

Physician Impairment and Rehabilitation: Reintegration Into Medical Practice While Ensuring Patient Safety: A Position Paper From the American College of Physicians

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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.

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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, phy-

sicians 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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fects 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 lim-

itations resulting from a disability, such as a hearing impairment, or a medical event, such as a stroke, may also impede a physician's ability to fulfill patient care responsibilities. However, the presence of a disorder or 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).

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 evaluation and assistance. Reports to licensing boards or clinical supervisors are urgently needed when patient harm is imminent or suspected. Although reporting standards may vary by locality, the privacy of physicians and their patients is an important guiding principle. At each step, the confidentiality of those who report and those who are reported should be respected (6), with confidential follow-up provided to those who report if any recommendations result (37).

Position 2

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

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 cur-

rent 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 effective

tive PHP, defines the value of PHPs, and identifies regulatory 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 patients. Collaborative policies informed by physician organizations 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 “changing political pressures” (38), as when medical board membership changes or legislative agendas shift.

Position 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.

Practicing medicine is a privilege. States issue medical licenses under specific conditions of competent 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 professional sanctions. Although the choice to participate in a PHP is restricted given state-specific obligations to report 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 ensure procedural fairness for physicians. This is an essential 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 committees, clinical experts from the community, and boards of 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 committees if there are disagreements. These are among the approaches that can serve professional standards of objectivity and community oversight.

Important ethical practices underlying such standards include being attentive to and having processes in place to manage competing and conflicting inter-

ests. Physician health programs should seek funding from diverse sources so that competing interests do not interfere with physician monitoring. Various constituencies, such as hospitals, insurers, boards, and medical societies, can support PHPs but should not influence day-to-day operations and case management. Physician health programs should also exercise due diligence to avoid competing interests created by any relationship with referral treatment programs or monitoring laboratories. The ACP has long held that “it is . . . unethical to participate in any arrangement that links income generation explicitly or implicitly to equipment 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 services when staffing and funding are limited. Although this may depend on legislative and regulatory mandates 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 distressed participants.

Financial considerations can be challenging for participants as well. Assessment and treatment for participation 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 centers. 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 condition. Choice and expertise should be fundamental elements of any community's commitment to rehabilitation and reintegration.

Informed consent standards, an element of ethical practice in physician health, should underscore openness and transparency and require confidentiality warnings 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 toxicology test may result in immediate board reports in some jurisdictions, and PHPs should seek to determine whether the full clinical picture—especially among voluntary participants—truly signals relapse. Contacting work monitors or other collateral information sources is an appropriate mechanism for this exploration. The decision 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, independent oversight, and robust informed consent can be undermined by poor communication among PHPs, workplace monitors, and treating clinicians. Case managers at PHPs rely on workplace monitors (colleagues who observe and support participating physicians) to be the eyes and ears of clinicians and PHPs. Their communication is the sine qua non of monitoring and reintegration. 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 collaboration required for rehabilitation and reintegration of physicians into practice. Treating clinicians and workplace monitors who report basic information to monitoring programs, such as attendance, sobriety, and behavioral stability, should meet professional standards and ensure that treatment remains confidential. Education 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 addressed in multiple ways, including at the organizational level. Special attention should be paid to preventive and holistic approaches. The profession and health care institutions should foster an appropriate environment and culture for promoting wellness and well-being, including helping an impaired or distressed colleague. The term “burnout” seems inadequate because it is often taken to imply that physicians should simply be more resilient. Optimizing clinician well-being requires attention to the deprofessionalization and structural problems in the current practice environment that can lead to demoralization. Emotional exhaustion, cynicism, 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 Accreditation 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 leadership 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 educating staff physicians and trainees on referral, rehabilitation, and reintegration of impaired physicians. Some have called on institutions to act more directly to identify impaired physicians, advocating for “a routine, formal, 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 communities (59). The greater the emphasis on well-being, the greater the effect on physician recruitment and retention (60). Individuals, families, and society commit considerable resources to the development of medical careers. A focus on physician health can save lives, relationships, and membership in the profession—a profession that requires substantial emotional, financial, 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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References

- Sulmasy LS, Bledsoe TA; ACP Ethics, Professionalism and Human Rights Committee. American College of Physicians ethics manual: seventh edition. *Ann Intern Med.* 2019;170:S1-S32. [PMID: 30641552] doi:10.7326/M18-2160
- The sick physician. Impairment by psychiatric disorders, including alcoholism and drug dependence. *JAMA.* 1973;223:684-7. [PMID: 4739202]
- Mueller P, Snyder L. Dealing with the "Disruptive" Physician Colleague. American College of Physicians Ethics Case Studies. Accessed at www.medscape.org/viewarticle/590319 on 15 May 2018.
- Mathes M, Sulmasy LS. When an Aging Colleague Seems Impaired. American College of Physicians Ethics Case Studies. Accessed at www.medscape.org/viewarticle/813533 on 15 May 2018.
- American Medical Association. Opinion 9.4.2: Reporting Incompetent or Unethical Behaviors by Colleagues. In: *AMA Code of Medical Ethics*. Chicago: American Med Assoc; 2016. Accessed at www.ama-assn.org/delivering-care/reporting-incompetent-or-unethical-behaviors-colleagues on 18 June 2018.
- American Medical Association. Physician Health Programs Act. 2016. Accessed at www.fsphp.org/ama-physician-health-programs-act-model-bill on 8 October 2018.
- Federation of State Physician Health Programs. Public Policy Statement: Physician Illness vs. Impairment. 30 July 2008. Accessed at www.fsphp.org/public-policy-statement-physician-illness-vs-impairment on 23 April 2019.
- Federation of State Physician Health Programs. Physician Health Program Guidelines. December 2005. Accessed at www.fsphp.org/2005-fsphp-physician-health-program-guidelines on 23 April 2019.
- Federation of State Medical Boards. Report of the Special Committee on Reentry for the Ill Physician. April 2013. Accessed at www.fsmb.org/globalassets/advocacy/policies/reentry-for-the-ill-physician.pdf on 9 July 2018.
- McLellan AT, Skipper GS, Campbell M, DuPont RL. Five year outcomes in a cohort study of physicians treated for substance use disorders in the United States. *BMJ.* 2008;337:a2038. [PMID: 18984632] doi:10.1136/bmj.a2038
- Buhl A, Oreskovich MR, Meredith CW, Campbell MD, Dupont RL. Prognosis for the recovery of surgeons from chemical dependency: a 5-year outcome study. *Arch Surg.* 2011;146:1286-91. [PMID: 22106321] doi:10.1001/archsurg.2011.271
- Skipper GE, Campbell MD, Dupont RL. Anesthesiologists with substance use disorders: a 5-year outcome study from 16 state physician health programs. *Anesth Analg.* 2009;109:891-6. [PMID: 19690263] doi:10.1213/ane.0b013e3181ad39d
- Rose JS, Campbell M, Skipper G. Prognosis for emergency physician with substance abuse recovery: 5-year outcome study. *West J Emerg Med.* 2014;15:20-5. [PMID: 24696748] doi:10.5811/westjem.2013.7.17871
- Rose JS, Campbell MD, Yellowlees P, Skipper GE, DuPont RL. Family medicine physicians with substance use disorder: a 5-year outcome study. *J Addict Med.* 2017;11:93-7. [PMID: 28067757] doi:10.1097/ADM.0000000000000278
- Yellowlees PM, Campbell MD, Rose JS, Burke Parish M, Ferrer D, Scher LM, et al. Psychiatrists with substance use disorders: positive treatment outcomes from physician health programs. *Psychiatr Serv.* 2014;65:1492-5. [PMID: 25270988] doi:10.1176/appi.ps.201300472
- Knight JR, Sanchez LT, Sherritt L, Bresnahan LR, Fromson JA. Outcomes of a monitoring program for physicians with mental and behavioral health problems. *J Psychiatr Pract.* 2007;13:25-32. [PMID: 17242589]
- Wood BA; North Carolina Office of the State Auditor. Performance Audit: North Carolina Physicians Health Program. April 2014. Accessed at www.ncauditor.net/EPSSWeb/Reports/performance/per-2013-8141.pdf on 15 January 2018.
- Wynia MK, Latham SR, Kao AC, Berg JW, Emanuel LL. Medical professionalism in society. *N Engl J Med.* 1999;341:1612-6. [PMID: 10577119]
- Bonnie RJ, Monahan J. License as leverage: mandating treatment for professionals. *Int J Forensic Ment Health.* 2004;3:131-8. doi:10.2139/ssrn.1758874
- Oreskovich MR, Shanafelt T, Dyrbye LN, Tan L, Sotile W, Satele D, et al. The prevalence of substance use disorders in American physicians. *Am J Addict.* 2015;24:30-8. [PMID: 25823633] doi:10.1111/ajad.12173
- Oreskovich MR, Kaups KL, Balch CM, Hanks JB, Satele D, Sloan J, et al. Prevalence of alcohol use disorders among American surgeons. *Arch Surg.* 2012;147:168-74. [PMID: 22351913] doi:10.1001/archsurg.2011.1481
- Earley PH. Physicians health programs and addiction among physicians. In: Miller SC, Fiellin DA, Rosenthal RN, Saitz R, eds. *The ASAM Principles of Addiction Medicine, Sixth Edition*. Philadelphia: Wolters Kluwer; 2018.
- Mata DA, Ramos MA, Bansal N, Khan R, Guille C, Di Angelantonio E, et al. Prevalence of depression and depressive symptoms among resident physicians: a systematic review and meta-analysis. *JAMA.* 2015;314:2373-83. [PMID: 26647259] doi:10.1001/jama.2015.15845
- Dyrbye LN, West CP, Satele D, Boone S, Tan L, Sloan J, et al. Burnout among U.S. medical students, residents, and early career physicians relative to the general U.S. population. *Acad Med.* 2014;89:443-51. [PMID: 24448053] doi:10.1097/ACM.0000000000000134
- Ruitenburt MM, Frings-Dresen MH, Sluiter JK. The prevalence of common mental disorders among hospital physicians and their association with self-reported work ability: a cross-sectional study. *BMC Health Serv Res.* 2012;12:292-8. [PMID: 22938170]
- Dellinger EP, Pellegrini CA, Gallagher TH. The aging physician and the medical profession: a review. *JAMA Surg.* 2017;152:967-71. [PMID: 28724142] doi:10.1001/jamasurg.2017.2342
- American College of Surgeons Board of Governors Physician Competency and Health Workgroup. Statement on the aging surgeon. *Bull Am Coll Surg.* 2016;101:42-3. [PMID: 26891501]
- American Medical Association. Competency and the Aging Physician. Report 5 of the Council on Medical Education (A-15). Chicago: American Med Assoc; 2015. Accessed at www.cppph.org/wp-content/uploads/2016/02/AMA-Council-on-Medical-Education-Aging-Physician-Report-2015.pdf on 15 May 2018.
- Steffen MW, Hagen PT, Benkhadra K, Molella RG, Newcomb RD, Murad MH. A survey of physicians' perceptions of their health care needs. *Occup Med (Lond).* 2015;65:49-53. [PMID: 25336036] doi:10.1093/occmed/kqu145
- Chiu YL, Kao S, Lin HC, Tsai MC, Lee CZ. Healthcare service utilization for practicing physicians: a population-based study. *PLoS One.* 2016;11:e0130690. [PMID: 26752592] doi:10.1371/journal.pone.0130690
- Benkhadra K, Adusumalli J, Rajjo T, Hagen PT, Wang Z, Murad MH. A survey of health care needs of physicians. *BMC Health Serv Res.* 2016;16:472. [PMID: 27600560] doi:10.1186/s12913-016-1728-4
- Merlo LJ, Singhakant S, Cummings SM, Cottler LB. Reasons for misuse of prescription medication among physicians undergoing monitoring by a physician health program. *J Addict Med.* 2013;7:349-53. [PMID: 24089039] doi:10.1097/ADM.0b013e31829da074
- Schneck SA. "Doctoring" doctors and their families. *JAMA.* 1998;280:2039-42. [PMID: 9863860]

34. Merlo LJ. A piece of my mind: healing physicians. *JAMA*. 2016; 316:2489-90. [PMID: 27997657] doi:10.1001/jama.2016.10339
35. Federation of State Medical Boards. Physician Wellness and Burnout. April 2018. Accessed at www.fsmb.org/globalassets/advocacy/policies/policy-on-wellness-and-burnout.pdf on 2 August 2018.
36. American Society of Addiction Medicine. Public Policy on Discrimination and the Addicted Professional. Rockville, MD: American Society of Addiction Medicine; 2011. Accessed at www.asam.org/advocacy/find-a-policy-statement/view-statement/public-policy-statements/2011/12/16/discrimination-and-the-addicted-professional on 8 October 2018.
37. DesRoches CM, Rao SR, Fromson JA, Birnbaum RJ, Iezzoni L, Vogeli C, et al. Physicians' perceptions, preparedness for reporting, and experiences related to impaired and incompetent colleagues. *JAMA*. 2010;304:187-93. [PMID: 20628132] doi:10.1001/jama.2010.921
38. Federation of State Medical Boards. Policy on Physician Impairment. April 2011. Accessed at www.fsmb.org/Media/Default/PDF/FSMB/Advocacy/grppl_policy-on-physician-impairment.pdf on 12 January 2018.
39. Dyrbye LN, West CP, Sinsky CA, Goeders LE, Satele DV, Shanafelt TD. Medical licensure questions and physician reluctance to seek care for mental health conditions. *Mayo Clin Proc*. 2017;92:1486-93. [PMID: 28982484] doi:10.1016/j.mayocp.2017.06.020
40. Worley LL. Our fallen peers: a mandate for change. *Acad Psychiatry*. 2008;32:8-12. [PMID: 18270275] doi:10.1176/appi.ap.32.1.8
41. American College of Physicians. Resolution 10-F17: Developing ACP Policy on Physician Impairment and Rehabilitation Towards Reintegration. 2017. Accessed at www.acponline.org/system/files/documents/about_acp/chapters/wi/f17_mtg_resolutions.pdf on 8 October 2018.
42. American Medical Association. Access to Confidential Health Services for Medical Students and Physicians. 2016. Accessed at www.ama-assn.org/sites/default/files/media-browser/i16-cme-reports.pdf on 8 October 2018.
43. Federation of State Physician Health Programs. About FSPHP. Accessed at www.fsphp.org/about on 10 February 2018.
44. American Medical Association. Report 2 of the Council on Science and Public Health (A-11). Physician Health Programs. Accessed at www.ama-assn.org/councils/council-science-public-health/physician-safety-csaph-council-reports on 30 April 2019.
45. Reynolds NT. Disruptive physician behavior: use and misuse of the label. *J Med Regul*. 2012;98:8-19.
46. John PR, Heitt MC. Disruptive physician behavior: the importance of recognition and intervention and its impact on patient safety. *J Hosp Med*. 2018;13:210-2. [PMID: 29505621] doi:10.12788/jhm.2945
47. DuPont RL, McLellan AT, Carr G, Gendel M, Skipper GE. How are addicted physicians treated? A national survey of physician health programs. *J Subst Abuse Treat*. 2009;37:1-7. [PMID: 19482236] doi:10.1016/j.jsat.2009.03.010
48. Federation of State Physician Health Programs. State Programs. Accessed at www.fsphp.org/state-programs on 16 May 2018.
49. Shore JH. The Oregon experience with impaired physicians on probation. An eight-year follow-up. *JAMA*. 1987;257:2931-4. [PMID: 3573292]
50. Morse RM, Martin MA, Swenson WM, Niven RG. Prognosis of physicians treated for alcoholism and drug dependence. *JAMA*. 1984;251:743-6. [PMID: 6694277]
51. Brooks E, Gendel MH, Gundersen DC, Early SR, Schirmacher R, Lembitz A, et al. Physician health programmes and malpractice claims: reducing risk through monitoring. *Occup Med (Lond)*. 2013; 63:274-80. [PMID: 23606266] doi:10.1093/occmed/kqt036
52. Federation of State Physician Health Programs. Performance Enhancement Review (PER) Guidelines. 2016. Accessed at www.fsphp.org/resource/physician-health-program-guidelines on 2 August 2018.
53. Federation of State Physician Health Programs. Membership update performance enhancement and effectiveness reviews (PEERs) of PHPs and provider accreditation [memorandum to FSPHP members]. 19 July 2018.
54. Coyle SL; Ethics and Human Rights Committee, American College of Physicians-American Society of Internal Medicine. Physician-industry relations. Part 1: individual physicians. *Ann Intern Med*. 2002;136:396-402. [PMID: 11874314]
55. Carr GD, Hall PB, Finlayson R, DuPont RL. Physician health programs: the US model. In: Brower KJ, Riba MB, eds. *Physician Mental Health and Well-Being: Research and Practice*. Dordrecht, the Netherlands: Springer; 2017:265-94.
56. Accreditation Council for Graduate Medical Education. ACGME Program Requirements for Graduate Medical Education in Internal Medicine. 2017. Accessed at www.acgme.org/Portals/0/PFAssets/ProgramRequirements/140_internal_medicine_2017-07-01.pdf on 18 June 2018.
57. Leape LL, Fromson JA. Problem doctors: is there a system-level solution? *Ann Intern Med*. 2006;144:107-15. [PMID: 16418410]
58. Shojania KG, Dixon-Woods M. 'Bad apples': time to redefine as a type of systems problem? [Editorial]. *BMJ Qual Saf*. 2013;22:528-31. [PMID: 23744535] doi:10.1136/bmjqs-2013-002138
59. Thomas LR, Ripp JA, West CP. Charter on physician well-being. *JAMA*. 2018;319:1541-2. [PMID: 29596592] doi:10.1001/jama.2018.1331
60. Shanafelt T, Goh J, Sinsky C. The business case for investing in physician well-being. *JAMA Intern Med*. 2017;177:1826-32. [PMID: 28973070] doi:10.1001/jamainternmed.2017.4340
61. Zwack J, Schweitzer J. If every fifth physician is affected by burn-out, what about the other four? Resilience strategies of experienced physicians. *Acad Med*. 2013;88:382-9. [PMID: 23348093] doi:10.1097/ACM.0b013e318281696b
62. Sanchez LT, Candilis PJ, Arnstein F, Eaton J, Barnes Blood D, Chinman GA, et al. Effectiveness of a unique support group for physicians in a physician health program. *J Psychiatr Pract*. 2016;22:56-63. [PMID: 26813489] doi:10.1097/PRA.0000000000000121
63. Lemaire JB, Ewashina D, Polachek AJ, Dixit J, Yiu V. Understanding how patients perceive physician wellness and its links to patient care: a qualitative study. *PLoS One*. 2018;13:e0196888. [PMID: 29763443] doi:10.1371/journal.pone.0196888

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