



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



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## 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.

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## 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

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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,

oppositional,” “conflicts with colleagues,” and any descriptions using the either the words *fighting* or *argument*\* that could pertain to the workplace.

We also included descriptions that might prevent physicians from blowing the whistle in an effort to improve patient safety and care, namely, descriptions of participating in *litigation* against the hospital; that the employee *complains*, is a *critic*\*, or *cynic*\* about the hospital; makes *public* or *derogatory comments*, or *blaming*, *shaming*, *belittling*, *berating*, *degrading*, *demeaning* comments, or “writes inappropriate medical record entries concerning the quality of care being provided by the hospital or any other individual.”

**2.3.5.3. “Indirectly prevent” complaints.** These descriptions could potentially describe physicians either asserting their rights or standing up for better care, and could pathologize their behaviors in indirect ways. For example, descriptions that attribute psychopathology to a physician who “often overreacts” or is “irritable” could be assigned to those who do not agree to a hospital’s request for a mental health examination. Descriptions that attribute psychopathology to a physician with the “appearance of never being happy or satisfied,” who has a “very low tolerance for others,” and “imposes idiosyncratic requirements on ancillary staff,” may also prevent physicians from expressing concerns about patient care. We provide a complete account of the descriptions included in this and all other categories in Supplementary Table A.

**2.3.5.4. Work hard.** We included in this category all descriptions that specifically mentioned hard work; those that mentioned making rounds late or at unusual hours; those that referred to changes in sleep with terms *sleep*, *tiredness*, *insomnia*, or *fatigue*; and all descriptions from the socially withdraw category, described below, which may also reflect hard work. What makes descriptions such as “excessive working” particularly noteworthy is that, rather than identifying individuals with impairment, they appear to identify those who may be especially dedicated to the care of their patients.

**2.3.5.5. Socially withdraw.** This category only included descriptions with terms *withdraw*\*, *isolate*\*, *avoid*\*, or *alienation*, as well as those with *neglect*\* that referred to neglect of family or other social commitments. Social withdrawal is a common reaction to discrimination (Volpone & Avery, 2013), and features among several sets of discrimination measures (Brohan, Slade, Clement, & Thornicroft, 2010). Treating social withdrawal as an indicator of impairment has potential to further discriminate against those with current or past discrimination experiences.

**2.3.5.6. Specific discrimination-related categories.** We coded certain descriptions as overt discrimination, such as “continual asking of special accommodations,” “unusual medical problems or disabilities,” and “multiple medical problems,” because they infer impairment simply by virtue of the presence of a physical or mental health condition or the need for an accommodation.

We also categorized some descriptions as forms of courtesy stigma if they described mental health or other problems in family members or friends, such as “spouse in therapy or taking psychoactive medication,” or “frequently associates with known alcohol or substance users/abusers.” Courtesy stigma has been defined as, “Stereotypes, prejudice, and discrimination by association with marked groups” (Pescosolido & Martin, 2015, p. 92), and is worthy of special scrutiny because it can effectively encourage further stigmatization and discrimination by those who might fear being regarded as impaired by virtue of their associations. This may result in a physician isolating from his/her spouse in the case of the first example or refraining from defending a colleague accused of being impaired in the second.

We also coded descriptions of rounding at late or unusual hours, which may result in harm for physicians with attention-deficit/

hyperactivity disorder (ADHD), specific learning disorders (SLD), or those with alternative learning and working styles.

We coded descriptions of *unemployment* or getting fired, which might further stigmatize physicians who have already experienced discrimination by asking members of the medical profession to be wary of those who have been fired and now are excluded from the workforce.

For similar reasons, we identified descriptions of *financial* problems, which also appear to stigmatize low socioeconomic status.

## 2.4. Techniques to enhance trustworthiness

As much as possible, we grounded our analysis and interpretations in the objective presence or absence of specific words in the website descriptions in order to minimize bias. We created a detailed, 34-page document available in the Supplementary material, which outlines the status and categorization of each description, with additional notes on the rationale for coding decisions, and links to the PHP webpages. We present as much information as possible for readers to interpret and evaluate all findings on their own.

## 3. Results

Table 1 provides the number and percentages of descriptions within each coding category. Given the descriptive nature of this study, we performed no other statistical analysis or hypothesis testing. We identified 23 states (including the District of Columbia) with PHP websites containing lists of physician signs or symptoms variously described as “possible reasons for referral,” or “indicators of impairment,” among others. The other 27 states did not have a PHP with a website containing such descriptions. The number of descriptions at each website ranged from 4 to 68 (mean = 25, median = 21) with 571 descriptions overall.

None of the descriptions appeared to provide sufficient indication for an employer to refer a physician to a PHP for an examination under the general rules and regulations of the ADA. One described “reports of positive urine drug screens,” which could permit an examination if it applied to the current work setting. Nine described alcohol on a physician’s breath, which would permit a urine drug screen, and a referral for examination only if positive. Twelve described signs such as “ataxic gait,” “tremor,” “slurred speech,” and others, which could warrant an exam if observed at work, depending on extent, on specialty of practice, and other factors. One description, “suicide attempt,” could permit an exam if the attempt occurred at work, and the circumstances indicated that the physician still posed a high risk of substantial imminent harm to self. Even if we coded all of these descriptions as legally permissible indications for a referral, however, they would comprise only 23 (4.0%) of the descriptions.

Reasons for considering 66 descriptions as potentially referring to physicians who work hard were as follows: 18 described lack of sleep, which could potentially result from hard work; 28 described social withdrawal that could reflect hard work; and the rest simply mentioned “excessive working,” “working long hours,” “constantly placing work ahead of personal needs,” and other similar behaviors.

Of the 23 states included, 8 (35%) had a PHP with a list that contained at least one description of denial; 14 (61%) contained at least one description likely to directly prevent physicians from complaining about the hospital, with 20 (87%) containing a description either directly or indirectly preventing complaints (see Deny, “Directly prevent” complaints, and “Indirectly prevent” complaints in Methods for descriptions of these categories). Nineteen (83%) included at least one description that could reflect hard work; and 16 (70%) contained a description of social withdrawal. The numbers of states with PHP lists containing at least one description in each of the discrimination-related categories was 5 (22%) for overt, 10 (43%) for ADHD/SLD, 7 (30%) for courtesy, 5 (22%) for unemployment, and 8 (35%) for financial problems (see Specific discrimination-related categories in Methods for explanations of these categories).

**Table 1**  
Characteristics of 571 physician descriptions on state physician health program websites.

State	Name of descriptions list	Total (no.)	Permit referral <sup>a</sup> (no.)	No. (%) describing physicians who				No. (%) within Specific discrimination-related Categories	No. (%) composite <sup>b</sup>	
				Deny	Complain		Work			Socially
				Directly	Total	Hard	Withdraw			
Colorado	Behavioral indicators of a possible health problem in medical professionals	58	0	1 (1.7)	3 (5.2)	3 (5.2)	9 (16)	6 (10)	1 (1.7) overt; 1 (1.7) ADHD/SLD; 2 (3.4) courtesy; 3 (5.2) unemployment; 1 (1.7) financial	18 (31)
DC	A caring approach based on the medical profession's tradition of healing	6	0	0 (0.0)	0 (0.0)	1 (17)	0 (0.0)	0 (0.0)		1 (17)
Florida	When to refer to professionals resource network	14	0	1 (7.1)	1 (7.1)	1 (7.1)	0 (0.0)	0 (0.0)		1 (7.1)
Georgia	Identification of the impaired physician	23	0	0 (0.0)	0 (0.0)	1 (4.3)	2 (8.7)	0 (0.0)	1 (4.3) overt; 1 (4.3) courtesy	5 (22)
Idaho	Warning signs	14	0	0 (0.0)	0 (0.0)	0 (0.0)	2 (14)	1 (7.1)	1 (7.1) financial	3 (21)
Indiana	Common warning signs	21	0	0 (0.0)	2 (9.5)	3 (14)	3 (14)	2 (9.5)	1 (4.8) ADHD/SLD	5 (24)
Louisiana	Warning signs	63	0	5 (7.9)	6 (9.5)	18 (29)	3 (4.8)	2 (3.2)	1 (1.6) ADHD/SLD; 2 (3.2) courtesy; 1 (1.6) financial	25 (40)
Maine	Signs and symptoms of impairment	20	0	1 (5.0)	2 (10)	2 (10)	1 (5.0)	1 (5.0)		3 (15)
Massachusetts	Signs of concern	25	0	0 (0.0)	0 (0.0)	3 (12)	2 (8.0)	0 (0.0)	1 (4.0) overt	6 (24)
Michigan	Potential signs of impairment...	18	0	2 (11)	2 (11)	3 (17)	2 (11)	1 (5.6)		5 (28)
Mississippi	Possible reasons for referrals	4	0	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		0 (0.0)
Montana	What are the warning signs?	8	0	0 (0.0)	0 (0.0)	1 (13)	2 (25)	0 (0.0)	1 (13) financial	4 (50)
North Carolina	Common warning signs of a substance use disorder	16	0	1 (6.3)	1 (6.3)	2 (13)	4 (25)	1 (6.3)	1 (6.3) ADHD/SLD	6 (38)
Nevada	Top 10 warning signs	10	0	0 (0.0)	1 (10)	1 (10)	2 (20)	1 (10)	1 (10) ADHD/SLD; 1 (10) financial	4 (40)
New York	Possible indicators of impairment	22	0	0 (0.0)	1 (4.5)	2 (9.1)	3 (14)	1 (4.5)	1 (4.5) ADHD/SLD; 1 (4.5) financial	6 (27)
Oklahoma	• Who or what is a distressed physician? • Chemical dependency: indicators of impairment	68	0	1 (1.4)	7 (10)	10 (15)	6 (8.8)	4 (5.9)	4 (5.9) overt; 1 (1.4) ADHD/SLD; 2 (2.9) courtesy; 4 (5.9) unemployment	26 (38)
Pennsylvania	Possible indicators of impairment	18	0	0 (0.0)	0 (0.0)	0 (0.0)	5 (28)	3 (17)	1 (5.6) financial	6 (33)
Rhode Island	Common warning signs	17	0	1 (5.9)	1 (5.9)	1 (5.9)	3 (18)	1 (5.9)	1 (5.9) ADHD/SLD; 1 (5.9) courtesy	6 (35)
South Dakota	Signs of concern of behavioral illness for professionals	22	0	0 (0.0)	2 (9.1)	3 (14)	0 (0.0)	0 (0.0)		3 (14)
Tennessee	Distressed conduct	26	0	0 (0.0)	10 (38)	15 (58)	1 (3.8)	1 (3.8)		17 (65)
Texas	• When do residents need help? • Early signs and symptoms of problem behavior • Continuing signs	52	0	0 (0.0)	0 (0.0)	2 (3.8)	10 (19)	3 (5.8)	3 (5.8) ADHD/SLD; 1 (1.9) courtesy; 3 (5.8) unemployment	17 (33)
West Virginia	Warning signs	24	0	0 (0.0)	0 (0.0)	2 (8.3)	3 (13)	2 (8.3)	1 (4.2) unemployment	6 (25)
Wyoming	• CAGE Questionnaire • Burnout Questionnaire • Signs of not coping well	22	0	0 (0.0)	2 (9.1)	7 (32)	3 (14)	1 (4.5)		10 (45)
Total		571	0	13 (2.3)	41 (7.2)	81 (14)	66 (12)	31 (5.4)	7 (1.2) overt; 11 (1.9) ADHD/SLD; 9 (1.6) courtesy; 11 (1.9) unemployment; 7 (1.2) financial	183 (32)

ADHD/SLD = attention-deficit/hyperactivity disorder/specific learning disorder; DC = District of Columbia.

<sup>a</sup> Descriptions providing sufficient evidence to permit an employer to refer a physician-employee to a physician health program for mental examination under the general regulations of the Americans with Disabilities Act. See Results for further discussion.

<sup>b</sup> Includes nonoverlapping descriptions of physicians who complain or work hard, or which can be included under a discrimination-related category.

Finally, we performed two composite calculations. The first, not shown in Table 1, revealed that 27% (153/571) of the descriptions could either be coded in the complaint, or specific discrimination-related categories. The second (see Table 1), which was calculated for each state, determined that between 0.0% and 65% of states' descriptions, and 32% (183/571) overall could either describe physicians who complained or work hard, or else could be included in one of the specific discrimination-related categories.

#### 4. Discussion

This report provides an important preliminary assessment of ADA compliance within the medical profession. It shows that less than 23 (4%) of the 571 signs and symptoms described by PHP websites would likely provide sufficient indication for an employer to refer a physician-employee for an examination under the general rules and regulations of the ADA. Most are only loosely related, if at all, to mental disorders or clinical performance in general. Many of these websites

also identify denial and criticism as possible criteria for a PHP referral, which is problematic because this may prevent physicians from asserting their rights under the ADA and from resisting unwarranted mental health inquiries, evaluations, and referrals. In essence, these PHP referral criteria create a wide net, imply mandated reporting, and then ensnarl victims within a Kafkaesque nightmare of no escape through their affiliations with employers and state medical boards.

There are many reasons to doubt that these descriptions actually promote the safety and welfare of patients. State PHP websites that include complaints about the hospital as a possible sign of impairment may both interfere with the ADA's protections and also prevent physician whistleblowers from raising legitimate concerns. They complement the perspectives voiced in various journals that physicians are now unlikely to be granted sufficient due process rights when they are targeted in peer review committees or hearings concerning their performance or conduct, which may effectively eliminate physicians attempting to advocate on behalf of their patients (Benson, Benson, & Stein, 2016; Chalifoux, 2005; Huntoon, 2004; Lauth, 2007; Lenzer,

2016; Meyer & Price, 2012a, 2012b; Vyas & Hozain, 2014) and prevent adverse outcomes. That descriptions like “involvement in litigation against hospital” are provided by PHPs as “indicators of impairment” due to mental illness should raise some important questions about the intended functions of these PHPs, their state medical boards, related state laws, and AMA policies.

Descriptions on PHP websites that include denial as a possible indicator of physician impairment are not likely to detect physicians who harm patients. Instead, physicians who are asked by their employer or hospital if they are impaired may deny the allegation, which in itself could be interpreted as evidence of impairment and subject them to referral. Many PHPs also cite characteristics such as social withdrawal, recurrent job loss, or financial problems, as possible indications of impairment, but a physician who exhibits any of these behaviors might have experienced discrimination in the workplace, and suspecting impairment as a cause of these behaviors might only result in further discrimination. State PHP descriptions that describe associating with persons who may have a mental disorder as a sign of impairment may also create further stigmatization, and leave those accused even more isolated and defenseless.

Even the idea of attempting to identify and scrutinize physician-employees with suspected mental disorders seems unlikely to promote patient safety (Banja, 2014) when there is no evidence to suggest that mental disorders in physicians overall pose a meaningful risk of harm to the patients they treat (Hall et al., 2016). Creating a system that encourages hypervigilance and demands members of the profession to be on the lookout for physicians with suspected mental disorders instead amounts to a systemic infraction of civil rights. Fundamentally, institutional guidance, PHP descriptions, state medical board regulations, state laws, and AMA policies on physician impairment target members of a protected class of individuals assumed to be impaired because of their membership in that class, and encourage extra scrutiny and considerations for discipline of these individuals, but do not place other groups or individual physicians within the same punitive context.

Employer referrals of physician-employees to a PHP on the basis of these PHP criteria also defy the restrictions imposed by federal law, as governed by the ADA. These PHP website descriptions take on particular significance because they are regularly reinforced at hospital orientations, presentations, and other educational events, and accompanied by reminders for physicians to report any colleagues who could be described by them. The effects of these PHP descriptions may not only be felt by physician-employees at a hospital, but also by physicians under contract in specialty clinics, urgent care centers, or through locum tenens companies. The descriptions may also lead to unwarranted referrals not just to state PHPs, but to other providers. The prevalence of implicit or explicitly made referrals to non-PHP sources and the prevalence of referrals to PHPs that do not result in physicians' presentations to a PHP has never been studied.

These state PHP descriptions also illustrate one way in which laws and processes that would otherwise protect employees may be circumvented within the medical workforce. Since state PHPs and medical boards are not employers, they are not subject to the same laws that would normally apply to employers and would protect their employees from prohibited mental health inquiries or examinations (US EEOC, 1997). Those considering litigation against these entities must consider a different set of rules than the ones applied here, which apply only to the employer-employee relationship. Yet since the AMA's policies on physician impairment were what gave rise to corresponding state laws (Sargent, 1985), medical board regulations, state PHP directions, and other institutional guidance, changing the AMA's policies may be the most direct way to change physician impairment policies and practice and ensure compliance with the ADA at every level. At least so far, current leadership has not been responsive (D. Barbe, personal communication, June 4, 2017).

#### 4.1. Limitations

Given the need for clarity in our study design and focus in limiting the scope of this research, we considered only Title I of the ADA, which pertains to employment, and did not consider potential violations of Title II of the ADA, which applies to public entities, the applicability of Fourth Amendment protections against unlawful search and seizure, whistleblower protection laws, and other relevant laws and legal principles.

Another limitation of our study, which is inherent to directed content analysis in general, is that its coding scheme may reflect the authors' biases and attempts to test their own hypotheses. Some of our coding might initially seem illogical, but should make sense when the complete context of a PHP referral is considered. Some descriptions coded as indirectly preventing complaints, for example, contained words (e.g., *abusive*, *passive-aggressive*, *degrading*, *threat\**) which might appear to represent clearly inappropriate behavior on the part of a physician-employee. Yet accounts of employees' behaviors are likely to vary substantially between these employees and their employers. Employees may threaten to file a discrimination complaint, or they may file a grievance without telling their employer, which could be described by employers as passive-aggressive behavior. Alternatively, they could actually represent inappropriate behavior on the part of these physician-employees, though they would not provide sufficient evidence of a mental disorder that would permit a physician referral. In light of these ambiguities, we included these descriptions in an ambiguous “indirect” category. By dividing our categories into different sub-components, we allowed for either a more inclusive or a more selective interpretation of the codes and results, giving readers a choice of different ways to interpret our data.

Directors of PHPs might also object to our evaluations of these descriptions individually as to whether or not each provides sufficient legal indication to warrant a referral. Directors of PHPs might argue that they do not specifically encourage interpretations of these descriptions as precise indications for referral, and a couple of PHPs do provide disclaimers on their websites that might limit their literal interpretation as such. The contexts of these webpages, however, are highly suggestive, and they still appear to indicate that these vague signs and symptoms warrant referrals. The presence of these descriptions on the websites of programs designed to treat impaired physicians further suggests that this is the case. Even qualifying that these descriptions are meaningful only with multiple signs or symptoms present seems unlikely to significantly increase the positive predictive value of these lists for detecting impairment, as we suspect that most readers and physicians in general will meet criteria for a lot of them.

#### 5. Conclusions

This study provides important new insights into the extent of ADA compliance within the medical profession. While other sources have reported that, unlike the ADA, AMA policies and state laws generally do not distinguish between mental illness and impairment (Myers & Gabbard, 2008), the results of this study demonstrate how these policies and laws can result in more directed instructions for identifying and referring physician-employees for examinations that are not consistent with the ADA. Consistent with our hypotheses, we found many descriptions that attributed psychopathology to those who criticized their employers in either direct or indirect ways, or who denied accusations levied against them.

These results should prompt reflection within the medical field about the underlying purpose of these PHPs, state laws, and AMA policies. Leaders both within and outside of medicine should consider the quality of evidence being cited to support the many claims that mental disorders will result in increased medical errors, and how pathologizing hospital criticism may also have an impact on safety. We appeal to those in the medical field with a special interest in physician suicide and ask

how promoting hypervigilance within the medical community to detect and potentially remove physicians who are described by these sites could reduce physician suicide. We ask the AMA to revise its policies on physician impairment to be consistent with the ADA, and specify that physicians must pose a “high” risk of “substantial,” “imminent” harm to warrant evaluations or referrals. And we believe this topic warrants considerable attention from lawyers, human rights leaders, and the federal government in order to ensure effective regulation of the profession and the safety of patients, and to facilitate the inclusion of qualified, yet heavily stigmatized individuals both within the medical profession, and everywhere else.

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### Appendix A. Supplementary data

Supplementary Table A containing all website descriptions, coding, comments, and links to the webpages included in the study can be found at <https://doi.org/10.1016/j.ijlp.2017.12.004>.

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