

9.3.1 Physician Health & Wellness

When physician health or wellness is compromised, so may the safety and effectiveness of the medical care provided. To preserve the quality of their performance, physicians have a responsibility to maintain their health and wellness, broadly construed as preventing or treating acute or chronic diseases, including mental illness, disabilities, and occupational stress.

To fulfill this responsibility individually, physicians should:

- (a) Maintain their own health and wellness by:
 - (i) following healthy lifestyle habits;
 - (ii) ensuring that they have a personal physician whose objectivity is not compromised.
- (b) Take appropriate action when their health or wellness is compromised, including:
 - (i) engaging in honest assessment of their ability to continue practicing safely;
 - (ii) taking measures to mitigate the problem;
 - (iii) taking appropriate measures to protect patients, including measures to minimize the risk of transmitting infectious disease commensurate with the seriousness of the disease;
 - (iv) seeking appropriate help as needed, including help in addressing substance abuse. Physicians should not practice if their ability to do so safely is impaired by use of a controlled substance, alcohol, other chemical agent or a health condition.

Collectively, physicians have an obligation to ensure that colleagues are able to provide safe and effective care, which includes promoting health and wellness among physicians.

AMA Principles of Medical Ethics: I, II, IV

Background report(s):

CEJA Report 5-I-03 Physician health and wellness

CEJA Report 4-A-99 Amend physicians with infectious disease

CEJA Opinions I-86 Substance use

3. When physicians participate in solicitation efforts as members of the general community, they should seek to minimize perceptions of overlap with their professional role, for example by not soliciting patients only, and avoiding the use of professional letterhead or business cards.

Finally, with regard to possible conflict of interests, physicians should ensure that solicitation efforts include disclosure of any benefits they derive. However, ultimately, physicians must provide treatment without regard to contributions.

(References pertaining to Report 4 of the Council on Ethical and Judicial Affairs are available from the Ethics Standards Group.)

5. PHYSICIAN HEALTH AND WELLNESS

HOUSE ACTION: RECOMMENDATIONS ADOPTED AND REMAINDER OF REPORT FILED

The World Health Organization defines health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.” This definition has existed since the 1940s, and despite criticism that it is overly inclusive and unattainable, there has been considerable progress toward more comprehensive health care in the United States over recent decades. This commitment to patients’ health, ideally, should serve as an impetus for the nation’s physicians to focus on their overall health.

Traditionally, problems of alcoholism, substance abuse, and related mental health concerns among physicians have received more sustained attention than other conditions. Unfortunately, these concerns often are expressed in terms of discipline to ensure the safety of patients, rather than in terms of treatments for the affected physicians. These conditions and the many other health-related conditions that may afflict medical professionals deserve thoughtful and compassionate care; certainly no less thoughtful and compassionate than the care we provide to our non-physicians patients.

Fortunately, physicians’ overall health may be receiving increased attention. Whether prompted by societal concern for health and wellness in general or by the reexamination of the medical environment that ensues from a culture of patient safety, there is growing awareness, for example, of the detrimental effects of excessive work hours and sleep deprivation that characterize the residency experience.

The Council on Ethical and Judicial Affairs believes it is important to develop ethics guidance in the area of physician health and wellness insofar as it affects physicians’ professional activities, including patient care and trust in the profession. Indeed, there is increasing evidence that a physician whose health or wellness is compromised risks providing substandard patient care. Efforts from organized medicine to promote and maintain health and wellness can be understood as upholding the goals of professionalism, as identified by the AMA’s Principles of Medical Ethics (Principles I, II, VIII).

Specifically, this report is intended to emphasize the continued need for forethought and sensitivity in addressing physicians’ health and wellness by fostering a culture committed to taking remedial steps at the first sign of deterioration. This requires mechanisms to identify when physicians are in need of assistance, as well as effective and appropriate methods of intervention. This report concerns itself primarily with practicing physicians. However, it must be acknowledged that medical professionals throughout the entire spectrum of their professional lives, beginning with medical education and training, are affected by health and wellness issues. Appropriate considerations and resources at each stage are important and necessary.

WHEN PHYSICIAN HEALTH AND WELLNESS ARE COMPROMISED--AN OVERVIEW

AMA Policy H-95.955, “Substance Abuse Among Physicians” (AMA Policy Database), has defined impairment as “any physical, mental or behavioral disorder that interferes with ability to engage safely in professional activities.” This definition recognizes that a range of conditions may impede physicians from practicing medicine with reasonable skills and safety. Physician welfare can also be compromised by mild conditions that escalate to become impairments. Finally, some environmental stressors may interfere with physician welfare. Although minimal

strains, such as an occasional sense of feeling overwhelmed, may constitute a simple inconvenience with an easy solution, they also can create problems by negatively affecting team functioning and patient care.

Disease Gradients and the Ability to Practice

Disease manifestations may interfere to varying degrees with physicians' ability to practice medicine. For this reason, determining whether a physician whose health is compromised should continue to be involved in patient care--in the present or future--is a complex endeavor.

Acute and chronic diseases have different implications according to severity and treatability, and their impact also may vary according to the nature of a physician's professional activities. For example, a physician suffering from the common cold generally could continue providing quality medical care using certain precautions, but should avoid patients whose immunity is critically compromised. More lethal infectious diseases, such as HIV, hepatitis C, or tuberculosis are far more complicated to address, especially for surgeons performing invasive procedures (See Opinion E-9.13). Cognitive difficulty and degenerative diseases, such as multiple sclerosis or Parkinson's disease, also could affect the practice of medicine, although some accommodations may enable physicians to prolong or maintain their practice without jeopardizing the safety of patients.

However, when a physician becomes impaired--that is affected by a condition that *interferes* with the ability to engage safely in professional activities--the physician and the physician's colleagues have a responsibility to take action to avoid harm to patients, the physician, and the medical profession. Foremost, this requires timely intervention to ensure that the physician ceases practicing -- whether temporarily or permanently.

Physician Health Programs

Those health programs that are geared toward physicians were established for the purpose of ensuring the personal health of physicians and protecting the public by providing support and avoiding punitive measures. They help coordinate intervention services, conduct screening assessments, make appropriate referrals for comprehensive assessment and treatment, provide case management services for those with chronic problems, and encourage a collegial, supportive environment. Moreover, they help promote physicians' overall health and wellness as a priority for the profession.

Physicians are encouraged to seek guidance from these programs at the earliest sign of need. To encourage utilization, help should be provided through a system that remains separate albeit appreciated by state licensing authorities.

Occupational Stressors in Medicine

Various factors have been identified as occupational stressors that occur among physicians, regardless of specialty or training. One area that has received particular attention is sleep deprivation, which can be more incapacitating than a high alcohol blood level, as recent studies have demonstrated. Recently, new rules limit the number of hours residency programs can require residents to work. However, "moonlighting" (residents' independent practice of medicine during off-work hours) remains a common practice, raising the same concerns of impairment from lack of sleep. Sleep deprivation also is particularly prominent among transplant and trauma surgeons who frequently may be required to continue working well beyond reasonable hours.

In addition to the challenges of their environmental stressors, physicians often experience psychological factors that lead to feeling overwhelmed or burned out. Some physicians may experience depression or turn to addictive substances for relief.

The implications of all these factors must be taken seriously in light of recent findings that decreased physician wellness is linked to serious consequences for patient care and negatively impacts prescribing habits, test ordering, patient compliance, and patient satisfaction with medical care. Whenever they can, individual physicians should be attentive to their practices and modify their work environment to eliminate or reduce stressors so as to enhance their wellness. Coping mechanisms such as stress management, family support, recreation, hobbies, or participation in support groups are among possible resources that may help physicians prevent fatigue, stress, or burnout.

Current Ethical Guidance

The *Code of Medical Ethics* acknowledges that some form of intervention--reporting to appropriate bodies and/or disciplinary sanctions in extreme cases--may be required in the face of a physician who is impaired, incompetent, or behaving unethically (Opinion E-9.031). The requirement is grounded in physicians' responsibility to self-regulate (professionalism). The *Code* also identifies as unethical the behavior of physicians who practice under the influence of controlled substances, alcohol, or any other agents that likely would interfere with the safe and effective practice of medicine (Opinion E-8.15).

With this report, CEJA wishes to promote overall physician health and wellness, while continuing to recognize that effective skills and patient safety are an absolute requirement in the practice of medicine. Understanding that impaired physicians cannot be allowed to engage in regular patient care, it behooves the profession to support such physicians so that hopefully they can recover and return to productive medical service.

PHYSICIANS WHO LACK ADEQUATE HEALTH AND WELLNESS

Individual Physicians' Obligations

When their health or wellness is compromised, individual physicians should engage in honest self-assessment of their ability to continue practicing and seek appropriate help and/or take suitable corrective measures (such as modifying their work environment). In many instances, adequate support will enable a physician to continue caring for patients--for example, at times of high stress, the opportunity to discuss the pressure or anxiety with peers may offer a sufficient outlet. Under other circumstances, physicians may need to cease their activities for the short term only--for example, an exhausted physician may require sleep before again being able to provide effective and safe care. In the face of impairment, physicians may need to undergo a more lengthy period of rehabilitation, during which their activities are temporarily or permanently interrupted.

While there is nascent research on the issue, more information is needed on what keeps physicians feeling well. Certainly, physicians can benefit from healthy living habits they recommend to their patients, from coping mechanisms and reliable support networks, as already discussed, to proactive attempts to modify their work environment, or lessen, if not eliminate, environmental stress.

In addition, physicians should be encouraged to select a personal physician who can perform regular check-ups to monitor health as well as serve in the face of illness. Indeed, the *Code of Medical Ethics* cautions that individual physicians generally lack the objectivity to engage in self-treatment or self-medication. Therefore, establishing a healing relationship with a physician whose objectivity is not compromised by factors such as shared income or referral relationships can be a significant step toward maintaining good health.

Some organizational factors that negatively impact physician wellness may not be within physician control. As a key component of quality, hospitals and other institutions in which physicians practice also should be concerned with staff health and wellness.

Obligations of the Medical Profession

Beyond individual members' responsibility to look after their personal health and wellness, the medical profession has an obligation to ensure that its members are able to provide safe and effective medical care. This obligation translates into different requirements: (1) to promote health and wellness among physicians, (2) to establish appropriate mechanisms to detect impairment, (3) to intervene in a supportive fashion, and (4) to refer and/or report impairment if necessary.

The effectiveness of the medical profession in identifying and intervening on behalf of its members in need of help has been limited by a reluctance to confront colleagues and refer them to appropriate resources. A possible explanation for this shortcoming is concern that a colleague, once identified as needing help, will incur licensure actions, shame, or stigmatization. Also, physicians may have a reluctance to think of themselves and members of their profession as needing help with health related matters. Finally, failure to intervene may be due to inadequate standards by which to identify signs of need, difficulty in ascertaining with confidence that a colleague is experiencing serious problems, and lack of familiarity with available resources that can offer supportive interventions.

However, the medical profession has developed considerable expertise through independent medical examinations in evaluating whether any type of employee (physician or not) has a condition that interferes with the capability to fulfill certain job responsibilities. Such occupational health assessment expertise must be expanded so that physicians become better able to evaluate whether a colleague can continue performing professional activities.

A physician who notices that a colleague's health or wellness seems to be compromised could approach the colleague to discuss reasons for concern, and the value in seeking assistance, a day of rest, a visit to a personal physician, a medical evaluation, or even help from a physician health program. Encouragement of this sort also may help the colleague weigh whether it is reasonable to discontinue patient care temporarily. If the affected colleague takes no action while continuing to exhibit signs of physical or mental compromise, concerns should be directed to an appropriate body. In particular, referral to a hospital or state physician health program may be appropriate.

Recognizing the importance of health programs, a recent mandate of the Joint Commission on Accreditation of Health Care Organizations (JCAHO) requires all hospital medical staffs to have physician wellness committees or to work with already established physician health programs in the state. More specifically, it insists that "medical staffs implement a process to identify and manage matters of individual physician health that is separate from the medical staff disciplinary function." The responsibilities of wellness committees include educating medical staff about illness, impairment, and referral of impaired physicians to appropriate resources for diagnosis and treatment. According to the JCAHO mandate, physicians who are referred to wellness committees should be evaluated to assess the validity of the cause for referral. Furthermore, wellness committees should monitor affected physicians, as well as their patients' safety, until the intervention is complete, report physicians who are providing unsafe treatment, and otherwise maintain the confidentiality of impaired physicians, except as limited by law, ethical obligation, or threat to patient safety.

Similar to this institutional commitment to address physician wellness, the medical profession has an overall obligation to develop appropriate physician health programs, which provide a supportive environment to maintain and restore health and wellness, as is consistent with the effective and safe practice of medicine. Within these programs, impaired physicians may be required to temporarily suspend activities until they have recovered the ability to resume the practice of medicine. In some instances, physicians may no longer be able to provide patient care.

When an impaired physician continues to practice medicine despite colleagues' reasonable efforts to help, including through referral to a physician health program, the impaired physician should be reported to an appropriate body. This ethical duty, which can be understood as stemming from physicians' obligation to protect patients against harm, may entail reporting to the licensing authority. It is also worth noting that in some jurisdictions, physicians may have a legal obligation to report impaired colleagues.

THE PHYSICIAN AS PATIENT

Physician-Patients and their Patients

Physicians ethically are required to "deal honestly and openly with patients" at all times to enable patients "to make informed decisions regarding future medical care" (Opinion E-8.12). This is one justification behind a physician's duty to disclose any information concerning a patient's medical condition, including information related to physician acts that may have negatively affected a patient's medical condition.

However, mandatory disclosure by physicians of personal medical information to patients may significantly deter physicians from seeking care. Moreover, it has been argued that such disclosure would place patients in the inappropriate role of having to determine whether a physician is safe, when the determination is most appropriately the responsibility of the profession. As previously noted, an impaired physician should not be involved in patient care until he or she has recovered. If neither effectiveness nor safety is compromised, a physician's illness or disability need not be disclosed, but a physician may choose to do so in the event that the condition may impact the patient-physician relationship.

Caring for Physicians as Patients

Physicians caring for colleagues should not report any aspects of their physician-patients' medical condition except as required by law, ethical and professional obligation, or when the safety of patients is at risk. In addition,

physicians involved in the treatment of physician-patients should be sensitive to some of the unique needs of physicians as patients. Some may have difficulty accepting their diagnosis, especially when their professional life has been devoted to treating similar health problems. Denial or minimization of symptoms may undermine adequate treatment or control, as may self-medication, self-adjustment of dosages, or discontinuance of treatment.

In caring for themselves and their colleagues, physicians demonstrate a commitment to their professional responsibilities and strengthen public trust in the medical profession.

RECOMMENDATIONS

The Council on Ethical and Judicial Affairs recommends that the following be adopted and the remainder of this report be filed:

To preserve the quality of their performance, physicians have a responsibility to maintain their health and wellness, construed broadly as preventing or treating acute or chronic diseases, including mental illness, disabilities, and occupational stress. When health or wellness is compromised, so may the safety and effectiveness of the medical care provided. When failing physical or mental health reaches the point of interfering with a physician's ability to engage safely in professional activities, the physician is said to be impaired.

In addition to maintaining healthy lifestyle habits, every physician should have a personal physician whose objectivity is not compromised (e.g., through shared income or referral relationships). Physicians whose health or wellness is compromised should take measures to mitigate the problem, seek appropriate help as necessary, and engage in an honest self-assessment of their ability to continue practicing.

Those physicians caring for colleagues should not disclose without the physician-patient's consent any aspects of their medical care, except as required by law, by ethical and professional obligation (Opinion E-9.031), or when essential to protect patients from harm. Under such circumstances, only the minimum amount of information required by law or to preserve patient safety should be disclosed.

The medical profession has an obligation to ensure that its members are able to provide safe and effective care. This obligation is discharged by:

- promoting health and wellness among physicians;
- supporting peers in identifying physicians in need of help;
- intervening promptly when the health or wellness of a colleague appears to have become compromised, including the offer of encouragement, coverage or referral to a physician health program;
- establishing physician health programs that provide a supportive environment to maintain and restore health and wellness;
- establishing mechanisms to assure that impaired physicians promptly cease practice;
- assisting recovered colleagues when they resume patient care;
- reporting impaired physicians who continue to practice, despite reasonable offers of assistance, to appropriate bodies as required by law and/or ethical obligations. This may entail reporting to the licensing authority.

(References pertaining to Report 5 of the Council on Ethical and Judicial Affairs are available from the Ethics Standards Group. The Council gratefully acknowledges the following individuals for their contributions to this report: Roger Brown, PhD, Physician Health Program, AMA; Martin Doot, MD, Medical Director, Illinois Professionals Health Program; Jenny Firth-Cozens, BA, BSc, MSc, PhD, FBPsS, Special Adviser on Modernization of Postgraduate Education, London Deanery; Mamta Gautam, MD, FRCP(c), Founding Director, University of Ottawa faculty Wellness Program, Chair, Expert Advisory Group, Canadian Medical Association, Centre for Physician Health and Well-being; Cassie Kuo, Medical Student, Northwestern University; Susan V. McCall, MD, MPH, Medical Director, Oregon Health Professionals Program; Leonard J. Morse, MD, Commissioner, City of Worcester Department of Public Health; and Herbert Rakatansky, Clinical Professor of Medicine, Brown University.)

3. CONFLICTS OF INTEREST: BIOMEDICAL RESEARCH

HOUSE ACTION: FILED

At the 1998 Interim Meeting, the House of Delegates reviewed and approved the recommendations of CEJA Report 3-I-98. This report supports the requirement that disclosure of conflicts of interests should accompany published research so that readers are fully informed. This includes many kinds of publications, such as letters to the editor. The Council issues the following revision of Opinion 8.031 derived from the conclusions of CEJA Report 3-I-98. The Opinion will appear in the next revised edition of the Code of Medical Ethics:

8.031 Conflicts of Interest: Biomedical Research.

Avoidance of real or perceived conflicts of interest in clinical research is imperative if the medical community is to ensure objectivity and maintain individual and institutional integrity. All medical centers should develop specific guidelines for their clinical staff on conflicts of interest. These guidelines should include the following rules: (1) once a clinical investigator becomes involved in a research project for a company or knows that he or she might become involved, she or he, as an individual, cannot ethically buy or sell the company's stock until the involvement ends and the results of the research are published or otherwise disseminated to the public; (2) any remuneration received by the researcher from the company whose product is being studied must be commensurate with the efforts of the researcher on behalf of the company; (3) clinical investigators should disclose any material ties to companies whose products they are investigating including: financial ties, participation in educational activities supported by the companies, participation in other research projects funded by the companies, consulting arrangements, and any other ties. The disclosures should be made in writing to the medical center where the research is conducted, organizations that are funding the research, and journals that publish the results of the research. An explanatory statement that discloses conflicts of interest should accompany all published research. Other types of publications, such as a letters to the editor, should also include an explanatory statement that discloses any potential conflict of interest.

In addition, medical centers should form review committees to examine disclosures by clinical staff about financial associations with commercial corporations.

4. PHYSICIANS AND INFECTIOUS DISEASES

HOUSE ACTION: FILED

INTRODUCTION

In December 1998, CSA Report 10 (I-98), "Bloodborne Pathogen Transmission To and From Health Care Workers," was adopted. Recommendation 1 of this report requested:

That the AMA use the terminology "significant risk" in AMA policies, correspondences, and official actions when indicating the threshold of risk that is appropriate for restrictions on medical practice of physicians infected with bloodborne pathogens that can be transmitted to patients;

The Council on Ethical and Judicial Affairs has decided to amend current Opinion 9.13, "Physicians and Infectious Diseases," to be consistent with this recommendation.

OPINION

The following text will appear in the next edition of the Code of Medical Ethics and the Policy Compendium:

9.13 Physicians and Infectious Diseases.

A physician who knows that he or she has an infectious disease, which if contracted by the patient would pose a significant risk to the patient, should not engage in any activity that creates an identified significant risk of transmission of that disease to the patient. The precautions taken to prevent the transmission of a contagious disease to a patient should be appropriate to the seriousness of the disease and must be particularly stringent in the case of a disease that is potentially fatal.

5. HIV-INFECTED PATIENTS AND PHYSICIANS

HOUSE ACTION: FILED

INTRODUCTION

In December 1998, CSA Report 10 (I-98), "Bloodborne Pathogen Transmission To and From Health Care Workers," was adopted. Recommendation 1 of this report requested

That the AMA use the terminology "significant risk" in AMA policies, correspondences, and official actions when indicating the threshold of risk that is appropriate for restrictions on medical practice of physicians infected with bloodborne pathogens that can be transmitted to patients;

The Council on Ethical and Judicial Affairs has decided to amend current Opinion 9.131, "HIV-Infected Patients and Physicians," to be consistent with this recommendation.

OPINION

The following text will appear in the next edition of the Code of Medical Ethics and the Policy Compendium:

9.131 HIV-Infected Patients and Physicians.

A physician may not ethically refuse to treat a patient whose condition is within the physician's current realm of competence solely because the patient is seropositive for HIV. Persons who are seropositive should not be subjected to discrimination based on fear or prejudice.

When physicians are unable to provide the services required by an HIV-infected patient, they should make appropriate referrals to those physicians or facilities equipped to provide such services.

A physician who knows that he or she is seropositive should not engage in any activity that creates an identified significant risk of transmission of the disease to others. A physician who has HIV disease or who is seropositive should consult colleagues as to which activities the physician can pursue without creating a risk to patients.

**C. RECENT OPINIONS OF THE COUNCIL ON
ETHICAL AND JUDICIAL AFFAIRS**
(Reference Committee on Amendments to Constitution and Bylaws, page 424)

HOUSE ACTION: FILED

The Council on Ethical and Judicial Affairs submits the following opinions to the House of Delegates for its information and recommends that this report be filed.

SEXUAL MISCONDUCT IN THE PRACTICE OF MEDICINE. Sexual misconduct in the practice of medicine violates the trust the patient reposes in the physician and is unethical.

SUBSTANCE ABUSE. It is unethical for a physician to practice medicine while under the influence of a controlled substance, alcohol or other chemical agents which impair his ability to practice medicine.

PHYSICIAN IMPAIRMENT. In order to protect patients and the public, physicians have the responsibility to report to the appropriate body credible evidence of a colleague's impairment that may affect competence. Such impairment may result from abuse of drugs or alcohol, or from mental or physical illness. All physicians have an obligation to urge impaired colleagues to seek treatment.

D. AFFILIATE MEMBERS

HOUSE ACTION: ADOPTED

The Council on Ethical and Judicial Affairs recommends the following individuals for Affiliate Membership in the American Medical Association:

NATIONAL MEDICAL SOCIETIES

Anthony R. Laws, M. D.
Canada

U. S. PHYSICIANS IN FOREIGN COUNTRIES

Ronald P. Baker, M. D.
Sierra Leone

**INDIVIDUALS WHO HAVE ATTAINED DISTINCTION
IN THEIR FIELDS OF ENDEAVOR**

Thomas J. Carroll
Chicago, Illinois