

## ARC Issue Brief: Confidential care to support physician health and wellness<sup>1</sup>

Prior to the COVID-19 pandemic, physician burnout was already a major challenge for the U.S. health care system, impacting nearly every aspect of clinical care. Recent studies show a national burnout rate of 43.9 percent among physicians in practice,<sup>2</sup> including private practice, academic medical centers and the U.S. Department of Veterans Affairs. Physician burnout can lead to devastating consequences for patients and doctors. Physicians are among the most resilient<sup>3</sup>, but the pressures and responsibilities affecting physicians do not always allow for opportunities for them to seek help or focus on what they need to remain resilient and healthy.<sup>4</sup> “*We must be vigilant for signs of burnout and depression within ourselves and among our colleagues, and we must not hesitate to seek help when we recognize something is amiss,*” said Susan R. Bailey, MD, AMA President, in a [recent article](#).

The COVID-19 pandemic has in some parts of the country pushed physician burnout to crisis levels, as physicians have been desperately needed to care for patients on the frontlines. Many physicians have for long periods of time been subject to extremely stressful conditions during the pandemic—conditions that have made them particularly vulnerable to negative mental and physical health effects. Stressors already present in their lives have become exacerbated, making the need to be able to obtain confidential counseling or other care more important than ever. It is important to distinguish that seeking assistance to ensure wellness is often separate and distinct from seeking care for an impairment—and that policy and care options provide for different levels of care while retaining key confidentiality protections to encourage physicians to seek the care they may need voluntarily.

This issue brief highlights several different options for physicians seeking care and provides tangible legislative and regulatory options for medical societies to support those efforts. It furthers goals of balancing privacy and confidentiality while also reducing stigma and protecting the public health.<sup>5</sup>

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<sup>1</sup> Updated September 2020. The information and guidance provided in this document is believed to be current and accurate at the time of posting but it is not intended as, and should not be construed to be, legal, financial, medical, or consulting advice.

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<sup>2</sup> Shanafelt TD, West CP, Sinsky C, et al Changes in burnout and satisfaction with work-life integration in physicians and the general US working population between 2011 and 2017. *Mayo Clin Proc.* 2019;94(9):1681–1694. doi: 10.1016/j.mayocp.2018

<sup>3</sup> West CP, Dyrbye LN, Sinsky C, Trockel, M, Tutty M, Nedelec L, Carlasare LE, Shanafelt TD. Resilience and Burnout Among Physicians and the General US Working Population. *JAMA Netw Open.* 2020;3(7):e209385. doi:10.1001/jamanetworkopen.2020.9385

<sup>4</sup> Annie Nedrow, MD, MBA, Nicole A. Steckler, PhD, and Joseph Hardman, MD. Physician Resilience and Burnout: Can You Make the Switch? *Fam Pract Manag.* 2013 Jan-Feb;20(1):25-30. <https://www.aafp.org/fpm/2013/0100/p25.html>

<sup>5</sup> For an excellent discussion of this balance, see the April 2018 Federation of State Medical Boards’ Recommendations of the Workgroup on Physician Wellness and Burnout, which stated, “Privacy and confidentiality of a physician’s health and treatment history is important to allow those in need of help to come forward without fear of punishment, disciplinary action, embarrassment or professional isolation. The use of confidential services whenever possible in lieu of regulatory awareness is preferred in order to mitigate fear of negative impacts on licensure, employment, or collegial relationships. When confidential services are not utilized, it is less likely licensees will receive early intervention and appropriate treatment, thereby foregoing opportunities for early detection of potentially impairing illness or recovery.” Available at <https://www.fsmb.org/siteassets/advocacy/policies/policy-on-wellness-and-burnout.pdf>

The issue brief also directly addresses ongoing concerns about inappropriate medical board licensing questions (or those that appear on credentialing applications) that may deter physicians from seeking care.<sup>6</sup> As noted by the Federation of State Medical Boards (FSMB):

“The FSMB recommends that state medical boards review their medical licensure (and renewal) applications and evaluate whether it is necessary to include probing questions about a physician applicant’s mental health, addiction, or substance use, and whether the information these questions are designed to elicit in the interests of patient safety may be obtained through means that are less likely to discourage treatment-seeking among physician applicants”

When medical boards do include questions pertaining to a physician applicant’s health, the FSMB recommends “**Application questions must focus only on current impairment and not on illness diagnosis, or previous treatment in order to be compliant with the Americans with Disabilities Act (ADA)**”.

Some states have already made changes to their application and renewal forms to move in this direction.<sup>7</sup> But much work remains to be done and a research project documenting each state’s regulation shows a wide variety of obstacles.<sup>8</sup>

This issue brief provides template language from existing AMA model state legislation, state laws, the FSMB and other trusted sources. Key topic areas include:

- **Confidential support as a member benefit.** Some medical societies and Physician Health Programs have established proven models to provide access to confidential and voluntary support for physicians seeking non-medical counseling or other support such as professional coaching to help with stress or other issues in a physician’s personal or professional life. This approach is differentiated from services that might be required when there is concern of impairment. Both approaches have helped thousands of physicians.
- **Legislative and regulatory changes to support low-barrier entry to confidential care.** Legislative or regulatory changes can be made that create a “safe space” through which physicians and other health care professionals could seek and obtain confidential care in ways that would not impact their careers. Legislative and regulatory changes could also require that medical licensing and credentialing applications inquire only about *current* impairment and not about past diagnoses.
- **Physician health programs remain a proven model to help physicians with impairment.** State physician health programs (PHPs) remain an evidence-based, comprehensive system supported by the AMA and state medical societies to help physicians at risk of potential impairment who may come forward voluntarily or when referred by a colleague, workplace or the licensing board. The AMA has

<sup>6</sup> Dyrbye LN, West C, Sinsky CA, Goeders LE, Satele DV, Shanafelt TD. *Medical Licensure Questions and Physician Reluctance to Seek Care for Mental Health Conditions*. Mayo Clin Proc. 2017;92(10):1486-1493

<sup>7</sup> The partnership of the North Carolina Medical Society, North Carolina PHP and others were instrumental in changing the question in North Carolina, for example. “Physicians Are Human, Too.” Available at <https://www.forbes.com/sites/physiciansfoundation/2018/07/18/physicians-are-human-too/#3f6cde754a29>

<sup>8</sup> See, for example, Wible, P., Palermi, A. “Physician-Friendly States for Mental Health: A Comparison of Medical Licensing Board Applications.” *Qualitative Research in Medicine & Healthcare* 2019; volume 3:107-119. Available at <https://www.pagepressjournals.org/index.php/qrmh/article/view/8649/8600>

developed model state legislation that, if enacted, ensures that PHP participation is a confidential, therapeutic alternative to discipline. Stigma is an ongoing barrier that can discourage physicians from seeking support including that from PHPs, which have helped thousands of physicians in a confidential, therapeutic alternative to discipline when there is not risk to patient safety<sup>9</sup>.

These options have different avenues for entry and levels of complexity. Some may be more relevant to meet a physician's individual need, and each allow for confidential care that supports a physician's ability to manage the stress, anxiety, depression, or other mental health conditions that burnout can create. The AMA stands ready to work with all states to help ensure that safe, confidential, voluntary options<sup>10</sup> are available and known to those who need access.<sup>11</sup>

## Medical Society Physician Wellness Programs

After a series of four physician suicides in Eugene, Oregon, the Lane County Medical Society created a model program in 2012 that provided a confidential, preclinical option for physicians seeking help with managing stressful situations. Those situations might include workplace conflicts, grief, depression, marriage or financial stress, or any other issue that a physician believes may be adversely affecting his or her personal and/or professional life. The model was subsequently replicated by several county medical society leaders who eventually published a free toolkit to disperse the model even more broadly. To date, there are around 30 programs at the county medical society level that are known to be operating. While these programs go by different names<sup>12</sup>, there are several common elements:

- Typically, the county medical society privately contracts with a local psychiatry or psychology group to allow a certain number of confidential sessions per member. Less often, programs may employ a therapist directly. These visits are free or discounted as a membership benefit. Claims are not submitted to insurance and instead the bill is sent to the medical society with no identifying information on it.
- The county medical society sets up a mechanism for appointments to be made without knowing the member's name. Some have 24/7 hotlines staffed by call centers and some allow physicians to set up an appointment directly with therapists.
- Funding for the programs may come from medical society membership dues, their society's foundation, hospital medical staff funds or foundations, and other sources.
- Limited non-demographic information such as age, gender, specialty, employment type, and presenting challenges are sent back to the society in a way to keep individual identification from happening.

<sup>9</sup> The Federation of State Physician Health Programs (FSPHP) maintains a full list of PHPs available to physicians and other health care professionals: <https://www.fsphp.org/state-programs>

<sup>10</sup> While this issue brief highlights areas where medical societies and legislative/regulatory options are available, there also are other options to help those at risk of self-harm or suicide, including the Interactive Screening Program offered by the American Foundation for Suicide Prevention: <https://afsp.org/interactive-screening-program>

<sup>11</sup> These issues also are experienced by medical students and residents as well as practicing physicians. See "Programs and Resources to Alleviate Concerns with Mental Health Disclosures on Physician Licensing." Welcher, C., Radabaugh, C., Aparicio, A., Chaudhry, H., Statz, M., Kirk, L., Bresnahan, L. *Journal of Medical Regulation* (2019) 105 (2): 24–32. <https://doi.org/10.30770/2572-1852-105.2.24>

<sup>12</sup> The free LifeBridge toolkit can be downloaded at [www.physicianwellnessprogram.org](http://www.physicianwellnessprogram.org). It explains how to start such a program, provides a reusable program name and logo, and lists the known county medical society programs in operation for reference.

“Being able to establish a confidential, evidence-based support system for my members is by far the most gratifying success of my professional career,” said Bryan Campbell, the former executive director of the Duval County Medical Society, who now is the chief executive officer of the Colorado Medical Society.

“We developed the LifeBridge Physician Wellness Program toolkit that can be used to help build a program from the ground-up,” said Belinda Clare, chief operations officer of the Travis County Medical Society in Austin, Texas.

“Ensuring confidentiality has been the number one factor in why these programs work,” said Steven Reames, executive director of the Ada County Medical Society in Boise, Idaho. “And since we pushed our therapists onto telehealth due to COVID-19, utilization has increased two-fold.”

“Since Eugene and Portland Oregon’s medical societies were the first to start these programs in 2012 and 2015, we’ve since seen the development of a network that allows physicians in rural counties statewide to access existing programs via telehealth,” said Amanda Borges, Executive Director for Medical Society of Metropolitan Portland.

## **New Virginia law provides low barrier entry to support confidential physician wellness**

According to the Medical Society of Virginia (MSV), [HB 115](#) furthers the goal of supporting physicians and other health care professionals to seek professional support to address career fatigue, burnout and behavioral health concerns with confidentiality and civil immunity protections. This new law enables physicians, who may avoid seeking help in other programs because of the fear of potential negative repercussions, to get the help they need. It is important to note that HB 115 uses the phrase “career fatigue and wellness” rather than “burnout.” HB 115 modifies prior Virginia law in two ways that lower barriers to physicians who want to be members of, or otherwise work with, PHPs<sup>13</sup> to assist physicians seeking help with carrier fatigue and wellness, and for physicians seeking that assistance.

- HB 115 expands the civil immunity that currently exists for physicians serving as members of, or consultants to, entities that function primarily to review, evaluate, or make recommendations related to health care services, to include physicians serving as members of, or consultants to, entities that function primarily to address issues related to physician career fatigue and wellness.
- HB 115 also clarifies that, absent evidence indicating a reasonable probability that a physician who is a participant in a PHP addressing issues related to career fatigue or wellness is not competent to continue in practice or is a danger to himself or herself, his or her patients, or the public, participation in such a PHP does not trigger the requirement that the physician be reported to the state, e.g., the state medical board.

Pursuant to HB 115, the MSV helped create a program to offer physicians and physician assistants a comprehensive set of well-being resources they can use to deal with stress, burnout and the effects of COVID-19, without risk to their licenses. MSV will administer the program—called [SafeHaven™](#)—for the state of Virginia. The resources offered to organizations enlisted in the program, include peer coaching, elite concierge services and expanded behavioral health resources to promote work/life balance and well-being for physicians, PAs and their families. It also is important to note that HB 115 exists in

<sup>13</sup> It is important to highlight that the Virginia Health Practitioner Monitoring Program has helped physicians for more than 20 years. For more information:

<http://www.dhp.virginia.gov/PractitionerResources/HealthPractitionersMonitoringProgram/index.html>

addition to the Virginia PHP<sup>14</sup>, which remains a trusted source to help physicians in need of support.

## Confidentiality central to Physician Health Programs

In addition to provisions taken from Virginia’s HB 115, the draft recommendations below contain key language from the Advocacy Resource Center’s (ARC) model legislation entitled the “Physician Health Programs Act,” which focuses more generally on physicians seeking and receiving treatment for substance use disorder, mental health condition, other medical disease or other potentially impairing conditions through a PHP. Provisions below also are taken from FSMB recommendations to focus on current impairment rather than past diagnosis.

“PHPs are a proven model to help physicians at risk of a potential impairment receive evidence-based care in a structured, confidential manner,” said Chris Bundy, MD, MPH, President, Federation of State Physician Health Programs. “PHPs have long recognized that confidentiality is critical to service utilization and effectiveness. It’s the cornerstone of the PHP model and should extend to all programs that support physician well-being.”

PHPs offer a therapeutic alternative for evidence-based care to physicians at risk of a potential impairment in a structured, confidential manner. Many PHPs also offer well-being programs and services to refer those in need to professional coaching, therapy and other support services in a confidential, voluntary, safe manner. While not all referrals to a PHP result in time of out of practice, there is expertise in place to facilitate a safe return to practice.<sup>15</sup> When time out of practice is indicated, PHPs work with the physician and his/her treatment providers to focus on how to safely return the physician to caring for his/her patients.<sup>16</sup> Most PHPs began with the state medical society, and remain affiliated or aligned with their state medical society.

## Draft legislative and regulatory options to support physician wellness<sup>17</sup>

### A. Support for physician wellness.

- a. No person or entity shall be obligated to report information regarding a health care provider licensed to practice medicine or osteopathic medicine who is a participant in a professional program to address issues related to career fatigue and wellness that is organized or contracted for by a statewide association exempt under 26 U.S.C. § 501(c)(6) of the Internal Revenue Code and that primarily represents health care professionals licensed to practice medicine or osteopathic medicine in multiple specialties to the Board.

<sup>14</sup> Virginia Health Practitioners Monitoring Program,

<http://www.dhp.virginia.gov/PractitionerResources/HealthPractitionersMonitoringProgram/index.html>

<sup>15</sup> A 2008 study of 16 state PHPs found that of 904 physicians admitted to a PHP between 1995 to 2001, more than 80 percent “completed treatment and returned to practice under supervision and monitoring. After five years, 631 (78.7%) physicians were licensed and working. McLellan AT, et al. Five year outcomes in a cohort study of physicians treated for substance use disorders in the United States. *BMJ*. 2008;337:a2038. Published 2008 Nov 4. Available at <https://pubmed.ncbi.nlm.nih.gov/18984632/>

<sup>16</sup> A 2017 report found that “24 percent of the 225 people who received services from the North Carolina PHP last year were self-referrals.” The NCPHP found that more than 90 percent felt they benefited from the services provided. Participants in the PHP said that they sought help due to “substance related issues (66.67 percent), followed by workplace stress (28.6 percent) and anxiety (28.6 percent).” See “Physicians Health Program Offered Help to Hundreds Last Year.” Elaine Ellis. North Carolina Medical Society. Jan 24, 2018. Available at <https://secure.ncmedsoc.org/physicians-health-program-offered-help-to-hundreds-last-year/>

<sup>17</sup> While this language may be useful to consider in your state, it is not a comprehensive AMA model bill. Additional considerations for peer review, PHPs and medical licensing likely are applicable.

- b. The protections under this section do not apply if the person or entity has determined that there is reasonable probability that the participant is a danger to themselves or to the health and welfare of their patients or the public.

**B. Immunity for persons acting in performance of their duties.<sup>18</sup>**

- a. Every member of, or consultant to, any PHP or any committee, board, group, commission, or other entity that reviews, evaluates, or makes recommendations in connection with a PHP, to address issues related to physician career fatigue and wellness shall be immune from civil liability or administrative action for any act, decision, omission, or utterance done or made in performance of his or her duties while serving as a member of or consultant to such PHP or committee, board, group, commission, or other entity.

**C. Proceedings and physician identity are confidential and privileged.**

- a. The proceedings, minutes, records, and reports of any PHP or other committee, board, group, commission, or other entity described in sections A or B, together with all communications, whether oral, electronic or written, originating in or provided to such committees or entities, are privileged communications that are privileged in their entirety, and are not discoverable.
- b. The analysis, findings, conclusions, recommendations, and the deliberative process of any PHP or other committee, board, group, commission, or other entity described in sections A or B, as well as the proceedings, minutes, records, and reports, including the opinions and reports of experts, of such entities shall be privileged in their entirety, and are not discoverable.
- c. A physician who is a participant in a PHP or other entity providing counseling, coaching or similar services to address issues related to career fatigue and wellness shall have his or her participation and identity deemed confidential, privileged in its entirety, and not discoverable.

**D. Patient safety organization.** The exchange of any of the following shall not constitute a waiver of any privilege established under sections A or B:

- a. Patient safety data among health care providers or patient safety organizations that does not identify any patient; or
- b. Information privileged pursuant to subsection B between PHPs or committees, boards, groups, commissions, or other entities described under section A.

**E. Reporting and disclosure.<sup>19</sup>**

- a. No individual, person, or entity shall be obligated to report information regarding a physician who is a participant in a PHP or other entity providing counseling, coaching or similar services to address issues related to career fatigue and wellness unless the person or entity has determined that there is reasonable probability that the participant is a danger to themselves or to the health and welfare of their patients or the public.
- b. A physician who is a participant in a PHP shall not be required to disclose such participation to any health care facility, hospital, medical staff, health insurer, government agency, or other entity that requests such information as a condition of participation, employment, credentialing, payment, licensure, compliance or other requirement.
- c. The failure to disclose the information described in this section shall not be grounds for suspension, removal, termination of employment or contract, or any other adverse action by a

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<sup>18</sup> It is important to highlight that these provisions may only be one component of more comprehensive protections, including peer review protections, needed as part of comprehensive legislation. One example can be found in Massachusetts: [http://www.massmed.org/Physician\\_Health\\_Services/Education\\_and\\_Resources/Peer\\_Review\\_Committee\\_Definition\\_M\\_G\\_L\\_c\\_111\\_%C2%A7\\_1/#.Xz\\_U4chKiUk?](http://www.massmed.org/Physician_Health_Services/Education_and_Resources/Peer_Review_Committee_Definition_M_G_L_c_111_%C2%A7_1/#.Xz_U4chKiUk?)

<sup>19</sup> Some states may allow for reporting to the medical board or an employer for compliance purposes that a participant in a PHP remains in treatment, is complying with the treatment plan, has completed treatment for the purposes of a safe return to practice.

- health care facility, hospital, medical staff, health insurer, government agency, or other entity.
- d. The obligation to disclose information described in this section shall not be a condition of participation, employment, credentialing, licensure, compliance or other requirement by a health care facility, hospital, hospital staff, health insurer, government agency, or other entity.
- F. No retaliation, discrimination, or other adverse action.** No individual, person, or entity may retaliate, discriminate, or otherwise take adverse action with respect to a physician who is a participating in a PHP to address issues related to career fatigue and wellness or based solely on their PHP participation..
- G. Focus on current impairment.**
- a. Medical board licensing applications, hospital and other facility-based physician employers, and health insurance company credentialing applications shall focus on current impairment and not past diagnosis and only include the following on such applications: “Are you currently suffering from any condition for which you are not being appropriately treated that impairs your judgment or that would otherwise adversely affect your ability to practice medicine in a competent, ethical and professional manner? (Yes/No)”<sup>20</sup>
- b. Any medical licensing, credentialing or employment application that does not focus on current impairment shall be deemed null and void.

## Additional federal and state laws

Although an in-depth discussion is beyond the scope of this Issue Brief, federal and state<sup>21</sup> disability, civil rights, and other laws also may provide protection from discrimination. For example, the U.S. Equal Employment Opportunity Commission (EEOC) is responsible for enforcing federal laws that make it illegal to discriminate against a job applicant or an employee because of the person's disability, race, age, and other factors. The laws enforced by the EEOC include Title I of the Americans with Disabilities Act of 1990 (ADA), Title VII of the Civil Rights Act of 1964, and sections 501 and 505 of the Rehabilitation Act of 1973.<sup>22</sup> The EEOC has stated that before a job offer has been made, a potential employer cannot ask questions about an applicant's disability or questions that are likely to reveal whether an applicant has a disability.<sup>23</sup>

Consequently, an employer cannot ask questions on a job application about history of treatment of mental illness, hospitalization, or the existence of mental or emotional illness or psychiatric disability because such questions are likely to elicit information about a psychiatric disability.<sup>24</sup> Specific examples of prohibited questions include asking about medications the applicant might be taking, or whether mental health conditions such as bipolar disorder, depression or schizophrenia run in the applicant's family.<sup>25</sup> These rules apply to any communications with or about the applicant, including application forms, interviews and reference checks.<sup>26</sup> Different rules apply, however, after a job offer is made and after the

<sup>20</sup> Alternatively, states may wish to use the following question as implemented by the Medical Board of California in 2019: “Do you currently have any condition (including, but not limited to emotional, mental, neurological or other physical, addictive, or behavioral disorder) that impairs your ability to practice medicine safely?” See <https://www.mbc.ca.gov/Download/Forms/application-physician-11a-11f.pdf>

<sup>21</sup> See, e.g., New York laws at <https://ag.ny.gov/civil-rights/disability-rights#:~:text=In%20New%20York%2C%20federal%2C%20state,other%20term%20or%20condition%20of.>

<sup>22</sup> See <https://www.eeoc.gov/statutes/laws-enforced-eeoc> for a list of laws that the EEOC enforces.

<sup>23</sup> See, e.g., <https://www.eeoc.gov/employers/small-business/4-what-cant-i-ask-when-hiring>

<sup>24</sup> See e.g., <https://www.eeoc.gov/laws/guidance/enforcement-guidance-ada-and-psychiatric-disabilities>

<sup>25</sup> *Id.*

<sup>26</sup> *Id.*

employee starts employment.<sup>27</sup> While the EEOC's jurisdiction applies to the employer-employee relationship, a minority of courts have held that the ADA and the Rehabilitation Act protect independently-contractor physicians with respect to the granting or termination of hospital privileges.<sup>28</sup>

## For more information

The AMA has several resources to help physicians and medical societies, including:

- AMA STEPS Forward™ module: [Physician Suicide and Support: Identify At-Risk Physicians and Facilitate Access to Appropriate Care](#)
- AMA public health resources: [Managing mental health during COVID-19](#)

For more information about the information contained in this issue brief, please contact the Advocacy Resource Center attorneys Daniel Blaney-Koen, JD, at [daniel.blaney-koen@ama-assn.org](mailto:daniel.blaney-koen@ama-assn.org) and Wes Cleveland, JD, at [wes.cleveland@ama-assn.org](mailto:wes.cleveland@ama-assn.org)

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<sup>27</sup> *Id.*

<sup>28</sup> See e.g., *Menkowitz v. Pottstown Mem'l Med. Ctr.*, 154 F.3d 113 (3d Cir. 1998)(holding that a non-employee surgeon with attention-deficit disorder whose medical staff privileges had been terminated by defendant hospital could pursue disability discrimination claims under Title III of the ADA and section 504 of the Rehabilitation Act); *Hetz v. Aurora Med. Ctr. of Manitowoc Cnty.*, 2007 U.S. Dist. LEXIS 44115, WL 1753428 (E.D. Wis. 2007)(ruling that an independent-contractor physician could maintain a Title III ADA claim against a hospital that denied his request for privileges because of his bipolar disorder and sleep apnea). See also *Fleming v. Yuma Reg'l Med. Ctr.*, 587 F.3d 938, 939 (9th Cir. 2009)(concluding that an independent contractor anesthesiologist with sickle-cell anemia could state a Rehabilitation Act discrimination claim against a hospital that refused to accommodate his operating room and call schedules). Other courts have reached a different conclusion. See e.g., *Wojewski v. Rapid City Reg'l Hosp., Inc.*, 450 F.3d 338 (8<sup>th</sup> Cir. 2006)(declining to extend the Rehabilitation Act to a physician independent contractor with bipolar disorder whose hospital privileges were terminated after the physician had a manic episode while performing surgery).