AMA *Code of Medical Ethics*

9.3.2 Physician Responsibilities to Colleagues with Illness, Disability or Impairment

Providing safe, high-quality care is fundamental to physicians' fiduciary obligation to promote patient welfare. Yet a variety of physical and mental health conditions—including physical disability, medical illness, and substance use—can undermine physicians' ability to fulfill that obligation. These conditions in turn can put patients at risk, compromise physicians' relationships with patients, as well as colleagues, and undermine public trust in the profession.

While some conditions may render it impossible for a physician to provide care safely, with appropriate accommodations or treatment many can responsibly continue to practice, or resume practice once those needs have been met. In carrying out their responsibilities to colleagues, patients, and the public, physicians should strive to employ a process that distinguishes conditions that are permanently incompatible with the safe practice of medicine from those that are not and respond accordingly.

As individuals, physicians should:

(a) Maintain their own physical and mental health, strive for self-awareness, and promote recognition of and resources to address conditions that may cause impairment.

(b) Seek assistance as needed when continuing to practice is unsafe for patients, in keeping with ethics guidance on physician health and competence.

(c) Intervene with respect and compassion when a colleague is not able to practice safely. Such intervention should strive to ensure that the colleague is no longer endangering patients and that the individual receive appropriate evaluation and care to treat any impairing conditions.

(d) Protect the interests of patients by promoting appropriate interventions when a colleague continues to provide unsafe care despite efforts to dissuade them from practice.

(e) Seek assistance when intervening, in keeping with institutional policies, regulatory requirements, or applicable law.

Collectively, physicians should nurture a respectful, supportive professional culture by:

(f) Encouraging the development of practice environments that promote collegial mutual support in the interest of patient safety.

(g) Encouraging development of inclusive training standards that enable individuals with disabilities to enter the profession and have safe, successful careers.

(h) Eliminating stigma within the profession regarding illness and disability.

(i) Advocating for supportive services, including physician health programs, and accommodations to enable physicians and physicians-in-training who require assistance to provide safe, effective care.

(j) Advocating for respectful and supportive, evidence-based peer review policies and practices to ensure fair, objective, and independent assessment of potential impairment whenever and by whomever assessment is deemed appropriate to ensure patient safety and practice competency.

Opinion 9.3.2 Physician Responsibilities to Colleagues with Illness, Disability or Impairment, re-organizes content from several previous opinions and associated background reports:

CEJA Report 3-A-22 Amendment to E-9.3.2, Physician responsibilities to colleagues with illness, disability or impairment

CEJA Report 3-Jun 21 Amendment to Opinion E-9.3.2, Physician responsibilities to impaired colleagues

CEJA Report 3-A-16 Modernized *Code of Medical Ethics*

CEJA Report 5-I-03 Physician health and wellness

CEJA Report 1-I-91 Reporting Impaired, Incompetent or Unethical Colleagues

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 03-A-22

Subject:	Amendment to E-9.3.2, "Physician Responsibilities to Colleagues with Illness, Disability or Impairment"
Presented by:	Alexander M. Rosenau, DO, Chair
Referred to:	Reference Committee on Amendments to Constitution and Bylaws

INTRODUCTION

At the November 2021 Special Meeting, the American Medical Association House of Delegates adopted Policy D-140.952, "AMA Council on Ethical and Judicial Affairs Report on Physician Responsibilities to Impaired Colleagues," asking the Council to consider specific amendments to guidance adopted by the House at its June 2021 Special Meeting as follows:

(i) Advocating for supportive services, including physician health programs, and accommodations to enable physicians and physicians-in-training who require assistance to provide safe, effective care.

with additional guidance

(k) Advocating for fair, objective, external, and independent evaluations for physicians when a review is requested or required to assess a potential impairment and its duration by an employer, academic medical center, or hospital/health system where said physician has clinical privileges or where said physician-in training is placed for a clinical rotations.

The Council thanks the House for offering these clarifications and fully concurs with the importance of ensuring fair assessment of any potential impairment.

RECOMMENDATION

The Council believes that a more general formulation that did not delineate specific actors would better emphasize the importance of fairness whenever and by whomever such assessment is sought and would help ensure that guidance remains evergreen. The Council therefore proposes to amend Opinion 9.3.2, "Physician Responsibilities to Colleagues with Illness, Disability or Impairment," by insertion as follows:

Providing safe, high-quality care is fundamental to physicians' fiduciary obligation to promote patient welfare. Yet a variety of physical and mental health conditions—including physical disability, medical illness, and substance use—can undermine physicians' ability to fulfill that

* *Reports of the Council on Ethical and Judicial Affairs are assigned to the Reference Committee on Amendments to Constitution and Bylaws. They may be adopted, not adopted, or referred. A report may not be amended, except to clarify the meaning of the report and only with the concurrence of the Council.

obligation. These conditions in turn can put patients at risk, compromise physicians' relationships with patients, as well as colleagues, and undermine public trust in the profession. While some conditions may render it impossible for a physician to provide care safely, with appropriate accommodations or treatment many can responsibly continue to practice, or resume practice once those needs have been met. In carrying out their responsibilities to colleagues, patients, and the public, physicians should strive to employ a process that distinguishes conditions that are permanently incompatible with the safe practice of medicine from those that are not and respond accordingly.

As individuals, physicians should:

(a) Maintain their own physical and mental health, strive for self-awareness, and promote recognition of and resources to address conditions that may cause impairment.

(b) Seek assistance as needed when continuing to practice is unsafe for patients, in keeping with ethics guidance on physician health and competence.

(c) Intervene with respect and compassion when a colleague is not able to practice safely. Such intervention should strive to ensure that the colleague is no longer endangering patients and that the individual receive appropriate evaluation and care to treat any impairing conditions.

(d) Protect the interests of patients by promoting appropriate interventions when a colleague continues to provide unsafe care despite efforts to dissuade them from practice.

(e) Seek assistance when intervening, in keeping with institutional policies, regulatory requirements, or applicable law.

Collectively, physicians should nurture a respectful, supportive professional culture by:

(f) Encouraging the development of practice environments that promote collegial mutual support in the interest of patient safety.

(g) Encouraging development of inclusive training standards that enable individuals with disabilities to enter the profession and have safe, successful careers.

(h) Eliminating stigma within the profession regarding illness and disability.

(i) Advocating for supportive services, including physician health programs, and accommodations to enable physicians and physicians-in-training who require assistance to provide safe, effective care.

(j) Advocating for respectful and supportive, evidence-based peer review policies and practices to ensure fair, objective, and independent assessment of potential impairment whenever and by whomever assessment is deemed appropriate to~~that will~~ ensure patient safety and practice competency. (II)

(Modify HOD/CEJA Policy)

Fiscal Note: Less than $500

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 03-JUN-21

Subject:	Amendment to Opinion E-9.3.2, "Physician Responsibilities to Impaired Colleagues"
Presented by:	Monique A. Spillman, MD, Chair
Referred to:	Reference Committee on Amendments to Constitution and Bylaws

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In conjunction with the adoption of the modernized *Code of Medical Ethics* by the American Medical Association House of Delegates in June 2016, several stakeholders raised concerns that the Council on Ethical and Judicial Affairs' (CEJA) guidance does not clearly distinguish being impaired from having a disability; does not acknowledge that not all illness or disability leads to impairment; and does not clearly address the fact that appropriate rehabilitation or accommodation can enable physicians who are impaired or who have a disability to practice safely.

The following report updates AMA ethics guidance to address these issues.

ILLNESS, DISABILITY & IMPAIRMENT

Opinion 9.3.2 defines impairment as "[p]hysical or mental health conditions that interfere with a physician's ability to engage safely in professional activities..." The fact that a physician has a physical or mental health condition does not necessarily entail that the individual is also impaired. As the Federation of State Medical Boards (FSMB) has noted, "impairment is a functional classification" and that "the diagnosis of an illness does not equate with impairment" [1].This distinction is fundamental to the goals of destigmatizing the conditions that can cause impairment and supporting physicians who become ill or have a disability but are nonetheless capable of safe and effective practice.

Disability leading to impairment has a broad range of meaning as it relates to the ability to practice medicine safely. A variety of physical and mental health conditions (including substance use or conditions related to aging), may result in cognitive or physical changes that can interfere with ability to practice safely. Among physicians, substance use disorder can also be a significant cause of impairment, with some studies showing rates as high as 21% [2]. And while physicians suffer many acute and chronic illness at similar rates to the general public, some illnesses, such as depression, occur with greater prevalence--medical residents, for example, experience depression at a rate of 15-30% compared to 7-8% in the general public [2]. Subtle changes in cognition or motor skills such as those associated with aging are difficult to identify and challenging to interpret with respect to their effect on ability to practice competently and safely. By contrast, sensory or physical disability (blindness, deafness, paraplegia) are often readily identifiable but do not necessarily impair safe practice in selected fields of medicine [1].

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Screening and testing can be important for identifying physicians whose ability to practice at accepted professional standards is compromised by illness or disability. Some experts recommend a multi-pronged approach: mandatory testing before employment, random drug testing, evaluations after a sentinel event like a patient death or medical error, and establishment of uniform, national standards to encourage consistency across jurisdictions [3].

However, testing is not without its own challenges. For example, a seemingly straightforward drug test can produce false positive results in response to a legitimate or prescribed substance, and if handled improperly could "destroy a career" [3]. Further, not all testing produces a definitive result. Tests of cognitive or physical capacity may provide some data, but leave important questions unanswered, such as "When does 'decline' become 'impairment'? And when does 'impairment' compromise safety?" [4]. Because impairment is a function of the nature of a physician's practice, test results must be interpreted in context [5]. Screening and/or testing must be fair and thoughtfully implemented to avoid discrimination. Testing should also balance the need to detect impairment with physicians' rights to privacy, autonomy, and due process [3].

RESPONDING TO IMPAIRMENT

Physicians' fiduciary obligation to patients encompasses responsibilities to maintain their own physical and mental health [Opinion 9.3.1], to cultivate self-awareness as a dimension of professional competence [Opinion 8.13], and a responsibility to respond when they believe a colleague is impaired to the extent patients are at risk, in keeping with the profession's overarching duty of self-regulation. These obligations are grounded in the principle that physicians "uphold standards of professionalism" in part by responding to other physicians who are "deficient in character or competence" [Principle II].

Seeking & Offering Assistance

Physicians' responsibility for self-awareness requires that they be sensitive to factors that affect their ability to provide appropriate care, one of which is their own health status. When they become aware that a physical or mental health condition may be interfering with their ability to provide sound patient care, they have a responsibility to address the problem, by consulting their personal physician or seeking other assistance. As CEJA has noted elsewhere,

> Physicians' ability to be sufficiently self-aware to practice safely can be compromised by illness, of course. In some circumstances, self-awareness may be impaired to the point that individuals are not aware of, or deny, their own health status and the adverse effects it can or is having on their practice. In such circumstances, individuals must rely on others—their personal physician, colleagues, family, social acquaintances, or even patients—to help them recognize and address the situation [CEJA Report 1-I-19].

Physicians are professionally responsible to one another and thus have an obligation to respond when a colleague appears to be unable to practice safely. They should intervene with respect and compassion to ensure, first, that the individual no longer endangers patients, and second, that the individual receives appropriate evaluation and care to treat any impairing condition.

Intervention

Ultimately, physicians have an ethical duty to act when colleagues continue to practice unsafely despite efforts to dissuade them, including reporting where appropriate and needed. This responsibility derives from the obligation of self-regulation, a central element of the medical

profession's contract with society to establish and uphold standards of competence and conduct for safe, ethical and effective patient care" [6] In some situations, physicians may have a legal duty to report colleagues whom they believe may be impaired [7].

A host of factors can complicate the duty to report, including not only uncertainty about whether impairment is actually present, but also denial, stigmatization, concerns about practice coverage, and fear of retaliation (especially when reporting a superior) [7]. Health care institutions and state medical boards should offer education and training to help physicians be more effective and comfortable with detecting impairment in the workplace. Fostering an environment where physicians know what to look for and feel comfortable reporting helps protect the well-being of all parties involved. Early detection mitigates harm by catching an impairment before it worsens and creates a less safe practice environment over time [4].

ACCOMMODATING DISABILITY

The 1990 Americans with Disabilities Act (ADA) ushered in a new era of legal protections and rights for people with disabilities, and its impact in creating opportunity and support is felt in health care as elsewhere. An increasing number of physicians with disabilities who are practicing medicine today represent the "ADA generation," individuals who, prior to the legal protections afforded by the ADA, would have been deterred from pursuing a career in medicine [8].

While accommodations that provide physicians with disabilities the opportunity to practice medicine help to ensure a more safe and equitable practice environment for physicians with disabilities, such accommodations also offer benefits more broadly to the patients they serve and by extension can strengthen the patient-physician relationship. Experts recognize that concordance between patients and physicians with disability is key in enhancing quality of care, noting that "increasing the number of physicians who actively identify as having a disability and who require accommodations to practice could improve health care experiences and outcomes for patients with disabilities", as they are better able to "provide patient-centered care" with greater empathy [9, 10]. Removing barriers to practice, when and where they are unnecessary, is ethically required and promotes a more just and diverse workforce [11]. Diversity is essential to combating bias and building empathy; as Ouellette succinctly notes: "one way to counter bias against outsiders [disabled patients] is to make them insiders [physicians]" [10].

Removing barriers should extend to those who seek to enter the profession as well. Technical standards—criteria for medical school admission that require applicants to "demonstrate certain physical, cognitive, behavioral, and sensory abilities without assistance" (emphasis added) [12], create a fundamental barrier for prospective medical students. Experts argue that medical schools should adjust their technical standards from an approach that focuses on students' limitations to a functional approach that focuses on "students' abilities with or without the use of accommodations or assistive technologies" [12] Making such an adjustment is a fundamental step to creating a more inclusive medical profession to the benefit of all. Though there is much work still to be done, the available data suggest that individuals with disability are increasingly successful in becoming educated and trained in medicine. More physicians with disability now enjoy successful careers in medicine [8,13]. Barriers to practice are often "attitudinal or cultural in nature," not barriers born from a valid foundation of safe medical practice [13].

RETURN TO SAFE PRACTICE

Physicians who have undergone successful treatment for an impairing condition or received an accommodation that enables the physician to practice safely should have the right and the

opportunity to practice medicine again. Data has demonstrated, that with proper treatment and help, physicians can successfully recover and return to practice [7,14].

A 2013 report by the FSMB offered guidance for state boards and physician health programs regarding re-entry to practice by impaired physicians [15]. Those recommendations provide for:

- Case by case review informed by FSMB's Policy on Physician Impairment,
- A re-entry plan modeled on the 2012 FSMB guide on re-entry that addressed matters of timing of re-entry, barriers, and common terminology [16].

CONCLUSION

Physician impairment can be the result of any illness or condition - physical or mental. In the interest of patient safety and to meet the profession's ethical obligation of self-regulation, it is important for physicians to be self-aware and sensitive to pressures of training and practice environments and be prepared to respond when signs of impairment are observed, both in themselves and their colleagues. Impaired physicians should receive the intervention and treatment needed and be given the opportunity to rehabilitate and reenter practice safely. Physicians should also be mindful that not all disability and illness cause impairment.

Society, health care systems, educational and training institutions, and practice environments must continue, where possible, to accommodate the needs of all physicians, including those with identified illness and disability. Medical schools should be encouraged to have technical standards that allow for students with non-impairing disabilities to enter the profession. Society and the profession must also have effective mechanisms in place to recognize and respond to physician impairment, in the interest of patient safety and meeting the needs to colleagues who can and want to be rehabilitated and reenter practice. The goal should be that with appropriate care or accommodations a physician will ultimately be able to return to practice safely and effectively, if possible.

RECOMMENDATION

The Council on Ethical and Judicial Affairs Recommends that Opinion 9.3.2, "Physician Responsibilities to Impaired Colleagues," be retitled as "Physician Responsibilities to Colleagues with Illness, Disability or Impairment" and amended by substitution as follows; and the remainder of this report be filed:

> Providing safe, high quality care is fundamental to physicians' fiduciary obligation to promote patient welfare. Yet a variety of physical and mental health conditions—including physical disability, medical illness, and substance use—can undermine physicians' ability to fulfill that obligation. These conditions in turn can put patients at risk, compromise physicians' relationships with patients, as well as colleagues, and undermine public trust in the profession.
>
> While some conditions may render it impossible for a physician to provide care safely, with appropriate accommodations or treatment many can responsibly continue to practice, or resume practice once those needs have been met. In carrying out their responsibilities to colleagues, patients, and the public, physicians should strive to employ a process that distinguishes conditions that are permanently incompatible with the safe practice of medicine from those that are not and respond accordingly.

As individuals, physicians should:

(a) Maintain their own physical and mental health, strive for self-awareness, and promote recognition of and resources to address conditions that may cause impairment.

(b) Seek assistance as needed when continuing to practice is unsafe for patients, in keeping with ethics guidance on physician health and competence.

(c) Intervene with respect and compassion when a colleague is not able to practice safely. Such intervention should strive to ensure that the colleague is no longer endangering patients and that the individual receive appropriate evaluation and care to treat any impairing conditions.

(d) Protect the interests of patients by promoting appropriate interventions when a colleague continues to provide unsafe care despite efforts to dissuade them from practice.

(e) Seek assistance when intervening, in keeping with institutional policies, regulatory requirements, or applicable law.

Collectively, physicians should nurture a respectful, supportive professional culture by:

(f) Encouraging the development of practice environments that promote collegial mutual support in the interest of patient safety.

(g) Encouraging development of inclusive training standards that enable individuals with disabilities to enter the profession and have safe, successful careers.

(h) Eliminating stigma within the profession regarding illness and disability.

(i) Advocating for supportive services and accommodations to enable physicians who require assistance to provide safe, effective care.

(j) Advocating for respectful and supportive, evidence-based peer review policies and practices that will ensure patient safety and practice competency.

Modify HOD/CEJA policy

Fiscal Note: Less than $500

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9.3.2 Physician Responsibilities to Impaired Colleagues

Physical or mental health conditions that interfere with a physician's ability to engage safely in professional activities *can put patients at risk, compromise professional relationships, and undermine trust in medicine.* While protecting patients' well-being must always be the primary consideration, physicians who are impaired are deserving of thoughtful, compassionate care. *[new content sets out key ethical values and concerns explicitly]*

To protect patient interests and ensure that their colleagues receive appropriate care and assistance, individually physicians have an ethical obligation to:

(a) Intervene in a timely manner to ensure that impaired colleagues cease practicing and receive appropriate assistance from a physician health program.

(b) Report impaired colleagues in keeping with ethical guidelines and applicable law.

(c) Assist recovered colleagues when they resume patient care.

Collectively, physicians have an obligation to ensure that their colleagues are able to provide safe and effective care. This obligation is discharged by:

(d) Promoting health and wellness among physicians.

(e) Establishing mechanisms to assure that impaired physicians promptly cease practice.

(f) Supporting peers in identifying physicians in need of help.

(g) Establishing or supporting physician health programs that provide a supportive environment to maintain and restore health and wellness.

AMA Principles of Medical Ethics: II

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 5 - I-03

Subject: Physician Health and Wellness

Presented by: Michael S. Goldrich, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws (Susan L. Polk, MD, Chair)

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."[1] 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.[2] 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-physician 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 (CEJA) 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.[3] 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).[4]

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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 House policy, H-95.955 (AMA PolicyFinder Database), "Substance Abuse Among Physicians," has defined impairment as "any physical, mental or behavioral disorder that interferes with ability to engage safely in professional activities."[5] 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).[6] 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.[7,8] 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.[9] Recently, new rules limit the number of hours residency programs can require residents to work.[10] 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.[11] 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.[12, 13, 14] 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.[8]

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).[15] 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).[16]

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.[17] 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.[12]

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.[18] 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.[8]

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: (i) to promote health and wellness among physicians, (ii) to establish appropriate mechanisms to detect impairment, (iii) to intervene in a supportive fashion, and (iv) 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.[19] 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.[20]

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).[21] 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.[22] 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.[11]

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 the 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. 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. (New HOD/CEJA Policy)

References are available from the Ethics Standards Group.

Fiscal Note: less than $500.00

The Council gratefully acknowledges the following individuals for their contributions to this Report:

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CEJA Report A – I-91
Reporting Impaired, Incompetent or Unethical Colleagues

INTRODUCTION

At the 1991 Annual meeting of the House of Delegates, Report C of the Council on Ethical and Judicial Affairs, regarding the reporting of impaired, incompetent, or unethical colleagues, was referred to the Council for further examination. The Council has reviewed the issue and issues the following report.

The medical profession has a long tradition of self-regulation. This tradition is based, at least in part, on the unique qualifications physicians possess, by virtue of their specialized knowledge and skills, to evaluate the clinical performance of their colleagues. The tradition of self-regulation in medicine also is based on the enduring commitment of physicians to safeguard the welfare and trust of the public, regardless of their personal interests or concerns.

Society generally has honored the right of professions to regulate the conduct of their members, provided the efforts employed for this purpose are effective in protecting members of society and promoting the public welfare. However, when the public perceives that appropriate initiative has not been displayed by members of a profession in promoting ethical standards or in safeguarding the public from abuse, the perceived deficiencies tend to be remedied through enhanced external control.

Despite a lengthy tradition of self-governance, the medical profession frequently has been a target of public criticism for its perceived failure to adequately identify and discipline impaired, incompetent, and unethical physicians. A public opinion survey conducted by the American Medical Association, (AMA), in 1988 revealed that 60% of respondents believe the medical profession is doing only a fair to poor job of policing its ranks and confronting physician impairment.[1] The profession has been accused of inappropriately protecting the careers and reputations of colleagues at the expense of the health and well-being of the public. Such practices, whether by many or by few, are contrary to the ethical principles which serve as the basis for medical practice and must not be tolerated by the profession.

DUTY TO REPORT: HISTORICAL ASPECTS

The ethical standards of the medical profession have required, for nearly 200 years, that physicians report to appropriate authorities potentially injurious conduct by colleagues. In 1803, an English physician and philosopher, Thomas Percival, published a treatise entitled "Medical Ethics; or a Code of Institutes and Precepts, adapted to the Professional Conduct of Physicians and Surgeons." This historic publication, which served as the basis for the American Medical Association's first code of ethics in 1847, was perhaps the most significant document since the Oath of Hippocrates in the filth century B.C. to establish standards of professional conduct for physicians and surgeons. Although Percival's code admonished physicians not to reveal to patients information or occurrences that may tend to injure the reputation of a colleague, the code also contained the following provision:

> [T]hough the character of a professional busybody, whether from thoughtlessness or craft, is highly reprehensible, there are occasions which not only justify but require a spirited interposition. When artful ignorance grossly imposes on credulity; when neglect puts to hazard an important life; or rashness threatens it with still more imminent danger; a medical neighbor, friend, or relative, apprized [sic] of such facts, will justly regard his interference as a duty.[2]

The obligation of physicians to report inappropriate conduct by colleagues was strengthened considerably in 1912, when the AMA's Principles of Medical Ethics were revised. The revised code of ethics stated, in

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part, that physicians "should expose without fear or favor, before the proper medical or legal tribunals, corrupt or dishonest conduct of members of the profession."

This ethical duty has been preserved for nearly a century despite numerous changes In the medical profession's standards of ethical conduct. In 1972, for example, the AMA Council on Mental Health issued a report on physician impairment,[3] in which it was noted that every physician has an ethical responsibility to recognize impairment or incompetence in colleagues and to provide appropriate counsel with respect to obtaining treatment and curtailing or suspending the practice of medicine. Today, the Principles of Medical Ethics of the AMA state that physicians must "strive to expose those physicians deficient in character or competence, or who engage in fraud or deception." In addition, the fundamental duty of physicians to report inappropriate conduct by colleagues has been reinforced by the Council on Ethical and Judicial Affairs of the AMA, through an ethical opinion on Discipline and Medicine:

> Discipline and Medicine. Incompetence, corruption or dishonest or unethical conduct on the part of members of the medical profession is reprehensible. In addition to posing a real or potential threat to patients, such conduct undermines the public's confidence in the profession. A physician should expose, without fear or favor, incompetent or corrupt, dishonest or unethical conduct on the part of members of the profession. (Section 9.04, *Current opinions of the Council on Ethical and Judicial Affairs of the American Medical Association)*[4]

REPORTING RESPONSIBILITIES MANDATED BY LAW

The duty of physicians to report conduct that may be injurious to patients has been incorporated not only into the code of ethics of the medical profession, but also, in one form or another, into the laws of numerous jurisdictions. Physicians in many states are obligated by law to report to the licensing board the conduct of any colleague who may be impaired, incompetent, or unethical. Failure to do so is grounds in such states for disciplinary action. In Minnesota, for example, three physicians were reprimanded and fined in 1987 by the state board of medical examiners for their failure to re- port the chemical dependency of a member of their group medical practice.[5,6] The penalties were imposed despite actions by the partners to enroll their colleague in a treatment program for impaired physicians and to prevent him from practicing medicine while under the influence of chemical substances. In some jurisdictions, physicians who fail to comply with reporting requirements not only are subject to disciplinary action, but also are liable for injuries sustained by patients as a result of any inappropriate treatment rendered by colleagues known to be impaired or incompetent.[7] Reporting also may be required of hospitals, professional liability insurers, court officials, medical societies, and other licensed professionals.

Despite the widespread adoption by states of mandatory reporting laws, few complaints against physicians are received from hospitals and physicians. In New York, for example, during a three-year period between September 1975 and September 1978, physicians were responsible for just over 3% of the 3,084 complaints filed with the licensing board.[8] Similarly, in Florida, during a six-year period from 1979 to 1985, hospitals accounted for fewer than 3% of the 6,400 complaints received against physicians.[9] In Texas, however, where reporting by individual physicians is mandated by law, 12% of the complaints received in 1985 and 1986 by the Texas State Board of Medical Examiners originated with licensed physicians.[10] Reports from such sources are important because, in comparison to patient complaints, they tend to result in more disciplinary actions.[11]

These data do not conclusively demonstrate that inappropriate conduct by physicians is underreported by their colleagues. They reflect only reports made directly to state licensing entities. It is likely that many physicians choose to confront a colleague directly when inappropriate conduct is suspected, or to bring the matter to the attention of a supervisor such as the chief of the department. This type of reporting is an important method of addressing inappropriate behavior of colleagues, since it is often a more direct and

efficient way of resolving problem behavior. However, when the number of reports by physicians directly to the licensing authorities are contrasted with the sensational accounts occasionally reported by the media, they tend to reinforce the widespread perception that physicians are reluctant to openly challenge the conduct of peers and to conscientiously protect the health and well-being of the public.

One recent study supports the explanation that impaired and incompetent colleagues are confronted directly when potential problems in care are observed, or that physicians tend to report such conduct to someone other than the licensing board, such as the chief of a hospital program or appropriate clinical service.[12] The study surveyed 76 resident physicians at an urban teaching hospital. Five scenarios involving impaired and incompetent physicians (including house officers and attending physicians) were described to each study participant. Five potential courses of action were presented and each participant was asked to specify which action, if any, was appropriate for each of the case scenarios. When faced with a fellow house officer who was alcohol-impaired, 96% of the residents would confront the impaired physician directly. However, when faced with an attending physician who was alcohol impaired, 72% indicated that they would report the impaired physician to the chief resident. In contrast, most of the residents who participated in the study, when faced with an incompetent physician, would inform the chief resident, regardless of whether the physician involved was an attending physician or house officer. It is impossible in this type of study however, to predict whether the actual behavior of physicians corresponds to the participants' responses.

Physicians are often discouraged from reporting by the burdens of the legal system. Reporting of impaired and incompetent colleagues often en- tails long and complex legal procedures.[13] Physicians may suspect inappropriate behavior but not feel that they have a sufficient factual basis to defend a formal report to licensing authorities. While statutes which are meant to protect good faith reporting are often helpful, often there is still fear of legal retaliation from the accused physician.[13] It is therefore important for physicians to work to assure that state laws regarding immunity for reporting are crafted to protect the reporting physician from retaliatory legal action on the part of the accused physician.

Physicians may also be discouraged from making reports to official authorities because of fear of negative professional repercussions, either from the accused physician or from colleagues. In cases where the potential for negative effects on the reporting physician's practice or career are great, some physicians may be prompted to make anonymous reports to an authority. While necessary under certain circumstances in order to minimize potential damage to the reporting physician, anonymous reports are not encouraged because of the potential for abuse. However, because physicians may have legitimate justification for making anonymous reports, such reports should receive appropriate review and confidential investigation by any disciplinary or investigatory bodies.

TYPES OF CONDUCT THAT ARE SUBJECT TO REPORTING

The ethical and legal standards to which physicians are expected to conform require the reporting of various kinds of conduct that typically falls within one of three categories: (1) impairment, (2) incompetence, and (3) unethical conduct.

Impairment

In a 1972 report of the AMA Council on Mental Health,[3] physician impairment was defined as "the inability to practice medicine with reasonable skill and safety to patients by reason of physical or mental illness, including deterioration through the aging process, the loss of motor skills, or the excessive use or abuse of drugs, including alcohol." Impairment can also include conditions such as extreme fatigue and emotional distress. Numerous studies published in the medical literature have included estimates of the number of impaired physicians practicing medicine in the United

States. These studies, however, have been criticized for being inconsistent or unreliable.[14]

However, reliable information does indicate that drug and/ or alcohol abuse by physicians, combined with inappropriate prescribing practices, account for 75% or more of the disciplinary actions currently reported by state licensing boards.[15] For every official action reported, five to ten licensed physicians are sanctioned informally by the state licensing boards,[16,17] generally through binding agreements that impose specific restrictions or conditions (e.g., submission to random drug screens) on the physician's license to practice medicine. Also, the first national survey of substance abuse among physicians showed that 8.2% of physician respondents report abuse or dependence on drugs or alcohol.[18] It is difficult to infer an accurate estimation of physician impairment from the data, since the study only surveyed physicians about usage and not impairment resulting from usage of these substances.

It has been found, however, that regardless of its prevalence, physician impairment-particularly when caused by drug and/ or alcohol abuse-can be curtailed dramatically through early identification and rehabilitation. Studies consistently have documented successful long-term rehabilitation rates of 66% to 75%.[19,20] Treatment is most effective when combined with random urine monitoring conducted over a two to four year period and when legal restrictions against the physician's medical license are avoided.[20]

To assist in the identification and rehabilitation of impaired physicians, medical societies in all 50 states have established impaired physician programs. In addition, many hospitals and state licensing boards have impaired physician programs.

These programs focus on rehabilitation, rather than on discipline and punishment. Physicians in these programs frequently are able to confront their impairment in a constructive manner, before irreparable harm occurs to their patients and their medical careers. General public good is best served by programs which emphasize rehabilitation of the impaired physician rather than punitive measures against a physician's license or ability to practice medicine. Because of their special expertise, physicians are a valuable social resource. Providing rehabilitation ensures that an impaired physician's valuable skills are not lost.

To safeguard patients, the hospital in which an impaired physician practices must be able to monitor the physician's actions. Accordingly, impairment should be reported to the hospital's in-house impairment program, if one is available. If the hospital does not have its own program, then either the chief of an appropriate service or the chief of the hospital staff should be alerted. Either of these individuals may then be able to facilitate the impaired physician's entrance into an external impaired physician program.

The extent of communication and coordination between hospital personnel or bodies and impaired physician programs may vary. If making a report of impairment through the usual hospital channels is inappropriate or unfeasible, then a report should be made to an external impaired physician program, such as one run by the county or state medical society or by the state licensing board.

Impaired physician programs vary in size, scope, and effectiveness. Reports of impairment should be directed toward that impaired physician program which would most effectively address the impaired physician's needs while safeguarding patient welfare. Although 96.8% of physicians – even when engaged in an office based practice - have clinical privileges at a hospital,[19] those with no hospital affiliation should be reported directly to an impaired physician program.

If reporting to an individual or program which would facilitate the entrance of the impaired physician into a rehabilitation program cannot be accomplished, then the impaired physician should be reported directly to the state licensing board.

Incompetence

Physician incompetence has been defined as "the inability to provide sound medical care because of deficient knowledge, poor judgment, or substandard clinical skills."[12] Data regarding the extent of physician incompetence not only is scarce, but it also is highly unreliable. Estimates of incompetence frequently are tied to the volume of malpractice litigation or to studies of adverse medical outcomes. However, these criteria are not reliable measures of true incompetence.

When identified early, the effects of incompetence frequently can be alleviated. Educational requirements can be imposed on physicians deficient in knowledge or training, clinical privileges can be restricted, or mandatory supervision of specified procedures can be imposed. The objective, as with physician impairment, is to identify and, when possible, to remedy deficiencies that may tend to compromise patient care. The primary emphasis is on remedial measures, which encompass education and additional training, and which complement the existing skills of the physician, rather than on punishment of the physician. Remedying the effects of incompetence also serves the public interest by ensuring that a physician's valuable skills are retained.

Initial reports of incompetence therefore should be made to the appropriate clinical authority who would be empowered to assess the potential impact on patient welfare and facilitate remedial action, such as the chief resident, the chief of an appropriate clinical service, or the chief of staff. For members of a group medical practice, the medical director would be the most appropriate individual to whom to address reports of incompetence. The physician's competence can then be evaluated and immediately addressed. The individual who receives a report of incompetence should notify the hospital peer review committee where warranted by the circumstances. Physicians who receive reports of incompetence have an ethical duty to critically and objectively evaluate the reported information and to assure that identified deficiencies are either remedied or further reported to the state licensing board. Instances of incompetence by physicians who have no hospital affiliation should be reported to the local or state medical society. In all cases, continued behavior that is potentially injurious to patients must be reported to the state licensing board.

Some specific instances of incompetence may be of a sufficiently serious nature as to warrant an immediate report to the licensing board, in order to prevent harm or injury to patients. Actions which would constitute an imminent danger to the health of patients should be reported directly to the licensing board. The licensing board may then temporarily suspend the physician's license until the proper remedial or disciplinary action can be taken.

Unethical Conduct

Unethical conduct in the practice of medicine encompasses a variety of behaviors, including fraud, corruption, dishonesty, greed, exploitation of patients, and violations of professional ethics. Physicians may behave in an unethical manner either because they are unaware of specific professional standards which they are expected to observe, or they may, through deliberate and conscious decisions, disregard such standards. Although the incompetent practice of medicine and the practice of medicine while impaired can also be considered unethical, both types of behavior should be reported according to the guidelines stated above.

Local medical societies are concerned with all violations of ethical standards, from withholding of medical records to life-threatening clinical practices. Unethical conduct which threatens patient care or welfare is under the purview of the appropriate authority for a particular clinical service. In addition, much of unethical behavior violates the standards set by the state licensing board. Some unethical acts also violate criminal laws and are under the jurisdiction of law enforcement authorities. Therefore,

unethical practices should be reported to the entity concerned with monitoring or reviewing a particular practice. If the reported activity resulted from a lack of awareness about ethical standards, the problem may be remedied simply by providing the physician with appropriate counsel and education. Actions of a more deliberate nature, however, may warrant punitive action by appropriate bodies, such as the hospital peer review committee, the state or county medical society, or the state licensing board.

In all circumstances, the physician or person who receives a report of impairment, incompetence, or unethical behavior should, to the greatest extent possible, maintain the confidentiality of both the reporting physician and the physician who has been reported.

SUMMARY-GUIDELINES FOR FULFILLING REPORTING OBLIGATIONS

The Council on Ethical and Judicial Affairs has developed a series of guidelines to assist physicians in fulfilling their ethical obligation to report the potentially injurious conduct of colleagues.

Physicians have an ethical obligation to report impaired, incompetent, and unethical colleagues. Physicians should be familiar with the reporting requirements of their own state and comply accordingly.

1. Impairment

a. Impairment should be reported to the hospital's in-house impairment program, if available. If no in-house program is available, or if the type of impairment is not normally addressed by an impairment program, e.g., extreme fatigue and emotional distress, then the chief of an appropriate clinical service, the chief of staff of the hospital, or other appropriate supervisor (e.g., the chief resident) should be alerted.

b. If a report cannot be made through the usual hospital channels, then a report should be made to an external impaired physician program. Such programs typically would be operated by the local medical societies or state licensing boards.

c. Physicians in office-based practices who do not have clinical privileges at an area hospital should be reported directly to an impaired physician program.

d. If reporting to an individual or program which would facilitate the entrance of the impaired physician into an impaired physician program can- not be accomplished, then the impaired physician should be reported directly to the state licensing board.

2. Incompetence

a. Initial reports of incompetence should be made to the appropriate clinical authority who would be empowered to assess the potential impact on patient welfare and to facilitate remedial action, e.g., the chief resident, the chief of an appropriate clinical service, the chief of the hospital staff, or the medical director of a group medical practice.

b. The individual who receives a report of incompetence should, in turn, notify the hospital peer review body where appropriate. Physicians who receive reports of incompetence have an ethical duty to critically and objectively evaluate the reported information and to assure that identified deficiencies are either remedied or further reported to the state licensing board.

c. Instances of incompetence by physicians who have no hospital affiliation should be reported to the local or state medical society.

d. Continued behavior that is potentially injurious to patients must further be reported to the state licensing board.

e. If the incompetence is of a sufficiently serious nature as to pose an immediate threat to the health of the physician's patients, then it should be reported directly to the state licensing board.

1. Unethical conduct. Unethical behavior (which does not fit into the category of either incompetence or impairment) should be reported in accordance with these guidelines:

a. Unethical conduct which threatens patient care or welfare should be reported to the appropriate authority for a particular clinical service, i.e., the chief resident, the chief of an appropriate clinical service, or the chief of the hospital staff.

b. Unethical behavior which violates the provisions of the state licensing board should be reported to the state licensing board.

c. Unethical conduct which violates criminal statutes should be reported to the appropriate law enforcement authorities.

d. Examples of unethical conduct which do not fall into the above three categories, or unethical conduct which has not been addressed through other channels should be reported to the local or state medical society.

4. Where the impairment, incompetence, or unethical behavior of a physician continues despite the initial report(s), the reporting physician should report to a higher or additional authority. In order to aid physicians who report inappropriate behavior of colleagues in carrying out this obligation, the person or body receiving the initial report should notify the reporting physician when appropriate action has been taken.

5. Physicians should work to assure that state laws provide immunity to those who report impaired, incompetent, or unethical colleagues.

6. In certain circumstances, an anonymous report may be the only practical method of alerting an authoritative body to a colleague's misconduct. Anonymous reports of misconduct should receive appropriate review and confidential investigation by authorities.

7. Principles of due process must be observed in the conduct of all disciplinary matters involving physician participants at all levels. However, the confidentiality of the reporting physician should be maintained to the greatest extent possible within the constraints of due process, in order to minimize potential professional recriminations.

8. The medical profession as a whole must correct the misperception that physicians are not adequately protecting the public from incompetent, impaired, or unethical physicians by better communicating its efforts and initiatives at maintaining high ethical standards and quality assurance.

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REPORTS OF COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS

The following reports, A-D, were presented by Oscar W. Clarke, M. D., Chairman:

A. REPORTING IMPAIRED, INCOMPETENT OR UNETHICAL COLLEAGUES

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS AND REMAINDER OF REPORT FILED:

INTRODUCTION

At the 1991 Annual Meeting of the House of Delegates, Report C of the Council on Ethical and Judicial Affairs, regarding the reporting of impaired, incompetent or unethical colleagues, was referred to the Council for further examination. The Council has reviewed the issue and issues the following report.

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DUTY TO REPORT: HISTORICAL ASPECTS

The ethical standards of the medical profession have required for nearly 200 years that physicians report to appropriate authorities potentially injurious conduct by colleagues. In 1803, an English physician and philosopher, Thomas Percival, published a treatise entitled "Medical Ethics; or a Code of Institutes and Precepts, adapted to the Professional Conduct of Physicians and Surgeons." This historic publication, which served as the basis for the American Medical Association's first code of ethics in 1847, was perhaps the most significant document since the Oath of Hippocrates in the fifth century B. C. to establish standards of professional conduct for physicians and surgeons. Although Percival's code admonished physicians not to reveal to patients information or occurrences that may tend to injure the reputation of a colleague, the code also contained the following provision:

> [T]hough the character of a professional busybody, whether from thoughtlessness or craft, is highly reprehensible, there are occasions which not only justify but require a spirited interposition. When artful ignorance grossly imposes on credulity; when neglect

> puts to hazard an important life; or rashness threatens it with still more imminent danger; a medical neighbor, friend, or relative, apprized [sic] of such facts will justly regard his interference as a duty.

The obligation of physicians to report inappropriate conduct by colleagues was strengthened considerably in 1912, when the AMA's Principles of Medical Ethics were revised. The revised code of ethics stated, in part, that physicians "should expose without fear or favor, before the proper medical or legal tribunals, corrupt or dishonest conduct of members of the profession."

This ethical duty has been preserved for nearly a century, despite numerous changes in the medical profession's standards of ethical conduct. In 1972, for example, the AMA Council on Mental Health issued a report on physician impairment, in which it was noted that every physician has an ethical responsibility to recognize impairment or incompetence in colleagues and to provide appropriate counsel with respect to obtaining treatment and curtailing or suspending the practice of medicine. Today, the Principles of Medical Ethics of the AMA state that physicians must "strive to expose those physicians deficient in character or competence, or who engage in fraud or deception." In addition, the fundamental duty of physicians to report inappropriate conduct by colleagues has been reinforced by the Council on Ethical and Judicial Affairs of the AMA, through an ethical opinion on Discipline and Medicine:

> DISCIPLINE AND MEDICINE. Incompetence, corruption or dishonest or unethical conduct on the part of members of the medical profession is reprehensible. In addition to posing a real or potential threat to patients, such conduct undermines the public's confidence in the profession. A physician should expose, without fear or favor, incompetent or corrupt, dishonest or unethical conduct on the part of members of the profession. (Section 9.04, Current Opinions of the Council on Ethical and Judicial Affairs of the AMA)

REPORTING RESPONSIBILITIES MANDATED BY LAW

The duty of physicians to report conduct that may be injurious to patients has been incorporated not only into the code of ethics of the medical profession, but also, in one form or another, into the laws of numerous jurisdictions. Physicians in many states are obligated by law to report to the licensing board the conduct of any colleague who may be impaired, incompetent or unethical. Failure to do so is grounds in such states for disciplinary action. In Minnesota, for example, three physicians were reprimanded and fined in 1987 by the state board of medical examiners for their failure to report the chemical dependency of a member of their group medical practice. The penalties were imposed despite actions by the partners to enroll their colleague in a treatment program for impaired physicians and to prevent him from practicing medicine while under the influence of chemical substances. In some jurisdictions, physicians who fail to comply with reporting requirements not only are subject to disciplinary action, but also are liable for injuries sustained by patients as a result of any inappropriate treatment rendered by colleagues known to be impaired or incompetent. Reporting also may be required of hospitals, professional liability insurers, court officials, medical societies and other licensed professionals.

Despite the widespread adoption by states of mandatory reporting laws, few complaints against physicians are received from hospitals and physicians. In New York, for example, during a three-year period between September 1975 and September 1978, physicians were responsible for just over 3 percent of the 3,084 complaints filed with the licensing board. Similarly, in Florida, during a six-year period from 1979 to 1985, hospitals accounted for fewer than 3 percent of the 6,400 complaints received against physicians. In Texas, however, where reporting by individual physicians is mandated by law, 12 percent of the complaints received in 1985 and 1986 by the Texas State Board of Medical Examiners originated with licensed physicians. Reports from such sources are important because, in comparison to patient complaints, they tend to result in more disciplinary actions.

These data do not conclusively demonstrate that inappropriate conduct by physicians is underreported by their colleagues. They reflect only reports made directly to state licensing entities. It is likely that many physicians choose to confront a colleague directly when inappropriate conduct is suspected, or to bring the matter to the attention of a supervisor such as the chief of the department. This type of reporting is an important method of addressing inappropriate behavior of colleagues, since it is often a more direct and efficient way of resolving problem behavior. However, when the number of reports by physicians directly to the licensing authorities are contrasted with the sensational accounts occasionally reported by the media, they tend to reinforce the widespread perception that physicians are reluctant to openly challenge the conduct of peers and to conscientiously protect the health and well-being of the public.

One recent study supports the explanation that impaired and incompetent colleagues are confronted directly when potential problems in care are observed, or that physicians tend to report such conduct to someone other than the licensing board, such as the chief of a hospital program or appropriate clinical service. The study surveyed 76 resident physicians at an urban teaching hospital. Five scenarios involving impaired and incompetent physicians (including house officers and attending physicians) were described to each study participant. Five potential courses of action were presented and each participant was asked to specify which action, if any, was appropriate for each of the case scenarios. When faced with a fellow house officer who was alcohol-impaired, 96 percent of the residents would confront the impaired physician directly. However, when faced with an attending physician who was alcohol-impaired, 72 percent indicated that they would report the impaired physician to the chief resident. In contrast, most of the residents who participated in the study, when faced with an incompetent physician, would inform the chief resident, regardless of whether the physician involved was an attending physician or house officer. It is impossible in this type of study, however, to predict whether the actual behavior of physicians corresponds to the participants' responses.

Physicians are often discouraged from reporting by the burdens of the legal system. Reporting of impaired and incompetent colleagues often entails long and complex legal procedures. Physicians may suspect inappropriate behavior but not feel that they have a sufficient factual basis to defend a formal report to licensing authorities. While statutes which are meant to protect good faith reporting are often helpful, often there is still fear of legal retaliation from the accused physician. It is therefore important for physicians to work to assure that state laws regarding immunity for reporting are crafted to protect the reporting physician from retaliatory legal action on the part of the accused physician.

Physicians may also be discouraged from making reports to official authorities because of fear of negative professional repercussions, either from the accused physician or from colleagues. In cases where the potential for negative effects on the reporting physician's practice or career are great, some physicians may be prompted to make anonymous reports to an authority. While necessary under certain circumstances in order to minimize potential damage to the reporting physician, anonymous reports are not encouraged because of the potential for abuse. However, because physicians may have legitimate justification for making anonymous reports, such reports should receive appropriate review and confidential investigation by any disciplinary or investigatory bodies.

TYPES OF CONDUCT THAT ARE SUBJECT TO REPORTING

The ethical and legal standards to which physicians are expected to conform require the reporting of various conduct that typically falls within one of three categories: (1) impairment, (2) incompetence and (3) unethical conduct.

Impairment

In a 1972 report of the AMA Council on Mental Health, physician impairment was defined as "the inability to practice medicine with reasonable skill and safety to patients by reason of physical or mental illness, including deterioration through the aging process, the loss of motor skills or the excessive use or

abuse of drugs, including alcohol." Impairment can also include conditions such as extreme fatigue and emotional distress. Numerous studies published in the medical literature have included estimates of the number of impaired physicians practicing medicine in the United States. These studies, however, have been criticized for being inconsistent or unreliable.

However, reliable information does indicate that drug and/or alcohol abuse by physicians, combined with inappropriate prescribing practices, account for 75 percent or more of the disciplinary actions currently reported by state licensing boards. For every official action reported, five to ten licensed physicians are sanctioned informally by the state licensing boards, generally through binding agreements that impose specific restrictions or conditions (e. g., submission to random drug screens) on the physician's license to practice medicine. Also, the first national survey of substance abuse among physicians showed that 8.2 percent of physician respondents report abuse or dependence on drugs or alcohol. It is difficult to infer an accurate estimation of physician impairment from the data, since the study only surveyed physicians about usage and not impairment resulting from usage of these substances.

It has been found, however, that regardless of its prevalence, physician impairment – particularly when caused by drug and/or alcohol abuse – can be curtailed dramatically through early identification and rehabilitation. Studies consistently have documented successful long-term rehabilitation rates of 66 percent to 75 percent. Treatment is most effective when combined with random urine monitoring conducted over a two- to four-year period and when legal restrictions against the physician's medical license are avoided.

To assist in the identification and rehabilitation of impaired physicians, medical societies in all fifty states have established impaired physician programs. In addition, many hospitals and state licensing boards have impaired physician programs.

These programs focus on rehabilitation, rather than on discipline and punishment. Physicians in these programs frequently are able to confront their impairment in a constructive manner, before irreparable harm occurs to their patients and their medical careers. General public good is best served by programs which emphasize rehabilitation of the impaired physician rather than punitive measures against a physician's license or ability to practice medicine. Because of their special expertise, physicians are a valuable social resource. Providing rehabilitation ensures that an impaired physician's valuable skills are not lost.

To safeguard patients, the hospital in which an impaired physician practices must be able to monitor the physician's actions. Accordingly, impairment should be reported to the hospital's in-house impairment program, if one is available. If the hospital does not have its own program, then either the chief of an appropriate service or the chief of the hospital staff should be alerted. Either of these individuals may then be able to facilitate the impaired physician's entrance into an external impaired physician program.

The extent of communication and coordination between hospital personnel or bodies and impaired physician programs may vary. If making a report of impairment through the usual hospital channels is inappropriate or unfeasible, then a report should be made to an external impaired physician program, such as one run by the county or state medical society or by the state licensing board.

Impaired physician programs vary in size, scope and effectiveness. Reports of impairment should be directed toward that impaired physician program which would most effectively address the impaired physician's needs while safeguarding patient welfare. Although 96.8 percent of physicians – even when engaged in an office-based practice – have clinical privileges at a hospital, those with no hospital affiliation should be reported directly to an impaired physician program.

If reporting to an individual or program which would facilitate the entrance of the impaired physician into a rehabilitation program cannot be accomplished, then the impaired physician should be reported directly to the state licensing board.

Incompetence

Physician incompetence has been defined as "the inability to provide sound medical care because of deficient knowledge, poor judgment, or substandard clinical skills." Data regarding the extent of physician incompetence not only is scarce, but it also is highly unreliable. Estimates of incompetence frequently are tied to the volume of malpractice litigation or to studies of adverse medical outcomes. However, these criteria are not reliable measures of true incompetence.

When identified early, the effects of incompetence frequently can be alleviated. Educational requirements can be imposed on physicians deficient in knowledge or training, clinical privileges can be restricted or mandatory supervision of specified procedures can be imposed. The objective, as with physician impairment, is to identify and, when possible, to remedy deficiencies that may tend to compromise patient care. The primary emphasis is on remedial measures, which encompass education and additional training, and which complement the existing skills of the physician, rather than on punishment of the physician. Remedying the effects of incompetence also serves the public interest by ensuring that a physician's valuable skills are retained.

Initial reports of incompetence therefore should be made to the appropriate clinical authority who would be empowered to assess the potential impact on patient welfare and facilitate remedial action, such as the chief resident, the chief of an appropriate clinical service or the chief of staff. For members of a group medical practice, the medical director would be the most appropriate individual to whom to address reports of incompetence. The physician's competence can then be evaluated and immediately addressed. The individual who receives a report of incompetence should notify the hospital peer review committee where warranted by the circumstances. Physicians who receive reports of incompetence have an ethical duty to critically and objectively evaluate the reported information and to assure that identified deficiencies are either remedied or further reported to the state licensing board. Instances of incompetence by physicians who have no hospital affiliation should be reported to the local or state medical society. In all cases, continued behavior that is potentially injurious to patients must be reported to the state licensing board.

Some specific instances of incompetence may be of a sufficiently serious nature as to warrant an immediate report to the licensing board, in order to prevent harm or injury to patients. Actions which would constitute an imminent danger to the health of patients should be reported directly to the licensing board. The licensing board may then temporarily suspend the physician's license until the proper remedial or disciplinary action can be taken.

Unethical Conduct

Unethical conduct in the practice of medicine encompasses a variety of behaviors, including fraud, corruption, dishonesty, greed, exploitation of patients and violations of professional ethics. Physicians may behave in an unethical manner either because they are unaware of specific professional standards which they are expected to observe, or they may, through deliberate and conscious decisions, disregard such standards. Although the incompetent practice of medicine and the practice of medicine while impaired can also be considered unethical, both types of behavior should be reported according to the guidelines stated above.

Local medical societies are concerned with all violations of ethical standards, from withholding of medical records to life-threatening clinical practices. Unethical conduct which threatens patient care or welfare is under the purview of the appropriate authority for a particular clinical service. In addition, much of unethical behavior violates the standards set by the state licensing board. Some unethical acts also violate criminal laws and are under the jurisdiction of law enforcement authorities. Therefore, unethical practices should be reported to the entity concerned with monitoring or reviewing a particular practice. If the reported activity resulted from a lack of awareness about ethical standards, the problem may be remedied simply by providing the physician with appropriate counsel and education. Actions of a more

deliberate nature, however, may warrant punitive action by appropriate bodies, such as the hospital peer review committee, the state or county medical society, or the state licensing board.

In all circumstances, the physician or person who receives a report of impairment, incompetence or unethical behavior should, to the greatest extent possible, maintain the confidentiality of both the reporting physician and the physician who has been reported.

RECOMMENDATION – GUIDELINES FOR FULFILLING REPORTING OBLIGATIONS

The Council on Ethical and Judicial Affairs has developed a series of guidelines to assist physicians in fulfilling their ethical obligation to report the potentially injurious conduct of colleagues. The Council recommends that the following guidelines be adopted:

> Physicians have an ethical obligation to report impaired, incompetent and unethical colleagues. Physicians should be familiar with the reporting requirements of their own state and comply accordingly.
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> 1. Impairment
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> a. Impairment should be reported to the hospital's in-house impairment program, if available. If no in-house program is available, or if the type of impairment is not normally addressed by an impairment program, e. g., extreme fatigue and emotional distress, then the chief of an appropriate clinical service, the chief of staff of the hospital or other appropriate supervisor (e. g., the chief resident) should be alerted.
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> b. If a report cannot be made through the usual hospital channels, then a report should be made to an external impaired physician program. Such programs typically would be operated by the local medical societies or state licensing boards.
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> c. Physicians in office-based practices who do not have clinical privileges at an area hospital should be reported directly to an impaired physician program.
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> d. If reporting to an individual or program which would facilitate the entrance of the impaired physician into an impaired physician program cannot be accomplished, then the impaired physician should be reported directly to the state licensing board.
>
> 2. Incompetence
>
> a. Initial reports of incompetence should be made to the appropriate clinical authority who would be empowered to assess the potential impact on patient welfare and to facilitate remedial action, e. g., the chief resident, the chief of an appropriate clinical service, the chief of the hospital staff or the medical director of a group medical practice.
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> b. The individual who receives a report of incompetence should, in turn, notify the hospital peer review body where appropriate. Physicians who receive reports of incompetence have an ethical duty to critically and objectively evaluate the reported information and to assure that identified deficiencies are either remedied or further reported to the state licensing board.

c. Instances of incompetence by physicians who have no hospital affiliation should be reported to the local or state medical society.

d. Continued behavior that is potentially injurious to patients must further be reported to the state licensing board.

e. If the incompetence is of a sufficiently serious nature as to pose an immediate threat to the health of the physician's patients, then it should be reported directly to the state licensing board.

3. Unethical Conduct

Unethical behavior (which does not fit into the category of either incompetence or impairment) should be reported in accordance with these guidelines:

a. Unethical conduct which threatens patient care or welfare should be reported to the appropriate authority for a particular clinical service, i. e., the chief resident, the chief of an appropriate clinical service or the chief of the hospital staff.

b. Unethical behavior which violates the provisions of the state licensing board should be reported to the state licensing board.

c. Unethical conduct which violates criminal statutes should be reported to the appropriate law enforcement authorities.

d. Examples of unethical conduct which do not fall into the above three categories, or unethical conduct which has not been addressed through other channels should be reported to the local or state medical society.

4. Where the impairment, incompetence or unethical behavior of a physician continues despite the initial report(s), the reporting physician should report to a higher or additional authority. In order to aid physicians who report inappropriate behavior of colleagues in carrying out this obligation, the person or body receiving the initial report should notify the reporting physician when appropriate action has been taken.

5. Physicians should work to assure that state laws provide immunity to those who report impaired, incompetent or unethical colleagues.

6. In certain circumstances, an anonymous report may be the only practical method of alerting an authoritative body to a colleague's misconduct. Anonymous reports of misconduct should receive appropriate review and confidential investigation by authorities.

7. Principles of due process must be observed in the conduct of all disciplinary matters involving physician participants at all levels. However, the confidentiality of the reporting physician should be maintained to the greatest extent possible within the constraints of due process in order to minimize potential professional recriminations.

8. The medical profession as a whole must correct the misperception that physicians are not adequately protecting the public from incompetent, impaired or unethical physicians by better communicating its efforts and initiatives at maintaining high ethical standards and quality assurance.

(References pertaining to Report A of the Council on Ethical and Judicial Affairs are available from the Office of the General Counsel.)