The Americans with Disabilities Act and Appropriateness of Referral in Physician Fitness for Duty Evaluation

Robert S. Emmons, M.D., William D. Goren, J.D.

Introduction

Physicians facing allegations of workplace impairment and mandated to submit to a "fitness for duty" evaluation (FFDE), under the threat of losing employment or license to practice medicine, are pushed onto a train with no brakes and no conductor. Health system employers, medical licensing boards (MLBs), Physician Health Programs (PHPs), and "preferred" physician evaluation/treatment programs are joined by ideology and mutual financial interests in a web of involuntary intervention so nearly seamless that we identify it as the medical regulatory therapeutic complex (MRTC).[1] In this field, claims of protecting the public take precedence over protecting the rights and well-being of individual physicians,[2,3] a stance that has been sharply critiqued in the broader professional and lay community.[4]

To the degree that the component agencies of the MRTC are not independent of each other, this system contains no built-in checks on error and bad faith.

Credible allegations of improper conduct by hospital employers, MLBs, and PHPs abound in the professional literature and popular media.[5,6] However, the MRTC is an insular community that actively resists public critique or accountability. Representatives of the MRTC typically respond to allegations of misconduct in their field by discrediting their critics.[7] PHPs and their allied medical boards and professional associations, citing physician privacy and public safety, routinely lobby legislatures for immunity from discovery and potential liability.[8,9]

For any one physician evaluee, the claim that a determination of workplace impairment has been made by an independent evaluator provides the basis for involuntary intervention in the MRTC. Because they are so often the gatekeepers to a cascading, interlocking series of intervention protocols that can become automatic and unstoppable once initiated, psychiatrist evaluators of physician fitness for duty must carefully consider their ethical responsibilities to evaluees. Ethical precepts for FFDE that have long been articulated in the professional literature include: a fiduciary duty to the evaluee, objectivity, assessment for improper motivations in the referral process, informed consent, and independence from referral sources.

The Americans with Disabilities Act (ADA), its implementing regulations, and its guidances all place strict limitations on medical investigation and intervention with allegedly impaired individuals,[10] and yet, references to those specific legal requirements are conspicuously missing in the professional guidelines, policies, and position statements authored by physicians in the FFDE field and MRTC lawyers. It is long-standing tradition in medical ethics that physicians must comply with the law.[11] This paper will provide a rationale for incorporating knowledge of ADA statutory and regulatory language into a foundational framework of ethics for psychiatric evaluators of physician "fitness for duty." For their part, physician evaluees are strongly advised to educate themselves about the ADA and obtain legal counsel knowledgeable about ADA as soon as possible before they exhaust their financial resources.

Because psychiatric FFDE can cause irreparable harm, and few institutional protections are afforded to evaluees, we take the position that appropriateness of referral must be verified, in a separate step, before proceeding to evaluation.

ADA Protections Against the Misuse of FFDE

Lawson and Boyd, in a pioneering review of the legality of PHP practices, point out that the ADA's employment provisions (Title I):

> [prohibit] an employer from requesting mental health information from, or requiring a mental health evaluation of, an employee without a reasonable belief based on objective evidence that 1) the employee is unable to perform essential job functions because of a mental disorder; or 2) the employee will pose a direct threat to safety due to a mental disorder.[12]

Note that Title I applies only to employers of 15 or more. An employer can only request such an exam of an employee where it is job-related and consistent with business necessity.[13] Title II and Title III apply to non-employees. While the definition of disability is the same across all the titles, the statutory provisions, regulations, and guidances are different.

Direct threat, which first appeared in *School Board of Nassau County, Florida v. Arline*,[14] is defined as a high risk of substantial harm to self or others (Title I),[15] or only to others (Title II and Title III)[16, 17] that cannot be reduced or eliminated through reasonable accommodation/modification. A speculative or remote risk is not sufficient. In the ADA arena, direct threat has a specific legal definition, and is not the garden variety threat to public safety. More than 20 years ago, the U.S. Supreme Court affirmed the authority of the Equal Employment Opportunity Commission (EEOC) to make its own regulations regarding what constitutes a "direct threat" to self or others.[18] While Title II and Title III regulations from the Department of Justice (DOJ)[16,17] pertain only to direct threat to others and do not include direct threat to self, the method of determining direct threat that appears in the regulations very much comes from *Chevron v. Echazabal*.[18,p 86]

Direct threat in the ADA context is a legal term of art and can only be found when based upon a reasonable medical judgment relying on the most current medical knowledge and/or the best available objective evidence, and it always requires an individualized analysis in each case.[18, p 86] Direct threat is an objective standard with strict legal definition, and is specifically *not* met with an allegation that a practitioner "may be unable to practice medicine with reasonable skill and safety" due to possible impairment. It is also specifically not met by a finding that a person has a condition that "may lead to an impairment."

Physician Evaluees Are Covered by the ADA

Because PHPs fall into the category of "healthcare provider, hospital, or service establishment," they are considered places of public accommodation, and therefore subject to Title III of the ADA. Regardless of whether the psychiatric evaluator is employed by a preferred physician treatment program or is in private practice, Title III of the ADA will apply in either eventuality because either the program or the private evaluator is performing a service.[19]

Under the ADA a person has a disability if the person: (1) has a physical or mental impairment that substantially limits one or more major life activities; (2) has a record of such an impairment; OR is regarded as having a physical or mental impairment.[20]

Often PHPs create a record of putative impairment by casting a wide net as to what impairments may exist. The common practice by MLBs of taking on faith allegations made by referral sources rather than investigating the validity of those allegations prior to insisting on a FFDE also activates the "regarded as" prong of the ADA's definition of a disability as well. In either eventuality, evaluators who proceed to examination without first vetting the objectivity and reliability of the initial allegations are regarding the evaluee as having a physical or mental impairment, and therefore have activated the "regarded as" prong of the ADA's definition of a disability.

The ADA was enacted to protect individuals with a disability as defined by the statute. Title II specifically states that individuals cannot be excluded, by reason of disability, from participation in or be denied the benefits of the services, programs, or activities of public entities, which includes medical licensing boards.[21]

Other important ADA regulations are relevant to the FFDE process. Key examples include: (1) A public entity may not administer a licensing or certification program in a manner that subjects qualified individuals with disabilities to discrimination on the basis of disability, nor may a public entity establish requirements for the programs or activities of licensees or certified entities that subject qualified individuals with disabilities to discrimination on the basis of disability;[22] (2) a public entity may not aid or perpetuate discrimination against a qualified individual with a disability by providing significant assistance to an agency, organization, or person that discriminates on the basis of disability in providing any aid, benefit, or service to beneficiaries of the public entity's program;[23] and (3) a public entity may not, directly or through contractual or other arrangements, utilize criteria or methods of administration that have the effect of subjecting qualified individuals with disabilities to discrimination on the basis of disability.[24]

The Psychiatrist Evaluator Is Subject to the ADA

Because they are "healthcare providers," psychiatrist evaluators of physician fitness for duty are subject to Title III of the ADA.[25] Any entity subject to Title III of the ADA takes on a variety of obligations beyond whether the individual can get into the office, including but not limited to making reasonable modifications in policies, practices, or procedures.[26]

Key provisions of the ADA that are relevant to the specific task of the psychiatric evaluator in an FFDE include:

- Health system employers, MLBs, PHPs, preferred physician evaluation/treatment programs, and psychiatric evaluators of fitness for duty are all subject to one or more titles of the ADA.
- Evidence used by referral sources to support their reasonable beliefs regarding the possibility of impairment(s) must be objective, and meet specific legal criteria.
- Evaluation, if appropriate, must be limited in scope so that unnecessary medical inquiries do not occur.[27-29]
- For referrals that originate from employers, specific job-related evidence must be available in order for medical examination to be legally permissible.[12] For referrals that come from sources covered by Titles II and III, the evaluator has an *ethical* duty to ensure that job-related evidence is in place before proceeding to evaluation, because there is no other way that the title II entity (the MLB) will be able to assess whether the evaluee is a qualified person with a disability (i.e. satisfies the essential eligibility requirements for their license with or without reasonable modifications),[30] and no other way for the title II entity and/or title III entity to determine whether a direct threat[15-18] actually exists.
- The evaluator can verify that a referral for FFDE is appropriate if the referral source presents sufficient evidence to support reasonable belief that a psychiatric medical condition exists, and sufficient evidence to demonstrate a current significant decrement in workplace performance.

Necessity of Consultation with Legal Counsel

In our experience, it is critical for the evaluee to retain ADA-knowledgeable counsel early. Keep in mind that Titles I, II, and III each have their own statutory and regulatory provisions when inquiring about the expertise of potential attorneys. ADA-naive counsel, even if experienced in licensing and health-care employment, are likely to fail to insist on an ADA-appropriate evaluation or even to utilize the ADA at all on behalf of the evaluee. This lack of experience with the ADA creates potential liability for the evaluee's lawyer for legal malpractice.[31] The evaluator may also be subject to accusations of retaliation, for example, for refusing to perform the exam once a person raises ADA concerns,[32] or to accusations of interference[33] if the evaluee is strongly discouraged from exercising ADA rights. "Interference" is another legal term of art, which has been defined in the case law as meddling in the rights of others.[34]

Even though we believe that the ADA applies widely in the physician FFDE field, we do not claim that an ADA challenge can be successfully asserted in every case. In a legal environment, prevailing ideas about best practices, the inertia of precedent, unconscious moral judgments, and power dynamics can all trump the requirements of justice. Therefore, we do not suggest that the ADA-informed approach is the exclusive method to address misuse of the FFDE process. Utilized in conjunction with current practices in employment and licensing law, the ADA-informed approach may enhance the chances for a successful outcome, but it will always be dependent upon the facts of each individual case.

Risks of Fitness For Duty Evaluation (FFDE)

It is typical in the MRTC to claim that physician participation in FFDE is voluntary.[8,35] In our view, if a physician is mandated to FFDE under threat of loss of licensure or employment, then it is a clear imbalance of power and from an ethical point of view, coercive rather than voluntary.[36]

Psychiatric illness is highly stigmatized in the medical and regulatory culture. Therefore, public exposure of allegations of workplace impairment, whether valid or not, damages the professional reputation of the evaluee, and especially when it is reported to the National Practitioner Data Bank, as invariably occurs with reduction of privileges or loss of licensure. Any allegation that a physician may not be able to competently carry out the duties of the job ("practice with reasonable skill and safety") creates moral injury in the evaluee by striking at the core of professional identity. Moreover, the use of coercion alone causes moral injury.[36]

It is typical for referral sources in the MRTC to require a comprehensive psychiatric evaluation well beyond what the ADA allows.[27-29] If an employee is involved, the FFDE should be evaluating whether the person can do the essential functions of the job with or without reasonable accommodations and without being a direct threat (as discussed previously), to self or others.[18] If an employee is not involved, then it depends upon context.

With respect to the MLB, the question is whether the person meets the essential eligibility requirements for licensure with or without reasonable modifications[37] and without constituting a direct threat to others. If the physician is not an employee, i.e., an independent contractor, then the question becomes ability to perform the work with or without reasonable modifications[38] and without constituting a direct threat to others.

Undergoing the kind of comprehensive FFDE required in the MRTC is not only harmful when legal rights are infringed upon, but it also carries the clinical risk of false positive findings. In our experience in this field, we have observed a propensity for psychiatric evaluators to cast a very wide net in their diagnostic inquiries, and to loosely interpret Diagnostic and Statistical Manual of the American Psychiatric Association (DSM) diagnostic criteria. In point of fact, we have never encountered a single FFDE by a colleague that made a finding of no mental illness at all. Not all mental illness, even if diagnosed accurately, is impairment, so the trend in the field toward overdiagnosis translates to many potential false positive findings of impairment.

One small but well-designed study showed that the rate of suicide was markedly elevated in a PHP population, relative to the background rate of suicide for physicians.[39] Larger studies, of course, are imperative, but the possibility that physician suicide results from MRTC intervention makes it irresponsible to wait for further verification before making it routine for practitioners in the field to take suicide into account as a significant potential risk.

Lack of Institutional Protections for Evaluees

To our knowledge, no formal code of ethics specific to the fitness-for-duty evaluator's task, along with a mechanism for enforcement, exists, and compliance with professional association practice guidelines is always voluntary.

Although ADA protections have been in place for years, the ADA is rarely utilized by counsel of physicians mandated to FFDE. In our experience observing the field, evaluees have sometimes been able to obtain legal relief from evaluator error, with the assistance of ADA-knowledgeable counsel, but the claims have been resolved out of court, so precedent has not been established. While we have yet to come across a malpractice suit against a licensing attorney for failure to utilize the ADA on behalf of the client, that risk is a real one.[31]

Published Guidelines for Ethical FFDE

Robust, comprehensive, published guidelines that apply to physician FFDE have been available for years, but in our experience in the field, different evaluators vary widely in their adherence to those published standards of practice.

We use two major practice guidelines as foundational for ethical FFDE: the American Academy of Psychiatry and Law (AAPL) Practice Guideline for the Forensic Evaluation of Psychiatric Disability,[40] and the American Psychological Association (APA) Professional Practice Guidelines for Occupationally Mandated Psychological Evaluations.[41] Below we review those guidelines and integrate the requirements of the ADA.

Fiduciary Relationship Between Evaluator and Evaluee

The AAPL practice guideline describes in detail the fiduciary relationship between evaluator and evaluee:

> Although a traditional treatment relationship does not exist, a limited doctor-patient relationship is established by a third-party evaluation. This relationship is best understood as one in which the psychiatrist has a duty to the referral source to provide a complete and thorough evaluation as well as certain duties to the evaluee, similar to but more limited than those in a traditional doctor-patient relationship.[40]

The guideline goes on to enumerate those duties to the evaluee: not causing harm, fully disclosing potential or perceived conflicts of interest, disclosing the limits of confidentiality, describing in advance the roles the evaluator takes toward the evaluee, maintaining objectivity, and disclosing significant findings.[40]

Assessment of Appropriateness of Referral

Once an allegation of workplace impairment is made against a physician, there exists no burden on the evaluee or an evaluator of fitness for duty to prove it wrong. As an ethical starting point for evaluation, the physician evaluee is considered to be "fit for duty" unless sufficient evidence has been provided to make a formal finding otherwise.

Both AAPL and APA practice guidelines endorse the principle that the psychiatric evaluator should assess the context and appropriateness of the evaluation at the time of referral, in order to avert the misuse of psychiatry or psychology by third parties with improper motivations. These guidelines suggest that it is ethically valid, when the evaluator determines that a referral is improper, either to refuse to do the evaluation, or continue with comprehensive evaluation with an ultimate finding that the referral was made for reasons other than impairment by psychiatric illness.[40,41] Neither of these practice guidelines, however, spell out the course of action that should be taken by the ethical evaluator if ADA requirements for mandatory evaluation are not met. Therefore, we depart from these guidelines and take the position that it is not an ethical or legal option to proceed to further evaluation if the legitimacy of a referral cannot be verified. This is particularly important because in ordinary clinical practice, patients can protect themselves from error and bad faith by firing their doctors, but evaluees under the jurisdiction of the MRTC possess very limited means to protect themselves.

We believe that it is ethically and legally required to assess the appropriateness of referral, as a separate step, before proceeding to an evaluation that is fuller, but still limited in scope per ADA requirements.[27-29] In our experience in the field, many referrals for FFDE come in with either no specific questions, no evidence that pertains to the ability to practice as a physician in a particular specialty, or highly speculative, tendentious hypotheses about future threats to workplace safety. Even if objective, plausible evidence of a mental disability exists, that is not sufficient all by itself to make FFDE ethically or legally permissible.

The ethical psychiatric evaluator addresses questions within the scope of his medical expertise, consistent with ADA compliance. A finding that further evaluation cannot proceed due to the evaluator's own ethical obligations, in responding to a demand to conduct an evaluation in a manner inconsistent with the ADA, is not the same thing as opining on fitness for duty. Should the evaluator have his FFDE exam business adversely affected by a finding that the referral cannot be verified as a result of the evaluator's ethical and ADA obligations, the evaluator may want to consider obtaining ADA-knowledgeable legal counsel for redress of the retaliation.[32]

Objectivity of Evidence

Objectivity in FFDE is called for in both AAPL and APA guidelines[40,41] and is a general ethical requirement of all psychiatric practice. Objectivity is especially important in a field

where the evidence available to the psychiatric evaluator is often ambiguous, subjective, and only vaguely descriptive.

We use the following markers for objectivity:

- High quality evidence is that which can be interpreted consistently by multiple independent evaluators.
- Contemporaneous written documentation is superior to subsequent recall after the fact.
- Specific accounts of the evaluee's problematic statements or descriptions of outwardly observable behaviors are superior to general impressions and inferences about motivations.
- The use of pejorative language in documenting allegations is almost invariably a reliable marker of bias and prejudice.

Subjective statements that reflect a complainant's perceptions ("He makes me feel uncomfortable") are important to take seriously and to treat respectfully as a matter of workplace management, but they cannot be used as reliable evidence in decisions regarding undertaking a FFDE, when so much harm to the evaluee can result from erroneous interpretation.

It is considered standard in the field of physician FFDE[42] for the evaluator to conduct so-called "collateral interviews." In our view, collateral interviews must be viewed with great caution, as they can perpetuate bias. Once a seemingly ominous story is told about a physician, and passed along from one unit of the MRTC to another, it is human nature for a kind of groupthink to set in that can shape the questions asked by evaluators. Of interest, the 2019 FSPHP practice guideline[8] explicitly allows for the use of data obtained from collateral sources who are known to be biased against the physician evaluee.

In our experience, referrals for FFDE are often made on the basis of a vague intuition: "Something's not right with the doctor," and an expectation that the psychiatrist can develop new evidence to verify the preexisting perception. Remember that the related provisions of the ADA strongly warrant that objective evidence of impairment in business-related job performance must exist *before* medical or psychiatric evaluation can be mandated. Therefore, in assessment of appropriateness of referral, the evaluator works primarily with evidence that has already been presented, because to go further in collecting evidence initiates the very evaluation that might be ethically inappropriate or legally impermissible.

Psychiatric Referral as Workplace Retaliation

The AAPL Practice Guideline speaks unambiguously to the misuse of psychiatry in third-party evaluations:

> In the event of workplace conflict, an employer may attempt to discredit or even terminate an employee by claiming the employee is mentally unstable…. Psychiatrists should be sensitive to the possibility that their expertise may be misused in this way. The use of a psychiatric examination as retaliation or as a deterrent against complaints is inappropriate.[40]

The ADA explicitly prohibits retaliation as well as interference with protected rights.[43]

In our own experiences with physicians referred for FFDE, we have encountered many instances in which the existence of workplace conflict prior to referral has created the appearance of both retaliation as well as interference[32,33] with protected rights. Therefore, we recommend making it routine to screen all referrals for FFDE for improper motivations.

It is not ethical, in our view, to use anonymous sources in FFDE, because without names, it is not possible to investigate the possibility of bad faith or bias.

Informed Consent for Evaluation

Both AAPL and APA guidelines call for informed consent.[40,41] In the MRTC process as it currently operates, the psychiatric evaluation of fitness for duty is perhaps the only place where true informed consent can occur, if the word "consent" is defined as a realistic opportunity to say "no" without penalty.

Dr. Emmons speaks personally with the prospective evaluee in advance of establishing an evaluator-evaluee relationship. The initial phone call, which typically takes 45 to 60 minutes, includes a brief review of the prospective evaluee's understanding of the reason for the referral. Most of the informed consent disclosures take place during this screening call, before the evaluee presents at the office.

Dr. Emmons details for the prospective evaluee the risks of disclosing personal information that will be reported to potentially hostile third-party referral sources. He describes his role as objective evaluator, which means he cannot guarantee a finding favorable to the evaluee. He spells out how he applies DSM diagnostic criteria (rigorously and precisely), how he collects and uses evidence, and his stance toward independence from referral sources. He answers all questions from the prospective evaluee, no matter how long it might take, prior to initiating the examination.

The ADA and Independence from Referral Sources

It is particularly important for physicians who are sent to psychiatric evaluation to be educated immediately about the ADA and published standards of practice for FFDE, so they can engage in a process of informed consent before initiating an evaluation. In a field that lacks systematic protections for evaluees, we believe they must be empowered to choose qualified evaluators who will perform the exam in a manner consistent with the ADA. If a referral source's preferred psychiatric evaluator of physician fitness for duty does not routinely assess the appropriateness of the referral, and does not systematically consider the requirements of the ADA, then it is eminently reasonable for the prospective evaluee to request a different evaluator who will conform to legal and ethical standards.

If the referral source will not accept the evaluee's choice of evaluator, then the burden of proof, in our view, falls on the referral source to demonstrate, in a transparent and unbiased way, why that evaluator is not acceptable, and how its evaluator will act consistent with its ethical and ADA obligations. The American Psychiatric Association guideline[35] spells out, as qualifications for psychiatric evaluators of fitness for duty, three areas of expertise: suicide risk assessment, diagnosing severe mental illness, and diagnosing addictions. This professional association guideline does not include many qualifying criteria that are added by PHPs, criteria we believe create bias toward making findings of impairment.

The requirements spelled out in the 2019 FSPHP guideline[8] for selection of evaluators are not ADA compliant.[10] A new scheme by the FSPHP[44]—which contains no mention of the ADA at all—to formally accredit treatment and evaluation experts in the field of "safety-sensitive occupational roles," undoubtedly violates the ADA by ignoring *Chevron v. Echazabal*[18] and the ADA's final implementing regulations.[15-17] This new program focuses on "may lead to impairment," which is not, as we have discussed in this paper, how the ADA works.

The AAPL guideline takes a very strong position on the independence of psychiatrists who conduct evaluations for third parties:

> [The psychiatrist] should not feel reticent to voice an opinion that does not support the referral source's desired outcome…. This obligation extends to recognizing that expressing an opinion in the interest of pleasing the referral source, either to maintain employment or garner future referrals, is unethical.[40]

Summary and Conclusions

Physicians who are sent to psychiatric FFDE under the auspices of a health system employer, MLB, or PHP are not systematically protected against the harms that can flow from error and bad faith.

In the absence of any enforceable formal code, ethical practice in the physician fitness for duty field depends on honest self-reflection by evaluators, and assertive self-protection by educated physician evaluees.

It is ethically imperative psychiatric evaluators of fitness for duty to be knowledgeable about the requirements of the ADA, to provide an authentic process of informed consent, to maintain objectivity, and to do no harm themselves. It is even more imperative that evaluees obtain ADA expertise as soon as possible in the process.

A routine and rigorous process to establish appropriateness of referral as a precondition for further psychiatric "fitness for duty" evaluation is a specific method that can be used to ensure that physician evaluees are treated with the compassion and respect they deserve.

Robert S. Emmons, M.D., practices as a psychiatric psychotherapist in Williston, Vermont. He has worked as an expert in the physician FFDE field since 2013. Contact: robertsemmons@comcast.net.

William D. Goren, J.D., LL.M., has a legal and consulting practice that focuses on understanding the ADA so that the client understands how to comply with that law and related laws, which includes but is not limited to understanding how the ADA applies to FFDEs. His blog/website is at www.understandingtheada.com.

REFERENCES

1. Emmons R, Manion K, Andrew LB. Systematic abuse and misuse of psychiatry in the medical regulatory therapeutic complex. *J Am Phys Surg* 2018;23(4):110-114. Available at: https://www.jpands.org/vol23no4/emmons.pdf. Accessed Feb 27, 2024.
2. Skipper G, DuPont R. Chapter 15. The Physician Health Program: a replicable model of sustained recovery management. In: Kelly J, White W, eds. *Addiction Recovery Management: Theory, Research and Practice* (Current Clinical Psychiatry). Humana Press; 2011:283.
3. Wall B. The clinical implications of doctors' evaluating doctors. *J Am Acad Psychiatry Law* 2005;33(1):89-91. Available at: https://jaapl.org/content/jaapl/33/1/89.full.pdf. Accessed Feb 11, 2024.
4. Wyden R, Booker C, Markley J. Letter to Attorney General Garland, Assistant Attorney General Kristen Clark, and Disability Rights Section Chief Rebecca Bond. United States Senate; Feb 23, 2023. Available at: https://www.wyden.senate.gov/imo/media/doc/Congressional%20Letter%20to%20DOJ%20re%20State%20Medical%20Boards%20Violating%20ADA%20with%20Intrusive%20Mental%20Health%20Questions.pdf. Accessed Jan 20, 2024.
5. Lenzer J. Physician health programs under fire. *BMJ* 2016;353:i3568. doi: 10.1136/bmj.i3568.
6. Huntoon LR. Sham peer review: Focused Professional Practice Evaluations (FPPE), Performance Improvement Plans (PIP) and Physician Health Programs (PHP). *J Am Phys Surg* 2023;28(3):81-84.
7. Anderson P. Physician Health Programs: more harm than good? *Medscape Med News*, Aug 19, 2015. Available at: https://www.medscape.com/viewarticle/849772?form=fpf. Accessed Jan 22, 2024.
8. Federation of State Physician Heath Programs. 2019 Physician Health Program Guidelines. Available at: https://fsphp.memberclicks.net/assets/guidelines/2019%20FSPHP%20PHP%20GUIDELINES%20FOR%20MEMBERS%20-%20COPYRIGHT%20FSPHP.pdf. Accessed Jan 24, 2024.
9. Federation of State Medical Boards. Policy on Physician Illness and Impairment: Toward a Model That Optimizes Patient Safety and Physician Health. Adopted by Federation of State Medical Boards House of Delegates, April 2021. Available at: https://www.fsmb.org/siteassets/advocacy/policies/policy-on-physician-impairment.pdf. Accessed Feb 10, 2024.
10. Goren W. Medical licensing boards, Physician Health Programs, and the lack of ADA compliance: an opportunity for plaintiff lawyers. Understanding the ADA Blog. https://www.understandingtheada.com/blog/2019/07/13/medical-licensing-boards-physician-health-programs-ada-compliance/. Accessed Jan 27, 2024.
11. American Medical Association. AMA Principles of Medical Ethics. Adopted June 1957; revised June 1980; revised June 2001. Available at: https://code-medical-ethics.ama-assn.org/principles. Accessed Jan 30, 2024.
12. Lawson ND, Boyd JW. Do state Physician Health Programs encourage referrals that violate the Americans with Disabilities Act? *Intl J Law Psychiatry* 2018;56:56:65-70.]
13. 42 U.S.C. §12112(d)(4)(A); 29 C.F.R. §1630.14(c).
14. *School Board of Nassau County, Florida v. Arline*. 480 U.S. 273 (1987).
15. Title I. 29 C.F.R. §1630.2(r).
16. Title II. 28 C.F.R. §35.139.
17. Title III. 28 C.F.R. §36.208.
18. *Chevron v. Echazabal*. 536 U.S. 73 (2002).
19. 42 U.S.C. §12181(7)(F).
20. 42 U.S.C. §12102(1).
21. 42 U.S.C. §12131(1).
22. 28 C.F.R. §35.130(b)(6).
23. 28 C.F.R. §35.130(b)(5).
24. 28 C.F.R. §35.130(b)(3)(i).
25. 42 U.S.C. §12181(7)(F).
26. 42 U.S.C. §12182(b)(2)(A)(ii).
27. 29 C.F.R. §1630.14.
28. DOJ Technical Assistance Memorandum Title II §3. 5300.
29. DOJ Technical Assistance Memorandum Title III §4.1300.
30. 28 C.F.R. §35.104.
31. Goren WD. Legal malpractice risks and the ADA. Understanding the ADA Blog; Apr 30, 2019. Available at: https://www.understandingtheada.com/blog/2019/04/30/legal-malpractice-risks-and-the-ada/. Accessed Feb 28, 2024.
32. 42 U.S.C. §12203(a).
33. 42 U.S.C. §12203(b).
34. *Piotrowski v. Signature Collision Ctrs*. 2:21-cv-02115-JDW (E.D. Pa. Oct. 8, 2021).
35. Recupero P, Pinals DA, Candilis P, et al. Workgroup of the Council on Psychiatry and Law. American Psychiatric Association Resource Document on Recommended Best Practices for Physician Health Programs; October 2017. Available at: https://www.psychiatry.org/File%20Library/Psychiatrists/Directories/Library-and-Archive/resource_documents/2017-Resource-Document-on-Physician-Health-Programs.pdf. Accessed Feb 28, 2024.
36. Emmons R. Coercion, moral injury, and suicide in the medical regulatory therapeutic complex. *J Am Phys Surg* 2019;24(2):40-48. Available at: https://mllangan1.files.wordpress.com/2019/12/emmons-2.pdf. Accessed Feb 27, 2024.
37. 28 C.F.R. §35.104.
38. *Menkowitz v. Pottstown Memorial Medical Center*, 154 F.3d 113 (3d Cir. 1998).
39. Iannelli RJ, Finlayson AJR, Brown KP, et al. Suicidal behavior among physicians referred for fitness-for-duty evaluation. *Gen Hosp Psychiatry* 2014;36(6):732–736.
40. Gold LH, Anfang SA, Drukteinis AM, et al. American Academy of Psychiatry and Law Practice Guideline for the Forensic Evaluation of Psychiatric Disability. *J Am Acad Psychiatry Law* 2008;4(Supplement):S3-S50. Available at: https://www.aapl.org/docs/pdf/Evaluation%20of%20Psychiatric%20Disability.pdf. Accessed Jan 23, 2024.
41. American Psychological Association Council of Representatives. Professional Practice Guidelines for Occupationally Mandated Psychological Evaluations; Feb 24, 2017. Available at: https://www.apa.org/pubs/journals/features/amp-amp0000170.pdf. Accessed Jan 25, 2024.
42. Federation of State Physician Heath Programs. 2005 Physician Health Program Guidelines. Available at: https://www.fsphp.org/resource/2005-fsphp-physician-health-program-guidelines. Accessed Oct 30, 2018. [No longer available online.]
43. 42 U.S.C. §12203.
44. FSPHP Evaluation and Treatment Accreditation™ (FSPHP-ETA ™). Federation of State Physician Health Programs. Available at: https://www.fsphp.org/fsphp-eta-. Accessed Feb 11, 2024.