The Status of Physician Health Programs in Wisconsin and North Central States: A Look at Statewide and Health Systems Programs

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ABSTRACT

There is increased recognition of the importance of physician health and the need to actively maintain and promote it. Attending to the health and well-being of medical clinicians is considered an important component of professionalism, and is important for the sustainability of safe, high-quality practice of medicine. This report highlights the importance of physician health programs, describes their history and evolution as well as the variability in program structure in various states, and reviews the present status of physician health resources, especially in Wisconsin. It gives an example of a program within a large, integrated health system and emphasizes the advantages of a statewide program.

INTRODUCTION

The intellectual, emotional, physical, and social demands of medical training are rigorous, as are the professional and personal demands of medical practice. Physicians make many sacrifices for the privilege of taking care of others. The good news is that most physicians thrive in their work environments and practice excellent strategies to safeguard their own well-being, and most physicians enjoy productive, long, and healthy lives.[1]

However, medical practice can exact a toll. Reported rates of physician burnout range from 25% to 67%.[2,3] Authors note, "Medicine becomes a strain only when a physician asks himself to give more than he has been given."[4] Some factors that contribute to physician stress and burnout include a perceived loss of autonomy, a perceived decrease in control over one's practice environment, and inefficient use of time attributed to administrative requirements.[5] Other factors that cause stress for physicians include workload, specialty choice, practice setting, sleep deprivation, lack of work-life balance, medical errors, risk of malpractice suits, characteristics of "difficult" patients, and how to deal with patient death and illness.[2,6] Female physicians face stresses specific to their gender and their historically minority status within the profession of medicine.[7-9]

When physicians' personal well-being and professional commitment are balanced, positive synergies result that sustain them in their profession and ultimately benefit patients and the health care system as a whole.[10] When these are not in balance, there is a risk for poor patient care,[11] which can be measured both as patient satisfaction (the patient's subjective experience of the care encounter) and as patient outcomes (objective measures of clinical results and rates of medical errors). Stress can lead to burnout, not only affecting quality of life for the physician and his/her family,[12] but also adversely affecting or impacting the health care team, as well as the "end-user" of clinical interventions–the patients. Physician stress can lead not only to medical errors,[13] but potentially also to reduced productivity, loss in revenue, and suboptimal performance. Improving physician health may benefit individual physicians, their patients, the health care organizations in which they work, and the well-being of spouses and children in "the medical family."[14] This can have serious implications for the medical profession and society as a whole.[15]

Physician Health Comes of Age

With the increasing recognition of risk factors and vulnerabilities, there has been parallel progress in the last 50 years in awareness of the importance of attending to physician health. The phrase "physician health" for many decades was a euphemistic reference to struggles with addiction, and it has been only in the last several decades that it has become acceptable

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and necessary to address physician health in a more comprehensive way.[16]

In Canada, physician health is identified as one of the essential competencies to achieve sustainability in practice.[16] In the United States, the American Medical Association (AMA) has developed policies[17] which state that the medical profession has an obligation to ensure that its members are able to provide safe and effective care. The AMA states that physicians are role models for their patients and colleagues, and that status makes their own personal health a factor in health promotion. Work by Frank et al[18] has shown that physicians who practice healthy behaviors for themselves are more likely to talk to their patients about these issues. The AMA has furthermore stated, "It is imperative to recognize and support personal health at each stage of professional development, as medical students, residents, and practitioners."[19]

Indeed, the physician health movement is now international in scope. The British, Canadian, and American Medical Associations have developed an International Physician Health Conference[20] that convenes every other year in rotating sites. The importance of physician health also has been noted by the American Society of Addiction Medicine, which adopted a comprehensive set of 11 public policy statements on the topic in 2011.[21]

A Brief History of Statewide Physician Health Programs

The development of physician health programs began in the late 1950s and early 1960s, when the Federation of State Medical Boards recognized an unmet need as a result of problems observed in disciplinary actions against licensed physicians.[22] In 1973, an article in the *Journal of the American Medical Association* entitled "The Sick Physician"[23] increased awareness and noted that discipline alone did not address the illness when physician illness was the explanation of subpar performance or unprofessional conduct by a licensee. In the 1980s, states began to form physician health programs, and physician support meetings called Caduceus meetings sprang up. In 1990, the Federation of State Physician Health Programs (FSPHP) was formed and facilitated the development of physician leadership in this area while creating a national forum for the various state programs to share concerns and network with each other. In the 1990s, Physician Health Programs (PHP) started collecting data which, when analyzed and published in 2008, confirmed that providing confidential programs encouraged referrals, and that monitoring was associated with high rates of treatment success with the health conditions that have the potential to lead to professional impairment.[24,25]

In 2001, the Joint Commission (then the Joint Commission on Accreditation of Healthcare Organizations [JCAHO]) published its accreditation standard on physician health, requiring hospitals and other accredited health care organizations to develop a confidential process of referral for assessment and treatment for physicians in need of a health intervention, one that would offer the physician support, intervention, and advocacy and would reside outside of the usual disciplinary structures of credentialing and privileging activities of the hospital/clinic medical staff (JCAHO Requirement MS 4.80, 2001). See boxes 1 and 2.

Wisconsin was one of the first states to adopt a statewide program. It was developed and administered by the State Medical Society (SMS) of Wisconsin, the professional organization of physicians. The Wisconsin Statewide Impaired Physician Program used designated staff from the SMS's Council on Peer Review to operate the program, with a managing committee appointed by the SMS's Board of Directors, and a part-time paid medical director retained by the managing committee to operate the program. Over time, the name was changed to the Statewide Physician Health Program. However, on October 15, 2007, the SMS's Board of Directors voted to discontinue the operations because of inadequate funding. This left Wisconsin without an independent statewide resource for treatment and advocacy for impaired physicians. Currently, Wisconsin is one of few states without a state PHP that is a member of the FSPHP. There is a monitoring program administered by the state government, called the Professional Assistance Procedure (PAP), which is focused on monitoring versus offering advocacy when physicians face discrimination based on their health or licensure status. The program was established for non-physician health professional licensees such as nurses, pharmacists, dentists, veterinarians, and others. That program was a classic "diversion program" that would receive referrals from the individual's relevant professional licensure board and would "divert" the licensee from a disciplinary path that could lead to licensure restriction, suspension, or revocation. When the statewide PHP Societies ceased operations in 2007, the Impaired Professionals Procedure of the DRL expanded its scope from the monitoring of non-physician licensees to the monitoring of licensed physicians. The Impaired Professionals Procedure has since changed its name to the PAP, and a reorganization of state government led to the DRL being renamed the Wisconsin Department of Safety and Professional Services.

Program Structures in Other North Central States

It has been glibly stated by some that "when you've seen one Physician Health Program, you've seen one."[26] (See Table 1 for a summary/comparison of programs in the Midwest.) This reflects the reality that licensure of physicians and other health professionals is a state-based enterprise, ultimately authorized by the legislature of a given state; so just as licensure operations vary from state to state, programs that offer an alterna-

Box 1.

Old "Impaired Physician" Model	Enhanced Physician Health and Wellness Model
Address substance use disorders only	Promote physician wellness and the treatment of all potentially impairing health conditions including substance use disorders and other addictions, mental and behavioral disorders, and physical illness.
Focus is disciplinary	Focus is to assure the public safety via comprehensive monitoring and rehabilitation and to support health professionals in recovery via advocacy.
No specific support services; work of providers of clinical monitoring only	While all physician health programs (PHPs) refer to a network of providers of clinical care who are experienced in dealing with health care professionals, some also offer support groups for licensees, sometimes in various locations throughout the state, for those in recovery and those seeking peer support.
Limited educational function; little, if any, outreach; focus on licensure and regulation	Provide educational programs and presentations for hospital administrators, hospital medical staff and leaders, and hospital-based physician health programs, to "spread the word" about how promotion of physician health and confidential non-disciplinary mechanisms for addressing matters of physician health are the best way to assure patient safety and high-quality outcomes of medical care. Some programs have interactive websites with education/information on physician health and wellness initiatives.
Exist for "The state" and not on behalf of the well-being of individual licensees; exist only to "respond to complaints" and not to do outreach or assist with case identification	Offer networking opportunities with colleagues for health professionals who have been to treatment or who have a potentially impairing health condition; establish a network of volunteers who will conduct interventions on colleagues who have been identified as having a potentially impairing health condition. Use data from monitoring of continuous remission to act as advocates for health professionals in recovery who face barriers to practice re-entry or other discriminatory acts.

Box 2.

The Joint Commission standard requires medical staff and organization leaders to:

- Design a process that provides education to licensed independent practitioners on the staff of the hospital or clinic.
- Address prevention of physical, psychiatric, or emotional illness among physicians and pother licensed independent practitioners on the medical staff.
- Facilitate confidential diagnosis, treatment, and rehabilitation of licensed independent practitioners who suffer potentially.

tive to discipline for licensed health professionals vary from state to state, based on local conditions, political climates, and history. Minnesota had one of the original professional society-operated (Minnesota Medical Association) programs for physicians, although it ceased independent operations in 1994 when the state of Minnesota established a "diversion program," for licensees of 16 health professionals' boards, (called the Health Professionals Services Program [HPSP]). Persons who want to refer a physician for intervention place their call to this entity which is operated jointly by the professional licensure/disciplinary boards under the Minnesota Department of Health. Physicians who would consider self-referral know that their self-disclosure may not involve information being kept confidential from the Board of Medical Practice itself. Iowa similarly has a "diversion program" operated by the Board of Medicine; separate programs are operated by the Board of Dentistry, the Board of Nursing, and the Board of Pharmacy. The South Dakota Health Professionals Assistance Program is similar to Minnesota's in structure and governance and to Iowa's in scope, except that it also includes as participants certified alcohol and drug counselors in addition to physicians, dentists, nurses, and pharmacists. Nebraska does not have a program that is a member of the FSPHP, but the department of state government responsible for licensing physicians and other health professionals contracts with a for-profit Employee Assistance Program (EAP) to offer assessment and monitoring services for its health professionals. The licensing agency in Michigan also contracts with a for-profit EAP to offer assessment and monitoring services for its health professionals.

What State Physician Health Programs Can Do

Today it is important to focus energies on enhancing the health and resiliency of the physician work force. Clearly, treatment and recovery take time and effort. Monitoring is necessary; with appropriate treatment and monitoring, a return to a productive professional role is the rule rather than the exception. Understanding and support work much better than judgment and punishment. When a professional with a potentially impairing illness becomes involved with a PHP and no harm to the public has been identified, he or she is ideally enrolled in an alternative pathway to professional discipline. PHPs provide the availability of a non-disciplinary alternative with rehabilitation and accountability being emphasized, facilitated, and carefully documented over time. When considering healthcare and other licensed professionals with addictive illness, the public health, safety, and welfare are paramount, and

Table 1. Overview of Physician Health Program Structures in 5 Midwestern States

Illinois Professionals Health Program	Indiana Physician Assistance Program	Iowa Physician Health Program	Michigan Health Professional Recovery Program	Minnesota Health Professionals Services
Medical Director				
Cynthia Gordon, MD, JD, Medical Director	Candace Backer, Program Coordinator	Deb Anglin, Program Coordinator	Patrick Gibbons, DO, Medical Director	Monica Feider
Medical Director's E-mail Address				
cynthia.gordon@advocate health.com	cbacker@ismanet.org	deb.anglin@iowa.gov	www.hprp.org	monica.feider@state.mn.us
Operated By				
A not-for-profit organization	State medical society	State licensing agency	Independent corporation	State licensing agency
Contractual Relationship with State Medical Board?				
No	No	Yes	No	Yes
Program Services				
Chemical dependency, mental health, behavioral problems, sexual misconduct, boundary violations, physical illness, stress management	Chemical dependency, mental health, behavioral problems, sexual misconduct, boundary violations, physical illness, referrals for marital and stress issues	Chemical dependency, mental health, physical illness	Chemical dependency, mental health, pain management	Chemical dependency, mental health, physical illness
Services Provided				
MD, DO, families of physicians, medical students, dentists, residents, psychologists, podiatrists, nurses, pharmacists, veterinarians, other	MD, DO, families of physicians, dentists, residents, physician assistants	MD, DO, residents	MD, DO, dentists, residents, physician assistants, chiropractors, professional counselors, dental hygienists, marriage/family counselors, occupational therapists, physical therapists, registered sanitarians, social workers	MD, DO, dentists, residents, psychologists, podiatrists, nurses, physician assistants, pharmacists, veterinarians, other
Funding				
State licensing agency, malpractice insurance companies, participant fees ($150/month)	State medical society, hospital and private contributions, participant fees ($75/month/member; $125/month/non-member)	State licensing agency	Department of Consumer Health (through licensing fees)	State licensing agency
Annual Budget				
$800,000, includes revenue and expenses for drug/alcohol testing	About $130,000	Not available	Not available	$596,000
Number of Licensed Physicians in State				
44,000	9000	6000	480,000 health care professionals	18,000
Number of Open Cases				
450	130	90	900	526

Note: The structure of these programs is current; numbers are from 2006.

they are best served when an otherwise competent professional with a potentially impairing illness is managed with a cohesive effort among all involved entities. Such management leads to earlier identification, appropriate evaluation, treatment with competent monitoring through a PHP, and the safe return to the active practice of their profession. Barriers to these goals must be removed.

Therapeutic pessimism is not warranted for addiction treatment in general, but especially for treatment of impaired physicians, where recovery rates are >85%. Once identified and treated, physicians and nurses often do better in recovery than others and typically return to a productive career and a satisfying personal and family life. Treatment can be career saving and lifesaving.[27] Three types of post-treatment monitoring are conducted by PHPs: behavioral, chemical, and worksite evaluations. Their success is largely attributable to this tripartite model of recovery monitoring. The intervention, referral, and post-treatment monitoring services offered by PHPs are gener-

ally conceptualized as being distinct from the clinical services offered by addiction treatment programs (ATPs). PHPs are also uniquely qualified to advocate for program enrollees with potential employers and regulatory agencies when enrollees have successfully engaged in an ATP and are compliant with PHP monitoring requirements.[21]

Educating the medical community about addiction among professionals, the risks of addiction in professionals, and the recognition of the subtle signs and symptoms of addiction in the workplace is also a function of PHPs. Such education and prevention services further enhance public safety by encouraging earlier detection and referral to treatment when appropriate. Well-run, statewide PHPs offer a comprehensive range of services including identification of problems as outlined in Table 1. While both models support prompt interventions and monitoring, the enhanced programs provide a more comprehensive approach and encourage more self-reporting.[21]

Clinic- and Hospital-Based Physician Health Programs

As demonstrated in other states, statewide physician health programs can improve the confidential, comprehensive treatment and monitoring of impaired professionals. In the absence of statewide programs, individual hospitals and physician groups are attempting to meet the needs of their physicians. However, there are neither guidelines nor templates for such programs, and there is no formal agreement or relationship with the state licensure apparatus. As a result, local hospital or clinic PHPs have widely varying levels of structure, functioning, and effectiveness. Table 2 provides some guidelines for setting up hospital-based PHPs.

To be sure, there is a role for both local and state physician health programs. There is, however, some debate within the FSPHP about the role and usefulness of stand-alone hospital-based and clinic-based programs: at times they attempt to "do too much" and may attempt to address all the needs of intervention and monitoring at the local level, without availing themselves of the expertise and objectivity of a statewide program (Luis Sanchez, personal communication, 2011). Moreover, local programs are unable to secure the relationship with the licensure board and the statutory validation of their role like a statewide program can. When there is a statewide program recognized by the licensure board and the state legislature alike, the best role for the local program is to promote physician health and well-being, promote the health of physicians' families, make physicians and their families aware of non-punitive interventions that can address physician health needs, and hand off identified cases to the statewide entity as quickly as possible. In situations like Wisconsin's current circumstance, when there is no statewide program independent of state government, local programs may feel more need to fill the void and assume more of the roles traditionally carried out by a statewide PHP.

A Case Example in Marshfield: Annals of a Small Town Physician Health Committee

To demonstrate what is possible for clinics and hospitals, a case example is presented. Ministry St. Joseph's Hospital and the Marshfield Clinic started a physician health committee (PHC) in 2001 in response to the Joint Commission mandate. The mission statement of the program is as follows:

> The Physician Health Committee exists to promote resilience, professionalism, and collegiality among Marshfield Clinic physicians and all Ministry St. Joseph's Hospital medical staff.

The PHC is made up of 6 physicians from the Marshfield Clinic, a large, nationally known, multispecialty medical group of almost 800 physicians located in over 40 regional centers in the northern and western parts of the state. It also offers residency training programs that are freestanding from Wisconsin's 2 medical schools. There is a partner committee at the Rice Lake, Wisconsin satellite location of the Marshfield Clinic. The program has received 125 referrals of physicians over the last 10 years, averaging about 1 referral per month. Referrals come from clinic or hospital administration, concerned colleagues, family members, or self-referrals. Reasons for referrals are outlined in Table 3. Most referrals have come from administration and departments, with only 14 coming by way of self-referral. The challenge of this PHC is to maintain visibility and accessibility to physicians throughout the system of care.

The process of dealing with administrative referrals is outlined in Figure 1. When someone contacts the PHC, the chair and committee members assess the situation and guide the individual through the appropriate channels. Participation is voluntary and confidential. Confidentiality is the cornerstone of physician health services. Information is confidential except in circumstances where an immediate threat to patients is perceived. This set of procedural assumptions creates a safe environment for physicians to talk to peers about work-related stress and the demands of medical practice. As is the case for most statewide and local (hospital/clinic) PHPs, Marshfield Clinic's PHC does not provide direct treatment or even direct clinical services for diagnostic assessment, but links physicians to specific resources for evaluation and treatment options. The PHC also provides advocacy and support for physicians with either a diagnosable health care condition or with workplace stress, burnout, family stress, or manifestations of disruptive/abusive behavior in the workplace. If at any time during the diagnosis, treatment, or rehabilitation phase of the process it

is determined that a practitioner is unable to safely perform the privileges he or she has been granted by the hospital or the clinic, the matter is forwarded for appropriate corrective action that includes strict adherence to state or federally mandated reporting requirements. Additional benefits of a local health system-based PHC are outlined in Table 4.

The Marshfield program also has developed a spousal support network that provides a social venue for physician families and helps with physicians retention. The PHC has provided networking opportunities such as monthly physician lunches and other social events. One very well received initiative has been a monthly newsletter on physician health topics, and there also have been health initiatives such as yoga and mindfulness training for stress management, disease prevention, and health promotion for physicians and non-physician members of the medical staff.

The success of this program lies in the support received from clinic and hospital leadership. Administration believes in the program and has provided financial support. The committee has made connections with department chairs and division medical directors and tried to be a resource to them when dealing with difficult physician matters. The committee has worked diligently to find competent resources for treatment around the country. By the same token, it is important to maintain the role of the program as a resource and advocate for physicians that is not part of the disciplinary process—a balance that is sometimes difficult to maintain. At times, there is the expectation that PHC be the voice of physicians in dealing with morale issues within the organization. It is useful to make connections with physicians before problems arise. Meeting with physicians at orientation, mentoring programs, and providing education and literature on physician well-being plants the seed that physician health can be a resource and not a last resort or a punishment for trouble makers only.

Table 2. Guidelines for Establishing Hospital-based Physician Health Programs

To be successful, program must have "buy in" from senior executive leadership.
Meet regularly, not only ad hoc when a matter of impairment or potential impairment in the workplace comes to light.
Maintain visibility and institutional status: perhaps have a standing agenda item on executive committee meetings with reports on matters related to physician well-being and morale.
Develop relationships with department chairs and medical directors and be a resource to them in the physician personnel issues they must address.
Maintain visibility to physicians in multiple venues: website, newsletter, CME events.
Provide confidential, individual, easily accessible resource for physician counseling.
Develop a list of competent resources for evaluation /treatment.
Maintain the role of advocate to physicians apart from the disciplinary process.

Table 3. Reasons for Referrals to Marshfield Clinic Physician Health Committee

Reason for Referral	Number of Referrals
Behavior issues	57
Alcohol/drug	11
Medical	4
Mental health	11
Peer counseling	19
Dictation backlog	9
Patient satisfaction	5
Pornography	3
Morale	6
Total	**125**

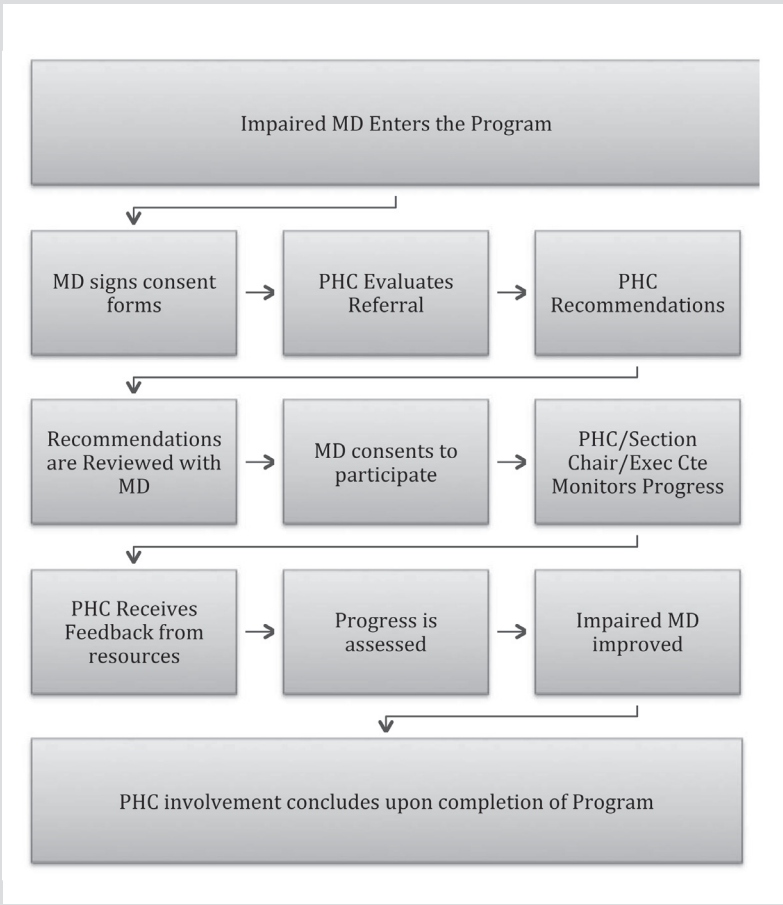
Table 4. Additional Benefits of the Local Health System-based Physician Health Program

Consultation resource to administration on matters related to physician well-being and/or illness
Clearinghouse for resources on treatment providers and programs
Source for continuing education and faculty development on physician well-being
Entity that can develop a mentoring program for physicians
Source of information and programming to improve cultural sensitivity and diversity training

CONCLUSION

Addressing physician health and wellness is now recognized as an important factor in the sustainability of physician practices and in the quality of patient care. Improving personal resiliency can help physicians cope and is of value to health care organizations and patient well-being as well as to physicians, other licensed health care professionals, and members of their families. Physician health programs have crucial roles in prevention, early detection, education, and referral to professionally administered treatment, as well as providing appropriate follow-up and monitoring. As of 2011, 45 states had active statewide physician health programs; only Wisconsin, California, Georgia, Nebraska, North Dakota, and Delaware do not have programs that are members of the FSPHP[26] (at the press time of this article, Georgia was bringing into operations the Georgia Professional Health Program, Inc, and California seems at the brink of adopting legislation to allow the establishment of California Public Protection and Physician Health, Inc, a statewide entity independent of state government but with authorization to operate as an alternative to discipline for California physicians). Health care organizations in Wisconsin must rely largely on their own local resources, which are limited in scope and effectiveness. What is needed in Wisconsin

Figure 1. Flow diagram showing Marshfield Clinic's process for administrative referrals.



Abbreviation=PHC, physician health committee

is a statewide program that physicians and licensees can trust to place their needs as individuals on a level comparable to the needs of the state in assuring physician fitness to practice. The "diversion program" in place can offer effective monitoring for persons with an identified health condition with the potential to lead to impairment, but any program that is an arm of government will inherently (and understandably) face barriers to having potential program participants trust the program to protect them rather than restrict or punish them. Working in collaboration with the MEB of the executive branch of Wisconsin's state government, the PHP at the Marshfield Clinic/Ministry St. Joseph's Hospital is one example of a health care facility attempting to meet the needs of physician well-being. We look forward to the day when an independent process, administratively housed outside of government, and with the robust support of the medical profession and other health professions, is re-established for the benefit of licensed independent practitioners in Wisconsin.

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