Physician impairment, the inability to carry out patient care responsibilities safely and effectively, is a problem of functioning. However, the presence or treatment of a potentially impairing illness or other condition does not necessarily imply impairment. This American College of Physicians position paper examines the professional duties and principles that should guide the response of colleagues and the profession to physician impairment. The physician should be rehabilitated and reintegrated into medical practice whenever possible without compromising patient safety. At the same time, physicians have a duty to seek help when they are unable to provide safe care. When identifying and assisting colleagues who might be impaired, physicians should act on collegial concern as well as ethical and legal guidelines that require reporting of behavior that puts patients at risk. Health care institutions and the profession should support practice environments in which patient safety is prioritized and physician wellness and well-being are addressed. Physician health programs should be committed to best practices that safeguard patient safety and the rights of physician-patients.

Physicians share a commitment to care for ill persons, including each other. When physicians become impaired and are unable to practice competently, they should seek medical help and assistance in caring for their patients. When they cannot or do not do so, the profession and individual physicians have a responsibility to safeguard the welfare of patients and assist colleagues in obtaining help.

The American College of Physicians (ACP) has long distinguished impairment from the underlying illness or condition (1). Impairment interferes with the ability of a physician to carry out patient care responsibilities safely and effectively. It can have many causes, including substance use disorders, mental illness, profound fatigue, or a decline in cognitive or motor skills due to age or disease (1, 2). Professional self-regulation, including state licensure practices, should focus on the functional impact of impairment. The presence or treatment of a disorder does not necessarily imply that the physician is impaired (1).

When identifying and assisting colleagues who might be impaired, physicians should act on collegial concern as well as ethical and legal guidelines that require reporting behavior that puts patients at risk (1, 3–5). A stepwise approach should be taken, starting with a sensitive but forthright discussion with the person if patient harm is unlikely and progressing to a report to licensing boards or clinical supervisors if patient harm is imminent or suspected. In uncertain cases, physicians should seek counsel from designated officials or supervisors (1).

Medical institutions should establish clear policies for handling and educating staff physicians and trainees on the referral, rehabilitation, and reintegration of impaired physicians, including respect for the confidentiality of those who report and are reported (6). Outreach, education, and collaborative leadership at every level of organized medicine, including physician health programs (PHPs), state medical boards, professional societies, and health care institutions, are needed to support physician wellness and well-being.

The goal for professionals, organizations, and communities should be to rehabilitate impaired physicians and facilitate reintegration into medical practice whenever possible. Rehabilitation should focus on treating the underlying illness or condition (7, 8), with different causes of impairment requiring different types of assessment and support. Clinical evaluation and treatment should be based on standards of care. A physician’s readiness to reintegrate should be determined on a case-by-case basis (9), focusing on the functional impact of the impairment and recognizing that its ef-

See also:

Editorial comment

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effects are role-specific and related to the physician’s specialty and clinical responsibilities. Most states have PHPs, many of which have demonstrated success in assisting impaired physicians and trainees, especially those with substance use disorders (10–16). However, PHPs vary in their approaches, and impairment may not be recognized or addressed by individual physicians or their colleagues. Also, some PHPs have been scrutinized for the adequacy of their protections of the rights and interests of physician participants (17).

This ACP position paper reaffirms the responsibility of physicians and the profession to protect patients while detailing the foundational principles and professional duties that should guide the response to physician impairment. This executive summary is a synopsis of ACP’s positions; the rationale for each is presented in the Appendix.

METHODS

This position paper was developed on behalf of the ACP Ethics, Professionalism and Human Rights Committee (EPHRC). Committee members abide by the ACP’s conflict-of-interest policy and procedures (www.acponline.org/about-acp/who-we-are/acp-conflict-of-interest-policy-and-procedures), and appointment to and procedures of the EPHRC are governed by the ACP’s bylaws (www.acponline.org/about-acp/who-we-are/acp-bylaws). After an environmental assessment to determine the scope of issues and literature reviews on PubMed and Google Scholar, the EPHRC evaluated and discussed several drafts of the paper, and the paper was reviewed by members of the ACP Board of Governors, Board of Regents, Council of Resident/Fellow Members, Council of Student Members, and other committees and experts. The paper was revised on the basis of comments from these groups and individuals. The ACP Board of Regents reviewed and approved the paper on 3 November 2018.

POSITIONS

1. The professional duties of competence and self-regulation require physicians to recognize and address physician illness and impairment.

2. The distinction between functional impairment and potentially impairing illness should guide identification of and assistance for the impaired physician.

3. Best practices for PHPs should be developed systematically, informed by available evidence and further research.

4. PHPs should meet the goals of physician rehabilitation and reintegration in the context of established standards of ethics and with safeguards for both patient safety and physician rights.

5. Maintenance of physician wellness with the goal of well-being must be a professional priority of the health care community promoted among colleagues and learners.

CONCLUSION

Physician impairment is a problem of professional functioning that has implications for both patients and impaired physicians. Impaired physicians should seek treatment when they are unable to provide safe care. Colleagues should assist and refer those who are impaired and who need medical assistance, including help in caring for their patients.

The profession, health care institutions, and organizations should promote practice environments in which patient safety is prioritized and physician wellness and well-being are addressed. State PHPs should be committed to best practices that help ensure patient safety, protect the rights and interests of physicians, and advance excellence in the rehabilitation of physicians back into medical practice.

The privilege of medical practice is predicated on the physician’s and the profession’s commitment to providing safe, competent, and ethical patient care. Self-regulation is part of the definition of a profession: Members of the medical profession share in the responsibility to safeguard patients from harm. This is one of the ways in which physicians demonstrate the commitment to care for ill persons—including caring for one another.

APPENDIX: EXPANDED RATIONALE

Position 1

The professional duties of competence and self-regulation require physicians to recognize and address physician illness and impairment.

Self-regulation is part of the definition of a profession (1) and of the medical profession’s social contract with society, a privilege that is predicated on the profession upholding standards of competence and conduct that ensure safe, ethical, and effective patient care (18, 19). Society grants professional prerogatives to physicians “with the expectation that physicians will use their position for the benefit of patients. In turn, physicians are responsible and accountable to society for their professional actions. Society grants physicians the rights, privileges, and duties pertinent to the patient-physician relationship and therefore has the right to require that physicians be competent, knowledgeable, and respectful of the patient as a person” (1). Physicians should strive to recognize when they are not able to provide appropriate care and seek treatment. Colleagues may need to assist—or, as appropriate, report—impaired physicians who require medical assistance and help in caring for their patients (1).

The ACP Ethics Manual has long urged a focus on the importance of an impairment’s functional impact—that is, the inability to carry out patient responsibilities safely and effectively. Physician impairment may have various causes, including substance use disorders, mental illness, profound fatigue, or a decline in cognitive or motor skills due to age or disease. Physical limi-
Physicians also do not always refer impaired colleagues. In a 2010 survey of 2938 physicians, almost a third with knowledge of an impaired or incompetent colleague did not report this to a relevant authority, and more than a third did not agree that physicians should report colleagues at all. The most common reasons for not reporting were the expectation that someone else would do so or that no action would result. Other reasons included fear of retribution, belief that it was not their responsibility, and worries about excessive punishment (37). In addition, colleagues may harbor concerns about misjudging someone as impaired. More data about current practices and behaviors would be helpful, and ACP encourages further study in this area.

None of these concerns diminish physicians' shared responsibility to protect patients and assist impaired colleagues. In uncertain cases, concerned colleagues should “seek counsel from a designated institutional or practice official, the departmental chair, or a senior member of the staff or the community” (1). Physicians must be careful in identifying someone as impaired, remembering that without a good-faith concern about a colleague’s impairment or competence, it is unethical “to use the peer-review process to exclude another physician from practice, to restrict clinical privileges, or to otherwise harm the physician’s practice” (1). Peer review is a vital element of the profession’s duty of self-regulation and must not be misused. Physicians should be aware that oversight bodies reserve the right to make the ultimate judgment about patient harm or imminent risk, including whether and how to act on a report.

Physicians should take a collegial approach to helping one another, acting in a stepwise manner to assist a colleague who might be in need. When there is no likelihood of patient harm, a sensitive but direct discussion with the physician can raise relevant issues. By acting on collegial concern, as well as on ethical and state guidelines that require reporting of behavior that puts patients at risk (1, 3–5), physicians can urge an impaired colleague to explore voluntary options for treatment for it does not necessarily imply impairment (discussed further in position 2) (1). The exact prevalence of physician impairment is unknown, but several important causes are common and require different types of assessment and support.

Although impairment has many potential causes, the most commonly studied is substance use disorders. Rates of alcohol use disorders among physicians, especially women, are equal to or greater than that of the general population—as high as 21.4% and 25.6% among female physicians and surgeons, respectively, versus 12.9% and 13.9% among their male counterparts (20, 21). In contrast, men are twice as likely as women to meet the criteria for alcohol abuse or dependence in the general population (21). The gender difference among physicians has not been fully explained but may be due to more conflicts between work and home for female physicians (20). Other contemporary issues, such as the implications of use of legal cannabis or medication-assisted treatment (for example, buprenorphine or other partial opioid agonists), also require further study and guidance (22).

Substance use disorders are also strongly associated with common mental health conditions (23–25), which can also lead to impairment. In a large 2014 survey, 40% of early-career physicians and 50.8% of residents screened positive for depression, and 6.3% and 8.1%, respectively, screened positive for suicidal ideation (24). Cognitive decline has also received more attention recently as a potential cause of impairment, especially as the number of practicing physicians aged 65 years or older grows rapidly (26–28). This will require a renewed focus on cognitive signs that signal risk to patients.

Physician impairment is too often unrecognized or untreated. Studies suggest that physicians are less likely than members of the general population to obtain needed care and are more likely to self-diagnose and self-treat (29–31). For example, in a study of physicians being monitored for misuse of prescription drugs, “self-medication” was a leading reason for misuse (32). Physicians may avoid seeking medical help because they fear loss of confidentiality and privacy, loss of livelihood, or the appearance of vulnerability or because they deny or subordinate their personal needs to practice demands and therefore do not recognize the impairment (33). The stigma of addiction and mental illness added to the concern that diagnosis may lead to professional liability or loss of licensure can compel physicians to suffer in silence and delay seeking help (34–36).
The Federation of State Physician Health Programs (FSPHP) and the Federation of State Medical Boards (FSMB) maintain an important distinction in their policies governing functional impairment and potentially impairing illness (7, 35, 38). Impairment is a functional classification concerning the physician’s inability to carry out patient care responsibilities safely and effectively. Illness does not necessarily signify impairment. This distinction has been central to the section on impaired physicians in many editions of the ACP Ethics Manual; the seventh edition states, “Impairment may result from use of psychoactive agents (alcohol or other substances, including prescription medications) or illness. Impairment may also be caused by a medical or mental health condition, the aging process, or profound fatigue that affects the cognitive or motor skills necessary to provide adequate care. The presence of these disorders or the fact that a physician is being treated for them does not necessarily imply impairment” (1).

Some licensure questions may be a barrier to recognition, referral, and treatment of impaired physicians (35, 39, 40). A resolution recently adopted by ACP advocates for “modernization of state licensure practices that focuses more on the functional impact of mental health diagnoses in physicians and limits additional administrative requirements so that it does not isolate prior or current mental health considerations from other medical considerations in the reporting process” (41). The American Medical Association (AMA) Council on Medical Education has also recommended that

AMA urge state medical boards to refrain from asking applicants about past history of mental health or substance use disorder diagnosis or treatment, and only focus on current impairment by mental illness or addiction, and to accept ‘safe haven’ non-reporting for physicians seeking licensure or relicensure who are undergoing treatment for mental health or addiction issues, to help ensure confidentiality of such treatment for the individual physician while providing assurance of patient safety (42).

In keeping with the focus on functional impact, ACP recommends that licensure questions address current status rather than past history, not distinguish between mental and physical health, and elicit objective information about functional status. A model question proposed by the FSMB, “Are you currently suffering from any condition for which you are not being appropriately treated that impairs your judgment or that would otherwise adversely affect your ability to practice medicine in a competent, ethical and professional manner?” (35), contains helpful elements that focus on current status and make no distinction between physical and mental health. Although these are important steps forward, such licensure questions should also elicit objective information about functional status; otherwise, physicians who are in denial about their condition or for whom appropriate treatment is not restorative could just answer “no.” Applying validated screening questions for use in individual self-assessment could also meaningfully improve the process.

Assistance for impaired physicians should focus on the underlying illness or condition (8, 38). Contemporary efforts to help impaired physicians have focused on treatment and rehabilitation and can be traced to a landmark report published in 1973 by the AMA Council on Mental Health (2, 43, 44). The impetus for that report was physician impairment due to “psychiatric disorders, including alcoholism and drug dependence.” The report recognized the significant scope of problems affecting physicians, the failure of physicians to seek help, and the “conspiracy of silence” surrounding the issue. It helped reorient physician impairment from a disciplinary issue to an illness requiring rehabilitation. This continues to inform the work of PHPs today (8, 43).

Different causes of impairment require different types of assessment and support. Potential causes are not limited to addiction and psychiatric disorders; they can include many treatable and resistant conditions. For example, ACP and FSMB note that disruptive behavior (3) and cognitive decline (4) can cause impairment. Although they may be manifestations of underlying personality, psychiatric, or substance use disorders, disruptive behavior and cognitive decline are not illnesses per se. The former may be due to personality or character traits, interpersonal conflicts exacerbated by gender and cultural factors, or other external stressors (45, 46), and the latter may be caused by health problems associated with aging (4, 26). In all cases, different stages of progression or severity may warrant different forms of intervention.

The nature and severity of the impairing condition and the degree of risk posed to patients and others should inform best practices for assisting an impaired physician. Rehabilitation should be sought whenever possible so that the physician might safely return to practice. Evaluation and treatment should be clinically based according to standards of care. A physician’s voluntary decision to seek or accept treatment should not “in [and] of itself, be used against the physician in disciplinary matters before the board” (38).

A physician’s readiness to reintegrate into medical practice should be evaluated on a case-by-case basis (9). The determination should focus on the functional impact of the impairment, with the recognition that this is role-specific and that reintegration will therefore depend on the physician’s specialty and clinical responsibilities. In all cases, continuing care and monitoring
should not compromise patient safety (8). Reasonable accommodations should be made to ensure that recovering physicians have the support they need to provide competent care. This may include time during the day for medical and therapy appointments, support group meetings, or urine screens and medical tests. More flexible shifts or gradual returns to work can be important corollaries to work schedule adjustments. When treatment or management of an impairing condition that is relevant to practice is not possible, the physician should discontinue practice. Retraining; mentoring; group support; or moving to related work, such as medical writing, may then be possible.

**Position 3**

Best practices for PHPs should be developed systematically, informed by available evidence and further research.

The profession assists impaired physicians primarily through state PHPs with varied organizational and operational structures. Physician health programs may be authorized or managed by the state medical board or medical society; almost all are nonprofit (47). Forty-six states and the District of Columbia have PHPs with the requisite staff and recognition of organized medicine in their state to be members of the FSPHP (48). However, financial support varies, leading the FSPHP to call for programs to be adequately funded by their sponsors so they can offer an appropriate range of services.

The FSPHP issues consensus policy statements and guidelines for its member PHPs (8), and the FSMB issues its own policy for state medical boards that support or establish PHPs (38). Most PHPs do not report monitored physicians to state licensure boards in cases of voluntary referral unless the physician is noncompliant or relapses. Referrals that are mandated by the state medical board have tighter reporting requirements, although PHPs maintain barriers between therapy and monitoring so that treatment can remain confidential (38). Physician health programs monitor and oversee treatment but do not treat physicians directly; most refer them to community consultants specializing in physician health for evaluation or diagnosis. Physician health programs also work with and advise third-party evaluation and treatment services, contract with the physician on treatment and monitoring plans, and serve as a repository for compliance records (38, 47).

Studies have shown some PHPs to be highly effective in monitoring addiction. In a 2008 retrospective cohort study involving 16 PHPs, 78.7% of physicians (n = 904) were still licensed and working at the 5-year follow-up, compared with relapse rates of 40% to 60% in standard nonphysician programs (10). Follow-up studies on the same data set indicated similar rates across specialties (11-15), and older studies show that success rates have held across time and states (49, 50). The effectiveness of PHPs for physicians with mental and behavioral health problems is less well established. A 2007 study of the Massachusetts PHP found similar rates of success between mental and behavioral health problems (n = 63) and substance use disorders (n = 132): 74% and 75% of participants, respectively, completed their monitoring contracts (16). Another study showed that completion of monitoring contracts in the Colorado PHP (n = 818) was associated with lower malpractice risk compared with a matched cohort (51).

More studies of state PHPs with different organizational and operational structures are needed to identify which PHPs are successful and the factors associated with success. Current studies rely on data from PHPs that may not be representative of other programs. For example, many recent studies on addiction-related illnesses used data from the 16 PHPs studied in 2008, which were selected for their ability to provide analyzable records and information on participants’ personal characteristics, participation in treatment, and outcomes. The study notes that the 16 PHPs were likely the best-funded or best-led programs at the time (10).

Future studies should also explore gender differences in rates of PHP enrollment and treatment success. As noted in position 1, rates of alcohol dependence seem to be higher among female physicians than male physicians nationally. However, the 2007 Massachusetts PHP study found that 82% of enrollees were male and 18% were female, even though an estimated 26% of physicians in Massachusetts are female (16). The study also found a statistically significant difference in time to relapse after mental health and substance use treatments, with women relapsing sooner than men in each. The disparity may be due to differences in “disease severity at baseline or inadequate treatment and support services for women during the monitoring period” (16). The generalizability of the data should be explored.

National efforts by the FSPHP are under way to help ensure the quality, accountability, and consistency of PHP operations by developing performance and independent review procedures; these efforts should be encouraged (52, 53). Physician health programs should be committed to providing effective data collection as well as services. Consensus definitions of recovery and completion can enable better interpretation of information across PHPs. Evaluation of PHP cases and finances is currently done by independent boards of directors and community advisory boards and can include review of data that indicate professional quality.

The FSMB Policy on Physician Impairment, which was adopted in 2011, “provides guidance to state medical and osteopathic boards for including PHPs in their efforts to protect the public” (38). It defines terms, describes types of impairment, lists elements of an effec-
tive PHP, defines the value of PHPs, and identifies regu-
latory issues. Such policy statements are important in
defining first principles and should evolve to address
contemporary challenges, such as the opioid crisis,
which may affect physicians as both clinicians and pa-
tients. Collaborative policies informed by physician or-
ganizations can provide standards that emphasize early
detection and confidentiality and articulate common
criteria for patient referral, evaluation and assessment,
treatment, continuing care, relapse management, and
monitoring. As the FSMB policy notes, PHP services
should be insulated as much as possible from “chang-
ing political pressures” (38), as when medical board
membership changes or legislative agendas shift.

Position 4

PHPs should meet the goals of physician rehabilita-
tion and reintegration in the context of established stan-
dards of ethics and with safeguards for both patient
safety and physician rights.

Practicing medicine is a privilege. States issue
medical licenses under specific conditions of compe-
tent practice, and physicians demonstrate competence
to earn licensure and accept oversight conditions each
time they renew. Because PHPs divert physicians from
board discipline, they offer an alternative to profes-
sional sanctions. Although the choice to participate in a
PHP is restricted given state-specific obligations to re-
port under certain conditions, the restriction is based
on legitimate ethical and social claims (19). Patients and
the states representing them have a strong interest in
how the privilege of a professional license is exercised,
especially among safety-sensitive professions.

While protecting patient safety, PHPs must also en-
sure procedural fairness for physicians. This is an essen-
tial element of monitoring that requires administrative
and legal oversight ranging from internal mechanisms
and community oversight to administrative law and civil
procedure. For example, when physicians challenge
case management, initial appeals can be made directly
to the PHP director. Some PHPs convene all staff to
review complaints or appeals. Clinical advisory commit-
tees, clinical experts from the community, and boards
directors are other available review mechanisms. For
example, after a state audit (17), the North Carolina
PHP added a case review committee to the compliance
committee overseeing individual cases and reviewing
cases anonymously with the licensing board. Physicians
considering participation in a PHP should be informed
before intake that they can access such review commit-
tees if there are disagreements. These are among the
approaches that can serve professional standards of
objectivity and community oversight.

Important ethical practices underlying such stan-
dards include being attentive to and having processes
in place to manage competing and conflicting inter-
est. Physician health programs should seek funding
from diverse sources so that competing interests do
not interfere with physician monitoring. Various constitu-
encies, such as hospitals, insurers, boards, and medi-
cal societies, can support PHPs but should not influ-
ence day-to-day operations and case management.
Physician health programs should also exercise due dil-
igence to avoid competing interests created by any re-
lationship with referral treatment programs or monitor-
ing laboratories. The ACP has long held that “it is . . . unethical to participate in any arrangement that
links income generation explicitly or implicitly to equip-
ment or facility usage . . . “ (54).

Physician health programs should ensure that all
operations and services are adequately funded. Such
funding often varies greatly. A national survey of PHPs
in 2009 found that annual operating budgets ranged
from $21,250 to $1.5 million (median, $270,000) (47).
Physician health programs must decide at what level
their resources allow adequate assessment, support,
monitoring, and advocacy and must prioritize their ser-
VICES when staffing and funding are limited. Although
this may depend on legislative and regulatory man-
dates as well as funding streams, prioritizing services is
an established practice among PHPs: All currently serve
participants with addictions, most address mental
health conditions and psychiatric illness, and a smaller
number address disruptive behavior and cognitive and
physical illness (55). A few offer coaching for less dis-
tressed participants.

Financial considerations can be challenging for
participants as well. Assessment and treatment for par-
ticipation in PHPs may not be covered by insurance.
TREATMENT referral centers, which are often required for
the more intense work of recovery among physician-
patients, are expensive. To address these concerns,
PHPs may ask local experts to adjust their fees for
independent assessments and advocate for scholarship
programs or other financial assistance at treatment cen-
ters. Seeking treatment locally may be preferable and
less expensive for some participants, whereas others
may prefer to be treated at a geographic distance from
their communities. Out-of-state treatment centers may
have the specific expertise needed for a particular con-
dition. Choice and expertise should be fundamental el-
ements of any community’s commitment to rehabilita-
tion and reintegration.

Informed consent standards, an element of ethical
practice in physician health, should underscore open-
ness and transparency and require confidentiality warn-
ings beyond those used in general medical practice.
Because information disclosure may result in reports to
licensing boards, PHPs should inform participants of
the limits of confidentiality and the consequences of
self-reports. Participants should be familiar with the
contents of their agreements, testing schedules, and
the consequences of nonadherence. For example, they
should be informed that a positive result on a toxicol-
ygy test may result in immediate board reports in some
jurisdictions, and PHPs should seek to determine
whether the full clinical picture—especially among vol-
untary participants—truly signals relapse. Contacting
work monitors or other collateral information sources is
an appropriate mechanism for this exploration. The de-
cision to report to a licensing board is a crucial element
of PHP practice, and the ethics of this decision merit
close attention in discussions between PHPs and
boards and between PHPs and their participants.
Such safeguards as appeals mechanisms, independ-
dent oversight, and robust informed consent can be
undermined by poor communication among PHPs,
workplace monitors, and treating clinicians. Case man-
gers at PHPs rely on workplace monitors (colleagues
who observe and support participating physicians) to
be the eyes and ears of clinicians and PHPs. Their com-
munication is the sine qua non of monitoring and rein-
tegration. Case managers and workplace monitors who
do not appreciate the confidentiality protections of
treatment and treating clinicians who do not adhere to
monitoring requirements can undermine the collabora-
tion required for rehabilitation and reintegration of
physicians into practice. Treating clinicians and work-
place monitors who report basic information to moni-
toring programs, such as attendance, sobriety, and be-
behavioral stability, should meet professional standards
and ensure that treatment remains confidential. Educa-
tion and vetting knowledgeable community partners
are therefore critical to successful reintegration.

**Position 5**

**Maintenance of physician wellness with the goal of
well-being must be a professional priority of the health
care community promoted among colleagues and
learners.**

Clinician wellness and well-being need to be ad-
dressed in multiple ways, including at the organiza-
tional level. Special attention should be paid to preven-
tive and holistic approaches. The profession and health
care institutions should foster an appropriate environ-
ment and culture for promoting wellness and well-
being, including helping an impaired or distressed col-
league. The term "burnout" seems inadequate because
it is often taken to imply that physicians should simply
be more resilient. Optimizing clinician well-being re-
quires attention to the deprofessionalization and struc-
tural problems in the current practice environment that
can lead to demoralization. Emotional exhaustion, cyn-
icism, and detachment directly affect patient care and
place patient safety at risk (24, 35) and should be a
focus of training and monitoring similar to the Accredi-
tation Council for Graduate Medical Education program
requirements for fatigue mitigation among attending phy-
sicians and trainees (56). Support for physician well-being
requires outreach, education, and collaborative leader-
ship at every level of organized medicine, including PHPs,
state medical boards, professional societies, and health
care institutions.

Support for physician wellness and well-being may
help reduce incidence of impairment (22). Institutions
should also establish policies for handling and educat-
ing staff physicians and trainees on referral, rehabilita-
tion, and reintegration of impaired physicians. Some
have called on institutions to act more directly to iden-
tify impaired physicians, advocating for “a routine, for-
mal, proactive system of monitoring that uses validated
measures to focus strictly on clinical and behavioral
performance” (57, 58), but some proposals, such as
mandatory drug testing and age-based cognitive
screening, have been controversial. Although blanket
screening diminishes the flexibility of individualized
case and risk assessment, it may be a strategy for
overcoming the hesitation to report one’s own health
difficulties.

As part of the medical profession’s social contract,
physician well-being should be identified as a quality
marker for healthy organizations and physician communi-
ties (59). The greater the emphasis on well-being, the
greater the effect on physician recruitment and retention
(60). Individuals, families, and society commit consider-
able resources to the development of medical ca-
areers. A focus on physician health can save lives, re-
lationships, and membership in the profession—a
profession that requires substantial emotional, finan-
cial, and time investment. Peer support in particular
is a common-sense and evidence-based approach
that can promote physician well-being (61, 62). The
ACP offers resources for physician well-being and
professional satisfaction (www.acponline.org/practice
-resources/physician-well-being-and-professional
-satisfaction). Patients may also support expanded
systemic and professional initiatives that attend to
the well-being and wellness of their clinicians (63).

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