Policy on Physician Illness and Impairment: Towards a Model that Optimizes Patient Safety and Physician Health

Section I – Introduction

In April 2019, Chair of the Federation of State Medical Boards (FSMB), Scott Steingard, DO, established the *FSMB Workgroup on Physician Impairment* to review, in collaboration with the Federation of State Physician Health Programs (FSPHP),[1] the FSMB Policy on Physician Impairment (HoD 2011) and make recommendations to revise and expand the policy in light of new and emerging issues, including but not limited to:

1. implementation of the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) (May 2013);
2. use of medication for the treatment of opioid use disorder by practicing licensees with opioid use disorders;
3. the role of Physician Health Programs (PHPs) to promote licensee wellness and combat burnout;
4. state medical board policies and procedures designed to ensure appropriate working relationships with PHPs;
5. revised PHP Guidelines (2019) by the FSPHP.

This policy provides guidance to state medical and osteopathic boards (referred to hereinafter as state medical boards) for including PHPs in their efforts to protect the public. There is a need to educate the medical profession and the public about physician illness, impairment, and illness that can lead to impairment. This document represents recommendations for medical boards and PHPs to effectively protect the public through the assistance of licensees, medical students, and trainees with functionally impairing illness(es) based on best practices.

Section II - Model Physician Health Program (PHP)

State medical boards are referred to the Federation of State Physician Health Programs (FSPHP) Physician Health Program Guidelines[2] which, along with this document, serve as a resource in selecting and evaluating any particular PHP. Implementation of these Guidelines will necessarily vary from state to state in accordance with state legal, contractual and/or regulatory requirements.[3]

The purpose of a Physician Health Program (PHP) is to guide the rehabilitation of potentially impaired and impaired physicians, other licensed healthcare professionals, or those in training suffering from substance use disorders, psychiatric, medical, behavioral or other impairing

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[1] A PHP (Physician Health Program) is a confidential program of prevention, detection, intervention, rehabilitation and monitoring of licensees or those in training with impairing conditions, approved and/or recognized by the state medical board. The FSPHP's mission is to support physician health programs in improving the health of medical professionals, thereby contributing to quality patient care.

[2] Federation of Physician Health Programs, Physician Health Program Guidelines, 2019.

[3] Whenever possible, the medical boards and PHPs should work collaboratively in the development of effective laws and regulations in the promotion of PHPs for the benefit of the public.

conditions, including burnout, consistent with the needs of public safety. This involves the early identification, evaluation, treatment, monitoring, documentation of adherence, and advocacy, when appropriate, of licensees with potentially impairing illness(es), ideally prior to functional impairment. PHPs should provide services to both voluntary and board mandated referrals without bias and should not provide assistance or guidance for illness outside their scope and expertise. The provision of confidentiality offers an incentive for the medical community and others to confidentially contact the PHP prior to a physician's illness becoming functionally impairing.

Ideally, PHP services would include the following:

- Wellness programs that address physician health, stress management, burnout and early detection of at-risk behavior.
- Educational programs on topics, including but not limited to, the recognition, evaluation, treatment and continuing care of impairing conditions.
- Opportunities to conduct and participate in valid IRB-approved research.
- Educational resources for the profession, the public, and medical boards about the role and function of PHPs.

The decision of a current or future licensee to seek or accept PHP assistance and guidance should not, in and of itself, be used against the physician in disciplinary matters before the board. However, PHPs must report substantive non-adherence with PHP recommendations and monitoring agreements and make periodic reports regarding adherence based on ongoing documentation to appropriate individuals, committees, boards or organizations on behalf of licensees under PHP monitoring.

The dual role of protecting the public through licensing and sanctions as well as the provision of a mechanism for the successful rehabilitation of impaired physicians falls within the statutory public protection mandate of state medical boards. Furthermore, early detection, evaluation, treatment, and monitoring of a physician with an impairing illness enhances a board's ability to protect the public.

It is necessary that PHPs function in a stable environment insulated, as much as possible, from changing political pressures. PHPs must also have a clearly defined mission and avoid any potential negative impact resulting from leadership and/or philosophical changes within the state medical association, state medical board or others. Consequently, the Workgroup optimally recommends that state medical boards enter into agreements with PHPs that have an independent organizational governance structure that prioritizes and allows for the fulfillment of the PHP mission.

Support for the PHP model from state medical boards and medical associations is essential for PHP effectiveness. PHPs and their boards of directors, medical associations and state medical boards should be aware of the competing nature of dual interests, understand the need for separation, and mitigate conflicts of interests where possible by maintaining appropriate boundaries between the medical association, the PHP and the state medical board.

A PHP should be empowered to take action based on verifiable signs and behaviors suggestive of impairment. Unlike the board, which must build a case capable of withstanding legal challenge, a PHP can quickly intervene based on a reasonable concern. The PHP can, therefore, be a significant benefit to public safety. Since 1995, FSMB policy has supported physician remediation via an effective PHP as an alternative to, or in conjunction with, sanctions.

Section III – State Medical Boards and PHPs

The goals and missions of the FSMB, FSPHP, and their partners align in many ways. This is especially true with respect to a desire to see healthy physicians providing excellent care to the patients they serve. While the PHP model is not the only feasible model for supporting impaired or potentially impaired physicians to safely return to practice, PHPs have developed experience and expertise in matters of physician health, they offer a therapeutic alternative to discipline where patient safety is not at risk, and they help encourage physicians to seek treatment early for impairing conditions. PHPs coordinate and monitor intervention, evaluation, treatment and continuing care of the impaired physician as well as those with impairing illnesses.

PHPs, regulatory agencies, and physicians agree that public protection is paramount. Yet, patient safety and physician wellness do not need to be at odds.[4] As stated in the FSMB policy on Physician Wellness and Burnout, "the duty of state medical boards to protect the public includes a responsibility to ensure physician wellness and to work to minimize the impact of policies and procedures that impact negatively on the wellness of licensees, both prospective and current."[5] Safe reintegration of the recovering physician back into the workforce constitutes the ideal scenario. At times, tension may arise among stakeholders regarding an appropriate balance between the goals of protecting the public, on the one hand, and assisting the physician in recovery, on the other. Collaboration among all stakeholders is required to effectively support physicians with impairing illness so that they may provide quality care to patients.

These efforts require that PHPs have a primary commitment to uphold the mission of their state medical and osteopathic boards in order to protect the public. To gain the confidence of regulatory boards, PHPs must develop quality reviews to enhance the effectiveness of their programs that demonstrate an ongoing track record of ensuring safety to the public and reveal deficiencies if they occur. Such transparency and accountability to the medical and osteopathic boards is necessary to the existence and continuation of a viable PHP.

The ideal relationship between a state medical board and a PHP is characterized by:

1. A commitment between both parties to open lines of communication and collaboration within the bounds of applicable confidentiality protections.

2. Mutual understanding of each organization's responsibility to program participants and the public.

3. No discrimination nor denial of PHP services based on a physician's race, creed, color, national origin, religion, sexual orientation, gender, gender identity, specialty, type of professional degree, or membership affiliations.

4. PHP acceptance of physician participants experiencing financial difficulties who otherwise meet program eligibility criteria, and availability for referrals by boards and other individuals or entities in need of services.

5. State medical board endorsement of a PHP and support to ensure the PHP has adequate staff and funding to meet its expected mission and goals.

6. PHP arrangement for emergency interventions and evaluations, where possible.

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[4] Lemaire JB, Ewashina D, Polachek AJ, Dixit J, Yiu V (2018) Understanding how patients perceive physician wellness and its links to patient care: A qualitative study. PLOS ONE 13(5): e0196888. https://doi.org/10.1371/journal.pone.0196888

[5] Federation of State Medical Boards *Policy on Physician Wellness and Burnout*, Adopted April 2018.

7. PHP establishment of a health monitoring agreement template designed to optimize continuing care, physician rehabilitation and patient safety. Details of each agreement should be individualized and subject to change based on case specifics.

8. Periodic review of laws and regulations by state medical boards, in consultation with PHPs, to ensure that the PHPs are legally able to adapt to evolving best practices.

A formal agreement should be executed between the state medical board and PHP, establishing the parameters of the relationship. Ideally, such an agreement will be based on the principles of mutual trust, respect, accountability, collaboration, and communication. Transparency of program policies and procedures while maintaining the appropriate confidentiality of individual participants is important.

Section IV – Supporting Physician Health: Key Considerations

For the purposes of this policy, physician impairment is defined as the inability of a physician to provide medical care with reasonable skill and safety due to illness or injury. The discussion of impairment in this policy applies to physicians broadly and includes not only licensed physicians and physician assistants, but also medical students, residents and fellows, and those seeking licensure. It also applies to other healthcare providers in instances where state medical boards license multiple types of healthcare professional.

It is important to distinguish illness from impairment. Illness, per se, does not constitute impairment.[6] When functional impairment exists, it is often the result of an illness in need of treatment. Therefore, with appropriate treatment, the issue of impairment may be prevented or resolved while the diagnosis of illness may remain.

Impairment is a functional classification which exists dynamically on a continuum of severity and can change over time rather than being a static phenomenon. At one end of this continuum can be found mild loss of function such as minimal cognitive decline, minor physical ailments, and other issues which do not, or which minimally, impact performance. At the other end of the continuum can be found more substantial loss of function such as that associated with severe cognitive decline, severe substance use disorder, or major physical, mental or emotional impairments that significantly limit the ability of a physician to provide safe medical treatment to patients. The location of a particular instance of loss of function along this continuum of severity is dictated by its impact on the functional ability of the physician to safely engage in the provision of medical care. An instance of loss of function only merits regulation by a state medical board if it meaningfully limits (and therefore impairs) a physician's ability to provide safe care to patients.

Any impairment should be evaluated according to the particular context of the physician's occupation, their specialty, and the patients and conditions they treat. An essential tremor in a surgeon could be considered a relatively severe impairing condition, whereas it may not be an impairment for a psychiatrist. Each particular instance of impairment should also be considered according to its severity and functional impact. For example, not every tremor would be too severe to perform simple procedures. Very minimal instances of cognitive impairment may not be significant enough to present risks to patient safety. In many cases, impairments can be improved through effective management.

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[6] Candilis PJ, Kim DT, Snyder Sulmasy L, (2019) Physician Impairment and Rehabilitation: Reintegration into Medical Practice While Ensuring Patient Safety: A Position Paper from the American College of Physicians, *Ann Intern Med*. 170:871-9

Stigma and Barriers to Treatment

The stigma associated with illness and impairment, particularly impairment resulting from mental illness, including substance use disorders, can be a powerful obstacle to seeking treatment, especially in the medical community where the presence of this stigma has been described in the literature.[7] Many physicians are averse to seeing themselves in the role of the patient. Physicians may fear the impact that a diagnosis of impairing illness might have on the perceptions of their peers, patients, and others, including their state medical board, regardless of earnestness on the part of boards in treating people fairly and respectfully. This stigma is compounded and perpetuated by questions on applications for licensing, employment, credentialing and recredentialing, and malpractice insurance that inquire about mental health diagnosis and previous treatment. This fear presents significant risks not only to the potentially impaired physician's own health, but also to the safety of their patients.

Reducing the stigma associated with illness and impairment is essential for ensuring that physicians with impairing illness feel comfortable seeking treatment in order to practice safely, or to re-enter practice after a period of treatment and rehabilitation. As recommended in the FSMB Policy on Physician Wellness and Burnout,[8] boards are encouraged to take advantage of opportunities to discuss physician wellness, communicate regularly with licensees about relevant board policies and available resources, and help engender positive cultural change to reduce stigma associated with impairment among those physicians seeking treatment, as well as stigma related to the treatment itself and acknowledging its need. Beyond discussion, boards are encouraged to find ways to promote health, rehabilitation and restoration, and reduce obstacles to seeking treatment, including by allowing treatment to be sought confidentially for impairing illness and not requiring this to be reported as part of the licensing process, while reminding licensees of their professional responsibility to address any health concerns and ensure patient safety. Physicians must be afforded the same access to care as the general public. When boards achieve positive change in these areas, they are encouraged to communicate this to licensees and the public to ensure greater awareness and protect licensees' ability to address health conditions without stigma or delay.

Assessment of Impairment

While each instance of impairment would need to be assessed based on its individual signs and behaviors, there are common features which might indicate impairment in any physician. For example, if a physician is suffering from impairment due to substance use, this may become apparent through changes in mood/affect, decreased productivity, apathy toward patient care, suicidal ideation or behavior, increasing medical errors, inconsistent hours, complaints from patients or other colleagues, deterioration in appearance or physical health, and changes in social interactions.[9] An overall pattern or cluster of signs and behaviors would be more indicative of an individual at imminent risk for impairment than individual and isolated events.

Medical Students, Residents and Fellows

It has been shown that students whose professionalism lapses in medical school are more likely to exhibit similar behaviors in residency training and practice.[10] Fostering greater understanding of the regulatory role in physician impairment and the purpose of PHPs, encouraging self-care and seeking treatment early among medical students, residents and fellows ("residents and fellows" are

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[7] Wallace, JE (2012) Mental Health and Stigma in the Medical Profession, *Health:*, 16(1): 3-18.
[8] Federation of State Medical Boards *Policy on Physician Wellness and Burnout*, Adopted April 2018.
[9] Santucci, Karen. Reporting an impaired colleague difficult but necessary. AAP News, 2018. https://www.aappublications.org/news/2018/11/28/law112818
[10] Krupat E, Dienstag JL, Padrino SL, Mayer JE, Shore MF, Young A, Chaudhry HJ, Pelletier SR, Reis BY, Do Professionalism Lapses in Medical School Predict Problems in Residency and Clinical Practice? *Acad Med*: June 2020, Vol.95(6):888-895.

hereinafter referred to as "residents", unless otherwise specified) and facilitating dialogue between state medical boards and the medical education community are therefore important elements of patient protection.

Stigma associated with mental health issues and impairment is negatively correlated with adaptive attitudes about help-seeking among medical students, especially those who are already having difficulties.[11] In considering the multitude of issues facing medical students and residents, including burnout, financial difficulties, educational stressors, geographic isolation, and a lack of support systems, supportive resources become invaluable. It is of the utmost importance to promote an awareness of how and when to access these resources. The crucial work of the FSMB's Workgroup on Physician Wellness and Burnout is applicable to medical students and residents and their professional development as well.

The development and provision of resources to help identify and prevent impairment in medical students is not in the direct purview of state medical boards. However, there are strategies boards may wish to implement to encourage and facilitate seeking treatment across the continuum of medical students, residents and practicing physicians. Among these are avoiding the inclusion of questions about current medical or psychiatric conditions or counseling, or previous history of impairment on applications for medical licensure, or offering a "safe haven" alternative of not reporting treatment sought either through the PHP model or a physician expert model that involves comprehensive care management and monitoring. Again, these should be replaced with reminders of the importance of physician wellness, and positive developments in these areas should be promoted widely through communications strategies to raise awareness, reduce stigma, and dispel myths about the ways in which state medical boards approach the issue of impairment.

State medical boards can also be supportive of medical schools relative to the early detection, prevention, evaluation and treatment of impairing conditions according to the same principles of confidentiality, collaboration, communication, accountability, professional assistance, and guidance adopted by the PHP community. These principles are indispensable during transition periods in training such as between medical school and residency and between residency and entry to independent or unsupervised practice. The concept of "warm handover"[12] during these periods, subject to a student's or resident's consent and after they have been accepted into a residency or fellowship program, that includes a confidential and appropriate focus on student well-being can be encouraged by the medical regulatory community.

Medical students, residents, and training programs can also benefit from greater availability of information about the considerations, processes and timelines used by state medical boards in arriving at licensing decisions related to impairment. While boards consider each instance of impairment based on the physician's individual context, transparent information about the considerations that factor into boards' decisions can help foster an appreciation for a consistent approach among boards and reduce anxiety associated with the licensing processes among applicants. It could also help reduce stigma associated with impairment and encourage treatment seeking.

State medical boards can also encourage greater awareness of their purpose and procedures by inviting students to attend board meetings and engaging in outreach with medical schools. The concept of student attendance at board meetings has already been adopted by several boards across the country and presents valuable opportunities to foster familiarity with the board and educate about the importance of seeking treatment, the continuum of (and differences between) illness and impairment, the value of early intervention, and the fact that illness can be treated in a safe,

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[11] Schwenk TL, et al. (2010). Depression, Stigma, and Suicidal Ideation in Medical Students. JAMA, 304(11):1181-1190.

[12] Warm, Eric J. MD; Englander, Robert MD; Pereira, Anne MD, MPH; Barach, Paul MD, MPH. Improving Learner Handovers in Medical Education. *Acad Med*: July 2017, Vol.92(7):927-931

confidential, respectful and professional manner without impact on the ability of the medical student to continue their education and ultimately obtain an unrestricted medical license. A greater understanding of these and other medical regulatory concepts can also be gained through the free online educational modules developed by the FSMB which are geared towards medical students and residents. Better educated and informed medical students become better residents who are more aware of their own well-being and behavioral and mental health needs and are better able to serve themselves and their patients after they complete their training.

Reporting

It is essential that state medical boards have timely information about instances of a physician practicing while impaired in order for them to carry out their patient protective functions. Gathering such information about all instances of practicing while impaired is not always possible in the course of state medical boards' typical regulatory processes. Boards will therefore depend on licensees and other individuals and entities to fulfill their ethical "duty to report" such instances. This is a duty of physicians and the profession of medicine to patients and society, to help ensure patients are provided safe medical care and that trust in medicine is maintained. It is also a duty to impaired physicians, as reporting aims to encourage physicians in seeking the assistance, guidance and support they need in order to continue practicing safely.

Some instances of practicing while impaired will require direct reports to state medical boards, including instances of patient harm and substantive non-adherence to agreements with PHPs. However, when a timely intervention to ensure that an impaired physician ceases practicing and receives appropriate PHP assistance is sufficient to protect patients, the ethical duty towards patients and colleagues has been discharged.[13]

While this ethical duty to intervene transcends state lines, legal requirements for reporting vary among states. Language used in state laws indicating when reporting an instance of impairment in a physician colleague is required can include "actual knowledge" of an impairment, "reasonable cause" to believe that an impairment exists, "reasonable belief" that an impairment is present, "first-hand knowledge" of an impairment, and "reasonable probability" (as distinguished from "mere probability") of an impairment.[14] Licensees should be expected to be familiar with reporting requirements in the state(s) in which they are licensed. State medical boards can support licensee understanding of reporting requirements by developing guidance documents in lay rather than legal terms. Where boards are permitted to work with legislatures on drafting or amending legislation, they may wish to ensure clear language regarding reporting requirements that emphasizes the theme of "reasonability." If it is reasonable to believe that a physician is impaired in such a way that they pose a threat to patient safety, then reporting should be required.

Reporting responsibilities also exist between PHPs and state medical boards. Reporting requirements may vary from state to state based on state laws, program regulations, as well as the relationship and level of trust between the PHP and the board. The PHP should report to the board on the status of program participants in accordance with the agreement between the board and the PHP. Some boards require periodic reports on participants **they have referred** to the PHP. Others may ask for reports on all participants. In that case, board mandated participants are identified by name while confidential participants are identified by number to maintain their confidentiality. Confidential PHP participants (those that are unknown to the board and/or those for whom there is no reporting requirement) risk forfeiting their confidentiality should they have substantive non-adherence to an agreement with their PHP, and will forfeit their confidentiality should they pose a risk to the public. PHPs reporting on

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[13] AMA Code of Medical Ethics, Opinion 9.3.2

[14] Starr, Kristopher T Reporting a Physician Colleague for Unsafe Practice: What's the Law? *Nursing2019*: February 2016 - Volume 46 - Issue 2 - p 14

those physicians who are board-mandated may report to the board on a periodic basis and include detailed reports on adherence to continuing care plans and monitoring results.

Referral

State medical boards should offer two separate tracks for referral of ill or impaired physicians to PHPs: a voluntary track and a mandated track.

Voluntary Track – A confidential process of seeking assistance and guidance through a PHP whereby the impairing illness is addressed without required personal identification to the state medical board. A voluntary track promotes earlier detection of potentially impairing illness before it becomes functionally impairing. The voluntary track participants are in a safe system whereby substantive non-adherence or relapse, depending on each state's non-adherence reporting requirements, will be promptly reported to the licensure board by name.

Mandated Track – Mandated licensees are those required by the state medical board to participate in a PHP. A mandated referral can be via an informal referral or via a formal public or private censure. In either instance the board may require quarterly progress reports. It is recommended that boards have a non-disciplinary process for referral to encourage early detection and intervention.

FSMB encourages referral to PHPs as an alternative to discipline to facilitate early detection, evaluation, treatment and monitoring before illness progresses to actual impairment. Non-disciplinary tracks also encourage self-referrals and more referrals by concerned colleagues, family members and patients.

FSMB recognizes that, for a variety of reasons, treatment of healthcare professionals may occur with or without oversight by a PHP. As recommended by the American Society of Addiction Medicine, "clinicians who treat healthcare professionals outside of PHPs should thoughtfully appraise their ability to provide credible assurance of safety to practice for professionals in their care and understand their legal and ethical requirements for public safety within the context of the therapeutic relationship. Clinicians with expertise in the treatment of healthcare professionals with (impairing illness) should understand when participation in a PHP may offer an advantage to (the physician-patient) and (utilize) this additional support."[15]

Criteria for Referral for Professional Assessment

One or more of the following should prompt referral of the physician, for additional screening and diagnostic assessment by a qualified professional evaluator:

1. Information or documentation of a medical condition that impairs the ability to practice medicine with reasonable skill and safety.

2. Information or documentation of excessive use of alcohol or other potentially impairing drugs, regardless of addictive potential (e.g., antipsychotics, anticholinergics, anticonvulsants, hallucinogens, stimulants)

3. Sufficient indications of current alcohol or other drug use that may include positive toxicology results for substances that are not prescribed by a treating healthcare professional.

[15] American Society of Addiction Medicine, Public Policy Statement on Physicians and other Healthcare Professionals with Addiction, Adopted by the ASAM Board of Directors February 6, 2020.

4. Behavioral, affective, cognitive, or other mental problems that raise reasonable concern for public safety.

5. Information or documentation of psychiatric illness or substance use disorder that impairs the ability to practice.

Evaluation and Diagnosis

PHPs accept self-referrals and calls from collateral sources who may be concerned about a physician. PHPs will gather the necessary information and guide the next steps. Evaluation of a physician may involve referral for a comprehensive clinical and/or multidisciplinary examination. The nature and content of the evaluation will be dictated by the specific circumstances of the physician being evaluated, their reasons for referral, and any concerns raised by the referring entity or individual. For suggestions on specific evaluation criteria, as well as credentials of the evaluator or evaluating team, state medical boards may wish to consult the FSPHP Guidelines.[16] High quality evaluations and treatment options are essential to the successful rehabilitation of providers. As such, state medical boards and PHPs should collaborate to ensure that evaluations of fitness to practice are carried out according to best practices and completed in a timely manner.

Treatment/Rehabilitation

Ensuring that physicians experiencing impairment are appropriately treated and rehabilitated in order to safely reenter practice is part of the mandate of state medical boards. The specific course of treatment and monitoring for rehabilitation of the individual physician participant, however, is under the purview of the treating healthcare professional and PHP, respectively.

In accordance with applicable statutory reporting requirements, PHPs, evaluators and treatment providers must report to the board any physician who is substantively non-adherent to the recommendations of a treatment agreement and poses a reasonable risk to patient safety.

Medications for the Treatment of Opioid Use Disorder

Medications for the Treatment for Opioid Use Disorder (MOUD) refers to the medications that are FDA-approved for the treatment of Opioid Use Disorder (OUD), including methadone, buprenorphine, and naltrexone. These medications are used in combination with an array of counseling, psychiatric, medical and psychosocial and/or spiritual therapies, and recovery support services based on a thorough assessment of individual needs. MOUD is recognized as being the standard of care for OUD and an important component of quality treatment.[17,18]

Methadone:
Methadone is a full opioid agonist[19] and an effective treatment for chronic pain and suppression of symptoms of opioid withdrawal and for treatment of OUD. While

[16] Federation of Physician Health Programs, Physician Health Program Guidelines, 2019.
[17] ASAM National Practice Guideline for the Treatment of Opioid Use Disorder, 2020 Focused Update.
[18] Substance Abuse and Mental Health Services Administration. *Medications for Opioid Use Disorder*. Treatment Improvement Protocol (TIP) Series 63. Publication No. PEP20-02-01-006. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2020.
[19] For definitions of opioid agonist, antagonist, and partial agonist, see Substance Abuse and Mental Health Services Administration. *Medications for Opioid Use Disorder*. Treatment Improvement Protocol (TIP) Series 63. Publication No. PEP20-02-01-006. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2020, p.1-2, Exhibit 1.1. Key Terms.

methadone is an effective treatment for OUD in the general population,[20,21] its characteristics include the potential for cognitive impairment until tolerance has developed.[22]

Buprenorphine:
Buprenorphine is a partial opioid agonist and is an effective treatment for suppression of symptoms of opioid withdrawal and for treatment of OUD. When buprenorphine is administered appropriately, it has minimal effects which would cause impairment.[23] New injectable buprenorphine formulations eliminate diversion risks associated with sublingual formulations.

Naltrexone:
Naltrexone is an opioid antagonist that is an effective treatment used to prevent relapse to opioid use in patients who are no longer physically dependent on opioids. Naltrexone can be administered orally or as time-release injections. Oral naltrexone has not been demonstrated to be an effective treatment for OUD in studies thus far. Long-acting injectable naltrexone outcomes in a 6-month study are similar to those for buprenorphine for patients who successfully initiate the medication.[24]

Substance use disorder (SUD) treatment is most effective when it involves a multimodal approach including evidence-based medical care, psychosocial interventions, and mutual support groups within a chronic disease management model, inclusive of toxicology testing.[25] Physicians and other health care professionals are safety-sensitive workers. It is recognized that safety-sensitive work confers a benefit to society that is not without risk to public safety. As such, safety-sensitive workers, organized medicine, and regulatory agencies have an ethical and legal obligation to take preventive measures to minimize identifiable safety risks and are accountable when harm occurs.

Physicians are just as susceptible to OUD and addiction as the general population and deserve the same consideration in terms of their privacy, treatment and safety. However, the safety-sensitive nature of medical practice and patient care may impact which treatment options are most appropriate for physicians who suffer from OUD *and* wish to continue to practice medicine. Physicians and other clinicians should not be put in a special category of

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[20] Mattick RP, Breen C, Kimber J, Davoli M. Methadone maintenance therapy versus no opioid replacement therapy for opioid dependence. Cochrane Database Syst Rev. 2009;3:CD002209

[21] Madras, B. K., N. J. Ahmad, J. Wen, J. Sharfstein, and the Prevention, Treatment, and Recovery Working Group of the Action Collaborative on Countering the U.S. Opioid Epidemic. *NAM Perspectives.* Discussion Paper, Washington, DC. https://doi.org/10.31478/202004b

[22] Substance Abuse and Mental Health Services Administration. *Medications for Opioid Use Disorder*. Treatment Improvement Protocol (TIP) Series 63. Publication No. PEP20-02-01-006. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2020.

[23] Substance Abuse and Mental Health Services Administration. *Medications for Opioid Use Disorder*. Treatment Improvement Protocol (TIP) Series 63. Publication No. PEP20-02-01-006. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2020.

[24] Lee JD, Nunes EV Jr, Novo P, et al. Comparative effectiveness of extended-release naltrexone versus buprenorphine-naloxone for opioid relapse prevention (X:BOT): a multicentre, open-label, randomised controlled trial. *Lancet*. 2018;391(10118):309-318. doi:10.1016/S0140-6736(17)32812-X

[25] Merlo LJ, Campbell MD, Skipper GE, Shea CL, DuPont RL. Outcomes for Physicians with Opioid Dependence Treated Without Agonist Pharmacotherapy in Physician Health Programs. *J Subst Abuse Treat*. 2016;64:47-54. doi:10.1016/j.jsat.2016.02.004

exclusion from treatment options that may effectively treat their addiction, but recognition of the safety-sensitive nature of their work is important. As such, decisions about whether it is safe to practice while receiving MOUD should include the following considerations:

- The potential for cognitive impairment[26] alone or in combination with other medications
- The potential for misuse or diversion of the medications
- The presence of co-occurring illness
- The relative importance and availability of complementary psychosocial treatments
- The feasibility of monitoring by a PHP or other physician expert with experience and expertise in the treatment and monitoring of physicians with SUD

As with any patient being assessed for MOUD, determination of the most appropriate course of treatment for a practicing physician should be based on the individual physician's case specific circumstances. Convenience, prescriber preference, and reimbursement rates should not outweigh considerations of patient safety, including both the physician as patient and the patients they treat if they continue to practice while receiving MOUD.

It is strongly recommended that physicians practicing medicine while taking a medication for OUD receive psychosocial treatment, including counselling and other treatment or services as determined based on their individual needs. These psychosocial treatments are often best understood and coordinated through PHPs or in collaboration with physicians with expertise in the treatment of physicians with addiction.[27] These programs and/or physician experts are also able to support physicians suffering from substance use disorders and associated co-occurring illness and can therefore provide comprehensive care management informed by experience and expertise of the unique needs of this cohort. PHPs represent a model for chronic disease management and monitor (longitudinally over time) health care practitioners who have health conditions that could impair their ability to safely practice, thereby mitigating this risk. The Workgroup recommends that state medical boards not require disclosure on licensing applications of treatment sought either through the PHP model or a physician expert model that involves comprehensive care management and monitoring.

Section V – Monitoring and Continuing Care

Monitoring agreements must be established between PHPs and participants. Agreements should clearly state the limits of confidentiality with respect to the PHP's statutory reporting obligations. Circumstances which would trigger a mandatory report to the state medical board, pursuant to statute or contract with the board, should be specified in the monitoring agreement. Reportable event(s) should result in notification of the board and appropriate others in a timely manner. Where abstinence from alcohol or other legal or illegal substances is required as part of a monitoring agreement, it should be understood as the complete avoidance of substances *that are not prescribed by a treating healthcare professional*.

[26] The opportunity for over and under dosing in patients receiving an opioid agonist or partial agonist is not readily detectable. Significant fluctuations in dosing can have negative effects on well-being and cognition.

[27] Available evidence has shown that physicians with OUD who are not treated with MOUD have low relapse and comparable success rates to other Substance Use Disorders under the PHP model of care (Merlo LJ, et al., *J Subst Abuse Treat*, 2016;64:47-54). These findings support the fact that long-term recovery from OUD is possible without the use of MOUD in the physician population.

The nature and duration of monitoring will vary based on the impairing illness of the PHP participant and should be informed by the conditions specified in the FSPHP Guidelines.

In the event of relocation of a participant, the PHP should have a mechanism to facilitate the transfer of monitoring to the appropriate state PHP or, in the absence of a PHP or board approved alternative, the licensing board. When a physician is licensed and working in more than one state, either the state of residence or the state in which most professional activities are occurring should agree to assume primary responsibility for monitoring with regular reports to the other state(s). Whenever possible, monitoring should not be duplicated.

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

Continuing care of the PHP participant is crucial to the successful recovery, safe return to the practice of medicine, and ultimately the successful completion of PHP participation. The board should receive regular monitoring adherence reports prepared by the PHP for all board mandated physicians.

Section VI – Conclusion

State medical boards fulfill their primary mission of protecting the public in many ways. One important way is by supporting the health and well-being of licensees so that they may provide quality care to patients. Boards promote the public health and safety when they ensure that tools and support are available to enable early detection, proper treatment, and professional continuing care of impaired physicians. Furthermore, early intervention with licensees with impairing illness may prevent progression of illness to overt impairment.

All stakeholders should become better informed regarding issues not only related to functional impairment but also to impairing illness. Ideally, state and federal law should facilitate the effective interface between boards, PHPs and physician experts in their effort to support the rehabilitation of licensees with impairing illness because it adds to public protection. State medical boards are encouraged, with input from their PHPs and other qualified experts, to revisit their Medical Practice Act routinely to ensure that it remains consistent with legislation and developments in the field.

Boards, PHPs, and non-PHP clinicians who care for physicians can support each other through developing relationships based on mutual respect and trust. When this occurs, the public benefits. A highly trained licensee who is safely rehabilitated is an asset to the medical community, the state, and the public.

Appendix A: Glossary of Key Terms

Physician Impairment
The inability of a physician to provide medical care with reasonable skill and safety due to illness or injury.

Physician Health Program
A confidential resource for physicians, other licensed healthcare professionals, or those in training suffering from or at risk of an impairing health condition. Such conditions include, but are not limited to, mental illness, including substance use disorders, non-psychiatric medical conditions and their treatments, and age-related cognitive and motor deterioration.

Substance Use Disorder
Substance use disorder (SUD) is a health condition marked by a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues to use alcohol, nicotine, and/or other drugs despite significant related problems.[28]

Opioid Use Disorder
A substance use disorder involving opioids.

Medication for Opioid Use Disorder (MOUD)
Medications for the Treatment of Opioid Use Disorder (MOUD) refers to the medications that are FDA-approved for the treatment of Opioid Use Disorder (OUD), including methadone, buprenorphine, and naltrexone. These medications are used in combination with an array of counseling, other biological and psychosocial and/or spiritual therapies, and recovery support services based on a thorough assessment of individual needs. MOUD is recognized as the standard of care and an important component of quality treatment.[29,30]

Physician Expert Model of Treatment and Monitoring
A physician expert model of treatment and monitoring for clinicians with impairing illness is an alternative to the PHP model where a PHP either does not exist in a given state or is not appropriate for the treatment or monitoring of a particular participant. For example, some PHPs do not monitor physicians who have been treated for professional sexual misconduct and returned to practice. Such a model is only recommended as an alternative option for the treatment and monitoring of an impaired physician provided that it involves the evaluation, treatment, monitoring, documentation of adherence with a treatment agreement, and the duty to report impairment in the context of medical practice that are accepted elements of the PHP model.

Physician experts who provide treatment and monitoring through such a model should understand when participation in a PHP may offer an advantage to the physician-patient and utilize this additional support.[31]

Abstinence
Abstinence is defined as the complete avoidance of potentially impairing drugs that are not legitimately prescribed.

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[28]American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). https://doi.org/10.1176/appi.books.9780890425596
[29] ASAM National Practice Guideline for the Treatment of Opioid Use Disorder, 2020 Focused Update.
[30] Substance Abuse and Mental Health Services Administration. *Medications for Opioid Use Disorder*. Treatment Improvement Protocol (TIP) Series 63. Publication No. PEP20-02-01-006. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2020.
[31] American Society of Addiction Medicine, Public Policy Statement on Physicians and other Healthcare Professionals with Addiction, Adopted by the ASAM Board of Directors February 6, 2020.

Relapse
A process in which an individual who has established disease remission experiences recurrence of signs and symptoms of active addiction, often including resumption of the pathological pursuit of reward and/or relief through the use of substances and other behaviors. When in relapse, there is often disengagement from recovery activities. Relapse can be triggered by exposure to rewarding substances and behaviors, by exposure to environmental cues to use, and by exposure to emotional stressors that trigger heightened activity in brain stress circuits. The event of using substances or re-engaging in addictive behaviors is the latter part of the process, which can be prevented by early intervention.[32] It is important to note that appropriate treatment of some participants may involve the use of prescription medications known to the PHP.

The FSPHP *Physician Health Program Guidelines* define three levels of relapse relevant to the monitored health professional which may be helpful to state medical boards:

- 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[33]

Substantive Non-Adherence
Substantive non-adherence is a pattern of non-adherence, dishonesty, or other behavior that compromises the integrity of PHP continuing care monitoring, or an episode of non-adherence which could place patients at risk.

[32] American Society of Addiction Medicine (ASAM). The ASAM National Practice Guideline For the Treatment of Opioid Use Disorder: 2020 Focused Update. Available at: https://www.asam.org/Quality-Science/quality/2020-national-practice-guideline
[33] Federation of Physician Health Programs, Physician Health Program Guidelines, 2019.

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