REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 03-JUN-21

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

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

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

ILLNESS, DISABILITY & IMPAIRMENT

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

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

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

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

RESPONDING TO IMPAIRMENT

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

Seeking & Offering Assistance

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

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

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

Intervention

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

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

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

ACCOMMODATING DISABILITY

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

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

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

RETURN TO SAFE PRACTICE

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

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

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

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

CONCLUSION

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

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

RECOMMENDATION

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

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

As individuals, physicians should:

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

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

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

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

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

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

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

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

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

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

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

Modify HOD/CEJA policy

Fiscal Note: Less than $500

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