

CMA ON-CALL: The California Medical Association's Information-On-Demand Service
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Document #1240

Adopted by the CMA Board of Trustees

**Guidelines for Physician Well-Being Committees
Policies and Procedures**

January 2005

INTRODUCTION

These Guidelines are intended to aid hospitals, medical societies, specialty societies and any other physician entities to create and operate a committee which assists physicians with matters related to health, chemical dependency, mental illness, or behavior. Commonly referred to as a “Physician Well-Being Committee,” this committee typically assists in obtaining evaluation and rehabilitation services, and often monitors the progress of physicians through most or all of any rehabilitation or treatment program and for an appropriate amount of time afterwards.¹

Well-Being Committees play several important roles. They act as an educational resource for the medical and other organization staff. They provide an informal, confidential access point for persons who voluntarily seek their counsel and assistance. They also provide a source of expertise whereby the medical staff may identify health factors underlying a clinical performance problem for which corrective action is under consideration. In the context of a formal investigation regarding clinical performance, the well-being committee may be called upon to determine the presence, and the nature, of an underlying problem of chemical dependency or mental illness which would necessitate a series of reports to the Medical Board regarding the progress of the investigation.

A “physician health” or well-being committee is now mandated by the Joint Commission on Accreditation for Health Care Organizations (JCAHO). According to Standard MS 2.6, a medical staff must implement “a process to identify and manage matters of individual physician health that is separate from the medical staff disciplinary function.” This process must include seven elements:

- a) Education of the medical staff and other organization staff about illness and impairment recognition issues specific to physicians;
- b) Self-referral by a physician and referral by other organization staff;
- c) Referral of the affected physician to the appropriate professional internal or external resources for diagnosis and treatment of the condition or concern;

¹ Other CMA ON-CALL documents referenced in this document include CMA ON-CALL documents #1210, “Medical Staff Applicants in MBC Diversion Program” #1241, “Disruptive Physicians” #1407, “Documentation of Peer Review Activities” CMA ON-CALL document #1430, “Credentialing - Liability Releases, Indemnification” #1443, “State Agency Requests For Peer Review Information” #1110, “Confidentiality of Substance Abuse, Developmental Disabilities, or Mental Health Information” CMA ON-CALL document #0812, “Disabled Physicians and Employees,” #0701, “MBC Diversion Program(Plus CMA Policy on Impairment Among Physicians)” #1220, “Reporting Investigations of Impaired Physicians” #1405, “NPDB & HIPDB: Overview” and #1415, “MBC and NPDB: Reporting Disciplinary Actions” on Medical Board and National Practitioner Data Bank Reports.

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- d) Maintenance of the confidentiality of the physician seeking referral or referred for assistance, except as limited by law, ethical obligation, or when the safety of a patient is threatened;
- e) Evaluation of the credibility of a complaint, allegation, or concern;
- f) Monitoring of the affected physician and the safety of patients until the rehabilitation or any disciplinary process is complete; and
- g) Reporting to the medical staff leadership instances in which a physician is providing unsafe treatment.

The purpose of this process is “assistance and rehabilitation” rather than discipline. However, if it is determined that a physician is unable to safely exercise the privileges that he or she has been granted, the matter should be reported to the medical staff leadership for appropriate corrective action.

The Well-Being Committee function is an essential element of medical staff² activity in the hospital setting, as well as for physician organizations outside of hospitals. In any context, the Well-Being Committee serves as one of an array of mechanisms physicians should utilize to assure patient safety. A general summary of its actions should be reported to the Medical Executive Committee and/or other organizational governing body at least quarterly.

Well-Being Committees formerly operated almost exclusively in the hospital medical staff and county medical society settings, and are still a vital part of the hospital medical staff structure. With changes brought on, however, by the growth of managed care in California and a more complicated physician practice environment, physician well-being Committees are now found in numerous other settings, e.g., within specialty societies. In certain practice situations, some committees have assisted other health professionals with their problems.

SUGGESTED NAMES FOR THE COMMITTEE

Committee on Physician Health

Committee on the Well-being of Physicians

The Well-Being Committee

² While the term “medical staff” typically refers to the organized medical staff found in the hospital setting, these Guidelines use the term to refer to any aggregate of physicians or other health care providers. Therefore, as used in these Guidelines, and unless otherwise noted, the term “medical staff” also refers, for example, to the physicians who are members of a medical specialty society or an IPA that maintains a Well-Being Committee for the benefit of its members.

BYLAWS

Designation of Committee

The Committee and its charges should be described in the controlling bylaws or rules of the medical staff within which the Committee is formed.³ A copy of the portion of the CMA Model Medical Staff Bylaws addressing “Medical Staff Aid Committees” may be found in Attachment A at the end of this document.

Reporting Relationship

In a hospital setting, the Committee should be advisory to the Medical Executive Committee (“MEC”) and such other appropriate hospital medical staff committees, as the MEC shall designate. In other settings, such as medical societies and medical groups, the Committee should be advisory to the appropriate governing committee.

MEETINGS

Consistent with Department of Health Services Title 22 regulations, the hospital Well-Being Committee should be a standing committee of the medical staff. The hospital Well-Being Committee should meet no less than quarterly,⁴ and as frequently as required to fulfill its charges in accordance with its policies and procedures. The non-hospital Well-Being Committee should also be a standing committee, and should meet regularly. Regular meetings help preserve and assure the Committee’s preparedness and efficiency in responding to problems as they arise. Regular meetings also enhance acceptance of Well-Being Committee’s role as an integral part of the medical staff structure. As a consequence, access to the Committee’s services by individuals is thereby facilitated. (See Attachment B, Making a Well-Being Committee Effective.)

CHARGES

In order to maintain and improve the quality of care and assist staff members in the maintenance of appropriate standards of personal performance, the Medical Staff is responsible to take note of and to evaluate issues related to the health, well being or impairment of medical staff members.

It is important to identify the role of the Committee as advisory in nature, and not a substitute for a personal physician or a disciplinary body.

The Committee should be charged to:

- a) be an effective resource to the medical staff and others as the point where information and concern about the health of an individual physician can be delivered for confidential consideration and evaluation;
- b) receive and assess information; seek corroboration and additional information;

³ Title 22 Regulations require hospital medical staffs to include a provision in their bylaws for the assistance of “medical staff members impaired by chemical dependency and/or mental illness to obtain necessary rehabilitation services.” Inclusion of a standing Well-Being Committee in the hospital bylaws not only satisfies Title 22 Regulations and JCAHO standards, but also assures that the Committee will receive the same confidentiality protections for its records under Evidence Code §1157 as any other medical staff committee. Inclusion of the Well-Being Committee in non-hospital governing rules or bylaws may also assure the protections of section 1157.

⁴ 22 C.C.R. §70703(d) requires reports of activities and recommendations relating to the functions of hospital well-being committees to be made to the executive committee and the governing body “as frequently as necessary *and at least quarterly.*” Thus, hospital-based well-being committees must meet at least quarterly to comply with this DHS Title 22 regulation.

- c) respond to the person, including the physician in question, or group who contacted the Committee (the referring source);
- d) provide advice, recommendations and assistance to the physician in question and to the referring source; provide recommendations for treatment and/or education; provide assistance in obtaining what is recommended, including referral to the appropriate professional internal or external resources for the diagnosis and treatment of the condition or concern; be an advocate for the physician;
- e) monitor physicians for compliance with the terms of a monitoring agreement;
- f) assist physicians with reentry issues;
- g) educate its members and the members of the medical staff about physician health, well-being and impairment; about appropriate responses to different levels and kinds of distress and impairment; about treatment, recovery and monitoring; about the responsibilities of the medical staff in response to concerns about a physician's health; about the importance of early intervention; and about appropriate resources for prevention, treatment, rehabilitation, monitoring and reentry.
- h) maintain confidentiality of the physician seeking referral or referred for assistance, except as limited by law, ethical obligation, or when the safety of a patient is threatened.

MEMBERSHIP ON THE WELL-BEING COMMITTEE

Expertise; Diverse Specialties

Members should be selected for specific expertise, experience and willingness to serve. An effort should be made to appoint members from several specialties. This includes involvement of

- physicians with expertise in addiction medicine;
- physicians with expertise in psychiatry;
- qualified persons recovering from alcoholism or other chemical dependence.

Number of Members

The number of members should be no fewer than three.

Appointment

Each member should be formally appointed to the Committee using the appointment process designated in the medical staff bylaws or other governing rules.

Membership Composition

Medical Staff Membership. Membership may be restricted to members of the medical staff. Individuals who are not members of the medical staff (including non-physicians) may be appointed when such appointment will materially increase the effectiveness of the work of the Committee. Physician members of the medical staff should comprise the majority of the members of the Committee.

Medical Staff Leaders as Members. The Committee may wish to recruit medical staff members who formerly served on the medical staff governing committee (e.g., in the hospital setting, the medical executive committee), peer review committees and/or as department heads. Such individuals can bring a wealth of knowledge regarding how the organization and its medical staff served by the Committee work both procedurally and politically. Additionally, such individuals may be able to facilitate institutional support for the Committee’s purposes given their prior leadership roles in the institution. It is important, however, that no Committee member currently hold any discipline-related position within the institution, e.g., active membership on the Medical Executive Committee or peer review committee. (See paragraph G. below regarding the dangers of “dual roles” for Committee members.)

House Staff. Where there is house staff, there should be house staff members on the Committee.

Duration of Service on Committee

To provide for continuity and development of expertise, the policy of the Committee should be to encourage terms of membership of several years.

Confidentiality; Evidence Code Section 1157

This Committee will maintain strictest confidentiality in its proceedings and shall be considered a Peer Review Committee for purposes of claiming the confidentiality protections afforded by Evidence Code §1157.

Membership on Other Committees; Restrictions

A physician should not serve on both the physician Well-being Committee and a committee which has review or authority over members of the medical staff. Particularly, members of the physician Well-being Committee should not also serve on the hospital Medical Executive Committee or Judicial Review Committee, or any other Committee considering disciplinary issues relating to conduct previously dealt with by the Well-being Committee.

Not only would such dual membership tend to inhibit a physician seeking the services of the Committee, but also it would place the physician serving on both committees in a precarious position in the event of discipline and a subsequent lawsuit. Further, JCAHO standards require that the process be separate from the medical staff disciplinary function. (Standard MS 2.6.)

When it is not feasible to maintain this separation, or when such appointment will materially increase the effectiveness of the work of the Committee, extra care should be taken to clarify the Committee’s policies concerning confidentiality of information. If a decision has been made that such dual membership is required, all should recognize that the member with overlapping responsibilities has obligations which may supersede the obligations and policies which govern the physician Well-being Committee.

POLICIES AND PROCEDURES

Purposes of the Committee

The Committee’s purpose is two-pronged: The Committee should focus on the needs of the physician in question, while at the same time considering patient safety.⁵ While the Committee should have no

⁵ According to the JCAHO, “the purpose of the process is assistance and rehabilitation, rather than discipline, to aid a physician in retaining or regaining optimal professional functioning, consistent with the protection of patients.” JCAHO intent of Standard MS 2.6.

authority to take disciplinary action, it should serve as a candid advisor to both the referral source and to the physician in question. In that role it should make appropriate recommendations, if necessary, to assure patient safety.

Objectives of the Committee

The Committee's focus is on the needs of the physician and the safety of patients treated by the physician, as well as on the responsibilities of the medical staff. Committee members should be mindful of their role as advocate for the physician and the appropriate limits on that advocacy which may be imposed by a need to protect patients from harm.

The Committee's first task is to evaluate the information and the concerns brought to them and to seek corroboration and sufficient additional information. All contacts by and with the Committee should be confidential to the fullest extent permitted by law.

Action in Matters Affecting Patient Safety

In the event information received by the Committee clearly demonstrates that the health or known impairment of a medical staff member creates a likelihood of harm to patients or others in the organization, that information shall be conveyed to those individuals or committees within the medical staff responsible for assuring that appropriate follow-up action is taken, including, if necessary, adherence to state or federally mandated reporting requirements. However, laws protecting the confidentiality of substance abuse treatment and disabled individuals must be complied with. *See CMA ON-CALL documents #1110, "Confidentiality of Substance Abuse, Developmental Disabilities, or Mental Health Information," and CMA ON-CALL document #0812, "Disabled Physicians and Employees."*

Should the Well-being Committee have questions regarding the ability of the physician to practice, appropriate expert opinion should be obtained. Following the receipt and evaluation of such opinion, the committee should determine if it will recommend that some limitation of practice is indicated.

Committee Recommendations Made Only To Referral Source and Subject Physician

Except in an instance where there is a likelihood of harm to patients (see prior paragraph), the Committee should report only to the referral source and to the physician in question. Many times the person or group which brings its concerns to the Committee and asks for the advice and services of the Committee will be a person or group with disciplinary authority, such as chief of staff, department head, Medical Executive Committee. In such cases, the same policy and procedure apply: the Committee should make recommendations only to the referral source and to the physician in question.

Treatment and Monitoring

The Committee should not provide treatment or supervision of clinical practice for a physician. The Committee should refer the physician to appropriate resources for treatment.

If it is appropriate, the Committee should recommend enrollment in the Medical Board of California's Diversion Program. *See CMA ON-CALL document #0701, "MBC Diversion Program (Plus CMA Policy on Impairment Among Physicians)."* The Committee should also advise on the appropriateness of aftercare, and on a monitoring plan and its provisions. The monitoring plan is the basis for a monitoring agreement between the physician and the designated medical staff committee.

Alternatively, if a physician enters the Medical Board of California's Diversion Program without involvement of the Committee, and the institution receives a notification of entry into the Diversion

Program, this communication should trigger the development of an institution-specific monitoring agreement between the Well-being Committee or the appropriate medical staff committee or entity and the physician in Diversion.

In either case, the Committee should monitor the physician for compliance with the provisions of the monitoring agreement. The Committee should insure that appropriate monitoring procedures are established and carried out. (See Attachment C for specific guidelines for monitoring, including a discussion of the Committee's response if the physician does not comply with the monitoring plan.)

A Committee member should be the coordinator of monitoring. The Committee should review and re-evaluate the physician and the monitoring agreement at regular intervals to be sure that the agreement fits the current needs and situations.

The Disruptive Physician

A response to physicians who exhibit disruptive behavior patterns in the absence of any evident alcohol or drug problem is also an appropriate charge to this Committee. See **CMA ON-CALL document #1241, "Disruptive Physicians,"** for "Guidelines for Assisting the Disruptive Physician."

Committee Reports to Governing Committee; Identity of Physician

Title 22 requires that hospital-based Well-being Committees shall provide a quarterly report to the Medical Executive Committee. Non-hospital Well-Being Committees should regularly report their activities to the governing body as well. The identity of a physician who voluntarily seeks assistance from the Committee shall not be disclosed in the report.

Where the physician has experienced some clinical performance failure and has been referred to the Well-being Committee by the MEC or other governing body for evaluation, the identity of the physician may be disclosed in the report.

ALTERNATIVES TO FORMATION AND OPERATION OF COMMITTEE

There are certain circumstances in which it may not be feasible or practical to create a standing Well-Being Committee. Medical staffs falling under this category should provide for appropriate alternatives to a standing committee. Alternatives may include a working agreement with the local county medical society and/or specialty societies for the services of their Well-Being Committees. It may also be possible for medical societies, or smaller medical staffs or groups of physicians from several institutions to create a consortium Well-Being Committee to serve where creation of a formalized committee in one organization may not be possible.

REPORTS TO THE MEDICAL BOARD OF CALIFORNIA, NATIONAL PRACTITIONER DATA BANK

The law requires that, under specified circumstances, reports must be made of physicians to the Medical Board and/or National Practitioner Data Bank. When such instances arise, the reporting responsibility should vest in the hospital Medical Executive Committee or equivalent governing body for the organization served by the Well-Being Committee. The Well-Being Committee should serve only as an advisory and monitoring body, conducting inquiries and evaluations, and making reports to the governing committee as necessary. The Committee is charged to provide support and advocacy for physicians, and should not assume responsibility to report to government agencies. The fact that reporting is done by the governing committee rather than the Well-Being Committee indicates a clear separation of the mission and activities of Well-Being Committees from those of the medical staff committees responsible for

credentialing, corrective action and other disciplinary matters. For information on reporting requirements applicable to investigations of impaired physicians, *see* [CMA ON-CALL document #1220, "Reporting Investigations of Impaired Physicians."](#) For information on Medical Board Reports, *see* [CMA ON-CALL document #1415, "MBC and NPDB: Reporting Disciplinary Actions."](#) For information on NPDB/HIPDB reports, *see* [CMA ON-CALL document #1405, "NPDB & HIPDB: Overview."](#)

RECORD KEEPING

Only those records should be kept which are appropriate to the charges given to the Committee by the medical staff. Detailed records of the deliberations about an individual physician would not be appropriate. *See* [CMA ON-CALL document #1407, "Documentation of Peer Review Activities."](#)

CONFIDENTIALITY OF RECORDS & RECORD SHARING

Hospital medical staffs and other peer review bodies *should* guard their peer review records carefully. All records of the physician Well-Being Committee should be maintained in the strictest confidence, preferably in locked files to which only certain key Committee members and staff have access. Indiscriminate sharing of those records, particularly if the information were to be leaked outside the legitimate peer review context, can severely compromise the confidentiality of the records. This is because California Evidence Code §1157, which protects such records from compelled or involuntary disclosure (e.g., when a malpractice attorney tries to subpoena them) applies only as long as the information is *utilized* for peer review and quality assurance purposes. However, peer review bodies need not be unduly hesitant to share information with other peer review bodies when the other peer review bodies provide reliable assurances that they will use this information only in furtherance of legitimate peer review activities and that the records will remain confidential.

Conversely, there is no general legal *duty* to share peer review information between hospital or non-hospital peer review bodies (such as hospital medical staffs, ambulatory surgical center staffs, HMOs, medical societies, medical schools, medical groups, and other bona fide peer review bodies). There is, however, significant public policy which favors the voluntary sharing of information between legitimate peer review bodies in order to assist in maintaining physician competence and protecting the public health. The issue of whether and to what extent a peer review body should share information with another peer review body, therefore, is a matter solely within the first peer review body's discretion. The decision of whether and to what extent the physician Well-being Committee shares information should be made in accordance with any existing medical staff policies and procedures, and after consideration of all relevant laws regulating disclosure of otherwise confidential information, and protections for communicating such information.

Factors to Consider When Deciding Whether to Share Protected Information

A key factor to evaluate in determining if information should be shared is whether the Committee wishes to share information in furtherance of its patient protection and physician rehabilitation goals (e.g., with another Well-Being Committee) or instead contemplates disclosing information only in response to a subpoena or other demand. Another factor of importance is that, while the Committee's records as a whole will generally be considered peer review records for purposes of legal protections, some of the records may be patient treatment records which are subject to special protections and may not be disclosed or shared voluntarily without meeting certain other requirements. *See* [CMA ON-CALL documents #1110, "Confidentiality of Substance Abuse, Developmental Disabilities, or Mental Health Information,"](#) [CMA ON-CALL document #0812, "Disabled Physicians and Employees."](#)

It must be emphasized that CMA supports a clear separation of the mission and activities of physician Well-being Committees from those of medical staff committees responsible for credentialing, corrective

action and other disciplinary matters. Therefore, CMA policy encourages the sharing of information *only* with the physician Well-being Committees of other medical staffs. Nonetheless, it is advisable to inform physicians that information may be shared in furtherance of the Committee's goals and to seek each physician's written acknowledgment of and authorization for such disclosures. Although the immunity protections discussed below will often apply even without physician authorization, obtaining a signed authorization from a physician may avoid subsequent questions or disputes regarding the disclosures. Moreover, a carefully worded authorization may also avoid charges regarding disclosures in this and other contexts that the Committee, either knowingly or inadvertently, violated the special confidentiality laws which protect special patient treatment information which the Committee may have in its possession.

Protections Against Liability In Sharing Peer Review Information

Under Civil Code §43.8 there can be no monetary liability against any person arising from the communication of information to any medical peer review committee, *so long as the communication is intended to aid in the evaluation of the qualifications, fitness, character or insurability of a medical practitioner*. A communication of information not known to be false is also protected from liability under federal laws by the Health Care Quality Improvement Act (42 U.S.C. §11111(b)). Thus, official communications related to a physician's competence, from (or to) a peer review committee or anyone on it to (or from) another peer review committee or anyone on it should not give rise to liability.

Sometimes medical staffs and other peer review bodies do not understand that they have discretion to share this information. Others are worried that, if they do share this information, they might be exposing themselves to liability or compromising the confidentiality of the information shared. In order to encourage the voluntary sharing of this information, the California Legislature has provided (1) numerous statutory immunities for individuals who communicate peer review information and (2) broad confidentiality protections for such information even after it has been shared with another peer review body. A thorough understanding of the available protections and some important practical concerns should go a long way toward protecting peer review bodies which might otherwise be hesitant to share this information.

Confidentiality Agreement Needed Before Sharing Information

While the communication of information between physician Well-being Committees of various medical staffs will not jeopardize the protection from discovery afforded by Evidence Code §1157 or confidentiality protections afforded by other laws, legal protections of this nature are only effective if they are asserted. Accordingly, CMA suggests there be a written agreement on the part of the receiving committee: 1) that the records will be used strictly for quality assurance activities, 2) that the records will be maintained exclusively as part of the peer review committee records, 3) that the peer review committee will assert the protections available under Evidence Code §1157 and other confidentiality laws to the fullest extent permitted by law in the event that any outside party attempts to obtain discovery or disclosure of these documents. For more information on sharing peer review, including] a sample confidentiality agreement, *see* [CMA ON-CALL document #1430, "Credentialing - Liability Releases, Indemnification."](#)

Consult With Legal Counsel; Develop Protocols

Because of the complexity of these laws, each Committee, with consultation from legal counsel, should develop a protocol and procedure governing the release of Committee information, to be approved by the medical staff.

COMMUNICATIONS IN RESPONSE TO A SUBPOENA OR OTHER DEMAND

Voluntary disclosure of information by the Committee in furtherance of the goals of protecting patients and rehabilitating physicians as discussed above must be distinguished from disclosure in response to a subpoena or other demand, which is generally discouraged by the laws. Generally, Evidence Code §1157 protects peer review records from compelled or involuntary disclosure except under certain narrowly defined circumstances. In 1996, the California Supreme Court created a new exception, namely that the Medical Board may obtain documents and information otherwise protected by Evidence Code §1157 upon issuance of an investigative subpoena. Records of this nature should only be produced to the Medical Board when requested in an investigative subpoena which is specific as to the records requested. All such subpoenas should be reviewed by legal counsel to assure that disclosure, if forthcoming, will be limited to only those items appropriate for discovery. For more information, *see* **CMA ON-CALL document #1443, “State Agency Requests For Peer Review Information.”** In any case, patient medical records or patient medical information generally may not be released *without a signed patient authorization specifically permitting release of such records*. Vigilance is of prime importance in protecting the confidentiality of medical staff and patient records.

ADDITIONAL RESOURCES

There are a number of organizations which may be of assistance to Well-being Committees. These include:

Substance Abuse and Mental Health Services Administration (SAMHSA)

5600 Fishers Lane
Rockville, MD 20857
Homepage: www.samhsa.gov
E-mail: info@samhsa.gov

Center for Substance Abuse Treatment (CSAT)

5600 Fishers Lane
Rockville, MD 20857
Homepage: www.samhsa.gov
E-mail: info@samhsa.gov
(301) 443-5700
FAX (301) 443-8751

Center for Substance Abuse Prevention (CSAP)

5600 Fishers Lane
Rockville, MD 20857
Homepage: www.prevention.samhsa.gov
(301) 443-0365
FAX (301) 443-5447

Center for Mental Health Services (CMHS)

P.O. Box 42537
Washington, D.C. 20015
Homepage: www.mentalhealth.samhsa.gov
(301) 443-0001
FAX (301) 443-1563

SAMHSA, a federal agency established by Congress in 1992, aims to improve the nation's ability to prevent, diagnose and treat substance abuse and mental illness. SAMHSA's website provides helpful information on the services and programs available through their Center for Substance Abuse Prevention (CSAP), Center for Substance Abuse Treatment (CSAT), and Center for Mental Health Services (CMHS). The site also provides direct links to SAMHSA's information clearinghouses on the topics of mental health, substance abuse prevention and treatment, and resources for substance abuse treatment service providers.

American Society of Addiction Medicine

4601 North Park Ave., Suite 101
Chevy Chase, MD 20815
Homepage: www.asam.org
email@asam.org
(301) 656-3920
FAX (301) 656-3815
Publications Center: (800) 844-8948

ASAM is a national medical society that works to educate physicians and the public about addiction medicine, improve the quality of addiction treatment and promote research and prevention. ASAM offers testing and certification for physicians in addiction medicine, sponsors several CME programs each year, and publishes a journal, a newsletter and a textbook, among other publications. Call the toll-free publications number to order materials or get information on a specific course.

California Society of Addiction Medicine

74 New Montgomery Street, Suite 230
San Francisco, CA 94105
Homepage: www.csam-asam.org
E-mail: csam@compuserve.com
(415) 927-5730
FAX (415) 927-5731

CSAM is the state specialty society in the field of addiction medicine and a chapter of the American Society of Addiction Medicine. CSAM can provide speakers to medical entities to educate members on well-being committee functions. However, groups must provide a site and reimburse for travel expenses. CSAM also sponsors and conducts conferences in California on addiction medicine and on physician well-being committee functions.

Hazelden Publishing and Educational Services (Learning Resources on Alcohol and Drugs)

15251 Pleasant Valley Road
P.O. Box 176
Center City, MN 55012
Homepage: www.hazeldenbookplace.org
(800) 328-9000
FAX (651) 213-4590

Hazelden offers a wide variety of educational materials on alcoholism, drug addiction, and mental illnesses. Their publications and videos are directed to both patients and clinicians by age, gender, and ethnicity. The materials offered address all aspects of treatment for chemical dependency: identification, intervention, recovery, relapse, family relationships and spirituality.

We hope this information is helpful to you. CMA is unable to provide specific legal advice to each of its more than 30,000 members. For a legal opinion concerning a specific situation, consult your personal attorney.

For information on other legal issues, use CMA ON-CALL, or refer to CMA's California Physician's Legal Handbook. This book contains legal information on a variety of subjects of everyday importance to practicing physicians. Written by CMA's Legal Department, the book is available on a fully searchable CD-ROM, or in a six-volume, softbound format. To order your copy, call (800) 882-1262 or visit CMA's Bookstore at www.cmanet.org.

ATTACHMENT A

CMA MODEL MEDICAL STAFF BYLAWS

ARTICLE XI

COMMITTEES

11.1 DESIGNATION

Medical staff committees shall include but not be limited to, the medical staff meeting as a committee of the whole, meetings of departments and divisions, meetings of committees established under this Article, and meetings of special or ad hoc committees created by the medical executive committee (pursuant to this Article) or by departments (pursuant to Sections 9.4(i) and (l)). The committees described in this Article shall be the standing committees of the medical staff. Special or ad hoc committees may be created by the medical executive committee to perform specified tasks. Unless otherwise specified, the chair and members of all committees shall be appointed by and may be removed by the chief of staff, subject to consultation with and approval by the medical executive committee. Medical staff committees shall be responsible to the medical executive committee.⁶

11.2 PROVISIONS

11.2-1 TERMS OF COMMITTEE MEMBERS

Unless otherwise specified, committee members shall be appointed for a term of [], and shall serve until the end of this period or until the member's successor is appointed, unless the member shall sooner resign or be removed from the committee.

11.2-2 REMOVAL

If a member of a committee ceases to be a member in good standing of the medical staff, or loses employment or a contract relationship with the hospital, suffers a loss or significant limitation of practice privileges, or if any other good cause exists, that member may be removed by the medical executive committee.

11.2-3 VACANCIES

Unless otherwise specifically provided, vacancies on any committee shall be filled in the same manner in which an original appointment to such committee is made; provided however, that if an individual who obtains membership by virtue of these bylaws is removed for cause, a successor may be selected by the medical executive committee.

⁶ Under hospital regulations, while a medical staff must perform certain functions, the medical staff retains discretion as to whether such functions will be performed by separate committees or whether an individual committee will perform some or all of the functions. So long as each of the mandated functions is performed, the requirements will be satisfied. (See 22 CCR §70703, requiring executive review of credentialing, medical records review, tissue review, utilization review, infection control, pharmacy and therapeutics and medical staff assistance regarding chemical dependency and mental illness.)

ATTACHMENT B

MAKING A WELL-BEING COMMITTEE EFFECTIVE

Creating a Well-Being Committee is only the beginning. The Committee is only as valuable as it is effective. The following discusses steps Well-Being Committees should take to increase the likelihood they fulfill their promise.

EDUCATING COMMITTEE MEMBERS

The Committee is charged to educate its members and the members of the organization about physician health, well-being and impairment; about appropriate responses to different levels and kinds of distress and impairment; about treatment, recovery and monitoring; about the responsibilities of the medical staff in response to concerns about a physician's health; about the importance of early intervention; and about appropriate resources for prevention, treatment, rehabilitation, monitoring and recovery. (See Guidelines, Section IV, "Charges" of the Committee.)

Every regular meeting of the Committee should have an educational component. It should vary from meeting to meeting, with different activities being chosen because of an identified "need."

The following methods have proven helpful in educating Committee members and are recommended:

- a brief presentation by a Committee member on a topic selected by the member or by the Committee;

- a brief presentation by an invited speaker;

- concurrent or retrospective review of a specific case which has been prepared for presentation and discussion. All the information needed to have a meaningful discussion should be gathered and presented to the Committee.

- retrospective case review, as described above, with a consultant invited to discuss it with the Committee;

- review/discussion of an article or book which has been distributed to each member of the Committee in advance.

The Committee's educational activities should follow these principles or guidelines:

- Needs assessment should be an assigned responsibility within the Committee. Needs assessment should be an on-going function to identify the areas of information which the Committee "needs to know."

- Preparing for and carrying out the educational activity at each regular meeting should be an assigned responsibility within the Committee.

- Regular liaison and communication with the Diversion Program for Physicians should contribute to the Committee's educational activities. The Committee should invite the local Diversion Case Manager to attend a regular meeting at least once a year.

- Every case or situation in which the outcome was not what the Committee would have liked should be prepared for presentation and retrospective case review and discussion.

In addition to these activities, Committee members should be encouraged to attend conferences or workshops on the subjects related to physician health/impairment and to the responsibilities of physician organizations. It is recommended that more than one Committee member attend each conference.

EDUCATING THE MEDICAL STAFF

If the physicians are unaware of the committee's existence, or how to access it, it won't be used. There are several ways in which committees can increase their visibility.

- Be assertive in keeping the existence of the Committee before the eyes of the staff; find ways to reinforce to the staff that you are there.

- Ask to be included in medical staff programs and plans, such as retreats for the medical staff.

- Offer to do medical grand rounds on the subject of physician health and impairment.

- Take the initiative in educating the nursing and other allied health staff.

To the extent the committee makes presentations on physician health and impairment, it has the dual benefit of increasing the sensitivity to these issues and the likelihood timely intervention will be sought.

ENGENDERING TRUST

Another crucial attribute of an effective Well-being Committee is trustworthiness. If physicians don't believe the Committee will deal with them or their colleagues appropriately, its counsel will not be sought. There are three areas of particular importance to developing and maintaining that trust:

- For the Committee to be effective, it must be the advocate, not the judge.

- The Committee has to be a confidential one.

- Involvement of qualified physicians recovering from alcoholism and other chemical dependence is desirable and deserves special consideration.

Finally, consideration should be given to establishing ways to encourage access to the Committee from all members of the relevant medical community and to facilitate the flow of communication to the Committee from those who might be reluctant to approach a Committee member with sensitive information. Early intervention can save physicians' careers and patients' lives. An effective committee will do what it can to increase the likelihood that such interventions occur where necessary.

ATTACHMENT C

IMPAIRED PHYSICIAN MONITORING

With respect to impaired physicians, monitoring means the process of gathering, compiling and evaluating different kinds of information over time. The purpose of monitoring is to assure the medical staff that a physician with patient care responsibilities can practice medicine safely.

The medical staff must be satisfied that the physician's current physical and mental health meets the medical staff's standards for appointment, re-appointment or resumption of patient care.

The medical staff must acknowledge that on-going, consistent monitoring is required for a specified period of time (a minimum of two years), and sufficient resources of physician time and attention must be allocated for it.

MONITORING PLAN AND MONITORING AGREEMENT

A monitoring plan should be drawn up and it should serve as the basis of a monitoring agreement between the designated medical staff committee and the physician. A detailed written agreement between the two "parties" should be prepared and signed. It should be an agreement between the physician and the appropriate representative of the medical staff. Circumstances should determine whether the appropriate representative is the Well-being Committee, other committee or an officer. Examples include a Department Head, the Chief of Services, Chief of Staff, Medical Executive Committee. In any case, it should be the Committee on the Well-being of Physicians (because of its charge, its role within the medical staff and the particular experience and expertise of its members) which coordinates the monitoring activities, insures that they are implemented, gathers information and assesses compliance with the different elements of the agreement.

The following elements should be addressed as the monitoring plan is designed:

Treatment. The Well-being Committee should satisfy itself that the physician receives appropriate treatment sufficient to assure that the problem is being addressed effectively. An initial course of treatment appropriate to the situation should be instituted and completed. The Well-being Committee should satisfy itself that the physician's current physical and mental health care sufficient to allow him/her to practice safely.

The monitoring plan should incorporate the elements of an aftercare plan and recovery plan which have been recommended by those responsible for the initial treatment.

Release of Information. The medical staff should require that the physician authorize the therapist(s) to communicate information to the Well-being Committee. Information should come from those responsible for primary care (initial treatment) as well as aftercare and/or on-going care.

Recovery Plan. The physician should have a specific, on-going recovery plan sufficient for the situation and to the physician's status in recovery. The monitoring plan should be designed to accumulate the information which will, over time, document the physician's participation in this recovery program.

When the problem is chemical dependency, regular participation in a self-help group of persons recovering from chemical dependence (where appropriate, a group of recovering physicians or health professionals) should be required.

Information to Be Gathered and Reviewed. Information about the health status of the physician in recovery and about his/her performance should be gathered and reviewed regularly and consistently for a specified period of time. The process of gathering and evaluating such information is called monitoring.

Information should come from several sources appropriate to the physician's situation. Examples are:

- from the [hospital] or other physician work place
- from body fluid test results
- from an aftercare coordinator
- from attending physicians and/or therapists
- from family
- from office colleagues

The Well-being Committee should designate those who are in a position to gather and submit to the coordinator of monitoring the different kinds of information appropriate to the case. These monitors should be appointed as members of the Well-being Committee for the purpose of carrying out this activity so that the peer review protections will be applicable.

Regular Contact with a Knowledgeable Observer. There should be regular, face-to-face contact between the physician and a monitor or monitors knowledgeable about the condition being monitored. The time and place of the contact should vary. The frequency and length of contact should be determined for each case. For some, daily or even more than once-a-day contact may be indicated, especially in the first days/weeks of the monitoring process. Usually, three times a week would be considered a minimum for the initial period. The frequency will vary with the particular physician's status in recovery. The length of contact must be sufficient to make an observation of the physician's behavior. The record should include periodic notes based on this observation.

The monitors should be able to create a relationship of mutual trust, support, helpfulness and respect. Monitors, however, should maintain objectivity and diligence throughout the monitoring process.

Coordinator of Monitoring. All who serve as sources of information should report to one coordinator of monitoring for the case, and that person should be a member of the Well-being Committee. The function of the coordinator is to assemble all the information and to review, interpret, evaluate and respond to the comprehensive picture.

Body Fluid Testing. Body fluid testing is desirable as one element of a monitoring plan. Body fluids (most commonly urine) should be collected on a random schedule and under direct observation.

NOTE: Body fluid testing alone does not comprise a sufficient monitoring plan and is not the highest priority element of the plan. Greater weight is given to regular observation of behavior by a knowledgeable monitor.

The monitoring agreement should specify what role body fluid testing will have in the overall monitoring plan. Where body fluid testing is required, the test done must be able to detect the drug(s) which the physician might use. The agreement should describe how positive results will be interpreted and what will be the response of the medical staff committee to positive results. The monitoring agreement should

specify the costs of testing and who pays the costs. The results should be sent to the coordinator of monitoring. For more information about urine testing, *see* discussion at the end of this document.

Regular Conferences. There should be regular face-to-face conferences with the frequency of conferences specified in the monitoring plan, and a mechanism for adjusting the frequency according to need. The conference should include the monitors, the physician monitored, the coordinator of monitoring and the medical staff committee responsible for the monitoring.

Re-Evaluation of the Recovery Plan and the Monitoring Plan. The monitoring plan should be re-evaluated regularly, e.g., every six months, by the Well-being Committee. This permits modifications of the plan as needed to keep it tailored to current circumstances while the monitoring period progresses.

It may be appropriate to have this evaluation made by an acknowledged expert outside of the medical staff who will provide a written report. The monitoring agreement should specify the costs of such evaluation and who pays the costs.

Record Keeping. For each case where there is monitoring, there must be a record. The record should include a copy of the signed monitoring agreement. The medical staff committee must have adequate information to assess the physician's status in recovery and compliance with the elements in the agreement. This information must be accumulated in the record and must be kept in strict confidence, preferably in a locked file or other secure storage which may be accessed only by Well-being Committee members. This information should be retained indefinitely, preferably as long as the physician practices in the hospital or other institution plus five years. Disclosure of this information outside of the Well-being Committee should be made only to another medical staff committee in order to assist that committee with its physician evaluation activities, and at the written request of the individual involved or with the advice of legal counsel.

Response to "Slips." The monitoring plan should take into consideration the fact that a relapse or resumption of use of alcohol or drugs (or "slip") is not uncommon for those recovering from chemical dependence, especially in the early phases of recovery. Statistics show that "slips" occur in a significant percent of cases, usually within the first year of sobriety. The response to a "slip" should be the same as a response to the initial diagnosis; that is, the "slip" should be assessed by a knowledgeable, experienced evaluator and the response should be tailored to the situation. A "slip" alone should not be considered cause for termination of privileges or loss of employment or position. The customary response to a "slip" is to intensify the treatment plan, of which monitoring is a part, for a period of time appropriate to the case. It may or may not be appropriate to require that the physician take a leave from patient care for a period of time. Consideration should be given to the physician's health and to patient safety in reaching a decision about whether a leave is appropriate.

MEDICAL BOARD DIVERSION PROGRAM FOR PHYSICIANS

The monitoring plan may include a requirement that the physician enter the Medical Board of California's Diversion Program for Physicians. When the medical staff requires a physician to participate in the Diversion Program, it should also require the physician to arrange for information from the Diversion Program to be sent to the coordinator of monitoring.

The following information is available from the Diversion Program, but only when it is requested and arranged for by the physician in the Diversion Program:

- a copy of the Diversion Program agreement which the physician signed;
- periodic reports in writing attesting to the physician's continuing participation in the Diversion Program.

The Diversion Program requires physicians to identify themselves as Diversion participants to the medical staff of each hospital where they have privileges: to the physician Well-being Committee if one exists or to the chief of staff or administrator if no physician Well-being Committee exists. The Diversion Program requires that participants have a physician monitor at each hospital where they have privileges.

The Diversion Program can be an important element in a comprehensive monitoring plan, but the medical staff cannot rely on it as the only element. The medical staff's own activities and information should document that the physician meets and continues to meet the standards of that medical staff for the exercise of privileges. For more information on the Diversion Program, *see CMA ON-CALL document #0701, "MBC Diversion Program (Plus CMA Policy on Impairment Among Physicians)."*

PURPOSE OF MONITORING

The purpose of monitoring described here is to assure the medical staff committee that the physician is in recovery, continues in recovery and is participating in an appropriate recovery program. Monitoring is designed to allow the Well-being Committee to evaluate the status of the physician's recovery.

Monitoring is a service to the physician as well as to the medical staff. For the physician, a comprehensive monitoring program establishes a history of performance, with documentation, which can be invaluable in vouching for a physician's current status in recovery. For the medical staff, a record is established over time, showing that the medical staff is acting in a knowledgeable, timely, thorough and responsible way to assure that the physician continues to deliver safe care.

MONITORING FOR CONDITIONS OTHER THAN CHEMICAL DEPENDENCE

When monitoring for a situation or condition other than chemical dependence is required, all principles of monitoring described here should be adapted and applied.

PROCTORING

The medical staff must also satisfy itself that the physician's clinical skills are intact. To that end, the monitoring plan should contain provisions for proctoring appropriate to each case.

There should be concurrent peer review and regular record review for all monitored physicians, for a period of time to be determined in each case. For those with surgical privileges, or those who perform other procedures in a hospital, there should be a proctor for a period of time to be determined in each case.

WHEN THE PHYSICIAN HAS PRIVILEGES AT MORE THAN ONE HOSPITAL

The monitoring agreement should provide for notifying the appropriate medical staff committee(s) of the other hospital(s) where the physician has privileges. In an optimal situation, monitoring activities will be integrated in a way which meets the responsibilities of each medical staff without unnecessary duplication. At a minimum, each medical staff should have a monitoring agreement (or each medical staff should be a

party to one monitoring agreement) and there should be regular contact with a knowledgeable observer at each hospital whose reports are submitted to one coordinator of monitoring.

PROTECTION OF THE PHYSICIAN'S IDENTITY

It is possible to carry out every element of monitoring described here and still protect the identity of the physician. The physician's identity and information about the situation needs to be known only to the signers of the monitoring agreement, the monitors and the medical staff committee responsible for the monitoring. Disclosure of this information may be required if it becomes relevant in a staff privilege dispute.

WHAT YOU NEED TO KNOW ABOUT URINE TESTING

Urine testing is a desirable, but not the most important, element in the monitoring plan. Before you begin a system of urine testing, you should be clear about how it fits into the overall monitoring plan and what you are expecting the results to show.

You should know enough of the technology to be able to judge whether your expectations are realistic, whether you are choosing a lab with a handling and reporting system and testing capability to produce the results you want. You should be sure that the lab can test for all the drugs which might be used. You should choose a lab with a good reliability record which can do the tests you need. You should learn what methods the lab uses and how they confirm their results. You should use a lab where positive results are confirmed by a second method of testing.

You should determine and agree in advance with the physician being monitored on these elements:

- who will pay the costs
- what name will be used on the sample
- where the results will be reported and where they will be kept
- what will be your response to a report that indicates drug use.

The timing of your requests for a urine sample from the physician must be decided by what role the results are to play in an overall plan of monitoring. For example, are they to be done only when there is an indication that there might be drug use? Are they to be done on a purely random, unannounced schedule independent of any indication? Are they to be done regularly every other day for a specified period of time?

The physician must be observed closely and carefully when he/she is giving the urine sample. While this is a sensitive task, it is a necessary practice and can be done without undue hardship or embarrassment when all agree that it is necessary and when the same methods and attitudes used in treatment programs are applied.

As a precaution, you should consider dividing the sample in half, freezing one half and sending one half to the lab. If there is a dispute about the validity of the test result, another sample will be available for a confirming test.

The chain of custody of the sample between the time of collection and the delivery to the lab must be clear and reliable.

It should be kept in mind that urine test results do not have unequivocal clinical applications. Urine test results are one mechanism to indicate whether drugs are being used, but they should not be relied upon as the only mechanism nor should they have the greatest weight in a monitoring plan. Greater importance is given to regular, frequent and consistent observation by a knowledgeable observer.

References:“Appropriate Urine Testing for the Recovering Physician,” by David G. Fluharty, Jr., M.D., Bulletin of the Federation of State Medical Boards, 83:4, 1996.