

American Medical Association Journal of Ethics

October 2015, Volume 17, Number 10: 888-893

FROM AN AMA JOURNAL OF ETHICS SPECIAL CONTRIBUTOR

Deciding Whether To Refer a Colleague to a Physician Health Program

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When a physician is suspected of having a substance use disorder, the potential ramifications are far reaching, and the situation is rife with ethical considerations. Not only can any disciplinary action have a significant impact—for better or for worse—on the physician, but the effects on that physician's patients can be dramatic. Take action against a physician incorrectly suspected of being impaired, and many patients can lose their in fact competent physician and be deprived of needed access to health care. Fail to take action against a physician who in fact has a substance use disorder, and patients can lose their lives. Thus, navigating these waters as well as possible is vitally important, even though it can be difficult at best, given the competing and overlapping interests and needs of the physician and his or her patients.

In theory, the recommendations for a physician who suspects a colleague of misusing substances are straightforward. The American Medical Association's (AMA) *Code of Medical Ethics*, for example, outlines the [reporting responsibilities](#) of physicians who suspect that a colleague might be impaired:

Physicians' responsibilities to colleagues who are impaired by a condition that interferes with their ability to engage safely in professional activities include timely intervention to ensure that these colleagues cease practicing and receive appropriate assistance from a physician health program (PHP)... Ethically and legally, it may be necessary to report an impaired physician who continues to practice despite reasonable offers of assistance and referral to a hospital or state physician health program. The duty to report...may entail...reporting to the licensing authority [1].

Even with these guidelines, ascertaining exactly how and when to intervene with a colleague can be tricky. I focus here on two aspects of the AMA's position. First, I address the ethical and practical issues of physicians assessing impairment and deciding whether to approach a colleague they suspect of impairment or whether to report that physician to a board of medicine or some other credentialing entity. And secondly, I consider the nature and operation of the physician health programs (PHPs) that the AMA recommends referring our colleagues to. Most physicians do not know much about these programs, but given that they wield a lot of power and generally operate outside the scrutiny of the wider medical community, a closer examination is warranted.

How Can I Be Sure There is a Problem?

Although we have a duty to prevent harm to patients by impaired physicians, it can be difficult to know if there is actually a problem. For example, questions often arise about the causes of various unusual or unprofessional behaviors: is the physician [intoxicated](#) or sleep-deprived? Is she [snappy and irritable](#) because she is abusing stimulants or because she is merely stressed at home or overwhelmed at work? Was that car accident in the hospital parking lot due to alcohol abuse or uncontrolled diabetes, or was it not even the physician's fault? In these and other instances, it might not be clear how best to honor one's ethical duty to promote good and prevent harm for all parties involved.

To further complicate matters, when considering possible impairment in one of our colleagues, our objectivity might be compromised. There could be occasions when bringing a colleague down in some manner might serve to improve our own standing—by, for example, increasing our patient panel or improving our status within our medical institution. Thus, can we be certain about the purity of our motivations when confronting or deciding whether to report a colleague? Do we like him or her? Do we stand to gain something if he or she is found to be impaired? Will our own workload increase if this person has to take time off? If we are in the same practice, will our practice's reputation be stained? So, while drawing a line between casual, nonproblematic drug use and dependence is always difficult, it is especially complex when thinking about this distinction in a colleague.

Will Intervening Do Good?

In addition to the fact that we often might be uncertain about whether there is in fact a problem, it is not clear that intervention universally results in good. The potential downside of reporting is that merely reporting a physician for suspicious behavior can result in a board of medicine asking that the physician stop practicing medicine until the allegations are investigated. This can result in potentially unnecessary loss of income for the physician, patients being deprived of their physician, and the physician's colleagues being overwhelmed with extra patients. Additionally, merely being investigated, much less actually disciplined or cited, can result in public ignominy for the physician, strained personal and professional relationships, and possibly legal bills. So when physicians have had action taken against them, at times it can be difficult to conclude that, all things considered, good has been accomplished. On the other hand, inaction could cause not only direct harm to the family members and patients of the physician, but also harm to or perhaps even the death of the physician.

We have a *prima facie* duty to respect the autonomy of physicians, but this duty can and should get trumped by other more pressing needs if we suspect that a physician is actively misusing psychoactive substances. Our duty to promote both beneficence (defined as "doing good") and nonmaleficence (defined as "preventing harm" and "not

inflicting harm on others”) has to trump the physician’s right to autonomy. Patients’ autonomy—the right to make choices about who they see for health care based on as much relevant information as possible—is more important.

When to Intervene

If the warning signs observed in clinical practice are overt—erratic behavior, slurring words, poor clinical decision making, and so on—then taking immediate action by confronting the physician with follow-up reporting to a clinic chief or even to the board of medicine itself (if the physician does not self-report) might be imperative. Doing so might save a life, perhaps even multiple lives. Given the high stakes in both directions, if in doubt about how to proceed, seek expert guidance and confer with those knowledgeable about physician health and substance abuse to help determine whether your thoughts and concerns are justified and warrant action of some sort.

Potential Concerns about Physician Health Programs

In its statement about how to proceed when one suspects a colleague of a substance abuse problem, the AMA says that we might be ethically and legally obligated to refer that colleague to a state PHP [1]. Currently, 47 states in the US have one of these programs [2]. The purpose of PHPs is generally to promote the health and well-being of physicians—especially those with substance use and mental health issues—and also to protect the public from physicians who might be impaired. PHPs vary in their composition and funding sources. Some are arms of their state medical societies, some are housed within the state medical boards, and others are freestanding [3].

Physicians can end up at PHPs through various means. In some instances, they might self-refer, seeking help with a substance abuse or mental health issue. In others, colleagues, a departmental chair, or a chief medical officer might insist that they meet with the PHP. In still others, the state licensing board might insist that physicians do so. In the latter two instances, physicians generally have no choice but to comply with any and all PHP recommendations if they want to be able to continue practicing medicine [3]. PHP recommendations often include a several-day evaluation. Physicians deemed to have a substance use disorder are often required to enter a 30-to-90-day inpatient stay for treatment. Generally, neither the evaluation nor treatment is covered by insurance [3]. And once treatment is complete, physicians are generally required to sign a monitoring agreement and begin random drug testing, Alcoholics Anonymous or Narcotics Anonymous attendance, and regular meetings with a PHP representative. Failure to comply with any aspect of the contract can, and often does, result in being reported to the licensing board. The board then might ask the physician to suspend practice while it investigates matters or simply revoke the physician’s license [4].

Given the authority that PHPs often have over the ability of physicians to practice medicine, their power is enormous and not necessarily wielded appropriately. A recent

class action lawsuit filed in Michigan alleges a coercive, punitive process within the PHP in that state [5]. The suit states that health care professionals “are forced into extensive and unnecessary substance abuse/dependence treatment under the threat of the arbitrary application of pre-hearing deprivations,” which include suspension by the Michigan licensing board. In addition, I have known some PHPs to report low-level positive drug tests to their boards even when these tests might indicate incidental exposure to a substance instead of intentional use or relapse. (For example, a physician who uses ethanol-based hand sanitizer repeatedly over the course of the day might have a low-level positive test the following day for metabolites of ethanol.) This can create significant hardships for the physician who is reported. Furthermore, some PHPs use physician participant data for research and publication purposes [6]. Even if PHPs obtain signed consent forms, are these physicians actually able to give noncoerced, informed consent, given the power the PHP holds over them?

There are often significant financial ties in both directions between PHPs and the evaluation and treatment centers they use [3, 7]. Many of these centers are more or less dependent on such PHP referrals for their own viability and are often principal sponsors of state, regional, or national meetings of PHPs. Such relationships between the PHPs and the evaluation and treatment centers create financial incentives for each to act in ways that favor the other’s interests. All of this would suggest that oversight of PHPs is crucial for ensuring ethically acceptable practices. But, even though PHPs work closely with their state medical societies or licensing boards, they often receive very little scrutiny from either of these entities because of their origins as organizations of “doctors helping doctors,” which can lead to a presumption that they are benevolent organizations working solely for the benefit of their physician clients [3].

Physicians who object to state PHP recommendations are often not taken seriously. In 18 years of working with PHPs in various capacities, I have generally seen that the only people who register concerns about PHPs are those who have been referred to them for evaluation or their loved ones. As a result, their complaints—which might be valid and important—are generally seen as mere sour grapes and viewed skeptically by hospital or state authorities. (The same is true for at least one journal editor. Several years ago, when a colleague and I submitted a paper to a major medical journal about ethical and managerial concerns regarding PHPs, I received a call from the editor in chief of the journal two days after submission asking if either I or my co-author had been referred to one of these programs. Only after I confirmed that we had not did the editor say she would send the paper out for review.) Formally appealing these decisions can be difficult or actually impossible. In my state, Massachusetts, appealing a PHP recommendation requires filing a lawsuit in the state court system, which can cost thousands of dollars in legal fees and take months or years to adjudicate. In many states, there is no avenue of appeal at all. Consider the case of North Carolina. After receiving several complaints from physicians, the state auditor’s office, for which I served as a consultant, audited the

North Carolina Physicians Health Program (NCPHP) and found that it lacked objective, impartial due process procedures for physicians who disputed its conclusions [7]. The auditor's office stated that "the lack of objective and independent due process procedures could prevent physicians from successfully defending themselves against potentially erroneous accusations and evaluations" [8] and decried the appearance of conflict of interest between the NCPHP and the evaluation/treatment centers that it utilized. It will revisit the NCPHP soon to ensure its various recommendations have been implemented.

Conclusion

Although there are currently no national standards for or routine audits of state PHPs, implementing such standards and regularly inspecting programs for compliance would go a long way to ensure the fair and ethical treatment of physicians suspected of substance abuse. Great thoughtfulness and care must be exercised when dealing with a colleague who might have a substance use disorder. Falsely accuse a physician, and the damage to your colleague's career, family, and patients can be extreme. Allow an impaired colleague to continue to work out of fear of taking action, and the danger to the physician and to patients can be extreme. Thus, it is imperative for health care personnel to properly navigate a course that carefully considers competing ethical principles and steers between the rocky shoals on either side. Moreover, given PHPs' power and the potential costs to physicians—much less the inability in many states to effectively protest PHP recommendations—caution should be exercised when considering referring a colleague to a PHP.

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ISSN 2376-6980**