

WPHP Report: Setting the Record Straight, Part 2



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Introduction

In Part 1 of “Setting the Record Straight,” I explored some of the challenges and rewards of working in the field of physician health. Chief among these challenges is my worry for colleagues who may avoid physician health program (PHP) assistance or have difficulty engaging collaboratively with the PHP due to inaccurate or misguided information. Unacceptably high rates of physician distress, burnout, and suicide, superimposed on a national addiction and mental health epidemic, make the potential harms of misinformation more serious, and real, than ever. In this installment of “Setting the Record Straight,” we will look more closely at some of the common questions I receive about the Washington Physicians Health Program (WPHP). The goal here is to empower physicians with accurate information so they may make informed decisions should they find themselves, or a colleague, in difficulty.

How is WPHP funded?

70% of WPHP’s operating budget is supported by license surcharge paid by all licensees of the professional groups we serve. Surcharge funding is critical to our ability to provide high quality services at a lower cost to participants while avoiding undue influence from extramural funding sources. The remaining 30% comes mostly from monitoring fees paid by program participants. Participants who do not require monitoring do not pay program fees and are only charged for initial toxicology testing. A small portion of our funding comes from donations, mostly from current or former participants, which are used to provide need-based financial assistance to other participants. WPHP has a strict conflict of interest policy that prohibits accepting gifts or financial support from entities (including evaluation or treatment centers) that have a business interest in WPHP activities.

Is WPHP part of the Washington Medical Commission (WMC)?

No, and this is often an area of confusion. WPHP is an independent, non-profit, physician-led organization contracted with the Department of Health to provide assessment, treatment referral, post-treatment monitoring and advocacy for medical professionals with health conditions that may impair their ability to practice safely. Enabling legislation permits WPHP to assist physicians and physician assistants confidentially without the involvement of the WMC. This therapeutic alternative to discipline promotes early intervention and treatment of health problems before patients are put at risk.

This model is only possible when the disciplinary authority trusts that WPHP will exercise its legal and ethical obligation to make a notification when a health professional or program participant poses a risk to patients. Effective collaboration between WPHP and the WMC is critical to maintaining the trust upon which our program depends. Unfortunately, such collaboration can lead some to assume there is little or no difference between the two organizations. However, closer analysis reveals a complementary truth; WPHP must also safeguard the trust of the professional community and participants we serve by making a report to the WMC only when necessary. We must use all means available to engage and collaborate with our participants, employers, credentialing entities, and other stakeholders to promote positive outcomes. Such efforts should serve the rehabilitative needs of our participants while averting the need to protect the public through professional discipline. That WPHP infrequently reports participants to the WMC, but will do so when necessary, suggests that we are effectively honoring our commitments to both.

How often does WPHP report a colleague to the disciplinary authority?

So far this year, a mandatory reporting requirement was triggered in only 4% of referrals under evaluation and 0.7% of monitoring participants. 92% of WPHP’s 319 current participants are unknown to their disciplinary authority. The vast majority of individuals who are known to their disciplinary authority were referred to WPHP by their Board or Commission as part of an investigation or disciplinary action and were, therefore, already known. Usually these are cases in which no one called WPHP when concerns of impairment came to light and eventually someone called their disciplinary authority instead.

Is WPHP really a voluntary program?

Yes. Participation in WPHP is completely voluntary. That said, for some it may not *feel* voluntary. In fact, there have been some who have gone so far as to describe PHP’s as coercive. To suggest as much reflects a misunderstanding of how PHP’s work as well as the social contract that governs medical practice [1].

WPHP offers a voluntary opportunity for confidential assistance to physicians who are worried about their health, their ability to safely practice or who want to avoid sanction by their employer, medical executive committee, or disciplinary authority. Participation in WPHP allows physicians to re-enter or remain in practice rather than

face these hardships. When physicians cannot or will not follow recommendations for rehabilitation, and pose a risk to patient safety, PHPs have mandatory reporting requirements to licensing boards and commissions and must withhold advocacy to workplaces. The use of mandatory reporting mechanisms in cases of suspected impairment recognizes that tying treatment adherence to future medical practice is highly effective at rehabilitating the professional *and* protecting public safety. However, it is ultimately physician workplaces and licensing bodies that mandate PHP participation; PHPs themselves cannot discipline or force physicians to participate. As such, WPHP cannot be considered coercive or non-voluntary.

Voluntary participation in a PHP is part of the broader social construct between physicians and their patients: the social contract. Physicians agree to practice in a professional manner in exchange for the privilege to practice interventions that would be illegal if conducted by other citizens. Unlicensed citizens are not permitted to do surgery, prescribe medications or conduct clinical evaluations without this privilege. The social contract is an agreement between professionals (physicians in this case) and governments (as public representatives) that secures a physician's privilege of practice in exchange for the benefit or right of citizens to expect safe care. The right of the state (via licensing authorities) to take action against the licenses of physicians on behalf of the public is not controversial. WPHP's fulfillment of its ethical, legal and professional obligations, pursuant to the American Medical Association *Code of Medical Ethics* [2-3] and applicable Washington statutes, is a critical societal interaction that serves to increase available options for physicians within the construct of the social contract between physicians and patients.

What mechanisms are in place to ensure WPHP's accountability to participants and the medical community?

WPHP is governed by a Board of Directors representing a broad range of stakeholders from across the medical and participant community. WPHP's Executive Director and Executive Medical Director are directly accountable to our Board for the execution of WPHP's mission. WPHP's Board of Directors and bylaws are, in turn, approved by the Executive Committee of the Washington State Medical Association (WSMA), ensuring WPHP's accountability to organized medicine in the state. WPHP provides WSMA with quarterly reports and an annual report to the WSMA House of Delegates.

WPHP is also accountable to the disciplinary authorities we serve through our contract with the Department of Health. Our contract specifies essential program elements as well as the special qualifications and expertise required for the evaluation and treatment of health professionals among the programs WPHP uses. Among other things, WPHP deliverables include quarterly statistical reporting and a detailed annual report to the Department of Health.

WPHP is accountable to our participants through annual and exit surveys that measure participant satisfaction, self-reported health, professional, and quality of life outcomes, as well as opportunities for improvement. WPHP also has a meaningful appeal process for individual participants who do not agree with WPHP's recommendations. Through the appeal process, participants are able to have their recommendations reviewed first by their clinical coordinator, then by a panel of clinical staff that were not involved in developing the recommendations under review and, finally, the Executive Medical Director. So far this year, only two cases have proceeded to final review by the Executive Medical Director and, in both cases, the recommendations were modified to the mutual satisfaction of WPHP and the participant.

WPHP will be among the first state physician health programs to undergo an external review by the Federation of State Physician Health Programs' (FSPHP) Program Enhancement and Effectiveness Review (PEER™). This national program, currently under development by the FSPHP, is intended to promote accountability, consistency and excellence among member PHPs. It is endorsed and supported by the American Medical Association, American College of Physicians, American Board of Medical Specialties, Federation of State Medical Boards, American Psychiatric Association and the American Osteopathic Association.

Finally, WPHP is accountable to the colleagues, employers, health care organizations, medical schools, graduate medical education programs, credentialing entities, and professional liability carriers that consult us. In short, WPHP operates under the tight scrutiny of our many stakeholders in order to effectively rehabilitate and advocate for program participants.

Conclusion

In WPHP's 33-year history, we have facilitated the rehabilitation and successful return to practice of over 1500 health professionals with impairing health conditions - roughly one-third of a large graduating medical school class each year. In addition, we have provided help and support to countless others who sought WPHP assistance but did not require monitoring-based advocacy. In Part 3 of "Setting the Record Straight," I will explore questions related to WPHP's evaluation and treatment referral process as well as WPHP satisfaction and outcomes data. I will continue to tell the story of how getting better works and how great better can be.

References:

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