FEDERATION OF STATE MEDICAL BOARDS

Policy on Physician Impairment

Adopted as policy by the House of Delegates of the Federation of State Medical Boards

April 2011

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Policy on Physician Impairment

Federation of State Medical Boards
of the United States, Inc.

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." (See Appendix I: History of the 1995 Report.)

Section I – Introduction

In June 2010, the Federation of State Medical Boards (FSMB) Chair, Freda McKissic Bush, MD, 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[2], FSPHP, AMA, ASAM and 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 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.

2. 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."

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.

Workgroup -

The workgroup for this 2011 document consisted of the following members: James A. Bolton, PhD, Workgroup Chair; Michael R. Arambula, MD, PharmD; Keith H. Berge, MD; Richard D. Fantozzi, MD; P. Bradley Hall, MD; Dianna D. Hegeduis, Esq.; Warren Pendergast, MD; Judy S. Rivenbark, MD; William Roeder, JD; and Scott A. Steingard, DO. Gary D. Carr, MD and Norman T. Reynolds, MD, Workgroup Vice-Chair, served as consultants. Freda M. Bush, MD, FSMB Chair (ex-officio) and FSMB staff: Humayun J. Chaudhry, DO, CEO, Lisa A. Robin, MLA, and Kelly C. Alfred, MS.

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." (See Appendix II for the complete policy.) The following is a quote from that policy:

According to the Federation of State Physician Health Programs:

> …[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[3] to practice medicine with reasonable skill and safety as result of:
   a. mental disorder (as defined below); or

   b. physical illness or condition, including but not limited to those illnesses or conditions that would adversely affect cognitive, motor, or perceptive skills; or

   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 American Medical Association (AMA) defines disruptive behavior as "a style of interaction with physicians, hospital personnel, patients, family members, or others that interferes with patient care". Behavior 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. For the purpose of this document, "physician" and "licensee" are sometimes used interchangeably.

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 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) [4] –
   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.

4. 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.

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) OR
- Disability (i.e., impairment in one or more important areas of functioning) OR
- Significantly increased risk of suffering, death, pain, disability, or an important loss of freedom.

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[5] 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[5].

18. Licensee –
A licensed physician or other healthcare provider whose practice falls under the regulatory authority of the medical board in that state. [6]

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5. 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".

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

Section IV - Model Physician Health Program (PHP)

Boards are referred to the Federation of State Physician Health Programs (FSPHP) Guidelines for the development and enhancement of Physician Health Programs (PHPs). (Appendix III) 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 Physicians Health Program (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, physical and cognitive disorders in physician 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 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 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", Section V, and FSPHP Guidelines, Appendix III, 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, individual counseling, as well as other types of treatment.

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

7. Discharge & 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 XI, and FSPHP Guidelines for Addressing Relapse, Appendix III. PHPs should develop a track record that supports board confidence in their judgment to manage relapse issues.

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 (MRO) 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, avoiding discrimination, and also assisting 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. Record Keeping –
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, Appendix III)

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.

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 organizations 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.

- 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 (i.e., 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. 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, 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, 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.

Addictive and Mental Illness

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 (5) years. Substance abuse may be monitored for a shorter period of time, typically one to two (1 – 2) 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 (1) and five (5) 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 worksite and may review records of patients treated by the participant physician to monitor safety to patients.

   c. The board should be kept appraised 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, 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 available.

   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 assure 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, they 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. (Refer to the unpublished article by Reynolds cited in the reference section of this report for a more complete discussion.) 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 (1) to five (5) years, depending on individual case specifics. The PHP Medical Director based on input from approved evaluation/treatment professionals should make this decision.

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 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, 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.

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 assure they have sufficient free time to attend required meetings.

f. Ongoing PHP evaluation of the licensee's compliance with contractual elements and especially 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 appraised 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 worksites 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, working within the same practice, nor shall they have a business or a fiduciary

   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 Medical Director, treatment providers, and others involved with 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. (See Attachment: FSPHP Guidelines.)

Addictive Illness

The state medical board'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 provides 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.

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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APPENDIX I

History:

In May 1993, Federation President Hormoz Rassekh, MD, established a special Ad Hoc Committee on Physician Impairment to evaluate current concepts regarding physician impairment and to develop medical board strategies for the regulation and management of such physicians.

After discussion of several forms of "physician impairment", the committee elected to focus primarily on chemical dependency, because of its prevalence. In May 1994, Federation President Gerald J. Béchamps, MD, expanded the charge to include other impairments to be addressed immediately after guidelines are established for regulating and managing chemically dependent physicians. Other sections on psychiatric and physical impairments were addressed, as well as an additional report on sexual boundary issues. The Federation of the State Medical Boards of the US, Inc., accepted the "Report of the Ad Hoc Committee on Physician Impairment "as policy in 1995. This policy remained in effect until superseded by the 2011 policy.

APPENDIX II

Federation of State Physician Health Programs, Inc.

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Public Policy Statement : Physician Illness vs. Impairment

The Federation of State Physician Health Programs (FSPHP) is the membership organization for the state physician health programs (PHPs) and has a dual mission. We are dedicated to the outreach, treatment and rehabilitation of physicians who are ill; consistent with the needs of public safety. The PHPs refer physicians who may be ill to highly skilled specialists for evaluation/treatment and then provide monitoring once clinical stability or remission of their disorder is attained.

The AMA has defined physician "Impairment" as "the inability to practice medicine with reasonable skill and safety due to 1) mental illness 2) physical illnesses, including but not limited to deterioration through the aging process, or loss of motor skill, or 3) excessive use or abuse of drugs, including alcohol."

This language has been adopted by most regulatory agencies and is a part of most state Medical Practice Acts. Unfortunately, some 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.

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.

In some jurisdictions the regulatory process addresses all *ill* physicians as if they were *impaired*. When the regulatory process reflexively disciplines a physician who is ill but is not impaired such doctors may, by regulatory decree or its sequelae, find they are no longer able to provide adequate services to their patients.

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.

FSPHP Public Policy Statement Illness vs. Impairment

FSPHP guidelines require long-term monitoring of physicians after successful completion of treatment and reporting to the appropriate regulatory agency any instance of a physician who is not able to cooperate with indicated treatment and monitoring or who becomes impaired.

The interest and safety of the public are best served when the regulatory agency and the PHP develop a confidential process allowing for early intervention, evaluation, treatment and monitoring of ill physicians. The model of a PHP working in close cooperation with its state regulatory agency can succeed in treating ill physicians with potentially impairing conditions. This model allows for accountability and quality case management, resulting in long term clinical outcomes vastly superior to usual treatment without monitoring or a legal / disciplinary approach. When this occurs, the public is better protected and a highly trained physician continues to be available to the benefit of the patients they serve.

Approved:
FSPHP Board of Directors
July 30, 2008

http://www.fsphp.org/Illness_vs_Impairment.pdf

APPENDIX III

FSPHP GUIDELINES
http://www.fsphp.org/2005FSPHP_Guidelines.pdf

Federation of State Physician Health Programs, Inc.

515 N. State Street - Room 8584
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Physician Health Program Guidelines

December, 2005 Edition

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Federation of State Physician Health Programs, Inc.

Physician Health Program Guidelines

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Additional sections on physical health conditions, behavioral disorders, boundary disorders and physician health promotion have been identified for development for inclusion in later editions of these guidelines.

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Cautionary Statement

The FSPHP Physician Health Program Guidelines are a clinical tool intended solely for use by physician health programs for program development and enhancement. These guidelines reflect the consensus of existing physician health programs. These guidelines are evolutionary in nature and are intended to be modified based upon future research and experience.

These guidelines may not encompass all administrative structures and program options available to PHPs. Implementation of these guidelines may be impacted by applicable state legal, contractual, or regulatory requirements. The ability of any given State Physician Health Program to implement all guideline components may be limited. Guideline modifications by individual PHPs are anticipated and are appropriate when based upon sound clinical judgment and/or regional/ local legal considerations or systems issues.

The Federation of State Physician Health Programs expressly disclaim that application of these guidelines to any individual physician health program will result in optimal programmatic function. The Federation of State Physician Health Programs expressly disclaims any and all responsibility for application of the guidelines to any individual program.

Acknowledgments

These Guidelines have been developed by the FSPHP Guidelines Task Force which was formed during the annual FSPHP meeting in May 2002. Comments were solicited from FSPHP programs over a two year period resulting in significant modification and revisions of the document. The 2004 version of these guidelines was presented to all voting members of FSPHP member programs in March 2004 for review. The Guidelines were approved for adoption by 79% of FSPHP voting members. The section *Management of Other Psychiatric Disorders* and the revision of Appendix II were approved by 66% of FSPHP voting members.

Portions of these Guidelines have been modeled upon information contributed by many individuals and state physician health programs via the FSPHP e-group. In particular information contributed by Dr. Greg Skipper and Dr. Michael Gendel has been generously incorporated. The forums of the Citizens Advocacy Center on the Regulatory Management of Chemically Dependent Health Care Practitioners provided additional background information and a broad perspective on regulatory issues. Thoughtful review and endless revision by members of the FSPHP Guidelines Taskforce refined these guidelines over a two year period. Detailed review of the guideline draft and constructive commentary was contributed by many programs and used by the Taskforce to further strengthen the document.

The FSPHP wishes to thank the members of the Guidelines Taskforce. Special recognition is due Dr. Susan McCall, Dr. Gary Carr, Dr. Warren Pendergast and Mr. Terry Bedient for their tireless efforts on behalf of the Federation.

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General Guidelines for State Physician Health Programs

I) Purpose and Use of Guidelines

A) The following guidelines are applicable to State Physician Health Programs serving physicians and are applicable specifically to physicians. Many programs monitor other health professionals with health conditions which may compromise their ability to practice with reasonable skill and safety. All or part of these guidelines may be used for these populations if determined appropriate. Guidelines for management of specific conditions are separately delineated. These guidelines may not encompass all administrative structures and program options available to PHPs. Implementation of these guidelines may be impacted by applicable state legal, contractual, or regulatory requirements. The ability of any given State Physician Health Program to implement all guideline components may be limited by lack of resources. These unavoidable limitations should not deter State PHPs from working towards implementation of all applicable guidelines. Guideline modifications by individual PHPs are anticipated and are appropriate when based upon sound clinical judgment and/or regional/ local legal considerations or systems issues.

II) Physician Health Program (PHP) Purpose and Philosophy.

A) Rehabilitation of physicians with potentially impairing health conditions is the primary function of PHPs.

B) PHPs provide a non-disciplinary therapeutic program for health care practitioners with health conditions which may compromise their ability to practice with reasonable skill and safety.

C) The scope of conditions which different PHPs address will vary. Comprehensive Programs are preferable, providing they have the expertise and resources to competently manage all areas in which they offer services.

D) PHPs are dedicated to excellence in medical practice and will not compromise patient care by supporting licensees practicing medicine during a period of impairment. PHPs will strive to have a practitioner voluntarily remove themselves from practice when indicated and refrain from practice until found to be medically stable to resume practice. Any practitioner unable or unwilling to withdraw from practice during a period of potential impairment will be reported to the licensing authority for determination of fitness to practice.

E) For non-board mandated participants, programs should provide confidential management. PHP participants should not be subject to investigation or disciplinary action by a licensing authority based solely upon a health diagnosis or affiliation with the PHP.

F) Chemically dependent PHP participants should not be disciplined based solely upon violations related to their manner of obtaining substances for their personal use. Nothing in this guideline is intended to imply that participants in PHPs are not accountable to licensure agencies for behavior which otherwise violates the medical practice act or is injurious to patients.

G) Non-board mandated PHP participants are granted full confidentiality and their treatment is not disclosed to the licensing authority if they maintain compliance and successfully complete the Physician Health Program. Participants remain fully accountable to licensure agencies for their professional practice during the period of their PHP participation.

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H) PHPs should accept referrals from the licensing agency to monitor practitioners under Board mandate.

I) PHPs must comply with CFR 42 for participants with substance use disorders and other confidentiality requirements as applicable.

J) PHPs assist participants in avoiding discrimination by documenting their recovery/health stability and verifying that they are not impaired in their ability to practice medicine by reason of their health condition while it is in remission or appropriately controlled.

K) PHPs should provide steadfast support / advocacy before state medical boards and other agencies to help prevent discrimination against recovering physicians. Support / advocacy should be based upon objective and verifiable measures of recovery through review of evaluation/treatment documentation and other indicators of recovery. Support / advocacy must be based on evidence that the participant's ability to practice medicine is not compromised by their health condition. Unconditional advocacy without regard to the quality of recovery or stability of health is detrimental to the credibility of the PHP and its participants.

L) PHPs promote activities that support physician well-being. This may involve sponsoring, encouraging, and/or conducting educational programs and research to better understand the antecedents (stressors, rates of burnout, and other obstacles to physician well-being), presentation and optimal treatment of health conditions commonly affecting health professionals.

III) Administrative Considerations

A) Multiple administrative structures are utilized by PHPs: These structures are not mutually exclusive and programs frequently meet criterion for several categories

1) Board Authorized Or Board Managed Programs

(a) Contract with Board
(b) Formal Documented Agreement with Board
(c) Board operated with independent clinical oversight
(d) Board operated with full board oversight

2) Medical Society Affiliated or Sponsored Programs

(a) Contract with Medical Society
(b) Formal Agreement of Understanding with Medical Society
(c) Medical Society Operated

3) Independent Not for Profit Corporation Programs

(a) Contract with Medical Society and/or Board
(b) Formal Agreement of Understanding with Medical Society and /or Board
(c) Independent corporation contracting for services with multiple licensing authorities and serving multiple professions within the state

B) PHPs require legal authority to operate which may be granted through formal agreement with the licensing agency or through legislative authority.

C) To operate effectively programs must develop and maintain a positive relationship with the state licensing authority.

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D) FSPHP members must have the support of organized medicine in their state through recognition of the State Medical Society/Association as specified in the FSPHP Constitution and Bylaws, Article III.

E) PHPs require independent confidential administrative and clinical oversight by a Board or Council whose members are experienced in addressing the health conditions commonly found in the population of monitored health professionals. No members of the PHP clinical oversight body (those having privy to the identity of program participants and involved in making clinical or case management decisions) should be engaged in the treatment of participants or have other conflicts of interest.

F) Board operated programs must provide for anonymity of voluntary program participants.

G) PHPs should be covered by malpractice insurance and/or equivalent (errors and omissions) risk management coverage.

H) PHPs must have access to legal counsel. Optimally PHPs will have qualified legal immunity for actions taken in good faith.

I) PHPs should not operate for the purpose of making a profit.

J) PHPs should be based within the state they serve.

K) PHPs will work collaboratively with other state programs when interstate monitoring or transfer is involved. The primary monitoring state will be the state in which client practices and/or lives (if not practicing). The primary monitoring state should provide quarterly reports to other states in which the physician holds an active license.

L) PHPs require qualified compensated staff in addition to any program volunteers.

M) PHPs require the oversight of a Medical Director committed to physician rehabilitation, with appropriate experience, training and skills, including expertise in addictions. Addiction certification through ASAM or ABPN is strongly encouraged. The Medical Director should work through the FSPHP and other appropriate organizations to stay abreast of developments in the field.

IV) Functions of Physician Health Programs

A) PHPs have mechanisms in place to accept and follow-up on reports of physicians with potentially impairing health conditions. PHPs accept self-referrals and referrals from others concerned about a physician's well-being.

1) Assessment of the validity/eligibility of a referral is performed when a concern is first reported.

(a) Collateral information may be gathered to determine if an intervention is warranted.

2) Intervention or initial contact is made for the purpose of having the professional complete an appropriate evaluation.

3) Arrangements for evaluation and/or treatment are made as indicated.

4) Aftercare monitoring and case management of potentially impairing health conditions is arranged after completion of primary/stabilizing treatment.

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5) Adjustment of treatment/aftercare/monitoring is undertaken based upon on-going evaluation of the monitored health condition.

6) Relapse detection and management for participants with substance use disorders is on-going. Monitoring the stability of other health conditions and their impact on the physician's ability to practice medicine will be reviewed and documented on an on-going basis.

7) Documentation of recovery/disease stability and the compatibility of the physician's health status with their ability to practice medicine will be used to advocate on for the physician. Advocacy is appropriate to assist the participant in maintaining an appropriate medical practice and avoiding discrimination. Advocacy provided by PHPs will be based upon objective information about the physician's health status.

B) PHPs promote physician wellness and the treatment of all health conditions including substance use disorders and other addictions, mental and behavioral disorders, and physical illness.

1) Educational opportunities for health professionals and medical communities regarding the treatment of substance use disorders, mental and behavioral disorders, physical illness, and other addictions commonly affecting health professionals will be supported. Educational programs provided or sponsored by PHPs should include education about the disease model of substance use disorders.

(a) Targets for outreach and education activities include: students, professional associations, hospitals, medical groups, licensing authorities, legislators, employee assistance programs, mental health providers, family members, treatment providers, malpractice insurers, managed care plans, consumer groups, and the general public.

(b) Educational techniques may include: lectures, brochures, web sites, publications/articles, newsletters, display booths, on-site consultations, and inclusion of information on licensure and renewal applications and on malpractice insurance forms.

(c) Toll free phone lines may be utilized to encourage individuals to call for information and pre-recorded information may be offered as an option to support anonymity.

2) Cultivation of relationships with state medical schools and residency programs to promote improved education of the next generation of physicians regarding the family illness of substance use disorders, mental and behavioral disorders, physical illness, and other addictions commonly affecting health professionals is encouraged.

3) PHPs should foster relationships with their state's medical association, hospital staffs, and colleagues to promote education, identification of illness, appropriate referral, treatment and monitoring for the professionals they serve.

(a) Assisting medical staffs to develop effective bylaws and mechanisms that promote physician health and compliance with JCAHO MS 2.6 is encouraged.

4) Through FSPHP membership individual PHPs support efforts to encourage advances in organized medicine's policies and approach to the broader issues of substance use disorders and mental illness in our society.

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5) Interactions with licensure authorities should communicate and reinforce the disease concept of addiction and educate about the availability of successful treatment options for all health conditions which may be used in place of disciplinary action.

C) PHPs should support and participate in research in the field of substance use disorders and physician health.

1) Data collection and research is encouraged for individual programs. Collaboration between programs and with the FSPHP is encouraged.

2) Collection of standardized information is encouraged to facilitate comparing and pooling information from multiple state programs.

3) Information routinely collected should include standardized information from intake, evaluation, treatment, and monitoring.

(a) At minimum information gathered includes referral source, patient demographics, diagnoses, treatment (type and duration), outline of the clinical course (disease exacerbations or chemical relapses), health status and compliance status at time of monitoring completion, i.e., successful completion, transfer, board referral, enrollment in continued voluntary monitoring, etc.
(b) For chemically dependent individuals, substance(s) of choice and detailed relapse information is recorded.

V) Maintenance of Records

A) PHPs should maintain documentation on participants for a minimum of ten years after case closure unless otherwise required by law or records retention policies. Preferably records will be kept indefinitely.

B) Participant records should be stored under double lock such as in a locked file within a locked office except when in use.

C) Usual record contents may include: intake, assessment, evaluation, and treatment records; consents to release information; monitoring agreements and informed consent; toxicology and/or other laboratory reports, monitoring/compliance reports; workplace reports, group reports and therapist reports; consultations; self-reports; meeting attendance logs; medications logs; pertinent medical records; correspondence; progress notes and anecdotal information.

VI) Quality Assurance Measures

A) Rates of successful completion, markers of program failures, suicides and substance related deaths, loss of licensure or leaving medical practice for impairment related reasons, and length of participant retention may be used to evaluate program effectiveness.

B) Detailed relapse statistics for chemically dependent individuals will facilitate an analysis of monitoring efficacy. Information should be recorded about the relapse (i.e. relapse severity, substance type, content/setting, temporal relationship to patient care, whether impairment was suspected, etc).

C) Program utilization may be reflected by referral numbers, enrollment numbers, non-enrollment numbers (ineligible, no diagnosis, refused services, etc), the frequency of consultation requests and the number of return customers along with the reason for program re-involvement (disease exacerbation/relapse, concern about a colleague, program volunteer, etc

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D) Demographics of participants may be analyzed as a marker of program visibility among licensees (marketing effectiveness) and acceptability of the program to different groups (perceived bias). Demographics may also be useful in evaluating clinical trends, identifying high risk groups and other research.

E) User friendliness may be measured through participant satisfaction surveys, satisfaction surveys from boards and professional organizations, number of participants requesting further program services after program completion and the number of complaints received.

F) Budget and financial statements document fiscal responsibility and cost effectiveness.

G) Personnel and staffing levels and documentation of staff continuing education activities reflect the quality of program management.

H) Public relations activities may be documented through the publication of an annual report and by the number of other promotional activities completed.

I) Documentation of cases requiring referral to the state licensing agency is a marker of responsible public safety considerations in the management of cases refractory to treatment.

J) Any trends and emerging issues should be evaluated upon identification.

K) The number of legal challenges a program receives may be a marker of clinical acumen, user-friendliness as well as the pathology of the population the program serves.

L) Formal program evaluation through quality assurance reports, peer review activities or contracted evaluation may also be desirable.

VII) Funding of PHP Monitoring Programs

A) Funding must be adequate to support all program services offered. Adequate resources to maintain competent case management and participant monitoring are critical. Funding must be available to support qualified professional staff, to provide on-going training and development and to sustain a professional work environment.

B) Due diligence must be taken to avoid acceptance of funds from sources that could create a conflict of interest.

C) Funding sources may include but are not limited to: licensing fees, participant fees and contributions from malpractice insurers, professional societies and associations, hospitals and other health care organizations, benefactors, endowments, and grants.

D) Program participants are personally responsible for payment for their medical costs including required evaluations, primary treatment and aftercare/monitoring costs.

E) Participant fees should be fair and equitable with full disclosure at intake.

Management of Substance Use Disorders (SUD)

I) All physician health programs manage physicians with substance use disorders. To effectively manage this population, a baseline of required knowledge, skills and resources is necessary. The following characteristics and abilities are vital for all physician health programs to maintain.

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A) High visibility in the medical community with a user friendly avenue to receive reports concerning physician health or behavior is necessary.

B) Ability or resources to gather relevant information about and determine the legitimacy of reports in a sensitive manner

C) Ability or resources to facilitate effective interventions.

D) Ability to make appropriate referrals for evaluation and treatment based on the participant's needs (not a preset list of providers). A choice of several appropriate evaluation/treatment options/programs should be offered participants whenever possible.

1) Maintenance of current information on multiple resources available to accept referrals for evaluation (See Appendix 1)

2) Maintenance of current information on multiple programs available to accept referrals for treatment (See Appendix 2)

E) Expertise to understand and incorporate recommendations from evaluation and treatment resources into aftercare plans.

F) Physician Health Programs must not have any conflict of interest or business association with programs utilized for referrals.

II) Physician Health Programs provide aftercare and monitoring for physicians with substance use disorders in accord with the parameters outlined below. Deviations from these guidelines should be based on sound clinical judgment and clearly documented in the participant's chart.

A) The minimum period of monitoring for substance dependence is 5 years which is consistent with the FSPHP Public Policy Statement on Length of Monitoring.

B) The minimum period of monitoring for substance abuse is 1 year and a maximum of 2 years assuming no additional concerns are raised during the monitoring period.

C) The minimum period of monitoring for diagnostic purposes is 1 year and a maximum of 2 years when there has been a significant incident involving drugs/alcohol, a SUD has not been diagnosed and abstinence is recommended.

D) Basic contractual components between state Physician Health Programs and participants, whether voluntary or mandated, should include the following components:

1) Agreement for good faith participation.

2) Agreement for abstinence and the requirement to immediately report any use of alcohol or mood altering chemicals.

3) Agreement to not prescribe scheduled drugs for family members and a strong recommendation to refrain from treating their family members.

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4) Agreement to not manage one's own medical care, i.e.

   (a) Participants will not diagnose or manage their own illnesses and will not self-prescribe or independently discontinue any medications.
   (b) Participants will have a personal physician and provide a copy of the monitoring contract. A release of information between the state Physician Health Program and personal physician will be maintained.
   (c) Participants must inform all treating physicians/dentists, etc of their diagnosis, their relationship with the state Physician Health Program and their duty to provide a release of information to communicate freely with the state Physician Health Program.
   (d) Participants should take no medication until the state PHP is notified. In case of emergency, the PHP should be notified within 24 hours or when the participant is medically stabilized.
   (e) Participants shall inform the PHP as soon as feasible in the case of medical or psychiatric hospitalizations.
   (f) Guidance should be provided about the use of over the counter medication.

5) Agreement to attend self-help groups such as AA/NA. Those with strong objections should be responsible for providing recovery focused alternatives with appropriate availability and intensity.

6) Agreement to attend a facilitated weekly support group for recovering professionals or approved alternative when not available.

7) Agreement to maintain consent for ongoing communication with an approved workplace monitor/contact.

8) Agreement to abide by any specified workplace restrictions.

9) Agreement to maintain consent for the physician health program to speak with the participant's family/SO as needed.

10) Agreement to submit to biological specimen monitoring without question.

11) A statement of the confidentiality provided and the limitations of same.

12) Informed Consent

   (a) A statement of actions which will follow a failure to comply with the monitoring contract or in the case of a relapse which may include withdrawal from practice, intensification of treatment, inpatient evaluation, additional treatment, or a report to the licensure board.
   (b) A statement defining any requirements for reporting to the licensure board.
   (c) A statement defining other reporting requirements.
   (d) A statement that the monitoring contract may be extended at the discretion of the state physician health program if the at the end of the contract period clinical reevaluation indicates the need for additional monitoring

13) A statement of individuals who must agree in writing to contractual monitoring changes if applicable.

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14) Agreement that monitoring will be transferred to the appropriate state PHP or Licensure Board if the participant moves.

15) Agreement to faithfully follow up with designated treatment providers (individual therapists, family therapists, marriage therapists, psychiatrists, relapse prevention group) and/or others designated in the participant's contract.

    (a) Agreement to maintain an active release of information to the state physician health program and necessary treatment providers.
    (b) Agreement to comply with necessary medication regimen
    (c) Monitored use of adjunct medications may be required.

16) Agreement to the release of information to the state licensure authority in the case of indefeasible non-compliance (not capable of being annulled or voided or undone).

17) Optional contract components may include, but are not limited to, notification of the state PHP for:

    (a) Travel outside monitoring area
    (b) Change of address
    (c) Change of employment
    (d) Malpractice claims
    (e) Arrests
    (f) Work site and performance difficulties

E) Return to Work requirements (if returning after medical leave)

1) Completion of any indicated treatment with staff endorsement of readiness to resume practice

2) Documentation that, to a reasonable degree of medical certainty, abstinence has been achieved

3) Monitoring/aftercare program has been defined and is under implementation

4) Workplace monitor/contact agrees to serve and understands expectations and responsibilities

5) Any legal, licensing and credentialing requirements have been satisfied

6) Agreement by all parties to any workplace modifications or practice restrictions

F) Evaluation of recovery stability is ongoing for the duration of the monitoring period. Documentation of recovery is used as evidence that the participant's ability to practice medicine is not impaired by a substance use disorder. The following monitoring components provide evidence of recovery.

1) Regular work site or other behavioral monitoring reports (at least quarterly) assess stability and reliability if appropriate for the individual being monitored. Work site monitoring is not designed to assess premorbid clinical skills or competence.

2) Status reports from program consultants, therapists, psychiatrists or other providers as applicable

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3) Appropriate toxicology test results

4) Work-site visits by the monitoring program as appropriate

5) Compliance with all aspects of monitoring agreement

G) Designing and Enforcing Practice Restrictions (when applicable)

1) Individually determined based upon return to work criteria

2) Workplace settings should be carefully evaluated for support of and/or risk to recovery at the time of return to work

3) When appropriate, work site monitor provides regular reports of compliance

(a) release for communication must remain valid at all times

4) Examples where PHP imposed limitations may be appropriate

(a) Inability to obtain adequate workplace monitoring may limit the settings in which a licensee may engage in patient care
(b) Limitation of hours may be imposed to avoid overwork
(c) Restriction of access to mood altering substances is frequently indicated
(d) Voluntary withdrawal from practice pending evaluation and/or treatment is usually indicated.
(i) if concerns of impairment arise
(ii) when inappropriate toxicology results are received.

H) Criteria for Work site or other Monitors

1) Regular on-going contact with the licensee

2) Avoid conflicts of interest: The monitored individual should not have supervisory authority over the worksite monitor.

3) The role of the work site monitor should be to evaluate the individual's performance, NOT their illness; otherwise this blurs boundaries and creates dual relationships. By providing general performance information (punctuality, professional demeanor to patients and staff, record keeping), work site monitors may identify behavioral changes, which may indicate relapse behavior.

4) Monitor ideally will have knowledge of the symptoms and signs of relapse

5) Monitor will provide routine reports, in no case less often than quarterly, to the state PHP and when required to other assigned oversight authority

6) Monitor agrees to immediately report any concern to state PHP

I) Toxicology Testing

1) Urine drug screens are routinely employed

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(a) Random schedule
(b) Frequency as determined clinically appropriate and in accord with program standards (Reference: Crosby RD, Carlson GA, Specker SM. *Simulation of Drug Use and Urine Screening Patterns*, J Addict D. Vol.22(3) 2003: 89–98.)
(c) Chain of Custody will be utilized on all specimens
(d) Witnessed collection is the gold standard: deviation from this collection protocol for a specimen must be approved by the PHP (dry room collection is acceptable only when witnessed collection is not possible)

2) A forensic laboratory facility qualified to perform and confirm a state of the art healthcare testing profile must be used

(a) Adulteration testing must include at a minimum specific gravity and creatinine and other tests for adulterants as recommended by the laboratory

(b) All positive screening results must be confirmed prior to reporting

(i) Alcohol positive results should be reflexed to test for glucose and yeast

(c) Level of detection testing rather than using predetermined cut-off should be employed in analysis and reporting

(d) Clinical toxicologist must be available for consultation in test interpretation

3) Toxicology test panels need to be as comprehensive and as sensitive as possible. Commonly abused pharmaceuticals must be tested for on a routine basis. Commonly marketed drug panels such as "NIDA-5" and "CSAT-7" are not adequate for testing in this population.

(a) All positive urine drug screens must be reviewed by the Medical Director
(b) The Medical Director must have the training and expertise to correctly interpret the test results. MRO training or certification is encouraged.

4) Additional forensically sound testing and monitoring methodologies may be employed as indicated

III) Guidelines for addressing relapse behavior and chemical relapse

A) A relapse protocol must be developed which is acceptable to the PHP and the licensing authority in each state

B) Each relapse should be evaluated clinically with a graduated response tailoring treatment intensification to relapse severity

C) State PHPs must respond immediately to any toxicology confirmed positive for drugs of abuse. Depending on circumstances, an immediate withdrawal from practice pending further evaluation may be indicated.

D) A mechanism for an independent review and/or second opinion beyond the PHP Medical Director must be available if there is dispute regarding the recommendations for intensification of treatment

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E) Immediate reporting to the licensing authority is required in certain cases

1) Impairment is identified and the practitioner refuses to cease practice
2) Treatment recommendations have been rejected
3) The participant is determined to be refractory to treatment following multiple treatment episodes
4) The participant is under Board Order requiring reporting
5) If otherwise required per relapse protocol (See III A).

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Management of Other Psychiatric Disorders

I) Physician health programs should provide services to physicians with psychiatric disorders. Physician health programs should be structured to manage this population. The FSPHP supports the development of mental health services in all programs. While not all psychiatric disorders reach a level of severity to warrant monitoring, many cases will benefit from the coordination of care provided by a PHP. Cases of psychiatric illness which have caused workplace concern or have been refractory to initial stabilization are especially appropriate for PHP referral. To effectively manage this population, a baseline of required knowledge, skills and resources is necessary. The PHP must have a psychiatrist available on staff or otherwise formally affiliated with the PHP in order to provide the necessary expertise to conduct various aspects of PHP work with psychiatric disorders (other than substance related disorders). Such expertise is necessary during the initial evaluation, in the understanding and implementation of treatment recommendations, and in the clinical monitoring of the psychiatric disorder. The following characteristics and abilities are vital for all physician health programs providing mental health services.

   A) Conducts outreach and educational activities to all physicians which serves to educate the medical community regarding this physician health concern, explains the role of the state PHP, educates potential referents, and encourages self-referral. .

   B) Ability to effectively interface with existing medical staff resources such as Wellness Committees.

   C) Ability to accept and triage self-referrals in addition to the ability or resources to facilitate effective interventions when indicated

      1) Ability to guide referent in crisis intervention with immediate referral to the appropriate level of care.

   D) High visibility in the medical community with a user friendly avenue to receive reports concerning physician health or behavior is necessary.

   E) Ability or resources to gather relevant information about and determine the legitimacy of reports in a sensitive manner

   F) Ability to make appropriate referrals for evaluation and treatment based on the participant's needs. A choice of several appropriate evaluation/treatment options/programs should be offered participants whenever possible. Alternatively, if appropriately staffed and structured, the PHP may perform the evaluation.

      1) Physician Health Programs should consider cultural competence and other specialized needs when making referrals

   G) Maintenance of current information on multiple resources available to accept referrals for evaluation and treatment (See Appendix 1 & 2)

   H) Physician Health Programs must not have any conflict of interest or business association with providers/programs utilized for referrals.

II) Physician Health Programs must be capable of flexibility in designing individualized aftercare and monitoring services for physicians with psychiatric disorders.

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A) A typical period of monitoring for psychiatric disorders is 1-5 years; however the length of monitoring should be based upon the condition being monitored and assessment of the physician participant. The length of monitoring agreements should be individualized with consideration given to the following factors:

1) Type and natural history of the psychiatric disorder

   (a) Severity of symptoms and level of impairment at presentation
   (b) Prior history including compliance with treatment
   (c) Responsiveness to treatment, stabilization of symptoms and sequelae, and projected timeframe for realization of maximum treatment and/or monitoring benefit

2) Presence or absence of comorbid conditions

3) Participant's level of Insight into their condition and their motivation for treatment

4) Quality of environmental and social supports

5) Relative risk for workplace impairment and the participants insight into and reaction to periods of impairment

B) Specific aftercare components should incorporate recommendations from evaluation and treatment resources. The PHP must have needed latitude in individual cases to modify treatment provider recommendations based upon additional information and consideration of available resources.

1) Ongoing treatment will normally require follow-up with a treating psychiatrist and frequently with additional mental health providers

   (a) Consents for release of information between providers and the PHP must be maintained.
   (b) Ongoing treatment providers and monitors must understand their responsibility to immediately notify the PHP in the case of significant changes in the status of the participant and whenever a program participant's ability to practice with reasonable skill and safety is in question.
   (c) The PHP must ensure ongoing treatment providers have all necessary information from which to formulate and implement a therapeutic treatment relationship.
   (d) The PHP should facilitate coordination of care between the participant's community providers throughout the treatment process.

2) Evaluation of mental/emotional stability is ongoing for the duration of the monitoring period. Confidentiality of therapy should be protected while at the same time documentation of psychiatric stability must be obtained as evidence that the participant's ability to practice medicine is not impaired by a psychiatric disorder. Clinical monitoring of the client is an essential activity. Components of clinical monitoring may include:

   (a) A qualified psychiatrist who is a PHP staff member or consultant should regularly assess the client in a face to face context. Forensic psychiatric experience is encouraged in this role.

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(b) The PHP may assign a monitoring psychiatrist who will independently evaluate the participant and consult with the treatment providers and provide an opinion on psychiatric stability omitting details of therapy content. Outside PHP consultants must be familiar with the documentation and reporting needs of the PHP. Such consultant(s) also must be familiar with the importance of timely documentation of compliance with treatment.
(c) An alternative to a) & b) above is direct reporting to the PHP from ongoing treatment providers. Status reports from therapists, psychiatrists or other mental health providers should specifically exclude content of psychotherapy sessions unless the therapist considers it vital to case management in which case the therapist should discuss the report with their patient in advance.
(d) Reports from therapists and psychiatrists should include, but are not limited to:

(i) A statement documenting attendance and productivity of sessions
(ii) Recommendations for any changes in treatment
(iii) Any medication changes
(iv) A statement of stability to practice medicine, need for medical leave or recommendation for re-evaluation

3) If appropriate resources are available, support group participation may be appropriate.

4) Abstinence from alcohol and other drugs of abuse should be incorporated when clinically indicated

(a) Recreational drugs of abuse are contraindicated during the contract period
(b) Treatment providers should be made aware of all PHP prescription drug requirements
(c) Abstinence is indicated in all cases of comorbid substance use disorder (utilize guidelines for treatment of SUD)
(d) Alcohol use may be contraindicated during stabilization of a mood disorder or other psychiatric condition when mood-altering chemicals are likely to jeopardize stability as well as to impair judgment regarding proper use of prescribed medications, regular sleep patterns, diet management, etc.
(e) Abstinence is indicated if there is a history of alcohol use exacerbating the psychiatric disorders or interfering with the efficacy of prescribed medications.
(f) When abstinence is a treatment requirement toxicology testing should be utilized as detailed in the section on Substance Use Disorders

C) Generic contractual components between state Physician Health Programs and participants, whether voluntary or mandated, should include the following components:

1) Agreement for good faith participation.
2) Agreement specifying limitations on recreational use of or abstinence from use of alcohol or mood altering chemicals...
3) Agreement to not prescribe scheduled drugs for family members and a strong recommendation to refrain from treating family members.
4) Agreement to not manage one's own medical care and to comply with necessary medication regimen.

(a) Participants will not diagnose or manage their own illnesses and will not self-prescribe or independently discontinue any medications.

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(b) As directed by the PHP, participants must inform appropriate treating physicians of their diagnosis, their relationship with the state Physician Health Program and their duty to provide a release of information to communicate freely with the state Physician Health Program.

(c) Psychotropic medication changes must be reported to the PHP in a timely fashion

(i) Participants may be required to provide documentation of medication refills and attestation statement of appropriate use if there has been a history of medication non-compliance or failure to stabilize their condition
(ii) Monitored use of medications or testing for therapeutic medication levels may be required.
(iii) Participants should be required to inform the PHP as soon as feasible (generally within 24 hr.) if a potentially addictive medication is required if there is a history of substance related disorder or significant vulnerability to developing a substance related disorder, and whenever urine toxicology testing has been implemented,

(d) Participants shall inform the PHP as soon as feasible in the case of medical or psychiatric hospitalizations

5) Agreement to maintain consent for ongoing communication with an approved workplace monitor/contact, if indicated.

6) Agreement to abide by any specified workplace restrictions.

7) Agreement to maintain consent for the physician health program to speak with the participant's family/SO as needed.

8) Agreement to submit to biological specimen monitoring without question if requested by the PHP

9) Informed Consent

(a) A statement of the confidentiality provided and the limitations of same.

(i) A statement defining any requirements for reporting to the licensure board.
(ii) A statement defining other reporting requirements.

(b) A statement of actions which will follow a failure to comply with the monitoring contract or evidence of impairment which may include, but is not limited to, withdrawal from practice, intensification of treatment, inpatient evaluation, additional treatment, and/or a report to the licensure board.

(c) A statement that the monitoring contract may be extended at the discretion of the state physician health program if, at the end of the contract period, clinical reevaluation indicates the need for additional monitoring

10) Agreement that monitoring will be transferred to the appropriate state PHP or Licensure Board if the participant moves while monitoring is still indicated.

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11) Agreement to faithfully follow up with designated treatment providers (individual therapists, family therapists, marriage therapists, psychiatrists) and/or others designated in the participant's contract.

(a) Agreement to maintain an active release of information to the state physician health program and necessary treatment providers.

12) The monitoring agreement should make clear the conditions under which anonymity can be broken, if any.

(a) Agreement that the state licensure agency will be notified in the event that the PHP determines that a participant's practice of medicine may pose a risk to patients and he/she refuses to refrain from practice or otherwise follow PHP directives for remediation as recommended.

13) Optional contract components may include, but are not limited to, notification of the state PHP for:

(a) Travel outside monitoring area
(b) Change of address
(c) Change of employment
(d) Malpractice claims
(e) Arrests
(f) Work site and performance difficulties

D) Return to Work Considerations, Practice Restrictions and Workplace Monitors

1) When indicated these components should be employed as outlined in the section on Substance Use Disorders

III) Guidelines for addressing recurrent episodes of psychiatric disorders

A) Each recurrence should be evaluated clinically tailoring further treatment or treatment modification to symptom etiology and severity

1) State PHPs must respond immediately to concerns of possible impairment which could place patients at risk. Depending on circumstances, an immediate withdrawal from practice pending further evaluation may be indicated.

2) Consideration should be given to implementing diagnostic monitoring with a requirement for abstinence to rule out a convert substance use disorder or exacerbation of the condition by substance use

B) A mechanism for an independent review and/or second opinion beyond the PHP Medical Director must be available if there is dispute regarding the recommendations for treatment

C) Immediate reporting to the licensing authority is required in certain cases

1) Impairment is identified and the practitioner refuses to cease practice

2) Evaluation or treatment recommendations have been rejected

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3) The participant is under Board Order requiring reporting

4) At any time there is a threat to the public safety refractory to immediate intervention efforts.

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Appendix 1: Evaluations

I) Types of Evaluations

A) Fitness for Practice Evaluations: Forensic Evaluation

1) Comprehensive evaluation which normally requires several days with repeated interviews and testing sessions

2) Determines if a health condition exist which impairs or is likely to impair normal professional performance.

3) Determines a working diagnosis

4) Evaluates Performance Issues

(a) Is the physician capable of practicing medicine?
(b) Is further evaluation of professional skill or competency required or is remedial training required?
(c) Is continuing work detrimental to the health, safety, morale or well being

(i) Of the physician?
(ii) Of others?

(d) Are there functional limitations?
(e) Does the individual have the ability to comply with relevant laws, regulations, procedures and codes of conduct?

5) Under what conditions is the practitioner appropriate to resume medical practice?

6) Makes treatment or monitoring recommendations

B) Clinical Evaluation: Establishing Treatment

1) May be the initial step in the development of a treatment relationship

2) May be appropriate in cases where workplace impairment is not an issue and there is no evidence of denial

3) Determines the diagnosis

4) Makes treatment/monitoring recommendations

C) Clinical and/or Forensic Re-evaluation

1) Evaluation is to determine if modification and/or Intensification of treatment is appropriate

2) This evaluation may be suitable during exacerbations of pre-existing conditions (substance use disorder relapse, depressive or manic episode, behavioral disturbance, multiple sclerosis, etc)

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(a) The presence of new conditions and status of prior diagnoses are assessed

3) Recommendations for treatment should specify the type and intensity of treatment required and provide information about a selection of competent providers

(a) If treatment is recommended, and such treatment is available from the evaluator, the participant shall always be offered the option to seek treatment from another provider acceptable to the PHP to avoid potential conflict of interest.
(b) In some cases, especially when the participant is in strong disagreement with the recommendation for treatment, it may be appropriate for the evaluating facility to encourage re-evaluation or require treatment elsewhere.

II) Characteristics of Evaluation Providers Appropriate for PHP Referrals

A) The evaluator must possess the knowledge, experience, staff, and referral resources necessary to fully evaluate the condition(s) of impairment in question

B) Adhere to all applicable confidentiality regulations

C) There should be no actual or perceived conflicts of interest between the evaluator and the referent or patient.

1) No secondary gain should accrue to the evaluator dependent on evaluation findings/outcome.

2) An evaluator should not be in a treatment relationship with the professional being evaluated.

3) If the evaluation is mandated, the evaluator should not be affiliated with the entity requiring the evaluation.

D) The evaluator must keep the PHP fully advised throughout the evaluation process. The evaluator will:

1) Apprise PHP of evaluation dates.

2) Apprise PHP, family, and other appropriate sources of the participant's safe arrival.

3) Execute any required PHP forms at the time of arrival or as soon as practical.

4) Notify the PHP immediately regarding AMA departures, or other significant occurrences.

5) Advise PHP of evaluation findings and recommendations before advising patient of recommendations.

6) Notify PHP before participant's discharge.

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7) Provide timely documentation including a brief typewritten summary of findings and recommendations by 2nd business day following completion of the evaluation. A comprehensive typewritten evaluation should follow within 14 days. Specific documentation of information supporting diagnostic and placement (level of treatment) criteria is especially helpful.

E) Have resources available and be prepared to conduct a secondary intervention at the time diagnoses and recommendations are discussed. Involve the state PHP with a secondary intervention as indicated/needed.

F) Have immediate access to medical and psychiatric hospitalization if needed.

G) Arrange for timely intake and admission.

H) Fully disclose costs prior to admission.

I) Evaluate All Causes of Impairment

1) Mental illness
2) Chemical dependency and other addictions
3) Dual diagnosis
4) Behavioral problems including: sexual harassment, disruptive behaviors, abusive behaviors, criminal conduct
5) Physical Illness including: neurological disorders and geriatric decline

J) Employ standardized psychological tests and questionnaires during the evaluation process

K) Conduct comprehensive and discrete collateral interviews of colleagues and significant others to develop an unbiased picture of all circumstances, behavior and functioning

1) Carefully identify and interview collateral contacts for evaluation.
2) Report an incomplete evaluation if the patient refuses to provide a release of information for necessary collateral interviews.
3) Evaluators must consider whether collateral sources may have an agenda outside the interest of the patient and balance this information accordingly.
4) Unless contraindicated collateral contacts should include: the person initiating report; representatives of the hospital/office work environment; colleagues; family members including spouse/significant other; health care providers; and others as identified.
5) Reports on collateral sources of information but avoids associating any specific information with its source.

L) Make Rehabilitation/Treatment Recommendations

1) State clearly if treatment or other intervention is needed
2) Identify if workplace modifications or accommodations are required
3) Identify if a change of specialty, employer or career should be explored
4) Detail any monitoring requirements

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M) If the patient disagrees with diagnosis (based of DSM-IV criteria) or treatment recommendations, the evaluator should encourage a second opinion regarding diagnosis/recommendations. The second opinion should be obtained at a PHP approved evaluation facility.

III) Criteria for Multidisciplinary Assessment

A) This type of evaluation is recommended whenever cognitive distortions are suspected; e.g. chemical dependency, bi-polar disorder, organic brain syndromes and behavioral disturbances.

B) Maintain qualified staff and referral resources to provide a multi-disciplinary evaluation which should include:

1) Standardized testing using validated instruments

(a) Psychological: personality testing, cognitive screening, and other screening instruments for depression, anxiety, etc...
(b) Substance Use Disorder Screening

2) Psychiatric Evaluation must be completed and supplemental psychological testing performed as indicated

(a) Cognitive and neuro-psychiatric assessment

3) Psychosocial Assessment

4) Medical Assessment

(a) Physical Examination

(i) Referral/treatment as indicated

(b) Laboratory Examination

(i) Chain of custody comprehensive toxicology testing
(ii) Screening blood tests

a At minimum should include: CBC, electrolytes, LFTs, communicable disease battery, and thyroid function tests
b other tests as indicated

5) Addiction Medicine Assessment

(a) Chemical Use History
(b) Family assessment
(c) Spiritual Assessment
(d) Inclusion in peer recovery group when available

6) Examinations by other specialists as indicated

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7) Collateral interviews

8) Records review

IV) Criteria for Independent Evaluator

A) Unbiased and Objective

B) Well respected in medical community

C) Appropriate credentials

D) Broad clinical experience in evaluating and monitoring in the hospital environment

E) Understands addiction as well as other mental and physical illness

F) Working knowledge of medical staff/hospital administration dynamics

G) Understands legal, liability and forensic issues

H) Cooperative attitude toward referent

I) Willing to share clinical findings with referent and appropriate workplace contacts

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Appendix 2: Treatment Programs

I) Characteristics of Treatment Programs which are appropriate for PHP referrals

A) Characteristic defined in Appendix 1 are also appropriate for treatment facilities and are hereby incorporated by reference.

B) Ability of PHP to visit site and referred patients

C) Business office must be capable of and willing to work with insurance providers and should have avenues available to assist with payment plans for the indigent physician

D) A peer professional patient population and a staff accustomed to treating this population is highly desirable

E) Programs and practitioners should make appropriate referrals when faced with a patient who has an illness/issue that is outside of the practitioner's area of expertise.

F) Staff to patient ratio should be conducive to each patient receiving individualized attention.

G) Must keep state PHP informed throughout the treatment process through calls from the therapists involved as well as written reports. Type and frequency of contact may be arranged with the state PHP but in all cases should occur no less than monthly.

H) A strong family program is desired. The family/SO should be kept apprised throughout the treatment process

I) Immediately report to the state PHP threats to leave AMA, AMA discharges, therapeutic discharges, any other irregular discharge or transfer, hospitalization, positive urine drug screen, non-compliance, significant change in treatment protocol, significant family or workplace issues, or other unusual occurrences.

J) Must have the medical, psychiatric, and addictions staff necessary to fully address all health issues, obvious and otherwise. Specifically, the staff must be vigilant in screening for, identifying and diagnosing covert co-occurring addictions and co-morbid psychiatric illnesses and address these concurrently with the presenting illness. This includes appropriate resources to assess and manage concurrent chronic pain diagnoses (in-house, consultative, and/or referral capacity).

K) A multi-disciplinary team approach should be used and include psychological, psychiatric and medical stabilization.

L) Funding for Treatment Programs

1) Participants are responsible for all payment for required treatment
2) Fees should be fair and equitable.
3) Full fees must be disclosed up front.

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4) A flexible payment plan should be available for the varied income levels of participants, but the patient should make some financial investment into the treatment process.

M) Length of stay must be clinically driven and justified

N) Complete and appropriate records must be maintained to fully defend diagnoses, treatment, and recommendations.

O) Discharge planning and coordination: Before discussing with patient, provide the state PHP with verbal notification of discharge planning and again prior to actual discharge. Documentation including a brief typewritten summary of final diagnoses, recommendations for return to work, and aftercare recommendations shall be transmitted electronically by 2nd business day following discharge, with a comprehensive typewritten evaluation following no later than 14 days.

P) Discharge summary must be adequate to:

1) Document diagnostic criteria and the basis for aftercare recommendations.
2) Show that patient needs were addressed.
3) Show that appropriate treatment was provided.
4) Show that criteria for discharge were met.
5) Justify return to work/fitness to practice recommendations.
6) Identify all Axis I - V diagnosis (with elaboration on co-morbid illnesses present) and define aftercare recommendations.
7) Define any special needs that treatment providers feel would be advantageous to include in an aftercare contract with the state PHP.
8) Return to work/fitness to practice assessment prior to discharge
9) Extended treatment options when indicated.

II) Substance Use Disorder Treatment Programs also require the following

A) Programs must use an abstinence-based model (appropriate psychoactive medication as prescribed). In rare cases that are refractory to abstinence-based treatment, alternative evidence-based approaches should be considered.

B) When a 12-step model is utilized for substance use disorders, appropriate therapeutic alternatives (acceptable to the PHP) should be made available to participants with religious or philosophical objections. If an appropriate alternative is not available at the initial facility, then the physician shall be responsible for working with the facility and the PHP to identify an alternative of appropriate intensity.

C) A strong family program is considered mandatory. Family program component should focus on disease education, family dynamics, and supportive communities for family members. Family/SO needs must be accessed early in the process and participation with family/SO programs and individual therapy encouraged.

D) Treatment services must include:

1) Intervention and denial reduction
2) Detoxification

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3) Ongoing assessment and treatment of patient needs to occur throughout treatment with referral for additional specialty evaluation and treatment as appropriate

   (a) Eating disorders
   (b) Gambling addiction
   (c) Sexual compulsivity/Addiction
   (d) Psychiatric Illness
   (e) Cognitive Impairment
   (f) Medical illness
   (g) Chronic pain
   (h) Other

4) Family treatment

5) Group and individual therapy

6) Educational programs

7) Mutual support experience (e.g. AA/NA/etc.) and appropriate alternatives when indicated

8) Development of continuing care plan and sober support system

   (a) Indicate any patient/family needs for ongoing therapy

9) Relapse prevention training

10) Return to work/fitness to practice assessment prior to discharge

11) Extended treatment options when indicated.

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