately qualified experts.

   If a board-referred physician refuses such evaluation, the PHP must report their findings and recommendations to the medical board.
2. If PHP assessment or professional evaluation reveals a physical impairment that impacts patient safety, the PHP should inform the board regardless of whether the referral is voluntary or board-mandated. To the extent possible, the report should state the nature and prognosis of the impairment, including whether the condition is treatable, stable or progressive and what reasonable accommodations would allow the physician's continued practice with reasonable skill and safety.
3. Any restrictions or limitations placed on the licensee should be specifically tailored to reflect the impact of the impairment on the physician's ability to practice with reasonable skill and safety.
4. The board should work with the PHP to develop mechanisms allowing intervention to occur outside of the board's formal disciplinary process.
5. The PHP may monitor a physically impaired physician to assist the physician and to protect the public.

Section XII: Allied Health Practitioners

Allied health professionals would benefit from the establishment of Professionals Health Programs that are approved by the medical board or other appropriate board that is responsible for their licensure and regulation. These Professionals Health Programs should meet the same criteria for approval as established by the FSPHP and this document.

Section XIII: Conclusion

Licensure boards fulfill their primary mission of protecting the public in many ways. One important way is through a professional relationship with the state PHP. Boards promote the public health and safety when they ensure that the PHP has all the tools and support they need to enable early detection, proper treatment, and professional continuing care of impaired physicians. Furthermore, early intervention of licensees with potentially impairing illness can prevent progression of illness to overt impairment.

The committee believes it important that all stakeholders become better informed regarding issues not only related to functional impairment but also related to potentially impairing illness. Ideally, state and federal law should facilitate the effective interface between boards and PHPs in their effort to support the rehabilitation of licensees with potentially impairing illness because it adds to public protection. The committee encourages boards, with input from their PHPs, to revisit their Medical Practice Act routinely to ensure that it is kept abreast of developments in the field.

Boards and PHPs can support each other through developing relationships based on mutual respect and trust. When this occurs, the public benefits. A highly trained licensee who is safely rehabilitated is an asset to the medical community, the state and the public.

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