

American Medical Association
Policies related to Physician Health

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H-20.912 Guidance for HIV-Infected Physicians and other Health Care Workers

(1) General Considerations. a) A health care worker who performs invasive procedures and has reasonable cause to believe he/she is infected with HIV should determine his/her serostatus or act as if that serostatus is positive; and b) As a general rule or until there is scientific information to the contrary, the HIV- infected health care worker should be permitted to provide health care services as long as there is no significant risk of patient infection and no compromise in physical or mental ability of the health care worker to perform the health care procedures.

(2) Patient Care Duties. a) A physician or other health care worker who performs exposure-prone procedures and becomes HIV-positive should disclose his/her serostatus to a state public health official or local review committee; b) An HIV- infected physician or other health care worker should refrain from conducting exposure-prone procedures or perform such procedures with permission from the local review committee and the informed consent of the patient; c) When the scientific basis for patient protection policy decisions are unclear, HIV- infected physicians or other health care workers must err on the side of protecting patients.

(3) Local Review Committee. a) If an HIV-infected physician or other health care worker performs invasive medical procedures as a part of his/her duties, then the individual should request that an ad hoc committee be constituted to consider which activities can be continued without risk of infection to patients. Membership on the review committee should be flexible to meet various needs. It should include an infectious disease specialist familiar with HIV transmission risks, the pertinent hospital department chair, a hospital administrator, an epidemiologist, the infected health care worker's personal physician, the infected health care worker, and others as appropriate. Committee members should be unbiased and at least some of the members should be familiar with the performance of the infected health care worker. b) This review committee may recommend to the appropriate authority restrictions upon the infected persons' practice, if it believes there is a significant risk to patients' welfare. A confidential review system should be established by the committee to monitor the health care worker's fitness to engage in invasive health care activities. Any restrictions or modifications to health care activities that may affect patient safety should be determined by the committee based on current medical and scientific information. When determining practice limitations for HIV -positive physicians, the panel might consider: (i) morbidity and mortality experience of the physician in question; (ii) frequency with which the physician performs the following: procedures that have been associated with injuries to physicians in the course of surgery; procedures that are conducted in confined or difficult to visualize anatomical spaces; procedures where a physician's blood is likely to come in to contact with a patient's mucosal surfaces, open surgical wounds, or blood stream; and procedures that have been known to be involved in HBV transmission; c) Where restrictions, limitations, modifications, or a change in health care activities are recommended, the committee should do its utmost to assist the health care worker to obtain financial and social support for these changes. Consideration should be given to adapting programs for impaired health care workers to serve those who are HIV infected; d) The committee should be empowered to monitor the HIV -infected physician or other health care worker for compliance with any practice limitations established by the committee, provide advice on the need to inform patients of the infected worker's HIV status, monitor the infected person's compliance with universal precautions, and assess the effects of the disease on clinical competency. Physicians and others who participate in making these decisions must be protected from legal challenges and personal legal responsibility; e) Any HIV- infected health care worker who repeatedly violates local committee-imposed practice limitations and/or universal precautions should be reported to appropriate authorities, such as the state licensure board, for possible discipline; f) If intra-institutional confidentiality cannot be assured, health care facilities should make arrangements with other organizations such as local or state medical societies to perform the functions of the ad hoc

committee; and g) HIV- infected health care workers not affiliated with a hospital may also use this procedure to form an ad hoc review committee.

4. Review Committee Liability. a) State medical societies should be encouraged to survey hospitals and review their own coverage to determine whether existing liability insurance for those serving on peer review or Physicians Health Committees provides protection for those serving on review committees for HIV- infected physicians; b) Our AMA should assist in the establishment of review committees by providing model state legislation that would afford committee members protection in state and federal courts and when they operate in good faith. Further, our AMA should prepare a protocol outlining how review committees would operate and further specify the definition of significant risk.

5. Confidentiality. a) Our AMA expresses its commitment to HIV -infected physicians concerning confidentiality of HIV serostatus, protection against discrimination, involvement in legislation affecting HIV- infected physicians, financial support through such means as insurance disability guidelines, and assistance with alternative careers through its Physician Health Program; b) Our AMA believes the confidentiality of the HIV- infected physician should be protected as with any HIV patient; and c) Knowledge of the health care worker's HIV serostatus should be restricted to those few professionals who have a medical need to know. Except for those with a need to know, all information on the serostatus of the health care worker must be held in the strictest confidence.

6. HIV -Infected Medical Students and Resident Physicians. a) Our AMA strongly supports indemnification of medical students and resident physicians infected with HIV as a result of contact with assigned patients. Our AMA supports examining possible mechanisms to achieve the intent of this recommendation, realizing that the issues for medical students and resident physicians differ; b) An equivalent level and manner of health care provided to medical students, residents, and other employees with other medical conditions should be provided to those with HIV infection.

7. Liability Coverage for HIV-Infected Physicians. Our AMA will continue the dialogue with liability insurance companies to monitor issues surrounding liability coverage for HIV- infected physicians and will establish guidelines for any collection or use of HIV serostatus data by professional liability carriers. Serostatus information should be treated with strict privacy and nondisclosure assurances. Discussions with liability insurance companies should include the position that to date there are no scientific grounds to require testing of physicians for HIV status. (CSA Rep. 4-A-03)

H-30.960 Physician Ingestion of Alcohol and Patient Care

Our AMA, believing that the possibility, or even the perception, of any alcohol-induced impairment of patient care activities is inconsistent with the professional image of the physician, (1) urges that physicians engaging in patient care have no significant body content of alcohol and (2) urges that all physicians, prior to being available for patient care, refrain from ingesting an amount of alcohol that has the potential to cause impairment of performance or create a "hangover" effect. (BOT Rep. Y, A-91; Reaffirmed: Sunset Report, I-01)

H-30.995 Alcoholism as a Disability

(1) The AMA believes it is important for professionals and laymen alike to recognize that alcoholism is in and of itself a disabling and handicapping condition. (2) The AMA encourages the availability of

appropriate services to persons suffering from multiple disabilities or multiple handicaps, including alcoholism. (3) The AMA endorses the position that printed and audiovisual materials pertaining to the subject of people suffering from both alcoholism and other disabilities include the terminology "alcoholic person with multiple disabilities or alcoholic person with multiple handicaps." Hopefully, this language clarification will reinforce the concept that alcoholism is in and of itself a disabling and handicapping condition. (CSA Rep. H, I-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed by CSA Rep. 14, A-97; Reaffirmed: CSAPH Rep. 3, A-07)

H-90.987 Equal Access for Physically Challenged Physicians

Our AMA supports the adoption of guidelines for equal access to all hospital facilities for physically challenged physicians as part of the standards of the JCAHO. (Res. 816, I-91; Reaffirmed: Sunset Report, I-01)

H-95.955 Substance Abuse among Physicians

(1) The AMA defines physician impairment as any physical, mental or behavioral disorder that interferes with ability to engage safely in professional activities and will address all such conditions in its Physician Health Program. (2) The AMA encourages state medical society-sponsored physician health and assistance programs to take appropriate steps to address the entire range of impairment problems that affect physicians, to develop case finding mechanisms for all types of physician impairments, and to collect data on the prevalence of conditions affecting physician health. (3) The AMA encourages additional research in the area of physician impairment, particularly in the type and impact of external factors adversely affecting physicians, including workplace stress, litigation issues, and restructuring of the health care delivery systems. (CSA Rep. 1, A-95; Reaffirmed: BOT Rep. 17, I-99)

H-95.968 Substance Abuse Hotline

It is the policy of the AMA (1) not to establish a substance abuse hotline, but to continue to respond to inquiries about all physician health issues, including substance abuse issues, on an individual basis; (2) to encourage physicians with substance use disorders to contact their state physician health program since that program is probably best able to render assistance; and (3) to publicize the existence and availability of the Drug Abuse Information and Treatment Referral Hotline as an alternative and secondary source of referral information. (BOT Rep. U, I-90; Reaffirmed: Sunset Report, I-00)

H-95.982 Substance Abuse in Medical Schools

The AMA advocates (1) further study (and continued monitoring of other studies) concerning the problem of substance abuse among students, residents, and faculty in U.S. medical schools; and (2) development of model policy and programmatic guidelines which might assist in the establishment of programs for medical students, residents and faculty which could significantly impact on this problem and potentially reduce the risk of future impairment among physicians. (Res. 111, I-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CME Rep. 10, I-98)

H-95.984 Issues in Employee Drug Testing

The AMA (1) reaffirms its commitment to educate physicians and the public about the scientific issues of drug testing; (2) supports monitoring the evolving legal issues in drug testing of employee groups, especially the issues of positive drug tests as a measure of health status and potential employment discrimination resulting therefrom; (3) takes the position that urine drug and alcohol testing of employees should be limited to (a) preemployment examinations of those persons whose jobs affect the health and safety of others, (b) situations in which there is reasonable suspicion that an employee's (or physician's) job performance is impaired by drug and/or alcohol use, (c) monitoring as part of a comprehensive program of treatment and rehabilitation of alcohol and drug abuse or dependence; and (d) urine, drug and alcohol testing of all physicians and appropriate employees of health care institutions may be appropriate under these same conditions. and (4) urges employers who choose to establish drug testing programs to use confirmed, positive test results in employees primarily to motivate those employees to seek appropriate assistance with their alcohol or drug problems, preferably through employee assistance programs. (CSA Rep. A, A-87; Reaffirmed: Sub. Res. 39, A-90, CSA Rep. D, I-90; BOT Rep. I, A-90; CSA Rep. 2, I-95; Reaffirmed: BOT Rep. 17, I-99)

H-140.886 Physician Health and Wellness

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

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

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

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

- ~ promoting health and wellness among physicians;
- ~ supporting peers in identifying physicians in need of help;
- ~ intervening promptly when the health or wellness of a colleague appears to have become compromised, including the offer of encouragement, coverage or referral to a physician health program;
- ~ establishing physician health programs that provide a supportive environment to maintain and restore health and wellness;
- ~ establishing mechanisms to assure that impaired physicians promptly cease practice;
- ~ assisting recovered colleagues when they resume patient care;

- ~ reporting impaired physicians who continue to practice, despite reasonable offers of assistance, to appropriate bodies as required by law and/or ethical obligations.

H-225.969 Disputes Between Medical Supervisors and Trainees

The AMA has adopted the following guidelines with regard to disputes between medical supervisors and trainees: (1) Clear policies for handling complaints from medical students, resident physicians, or other staff should be established, as outlined in the recommendations of the AMA's Guidelines for Establishing Sexual Harassment Prevention and Grievance Procedures and Council on Ethical and Judicial Affairs (CEJA) Opinion 9.031; "Reporting Impaired, Incompetent or Unethical Colleagues." Grievance Committees or other mechanisms for handling complaints should provide for participation by peers of the medical student or resident physician complainant. (2) Policies for handling complaints should include adequate provisions for protecting the confidentiality of complainants when possible. Retaliatory or punitive actions against those who raise complaints are unethical and are a legitimate cause for filing a grievance with the appropriate institutional committee. (3) Mechanisms for adjudicating disputes requiring immediate resolution should be in place. Disputes requiring immediate resolution are defined as those involving serious errors in clinical or ethical judgment, or physician impairment, that result in a threat of imminent harm to the patient or to others. Third party mediators of such disputes may include the chief of staff or the involved service, the chief resident, a designated member of the institutional grievance committee, or, in large institutions, an institutional ombudsperson largely outside of the established hospital staff hierarchy. (4) In accordance with item 3, medical students, resident physicians, and other staff should refuse to participate in patient care ordered by their supervisors in those rare cases in which the orders reflect serious errors in clinical or ethical judgment, or physician impairment, that result in a threat of imminent harm to the patient. In these rare cases, the complainant may withdraw from the care ordered by the supervisor, provided that withdrawal does not itself threaten the patient's immediate welfare. In any event, it is essential that the student, resident physician, or staff member communicate his or her concerns to the physician issuing the orders and, if necessary, to the appropriate persons for mediating disputes requiring immediate resolution, as defined in item 3 above. Retaliatory or punitive actions against complainants are unethical and are a legitimate cause for filing a grievance with the appropriate institutional committee. (5) Access to employment and evaluation files should be carefully monitored to remove the possibility of inappropriate alteration or tampering. Resident physicians should be permitted access to their employment files and also the right to copy the contents thereof, within the provisions of applicable federal and state laws. (CEJA Rep. 1, I-93; Reaffirmed: CME Rep. 2, A-05)

H-235.977 Medical Staff Committees to Assist Impaired or Distressed Physicians

Our AMA recognizes the importance of early recognition of impaired or distressed physicians, and encourages hospital medical staffs to have provisions in their bylaws for a mechanism to address the physical and mental health of their medical staff and housestaff members. (Sub. Res. 67, A-89; Reaffirmed: BOT Rep. 17 and Sunset Report, A-00)

H-275.927 Medicare/ Medicaid Exclusion: Amendment of Definition of Conviction in Health Insurance Portability and Accountability Act

1. It is AMA policy that a recovering physician who is convicted of a felony for an offense which relates to the "unlawful manufacture, distribution, prescription or dispensing of a controlled

substance," and in order to resolve criminal charges arising from personal substance abuse, has entered into a first offender, deferred adjudication or other such arrangement (42 USC § 1320a-7[i]), should not be excluded from the Medicare and Medicaid programs for a mandatory five years. 2. Our AMA seeks legislation either to (a) delete this first offender, deferred adjudication definition of "conviction" from the statute, or (b) seek to exempt recovering providers from its application. (BOT Action in response to referred for decision Res. 215, I-97; Reaffirmed: CMS Rep. 9, A-07)

H-275.934 Alternatives to the Federation of State Medical Boards Recommendations on Licensure

Our AMA adopts the following principles:(1) Ideally, all medical students should successfully complete Steps 1 and 2 of the United States Medical Licensing Examination (USMLE) or Parts 1 and 2 of the Comprehensive Osteopathic Medical Licensing Examination (COMLEX) prior to entry into residency training. At a minimum, individuals entering residency training must have successfully completed Step 1 of the USMLE or Part 1 of COMLEX. There should be provision made for students who have not completed Step 2 of the USMLE or Part 2 of the COMLEX to do so during the first year of residency training. (2) All applicants for full and unrestricted licensure, whether graduates of U.S. medical schools or international medical graduates, must have completed one year of accredited graduate medical education (GME) in the U.S., have passed all licensing examinations (USMLE or COMLEX), and must be certified by their residency program director as ready to advance to the next year of GME and to obtain a full and unrestricted license to practice medicine. The candidate for licensure should have had education that provided exposure to general medical content. (3) There should be a training permit/educational license for all resident physicians who do not yet have a full and unrestricted license to practice medicine. To be eligible for an initial training permit/educational license, the resident must have completed Step 1 of the USMLE or Part 1 of COMLEX. (4) Residency program directors shall report only those actions to state medical licensing boards that are reported for all licensed physicians. (5) Residency program directors should receive training to ensure that they understand the process for taking disciplinary action against resident physicians, and are aware of procedures for dismissal of residents and for due process. This requirement for residency program directors should be enforced through Accreditation Council for Graduate Medical Education accreditation requirements. (6) There should be no reporting of actions against medical students to state medical licensing boards. (7) Medical schools are responsible for identifying and remediating and/or disciplining medical student unprofessional behavior, problems with substance abuse, and other behavioral problems, as well as gaps in student knowledge and skills. (8) The Dean's Letter of Evaluation should be strengthened and standardized, to serve as a better source of information to residency programs about applicants. (CME Rep. 8, A-99; Reaffirmed: CME Rep. 4, I-01)

H-275.940 Physician Impairment

The AMA adopts the policy that, except in the case of summary suspension necessary to protect patients from imminent harm, no adverse action be taken against the privileges of a physician by a hospital, managed care organization or insurer based on a claim of physician impairment without a suitable due process hearing in accordance with medical staff bylaws to determine the facts related to the allegations of impairment and, where appropriate, a careful clinical evaluation of the physician. (Res. 701, I-97; Reaffirmed: CME Rep. 2, A-07)

H-275.949 Discrimination against Physicians Under Supervision of Their Medical Examining Board

The AMA opposes the exclusion of otherwise capable physicians from employment, business opportunity, insurance coverage, specialty board certification or recertification, and other benefits, solely because the physician is either presently, or has been in the past, under the supervision of a medical licensing board in a program of rehabilitation. (Sub. Res. 3, A-92; Reaffirmed: BOT Rep. I-93-18)

H-275.952 Reporting Impaired, Incompetent or Unethical 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) Physicians should work to assure that state laws provide immunity to those who report impaired, incompetent, or unethical colleagues.
- (2) 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.
- (3) 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. (CEJA Rep. A, I-91; Reaffirmed: BOT Rep. 17, I-99; Modified and Reaffirmed: CEJA Rep. 1, A-03; Reaffirmation I-03)

H-275.964 Impaired Physicians Practice Act

Our AMA encourages state medical societies that do not have effectively functioning impaired physicians programs to improve their programs and to urge their states to adopt the AMA 1985 Model Impaired Physician Treatment Act, as necessary. (Sub. Res. 7, A-89; Reaffirmed: BOT Rep. 17 and Sunset Report, A-00)

H-275.998 Physician Competence

Our AMA urges: (1) The members of the profession of medicine to discover and rehabilitate if possible, or to exclude if necessary, the physicians whose practices are incompetent.

- (2) All physicians to fulfill their responsibility to the public and to their profession by reporting to the appropriate authority those physicians who, by being impaired, need help, or whose practices are incompetent.
- (3) The appropriate committees or boards of the medical staffs of hospitals which have the responsibility to do so, to restrict or remove the privileges of physicians whose practices are known to be incompetent, or whose capabilities are impaired, and to restore such physicians to limited or full privileges as appropriate when corrective or rehabilitative measures have been successful.

(4) State governments to provide to their state medical licensing boards resources adequate to the proper discharge of their responsibilities and duties in the recognition and maintenance of competent practitioners of medicine.

(5) State medical licensing boards to discipline physicians whose practices have been found to be incompetent.

(6) State medical licensing boards to report all disciplinary actions promptly to the Federation of State Medical Boards and to the AMA Physician Masterfile. (Failure to do so simply allows the incompetent or impaired physician to migrate to another state, even after disciplinary action has been taken against him, and to continue to practice in a different jurisdiction but with the same hazards to the public.) (CME Rep. G, A-79; Reaffirmed: CLRPD Rep. B, I-89; Reaffirmed: Sunset Report, A-00; Reaffirmation I-03)

H-285.985 Discrimination Against Physicians by Health Care Plans

Our AMA: (1) will develop draft federal and model state legislation requiring managed care plans and third party payers to disclose to physicians and the public, the selection criteria used to select, retain, or exclude a physician from a managed care or other provider plans; (2) will request an advisory opinion from the Department of Justice on the application of the Americans with Disabilities Act of 1990 to selective contracting decisions made by managed care plans or other provider plans; (3) will support passage of federal legislation to clarify the Americans With Disabilities Act to assure that coverage for interpreters for the hearing impaired be provided for by all health benefit plans. Such legislation should also clarify that physicians practicing in an office setting should not incur the costs for qualified interpreters or auxiliary aids for patients with hearing loss unless the medical judgment of the treating physician reasonably supports such a need; (4) encourages state medical associations and national medical specialty societies to provide appropriate assistance to physicians at the local level who believe they may be treated unfairly by managed care plans, particularly with respect to selective contracting and credentialing decisions that may be due, in part, to a physician's history of substance abuse; and (5) urges managed care plans and third party payers to refer questions of physician substance abuse to state medical associations and/or county medical societies for review and recommendation as appropriate. (BOT Rep. 18, I-93; Appended by BOT Rep. 28, A-98; Reaffirmation A-99; Reaffirmation A-00)

H-295.927 Medical Student Health and Well-Being

The AMA encourages the Association of American Medical Colleges, Liaison Committee on Medical Education, medical schools, and teaching hospitals to address issues related to the health and well-being of medical students, with particular attention to issues such as HIV infection that may have long-term implications for health, disability and medical practice, and consider the feasibility of financial assistance for students with disabilities. (BOT Rep. 1, I-934; Modified with Title Change: CSA Rep. 4, A-03)

H-295.942 Providing Dental and Vision Insurance to Medical Students and Resident Physicians

The AMA urges (1) all medical schools to pay for or offer affordable policy options and, assuming the rates are appropriate, require enrollment in disability insurance plans by all medical students; (2) all residency programs to pay for or offer affordable policy options for disability insurance, and strongly

encourage the enrollment of all residents in such plans; (3) medical schools and residency training programs to pay for or offer comprehensive and affordable health insurance coverage, including but not limited to medical, dental, and vision care, to medical students and residents which provides no less than the minimum benefits currently recommended by the AMA for employer-provided health insurance and to require enrollment in such insurance; (4) carriers offering disability insurance to: (a) offer a range of disability policies for medical students and residents that provide sufficient monthly disability benefits to defray any educational loan repayments, other living expenses, and an amount sufficient to continue payment for health insurance providing the minimum benefits recommended by the AMA for employer-provided health insurance; and (b) include in all such policies a rollover provision allowing continuation of student disability coverage into the residency period without medical underwriting. (5) Our AMA: (a) actively encourages medical schools, residency programs, and fellowship programs to provide access to portable group health and disability insurance, including human immunodeficiency virus positive indemnity insurance, for all medical students and resident and fellow physicians; (b) will work with the ACGME and the LCME, and other interested state medical societies or specialty organizations, to develop strategies and policies to ensure access to the provision of portable health and disability insurance coverage, including human immunodeficiency virus positive indemnity insurance, for all medical students, resident and fellow physicians; and (c) will prepare informational material designed to inform medical students and residents concerning the need for both disability and health insurance and describing the available coverage and characteristics of such insurance. (BOT Rep. W, I-91; Reaffirmed: BOT Rep. 14, I-93; Appended: Res. 311, I-98; Modified: Res. 306, A-04)

H-295.948 Health and Disability Insurance for Medical Students

The AMA (1) takes the position that all medical schools and residency programs provide insurance policy options that include a reasonable definition of "sickness" or "disability" that includes HIV infection, and require enrollment in such health and disability insurance plans for all their medical students and residents, and (2) encourages other health professions to provide similar health and disability insurance policies for their students. (BOT Rep. Q, A-91; Amended: BOT Rep. J, I-92; Reaffirmed: CME Rep. 2, A-03)

H-295.965 Medical Student Abuse

It is the policy of the AMA that the AMA, in cooperation with other appropriate agencies such as the LCME and the AAMC, define medical student abuse, study the pervasiveness of medical student abuse in U.S. medical schools and develop model guidelines to address abuse. (Res. 290, A-90; Modified: Sunset Report, I-00)

H-295.979 Substance Abuse

The AMA (1) reaffirms its position which recognizes the importance of preventing and treating psychiatric illness, alcoholism and substance abuse in medical students, residents and fellows; (2) urges medical schools to include substance abuse prevention programs in their curriculum; and (3) urges medical schools, hospitals with graduate medical education programs, and state and county medical societies to initiate active liaison with local impaired physician committees in order to more effectively diagnose and treat medical student and resident substance abuse. (Res. 106, I-85; Reaffirmed by CLRPD Rep. 2, I-95; Reaffirmed: CME Rep. 10, I-98; Reaffirmed: BOT Rep. 17, I-99)

H-295.987 Impairment Prevention and Treatment in the Training Years

The AMA (1) reaffirms the importance of preventing and treating psychiatric illness, alcoholism and substance abuse in medical students, residents and fellows; and (2) strongly encourages medical schools and teaching hospitals to develop and maintain impairment prevention and treatment programs with confidential services for medical students, residents and fellows. (Sub. Res. 25, A-84; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmed: CME Rep. 2, A-04)

H-295.988 Alcohol and Substance Abuse Education of Medical Students and Residents

In cooperation with other organizations, the AMA supports the education of medical students and residents in the prevention and treatment of alcoholism and substance abuse in our nation's youth. (Sub. Res. 100, A-84; Reaffirmed by CLRPD Rep. 3-I-94; Reaffirmed: CME Rep. 2, A-04)

H-295.992 Medical Student Education Concerning Physician Impairment

The AMA (1) supports the teaching of the prevention of physician impairment to medical students and residents; and (2) encourages state medical society physician impairment committees and institutions offering medical education to address student and resident problems with substance abuse. (Sub. Res. 80, I-82; Reaffirmed by CLRPD Rep. A, I-92; Reaffirmed: CME Rep. 2, A-03)

H-295.993 Inclusion of Medical Students and Residents in Medical Society Impaired Physician Programs

The AMA recognizes the need (1) for appropriate mechanisms to include medical students and resident physicians in existing medical society impaired physician programs; and (2) for these programs to include activities to prevent impairment.

Our AMA encourages medical school administration and students to work together to develop creative ways to inform students concerning available medical school impairment treatment programs and that schools ensure that these services are provided confidentially. (Sub. Res. 84, I-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed and appended: CME Rep. 4, I-98)

H-295.999 Medical Student Support Groups

(1) Our AMA encourages the development of alternative methods for dealing with the problems of student-physician mental health among medical schools, such as: (a) introduction to the concepts of physician impairment at orientation; (b) ongoing support groups, consisting of students and house staff in various stages of their education; (c) journal clubs; (d) fraternities; (e) support of the concepts of physical and mental well-being by heads of departments, as well as other faculty members; and/or (f) the opportunity for interested students and house staff to work with students who are having difficulty. (2) The AMA supports making these alternatives available to students at the earliest possible point in their medical education. (Res. 164, A-79; Reaffirmed: CLRPD Rep. B, I-89; Reaffirmed: CME Rep. 4, I-98)

H-310.947 Revision of the "General Requirements" of the Essentials of Accredited Residency Programs

The AMA supports the following principles of the ACGME Institutional Requirements: Candidates for residencies must be fully informed of benefits including financial support, vacations, professional leave, parental leave, sick leave, professional liability insurance, hospital and health insurance, disability insurance, and other insurance benefits for the residents and their family and the conditions under which living quarters, meals and laundry or their equivalent are to be provided. Institutions sponsoring graduate medical education must provide access to insurance, where available, to all residents for disabilities resulting from activities that are part of the educational program. Institutions should have a written policy and an educational program regarding physician impairment, including substance abuse. (CME Rep. Q, A-93; Modified: CME Rep. 2, A-03)

H-355.992 Reporting Impaired Physicians to the National Practitioner Bank

Our AMA will continue to monitor the issue of reporting impaired physicians to the National Practitioner Data Bank and will seek further clarification of ambiguities or misinterpretations of the reporting requirements for impaired physicians. (BOT Rep. J, A-91; Reaffirmed: Sunset Report, I-01)

H-375.965 Principles for Incident-Based Peer Review and Disciplining at Health Care Organizations

AMA policy is that: (1) Summary suspension of clinical privileges is an extraordinary remedy which should be used only when the physician's continued practice presents an "imminent danger to the health of any individual." The decision to summarily suspend a member's medical staff membership or clinical privileges should be made by the chief of staff, chair or vice-chair of the member's clinical department, or medical executive committee. The medical executive committee (MEC) must meet as soon as possible, but in no event more than 14 days after the summary suspension is imposed, or before the time in which a report would be required to the state licensing agency if applicable, whichever is shorter, to review and consider the summary suspension. The MEC shall then promptly modify, continue or terminate the summary suspension. The suspended physician must be invited to attend and make a statement concerning the issues under investigation, but the meeting with the MEC shall not constitute the physician's fair hearing. If the MEC sustains the suspension, said action will trigger the fair hearing procedures contained in these policies. (2) At the request of a medical staff department or of a member under review, or at its own initiative if needed for adequate and unbiased review, the medical executive committee may arrange, through the state or local medical society, the relevant specialty society or other appropriate source, for an external hearing panel to hear the case in order to assure professional and impartial clinical assessment. (3) Prior to any disciplinary hearing, the physician should be provided with a clear, and if applicable, clinically supported basis for the proposed professional review action. A hearing panel of a health care organization should be guided by generally accepted clinical guidelines and established standards in its review actions. (4) Physician health and impairment issues should be identified and managed by a medical staff committee, which should operate separately from the disciplinary process. (BOT Action in response to referred for decision BOT Rep. 23, A-05)

H-375.990 Peer Review of the Performance of Hospital Medical Staff Physicians

Our AMA encourages peer review of the performance of hospital medical staff physicians, which is objective and supervised by physicians. Membership on peer review committees and hearing panels should be open to all physicians on the medical staff and should not be restricted to those physicians who have an exclusive contract with the hospital, salaried physicians, or those on the faculty. (Res. 57,

I-85; Reaffirmed CLRPD Rep. 2, I-95; Reaffirmed: BOT Rep. 8, I-01; Amended: BOT Action in response to referred for decision BOT Rep. 23, A-05)

H-420.961 Education -- Policies for Maternity, Family and Medical Necessity Leave for Residents and Employed Physicians

AMA adopts as policy the following guidelines for, and encourage the implementation of, Maternity and Family Leave for Residency Programs and Employed Medical Staffs: (1) The AMA urges medical schools, residency training programs, medical specialty boards, and the Accreditation Council for Graduate Medical Education to incorporate and/or encourage development of written leave policies, including parental leave, family leave, and medical leave; (2) Residency program directors should review federal and state law for guidance in developing policies for parental, family, and medical leave; (3) Physicians who are unable to work because of pregnancy, childbirth, and other related medical conditions should be entitled to such leave and other benefits on the same basis as other physicians who are temporarily unable to work for other medical reasons; (4) Residency programs should develop written policies on parental leave, family leave, and medical leave for physicians. Such written policies should include the following elements: (a) leave policy for birth or adoption; (b) duration of leave allowed before and after delivery; (c) category of leave credited (e.g., sick, vacation, parental, unpaid leave, short term disability); (d) whether leave is paid or unpaid; (e) whether provision is made for continuation of insurance benefits during leave and who pays for premiums; (f) whether sick leave and vacation time may be accrued from year to year or used in advance; (g) extended leave for resident physicians with extraordinary and long-term personal or family medical tragedies for periods of up to one year, without loss of previously accepted residency positions, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life; (h) how time can be made up in order for a resident physician to be considered board eligible; (i) what period of leave would result in a resident physician being required to complete an extra or delayed year of training; (j) whether time spent in making up a leave will be paid; and (k) whether schedule accommodations are allowed, such as reduced hours, no night call, modified rotation schedules, and permanent part-time scheduling; (5) Staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in the workloads of other physicians, particularly those in residency programs; (6) Physicians should be able to return to their practices or training programs after taking parental leave, family leave, or medical leave without the loss of status; and (7) Residency program directors must assist residents in identifying their specific requirements (for example, the number of months to be made up); because of leave for eligibility for board certification. Residency program directors must notify residents on leave if they are in danger of falling below minimal requirements for board eligibility. Program directors must give these residents a complete list of requirements to be completed in order to retain board eligibility. (CME Rep. 6, A-98; Reaffirmation I-03)

H-420.967 Maternity Leave Policies

Over the past decade, the medical community has made significant progress in responding to the unique needs of women medical students and physicians, including the issue of maternity leave. The continuation and enhancement of these efforts should be encouraged. Therefore, (1) The AMA urges medical schools, residency training programs, medical specialty boards, the Accreditation Council for Graduate Medical Education, and medical group practices to incorporate and/or encourage development of written maternity leave policies as part of the physician's standard benefit agreement. (2) AMA policy regarding recommended components of maternity leave policies for physicians, as specified in Policy 420.987 is expanded to include physicians in practice, reading as follows: (a)

Residency program directors and group practice administrators should review federal law concerning maternity leave for guidance in developing policies to assure that pregnant physicians are allowed the same sick leave or disability benefits as those physicians who are ill or disabled; (b) Staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in other physicians' work loads, particularly in residency programs; and (c) Physicians should be able to return to their practices or training programs after taking maternity leave without the loss of status. (3) Our AMA encourages residency programs, specialty boards, and medical group practices to incorporate into their maternity leave policies a six-week minimum leave allowance, with the understanding that no woman should be required to take a minimum leave. (BOT Rep. HH, I-90; Modified: Sunset Report, I-00)

H-420.987 Maternity Leave for Residents

The AMA believes that: (1) Residency program directors should review federal law concerning maternity leave and note that for policies to be in compliance, pregnant residents must be allowed the same sick leave or disability benefits as other residents who are ill or disabled. (2) The duration of disability leave should be determined by the pregnant resident's physicians, based on the individual's condition and needs. (3) All residency programs should develop a written policy on maternity and paternity leave for residents that addresses: (a) duration of leave allowed before and after delivery; (b) category of leave credited; (c) whether leave is paid or unpaid; (d) whether provision is made for continuation of insurance benefits during leave, and who pays the premium; (e) whether sick leave and vacation time may be accrued from year to year or used in advance; (f) how much time must be made up in order to be considered board eligible; (g) whether make-up time will be paid; (h) whether schedule accommodations are allowed; (i) leave policy for adoption; and (j) leave policy for paternity. (4) Resident numbers and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in other residents' work loads. (5) Residents should be able to return to their training program after disability leave without loss of training status. (BOT Rep. Z, A-84; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmed and Modified: CME Rep. 2, A-04)

D-95.998 Physicians as Patients: their Right to Confidentiality

Our AMA will continue to work with the American Society of Addiction Medicine, the American Psychiatric Association, and other interested organizations to address concerns regarding substance abuse among physicians. (BOT Rep. 17, I-99)

D-295.946 The Status of Education in Substance Use Disorders in America's Medical Schools and Residency Programs

Our AMA will: (1) advocate for in-depth qualitative studies to facilitate the preparation of physicians to care for patients with substance use disorders; (2) facilitate the identification, dissemination, and implementation of successful substance use disorder educational programs across the educational continuum; (3) encourage the Accreditation Council for Graduate Medical Education (ACGME) to include education about substance use disorders in their program accreditation requirements; (4) encourage the American Board of Medical Specialties (ABMS) to encourage its member boards to include substance use disorder questions in their certification process; and (5) through its Council on Medical Education, monitor and track implementation of the recommendations of the December 2006 House Office of National Drug Control Policy White House Leadership Conference on Medical Education in Substance Abuse report. (CME Rep. 11, A-07)

D-295.948 Report on the Status of Education in Substance Abuse and Addiction in America's Medical Schools and Residency Programs

Our AMA Council on Medical Education will produce a report of the status of education in substance use and addiction in America's medical schools and residency programs. (Res. 314, A-06)

D-295.999 Extending Impaired Physician Programs to Medical Students

Our AMA will inform students of the variety of options available for treatment of impairment, including medical school and state medical society programs. (CME Rep. 4, I-98; Reaffirmed: CME Report 2, A-08)

D-300.984 Physician Reentry

Our AMA: 1. Will continue to collaborate with other appropriate organizations on physician reentry issues including research on the need for and the effectiveness of reentry programs. 2. Will work collaboratively with the American Academy of Pediatrics and other interested groups to convene a conference on physician reentry which will bring together key stakeholders to address the development of reentry programs as well as the educational needs of physicians reentering clinical practice. 3. Will work with interested parties to establish a physician reentry program (PREP) information data base that is publicly accessible to physician applicants and which includes information pertaining to program characteristics. 4. Will support efforts to ensure the affordability and accessibility, and to address the unique liability issues related to PREPs. 5. Will make available to all interested parties the physician reentry program (PREP) system Guiding Principles for use as a basis for all reentry programs: a. Accessible: The PREP system is accessible by geography, time and cost. Reentry programs are available and accessible geographically across the United States and include national and regional pools of reentry positions. Reentering physicians with families or community ties are not burdened by having to relocate to attend a program. The length of time of reentry programs is standardized and is commensurate with the assessed clinical and educational needs of reentering physicians. The cost of reentry programs is not prohibitive to the physician, health care institutions or the health care system. b. Collaborative: The PREP system is designed to be collaborative to improve communication and resource sharing. Information and materials including evaluation instruments are shared across specialties, to the extent possible, to improve program and physician performance. A common nomenclature is used to maximize communication across specialties. Reentry programs share resources and create a common repository for such resources, which are easily accessible. c. Comprehensive: The PREP system is comprehensive to maximize program utility. Physician reentry programs prepare physicians to return to clinical activity in the discipline in which they have been trained or certified and in the practice settings they expect to work including community-based, public health, and hospital-based or academic practice. d. Ethical: The PREP system is based on accepted principles of medical ethics. Physician reentry programs will conform to physician licensure statutes. The standards of professionalism, as stated in the AMA Code of Medical Ethics, must be followed. e. Flexible: The PREP system is flexible in structure in order to maximize program relevancy and usefulness. Physician reentry programs can accommodate modifications to program requirements and activities in ways that are optimal to the needs of reentering physicians. f. Modular: Physician reentry programs are modularized, individualized and competency-based. They are tailored to the learning needs of reentering physicians, which prevents the need for large, expensive, and standardized programs. Physicians should only be required to take those modules that allow them to meet an identified educational need. g. Innovative: Innovation is built into a PREP system allowing programs to offer state of the art learning and meet the diverse and changing needs of reentry physicians.

Physician reentry programs develop and utilize learning tools including experimenting with innovative and novel curricular methodologies such as distance learning technologies and simulation. h. Accountable: The PREP system has mechanisms for assessment and is open to evaluation. Physician reentry programs have an evaluation component that is comparable among all specialties. Program assessments use objective measures to evaluate physician's competence at time of entry, during the program and at time of completion. Program outcomes are measured. Reliability and validity of the measures are established. Standardization of measures exist across programs to assess whether or not national standards are being met. i. Stable: A funding scheme is in place to ensure the PREP system is financially stable over the long-term. Adequate funding allows physician reentry programs to operate at sufficient and appropriate capacity. j. Responsive: The PREP system makes refinements, updates and other changes when necessary. Physician reentry programs are equipped to address systemic changes such as changes in regulations. Additionally, the PREP system is prepared to respond efficiently to urgent health care needs within society including mobilizing clinically inactive physicians temporarily into the workforce to attend to an acute public health crisis, such as a terrorist, biological, chemical, or natural disaster. 6. Will, as part of its Initiative to Transform Medical Education strategic focus and in support of its members and Federation partners, develop model program standards utilizing PREP system Guiding Principles with a report back at the 2009 Interim Meeting. (CME Rep. 6, A-08)

D-310.968 Intern and Resident Burnout

1. Our AMA recognizes that burnout, defined as emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment or effectiveness, is a problem among residents and fellows.
2. Our AMA will work with other interested groups to regularly inform Graduate Medical Education designated institutional officials program directors, resident physicians, and attending faculty about resident/fellow burnout (including recognition, treatment, and prevention of burnout) through such media as the AMA's GME e-Letter.
3. Our AMA will encourage the Accreditation Council for Graduate Medical Education and the Association of American Medical Colleges to address the recognition, treatment, and prevention of burnout among residents/fellows.
4. Our AMA will encourage further studies and disseminate the results of studies on physician burnout to the medical education and physician community.
5. Our AMA will continue to monitor this issue and track its progress, including publication of peer-reviewed research and changes in accreditation requirements, with a report back at the 2009 Interim Meeting of the AMA House of Delegates. (CME Rep. 8, A-07)

D-315.993 Physicians as Patients: their Right to Confidentiality

Our AMA will consider for possible intervention pending and future court cases in which the principles of informed consent are inappropriately expanded to require disclosure of a physician's impairment, including substance abuse problems, or information otherwise protected by laws governing patient privacy and confidentiality. (BOT Rep. 17, I-99)

D-345.993 Physician Suicide

Our AMA will: (1) work with the American Foundation for Suicide Prevention and the Federation of State Physician Health Programs to study, to educate physicians, and to increase awareness through medical schools, state physician health committees, the AMA Alliance, and internal publications to anticipate, mitigate and eliminate, as far as possible, the preventable endemic catastrophe of physician suicide; and (2) contact the director of the Substance Abuse and Mental Health Services Administration and the American Psychiatric Association to join with the initiative to explore ways to

act now to reduce the high prevalence of suicide in the United States particularly among physicians.
(Res. 429, A-06)

D-405.992 Physician Health and Wellness

Our AMA: (1) supports programs related to physician health and wellness, including those offered in conjunction with the Federation of State Physician Health Programs; (2) will convene those interested in medical education in an effort to bring the dialogue about healthy lifestyle and balance early in the careers of medical students and residents; and (3) considers the concept of physician wellness as an element of the AMA Strategic Plan. (Res. 609, A-08)

D-405.996 Physician Well-Being and Renewal

Our AMA will work with the Federation of State Physician Health Programs to establish and promulgate a networking resource/database and web site clearinghouse for Medical Staff Physician Health Committees or their equivalents in physician groups throughout the country, and to provide resources that will allow such committees to proactively initiate programs of wellness and illness prevention for physicians. (Res. 409, A-03)

G-600.025 Official Observers in Our AMA House

Organizations granted official observer status since December 1998 include the following: (1) Our AMA grants the American Nurses Association Official Observer Status in the House of Delegates and invites them to send a non-voting official observer to all House of Delegates Meetings. (December 1998) (2) Our AMA grants the Commission on Graduates of Foreign Nursing Schools Official Observer Status in the House of Delegates and invites them to send a non-voting official observer to all House of Delegates Meetings. (June 1999) (3) Our AMA grants the Alliance for Continuing Medical Education Official Observer Status in the House of Delegates and invites them to send a non-voting official observer to all House of Delegates Meetings. (December 1999) (4) Our AMA grants the Association of PeriOperative Nurses Official Observer Status in the House of Delegates and invites them to send a non-voting official observer to all House of Delegates Meetings. (June 2000) (5) Our AMA grants the Federation of State Medical Boards of the United States, Inc, Official Observer Status in the House of Delegates and invites them to send a non-voting official observer to all House of Delegates Meetings. (June 2000) (6) Our AMA grants the National Commission on Correctional Health Care Official Observer Status in the House of Delegates and invites them to send a non-voting official observer to all House of Delegates Meetings. (December 2000) (7) Our AMA grants the National Council of State Boards of Nursing Official Observer status in the House of Delegates and invites them to send a non-voting observer to all meetings of our AMA House of Delegates. (December 2000) (8) Our AMA grants the Society for Academic Continuing Medical Education Official Observer Status in the House of Delegates and invites them to send a non-voting official observer to all House of Delegates Meetings. (June 2003). (9) Our AMA grants the Federated Ambulatory Surgery Association Official Observer Status in the House of Delegates and invites them to send a non-voting official observer to all House of Delegates Meetings. (June 2005) (10) Our AMA grants the Federation of State Physician Health Programs Official Observer Status in the House of Delegates and invites them to send a non-voting official observer to all House of Delegates Meetings. (June 2006) (11) Our AMA grants the Council of Medical Specialty Societies Official Observer Status in the House of Delegates and invites them to send a non-voting official observer to all HOD meetings. (June 2008) (BOT Rep. 27, I-98; BOT Rep. 1, A-99; BOT Rep. 11, I-99; BOT Rep. 1 and 5, A-00; BOT Rep. 5 and 12, I-00;

Consolidated: CLRPD Rep. 3, I-01; Appended: BOT Rep. 17, A-03; Appended: BOT Rep. 2, A-05; Appended: BOT Rep. 7, A-06; Appended: BOT Rep. 10, A-08)

G-630.120 Grants and Funding

AMA policy on grants and funding includes the following: Our AMA: ... (2) supports continuing to adequately fund and maintain a physicians health program (Physicians' Assistance Program), whose charge will include, but not be limited to, promoting state medical society impaired physician programs and medical student impairment programs, providing technical assistance to these programs, conducting scientific and socioeconomic research and hosting an annual conference to share research and exchange ideas on the field of physician impairment. (Res. 102, I-89; Res. 604, A-93; Reaffirmed: Sunset Report, A-00; Consolidated: CLRPD Rep. 3, I-01)

E-8.088 Resident Physicians' Involvement in Patient Care

Residents and fellows have dual roles as trainees and caregivers. First and foremost, they are physicians and therefore should always regard the interests of patients as paramount. To facilitate both patient care and educational goals, physicians involved in the training of residents and fellows should ensure that the health care delivery environment is respectful of the learning process as well as the patient's welfare and dignity. (1) In accordance with graduate medical education standards such as those promulgated by the Accreditation Council for Graduate Medical Education (ACGME), training must be structured to provide residents and fellows with appropriate faculty supervision and availability of faculty consultants, and with graduated responsibility relative to level of training and expertise. (2) Residents' and fellows' interactions with patients must be based on honesty. Accordingly, residents and fellows should clearly identify themselves as members of a team that is supervised by the attending physician. (3) If a patient refuses care from a resident or fellow, the attending physician should be notified. If after discussion, a patient does not want to participate in training, the physician may exclude residents or fellows from that patient's care or, if appropriate, transfer the patient's care to another physician or non-teaching service, or to another health care facility. (4) Residents and fellows should participate fully in established mechanisms for error reporting and analysis in their training programs and hospital systems. They should cooperate with attending physicians in the communication of errors to patients. (See Opinion E-8.121, "Ethical Responsibility to Study and Prevent Error and Harm.") (5) Residents and fellows are obligated, as are all physicians, to monitor their own health and level of alertness so that these factors do not compromise their ability to care for patients safely. (See Opinion E-9.035, "Physician Health and Wellness.") Residents and fellows should recognize that providing patient care beyond time permitted by their programs (for example, "moonlighting") might be potentially harmful to themselves and patients. Other activities that interfere with adequate rest during off-hours might be similarly harmful. (6) Residency and fellowship programs must offer means to resolve educational or patient care conflicts that can arise in the course of training. All parties involved in such conflicts must continue to regard patient welfare as the first priority. Conflict resolution should not be punitive, but should aim at assisting residents and fellows to complete their training successfully. When necessary, higher administrative authorities or the relevant Residency Review Committee (RRC) should be involved, as articulated in ACGME guidelines. (I, II, V, VIII) Issued November 2005 based on the report "Resident Physicians' Involvement in Patient Care," adopted June 2005.

E-8.15 Substance Abuse

It is unethical for a physician to practice medicine while under the influence of a controlled substance, alcohol, or other chemical agents which impair the ability to practice medicine. (I) Issued December 1986.

E-9.0305 Physician Health and Wellness

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. (I, II) Issued June 2004 based on the report "Physician Health and Wellness," adopted December 2003.

E-9.031 Reporting Impaired, Incompetent, or Unethical Colleagues

Physicians have an ethical obligation to report impaired, incompetent, and/or unethical colleagues in accordance with the legal requirements in each state and assisted by the following guidelines:

Impairment. Physicians' responsibilities to colleagues who are impaired by a condition that interferes with their ability to engage safely in professional activities include timely intervention to ensure that these colleagues cease practicing and receive appropriate assistance from a physician health program (see Opinion E-9.0305, "Physician Health and Wellness"). Ethically and legally, it may be necessary to report an impaired physician who continues to practice despite reasonable offers of assistance and referral to a hospital or state physician health program. The duty to report under such circumstances, which stems from physicians' obligation to protect patients against harm, may entail reporting to the licensing authority.

Incompetence. 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. The hospital peer review body should be notified where appropriate.

Incompetence that poses an immediate threat to the health and safety of patients should be reported directly to the state licensing board. Incompetence by physicians without a hospital affiliation should be reported to the local or state medical society and/or the state licensing or disciplinary board.

Unethical conduct. With the exception of incompetence or impairment, unethical behavior should be reported in

accordance with the following guidelines and, considering, as necessary, the right to privacy of any patients involved: Unethical conduct that threatens patient care or welfare should be reported to the appropriate authority for a particular clinical service. Unethical conduct that violates state licensing provisions should be reported to the state licensing board. It is appropriate to report unethical conduct that potentially violates criminal statutes to law enforcement authorities. All other unethical conduct should be reported to the local or state professional medical organization. When the inappropriate conduct of a physician continues despite the initial report(s), the reporting physician should report to a higher or additional authority. The person or body receiving the initial report should notify the reporting physician when appropriate action has been taken. Physicians who receive reports of inappropriate behavior, including reports submitted anonymously, have an ethical duty to critically, objectively, and confidentially evaluate the reported information and assure that identified deficiencies are either remedied or further reported to a higher or additional authority. Information regarding reports or investigations of impairment, or of incompetent or unethical behavior should be held in confidence until the matter is resolved. (II) Issued March 1992 based on the report "Reporting Impaired, Incompetent, or Unethical Colleagues," adopted December 1991 (J Miss St Med Assoc. 1992; 33: 176-77); updated June 1994; updated June 1996; and updated June 2004, based on the report "Physician Health and Wellness," adopted December 2003.

E-9.055 Disputes Between Medical Supervisors and Trainees

Clear policies for handling complaints from medical students, resident physicians, and other staff should be established. These policies should include adequate provisions for protecting the confidentiality of complainants whenever possible. Confidentiality of complainants should be protected when doing so does not hinder the subject's ability to respond to the complaint. Access to employment and evaluation files should be carefully monitored to remove the possibility of tampering. Resident physicians should be permitted access to their employment files and also the right to copy the contents thereof, within the provisions of applicable federal and state laws. Medical students, resident physicians, and other staff should refuse to participate in patient care ordered by their supervisors in those rare cases in which they believe the orders reflect serious errors in clinical or ethical judgment, or physician impairment, that could result in a threat of imminent harm to the patient or to others. In these rare cases, the complainant may withdraw from the care ordered by the supervisor, provided withdrawal does not itself threaten the patient's immediate welfare. The complainant should communicate his or her concerns to the physician issuing the orders and, if necessary, to the appropriate persons for mediating such disputes. Mechanisms for resolving these disputes, which require immediate resolution, should be in place. Third-party mediators of such disputes may include the chief of staff of the involved service, the chief resident, a designated member of the institutional grievance committee, or, in large institutions, an institutional ombudsperson largely outside of the established hospital staff hierarchy. Retaliatory or punitive actions against those who raise complaints are unethical and are a legitimate cause for filing a grievance with the appropriate institutional committee. (II, III, VII) Issued June 1994 based on the report "Disputes Between Medical Supervisors and Trainees," adopted December 1993 (JAMA. 1994; 272: 1861-65).