

Physicians’ health programs — what’s happening in the USA?

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Despite a still small evidence base, programs throughout the country are tackling doctors’ illness and doctors’ health

In 1973 the American Medical Association’s (AMA) Council on Mental Health published *The sick physician. Impairment by psychiatric disorders, including alcoholism and drug dependence*. While a handful of programs were already operating, this report is generally regarded as the watershed for doctor health programs that now exist in nearly all states across the United States. The report noted that “the [profession’s] primary responsibility for ensuring safe, competent care to the patient population affected must be reemphasized.” In December 2003, the AMA’s Council on Ethical and Judicial Affairs (CEJA) issued a report to provide “guidance in the area of physician health and wellness insofar as it affects physicians’ professional activities, including patient care and trust in the profession.”² In this article, we discuss what transpired with physician health in the United States in the 30 years between these two reports.

State programs

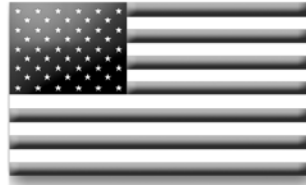
The most visible effect was the development of programs in nearly every state. These programs typically evaluate doctors who may have problems and monitor them after treatment. They operate to ensure that a doctor complies with the provisions of treatment and is able to practice; few programs provide care *per se*, and a number have wellness programs.

There are a variety of models, with some under the auspices of the state licensing board (generally known as diversion programs, as the doctors are diverted to treatment rather than to disciplinary action), and some being programs of the state medical society or independent agencies, which generally have ties to their respective medical societies or boards. Considerable variation is found with other aspects of the programs. Some are largely restricted to doctors (including doctors in training), while others deal with virtually all healthcare professionals, including veterinarians, chiropractors, nurses and medical students.

The types of problems dealt with also vary, but substance-misuse disorders are routinely addressed in all programs. Other issues, such as malpractice stress, physical disabilities and behavioural (personality) disorders, are less frequently included. The level of funding and range of sources for program funding are even more disparate. Details of program comparisons are available on the Federation of State Physician Health Programs (FSPHP) website.³

What do the programs share in common? There is unquestionably an emphasis on professionalism in the sense used by sociolo-

gists (ie, the programs are developing specialised knowledge along with special skills to apply to the problems they encounter).⁴ Before 1990, the state programs were loosely associated with the AMA’s impaired physician program, which facilitated communication among the various state programs by means of a subscription-based newsletter, and encouraged the adoption of consistent policies (such as model legislation that would sanction cooperative relationships between licensing boards and the medical society), and hosted regular conferences on the *impaired* physician. In December 1990, as the AMA was refocusing its program on doctors’ health rather than impairment, the FSPHP was formed.



The Federation of State Physician Health Programs

The FSPHP’s mission is “to provide a forum for education and exchange of information among state programs, to develop common objectives and goals, to develop standards, to enhance awareness of issues related to physician health and impairment, to provide advocacy for physicians

and their health issues at local, state, and national levels, and to assist state programs in their quest to protect the public.”³ It offers state programs (44 states are full members, as membership is voluntary), regional and national meetings and an electronic forum (open only to those with direct involvement in state or provincial programs) for discussing issues such as drug screening, monitoring agreements, treatment options, and program policies, particularly in dealing with refractory cases. Despite program differences, consensus on key issues is the norm. For example, recently completed are guidelines for doctors’ health program development and enhancement, despite a limited evidence base.

Gathering the evidence

Recognising the lack of good evidence on many of the issues, the AMA and the Canadian Medical Association jointly sponsor, in cooperation with the FSPHP, the Federation of State Medical Boards and the Federation of Licensing Authorities of Canada, a biennial conference on doctors’ health, the program of which includes plenary sessions and papers that are peer reviewed. Though small, the conference attracts an international audience, including Australian doctors. Divergent international norms have generated many discussions on the merits of some program standards. For example, abstinence from all psychoactive substances, including alcohol, is the norm for a physician recovering from a substance-misuse disorder in North America.⁵ In a presentation at the 2002 conference, Jack Warhaft, of the Victorian Doctors Health Program, commented that abstinence from alcohol is not necessarily required for narcotic misuse or dependency. This is an area where the science needs to expand in support of practice.

One effort to advance the science of physician health has been the establishment of a loosely formed physician-health research

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group, a process encouraged by the AMA, the FSPHP and other organisations. The group has developed a tool to collect reliable and valid data, which is based on well validated instruments used in psychiatric epidemiology, and will allow researchers to compare cases across programs while protecting doctors' confidentiality. At the same time, doctor wellness is vital, with many examples of topics worthy of investigation, possibly for their effects on overall public health.⁶⁻⁸

Future directions

An emerging issue is the future direction of the state programs. Over the years, some have separated from their respective medical associations, largely for financial reasons. A more recent trend is outsourcing. Programs operated by licensing boards or those operating as independent corporations with financial support from the licensing board are being outsourced, with bidders most likely to come from the for-profit sector.

The recent revelation that Vice President Dick Cheney's personal doctor was being monitored by the physician health program of the Medical Society of the District of Columbia and that his care had been kept confidential^{9,10} may have as yet unknown effects. One might anticipate, for example, efforts to breach confidentiality for physicians undergoing treatment or a move to mandatory disciplinary actions such as licensure suspension or revocation. This matter was the subject of numerous editorials, although at least one of these advocated a system used in the New Jersey state physician health program, in which information is shared with the licensing board in a way that maintains confidentiality.¹¹

Less newsworthy perhaps will be the development of hospital-based committees that were established as required by the Joint Commission on Accreditation of Healthcare Organizations in 2001. In some states, hospitals are working with state programs,

while in others services are probably duplicated. The value for doctors and their health is unknown.

Progress has been fitful over the past 30 years, but things are moving forward. Today, the AMA and the various state programs deal with health issues, not just illness, and they support a variety of treatment models, recognising that the evidence base for this work is really just beginning to be built. As the evidence base expands, progress will be swifter.

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(Received 2 Aug 2004, accepted 13 Aug 2004)

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