CRITICAL EVALUATIONS: LEADERSHIP PERSPECTIVES ON THE ROLE AND EFFECTIVENESS OF PHPS IN SUPPORTING PHYSICIAN WELL-BEING

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Abstract

The purpose of this qualitative study is to explore leadership perspectives on the role and effectiveness of physician health programs (PHPs) in supporting physician well-being. This research addresses a critical gap in the literature regarding how PHPs function beyond substance use disorder monitoring and support. Through semi-structured interviews and a review of PHP-related artifacts, this study examines the successes, challenges, and implications of the PHP role. The overarching research question investigates how PHP leaders perceive the PHP role in supporting physician well-being, with subquestions focusing on methods used to evaluate effectiveness. The rationale for this study is grounded in the growing attention and institutional obligations to support physician well-being, given that traditional approaches have not sufficiently ameliorated rates of burnout and the increasing evidence on the link between physician health, well-being, and the quality and safety of clinical practice. The exploratory case study approach uses qualitative data collection methods to gain an in-depth understanding of leadership perspectives and PHP functioning. The pool of participating PHPs consisted of those registered through the Federation of State Physician Health Programs (FSPHP), where PHP leaders were invited to participate. Data was collected from eight distinct PHPs through semi-structured interviews and supplemented with a document review for triangulation. Data analysis was conducted using thematic coding, allowing for the identification of emergent patterns and themes. The research showed that a PHP's accessible expertise, education and outreach efforts, established confidentiality, individual and organizational supports, and stakeholder collaborations contribute to a program's ability to provide comprehensive services. Identified barriers included limited scopes of service, resource availability, and organizational and individual components contributing to the underutilization of PHPs. Findings underscore the

importance of strengthening collaborations between PHPs, regulatory agencies, and healthcare organizations to expand support systems and improve physician access to PHP services. They also emphasize the importance of the continued advocacy of physician confidentiality, the need for prevention, addressing systemic obstacles, and support at all career stages. A proposed support framework for PHPs is suggested as a result of this study. This structure combines research on how PHPs are understood as organizations working under a resource-conservation model. It stresses the importance of meeting the autonomy, competence, and relatedness needs of PHPs in order for them to function optimally, just like the physicians they serve. The study's implications extend to healthcare policy, organizational practices, and future research.

Dedication

To my children, for whom I have sacrificed and remained steadfast in completing this work, as a testament that no matter the obstacles, you can accomplish anything you wholeheartedly commit your energy and passion to. To the countless physicians who selflessly dedicate their lives in service to others, often at significant personal cost. To all PHP staff who also tirelessly give of themselves to support their medical communities and protect patient safety. Finally, with the deepest gratitude, I dedicate this to the Universal source of Love and Light for the guidance and abundance that made this possible.

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CHAPTER 1. INTRODUCTION

The rising demands placed on physicians and the weight of the psychological and occupational hazards of medical practice require the exploration of the support systems accessible to physicians throughout their careers. This study examines the importance of physician health programs (PHPs), a crucial yet frequently ignored resource of the healthcare industry. By examining the viewpoints of PHP leaders, this research seeks to understand how these programs benefit physician well-being. This is of great importance given the adverse impacts of physical and mental health problems on the quality and safety of patient care and the complexity of internal and external pressures within the healthcare field that influence physician well-being.

Chapter One presents the research topic, establishing the study's context, problem, and significance, including exploring the PHP model and its unique role within the healthcare system. The peer-driven frameworks of PHPs and their mission purpose set them apart from traditional Employee Assistance Programs (EAP), which the general public and employees are more familiar with. The study's background reviews the specialized roles of PHPs and outlines their evolution into fundamental support mechanisms in the healthcare field today. Emphasizing its peer-to-peer support and monitoring structure, this chapter contrasts PHPs with traditional Employee Assistance Programs (EAPs), tracing the evolution of PHPs into their current form and function.

The chapter further describes the need for the study, highlighting the growing demands on physicians and their impacts. It also reviews PHP challenges in evaluating, monitoring, and

supporting physicians and their healthcare systems. This section underscores the general and specific problems that PHP leadership encounters, mainly focusing on the barriers to PHP service utilization, like confidentiality concerns and misinformation, as well as the heightened mental health risks in the medical profession, exacerbated by recent global events of the COVID-19 pandemic.

The research aims to explore two primary dimensions: initially, to examine and understand the views of PHP leaders on the impact of their PHPs on physician well-being. By integrating these insights from PHP leaders with a detailed analysis of PHP-related artifacts, the study aims to uncover the profundity of PHPs and to describe any identified supportive influence of PHPs and physician well-being, or lack thereof.

The significance of this study is framed within the broader context of healthcare policy and PHP effectiveness. The research question and subquestions offer a well-defined roadmap for examining how PHP leaders perceive their role, the factors contributing to PHPs' successes and challenges, and how these programs evaluate and monitor their effectiveness in supporting physician well-being.

The chapter also defines key terms throughout the study, ensuring clarity and specificity. It also introduces the research design. The chapter closes with a review of the study's assumptions and limitations, setting up a specific framework to outline the research's scope and boundaries. The rest of the dissertation is organized to lead the reader through a literature review, methodology, findings, and discussions while providing implications and recommendations from the outcomes.

Background of the Problem

Physician wellness gained attention in the early 1970s, with the American Medical Association (AMA) highlighting impaired physicians and their susceptibility to illnesses (AMA, 1973). Impairment in a physician's ability to safely practice medicine can stem from medical, psychiatric, or behavioral problems. The culminating result of the public acknowledgment of these vulnerabilities concerning addiction and other health problems was the formation of the PHP. PHPs of that time were focused on substance use disorders (SUD) and aimed to divert physicians away from perceived punitive regulatory actions and into treatment, sustained recovery, and the eventual return to practice. Initially, these programs were called "diversion" or "impaired professionals" programs.

PHPs mimic EAP services but differ in the evaluation, monitoring, and support models due to their peer-to-peer approach (Sudan & Seymour, 2016). PHPs do not provide direct treatment to their participants, unlike EAPs, and provide long-term monitoring and accountability under voluntary and mandatory circumstances. There are approximately 49 PHPs across the United States. Some states have more than one (FSPHP, 2022); program structures depend on the state's legislation and regulatory agency. PHPs have a two-fold mission: (a) to assist physicians with their health issues and (b) to ensure regulatory agencies that a physician is fit to practice medicine safely from a medical and psychiatric perspective. However, the services of PHPs are not limited to regulatory agencies; they extend to healthcare entities and individual physicians seeking evaluation, treatment referral, monitoring, support, and education (Fitzgerald, 2021).

Problem Statement

The general problem for leaders among PHPs is the growing needs of the physician population as it relates to their overall well-being while combatting reluctance and resistance to PHP services (Brooks et al., 2017). A lack of information surrounding PHPs and how they support physicians' overall well-being adds to the underutilization of PHPs in proactive and preventative ways. That said, the obstacles to utilization are primarily associated with fears surrounding confidentiality and misinformation about the role, functions, and scope of services of PHPs (Brooks et al., 2016; Candilis, 2016; Sterman et al., 2022). Additionally, the limited research on PHPs contributes to opponents spreading false information about the purpose and responsibilities of PHPs (Lawson & Boyd, 2018a; Lawson & Boyd, 2018b; Miller, 2018).

The unique challenge faced by PHPs is connected to the changes in political, cultural, and economic environments, which further increase the dangers linked to mental health issues among doctors (Shanafelt, 2021; Shanafelt et al., 2023; Shanafelt et al., 2017). This results in a higher demand for intervention services such as those offered by PHPs. If left unattended, these issues strain healthcare systems (e.g., turnover), impact provider well-being, and jeopardize care quality and safety.

Despite their critical role, literature regarding today's PHPs is scarce and in contrast with the growing global body of knowledge that exists on the needs of the physician and the individual and organizational factors contributing to these (Bhugra et al., 2019; Hall et al., 2016; Rimmer & Chatfield, 2020; Shanafelt, 2021; Siddiqui et al., 2021). Explicitly, stress and burnout, anxiety, depression, disruptive behavior, and physician deaths by suicide are concerning and well-documented problems within this population (Andrew, 2022; Lebares et al., 2017; Lheureux et al., 2016; Wong, 2020) with a significant impact among the medical community. Physicians

today remain susceptible to adverse mental and physical risks, much like other high-stress, safety-sensitive positions (Brooks, 2017), and are seen by PHPs nationwide. However, little research reflects PHPs' effectiveness in evaluating and monitoring these areas. Demonstrating outcomes is crucial (Rotenstein, 2021) to the unitization of specialized services for physician health and well-being.

Study Rationale

Within the last decade, literature linking well-being to patient safety has underscored the critical implications of physician well-being (Wallace et al., 2009; Welp et al., 2015; West et al., 2009; Scheepers et al., 2015; Shanafelt et al., 2016). These implications are of the utmost importance to PHPs, regulatory agencies, healthcare entities, and the public (Candilis, 2016; Carpenter et al., 2021; Williams & Flanders, 2016). Efforts to address these problems have been siloed and fragmented among healthcare institutions, medical societies, and other professional associations. Furthermore, research directly from PHPs remains limited due to restricted funding. Eight studies of state PHP and outcomes were conducted between 1980 and the early 2000s, and these focus on the outcomes of physicians with PHP involvement associated with SUD (Goldenberg et al., 2018; McLellan et al., 2008). These studies highlight the effectiveness of the PHP model in addressing SUD (Goldenberg et al., 2018; Goldenberg et al., 2020). There are only a few non-SUD PHPs studies. One of the eight noted outcome-based research projects included a comparison study between mental health problems and the outcomes of SUD; findings suggested that mental health could be similarly evaluated and monitored with successful results using the PHP model (Knight et al., 2007).

Brooks et al. (2013) focused on the risk reduction of malpractice suits after being involved in a PHP. Results showed that malpractice costs were 111% higher before PHP

monitoring than in their matched physician cohort, and after monitoring, it was 20% compared to their matched cohort (Goldenberg et al., 2018; Brooks et al., 2013). Another non-SUD-related study examined the prevalence of psychiatric diagnoses among physicians referred to their PHP due to disruptive behavior, where results indicated that of the 53 physicians referred for disruptive behaviors, only 3.7% had no Axis I diagnosis outside of occupational problems; 50%, however, had Axis I and Axis II diagnoses and traits (Merlo et al., 2014).

The role of PHPs is vital to physicians' health, given its proven effectiveness in evaluating and monitoring physicians with addictions. Best (2010) and Brooks et al. (2017) highlighted the importance of specialized physician assistance programs, like PHPs, to address behavioral and performance problems, which are often precipitated by both organizational factors (i.e., high-demands, low-decision latitude, and low-support environments) as well as individual factors such as well-being and psychological and health vulnerabilities. However, in most cases, negative organizational factors outweigh positive individual factors (Demirović Bajrami et al., 2022). Thus, the emphasis is on establishing and strengthening physician support systems (i.e., PHPs) and the significance of expanding PHP research as it relates to physician well-being.

Significance of the Study

The study investigates a void in the literature concerning the roles and functions that PHPs fulfill within medical communities. It adds to the foundational knowledge of PHP work and its impact and analyzes the diverse PHP models and their efforts in fostering physician well-being. The research examines program dynamics and effectiveness to identify potential best practices and limitations regarding service delivery.

The outcomes of this study could help shape policymaking at PHP levels, institutions, and regulatory bodies, thereby raising awareness and encouraging support for proactive and preventive measures through PHP collaborations. Developing improved support structures for physicians can impact job satisfaction, the quality and safety of patient care, health, and overall well-being (The National Academies of Sciences, Engineering, and Medicine, 2019).

The study seeks to understand the leaders' experience overseeing a PHP in the US – particularly perspectives on a) approaches to evaluation and monitoring physician health and well-being, b) the impact of psychological and behavioral problems among the physician population, c) contributing and mitigating factors of physician health and well-being; d) the utilization of PHPs; and e) solutions for reduction and prevention of burnout, from a systemic viewpoint. As noted, the study approach could help improve the conceptualization of PHPs, processes, and leaders' experience in PHPs. Furthermore, this inquiry can be used to evaluate the need for cultural change, policy adjustments, or the implementation of new initiatives related to the role and function of PHPs in supporting physician well-being (Yin, 2018).

Identified Gap

The research literature on the effectiveness of PHPs is mainly within the context of substance disorder recovery outcomes (Brown & Bohler, 2019; Early & Rowland, 2022; Goldenberg et al., 2018; Goldenberg et al., 2020) and reflects that involvement in PHPs does have a mediating effect on malpractice risk (Brooks et al., 2013). However, what remains largely unexplored is how PHPs approach and fare as it relates to servicing the myriad of other psychiatric and psychological problems impacting the well-being and practice of physicians. Brown et al. (2009) illuminated the issues beyond physician substance disorders, speaking to disruptive behavior (Merlo et al., 2017), physician impairment, comorbidity, and stress-related

symptoms and the need to be addressed. They further spoke to the limited validated, systematic interventions or programs available to address psychiatric and behavioral disturbances (Brown et al., 2009).

Despite the statistics on mental health and behavioral issues within medicine and studies that highlight the adverse professional and organizational impacts of these (Shanafelt et al., 2021; Shanafelt & Noseworthy, 2017; Shanafelt et al., 2017), the literature is not representative of how these matters have impacted PHPs or how they are addressing them. The trend of services among PHPs and the impacts of this throughout the PHP industry and individual state PHPs are imperative additions to the literature on physician well-being (Brooks et al., 2019). Without adequate research on PHPs in these domains, obstacles will continue to limit the utilization of PHP services, leaving physicians, healthcare entities, and patients at risk.

Research Question

The overarching research question for this study is as follows: How do individuals in leadership roles among PHPs perceive the role and function of PHPs in supporting the well-being of physicians? These subquestions support this qualitative study:

SQ1: How are key factors contributing to the success or limitations of PHPs in supporting physician well-being?

SQ2: How do PHPs evaluate and monitor the effectiveness of their programs in supporting physician health and well-being?

Overview of the Methodology

Qualitative inquiry is a naturalist paradigm founded on philosophical assumptions that hold to the existence of more than one reality (ontology) (Kostere & Kostere, 2021; Percy et al., 2015). Thus, the qualitative researcher seeking to explore an experience or context must delve

into the multiple realities (epistemology) among individuals within it to develop a deep and rich understanding (Yazan, 2015). Furthermore, compiling and synthesizing these individual observations through a rigorous and methodical process allows for broader interpretations and relevant, practical applications of the research findings (inductive). The study is value-laden in objectivity, integrity, and individual and organizational stewardship (axiology), both for the researcher and study participants. The ontological, epistemological, and axiological underpinnings support this study's qualitative framework (Yazan, 2015).

Exploring individual perspectives (i.e., opinions, attitudes, and beliefs) associated with unique contexts and experiences calls for a qualitative method, where knowledge is collected and understood via words rather than numbers (Kostere & Kostere, 2021). The literature reflects, through statistical means, the prevalence of burnout and psychological distress among physicians (Andrew, 2022; Lebares et al., 2017; Lheureux et al., 2016; Wong, 2020). Scientific inquiry has further investigated the ramifications of this phenomenon from both a systemic and economic perspective, underscoring the financial burdens imposed on healthcare institutions and consumers concerning quality and safety (Chênevert et al., 2021; Fahrenkopf et al., 2008; Scheepers et al., 2015; Shanafelt & Noseworthy, 2017; Wallace et al., 2009; Welp et al., 2015; Williams & Flanders, 2016). However, literature about PHPs is surprisingly scarce given that PHPs are often seen as experts in the realm of physician health. This study provides a much-needed perspective toward understanding physicians' occupational hazards, vulnerabilities, and overall well-being – and the specialized programs that exist to address these. Furthermore, this is an opportunity to collect and integrate the collective insights of leaders, experts, and specialists in the assessment, monitoring, and enhancement of the well-being and safety of physicians.

Definition of Terms

Physician Health Programs. PHPs are legislatively established peer-assistance programs in each state, funded through state medical boards to evaluate, provide treatment referrals, and monitor physicians in their state (Brooks et al., 2013; Candilis, 2016). State medical boards mandatorily refer licensed physicians due to complaints that may have underlying medical or psychiatric conditions that contribute to problems in their medical practice (Brooks et al., 2013; Candilis, 2016). However, PHPs also serve the community via voluntary referrals (Brooks et al., 2013).

Physician Health Program Leaders. For this study, PHP leaders will have ten or more years of experience in physician health and PHPs. Leadership role titles include Executive Director, Medical Director, Associate Medical Director, Clinical Director, and Program Manager. PHP leaders oversee the clinical and often administrative processes within the PHP.

Physician Health. Like other safety-sensitive professions (i.e., pilots, train conductors, and police officers), internal and external factors impact a physician's health (Hategan & Riddell, 2020; Montgomery et al., 2021). A physician's health can be affected secondary to exposure to chronic high stress, patient workloads, long work hours, and the absence of organizational support (Sauerteig et al., 2019). Physician health refers explicitly to physicians' medical or psychiatric conditions, including the presence or absence of these. Life and work stressors in the context of no or unhealthy coping mechanisms also contribute to the state of a physician's health and can lead to psychological distress (Hategan & Riddell, 2020; Montgomery et al., 2021).

Physician Well-being. Well-being, as defined by Simons & Baldwin (2021), refers to an individual's overall health, welfare, and biopsychosocial and biomedical state. It is a complete

idea of health, including various aspects such as physical, emotional, intellectual, spiritual, social, occupational, environmental, and financial elements (Nikolis et al., 2021). Factors within organizations, such as supportive cultures and engaged leadership, along with job satisfaction, work-life balance, purpose, and meaning, have the potential to impact physician well-being (Shanafelt, 2021; Shanafelt et al., 2023; Sinskey et al., 2022; Walker & Pine, 2018).

Physician Health Stakeholders. Stakeholders involved in physician health include physicians and other healthcare professionals, medical institutions, medical societies, state medical boards, PHPs, and healthcare consumers (Brooks et al., 2013; Candalis, 2016).

Research Design

The exploratory case study approach aims to comprehensively understand PHPs by exploring PHPs through the lens of leadership perspectives within the context of physician well-being. This approach provides an in-depth exploration of the perceptions and practices of PHP leaders involved in supporting physician well-being through a semi-structured interview and other data sources. Moreover, there is an inquiry into how certain key factors contribute to the success or limitations of PHPs in promoting physician well-being and how PHPs evaluate and monitor the effectiveness of their programs in this endeavor. In studies involving research questions focused on answering the "how" of a particular contemporary phenomenon and with which one has little or no control, an exploratory case study is an acceptable design (Yazan, 2015; Yin, 2018).

The richness of this methodological approach stems from the combination of semi-structured interviews with PHP leaders, the extensive review of documentation, observations, and researcher field notes (Yin, 2018). Documentation review for this study includes program-related documents and websites, FSPHP and Federation of State Medical Board (FSMB)

archives, and other publicly archived data relating to the role and function of PHPs. These data sources provide a rich and solid foundation on the role and function of PHPs. Becoming familiar with, analyzing, and interpreting these artifacts, in addition to the interviews, provides a more profound comprehension of each case through the triangulation of multiple data sources (Yazan, 2015; Yin, 2018). The array of data sources contributes supplementary context that could either reinforce or challenge the participant's perspectives and furnish corroborative evidence for the interpretations and conclusions drawn in the case study, thereby enhancing the overall validity of the research.

Assumptions

This study, like all research, requires several foundational assumptions to establish a basis for the methods and insights it aims to generate. When delving into the methodological assumptions of a qualitative case study approach, one central assumption is that participants—here, PHP leaders—will respond openly and truthfully during interviews. Since qualitative research relies on the depth and honesty of participant responses, it is assumed that these leaders will share genuine insights about the functions and challenges of PHPs, even when discussing sensitive or controversial topics like physician well-being or program constraints. While honesty cannot be directly verified, building rapport and ensuring confidentiality are measures intended to encourage candid and authentic responses. Additionally, with the uniqueness of each PHP, an assumption is being made that PHPs across the US operate under similar pressures. This assumption allows the insights drawn from this study to be relevant across the broader PHP context.

Philosophical Foundations

With its qualitative lens, the study's epistemological foundations adopt a constructivist stance, positing that reality is a construct shaped by social interactions and shared viewpoints. It is assumed that the experiences of PHP leaders embody a collective comprehension of PHP operations, challenges, and their influence on physician well-being rather than an objective and single truth. This implies that both I and the participants, engaging dynamically through the interview process, shape the data collection process. It further acknowledges that my interpretations play a critical role. The study's axiological principles recognize the inherently value-laden aspect of qualitative research, as the values and motivations of PHP leaders, combined with my commitment to advancing physician wellness, may also influence interpretations. It is posited that my objective of enhancing the understanding and effectiveness of PHPs is in harmony with the values of participants, fostering a collective emphasis on strengthening physician support systems while maintaining rigorous critical analysis.

Theoretical Framework

The theoretical assumptions of this study draw from self-determination theory (SDT) and the job demand-control-support (JDCS) models to analyze factors impacting physician well-being and PHP effectiveness. It assumes that these frameworks are appropriate for exploring autonomy, support, and control in the PHP setting, based on the assumption that SDT and JDCS capture essential motivational and stress-related elements affecting physicians. This alignment with existing research on physician mental health and occupational stress supports the choice of these frameworks as fitting lenses for evaluating the role and efficacy of PHPs. The assumption here is that SDT's focus on autonomy, competence, and relatedness, along with JDCS's

emphasis on job demands and support, accurately reflects the core factors that PHPs are meant to address.

Overall, the topic-specific assumptions held within the study assume that existing literature on PHPs is accurate in its portrayal of challenges related to substance use disorder (SUD) and the expansion into mental health support. Since past studies mainly emphasize SUD treatment outcomes, it is assumed that similar approaches could be effective in addressing broader issues such as burnout, anxiety, and depression. Furthermore, it is assumed that PHPs face structural and cultural challenges (e.g., stigma, regulatory constraints) that restrict their expansion into broader wellness roles—a perspective supported by recent findings on PHP limitations in non-SUD support areas. This is further explored in subsequent chapters.

Limitations

Several limitations impact the generalizability and depth of this study's findings, specifically regarding design constraints, participant selection, and topic scope. The qualitative case study design limits generalizability. While the study provides in-depth insights from PHP leaders, the findings may not be fully applicable to PHPs with vastly different regulatory, cultural, or access to resources. Qualitative data captures nuanced perspectives, yet it cannot represent all PHPs across states or fully generalize to all physician health programs, especially in areas with significant operational differences.

Sampling

A limitation is held in the reliance on a purposeful sample of PHP leaders. Though the sampling strategy is suitable for gathering expert insights, it restricts the study's ability to capture experiences across a broader range of PHP roles or settings. Leaders may hold different views or face unique challenges not shared by others within PHPs, such as frontline staff or

physicians directly participating in these programs. Additionally, variability in PHP size, funding, and operational scope further complicates the generalizability of findings, particularly when comparing larger, well-funded PHPs with smaller, resource-limited ones.

Data Collection

Response bias is increased when studies rely on self-reports, such as those in semi-structured interviews. PHP leaders may consciously or unconsciously present their programs in a positive light, emphasizing strengths over challenges due to concerns about public perception or professional reputation. Relying solely on self-reports (e.g., interviews) could skew results, potentially leading to an overly optimistic view of PHP effectiveness or excessively pessimistic views of the challenges experienced. With objective and third-party measures, it is easier to fully assess the limitations and verify all aspects of PHP operations.

Stigma Impact

A notable constraint is the stigma surrounding mental health within the medical profession. This stigma, rooted in concerns over confidentiality and licensure, continues to deter physicians from seeking help, impacting data on PHP usage and efficacy. Because the stigma around mental health is so strong and common in the medical field, physicians might not feel entirely comfortable or willing to engage with PHPs. This means that the study might not show the complete picture of how often physicians use PHPs or the real challenges they face when trying to get support. As a result, the findings might underestimate how much support physicians need and what obstacles prevent them from using PHP services.

Structural Constraints

Structural and regulatory constraints within certain states limit PHPs from addressing physician wellness needs beyond SUD (or specific diagnoses) nor to non-licensed individuals.

This is particularly limiting for medical students or for licensed physicians who want to seek help preventatively. These limitations prevent funding to specific areas, reducing proactive or preventive support for trainees and placing an additional burden on already resource-limited PHPs. Unfortunately, PHPs that do not receive adequate funding yet still provide prophylactic services to students and early career physicians are especially overburdened. This structural limitation impedes the study's conclusions by limiting the scope of PHP functionalities, with reactive over proactive methods of support. Consequently, this restricts the exploration of PHPs' possible influences on overall physician well-being.

Methodological Constraints

While the findings provide meaningful insights into PHP leader perspectives, they may only capture some factors influencing physician well-being. Future research might benefit from longitudinal studies that track changes in PHP effectiveness over time or include objective measures of physician well-being, such as physiological stress markers, to supplement self-reported data. Stretching the research to explore other PHP stakeholders' perspectives could also provide a more comprehensive understanding of PHP's impact.

Delimitations

Delimitations, or intentional boundaries, have also been set in this study. First, this research does not aim to evaluate the direct impact of PHPs on individual physicians' health outcomes, such as specific mental health or substance use recovery metrics, as this would require extensive longitudinal data outside the scope of the current study. The emphasis is placed on the insights of the PHP leaders regarding program delivery, constraints, and overall effectiveness. While some medical stakeholder perspectives are included through the triangulation of documents, this research intentionally excluded the specific viewpoints of other PHP

stakeholders, including representatives from state medical boards or physicians directly engaging with PHPs.

Organization of the Remainder of the Study

In Chapter 1, the central research focus was introduced. I sought to understand the viewpoints of PHP leaders on the vital role of PHPs in supporting physician health and well-being. The chapter emphasized the significance of the research, particularly in the context of the increasing worries about physician well-being, burnout, and the critical need for accessible mental health and stress support. Theoretical frameworks, SDT and JDCS, were established to provide a solid foundation related to motivation and occupational health as they relate to the context of PHPs and the prevalence of psychological distress among physicians. A summary of the study's assumptions, limitations, and boundaries aims to provide clarity on the focus and research methodology.

Chapter 2 presents a review of the literature relevant to PHPs, delving into existing research on their effectiveness, the stigma faced within the medical profession, physician well-being, associated mental health challenges, and the individual and organizational contributors of these. This chapter lays a meaningful foundation for understanding the context in which PHPs operate and will highlight the gaps in current research, particularly concerning the non-substance-related support needs of physicians.

Chapter 3 details the research methodology employed in this study and the qualitative case study design. It reviews participant selection, data collection methods, and data analysis processes. This chapter also considers ethical considerations and explains how the study's design aligns with its goals. It also offers a review of how data was collected, analyzed, and interpreted.

Chapter 4 houses the results of interviews and the artifact reviews. It summarizes PHP leaders' perspectives on the benefits, challenges, and constraints of PHPs, providing an in-depth exploration of how PHPs operate. This chapter will also describe recurring themes and patterns identified from participant input, offering the basis for the final chapter.

Chapter 5 presents the interpretation of the study's findings as they relate to the research questions and theoretical frameworks. I examine the implications of the results, linking them back to the literature review and identifying potential pathways for enhancing PHP support systems. Limitations recognized during the research process will also be discussed with understanding and suggestions for future opportunities to expand upon this vital research.

CHAPTER 2. LITERATURE REVIEW

Chapter Two examines the relationship between PHPs, I/O psychology, and occupational health, highlighting their combined influence on physician well-being. Considering escalating concerns regarding physicians' psychological well-being, the review examines personal, occupational, and institutional determinants that exacerbate physician strain, exhaustion, and overall well-being. The literature establishes the backdrop for this qualitative study by integrating a diverse array of scholarly and peer-reviewed works. It provides an overview of the current state of knowledge in the field of physician health.

The theoretical frameworks of SDT and the JDCS models serve as pillars for the study. At the heart of this review are the theoretical frameworks of SDT and the JDCS models, which serve as the scaffolding for the study. SDT provides a practical and psychological explanation for the motivations that drive physician engagement and satisfaction, focusing on autonomy, competence, and relatedness in a supportive work environment. The JDCS model lends insights into the balance between job demands, control, and support and how this affects healthcare professionals' stress and job satisfaction. The articles included within the literature reviewed were guided by the theoretical underpinnings of SDT and JDCS, enabling a focused examination of how PHPs, workplace psychology, and occupational health initiatives can contribute to or detract from physician well-being. Moreover, these foundations also provide a lens for PHPs to consider their scope, services, and strategies for addressing and supporting physician health, safety, and well-being.

The literature review starts by assessing the effectiveness of PHPs in addressing substance use, mental health issues, and occupational stress across different career stages, from medical students to late-career physicians. It also explores how I/O psychology applies to

healthcare, focusing on organizational culture, job satisfaction, and physician well-being. The review examines the organizational role in reducing workplace hazards and improving physician safety. Through this structured approach, the following not only identifies key themes and gaps in the existing literature but sets the stage for future research directions, aiming to deepen the understanding of physician well-being and improve support mechanisms within the healthcare industry and underscores the need to deepen our understanding of where PHPs fit within this as a supportive, preventative, and interventional resource.

Methods of Searching

The methodology used in conducting the literature search was designed with the explicit goal of delivering an exhaustive review of a diverse array of scholarly articles, dissertations, and other pertinent literature that specifically pertains to the effectiveness of PHPs, the critical and influential I/O psychology concepts that playout within the healthcare sector, and the significant impact that various occupational hazards can have on the mental health of physicians. Using this approach, I captured and analyzed pertinent PHP literature, the intricacies of workplace psychology, and the aspects of physician health, ensuring a thorough review. This review adds to our understanding of these interlinked topics and points to their relevance in addressing these issues to create sustainable, healthier, and supportive work cultures and environments for future and practicing physicians.

The initial phase of the search strategy involved the identification of a broad spectrum of keywords and phrases directly related to the dissertation's central themes. Keywords such as *physician health programs, physician health program effectiveness, physician health program supports, physician health monitoring, physician health programs and well-being, physician well-being, provider well-being and safety, occupational stress in healthcare, supportive*

resources and physicians health, *physician burnout*, and *industrial-organizational psychology in healthcare settings* were selected. Using these keywords in different combinations was crucial in ensuring the search was comprehensive.

The Capella University Library's Summon search tool served as the primary database for the literature search, along with searches on online databases such as The National Library of Medicine and Google Scholar. With extensive access to academic journals, dissertations, and scholarly texts across a wide range of disciplines, the Summon search tool was instrumental in facilitating a broad search of peer-reviewed literature pertinent to the research questions at hand as it relates to this study. To refine the search results further, filters were applied to include only peer-reviewed articles, starting with a broader range of dates (to capture seminal articles) and limited periods, such as 2015 to 2023, to capture recent studies. This specific time was chosen to guarantee the relevance and currency of the literature reviewed. While it is standard to have a smaller window, a wider window was used, given the limited research on PHPs.

Search execution was carried out using simple and advanced database search functionalities. The advanced search features allowed for the nuanced combination of multiple keywords and the application of specific filters, such as publication date and document type. Boolean search terms were also used to help narrow or expand search parameters. This approach helped narrow the results to sources most relevant to the research topics. Various medical publications, such as the *Journal of American Medicine*, PubMed/National Library of Medicine, and British medical journals, were also used as resources to search the aforementioned key terms and the Google Scholar search engine. With often limited access to journals outside abstract and results, the Capella Summons tool was used to gain access to specific articles once found within the other journals.

The selection process began with assessing the relevancy of titles and abstracts of retrieved articles under the specific topics. This preliminary step was essential in excluding sources that did not directly address the core themes of PHP effectiveness, occupational health, and I/O in healthcare settings. Articles considered potentially important were then evaluated in full text by examining the studies' goals, methods, results, and conclusions in detail. These strategies helped maintain alignment with the research questions and objectives of the study. I also reviewed the references section of relevant articles to confirm that any pivotal resources were not overlooked. The approach helped develop a strong base for the literature review, grounding them in trustworthy and appropriate sources.

Theoretical Framework for the Current Study

The field of industrial/organizational (I/O) psychology incorporates a wide range of workplace behavior topics. Psychological and scientific principles are utilized to examine and further explore work-related phenomena (Society of Industrial and Organizational Psychology, 2023). I/O practitioners and researchers seek to understand and improve employee productivity and organizational effectiveness (Cascio & Aguinis, 2008). Industrial psychology covers employee selection, onboarding, professional development, job analysis, appraisals, and motivation at individual and group levels. These areas can affect performance, productivity, efficiency, and overall well-being, subsequently influencing organizational outcomes (Schneider & Pulakos, 2022). Organizational psychology includes topics related to culture, ethics, safety, and leadership, impacting industrial psychology components (Fidyah & Setiawati, 2020). The I/O practitioner understands the distinction between them and appreciates the overlays and complementary nature of the two. Organizational culture can influence recruitment strategies, employee engagement, and professional development approaches (Huynh et al., 2020).

Moreover, industrial and organizational factors impact employee engagement and job satisfaction (Yanti & Dahlan, 2018).

Occupational Health

One sub-topic of I/O psychology is Occupational Health, which focuses on exploring, improving, and promoting employees' health, safety, and well-being (Beehr, 2019). This subtopic falls under industrial psychology but is strongly influenced by organizational factors. In previous contexts, individual employees bore sole responsibility for their health. Contemporary practices emphasize shared accountability between employees and organizations. The evolution of this shared responsibility has been slow, given the complexity and often perceived resource-intense solutions to creating and maintaining healthy organizations that prioritize employee well-being. Fortunately, research in this area encourages shifts toward work cultures that promote employee well-being (Tawfik et al., 2019). Global occupational health and safety movements support initiatives emphasizing employee health and supportive organizations (International Labour Organization, 2022).

The importance of wellness among workers is not a new concept. Research formally began in this arena as the field of occupational health developed, with scientists such as Hugo Munsterberg, Walter Scott (Landy & Conte, 2016), and Charles Thackrah (Mathie, 2017). With the advent of the Industrial Revolution, scientists took an interest in studying efficiency. Later, research shifted toward psychological ideas relating to motivation, ability, and wellness and its impact on performance and productivity. Subsequently, research expanded to organizational structure and workplace environmental influences on the employee.

By the 1980s, the development of Employee Assistance Programs (EAP; Attridge, 2019) underscored the support needs of employees and the negative impacts of unwell and distressed

employees on organizations. Various psychological theories involving work stress, occupational health (Fila, 2016), and organizational systems (Sandys, 2015) support the formation and utilization of EAP-like programs. However, little has been written regarding theories that suit Physician Health Programs (PHP), focusing on physician-specific health and safety.

Industrial/Organizational Psychology

The research in I/O psychology is grounded in various theoretical foundations, each providing frameworks to understand human behavior, workplace interactions, and organizational processes. These frameworks are crucial for researchers who intend to expand or challenge previous studies. They also help structure and organize knowledge (i.e., concepts, variables, and tools) (Bates, 2019). Theoretical frameworks in I/O psychology serve multiple purposes: explaining workplace phenomena, predicting behavior and outcomes for employees and organizations, and facilitating the identification and enhancement of day-to-day experiences within the workplace.

Organizations and employees must acknowledge and adapt to the workplace's internal and external fluctuating demands. A failure to respond to organizational and employee needs leads to operational disruption, undermining long-term success and potential performance outcomes. An ongoing example of this is occupational health. Significant work has supported earlier initiatives focused on health and wellness in the workplace prompted by the recognition of alcoholism and other workplace problems impacting behavior and productivity (Gilbert, 1994). Munsterberg (1913) had written about the social influences and effects of alcohol use on productivity in his earlier work in Psychology and Industrial Efficiency. Theoretical frameworks focused on the psychology of employee well-being often support research in motivation, stress, health, and safety. Research in these areas has illuminated the critical connection between

motivation, health, and workplace outcomes. They also underscore the implications of unresponsive systems. Thus, research in this specialization seeks to expand the understanding of occupational health implications and to find proactive and mitigating approaches that buffer and support employees and the organization. Two theoretical psychological frameworks often utilized in the field of I/O, as they relate to occupational health and employee needs, are self-determination theory (SDT) and job demand-control-support (JDCS).

Self-Determination Theory

Ryan and Deci (2000) identified three facets of motivation that impact workplace behavior. They found these to be crucial for promoting and supporting the development of the innate strengths of employees and in anticipating and addressing the motivational needs of employees. When employers consider and structure systems (i.e., job analysis, leadership approaches, and organizational cultures) within this framework, they can motivate employees toward commitment, skillfulness, and quality work engagement and performance that support employee well-being. Ryan and Deci found that organizational factors can hinder employee motivation when the abovementioned facets are unattended.

There is little motivation to perform when there is limited autonomy (control over one's work). The levels of connection and support an employee feels within their organization, known as relatedness, can have a meaningful influence on their motivation. A disengaged and unsupportive supervisor may decrease motivation in their employees. Thus, employee engagement within an organization is paramount. Competence can be supported in the workplace through ongoing training and educational opportunities to strengthen key skill sets that facilitate successful task completion (as it relates to their position). When psychological needs are unmet,

employees become vulnerable to developing psychological and behavioral problems. Unmet psychological needs increase the risk of developing psychological and behavioral problems.

These issues may lead to decreased performance or behaviors that hinder productivity, like arriving late, missing work, or displaying unfavorable behaviors (e.g., incivility). SDT suggests that different forms of motivation, autonomous and controlled, influence workplace behavior (autonomy, relatedness, and competence) (Deci et al., 2017). Autonomous motivations are derived intrinsically, whereas controlled motivations are externally driven, for example, to reward or avoid punishment (Deci et al., 2017; Rigby & Ryan, 2018). Self-determined employee motivations lead to more satisfaction and successful work outcomes (Rigby & Ryan, 2018). When reviewing organizational context, the two components of SDT (psychological needs and motivations) mediate between the independent variables of workplace contexts and individual differences and the dependent variables of workplace performance and employee well-being (Deci et al., 2017).

The quality motivation (QM) spectrum ranges from motivation, external pressure, internal pressure, personal value, and intrinsic. High-Quality Motivation (HQM), as termed by Rigby and Ryan (2018), has a critical role in performance and wellness. Indeed, it is incumbent upon organizational leaders to create values and cultures that focus on meeting the psychological needs of employees and that promote relationships centered on supporting HQM, employee engagement, professional aspirations, value-work congruency, quality performance, and organizational commitment.

When we place these three critical facets (autonomy, relatedness, and competence) of motivation along Maslow's hierarchy of needs (safety, self of belonging, and actualization) (Vermote et al., 2022), the ability of an organization to support and meet these needs cannot be

understated. An employee with unmet needs may be susceptible to exhibiting distress through counterproductive behaviors, absenteeism, anxiety, depression, and other stress syndromes that can eventually lead to performance problems, especially in the context of high acuity and critical conditions.

Job Demand-Control and Support

The Job Demand-Control-Support (JDCS) theory serves as a foundation for this study, as it helps explain the psychiatric and psychological challenges physicians face.JDCS provides a lens to explore how PHPs support physicians in maintaining well-being and addressing these challenges (Chênevert et al., 2021; Dreison et al., 2018). Karasek's Job Demands and Job Control theory (JD-C) (1979) explains that when there are imbalances between demands and controls, workers experience adverse physiological and psychological effects.

Johnson and Hall (1988) added Karasek's work by including the variable of support after finding that job support could buffer the negative impact of high demands and low control situations – this is known as the JDCS (Job demand-control-support) theory (Hausser et al., 2010; van Doorn et al., 2016). Buffers encompass supervisor support, restructuring of job responsibilities, assessing autonomy, and job crafting, all of which increase job satisfaction (Tims et al., 2013).

Employees with high cognitive demands and limited autonomy experience adverse impacts on their health, efficiency, and safety (Leitao et al., 2018). Johnson and Hall (1988) illuminate the need for job support as a proactive and mediating impact of JD-C. This theory is in tune with the lived experience of high-stress and safety-sensitive medical professionals, many of whom have already felt the effects of JDCS tenets and systemic pressures in problematic ways, as seen in the prevalence of psychiatric and psychological problems among this population.

Moreover, organizational efforts have been made to address them (Shanafelt & Noseworthy, 2017).

Job Demand-Control and Resources

As noted, in concert with the theoretical implications of SDT, organizations can have positive and negative influences on employee well-being. Without support, psychological impacts on employees subsequently influence job performance, satisfaction, and well-being (Villarreal-Zegarra et al., 2022). Job demands include mental workload, time pressure, emotional and physical components (Hausser et al., 2010), and role conflicts (van Doorn et al., 2016). Autonomy and decision-making latitude fall under job controls. Job demands do not solely encompass the daily list of tasks one is expected to execute but the physical, psychosocial, and organizational expectations of the workplace context (Lopez-Martin & Topa, 2019). These demands can be incredibly taxing on an employee's emotional and physical well-being, leaving workers feeling drained and susceptible to various health challenges (e.g., sleep issues, fatigue, heart-related concerns, anxiety, and depression) (Elovainio et al., 2015). When a worker has a high mental workload but has low job control, workers are adversely affected to the detriment of productivity and safety (Leitão et al., 2018).

Job-Demand Resource (JD-R) theory also holds that job demands create tension between resource availability and expenditures, significantly when work demands outweigh resources (Melnikow et al., 2022). Like JD-C, over time, a lack of resources can strain employees in a way that compromises their well-being and overall health (Elovainio et al., 2015; Lopez-Martin & Topa, 2019). In sum, a well-documented consequential relationship exists between job demands and well-being. This relationship has significant implications for workplace industrial and organizational factors and is well within an organization's control to address.

Industrial/Organizational Lens

I/O psychology involves, among other areas, the scientific inquiry into employee health, occupational hazards, stress, and wellness of employees (SIOP, 2022). In alignment with I/O priorities, the JDCS framework helps in understanding the high rates of burnout and suicide among physician populations (Andrews, 2017; Brooks, 2017; Shanafelt, 2021), the prevalence of psychological disorders and emotional distress among physician trainees (Lebares et al., 2017), and the relationship between psychological problems on performance and patient safety (Williams & Flanders, 2016; Wallace et al., 2009).

The I/O perspective provides a lens through which to view the physician and their work environment. Over the past 5-10 years, there has been a shift in the research as it relates to factors that contribute to workplace well-being; a shift from the individual to healthcare organizations recognizing and addressing their impact on provider well-being (Shanafelt & Noseworthy, 2017; Shanafelt et al., 2017). Stakeholders and constituents involved in the medical field depend on PHPs to provide services that address physicians' medical and psychiatric conditions, as outlined in their contractual agreements with medical state boards on the premise of consumer protection (Candilis, 2016). Due to its potential implications in medical practice, Shanafelt and Noseworthy (2017) argue that addressing physician well-being is an ethical and moral imperative. Additionally, the manifestations of illnesses left unattended and observable become the responsibility of the physician and their peers to report impairment to the regulatory agencies (White & Flanders, 2016).

Review of the Literature

This section moves into the multifaceted issues of physician well-being, safety, and health within the modern healthcare environment, where increasing job demands and evolving

challenges in medical practice are of growing concern. Central to this discussion is the recognition that physician well-being is not just a personal issue but also crucial to the quality of patient care, care delivery, and organizational effectiveness. The literature review presented herein aims to dissect the theoretical underpinnings and empirical research surrounding the factors influencing physician health and the mechanisms through which these factors exert their influence.

The literature review is organized into several sections, each exploring different dimensions of physician well-being or factors that impede or support health and safety. The review begins by establishing the theoretical foundations that guide current research and interventions in this field, mainly focusing on SDT and JDCS models. These frameworks offer valuable lenses to examine the intrinsic and extrinsic motivations that impact physician health and the role of job demands, control, and social support in shaping their work environment.

The review transitions to an examination of empirical studies, which explain how these concepts aid in grasping the specific pressures and difficulties physicians face. This includes examining the impact of job demands and control, the significance of autonomy and relatedness, and the psychological needs of physicians in the face of occupational stress and burnout. Special attention is given to the effects of the COVID-19 pandemic, which has exacerbated existing pressures and introduced new dimensions to physician stress and well-being.

The following sections of the literature review highlight responses to these challenges, focusing on the role of PHPs in evaluating and monitoring physicians, as well as supporting their mental health and occupational well-being. This includes an analysis of the effectiveness of PHPs in addressing substance use disorders, with an emphasis and inquiry as to how PHPs could further support mental health issues and the broader spectrum of well-being concerns among

physicians. The review critically assesses the literature on PHP outcomes, the barriers to seeking help, and the need to expand PHP-specific research that reflects the scope and benefits of PHP services and supports.

The review concludes with a synthesis of the literature and outlining future research directions on physician health and well-being in relation to PHPs. The review points to critical areas that require more research if stakeholders intend to develop and implement adequate, proactive, efficient, and practical support systems tailored to the specific needs of physicians. It also builds a contextual discourse of physicians' health, safety, and overall welfare while highlighting the essential role of PHPs in this vital context, providing a solid foundation for the analysis and interpretation of the study's findings.

Theoretical Foundations

How employees respond (or react) to everyday stress can become problematic if the stress outweighs the individual's internal resources (e.g., motivation, resiliency, and coping mechanisms). A lack of external resources such as time, finances, and social or organizational support can compound the psychological burden on employees. SDT and JDCS theories identify factors that impact and support the health of an organization and its employees and performance outcomes. These theoretical frameworks also highlight the ethical considerations of employers and individuals regarding the accountability and responsibilities of well-being, as reviewed in previous and more recent research.

Self-Determination Theory

SDT is a crucial framework for understanding the well-being of physicians, especially regarding work motivation and occupational health. In a nationwide study, Moller et al. (2019) surveyed 2247 active physicians to investigate the link between motivations and occupational

health. The research applied two elements of SDT—autonomous and controlled work motivation—as its conceptual basis. The researchers identified six factors of physician occupational health: health, risk of depression, burnout, job satisfaction, and intentions to leave or retire from medicine. The results reflected that autonomous motivations positively impacted all occupational health factors, while controlled motivations were linked to higher risks of depression, burnout, and decreased job satisfaction. Findings highlight the necessity of work environments that encourage autonomy among physicians, which can improve their overall well-being and job satisfaction. Building on this, new literature is still examining the intricacies of physician well-being through the perspective of SDT.

Organizational factors leading to physician burnout and a decline in overall well-being can be understood with an SDT lens. In a 2015 editorial, Ariely and Lanier articulated the role of autonomy in job satisfaction and burnout. They emphasized that when physicians feel they have control over their work and decisions, they are more apt to reach healthier and more positive physical and mental health status. Fostering autonomy and addressing psychological needs can mitigate burnout and enhance job satisfaction (McAnally et al., 2024). Similarly, a study by Lases et al. (2018) explored physician resident well-being and found that perceived autonomy enhances well-being through decision-making in patient care training. They also found that autonomy, peer connections, and engaged supervisors help boost satisfaction and overall well-being. These findings elevate the need for academic institutions and healthcare organizations to shift cultures to be more closely aligned with the tenets of SDT. Doing so can help buffer factors that contribute to burnout and improve the well-being of their trainees and medical staff.

Intrinsic Aspirations and Need Satisfaction

Findings in the Moller et al. (2019) study were supported by a more recent national study conducted by Moller et al. (2022), in which a substantial sample of 2116 practicing physicians was rigorously surveyed to gather comprehensive insights. The study expanded on previous findings, exploring the various precursors contributing to developing autonomous work motivations among physicians in their professional environment. Researchers measured several crucial factors, including physician intrinsic aspirations, the degree of need satisfaction experienced at work, overall work motivation, and various aspects of occupational health, which comprised six important indicators previously noted in their earlier research. The results highlighted the importance of intrinsic aspirations and the satisfaction of needs, especially emphasizing the aspects of autonomy, competence, and relatedness as fundamental stepping stones that nurture the growth of autonomous motivation among physicians. The findings highlighted the role of intrinsic aspirations and the positive influence of autonomous motivation. Notably, the absence of autonomous motivations can adversely impact all six occupational health indicators. This consequently results in a decrease in the quality of care, accentuating the importance of creating supportive healthcare environments that amplify intrinsic factors, which will not only enhance the well-being of our physicians but also improve the overall effectiveness of healthcare delivery.

Basic Psychological Needs during COVID-19

With the onset of the COVID-19 pandemic, which affected and continues to impact healthcare providers globally, researchers have had yet another opportunity to apply and expand on SDT in work-related stress, psychological distress, and burnout syndrome. Van der Goot et al. (2021) conducted a mixed-method study assessing frontline workers' psychological needs,

satisfaction, and frustration during COVID-19. SDT was used as the theoretical lens. Basic Psychological Needs Theory (BPNT), a component of SDT, focuses on the individual's needs (autonomy, competence, relatedness), which may be either met or frustrated (Maarten et al., 2020). In the workplace context, thwarted or frustrated needs can lead to dysfunction in performance and psychological well-being (Manganelli et al., 2018). With its mixed approach, 259 surveys (quantitative) were completed, and 60 audio diaries were qualitatively analyzed using thematic analysis. SDT and BPNT are captured in the measure used to quantify their data: the Basic Psychological Needs Satisfaction/Frustration scale (Van den Broeck et al., 2016).

Findings highlighted an increase in psychological distress consequent to autonomy and competence frustrations. They spoke to the pressure and sudden onset of the novel situations that healthcare leaders and providers were thrust into. Procedural processes and experience with COVID-19 were unfamiliar, leading to uncertainties and disorganization. Organizational and leadership shortcomings in directives, communication, and resources (i.e., protective gear and ventilators) exacerbated the frustrations related to these areas (autonomy and competence). Quantitative and qualitative data reflected a need for satisfaction in relatedness because of the shared experiences and support of colleagues and connections made with patients and families, which decreased perceived levels of psychological distress.

A more recent article by Mannion et al. (2023) discussed healthcare professionals' experiences during the pandemic. The article conveys that providers who are able to maintain their role autonomy are better at managing stress during times of uncertainty and increased work demands. The authors suggested that encouraging autonomy is essential during tough times to support resilience and well-being among providers. The application of SDT in discussions about physician well-being is visible in the current literature. An expanding range of research supports

autonomous motivation as a critical factor for positive health outcomes, emphasizing the need for supportive work environments that prioritize physician autonomy and involvement.

Job Demand Control Support

JDCS is a significant theoretical framework for understanding physician well-being, particularly in high-stress and safety-sensitive environments. Based on SDT principles, JDCS has been featured in recent studies, particularly in the context of the COVID-19 crisis (Melnikow et al., 2022). As reviewed, the JDCS model states that the combination of job demands, job control, and social support impacts the well-being and performance of employees, especially in healthcare, where workers encounter distinct challenges.

A study conducted by van Doorn and colleagues in 2016 utilized the JDCS model with Nigerian nurses, incorporating distinct JDCS variables to establish their research hypotheses. Researchers expected that job demands would increase emotional exhaustion, and job control and social support would decrease the impact. They also noted that active learning would have a positive connection with job demands, job control, and social support. Results supported previous studies by Karasek (1998), proposing that high job demands and high job control can enhance motivation, active learning, and overall performance.

The results from van Doorn et al. (2016) reaffirmed the JDCS framework, demonstrating again that increased work-related strain was associated with higher job demands and emotional exhaustion among nurses. The study pointed to the role of supervisor support in active learning and mitigating emotional exhaustion. This finding reestablished previous research by Halbesleben (2006), which emphasized the role of social support in buffering the adverse effects of job demands on employee well-being. The study failed to find a significant connection

between job demands and active learning, suggesting that not every aspect within the JDCS framework applies the same way across varied contexts.

Moreover, the importance of high job control and supportive supervision in creating opportunities for professional growth was underscored in their findings. This resonates with previous work by Bakker and Demerouti (2007), who proposed the JD-R model, a model suggesting that high job demands paired with adequate resources (e.g., supervisor support) could lead to positive outcomes like engagement and learning. Overall, the JDCS model still offers important insights into job demands, control, and support within the healthcare industry. Future research could build on these results by including a variety of healthcare environments and examining how job pressures and support networks interplay to impact the health and job performance of different healthcare workers.

High-Stress Physician Specializations

Similarly, in a recent study by Somville et al. (2020), the determinants of JDCS were explored among Belgian emergency physicians compared to other high-stress physician specialties. The results indicated that emergency physicians experienced higher job demands with lower job control. The JDCS theory was used as a basis for the study. The study expanded the model to include organizational and environmental hazards, variables indicating psychological strain (i.e., fatigue, stress, anxiety, and depression), and job-related outcomes (i.e., job satisfaction, work engagement, and turnover intention). Among its findings, the tenets of JDCS were reconfirmed and expanded upon.

Safety, Climate, and Well-being

Leitão et al. (2018) investigated the health and well-being of health and safety practitioners (HSP) using JDCS and safety climate. Safety climate (SC), separate from safety

culture, is the perception of individuals surrounding the organization's and its leaders' priority on safety (e.g., safety procedures, policies, practices) and its impact on employee well-being. They hypothesized the following:

> Hypothesis 1. Demands are negatively associated with HSPs' health, wellbeing and efficacy. Control and support are positively associated with HSPs' health, wellbeing and efficacy. Hypothesis 2. Safety climate is positively associated with health, wellbeing and efficacy of HSPs…Hypothesis 3. Safety climate is negatively associated with job demands but positively associated with job control and support of HSPs. (p. 132)

All three hypotheses were supported. The association was strongest between mental well-being, job control, and support. These results are significant to the literature in connecting the impact of SC on well-being, but not surprising because when the perception of safety climate is high, it indicates that employees feel safe and valued. The study highlights the utility and importance of JDCS in investigating organizational and psychosocial conditions and that demand, control, and support impact performance and well-being. This study provided one of the first inquiries into SC and efficacy and linked SC with the JDCS model. This study emphasizes the need for organizational commitments toward safety climates where physicians feel supported, safe, and valued, given the context of their high-demand and low-control environments.

Physician Health Programs

Over time, PHPs have expanded their services to address most medical, health, and behavior-related problems. Studies continue to show the footprints of occupational stress within medicine, as evidenced by growing studies on the prevalence of mental health and behavioral issues among medical students, residents, and physicians. The occupational hazards in the

medical field vary among specializations; however, the adverse psychological influences are similar (i.e., burnout) (Marco et al., 2016; Memon et al., 2016). Brooks (2016) explains that physicians remain susceptible to adverse mental and physical risks, much like other professions with high-stress levels. Explicitly, stress and burnout, anxiety and depression, disruptive behavior, and physician deaths by suicide are concerning and well-documented problems within this population (Andrew, 2022; Lebares et al., 2018; Lheureux et al., 2016).

As a result of the problems noted above, there has been a shift in the utilization of PHP to address issues outside of SUD. PHPs help hospitals and physicians limit potential adverse impacts of mental health and behavioral problems within the workplace. However, while the PHP-model approach to SUD has been successfully researched, its process and role in addressing the physician's mental health and behavioral issues are poorly documented. The shift in utilization and expansion of services has undoubtedly impacted the individual state PHPs on various levels. Still, the extent of this remains unexplored. The following section in this literature review focuses on PHPs, Physicians' physical and mental health, manifestations of behavioral disruption within the workplace environment, and organizational factors that contribute to and support physician health and safety in practice.

PHP Model and SUD

Similar to the general population, approximately 10-12% of US physicians will develop a substance use disorder (SUD); however, some may be at higher risk due to their specializations and the accessibility of potent, habit-forming medications (i.e., anesthesiologists) (Brooks et al., 2012; Oreskovich et al., 2015). There were several studies between the 1980s and the early 2000s on PHPs, much of which focused on the PHP model of evaluating and monitoring physicians suffering from SUDs (Goldenberg et al., 2018)—the Blueprint (BP) studies of 2005

were among these. The BP study consisted of two phases: the initial phase was on the structure and processes of PHPs, and the second phase entailed a collection of retrospective studies (the first of its kind related to the PHP) associated with the involvement of physicians with SUD and their outcomes (Goldenberg et al., 2018; McLellan et al., 2008). Goldberg et al. (2020) study further supported the structures and the outcomes of PHPs and SUD.

The purpose of the BP studies was to have a foundational study that outlined the design of the PHP model in addressing SUD and to have baseline outcomes on the success of the program model. Their findings illustrated that five-year monitoring of physicians resulted in lower relapse rates than the general population, with recovery rates between 72%-96% (Brown & Bohler, 2019; Dupont et al., 2009). The PHP model paradigm continues to be studied, and results support high rates of recovery because of the extended accountability and support that PHPs provide for recovering physicians, including a gradual and monitored return to work, collaborations with providers, and specimen testing, among other components of their individualized program (Merlo et al., 2016).

There are only a few non-SUD and PHP studies, as reviewed in the literature gap. One outcome-based research project included a comparison study between mental health problems and the outcomes of SUD; findings suggested that mental health could be similarly evaluated and monitored with successful results using the PHP model (Knight et al., 2007). This study aims to continue to support the role and functioning of PHPs in addressing physician health and well-being. Research to this effect, related to the involvement in PHPs, addressing mental health, behavior, and overall well-being, would be a substantial gain for the literature on PHPs.

Physician Mental Health

Numerous variables contribute to the vulnerability, susceptibility, and prevalence of psychological distress for physicians. Many of these are observable in medical cultures that have not historically prioritized the well-being of students, trainees, and practicing physicians. The inception of physician psychological distress begins upstream during medical school, where approximately 28% of medical students have been found to experience depression, in contrast to 8% of the general population (McFarland et al., 2019). These statistics follow students into their internship and residency years, with one study finding that over 51% of anesthesiology interns and residents had a degree of burnout, 32% were in distress, and 12% met the criteria for depression (Sun et al., 2019). As training progressed, rates increased. Unattended, these symptoms can lead to severe and tragic outcomes. The prevalence of psychological distress, as noted, begins in medical school and continues throughout the physician career span. Practicing physicians have rates above that of the general population of workers in the US. Research reflects this as a global problem, with the prevalence of burnout, anxiety, depression, and suicide at concerning levels, with aggregate estimates of depression rates at approximately 28.8% and generalized anxiety rates at 24% (Harvey et al., 2021; Locke, 2019).

These studies and the ones to follow highlight the global problem of physician psychological and occupational hazards but point out that a physician's intellect does not necessarily provide immunity to the demands of their profession. A constellation of individual and organizational factors places physicians at a heightened risk, eroding their overall well-being over time.

Individual Contributors

When considering career choice and specialties among physicians, individual and personality factors play a role (Mullola et al., 2018). Additionally, personality factors can influence their susceptibility and stress vulnerability (Eley et al., 2020; Brown et al., 2019; Martin et al., 2022). As Wong (2020) reviews, while there are various personality profiles among physicians, there are commonalities among interpersonal and personal characteristics that cause physician distress. Interpersonal factors include empathic distress, moral suffering, and bullying and marginalization. Personal factors encompass unhealthy perfectionism, pathologic altruism, self-recrimination, and pitfalls of success. The components of perfectionism are a double-edged sword in that it carries with it, as it relates to patient care, a focus on high quality and conscientious care; however, it is also burdened by rigid expectations of self and others that may make it challenging to work in teams and increases the stress of their day-to-day experience. Maladaptive perfectionism is defined by unreasonable self-expectations, unhealthy inner critique, and failure to meet self-imposed expectations (Hu et al., 2019).

In a cross-sectional study, Martin et al. (2022) examined the association between perfectionism and physician burnout. The sample included 69 pediatric physicians. The instruments used were the Maslach Burnout Inventory, the Big Five Inventory, and the Big Three Perfectionism Scale. The study found that 42% of physicians reported high emotional exhaustion (EE), burnout, or depersonalization (DP). More specifically, those with high self-criticism were predicted to have high EE and DP. Other personality profiles with low agreeableness were also expected to have high EE and DP. Prior studies have also found that maladaptive perfectionism in students can lead to greater resonance with shame, depression, anxiety, imposter syndrome (Hu et al., 2019), and suicidal ideation (Brennan-Wydra et al., 2021).

A couple of years before Martin et al.'s (2022) study, Brown et al. (2020) had focused on the relationship between personality and burnout. However, their sample focused on primary care physicians (PCP) in Canada and Jamaica. Their sample was only slightly larger, with 77 participants. The results indicated that 38% were experiencing low levels of accomplishment, 34% felt emotionally exhausted, and 20% felt disconnected from their patients. Neuroticism, a Big Five personality trait characterized by a higher proclivity toward stress, anxiety, and negativity, was linked to feeling less accomplished, more exhausted, and detached. Conversely, those with higher scores in agreeableness (open to cooperation and kindness) and conscientiousness (apt to be more organized and responsible) felt more connected to patients and accomplished.

In a much older and more extensive longitudinal study with over 2000 physicians in the UK, researchers found that higher levels of neuroticism were associated with burnout, stress levels, and professional satisfaction (McManus et al., 2004). Additionally, agreeableness and conscientiousness traits can be protective against stress and burnout. Their findings are upheld in the more current research noted above.

Other personal factors noted by Wong (2020), such as pathological altruism and self-recrimination, are deeply embedded in an exaggerated sense of responsibility, leading to other psychological pressures, such as guilt and self-doubt. The maladaptive mindsets create blinders and obstacles to self-awareness and seeking support, often leading to distress, manifestations, and exacerbations of other psychological symptoms (including suicidal ideation) and self-neglect.

Physician Suicide

The prevalence of mental illness and deaths by suicide among doctors is a global problem that sheds light on the unique pressures that medical professionals face (Harvey et al., 2021). Medicine has traditionally been perceived as a fulfilling and rewarding profession. However, the experiences of modern-day physicians are often fraught with profound psychological challenges that have led to both personal and professional consequences. The concern extends beyond the realm of medicine; comparable mental health struggles have been identified in other high-stress occupations, like law (Krill et al., 2023) and education (Agyapong et al., 2023), suggesting a troubling trend of inherent psychological vulnerabilities found in high-stress occupations. Prioritizing physician well-being is further elevated by compelling data that associates stress syndromes and other mental health problems with a rise in errors (van Steijn et al., 2019; Nagasaki et al., 2024) and regulatory scrutiny (Blassingame et al., 2024).

The problem of suicide among physicians is not just confined to the US but is a concerning issue seen worldwide, impacting numerous people in different countries and societies. Awareness in the US of physician suicides goes back to a crucial 1903 article in the Journal of the American Medical Association (JAMA), prompted by a report from London showing an increase in physician suicides. The article considers the complex factors leading to the trend, including financial struggles, knowledge, and capacity. The findings of the article emphasize that the suicide rates among physicians during that historical period were remarkably and distressingly higher than that of the general population.

In contemporary times, a multitude of research studies have brought to light the critical issues surrounding physician wellness and impairment, as well as the significant impacts that occupational stress and burnout have on those within the demanding medical profession.

Statistics reflect a suicide rate that is higher than the general population, highlighting a worrisome trend, but as noted, this is not a new problem, yet the prevalence remains. Female doctors have a 130% and male doctors have a 40% increased risk of dying by suicide in comparison to the general population (Brooks, 2016).

With burnout rates among physicians exceeding 50% (Shanafelt & Noseworthy, 2017), combined with the alarmingly high rates of suicide within this demographic, the implementation of preventative programming and crisis intervention services has become not only necessary but also critically important. This urgency is particularly pronounced in light of the exacerbation of psychological distress and the immense pressures that physicians have been enduring as a direct consequence of the ongoing COVID-19 pandemic, which has placed unprecedented strain on mental health resources and support systems for healthcare workers (Robeznieks, 2022).

Burnout

Burnout has been at the forefront of interventions in the physician health field for decades. However, given the continued prevalence of burnout and the realities and emotional residue of the COVID pandemic, researchers across various sciences are united in finding practical and effective solutions. With research confirming the impacts of burnout and other psychological distresses on quality patient care, safety, and organizational outcomes (i.e., turnover, retention, performance) (Scheepers et al., 2015), the pressure is palpable among the scientific and research community. It is also palpable among physicians themselves, who perceive burnout to be primarily organizational, with contextual, relational, and individual factors following, respectively (Sibieoni et al., 2019).

The pre-COVID prevalence of anxiety, depression, and burnout was unacceptable, with a study finding that approximately 69% of residents in a surgical program were experiencing

burnout (Lebares et al., 2017), with higher rates of burnout putting them at higher risk of depression and suicidal ideation. Bui et al. (2020) surveyed residents in 2018 and found that residents were experiencing high rates of burnout (63%) and depression (36%). Recent studies further reflect the impact of COVID-19 on anxiety, depression, and burnout.

In a 2021 survey in April 2020 across 40 US medical schools, the rates of anxiety and depression were 61% and 70% higher than pre-COVID statistics, respectively (Halperin et al., 2021). Resident rates of burnout and depression in the context of COVID were similarly high, with one study reporting that 31% of surgical residents experiencing depressed mood, 54% anxiety, and 55% reported emotional exhaustion (one of the three symptoms of burnout syndrome) (Coleman et al., 2021). Additionally, Shanafelt et al. (2022) studied the burnout and satisfaction of physicians during the first two years of COVID-19, having surveyed 2440 physicians, and found an increase in burnout, from 38% in 2020 to 62% in 2022. The effects of the pandemic have influenced the medical community in significant and multiple ways, and efforts to address these are underway (Aiken et al., 2023).

Disruptive Behavior

Brown et al. (2009) highlighted the problems beyond physician SUD, including disruptive behavior, physician impairment, comorbidity, and stress-related symptoms. They underscored the limited validated, systematic interventions or programs addressing psychiatric and behavioral disturbances. One PHP study examined the prevalence of psychiatric disorders among physicians referred to their program due to disruptive, problem behavior. Results indicated that of the 53 physicians referred for disruptive behaviors, only 3.7% had no Axis I diagnosis outside of Occupational Problems; 50%, however, had Axis I and Axis II diagnoses and traits (Merlo et al., 2014). Disruptive behavior, such as dismissive and aggressive

communication and behaviors and other incivilities, significantly compromises patient quality and safety (Lewis, 2023). Such behavior undermines trust, hampers communication, and has the potential to result in medical mistakes and suboptimal outcomes for patients. Furthermore, they can be indicators of stress, burnout, or other psychiatric and behavioral problems needing evaluation and intervention (Brown et al., 2009; Merlo et al., 2014).

Organizational Component

Attridge (2019) highlights that psychological problems affect approximately 200 million employees globally. Specifically, in the US, the prevalence of mental disorders among employees is around 20%. Literature is rich regarding specific occupational hazards (both physical and psychological) among different industries, such as medicine or other safety-sensitive industries (Shanafelt & Noseworthy, 2017). These health and psychological issues have a tremendous adverse impact on organizations; therefore, more than ever, given the prevalence of psychological distress among physicians, healthcare organizations seek to shift cultures and prioritize their employees' health and well-being.

Aside from the importance of competency and technical skill, the well-being of employees impacts organizational and team effectiveness. Shanafelt et al. (2023) also spoke to unit-level interventions that address clinicians' well-being. In addition, Burton (2010) notes that additional factors impacted by well-being are productivity, team morale, financial resources, and consumer satisfaction. Therein lies the vested interest of the hospital and practice organizations to address the problem of physician wellness. The physician health and distress literature shares a denominator of collaboration and focuses on organizational structures and culture (Montgomery, 2014).

Shanafelt and Noseworthy (2017) provide practical actions and an overview of the organizational responsibility to assist in developing, strengthening, and maintaining a culture of wellness. They highlight stress and burnout's personal and professional repercussions and the organization's role in reducing, reversing, and preventing institutional factors contributing to the problem. Moreover, they speak of the importance of having agency support within the medical community to help support and address these problems (i.e., PHPs). Physician health is a significant factor, as are the culture and resources available within an organization (Burton, 2010; Shanafelt & Noseworthy, 2017). The development of worksite wellness programs and the accessibility of PHPs are steps forward in addressing problems in physicians' occupational health.

Well-Being and Occupational Stress

Studies have distinguished between two types of occupational stress: operational and organizational. Operational stressors consist of work-related content, such as responsibilities and work shifts, while organizational stressors involve workplace culture, leadership approaches, and bureaucratic processes (Ricciardelli et al., 2020). Studies have spoken to the adverse effect of organizational stressors, which similarly and significantly impact health and well-being to operational stressors (Acquadro Maran et al., 2022; Edgelow et al., 2022).

In a recent study (Di Nota et al., 2024), researchers sought to understand the physiological impact of organizational stressors among police managers and compare them to fieldwork stress. While the study had only 25 participants, findings suggested that physiological responses to stressful organizational contexts and circumstances have similar impacts to fieldwork stress despite the absence of crisis and other physically activating scenarios.

When applying these findings to the medical field, we can extrapolate that physicians not only endure the demands of their safety-sensitive positions as they relate to clinical practice (with some specialties having increased stress) but also carry the burden of organizational stressors highlighted above and discussed in the work of Shanafelt et al. (2023) and Shanafelt and Noseworthy (2017).

Credentialing processes add to organizational stress with intrusive questions on credentialing applications. These stigmatizing practices have historically started early on during medical training, where delayed gratification and performance over personal health and care are the norm. This is still visible today as we look at recent studies that reflect the adverse impact of organizational cultures on healthcare workers and other safety-sensitive professions, as noted previously.

In a moderately sized 2020 study, physicians were found to be more resilient than the general employee population; however, burnout rates were still substantially higher. Contributors to the rates of burnout were highlighted to be associated with systemic issues (West et al., 2020). The rates of burnout and other psychological distress have persisted despite the shift from the individual to a more significant and shared association with systems issues and organizational cultures. Cultures that perpetuate unrealistic expectations, lack of control, and value misalignment (i.e., profits over people and productivity over quality patients) through inefficient processes, inadequate resource allocations, and excessive administrative demands contribute to the deterioration of physician health and well-being, which consequently impact the quality of patient care.

Well-being and Patient Safety

Research has shown a link between physician well-being and patient care (Wallace et al., 2009; Welp et al., 2015; West et al., 2009; Scheepers et al., 2015; Shanafelt et al., 2016), causing a flurry among researchers and administrative leaders in developing and exploring evidence-based interventions. These implications are of the utmost importance to PHPs, regulatory agencies, healthcare entities, and the public (Candilis, 2016; Carpenter et al., 2021; Williams & Flanders, 2016). Efforts to address these problems have been siloed and fragmented among healthcare institutions, medical societies, and other professional associations. Literature has identified factors impacted by physician well-being, including patient satisfaction, patient adherence to treatment, and the interpersonal aspects of patient care (Scheepers et al., 2015).

While burnout is often a focal point among medical communications, it is not the only reason a physician will disengage from work and experience work dissatisfaction. Disengagement, work dissatisfaction, and performance issues are also impacted by psychological distress, which often manifests in behavioral disruptions and other unprofessional behavior. Since clinical performance involves communication, competency, and team collaboration on many levels – care can be compromised when physicians suffer from anxiety, depression, or other mental health/behavioral problems or psychiatric illnesses.

Hall et al.'s (2016) systematic review synthesized existing literature on the impact of well-being on patient safety, burnout on patient safety, and both measures of burnout and well-being. Like Scheepers et al. (2015), their findings showed that well-being included various psychological distresses and was associated with patient safety. Providers with depression were more likely to perceive themselves as having near misses, and anxiety and stress were found to impact medical errors significantly. Burnout was also significantly associated with medical,

therapeutic, and diagnostic errors. The article highlights the link between a provider's well-being and patient safety and the various presentations of psychological distress.

Only one study (Brooks et al., 2013) focuses on the risk reduction of malpractice suits after being involved in a PHP. The findings indicated that malpractice costs were 111% higher before PHP monitoring than those of their comparable physician group. However, after implementing monitoring, these costs were reduced to 20% compared to the same matched cohort of physicians.

Seeking Help & Confidentiality

Despite the evidence of the criticality of physician mental health, there remains resistance to involvement in wellness programs and PHPs. Much of the reluctance concerns confidentiality, the potential impact on licensing, time constraints, and stigma (Kuhn & Flanagan, 2017). Due to its dual mission of physician health and consumer protection, there has been much debate and contention about confidentiality among PHPs. Regulatory agencies and state boards that review licensure have historically required physicians to disclose their health information (physical and mental) to assess the safety potential risk of practice, often confusing illness and impairment.

PHPs are often contracted by licensing boards to provide evaluations and monitor physicians. This relationship frequently alarms physicians and limits their willingness to seek help (Garelick, 2012). Many states have options for voluntary and confidential involvement; however, concerns remain regarding confidentiality, mandatory health disclosures, and the fear of adverse actions on physician licenses. More recently, the FSMB, at the encouragement and insistence of PHP leaders and other physician-health-focused organizations, has begun to amend licensing questions to decrease the stigma and confidentiality of physicians seeking treatment and support (Aruleba et al., 2022).

Moreover, physicians traditionally have difficulty transitioning roles from a doctor to a patient, creating an additional barrier to seeking, accepting, and engaging in treatment and support (Wristrand, 2017). Physicians often take to curbside consulting with peers or self-treating instead of seeking appropriate care and help. When they do seek help, if the provider is unfamiliar with working with high-functioning professionals, role confusion with the patient-physician can occur – with the patient-physician taking charge. Power dynamics of this nature can lead to undertreatment and deference to the patient-physician. Thus, this population is optimally treated by providers skilled in evaluating and treating healthcare professionals (Garelick, 2012). PHPs are well-suited to provide optimal recommendations and resources for physicians seeking support.

As an effort to address these barriers to seeking support and improving cultures that prioritize provider well-being, the AMA initiated the Joy in Medicine Health System Recognition Program to acknowledge those institutions taking action to combat burnout (AMA, 2024). This initiative draws attention to the role of systems in combatting the chronic and persistent state of physician health and well-being in the US and further underscores the importance of taking steps to create work environments that help physicians and other healthcare professionals find joy, meaning, purpose, and satisfaction in the demanding profession that is medicine. The core goals of the Joy in Medicine initiative are to promote a culture of well-being to reduce stigma and foster resilience; reduce administrative burdens, a pivotal component to organizational stress and burnout; support improved work-life balance as it relates to having adequate flexibility and autonomy in their schedules and sufficient coverage for providers to take time off; providing accessible mental health and support resources, and addressing systemic issues that actively contribute to burnout (e.g., staff shortages and inefficient and cumbersome

processes). PHPs fit nicely into this initiative as expert and accessible resources for systems and providers needing physical and mental health support.

Synthesis of the Literature

The body of literature presented provides compelling evidence that outlines the myriad of factors—both those that stem from individual circumstances and those that arise from organizational dynamics—that detrimentally influence the overall health and well-being of physicians who are practicing and those who are still in training. Employing the theoretical lens of SDT and JDCS, the profundity of these critical factors is accentuated. The imperatives of fostering internal motivation, nurturing a sense of autonomy, and providing interpersonal support are reflected in the literature, showing their buffering effect on high work demands.

A recurring theme in the literature is the influence of autonomy on well-being. Research repeatedly establishes that encouraging autonomous motivation can increase job satisfaction, lower burnout rates, and improve physicians' mental health. Research has also established the importance of organizational cultures and systemic processes that correspond with SDT components (Moller et al., 2019; Shanafelt, 2021).

The JDCS and JD-R models emphasize the importance of social support in the workplace. Research shows that supervisor support and positive colleague relationships can help reduce emotional exhaustion, especially in high-stress medical specialties like emergency medicine, and bolster resilience (Somville et al., 2020). Study findings by Halperin et al. (2021) and Shanafelt et al. (2022), however, reveal rising levels of anxiety, depression, and burnout, which suggests that current healthcare support structures might not be sufficient to handle the increasing work demands.

A fundamental deficiency reflected in the research is the lack of extensive studies on the effectiveness of PHPs outside of SUD as it relates to other mental health issues. Although past research has confirmed the effectiveness of the PHP model in treating SUDs, there is a noticeable lack of current literature in this area. Moreover, there is a gap in examining how PHPs can be adjusted to help physicians deal with stress syndromes and other mental health problems. There is a need for further research to examine how effective PHPs are in improving overall well-being and to explore strategies that address individual and systemic obstacles to proactive mental health support.

Research illustrates the stigma surrounding mental health in the medical field, which often prevents physicians from seeking the help they need. Many doctors hesitate to use PHPs or wellness resources because of concerns about confidentiality and negative professional consequences, such as licensing or credentialing challenges. This issue signals the need to address stigma directly with policy reforms and organizational shifts toward wellness-focused cultures that encourage physicians to tend to their needs without fear or shame. Future research should address gaps in the literature, particularly concerning the role of PHPs and the impact of organizational culture on physician mental health. This research seeks to contribute to this ongoing discussion by exploring these subjects further from the perspective of PHP leaders on the roles of PHPs.

Conceptual Framework

The conceptual framework of the study incorporates key tenants from each of the theories reviewed herein: 1) JD-C, the impact of the high mental workloads, and the psychological effects of levels of control within the workplace (Chênevertet al., 2021; Dreison et al., 2018), 2) JDCS, the influence of organizational supports in mitigating the impact of JD-C, and 3) SDT, the

intrinsic need for autonomy, competence, and relatedness and the effects of these on well-being (Koole et al., 2019). The JD-C model provides a vantage point from which to view the physician and their work environment, the prevalence of burnout, and other manifestations of psychological distress experienced by today's physicians and other healthcare providers, for which there is an abundant body of scholarly knowledge. Furthermore, expansions of the JD-C model to include JD-Resource and JD-Support models also provide a solid theoretical foundation for the study via their focus on resources and supports both on individual and organizational levels that help address, mitigate, and prevent organizational factors that implicate physician well-being and safety.

The tenets outlined within the JDCS are exceedingly relevant today in medicine, given the shifting landscapes of healthcare, which increasingly influence the demands of healthcare institutions and providers. As leadership navigates internal and external pressures (i.e., regulatory, economic, cultural, and political), they must identify resources and support to meet the needs of their providers. Because the JDCS theory incorporates factors that influence physical and psychological health and performance, it stands to reason that JDCS can provide fertile ground for exploring the well-being and safety of physicians in the context of their workplace. Additionally, JDCS provides a robust scaffolding for studying the role of PHPs in supporting physician well-being and medical institutions (i.e., healthcare organizations, training programs, and medical schools).

By addressing the core psychological needs of autonomy, competence, and relatedness outlined in SDT, PHPs can improve their impact on participants, considering these essential well-being factors. This can be done by offering services that empower physicians to make autonomous decisions regarding their care, providing opportunities for skill development and

connection. Thus, PHPs can contribute to the well-being of physicians. Integrating SDT principles guarantees that PHP interventions are empowering, encourage active participation, and support a dedication to their well-being practices.

The JDCS model, emphasizing the balance of job demands with control and support, provides PHPs with a valuable lens to address the organizational and environmental factors contributing to physician stress and burnout. This model encourages PHPs to advocate for workplace adjustments that ease overwhelming demands, increase physician autonomy, and strengthen support from administrative leaders and clinical supervisors. By weaving insights from JDCS into their program structures, PHPs can work closely with healthcare administrators to consult on potential changes within their unique workplace contexts.

Applying both the SDT and JDCS frameworks allows PHPs to extend their influence beyond individualized evaluation and monitoring to embrace broader organizational and systemic approaches that are well-known drivers of physician burnout. This strategy positions PHPs to adapt their services in response to the demands of physicians within an evolving industry. Embedding these models within their operational approach and services enhances the effectiveness and relevance of PHPs, playing a substantial part in creating healthcare settings that are supportive, empowering, and resilient.

Physician Health and Well-Being

The stakeholders in the medical community include state medical boards (regulatory agencies), medical societies and associations, hospitals, private practice, PHPs, physician health researchers, and all healthcare providers and consumers. As reviewed in the literature, the medical community's focus on physician well-being makes it paramount that research on the effectiveness and processes throughout state PHPs be studied. The surmounting stress and

statistics related to burnout and lingering and languished distress surrounding the COVID pandemic amplify this need.

The impacts of occupational stressors and their manifestations among the medical student, resident, and physician populations have undoubtedly begun to shift the culture of medicine and are influencing organizational change (Shanafelt & Noseworthy, 2017; Sharp & Burkart, 2017). These changes are evident in the emerging hospital (on-site) wellness programs (Rotenstein et al., 2021; Sinsky & Linzer, 2020) and medical stakeholder collaborations, such as through the National Academy of Medicine (NAM), towards physician well-being and clinician resilience (NAM, 2019, 2022).

The trend of services among PHPs and the effectiveness of PHP intervention outside of addictive disorders remains unstudied to the necessary degree of influence among regulatory agencies and hospital systems. PHP leaders have, however, worked toward communication and collaboration among these systems with some success. Research would further support these movements to increase the visibility and impact of PHPs in the medical community. Lastly, with detractors ready to criticize and diminish the role and function of PHP services, PHPs must validate their work through scholarly and rigorous inquiry, such as this study.

Research Opportunities

While there are wellness and well-being initiatives among hospitals across the US, PHPs are optimally positioned to add to the literature on physician health and well-being as it relates to evaluation, interventions, monitoring, and recommended interventions to physicians and their organizations to mitigate factors that lead to psychological distress, poor performance, and consequent risks to quality and safe patient care.

Wellness Programs

Research has yet to consistently show that wellness programs are an effective strategy as an interventional approach toward employee well-being (Jones et al., 2019; Petrie et al., 2022; Reif et al., 2020). Thus, the widespread eruptions of wellness-centered programs that have pulled financial resources from healthcare institutions have been a questionable response to burnout and psychological distress rates among physicians, primarily as established programs such as PHPs exist and stand ready to intervene and collaborate with their local communities. These programs are often costly and misguided as they relate to sustainable and preventative interventions when they are created without real-time feedback from the physician and other potential participants (Brooks et al., 2018; Mendelsohn, 2022). Additionally, changed organizational structures and cultures continue to exacerbate environmental conditions that contribute to increased psychological demands and distress for medical staff, thus requiring both individual and organizational-level interventions (Petrie et al., 2022).

Regulatory Support

State Boards and state regulators whose missions are geared toward consumer protection seem to take contradictory stances as it relates to funding and supporting PHPs in their efforts to support physician health, safety, and overall well-being, as evidenced by the dismantled PHP programs (Cox, 2020; Skipper, 2021), stances related to provider confidentiality (Washburn, 2021; Zilber, 2019) and perceived punitive approaches towards mental and behavioral health conditions and licensing which impact physician well-being (Sindhu & Adashi, 2022). However, through changes in regulatory agency shifts (FSMB, 2021) and efforts such as the Lorna Breen Health Care Provider Protection Act (2021), there is a movement toward awareness and progress towards the prioritization and acknowledgment of the criticality of physician health, well-being,

and supportive resources to this end. This movement calls for action and collaboration among the FSPHP, FSMB, individual PHPs, professional associations, and healthcare institutions to continue toward healthy, supported, and safe practitioners.

This said, PHPs and research funding have yet to benefit from the progress in the efforts noted above. This limitation of resources for PHPs stalls research that highlights and supports PHPs' mission to identify, support, and oversee physicians' health and safety (Brooks et al., 2019). Consequently, evidence-based interventions involving PHPs still need to grow, including crucial funding for more pressing interventions for struggling physicians and upstream approaches for early prevention services for early career physicians.

Contradictions in the Literature

Detractors against PHPs often highlight onerous and costly processes and focus on both sides of the argument as it relates to confidentiality, some pushing against the limited confidentiality and difficulty of access to confidential services. In contrast, others argue for limited confidentiality to provide more transparency toward healthcare consumers who purportedly *should* have access to all healthcare information on their providers (Sterman et al., 2022). Others argue against the processes and practices of PHPs, stating that they are unethical practices and processes (Lawson & Boyd, 2018a; Lawson & Boyd, 2018b; Miller, 2018).

Articles of this nature are often not based on scientific inquiry and are often ill-informed and misguided opinions and editorials based on individual circumstances or personal perspectives. While all concerns can be thoughtfully considered and may be founded on valid principles, physician and patient safety are best protected when physicians are well-supported and healthy; this is reflected in the literature. Without research, PHPs will continue to become

the target for detractors of PHP services that fuel misunderstandings and myths related to PHPs, further impacting the utilization of well-established and community PHPs.

Discussions circulate among PHPs regarding the scope and service across the various programs, each funded and structured with differences given the nature of fluctuations among the states' political, economic, and socio-cultural leanings. These may further how leaders view their role in addressing wellness instead of focusing on health and safety alone. Additionally, it supports the study in its efforts to understand leadership perspectives and attitudes around PHPs and the support of overall well-being. It also identifies potential variations and similarities in perspectives and approaches among the PHPs.

Identified Knowledge Gaps

In addition to the lack of research surrounding PHPs in the realm of wellness and well-being, identified knowledge gaps as they related to PHPs include an understanding of the benefits of PHP utilization overall b) Large-scale studies on PHP effectiveness throughout career span (i.e., PHP and medical student and or residents) c) Studies exploring service utilization by various referral sources, strategies and outcomes d) Comparisons studies between in-house wellness programs, external programming, and PHPs, and e) Expansion of previous studies on effectiveness, success rates, safety and malpractice risks in the PHP context. Addressing these gaps through research can significantly advance our understanding of PHPs and their role in supporting physician well-being. However, with underfunding as the Achilles heel of PHPs in demystifying the scope of their work, foundational explorations such as this qualitative study are pivotal in keeping momentum and progress towards PHPs and their mission toward health and safety.

Proposed Research

In the face of perpetual shifts and pressures of economic, political, environmental, and cultural nature, it is imperative that I/O practitioners continually assess the evolving needs of employees and organizations. I/O research provides organizations with evidence-based interventions and practices that help address or explain specific problems and work-related phenomena. I/O topics include employee wellness and well-being, organizational change and strategies, burnout, work-life integration, remote work, and other areas (Riggio, 2017; Stark, 2021). The limited research on PHPs, occupational health, and overall physician well-being from the PHP and PHP leaders' perspectives adds to the literature on I/O psychology, occupational health, and medical practice and administration.

As a review, the literature has been primarily focused on substance abuse monitoring and outcomes within PHPs. However, like traditional employee assistance programs (EAPs), PHPs often help with various presenting problems, support their medical communities, and have an underlying focus on public safety (Candilis, 2016; Carpenter et al., 2021). Physicians continue to need support, and researchers must expand the literature around PHP services, their role and function within the medical communities, and the collective experience of PHP leaders.

Critique of Previous Research Methods

The vast and existing body of research that delves into and examines physicians' well-being, mainly when analyzed through the comprehensive and multifaceted lenses of SDT and the JDCS model, presents a complex and intricate mix of notable strengths and significant weaknesses in various aspects of the research methodologies used.

Strengths

In research by Moller et al. (2020), the extensive sample sizes of 2247 and 2116 doctors improve the applicability of the results and enable subgroup examinations to show variations in wellness among different fields like surgery, pediatrics, and family medicine. This level of detail is important because it recognizes that the pressures and resources that doctors encounter can differ greatly depending on their particular specialties and work environments. Mixed-method studies can provide comprehensive and reliable results (Van der Goot et al., 2021). Moreover, studies investigating the motivational factors impacting physician engagement and burnout demonstrate the utilization of established theoretical concepts like SDT (Ryan & Deci, 2017). By situating their research within this theoretical framework, scholars can methodically examine how these sources of motivation interplay with job requirements and support structures.

Weaknesses

The Shanafelt et al. (2012) study examined burnout among physicians across various specialties, surveying over 7,000 physicians and providing a robust dataset on burnout prevalence and work-life balance. While it included multiple specialties, the focus was primarily on high-stress specialties such as internal medicine, primary care, and emergency medicine, possibly causing selection bias. The results may not apply to all doctors, so research involving a wider range of specialties is necessary to better understand physicians' well-being.

In their 2014 cross-sectional study, Dyrbye et al. examined the prevalence of burnout in medical students, residents, and early-career physicians and provided information on their challenges. The cross-sectional design restricted the ability to determine causality related to factors that lead to burnout. Additionally, reliance on self-reported measures in studies like

Dyrbye et al. (2014) introduces potential response biases, as participants may underreport burnout levels because of concerns about social desirability.

Impact on Argument and Addressing Opposing Views

The effectiveness of prior research supports the case that promoting autonomy and nurturing supportive work settings significantly benefits physician well-being. Large sample sizes and rigorous methodologies strengthen the assertion that organizational adjustments can help reduce burnout and boost job satisfaction. Many might argue, however, that focusing on individual motivations and autonomy only minimizes and distracts from the broader systemic contributors. For example, healthcare policies, administrative demands, and resource allocations, all of which impact physician well-being. This critique is valid, as numerous studies overlook how these more prominent systemic elements intersect with individual experiences. Biases and limitations in cross-sectional designs imply that although findings offer valuable insights, they may not fully grasp the complexities of physician well-being.

My research design tackles several limitations found in previous studies on physician well-being and the efficacy of PHPs. By utilizing a qualitative case study approach that includes interviews, artifact analysis, and diverse sampling across various PHPs, this study captures the intricacies of PHP leader experiences. It uses their collective wisdom to understand the factors that support and hinder PHPs. It steers clear of the sweeping generalizations that often stem from cross-sectional designs. Having diverse PHP participation also expands the generalizability of the study. Lastly, the potential bias inherent in self-reports is minimized by incorporating document review and triangulation, thereby increasing the reliability of the study.

Summary

Current studies provide valuable perspectives on the intricacies of physician health and well-being, yet they still need to fully capture its complexity, especially in the context of a PHP. In the future, longitudinal studies, a wider range of medical specialties, and a more thorough examination of PHPs within this context will be essential for understanding and improving physician health outcomes. The incorporation of frameworks like SDT and the JDCS allows exploration not only of personal motivations but also of the more prominent organizational influences on physician well-being. By exploring the specific functions of PHPs beyond that of substance disorders and taking into account stigma and confidentiality issues, this research aims to offer a deeper understanding of how these programs support physician well-being and identify areas for further exploration. I sought to explore the complexities of PHPs and their effectiveness as they relate to physician wellbeing, offering a new perspective through the collective wisdom of experts in the field, a vantage point that has remained unexplored in the literature.

CHAPTER 3. METHODOLOGY

As noted in the preceding chapters, PHPs serve the medical community through programming that monitors conditions that could pose a risk to quality patient care and safety. The Federation of State Medical Boards (FSMB) (2021a) notes that the PHPs' role is to support their local medical communities through preventative and interventive services. PHP's effectiveness in addressing addictive illnesses is well-established. Beyond addiction, physicians face a range of occupational hazards, including burnout and psychological distress (Andrew, 2022; Lebares et al., 2018; Lheureux et al., 2016; Wong, 2020). These issues carry significant implications for clinical practice and patient safety. However, literature on how the PHP models fare in other medical, psychiatric, cognitive, behavioral, or overall well-being contexts is scarce.

Previous PHP studies have focused mainly on quantitative inquiries of PHP effectiveness, specifically in addressing addictive illnesses. A qualitative, exploratory design is appropriate for this study, as it is among the first to explore PHP leaders' perspectives on physician well-being (Yin, 2018). The emphasis is on real-life context and developing a holistic understanding of PHPs and how they support physician well-being. Moreover, it is a starting point for future research on how PHPs address and respond to the well-studied factors perpetuating the high prevalence of psychological distress, suicide, and burnout among the physician population. While no previous case studies have examined the role and function of PHPs, qualitative studies on physician job satisfaction (Kase & Doolittle, 2023), burnout (Walsh et al., 2019), well-being (Weisbaum & Chadi, 2021), and help-seeking (Geuijen et al., 2022) provide relevant insights. This study fills a gap in the literature by exploring PHPs' impact on physician well-being.

Research Questions

The overarching research question for this study is: How do individuals in leadership roles among PHPs perceive the role and function of PHPs in supporting the well-being of physicians? These subquestions (SQ) support this qualitative study:

SQ1: How are key factors contributing to the success or limitations of PHPs in supporting physician well-being?

SQ2: How do PHPs evaluate and monitor the effectiveness of their programs in supporting physician health and well-being?

Research Design

Qualitative inquiry is a naturalist paradigm founded on philosophical assumptions that hold to the existence of more than one reality (ontology) (Kostere & Kostere, 2021; Percy et al., 2015). Thus, the qualitative researcher seeking to explore an experience or context must delve into the multiple realities (epistemology) among individuals within it to develop a deep and rich understanding (Yazan, 2015). Furthermore, compiling and synthesizing these individual observations through a rigorous and systematic process allows for broader interpretations and relevant, practical applications of the research findings (inductive). This study is value-laden in objectivity, integrity, and individual and organizational stewardship (axiology). The ontological, epistemological, and axiological underpinnings support the study's qualitative framework.

Qualitative research designs seek to derive meaning and understanding of the personal experience of humanity in day-to-day life and within specific phenomenological contexts in a nonexperimental research design. Nonexperimental designs are absent in manipulating variables and seek to observe, describe, and understand social phenomena in the natural world as they are (Yazan, 2015). Exploring individual perspectives (i.e., opinions, attitudes, and beliefs) associated

with unique contexts and experiences calls for a qualitative method, where knowledge is collected and understood via words rather than numbers (e.g., experimental or quasi-experimental designs fall under the quantitative methodological approaches) (Kostere & Kostere, 2021).

Qualitative Methodological Approaches

Under the umbrella of qualitative research, several frameworks are available to choose from, including phenomenological, grounded theory, case study, narrative, and ethnography methods (Patton, 2015; Percy et al., 2015). The methodological approach in a study provides support and guidance for specific types of investigations as they pertain to the purpose, methodology, data collection, analysis, and interpretation of findings (Collins & Stockton, 2018). The research design and method are selected based on the research question or questions.

Methodological Approach: Case Study

Researchers select the case study method when exploring, describing, or explaining an exceptional case with rich detail and depth to include all relevant contextual components (Yin, 2018). Context is a crucial factor for case studies and, therefore, requires the collection of data points from multiple sources. In contrast to quantitative and experimental designs, a case study is less concerned about statistical generalizations and looks to offer analytical generalizations toward established theories or theoretical postulations.

A single-case study can be a holistic or embedded design; holistic involves a single unit of analysis, while embedded involves multiple units of analysis (Yin, 2009). The design for this study involves more than one unit of analysis (e.g., interviews and artifacts). Multi-case studies allow for comparative analysis and enable the researcher to highlight the variations and the specific context within and across each unit of analysis in the study, with each case being

considered a bounded system to be studied independently (Bettie & Evans, 2021). Given the small population size and the need for detailed analysis, conducting both within-case and cross-case analyses presented significant risks to maintaining confidentiality. The sensitive nature of PHPs, along with the political dynamics involved, heightened the importance of protecting the identities and reputations of the participants. To address and minimize potential risks, a single case study with an embedded design was selected. This approach allows for thorough exploration while preserving participant anonymity, thus reducing the potential for any negative repercussions.

Case Study Justification

This exploratory case study aims to understand how leadership among PHPs perceives the role and function of PHPs in supporting the well-being of physicians. The subset questions go further in asking whether PHPs support physician well-being and how they evaluate their effectiveness in doing so. In studies involving research questions focused on answering the "how" of a particular contemporary phenomenon and with which one has little or no control, an exploratory case study is an acceptable design (Yazan, 2015; Yin, 2018). A researcher's chosen sources can determine the depth of a case or case study. In this case study, we examine PHPs through the subunits of leadership perspectives and artifacts. The depth of sources is significant for triangulation, allowing researchers to explore and validate findings while also providing a deep contextual understanding (Yin, 2018).

Contextual Depth

The case study approach creates richness and depth that are absent in other qualitative designs. The semi-structured interviews and the extensive review of documentation, observations, and researcher field notes allow for a deep exploration and interpretation of the

data (Yin, 2018). The documentation review for this study includes program-related documents and websites, the FSPHP, the FSMB, and other publicly archived data relating to the role and function of PHPs. This material highlights the varying contexts for each case (bounded system). Becoming familiar with, analyzing, and interpreting these artifacts, in addition to the interviews, provides an expanded and collective comprehension of perspectives through the triangulation of multiple data sources (Yazan, 2015; Yin, 2018). The varied data sources provide additional context that can support or contradict the interview responses and offer supporting evidence to interpretations and findings made in the case study, increasing the study's validity. Including leader perspectives and contextual factors helps researchers speak to literal or theoretical replications.

Sampling

In case-study designs, the selection of cases is purposive and focused on replication rather than sampling logic (Yin, 2018). While replication logic is typically tied to multiple case study designs, using the replication logic is still relevant in a single case study with embedded designs. Replication logic was applied within this study subunits (of analysis) being used. Each of the 8 PHPs in the study acts as a subunit within the larger single case. Although the study examines PHPs collectively as one case, each PHP (represented by an interview with a PHP leader) is treated as a distinct subunit. The replication logic comes into play as each interview is analyzed, looking for consistent patterns, themes, or outcomes across all eight PHPs. Identifying similar themes or issues emerging across multiple PHPs adds consistency, strengthening the validity of the study findings under literal replication. Theoretical replication can be found where variances are observed and explained by different contextual factors, which can elucidate and

refine our overall insights into how PHPs operate or could operate within the context of physician well-being.

Procedures

The selection of PHPs considered geographical location, organizational structure (size, funding, state contracts), program services (populations served), and participant confidentiality. Given the differences among PHPs from state to state, programs were chosen to highlight those that can support physician well-being and those that are limited. Including both ends of the spectrum allows the researcher to generate rival explanations and interpretations when analyzing collected data from theoretical perspectives.

To avoid problems with replication, I remained focused on answering the study research questions. This study's overall purpose is to understand how PHP leaders perceive the role and function of PHPs in supporting physician well-being and explore how PHPs support physician well-being. The study examined the extent to which PHPs support physician well-being through the perspectives of PHP leaders, identified specific limitations and obstacles for PHPs in supporting physician well-being, and explored any successful programming or collaborations supporting PHPs in supporting physician well-being.

Participant Selection

PHPs were invited to participate in the study after consultation with the FSPHP Research Committee and the FSPHP Executive Director. Invitations to participate were sent via emails to state PHPs registered with the FSPHP. With the variations among PHP sizes and structure, various leadership position titles were included as potential interviewees: Executive Director, Medical Director, Associate Medical Director, Clinical Director, and Program Manager. PHP

leaders oversee the clinical and often administrative processes within the PHP and thus can provide valuable information for the study.

Eligibility for the PHP depended on whether the PHP had a leader who met the following criteria: currently, hold a leadership position within a U.S.-based PHP, have a minimum of five consecutive years of leadership experience within a PHP, and be actively involved in policy development, program implementation, or decision-making related to the PHP's day-to-day operations.

The PHP Leader, and subsequently the PHP, was excluded if the PHP Leader had any vested interest in the outcomes of this study, such as involvement in legal disputes related to PHPs or financial ties to specific treatments or other interventions, had transitioned into or out of PHP leadership roles within the last 12 months, or was unable, if available, to provide comprehensive programmatic documentation for their PHP, including (but not limited to) operational procedures, policy manuals, program, protocols, or annual reports. The goal number of interviews was eight (Yin, 2018).

Selection Process

The FSPHP provided the initial recruitment notification to its membership of the opportunity to participate in this PHP study through the FSPHP list-serve (an internal method of cross-communication between various members or sub-groups within an entity through email). Direct email invitations to PHP leaders and program administrators followed the initial notification. Like the initial recruitment notification by the FSPHP, the follow-up and direct invitation to participate introduced the research, the purpose of the study, eligibility criteria, and the voluntary nature of participation.

Upon response from the invited potential participants, I conducted a screening process to ensure that the inclusion criteria were met and did not fall under the exclusion criteria. A brief pre-screening email was sent to those with interest to confirm their eligibility and provision of the consent form. The participant was assigned a unique identifier and entered in a database upon receipt of the eligibility attestation and consent of information. The consent form explained the research purpose, methodology, potential risks and benefits, confidentiality measures, and their rights as participants in this voluntary study (Creswell & Poth, 2016). With both eligibility forms and consent forms completed, a 90-minute semi-structured interview was arranged.

Theoretical Saturation

Replication logic reflects literal replication among cases or subunits given a particular set of contexts (Yin, 2018). In some studies, researchers may anticipate contrasting findings among cases supporting their selected theoretical frameworks and propositions, underscoring the importance of case selection based on sample characteristics (Wan & Xia, 2023). A researcher employing a case-study approach must be flexible, open to its iterative process, and transparent about the purpose or propositions to guide specific inquiries and information collected.

Given the variations among PHPs and anticipated obstacles to PHP participation (i.e., understaffing or lack of time), the recruitment was an ongoing effort until perceived saturation or a minimum of eight PHP/PHP leaders were selected, as required by academic institutional parameters. I set out to have at minimum three distinct geographic locations (East et al.) as well as variability in sizes (small to large number of participants), structure (state to privately funded), and scope of programming within the PHP (populations and presenting problems served). This diversity allows for exploring potential regional differences (or similarities) that may influence leadership perspectives, program structures, services, stakeholder involvement, and overall

utilization. Additionally, the diversity among PHPs and their regions could illuminate how funding, policies, and political environments support or hinder program outcomes.

With PHPs focused on two primary missions, physician health, and patient safety, it was presupposed that additional interviews and PHP documentation would yield redundancies among the content collected, reaching theoretical saturation. As results reflect, many themes were repeating across leaders with identified variances in PHPs.

Data Collection

After carefully reviewing the purpose of the study, informed consent matters, and any questions or concerns of each participant, a 90-minute semi-structured interview was scheduled for each participant via virtual video conference in a private area, free from interruption. I obtained permission to record video sessions for transcriptions and reviews. Before each interview, I provided a brief overview of the informed consent and allotted time for any additional questions or concerns to be discussed.

After transcription and initial researcher review, the respondent received a copy to review to ensure that the information accurately reflected what they wanted to convey. Additionally, I captured nonverbal cues and observations throughout the interview and documented these in field notes (Yin, 2018). The data was stored under the corresponding deidentified case file.

In alignment with the case study approach, the artifacts reviewed alongside the semi-structured interviews included program guidelines, annual reports, FSPHP and FSMB conference agendas, and other publicly available data relevant to the role and function of PHPs. For additional context, documents related to physician well-being initiatives at the national and state levels were also reviewed. These materials included mission statements, program brochures, annual activity summaries, newsletters, clinical guidelines, and promotional literature. Together,

these publicly available artifacts provided a deeper understanding of PHP structures, operations, and impacts, enriching the qualitative analysis.

These artifacts provide insight into the PHPs' structures, operations, and impacts, enriching the qualitative analysis. To ensure a comprehensive triangulation of data, the artifacts were categorized into five groups: scholarly/policy reports, government/regulatory reports, non-profit/advocacy reports, organizational statements/position papers, and policy documents. These categories were used to cross-check and validate the data collected through participant interviews, enhancing the reliability and depth of the findings.

Participant Protection

Security and confidentiality procedures were implemented throughout the data collection process. Interviews were conducted using an encrypted digital recording application through Zoom. The consent process was not recorded to maintain privacy. Upon completion of the interviews, the audio files were promptly transferred to the encrypted USB drive. After confirming that the audio files from Zoom were on the encrypted USB, the Zoom audio recordings were immediately deleted. Data was analyzed and synthesized using NVivo Qualitative Software, which offers robust encryption and data protection features suitable for sensitive research data. All data sets are saved locally on a designated encrypted USB and accessed as needed for data analysis through the desktop NVIVO application.

File naming and anonymization were attended to through uniquely assigned identifiers. Participants were not asked to state their names or other identifiable information during the interviews, and any mentions of third-party names were redacted in transcripts. No printed materials were used, and all documents were completed via electronic means. The encrypted USB drive is the central repository for all forms, transcriptions, and other collected documents.

After the mandated retention period of seven years, the destruction of all private and confidential data used in this study will be destroyed.

Instrument

The development of the semi-structured interview focused on questions that explore the perceptions, experiences, and beliefs of PHP leaders regarding the role and function of PHPs in supporting physician well-being. The interview questions were generated to answer the research questions for the study and were formed using my previous experience and knowledge of PHPs (documented in field notes). Questions were separated into seven categories: Introduction and Demographics, Functions of PHP, Physician Well-being, Role of the PHP in Supporting Well-being, Evaluation and Monitoring of Physician Health, Utilization of PHPs, and Stakeholder Collaboration. While the interview is semi-structured with categories, I remained open to emerging themes and patterns within the data (Braun & Clarke, 2021; Kostere & Kostere, 2021; Percy et al., 2015; Yin, 2018).

Guiding Interview Questions

Introduction & Demographics

1. How many years have you been actively involved with a physician health program, and what has been your role during this time?
2. What inspired you to pursue a career in physician health and well-being? Can you elaborate on the factors that motivated you to work in this field?
3. Please describe your current position and your primary responsibilities within the physician health program.
4. What are your professional qualifications, and how do they align with your role in the physician health program? Please detail any specific areas of expertise you possess.

5. Please provide an overview of the physician health program you are affiliated with, including its size and the range of services offered.

The function of PHPs

6. In your view, what is the overall purpose and mission of a physician health program?
7. How would you describe the primary functions of PHPs in supporting the well-being of physicians?
8. What specific activities or services offered by PHPs contribute to physician well-being?

Physician Well-being

9. How do you define or understand physician well-being?
10. Based on your experience and observations, what are the key contributing and limiting factors to the well-being of physicians?
11. From your perspective, what strategies or approaches can help mitigate the factors that negatively impact physician well-being?
12. What are the implications of physician well-being on patient care?

Role of PHPs in Supporting Physician Well-being

13. Based on your experience, what specific role do PHPs play in supporting the well-being of physicians?
14. Please describe any unique aspects or features of PHPs that make them effective in addressing physician well-being concerns.
15. What are the challenges or limitations faced by PHPs in supporting physician well-being?

Evaluation and Monitoring of Physician Health

16. How do PHPs evaluate and monitor the effectiveness of their programs and interventions in supporting physician health and well-being?
17. What specific approaches or methods do PHPs use to assess the impact of their initiatives on the well-being of physicians?

Utilization of PHPs

18. How do physicians typically become aware of and engage with PHPs?
19. What factors influence the utilization of PHP services by physicians?
20. Please describe the barriers and facilitators to physician engagement with the PHP.

Stakeholder Collaboration

21. How do PHPs collaborate with other stakeholders to support physician well-being?
22. What systemic changes or interventions are necessary to promote physician well-being?
23. Please share example/s of successes in collaborations between PHPs and other organizations to promote physician well-being.?

Closing

24. What, if anything, would you like to add that we haven't discussed?

Data Analysis

Thematic Analysis (TA) was used to analyze the data collected in this qualitative design. The rationale underlying the utilization of TA is that I was not only seeking an exploration of PHP leadership perceptions but aimed to have actional outcomes with clear implications and intentions, with the development of 'thematic statements' (Braun & Clarke, 2021). There are several ways to conduct TA: inductively, theoretically, and in constant comparison (Percy et al.,

2015). This study included a theoretical approach involving some predetermined themes based on research questions, my experience among PHPs, and the existing literature on PHPs and physician well-being. I sought to understand PHP leaders' perceptions about the role and function of PHPs in supporting physician well-being. I thus remained open to identifying additional themes and categories that arise.

While having predetermined categories, the TA approach for the data analysis was reflexive thematic analysis, which is used in inductive and theory-framed TA. The study utilized Braun and Clarke (2006; 2021) prescribed six-step process for TA: 1) familiarization of the dataset, 2) coding, 3) generating initial themes, 4) developing and reviewing themes, 5) refining, defining, and naming themes, and 6) report production. While familiarizing the data set, annotations were made with any insights, patterns, or frequency of statements or words within each case (Yin, 2018). These were then coded, representing specific ideas, topics, or concepts. These codes were conscientiously entered into an electronic codebook to address coding reliability during data review (Appendix A - Codebook). The codebook housed the justifications for decisions made for coding and developing themes (major and sub-themes). NVivo, qualitative data software, was used to organize, review, and synthesize data, enhancing the study's trustworthiness and rigor (Dhakal, 2022; Mattimoe et al., 2021).

Ethical Considerations

Ethical considerations of informed consent, minimization of any risk to participation, and anonymity as it pertains to privacy and confidentiality are of the utmost importance as enforced by the Institutional Review Boards (IRB) and outlined throughout the *Belmont Report* (National Commission, 1979). Patton (2015) underscores that the scientific rigor underpinning a particular

design does not alone secure validity and credibility; this requires scientific and rigorous thinking throughout a research study – from its inception to its publication.

Informed Consent

At the inception of the selection process, after approvals had been received by the IRB and consultations with FSPHP leadership and research committee were completed, recruitment notice and invitations to the PHPs were sent as previously described. The invitation to participate included the informed consent information reviewing the purpose of the study, the expected time involved with participation in the interview, a notice of voluntary involvement and their ability to withdraw from the study at any time, potential risks and benefits of the study, and procedures that will outline confidentiality and privacy of data collected (Manti & Licari, 2018). This information was re-reviewed directly at the beginning of the scheduled interviews.

Data Security

To maintain the integrity of the research data, all collected information was safely stored in a password-protected, encrypted USB drive. All printed documents were scanned into the encrypted drive and then destroyed. Identifying information was deleted from data sets to maintain confidentiality, and participants were assigned unique codes to protect their responses. The data will be electronically secured and stored for the required seven-year timeframe after the study concludes, then permanently erased. The Capella University IRB reviewed and approved the research, endorsing that the study complies with ethical and legal requirements for data security and participant confidentiality. The approved protocols were adhered to throughout the study.

Researcher Role

When data collection includes interviews, as do most qualitative designs, the researcher can pose an ethical risk. Absent the researcher's understanding of their biases and assumptions, there can be unanticipated influences on how data is collected, interpreted, and subsequently reported (Patton, 2015; Walker, 2007). Thus, the researcher needs to engage in a self-reflective process through reflective journaling and field note annotations.

A lack of researcher self-awareness can adversely influence a study's integrity. In alignment with reflexive thematic analysis, it is necessary that the researcher reflect, document, and seek proper guidance from mentors, colleagues, and dissertation committee members (Braun & Clarke, 2021). An awareness of personal biases, assumptions, and potential influences is integral. In this study, these were carefully considered and are further discussed in the subsequent chapter.

Reflexivity contributes to the transparency necessary for enhancing a study's reliability, validity, and trustworthiness (Braun & Clarke, 2021; Elo et al., 2014).
In reflexive TA, the researcher's subjective experiences play a central role in data analysis and are used as a tool. This, along with data triangulation, adds to the robustness of study conclusions (Stake, 2006; Yazan, 2015; Yin, 2018). The analysis and reporting of findings are supported by the inclusion of rich descriptors of perspectives (i.e., quotes) and the use of relevant and supporting evidence (i.e., artifacts), strengthening the validity and transferability of the study.

Potential Conflicts of Interest

The case study PHPs and interviewees were recruited from PHPs registered with the FSPHP, of which I have been an associate since 2016. From 2016 to 2022, I co-chaired the Medical Student and Residents Committee. Additionally, serving as Director of Clinical Services

for a well-established PHP facilitated ongoing interactions with PHP program leaders and staff and involvement with the FSPHP. However, no personal relationships existed among any of the selected PHPs besides professional acquaintances working in the physician health field. No foreseeable undue influences were anticipated outside the potential for pressure to participate. Considering potential pressure to participate, the consent form and invitation (to participate in the study) highlighted the following: "Please know that your participation is entirely voluntary, and you have the complete freedom to decide whether to engage. We want to reassure you that regardless of your choice, it will not affect any prior professional relationships. Your decision will be met with the utmost respect and understanding." The FSPHP Executive Director, FSPHP Research Committee, and assigned research mentor were available for ethical questions, consultations, and considerations that arose throughout the research project.

Minimizing Bias

To reduce bias, I held my professional background and role as a researcher at the forefront of the study process in an effort to prevent unintended influence on participants. I aimed to adopt an objective stance during the interviews and was careful to avoid leading questions. In addition to maintaining a neutral stance during interviews, the data collection procedures involved using transcription services and member checking to validate the data. Member checking involves sharing interview transcripts with participants, allowing them to confirm, correct, or elaborate on the information provided. Member checking is vital in ensuring the data's accuracy, reliability, or trustworthiness (Braun & Clarke, 2021).

To ensure the integrity of the data analysis and its interpretation, I used data triangulation, which uses multiple data sources to corroborate findings (Yin, 2018). Triangulation includes comparing interview data with document analysis. Additionally, where needed, I reflectively

journaled and added field note annotations throughout the research process. I journaled my preliminary thoughts and feelings during and after the interviews. This exercise helped me maintain an awareness of potential biases and judgments stemming from my professional and personal experiences within the PHP, mental health, and medical fields. Carefully adhering to established protocols for data collection and analysis further assisted in limiting these influences.

Additionally, the use of blinded reviews, a process where identifying information is removed from the data before analysis, helped guard against biases stemming from assumptions related to specific participants or their PHPs. These strategies allowed me to address potential conflicts of interest in a structured and thoughtful manner, thereby upholding the integrity of the research and ensuring that the findings accurately reflect the perspectives and experiences of PHP leaders.

Interpretations & Reporting

Ethical considerations must extend to the implications of interpretation and reporting. As the scientific community continues the discourse on the rigor and credibility of qualitative data, methods of analysis and interpretations must be well-articulated in the study. Software applications like those used in quantitative methods can help researchers bolster their interpretations through transparent, organized, and systematic processes. These systems aid in the analysis and enhance the replicability of qualitative studies (Allsop et al., 2022).

Reporting findings and implications can be a landmine of potential ethical implications for stakeholders (i.e., physicians, healthcare institutions, and regulatory agencies). If precautions are not taken to de-identify specific locations, case study descriptions, or specific leader perspectives, problems could arise for the PHP, especially around criticisms or negative attitudes related to local stakeholders. This is particularly true as it relates to the state regulatory agency,

which is the primary funding source for most PHPs. Moreover, if findings suggest a PHP cannot or does not support physician well-being, it may add to resistance or reluctance for referral sources and physician voluntary referrals. Thus, data was properly and cautiously deidentified. Understanding and exploring ethical considerations are a part of scientific rigor and can have severe implications for the research process and outcomes. Given the sensitive nature of PHPs, these were carefully considered**.**

Summary

As noted, the qualitative and case study design is a well-fitted approach to exploring the research questions and requires efforts to do so with scientific merit. Yin (2018) highlights four critical aspects of rigorous case study analysis, including the exhaustive review of the evidence (i.e., artifacts and interviews) and how they individually and collectively played a role in the interpretations—secondly, considering, explaining, and reporting any potential competing interpretations, as reviewed in the following chapter and five. Third, a well-established analytical process provided guidance and direction, limiting derailment from the research questions, as outlined in the data analysis portion of this chapter. Last, the researcher must demonstrate expertise in the subject matter and its analysis, explored above and in subsequent chapters.

CHAPTER 4. RESULTS

Chapter four examines the findings of this qualitative case study, which aimed to explore the role of physician health programs (PHP) in supporting the well-being of physicians through the perspective of PHP leadership. The thematic analysis revealed several significant themes highlighting the barriers and facilitators for PHPs in supporting physician well-being. The analysis also reviews the efforts and limitations of PHP program evaluation.

The chapter begins with a critical review of my background and potential influences on the study. The contextual review provides insights into the derived themes and overall results. The chapter proceeds to discuss the analytic framework outlined in the preceding chapter, which facilitated the identification of codes, data organization, and thematic findings. A brief non-identifying overview of the PHPs from which the interviewed leaders were employed or contracted is also provided under the case and participating leader descriptions. The data is presented by emergent themes, with an emphasis on the use of supportive data drawn from participant quotes and relevant, publicly available artifacts. The chapter concludes with a summary of the thematic results.

The Study and the Researcher

Acknowledging my potential impact as a researcher is essential in enhancing transparency, researcher reflexivity, reducing bias, and strengthening the study's validity. The rigor of a study increases trustworthiness and study replication. This is particularly important in qualitative studies, where the researcher has direct knowledge and experience in the field of study and is the primary investigator. Under these circumstances, complete objectivity is unlikely, given that, with qualitative inquiry, a fundamental theoretical assumption is the acknowledgment and acceptance of subjectivity and the role of the researcher. However, through

journaling, mentor consultations, data triangulation, and member-checking, I was committed to amplifying the integrity of the scientific inquiry toward an ethical, credible, and valuable contribution to the literature.

PHP Context

PHPs were established in the mid-1980s consequent to the revelation that physicians are equally and at times increasingly susceptible to illness, whether medical or psychiatric. At that time, substance use disorders were often perceived as egregious and stigmatized moral failings requiring disciplinary action that made it difficult for physicians to seek help, support, and rehabilitation. In response to perceived punitive approaches, medical stakeholders worked toward alternative paths to discipline to encourage physicians to obtain treatment and return to practice with assured safety via PHP monitoring and support. With a focus on developing evidence-based practices for PHP models and research supporting recovery rates among the physicians monitored by PHPs, they became an established fixture and resource for medical professionals struggling with substance use disorders.

Over time, however, as discussed in the literature review, evidence continues to grow on the prevalence of psychological manifestations outside of substance disorders, consequent to the shifting, growing, and competing demands on physicians. Moreover, medical cultures have been slow to change from perpetuating self-sacrifice for profitable productivity over self-care and safety-in-service provision perspectives. These organizational prioritizations have too often led to tragic outcomes where physicians become trapped by stigma and historically unresponsive and punitive systems, a phenomenon I have witnessed and worked to combat throughout my work with physicians and healthcare systems.

Researcher Interest

A movement, however, toward physician health and well-being took hold consequent to the prevalence of physician burnout, a dwindling workforce, growing evidence of the implications of illness and impairment on patient safety, and rates of physician deaths by suicide within the last ten to fifteen years, a harsh reality confronting PHP staff and leadership day-to-day. Coincidently, the surmounting evidence of these problems has encompassed and expanded my career in physician health. Explicitly, within the last four years, the unprecedented COVID-19 pandemic additionally underscored the psychological and physical occupational hazards for physicians, leading to concerted organizational efforts to support the health and well-being of physicians. The movement toward physician health and well-being has been a topic of national discourse, contributing to shifts in licensing questions across the United States.

I have directly observed the movements and systemic shifts described and have actively contributed to my medical community by initiating proactive approaches. I have also fuelled the discourse of the imperativeness of addressing well-being as a cornerstone of quality care and educated on the cultural adjustments required to sustain a healthier, engaged medical workforce. I remain hopeful about the future of physician health through the evolving awareness of medical stakeholders surrounding the need for cultural and systemic changes.

Given the history of PHPs and their mission toward physician health and public safety, as well as the evidenced-based literature supporting the link between well-being, quality care, and safety, I was inspired to explore whether PHPs could, or do, support physician well-being and, if so, how. Traditionally, PHPs have taken a reactive medical model, where individuals self-refer or are referred only after a problem has occurred. A proactive approach would be optimal to support physician well-being and combat adverse outcomes for the physician and their patients.

As a starting point, to explore the viability of PHPs in supporting physician well-being proactively, I sought to explore the perception of PHP leaders.

Researcher Influence

The interest and passion behind this study are the culmination of my personal and professional background and academic pursuits toward a more proactive and healthier physician workforce. Moreover, I believe PHPs are an excellent source of expertise, knowledge, and structure capable of providing the proactive support needed at individual and systemic levels. Motivations underlying my specific topic and inquiry were further supported by the paucity of research that speaks primarily to PHPs within the context of monitoring substance-related disorders and only peripherally discusses the roles and functions of PHPs within the context of overall well-being. Through my academic education and proficiency in qualitative research, my motivation to investigate the viewpoints of PHP leaders is genuine and in alignment with my academic and professional goals, providing me with the direction, skills, and insights required to make a meaningful contribution to physician health literature.

Notably, throughout my career, I have been associated with the Federation of Physician Health Programs (FSPHP) and have networked and presented on various topics over the last ten years. My familiarity with PHPs and other PHP leaders was considered a strength and potential limitation, and my considerations are discussed below.

Research Preparation

I was keenly aware of the potential implications of participating in a study that openly discusses and explores the topic of well-being among physicians, a topic that not all agree falls within the purview of PHPs. While agreeance on the two-fold mission of physician health and patient safety is straightforward and foundational to PHPs, the field of well-being, wellness, and

prevention has not been the focal point for most programs for various reasons, as discussed in subsequent portions of this chapter. Furthermore, an even more profound awareness of the sensitive nature of regulatory and other stakeholder relationships was ever-present throughout the research design and implementation of recruitment, data collection, analysis, and reporting. These relationships are sometimes tenuous and, at worst, adversarial because of the fiduciary connections and misaligned or misperceived perspectives between them. PHP leaders understand the criticality of their relationships and cannot afford to inadvertently implicate their support or funding due to misinterpreted responses or poorly reported study findings.

Recruitment

In addition to the considerations noted above, given my knowledge of PHP leaders' workload and time limitations, hesitations to participate were expected during recruitment. Recruitment was from January 2024 through June 2024, and eligibility and exclusion criteria adjustments were required because potential participants were concerned with providing internal documentation. With IRB review and approval, amendments were made to remove the internal documentation as a required portion of the study, and instead, publically available documentation was reviewed. In conjunction with study mentorship from the Research Committee and Mentor, subject-matter-experts within the FSPHP were consulted regarding study design and recruitment. The FSPHP endorsement of the study provided reassurance that the study had been amply vetted. PHP-related research can have a reverberating impact on PHPs, PHP participants, the medical community, and patients. Thus, the endorsement was an essential and invaluable part of the study.

Data Collection

Data collection was done with the utmost consideration given to study participants and their corresponding PHPs. As a result of my familiarity with the topic of study and expertise within the field, the semi-structured interview was crafted to fully grasp the intricacies of the work within PHPs and their perspectives relating to the study research questions surrounding supporting well-being. With experience as a PHP leader, I conducted interviews with empathy and resonance for their shared experiences. There was a conscientiousness throughout interactions during the interview of potential impositions of my beliefs and expectations, with efforts made not to lead or to lack critical follow-up questions due to over-familiarity. My background lent itself to a deeper understanding of study participant experiences, creating a more comfortable, safe, and meaningful dialogue. Furthermore, I had understanding in moments of reluctance or reactions to specific questions that could potentially have been frustrating or discouraging to someone without adequate contextual understanding.

Data Analysis & Interpretation

Solid contextual awareness improves recognition of pertinent codes, data patterns, and subtleties that a more novice or unacquainted researcher might overlook or disregard. That said, knowledge and expertise in a field can sometimes jeopardize research integrity and credibility, particularly if analysis and interpretation lack adequate structure and critical review. For this reason, mentorship and a consistently reflexive approach were essential elements for me throughout this process. The reflexivity, as applied to my role in the study, created space for me to question my experiences, understandings, and perspectives throughout all stages of the research and prompted me to consult and debrief as needed with peers, subject-matter-experts, and my mentor as appropriate, and always within the confines of participant confidentiality.

Research Methodology Applied to the Data Analysis

Reflexive Thematic Analysis (RTA) encompasses the data collected, the theoretical assumptions of qualitative analysis, and the researcher (Byrne, 2022). RTA fits well with the naturalist paradigm of qualitative research. It is further complemented by applying constructivism and interpretivism lenses throughout the data analysis process. This facilitated my understanding of the individual's experience and perspective (constructivism) alongside the meanings ascribed within their unique and shared social contexts (interpretivism).

Coding and Theme Identification

A systematic and iterative process through Thematic Analysis was applied to identify codes and themes. The coding involved carefully reviewing each transcribed interview line by line and identifying significant and relevant statements. I used an interpretive approach to coding, where I reflected upon the statement, exploring the perspective and feeling behind it and how it fits into answering the research questions.

The research questions organized the codes, and if the statement did not directly address the research question, the line was coded and separated for further exploration. This process allowed for concise and direct results. The codes were refined by pairing and condensing them into broader categories and subthemes that later became themes under the corresponding research question. All emerged themes are presented in Table 1, broken down by factor type, and a description of themes is provided.

Table 1

Emerged Themes by Factor-Type and Descriptions

Factor Type	Theme	Description
Success	Theme 1. Accessible Expertise	This theme centers around the availability and specialized knowledge offered by PHPs. PHP leaders have acquired personal and professional expertise through years of experience, specific to physicians and other safe-sensitive professionals.
	Theme 2. Education & Outreach	This theme emphasizes the concerted efforts among PHPs to provide education on physician health and safety-related topics at various phases of an individual's medical career, including academic and graduate medical education levels (i.e., students and trainees) and mid-to-late career providers. These efforts are focused on expanding awareness of PHP services, the importance of self-care and help-seeking, and improving utilization.
	Theme 3. Confidentiality	This theme highlights the importance of a confidential track of involvement, which is made possible through regulatory support and or unique PHP structures that protect the confidentiality of its participants. These were perceived as crucial to the health and overall well-being of physicians seeking support and the utilization of PHP services.
	Theme 4. Individual & Organizational Supports	This theme reflects the comprehensive approaches PHPs take to supporting participants and referring organizations by developing and maintaining relationships that enhance trust and reassurance.
	Theme 5. Stakeholder Collaborations	This theme speaks to the perceived necessity of stakeholder support. PHPs depend on stakeholder collaborations to generate and sustain momentum in awareness and action toward organized efforts in physician health, safety, and well-being at community, state, and national levels.
Limiting	Theme 1. Limited Scope	This theme reflected a limitation in supporting overall physician well-being. PHPs face challenges driven by limiting statutes that restrict voluntary involvement and emphasize diagnosis over prevention, often leading to reactive rather than proactive approaches.
	Theme 2. Funding & Staffing	This theme underscored the variations among program structures and the pervasively perceived inadequate funding among PHPs, leading to understaffing and overstretched leadership burdened by multiple roles.
	Theme 3. Organizational Components	This theme represented the perceived systemic factors that hinder PHPs in effectively supporting physician health and well-being, often delaying interventions, contributing to stigma, and discouraging help-seeking among providers.
	Theme 4. Individual Components	Individual characteristics and factors that adversely impact help-seeking behaviors among the physician population.
	Theme 5. Underutilization	Various factors adversely impact the utilization of PHPs despite efforts to educate and increase awareness throughout the states; stigma and misinformation are two main contributors.

Description of the Case and PHP Leaders

The focus of this study is the collective entity of PHPs as a singular unified case rather than isolating each program as a distinct case. The PHP leadership perspectives span different US regions, including Northern, Southern, Eastern, Western, and Central states. The study employs an embedded case design, with the perspectives of its PHP leader functioning as a unit of analysis within the larger case context of PHPs. While each PHP site has distinct characteristics, the overall operational contexts among PHPs provide a shared conceptualization of the role and function of PHPs, as outlined and described in policies and public statements from medical associations, societies, and governing bodies. Structures and services do, however, vary mainly in part due to state-dependent contracts and program structures. PHPs thus lend themselves to exploration, given their differences yet aligned mission objectives of provider health and safety, especially as the topics of physician health and well-being continue to permeate and take a focal point within the medical field, as reviewed in the literature review of this study.

The primary data was collected through PHP leaders' semi-structured interviews in conjunction with documents and other supporting artifacts. PHPs were selected by the voluntary participation of PHP leaders recruited through the FSPHP member registry. Given the smaller overall population of PHPs, with less than 50 PHPs in the US, specific details about the PHPs or leaders are not disclosed to protect the confidentiality and anonymity of those who participated in the study. The perspectives of PHP leaders illustrate the current role and functioning of PHPs in supporting physician well-being, which serves to explore the overarching research question.

PHP Leaders

All participants were in active leadership positions within a US-based physician PHP, had at least five consecutive years of leadership experience within a PHP, and were actively involved in policy and program development, implementation, and day-to-day operational decision-making. Each leader reviewed the eligibility and exclusion criteria and the consent form provided. Both the eligibility and consent forms were required before the interview, and space was allotted for questions and discussions both prior to the scheduling of the interview and before the beginning of the interview. Participant leaders were identified as Participants 1 – 8 (P1 – P8) and are referred to as such throughout the remainder of the study, with each participant representing their viewpoints within their corresponding PHP context.

PHPs varied in size, with four falling under an average of 100 active participants and four above. All PHPs represented within this study addressed issues outside of substance use disorder, including medical and psychiatric diagnoses. There were variances among organizational structures, services provided, and populations served. The average PHP leadership experience of the participating leaders was 18 years. All leaders had advanced educational qualifications, some with additional certifications, training, and relevant work experience prior to their PHP leadership positions.

Artifacts & Triangulation

Where available, I reviewed artifacts, including annual reports, FSPHP state program information, the PHP website, program brochures, state-specific news, and other publicly available PHP-related articles and documents. *Artifacts* refer to a range of external materials, including scholarly reports, government/regulatory documents, policy guidelines, and organizational position papers. These artifacts were systematically classified into five categories:

scholarly/policy reports, government/regulatory reports, non-profit/advocacy reports, organizational statements/position papers, and policy documents.

This classification ensured the reliability and validity of the findings by triangulating participant data with credible external sources. The systematic cross-checking of these artifacts with leader interviews provided additional contextual understanding of the participating leaders and enhanced the overall rigor of the study.

Presentation of Data and Analyses

The thematic analysis results are presented by theme under their corresponding research question. The overarching research question for this study is: How do individuals in leadership roles among PHPs perceive the role and function of PHPs in supporting the well-being of physicians? I sought to explore this question with two specific subset questions (SQ): 1. How are key factors contributing to the success or limitations of PHPs in supporting physician well-being? 2. How do PHPs evaluate and monitor the effectiveness of their programs in supporting physician health and well-being? SQ1 is divided into Key Success Factors and Key Limiting Factors. The results are reported in aggregate, with quotations being thoughtfully selected to ensure no identifiable information could be traced back to the participant or their PHP. These steps secured confidentiality and anonymity for participants and their corresponding PHPs while conveying the depth and significance of the data gathered and the emergent themes.

Overarching Research Question

The primary purpose of this study was to explore the perspective of PHP leaders on whether PHPs support physician well-being. This assumes that there is a well-defined or agreed-upon conceptualization among all leaders. Before moving into the specific themes outlined below, the following describes how leaders across the PHPs explained physician well-being.

With this foundational base, the emerging themes that answer the subsequent research questions follow.

Conceptualizing Physician Well-being

PHP leaders in this study agree that physician well-being contributes to physician health and safety and is an essential concept in physicians' lives. However, well-being as a proactive measure and the roles of PHPs in proactively addressing well-being varied, as explored in detail in the Key Factors: Limitations section of this report.

- I think physician well-being is that a physician who is mentally, physically, and cognitively capable of safely practicing medicine is in a state of well-being and is qualified and capable of performing the duties of their specific profession without any disability. (P1)
- A physician who is in a physical, mental, and cognitive state of health that allows them to safely and effectively perform the duties of their profession or specialty and lack in any of those areas is potentially risky to everyone involved. (P2)
- Being able to look at … the areas in your life … and figure out what are the things you need in order to feel healthy, alive, alert, capable. And for some people, that's, I have to run every day… more time with my family… really figuring out what gives your life meaning. And then having you live that so that you can have that sense of wellness. (P3)
- Well, the physician being able to be well and healthy… Our focus is to try to help the person do well and understand what those healthy components would be defined for them…. We need to look at their wellness from an overall well-being standpoint, which needs to occur much earlier in their career and not just when they get in trouble. (P4)
- It's not the mere absence of distress... it's motivated engagement in living, both personally and professionally. It's living in alignment with one's values, knowing what those values are, and having the freedom to apply the energy and effort to the things that reflect your values and what matters. It's about having a life of meaning and purpose and feeling connected to that meaning and purpose... being meaningfully connected to a community of others and in life. (P5)
- Well-being is looking at the physician's life as a whole. And so we tend to talk about our work, and that is important, and that's part of our identity as docs…but things that bring people in rarely have to do with the work… it's usually satisfaction… satisfaction with your primary relationship… extend from that…family and then social and community activities and those kinds of things. I think all that needs to be assessed and to get an idea of… somebody's well-being. And then…physical health…we really should probably be looking at all the things that contribute to well-being. (P6)

- Personal well-being through the integration of both the personal and professional life in a way that is beneficial to the individual and, therefore, the workplace and patient care…At the individual level, it's taking care of yourself physically, mentally, emotionally, spiritually, financially, you know, having a 'we' in your life, having to support family and whatever roles you have, such as parents or being grandparents or children, brother, sister. And then in the professional area, it's really about…doing your career in a way that you maintain your ability to be satisfied. And are fulfilling your own internal personal value system of making a difference in the lives of others. (P7)
- I think well-being is a personal journey of taking care of oneself. And I think people that are monitored in our program are exposed to the ways of doing that. And those are enhanced. But that's not our primary purpose. (P8)

Key Success Factors

Five themes emerged from the semi-structured interviews, which specifically asked for leadership perspectives on the key factors contributing to the success of their PHP supporting physician well-being. Table 2 outlines the themes specific to the supportive factors identified. The theme descriptions are further built upon and supported by specific quotes and materials reviewed throughout this chapter.

Table 2

Emergent Themes of Key Success Factors of PHPs in Support Physician Well-Being

Themes	Descriptions	Subthemes
Theme 1. Accessible Expertise	This theme centers around the availability and specialized knowledge offered by PHPs.	-Role & Functions -Services Offered
Theme 2. Education & Outreach	This theme emphasizes the concerted efforts among PHPs to provide education on physician health and safety-related topics.	No subtheme
Theme 3. Confidentiality	This theme highlights the importance of a confidential track of involvement.	No subtheme
Theme 4. Individual & Organizational Supports	This theme reflects the comprehensive approaches PHPs take to support participants and referring organizations.	-Support, Trust, & Reassurance -Contextual Understanding
Theme 5. Stakeholder Collaborations	This theme speaks to the perceived necessity of stakeholder support.	No subtheme

Theme 1. Accessible Expertise

All leaders perceived that the expertise offered by their PHP and across PHPs, overall, was an essential means to supporting physician well-being. PHP leaders described their backgrounds and how their qualifications and experience are well-suited for their PHP roles. One leader noted, "We have probably the most knowledge of that among the general medical and hospital community about impairing conditions" in the context of physician health and well-being (P1). Another noted, "I think PHPs can support the well-being of physicians by being available" (P8). The importance of availability and the role of experienced staff was underscored when a leader said, "You know, you got to have availability…The clinicians that we have are used to dealing with docs, and our front office is used to dealing with docs… And so I think those things might seem a little minor, but they're incredibly important" (P5).

With over 150 years of combined PHP-related experience across the leadership interviewed, paired with the experience of other leaders and staff within the PHP, they conveyed standing ready to assist in all circumstances within their scope. Additionally, their careers as advanced-level practitioners and administrators in medicine, and some with their personal stories and those of peers needing health support throughout their careers, embody leadership with a deep resonance of the experiences among the medical community at multiple levels. These stories amplified the passion, dedication, and meaning that cradles their work in the field with an emphasis on being accessible for the medical community, be it the individual or organizations, in supporting physician well-being.

- I really think PHPs have to be involved in this National conversation about this [Physician Well-being] because we are seeing the effects… I do think we have, PHPs have, a lot of knowledge about this. And I think it's important that we be at the table. (P3)

- One of the most valuable things that I think is that a person or anybody can call our staff confidentially and say, can I call you Dr. Doe and just ask how this one works? I think for me, PHPs making sure that they're available… (P4)
- It takes time to build relationships… you really have to make yourself available. I think you have to encourage people to call the program. We're here to be a voice on the other end of the line so that you don't have to worry alone. And so, I think just being available in that way, in that consultative fashion. (P5)
- And we take all phone calls. So, if somebody is asking questions and it's not a participant, they may be looking for resources for all those other things that we are connected to and will provide... And, you know, people call us to get that advice. (P7)

Subtheme 1. Role & Functions. Falling under the capabilities of PHPs to provide expert services (Theme 1) was the capacity to provide an alternative to disciplinary measures from regulatory agencies and the protection of patient safety through the monitoring of health conditions, such as a progressive medical diagnosis or other mental health diagnosis (i.e., mood disorder). One participant described their model as "…we're a confidential alternative to reporting to the board…" (P8). Further explanation as to the role of protecting patient safety was provided by one PHP leader who noted:

> I look at it as dual roles of protecting the public, through the successful intervention or rehabilitation of potentially impairing conditions. And you can flip it around and say our dual roles are successful rehabilitation of potentially impairing conditions and better protecting the public. And what happens is those two goals together accomplish the goal better than either one of them could alone. (P7)

One participant described their function of monitoring, inclusive of working monitoring to ensure safety to practice:

> I think that the monitoring process, which is, I think, standard for all PHPs, but I'll just speak to ours; our monitoring process of our staff staying in contact with a work monitor. I know some PHP don't have a work monitor; we think a work monitor is absolutely key in the effectiveness of what we do. Because the physician is, after all, expected to provide quality patient care to the patient. (P4)

While another noted their monitoring process, that does not typically include workplace monitoring:

> They go to weekly relapse prevention groups that are subject to random drug testing. During the entire time, there are a minimum of every six months case management evaluations and progress evaluations. And we have releases of information for anyone treating these individuals: primary medical care, specialty care, psychiatric care, independent therapy. So we receive those reports on a routine basis, quarterly, but everything is as needed … We do not have workplace monitors typically. Yeah, we do on occasion, and we do occasionally have chaperones for individual boundary issues. (P1)

Subtheme 2. Services Offered. Services offered at PHPs vary; however, by and large, most leaders described referrals for evaluations, specialized treatment referrals, consultations, monitoring, and case management as primary services offered. Monitoring occurs with some variation across PHPs, and frequently, programs are unaware of what those variations are, as two participants said:

- But in terms of direct service to participants, the referral management, initial assessment, referral to services… Typically, we're providing referrals to community support, community services. And then, I'd say depending on how you look at monitoring per se…we provide continuing care case management and… oversight of the care that people are receiving and ensuring that they're getting to their appointments and following up. And … I think a lot of that's included for most programs monitoring. But not sure what everybody else is doing outside of their monitoring, you know, workplace liaisons, toxicology testing, health provider reporting. (P5)
- A lot of PHPs require a 90-, 60- or 90-day treatment program, and we're all for that. We're delighted that people want to do that. We never require it… It may take them months or years longer to get well enough to go back. But that's okay. We're not in a rush. So therefore, our approach is, I think, different than a number of PHPs. (P4)

Theme 2. Education & Outreach

In addition to the PHP roles and functions of evaluation, monitoring, and referrals, all participating leaders underscored their exhaustive efforts in providing education and outreach locally and, where possible, nationally - perceiving that this is a primary way of supporting physician well-being. A couple of respondents perceive that this responsibility for education and outreach must be shared with other medical institutions due to funding and staffing issues, which are explored in subsequent sections of this chapter. All leaders provided ongoing education,

whether as a part of the curriculum, advising institutions, or collaborating with state societies and medical malpractice carriers to present on matters of physician health, safety, and well-being.

One participant (P1) noted the various outreach efforts made in their smaller program, "We also do outreach - going to hospitals, medical staff meetings, medical staff, leadership, and medical group leadership to educate people on physician health issues, well-being, and what resources are available." Another commenting (P2), "we have always been available to come to hospitals, medical groups, executive committees, medical staff meetings to present what we do and, who we are and, how to reach us, and our availability. Providing education is a function that all PHP leaders felt crucial in their outreach:

- And when we talk about it [well-being] in our talks, we list burnout and wellness saying, you know, we want to be proactive and get to this before you end up with a major mental health diagnosis or, you know, a substance use diagnosis, because of the way you've been trying to address this. (P3)
- We do lots of educational presentations, as all PHPs do. We're on the list for the major medical centers, residents, and fellows orientations every year. And some other specialties have special requirements under GME to do some education training. (P4)
- We do a ton of education outreach…to the medical community in the state. Presentations. Meetings with healthcare leaders…meeting with HR people or the medical staff specialists, not necessarily always meeting with physician leadership…So, we're putting out information…trying to talk about topics that are also relevant, timely, to physician health and well-being. (P5)
- We spend a lot of time and effort in the community trying to, you know, beat the drum and let them know that we can help them and let them know what problems are familiar to all physicians or at least all physicians at some point in their careers. (P6)
- In-person education, writing of articles, websites, distribution, and publication in journals. The issue to me is. Unfortunately, you know, PHPs, in my mind, could easily have, say, a physician-educator that their full-time job was education… 365 days a year. (P7)

An area later visited is the lack of resources supporting PHPs, which limits the reach of their education to the medical community. PHP leaders expressed exhausting much of their energy and resources in this area as they believe it to be an impactful activity, thus making

themselves available where possible; as one leader (P8) described, “We make ourselves available for any kind of presentations, for any conversation, at almost any time with any facilities.”

Theme 3. Confidentiality

Confidential engagement with PHPs has been an ongoing discussion among the PHPs since their establishment. PHPs emphatically connect utilization rates to safe-haven or safe-harbor laws, which vary across the states. This will be further discussed under the Key Factors: Limitations section. Those states with confidentiality tend to have higher rates of utilization in larger program settings where resources are more robust, thus enhancing education surrounding concerns related to confidentiality. The ability to seek help with safety supports physician health and well-being by providing the physician an opportunity to proactively attain the evaluation, treatment, and monitoring they need. One participant stated in response to factors supporting physician well-being, “One of the contributing factors is we can see anyone, and we don’t have a mandatory duty to report someone to a Board” (P2). Another, when asked about the overall purpose and missive of the PHP, described:

> I think it is to have a confidential service that’s available to health care practitioners where, whether they’re having personal or professional difficulties or a significant medical condition that’s affecting their ability to practice safely, that they have a place where they can come that’s confidential, and we can try to get them the help that they need…we can see people without having to report people necessarily unless a major concern about safety. (P3)

One participant provided an example that reflected the “great respect for the confidentiality part of this program” with their partnering and overseeing body. Much to their delight, there had only been one example over their PHP career where a participant’s identity was revealed due to a necessary process, and even in this circumstance, redactions were made to

protect the confidentiality of this individual seeking legal action against the PHP. “We have a hard firewall” (P4). Other participants underscored sentiments on matters of confidentiality:

- I think it’s our job to provide a confidential track so that people can get help with us and know that they can do that and not have their diagnosis and treatment revealed to people that they don’t want it revealed to, including licensing. (P5)
- You know, it’s common for a lot of PHPs to have only mandated referrals, basically behaving only as a diversion program. If you’re going to get beyond that, you know, into nonsubstance use disorders, that can affect us the same way a substance addiction does. You’ve got to be able to protect that doc’s ability to get treatment without becoming known to the board. (P6)

For many PHPs with confidential involvement tracks, confidentiality still has limitations, and those typically involve matters of non-compliance. For example, one participant noted, “By statute, we do have safe-haven and voluntary confidential participation that includes medical records protection and the immunity to subpoena…if they’re non-compliant, the board would have access to our internal records” (P7). Another participant described their model as “… a confidential program…boards then are never aware of that person’s involvement unless they’re non-compliant in a major way with their contract, their monitoring contract” (P8). Transparency in communication surrounding limitations to confidentiality and continued support toward macro-level changes on licensure questions and disclosures were deemed essential movements toward improved confidentiality for physicians.

PHP leaders frequently emphasized that maintaining confidentiality is essential for encouraging physicians to seek help. Privacy concerns often prevent physicians from engaging with PHPs, making strong confidentiality measures a crucial factor in the success of these programs. The FSPHP consistently reinforces this theme, more recently addressed in the Issue Brief on Effective Communication Regarding PHP Confidentiality (FSPHP, 2024b), which stresses the importance of transparent communication about confidentiality to reduce stigma and

encourage participation. Additionally, Arizona's Peer Support Law (AMA, 2022a) highlights the necessity of legally protected confidential spaces for physicians, further supporting the need for clear and comprehensive confidentiality policies across PHPs. In alignment with these statements and movements toward increased confidentiality, the AMA (2024) issued a brief supporting the call to action surrounding physician well-being, confidentiality, and the utilization of PHPs. These documents align with the interview data, emphasizing how pivotal confidentiality is to fostering an environment where physicians feel secure seeking help.

Theme 4. Individual & Organizational Support

PHPs provide individual and institutional support through developing and maintaining trust and reassurance, peer support, acknowledging authority, and the need for advocacy at both micro and macro levels. These are accomplished through various methods largely dependent on the resources available to the PHPs and scaffolded by the expertise and accessibility mentioned earlier for those seeking and receiving services. Individual support is provided through skilled, empathic, and structured approaches to participant circumstances, which often require an in-depth contextual understanding specific to the individual, their internal experience, and multi-dimensional external environments. These internal and external pressures, at times conflictual in nature, are often unique and complex, adding to the psychological stress around seeking support or leading to mandatory referrals.

Subtheme 1. Contextual Understanding. PHP leadership perspectives reflected an emphasis on supporting and helping clients navigate their circumstances toward their health, well-being, and career preservation. One leader highlighted the significant and supportive experience of connecting with someone who understands the context of the individual:

> The most sort of poignant interviews are when, you know, the physician says, 'This is the first time I've been able to sit down and talk to someone for an hour about what it's like right now'…if we can be anything, to be able to provide the space for them, to take a moment to breathe, look at their lives…look at where they're at, look at their bodies. (P3)

They further described the opportunity in those moments to drive home the message that their "health matters" not just because of their role as a provider but because they, as an individual, matter. Another leader commented on the support provided to individuals in developing insight and awareness of the link between their decision-making as it relates to their personal life and its implications on their professional identity, holding a safety-sensitive position with the privilege to practice medicine – "the stakes are higher" (P6).

PHP leaders shared various examples of organizational support, many examples falling under the consultation services provided to administration and leadership ranging from larger healthcare institutions to smaller private practice groups and solo practitioners. The context for healthcare administration and leadership is also important and was acknowledged by participants, as reflected in one participant's description of some of their work with administration, where they provide education as well as "policy review" and noted they spend "lots of time advising hospitals… in many respects turns out to be management consultation" (P4).

Subtheme 2. Support Trust & Reassurance. Systems, similar to individuals, contend with shifting and competing demands that pressurize bottom lines and stretch already tight resources. Many PHPs relayed strong connections with large hospital systems within their state. They were seen as a significant source of referrals, placing an asterisk in providing credible reassurance to referral sources. One participant noted, "We want to be of service to the stakeholders who have concerns about somebody who they are referring…we can provide some reassurance of safe practice," while also having difficult conversations with the individual "about

stopping practice and taking medical leave when necessary to both support health and well-being, and, and safe practice" (P5). Another noting the criticality of being seen as a "trusted, credible resource" (P2).

- But what the organization realized is that, for good or for bad, and it was true then, and true now, that the majority of our referrals come through healthcare organizations…We would love to get doctors calling and asking for help. But the truth is… that largely, the referrals are motivated by someone, by a boss, by a state medical board, by a divorce attorney, by a finance person, by a husband, and by group practice. (P4)
- Another quality of our program is, is the trust that we've built over decades of working within our state healthcare ecosystem to develop the trust of healthcare organizations and the healthcare community to know that we can do this work or we can do it well. (P5)

Supporting organizations through consistent and dependable services that aim to understand the contextual implications of unaddressed concerns from an organizational perspective and the individual needs of the referred can be challenging and of a significant imperative. Supports for the individual and organization require guidance, education, support, advocacy, and authority in carrying out the PHP dual-fold mission of physician health and public safety. These supports are only possible among PHPs where trust, credibility, and reassurance are present.

Theme 5. Stakeholder Collaboration

PHP Leaders collectively highlighted the pivotal role of stakeholders at local, state, and national levels. Stakeholders included academic and healthcare institutions, legislators and regulators, medical society, associations, and specialty boards, as well as other individuals and entities with a vested interest in provider well-being, health, and safety. PHP stakeholder engagement was described as not only providing support but also functioning as sounding boards, mentors, and allies for PHPs. This was especially critical for PHPs during regulatory or

legislative changes or turmoil threatening their existence. One leader said, “It's also incredibly important to us when there have been various threats and challenges that have come to the organization to have the backing and support of the state medical association is incredibly helpful” (P5). Moreover, engaged stakeholders provided opportunities for collaboration that expanded outreach, education, and awareness about the scope and services of PHPs.

One participant noted that “all PHPs realize their needs to have a working relationship with the medical board” and the importance of the relationship between PHPs and hospital administrators (P4). One participant described having close relationships with “licensing boards, chief physician executives, hospital systems, and medical group leaders” (P1) and legislators. Several noted the importance of having strong relationships with state medical associations.

A focus was observed on the role of relationship and trust building over time among all stakeholders and emphasized the involvement and presence of PHP leaders at stakeholder events and meetings, and working to get on agendas that align with physician health, well-being, and safety topics. One participant noted, “To me, the biggest thing is getting the stakeholders together in a room discussing the various issues. And building bridges to solutions instead of burning them, and understanding each other's roles and responsibilities and wants” (P7). With a couple underscoring the various opportunities collaborations can lead to, such as systemically embedded policy developments and mission-focused initiatives:

- We are usually invited to the table, at this point, by the medical school and work they've been doing. There's a couple committees that have been established, wellness committees… and they have included us. So, I think that's really important. And they do acknowledge the program and the work that we've been doing. (P3)
- So the supports that we find that are most helpful are when…. hospitals or health systems will write into their structure - write into the policy and procedures, operating regimen, on how a person can get help and how they can do it confidentially. (P4)

PHPs frequently discuss the importance of building and nurturing stable and strong community connections with diverse and crucial stakeholders, which typically include the regulatory boards, healthcare systems, medical associations, and lawmakers, and are essential to supporting the viability and efficiency of PHP services. The significance of collaboration is mirrored in the Dr. Lorna Breen Health Care Provider Protection Act (Dr. Lorna Breen Heroes Foundation, 2023), demonstrating how coordinated efforts, at both national and state levels, can reduce the barriers for physicians and promote well-being. The FSPHP (2024) Task Force Action Plan and AMA (2024) encourage legislative partnerships toward protecting confidentiality and augmenting program resources. These sources resonate with the perspectives of PHP leaders, underscoring the collective role of stakeholders in sustaining PHPs and enhancing their impact.

Key Limiting Factors

Five themes emerged from the semi-structured interviews, reflected in Table 3.

Table 3

Emergent Themes of Key Limiting Factors of PHPs in Support Physician Well-Being

Theme	Description	Subthemes
Theme 1. Limited Scope	This theme reflected a limitation in supporting overall physician well-being.	No subtheme
Theme 2. Funding & Staffing	This theme underscored the variations among program structures and the pervasively perceived inadequate funding.	No subtheme
Theme 3. Organizational Components	This theme represented the perceived systemic factors that hinder PHPs in effectively supporting physician health and well-being.	No subtheme
Theme 4. Individual Components	Individual characteristics and factors that adversely impact help-seeking behaviors among the physician population.	No subtheme
Theme 5. Underutilization	Various factors adversely impact the utilization of PHPs despite efforts to educate and increase awareness throughout the states.	Stigma & Misinformation

The themes emerged from the semi-structured interviews, which specifically asked for leadership perspectives on the key factors limiting the success of their PHP supporting physician well-being. The theme descriptions are further built upon and supported by specific quotes and materials reviewed throughout this chapter.

Theme 1. Limited Scope

While some PHPs noted they have voluntary, self-referral options, other PHPs were limited in their scope and services in the absence of a diagnosis. This narrow focus constrains these programs' ability to proactively support physician well-being, which can lead to delayed interventions. Some of the reasons behind this stemmed from conflicting ideologies about the mission and focus of PHPs. Proactive and upstream approaches were at times seen as perceived mission creeps into prevention spaces, with one participant describing the sentiment of one individual in a position of influence saying, “No, we deal with illness; we don’t fit into that business,” as it related to proactive upstream well-being initiatives (P3). State statutes and program contracts were described as limiting factors as they related to confidentiality and the scope of services provided:

- We don’t have a safe-haven law... We don’t have the ability to take people who independently seek help, who would technically fall under the reporting statutes for them self-reporting or us or others reporting them. And I think having the ability to get people in to help without those fears sooner would be very helpful… but most of our referrals are mandatory. I think if we have a safe haven law, we would have many more voluntary referrals. I think the fear of license, action, and employment action keeps people getting sick instead of getting, well, sooner. (P1)
- Physicians are licensed by every state to provide quality medical care, and to the state's licensure purpose, wellness is kind of an asterisk. So, I think these are great opportunities for the PHPs. And I think the biggest obstacle for me, and I surmise for everybody else, is that issue of privacy and confidentiality and how to carry the wellness banner, knowing that ultimately, public health is something that we have to be responsible for. (P4)
- You know, it's common for a lot of PHPs to have only mandated referrals, basically behaving only as a diversion program. If you're going to get beyond that, you know,

into nonsubstance use disorders (that can affect us the same way a substance addiction does), you've got to be able to protect that doc's ability to get treatment without becoming known to the board. And it's not just the board…then stipulations that follow where they're considered to have a restricted license. And then they can't get on insurance panels, which means they can't work most places… It's a very real concern, and so if you can't protect confidentiality, you're not going to see the majority of docs that need help. (P6)

- 90% of those are probably substance use disorder or dual diagnoses, and maybe 10% or so are mental illnesses. We don't just get a lot of those. And by statute, we're limited to those, too. You have to have a diagnosis. Substance abuse or mental illness. (P7)

Leaders expressed concern over the legal and regulatory frameworks that require PHPs to focus on diagnosing impairment rather than taking a preventive approach. This was seen as a significant limitation, as many physicians would benefit from early interventions before a diagnosis becomes necessary. These concerns are reflected in Virginia's House Bill 1573, which proposes changes to licensure applications that would remove mental health-related questions and allow physicians to seek help without fear of professional repercussions (Simmons et al., 2024; AMA, 2022b). Similarly, the FSMB (2021) and FSPHP (2019, 2023) advocate for a reduced focus on diagnosis to early intervention, providing a more supportive framework for struggling physicians. This triangulated evidence demonstrates the need for regulatory reform to allow for more preventive measures within PHPs.

Theme 2. Funding & Staffing

PHPs require adequately trained staff, proper funding, and clearly delineated mission-focused objectives and processes. With varying structures and funding sources, PHPs range from well to poorly funded, with even those who consider themselves well-funded constrained by limited bandwidth when carrying out initiatives. Many leaders, as reflected below, describe wearing multiple hats on account of the multitude of responsibilities they carry. One participant noted that they are responsible for taking all referral calls that come into the program,

scheduling, creating a plan for review by the team, and all monitoring activities, in addition to "all the presentations on the physician health program and other subjects" without administrative support (P3).

One leader said, when asked about physician well-being initiatives, "We're not really funded for it. Nobody's going to want to fund us for it. You know, everybody loves talking about well-being…but it's not something that anybody's really putting genuine resources behind" (P6). Another participant noted that the PHP model "stemmed from substance use disorder treatment, and it fits really well with that – and the ability to adapt and expand is going to take more staff and funding" as it related to PHPs supporting physician well-being with more concerted efforts (P7). Similarly, one leader said, in reference to where PHPs can support physician well-being, "I think it has to be from a different source other than expecting a little PHP with a poor budget to go out and try to have enough of a voice to matter when people need it" (P8). Some participants felt adequately funded but highlighted the need for funding across PHPs for consistency among PHPs and quality, evidenced-based practices as it relates to traditional PHP services, and venturing into upstream and proactive well-being domains:

- I think that we are well-funded to carry out our mission. So, I think not all these [PHPs] are really funded adequately to provide the services, support staffing, to, to carry out their mission with, you know, with an eye towards really best practices across the board… I think a lot of physician health programs have evolved kind of in a system of need where they've been asked to do more and more things over time that may or may not really be within their scope of expertise… They're trying to be there and be supportive, but they also, don't have, you know, no resources added to help them be effective in that mission. So, I can't, you know, sort of overstate the importance of adequate funding. (P5)
- I can speak mainly from the small program perspective. We're so under-resourced, you know, I always say this when people say, "Oh, you need to do this… and you do that. And I'll say, "you know what, the casework always comes first." I am happy to go out and speak. I'm happy to try to do these other things, but I've got to make sure my cases are covered. (P3)

- I'm currently the executive medical director who functions as the executive director, the medical director and the clinical coordinator. I'm also the primary educator… and interface with all of organized medicine relative to the work we do, whether it's hospitals, medical boards, and others. (P7)

PHP leaders expressed frustrations over inconsistent and inadequate funding and staffing that have made it challenging to meet the increasing demands of their state. Limited resources often force PHPs to make difficult choices about the services they can offer, affecting the overall support physicians receive, outside of down-hill reactionary responses to impairments that may have already compromised clinical care. Several leaders spoke to these shortages as limiters to their ability to expand and adapt to well-being efforts. PHPs often operate with less than optimal resources, forcing leaders to take on multiple roles and increasing operational stress and limitations. Specific sources related to underfunding are sparse, but the FSMB (FSPHP, 2021) highlights the need for adequate funding and legislative support to ensure that PHPs are fully resourced to meet their goals. The Dr. Lorna Breen Health Care Provider Protection Act (Dr. Lorna Breen Heroes Foundation, 2023) also recognizes this issue, advocating for increased funding to address physician burnout and promote well-being. Together, these sources emphasize the ongoing need for sufficient resources to support PHP operations and their effectiveness.

Theme 3. Organizational Components

This theme encompasses perspectives of PHP leaders who pinpoint organizational challenges that collectively restrict PHPs in fostering a more supportive and proactive process for physician health and well-being interventions. Institutional actions are too often delayed, and there is a lack of comprehensive institutional policies that could guide proactive referrals and support. The theme also addresses the prevalence of surface-level wellness programs that fail to

address deeper systemic issues and core underlying individual issues, which also add to delayed self and workplace referrals. Additionally, the entrenched culture of medicine, in conjunction with provider administrative burdens, was perceived to contribute to the manifestation of stress and burnout syndromes.

- I'm in that camp of feeling that it's very much a systemic problem… you can offer free yoga and meditation, but if the system is still broken with not adequate staffing and…I know there are a lot of very smart people trying to work on this. But also, you know, I think medicine has changed so much, too. It really is more of a business model. And the physicians feel that it's like, how much can you produce and how much money can you make so we can stay afloat. And it's huge pressure. (P3)
- I think the key thing that I think would support physician well-being are strategic planning as to how to do proper staffing, how to provide time for the physician to take their vacation time, and to try to help from a corporate culture standpoint, take people look at themselves as people are not just as not just as physicians... So the supports that we find that are most helpful are when… hospitals or health systems will write into their structure - write into the policy and procedures, operating regimen, on how a person can get help and how they can do it confidentially. (P4)
- Some of the things that get in the way is, is, is the, you know, the ways in which the culture of medicine indoctrinates people into a pattern into habitual patterns that require self-sacrifice and compromise of one's own health and well-being in the service of a profession that is extraordinarily demanding. (P5)

Several leaders shared concern for the dwindling physician workforce secondary to the pressures and administrative burdens leading to burnout, pushing individuals into retirement or limited work schedules. In these circumstances, the stress of those remaining in the workforce is that they are unable to attend to their own health needs. “You don't have enough doctors, and we're not taking care of the well-being of the workforce in a workforce preservation manner. It's like anything else is, you know, you're not going to be able to provide your own service goals as well” (P7).

While most leaders felt encouraged that workplaces were making efforts toward wellness programs, the variation of wellness efforts and the potential for delayed or inadequate interventions raised concerns:

- I think most hospital systems and other healthcare organizations are creating wellness programs and wellness officers to try and identify people who are suffering from burnout or other stress-related issues before they progress to an impairing condition. I'm not sure how well they're utilized or structured yet. I think there's a lot of variability and a lot of inconsistency. So, I think we are more of the last stop rather than the first step. (P1)
- Number two is just competing processes under this well-being kind of umbrella that's pretty vague and without accountability and without the expertise of knowing when more is needed. I think it's just very sad. Because we see people that are much further down the road before they get to us because they think these alternatives are equivalent and they're not. (P8)

Interviews revealed that systemic factors such as workload, culture, and administrative burdens can create obstacles for physicians in accessing support. Healthcare organizations and training programs are often understaffed, creating pressure on physicians to continue to work despite feeling unwell. Additionally, this adds to delayed action on both the side of administrators intervening and individuals considering taking time off to address health and well-being, thus preventing PHPs from fully supporting physicians. The FSMB Workgroup studying risk and support factors affecting physician performance supports these findings by identifying systemic barriers within healthcare environments that limit physician access to PHPs and other wellness programs (FSMB, 2018, 2021a, 2021b).

Leaders hoped for earlier actions from physicians and workplaces, stressing that the current approach to addressing issues after they have impacted a physician's practice is inadequate. The FSPHP Physician Illness, Disability, and Impairment public policy statement (2022) strongly supports the need for early intervention, advocating for timely referrals before impairment becomes severe. Additionally, the FSMB policy on physician illness (American

College of Surgeons, 2022) also promotes timely intervention and non-punitive measures to support physician health. These documents align with the perspectives shared by PHP leaders, reinforcing the idea that proactive support Lois crucial for effective PHP functioning and for preventing physicians from reaching critical points of impairment.

Theme 4. Individual Components

Collectively, leaders perceived two major individual components that create a barrier in PHP efforts to support physician well-being. The first is personality characteristics, and the second is poor education and training related to self-awareness, self-care, and help-seeking. Regarding personality, one participant said, “I think we’re not very good at taking care of ourselves in general” (P1). A sentiment echoed by another participant, “Business of caregiving often puts self-care on the bottom,” an example story followed this:

- We had one call to one of our committee members, actually a patient of a doctor who knew that this person was on the Physician Health Committee. And he said, “I just had my annual visit with my primary care doctor, and he looks awful. And I'm really concerned about him; I don't think he's taking care of himself. He's lost way too much weight,” and so we did like an outreach call. But I thought, you know, patients notice these things. They notice if the physician seems distracted or stressed or and, you know, you want. But you've got to have time to replenish…and a lot of them don't have that. (P3)

Some leaders expanded on the physician personality:

- And I think physicians, you know, are also compulsive and that the profession selects for and reinforces and praises compulsivity that is socially desirable, personal, and costly…when you're working against that kind of wiring, in terms of how, how people come to the profession, loaded with some impulsivity characteristics, I think that that can get in the way. I also, think that that intelligence and a little bit of knowledge can be a bit of a barrier as well, because I think physicians are more apt to question and challenge one another… I think, physicians are so dedicated to their colleagues and to their patients that they feel really, we're very much trained like don't be a burden on others. And so, like part of that unwillingness to, to take care of oneself is that feeling of guilt that we have about not burdening our peers and our colleagues in order to step out of. And but once we get over some of those barriers, I

feel like physicians really do and can engage in very positive and proactive ways. (P5)

- I think the way that we're picked to be doctors is probably the one most prominent to me. You know that we are not taught to be healthy. We are not taught to take care of ourselves. As a matter of fact, the opposite is true. You know, where we're taught to do everything at our expense in order to make sure that we save our patients. You know, and then and then beyond that, we're selected for a rather rigid personality structure. (P6)
- Our personality is trained to be more problem-solving, vertical, helping everybody else, guiding, and leading. But in the human journey, those tools don't always serve you real well… You know, self-care translates into better patient care, and it's counterintuitive to our personality. (P7)

Other leaders highlighted the lack of training and education provided during medical school and training programs in the area of self-care and seeking supportive resources when appropriate. One participant explicitly highlighted that it is not enough to educate on help-seeking; however, it is also "about help acceptance as well. Because it's one thing to be seeking care and it's another to accept the care that's being proposed" (P5). Another participant emphasized educating on the safety-sensitive positions they hold, "Because a lot of them don't understand until you talk to them in terms of - what if you were a pilot, would you get on your plane? And then they start realizing, hey, they really are in a safety-sensitive" role (P7).

PHP leaders frequently mentioned the culture of medicine as a systemic barrier that discourages physicians from seeking help. Physicians often internalize the belief that asking for help is a sign of weakness, contributing to burnout and mental health issues, which is a combination of systemic, cultural, and individual factors creating barriers to help-seeking. Research from NAM highlights how the hierarchical and high-pressure culture of medicine contributes to the stigma surrounding mental health care (NAM, 2019, 2022). The NAM has also reported that this culture plays a significant role in physicians' reluctance to access PHP services (Hengerer & Kishore, 2017). These findings emphasize the need for cultural shifts within the

medical profession to prioritize physician well-being, breaking down enculturated behaviors that build barriers to providers seeking help.

Theme 5. Underutilization

Despite focused efforts, as reviewed in the identified supportive key factor of Education and Outreach, PHPs continue to feel underutilized as a result of concerns for confidentiality, circulating misinformation and myths, associated costs, and stigma and fear. Part of this stems from the lack of research surrounding PHPs outside the context of substance use disorders, which only fuels misconceptions about the scope and services of PHPs. The excerpts below resonated throughout each interview:

- Well, as hard as I try, we are often conflated with the board of licensing, and I do explain we're not part of the board of licensing... And people confuse that still. And still, I combat this perception of it being a punitive program. And that saddens me… You know that this [year] was one of the lowest number of referrals I had. But I was wondering if a lot of the hospitals here have hired chief wellness officers. There's been a lot more push for people to get mental health care when they need it, and we're changing the [licensure] questions. And yeah, I'm hoping it's partly because people are getting help. And so, that's what we hope, right? And so, we're probably seeing, and we've been seeing some fairly complicated, problematic cases, which may be… the new fate of the PHP. (P3)
- If you're talking about the things that physicians would perceive the obstacles for them, cost would be right up there. So, I think that greatest obstacle would cost and impact on a career… the ability for physicians to utilize something that was equivalent to their own health insurance to get to care. Right now, for example, the independent medical evals, which we have to do externally from a legal standpoint are something that the physician has to pay for him or herself. On the other hand, far fewer physicians in our program utilize their insurance than I think would. They often want to make sure there's insurance, but then, for confidentiality or convenience or whatever, they don't use it. (P4)

Subtheme. Stigma and Misinformation. One participant's perspective, which was echoed among other participants, was that PHPs are "vastly underutilized by organized medicine. And the importance of it is underestimated and not understood" and went on to say:

- First of all, anything that can reduce stigma or fear because everyone is afraid of losing their license or losing their job. And so, anything that can reduce that and encourage people to get help. Early preventive medicine, in general, has a terrible track record in this country for the population at large to get help before something becomes a problem or a worse problem, and this is no different. I think anything that can, again, encourage people to seek help and have resources available with less fear, less anxiety, and more willingness to get help would be good. (P1)
- I think misunderstanding and misinformation and the difficulty that PHPs have had…we struggle because we won't violate confidentiality to defend our programs with people who are saying things that may be untrue and we know them to be untrue…I think now more and more it's become acceptable for people to talk about what have been historically stigmatized conditions, where they've really wanted the anonymity… I also think there's just a relative paucity of, of good data and research. The data that we have is dated and probably methodologically strong for the time, but, but less so, as research methods have evolved… So, I mean, I think there's a lot of unanswered questions in PHPs, and these individually and collectively are relatively under resourced to answer…(P5)
- Stigma of thinking it's the Impaired Doctors Club, which a lot of people naively don't understand, thinking we're associated with other pieces of organized medicine, like the medical board… not realizing we're completely independent of all these other organizations. Not understanding the confidentiality of the statute and the PHP and how aggressively PHPs protect the confidentiality of their patients or parties. (P7)

Several PHP leaders attributed low participation rates to the stigma associated with seeking mental health or addiction treatment, often exacerbated by concerns about career repercussions. The World Health Organization (WHO) guidelines on mental health in the workplace support this finding, emphasizing that healthcare workers are particularly vulnerable to stigma when seeking mental health assistance (World Health Organization, 2020). This concern is echoed in research from the NAM, which again identifies stigma as a significant barrier to physician well-being, particularly in how it prevents physicians from utilizing available support systems like PHPs (NAM, 2019). Research published in JAMA reported that doctors frequently turn away from seeking mental health support due to concerns over stigma and

potential harm to their professional image (Gold et al., 2020), a large part of the problem around the underutilization of PHPs.

Similarly, the FSMB reports highlight how fear of intrusive mental health disclosures during license renewals and applications contributes to PHP underutilization despite existing confidentiality protections (FSMB, 2021a). These findings align with PHP leaders' concerns and reinforce the importance of confidentiality protections in improving physician engagement with PHPs.

Program Effectiveness

For the second research question, relating to program evaluation and effectiveness, there were differences among PHPs as to the depth of internal processes for program evaluation. There appeared to be clear links to well-funded programs with more structures to assess participant satisfaction, tracking demographics, and program outcomes. Standard practices, although not consistent throughout all eight PHPs, were the generation of annual reports and efforts for feedback from participants and stakeholders:

- We don't. We need to. And we certainly get feedback from people, you know, from our participants. And sometimes, most of the time, it's very positive, and they're very grateful for the experience, and sometimes they make suggestions. But do we have a formalized, you know, we don't really have anything like that in place? We need it… So, would probably take a grant or something to help us come up with, you know, whether it's sending out a questionnaire after someone finishes or even to the referral sources - How satisfied were you with the outcome of your referral to the PHP? We don't even do that. (P3)
- With regard to program success, we've had a pretty consistent success comparable to the Blueprint study data, 70 to 80%, really focused on so many things, so it's really hard to are too hard to define. But for a person to be able to get back to medicine fully employed, living a decent lifestyle is not crazy. Be able to do some things in their life when they want to do. That's, that's, that's how we define success. (P4)
- ..we have very strong satisfaction outcome data…what I think of as a strength of the program is that, we value the participant voice, and we seek out ways of elevating that voice so that I think we have a meaningful reconsideration process for people who disagree…we track basic statistics…how many referrals translate into

monitoring agreements… Successful program completion, and how we define that…we track board records where we're violating confidentiality to make a mandated report…(P5)

- I think the biggest thing that we've done is our exit survey… we're, I think, hitting around 90% satisfied, which is pretty impressive given that two-thirds of the people didn't want to be here in the first place, you know? (P6)
- I can just speak to our program. So we have internal quality, quality assurance, and quarterly internal quality with very specific benchmarks that we're using. We also have an external review. We have to give a monthly report, written report, extensive written report about our compliance with our contract… (P8)

PHP leaders reviewed a mix of challenges and successes they encounter when assessing program effectiveness, pointing out the inconsistencies in evaluation methods and the hurdles of tracking outcomes over extended periods. Although many PHPs use annual reports and gather participant feedback, limited resources remain a primary issue, preventing them from conducting more in-depth evaluations. The FSPHP Performance Enhancement Guidelines (PEG) (2016) provide a structured process for evaluating PHPs, focusing on regular performance reviews, stakeholder input, and consistent reporting practices. The FSPHP PHP Program Guidelines (2019) encourage data collection processes that help PHPs conduct program assessments to understand PHP outcomes better. Both guidelines aligned with interview results, noting the need for standardized evaluation practices to improve PHP abilities in conducting and reporting overall successes and their impacts, as well as enabling data to be collected, compared, and analyzed to, again, better understand individual PHP impacts.

PHP leaders noted differences in evaluation across programs, which makes cross-program comparisons challenging, with many programs being unable to conduct evaluations. Some programs focus on detailed performance metrics; others prioritize qualitative feedback and participant surveys. The FSPHP PHP guidelines and PEG respond to these challenges by calling for consistent evaluation metrics to aid cross-program comparisons and better align the metrics

for all PHPs. They also underscore the value of standardized metrics for dependable benchmarking and evaluation. These guidelines mirror the perspectives from the interviews, strengthening the case for more comprehensive and uniform evaluation practices across programs.

Leaders conveyed that although feedback from participants and stakeholders is beneficial, many PHPs do not have the resources to gather and interpret this data. As previously noted, this limitation creates gaps in thoroughly assessing program effectiveness and tracking long-term outcomes. A few leaders advocated for creating a standardized database to collect longitudinal data on PHP participants, which would help assess both short-term and long-term outcomes more effectively. Another suggestion from FSPHP guidelines is to request ongoing feedback from stakeholders (e.g., regulatory agencies, referral sources, and participants) to confirm that expectations are being met. Leader views appeared to align with the guidelines, pointing to the importance of collecting organized data and gathering input to understand PHPs' effectiveness.

Classification of Artifacts

To ensure comprehensive triangulation of data and to enhance the reliability of the findings, the external documents used in this research have been classified into five distinct categories: scholarly/policy reports, government/regulatory reports, non-profit/advocacy reports, organizational statements/position papers, and policy documents. The categories served to triangulate participant interviews, adding context to each response, reinforcing themes, and providing depth to the analysis. They offered a way to organize the documents and provided value by helping to validate findings across the different identified themes, such as accessible expertise, confidentiality, stakeholder collaborations, and funding and staffing. The artifacts’

roles are outlined below to demonstrate their contribution to the overall understanding of PHPs' roles in supporting physician well-being. For a complete list of the artifacts reviewed, refer to Appendix B.

Scholarly Reports

Scholarly reports provided evidence-based research that aligned with many of the themes discussed by participants. Welcher et al. (2019), for example, reviewed the barriers of physician licensing questions as it relates to physician help-seeking and efforts made to address this and highlight the role and expertise of PHPs. As a second example, Shanafelt et al. (2019) poignantly review the contradictions within medical culture that place consequential burdens on physician health and well-being, ultimately compromising patient safety.

Government/Regulatory Reports

Reports on legislative changes or regulatory policy, such as the Dr. Lorna Breen Health Care Provider Protection Act (College of Cardiology, 2022), provided context regarding the legal frameworks influencing PHP operations. These documents were used to cross-reference participants' concerns about funding and staffing limitations, especially in light of the need for financial support to expand PHP services.

Non-Profit/Advocacy Reports

Non-profit advocacy reports aligned with many of the themes discussed by participants. For example, the AMA (2024) advocacy brief highlighted key national trends in addressing physician burnout, directly supporting participant concerns related to confidentiality and the need for education and awareness. The AMA's focus on increasing awareness and advocating for policy changes speaks to the energy placed among PHPs around PHP awareness, outreach, and education efforts, as noted by most participants.

Organizational Statements/Position Papers

Position papers, such as the one from the American College of Surgeons (2022), echoed the theme of restricted funding. They highlighted the importance of PHPs in providing confidential peer support, resonating with participants' perceptions of their role in providing expert and accessible services. Moreover, The American College of Physicians (Candilis et al., 2019) reviews their position on PHPs. They highlight various points, including appropriate funding for programs and the need for physicians with impairment to seek appropriate confidential and quality care.

In their position statement, the FSPHP (2024) noted that they seek to codify the triad of confidentiality to support voluntary and confidential involvement and enhance confidential care for physicians and other healthcare professionals. Their action plan included a referral process that covers a variety of health and behavioral issues and is not limited to diagnosis, supporting the problem of limited-scope PHPs that are held back in their potential to provide preventative well-being services.

Policy Statements

Policy statements such as those made by the FSPHP and FSMB have been crucial to supporting the work of PHPs and the perspectives shared by participating PHP leaders. The FSMB Wellness and Burnout Policy (2018) provided critical guidelines on addressing physician burnout, supporting themes related to confidentiality, funding, and staffing. These documents highlighted the structural challenges PHPs face in offering effective and confidential services while underfunded. The FSMB (2021) policy on Physician illness and impairment also emphasized the need for confidentiality to support early identification of illness and encourage physician help-seeking behavior.

Summary

In summary, the results present a comprehensive view of the critical factors that influence physician well-being as supported by PHPs. The first research question was divided into supportive and limiting factors. The factors that facilitate PHPs in supporting physician well-being include the specialized knowledge acquired through years of personal and professional experience of PHP leaders. This expertise appeared fundamental to the success of PHP functioning. PHPs also play a pivotal role in providing education on physician health and safety topics across various stages of a medical career, from academic and graduate medical education levels (i.e., students and trainees) to mid-to-late career providers. Confidentiality, upheld by regulatory systems or distinct PHP arrangements, was acknowledged as essential for physicians and PHP utilization. Moreover, PHPs highlight the significance of cultivating and sustaining robust connections with participants and referring entities.

Collaboration with stakeholders is critical in raising awareness and fostering organized efforts for physician well-being at community, state, and national levels. PHPs work with stakeholders in multiple ways, offering customized and responsive services that fit their program objectives. PHP outreach initiatives—from referral presentations to program services—target healthcare institutions, private practices, medical associations, and regulatory authorities. These organizations count on PHPs as expert resources for assessment, treatment recommendations, oversight, consultations, and support services.

Despite these strengths, PHPs face several limiting factors that challenge their ability to support physician well-being effectively. A challenge exists with restrictions around voluntary or preventative-type participation, with some programs requiring diagnoses. Differences in program frameworks and insufficient funding lead to problems such as understaffing and overwhelmed

leadership, which increasingly pressure PHPs' ability to achieve their objectives. Organizational factors also impede the effectiveness of PHPs through a lack of institutional memory of PHP services, problems within cultures, or unclear policies to address illness, behavior, or impairment. Moreover, some individual traits can further influence a physician's willingness to seek help, hindering motivations to engage in PHP services. Even with continuous education and outreach initiatives throughout states, these obstacles still restrict the usage of PHPs.

The second research question explored how PHPs evaluate and monitor the effectiveness of their programs in supporting physician health and well-being. While methods for evaluation and monitoring differed across PHPs, every program recognized the benefits of feedback and program assessment systems. Though variable, these efforts were acknowledged as vital to understanding PHPs' impact on physician health and well-being.

This chapter presented the elements that enable and constrain PHPs in their efforts to support physician well-being and the methods used to evaluate their impact, as conveyed by participants. The analysis highlighted the vital role PHPs play in the healthcare system while acknowledging the obstacles they face in meeting their goals. The emergent themes reflect how specialized expertise, confidentiality, and collaboration with stakeholders facilitate the support for physician well-being. At the same time, they shed light on substantial challenges, including restrictive policies, variability among programs, and more considerable systemic obstacles.

These findings are further discussed in the next chapter, and their implications are examined against the backdrop of existing research and the broader context of physician well-being. This discussion will explore how these findings deepen our understanding of the role PHPs play in supporting well-being and suggest pathways for future research and practical advancements.

CHAPTER 5. FINDINGS AND CONCLUSION

This chapter encompasses the synthesized findings and conclusions of the study. It reviews the compiled perspectives of PHP leaders on the impact of their programs on physician well-being and the factors that enhance or impede their success. The study grew from the continued observation of increasing concerns about physician burnout and mental health issues that PHPs continue to see. Another prompt toward the study is the limited understanding of how PHPs operate beyond their focus on diagnoses such as substance use and psychiatric disorders. The results, framed through the lenses of SDT, Conservation of Resources (COR) theory, and JDCS, offer a conceptualization of PHPs as organizations that must meet their own psychological needs for autonomy, competence, and relatedness to function optimally. This section also covers suggestions for theory and application, along with recommendations for future studies, with an emphasis on improving the role of PHPs in the evaluation and monitoring of all presenting issues and consistent program assessments.

Summary of Findings

The study aimed to investigate the ways in which PHPs support physicians' overall health, going beyond the usual focus on substance abuse and mental health problems. By analyzing interviews with PHP leaders qualitatively, we find poignantly consistent themes. While there was some slight discordance among PHP leaders on whether well-being falls within the scope of PHP services, the overarching sense was that absent the constraints of limited resources and rigid statutes, PHPs could serve in a more expanded, supportive, and preventative role within their communities. PHPs provide education and outreach on their confidential services and leverage their available expertise within their states toward health and safety. The PHP stakeholder collaboration is a primary facilitator for PHPs in many situations. It helps PHPs

when they are at risk from a legal standpoint, with education and outreach, as well as promoting advocacy on matters that adversely impact physician health and safety. Stakeholder collaboration and maintaining peer-support models are two primary factors facilitating PHP work in supporting physician well-being. However, their ability to initiate upstream approaches is constrained by limited resources, state statutes, and culture. The research showed differences in standardized program evaluations among PHPs due to limited resources, underscoring the importance of having a standardized evaluation framework for PHP leaders to measure program effectiveness.

The results of this study provide an authentic leadership view of how PHPs balance their supportive role with the constraints imposed by external factors such as statutory limitations and stigma. This section interprets the results through the theoretical frameworks that guided the study. It offers an initial conceptualization of what these findings mean for PHPs and their capacity to support physician well-being.

Findings in Context of the Theoretical Framework

The combination of SDT, COR, and JDCS frameworks provides a cohesive I/O perspective that facilitates the interpretation of results. SDT is typically an individual-based lens within a work setting that centers on meeting the psychological needs of autonomy, competence, and relatedness to enhance the motivation and well-being of an employee (Ryan & Deci, 2017). This study applies SDT to PHPs as organizations that must meet these needs to function effectively. In the organizational context, autonomy reflects the ability of PHPs to independently manage their operations, make decisions, and adapt to the mental health needs of physicians. As reviewed by all participating leaders, the majority of PHPs face resource deficits and legal constraints that restrict their independence (autonomy) in delivering preventative services.

The tenants of COR include that the loss of resources is more detrimental than gains; that leaders and organizations must conserve and protect resources, leading to often defensive stances in the context of resource distribution and allocation; and in circumstances with limited resources, resource deplete can spiral, as organizations tend to reallocate and take valuable resources from one area to support another (Hobfoll et al., 2018). This was demonstrated in the need for PHP leaders to take on multiple roles due to understaffing and overextending other staff to meet the demands of the community. COR bolsters the conceptualization by holding up the significance of available resource and their preservation. The inadequate funding and staffing among PHPs contribute to unsustainable organizational competence and an inability to meet PHP program missions effectively. With no one-size-fits-all solution that will remove all external pressures, reducing stigma or statutory restrictions could enable PHPs to use their limited resources more efficiently. The optimal situation is a PHP's ability to focus on service quality rather than existing in a perpetual state of reactivity to the fluctuation of external pressures.

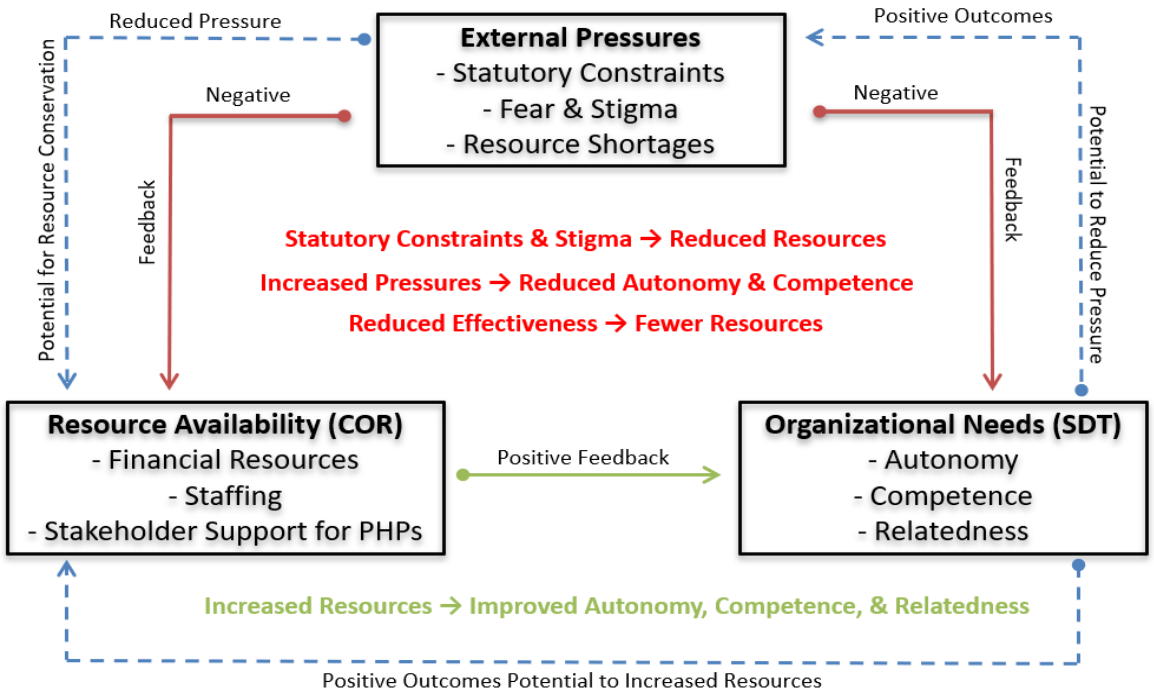
From an organizational perspective, relatedness involves a PHP's ability to foster strong stakeholder relationships and build trust with physicians, medical boards, and regulatory bodies. As participant 4 noted, "Confidentiality and peer support are critical to fostering trust with physicians." However, despite the momentum in state licensure disclosure changes, generational shifts in understanding mental health, and organizational efforts to address the prevalence of burnout and other work-related syndromes, mental health stigma frequently obstructs connections, as doctors may hesitate to seek assistance because of worries about privacy and possible consequences.

The JDCS theory further informs the study by highlighting the balance of job demands, control, and support that PHPs offer to physicians. JDCS explains that the adverse effects of high

job demands can be mitigated when control (i.e., the ability to make decisions about one's work) and support are present (Karasek, 1979; Johnson & Hall, 1988). Peer-to-peer services are often a staple of PHPs, as evidenced by the backgrounds of many of the PHP leaders participating in this study, although not all. PHPs provide support through peer-to-peer confidential services that buffer against the high demands physicians face in their work. Yet, when PHPs face resource constraints, their ability to provide such assistance decreases, reducing their effectiveness in alleviating physician stress.

Figure 1

PHP Feedback Loops Between Resources, Needs, and External Pressures



Viewing PHPs through these three theoretical frameworks—SDT, COR, and JDCS—sheds light on how resource limitations, statutory constraints, and stigma undercut the autonomy, competence, and relatedness PHPs need to function optimally. For example, statutory restrictions limit PHPs' reach, scope, and services when requiring participants to have a diagnosis before

receiving services. Thus, those physicians who seek services but are either hesitant or do not meet eligibility for services turn to unspecialized or curb-side consultations, leading to poor quality care and delayed effective interventions. The shared perspectives of PHP leaders point to the adverse impacts of resource shortages. Shortages limit PHP competence in their capacities to address upstream and more preventative services despite the needs among academic and healthcare facilities. All PHP leaders emphasized the role stigma plays in contributing to physician help-seeking avoidance out of fears of disclosures and punitive systemic approaches, even when confidentiality is emphasized.

Overarching systems that undervalue PHPs' role weigh down their efficacy. The above conceptualization illuminates the complex nature of a PHP's context. These findings underscore the need for targeted interventions to resolve some of the adverse systemic influences and improve PHPs' overall functioning and impact.

Findings in Context of the Previous Literature

Study findings align with prior studies highlighting the significance of confidentiality, peer support, and stakeholder engagement in enhancing physicians' health and wellness. However, this study stretches beyond previous research by exploring the system pressures that PHPs encounter by applying the SDT, COR theory, and JDCS theory to frame these challenges. The use of SDT shows that PHPs must meet their own autonomy, competence, and relatedness needs for program success. Nevertheless, the research discovered that PHPs frequently need more resources and flexibility to address these demands because of the aforementioned external pressures and limited resources.

The addition of the COR theory helped widen the perspective towards a better understanding of how resource conservation and loss impact PHPs' ability to maintain their

organizational competence. As noted by Hobfoll et al. (2018), organizations that experience resource loss are at risk of diminished capacity to fulfill their core functions. What this means for PHPs is a reduced ability to respond supportively and proactively to physician needs. Furthermore, this limits the capacity to respond to the medical community's needs as a whole. The JDCS lens reinforces the importance of adequately mitigating the impact of high job demands physicians face. However, as this study reveals, PHPs themselves must be supported (in terms of resources and statutory flexibility) to deliver this support to physicians effectively.

Discussion of Results

Results of this research indicate that although PHPs have a unique advantage in offering assistance to physicians, they encounter substantial structural obstacles that hinder their impact. Mandated limitations make it so PHPs can only help specific diagnoses, leaving out broader issues that are just as likely, if not more, to impact patient care. PHPs' ability to adapt to the expanded needs of providers is restricted by resource scarcity, worsening the issues of access to specialized evaluation, treatment referrals, and monitoring capabilities. Thus, healthcare institutions are left in positions of finding superficial solutions to manage symptoms rather than the root causes. Legal limitations confine PHPs to reactive services, answering Research Question 1, which explores PHPs' effectiveness in supporting physician well-being. However, findings indicate that while PHPs aim to provide physical and mental health support, these constraints limit the scope of PHP services by requiring diagnoses in some PHP cases. Additionally, funding is limited as it relates to proactive approaches, meaning that PHPs only partially address the research question regarding support for overall well-being.

This limits PHPs, in particular, smaller, less funded, and understaffed PHPs, from expanding their scope toward awareness and prevention in the areas needed to help mitigate the

prevalence of burnout, anxiety, depression, and suicide through collaborative educational initiatives. A critical cause that the literature reflects is linked to poor quality care and medical errors (Shin et al., 2023), an area that is often tied to early career trainees (Fatima et al., 2021). Depending on the PHP structure, size, and services, programs put efforts into service provision for students and trainees. However, some states are bound to restrictions toward the utilization of received regulatory funds and are prohibited from utilizing funding for non-licensed physicians. Again, another strain on already limited funding is blocking crucial proactive support where it is needed most. This limitation suggests that regulatory structures may contribute to the constrained PHP services observed in this study, underscoring the need for policy adjustments to improve PHP accessibility across different stages of a physician's career.

The data revealed that, despite extensive efforts from all participating PHPs, stigma continues to be a significant barrier to physician involvement with PHPs. Physicians remain reluctant to seek help from PHPs due to myths and fears regarding confidentiality and licensure. Fears, however, are not unfounded in that confidentiality is limited in many states, and confidentiality does not extend to credentialing bodies or board certifications in most cases. While PHPs offer confidential services, the fear of disclosure and stigma surrounding mental health continue to hinder relatedness—one of the core needs identified by SDT. This finding ties directly into Research Question 2, examining factors that influence physician engagement with PHPs, potentially in partnership with medical training institutions and healthcare organizations. Stigma within the culture of medicine is deeply embedded and a topic that came up throughout all leader interviews in relation to utilization rates. This a problem that requires the collaboration of stakeholders (e.g., academic and healthcare institutions) alongside PHPs, given its far-reaching impact on individual providers, healthcare institutions, and, consequently, patients.

Study findings support the realized efforts of the FSPHP, which has created a thorough collection of assessment criteria, metrics, and assessment method specifications that correspond with the 2019 FSPHP PHP Guidelines by involving a wide range of subject-matter experts in a robust consensus-building process. This program, the Performance Enhancement and Effectiveness Review (PEER), has the potential to provide the standardized metrics needed to evaluate PHPs' success in supporting physician health and well-being and facilitating consistency across PHPs in crucial areas. The PEER initiative was visited during several interviews, where leaders were encouraged that it could improve the consistency among PHPs and help with gaps in PHP quality and efficiency. These findings suggest that adopting standardized metrics like those proposed by PEER could help resolve some of the inconsistencies noted across PHPs in this study. PEER's progress highlights the importance of research-backed tools in establishing a more reliable PHP evaluation process, indicating a key area for ongoing research to monitor PEER's impact over time.

Statements from both the FSPHP and FSMB support this study's findings. In its safe-haven position statement, the FSPHP (2024) emphasizes the significance of advocacy around confidentiality and notes that confidentiality promotes early intervention and trust, both of which are pivotal in encouraging physicians to seek help. The FSMB's Policy on Physician Illness and Impairment (2021) speaks to the role of PHPs in supporting physician health through wellness programs, early detection, and ongoing monitoring. Together, these endorsements suggest a unified call for collaboration between PHPs and state medical boards to strengthen confidentiality measures. This aligns with this study's finding that confidentiality remains a major barrier to PHP engagement. Given the apparent consensus on the importance of

confidentiality, future research should examine the efficacy of recent policy efforts to protect physician privacy and assess how these changes impact PHP participation rates.

The importance of PHPs and state medical boards working together cannot be overstated; efficient monitoring and evaluation processes are reiterated in this document, accentuating the need for standardized metrics to measure program results (FSMB, 2021). Together, the next area of focus is creating a reliable process for assessing PHP programs, facilitating more research, and, consequently, providing more evidence-based support around effective evaluation, monitoring, and support for physicians and corresponding institutions. Ultimately, the findings suggest that a more reliable, standardized approach to PHP evaluation is essential to achieving consistent quality and care. Continued research on PHP evaluation metrics and policy impacts could play a significant role in validating PHPs and addressing the systemic barriers currently limiting their potential.

Study Limitations

This study had a small sample of PHP leaders, which may only partially represent the experiences of some PHPs across different regions. While efforts were made to locate PHPs spanning these regions, the unique economic and political states influencing programs, even within the same region, could cause results to vary with limited generalizability—a common criticism of qualitative research. Since the study relied heavily on interviews with PHP leaders, participant bias is a limitation, as the results reflect only their perspectives, which again may differ according to their personalities, educational backgrounds, and lived personal and professional experiences. As reviewed earlier as a part of the methodology section of this report, my own biases as the researcher and interviewer are limiting factors of this design. Finally, the theoretical frameworks utilized in the conceptualization of results may not fully capture the

complexities experienced by all PHPs, which could limit the external validity of these findings; however, the framework provides a fertile foundation for understanding the key contributing and limiting factors of PHPs in their support of physician well-being, and from which to grow upon.

Study Implications

This study's theoretical contribution falls within the realm of I/O psychology, relating to organizational culture, leadership, and employee well-being. While adjacent, PHPs are established entities across the US that support regulatory agencies in protecting healthcare consumers through evaluating and monitoring physician health (including mental health). This study lays the groundwork for continued research on how PHPs can enhance their reach, utilization, and overall efficacy.

The case conceptualization expands the application of I/O literature in its application of SDT and COR theories on an organizational scale. It offers new perspectives on how PHPs manage their resources and overcome obstacles. The lens considers PHPs as entities with their own psychological needs for autonomy, competence, and relatedness. The JDCS theory emboldens the lived experiences of PHP leaders in physician health. It offers a new perspective on which to view how external entities, like PHPs, can and do create a safe space to listen, evaluate, and help address the pressures experienced by doctors and as far as the participating leaders in this study, they come by this work authentically, with passion, and dedication toward helping the physicians. The research shows, however, that a PHP's capacity to offer adequate services is closely tied to the resources afforded to them.

Practice & Policy Implications

The practice implications of this study are significant for healthcare institutions, policymakers, and PHPs themselves, with findings suggesting that increasing funding and

resources for PHPs would enable them to offer preventive care and address a broader range of mental health issues. Most PHPs have a portion of their funding that comes through donations and for the contracted services they provide through academic training institutions; however, these remunerations typically fall short of the value gained from PHP involvement. Additionally, the study highlights the need for policy reforms to reduce stigma and improve confidentiality protections for physicians seeking help; these reforms are in motion at the national level. However, the movements need to be more cohesive and consistent at institutional levels. Continued work and collaboration between PHPs and healthcare leaders, particularly in positions where health and well-being are focal objectives, are necessary.

Collaborations with healthcare leaders and institutional partnerships could take form through conversations regarding hospital onboarding procedures, where physicians are provided education on the links between physician health and well-being on quality patient care and safety and available resources within the system and external, for example, through PHPs. Essentially, it is a preventative inoculation for onboarding physicians into a culture that prioritizes health and well-being as a measure of professionalism and standard of care. PHPs have the potential to seek consultations with hospital administration to support the development of guiding institutional policy and procedures (e.g., processes by which voluntary and mandatory referrals are made to the local PHP) that underscore health and behavioral expectations and standard operating procedures when complaints and circumstances arise where matters of professionalism, illness, or impairment may be a contributing factor.

Similarly, PHP partnerships with academic institutions are vital, and most participating PHPs have some level of involvement with local medical schools, although this varies depending on size, structure, and sources. PHPs can be involved and engaged with incoming students

through tailored presentations and orientations, collaborations on a curriculum focused on physician health topics (self-care as a professionalism imperative), and educating on the criticality of self-awareness, resource-building, and help-seeking proactively. These concentrated efforts provide concretized policy and procedures that ingrain PHPs into the institution structure, reducing the resources spent educating on the scope and services of PHPs, secondary to leadership transitions and administrative turnover – which was noted as a challenge for PHPs when it comes to myths, underutilization, and PHPs being seen as punitive action. Upstream approaches in this vein provide, for medical students and trainees, evidence toward a necessary shift in the culture of medicine. A shift in a direction where the prevalence of anxiety, depression, burnout, and suicide are acknowledged, prioritized, and actively addressed at the systemic level. Even micro-adjustments can lead to significant beneficial impacts.

Recommendations for Future Research

Future research should focus on the expansion of the scope of PHPs to address the full spectrum of physician mental health issues, including burnout. More evidenced-based literature exploring the efficacy and efficiency of the PHP model is needed. Additionally, within I/O psychology researchers, the field of medicine is ripe with opportunities to investigate further the role of organizational culture in shaping physician engagement with PHPs and the rates of success of PHP involvement in both voluntary and mandatory referrals. Because research on PHPs, as they function today, is so scant, an in-depth exploration of how medical-cultural factors influence the utilization rates of PHP services could also yield valuable information.

Participants shared that a collective database among PHPs would be highly beneficial in advancing PHP-related research. A collective database could facilitate more comprehensive data collection and cross-program comparisons, helping PHPs better understand trends, outcomes,

and areas for improvement. This would also support the ongoing development of programs like the FSPHP PEER program by providing valuable longitudinal data that could enhance standardized evaluation metrics. Investing in a shared resource like this could help accelerate research and provide deeper insights into PHPs' effectiveness in promoting physician well-being.

In addition to developing more robust evaluation systems, future research should consider piloting upstream approaches through academic institutions that train medical students and trainees in physician health, emphasizing the importance of self-care as an ethical and professional imperative. Assessing whether programming at this level influences students and trainees and how they fare later in their careers could provide support for specific and practical program implementations.

Educating future physicians on the implications of physician well-being for academic and clinical performance could play a critical role in promoting early intervention and preventing mental health crises. These initiatives should also focus on cultivating self-awareness—teaching students and trainees to recognize when, how, and where to seek help and access available resources. Bolstering *healthcare-self-care* modules could normalize seeking help and lessen mental health stigma among early-career physicians.

Piloting programs for licensed physicians that introduce or refresh these same topics upon onboarding to a healthcare institution could further extend the impact of PHPs. These programs could incorporate education on physician health, self-care, and resource access, ensuring that practicing physicians are equipped with the tools to prioritize their own well-being, which, in turn, can improve patient care. Adding these types of upstream initiatives to the PHP literature would offer valuable insights into how PHPs can influence physician well-being from the earliest stages of training through the entirety of their careers. By piloting these programs, PHPs could

demonstrate their role in preventing burnout and ensuring the long-term health and safety of physicians.

There is also a need for longitudinal studies that track the long-term outcomes of physicians who participate in PHPs better to understand the effectiveness of these programs over time. A replication of this study at a grander scale, including all PHPs, could yield a better generalization of the PHP leadership perspective, with more specifics around internal structures and operations, which could be helpful. Establishing a centralized database could serve as a foundation for these studies, enabling PHPs to assess not only short-term recovery but also the long-term well-being of physicians.

CONCLUSION

This qualitative study explored PHP leaders' perceptions of the roles that PHPs play in supporting physicians' well-being. The study included triangulation of national-level stakeholder documents. Findings show that although PHPs are primarily focused on evaluating health conditions, a significant number of programs find that their services generally promote well-being. More specifically, they could do so more explicitly with adequate resources.

PHP leaders see outreach efforts, educational initiatives, and partnerships with stakeholders as ways PHPs support physician well-being. While PHPs are not necessarily seen explicitly as wellness programs, nor are they advertised as such, leaders see them as helpful efforts within the community. Findings also noted that PHPs are not able to expand on these efforts in a more concentrated way due to a lack of funding, staffing, and regulatory restrictions that place this beyond the scope and reach of most PHPs.

The results showed that PHPs struggle to meet their organizational autonomy, competence, and relatedness needs because of external pressures. As reflected in the perspective

of PHP leaders, external pressures encompassed statutes, inadequate resources, and the stigmatization of mental health. These perspectives are supported by theoretical models used as frameworks for this study, such as SDT, JDCS, and COR. Moreover, it reflects that although PHPs are in excellent and expert positions to provide support, they are encumbered by obstacles restricting their efficiency and utilization. Statutory mandates, for example, frequently require PHPs to offer assistance within specified parameters (e.g., specific diagnoses), which hinders their ability to branch out into broader prevention areas such as burnout. Lack of resources due to outside pressures hinders prevention, ultimately leading to reactive rather than proactive services by PHPs.

The study findings are supported by FSPHP and FSMB statements emphasizing the importance of confidentiality, stakeholder engagement, and program metrics. The emphasis elucidates the need for more standardized programming and metrics among PHPs to ensure stable and solid outcomes across US PHPs. This was an area perceived as needing improvement by most participants. However, it remains a significant potential endeavor, one that could help expand the evidence-based research on PHP models. Other initiatives like those from the NAM Action Collaborative on Clinician Well-Being and Resilience (NAM, 2024) and the Lorna Breen Foundation (Robeznieks, 2024) have magnified the need for confidentiality and upstream approaches, offering additional support for this study's findings.

Although the study provides valuable insights, it has its limitations, as previously reviewed. The qualitative nature of the research, along with the focus on PHP leadership perspectives, potentially obscures the complete capture of the experiences of physicians involved with PHPs. Future studies could incorporate the perspectives of PHP participants or referral sources to examine how PHPs could further collaborate on preventive projects. This study

offered considerations for policy development in academic and healthcare systems, as well as COR-framed insights. COR allows us to specifically consider the resource needs of PHPs in order to enhance the ability of PHPs to meet the growing needs of medical communities, ensuring that both physician well-being and patient safety are prioritized.

This study provided valuable insights into PHPs' role in promoting physician well-being while also introducing a conceptual framework that integrates SDT, COR, and JDCS theories at the organizational level. It showed that when PHPs are viewed as entities with their own requirements for autonomy, competence, and relatedness, it highlights the structural constraints that hinder them from adequately promoting physician well-being. Resource shortages, legal restrictions, and stigma limit the PHPs' ability to offer preventive approaches and mental health services.

Improving PHP effectiveness and promoting physician well-being requires addressing limitations through resource allocation, policy reforms, and standardized evaluation practices like FSPHP PEER. Moreover, upstream projects such as implementing early interventions in school and training programs present hopeful prospects for PHPs to have a broader influence on physicians' well-being from their education to their professional lives. PHPs can have a powerful impact on promoting cultures of wellness and enhancing healthcare safety.

In reflection, I have a deepened and renewed understanding of the challenges that PHPs, physicians, and academic and healthcare entities contend with in supporting physician well-being. Most stakeholders are vested in supporting the health and safety of community providers. However, moving forward requires the continued collective and concerted efforts and resources of critical leaders at regulatory, governmental, and institutional levels. This research journey has reinforced and renewed my commitment as a champion of physician health and the overall well-

being of all healthcare providers, as well as providing growth and direction for the future applications of I/O psychology within medicine.

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