Coercion, Moral Injury, and Suicide in the Medical Regulatory-Therapeutic Complex

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Introduction

The purpose of this paper is to continue the clinical, ethical analysis, started by J. Wesley Boyd, M.D., Ph.D., and John R. Knight, M.D., of compulsory treatment in what I am calling the medical regulatory-therapeutic complex (MRTC), with special emphasis on the moral injury that can result to physicians facing allegations of impairment, and the denial of the coercive nature of treatment and its consequences by its practitioners and leaders in the field. The encouragement of ethical practice with this vulnerable, marginalized population of physicians may reduce the overuse and misuse of coercive therapies, thus reducing the frequency of moral injury and suicide. This inquiry is not intended as an authoritative analysis of the methods of law or forensic psychiatry as they are properly practiced within their own spheres; rather, it is an investigation into the potential harms that can result when those approaches drive interventions with physicians, who mistakenly expect that what they consider to be treatment in the MRTC is governed by ordinary clinical, ethical standards.

Modern Physician Health Programs (PHPs) can trace their descent from Impaired Physician Committees, programs staffed by volunteer physicians in order to treat colleagues with substance-use disorders and return them to the workplace, as a compassionate alternative to ending their professional careers.[1] However, physicians no longer exclusively govern the system of intervention with allegedly impaired colleagues. PHPs are now incorporated, most often as independent nonprofits, with legal authority to operate granted formally by the state. Some PHPs are sponsored by state medical societies, and some are directly managed by medical licensing boards (MLBs).[2]

The routine use of PHPs by medical licensing boards (MLBs) as diversion programs not just for addictions, but for an expansive list of allegedly impairing mental conditions,[3] has brought legal methods and adversarial attitudes into what began as a collegial, clinical process. In a previous paper, my coauthors and I have described how exclusive referral relationships and often unregulated financial ties now seamlessly bind nominally independent MLBs, hospital peer review committees, PHPs, and preferred physician treatment programs into a "medical regulatory-therapeutic complex" (MRTC).[4] In this system, when allegations of workplace impairment arise, compliance with orders for mental health screening and treatment are enforced against physicians with one morally blunt tool, the threat of loss of licensure.[5] Counterintuitively, practitioners in the MRTC and their supporters in organized medicine deny that this arrangement is coercive, although Boyd and Knight, two former associate PHP directors, have detailed the ways that the structure of these programs and their relationships with MLBs inherently create coercive pressure for program participants.[6]

As a consultant and expert witness for physicians ordered for evaluation and treatment in the MRTC, I have personally observed, in many cases, but not all, the adverse outcomes already reported the literature:[7] inconvenience, loss of time and income from work, massive legal expenses, and unwarranted loss of medical license. In addition, I have observed a universal perception by recipients of the process that it is coercive. I am struck as well by the high prevalence, in this physician population, of moral injury: the characteristic constellation of loss of trust, grief, anger, shame, despair, and too often, suicidality, that result from betrayal by persons in authority. The close and regular proximity of coercion, moral injury, and suicide in the MRTC suggests causal links.

Denial about Coercion in the MRTC

Prompted by numerous reports of abuse in the MRTC, and authored with participation of that field's representatives, the American Psychiatric Association made a statement on best practices for PHPs in 2017. This report characterizes as a "misconception" the perception of the common contingency arrangement in the MRTC as coercive, describing the process instead as one in which a medical licensing board "has found grounds for a referral, and the physician and PHP have agreed to proceed under those conditions."[8] The practice of enforcing orders for mental health screening, and subsequent treatment compliance, with the threat of losing one's medical license is rationalized as just one provision of the "social contract," analogous to the kind of leverage often used with mentally ill patients receiving treatment in the public sector.[9] Representatives of organized psychiatry thus reach outside the field of medical ethics and into political philosophy for moral justification of practices in the MRTC, failing to acknowledge that physicians on the receiving end of intervention expect clinical ethics, not politics, to govern how they are handled.

The claim has been made that physicians knowingly agree, when they apply for a medical license, to mental health screening at the will of the board. Anfang et al. assert: "It must be recognized that being granted a license to practice medicine is a privilege, not an inherent right. The laws that govern the ability of a licensing board to order an evaluation are known (or should be known) to the physician at the time of licensure and renewal (since these are delineated in the medical practices act of each state)."[5] Leaders in the PHP field have echoed this theory of informed consent,[10] a logic that will not be recognized by physicians who lack forensic experience in this very specialized

field. Physicians naive to the MRTC generally do not read these provisions of their state's medical practice acts, as it would not occur to them, if they do not suffer from schizophrenia, severe bipolar disorder, or dementia, that they would ever be ordered to mental health screening by their licensing board.

The Federation of State Physician Health Programs (FSPHP)[11] has gone on record to deny that practices in its field are coercive. Past FSPHP President Doris Gunderson, M.D., in a response to the Medscape article "Physician Health Programs: More Harm Than Good?" dismisses the experience of physicians treated in the MRTC: "The detractors of PHPs…maintain that PHPs are coercive. Yet…PHPs have no authority to mandate treatment and monitoring, suspend or revoke licensure, or otherwise discipline physicians."[12] The precise location of legal authority matters little to physicians who face coercive intervention that is not necessarily designed to serve their best interests; to them, PHPs function as de facto extensions of MLBs. Dr. Gunderson's choice to respond to ethical and clinical critiques with a crafty legal formulation sends an important signal that PHPs play by a different set of rules than the rest of the medical profession.

PHPs and their forerunners were developed to treat addictions. In that field as well, therapeutic coercion is sometimes denied: a contingency arrangement for treatment can be construed not as coercive, but instead "an option to alternative consequences of addiction," one of which can be loss of employment.[13] This argument does not apply to much practice in PHPs, as they have expanded their treatment portfolios to include non-addictive, non-DSM conditions such as "burnout" or the workplace conflicts in which one physician gets labeled as "disruptive." A study of one PHP, for example, showed that only 17 percent of its participants were diagnosed with addictions.[14]

Even for the population of physicians who do meet bona fide DSM criteria for substance-use disorders, however, loss of employment is not inevitable. Clinical experience teaches us that many addicted persons keep the consequences of their conditions safely contained outside the workplace. Practitioners in the PHP field often describe their practices as "contingency management," analogous to the use of vouchers to treat addictions,[1] but in that field, a clear distinction is made between vouchers as an "artificial" consequence (voluntarily accepted at the outset of treatment), in contrast to "natural" consequences based in the community.[15] In the MRTC, the threat of loss of employment is an artifact of the disciplinary process, not a natural consequence of a medical condition.

So far, in the above review of the literature, coercion is defined, and denied, from the perspective of the coercers. Ethical analysis of coercion in the MRTC cannot be complete without understanding this kind of clinical pressure from the perspective of the physician receiving the intervention.

Perceived Coercion in Regular Clinical Practice

In everyday clinical practice, clinicians rely most often on persuasion and pure appeals to reason to motivate patients toward treatment goals. If, for example, a patient uses alcohol to excess, the treating clinician is apt to inform the patient about associated health risks in order to motivate abstinence or reduction of use. When the clinician determines that the level of risk has crossed an unacceptable threshold, or treatment is deemed to be rendered ineffective by noncompliance, the patient's emotional dependency on the clinician can be used as "leverage."[16] This kind of leverage is exemplified by the common practice in the addiction field of making psychotherapy sessions contingent upon abstinence at the time of the appointment.

When does leverage end and coercion begin? Alan Wertheimer, a philosopher often quoted in this field, locates inducements, persuasion, and authority on a spectrum that can be perceived as coercive under different circumstances. In his logic, a "threat" that is coercive is a proposal that makes a person worse off, and an "offer" is one that does not.[17] A recent study by Opsal et al. further develops this theme by understanding coercion from the perspective of the recipient: "perceived coercion" is defined as the "sense of pressure related to the experience of being referred to treatment." The sense of pressure arises from the patient's internal perception of coercion from "the legal system, the family, the health system, or self-criticism (internal sources)."[18] In the example of making office visits into a treatment contingency, the clinician might perceive that he is offering a benefit, a psychotherapy session, in exchange for abstinence at the time of the visit, while the patient might perceive this clinical intervention as coercive, a threat to remove something to which he is already entitled, the therapeutic relationship. Put another way, the definition of "worse off" is, for ethical and clinical purposes, best left to the patient.

The Use of Leverage in the MRTC Does Not Correspond to Its Use in Regular Clinical Practice

In the examples above, the use of inducement that might be perceived as coercive is directed by the clinician who can closely evaluate the benefits and monitor for the adverse side effects that might ensue; coercion is used reluctantly only after other interventions fail; it is motivated by paternalism, based upon a clinical assessment of the best interests of the patient; and it arises from a relationship of trust in which the clinician is morally accountable to the patient. None of these clinical or ethical conditions apply when inducements that might be perceived as coercive are applied to physicians within the MRTC. Control of the use of a potential penalty (as noted by Dr. Gunderson, above) is in the hands of legal or administrative authorities who bear no clinical responsibility for the consequences; coercive pressure is often applied first before any other, less invasive, intervention; the duty to do no harm to the referred physician is explicitly set aside in favor of a duty to protect the public;[19] and inducement is applied in an overtly non-collegial, adversarial legal relationship that sets an almost impossibly high bar to accountability in the event of error or bad faith.[20]

Does Intervention in the MRTC Qualify as Treatment?

PHPs have steadfastly denied that they treat physicians;

rather, the intervention is framed as evaluation, diagnosis, contracting, and mediation with regulators.[21] The APA Resource Document, aptly enough in a footnote, clarifies exactly what program participants in PHPs should expect: "When the PHP relationship is mandated by a licensing board, the primary aspect is forensic, and the fiduciary duty on the part of the PHP towards the monitored physician may be secondary to the PHP's fiduciary responsibility to the board of medical licensure or may even be absent."[8]

If a medical diagnosis is made (a requirement for a finding of physician impairment),[2,5] and the claim is made that intervention is designed to improve or cure that condition, and the claim is made that the contingency of license forfeiture is critical to the cure of a medical condition, and interventions are made by trained mental health professionals, then a claim that intervention in the MRTC is not treatment can be accounted as perhaps technically correct as a description of a very specialized legal-administrative arrangement, but the moral expectations of physicians facing this intervention will be greatly challenged. Even in the MRTC field itself, role confusion exists, as exemplified in a recent paper by DuPont and Merlo that alternately refers to PHP intervention as "care," "care management," and a "treatment model."[22] In my personal experience with physicians who face allegations of impairment, they uniformly cannot help, even when they know better, but to perceive their face-to-face encounters with trained clinicians as clinical, and therefore meriting ordinary clinical trust. (Paradoxically, in my reading of reports of evaluation and treatment conducted within the MRTC, physicians who voice any concern that those who evaluate or treat them might not be entirely on their side are frequently labeled as pathologically lacking in trust, and therefore untrustworthy themselves, and therefore a potential danger to patients.)

For purposes of this ethical analysis, the terms of the encounter in the MRTC will be defined from the perspective of the physician recipient who expects an ordinary clinical relationship of trust, rather than the provider whose primary allegiance is to the state. In this paper, participants in MRTC programs are referred to as physician-patients. In their minds, coercive authority and clinical intervention are fused: official legal separations of authority for different functions in the MRTC are largely irrelevant to the emotional experience of the recipient. To deny program participants' expectations of trust with legalistic formulations is to overlook the conditions in a psychological environment that have the potential to create feelings of betrayal, moral injury, and risk for suicide.

Physicians Treated in the MRTC Perceive Coercion

In my experience of physicians facing allegations of impairment, the perception of coercion in the MRTC process has been universal. I have heard versions of all of the following: "I had no choice but to comply"; "My lawyer advised me that complying with the order for mental health screening, even though I didn't want to, was the most expeditious way to resolve the matter and keep working. Now I regret taking his advice"; "I want to fight it, but I can't afford the time and legal fees"; "I'd gladly resolve this by leaving the hospital where I work now, but no one else will hire me with this on my record"; "It was a mistake to disagree with them." Even physicians who retrospectively appreciate the intervention, and believe it was instrumental in their recovery, acknowledge the intervention as coercive: "I would not have stopped using if my license had not been on the line."

In the MRTC, as described by Boyd and Knight, the use of licensing as leverage is almost exclusively based on compliance with PHP monitoring contracts,[6] not on physician conduct in clinical practice that poses direct, recognizable hazards to patients. This creates for physician-patients a perception of arbitrariness that is linked to feelings of coercion. According to official publications in the field such as the practice resource from the American Academy of Psychiatry and the Law, the standardized contracts used in PHPs are supposed to be individualized based on evaluator recommendations,[19] but in my experience, the standard contracts can be left to stand unmodified, often in direct contradiction to evaluator recommendations, so the perception of physician-patients that they can be subject to capricious authority in this system does not look unrealistic.

Potential consequences for noncompliance with the PHP contract include warning, increased monitoring, mandated return to inpatient treatment, or a report to the MLB.[23] Even physicians who voluntarily enter into a contract with a PHP still face the possibility that noncompliance will result in reporting to the MLB. Noncompliance, even if it is not a marker of actual danger to patients, is apt to be interpreted by the MLB as a marker of moral unreliability or psychological denial, and thus a hypothetical risk to patients, and thus a justification for sanction or loss of license. Physician-patients are regularly reminded that noncompliance with even the most trivial parts of their contracts could lead to the most severe consequence, a report to the MLB. The interpretation of what is reportable is left undefined and up to the discretion of PHP staff, many of whom are not physicians. The threat of severe punishment when one does not expect it, particularly in those cases in which a false positive identification of impairing mental illness has been made, make the perception of coercion even more intense for some physician-patients in the MRTC.

Reliance on Legal Standards as Failure of Psychic Identification in the MRTC

Physicians who lack experience in the forensic field typically perceive medical licenses and hospital privileges as their personal intellectual properties, earned through dint of many hours of study, training in underpaid apprenticeship environments, and years of strenuous clinical practice. The threat to remove what is interpreted as a right is therefore experienced as coercive. There is support in the legal field for the theory of medical license as a property right that ought to be suspended only for a very narrow range of compelling state

interests.[24] As the coercive use of licensing is used more broadly to enforce nonclinical social norms upon licensees, the practice can only lose moral legitimacy. In my home state of Vermont, for example, failure to complete a physician workforce survey is grounds for a finding of unprofessional conduct (!)[25] and therefore hypothetically puts one's license at risk.

While precedent undoubtedly exists for the theory of medical license as privilege,[26] using legalistic reasoning to deny the centrality of the perception of coercion may leave evaluators and treaters in the MRTC dangerously blind to the lived experiences of the physicians with whom they intervene. Physician-patients will judge themselves to be considerably worse off, sometimes to the point of life not being worth living, if they cannot practice medicine,[27] and that despair is a direct consequence of the coercive structure of the MRTC.

Black's Law Dictionary defines coercion as "compulsion; force; duress…where physical force is put upon a man to compel him to do an act against his will, or implied…where the relations of parties is such that one is under subjection to the other."[28] The bar for a finding of coercion in the law is thus very high, so by that standard, the American Psychiatric Association workgroup has a basis for its MRTC-friendly interpretation of the contingency arrangement in that field. This seeming reliance upon a legal definition of coercion by both the APA and the FSPHP can be considered an important signal that organized psychiatry, and evaluators and treaters in the MRTC, may identify with MLBs and legal methodology more than they identify with their vulnerable colleagues and ordinary clinical, ethical methods.

Medicine is, at its heart, a moral enterprise in which trust depends on mutual psychic identification between patient and physician. Failure of identification is highly predictive of failure of treatment, so the prospects of successful outcomes in the MRTC are severely burdened from the start if administrators and treaters, in failing to acknowledge the reality of perceived coercion, do not fundamentally identify with the worldview of their physician-patients.

Coercion in Civil Commitment and Drug Court

For the purpose of ethical analysis, it is useful to compare the use of coercion in civil commitment to its use in the MRTC. In civil commitment, a family member or concerned third party can apply directly to a court in order to initiate the legal process without the prior involvement of a qualified mental health professional,[29] but in everyday practice, a psychiatrist or other qualified mental health professional most often makes a finding of dangerously impairing mental illness before coercion is instituted. In the community mental health setting, the clinician who initiates the process of civil commitment is apt to know the patient over time and to be responsible for that patient's care, which can only improve the chances that coercive treatment will be used effectively, for the right reasons. In the MRTC, in contrast, coercion is generally applied before a valid determination of mental illness is made by a qualified psychiatrist or mental health professional.[19]

It must also be noted that in civil commitment, it is a statutory requirement that coercion can be used only when patients are determined to lack decision-making capacity, due to some sort of serious mental illness.[29] As Sullivan et al. note, the idea that individuals with addictions lack decision-making capacity is considered too controversial to be used as a justification for coercive civil commitment.[13] In civil commitment, the standard for impaired decision-making capacity due to serious mental illness has achieved considerable consistency through years of practice, legal oversight, and transparency about its use; strict oversight of the preservation of the patient's civil rights is extensive.

In contrast, in the MRTC, a different, broader, standard is used: "Impairment is the inability of a licensee to practice medicine with reasonable skill and safety as result of (a) mental disorder…, or (b) physical illness or condition, including but not limited to those illnesses or conditions that would adversely affect cognitive, motor, or perceptive skills; or (c) substance-related disorders including abuse and dependency of drugs and alcohol."[30] In my personal reading of evaluations done in the MRTC, the criteria used by experts for findings of physician impairment vary quite widely. The interpretation of potential danger to patients, in the context of physician impairment, is particularly problematic and subject to evaluator bias, because no standard has ever been defined.

Here the description by Monahan and Bonnie of the system set up for airline pilots provides a useful contrast: the kind of mental illness that counts as impairment is defined as diagnosis of '"a personality disorder severe enough to have manifested itself by overt acts,' a psychosis in which the individual either 'has manifested' or 'may reasonably be expected to manifest' 'delusions, hallucinations, grossly bizarre or disorganized behavior,' bipolar disorder, or substance dependence."[26] While pilots I have treated have complained that they must conceal routine use of antidepressants in order to avoid the loss of their certifications to fly, at least the mental disorders are defined precisely enough in regulatory language to create a chance that bona fide functional impairment can be correctly identified.

The use of coercion in civil drug courts has been studied and elucidated,[31] and is sometimes used as an analogy to justify coercive intervention with allegedly impaired physicians. It is important to note a very big difference between the use of coercion in drug court and in the MRTC: in drug court, sufficient evidence has been found to warrant conviction of a crime. Medical licensing boards construe their orders for mental health screening as based on "probable cause," but the publication of legal findings on medical board websites do not contain sufficient detail for independent physicians to evaluate whether the underlying reasoning corresponds to ordinary clinical standards. My personal review of nonpublic documents has placed me, in some cases, in substantial disagreement with the judgment of medical board attorneys who ordered physicians to psychiatric evaluation.

Legal due process in drug court provides a constraint on the use of coercion; much narrower provisions for due process are afforded in the MRTC.[19] Moreover, in drug court, prosecutors and

other officers of the court may have ongoing relationships with adjudicated individuals and their families, relationships that can be caring and compassionate, perhaps the best possible check on improper use of coercive treatments. Suffice it to say that MLBs are not expected to provide caring, compassionate relationships with licensees.

Moral Injury in the MRTC

Exploration here of the causal links between coercion and moral injury is intended as a starting point for further discussion. The prevalence of potentially dangerous psychic injury to physician-patients in the MRTC is documented more online[32] than in major scientific journals, which may say something about organized medicine's willingness to critique potential abuses of institutional power. Large, systematic surveys of clinical outcomes in the MRTC, conducted by investigators outside the field, are needed to rule out the possibility that the use of coercion can create unintended side effects such as moral injury and completed suicide. Independent verification is paramount when questions about safety and efficacy arise[20] about a treatment that is imposed upon unwilling patients.

Jonathan Shay, who has worked mainly with combat veterans, defines moral injury as "a betrayal of 'what's right' by a person in legitimate authority, in a high stakes situation."[33] He describes a constellation of despair, and suicidal thoughts and actions, in which trust is replaced by an "expectation of harm, exploitation, and humiliation by others." He further quotes his colleague Michael Linden's description of a syndrome of "Post Traumatic Embitterment Disorder." Shay conceptualizes the violator as the powerholder, not the self. It is very important, in understanding the experience of physician-patients in the MRTC, to avoid mislabeling as individual physician pathologies what are really systemic problems; the construct of moral injury helps to keep that distinction clear.

Anfang et al. usefully list three criteria for a finding of physician impairment: (1) mental illness; (2) harm to patients; and (3) a causal link between the two that can be followed logically.[5] I have reviewed a number of cases from the MRTC with an official finding of physician impairment in which I found that none, or only one, of these three criteria were met. In this series of false allegations and erroneous findings of impairment, the genesis of moral injury can easily be appreciated, because medically unnecessary, potentially harmful psychiatric evaluation and treatment, against the will of the recipient, violates the ethical norms of our profession. Even in cases, however, where bona fide mental illness exists and treatment might plausibly be indicated, the process used in the MRTC still has the potential to create moral injury.

In my observations of physicians who are mandated into evaluation or treatment in the MRTC, I have seen moral injury manifest in a variety of ways: social and professional isolation; anxious, hypervigilant, self-deprecating compliance with authority; a highly off-putting ruminative preoccupation with the real injustice that has been done, to the exclusion of other, healthier activities; and worst of all, completed suicide. I have heard versions of all of the following: "Once you get referred, there's no way out"; "Nothing in my training prepared me for this"; "I just want my life back"; "They want to destroy me"; "If I lose my license, my life is over"; "No one believes me"; "My family is sick of hearing about this"; "I thought he was my therapist who I could trust"; "I can't face my colleagues"; "I had to make a false confession in order to avoid a report to the medical board"; "the state's attorney and the PHP director ought to go to jail."

In a number of the cases in my experience, engagement with the MRTC created not only moral injury, but identifiable psychopathology that did not previously exist, most often anxiety and depression, and it was not uncommon for that psychopathology to be cited as evidence of impairment. Fortunately, the physicians who face this kind of professional catastrophe do show considerable resilience. The best outcomes have resulted when physicians are able to keep working in spite of their involvement with the MRTC, when they have been able to channel their anger and grief into useful advocacy, and when they maintain supportive contact with colleagues, friends, and family. In my work with this population, whether it is as an expert witness or consultant, validation of the physician's perceptions of the process is a primary element in both accurate diagnostic evaluation and the mitigation of moral injury. Assessment of suicide risk is paramount in the emotionally dangerous environment of the MRTC.

In everyday clinical practice, patients come to grips with aspects of themselves that they would rather not face, and clinicians provide guidance in sometimes paternalistic ways. Patients can feel quite dissatisfied with treatment and treaters who confront them with unpleasant truths, or who err, but ordinarily all of this can happen without the feeling of moral injury. We recognize some patients who will feel universally aggrieved in all their relationships, but most patients can accept differences of opinion with their doctors without permanent moral injury, an acceptance no doubt facilitated by the freedom to say "no" to treatment in the first place.

We can find physicians treated in the MRTC field, too, who have thought the world was against them for their entire lives, but history-taking that focuses on the longitudinal experience of moral injury reveals that it more often starts for the first time after involvement with the MRTC. I have observed a lower prevalence of post-treatment moral injury in the ordinary clinical population, relative to physicians who have engaged with the MRTC. If anecdotal observations like mine can be confirmed in larger, systematic surveys, then it can more definitively be taken as an indicator that something is truly different in the MRTC. In the meantime, it may be useful to compare the experience of patients in the MRTC and involuntary psychiatric treatment settings, because they share the common element of coercion.

Many patients who have been treated involuntarily in psychiatric inpatient units, and some physicians treated in the MRTC, when they are recovered from bona fide illness, feel appreciative: these are the cases in which coercion, viewed retrospectively, may have worked in the best interest of the patient. Just as is the case for physician-patients in the MRTC, not all, but an importantly large number of patients treated

under civil commitment laws experience moral injury, feeling unjustly treated by courts, government agencies, hospitals, and psychiatrists who work in those settings.[34,35] The experience of patients who emerge from civil commitment or the MRTC feeling permanently damaged may well indicate that moral injury, when it is newly created in a legal-administrative-clinical process, is a valid clinical marker of the inappropriate use of coercion.

The Use of Coercion in the MRTC May Cause Moral Injury

Coercion in asymmetrical power relationships is sometimes accepted in our society when reliable ethical norms are honored and harm to subjects does not result, but coercion is considered abusive when it is combined with violation of moral norms and harm to subjects.[36] In a legal context, the use of the term "coercion" might be restricted to the threat of physical violence, but in a clinical context, the threat of loss of relationship for noncompliance is widely recognized as coercive. Common elements of abuse of power include telling vulnerable individuals that what they find harmful is good for them, that they are responsible for it, and that they agreed to it. Invasion of psychic space and being told that one should not trust one's own perceptions are central mechanisms of the abuse of authority and the moral injury that follows. Abuse by strangers is widely considered to be less toxic to the mind than abuse by persons in relationships of trust, such as parents, teachers, priests, or doctors.

Practices in the MRTC have the potential to be perceived by physician-patients as analogous to other abuses of power that are commonly recognized as creating moral injury. When it is used improperly, the coercive threat of expulsion from the profession with which one identifies strongly is comparable to the threat of loss of relationship so often exercised by abusers: when a physician loses her license, she is now, psychically, an outsider, no longer a member of the medical family. Moreover, she is robbed of the life trajectory she expected.[37] Vulnerable physicians in the MRTC, whether they are correctly or falsely identified with impairing illness, are told that what is being done to them is therapeutic, that they are responsible for what is happening to them due to their conduct, and that they agreed to it all in advance by applying for a medical license (see Anfang et al.[5] and Candilis[10] above).

The use of lie detectors and routine drug and alcohol screening in the absence of any specific clinical indication (personal communication, Lawrence Huntoon, M.D., Ph.D., May 5, 2019) amount to uninvited invasions of psychic and physical space that are apt to be experienced by physician-patients as equivalent to the other forms of physical assault that cause moral injury. Many of the provisions of standardized PHP contracts are designed to expose the kind of dishonesty that can be seen in substance-use disorders. Misapplication of this model, when it is not medically indicated, amounts to treating physician-patients as liars when they are not, and subjecting them to constant surveillance under threat of arbitrary punishment is a recipe for moral injury.

In the past, physicians were taught to identify with their patients, directing their moral impulses toward them. Nowadays, trainees are heavily indoctrinated to identify with institutional authority, as they are admonished to think of themselves first and foremost as "good team players." Constant standardized testing, regular exposure to surveillance through electronic health records, and relentless use of financial incentives to enforce practice guidelines only heightens identifications with institutional authority. Reliance on administrative structures and measuring sticks, rather than diligent patient care, for validation of clinical efficacy and moral rightness sets physicians up for more severe levels of moral injury in the cases in which bad faith and error emanate from the institutions they thought they could trust.

Widespread use of legal methodologies in PHPs and preferred physician treatment programs amounts to an inversion of moral norms, from the perspective of physician-patients, because they cannot help but expect to be treated according to ordinary clinical, ethical methodologies by persons nominally identified as colleagues. For example, when conviction of DUI is used in the MRTC to justify a diagnosis of substance-use disorder in physician, in the absence of any other clinical criteria, a legal definition is being used as a proxy for a bona fide DSM diagnosis. A physician treated under that regime will interpret this as malfeasance and misdiagnosis, even if it is a legally authorized, common practice in the MRTC,[26] because substitution of legal standards for clinical standards, in what is perceived as a clinical setting, is not consistent with the ordinary moral norms of our profession. The FSPHP, in its 2005 guidelines for programs, sets out the principle that they should be judged strictly by the standards they define for themselves: "optimally Physician Health Programs will have qualified legal immunity for actions taken in good faith,"[2] but in order to understand the important problem of moral injury in physician-patients, *their* moral expectations must be defining.

Denial of the personal reality of the coerced physician, including the fact of coercion itself, may be a central mechanism of moral injury for that group of physicians for whom coercion is used in the wrong way for the wrong reasons. Put another way, denial about the use of coercion by the MRTC field and organized psychiatry is apt to rub salt in the wounds of those physician-patients who are morally injured in the process.

Coercion and Suicide

In ordinary, non-coercive clinical environments, patients who receive bad advice or who simply do not agree with evaluators or treaters, can escape by seeking second opinions. The harms that result when physicians are not allowed to refuse to accept a false positive diagnosis, unnecessary care, or bad-faith practice in the MRTC are all well-documented.[7]

Suicide is the most serious potential adverse outcome for physican-patients in the MRTC, and moral injury might play a part. A recent well-designed study, using deidentified data from one PHP, reveals that the rate of suicide was increased for program participants relative to the rates reported in the general population of physicians. A perception of entrapment is well-recognized as a central part of the psychic state of mind that often precedes suicide, and yet the authors, who ran the program in which the suicides occurred, offer the following interpretation of the bad outcomes:

> It is doubtful that being monitored and supported by the physician health program engendered fear and additional stress. The failure to avert physician suicidal behavior seems more likely due to the shame and stigma surrounding mental health and substance-use issues, which prevent seeking help and cooperating with treatment and support. The help-avoidant, treatment-non-compliant nature of pre-suicidal behavior in our physician sample seems a more plausible explanation of outcome than ineffective or aversive aspects of physician monitoring. Perhaps the physician who is unable to avoid detection but does manage to avert support and monitoring may be more malignantly ill and at greater risk for suicide.[14]

This attitude toward responsibility for adverse outcomes, and the degree of empathy shown for physician-patients, revealed in a seemingly unself-conscious way, speaks for itself, and perhaps for the entire MRTC field.

Physicians who do not personally work in the MRTC might reasonably interpret the above data on suicide differently. The use of coercion in physicians falsely identified as impaired is particularly noxious, and dangerous, but even in patients with bona fide affective disorders, addictions, and severe personality disorders, experienced clinicians recognize very well the peril inherent in confronting them with the adverse consequences of their maladaptive behaviors: most will improve, but a few will take their own lives. A form of active intervention in the MRTC that is known to increase psychic pressure, particularly when the level of clinical risk is not adequately assessed, entails a higher level of ethical responsibility for a bad outcome than a conscientious offer of voluntary treatment refused by an ill person with decision-making capacity. Intensive, independent investigation of practices in the MRTC is needed before we can satisfy ourselves that coercion is not a potent mental toxin that creates risk for suicide.

Ethical Rationale for Coercive Treatment of Addictions

Sullivan et al.[13] offer a useful catalog of plausible ethical justifications for coercive treatments in the treatment of patients with substance-use disorders:

(1) If treatment works, then the argument can be made that the ethical principle of doing good—beneficence—outweighs the competing principle of autonomy.

(2) Addicts really do want to quit in spite of themselves, so coercion serves autonomy to that extent.

(3) Decision-making capacity is compromised by the "cognitive and neurobiological effects" of prolonged substance use, so autonomy does not apply in the usual way.

(4) There is a duty to protect others around the patient who might be harmed by the effects of his untreated substance use.

While these arguments are sound, I note that Sullivan and her coauthors, in the same paper, curiously offer largely anecdotal evidence for the efficacy of coercive treatment in their field. Moreover, the accelerating trend in neuroscience of finding more and more correlations between mental function and anatomical structure only undermines, by overuse, arguments that rely on neurobiological determinism.[38]

For purposes of ethical analysis, the use of coercive treatment, defined from the perspective of physician-patients in the MRTC, can be measured against the above standards:

(1) In the MRTC, the standard of efficacy is not met, so beneficence does not apply. At the present time, if representatives of the MRTC deny that coercion is used as a mode of treatment of physicians, then it cannot, by definition, have been scientifically validated. There can be no systematic investigation of the potentially deleterious effects of this specific element of the MRTC intervention if its existence is denied. There can be no clinical understanding of how to use coercion with mentally ill physicians in sequence after other, lower level interventions have failed, particularly when coercion in the MRTC is regularly used right from the start before any other intervention is attempted.

(2) Physician-patients who retrospectively endorse the coercive intervention in the MRTC as effective for them may represent the subpopulation of physicians who authentically wanted help with a condition they could not overcome without third-party intervention. Physicians who experience moral distress during and after the intervention, by definition, represent the population for which this argument is not valid. Thus, the ethical justification of supporting autonomy is valid only part of the time in the MRTC, and great harm can result when this principle is misapplied.

(3) The standard for impairment in the MRTC is poorly defined and not equivalent to the definition of impaired decision-making capacity used outside the MRTC field. The concept of "physician impairment" is used unreliably in the MRTC field, greatly undermining the validity of the ethical justification that autonomy does not apply.

(4) In the MRTC, the criteria for potential danger to patients are poorly defined. Inconsistent application of this standard in MRTC practice undermines the validity of the ethical justification of protecting the public.

Even when PHP practitioners do acknowledge coercion as an integral part of their method, the case for efficacy is made by using patients with substance-use disorders in the general population as the control group.[22] This can be recognized as an inadequate control group, and results for the coercive treatment of addictions cannot be generalized to the majority of PHP participants, who are not in fact diagnosed with substance-use disorders. In currently published studies that do reach a conclusion of efficacy, administrative markers

(completion of programs, urine drug screen results, and license status) are used as proxies for actual clinical outcomes,[1] providing further reason to conclude that efficacy in the MRTC is not established sufficiently to justify the ethical principle of beneficence.

The Ethical Use of Coercion in the Treatment of Physicians

To date, as Boyd and Knight point out, no enforceable code of ethics for the use of coercion to address potential impairment in the physician workplace has been published.[6] Therefore, the following ethical guidelines are proposed. Until the time that enforceable ethical guidelines are published by organized psychiatry and/or the MRTC field itself, physicians facing allegations of impairment in the MRTC, and their legal counsel, can use these provisional guidelines, in the service, it is hoped, of both consideration of legal strategy and mitigation of moral injury, and to facilitate the search for evaluators and treaters who would agree to practice ethically:

(1) Coercion must be defined from the perspective of the physician-patient, and taken into account in treatment planning, as denial of the physician's reality is apt to create moral injury.

(2) The use of coercion, because it might result in moral injury and completed suicide, must follow a proper determination of impaired decision-making capacity, due to serious mental illness, by a qualified, unbiased mental health professional.

(3) The appropriate standard for defining impairment in the physician workplace is, at a minimum, the same as the well-validated and consistently applied standard that is used for civil commitment: impaired decision-making capacity due to serious mental illness. This serves the ethical principle of nonmaleficence, by averting false positive identification of impairing mental illness, and thus the erroneous and dangerous application of coercion.

(4) Even in physician-patients who lack decision-making capacity, coercive treatment is properly used only after the systematic trial, and failure, of less intrusive interventions, in order to conform to the ethical principle of respecting autonomy.

(5) The use of coercive treatment can only be justified when its efficacy has been properly validated scientifically, in order to conform to the ethical principle of beneficence.

(6) Coercion, when it is used, must still be accompanied by disclosure of all potential risks of treatment, in order to conform to the ethical principle of nonmaleficence. In the MRTC, for example, known risks of treatment that should be disclosed at the time of physician entry into it might include moral injury, the creation of new psychopathology, and suicide.

(7) The use of coercion with unwilling physicians, because it places other considerations above the ethical principle of respect for autonomy, carries with it a higher burden of clinical and ethical responsibility for bad outcomes. This responsibility rightly falls upon clinicians who accept responsibility for enacting the coercive intervention in an environment that is represented as therapeutic and rehabilitative, even if the compulsion technically originates in the legal sphere.

(8) When the authority for the coercion of physicians originates in the legal-administrative sphere, evaluators and treaters should, if adequate due process has been denied, take all possible steps to avoid facilitating the abuse or misuse of psychiatry, as my coauthors and I have suggested elsewhere.[4]

"Physician impairment" is a legal-administrative concept that is unlikely to go away soon, but it should be recognized, for clinical and ethical purposes, that it is too broadly and inadequately defined, resulting in an unacceptable rate of false positive identifications. Perhaps the best constraint on the misuse of the concept of physician impairment to justify coercion is for all in the field to exercise circumspection and intellectual honesty. I have personally observed a number of cases in which colleagues and medical administrators have intervened compassionately and effectively with problematic conduct by physicians in the workplace, without resorting to the very blunt tool of ordering a fitness-for-duty evaluation in the MRTC.

This set of ethical guidelines for the use of coercion with physicians facing allegations of impairment is novel, and thus, provisional, but on review, it can be recognized as corresponding to practices that largely prevail in the treatment of patients under civil commitment laws, so it can be said that considerable clinical experience already validates these principles. This development of ethical principles is perhaps novel in that it is derived from the perspective of patients injured by problematic clinical practice, not the perspective of the physicians who might do the injuring, or their associates. Finally, and perhaps again in a novel way, this is a set of ethical principles in search of clinicians willing to abide by them.

Current Use of Coercion in the MRTC May Not Withstand Ethical Scrutiny

While practices in the MRTC vary among states and their PHPs, they general fall short of the above guidelines, as well they may if practitioners in that field construe what they do as not really treatment, and if they perceive that their fiduciary responsibility to the state routinely overrides their fiduciary responsibility to persons perceived not as patients but as program participants. The approach used in the MRTC stands starkly in contrast to the setting of ordinary clinical practice, in which clinicians strive to understand every aspect of their patient's experiences, including perceptions of coercion. Failure to acknowledge the perception of coercion in the MRTC is a failure of trust, which hampers any therapeutic efficacy, and it may lead, in individual cases, to overlooking important clinical data. Coercion, and denial of it, is apt to create moral injury and exacerbate its psychiatric sequelae—at worst, suicide—in physician-patients in the MRTC.

At a broader, systemic level, denial of the existence of coercion impedes study of its use as a clinical intervention. As it stands today, the way evaluation and treatment for physicians is conducted in the MRTC has the potential to do harm to those it is designed to help. The routine use of

coercion amounts to an inadequately validated intervention, with virtually no legal or ethical framework to constrain its inappropriate use. Ethical, compassionate physicians who identify with their vulnerable colleagues facing allegations of impairment cannot accept the current prevalence of moral injury and suicide in the population of physicians treated in the MRTC. Further study is needed to understand the potential links between coercion and moral injury, with its attendant psychiatric sequelae, especially suicide, before ethical psychiatrists can accept the routine use of coercive therapies with their colleagues.

Is There a Future Role for PHPs?

Progress toward truly independent, third-party oversight of the MRTC may be slow, but practitioners in that field can immediately begin to acknowledge their program participants' perceptions of coercion, a step that has the potential to mitigate the risks of moral injury and suicide. The MRTC might be reconfigured by placing all PHPs and preferred physician treatment programs under the full administrative and financial control of MLBs, with a clearly defined function of clinically informed surveillance for the state. Any measure that can be taken to make physician-patients' expectations of how they will be treated in the MRTC more realistic can reduce the moral risks that flow from unwarranted trust.

Conclusion

Based on the assertion that medicine is a public-safety profession, it can be claimed that potentially impaired physicians need different standards for evaluation of impairment, and specialized treatment.[19] PHPs step forward to claim that role. My observation of PHPs and preferred physician treatment programs is that they differ from the world of non-MRTC clinicians in their authoritarian world view, seemingly uncritical acceptance of coercion as an everyday treatment method, and predominant use of legal standards and methods rather than ordinary clinical, ethical attitudes and methods.

Attorneys who represent physicians need to understand the clinical risks and ethical problems with coerced treatment and fitness-for-duty assessment in the MRTC before advising their clients on their responses to mandates from MLBs and other referring entities. Physicians who recognize mental illness in themselves, or who face allegations of impairing mental illness in the workplace, need to understand the reality of the moral and legal standards that prevail in the MRTC field. As an alternative to the MRTC, evaluation and treatment can be sought from ethical psychiatrists who provide noncoercive, scientifically validated treatment in confidential settings. In the private setting, the duty to protect the public still obtains, so if physician-patients are identified as lacking decision-making capacity, their psychiatrists are still required to intervene effectively, but the duty to protect the public is, appropriately, contained within a relationship of trust and the duties to advocate clinically and do no harm.

Ethical psychiatrists who do not ordinarily think of themselves as forensic experts should consider work as evaluators or treaters of their colleagues who face allegations of impairment. Evaluation and treatment should include routine assessment of the perception of coercion in the MRTC, recognition of moral injury, and regular evaluation of risk for suicide. I have found no reason to treat my physician-patients any differently from any other patients. The work is rewarding, sometimes lifesaving, and on a larger level, because it promotes collegial identification over identification with nonmedical methods and standards, an important part of preserving the ethical integrity of our profession.

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AAPS Principles of Medical Policy

Medical care is a professional service, not a right. Rights (as to life, liberty, and property) may be defended by force, if necessary. Professional services are subject to economic laws, such as supply and demand, and are not properly procured by force.

Physicians are professionals. Professionals are agents of their patients or clients, not of corporations, government, insurers, or other entities. Professionals act according to their own best judgment, not government "guidelines," which soon become mandates. Physicians' decisions and procedures cannot be dictated by overseers without destroying their professionalism.

Third-party payment introduces conflicts of interest. Physicians are best paid directly by the recipients of their services. The insurer's contract should be only with subscribers, not with physicians. Patients should pay their physician a mutually agreed-upon fee; the insurer should reimburse the subscriber according to the terms of the contract.

Government regulations reduce access to care. Barriers to market entry, and regulations that impose costs and burdens on the provision of care need to be greatly reduced. Examples include insurance mandates, certificate of need, translation requirements, CLIA regulation of physician office laboratories, HIPAA requirements, FDA restrictions on freedom of speech and physicians' judgment, etc.

Honest, publicly accessible pricing and accounting ("transparency") is essential to controlling costs and optimizing access. Government and other third-party payment or price-fixing obscures the true value of a service, which can only be determined by a buyer's willingness to pay. The resulting misallocation of resources creates both waste and unavailability of services.

Confidentiality is essential to good medical care. Trust is the foundation of the patient-physician relationship. Patient confidences should be preserved; information should be released only upon patient informed consent, with rare exceptions determined by law and related to credible immediate threats to the safety or health of others.

Physicians should be treated fairly in licensure, peer review, and other proceedings. Physicians should not fear loss of their livelihood or burdensome legal expenses because of baseless accusations, competitors' malice, hospitals' attempts to silence dissent, or refusal to violate their consciences. They should be accorded both procedural and substantive due process. They do not lose the basic rights enjoyed by Americans simply because of their vocation.

Medical insurance should be voluntary. While everyone has the responsibility to pay for goods and services he uses, insurance is not the only or best way to finance medical care. It greatly increases costs and expenditures. The right to decline to buy a product is the ultimate and necessary protection against low quality, overpriced offerings by monopolistic providers.

Coverage is not care. Health plans deny payment and ration care. Their promises are often broken. The only reliable protection against serious shortages and deterioration of quality is the right of patients to use their own money to buy the care of their choice.