International Journal of Law and Psychiatry 56 (2018) 65–70

Contents lists available at ScienceDirect

International Journal of Law and Psychiatry

Do state physician health programs encourage referrals that violate the Americans with Disabilities Act?

Nicholas D. Lawson *, J. Wesley Boyd [a,b]

[a] Center for Bioethics, Harvard Medical School, United States
[b] Department of Psychiatry, Cambridge Health Alliance/Harvard Medical School, United States

ARTICLE INFO

Article history:
Received 7 July 2017
Received in revised form 2 December 2017
Accepted 4 December 2017
Available online 5 January 2018

Keywords:
Physician impairment
Physician health program
Stigma
Peer review
Whistleblowing
Social discrimination
Physician health
Americans with Disabilities Act

ABSTRACT

The websites of many physician health programs provide lists describing signs of impairment or indications to refer physician-employees for evaluation and possible treatment. This study aimed (1) to determine how many of these descriptions likely provide physicians' employers with sufficient evidence to legally request mental health examinations under the general regulations of the Americans with Disabilities Act (ADA); and (2) to find out who they described. The authors applied US Equal Employment Opportunity Commission guidance documents and sought expert legal advice to evaluate the descriptions for their consistency with the ADA. They used directed content analysis to review and code these descriptions into categories. Very few, if any, of the 571 descriptions appeared to provide sufficient evidence for employers to request an examination under the ADA. About 14%, however, could refer to physicians attempting to defend themselves, assert their ADA rights, or otherwise complain about the hospital; and 27% either described physicians who complain or else had discriminatory effects in one of several different ways. Leaders within the medical field should ensure that their policies and state laws pertaining to physician impairment comply with and incorporate the language of the ADA. They should also reevaluate the functions of these policies, laws, and physician health programs, and the implications for patient safety, physician wellness, suicide, and other important issues.

1. Introduction

In the early 1970s, leaders in the US medical field faced the prospect of increased government oversight amid growing public concerns that the medical profession was insufficiently regulated. These calls posed a serious threat to the profession's long tradition of self-governance and relative autonomy from outside intervention (Stimson, 1985).

Then, in 1972, a pair of psychiatrists wrote *The Sick Physician*, which was subsequently adopted by the American Medical Association (AMA) Council on Mental Health. This report blamed physicians with mental disorders, including alcohol and other substance use disorders, for jeopardizing the profession's accountability to the public, and it proposed identification, and referrals for evaluation and treatment of these physicians as a way to solve the problem internally within medicine (AMA, 1973) and became the basis for the movement to identify impaired physicians, assist them in receiving needed treatment, and ensure their safety if they are in practice. The AMA's policies resulted in the adoption of numerous state laws consistent with the aims of the movement starting in the mid-1970s (Sargent, 1985) and also, in part, gave rise to the creation of state physician health programs (PHPs) as entities charged with identifying impaired physicians and overseeing their monitoring and treatment.

The AMA's policies and state laws pertaining to physicians with mental disorders differ in significant ways from the Americans with Disabilities Act (ADA), which was passed in 1990. While the AMA and state laws generally do not distinguish between mental illness and physician impairment (AMA, 2009; Myers & Gabbard, 2008), the ADA provides clear guidance to prevent unwarranted examinations of any employee who has or is suspected of having a mental disorder, but who is not impaired. The AMA's policies have also encouraged physicians and employers to abide by medical board regulations and state laws, instead of the ADA, when considering how to respond when they suspect that a colleague or employee might be impaired (AMA, 2004; AMA, 2013). In these respects, standard practice in the medical profession does not appear to comply with ADA.

Physicians with mental disorders are not necessarily impaired by any means. In fact, research on physicians has generally not evaluated the impairments associated with specific mental disorders but instead has focused on symptoms of burnout or poor wellbeing to determine whether they result in more patient errors or have adverse effects on safety outcomes. Even within this body of research, however, few studies have determined whether physicians make errors which result in

* Corresponding author.
E-mail addresses: nick.d.lawson@gmail.com (N.D. Lawson), jwboyd@cha.harvard.edu (J.W. Boyd).

https://doi.org/10.1016/j.ijlp.2017.12.004
0160-2527/

burnout symptoms, or whether symptoms of burnout result in medical errors. Few of these studies have incorporated objective measures of patient safety outcomes, and those that have report mixed, if any, positive results (Hall, Johnson, Watt, Tsipa, & O'Connor, 2016).The literature has not established burnout, let alone mental disorders, as a meaningful cause of medical errors or preventable adverse events (Banja, 2014).

These inconsistencies highlight important gaps in current knowledge regarding the extent of possible ADA noncompliance within the medical profession in its handling of physicians who might be impaired in some way. To assess this issue, we decided to examine the descriptions of impairment and/or indications for referring physicians to a state PHP on PHP websites, given that these descriptions represent direct translations of these policies and laws into instructions for other physicians, employers, and hospitals, and their analysis could be particularly informative.

We then performed a directed content analysis of these descriptions in order to evaluate their consistency with the ADA, and also identify who they described. To the best of our knowledge, no previous studies have examined the content of these descriptions. Based on our historical review of the impaired physician movement, prior research, and other data, we hypothesized that the descriptions would generally not be consistent with the ADA and that, additionally, these descriptions might potentially be used to identify practitioners who are critical of standard operating procedures in an effort to silence or punish those individuals.

2. Methods

2.1. Qualitative approach and research paradigm

Directed content analysis develops from preexisting theory and provides supporting or non-supporting evidence for researchers' hypotheses (Hsieh & Shannon, 2005), with direct implications for research and policy. Directed content analysis is performed from a post-positivist point of view, which seeks to establish probable truth by testing hypotheses, and using well-defined concepts and variables with precise instrumentation (Bunniss & Kelly, 2010).

2.2. Sampling strategy

In April 2017, the authors used the links to PHP websites provided on the Federation of State Physician Health Programs website to review the entire site of each PHP, including attachments, in search of any lists of potentially problematic signs or symptoms in physicians. After purposefully sampling, compiling, and reviewing these descriptions, we developed the coding scheme below.

2.3. Data analysis

2.3.1. Distinguishing individual descriptions

Individual descriptions of signs and symptoms were the units of analysis. We considered descriptions to be separate and unique if they were demarcated with bullets, row borders, capital letters, dashes, or horizontal placement. We did not consider headings or subheadings that preceded other descriptions, however. The state of Maine was the only program whose individual descriptions were placed altogether in paragraphs, and we used commas to distinguish them individually.

2.3.2. Complex descriptions

Some descriptions (e.g., "intoxicated at social events or odor of alcohol on breath while on duty") contained multiple components, with one component ("intoxicated at social events") that seemed less likely to warrant a referral, while another ("odor of alcohol on breath while on duty") seemed relatively more likely. In these cases, we considered the component less or the least likely to permit a referral when determining the status of the overall description.

2.3.3. Current level of performance

When evaluating descriptions of potentially impaired performance, we excluded those that did not permit an assessment of the employee's current level of performance. Descriptions that referred only to changes in an employee's performance did not indicate whether or not the employee was actually providing good care. For example, a decline in performance might only make a physician's previously exceptional performance now just a little less exceptional. Descriptions whose interpretations depended on the words *affect*, *impact*, *interfere*, or *deteriorate* also did not permit an assessment of current performance.

2.3.4. Determining whether descriptions legally permitted employer referrals for a mental health examination

Title I of the ADA prohibits an employer from requesting mental health information from, or requiring a mental health evaluation of, an employee without a reasonable belief based on objective evidence that

1. the employee is unable to perform essential job functions because of a mental disorder; or
2. the employee will pose a direct threat to safety due to a mental disorder.

Direct threat is defined as a high risk of substantial harm to self or others in the workplace that cannot be reduced or eliminated through reasonable accommodation, and a speculative or remote risk is not sufficient (US EEOC, 1997). We referred to guidance documents from the US Equal Employment Opportunity Commission (US EEOC) when assessing whether each sign or symptom described in the websites represented a sufficient legal indication for requesting an examination under the ADA. For difficult coding decisions, we sought additional guidance from an attorney at the US EEOC.

This approach can be applied to an analysis of the first description from Colorado's state PHP: "withdrawal from family activities." Were an employer made aware of or informed of a physician-employee's "withdrawal from family activities," this would not be sufficient indication that the employee was unable to perform essential job functions because of a mental disorder, nor would it provide sufficient indication that the employee posed a direct threat to safety due to a mental disorder. In sum, it would not allow an employer to request mental health information or evaluations or refer for such an evaluation under the general rules and regulations of the ADA.

2.3.5. Categories

What follows is a list of specific categories that we employed in this analysis. The asterisk (*) symbol is used as a placeholder to represent multiple terms. "*Deni**," for example, includes both *denial* and *denies*.

2.3.5.1. Deny. This category only incorporated descriptions of physicians who are defensive and used terms *defens**, *deny**, or *deni**; and/or who are suspicious and used terms *suspicious*, *paranoia*, *mistrusting*, or *delusional*.

These descriptions are problematic not only because denial is not a diagnostic criterion in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5; American Psychiatric Association, 2013), but also because treating denial as indicative of physician impairment may make it more difficult for those wrongfully accused of impairment to defend themselves.

2.3.5.2. "Directly prevent" complaints. We classified some descriptions as directly preventing employees from asserting their rights. These included all descriptions from the denial category, as well as "unreasonable sensitivity to normal criticism from peers," "resistance to pre-employment physical or family interview," "reluctance to have laboratory tests done or physical exam performed," "uncooperative, defiant approach to problems," "uncooperative, defiant, rigid, inflexible," "recurrent conflict with others, particularly authority figures; irrational,