Federation of State Physician Health Programs (FSPHP), Inc.

Physician Health Program Guidelines

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ACCOUNTABILITY • CONSISTENCY • EXCELLENCE (ACE) COMMITTEE

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Section One: Introduction

Acknowledgments

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Cautionary Statement as to Purpose and Use of Guidelines

The following Guidelines have been designed to assist State Physician Health Programs (PHPs) and, therefore, are specifically directed to physician support. An earlier version of these Guidelines was developed and accepted by the Federation of State Physician Health Programs (FSPHP) in 2005.[1] This document updates and expands the original Guidelines, reflecting developments in the science, practice, and scope of PHP services over the past decade. Many PHPs assist healthcare professionals in addition to physicians, such as dentists, nurses, veterinarians, and/or pharmacists. The use of the Guidelines for other professionals is left to the discretion of the individual PHP.

As in the original Guidelines, these Guidelines may not encompass all administrative structures or options available to PHPs. Legal, contractual, or regulatory requirements of each state may render some or all of the Guidelines inapplicable to an individual PHP. It is important that the user of the Guidelines be fully aware of individual state laws, rules, regulations, and responsibilities defined with licensing and regulatory agencies.

Many PHPs have insufficient resources or lack statutory authority to fully implement the recommendations presented in these Guidelines. For such a PHP, the Guidelines may assist in defining the scope of services it can offer, while providing a path forward for program enhancement and expansion inclusive of the necessary funding. State PHPs are encouraged to work toward the implementation of these Guidelines and to limit scope, if appropriate, to ensure that the services provided meet the minimum standards of expectations for the conditions covered.

The FSPHP Guidelines for PHPs do not address cases involving sexual misconduct. These Guidelines and the PHP model references are applicable to potentially impairing illness related to substance use and physical or mental health disorders. As such, these guidelines should not be referenced as a guide for managing matters related to professionals with allegations of sexual misconduct. Matters involving allegations of sexual misconduct are guided by applicable reporting laws in each state. Determination of discipline is the sole responsibility of the respective state licensure board. Participation in a PHP is not in lieu of reporting requirements. Physicians involved in such matters may or may not be eligible to participate in a PHP. Please refer to the FSPHP statement on sexual misconduct for more information.

While the Guidelines represent best practices developed by PHPs across the United States and Canada, this document should not be construed as establishing standardized practices for physician health programs. PHPs operate in diverse legal and regulatory climates and have disparate resources that, of necessity, influence an individual program's practices and services. Use of these Guidelines (in whole or in part) is expected to be informed by sound judgement, experience, and discretion that reflect the PHP's unique circumstances. Most important, the Guidelines are not intended to eliminate the use of discretion by experienced PHPs.

PHPs are encouraged to use these Guidelines as a resource to strive for accountability, consistency, and excellence in the delivery of PHP services.

Federation of State Physician Health Programs

Purpose

The Federation of State Physician Health Programs, Inc. (FSPHP), is a nonprofit corporation whose purpose is to provide a forum for education and exchange of information among state physician health programs (PHPs). The FSPHP develops common objectives and goals, enhances awareness of issues

related to physician health and impairment, and provides advocacy for physicians and their health issues at local, state, and national levels. By supporting member PHPs, FSPHP aims for a successful means of confidential and professional support of physicians and other licensed healthcare professionals experiencing substance use disorders, mental illness, physical illness, and other potentially impairing conditions that may adversely affect the physician's or other healthcare professional's ability to safely and effectively treat patients.

History

The Federation of State Physician Health Programs, Inc. (FSPHP), evolved from initiatives taken by the American Medical Association (AMA),[2] the Federation of State Medical Boards (FSMB),[3] and individual state PHPs, focusing upon rehabilitation and monitoring of physicians experiencing substance use disorders, mental illness, physical illness, and other potentially impairing conditions. The initial success of these efforts led to the creation of an independent organization that would carry out this mission in a consistent and objective fashion. Beginning in December 1990, the FSPHP assumed this role. The FSPHP is a nonprofit organization with elected officers and a Board of Directors. Initiated by several states with advanced programs, it now has a membership of 47 state programs.[4]

Mission: To support physician health programs in improving the health of medical professionals, thereby contributing to quality patient care.

Vision: A society of highly effective PHPs advancing the health of the medical community and the patients they serve.

Guiding Values

Membership: FSPHP is dedicated to enhancing the value of membership and upholding an environment of collegiality and networking.

Advocacy: FSPHP strengthens PHPs by promoting best practices and providing Guidelines, advocacy, and other resources that enhance their effectiveness. FSPHP encourages partnerships among physician health programs, regulatory boards, and other appropriate components of organized medicine.

Collaboration: FSPHP fosters collaboration and engagement with other national and international medical organizations.

Equality: FSPHP opposes discrimination against physicians and the medical community solely based on the presence of a particular diagnosis and/or other discriminatory factors and supports the use of PHP services in lieu of disciplinary action whenever possible.

Education: FSPHP supports education and research designed to establish best practices for the prevention, treatment, and monitoring of physicians experiencing substance use disorders, mental illness, physical illness, and other potentially impairing conditions.

History of Physician Health Programs

Evidence of physicians having psychoactive substance use disorders, mental health problems, and physical illnesses has been documented throughout history.[5,6] Formal efforts to deal with physician impairment existed as far back as 1958.[7] At that time the Federation of State Medical Boards (FSMB) of the United States identified drug addiction and alcoholism among doctors as a disciplinary problem. The

FSMB called for the development of model programs of probation and rehabilitation to be utilized by individual state boards and later approved a resolution calling for programs nationwide.

In the early 1970s, the American Medical Association (AMA) recognized there were struggling physicians within the United States who needed their own place to go for a myriad of problems. The AMA published "The Sick Physician Impairment by Psychiatric Disorders, Including Alcoholism and Drug Dependence" in the *Journal of American Medical Association*.[2] With the advice and consent from the AMA and the Federation of State Medical Boards, a national initiative was launched to develop therapeutic alternatives in lieu of automatic discipline for physicians who needed assistance. Such initiatives recognized the position of healthcare professionals as safety-sensitive workers responsible for their patients' health and safety and the need to promote physician well-being.

Today, the PHP model of care management includes physicians and other healthcare professionals and occurs with the knowledge that (1) addictive, psychiatric, or other potentially impairing conditions may be chronic relapsing conditions, and (2) without appropriate treatment and accountability, individual health and public safety are at risk. This coordination and documentation of a participant's progress allow the PHP to provide verification of a participant's compliance with treatment and/or continuing care recommendations. PHPs are committed to educating the healthcare community as to principles of the program and other issues of physician well-being through the promotion of written materials and educational opportunities for health professionals.

PHPs usually operate independently from other organizations and regulatory agencies. They operate in a manner that protects the privacy and dignity of the participants in accordance with state and federal laws or regulatory contracts as more fully discussed within these Guidelines.[8] When appropriately authorized, PHPs may offer unique benefits while still respecting regulatory limitations to privacy. This includes, but is not limited to, a safe haven where licensees are not required to disclose psychiatric, addictive, and/or other potentially impairing illness to their regulatory agency when such licensees are compliant with the health and safety requirements of their PHP. PHPs typically do not provide treatment. Instead, they offer case-management services, coordinate continuing care, and document appropriate illness management.

Healthcare Professionals as Safety-Sensitive Workers

When a healthcare worker develops a potentially impairing condition, such as a mental health or substance use disorder (SUD), the very nature of his or her work demands comprehensive and sustained monitoring to ensure his or her health and well-being. Safety-sensitive workers such as healthcare professionals, airline pilots, and others have several qualities that create distinct treatment and case-management needs. These include but are not limited to workplace environment issues, personality factors, a responsibility to the public, and a need to balance the individual's need for privacy with the need for public safety. Some healthcare professionals work in high-risk environments with direct access to controlled substances, thereby increasing the risk and consequences of misusing these substances. Healthcare professionals often have difficulty accepting the role of patient, which necessitates care by treatment providers that are capable of helping the individual overcome such obstacles. The potential impact on the public takes into consideration the size of the population potentially affected, the depth of damage to a given individual, and the loss of trust in a profession or industry that is caused by a breach of this trust. For healthcare workers, the potential for significant damage to a single person arising from actual impairment and the loss of public trust qualifies healthcare as a safety-sensitive occupation. Recidivism in the healthcare worker and the associated potential for harm to the public necessitate care at the highest level available to minimize risk. The healthcare system is, of necessity, concerned about the

safety issues should a professional relapse into substance use or suffer an exacerbation of a mental illness. Regulatory agencies, organized medicine, hospitals, employers, and others partner with PHPs in efforts to reduce the risk (and the perception of risk) of public harm.

A single relapse in a substance use disorder may result in a loss of hospital privileges, loss of a practice or career, or loss of license.[9] Therefore, it is critical that professionals with potentially impairing conditions be identified prior to any patient harm and be allowed the opportunity to work with the PHP. The privilege of providing care to others requires that such professionals engage in treatment that is often felt to be more rigorous than that required of the general population and to submit to monitoring that is comprehensive and prolonged. This is acknowledged in the ASAM Criteria: Treatment Criteria for Addictive, Substance-related, Co-occurring Conditions.[10] The combination of a more extensive episode of initial care and uninterrupted random drug testing results in remarkable remission rates from substance use disorders.[11-17] Data about mental health conditions other than substance use disorders is hopeful but sparser.[18,19]

Mental health, substance use disorder, and other potentially impairing illness treatment among healthcare workers is markedly more effective in a cohort of peers and in specialized treatment centers that are skilled in the illnesses being served.[20,21] As discussed below, specialized treatment centers and providers must be experienced in working with the healthcare professional personality styles and other nuances related to the healthcare profession.[22] Effective treatment can occur when the healthcare professional is able to address comorbid conditions and other relevant issues amongst a cohort of peers and the triggers or stressors of the work environment to which he or she will return are understood and properly addressed.[16,23]

The PHP model of managing mental health disorders, substance use disorders, and other potentially impairing illnesses is gaining increasing attention. More treatment providers who are willing to actively participate in this effective disease-management model are needed in the United States and Canada. Healthcare professionals in safety-sensitive occupations must be encouraged to access treatment without fear of reprisal. Despite the stigma[24] promulgated by credentialing and regulatory agencies asking a professional to disclose if he or she has had treatment for a mental health condition or substance use disorder, PHPs offer the best means available to balance personal privacy and public trust.

Role and Philosophy of PHPs

PHPs protect the public by providing case-management services to healthcare professionals with potentially impairing illnesses. Case-management services include intervention, care coordination, and ongoing monitoring of the healthcare professional's illness management. PHPs also provide education to a variety of stakeholders and may engage in research.[25] The services of most PHPs are confidential, with exceptions defined by state statute or the PHP's relationship to regulatory agencies. PHPs provide a nondisciplinary program of accountability for healthcare professionals with health conditions that have the potential to compromise the ability to practice with reasonable skill and safety if left untreated. PHPs require legal authority to operate as an alternative to discipline. Their services are most often granted through a formal agreement with their respective regulatory agency or through legislative mandate.

PHPs vary as to the scope of conditions they address, often referred to as "qualifying conditions." For example, some PHPs may be limited to providing services for healthcare professionals with substance use disorders, while other PHPs may also offer assistance for potentially impairing psychiatric and non-

psychiatric health conditions, including cognitive decline.[26] A PHP should have the expertise and resources to competently and effectively manage any area in which it offers services.

PHP participants should not be subject to investigation or disciplinary action by a regulatory or credentialing authority based solely upon a health diagnosis or affiliation with a PHP. Similarly, a healthcare professional with a substance use disorder should not be disciplined based solely on the manner of obtaining substances, the type of substance used, or the method of delivery. When a healthcare worker diverts substances for personal misuse and that diversion does not impact patient care, a rehabilitative approach that includes future accountability is the best response. This balanced, science-based action enhances the long-term prognosis for the professional and at the same time is the most optimal means to support public safety. Effective use of an alternative to discipline process enhances the likelihood of earlier detection of potentially impairing illness.[27]

PHPs accept good-faith referrals from colleagues, family members, employers, health organizations, credentialing bodies, and boards/regulatory agencies. If referral to a PHP satisfies a state-mandated reporting law, it is the referent's responsibility to demonstrate compliance unless otherwise provided by law. A PHP participant may be entitled to confidentiality provided he or she maintains compliance and successfully completes the PHP program.[28,29] For a further discussion of confidentiality, see page 16 in these Guidelines. Disclosure of PHP participation to third parties may be required by law, PHP Agreement, or consent. Confidentiality within a PHP means, except as noted above, information will not be shared with the National Practitioner Data Bank, other data collection systems, boards, or commissions.

PHPs are dedicated to promoting excellence in medicine and work to prevent licensees from practicing medicine while impaired. PHPs typically require a participant to voluntarily refrain from practice until the treatment providers determine that the participant is fit to safely return to practice with endorsement of the PHP. A healthcare professional unable or unwilling to withdraw from practice during a period of impairment or illness exacerbation may be reported to the appropriate authority in accordance with state reporting obligations or individual PHP operations. Nothing in these Guidelines is intended to suggest or imply that participants in PHPs are not accountable to regulatory agencies for behavior which otherwise violates a medical practice act or jeopardizes patient safety.

Through rigorous longitudinal monitoring, PHPs are able to provide documentation of compliance and associated endorsement of participant well-being, and so combat the discrimination, shame, and stigma associated with potentially impairing illness. PHPs' longitudinal monitoring and endorsement provide an avenue of continuing or returning the participant to the active practice of medicine. PHPs' support is based upon periodic contact with the participant as well as objective and verifiable measures of recovery including but not limited to review of independent evaluations, periodic treatment reports, and other documentation indicative of wellness, such as laboratory tests. By consistently applying objective and verifiable accountability measures, PHPs and their participants develop and maintain credibility with the public as well as positive relationships with regulatory agencies and credentialing entities.

Functions of Physician Health Programs (PHPs)

The essential function of a PHP is to enhance public safety by promoting the health of physicians in their state or province. This is accomplished through outreach services, providing oversight of mental health care and following the status of that care so that when participants are engaged in active practice, such

participants are considered capable of practicing their profession safely and effectively. These objectives are further broken down into multiple components:[30]

1. Accepting self-referrals and referrals from others concerned about a healthcare professional's well-being.
2. Assessing the validity or eligibility of the referral to the PHP program in a confidential, respectful, and professional manner. Collateral information may be obtained to determine the appropriate next steps.[25]
3. Making initial contact for the purpose of coordinating an appropriate interview, evaluation, or referral as deemed appropriate. Some PHPs perform an initial assessment to determine the needs of a potential participant, while others refer all participants to outside providers.[8]
4. Coordinating evaluation and/or establishing treatment at an appropriate level of care.[11]
5. Oversight of the participant through the course of evaluation and any subsequent treatment, monitoring participant response and compliance with care provided by qualified healthcare providers.
6. Establishing a structure for accountability, including case management. This is usually accomplished through a written agreement between the participant and the PHP.
7. Responding to changes in health conditions or other concerns that emerge during the course of monitoring.[25]
8. Providing mechanisms to enhance detection of relapse and to support stability on an ongoing basis.
9. Using objective data to document participant activities that achieve and sustain remission and document appropriate illness management. Such data is used to endorse a participant's well-being and ability to practice medicine safely, from a health perspective, supporting credentialing, licensing, and insurability.[11]

PHPs also function as a primary, secondary, and tertiary prevention educational resource regarding physician wellness and the development and utilization of effective treatment. PHPs support educational opportunities for health professionals and medical communities. PHPs promote recognition and understanding of the disease model of addiction, other psychiatric illnesses, and early detection of potential impairment. Cultivating relationships with medical schools and residency training programs promotes prevention and education of the next generation of physicians regarding these illnesses.

Ideally, PHPs offer outreach and educational activities to peer professionals, training institutions, professional associations, hospitals, medical groups, licensing authorities, legislators, employee assistance programs, mental health providers, treatment providers, malpractice insurers, managed care plans, consumer groups, family members, and the general public, whenever possible.

Opportunities for education occur in individual discussions as well as lectures, brochures, websites, publications/articles, newsletters, display booths, and on-site consultations. Offering support and guidance for development of information to be provided in licensing/credentialing applications and malpractice and other insurance forms also becomes an educational opportunity to promote physician wellness. PHPs may assist medical staff to develop effective bylaws and mechanisms that promote physician health and compliance with credentialing for both the individual and facility.[31]

PHPs are a unique interface between regulatory agencies and licensees with potentially impairing illnesses. PHPs promote transparency and accountability regarding process and procedures, which facilitates communication and strengthens relationships. PHPs emphasize that early diagnosis, treatment, and monitoring of health professionals with potentially impairing health conditions are more effective than disciplinary action alone. PHPs also offer the same unique interface with organized medicine and other entities when appropriate.

References for Section One: Introduction

1. Federation of State Physician Health Programs. The 2005 physician health program guidelines. In:2005: http://www.fsphp.org/2005FSPHP_Guidelines.pdf. Accessed April 3, 2012.
2. American Medical Association: Council on Mental Health. The sick physician: Impairment by psychiatric disorders, including alcoholism and drug dependence. *Journal of the American Medical Association.* 1973;223(6):684-687.
3. Federation of State Medical Boards. *Report of the Ad Hoc Committee on Physician Impairment.* Ft. Worth, Texas 1995.
4. Federation of State Physician Health Programs. List of State Programs. 2016; http://www.fsphp.org/state-programs. Accessed 11/18, 2018.
5. White WL. *Slaying the dragon: the history of addiction treatment and recovery in America.* Bloomington, Ill.: Chestnut Health Systems/Lighthouse Institute; 1998.
6. White WL, DuPont RL, Skipper GE. Physicians health programs: What counselors can learn from these remarkable programs. *Counselor.* 2007;8:42-47.
7. Wall J. The results of hospital treatment of addiction in physicians. *Federation bulletin.* 1958;45(5):144-152.
8. DuPont R, McLellan A, Carr G, Gendel M, Skipper G. How are addicted physicians treated? A national survey of Physician Health Programs. *Journal of substance abuse treatment.* 2009;37(1):1-7.
9. Centrella M. Physician addiction and impairment—current thinking: a review. *Journal of addictive diseases.* 1994;13(1):91-105.
10. American Society of Addiction Medicine. *The ASAM Criteria: Treatment Criteria for Addictive, Substance-related and Co-occurring Disorders.* Third ed. Carson City, Nevada: The Change Companies; 2013.
11. DuPont R, McLellan A, White W, Merlo L, Gold M. Setting the standard for recovery: Physicians' Health Programs. *Journal of substance abuse treatment.* 2009;36(2):159-171.
12. McLellan AT, Skipper GE, Campbell M, R.L. D. Five year outcomes in a cohort study of physicians treated for substance use disorders in the United States. *BMJ.* 2008;337:1-6.
13. Rose JS, Campbell MD, Yellowlees P, Skipper GE, DuPont RL. Family medicine physicians with substance use disorder: a 5-year outcome study. *Journal of addiction medicine.* 2017;11(2):93-97.
14. Domino K, Hornbein TF, Polissar NL, et al. Risk factors for relapse in health care professionals with substance use disorders. *JAMA : the journal of the American Medical Association.* 2005;293(12):1453-1460.
15. Skipper G, Campbell MD, DuPont RL. Anesthesiologists with Substance Use Disorders: A 5-Year Outcome Study from 16 State Physician Health Programs. *Anesthesia and analgesia.* 2009;109:891–896.

16. Skipper GE. Treating the chemically dependent health professional. *Journal of addictive diseases.* 1997;16(3):67-73.
17. Buhl A, Oreskovich M, Meredith C, Campbell M, DuPont R. Prognosis for the Recovery of Surgeons From Chemical Dependency: A 5-Year Outcome Study. *Arch Surg.* 2011;146(11):1286-1291.
18. Knight JR, Sanchez LT, Sherritt L, Bresnahan LR, Fromson JA. Outcomes of a Monitoring Program for Physicians with Mental and Behavioral Health Problems. *Journal of psychiatric practice.* 2007;13(1):25-32.
19. Knight JR, Sanchez LT, Sherritt L, Bresnahan LR, Silveria JM, Fromson JA. Monitoring physician drug problems: attitudes of participants. *Journal of addictive diseases.* 2002;21(4):27-36.
20. Gastfriend DR. Physician substance abuse and recovery: What does it mean for physicians—and everyone else? *JAMA : the journal of the American Medical Association.* 2005;293(12):1513-1515.
21. American Society of Addiction Medicine. Persons in Safety Sensitive Occupations. In: Mee-Lee D, ed. *The ASAM Criteria: Treatment Criteria for Addictive, Substance-related and Co-occurring Disorders.* Third ed. Carson City, Nevada: The Change Companies; 2013:340-349.
22. Merlo LJ, Gold MS. Prescription opioid abuse and dependence among physicians: hypotheses and treatment. *Harvard review of psychiatry.* 2008;16(3):181-194.
23. Angres DH, Bettinardi-Angres K. *Healing the healer: The addicted physician.* Psychosocial Press; 1998.
24. Wallace JE. Mental health and stigma in the medical profession. *Health:.* 2012;16(1):3-18.
25. Carr GD, Hall PB, Finlayson AR, DuPont RL. Physician Health Programs: The US Model. In: *Physician Mental Health and Well-Being.* Springer; 2017:265-294.
26. As of January 2017, the 47 state members of the FSPHP provide services for substance use disorders, 43 of the 47 provide additional mental health services, and 37 of the 47 members provide services for behavior management.
27. O'Connor PG, Spickard A, Jr. Physician impairment by substance abuse. *The Medical clinics of North America.* 1997;81(4):1037-1052.
28. AMA Board of Trustees. AMA Statement on Physician Health Programs. In: AMA, ed2008.
29. Merlo LJ, Greene WM. Physician views regarding substance use-related participation in a state physician health program. *The American journal on addictions / American Academy of Psychiatrists in Alcoholism and Addictions.* 2010;19(6):529-533.
30. Federation of State Physician Health Programs. FSPHP Physician Health Program Guidelines. 2005; https://www.fsphp.org/assets/docs/2005_fsphp_guidelines-master_0.pdf, 2016.
31. Joint Commission on Accreditation of Healthcare Organizations. Comprehensive accreditation manual for hospitals, Section on Provider Wellness. In: Oakbrook Terrace, Ill.: The Joint Commission; 1994.

Section Two: Physician Health Program Fundamental Principles

Organizational and Administrative Considerations

PHPs vary widely as to their organizational structure.[8] A PHP should have the support of organized medicine and the regulatory agency, and the PHP must have a diversionary role allowing for a therapeutic alternative to disciplinary action when addressing potentially impairing health conditions. Several archetypal structures appear below. However, these typical structures are not mutually exclusive; in fact, many PHPs frequently meet a criterion in more than one of the following categories. With this caveat, PHP structures may be:

1. **Independent Not-for-Profit Corporate Programs:** Such a PHP may be a federally recognized 501(c)(3) corporation authorized by legislative authority or by formal agreement/contract with a licensing board and/or organized medicine. This nonprofit corporation engages with one or more regulatory agencies.
2. **Medical Society Affiliated or Sponsored Programs:** Such a PHP operates under a contract or formal agreement of understanding with Medical Society. The Medical Society commonly provides a varying degree of oversight; or
3. **Regulatory Agency Authorized or Regulatory Agency Managed Programs:** Such a PHP commonly has a contract or formal documented agreement with its Regulatory Agency. The Regulatory Agency then operates the PHP with varying degrees of independent clinical oversight. The FSPHP believes full Regulatory Agency oversight, where there is no firewall between the Regulatory Agency and PHP, derails the mission of the PHP, decreases efficacy, and discourages early referral for care. Therefore, it is never optimal to structure a PHP without some form of safe harbor.

It is preferred that the PHP is based in the same state as the Regulatory Agency and does not operate for the purpose of making a profit.

PHPs should operate with qualified, compensated staff and/or volunteers. PHPs should utilize medical oversight by a professional committed to physician health with appropriate experience, training, and skills. Board certification in psychiatry and/or addiction medicine is preferred.[32] PHPs should have access to a certified Medical Review Officer (MRO) with expertise in forensic testing of healthcare professionals. It is optimal to have a certified MRO as part of the PHP staff.[33,34] In addition to education, in-service, and internal program training, PHP directors, staff, and volunteers are encouraged to use resources available through FSPHP and other appropriate organizations to maintain current knowledge of developments and trends related to professional health.[35]

PHPs benefit from one or more of the following: an independent confidential administrative and/or case-management review committee, an active Board of Directors, or councils whose members are experienced in addressing the health conditions commonly addressed by the PHP. The case-management review committee(s) may be structured as a peer-review body and the functions of the committee must not be subject to discovery in any civil, criminal, or administrative action. Such a case-management review committee serves a different role from a Board of Directors. While a PHP Board of Directors reviews operations and fiscal viability of the PHP, the case-management review committee reviews

evaluations, treatment provider reports, and other relevant documentation, including status of compliance of participants. When appropriate, the case-management review committee would provide input or feedback regarding overall management of participants to the PHP staff.

Most PHPs require voluntary participation on the part of the identified healthcare professional. While this voluntary participation may be motivated by professional or personal issues, failure to work with the PHP may require the participant to be subject to mandated reporting to a regulatory agency. The decision to participate with the PHP is essentially intended to represent a voluntary desire to address one's health and well-being. If a participant disagrees with the PHP and/or the PHP case-management review committee, the PHP should have available a system for independent oversight or a nondisciplinary means for review.

Internal Review Process

The PHP model initially arose from peer-review processes. Protected peer-review allows for the free exchange of opinions without fear of punitive actions or liability in the interest of improving the delivery of healthcare, and peer-preview processes were not subject to review. Healthcare professionals who have been referred to PHPs often respond to the referral and subsequent evaluation or case management in a defensive manner, which may be motivated by fear, anger, denial, or their illness. Offering these professionals an additional review process serves both the PHP and the participant by reinforcing the reality that PHP decisions are based on recommendations of evaluators/treaters and other data.

Each PHP defines its own decision-making process, which may be impacted by individual state laws, rules, regulations, or regulatory agency agreements. A mechanism for a participant to request an internal review of decisions made in the PHP process should be available within the PHP process. Such a review allows the participant to request reconsideration by the initial decision makers with the participant submitting the basis for his or her request to the PHP with supporting documentation. An additional level of internal review may allow for access to an independent review by professionals who are part of the PHP, but who did not participate in the underlying decisions that are subject to review. Although such a review does not override the initial determination, it may provide the opportunity for reconsideration when evidence-based indications are identified.

If a participant is unwilling to proceed with PHP recommendations and is thought to have a potentially impairing condition, healthcare providers and/or physicians may have obligations to report the professional to the applicable regulatory agency in such instances, although the specific requirements, rules, and regulations vary from state to state or province.

Liability and Immunity

PHPs are required to engage in frank discussions and often participate in difficult decisions with the healthcare professional. A PHP is unable to do this effectively if the PHP is subject to acts of intimidation, bullying, or threats of litigation. PHPs should be afforded conditional or qualified privilege or immunity from civil liability.[36,37] In general, a conditional privilege or qualified immunity is afforded when the PHP acts in the bona fide exercise of its duties.[38] This privilege is lost if the PHP acts with malice, improper motive, or in bad faith. Such immunity must be granted by legislative authority. Many states that require mandated reporting of potentially impaired professionals also extend this immunity to the individual making the referral. This recognizes the important public policy that healthy professionals are believed to be more likely to deliver quality healthcare.

As such immunity is not absolute, PHPs may consider obtaining appropriate liability insurance. Typical types of insurance to consider include Directors and Officers, Errors and Omissions, Employers Insurance, and Administrative Medicine. These and other types of insurance coverages are outside the scope of this document.

Confidentiality

PHPs should serve as a confidential resource for healthcare professionals, and ideally any limits to confidentiality should be set forth within enabling legislation and/or contracts with regulatory agencies. The parameters for eligibility and confidentiality should be well defined to allow the physician anonymity and safe harbor when appropriate.[25,39] The opportunity for confidential support encourages professionals to seek help within the PHP system and encourages colleagues and others to refer professionals for assistance and treatment under the direction of a PHP.[40] The accountability and transparency required of PHPs to regulatory agencies does not mean a participant's individual information is publicly available.

Fear of judgment, the desire to protect one's privacy, and the real threat of personal and professional consequences, including public sanctions, discourage professionals from accessing the formal healthcare system and cause many to seek alternative care. PHP oversight and support enhance the likelihood of positive response to treatment.[29] For professionals to be willing to access PHP services, confidentiality of their medical information and participation with the PHP is paramount.[40] The need for confidentiality is recognized not only by the FSPHP[30] but also by the FSMB,[41] the AMA,[42] and the American Society of Addiction Medicine (ASAM).[40]

While addiction and psychiatric medical records are afforded protections from invasion of privacy under state and federal laws,[43] most PHPs do not provide treatment. Therefore, the scope of confidentiality allowed under the PHP depends on state law enabling the PHP to be an alternative to a discipline program, peer-review protected statutes, mandated reporting laws, and/or responsibilities defined with the regulatory agency. The scope of confidentiality balances the PHP's dual roles in protecting the public and the successful rehabilitation of professionals with potentially impairing illnesses.

While confidentiality of medical or health information is broad, confidentiality regarding participation with a PHP is contingent upon maintaining current authorizations that enable the PHP to share authorized information with collaborating parties, such as evaluators, treatment providers, and worksite monitors or liaisons. Credentialing bodies, managed care provider panels, and potential employers may need to be aware of a participant's PHP participation. In most instances, the participant will want to authorize the PHP to provide compliance information to appropriate bodies or individuals. A PHP should not disclose information without an appropriately signed authorization or as required by law. A PHP should only disclose essential information and not reveal nonessential personal medical information.

A PHP provides documentation of compliance with the requirements of PHP participation with written consent. A PHP may provide medical information to evaluators, treatment providers, or other PHPs co-monitoring the participant only with the participant's consent. PHP records, including the PHP agreement with the participant, are not to be distributed by the PHP to any third party except as may be required by state or federal laws or if needed for evaluation and continuing treatment.[44]

PHP records are not treatment records and do not belong to the participant. In many states, in addition to protections within enabling legislation or other sources, the PHP process is afforded protections as a peer-review body. Peer-review proceedings were granted privilege against public disclosure to promote full and free discussion among healthcare professionals, allowing for constructive or therapeutic change and

remediation when necessary. Courts recognized disclosure of peer-review proceedings in malpractice cases would have a chilling effect on meaningful reviews and could result in failure to effectuate system improvements and individual responsibility. Any information obtained by the PHP is essentially intended for the purpose of peer review of a colleague.

Third parties, including participants, are not entitled to PHP records, notes, internal reports, referent information, or other PHP documentation. Individuals making referrals are not entitled to any information obtained, collected, or generated by the PHP. To release information to a referent, the PHP requires a properly executed consent.

In some PHPs, a participant may receive a copy of some PHP records, such as documents signed or created by the participant. Each PHP should have a consistent manner of handling records.

Confidentiality is a cornerstone of PHP success for participants and for referents. A participant may not be entitled to know who made the referral to the PHP, depending on individual practices, state laws, and, on occasion, referent safety. Carr et al. state, "If the individual who reports a concern requests anonymity, the PHP will honor that request to the extent allowable by law. Without confidentiality, subordinates and other non-subordinate referents would likely not make such a report."[25] This also applies to collateral sources. Although authorizations are necessary for PHPs and evaluators to acquire pertinent information from collateral sources, many collateral sources do not want to have information they provide given to the professional and this should be respected whenever possible. Fear of retaliation or contributing to perceived negative consequences must be respected when gathering collateral information. A participant's refusal to sign authorizations allowing the gathering of collateral information considered necessary invalidates an evaluation or treatment. Refusing consent may be considered noncompliance or failure to cooperate with the PHP. Noncompliance is sufficient to constitute reporting to appropriate others as may be required and may result in surrendering or waiving confidentiality. Refusal to sign consents or a subsequent revocation of needed consents may result in notification to regulatory agencies.

If a PHP receives a subpoena requesting the disclosure of PHP records or other information, the PHP should consider retaining legal counsel. A PHP should not give information confirming or denying PHP participation absent an express court order or participant consent.

Despite the essential need for confidentiality, "anonymity and the ability to receive help without a report to the state medical board is contingent upon the participant's full cooperation with evaluation, treatment, monitoring and agreement compliance."[25] Confidentiality is waived in the event of noncompliance or return to use of prohibited substances or exacerbation of symptoms suggestive of potential impairment as determined by individual state requirements and PHP Agreements. If a PHP has grounds to believe a healthcare professional is a threat to public safety, the PHP is not bound by confidentiality and is expected in most states to act in the interest of patient safety.

Mandated Reporting and Safe Harbor

Many states have mandatory reporting statutes, requiring healthcare professionals to report other professionals to regulatory authorities whose ability to practice is impaired or potentially impaired by alcohol or drug use or by physical or mental illness.[45] The AMA and other professional membership organizations have identified an "ethical obligation to report" and further expect physicians and other healthcare professionals to "participate in the process of self-regulation."[46,47] Although most professionals support this in concept, such statutes or ethics are underused.[48]

Many regulatory agencies and credentialing bodies inquire about substance use, psychiatric illness, and other potentially impairing medical conditions. Well-meaning though they may be, these inquiries stigmatize access to care.[49] In contrast, PHPs earn the trust of the medical community and public through transparent and accountable processes that allow confidential care for the ill professional.[50] PHPs become a fulcrum that balances the public's expectation for safe and healthy professionals and the individual physician's right to medical treatment and privacy.

Each PHP operates under its state-specific reporting statutes. Ideally, such laws are construed to allow a report by a referent to the PHP in lieu of a report to the regulatory agency when the concern arises out of a health issue. Conduct that requires disclosure of the identity of the physician to the regulatory agency should be clearly specified.[50] This includes a determination of whether a program should meet the requirements outlined in the Code of Federal Regulations, Title 42 - Chapter I - Subchapter A - Part 2 §2.13 *Confidentiality restrictions and safeguards.*[51] This federal statute applies to individuals and entities that hold themselves out as providing, and do provide referral for substance use treatment, and/or substance use treatment, and have federal tax-exempt status. Reporting to regulatory authorities is recommended under the following circumstances:

- Impairment is identified and the physician's refusal to cease practice places the public at risk.
- Treatment recommendations have been rejected and an acceptable alternative has not been identified.
- The physician is determined to be refractory to treatment, his or her illness has the potential to affect public safety, and there is concern that he or she may attempt to continue to practice.
- The physician was referred as part of a Regulatory Order with attendant reporting requirements to the regulatory agency as a condition of the Regulatory Order.
- PHP Agreement requires reporting, for example, participant violation of Agreement.
- If otherwise required per PHP protocol.

Informed Consent

Informed Participation

Informed consent is recommended from the first meeting with or interview by the PHP. As the decision to work with a PHP is voluntary, participants should be given information regarding their options, conditions for eligibility, and fees. The PHP should inform the participant of PHP responsibilities if a participant elects not to work with the PHP.

Healthcare professionals who enter into PHP monitoring should be informed of the requirements of their PHP Agreement.[52]

An informed consent process includes the following:

(a) An opportunity to review the terms of the agreement, provided the ability of the PHP to perform its duties in a timely manner is not compromised

(b) Notification of consequences of violations of the agreement (noncompliance), including any reporting requirements and subsequent recommendations to regulatory agencies, malpractice carriers, treatment providers, credentialing entities, designated practice liaisons, or appropriate others

(c) Notification that compliance with monitoring is determined by the PHP, and when clinically indicated, possible intensification of monitoring services or extension of the term of monitoring services may be required

(d) Documentation that the participant has been provided with the opportunity to review the agreement and questions or concerns have been addressed to demonstrate the informed participation of the participant

Conflict of Interest

All decisions and actions of a PHP must be free of undue influence by any special interests. Representatives of PHPs, including officers, directors, committee members, executive staff, and volunteers acting on behalf of PHPs have a duty to the PHP and its mission, including the duties of loyalty, diligence, and confidentiality.[53,54] Representatives of PHPs are obligated to act in utmost good faith on behalf of the PHP. Each PHP should adopt a Conflict of Interest Policy that is signed by officers, directors, committee members, executive staff, and volunteers acting on behalf of PHPs.

Conflicts of interest arise when those in positions of responsibility have personal or outside financial, business, or professional interests or responsibilities that conflict with their duties to the PHP and create a bias or predisposition on an issue that may compromise the interests of the PHP or unduly influence monitoring of a participant.

When a representative of the PHP believes that an individual may have a conflict of interest that has not been properly recognized or resolved, the representative should raise that issue and seek proper resolution. A representative may raise the issue of conflict of interest by bringing it to the attention of the Board of Directors through the Medical Director, Executive Director/Chief Governance Officer, or President of the Board.[55] The final resolution of any potential conflict of interest rests with the Board of Directors of the PHP. The FSPHP has an Ethics Committee, which may be able to offer some assistance. Ethical boundaries are complex issues and beyond the scope of these Guidelines.

All individuals who serve in positions of responsibility with the PHP should avoid conflicts of interest that could compromise the integrity of the organization. Dealing effectively with actual or potential conflicts of interest is a shared responsibility of the individual and PHP. On an annual basis, officers, directors, committee members, executive staff, and volunteers acting on behalf of the PHP should sign a statement disclosing any outside interests or relationships, affiliations, investments, compensation, or other situations that may represent or appear to represent a conflict of interest.

Maintenance of Records

Most PHPs do not provide treatment, but they do store medical records from outside providers. Such records must be maintained in accordance with state and federal laws governing the maintenance of treatment records. PHPs aim to protect all participant records in a secure and confidential manner for a minimum of ten (10) years after the most recent contact, unless otherwise required by law or record-retention policies. PHPs should have written procedures to regulate and control access to and use of participant records. Record-retention practices take into consideration the interests of both the PHP and the participant.

PHPs should maintain record-retention policies that ensure records are maintained subject to state and/or federal laws and internal guidelines, which may include:

(a) Paper Records:

1. **Active Participant Records** (including any documents that contain identifying information and/or private health information) should be stored under double lock, such as in a locked file within a locked office. No records should be in public sight or accessible to those who are unauthorized. Access should be limited to those within the PHP who need access.
2. **Inactive Participant Records** (storage/retrieval): Inactive records are documents that are no longer referenced on a regular basis. Important considerations for inactive records include:
    - **Privacy:** assuring that the records are protected from access by unauthorized individuals;
    - **Safety:** assuring that the records are sufficiently packed and/or stored so that they will be protected from fire or flood damage; and
    - **Accessibility:** assuring that the records can be retrieved without undue burden when access is needed.
    - Offsite storage is acceptable, if it can meet the above requirements.

(b) Electronic Records:

Electronic participant records should be stored in a system parallel to that of a locked cabinet using computer security. Electronic records should be accessible only by authorized individuals. Access should be controlled via usernames and complex passwords consistent with the current standards for secure technology. Records that are secure are unusable, unreadable, or indecipherable to unauthorized individuals.

Records in transit between systems should be securely encoded. Electronic systems should track who has accessed and/or made changes to any records or documents and when those changes were made.

Destruction of Records:

PHPs should have policies that address the duration of record maintenance, and processes for the destruction of records in a manner that does not jeopardize confidentiality. Records in transit to shredding or incineration should be maintained in a manner inaccessible to others.

Cautionary Statement:

PHPs may be required to comply with HIPAA and/or 42 CFR Part 2. If so, practices regarding handling and maintenance of records may be impacted. In addition, an operating agreement with a regulatory agency or other law may override the recommendations set forth in these Guidelines: Title 42 - Chapter I - Subchapter A - Part 2 §2.13 *Confidentiality restrictions and safeguards.*[56]

Quality Assurance

Quality assurance (QA) and quality improvement (QI) principles should be integrated into PHP operations. QA is retrospective in nature, typically studying outcomes and processes.[57] The PHP can benefit from the formulation of a QA committee, or designate certain QA tasks to a specific PHP employee with relevant expertise.

QI is projective in nature, intended to improve program processes and outcomes.[58] Eight dimensions of quality are commonly discussed: safety, accessibility, acceptability, appropriateness, provider competence, efficiency, effectiveness, and outcomes. These dimensions encompass the breadth of healthcare and are not mutually exclusive, but rather may be overlapping. The Institute for Healthcare

Improvement (IHI) uses a Model for Improvement to help organizations implement QI and test changes on a small scale using the Plan-Do-Study-Act (PDSA) cycles.[59]

Both QA and QI initiatives promote excellence within PHP program delivery. Such initiatives may be reported to constituents and key stakeholders in annual reports or in education and outreach efforts. Internal evaluations can examine success markers as well as critically study existing processes and procedures that might benefit from revision or improvement. Internal evaluations answer the call for PHPs to provide proactive self-scrutiny and transparency and to demonstrate the quality of clinical service delivery.

Examples of quality assurance or improvement evaluations may include the following:

- Examining the length of time between referral to a PHP and initial interaction with the PHP
- Examining the length of time between the PHP initial interaction and completion of an evaluation or other clinical assessment
- Quantifying the measures taken to assure patient safety; during consultation with the workplace, and at the intersection (if applicable) of involvement with the licensing board
- Examining the length of time to provide the referral source or licensing board with a final evaluation report or other appropriate feedback
- Quantifying utilization of services, for example, annual or quarterly number of referrals, enrollment numbers by specialty, voluntary versus mandatory referrals, non-enrollment numbers (ineligible, no diagnosis, refused services, etc.), noncompliance reporting, successful completions, and the frequency of workplace consultation requests
- Evaluating the reasons for re-referrals for previous participants
- Evaluating the length of time taken to identify and subsequently report an unsafe referral or participant to the regulatory agency
- Evaluating the length of time taken to identify then report to the regulatory agency a noncompliant participant
- Delineating the number of participants engaged with the PHP who successfully maintain their medical careers
- Analyzing the demographic makeup as a marker of program visibility among licensees (marketing effectiveness) and acceptability of the program to different groups (perceived bias); demographics may also be useful in evaluating clinical trends, identifying high-risk groups, and other research
- Identifying the length of time from identification of an illness to treatment referral
- Studying the number of positive drug tests not verified by legitimate prescription or relapses (with substance use, but also other health conditions) per quarter or year, and the PHP's response time to intervention
- Quantifying the number of professional collaborations, community outreach efforts, or education to the larger community regarding physician health the PHP has provided
- Evaluating program satisfaction with client satisfaction surveys, exit surveys, and community/key stakeholder satisfaction surveys

- Assessing fiscal responsibility with budget and financial statement reports
- Evaluating the status of the PHP's privacy and confidentiality policies and procedures in terms of alignment with most recent regulations, their implementation in work processes, and the staff training

The FSPHP recommends that PHPs conduct Performance Enhancement and Effectiveness Reviews (PEER).[60]

The FSPHP also notes that ongoing data collection on QA/QI as part of daily PHP operations is a powerful guiding force for program delivery. To enhance the principles of transparency, accountability, consistency, and excellence, PHPs may periodically implement a formal external evaluation.

Research

Physicians have a long and storied history of self-evaluation as part of their commitment to the greater good. PHPs have deep insight into the treatment of several important disease states. The FSPHP believes one of the many benefits of PHP activities is research into substance use disorders and other behavioral diseases.[61] PHPs by their nature collect data and closely monitor large populations of individuals longitudinally over time. The FSPHP promotes standardized data collection by member PHPs to allow for data analysis and research.[62] A PHP is required to use Institutional Review Board approval and oversight when engaging in research.

PHPs have significant data available for potential research, which at a minimum may include:

(a) For all participants:

- referral source
- demographics
- psychological and psychiatric symptoms
- diagnoses
- treatment (type and duration)
- clinical course before and during monitoring (including, for example, disease exacerbations or chemical relapses)
- health status and compliance status at time of monitoring completion, that is, successful completion, transfer, board referral, enrollment in continued voluntary monitoring, etc.

(b) For individuals with substance use disorders, additional data items may include:

- substance(s) of choice
- detailed relapse information
- drug screen results
- attendance at therapeutic and support group meetings, correlating this with myriad other variables

Guidelines specific to researchers, the research process and methodology, collaboration, and other matters appear below:

1. Evaluation of Proposed Researchers
The primary concern in vetting researchers is their track record of sound scientific work. When considering a research project, bringing said project to the FSPHP Research Committee should be among the first steps. Researchers' publications will be reviewed by the Research Committee of the FSPHP. History of successful grant funding and stature as scientists are considered when reviewing a research proposal, although less experienced researchers would also be considered, especially when collaborating with other more experienced researchers. Previous research in the field of physician health or previous research with PHPs is a positive element.

2. Evaluation of Proposed Research—Subject
The value and importance of a proposed project and the relevance of research questions to the field of physician health and/or to the FSPHP are key in evaluating proposed research. PHPs are encouraged to consult the FSPHP. The FSPHP has a responsibility to make sure that the proposed research subject is sufficiently important to the field before individual PHPs commit limited resources or other PHPs are approached to increase the impact of the research.

3. Evaluation of Proposed Research—Methodology
PHPs may submit written proposals to the FSPHP Research Committee. The FSPHP Research Committee's approach to evaluating the methodology of proposed research will vary with the proposal. For instance, in cases of research associated with a grant application to a major research funding institution (e.g., one of the National Institutes), the Committee may choose to leave the methodology evaluation to that institution. In other situations, the chairperson of the Research Committee will appoint an ad hoc subcommittee to review the methodology.[63]

4. Collaboration
A collaborative relationship between the PHP, FSPHP leadership, the FSPHP Research Committee, and researchers in a proposed project is considered paramount, and essential. Evidence of collaborative spirit or intention may include early involvement of the FSPHP leadership or Research Committee on the part of the researchers. We encourage PHPs and researchers to include the FSPHP in early discussions of the project. Early collaboration with the Federation will benefit PHPs and researchers by allowing coordination of research being conducted by other PHPs and providing a global PHP perspective on the issues to be researched. Prospective investigators should feel free to contact and discuss the project early in the planning phase, without feeling compelled to outline a formal proposal or to know the answers to questions that may be asked in formal review. The chairpersons of the Research Committee would welcome preliminary discussions and may refer interested researchers to members who have experience or expertise in the field. For each research project that goes forward—that is, is endorsed by the FSPHP, involves one or more PHPs, and is funded—the Research Committee will designate a primary contact to liaison with the researchers during the course of the research and in the writing of papers based on the work. Matters pertaining to the review and authorship of papers for publication are considered collaborative issues. In all cases that involve the participants of one or more PHP, the authorship of research publications should include one or more PHP members involved in said research.

5. Other Structural Matters
When a PHP's employees dedicate significant labor on a partnered research project, some funding for personnel should be considered. A document defining the financial relationship between a PHP and/or the FSPHP and the researchers may be required. In addition, when a project receives the endorsement of the

Research Committee of the FSPHP, the proposal will then be presented to the Board of Directors of the FSPHP for final approval. If approved, the Board or its designee (e.g., the Research Committee) will communicate with members of the FSPHP concerning its endorsement and when appropriate will encourage participation in the project.

6. Other Matters
These Guidelines are not intended to be inclusive of every scenario in which a PHP and/or external researchers will ask for help from the FSPHP. For instance, researchers might wish the FSPHP to endorse a project for the sake of a grant proposal, but not want FSPHP or PHP participation in the work itself. The FSPHP Research Committee will evaluate each situation on a case-by-case basis using the principles articulated in these Guidelines and other applicable FSPHP documents.

Education and Outreach

Most PHPs provide education and outreach to their stakeholders. PHPs are resources to the appropriate regulatory agencies, hospitals, malpractice carriers, medical schools, training programs, medical societies, and other healthcare organizations and professional associations. PHP physicians and personnel are experts in the field of physician health. They provide proficient presentations to a growing number and variety of audiences at academic centers, community hospitals, educational events, and conferences throughout North America. Education topics cover the spectrum from wellness and work–life balance to burnout, suicide, substance use disorders, and mental health concerns in health professionals. PHPs are working with the medical community to tailor presentations to the specific needs of each group. These outreach activities are essential to relationship building, promotion of personal resilience, prevention of health problems, and early identification of potentially impairing conditions in those health professionals who are experiencing stress, distress, and illness.

Interstate Monitoring

Professionals commonly hold medical licenses in more than one state or province. These Guidelines are not intended to address compact licensing, but rather are intended to address the coordination amongst PHPs as well as licensees and the states or provinces in which they are licensed. To these ends, when a physician seeks the support of a PHP, the PHP should require the professional to identify:

- all states/provinces/countries where professional holds or is seeking a professional license;
- all states/provinces/countries where professional has adverse regulatory agency and/or legal action; and
- any prior participation in a PHP, regardless of the status and date of that participation.

Communication, collaboration, and supportive accountability across all states, provinces, and even countries enhance the integrity of all programs, physician health, and patient safety.[17]

The professional is responsible to understand his or her responsibilities in each state where he or she holds a license or seeks application for licensure. The PHP should obtain authorization to share information with the professional health program of each state where the professional holds a license or plans to obtain a medical license. When more than one state is involved, each state PHP should obtain the appropriate authorizations for communication with the other PHPs.

When more than one state PHP is involved, one state program should be identified as the primary state of monitoring while the other PHPs involved hold secondary roles. These roles may change as circumstances change. The essential factor to identify the primary PHP is the primary locus of practice. If the professional has an active practice in more than one state, the number of hours of practice in each state and state of legal residency identify the primary PHP in most instances. Legal residence is not an essential factor when the professional is not actively practicing in the state of residence. PHPs are charged to work collaboratively and effectively in determination of primary and secondary roles.

When a participant in a PHP health agreement seeks employment or licensure in another state, the current state continues to serve as primary monitor until the professional is officially accepted by the other state program and that program agrees to assume the primary role or there is a written understanding as to which PHP is primary. Any changes of role should be accomplished in a manner without interruption of monitoring and support.[29]

Because state PHP requirements differ, the primary PHP collaborates with other states, establishing and maintaining criteria that meet administrative, legal, and/or board requirements across all states in which the professional is licensed. The primary program is expected to send reasonable periodic compliance reports to the other programs where the professional is licensed or being monitored. In addition to the periodic reports, a secondary PHP should be timely informed of the following:

- Positive toxicology results not verified by legitimate prescription
- Unsatisfactory reports
- Adverse license action
- Program noncompliance
- Other significant events or concerns

A secondary PHP agrees to monitoring practices of the primary PHP unless other arrangements are requested and agreed upon. If the primary PHP is not able or willing to maintain monitoring criteria required by another state, it is the responsibility of the participant to make any necessary arrangements to fulfill requirements of each state in which he or she is licensed or subject to potential regulatory action.

Funding

Appropriate funding of PHPs is paramount to ensure adequate PHP services. Sufficient funding provides long-term availability and viability of a cost-effective PHP process to the mutual benefit of the public and participants. Investing in PHPs with proper funding is essential. It ensures the comprehensive disease management that in turn enhances the health of its workforce and a safer, quality healthcare system for all.

Appropriate funding enhances the ability to manage increases in referrals and allows the utilization and expansion of services in support of physician health and well-being. PHP maturation is impeded as a result of inadequate funding.

It is not recommended for PHPs to be subject to a bidding process based primarily on cost. Bidding creates a financial incentive to minimize expenses and potentially sacrifice quality. Bidding leads to PHP instability, service disruption, and records-management challenges.

Major savings to the individual and greater workplace productivity and fewer drug-related accidents, including overdoses and deaths, are difficult to quantify. However, it is apparent a significant cost benefit exists in protecting the public and salvaging careers through investing in appropriately funded physician health programs. Adequate resources are required to maintain competent case management and participant monitoring through the provision of qualified professional support services. Stakeholders of the healthcare system are needed to fully share in the funding of their state PHP. PHPs coordinate effective detection, evaluation, treatment, and monitoring of physicians suffering from addictive, psychiatric, medical, behavioral, or other potentially impairing conditions. According to a 2009 study in the *Journal of Substance Abuse Treatment*, more than 75 percent of doctors who entered a PHP stayed drug-free after five years, with 71 percent retaining their license and employment after five years.[8] The success of the PHP model, given its benefit to the public and impact on physician health and well-being, is a value-driven economic investment.[20,64]

In summary:

- PHPs must be adequately funded to provide needed services.
- Funding must be stable and uninterrupted to ensure that PHPs operate effectively.
- PHPs need to work collaboratively with organized medicine and others to ensure their own financial viability to fulfill their mission and best meet the needs of healthcare professionals with potentially impairing illnesses, the healthcare community, and the public.
- Funding must be adequate to support all program services and to maintain competent case management, comprehensive and continuous, as participant monitoring is critical. Funding must be maintained at a level that supports a qualified professional staff, provides ongoing training and development, and sustains a professional work environment.
- Participants are typically personally responsible for the cost of medical treatment, including required evaluations, continuing care, and random drug tests. Sufficient funding ensures participant fees are fair and equitable with full disclosure at intake.
- Funding sources may include but are not limited to: licensing fees, participant fees, contributions from malpractice insurers, monies from professional societies and associations, support from hospitals and other healthcare organizations, and donations from benefactors, endowments, and grants. PHPs should exercise due diligence to avoid acceptance of funds from sources that could create a conflict of interest.
- Regulatory agencies should endorse a PHP in achieving adequate, stable, ongoing funding to meet its expected mission and goals.
- In states that require bidding processes, the quality and scope of services should be the most important determinants in awarding a PHP contract, and gaps in services should be avoided.

References for Section Two: Physician Health Programs Fundamental Principles

8. DuPont R, McLellan A, Carr G, Gendel M, Skipper G. How are addicted physicians treated? A national survey of Physician Health Programs. *Journal of substance abuse treatment.* 2009;37(1):1-7.

17. Buhl A, Oreskovich M, Meredith C, Campbell M, DuPont R. Prognosis for the Recovery of Surgeons From Chemical Dependency: A 5-Year Outcome Study. *Arch Surg.* 2011;146(11):1286-1291.

20. Gastfriend DR. Physician substance abuse and recovery: What does it mean for physicians—and everyone else? *JAMA : the journal of the American Medical Association.* 2005;293(12):1513-1515.

25. Carr GD, Hall PB, Finlayson AR, DuPont RL. Physician Health Programs: The US Model. In: *Physician Mental Health and Well-Being.* Springer; 2017:265-294.

29. Merlo LJ, Greene WM. Physician views regarding substance use-related participation in a state physician health program. *The American journal on addictions / American Academy of Psychiatrists in Alcoholism and Addictions.* 2010;19(6):529-533.

30. Federation of State Physician Health Programs. FSPHP Physician Health Program Guidelines. 2005; https://www.fsphp.org/assets/docs/2005_fsphp_guidelines-master_0.pdf, 2016.

32. Rasyidi E, Wilkins JN, Danovitch I. Training the next generation of providers in addiction medicine. *Psychiatric Clinics.* 2012;35(2):461-480.

33. Clark HW. The medical review officer and workplace drug testing. *Journal of psychoactive drugs.* 1990;22(4):435-445.

34. Clark HW. The role of physicians as medical review officers in workplace drug testing programs. In pursuit of the last nanogram. *The Western journal of medicine.* 1990;152(5):514-524.

35. FSPHP Constitution and Bylaws, 2018 https://fsphp.memberclicks.net/assets/docs/fsphp_constitution_and_bylaws_6-28-13.pdf

36. e.g., West Virginia Board of Medicine, Designation of Physician Health Program, https://wvbom.wv.gov/PhysicianHealthprogram.asp

37. e.g., Washing State Legislature, Revised Code, https://app.leg.wa.gov/rcw/default.aspx?cite=18.130.300

38. Walzer RS. Impaired physicians: An overview and update of the legal issues. *Journal of Legal Medicine.* 1990;11(2):131-198.

39. Summers RF. Physician Mental Health and Well-Being: Research and Practice. In: Am Psychiatric Assoc; 2017.

40. American Society of Addiction Medicine. Confidentiality in Healthcare and Other Licensed Professionals with Potentially Impairing Illness. *Policies Regarding Physicians and Other Licensed Health Care Professionals* 2011; https://www.asam.org/advocacy/find-a-policy-statement/view-policy-statement/public-policy-statements/2011/12/16/confidentiality-in-healthcare-and-other-licensed-professionals-with-potentially-impairing-illness.

41. Federation of State Medical Boards. Policy on Physician Impairment. 2011; https://www.fsmb.org/Media/Default/PDF/FSMB/Advocacy/grpol policy-on-physician impairment.pdf.

42. American Medical Association. Physician Health Programs Act, Approved AMA HOD. In. Chicago, IL: AMA; 2016.

43. United States Department of Health and Human Services. Confidentiality of Alcohol and Drug Abuse Patient Records. *Federal Register.* 1987;42:21796-21813.

44. The participant, as signatory to the agreement, may elect to provide a copy of his or her agreement.

45. e.g., Conneticutt Geneneral Statutes Section. 19a-12e, Massachusetts General Laws, chapter 112, Section 5F, .Va. Code Sec. 30-3D; Iowa Administrative Code 653-22.2(272C)

46. Taub S, Morin K, Goldrich MS, Ray P, Benjamin R. Physician health and wellness. *Occupational Medicine.* 2006;56(2):77-82.

47. American Medical Association. Ethics of Professional Self-Regulation. In: *Code of Medical Ethics.* AMA; 2016.

48. DesRoches CM, Rao SR, Fromson JA, et al. Physicians' perceptions, preparedness for reporting, and experiences related to impaired and incompetent colleagues. *JAMA : the journal of the American Medical Association.* 2010;304(2):187-193.

49. Dyrbye LN, West CP, Sinsky CA, Goeders LE, Satele DV, Shanafelt TD. Medical Licensure Questions and Physician Reluctance to Seek Care for Mental Health Conditions. Paper presented at: Mayo Clinic Proceedings2017.

50. Federation of State Medical Boards. Physician Wellness and Burnout. 2018; https://jmronline.org/doi/pdf/10.30770/2572-1852-104.2.37, 2018.

51. See: https://www.ecfr.gov/cgi-bin/text-idx?SID=0f9b2a146b539944f00b5ec90117d296&mc=true&node=pt42.1.2&rgn=div5

52. Candilis PJ. Physician health programs and the social contract. *AMA journal of ethics.* 2016;18(1):77.

53. National Council of Nonprofits. Conflicts of Interest. 2015; https://www.councilofnonprofits.org/tools-resources/conflicts-of-interest. Accessed 2018.

54. Monahan J, Bonnie RJ. License as leverage: mandating treatment for professionals. *International Journal of Forensic Mental Health.* 2004;3(2):131-138.

55. Walzer RS, Miltimore S. Mandated supervision, monitoring, and therapy of disciplined health care professionals: Implementation and model regulations. *Journal of Legal Medicine.* 1993;14(4):565-596.

56. See: https://www.ecfr.gov/cgi-bin/text-idx?SID=0f9b2a146b539944f00b5ec90117d296&mc=true&node=pt42.1.2&rgn=div5

57. Daniels A, Teems L, Carroll C. Transforming Employee Assistance Programs by crossing the quality chasm. *International Journal of Mental Health.* 2005;34(1):37-54.

58. Langley GJ. *The improvement guide : a practical approach to enhancing organizational performance.* 2nd ed. San Francisco: Jossey-Bass; 2009.

59. Institute for Healthcare Improvement. How to Improve. 2016; http://www.ihi.org/resources/Pages/HowtoImprove/default.aspx.

60. See Appendix B: Program Enhancement and Effectiveness Review (PEER)

61. Federation of State Physician Health Programs. FSPHP Research Policy And Guidelines For Investigators. 2012; https://www.fsphp.org/fsphp-research-policy-and-guidelines-investigators, 2016.

62. See: FDA description of Good Clinical Practice: https://www.fda.gov/AboutFDA/CentersOffices/OfficeofMedicalProductsandTobacco/CDER/ucm090259.htm

63. Merlo LJ, Singhakant S, Cummings SM, Cottler LB. Reasons for Misuse of Prescription Medication Among Physicians Undergoing Monitoring by a Physician Health Program. *Journal of addiction medicine.* 2013;7(5):349-353 310.1097/ADM.1090b1013e31829da31074.

64. Brooks E, Gendel MH, Gundersen DC, et al. Physician health programmes and malpractice claims: reducing risk through monitoring. *Occupational medicine (Oxford, England).* 2013;63(4):274-280.

Section Three: Services Provided By PHPs

Referral, Consultation, and Intake

Professionals referred to PHPs present under a wide variety of circumstances and complexity. As such, PHPs require a reliable system for tracking and documenting referral information and case status. PHPs develop quality assurance practices to ensure that documentation and timeliness of case development are consistent with PHP policies and procedures and meet the needs of PHP stakeholders. While physicians are encouraged to make self-referrals, PHPs accept referrals from any reliable source, including regulatory agencies, employers, colleagues, family, and friends. Each PHP should have easily accessible methods of processing inquiries and accepting referrals.

Referrals need not be submitted in writing. Referrals made by telephone or other verbal method should be documented and included in the participant records. Referrals and subsequent inquiry by the PHP should provide sufficient facts to support a good-faith basis for access to PHP services. However, PHPs do not act as investigatory bodies, and they typically lack authority to mandate participation. PHP participation is typically voluntary and confidential. If a referent is unwilling to give his or her name to the PHP or facts provided seem insufficient, the PHP must exercise due caution in proceeding with the referral and should have a mechanism to not accept a referral when appropriate. However, if the referent is willing to identify himself or herself on condition that his or her identity not be revealed, the PHP should have a process to manage such a referral.

At a minimum, the referent should identify his or her relationship to the potential PHP participant; provide facts underlying the concern that a professional may suffer from a potentially impairing condition; and identify any other sources that may provide additional information regarding the underlying concern. The PHP should explain to the referent that the PHP will be unable to provide information to the referent without authorization from the potential participant and may also explain next steps if the potential participant does not respond to the PHP's efforts to engage him or her. The PHP may also advise the referent of the time anticipated to make initial contact, so that if more immediate attention is needed the referent may also contact a crisis center or other emergency resource.

After the referral, initial contact with the potential participant is made as expeditiously as possible. The PHP staff should be qualified to assess the immediacy of need for medical or emotional support, and to explain the limits of confidentiality. The PHP should follow a process to promote informed consent as noted on pages 18–19. Demographic information and medical history as well as substance use and other mental health history should be obtained. The demographic information should also include licensing information, including all states where he or she holds a medical license and prescribing privileges as well as any other PHP involvement, history of licensure investigation, discipline, or criminal arrests. Authorizations for release of information and ability to obtain information from treatment providers and collateral sources should be obtained, allowing the participant to ask questions prior to executing the authorizations. It is especially important that the participant identify an emergency contact person that the PHP may use at its discretion. Lastly, PHPs should determine the immediacy of a referral, taking into account the safety of the referent and the potential safety risk they pose.

To summarize, key activities during the initial phase of PHP engagement include:

1. Ensuring an easily accessible method for accepting self-referrals and referrals from others concerned about a healthcare professional's well-being and responding with the appropriate level of urgency.
2. Evaluating the eligibility of the referral to the PHP program.
3. Making initial contact to coordinate an initial interview, evaluation or referral. Some PHPs perform an initial consultation or assessment to determine the needs of a potential participant, while others refer all participants to outside evaluators. Both management routes are equally acceptable.
4. Evaluating the participant's immediate need for medical or psychosocial support.
5. Obtaining sufficient information to determine whether immediate cessation of clinical practice, pending further evaluation and/or treatment, is advised. A professional who has been referred for substance use concerns is typically expected to refrain from practice until the PHP has sufficient information that the participant is ready to return to practice.
6. Explaining PHP processes, obligations, and limits of confidentiality

Evaluation

Most PHPs determine a potential participant's eligibility for participation in the PHP based upon the findings of a comprehensive clinical evaluation.[3,65] Comprehensive clinical evaluations vary in type depending on case-specific identified areas of concern and the purpose of the evaluation.[66] Comprehensive clinical evaluations may be completed: (1) by multidisciplinary teams at evaluation centers with established expertise in the assessment of healthcare or other safety-sensitive professional,[67] (2) on an outpatient basis by a qualified specialist(s) approved by the PHP, or (3) by the PHP if permitted by the PHP structure and state enabling laws.

Many PHPs develop and maintain a referral list of approved evaluators. Evaluators are selected based on a combination of objective criteria and the PHP's experience and expertise. PHPs often identify the minimum education and licensure requirements for approved evaluators based on the needs of the program. The evaluator must be a qualified and trained professional with expertise in the areas of concern and preapproved by the PHP. An evaluator must be willing to provide an impartial opinion on fitness to practice. If the potential participant has clear symptoms of an active substance use disorder or other health condition requiring acute treatment, the PHP may make timely referral to the appropriate level of care and/or appropriate specialist in lieu of an evaluation.

Evaluators and treatment providers must keep the PHP informed, including advising the PHP if the participant is reluctant or refuses to fully participate in the evaluation or leaves against medical advice or under an administrative discharge.

The PHP should select the evaluator(s) and type of evaluation based on information available to the PHP at the time of the referral. As more information becomes available, the PHP may identify additional evaluative components that will enhance the likelihood of correct and comprehensive diagnoses and appropriate referrals to subsequent care.

Whenever possible, PHPs should provide participants with a choice of approved evaluators. Concerns about conflict of interest in the evaluation process typically center on two issues: (1) misguided worries

about conflicts of interest in the relationship between a PHP and the chosen evaluator, and (2) the dual role of evaluators as treatment providers. In no case, should there be a financial or business interest between a PHP and an approved evaluator. Potential conflict of interest is inherent when evaluators also serve as treatment providers. This situation is neither unique nor discouraged in the medical profession where it is customary for physicians and healthcare organizations to provide both diagnosis and treatment services. However, because of the potential professional and legal implications involved in such evaluations, reasonable measures to mitigate actual or perceived conflict of interest should be employed. Such measures include the following:

1. If possible, providing the participant with a choice of several approved evaluators
2. Informing the participant when referrals include evaluators that also provide treatment for the conditions they diagnose
3. Advising the participant that if treatment is recommended, they may choose from a number of approved treatment providers other than the evaluator
4. Advising the participant that they may inform the evaluator prior to the assessment that should treatment be recommended, they will choose a different approved treatment provider
5. Advising the evaluator that should a participant's level of concern about conflict of interest rise to the level that it jeopardizes the assessment process, the evaluator should recuse itself from offering treatment to preserve the integrity of the assessment
6. Providing the participant the opportunity for a second opinion assessment, utilizing a PHP-approved evaluator, if the participant disagrees with the diagnosis or recommendations of the evaluator

Characteristics of evaluators appropriate for PHP approval include the following:[67]

1. The knowledge and expertise necessary to fully evaluate the condition(s) of possible impairment.
2. The ability to adhere to applicable confidentiality regulations.
3. Full disclosure of costs prior to evaluation.
4. The resources to arrange timely intake and evaluation.
5. Ability to evaluate all causes of impairment or to make appropriate referrals for additional evaluations.
6. The ability to keep the PHP fully advised throughout the evaluation process.
7. Access to medical and psychiatric hospitalization if needed.
8. The use of standardized psychological tests and questionnaires during the evaluation process.
9. The resources to conduct comprehensive and discrete collateral interviews of colleagues, appropriate others, and other involved parties to develop an unbiased picture of all circumstances, behavior, and functioning:
    a. Carefully identify and interview collateral contacts for evaluation.
    b. Report an incomplete evaluation if the patient refuses to provide a release of information for necessary collateral interviews.
    c. Evaluators must consider whether collateral sources may have a bias outside the interest of the patient and balance this information accordingly. However, such bias should not, in most cases, be a reason to completely avoid data collection from such individuals. For example, an

estranged or divorced spouse, although biased, may have cogent information about the evaluatee's substance use or behavior.

d. Unless contraindicated, collateral contacts should include: the person initiating report; representatives of the hospital/office work environment; colleagues; family members including spouse/significant other; healthcare providers; and others as identified.

10. The timely documentation, including a brief written or verbal summary of findings and recommendations at the completion of the evaluation. A comprehensive written evaluation should follow in a timely manner. Reports should include specific documentation of information supporting diagnostic and placement (level of treatment) criteria and practice recommendations, including fitness for duty.
11. Make recommendations regarding rehabilitation/treatment and outstanding items that need further investigations. The conclusions should do the following:
    a. State clearly diagnosis and if treatment or other intervention is needed.
    b. Identify if workplace modifications or accommodations are required.
    c. Identify if a change of specialty, employer, or career should be explored.
    d. Detail any monitoring recommendations.
    e. Determine ability to return to the practice of medicine.
    f. If recommendations are preliminary, they can and often will change over the course of initial care.
12. If the patient disagrees with the diagnosis (based on *DSM-5* criteria) or treatment recommendations, the PHP should encourage a second opinion regarding diagnosis and/or recommendations. The second opinion should be obtained by a PHP-approved evaluator.

Comprehensive clinical evaluations should be performed face-to-face and in accordance with acceptable professional standards.[65] In the event a PHP allows an evaluation to be done in another manner, the reason and validity of allowing other than face-to-face evaluation should be carefully considered and documented.

A comprehensive clinical evaluation includes the following areas,[1] which should be delineated in a written report submitted to the PHP with the authorization of the professional:

1. Brief history and reason for referral
2. Medical history, including status and problems
3. Psychological status, including previous cognitive screening or assessments[68]
4. Psychiatric history, including suicidal ideation or attempts
5. Psychosocial problems, social functioning, behavioral history
6. Family history and peer relations
7. Education/professional training, employment history, and job/training performance
8. Administrative, criminal, or other behaviors and legal history/problems
9. Substance use history, frequency and patterns of use, types of drugs or alcohol used
10. Sexual history (if pertinent to the referral question/presenting problem)
11. Severity of mental health disorders, including history of previous treatment
12. Current assessment and/or examination

13. Laboratory testing, including toxicology testing
14. Motivation to participate in treatment or readiness for treatment
15. Religious/spiritual history
16. Socioeconomic status and problems, for example, financial stressors
17. Withdrawal or active symptoms
18. Other process disorders (i.e., eating, gambling, spending, hoarding)
19. History of tobacco use and tobacco use disorders[69]
20. Support systems
21. Summarized information from collateral data sources, other assessments, which may be deidentified in the final report provided to the PHP
22. Pertinent information extracted from relevant medical records

The assessment may include a battery of tests or use of standardized instruments, mental status examination, and cognitive screening at the discretion of the assessor. The evaluator may refer for more specialized neuropsychological testing if warranted by the facts of the referral or response to screening.

The final assessment report also includes:

1. Diagnoses in accordance with generally acknowledged and accepted diagnostic criteria
2. Recommendations for appropriate care and treatment of all identified conditions
3. Referral to specialists as needed
4. Opinion as to whether or not the individual is fit to practice at the present time

To summarize, the key objective of the evaluation phase is to obtain objective, high-quality, independent evaluations that are diagnostically rigorous, tailored to the specific needs of health professionals, assess the professional's fitness for professional practice,[70] and which allow timely, informed communication with participants, evaluators, and stakeholders in accordance with applicable confidentiality and consent procedures.

Initial Treatment

When a participant has a clearly diagnosable condition and has insight into his or her illness, an independent evaluation may not be required. If willing, such a participant may be referred directly to appropriate care. Whenever possible, participants should have a choice of approved facilities. The PHP should take into consideration health insurance and finances, but the determination of whether a facility or treatment provider may be approved by the PHP should be based on the expertise of each program or treatment providers.[16] Physicians do best when treatment facilities and treatment providers have knowledge and experience in treating safety-sensitive workers in general and healthcare workers in specific.[21]

The treatment facility or treatment provider must have an understanding and ability to work in collaboration with the PHP. The treatment provider should provide an initial assessment report or summary narrative report, including relevant components described under evaluations above.[71, pages 117-127]

The treatment provider must provide periodic reports on treatment progress and collaborate with the PHP for continuing care and treatment, accountability, and fitness for duty.

If the treatment is in a residential-type setting, the treatment facility must engage the PHP prior to discharge and assist the PHP in establishing appropriate continuing care and treatment recommendations in an outpatient setting and return to practice recommendations. Similarly, if the treatment is in an intensive outpatient treatment program, the treatment facility should contact the PHP prior to discharge and assist the PHP in establishing continuing care and treatment that meet the participant's needs. If the treatment is by an outpatient provider, after the initial report to the PHP discussed above, continuing care reports are discussed under Monitoring below.

A PHP must have the discretion to work with treatment providers and facilities that may not be known to the PHP. When the PHP exercises such discretion, the PHP should use due diligence to assure that the treatment provider or facility is qualified and willing to provide the participant and PHP with the support necessary to meet the challenges of demonstrating fitness for duty in a safety-sensitive occupation.

While an evaluation is time limited, treatment is anticipated to continue throughout the duration of the participant's participation with the PHP. Although both evaluations and treatment may need to be periodically reassessed, effective treatment and support longitudinally are believed to account for the success of most PHP participants. Therefore, continuing care monitoring and accountability to treatment are essential and the next phase of PHP services.

Monitoring

Upon receipt of the evaluation, treatment, and/or other medical records, the PHP develops the terms and conditions for the professional to maintain health and wellness accountability.[71, pages 139-147] The participant is offered the opportunity to enter into and comply with a PHP Agreement that contains the specific terms and conditions for participation in the PHP. PHPs may call these documents by different names, but all contain the essential criteria in a written document that outlines the ongoing health plan and establishes the measures that the PHP will use to confirm the participant's accountability.[72,73]

Overview of PHP Agreements

Although PHP Agreements are individualized to the identified needs of the participant, such agreements should have the following general elements:

1. Agreement for good faith participation and cooperation with PHP staff
2. Statement identifying the length or time frame of the PHP Agreement
3. Reference to AMA policy and/or other law or regulation that prohibits prescribing scheduled drugs for family members or others who are not legitimate patients within the scope of the participant's practice
4. Agreement to identify a primary care provider to manage one's medical care and to comply with the treatment plan, including but not limited to complying with treatment provider's recommendations and not self-prescribing or independently discontinuing any medications
5. Agreement to follow the treatment and continuing care recommendations of designated treatment providers (individual therapists, family therapists, psychiatrists) and/or others designated in the participant's PHP Agreement

6. Agreement not to change or discontinue therapy/treatment without approval of therapist and PHP
7. Agreement to notify the PHP as soon as feasible in the case of hospitalizations for any reason
8. Agreement to abide by any workplace accommodation or practice conditions
9. Agreement to maintain authorizations to allow communication with an approved practice or workplace liaison or other workplace contact
10. Agreement to allow communication with any third parties such as emergency contacts and treatment providers deemed necessary by the PHP
11. Agreement to submit to biological specimen testing without question if requested by the PHP[55]
12. Agreement to notify of any arrests, investigations, or complaints, including regulatory agency complaints
13. Agreement to notify of any disciplinary notices by regulatory agency, hospital, or other regulatory agency or employer
14. Statement of confidentiality provided and limitation of the same, including conditions under which anonymity can be broken, such as which regulatory agency will be notified in the event the PHP determines that a participant's practice of medicine may pose a risk to patients and he or she refuses to refrain from practice or otherwise follow PHP directives for remediation
15. Statement of potential consequences for failure to comply with the PHP Agreement, withdrawal of essential authorizations, or signs of active impairment, which may include but are not limited to refrain from practice, intensification of treatment, independent evaluation, inpatient evaluation, additional treatment, and/or report to the regulatory agency
16. Statement that PHP Agreement may be extended at the discretion of the PHP if, at the end of the contract period, there is reason to support the need for additional monitoring or extended treatment
17. Agreement that monitoring may be transferred or shared with another appropriate PHP if the participant moves or holds an active license in another state, as permitted under the laws of each applicable state
18. Authorization to release information to the licensure authority, if required by PHP Agreement, contract with regulatory agency, or other state law
19. Specify circumstances under which reporting to regulatory agency is required, such as:
    i. Impairment is suspected and the professional refuses to refrain from practice;
    ii. Treatment recommendations have been rejected without identification of acceptable alternatives;
    iii. Noncompliance with the PHP Agreement;
    iv. Resistant to treatment following multiple treatment episodes, making monitoring ineffective; and
    v. Board order or other legal requirement for reporting.
20. Other suggested terms: Notification of travel outside the jurisdiction of the PHP; change of address, change of employment, notice of adverse events and/or malpractice claims

Additional terms may be required depending on the underlying condition requiring PHP participation. See Additional Considerations for Conditions Managed by PHPs on page 44.

Some PHPs may offer opportunities for professionals to demonstrate fitness for practice or licensure who may not be eligible for a PHP Agreement as described above. If the professional does not hold an active license, the PHP may not be required to notify the regulatory agency of noncompliance or determination that the professional is not fit for licensure endorsement. These agreements should clearly state the purpose for engagement, limits of confidentiality, if any, and may include many of the other elements identified above. These conditional agreements should also identify the circumstances in which the PHP may decline to provide services at the PHP's discretion.

Elements of Monitoring

Case Management

Most PHPs utilize a case-management system for participant monitoring and accountability for continuing care. Case management refers to the coordination of services on behalf of an individual participant to ensure the integrity of monitoring and continuing care accountability.[74] Depending on PHP staffing and resources, participants may be assigned to an individual case manager, or case-management services may be shared among several staff members.

Participant Contact

PHPs provide oversight and support for participants through case-management services. Case management includes periodic, scheduled, in-person meetings with PHP staff or teleconferencing/ videoconferencing at a frequency commensurate with the PHP's staffing and resources. Contact with participants promotes the development of a positive relationship and enhances the likelihood of effective case management.

Some PHPs have sufficient resources to conduct professionally facilitated monitoring groups as a means of more frequent, direct observation of participants. Groups meet at varying frequency from weekly to quarterly, sometimes at multiple locations across the state. While group facilitators are not providing group therapy or counseling and the monitoring groups are not treatment, they often serve as a source of mutual support for participants while creating an opportunity for PHPs to gather information from the participants about their health and recovery status. Facilitated group monitoring, where available, has provided participants with support from peers with mental health conditions, stress/burnout, chronic pain, degenerative physical illnesses, and substance use disorders.

Quarterly Reports

In addition to meeting with participants, case-management services require periodic reports from collateral sources that affirm compliance with the PHP Agreements. These reports may be from treatment providers, including medication management, specialists, therapists, and worksite monitors or practice liaisons. Such reports should be collected not less than quarterly. Other required records may include confirmation of annual primary care physician visits or documentation of specialist treatment, which may be provided annually or at the time care is provided. These reports are considered part of the collaboration between the participant, reporter, and PHP. PHPs cannot provide endorsement of compliance without documentation.

Reports from treatment providers: Provider reports may include reports from therapists, substance use counselors, physicians, and/or specialists, as outlined in the PHP Agreement. Such reports are indicated for participants who require continuing care accountability for a potentially impairing health condition. PHP-approved treatment providers work collaboratively with the PHP by providing treatment reports to

the PHP at such time frames as determined by the PHP and by communicating directly with PHP staff as the need arises. Treatment reports contain only information essential for case management, such as the date of last visit, compliance with recommended visit frequency, type of treatment and/or medications prescribed, treatment adherence, treatment response, any concerns the treatment provider may have regarding the participant's health or well-being, and any concerns regarding ability to practice safely from the treatment provider's perspective.

Medication-Management Reports or other documentation are indicated for participants who require verification of medication adherence. Similar to therapy reports, medication-management reports contain only information essential for case-management services as noted above. These reports or medical records should also identify other alternative treatments that have been considered and any plan to taper or discontinue medications that may be mood altering or addictive.

Medication Logs: Unlike medication reports, medication logs are submitted by the participant or by an individual who is witnessing medication use by a participant. Medication logs are recommended when (1) there is a medically verified need to use a mood-altering or potentially addictive medication, or (2) there is a medically verified need to use a medication on a regular basis, which failure to use may result in destabilization. Copies of prescriptions should be provided to the PHP. Such logs should carefully document medication use for psychiatric or non-psychiatric conditions. Use of controlled substances or potentially mood-altering substances should be approved by the PHP whenever a participant intends to practice while using such medications.

Reports from Practice or Workplace Liaisons: As participants will be working in a healthcare facility or practice setting, a workplace supervisor or coworker is recommended to be identified and made aware of the participant's engagement with the PHP with the appropriate consent and authorization of the participant. The designated liaison should have knowledge of the behavioral indicators of illness recurrence and should call the PHP with any questions or concerns. The role of the practice liaison is not to monitor illness or the quality of work performance. Workplace monitors provide quarterly reports regarding signs of potential concerns that may display in the workplace such as attendance, punctuality, record keeping, and professional demeanor, or such other comments relevant to the liaison. Additionally, workplace liaisons and PHPs communicate when concerns arise regarding performance, illness status, or other areas of compliance with the PHP agreement. Although there are circumstances where a PHP may not mandate workplace reports, in all situations, a PHP should have an identified workplace contact with authorization to notify this contact in the event a question or concern arises regarding potential impairment.

Support group attendance: Logs or other means of documenting attendance or participation at various group activities such as mutual support groups or facilitated support groups are recommended. Engagement in support group attendance contributes to documenting appropriate illness management. The decision to require third-party verification may be determined by the PHP on a case-by-case basis, taking into consideration the innate principles of anonymous support groups and the individual's history of reliability. Such attendance may be documented monthly or quarterly at the discretion of the PHP.

Documentation of toxicology testing: While reports and logs offer subjective and objective perspectives to the PHP on the participant's compliance, toxicology testing provides PHPs with vital data to use in case management. The nature and extent of toxicology testing will depend on diagnosis and history as discussed on the following page.

Toxicology Testing

Overview

Toxicology Testing is used to both deter and detect unauthorized drug or alcohol use by participants who are expected to maintain abstinence as a condition of participation with the PHP.[71, pp. 149-160] Prior to initiating the monitoring process, the type of testing and the consequences of testing noncompliance are described to participants.[75,76] Noncompliance has many forms, including a test that is positive for an illicit substance, a non-negative test result that is not supported by a verified prescription, not submitting a drug test when required, overhydration, or specimen adulteration. In addition, random drug testing may be used to ensure that participants are adherent to prescribed medication.

Testing Matrices

Urine, blood, oral fluid, hair, nails, sweat, and breath are common biological matrices used for testing purposes. Drug testing is rapidly improving in sensitivity and specificity and PHPs should remain current regarding developments and limitations in resources and testing methods.[77] Details of drug testing are beyond the scope of these Guidelines. PHPs have discretion to determine appropriate testing matrices and regularly review their practice in this regard as technology evolves.[78-80] PHPs employ methodologies that are accepted as forensically valid, especially as the test results may be used as a basis for decisions and actions that may affect the participant's need for additional treatment or his or her license or credentialing.

PHPs are recommended to use a forensic laboratory facility certified to perform and confirm a comprehensive healthcare testing profile.[81] Forensic testing ensures that test results will meet rules of evidence in administrative, civil, or criminal proceedings. In addition, the laboratory should conduct specimen validity testing and confirmatory testing.

Biological samples should be handled using chain of custody collection procedures and protocols. Collection sites that employ chain of custody procedures reduce the likelihood of errors occurring in the collection and transporting of the specimens. Chain of custody collection procedures and protocols allow the participant providing the sample the right to directly observe the collection process.

The testing laboratory should submit results directly to a PHP-approved third-party administrator or the PHP. When appropriate, non-negative or abnormal tests should be addressed by a Certified Medical Review Officer (MRO) or Medical Director with appropriate expertise available to conduct a toxicology review of presumptive non-negative results.[82] The MRO, or other designated PHP representative, at the request of the MRO, should contact the participant regarding the drug test result when appropriate.

Reliability – Randomization

The optimal protocols for randomization selection of testing dates utilize computer-generated randomization software. Randomization will produce unpredictability in multiple ways, including periodic consecutive or "back-to-back" testing. Weekend testing should be considered. In addition, the PHP should vary both the drug panel tested and matrices used. This ensures the broadest coverage for abusable substances and patterns of use. Randomizing test selection increases the likelihood that the tests will shape behavior and decreases the opportunity for the professional to use substances in a manner that escapes detection. Randomized testing functions as a deterrent to relapse and supports abstinence.

PHPs are expected to address urine specimens that are invalid due to dilution, low creatinine, abnormal pH, or adulteration. Specimens must represent a voided sample. Intentional dilution may avoid detection of drugs or alcohol metabolites by rendering metabolites below the cut-off level identified by the laboratory. Each PHP should identify criteria when the participant is cautioned to avoid over-hydration. If dilute specimens persist, a medical or organic cause for persistent dilute specimens should be assessed. Each PHP, with the guidance of a medical review officer or other qualified physician, may determine when a dilute test is suspect for intentional dilution, requiring the PHP to assess the recovery of the participant. PHP follow-up of dilute test results includes but is not limited to:

- Requiring additional witnessed collection of urine,
- Resubmitting specimens for "level of detection" analysis,
- Increasing frequency of testing, and
- Use of an alternative testing matrix.

Specimens suspect of dilution may be an indicator for a participant at risk and may offer an opportunity for meaningful early intervention.

Testing Frequency

Frequency of testing will be determined by the purpose of the testing and may be influenced by requirements of state regulatory and licensing authorities.[77] The frequency of testing may be greater at the start of monitoring and decrease in frequency as the individual demonstrates compliance with the requirements of the PHP Agreement and appropriate illness management. However, the testing interval should always bear in mind the detection window of different drugs.[83] The frequency of testing is also influenced by the matrices or combination of matrices selected by the PHP for the individual. Cost may be considered a factor in making the selection of matrices as long as the health of the participant and the integrity of monitoring are not compromised. Currently, the most common, reliable, and well-studied testing matrix is urine, in part because of the comprehensive substance testing availability.[84]

Although there is no definitive standard, many PHPs test on a weekly basis for the first one to two years of monitoring and, if other criteria are met, the frequency may decrease. However, it is recommended that PHPs identify a range of tests to be done on an annual basis, rather than a specific number. Limited data supports higher-frequency testing in years one and five with reduced testing in the middle years.[11] Some PHPs offer uninterrupted drug and alcohol testing to participants after the conclusion of their initial agreement if requested by the participant. Each PHP may exercise its discretion to determine frequency of testing for its program and participants.

Assessing Compliance and Management of Noncompliance

The FSPHP uses the word *compliance* in the context of assisting participants achieve a clinical care plan with the physician's health and patient safety in mind. The issue of "noncompliance" can entail legal implications and reporting responsibilities on the part of the PHP. Therefore, it is important for each PHP to have a clear understanding of what constitutes noncompliance in accordance with its individual practices, state law, or regulatory agency requirements. As discussed earlier in the Informed Consent section of this document, participants are informed about what constitutes noncompliance and potential consequences for noncompliance with the terms of the PHP Agreement.

The following are taken into consideration when assessing a participant's compliance with the PHP Agreement:

- Following all treatment and monitoring recommendations with a signed PHP Agreement
- Scheduling appointments with the PHP
- Timely response to PHP calls and queries, and returning requested materials in a timely manner
- Complying with toxicology testing and relevant laboratory testing
- Complying with requested evaluations and related treatment recommendations and continuing care
- Complying with recommendations of treatment providers
- Refraining from the practice of medicine if requested by the PHP
- Ensuring contact and timely feedback to PHP from requested entities (treatment providers, workplace, collateral sources)
- Payment of the participant's financial obligations—to their treatment provider, random drug testing company, or PHP
- Return to use of alcohol or other unauthorized substance
- Absence of disruptive or distressed behavior at the workplace

Accountability and Return to Work

PHPs are simultaneously committed to the health of their participants and to the safety of the public.[85] Thus, all PHPs balance these difficult and often conflicting needs when assessing a participant's fitness for duty.[65,66] Determination of fitness for duty is a complex process that should include a skilled approach with providers who are experienced in making such determinations.

When considering return to practice, the PHP's role is to coordinate the data and to endorse return to practice if supported by an approved evaluator or to assist the participant with alternatives. When reviewing an evaluator's recommendations for fitness for duty, PHPs should determine if the following have been addressed:[86]

- Fitness to return to medicine and his or her practice speciality
- Description of any accommodations that are recommended to enhance workplace safety
- Identification of stressors in the work environment that may undermine health so that these may be addressed
- External factors with regulatory agencies or other authorities that impact the return-to-work status

Prior to endorsing return to practice, the PHP's documentation should include the following:

- Opinion of authoritative evaluator or treatment provider that professional has been cleared to return to practice and any recommended accommodations

- Documentation of engagement in treatment (e.g., meetings several times per week, urine drug screens [UDS] have begun, the client is comfortable with their treatment provider[s], a sponsor is obtained, etc.)
- A clearly delineated monitoring program set forth in a PHP Agreement and compliance with said Agreement
- Agreement by all parties to any workplace modifications or practice accommodations
- Identification of the workplace monitor

In summary, each PHP should develop criteria required to determine readiness to return to practice. Indicators of readiness include completion of a comprehensive evaluation,[87] engagement in level of care recommended by an evaluator, and written opinion by a treater or evaluator that supports fitness to practice with or without reasonable accommodations.

Professional Re-entry (Prolonged Time Away, Physician Re-entry Programs, Retraining)

When a participant has been away from practice three or more years, the participant may be required to undergo competence testing using the SPEX or other knowledge-based examination and/or demonstrate competency in his or her area of practice.[88] Such examination should be conducted in accordance with the requirements of the PHP and the participant's relevant regulatory agency.[85] This standard is intended for the participant who has an illness requiring an extended absence from clinical practice for treatment or rehabilitation purposes. However, each physician's case must be considered individually. For the purposes of this document, extended absence is considered 12 months of continuous absence from medical practice.

Once the participant has been appropriately treated, and particularly if they have not been under continuous follow-up treatment or monitoring subsequent to that treatment episode, they may need to have another evaluation that determines their current ability to safely return to clinical practice. These Fitness for Duty evaluations do not determine technical skills. These evaluations are only to determine the physician's ability to return to clinical practice because of a diagnosed illness or impairment.

In addition to being found fit to practice with reasonable skill and safety with PHP monitoring, the rapidity in which the participant returns to a full-time schedule along with any modifications or practice accommodations as well as other aspects of accountability listed in the "Monitoring and Accountability and Return to Work" headings should be delineated. It is noteworthy that contractual limitations/restricted practice clauses, such as work hour limitations, may inadvertently imply that there are concerns about a participant's professionalism or competence rather than a consideration of medical fitness to practice with accommodations, and therefore should be decided upon with care. The practice group or employer is responsible to ensure the participant is, in fact, practicing with reasonable skill and safety.

It is prudent for the participant to fulfill the requirements for maintenance of licensure in his or her state regarding continuing education credits and to attend specialty area conferences when there is a gap in practice, as practicable. In situations in which there is a prolonged absence from clinical practice or there is a concern for loss of technical proficiency or failure to maintain current knowledge or critical technical/mechanical skills, formal assessment of fitness to practice specific to the participant's specialty by programs that are designed for this purpose may be necessary.

Occasionally, a physician may need to be retrained in another area of practice if their original practice setting or specialty is restricted by regulatory or disciplinary actions, or if the former setting or specialty presents hazards that significantly elevate the risk for reactivation of the potentially impairing condition. Any or all of these recommendations should be enacted with the evaluating/treatment teams' input as central advisors to the process.

References for Section Three: Services Provided By PHPs

1. Federation of State Physician Health Programs. The 2005 physician health program guidelines. In:2005: http://www.fsphp.org/2005FSPHP_Guidelines.pdf. Accessed April 3, 2012.

3. Federation of State Medical Boards. *Report of the Ad Hoc Committee on Physician Impairment.* Ft. Worth, Texas 1995.

11. DuPont R, McLellan A, White W, Merlo L, Gold M. Setting the standard for recovery: Physicians' Health Programs. *Journal of substance abuse treatment.* 2009;36(2):159-171.

16. Skipper GE. Treating the chemically dependent health professional. *Journal of addictive diseases.* 1997;16(3):67-73.

21. American Society of Addiction Medicine. Persons in Safety Sensitive Occupations. In: Mee-Lee D, ed. *The ASAM Criteria: Treatment Criteria for Addictive, Substance-related and Co-occurring Disorders.* Third ed. Carson City, Nevada: The Change Companies; 2013:340-349.

55. Walzer RS, Miltimore S. Mandated supervision, monitoring, and therapy of disciplined health care professionals: Implementation and model regulations. *Journal of Legal Medicine.* 1993;14(4):565-596.

65. Anfang SA, Faulkner LR, Fromson JA, Gendel MH. The American Psychiatric Association's resource document on guidelines for psychiatric fitness-for-duty evaluations of physicians. *The journal of the American Academy of Psychiatry and the Law.* 2005;33(1):85-88.

66. Earley P. Physicians Health Programs and Addiction among Physicians. In: Miller S, Fiellin D, Rosenthal R, Saitz R, eds. *American Society of Addiction Medicine, Principles of Addiction Medicine.* Fifth ed. Philadelphia: Wolters Kluwer; 2019:671-692.

67. CPPPH. Guidelines for Evaluations of Health Care Professionals. 2013; https://www.cppph.org/cppph-guidelines/, 2019.

68. Tarter RE. Psychological evaluation of substance use disorder in adolescents and adults. *Clinical textbook of addictive disorders.* 2005:37-62.

69. Stuyt E, Gundersen D, Shore J, Brooks E, Gendel M. Tobacco use by physicians in a physician health program, implications for treatment and monitoring. *Am J Addict.* 2009;18(2):103-108.

70. Federation of State Medical Boards. Policy on Physician Impairment - 2011. 2011; https://www.fsmb.org/Media/Default/PDF/FSMB/Advocacy/grpol_policy-on-physician-impairment.pdf. Accessed 11/21, 2016.

71. National Council of State Boards of Nursing. Substance Use Disorder in Nursing Resource Manual. 2011. https://www.ncsbn.org/770.htm.

72. McLellan AT, McKay JR, Forman R, Cacciola J, Kemp J. Reconsidering the evaluation of addiction treatment: from retrospective follow-up to concurrent recovery monitoring. *Addiction.* 2005;100(4):447-458.

73. Merlo L, DuPont R. Essential Components of PHP Participation: Perspectives of Participants Five Years Post-Mandatory Monitoring. In: Institute for Behavior and Health and University of Florida; 2016:5.

74. Skipper GE, DuPont RL. The physician health program: A replicable model of sustained recovery management. In: *Addiction Recovery Management.* Springer; 2010:281-299.

75. Center for Substance Abuse Treatment. TIP-47: Substance abuse: Clinical issues in intensive outpatient treatment. In: Rockville, MD: SAMHSA; 2006:237-245.

76. Jarvis M, Williams J, Hurford M, et al. Appropriate use of drug testing in clinical addiction medicine. *Journal of addiction medicine.* 2017;11(3):163-173.

77. American Society of Addiction Medicine. *Drug Testing: A White Paper of the American Society of Addiction Medicine (ASAM).* Chevy Chase, Maryland: ASAM; October 26, 2013 2013.

78. Skipper GE, Thon N, DuPont RL, Baxter L, Wurst FM. Phosphatidylethanol: the potential role in further evaluating low positive urinary ethyl glucuronide and ethyl sulfate results. *Alcoholism: Clinical and Experimental Research.* 2013;37(9):1582-1586.

79. Skipper GE, Weinmann W, Thierauf A, et al. Ethyl glucuronide: a biomarker to identify alcohol use by health professionals recovering from substance use disorders. *Alcohol and Alcoholism.* 2004;39(5):445-449.

80. Wurst FM, Skipper GE, Weinmann W. Ethyl glucuronide—the direct ethanol metabolite on the threshold from science to routine use. *Addiction.* 2003;98(s2):51-61.

81. Johnson-Davis KL, Sadler AJ, Genzen JR. A retrospective analysis of urine drugs of abuse immunoassay true positive rates at a national reference laboratory. *Journal of analytical toxicology.* 2015;40(2):97-107.

82. Substance Abuse and Mental Health Services Administration. *Medical Review Officer Guidance Manual for Federal Workplace Drug Testing Programs.* Substance Abuse and Mental Health Servicies Administration; 2018.

83. Verstraete AG. Detection times of drugs of abuse in blood, urine, and oral fluid. *J Therapeutic drug monitoring.* 2004;26(2):200-205.

84. Cook JD, Caplan YH, LoDico CP, Bush DM. The characterization of human urine for specimen validity determination in workplace drug testing: a review. *Journal of analytical toxicology.* 2000;24(7):579-588.

85. Federation of State Medical Boards. Reentry for the Ill Physician. *FSMB Policies* 2013, 2019.

86. Myers MF, Gabbard GO. *The physician as patient: a clinical handbook for mental health professionals.* American Psychiatric Pub; 2009.

87. See the previous section on Evaluation

88. Warhaft N. The Victorian Doctors Health Program: the First 3 Years. *Medical journal of Australia.* 2004;181(7):376-379.

Section Four: Additional Considerations for Conditions Managed By PHPs

Substance Use Disorders (SUDs)

Perhaps the most common referrals to PHPs are participants who are suspected of having substance use disorders. Providing accountability for professionals with substance use disorders has been a primary function of most PHPs. The signs and symptoms of substance use disorders may often be confused with other medical and mental health conditions. For this reason, PHP staff must be adequately trained and knowledgeable to conduct initial interviews or contacts and to develop initial plans for evaluation and treatment.

Evaluation and/or Treatment

The PHP should use approved evaluators. Whether the evaluator is a facility or treatment provider, they should have an understanding of the interactions among substance use disorders, personality dynamics, co-morbid psychiatric illnesses, process addictions, the healthcare work environment, and other conditions that will affect the recovery from the participant's primary addiction illness. A PHP may consider multidisciplinary comprehensive evaluations with a residential component or outpatient evaluations. The PHP should have available residential, intensive outpatient evaluators, as well as approved community resources with expertise and credentials in addiction medicine and with experience in evaluating and treating safety-sensitive workers.

Individuals with substance use disorders often suffer from a number of other comorbid issues, requiring additional supports such as psychiatrists, pain-management specialists, family therapists, individual psychotherapists, trauma specialists, relapse prevention coaches, and attorneys with expertise in managing physician legal issues. Ideally, care providers will have experience and expertise in the care of healthcare professionals. Staff of the PHP should not have a conflict of interest or business association with the programs or practices utilized. As with treatment facilities, open communication between the PHP and all treatment providers involved in the participant's achievement of sustained remission is essential for the long-term success of this population of safety-sensitive professionals.

Substance Use Disorder Agreement

Substance Use Disorder Agreements are indicated for participants with mild, moderate, or severe substance use disorders alone or co-occurring with other health conditions. Co-occurring conditions, if present, may be monitored through provisions of a PHP substance use disorder monitoring agreement. Substance use disorder monitoring agreements employ a variety of monitoring elements, including the requirement for abstinence from the use of prohibited mood-altering or addictive substances.

The written agreement is based on a presumption of good faith participation and, in addition to some or all of the provisions identified earlier, a PHP Substance Use Disorder Agreement should include the following provisions:

- To remain abstinent from mood-altering substances, including but not limited to sedatives, alcohol, non-prescribed, and some psychotropic or over-the-counter medications

- To abide by the AMA recommendation or other law or regulation recommending not to prescribe for one's self or for anyone who is not a legitimate patient, including family members, and to prescribe only within the scope of one's medical specialty[89]
- To receive medications from treatment providers with whom there is a legitimate patient relationship and who are aware of the participant's terms and conditions for participating in the PHP
- To provide copies of any prescriptions, including but not limited to controlled substances, received during the term of the contract[90]
- To notify the PHP prior to the use of any controlled or mood-altering substance(s), except in the case of emergency
- To require pursuit of effective alternatives or require a second opinion prior to the use of any controlled or mood-altering substances in a nonemergency situation
- To provide current authorization to review medication profile registries where available to PHP
- To provide current authorizations authorizing PHP communication with primary care providers, treatment providers as needed to verify medical issues, and to provide or to request information on prescribed medications
- To notify the PHP as soon as feasible in the case of any medical or mental health hospitalizations
- Engagement with continuing care therapy and/or medication management with treatment providers approved by PHP until such time as treatment objectives are met as determined by the treatment provider and treatment is discontinued with approval by PHP
- Attendance at a minimum number of mutual support group meetings (generally 8 to 12 per month), documented in a manner acceptable to the PHP
- Attendance at weekly facilitated support groups for recovery professionals (if the same are part of a PHP's management process) or an alternative approved by the covering PHP
- Identification of and authorization to communicate with a practice liaison who is aware that the professional is working with the PHP and the purpose of the health-monitoring program
- Agreement to comply with any practice accommodations or limitations, such as hour or shift limitations, restriction of access to mood-altering substances, use of medication-assisted treatment
- Quarterly reports by therapists
- Quarterly reports by a practice liaison
- Agreement to voluntarily refrain from practice if at risk of impairment for any reason and to not return to practice until approved by PHP
- Identification of consequences for noncompliance:
    - Regarding concerns for lapses or lapsing behaviors, consequences may include referral to higher level of care, increased frequency of treatment, increased frequency of drug testing, additional biologic testing, refrain from practice as appropriate, and report to the licensing board or other regulatory agency.

Additional elements that may be individualized by the PHP, but are not limited to, include notification for travel/vacations, changes of address, changes of employment, malpractice claims, arrests, worksite and practice difficulties, and reevaluation prior to successfully concluding the PHP agreement.

A Diagnostic or Rule-Out Substance Use Disorder Monitoring Agreement is typically indicated for participants who are suspected of suffering from a substance use disorder and require a period of extended abstinence to confirm or rule out a diagnosis of mild, moderate, or severe substance use disorder. Such Agreements may also be used in other circumstances where an extended period of abstinence is recommended to promote health and well-being. A Diagnostic or Rule-Out Substance Use Disorder Agreement may contain fewer elements than a Substance Use Disorder Agreement, but, at a minimum, must contain a commitment to abstinence and random toxicology testing.

SUD Case Management

The period or time frame for monitoring substance use disorders is generally determined by the severity of the disorder:

1. Diagnostic Monitoring: generally, 6 months to 2 years. Two years may be indicated when a significant incident involving controlled or mood-altering substances has occurred and substance use disorder has not been diagnosed, but abstinence is recommended.
2. Substance Use Disorder, mild: generally, 2 to 5 years
3. Substance Use Disorder, moderate/severe: generally minimum of 5 years[12,66,70]

PHPs have the privilege of documenting the participant's progress and commitment to managing a potentially impairing, chronic, and fatal disease. The PHP uses quarterly therapy reports, meeting logs, random toxicology testing, and practice liaison reports to help the participant demonstrate stability in recovery.

Medication Management

For a participant with a substance use disorder, medication management may include documented, observed administration of medications by a healthcare provider, pharmacist, or other trusted individual and laboratory testing to confirm presence of recommended medications.[91] Documented administration of injectable/depot medications by a treatment provider may also be obtained as well as corresponding evidence by urine toxicology testing, discussed below.

Workplace Liaison Reports

Practice liaisons should be aware of signs of potential concern. Behavioral indicators often provide an opportunity for early intervention. Physical signs include watery eyes, pinpoint pupils, dilated pupils, jaundice, icterus, excessive bruising, unsteady gait, slurred speech, runny nose, nausea, vomiting, weight loss or weight gain, tremors, deterioration in appearance and/or hygiene, excessive fatigue. Signs specific to the practice setting include absenteeism, tardiness, isolation from coworkers, memory loss or difficulty concentrating, decreasing quality of performance, inappropriate orders, round late, or unavailable when needed, excessive daytime insomnolence, inappropriate behavior, alcohol on breath, intoxicated at home while on call, frequent trips to lavatory, appear on unit on days off, unacceptable or sloppy documentation, difficulty completing tasks and records, mood changes after a break. No one symptom is indicative of a substance use disorder and individual signs may be attributed to non-impairing or isolated

issues. However, a constellation of signs should not be ignored and the practice liaison should contact the PHP. When contacted by the practice liaison, the PHP may gather additional collateral information, require an immediate toxicology test, and meet with the participant and/or consult the participant's therapist. The PHP will use its discretion and expertise to determine any next steps to support the participant's well-being.

Application of Toxicology Testing

Toxicology testing for alcohol and drugs (both licit and illicit) is an indispensable tool in monitoring. Such testing provides (a) a mechanism for early detection of relapse to protect patient safety, (b) verification of abstinence that aids in the participant's restoration of credibility, (c) enhanced contingency management strategies and accountability in support of recovery goals, and (d) indication of the need for increased level of care and treatment.

Participants must remain in remission from their substance use disorder to be in compliance with their state program. A requirement for total abstinence from mood-altering substances is also required for those who are engaged with the PHP for the purpose of ruling out a substance use disorder or who have been recommended to maintain a period of abstinence in order to stabilize other potentially impairing health conditions. Comprehensive drug testing protocols are used to validate that a participant remains in remission.[11]

PHPs' reliance on toxicology testing is immensely important, but only a part of the information available to the PHP. Negative toxicology tests are one factor in assessing remission status. Biologic testing demonstrates the absence of the substances in a given testing panel above an established cutoff level during the window of detection. For this reason, a PHP should consider random test results as part of the constellation of information available to the PHP.

A confirmed positive test for a substance of abuse, a substance not verified by a legitimate prescription or without another verified explanation may identify a participant who is no longer in remission and requires a timely response. Such a positive test suggests that further evaluation is required. The PHP's focus should balance the health needs of its participant with public safety. A PHP may require the participant to complete an independent evaluation or reassessment by a specialist or facility with expertise in professional health and safety-sensitive workers, or a PHP may consider recommendations from current treatment providers.[30] The PHP may request the participant to refrain from practice pending further analysis, evaluation, and treatment.

PHP practices and procedures used for drug testing should recognize that an individual with a substance use disorder may make extraordinary effort to circumvent the testing process. Such conduct is a symptom of illness that requires intervention and treatment. The failure to submit a specimen on the date selected may be interpreted as a presumptive positive test, unless the test has been excused by the PHP. While the PHP may exercise discretion in determining when tests may be excused, such discretion should be objective and used in cases of true emergencies or for unforeseen/unmanageable events. Any valid reason for testing delay is to be documented by the practice liaison, and the type and date of next testing should be authorized by the PHP.

As the focus on substance use changes over time, participants should be screened for multiple compounds. All participants should have some screening for alcohol and cannabis. The alcohol byproducts and matrices have expanded significantly over the past two decades. PHPs should consider urine testing for Ethyl Glucuronide (EtG)[79,92-94] and Ethyl Sulfate (ETS),[92,95-97] breathalyzer testing for

exhaled ethanol, blood testing for phosphatidyl ethanol (PEth),[98,99] and hair for EtG.[100] When to use a given matrix depends on many factors and requires significant expertise in human metabolism, ethanol pharmacokinetics, and myriad clinical factors. PHPs work collaboratively with an MRO and external toxicologists in deciding when and how to use ethanol marker tools.

Fitness to Practice/Return to Work

A participant who has been referred for concerns of a substance use disorder may be required to refrain from practice until endorsed to return to practice. Return to practice recommendations should be made by the treatment team or designated evaluator. The PHP should have a written or verbal consensus from the evaluators and/or treatment providers regarding fitness to return to practice with note of any conditions that are recommended prior to return to practice. The PHP should also have documentation of a period of abstinence and a written agreement to maintain abstinence. A signed PHP Substance Use Disorder Agreement is preferred. Random chain-of-custody toxicology testing should be established prior to returning to practice.

The successful completion of a treatment program is only one component in determining whether the professional is ready to return to practice. Confirmation and documentation demonstrate that the continuing care program, including therapists and medication management, has been established, implemented, and maintained. A practice liaison should be identified as well as any workplace accommodations or limitations. All legal, licensing, and credentialing requirements should be considered. The professional should express a readiness to assume the responsibilities of return to practice while maintaining his or her commitment to continuing care, mutual support group meetings, random toxicology testing, and any other applicable requirements.

Other factors, including but not limited to, the participant's specialty and/or the drug of choice may influence the period away from practice and the terms and conditions for the return to practice. For example, an anesthesiologist whose drug of choice is an anesthetic agent may never be considered safe to return to anesthesiology or may be required to return to practice with accommodations, such as refraining from the operating or procedure setting until his or her recovery and relapse prevention are demonstrated, and workplace safety is established. An anesthesiologist will typically be required to use extended release naltrexone as an additional safeguard when returning to an environment with access to anesthetic agents. Periodic hair testing and/or other biological testing in addition to random urine drug tests for specific drugs of abuse should also be considered for anesthesiologists and other specialities as appropriate. Such measures recognize the higher risk of certain speciality populations and are intended to encourage sustaining long-term remission and enhancing the likelihood of a safe re-entry into the monitored practice of medicine. In some situations, a participant may need to consider retraining or selecting an alternative practice setting.

Noncompliance with PHP Requirements

The PHP's primary concern is for the health of the recovering physician. Substance use disorders are potentially impairing and fatal, if untreated or inadequately treated. Any unauthorized substance use requires clinical evaluation and may require removal from practice. This evaluation needs to determine the severity of addictive illness, the participant's commitment to achieving remission, and the existence of comorbid conditions. The evaluator is expected to make recommendations for treatment and monitoring as well as fitness for duty.

Relapse may result in a recommendation for further treatment, increased support group participation, refrain from practice until approved to return, increased urine and other toxicology testing for drugs and alcohol, more frequent interactions with the PHP, and revision of the PHP agreement, such as extending the period of monitoring. If it has been determined the addictive illness is complicated by psychiatric or medical illness, a revision of the PHP Agreement should be considered.

Compliance issues that do not involve misuse of substances, such as documentation deficiencies or failure to attend therapy or anonymous support group meetings, require intervention by the PHP, as such behavior can be predictive of pending or potential lapse. A participant should be allowed a reasonable opportunity to correct such noncompliance. The extent of PHP intervention is determined by the individual circumstances and with consideration for all data available to the PHP. For example, when there has been a failure to attend therapy or meetings and the participant has submitted dilute toxicology tests, the PHP may require a temporary refrain from practice until the participant meets with his or her therapist who supports return to practice and has submitted consecutive acceptable urine drug tests. Ultimately, the responsibility to maintain sustained remission is with the participant, as best efforts on the part of the PHP cannot guarantee that a participant will not experience exacerbation of illness.

PHPs should strive to communicate early and often to those participants in recovery of the possibility of relapse to their addictive illness, and what steps to consider should relapse occur. Relapse is a clinical event, and may provide opportunity to strengthen the participant's recovery program. If the relapse has not impacted patient care or involved patient safety, such a relapse should not result in public discipline and is strongly recommended that the participant continue to work with the PHP. Each PHP must respond in accordance with the rules and regulations of the individual state. Research has demonstrated a single relapse does not predict the ultimate success of the recovering physician.

Toxicology testing demonstrating a confirmed positive for a drug of abuse or admitted exacerbation of the substance use disorder is understood as noncompliance with the PHP requirement of total abstinence. Depending on the circumstances, immediate withdrawal from practice pending further evaluation may be indicated. A relapse protocol should be developed that is acceptable to the PHP and the applicable regulatory agency. At a minimum, each relapse should be evaluated clinically with a graduated response tailoring treatment intensification to relapse severity. A mechanism for an independent review and/or second opinion should be available if there is a dispute regarding the recommendations for intensification of treatment. PHPs should respond in a timely manner to any toxicology confirmed positive for drugs of abuse, including notification to the regulatory agency as required by established state-specific protocol.

A participant who relapses may be hesitant to report the relapse to the PHP, either because of the belief that PHP will be disappointed, the participant's disappointment in his or herself, or fear of consequences. Reporting to the PHP is essential. The strength of recovery is often reflected by what the participating physician does after or during the relapse. Those who call their support team immediately—sponsor, treatment providers, PHP—go to more meetings, and promptly ask for help demonstrate far more health than those who keep secret the return to alcohol or drug use until "caught" by a positive drug screen or some other serious adverse consequence. For many participants whose relapse stimulates them to face their illness more seriously, accept the need for support, and commit themselves more rigorously to recovery, the relapse is experienced as an opportunity to achieve sustained remission. For this reason, it is important that regulatory agencies do not immediately discipline a professional who suffers a relapse or remove the participant from PHP services.

Cannabis Use

With the advent of state laws legalizing medical and/or recreational cannabis use, PHPs increasingly face questions regarding the use of cannabinoids among medical professionals, including those under monitoring agreements. Preparations containing tetrahydrocannabinol (THC) are known to be potentially impairing and thus should be addressed by general PHP policy with respect to whether these substances are allowed while under any type of monitoring. As of 2018, there is little clinical consensus as to whether THC use is ever appropriate by those with psychiatric diagnoses, including major depression or bipolar I disorder. There may be some developing clinical consensus regarding the use and impairment potential of other cannabinoid substances such as cannabidiol (CBD), but there is scant peer-reviewed data available at present.

As of 2018, thirty states and the District of Columbia allow for marijuana and cannabis use in some form.[101] The Federal Controlled Substances Act identifies marijuana as a schedule I substance with a high potential for dependency and no medical purpose. Although marijuana remains criminalized under federal law, federal law enforcement agencies have relaxed enforcement of these provisions[102] and so, each state PHP is recommended to have a policy addressing the use of marijuana by professionals who have been referred to the PHP.

The use of marijuana for medical or palliative purposes by a licensed health professional requires the PHP to understand its state laws. The use of cannabis or cannabinoid products should be evaluated by the PHP consistent with evaluations for other substances with potentially impairing effects.

The practice of medicine and healthcare is considered a safety-sensitive occupation.[103] Most health employers have drug-free workplace policies and/or zero-tolerance policies. As marijuana may remain in the body as long as thirty days after the last use, there are no scientifically developed reliable measures to confirm the time of actual use or whether the use is "as directed." There have been no valid measures to determine what serum levels of THC correlate with safety to practice.[104] In one study of airline pilots, impairment on flight simulators persisted up to twenty-four hours after smoking a marijuana cigarette, even though subjects were unaware of impairment.[105] Decision-making errors were 50 percent to 70 percent in long-time marijuana users compared with 8 percent of the time in non-users.[106] Research on cannabis conducted over 20 years found that cannabis can be addictive, causes mental health problems, and can lead to other drug use.[107,108]

Until there are further developments in science and law, PHP Guidelines recommend that PHPs do not allow the use of medical marijuana or cannabis by medical or healthcare professionals who are actively engaged in the practice of medicine.[109] Alternative treatment options should be explored. If the participant suffers from a condition for which the only effective treatment alternative is marijuana or cannabis products, the participant should be required to voluntarily refrain from practice and continue to submit to random drug tests. The participant may be allowed to return to practice when the participant is determined to be medically fit to practice and has two to four consecutive urine drug tests negative for marijuana and marijuana metabolites. If the participant does not agree to refrain from patient care duties, the PHP cannot verify safety to practice; and therefore, the PHP must follow the requirements in its state when the PHP has knowledge that a participant is or may be unable to practice with skill and safety and is not complying with PHP conditions for participation.

A PHP should consider including its policy on managing the use of medical marijuana in any agreement the PHP uses with participants. By including the language in the agreement, the participant has notice of the conditions and has accepted the same at the outset of participation.

Psychiatric Conditions

Overview

While referrals to PHPs for substance use disorders are relatively common within the medical community, many professionals are reluctant to make referrals for psychiatric conditions. As many professionals with substance use disorders suffer from comorbid psychiatric conditions, PHPs have developed comprehensive resources that benefit healthcare professionals with psychiatric disorders. PHPs should have the knowledge, skills, and resources available to provide assistance and support for such physicians. The FSPHP supports the development of comprehensive mental health management in all PHPs. While not all those physicians with psychiatric disorders will self-refer or be referred by others for PHP services, many would benefit from the coordination of care provided by a PHP. When symptoms of psychiatric illness cause workplace concern or have been refractory to initial stabilization, or safe-haven legislation exists, referral to a PHP is appropriate.

For PHPs to adequately address comprehensive mental health support, the PHP must be able to:

- Conduct outreach and educational activities to the medical community regarding psychiatric and behavioral health concerns, explain the role of the PHP for comprehensive health and wellness, educate potential referents, and encourage referrals.
- Interface effectively with existing medical staff resources such as Hospital Wellness Committees.
- Maintain high visibility in the medical community with a user-friendly avenue to receive reports concerning physician health or behavior as necessary.

A psychiatrist or professional with psychiatric and/or psychological training should be readily available to provide necessary expertise to the PHP. Such expertise is useful, especially during the initial intervention, in reviewing evaluation and/or treatment recommendations, and for monitoring adherence to treatment.

Evaluation

As with all conditions covered by the PHP, whenever possible, a choice of several appropriate evaluation or treatment options is offered to participants. PHPs should consider cultural competence and other specialized needs when making referrals for evaluation and/or treatment. Recommendations from the participant's current treatment providers may be given consideration.

Recurrent exacerbations of psychiatric disorders may occur over the course of the PHP Agreement. Each recurrence should be evaluated with recommendations for further treatment or treatment modification based on severity of illness and potential for impairment. PHPs must respond to concerns of possible impairment in a timely manner. Depending on circumstances, a requirement to refrain from practice pending further evaluation may be indicated. The PHP should consider implementing a requirement for abstinence from alcohol and other recreational drugs to rule out a substance use disorder or an exacerbation of the psychiatric condition due to substance use.

PHP Mental Health Agreements

A Mental or Behavioral Health Agreement is indicated for a participant with mental health conditions in the absence of a co-occurring moderate-to-severe substance use disorder. In addition to the general elements of PHP Agreements, a PHP Mental Health Agreement may include some or all of the following components:

- Limitations on recreational use of or abstinence from use of alcohol or mood-altering substances, if applicable. In situations of comorbid substance use disorder, a PHP Agreement should also include the terms and conditions of a PHP Substance Use Agreement. Participants in Mental Health Agreements may request to not refrain from alcohol use. However, alcohol use may be contraindicated during stabilization of a mood disorder or other psychiatric condition when mood-altering chemicals are likely to jeopardize stability as well as to impair judgement, sleep patterns, diet management, or medication efficacy. Abstinence from alcohol use is also indicated when there is a history of alcohol use exacerbating the psychiatric disorders or interfering with the efficacy of prescribed medications. In situations in which a participant has used alcohol or other substances in a context of harm to himself or herself, total abstinence is recommended.
- Directive not to manage one's own medical care and to comply with treatment plans and recommendations of designated providers. This means participants will not diagnose or manage their own illnesses and will not self-prescribe or independently discontinue any medications. The PHP Agreement should specify continuing care components, incorporating recommendations from evaluation and treatment resources, such as medication management and individual and group therapy. Continuing care will typically require follow-up with a treating psychiatric provider and frequently with additional mental health providers who may be identified in the Agreement.
- Mandate to inform appropriate treatment providers of the complete medical and mental health history, including diagnoses and relationship with the PHP as well as to provide an authorization to allow communication directly with the PHP.
- Establish regular reporting requirements from continuing care treatment providers to the PHP. The PHP should consider use of a report form that minimizes interference with development of a therapeutic relationship between the participant and treatment provider. Consents for release of information between treatment providers and the PHP must be maintained not only so that the PHP may confirm established treatment, but also that the PHP may collaborate in coordination of care between the participant's community providers throughout the treatment process as needed. If a participant refuses to allow communication between the treatment provider and the PHP, the PHP should decline to provide support services and when appropriate, make referral to the applicable regulatory agency.
- Directive to inform the PHP in a timely fashion of all medication use. This requires providing a copy of all prescriptions to the PHP as well as documentation of medication refills. Participants should report as soon as feasible and preferably within 24 hours any prescription for a potentially addictive medication. If a mind- or mood-altering substance is prescribed, it is reasonable for the PHP to require that the participant refrain from practice. The participant may be required to submit to a fitness for duty evaluation prior to returning to practice.
- Biologic testing or random toxicology testing or toxicology testing when requested. Such testing is especially appropriate to confirm medication compliance and/or to demonstrate abstinence

from alcohol and other prohibited substances. When abstinence is a treatment requirement, toxicology testing should be utilized as appropriate.

- Requirement that any medical or psychiatric hospitalizations should be reported to the PHP as soon as possible.

Case Management

Periodic contact with the participant is a critical component of PHP support for participants in mental health or behavioral agreements. Therapist, Medication Management, and Practice Liaison reports are also essential for establishing accountability in mental health agreements. The PHP should exercise its discretion in determining whether reports should be submitted quarterly or more frequently. The PHP should consider requiring participants to submit monthly medication logs, especially if "as-needed" medications are part of the medication regimen or if non-adherence with prescribed medication has been a part of the participant's history.

Toxicology Testing

Laboratory monitoring for the presence and therapeutic plasma concentrations of prescribed psychotropics may be appropriate.

Fitness for Practice/Return to Work

In addition to the previously discussed considerations for determination of fitness for practice or return to work, participants with mental health conditions should demonstrate that any condition has been stabilized. Medication adjustment should be completed, or the prescriber should state in writing that continuing care adjustments will not interfere with the ability to provide care to patients, taking into consideration the participant's practice speciality. Treatment providers should render professional opinions on the participant's fitness to practice.

Noncompliance

Exacerbation of the underlying mental health condition is not necessarily indicative of noncompliance with the PHP Mental Health Agreement. The PHP must respect the nature of the illness and keep in mind the PHP role to assist the participant in understanding when he or she may be at risk for impairment. Ideally, the participant will self-initiate withdrawal from practice when necessary.

Refusal to engage in evaluation or treatment, discontinuing medication without the prescriber's approval, use of unapproved recreational substances or misusing prescribed medications, and intentionally engaging in conduct which may destabilize mood or behavior are examples of noncompliance that require PHP intervention. Intervention may result in a recommitment to wellness and compliance with the PHP Agreement; intensification of treatment; obtaining an independent evaluation or obtaining a consultation; conversion to a Substance Use Agreement; extension of the monitoring period; or report to the regulatory agency.

Refusal to refrain from practice when directed by the PHP should require notification to the regulatory agency. When a participant's illness is refractory to multiple treatment efforts, such that the participant represents an ongoing risk to self or others, this may also require notification to the regulatory agency.

Unipolar Depressive Disorder

This is a broad category of conditions, including major depressive disorder and dysthymic disorder among others. Most professionals who experience depressive symptoms are never referred to PHPs. Reasons for referral to a PHP include:

- Deterioration in work performance related to depressed mood and associated symptoms, including cognitive difficulties, fatigue, sleep disturbance, and suicidal ideation
- Inappropriate behavior in or out of the workplace
- Disrupted friendships and domestic relations
- Need for advocacy in dealing with professional issues
- Other perceived risks to the professional or public safety

Whether self-referred or referred by others, the first step is to engage the participant and arrange for an evaluation to establish a diagnosis and development of a treatment plan. Medication management with antidepressants may be required. Medications should be managed by a psychiatric professional and should not be managed solely by a primary care physician.

If the physician is already receiving treatment for depression, every effort should be made to establish contact with and take into consideration the opinions of any treating professionals. Whenever possible, the physician should be offered several choices of approved evaluators experienced in assessing mood disorders in medical professionals. The evaluation should not be performed by the current treatment provider. Collateral information from the treatment provider should be included in the overall assessment. The evaluation should include a comprehensive clinical interview with the participant, review of relevant medical records, and collateral contacts with referral sources, treatment providers, and in some instances, family members. Neuropsychological screening may be included if cognitive symptoms are prominent and/or if an underlying cognitive disorder is suspected. The evaluation report will include a diagnostic formulation and recommendations for treatment and monitoring.

A monitoring agreement can be developed based on the treatment plan, with reports from treatment providers to the PHP, with releases for communication with other interested parties as indicated. Support groups for depressed physicians or groups for professionals with psychiatric disorders, which can be very valuable in helping the professional move beyond fear, shame, and resistance to monitoring, should be used when available.

Length of monitoring agreements for depressive disorders without comorbid substance use varies on a case-by-case basis generally between one and three years. Recurrence of symptoms during treatment, non-adherence with treatment and/or monitoring, and other complications may be indicators for extended monitoring beyond three years.

Bipolar Disorder

Bipolar disorders include Bipolar I, Bipolar II, Cyclothymic disorder, and others with qualifiers for anxious features, mixed features, rapid-cycling, catatonic features, psychotic features, and melancholic features, including onset in the postpartum period. Most participants are referred to PHPs due to manic or manic-like features, which often result in a dramatic change in behavior and may be accompanied by impaired judgment and/or impulse control.

As with all psychiatric disorders, a careful and comprehensive evaluation is needed to clarify the diagnosis, and to determine if other co-occurring disorders are present in order to develop an effective comprehensive treatment plan. Medication management is an essential component of a comprehensive treatment plan. A PHP should require medication management by a psychiatric specialist.

Because people with bipolar disorder are often stigmatized, and because persons experiencing manic or hypomanic symptoms often demonstrate strong rationalization, minimization, and justification of behaviors, participants with bipolar disorders can be very difficult for PHPs to engage and refer for evaluation. Developing and implementing a monitoring plan can be challenging, and the focus needs to remain on the participant's need for accountability to treatment and support and advocacy, which enhance the ability to practice safely. Monitoring should include regular reports of progress and stability from treatment providers, satisfactory performance in the workplace, and attendance at support groups when available and deemed appropriate. Toxicology testing is recommended to confirm the presence of prescribed medications. Toxicology testing to confirm abstinence from recreational substances, including alcohol or self-medication with unapproved prescription drugs, should be employed for participants with the diagnosis of bipolar disorder.

Length of monitoring agreements may begin at three years with the option to extend. The need for continued monitoring beyond the typical three- to five-year agreement is determined on a case-by-case basis depending on the response to treatment and development of reliable self-awareness and demonstrated stability. Participants who demonstrate adequate insight about their illness, recognize early warning symptoms of impending exacerbations (hypomania or mania), and comply with recommended treatment may not need extended monitoring. Licensure-long monitoring may be considered in some cases, dependent on PHP or regulatory agency requirements or other state laws. In such cases, the participant may be unable to acquire insight into symptoms that may signal professional impairment and the need to refrain from practice. However, the PHP also needs to be cognizant of when a participant's illness is beyond the PHP's ability to monitor effectively.

Anxiety and Trauma-Related Disorders

Many physicians and other healthcare professionals experience anxiety symptoms, and the incidence of anxiety disorders is similar to that observed in the general U.S. population. Anxiety disorders are the most commonly diagnosed psychiatric illnesses in the United States. However, anxiety disorders are among the least common primary diagnoses in PHPs. Referrals to PHPs arising from anxiety disorder typically arise from compromised function in the practice setting, such as difficulty maintaining practice demands or matters compromising interpersonal effectiveness. Anxiety disorders often present to PHPs in the form of self-treatment, especially self-prescription of benzodiazepines and other sedatives. In such circumstances, the PHP should follow the Guidelines for ruling out a substance use disorder in addition to providing support for an anxiety disorder.

The PHP should have available evaluators and treatment providers with expertise in trauma-informed care for participants referred for anxiety, and post-traumatic stress should be considered. Medical training and medical practice are considered stress provoking and/or traumatic in the normal course of any practice. Participants may demonstrate behavioral dysregulation or burnout, prompting referral to the PHP.

Individual and group therapies are commonly recommended as part of the overall treatment plan. PHPs should be aware of resources for multiple therapeutic modalities, including cognitive behavioral therapy, dialectical behavioral therapy, and mindfulness. Anxiety and trauma-related disorders, including Post

Traumatic Stress Disorder (PTSD) may require antidepressant and/or anxiolytic medications, preferably those that do not lead to dependency and do not impair cognition. If a medication potentially impairs cognition, baseline cognitive testing should be obtained with periodic follow-up cognitive assessments.

Whether or not a participant requires PHP monitoring of anxiety or trauma-related illnesses depends on the severity of symptoms, the degree of insight the participant has about the illness, how motivated the physician is for treatment as well as treatment compliance, and whether medication management is part of the treatment plan.

Length of PHP Agreements varies from one to five years and is determined on a case-by-case basis. Trauma-related disorders tend to be complex, and both treatment and monitoring may be prolonged.

Eating Disorders

There are several different eating disorders, including anorexia nervosa, bulimia, and binge eating. Anorexia nervosa and bulimia tend to be the most disabling and life threatening. Eating disorders are especially difficult for a PHP to monitor. Whether or not a participant requires monitoring for an eating disorder depends on the severity of the illness, the level of insight about the nature of the illness, and treatment compliance. When formulating treatment and monitoring plans, the following should be taken into consideration:

- Circumstances that caused referral to the PHP
- Co-morbid disorders needing treatment
- Treatment recommendations provided by an individual or program evaluation conducted by those with the requisite expertise for evaluating eating disorders
- The type of treatment completed (inpatient, partial hospitalization, residential, intensive outpatient, or individual therapy) before considering a return to work
- Continuing care needs (individual therapy, nutrition counseling/monitoring, weight monitoring, metabolic monitoring, family and/or marital counseling, group therapy)

PHP monitoring, if indicated, should include regular updates from all treatment providers and the workplace. The PHP may require the participant to identify an individual who lives with the participant to provide collateral information as needed and, when resources allow, should have periodic face-to-face meetings with the participant. It is important to note that despite all of the above, the PHP cannot ensure that the participant with an eating disorder will be compliant. The PHP role is to confirm engagement with treatment and to obtain periodic endorsement from treatment providers of the participant's ability to practice safely.

Distress, Burnout, and Disruptive Behavior

Many PHPs serve distressed physicians referred for disruptive behavior, which is manifested as an intractable pattern of conflicted relationships in the hospital or clinic setting. This behavior can be characterized by emotional or behavioral dysregulation and a breakdown in essential communication between members of the healthcare team that threatens to compromise the efficient delivery of care and detracts from a culture of safety within the organization.[110-112]

PHPs can play a pivotal role in assisting medical groups and hospital organizations by providing education and outreach, as well as assessing underlying psychiatric or medical conditions predisposing the participant to such behavior. PHPs are encouraged to develop strategies that are responsive to the needs of participants, hospitals, credentialing bodies, and medical boards consistent with statutory and regulatory requirements, contractual obligations, fiscal considerations, and staffing availability. Larger PHPs may enjoy sufficient resources to provide for the needs of distressed physicians with internal resources, or a combination of PHP staff and external evaluation and treatment providers, while smaller PHPs may rely upon qualified external resources.

PHPs should encourage practice groups, facilities, or hospitals to address disruptive behavior when it is first observed via institutional leadership channels. The contribution of each team member involved in the offending incidents should be assessed. Initial involvement with the PHP may be informal, but all behavioral incidences should be well documented with primary observations along with actions assigned and taken to remediate reported concerns. PHPs should encourage review of system triggers as well as individual triggers for behavior. The PHP should have the discretion to recommend other members of the healthcare team who contributed to the offending behavior be referred to the PHP. Should the offending behavior continue, more formal engagement with the PHP should be undertaken, with behavioral observations, improvement plan, and action to be taken clearly outlined in writing and acknowledged by the participant.

Distressed physicians should not be referred to PHPs for primarily political or economic reasons. Although disciplinary action may be mitigated or prevented by full participation and cooperation with a PHP, the PHP should not be utilized or viewed as a punitive step toward a disciplinary outcome. Thorough and timely documentation of reported concerns is essential to assure fair and impartial assessment and resolution for the participant and the healthcare team.

Physician, resident, and medical student burnout is a growing problem throughout the U.S. healthcare system, and a great deal of research is available describing this widespread phenomenon.[113-115] Some PHPs offer services to physicians and other professionals experiencing symptoms of burnout. In addition, upon referral of these professionals for assistance such as therapy, coaching, and/or support groups, some are found to have diagnosable psychiatric disorders requiring more intensive treatment. The stigma associated with psychiatric illness continues to prevent some physicians from seeking professional treatment.[116]

Assessment

At the initial meeting with the participant, the PHP needs to assess the participant's understanding of why the participant has been requested to work with the PHP and to identify mutually agreed-upon goals for his or her participation. Initial assessment should include:

- determination as to whether the distressed physician warrants a clinical or medical diagnosis, including substance use disorder and/or psychiatric condition and referral for evaluation;
- whether psychological evaluation is needed to rule in or out the presence of problematic personality features; and
- determination of whether there exists systemic problems within the hospital or medical organization that may be contributing to the disruption among the healthcare team.

Processes for support, evaluation, and/or treatment of distressed physicians should be developed consistent with best practices for evaluation and treatment of participants with other conditions of possible impairment. Evaluations should be conducted by well-qualified evaluators, the choice of which is consistent with the criteria used for selecting a provider for fitness for duty evaluations, with the additional qualifications of also being well versed in organizational management, hospital culture, medical staff processes, administrative law, and difficult personalities.

There may be instances when an evaluation conducted by a well-qualified evaluator results in a determination of no clinical or medical diagnoses, and the problem behavior is attributed solely to problematic personality features or a combination of a personality disorder alone in the context of systemic problems at the organizational level. In these instances, a determination should be made concerning whether the identified physician may or may not benefit from professional oversight and monitoring by the PHP. Staffing and resources should be assessed to determine the extent to which further PHP involvement is warranted in such circumstances. If a behavior-management plan is designed in which the PHP has an identified role and yet, the behavior persists, the PHP may refer for additional evaluation and potential treatment or may determine that the participant is not an appropriate candidate for PHP services.

PHP Behavioral Agreement

A Distressed/Disruptive Behavior Agreement is indicated for participants whose behavior undermines a culture of safety in the practice environment and is not accounted for by another health condition. Some PHPs monitor such individuals under a behavioral health/psychiatric monitoring agreement, while others have separate agreements specifically addressing these concerns.

Behavioral monitoring agreements should include provision for frank feedback from principal parties in the hospital or clinic setting, with provision for real-time reporting of sentinel events to principal stakeholders. Additional terms for monitoring, such as adherence to standards of behavior or expectations of civility, education on managing workplace conflict, reports from professional coaches, and others should be clearly stated.

Length of monitoring should be informed by clinical diagnoses, presenting condition(s), demonstrated stability in practice, and recommendations of the evaluation/treatment team. Duration and scope of monitoring agreements for participants with substance use disorder or psychiatric diagnoses should be as specified elsewhere in these Guidelines.

Case Management

If a clinical or medical diagnosis is made, PHP monitoring should include treatment and other modalities as identified in these Guidelines. Specific concerning behaviors may also be addressed with or without such a diagnosis using the following strategies:

- Professional coaching
- Didactic education
- Values clarification and goal setting
- Outpatient, intensive outpatient, or residential treatment
- Worksite modification or accommodation

- Reassignment or relocation
- Practice transition or retirement
- Defined criteria warranting referral for discipline

Careful documentation of the history of these incidents should be provided to the evaluation and/or treatment team for periodic re-evaluation.

Physician Suicide

PHPs should be aware of the risk of suicide among health professionals.[117,118] Fear of treatment, consequences, or loss of licensure may become additional risk factors for a potential participant. The grounds for the referral to a PHP may coincide with risk factors for potential suicidality, making safety assessments an important part of an initial meeting.

The actual rate of suicide among physicians and other healthcare professionals is not known. Although some studies have suggested that physicians have a risk of suicide much higher than the general population,[119] more recent reviews, including a recent study by the Centers for Disease Control and Prevention, do not support this finding.[120] It is also thought that physicians who attempt to end their lives, having more knowledge and access to more lethal means, are more likely to complete suicide.

Multiple studies of physician burnout over the past decade have demonstrated that suicidal ideation is a significant feature, along with emotional exhaustion, detachment, cynicism, and questioning the meaning of one's life.[121-124] However, in other studies not specific to physicians, suicidal ideation does not correlate with actual attempted or completed suicide.

Experts agree that suicide usually occurs in the context of one or more of the following:

- Unbearable pain, including emotional torment with a sense of hopelessness; an overwhelming sense of failure; and/or physical agony
- Murderous rage
- Psychotic stimuli
- The influence of substance(s) or conditions that impair impulse control and judgement
- By accident, when a self-destructive gesture becomes lethal

Suicide is often related to severe depression or other mood disorders. Physicians and other healthcare professionals are reluctant to seek treatment and support for symptoms of depression for multiple reasons.[125] Physicians often have personality traits and belief systems, including perfectionism; difficulty relinquishing control and trusting others; reliance on minimization and externalization; and a perceived obligation to appear healthy and invulnerable, that make it very difficult to ask for or accept help.[126] In addition, they fear the impact of seeking treatment on their careers, and this fear is intensified by stories of colleagues whose practices were severely disrupted when it became known that they were being treated for a mental health condition.[127]

For physicians, suicide can also occur in the context of a substance use disorder prior to receiving treatment and especially in the context of relapse(s) following primary treatment. Some physicians kill themselves in response to an event or series of events that produce intense shame and guilt, such as the death of a patient, a major financial failure, involvement in a scandal, or arrest for or conviction of

criminal activities. A PHP should attempt a safety check at the time of the initial contact. Unfortunately, a professional who decides that suicide is a rational option is unlikely to be deterred. Treatment and monitoring of physicians who are at high risk of suicide would depend upon the diagnosis(es) and other complicating factors as outlined in the other sections of these Guidelines.

Chronic Degenerative Medical Conditions

Overview

Chronic physical conditions generally do not trigger the stigma and shame associated with mental health conditions. A physician facing a medical condition is considered more likely to follow appropriate treatment and continue with treatment sufficient to maintain fitness to practice. The physician is more likely to be considered reliable to remove himself or herself from active practice when the medical condition jeopardizes fitness to practice. As a result, medical or physical conditions are less likely to prompt referral to a PHP for monitoring. However, when the medical condition requires use of potentially impairing medications or is a degenerative condition the physician is reluctant to accept, referral to a PHP may be appropriate or even rise to the level of a mandated report.

Pain Management

Pain, by definition, is "an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage."[128] Pain is potentially impairing insofar as it may cause fatigue and distraction and limit range of motion, stamina, and motor control, which may detrimentally impact the ability to provide patient care. The desire to alleviate pain may result in self-medication leading to substance use disorders. Given the inherent motivation for participants with emotional or physical pain to achieve relief or the natural tendency for a participant with a substance use disorder to deny his or her substance use disorder due to a chronic pain condition, it is important for PHPs to understand appropriate pain management and to have pain experts as part of available resources for referral. All PHP participants deserve appropriate evidence-based medical care. The role of the PHP is to monitor a participant's compliance with the clinical management of pain and endorse when the participant is considered fit to practice.

Assessment

At the initial meeting, PHPs will generally focus on classification based on the length of time the pain has been present related to the healing process. Acute pain is defined as pain that is expected to be over within a limited period of time. Chronic pain is pain that lasts beyond the healing of the causative injury and continues for more than three months. The classification of pain is important because it helps dictate treatment options and case-management needs. Many treatment options for both acute and chronic pain include controlled prescription drugs that require PHP attention and may impact a participant's fitness to practice.

The initial meeting is conducted similarly to initial meetings for any other condition monitored by the PHP. The PHP obtains authorizations to obtain medical records. The PHP will determine whether an independent evaluation is required or whether the participant may benefit from evaluation by additional specialists.

Evaluation

As discussed previously, the participant should be provided a choice of potential evaluators. While the focus of the evaluation is determining accurate diagnoses and treatment options, the goal for participation in the PHP is improved function with reduced or controlled pain. The elimination of pain is not a realistic goal for a participant with an identified chronic pain condition. In lieu of or in addition to a PHP-approved independent evaluation, the PHP may suggest a second opinion or require the participant to follow up with specialists. The treatment of chronic pain is best achieved through a multimodal approach by a multispecialty pain clinic staffed with a psychiatrist, neurologist, neurosurgeon, physiatrist, addictionologist, and/or anesthesiologist working in collaboration with each other and the participant. Despite working with the participant to identify an effective treatment plan, the PHP does not assume responsibility for the quality of care.

PHP Pain Management Agreement

In addition to the general terms for a PHP Agreement, a Pain Management Agreement may include the following additional terms:

- Agreement for cognitive testing baseline and annually for the duration of the Agreement, if warranted
- Agreement to refrain from practice when pain is not effectively controlled or when participant may be impaired
- Agreement to consult specialists when recommended by treatment providers or PHP
- Specify diversion-prevention strategies
- Agreement for medication management and other therapy or modalities

Pain Case Management

Pain cannot be measured like a vital sign. Pain scores have person-to-person variability based in part on genetics and cultural differences. Pain cannot be objectively measured with any degree of specificity by an observer. Pain is always subjective, as are other emotional experiences. This makes monitoring participants with pain challenging for PHPs.

A PHP expects a provider to review the state's Prescription Drug Monitoring Program (PDMP) and to notify the PHP if concerns arise. The PHP and participant will follow medication prescribed in quality and quantity that is appropriate for the diagnosis.

In general, a PHP working with a participant who suffers from pain with or without a history of substance use disorder should have in its file:

- Copies of the Pain Agreements between the participant and the prescribers, if applicable;
- Medical records including history, treatment plans, and recommendations;
- Toxicology tests;
- Random reviews of the state prescription-monitoring program run by the PHP if allowed or confirmation that the prescriber has made such reviews; and
- Independent competency, including cognitive assessments, if appropriate.

When the PHP obtains medical records from a prescriber for acute or chronic pain, the PHP should confirm that medical history is documented, including social and family history as well as medication history including both controlled and over-the-counter (OTC) medications. Substance use disorder risk assessments and comprehensive physical exams should be performed and documented with identification of a diagnosis and treatment plan. The participant is expected to disclose to the treatment providers that he or she is working with the PHP and sign authorizations allowing the full exchange of information between the PHP and the provider.

Although PHPs value the clinical judgements of treatment providers and respect the physician–patient relationship, PHPs may use discretion to request clinical justification for treatment choices and/or for the treatment provider to specify why other alternatives may not be considered effective. The PHP should encourage a participant to advocate for him or herself, and the PHP may also deal directly with the prescriber with the appropriate consents.

Participants are generally not referred to PHPs solely for acute pain conditions. As PHPs will monitor participants for years, it is possible a participant will experience a legitimate acute pain condition at some time during the monitoring period. Acute pain management includes oral analgesic medications, patient-controlled analgesia (PCA) with systemic opioids, and peripheral analgesic techniques such as nerve blocks using local anesthetic infiltration, or a combination of different approaches known as multimodal pain management. The choice of medication, dose, route, and duration of therapy should be individualized and based on the source of acute pain by the treating specialists. The role of the PHP is to monitor a participant's compliance with the clinical management of acute pain and affirm when the participant may return to practice. In most instances, the participant will not be engaged in practice until such time as the acute pain has resolved or is managed by non-mood-altering, potentially impairing substances.

PHPs advocate for the use of non-mood-altering, non-addictive, non-impairing modalities whenever possible. However, treatment decisions are to be made by providers. The many treatment options are dictated by the diagnosis.[129] A PHP may expect that the first line of pain medication will be a non-opioid analgesic.[130]

If the non-opioid analgesic medications do not control pain or improve function satisfactorily, then medications from the adjuvant list can be added. This group of adjuvant medications include, but are not limited to, the antidepressants with noradrenergic effects (tricyclics—amitriptyline, SNRIs—duloxetine), topical agents (lidocaine, capsaicin), the anticonvulsants (carbamazepine, oxcarbazepine, topiramate, gabapentin, and pregabalin), and the muscle relaxants (tizanidine).

Non-medication adjuvants including thermal modalities (cold and heat), counterstimulation (TENS unit), manual therapy (massage, deep-tissue manipulation), active movement, physical therapy (stretching, conditioning, and strengthening), orthotics (splints, braces, pillows, and supports), and acupuncture may be effective. Additional adjuvants are the psychological interventions that include deep relaxation, chiropractic, yoga, hypnosis, sleep management, biofeedback, guided imagery, mindfulness, affective disorders treatment, individual or family therapy, and cognitive behavioral therapy.

Use of opioid analgesic medication may be required if other modalities are not effective. Participants should be restricted from clinical care if prescribed medications cause cognitive impairment that may not be reasonably accommodated. Comprehensive cognitive testing, including neuropsychological testing, may be required to assess level of function as part of the return-to-work assessment or as part of a periodic assessment to confirm fitness to practice while engaged in treatment with such medications. The

PHP should have good communication with the pain management or medication management provider so that the PHP record accurately documents treatment efforts and reasoning regarding fitness to practice.

Reports and Logs

Medication-management reports and therapist reports as discussed above are essential in monitoring participants with pain conditions.

Participant logs detailing medication use for headache, pain, and efforts at other interventions prior to medication use may also be employed and shared with treatment providers at the discretion of the PHP.

Toxicology Testing

Toxicology testing is especially helpful in monitoring participants with pain needs as such testing will confirm compliance with prescribed medication, and the absence of prohibited substances. The PHP may collaborate with the provider by sharing random drug test results.

Fitness to Practice

Participants who are prescribed controlled drugs for acute or chronic pain, including opioid analgesics, benzodiazepines, muscle relaxants, and hypnotic agents, are at risk for having cognitive impairment caused by these medications. As the practice of medicine is a safety-sensitive profession, participants should be restricted from clinical practice if they are prescribed medications that can impact fitness to practice until they are no longer taking these medications or have assessments of competency. Repeat cognitive testing may be warranted to demonstrate ongoing fitness to practice.

Acute and Chronic Pain Management for a Participant with a Substance Use or Other Compulsive Disorder

The participant who has a diagnosis of a substance use disorder or process addiction and has established sustained remission may experience intense fear or anxiety because of his or her awareness of the risks presented by exposure to opioid analgesics. The participant may also be inclined to deprive him or herself of needed care due to the stigma within recovery circles associated with use of opioid analgesics. The PHP role is to require safeguards when such a participant needs pain management and to destigmatize his or her experience. Recovering participants deserve the same care as any other patient and should receive the same quality of pain management as any other patient. Multimodal pain management should again be implemented, and nonaddictive medications should be utilized as much as possible.

Although the PHP focus is on the treatment plan, pain itself is a powerful relapse trigger. In most instances, a PHP should require the participant who requires mood-altering substances and suffers from a substance use disorder to refrain from practice while using potentially addictive substances.

A PHP should also require the participant with a history of substance use disorder or other compulsive disorder to implement safeguards to decrease the risk of relapse when requiring prescribed opioids or other addictive medications.[131] Additional safeguards include:

- Written confirmation that the prescriber is aware of the participant's full medical history, including the substance use disorder or process addiction;

- Use of the participant's support system. For example, the participant's spouse, significant other, sponsor, or first-line relative should control the medication in a lock box to be dispensed as directed on the bottle on a scheduled basis;
- The participant should make a written commitment not to receive, control, self-prescribe, self-dispense, or dictate their pain medication use;
- "As-needed" medication regimens should be avoided, as should "breakthrough" medications;
- The lowest effective dose should be used for the shortest possible duration; and
- The participant should be encouraged to discuss his or her fears about pain and pain management at self-help support meetings and with a therapist.

The PHP should receive documentation supporting the treatment plan. Although the PHP must rely on the treatment provider, the PHP may encourage the participant to advocate for him or herself. The participant should agree in advance that when the acute pain is resolved, the remainder of the pills/tablets will be safely and appropriately discarded with a witness.

The participant who receives pain management remains at increased risk for relapse of the substance use disorder even after the opioid medication is completed because of the exposure to the mood-altering substance.[132] The PHP may require a participant to renew their involvement with the recovery process by increasing attendance at self-help support meetings, increasing contact with a sponsor, or engaging in mindfulness or self-reflection practices. The PHP may increase frequency of toxicology monitoring for some time after the prescribed medications are no longer needed and may enter into a separate agreement regarding use of controlled substances.

The participant with a history of substance use disorder and treated for a chronic pain process is challenging for a PHP to monitor and support because of the multitude of medications, procedures, and appointments he or she may require. Sometimes the participant will need to be admitted to an inpatient unit to safely detoxify from the medications or to simplify the medication regimen. Some participants may need to leave the practice of medicine or healthcare, as medications may result in cognitive changes or frank impairment. As noted above, a participant on medications for chronic pain should be refrained from returning to work while being treated with controlled prescription drugs until fitness to practice has been assessed. As noted above, cognitive testing such as neuropsychological testing may be required as part of a comprehensive assessment.

In summary, a PHP should approach with caution use of controlled analgesic and other high-risk medications by participants. Participants who are diagnosed with an acute or chronic pain condition co-occurring with a substance use disorder or process addiction should be treated with the same modalities as those without addiction, but with greater support and monitoring. Participants should not return to clinical practice while being prescribed controlled prescription drugs that impact cognition until such medications are no longer required or cognitive function is determined to be adequate for performance of the essential functions of his or her specialty with or without reasonable accommodations.

Cognitive Impairment

Professional practice within the healthcare setting requires the ability to sustain high levels of cognitive performance often under demanding conditions. Several studies have demonstrated that impairing levels of cognitive performance are common among individuals referred for concerns of impairment, regardless

of the reason for referral.[133-136] This suggests that the negative impact of illness on cognition may represent a final common pathway to impairment among healthcare professionals. As such, all PHPs are encouraged to develop the structure and resources necessary to effectively evaluate and manage cognitive impairment in health professionals.

Other sections of these Guidelines describe the expertise and characteristics of PHPs essential for the management of psychiatric conditions. In general, PHPs that meet these requirements will be prepared to effectively manage concerns of cognitive impairment in the health professionals they serve.

Evaluation

The evaluation of cognitive impairment among health professionals can be challenging for reasons including, but not limited to:

- Health professionals understandably place a high value on their intellectual capabilities, which are often core aspects of their identity. Threats to this identity can be met with anger, suspicion, fear, and resistance.
- Like many impairing conditions, cognitive impairment is often characterized by insight that is inversely proportional to the degree of deficit. Participants may refuse to participate in evaluations of their cognitive function simply because they are unaware of a problem.
- Health professionals (and others with high intellectual capacity) tend to have superior verbal intelligence and substantial cognitive reserve, which can mask impairing levels of cognitive decline during normal discourse.
- Finally, the gradual onset of cognitive impairment, the effect of masking, economic pressures, and the psychological reactions of those around the participant often conspire, intentionally or unintentionally, to enable the cognitively impaired professional to continue clinical practice until a sentinel event results in harm to a patient, a complaint to the regulatory agency, or a referral to the PHP.

Therefore, PHPs who work with participants with concerns for cognitive impairment should have identified specialists who have expertise in evaluating professionals with skill and compassion. Such specialists should include but not be limited to neuropsychologists, psychologists, primary care providers, and geriatricians.[137] Expertise in evaluating high-functioning individuals is essential, as healthcare professionals tend to overperform on cognitive screening tests and scoring cutoffs may need to be adjusted to take this into account.

PHPs are encouraged to develop a structured approach to screen for cognitive impairment, regardless of age or referral question. Experience and research[133] have shown that cognitive impairment can go undetected in the absence of formal cognitive screening, especially among health professionals. A positive screen may aid in the identification of primary or secondary cognitive impairment and may provide clues as to the presence and/or severity of underlying illness.

Results of cognitive screening tests should not be used by a PHP as absolute or sole measures of cognitive ability or impairment. Rather, scores on cognitive screening should be interpreted within the broader context of available clinical data by evaluators experienced in assessing healthcare professionals. For example, borderline abnormal screens should be interpreted with caution in individuals with no clinical correlates of cognitive dysfunction, while normal scores should not be used to "rule out" cognitive

impairment when the referral question suggests performance-related cognitive concerns. PHPs should also confirm that any visual or hearing impairments are corrected or appropriately accommodated during the cognitive screening.

Depending on the circumstances of the PHP referral, cognitive screening results, and/or data obtained during preliminary or subsequent clinical investigations, clinical evaluation of cognitive dysfunction concerning impairment may require:

a. medical evaluation, including detailed neurological and mental status examinations;

b. laboratory evaluation;

c. neuroimaging studies; and

d. neuropsychological evaluation.

The goal of the clinical evaluation is to determine the cause and extent of the cognitive dysfunction, whether it impairs safe clinical practice, and the potential for rehabilitation. If impairment is suspected or determined to be present, the PHP must recommend the participant cease clinical practice until appropriate evaluation, treatment, remediation, and reassessment are complete. In many cases, cognitive deficits will resolve with treatment of the underlying condition (e.g., substance use disorders, major depression) or may be remediated with cognitive rehabilitation. In other cases, cognitive dysfunction is not expected to improve or may be expected to worsen over time (e.g., traumatic brain injury, neurodegenerative disorders). Thus, an important goal of clinical evaluation is to provide participants with an accurate appraisal of the expected impact of the cognitive problem on their professional work so that they may make informed life-planning decisions. PHPs should provide assistance and support during life/career changes resulting from persistent or progressive cognitive impairment.

Aging and Cognition

Studies demonstrate declines in physician practice performance with advancing age and adverse patient outcomes associated with age-related performance deficits.[138,139] Age is the strongest risk factor for neurodegenerative disorders (such as Alzheimer's or vascular neurodegenerative disease). However, there is substantial variation in age-related cognitive decline and practice performance among individuals. While age is a risk factor for cognitive impairment, a PHP cannot assume, based on age alone, that an older health professional's cognitive performance or related practice abilities are lower than those of his or her younger peers.[140]

Neuropsychological Assessment

PHPs should develop referral resources with the expertise to perform full-battery neuropsychological evaluations for participants who demonstrate signs or symptoms of impairing cognitive function. While neuropsychological assessment is not indicated in the routine clinical evaluation of cognitive impairment, it is often critical in the evaluation of healthcare professionals in forensic settings where fitness for duty is a central evaluative concern.

Neuropsychological evaluations should be performed by professionals with doctoral-level licensure in clinical psychology and special expertise or training in neuropsychology and neuropsychological testing. Evaluators should be approved by the referring PHP for the evaluation of healthcare professionals. Additional qualifications to consider include:

- experience in the evaluation of healthcare and/or other safety-sensitive professionals;
- ability to normalize results of neurocognitive testing to comparably educated professional peers; and
- broad understanding of the job-specific cognitive demands of the professional under evaluation and the ability to interpret testing results in light of those demands.

Neuropsychological evaluators should always incorporate data obtained from the PHP, outside treatment providers, and other collateral sources in the overall neuropsychological assessment. Evaluators, at all times, should work collaboratively with the PHP by maintaining proper consent, release of information, and confidentiality procedures. Regular PHP contact to facilitate timely evaluation, scheduling, testing completion, and results reporting is essential. Whenever possible, PHPs should ensure that the participant's treatment providers are involved in the ongoing assessment and receive the results of any testing. Written reports should be submitted to the PHP in a timely fashion and include:

a. clinical history and detailed neuropsychological testing results;
b. collateral data sources used in the evaluation;
c. clinical diagnostic formulation;
d. recommendations for remediation, treatment, and/or additional medical or other evaluations if indicated;
e. assessment of fitness for duty with or without accommodation; and
f. recommendations for neuropsychological re-evaluation and the time frame for re-evaluation if indicated.

Evaluators should meet with the participant following testing to discuss the results of testing, clinical, and forensic implications, and have PHP-approved referral resources available for additional evaluations and/or treatment. Neuropsychological evaluators should provide PHP-approved referrals for second opinion evaluations in cases where the results are disputed by the participant. In order to avoid retest bias and properly structure the retest battery, second opinion evaluators must have the results of the initial neuropsychological assessment for review prior to initiating their evaluation.

Professional Clinical Practice Assessment

In the context of cognitive impairment evaluations, practice assessment should be reserved for cases in which the determination of impairment or fitness for duty, based on neuropsychological testing, is inconclusive. The goal of the practice assessment is to assess the functional impact of observed cognitive deficit(s) specific to the work demands of the individual and provide recommendations regarding fitness for duty with or without accommodations. There are a number of referral centers throughout the United States that have experience evaluating health professionals and expertise in the job-specific demands of various types of clinical practice.

Case Management

Monitoring may or may not be appropriate for participants with evidence of cognitive dysfunction. In cases where the participant is deemed not fit for duty and prognosis for rehabilitation is poor (e.g., neurodegenerative disorders), monitoring is unlikely to be helpful. In such cases, the PHP should strive to facilitate and support the professional's dignified and graceful discontinuation of medical practice. This

may include compassionate support and treatment referral for the professional and concerned others, referral to social service and community assistance organizations, coordination with the regulatory agency regarding licensing issues in accordance with applicable laws and regulations, advocacy with employers and credentialing bodies, and assisting with disability insurance if the individual is not retirement eligible.

PHPs must recognize that medical retirement due to cognitive impairment is a highly stressful life event for medical professionals and their families, particularly in younger professionals who may not have anticipated or planned for such an event.

Monitoring is indicated in circumstances where the participant is deemed not fit for duty and the prognosis for cognitive improvement is uncertain but likely to improve. Monitoring in such cases should include:

a. compliance with medical, mental health, or other treatments aimed at improving cognitive function;

b. compliance with voluntary discontinuation of professional practice; and

c. compliance with follow-up evaluations to determine fitness for duty at appropriate time intervals.

Monitoring may also be indicated in cases where the participant is deemed fit for duty but would benefit from the reassurance that ongoing PHP monitoring might provide to employers, credentialing bodies, regulatory agencies, or other concerned parties. In such cases, elements of the monitoring agreement should be individualized to the needs of the participant, but include treatment provider reports, practice liaison reports, and periodic reassessment of fitness for duty.

In cases where cognitive impairment has been identified but the need to monitor for another health condition takes precedence (e.g., substance use disorder), PHPs should incorporate elements of cognitive monitoring into the primary monitoring agreement.

References for Section Four: Additional Considerations for Conditions Managed by PHPs

11. DuPont R, McLellan A, White W, Merlo L, Gold M. Setting the standard for recovery: Physicians' Health Programs. *Journal of substance abuse treatment.* 2009;36(2):159-171.

12. McLellan AT, Skipper GE, Campbell M, R.L. D. Five year outcomes in a cohort study of physicians treated for substance use disorders in the United States. *BMJ.* 2008;337:1-6.

30. Federation of State Physician Health Programs. FSPHP Physician Health Program Guidelines. 2005; https://www.fsphp.org/assets/docs/2005_fsphp_guidelines-master_0.pdf, 2016.

66. Earley P. Physicians Health Programs and Addiction among Physicians. In: Miller S, Fiellin D, Rosenthal R, Saitz R, eds. *American Society of Addiction Medicine, Principles of Addiction Medicine.* Fifth ed. Philadelphia: Wolters Kluwer; 2019:671-692.

70. Federation of State Medical Boards. Policy on Physician Impairment - 2011. 2011; https://www.fsmb.org/Media/Default/PDF/FSMB/Advocacy/grpol_policy-on-physician-impairment.pdf. Accessed 11/21, 2016.

79. Skipper GE, Weinmann W, Thierauf A, et al. Ethyl glucuronide: a biomarker to identify alcohol use by health professionals recovering from substance use disorders. *Alcohol and Alcoholism.* 2004;39(5):445-449.

89. Despite the fact that agreeing not to prescribe for self or outside a legitimate patient relationship or practice specialty codifies ethical practices, some board certification bodies consider this

language a restriction. For this and myriad other reasons, PHP Agreements should not be provided to third parties. However, such acknowledgments may be included in documents that are separate and distinct from the PHP monitoring agreement.

90. Each PHP should have a policy regarding the use of potentially legitimately prescribed medications which may be considered contraindicated by the PHP, such as stimulants, benzodiazepines, and opioids. For example, opioids may be used in the case of severe pain or surgery when medical records clearly document that the professional has disclosed the history of substance use disorder, alternatives were requested, and no effective alternative was available. In an emergency, use at lowest possible dose for the shortest duration with notice to PHP within 24 hours or as soon as practical after medically stabilized.

91. Brooks E, Early SR, Gundersen DC, Shore JH, Gendel MH. Comparing substance use monitoring and treatment variations among physician health programs. *The American journal on addictions.* 2012;21(4):327-334.

92. Helander A, Böttcher M, Fehr C, Dahmen N, Beck O. Detection times for urinary ethyl glucuronide and ethyl sulfate in heavy drinkers during alcohol detoxification. *Alcohol and alcoholism.* 2009;44(1):55-61.

93. Helander A, Olsson I, Dahl H. Postcollection synthesis of ethyl glucuronide by bacteria in urine may cause false identification of alcohol consumption. *Clinical chemistry.* 2007;53(10):1855-1857.

94. Skipper G, Wurst F, Weinmann W, Liepman M. Ethanol-based hand sanitizing gel vapor causes positive alcohol marker, ethylglucuronide, and positive breathalyzer. *Journal of addiction medicine.* 2009;3(2):1-5.

95. Reisfield GM, Goldberger BA, Pesce AJ, et al. Ethyl glucuronide, ethyl sulfate, and ethanol in urine after intensive exposure to high ethanol content mouthwash. *Journal of analytical toxicology.* 2011;35(5):264-268.

96. Reisfield GM, Goldberger BA, Crews BO, et al. Ethyl glucuronide, ethyl sulfate, and ethanol in urine after sustained exposure to an ethanol-based hand sanitizer. *Journal of analytical toxicology.* 2011;35(2):85-91.

97. Helander A, Dahl H. Urinary tract infection: a risk factor for false-negative urinary ethyl glucuronide but not ethyl sulfate in the detection of recent alcohol consumption. *Clinical chemistry.* 2005;51(9):1728-1730.

98. Schröck A, Thierauf-Emberger A, Schürch S, Weinmann WJIjolm. Phosphatidylethanol (PEth) detected in blood for 3 to 12 days after single consumption of alcohol—a drinking study with 16 volunteers. 2017;131(1):153-160.

99. Aradottir S, Asanovska G, Gjerss S, Hansson P, Alling C. Phosphatidylethanol (PEth) concentrations in blood are correlated to reported alcohol intake in alcohol-dependent patients. *Alcohol and Alcoholism.* 2006;41(4):431-437.

100. Crunelle CL, Yegles M, van Nuijs AL, et al. Hair ethyl glucuronide levels as a marker for alcohol use and abuse: a review of the current state of the art. *Drug and alcohol dependence.* 2014;134:1-11.

101. For a list of state medical marijuana laws, as of February 2019, see: http//www.ncsl.org/research/health/state-medical-marijuauna-laws.aspx November 9, 2016

102. See: U.S. Department of Justice Memo October 2009- Ogden: Federal resources should not focus on prosecuting medical marijuana patients and caregivers who were operating in "clear and unambiguous compliance with existing state laws."

103. Executive Order of the President if the United States. Drug Free Workplace. 1986;12564. https://www.archives.gov/federal-register/codification/executive-order/12564.html.

104. Salomonsen-Sautel S, Min S-J, Sakai JT, Thurstone C, Hopfer C. Trends in fatal motor vehicle crashes before and after marijuana commercialization in Colorado. *Drug and alcohol dependence.* 2014;140:137-144.

105. Yesavage JA, Leirer VO, Denari M, Hollister LE. Carry-over effects of marijuana intoxication on aircraft pilot performance: a preliminary report. *The American journal of psychiatry.* 1985;142(11):1325-1329.

106. Messinis L, Kyprianidou A, Malefaki S, Papathanasopoulos P. Neuropsychological deficits in long-term frequent cannabis users. *Neurology.* 2006;66(5):737-739.

107. Gilman JM, Kuster JK, Lee S, et al. Cannabis use is quantitatively associated with nucleus accumbens and amygdala abnormalities in young adult recreational users. *Journal of Neuroscience.* 2014;34(16):5529-5538.

108. Hall W. What has research over the past two decades revealed about the adverse health effects of recreational cannabis use? *Addiction.* 2015;110(1):19-35.

109. See: https://www.fsmb.org/Media/Default/PDF/Advocacy/FSMB%20Resolution1.pdf.

110. American Medical Association. Code of Medical Ethics, Opinion 9.4.4, Physicians with disruptive behavior. 2000; https://www.ama-assn.org/delivering-care/ethics/physicians-disruptive-behavior. Accessed Dec 2017.

111. Cohen B, Snelson E. Model Medical Staff Code of Conduct. *American Medical Association.* 2009.

112. Joint Commission. Sentinel event alert, issue 40: behaviors that undermine a culture of safety. 2008. *Available at: Accessed May.* 2014;5.

113. Dyrbye LN, Harper W, Durning SJ, et al. Patterns of distress in US medical students. *Medical teacher.* 2011;33(10):834-839.

114. Dyrbye LN, West CP, Satele D, et al. Burnout among US medical students, residents, and early career physicians relative to the general US population. *Academic Medicine.* 2014;89(3):443-451.

115. Schwenk TL. Physician well-being and the regenerative power of caring. *JAMA : the journal of the American Medical Association.* 2018;319(15):1543-1544.

116. Hill AB. Breaking the stigma—a physician's perspective on self-care and recovery. *New England Journal of Medicine.* 2017;376(12):1103-1105.

117. Schernhammer E. Taking their own lives—the high rate of physician suicide. *The New England journal of medicine.* 2005;352(24):2473-2476.

118. Schernhammer ES, Colditz GA. Suicide rates among physicians: a quantitative and gender assessment (meta-analysis). *The American journal of psychiatry.* 2004;161(12):2295-2302.

119. Gold KJ, Sen A, Schwenk TL. Details on suicide among US physicians: data from the National Violent Death Reporting System. *General hospital psychiatry.* 2013;35(1):45-49.

120. McIntosh WL. Suicide rates by occupational group—17 states, 2012. *MMWR Morbidity and mortality weekly report.* 2016;65.

121. Dyrbye, L, Trockel M, Frank E, et al. Development of a Research Agenda to Identify Evidence-Based Strategies to Improve Physician Wellness and Reduce Burnout. 2017; annals.org.

122. Shanafelt TD, Boone S, Tan L, et al. Burnout and satisfaction with work-life balance among US physicians relative to the general US population. *Archives of internal medicine.* 2012;172(18):1377-1385.

123. Shanafelt TD, Dyrbye LN, West CP. Addressing physician burnout: The way forward. *JAMA : the journal of the American Medical Association.* 2017.

124. West CP, Dyrbye LN, Erwin PJ, Shanafelt TD. Interventions to prevent and reduce physician burnout: a systematic review and meta-analysis. *The Lancet.* 2016;388(10057):2272-2281.

125. Brooks E, Gendel MH, Early SR, Gundersen DC. When Doctors Struggle: Current Stressors and Evaluation Recommendations for Physicians Contemplating Suicide. *Archives of suicide research.* 2018:1-10.

126. Ziegler P. What you need to know when treating physicians: issues, sensitivities and considerations. *Psychiatric Times.* 2016;33(6):33-36.

127. Gold KJ, Andrew LB, Goldman EB, Schwenk TL. "I would never want to have a mental health diagnosis on my record": a survey of female physicians on mental health diagnosis, treatment, and reporting. *General hospital psychiatry.* 2016;43:51-57.

128. Merskey H, Bogduk N, International Association for the Study of Pain. Task Force on Taxonomy. *Classification of chronic pain : descriptions of chronic pain syndromes and definitions of pain terms.* 2nd ed. Seattle: IASP Press; 1994.

129. Richards D. The Oxford Pain Group League table of analgesic efficacy. *Evidence-Based Dentistry.* 2004;5(1):22.

130. Derry CJ, Derry S, Moore RA. Single dose oral ibuprofen plus paracetamol (acetaminophen) for acute postoperative pain. *Cochrane Database of Systematic Reviews.* 2013(6).

131. Weisner CM, Campbell CI, Ray GT, et al. Trends in prescribed opioid therapy for non-cancer pain for individuals with prior substance use disorders. *Pain.* 2009;145(3):287-293.

132. Chang Y-P, Compton P. Management of chronic pain with chronic opioid therapy in patients with substance use disorders. *Addiction science & clinical practice.* 2013;8(1):21.

133. Brooks E, Gendel M, Parry A, Humphreys S, Early S. Challenging cognitive cases among physician populations: case vignettes and recommendations. *Occupational Medicine.* 2016;67(1):68-70.

134. Perry W, Crean RD. A retrospective review of the neuropsychological test performance of physicians referred for medical infractions. *Archives of clinical neuropsychology.* 2005;20(2):161-170.

135. Turnbull J, Carbotte R, Hanna E, et al. Cognitive difficulty in physicians. *Academic Medicine.* 2000;75(2):177-181.

136. Turnbull J, Cunnington J, Unsal A, Norman G, Ferguson B. Competence and cognitive difficulty in physicians: a follow-up study. *Academic Medicine.* 2006;81(10):915-918.

137. CPPPH. Assessing Late Career Practitioners: Policies and Procedures for Age-based Screening. 2015; https://www.cppph.org/wp-content/uploads/2015/05/assessing-late-career-practitioners-adopted-by-cppph-4-14-15.pdf, 2019.

138. Choudhry NK, Fletcher RH, Soumerai SB. Systematic review: the relationship between clinical experience and quality of health care. *Annals of internal medicine.* 2005;142(4):260-273.

139. Schaie KW. *Intellectual development in adulthood: The Seattle longitudinal study.* Cambridge University Press; 1996.

140. Drag LL, Bieliauskas LA, Langenecker SA, Greenfield LJ. Cognitive functioning, retirement status, and age: results from the Cognitive Changes and Retirement among Senior Surgeons study. *Journal of the American College of Surgeons.* 2010;211(3):303-307.

Appendices

Appendix A: Definitions

Abstinence
The absence of substances that are nonapproved mind or mood-altering, including alcohol and other substance use disorder potentiating substances.

Addictive Illness
A biochemical, psychosocial, genetically influenced primary illness hallmarked by loss of control or continued use of mind- and/or mood-altering substances regardless of negative consequences, frequently accompanied by a powerful denial of the existence and effects of the illness.

Case-Management Review Committee
An internal or external oversight body utilized to review overall management as it relates to the health and well-being of the participant and/or associated processes of the PHP.

Chain of Custody (CoC)
The chronological documentation or paper trail that records the sequence of custody, control, transfer, analysis, and disposition of biologic specimens used in toxicology testing.

Continuing care
Care that follows the acute phase of intervention and initial treatment is referred to as continuing care, sometimes referred to as aftercare. PHPs oversee and monitor the continuity of care to ensure progress and continued compliance. Continuing care includes PHP guidance, support, toxicology collection, and accountability through a formal monitoring contract concurrent with or following an evaluation and/or treatment process.

Disruptive physician behavior or "distressed"
The American Medical Association (AMA) defines disruptive behavior as a style of interaction with physicians, hospital personnel, patients, family members, or others that interferes with patient care. Behavior is exhibited as a pattern of being unable, or unwilling, to function well with others to such an extent that his/her behavior, by words, attitude or action, has the potential to interfere with quality healthcare. The physician's behavior (attitudes, words, or actions) intimidates and demeans others, potentially resulting in a negative impact on patient care.

Evaluators
Qualified clinical experts who are consulted to investigate possible psychiatric and/or physical illness that potentially can cause impairment. Evaluators are utilized to formulate impressions, diagnoses, treatment plans, and suggestions for effective monitoring.

Healthcare professional
General term describing the population eligible for PHP services. Most frequently includes, but is not limited to, physicians, physician assistants, podiatrists, nurses, advanced practice nurses, and dentists. It is not intended to exclude other populations served by physician health programs, such as veterinarians, pharmacists, and allied health professionals. It also often includes medical students and residents.

Impairment
Impairment is the inability of a healthcare professional to practice medicine with reasonable skill and safety as result of:

a. mental disorder (as defined below); or

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

c. substance-related disorders, including abuse and dependency of drugs and alcohol as further defined.[141]

Impairment is a functional classification that exists dynamically on a continuum of severity and can change over time rather than being a static phenomenon. Illness, per se, does not constitute impairment. When functional impairment exists, it is often the result of an illness in need of treatment. Therefore, with appropriate treatment, the issue of potential impairment may be resolved, while the diagnosis of illness may remain.

Intervention
An intervention is a strategy orchestrated by an individual or group, in an attempt to encourage a physician to seek professional evaluation and assistance.

Licensee
A licensed physician or other healthcare professional whose practice falls under auspices of the regulatory authority. Licensees may also include those anticipated to become licensed, including early career healthcare professionals in training such as medical students and residents or healthcare professionals licensed in another state or country.

Mental health disorder/condition/illness – *DSM-5*
Mental health disorder, condition, or illness means a syndrome characterized by a clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities. (See *DSM-5* page 20 for complete definition.)

Medical Review Officer (MRO)
A medical review officer is a licensed physician who is responsible for receiving and reviewing laboratory results generated by an employer's drug testing program and evaluating medical explanations for certain drug test results.

Participant
A participant is a licensee referred to or enrolled in a PHP pursuant to an executed agreement.

Participant records
Any and all documents contained within a Physician Health Program participant file.

Performance Enhancement and Effectiveness Reviews (PEER)
As defined by the Federation of State Physician Health Programs, a PEER is the process of reviewing program operations for the purposes of enhancement of program performance.

Physicians Health Program (PHP)
Physician Health Program means a confidential resource for physicians, other licensed healthcare professionals, or those in training suffering from addictive, psychiatric, medical, behavioral, or other potentially impairing conditions.

Physician Health Program Agreement
The executed agreement or written understanding by and between the PHP and participant with mutually agreed-upon terms and obligations or conditions for participation with the PHP.

Potentially impairing illness
An illness or condition, which in its current state or if left untreated may potentially impact the ability to practice medicine with reasonable skill and safety.

Practice liaison
A practice liaison is essentially a workplace monitor or support person who has regular contact with the professional in the practice setting. This liaison may be a colleague who has knowledge of the signs and symptoms of exacerbation of illness. The liaison should be in a supervisory capacity or have the ability to make independent objective judgments without risk of undue influence by the participant. The liaison is not evaluating the participant's work performance, but rather is providing observation at the workplace to enhance the likelihood of timely intervention in the event concerns for potential impairment arise.

Process addiction
A process addiction is a compulsive activity or process of psychological dependence on a behavioral activity. The process consumes the attention of the individual to the exclusion of other aspects of the individual's life and it thereby creates problems. The following are some examples of activities—if they are compulsive and excessive activities—that fall into the category of process addictions: compulsive gambling, compulsive spending, compulsive video gaming, and workaholism.

Professional incompetence
Professional incompetence is the failure to perform his or her professional obligations with reasonable skill or safety as required by the Board or within the scope of the applicable practice act.

Qualifying condition
The illness or condition eligible for PHP services as defined in state statute and/or agreements with the regulatory agency.

Quality assurance (QA)
Quality assurance, retrospective in nature, typically studies outcomes and processes. It is a systematic process of checking to see whether the policies and processes in delivering services are meeting specified requirements or criteria/benchmarks for quality.

Quality improvement (QI)
Quality improvement, projective in nature, is implemented and evaluated to improve program processes and outcomes. It is a formal approach to analyze policies and processes and devise systematic and continuous ways to lead to measurable improvement.

Recovering physician
A recovering physician has been impaired or has been diagnosed with a potentially impairing illness, such as addictive or mental illness, and is receiving or has received appropriate evaluation and/or treatment and associated continuing care.

Regulatory agency
Regulatory agency includes state or provincial professional licensing or certifying bodies governing the medical and/or prescribing practices of physicians and other licensed professionals including but not limited to Boards and Commissions.

Relapse
Addictive illness "relapse" is the recurrence of behavior or other substantive indicators of active disease after a period of remission—that is, abstinence from proscribed substances. It is important to note that appropriate treatment of some participants may involve the use of prescription medications known to the PHP. Relapse can involve return to the drug of choice or use of some other substance.

There are three levels of relapse behavior having the potential to impact public safety:
Level 1 Relapse: Behavior without chemical use that is suggestive of impending relapse
Level 2 Relapse: Relapse, with chemical use, that is not in the context of active medical practice
Level 3 Relapse: Relapse, with chemical use, in the context of active medical practice

Return to work
Return to work means the comprehensive approach to approve return to practice for those healthcare professionals who have experienced a period of medical leave and require a determination of fitness for duty, including a process of steps that need to be taken to ensure a safe and supported return to practice.

Stakeholders
Organized medicine, community, and constituents, including the public at large. Primary stakeholders are PHP participants, and secondary stakeholders are all others, which include all other components of organized medicine, organizations, patients, and the public at large.

Substance
Mind- and mood-altering substances defined in law as controlled substances; for example, alcohol or other legal or illegal substances that are mood altering and can potentially impact the ability to practice.

Substance abuse
The essential feature of substance abuse is a maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to the repeated use of substances.

Substance dependence (*DSM-IV*)
The essential feature of substance dependence is a cluster of cognitive behaviors and physiological symptoms indicating that the individual continues use of the substance despite significant substance-related problems.[142]

Substance use disorder (*DSM-5*)
Shall mean a medical disease in which the essential feature is a cluster of cogitative, behavioral, and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems.

Substantive noncompliance
Substantive noncompliance is a pattern of noncompliance in PHP continuing care monitoring or an episode of noncompliance that could potentially place patients at risk.

Treatment
Treatment involves the delivery of care and rehabilitation to participants experiencing a potentially impairing illness including but not limited to a course of inpatient or outpatient care, treatment, or rehabilitation services provided or supervised by an individual, organization, or other entity authorized to provide such services for the purpose of alleviation of impairment and improvement of illness.

Treatment providers
Treatment providers are individuals, organizations, or another entity composed of licensed professionals who are providing care and treatment to a participant.

Worksite monitor/practice liaison
A support person who has regulator contact with the participant in the practice setting, who is willing to report to the PHP on workplace behavior and performance. This non-subordinate colleague/individual has knowledge of signs and symptoms of exacerbation of illness, awareness of PHP participation, and has the ability to make independent objective judgments without risk of undue influence by the participant.

Appendix B: Program Enhancement and Effectiveness Review (PEER)

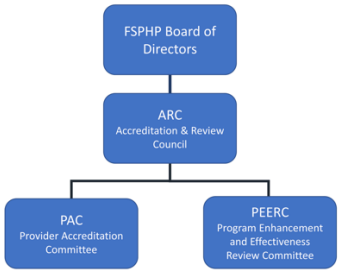
FSPHP's Performance Enhancement and Effective Review (PEER™) Program and Provider Accreditation

FSPHP's top strategic goal is to develop a Performance Enhancement and Effectiveness Review (PEER™) Program and a Provider Accreditation Program. The PEER™ program will create and manage an on-site review process of PHPs across the United States and Canada. The Provider Accreditation (PA) Program will accredit treatment providers and centers that care for health care professionals, again ensuring that our physicians who become ill are given the best treatment using evidence-based care. The overall outcome will be for both review programs to provide a baseline for a PHP's record of enhancing professional health and identify areas that will benefit from improvements. As such reviews become more common, the data will enable the development of deeper insight and awareness into the importance of allowing our professionals the dignity to be patients, as well as providers, thereby enhancing patient health and safety.

The FSPHP is forming an alliance of national organizations to ensure the success of this important project. Our first enthusiastic support has already come from the Federation of State Medical Boards (FSMB), the American Medical Association (AMA), the American Psychiatric Association (APA), the Accreditation Council for Graduate Medical Education (ACGME), the American Board of Medical Specialties (ABMS), the American College of Physicians (ACP), and the American Osteopathic Association (AOA).

The FSPHP Board of Directors has created an oversight committee—the Accreditation and Review Council (ARC)—and two technical committees—the Provider Accreditation Committee (PAC) and the Performance Enhancement and Effectiveness Review (PEER™) Committee (PEERC).

- The ARC, PEERC, and PAC each consist of a highly diverse group of stakeholders. The ARC includes FSPHP members and distinguished representatives of the ABMS, AMA, MPLA, AOA, ACP, and ACGME. The PAC includes FSPHP members and providers (potential participants in the PA Program).
- The PAC organizes ad hoc focus groups to empower the full array of providers (assessment facilities, treatment centers, etc.) to engage and participate in the PA Program development process.



Accreditation Review Council (ARC)

The purpose of the ARC is to review the work product of the two technical committees (the PAC and the PEERC) and provide final recommendations on both committees' work product to the FSPHP Board.

Performance Enhancement and Effectiveness Review™ (PEER™) Committee (PEERC)

The purpose of the PEERC is to develop a Performance Enhancement and Effectiveness Review™ (PEER™) program. The program will empower PHPs and other health programs for workers in safety-sensitive occupational roles to use the FSPHP Guidelines as a practical tool for identifying opportunities to optimize performance and effectiveness in alignment with best practices.

Provider Accreditation Committee (PAC)

The purpose of the PAC is to develop the "Provider Accreditation" (to be named later) Program that will recognize treatment centers and other providers that are qualified to specialize in the care of medical students, residents, career physicians, and other safety-sensitive professionals. The PAC also will provide a defensible basis for PHPs selecting providers that have proven their compliance with objective standards.

PAC Focus Groups

The PA Committee will organize ad hoc focus groups and other activities to empower the full array of providers (assessment facilities, treatment centers, etc.) to engage and participate in the PA Program development process.

Appendix C: Return-to-Work Process

Sample of Return-to-Work Participant Worksheet

1. Is it safe to return to the practice of medicine at all? When considering safety to practice, and potential danger to patients, consider the following:
    - Potential danger to patients due to diminished skill
    - Potential danger to patients due to poor judgment, poor communication, or poor boundary awareness
    - Potential danger to patients due to the appearance of impairment (consider practice or workplace knowing history of impairment)
    - Potential danger to my practice due to ongoing diminished vulnerabilities to stress
2. Is it safe to return to your practice specialty?
3. How do you feel? Do you feel ready to return to work?
4. What is the status of your recovery (whether it be from substance abuse, a medical event, or mental illness)?
5. What was your experience in treatment? How solidly are you engaged in treatment now? (e.g., meetings several times per week, UDS has begun, comfortable with treatment provider(s), a sponsor is obtained, etc.)
6. What is your propensity toward self-care? Identify important aspects of your social support network.
7. What disclosure needs to occur at the workplace?
8. What will the level of supervision be at the workplace? For example, is a practice monitor in place, is this a solo practice, a residency, or something else?
9. Does your medical license have any practice restrictions? Does your medical board need to make a legal decision regarding return to practice at this time?
10. Summary of main job duties and how illness could impact each:
    a. _____
    b. _____
    c. _____
    d. _____
    e. _____
11. Notification of malpractice carrier done? _____

12. Potential workplace issues/plans to address those (access to substances, overworking culture, etc.):
    a. _____
    b. _____
    c. _____
    d. _____
    e. _____

13. Sharing this information with treatment provider(s)/sponsor. Plan:
14. Identification of communication feedback loop:
    - Identify main workplace contact for information sharing
    - Identify any other important workplace contacts and execute Release of Information Forms
    - If problems do arise: What is your plan? (Notify the PHP, treatment providers, sponsors, etc.)

Appendix D: Criteria to Assess Evaluation and Treatment Programs

I. Types of Evaluations

A. Fitness for practice evaluations: forensic evaluation
   1. Comprehensive evaluation, which normally requires several days with repeated interviews and testing sessions
   2. Determines if a health condition exists that impairs or is likely to impair normal professional performance
   3. Determines a working diagnosis
   4. Evaluates performance issues
      a. Is the physician capable of practicing medicine?
      b. Is further evaluation of professional skill or competency required, or is remedial training required?
      c. Is continuing work detrimental to the health, safety, morale, or well-being
         i. Of the physician?
         ii. Of others?
      d. Are there functional limitations?
      e. Does the individual have the ability to comply with relevant laws, regulations, procedures, and codes of conduct?
   5. Under what conditions is it appropriate for the practitioner to resume medical practice?
   6. Makes treatment or monitoring recommendations

B. Clinical evaluation: establishing treatment
   1. May be the initial step in the development of a treatment relationship
   2. May be appropriate in cases where workplace impairment is not an issue and there is no evidence of denial
   3. Determines the diagnosis
   4. Makes treatment/monitoring recommendations

C. Clinical and/or forensic reevaluation
   1. Evaluation is to determine if modification and/or intensification of treatment is appropriate.
   2. Evaluation may be suitable during exacerbations of preexisting conditions (substance use disorder relapse, depressive or manic episode, behavioral disturbance, multiple sclerosis, etc.).
      a. The presence of new conditions and status of prior diagnoses are assessed, Federation of State Physician Health Programs, Inc.
   3. Recommendations for treatment should specify the type and intensity of treatment required and provide information about a selection of competent providers.
      a. If treatment is recommended, and such treatment is available from the evaluator, the participant shall always be offered the option to seek treatment from another provider acceptable to the PHP to avoid potential conflict of interest.
      b. In some cases, especially when the participant is in strong disagreement with the recommendation for treatment, it may be appropriate for the evaluating facility to encourage reevaluation or require treatment elsewhere.

II. Characteristics of Evaluation Providers Appropriate for PHP Referrals

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

B. Adhere to all applicable confidentiality regulations

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

1. No secondary gain should accrue to the evaluator dependent on evaluation findings/outcome.
2. An evaluator should not be in a treatment relationship with the professional being evaluated.
3. If the evaluation is mandated, the evaluator should not be affiliated with the entity requiring the evaluation.

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

1. Apprise PHP of evaluation dates.
2. Apprise PHP, family, and other appropriate sources of the participant's safe arrival.
3. Execute any required PHP forms at the time of arrival or as soon as practical.
4. Notify the PHP immediately regarding AMA departures, or other significant occurrences.
5. Advise PHP of evaluation findings and recommendations before advising patient of recommendations.
6. Notify PHP before participant's discharge.
7. Provide timely documentation, including a brief typewritten summary of findings and recommendations by second business day following completion of the evaluation. A comprehensive typewritten evaluation should follow within 14 days. Specific documentation of information supporting diagnostic and placement (level of treatment) criteria is especially helpful.

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

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

G. Arrange for timely intake and admission.

H. Fully disclose costs prior to admission.

I. Evaluate all causes of impairment

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

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

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

1. Carefully identify and interview collateral contacts for evaluation.

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

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

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

III. Criteria for Multidisciplinary Assessment

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

B. Maintain qualified staff and referral resources to provide a multi-disciplinary evaluation, which should include:
1. Standardized testing using validated instruments.
a. Psychological: personality testing, cognitive screening, and other screening instruments for depression, anxiety, etc.
b. Substance use disorder screening
2. Psychiatric evaluation must be completed and supplemental psychological testing performed as indicated.
a. Cognitive and neuropsychiatric assessment
3. Psychosocial assessment
4. Medical assessment
a. Physical examination
i. Referral/treatment as indicated
b. Laboratory examination
i. Chain of custody comprehensive toxicology testing
ii. Screening blood tests
a) At minimum should include: CBC, electrolytes, LFTs, communicable disease battery, and thyroid function tests
b) Other tests as indicated
5. Addiction medicine assessment
a. Chemical use history
b. Family assessment

c. Spiritual assessment
d. Inclusion in peer recovery group when available

6. Examinations by other specialists as indicated
7. Collateral interviews
8. Records review

IV. Criteria for Independent Evaluator

A. Unbiased and objective

B. Well respected in medical community

C. Appropriate credentials

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

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

F. Working knowledge of medical staff/hospital administration dynamics

G. Understands legal, liability, and forensic issues

H. Cooperative attitude toward referent

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

Appendix E: Treatment Programs

I. Characteristics of Treatment Programs That Are Appropriate for PHP Referrals

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

B. Ability of PHP to visit site and referred patients.

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

D. A peer professional patient population and a staff accustomed to treating this population are highly desirable.

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

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

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

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

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

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

K. A multidisciplinary team approach should be used and include psychological, psychiatric, and medical stabilization.

L. Funding for treatment programs

1. Participants are responsible for all payment for required treatment.
2. Fees should be fair and equitable.
3. Full fees must be disclosed up front.
4. A flexible payment plan should be available for the varied income levels of participants, but the patient should make some financial investment into the treatment process.

M. Length of stay must be clinically driven and justified.

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

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

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

II. Substance Use Disorder Treatment Programs also Require the Following

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

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

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

D. Treatment services must include:
   1. Intervention and denial reduction
   2. Detoxification
   3. Ongoing assessment and treatment of patient needs to occur throughout treatment with referral for additional specialty evaluation and treatment as appropriate.
      a. Eating disorders
      b. Gambling addiction
      c. Sexual compulsivity/addiction
      d. Psychiatric illness
      e. Cognitive impairment
      f. Medical illness
      g. Chronic pain
      h. Other
   4. Family treatment
   5. Group and individual therapy
   6. Educational programs
   7. Mutual support experience (e.g., AA/NA/etc.) and appropriate alternatives when indicated

8. Development of continuing care plan and sober support system
    a. Indicate any patient/family needs for ongoing therapy
9. Relapse prevention training
10. Return to work/fitness to practice assessment prior to discharge
11. Extended treatment options when indicated

Bibliography for the Entire Publication

1. Federation of State Physician Health Programs. The 2005 physician health program guidelines. In:2005: http://www.fsphp.org/2005FSPHP_Guidelines.pdf. Accessed April 3, 2012.
2. American Medical Association: Council on Mental Health. The sick physician: Impairment by psychiatric disorders, including alcoholism and drug dependence. *Journal of the American Medical Association.* 1973;223(6):684-687.
3. Federation of State Medical Boards. *Report of the Ad Hoc Committee on Physician Impairment.* Ft. Worth, Texas 1995.
4. Federation of State Physician Health Programs. List of State Programs. 2016; http://www.fsphp.org/state-programs. Accessed 11/18, 2018.
5. White WL. *Slaying the dragon: the history of addiction treatment and recovery in America.* Bloomington, Ill.: Chestnut Health Systems/Lighthouse Institute; 1998.
6. White WL, DuPont RL, Skipper GE. Physicians health programs: What counselors can learn from these remarkable programs. *Counselor.* 2007;8:42-47.
7. Wall J. The results of hospital treatment of addiction in physicians. *Federation bulletin.* 1958;45(5):144-152.
8. DuPont R, McLellan A, Carr G, Gendel M, Skipper G. How are addicted physicians treated? A national survey of Physician Health Programs. *Journal of substance abuse treatment.* 2009;37(1):1-7.
9. Centrella M. Physician addiction and impairment—current thinking: a review. *Journal of addictive diseases.* 1994;13(1):91-105.
10. American Society of Addiction Medicine. *The ASAM Criteria: Treatment Criteria for Addictive, Substance-related and Co-occurring Disorders.* Third ed. Carson City, Nevada: The Change Companies; 2013.
11. DuPont R, McLellan A, White W, Merlo L, Gold M. Setting the standard for recovery: Physicians' Health Programs. *Journal of substance abuse treatment.* 2009;36(2):159-171.
12. McLellan AT, Skipper GE, Campbell M, R.L. D. Five year outcomes in a cohort study of physicians treated for substance use disorders in the United States. *BMJ.* 2008;337:1-6.
13. Rose JS, Campbell MD, Yellowlees P, Skipper GE, DuPont RL. Family medicine physicians with substance use disorder: a 5-year outcome study. *Journal of addiction medicine.* 2017;11(2):93-97.
14. Domino K, Hornbein TF, Polissar NL, et al. Risk factors for relapse in health care professionals with substance use disorders. *JAMA : the journal of the American Medical Association.* 2005;293(12):1453-1460.
15. Skipper G, Campbell MD, DuPont RL. Anesthesiologists with Substance Use Disorders: A 5-Year Outcome Study from 16 State Physician Health Programs. *Anesthesia and analgesia.* 2009;109:891–896.
16. Skipper GE. Treating the chemically dependent health professional. *Journal of addictive diseases.* 1997;16(3):67-73.
17. Buhl A, Oreskovich M, Meredith C, Campbell M, DuPont R. Prognosis for the Recovery of Surgeons From Chemical Dependency: A 5-Year Outcome Study. *Arch Surg.* 2011;146(11):1286-1291.

18. Knight JR, Sanchez LT, Sherritt L, Bresnahan LR, Fromson JA. Outcomes of a Monitoring Program for Physicians with Mental and Behavioral Health Problems. *Journal of psychiatric practice.* 2007;13(1):25-32.

19. Knight JR, Sanchez LT, Sherritt L, Bresnahan LR, Silveria JM, Fromson JA. Monitoring physician drug problems: attitudes of participants. *Journal of addictive diseases.* 2002;21(4):27-36.

20. Gastfriend DR. Physician substance abuse and recovery: What does it mean for physicians—and everyone else? *JAMA : the journal of the American Medical Association.* 2005;293(12):1513-1515.

21. American Society of Addiction Medicine. Persons in Safety Sensitive Occupations. In: Mee-Lee D, ed. *The ASAM Criteria: Treatment Criteria for Addictive, Substance-related and Co-occurring Disorders.* Third ed. Carson City, Nevada: The Change Companies; 2013:340-349.

22. Merlo LJ, Gold MS. Prescription opioid abuse and dependence among physicians: hypotheses and treatment. *Harvard review of psychiatry.* 2008;16(3):181-194.

23. Angres DH, Bettinardi-Angres K. *Healing the healer: The addicted physician.* Psychosocial Press; 1998.

24. Wallace JE. Mental health and stigma in the medical profession. *Health:.* 2012;16(1):3-18.

25. Carr GD, Hall PB, Finlayson AR, DuPont RL. Physician Health Programs: The US Model. In: *Physician Mental Health and Well-Being.* Springer; 2017:265-294.

26. As of January 2017, the 47 state members of the FSPHP provide services for substance use disorders, 43 of the 47 provide additional mental health services, and 37 of the 47 members provide services for behavior management.

27. O'Connor PG, Spickard A, Jr. Physician impairment by substance abuse. *The Medical clinics of North America.* 1997;81(4):1037-1052.

28. AMA Board of Trustees. AMA Statement on Physician Health Programs. In: AMA, ed2008.

29. Merlo LJ, Greene WM. Physician views regarding substance use-related participation in a state physician health program. *The American journal on addictions / American Academy of Psychiatrists in Alcoholism and Addictions.* 2010;19(6):529-533.

30. Federation of State Physician Health Programs. FSPHP Physician Health Program Guidelines. 2005; https://www.fsphp.org/assets/docs/2005_fsphp_guidelines-master_0.pdf, 2016.

31. Joint Commission on Accreditation of Healthcare Organizations. Comprehensive accreditation manual for hospitals, Section on Provider Wellness. In: Oakbrook Terrace, Ill.: The Joint Commission; 1994.

32. Rasyidi E, Wilkins JN, Danovitch I. Training the next generation of providers in addiction medicine. *Psychiatric Clinics.* 2012;35(2):461-480.

33. Clark HW. The medical review officer and workplace drug testing. *Journal of psychoactive drugs.* 1990;22(4):435-445.

34. Clark HW. The role of physicians as medical review officers in workplace drug testing programs. In pursuit of the last nanogram. *The Western journal of medicine.* 1990;152(5):514-524.

35. FSPHP Constitution and Bylaws, 2018 https://fsphp.memberclicks.net/assets/docs/fsphp_constitution_and_bylaws_6-28-13.pdf

36. e.g., West Virginia Board of Medicine, Designation of Physician Health Program, https://wvbom.wv.gov/PhysicianHealthprogram.asp

37. e.g., Washing State Legislature, Revised Code, https://app.leg.wa.gov/rcw/default.aspx?cite=18.130.300

38. Walzer RS. Impaired physicians: An overview and update of the legal issues. *Journal of Legal Medicine.* 1990;11(2):131-198.

39. Summers RF. Physician Mental Health and Well-Being: Research and Practice. In: Am Psychiatric Assoc; 2017.

40. American Society of Addiction Medicine. Confidentiality in Healthcare and Other Licensed Professionals with Potentially Impairing Illness. *Policies Regarding Physicians and Other Licensed Health Care Professionals* 2011; https://www.asam.org/advocacy/find-a-policy-statement/view-policy-statement/public-policy-statements/2011/12/16/confidentiality-in-healthcare-and-other-licensed-professionals-with-potentially-impairing-illness.

41. Federation of State Medical Boards. Policy on Physician Impairment. 2011; https://www.fsmb.org/Media/Default/PDF/FSMB/Advocacy/grpol policy-on-physician impairment.pdf.

42. American Medical Association. Physician Health Programs Act, Approved AMA HOD. In. Chicago, IL: AMA; 2016.

43. United States Department of Health and Human Services. Confidentiality of Alcohol and Drug Abuse Patient Records. *Federal Register.* 1987;42:21796-21813.

44. The participant, as signatory to the agreement, may elect to provide a copy of his or her agreement.

45. e.g., Conneticutt Geneneral Statutes Section. 19a-12e, Massachusetts General Laws, chapter 112, Section 5F, .Va. Code Sec. 30-3D; Iowa Administrative Code 653-22.2(272C)

46. Taub S, Morin K, Goldrich MS, Ray P, Benjamin R. Physician health and wellness. *Occupational Medicine.* 2006;56(2):77-82.

47. American Medical Association. Ethics of Professional Self-Regulation. In: *Code of Medical Ethics.* AMA; 2016.

48. DesRoches CM, Rao SR, Fromson JA, et al. Physicians' perceptions, preparedness for reporting, and experiences related to impaired and incompetent colleagues. *JAMA : the journal of the American Medical Association.* 2010;304(2):187-193.

49. Dyrbye LN, West CP, Sinsky CA, Goeders LE, Satele DV, Shanafelt TD. Medical Licensure Questions and Physician Reluctance to Seek Care for Mental Health Conditions. Paper presented at: Mayo Clinic Proceedings2017.

50. Federation of State Medical Boards. Physician Wellness and Burnout. 2018; https://jmronline.org/doi/pdf/10.30770/2572-1852-104.2.37, 2018.

51. See: https://www.ecfr.gov/cgi-bin/text-idx?SID=0f9b2a146b539944f00b5ec90117d296&mc=true&node=pt42.1.2&rgn=div5

52. Candilis PJ. Physician health programs and the social contract. *AMA journal of ethics.* 2016;18(1):77.

53. National Council of Nonprofits. Conflicts of Interest. 2015; https://www.councilofnonprofits.org/tools-resources/conflicts-of-interest. Accessed 2018.

54. Monahan J, Bonnie RJ. License as leverage: mandating treatment for professionals. *International Journal of Forensic Mental Health.* 2004;3(2):131-138.

55. Walzer RS, Miltimore S. Mandated supervision, monitoring, and therapy of disciplined health care professionals: Implementation and model regulations. *Journal of Legal Medicine.* 1993;14(4):565-596.

56. See: https://www.ecfr.gov/cgi-bin/text-idx?SID=0f9b2a146b539944f00b5ec90117d296&mc=true&node=pt42.1.2&rgn=div5

57. Daniels A, Teems L, Carroll C. Transforming Employee Assistance Programs by crossing the quality chasm. *International Journal of Mental Health.* 2005;34(1):37-54.

58. Langley GJ. *The improvement guide : a practical approach to enhancing organizational performance.* 2nd ed. San Francisco: Jossey-Bass; 2009.

59. Institute for Healthcare Improvement. How to Improve. 2016; http://www.ihi.org/resources/Pages/HowtoImprove/default.aspx.

60. See Appendix B: Program Enhancement and Effectiveness Review (PEER)

61. Federation of State Physician Health Programs. FSPHP Research Policy And Guidelines For Investigators. 2012; https://www.fsphp.org/fsphp-research-policy-and-guidelines-investigators, 2016.

62. See: FDA description of Good Clinical Practice: https://www.fda.gov/AboutFDA/CentersOffices/OfficeofMedicalProductsandTobacco/CDER/ucm090259.htm

63. Merlo LJ, Singhakant S, Cummings SM, Cottler LB. Reasons for Misuse of Prescription Medication Among Physicians Undergoing Monitoring by a Physician Health Program. *Journal of addiction medicine.* 2013;7(5):349-353 310.1097/ADM.1090b1013e31829da31074.

64. Brooks E, Gendel MH, Gundersen DC, et al. Physician health programmes and malpractice claims: reducing risk through monitoring. *Occupational medicine (Oxford, England).* 2013;63(4):274-280.

65. Anfang SA, Faulkner LR, Fromson JA, Gendel MH. The American Psychiatric Association's resource document on guidelines for psychiatric fitness-for-duty evaluations of physicians. *The journal of the American Academy of Psychiatry and the Law.* 2005;33(1):85-88.

66. Earley P. Physicians Health Programs and Addiction among Physicians. In: Miller S, Fiellin D, Rosenthal R, Saitz R, eds. *American Society of Addiction Medicine, Principles of Addiction Medicine.* Fifth ed. Philadelphia: Wolters Kluwer; 2019:671-692.

67. CPPPH. Guidelines for Evaluations of Health Care Professionals. 2013; https://www.cppph.org/cppph-guidelines/, 2019.

68. Tarter RE. Psychological evaluation of substance use disorder in adolescents and adults. *Clinical textbook of addictive disorders.* 2005:37-62.

69. Stuyt E, Gundersen D, Shore J, Brooks E, Gendel M. Tobacco use by physicians in a physician health program, implications for treatment and monitoring. *Am J Addict.* 2009;18(2):103-108.

70. Federation of State Medical Boards. Policy on Physician Impairment - 2011. 2011; https://www.fsmb.org/Media/Default/PDF/FSMB/Advocacy/grpol_policy-on-physician-impairment.pdf. Accessed 11/21, 2016.

71. National Council of State Boards of Nursing. Substance Use Disorder in Nursing Resource Manual. 2011. https://www.ncsbn.org/770.htm.

72. McLellan AT, McKay JR, Forman R, Cacciola J, Kemp J. Reconsidering the evaluation of addiction treatment: from retrospective follow-up to concurrent recovery monitoring. *Addiction.* 2005;100(4):447-458.

73. Merlo L, DuPont R. Essential Components of PHP Participation: Perspectives of Participants Five Years Post-Mandatory Monitoring. In: Institute for Behavior and Health and University of Florida; 2016:5.

74. Skipper GE, DuPont RL. The physician health program: A replicable model of sustained recovery management. In: *Addiction Recovery Management.* Springer; 2010:281-299.

75. Center for Substance Abuse Treatment. TIP-47: Substance abuse: Clinical issues in intensive outpatient treatment. In: Rockville, MD: SAMHSA; 2006:237-245.

76. Jarvis M, Williams J, Hurford M, et al. Appropriate use of drug testing in clinical addiction medicine. *Journal of addiction medicine.* 2017;11(3):163-173.

77. American Society of Addiction Medicine. *Drug Testing: A White Paper of the American Society of Addiction Medicine (ASAM).* Chevy Chase, Maryland: ASAM; October 26, 2013 2013.

78. Skipper GE, Thon N, DuPont RL, Baxter L, Wurst FM. Phosphatidylethanol: the potential role in further evaluating low positive urinary ethyl glucuronide and ethyl sulfate results. *Alcoholism: Clinical and Experimental Research.* 2013;37(9):1582-1586.

79. Skipper GE, Weinmann W, Thierauf A, et al. Ethyl glucuronide: a biomarker to identify alcohol use by health professionals recovering from substance use disorders. *Alcohol and Alcoholism.* 2004;39(5):445-449.

80. Wurst FM, Skipper GE, Weinmann W. Ethyl glucuronide—the direct ethanol metabolite on the threshold from science to routine use. *Addiction.* 2003;98(s2):51-61.

81. Johnson-Davis KL, Sadler AJ, Genzen JR. A retrospective analysis of urine drugs of abuse immunoassay true positive rates at a national reference laboratory. *Journal of analytical toxicology.* 2015;40(2):97-107.

82. Substance Abuse and Mental Health Services Administration. *Medical Review Officer Guidance Manual for Federal Workplace Drug Testing Programs.* Substance Abuse and Mental Health Servicies Administration; 2018.

83. Verstraete AG. Detection times of drugs of abuse in blood, urine, and oral fluid. *J Therapeutic drug monitoring.* 2004;26(2):200-205.

84. Cook JD, Caplan YH, LoDico CP, Bush DM. The characterization of human urine for specimen validity determination in workplace drug testing: a review. *Journal of analytical toxicology.* 2000;24(7):579-588.

85. Federation of State Medical Boards. Reentry for the Ill Physician. *FSMB Policies* 2013, 2019.

86. Myers MF, Gabbard GO. *The physician as patient: a clinical handbook for mental health professionals.* American Psychiatric Pub; 2009.

87. See the previous section on Evaluation

88. Warhaft N. The Victorian Doctors Health Program: the First 3 Years. *Medical journal of Australia.* 2004;181(7):376-379.

89. Despite the fact that agreeing not to prescribe for self or outside a legitimate patient relationship or practice specialty codifies ethical practices, some board certification bodies consider this language a restriction. For this and myriad other reasons, PHP Agreements should not be

provided to third parties. However, such acknowledgments may be included in documents that are separate and distinct from the PHP monitoring agreement.

90. Each PHP should have a policy regarding the use of potentially legitimately prescribed medications which may be considered contraindicated by the PHP, such as stimulants, benzodiazepines, and opioids. For example, opioids may be used in the case of severe pain or surgery when medical records clearly document that the professional has disclosed the history of substance use disorder, alternatives were requested, and no effective alternative was available. In an emergency, use at lowest possible dose for the shortest duration with notice to PHP within 24 hours or as soon as practical after medically stabilized.

91. Brooks E, Early SR, Gundersen DC, Shore JH, Gendel MH. Comparing substance use monitoring and treatment variations among physician health programs. *The American journal on addictions.* 2012;21(4):327-334.

92. Helander A, Böttcher M, Fehr C, Dahmen N, Beck O. Detection times for urinary ethyl glucuronide and ethyl sulfate in heavy drinkers during alcohol detoxification. *Alcohol and alcoholism.* 2009;44(1):55-61.

93. Helander A, Olsson I, Dahl H. Postcollection synthesis of ethyl glucuronide by bacteria in urine may cause false identification of alcohol consumption. *Clinical chemistry.* 2007;53(10):1855-1857.

94. Skipper G, Wurst F, Weinmann W, Liepman M. Ethanol-based hand sanitizing gel vapor causes positive alcohol marker, ethylglucuronide, and positive breathalyzer. *Journal of addiction medicine.* 2009;3(2):1-5.

95. Reisfield GM, Goldberger BA, Pesce AJ, et al. Ethyl glucuronide, ethyl sulfate, and ethanol in urine after intensive exposure to high ethanol content mouthwash. *Journal of analytical toxicology.* 2011;35(5):264-268.

96. Reisfield GM, Goldberger BA, Crews BO, et al. Ethyl glucuronide, ethyl sulfate, and ethanol in urine after sustained exposure to an ethanol-based hand sanitizer. *Journal of analytical toxicology.* 2011;35(2):85-91.

97. Helander A, Dahl H. Urinary tract infection: a risk factor for false-negative urinary ethyl glucuronide but not ethyl sulfate in the detection of recent alcohol consumption. *Clinical chemistry.* 2005;51(9):1728-1730.

98. Schröck A, Thierauf-Emberger A, Schürch S, Weinmann WJIjolm. Phosphatidylethanol (PEth) detected in blood for 3 to 12 days after single consumption of alcohol—a drinking study with 16 volunteers. 2017;131(1):153-160.

99. Aradottir S, Asanovska G, Gjerss S, Hansson P, Alling C. Phosphatidylethanol (PEth) concentrations in blood are correlated to reported alcohol intake in alcohol-dependent patients. *Alcohol and Alcoholism.* 2006;41(4):431-437.

100. Crunelle CL, Yegles M, van Nuijs AL, et al. Hair ethyl glucuronide levels as a marker for alcohol use and abuse: a review of the current state of the art. *Drug and alcohol dependence.* 2014;134:1-11.

101. For a list of state medical marijuana laws, as of February 2019, see: http//www.ncsl.org/research/health/state-medical-marijuauna-laws.aspx November 9, 2016

102. See: U.S. Department of Justice Memo October 2009- Ogden: Federal resources should not focus on prosecuting medical marijuana patients and caregivers who were operating in "clear and unambiguous compliance with existing state laws."

103. Executive Order of the President if the United States. Drug Free Workplace. 1986;12564. https://www.archives.gov/federal-register/codification/executive-order/12564.html.

104. Salomonsen-Sautel S, Min S-J, Sakai JT, Thurstone C, Hopfer C. Trends in fatal motor vehicle crashes before and after marijuana commercialization in Colorado. *Drug and alcohol dependence.* 2014;140:137-144.

105. Yesavage JA, Leirer VO, Denari M, Hollister LE. Carry-over effects of marijuana intoxication on aircraft pilot performance: a preliminary report. *The American journal of psychiatry.* 1985;142(11):1325-1329.

106. Messinis L, Kyprianidou A, Malefaki S, Papathanasopoulos P. Neuropsychological deficits in long-term frequent cannabis users. *Neurology.* 2006;66(5):737-739.

107. Gilman JM, Kuster JK, Lee S, et al. Cannabis use is quantitatively associated with nucleus accumbens and amygdala abnormalities in young adult recreational users. *Journal of Neuroscience.* 2014;34(16):5529-5538.

108. Hall W. What has research over the past two decades revealed about the adverse health effects of recreational cannabis use? *Addiction.* 2015;110(1):19-35.

109. See: https://www.fsmb.org/Media/Default/PDF/Advocacy/FSMB%20Resolution1.pdf.

110. American Medical Association. Code of Medical Ethics, Opinion 9.4.4, Physicians with disruptive behavior. 2000; https://www.ama-assn.org/delivering-care/ethics/physicians-disruptive-behavior. Accessed Dec 2017.

111. Cohen B, Snelson E. Model Medical Staff Code of Conduct. *American Medical Association.* 2009.

112. Joint Commission. Sentinel event alert, issue 40: behaviors that undermine a culture of safety. 2008. *Available at: Accessed May.* 2014;5.

113. Dyrbye LN, Harper W, Durning SJ, et al. Patterns of distress in US medical students. *Medical teacher.* 2011;33(10):834-839.

114. Dyrbye LN, West CP, Satele D, et al. Burnout among US medical students, residents, and early career physicians relative to the general US population. *Academic Medicine.* 2014;89(3):443-451.

115. Schwenk TL. Physician well-being and the regenerative power of caring. *JAMA : the journal of the American Medical Association.* 2018;319(15):1543-1544.

116. Hill AB. Breaking the stigma—a physician's perspective on self-care and recovery. *New England Journal of Medicine.* 2017;376(12):1103-1105.

117. Schernhammer E. Taking their own lives—the high rate of physician suicide. *The New England journal of medicine.* 2005;352(24):2473-2476.

118. Schernhammer ES, Colditz GA. Suicide rates among physicians: a quantitative and gender assessment (meta-analysis). *The American journal of psychiatry.* 2004;161(12):2295-2302.

119. Gold KJ, Sen A, Schwenk TL. Details on suicide among US physicians: data from the National Violent Death Reporting System. *General hospital psychiatry.* 2013;35(1):45-49.

120. McIntosh WL. Suicide rates by occupational group—17 states, 2012. *MMWR Morbidity and mortality weekly report.* 2016;65.

121. Dyrbye, L, Trockel M, Frank E, et al. Development of a Research Agenda to Identify Evidence-Based Strategies to Improve Physician Wellness and Reduce Burnout. 2017; annals.org.

122. Shanafelt TD, Boone S, Tan L, et al. Burnout and satisfaction with work-life balance among US physicians relative to the general US population. *Archives of internal medicine.* 2012;172(18):1377-1385.

123. Shanafelt TD, Dyrbye LN, West CP. Addressing physician burnout: The way forward. *JAMA : the journal of the American Medical Association.* 2017.

124. West CP, Dyrbye LN, Erwin PJ, Shanafelt TD. Interventions to prevent and reduce physician burnout: a systematic review and meta-analysis. *The Lancet.* 2016;388(10057):2272-2281.

125. Brooks E, Gendel MH, Early SR, Gundersen DC. When Doctors Struggle: Current Stressors and Evaluation Recommendations for Physicians Contemplating Suicide. *Archives of suicide research.* 2018:1-10.

126. Ziegler P. What you need to know when treating physicians: issues, sensitivities and considerations. *Psychiatric Times.* 2016;33(6):33-36.

127. Gold KJ, Andrew LB, Goldman EB, Schwenk TL. "I would never want to have a mental health diagnosis on my record": a survey of female physicians on mental health diagnosis, treatment, and reporting. *General hospital psychiatry.* 2016;43:51-57.

128. Merskey H, Bogduk N, International Association for the Study of Pain. Task Force on Taxonomy. *Classification of chronic pain : descriptions of chronic pain syndromes and definitions of pain terms.* 2nd ed. Seattle: IASP Press; 1994.

129. Richards D. The Oxford Pain Group League table of analgesic efficacy. *Evidence-Based Dentistry.* 2004;5(1):22.

130. Derry CJ, Derry S, Moore RA. Single dose oral ibuprofen plus paracetamol (acetaminophen) for acute postoperative pain. *Cochrane Database of Systematic Reviews.* 2013(6).

131. Weisner CM, Campbell CI, Ray GT, et al. Trends in prescribed opioid therapy for non-cancer pain for individuals with prior substance use disorders. *Pain.* 2009;145(3):287-293.

132. Chang Y-P, Compton P. Management of chronic pain with chronic opioid therapy in patients with substance use disorders. *Addiction science & clinical practice.* 2013;8(1):21.

133. Brooks E, Gendel M, Parry A, Humphreys S, Early S. Challenging cognitive cases among physician populations: case vignettes and recommendations. *Occupational Medicine.* 2016;67(1):68-70.

134. Perry W, Crean RD. A retrospective review of the neuropsychological test performance of physicians referred for medical infractions. *Archives of clinical neuropsychology.* 2005;20(2):161-170.

135. Turnbull J, Carbotte R, Hanna E, et al. Cognitive difficulty in physicians. *Academic Medicine.* 2000;75(2):177-181.

136. Turnbull J, Cunnington J, Unsal A, Norman G, Ferguson B. Competence and cognitive difficulty in physicians: a follow-up study. *Academic Medicine.* 2006;81(10):915-918.

137. CPPPH. Assessing Late Career Practitioners: Policies and Procedures for Age-based Screening. 2015; https://www.cppph.org/wp-content/uploads/2015/05/assessing-late-career-practitioners-adopted-by-cppph-4-14-15.pdf, 2019.

138. Choudhry NK, Fletcher RH, Soumerai SB. Systematic review: the relationship between clinical experience and quality of health care. *Annals of internal medicine.* 2005;142(4):260-273.

139. Schaie KW. *Intellectual development in adulthood: The Seattle longitudinal study.* Cambridge University Press; 1996.

140. Drag LL, Bieliauskas LA, Langenecker SA, Greenfield LJ. Cognitive functioning, retirement status, and age: results from the Cognitive Changes and Retirement among Senior Surgeons study. *Journal of the American College of Surgeons.* 2010;211(3):303-307.

141. This definition is in keeping with the definition offered by the American Medical Association in 1973.

142. According to ASAM, these disorders can also be referred to as addiction diseases.

