MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

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| BILL NUMBER: | AB 408 |
| AUTHOR: | Berman |
| BILL DATE: | July 8, 2025, Amended |
| SUBJECT: | Physician Health and Wellness Program |
| SPONSOR: | Medical Board of California |

DESCRIPTION OF CURRENT LEGISLATION

Authorizes the Medical Board of California (Board) to establish a Physician Health and Wellness Program (PHWP) for the early identification of, and appropriate interventions to support, treat, monitor, and rehabilitate applicants and licensees of the Board who have impairing or potentially impairing physical or mental health conditions, including substance use disorders, that may impact their ability to practice their profession in a reasonably safe, competent, and professional manner.

The proposed legislation provides the Board with new authority to prevent patient harm from occurring, without requiring the filing of a complaint. As with current law, those who participate in the PHWP pursuant to a probationary order from the Board will be subject to the Uniform Standards for Substance-Abusing Licensees (Uniform Standards).

AB 408 does not mandate participation in the PHWP. The Board, however, may include participation in the PHWP pursuant to a disciplinary order against a licensee.

**AB 408 was not amended after the previous Board meeting.**

RECENT AMENDMENTS

On July 8, 2025, AB 408 was amended, as follows:

- References to the term “disruptive behavior” were removed.
- States that the program will be available to California medical school students after the administering entity and the Board determines that sufficient resources are available.
- Clarifies the definition of voluntary participant by including a cross reference to the proposed section related to the Board’s authority to refer an individual into the program in lieu of discipline.
- Clarifies the qualifications for individuals to be appointed to an advisory committee.
- Other technical and clarifying changes were adopted.

BACKGROUND

During the November 21-22, 2024, meeting, the Board approved a motion that directed staff to work with the Legislature to find an author for its PHWP proposal and authorized the Board President and Board Vice President to work with staff, the Legislature, and other stakeholders in furtherance of the proposal.

BPC sections 315-315.4 established in DCA the Substance Abuse Coordination Committee (SACC). The SACC is charged with formulating uniform and specific standards in various areas that a healing arts board shall use in dealing with substance-abusing licensees. The Board incorporated those standards into its regulations in 2015. BPC section 820 authorizes a healing arts licensing board within the Department of Consumer Affairs (DCA) to order a licensee to be examined by a physician or psychologist if it appears that the licensee may be unable to practice safely due to their mental or physical health condition. A report of such an examination shall be made available to the licensee and the approved licensing board, which may be used in a disciplinary proceeding.

**Legislative Progress and Next Steps**

Since the introduction of AB 408, this legislation has been approved during the following successful legislative votes:

- 16-0 on April 22, 2025, in the Assembly Business and Professions Committee (two legislators did not vote).
- 10-0 on April 29, 2025, in the Assembly Judiciary Committee (two legislators did not vote).
- 14-1 on May 21, 2025, in the Assembly Appropriations Committee.
- 72-0 on May 27, 2025, in the full Assembly (seven legislators were absent or did not vote).
- 7-1 on July 7, 2025, in the Senate Business, Professions, and Economic Development Committee (three legislators did not vote).

AB 408 is now pending in the Senate Judiciary Committee and will be eligible for further consideration in 2026. The details of the various vote counts and analyses of the bill produced by the Legislature are available online. The Assembly and Senate archive recordings of their proceedings on their websites.

ANALYSIS

AB 408 repeals the existing authority to establish a PHWP in BPC sections 2340 to 2340.8 and replaces it with the following sections that are summarized below:

**BPC section 2340**

- Establishes the vision for the program: Protecting consumers by addressing impairing, or potentially impairing, health conditions that may impact a current or future licensee's ability to practice in a reasonably safe, competent, and professional manner.

- Defines various terms, including, but not limited to:

    - Administering entity.
    - Applicants, prospective applicants, trainees, and students.
    - Mental/physical illness.
    - Substance use disorder.
    - Voluntary participant.

**BPC section 2341**

- A PHWP established by the Board shall do all the following:

    - Educate the public, licensees, applicants, prospective applicants, trainees, students, health facilities, medical groups, health care service plans, health insurers, and other relevant organizations on specified topics.
    - Establish relationships supportive of the program with professionals experienced in working with health care providers to provide education, evaluation, monitoring, or treatment services.
    - Receive and assess reports of suspected impairment from any source.
    - Intervene in cases of verified impairment or suspected impairment, as well as in cases where the individual has a condition that could lead to impairment if left untreated.
    - Upon reasonable cause, refer participants for evaluation, treatment, monitoring, or other appropriate services.
    - Provide consistent and regular monitoring, care management support, or other appropriate services for program participants.
    - Advocate on behalf of participants, with their consent, to the board to allow them to participate in the program as an alternative to disciplinary action, when appropriate.
    - Offer guidance on participants' fitness for duty with current or potential workplaces, when appropriate.
    - Perform other services as agreed between the program and the Board.

- Authorizes the Board or PHWP to choose whether to impose or follow the Uniform Standards upon voluntary participants.

- Licensees with a probation order that includes the Uniform Standards must follow that order. The PHWP shall provide the evaluations, treatment, monitoring, and reports required by that order.

**BPC section 2342**

- If the Board establishes a PHWP, it shall contract with a 501(c)(3) non-profit organization, referred to as the administering entity, with leadership, expertise, and experience in impairment/rehabilitating healthcare providers. The section also streamlines the process to obtain a multi-year contract.

- The administering entity shall do the following:

  - Establish agreements with treatment resources.
  - Refer participants and others affiliated with the participants to appropriate services.
  - Makes services available to all Board licensees, applicants, prospective applicants, trainees, students (when sufficient resources are available), and those who self-refer.
  - Make prompt and diligent efforts to contact, evaluate, and enroll appropriate participants.
  - Provide immediate confidential reporting to the Board of withdrawals/terminations prior to program completion.
  - Provide regular communication with the Board.
  - Participate in Board meetings.
  - Submit reports with statistical information (as requested by the Board) and those pertaining to participants and other individuals, as required.
  - Comply with periodic quality and compliance evaluations by an independent third-party selected by the Board.

**BPC section 2343**

- A contract between the Board and an administering entity would be required to include procedures on the following topics:

  - Regular participation in Board meetings and regular reporting of statistical information to the Board.
  - Periodic joint reviews of referrals made to the PHWP.
  - Various reporting requirements to the Board, including, but not limited to, participants who commit a program violation, fail to cooperate with the program, or in the opinion of the PHWP are a danger to the public.
  - Informing participants of PHWP procedures, responsibilities, and consequences of noncompliance.
  - Qualifications of those who serve participants.
  - Prevention of conflicts of interest.
  - Quality assurance and improvement principles.

- Maintenance and confidentiality of records.
- PHWP staff contacts.
- Data collection and analysis.
- Research process and methodologies.
- Education and outreach to stakeholders.
- Monitoring and accountability for licensees who practice across state lines.
- Notification, compliance, and cures to program deficiencies.
- Other relevant topics determined by the Board.

**BPC section 2344**

- The Board would be authorized to refer a licensee to the PHWP in lieu of discipline, with the consent of the licensee. If the licensee does not consent or does not successfully complete the program, the Board may proceed with appropriate disciplinary action, as authorized under current law.

    - Referring in lieu of discipline is not an option for those alleged to have harmed a patient or client or engaged in sexual misconduct.

- Participants shall be responsible for PHWP costs, but other payment from other sources is authorized.

- Services for participants shall be conducted by approved providers with expertise working with health care professionals with impairing or potentially impairing conditions.

- When the Board receives a required report that a deidentified voluntary participant has committed a program violation, the Board may:

    - Encourage continued participation in lieu of discipline, if appropriate.
    - Request the participant's identity, contact information, and a factual summary of events and findings from the PHWP, and begin an investigation and take appropriate disciplinary action.
    - Take other action consistent with the procedures established in the contract.

- Participants must authorize the release of information to the Board, as specified.

- The PHWP shall make the required reports to the Board in the following circumstances:

    - A participant fails to comply with the program or the PHWP determines that they are unable to practice in a reasonably safe, competent, and professional manner.

    - A licensee, applicant, or trainee (as defined) fails to enter the program and the PHWP determines they are unable to practice in a reasonably safe, competent, and professional manner.

- A licensee, applicant, or trainee (as defined) is required to notify the Board that they withdrew or were terminated from the program without completing the requirements within three days of that occurrence.

- Participants who leave the PHWP due to noncompletion may re-enroll with the agreement of the Board and the PHWP.

- The Board maintains the authority to discipline participants or to deny a licensure application to a participant who withdraws or is terminated from the program, including, but not limited to, ordering an evaluation of an illness that impacts their competency.

**BPC section 2345**

Provides that participants must execute a written agreement with the PHWP that includes, at least, all the following:

- A jointly agreed upon treatment plan, including conditions and procedures to monitor compliance. Compliance with a probationary order of the Board shall be included in the agreement, if relevant.

- Criteria for:

    - Compliance with the terms and conditions.
    - Program completion and termination.
    - When a report due to noncompliance will be made to the Board.

- An agreement to authorize communication between the PHWP, Board, or others, as appropriate.

- An acknowledgment of the following:

    - Withdrawal or termination prior to completion will be reported to the Board.
    - The PHWP is required to make reports to the Board when a participant withdraws or is terminated from the program, or is unable to practice in a reasonably safe, competent, and professional manner.
    - Participation in the PHWP is not a defense to a disciplinary or licensing action of the Board.
    - The participant is responsible for PHWP costs, but they may be paid by other sources.

**BPC section 2346**

- Provides that program records are exempt from the California Public Records Act and not subject to discovery by subpoena or admissible as evidence except:
    - To defend the PHWP in certain civil or administrative actions related to current or former participants.
    - If records must be provided to the Board under the laws that establish the PHWP.
    - Records held by the Board may be used as evidence in a licensing or enforcement action.

**BPC section 2347**

- States that anyone who acts in good faith related to the PHWP is immune from civil liability, including:
    - The administering entity, the Board (and related members, employees, and agents) and advisory committees.
    - Those reporting an impaired person or provides information about someone to the PHWP/Board.

- This section does not require the Board to defend or indemnify someone in a civil action.

- The immunity does not apply in a case where it can be proven that someone made a report they knew was false, or with a reckless disregard of the truth or falsity of the report.

**BPC section 2348**

- This section authorizes the Board to establish one or more advisory committees to assist the Board in carrying out its duties related to the PHWP. The advisory committees shall operate under the direction of the Board's executive director or their designee, as follows:
    - Appointments are by majority vote of the Board for up to four years, with at least three members per committee.
    - A majority of those appointed shall be physician licensees of the Board with expertise in the evaluation, diagnosis, treatment, or management of health care professionals who are impaired due to substance use disorders, mental illness, or physical illness.
    - Committee members must be unaffiliated with the PHWP (or its contractors) and all physician appointees shall have a current and active license from California.
    - Provides for the following additional committee member criteria:

- At least one member who is not licensed by the Board and has expertise in a Board-recognized field related to substance use disorders, mental illness, or physical illness.
- At least one physician appointed shall specialize in diagnosis/treatment of substance use disorders in health care professionals.

- The section authorizes a committee to meet in closed session to review information related to PHWP participants, those being considered for entry into the program, or to hear reports from the PHWP about a participant. Further, the section states that committee members shall receive per diem and expense reimbursement.

**BPC section 2349**

- Advisory committees are authorized to have the following duties and responsibilities:
    - Evaluate licensees for possible referral to the PHWP in lieu of discipline and make related recommendations to the Board's executive director or their designee.
    - Review information about participants, including those reported to the Board, and make related recommendations to the Board's executive director or their designee.
    - Make recommendations to the Board's executive director or their designee whether a participant should be reported to the Board or that the PHWP should take other action(s).
    - Consider requests of potential participants or other matters requested by the Board.
    - Periodically hold open meetings to evaluate the PHWP, prepare reports to the Board, and consider PHWP changes or other matters requested by the Board.

- The section provides Board and committee members (including agents and contractors) immunity from civil damages due to acts or omissions while acting in good faith.

**BPC section 2350**

- This section continues the existing PHWP Program Account for the purpose of holding funds collected or allocated by the Board for the support of the PHWP. It provides that those funds shall be available upon appropriation by the Legislature.

- The Board is authorized to seek and use grant funds and gifts of financial support from public or private sources and requires annual reporting to the Legislature (including upon request of the public) the amounts and source of funds received to support the program.

**BPC section 2351**

- If the Board establishes a PHWP, licensees would be required to make a report to the Board or PHWP if they, in their good faith judgment, believe another licensee may be impaired. PHWP staff and agents are exempt from this requirement in situations where the licensee in question does not pose a risk to patient safety.

- Prohibits disclosure of the reporter's name to the referred licensee, unless the reporter provides written permission, or disclosure is otherwise required by law.

**BPC section 2352**

- States that these laws are not applicable to the Osteopathic Medical Board of California or their licensees, applicants, prospective applicants, students, or trainees.

**Claims Raised by Opponents**

Throughout the legislative process, opponents of AB 408 have made various claims about the legislation and the PHWP, including, but not limited to:

**Claim:** AB 408, including the proposed exemption from the Uniform Standards for Substance Abusing Licensees, puts patient safety at risk.

**Reality:** This legislation reduces the existing patient safety risks and enhances patient safety by authorizing a program aligned with best practices that will prevent patient harm by prioritizing early intervention before a physician is unsafe to practice. Too often, the Board first learns that a physician is unsafe to practice when a complaint has been filed or the physician has been arrested.

Licensees disciplined by the Board would still be subject to the Uniform Standards. AB 408 does not require voluntary participants to follow the Uniform Standards because experts informed the Board that such a requirement will prevent physicians from joining a PHWP voluntarily and getting help early. Those who enter the program voluntarily will not be able to hide their issues; instead, they will receive treatment and be monitored. If a participant fails to cooperate with the PHWP, or is unable to practice safely, they will be reported to the Board. The Board always retains authority to discipline program participants.

If the physician agrees to enter the program, the PHWP can act much more quickly than the Board to get the physician evaluated, obtain an agreement for the physician to stop practicing, if warranted, and to set up biological fluid testing, monitoring, and appropriate treatment.

**Claim**: AB 408 creates a secret program.

**Reality**: This legislation includes various reporting requirements and requires greater transparency than private treatment programs. Participants who withdraw, who are terminated prior to completion, who fail to cooperate with the PHWP, whose impairment is not substantially alleviated through treatment, or are unable to practice safely will be reported to the Board. As required by current law, non-voluntary participants are subject to the reporting requirements of the Uniform Standards.

The administering entity is required to provide regular communications and reports to the Board and participate in Board meetings. The administering entity will be subject to quality and compliance evaluations by an independent third party.

**Claim:** AB 408 violates the rights of physicians and forces them into a program that they don't want.

**Reality**: A physician who is contacted by the program is not required to participate and may choose whether to enter the program or not. The Board is already authorized to investigate a physician for possible impairment, and if their impairment can be proven by clear and convincing evidence, they may be ordered into treatment and monitoring. AB 408 does not change the due process rights available to physicians.

**Claim:** AB 408 recreates the Board's failed diversion program that allowed doctors under investigation because of substance abuse to avoid discipline by entering the program. These programs are not needed.

**Reality:** The prior program failed because it was underfunded and poorly managed. Under AB 408, the PHWP will be administered by a 501(c)(3) organization whose leadership has expertise treating health professionals, whereas the previous program was managed by board staff without the expertise required under this bill. Without this legislation, physicians experiencing an illness that could lead to impairment may have to seek help on their own from a private program that lacks the safeguards, expertise, and reporting requirements mandated in the PHWP.

The Board's only option now is to attempt to discipline physicians for their impairing condition, which can take years to complete at a five-to-six figure cost per case. Further, if the Board cannot obtain clear and convincing evidence that a violation has occurred, the Board cannot discipline a physician. During the 2022-2023 and 2023-2024 fiscal

years, the Board had 145 and 141 licensees, respectively, on probation related to a substance-abuse problem. Experts advise that these numbers are well below the number of physicians expected to be experiencing an impairing, or potentially impairing, health condition.

PHWPs have a track record of success. See the June 24, 2025, letter from the Federation of State Physician Health Programs for additional information.

FISCAL: No costs are mandated by AB 408, as the bill authorizes, but does not require establishing a PHWP. The costs to fund the contract with the administering entity are undetermined.

SUPPORT:
Amer. College of Obstetricians and Gynecologists, District IX/CA
California Academy of Child and Adolescent Psychiatry
California Dental Association
California Medical Association
California Orthopedic Association
California Public Protection & Physician Health
California Society of Addiction Medicine
California Society of Anesthesiologists
California Society of Dermatology and Dermatologic Surgery
California Society of Pathologists
Center for Professional Recovery
Dr. Lorna Breen Heroes' Foundation.
Dr. David Kan
Drug Policy Alliance
Federation of State Physician Health Programs
SEIU California
Physician Association of California
Psychiatric Physician Alliance of California
San Francisco Marin Medical Society
Union of American Physicians and Dentists

OPPOSITION:
Consumer Attorneys of California (unless amended)
Consumer Protection Policy Center, USD Law School Law
Consumer Watchdog
Disability in Medicine Mutual Mentorship Program
Disability Rights California

ATTACHMENT: AB 408, Berman – Physician Health and Wellness Program.
Version: 7/08/25 – Amended

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June 24, 2025



Senate Business, Professions and Economic Development Committee
Attn: Senator Angelique V. Ashby, Chair
1021 O. Street, Room 3320
Sacramento, CA 95814
**Re: Response to Comments Regarding AB 408**

Dear Senator Ashby,

FSPHP is writing in response to concerns and inaccuracies submitted regarding Physician Health Programs and Assembly Bill 408 (AB 408).

**Legal and Public Health Value of Physician Health Programs (PHPs)**
It is critical to emphasize that PHPs are not only a public health resource but also a legally recognized mechanism for balancing the rights of physicians with the imperative of patient safety. PHPs have been upheld in legal precedent as a therapeutic alternative to discipline, providing due process protections and ensuring compliance with federal disability law, including the ADA.

**Role of FSPHP**
The role of the Federation of State Physician Healthcare Programs ("FSPHP") is central to the national landscape of physician health and safety. FSPHP is a national membership association of Physician and Health Professional Programs ("PHPs") that supports these programs by providing education, published guidelines, and structured review to improve performance. FSPHP's mission is to support the improvement of all PHP services through education and guidance. FSPHP member programs are supported by organized medicine and have the authorization to accept referrals of healthcare professionals at risk of mental health disorders, including substance use disorders, instead of reporting to a medical board. This offers a confidential pathway that is often enabled by state legislation or memoranda of understanding and recognized within a legal framework as best practice for both public safety and provider rights. [1-13]

FSPHP has the unique opportunity to understand, observe, and appreciate the differences and similarities between programs. FSPHP bears witness to the successes of these programs. FSPHP also understands the systemic risks when such programs are unavailable—risks that can affect both provider well-being and patient safety.

**Stigma Has No Place in Disability Advocacy**
Certain comments on the proposed legislation have undermined providers in recovery. Some PHP leaders and staff are themselves in recovery, bringing empathy and deep insight to their work. Questioning the qualifications of healthcare providers based on recovery status serves only to perpetuate a damaging stigma. FSPHP and its member programs actively work to eliminate stigma. One opponent of the legislation referred to PHP leaders as "addicts in recovery," implying diminished qualifications due to past disciplinary histories.

Such language can be seen as inconsistent with principles of inclusion, dignity, and person-first advocacy. In fact, substantial evidence supports the value of lived experience in recovery leadership. For example, peer support mutual help models have been shown to be highly effective in supporting sustained recovery and improving outcomes.[14] Recovery enhances, not diminishes, leadership in PHPs.

**Physician Health Programs ("PHPs") Do NOT Discriminate – They Protect**

The perspective that PHPs discriminate overlooks the legal and practical intent of these programs. Programs established in compliance with the FSPHP guidelines:

- Do not authorize profiling based on diagnosis.
- Do not impose punitive or coercive treatment.
- Do not bypass due process or physician rights.

Instead, these programs:

- Focus on functional assessment of current impairment;
- Ensure voluntary participation in PHPs.
- Require referral based on observable fitness to practice, not labels—aligned with ADA principles and federal guidance.

**Physicians can decline participation in any PHP. They are free to seek a second opinion or work directly with the Board.** PHPs hold no disciplinary authority, and they serve as confidential, supportive resources, not punitive entities.

**The Risk of Inaction**

California remains one of just **three states without a fully operational PHP**. Forty-seven other states utilize PHPs as a core component of their public safety and physician wellness infrastructure—with **Nebraska and Wisconsin now well into development** of programs based on the very model AB 408 supports. **California is an outlier in its lack of a comprehensive, evidence-based PHP.** The legislation proposed in AB 408 is an opportunity to bring California in line with national best practices.

One commenter suggests that California does not need a PHP, based on historical and statistical data. However, this perspective may not account for the possibility that impaired providers are less likely to seek treatment in California due to the lack of a PHP. FSPHP guidelines encourage a triad of confidentiality to allow impaired providers to seek appropriate treatment without fear of stigma, prejudice, or retribution. Mental Health Disorders, including substance use disorders, are a nationwide problem, and one which does not respect state or territorial borders. The low probation numbers in California may well speak to a need for PHP services, and not to the opposite.

**Ensuring Safe Practice Under Disability Law**

No diagnosis – psychiatric, medical, or substance-related – should ever be a basis for restriction. That philosophy is written largely in the guidelines that FSPHP published in 2019. However, an active impairment that poses risks to patients or to the public is – and must be – a basis for practice restriction. The courts have consistently affirmed that patient safety takes precedence. PHP programs in compliance with FSPHP guidelines, like all responsible public health frameworks, aim to balance the rights of the participants with the duty to protect the public. The ability to differentiate illness from impairment is central to the PHP model and is one of its greatest strengths.[15] **This approach aligns with federal disability law, including the Americans with Disabilities Act (ADA), which protects individuals from discrimination but allows for safety-based restrictions when functional impairment exists.**

**A Record of Success and Oversight**

PHPs operate under clear guidelines, national standards, and regular oversight. These standards are supported by organizations such as the American Medical Association, the American Psychiatric Association, the Accreditation Council for Graduate Medical Education, the American Board of Medical Specialties, and the American Society of Addiction Medicine (ASAM). While continuous improvement is essential, PHPs have a proven track record of helping physicians safely maintain licensure, avoid relapse, and return to safe, compassionate practice. These national organizations have policies that support the core principles of the PHP model, including enabling legislation for a therapeutic alternative to discipline and providing confidential support outside the workplace and separate from the medical board.

PHPs have extensive expertise in monitoring and managing safety-sensitive professionals, including physicians who have recovered from a substance use disorder.[16-21] Studies that review the long-term model of PHPs confirm that physician recovery rates are markedly higher than the general population, even when extended into 5 years or more.[22-23] One study reports that malpractice risk for those who complete a PHP is lower than for physicians practicing medicine who have never been followed by PHP monitoring. [24]

Data indicate that a variety of factors contribute to the highly effective PHP disease management process. A national study with collated data from 16 PHPs across the United States outlined the unique model of peer support provided to physicians with potentially impairing conditions. Collecting 904 sequential admissions to these same programs and following them over five or more years resulted in 81% of participants having zero positive drug screens. Of those who completed monitoring, 95% had a license and worked as physicians.

Single state results reflect similar statistics with positive outcomes. For example, a retrospective cohort study of 292 health care professionals enrolled in the Washington PHP noted that 25% of participants had at least one relapse, 5% had two relapses, and 3% had three or more relapses during the five-year period.[25] Each relapse was managed within the PHP, balancing compassionate responses with public safety.

Additional studies support the efficacy of the systematic monitoring provided by PHPs.[26-28] Although the studies are more limited, similar outcome data suggest that physicians with mental and behavioral health conditions can be successfully monitored in a similar fashion as physicians with substance use disorders—and with similarly positive outcomes.[28] The attitude of participants in PHPs is well studied. In a study of the Massachusetts PHP, Knight et al. reported that total satisfaction, as measured by the percentage of the highest possible total score, was high (median score 83%).[29] In 2017, the NCPHP provided services to 225 physicians; of these, 54 (24%) were self-referrals. An exit survey conducted by the NCPHP showed that 90.5% of physicians who had participated in NCPHP and received services for substance-related issues (66.67%), workplace stress (28.6%), and anxiety (28.6%) reported “feeling better off” than when they first presented for services.[30]

**The Dual Responsibility of Physician Health and Patient Safety**

The PHP process is designed to navigate illness and unsafe practice (i.e., impairment) while protecting patient safety. PHPs rely on referrals to specialized evaluation and treatment centers experienced in working with safety-sensitive professionals.

This is particularly important because physicians, by virtue of their roles, are safety-sensitive professionals whose impairment can have significant consequences for patient care. As highlighted in the ASAM Criteria,

effective support and monitoring for individuals in safety-sensitive occupations—such as physicians—require specialized expertise and protocols tailored to the unique demands and risks of their professions.[31]

PHPs reduce the overall risk to the public by:

1. **Enabling Early, Effective Intervention:** They facilitate early self-reporting and support, which reduces the risk of impairment-related harm. Without PHPs, physicians may avoid seeking help, increasing patient risk.
2. **Learning from past missteps:** The failures in California's former PHP program were structural, not conceptual. California's earlier diversion program faltered due to its structure, chronic underfunding, and staffing shortages, not flaws in the PHP model.
3. **Using Robust and Independent Oversight:** Programs follow national standards, respond immediately to signs of impairment, and do not allow unsafe practice to continue. New this year, FSPHP has introduced a Performance Enhancement Effective Review Program™ for all PHPs to participate in a structured review designed to identify opportunities to optimize performance in alignment with best practices. https://www.fsphp.org/peer-program.
4. **Providing Much Needed PHP Expertise:** Regulatory bodies lack the specialized support and structure needed to safely monitor impairment cases. Without a PHP, those at risk of impairment may go undetected while their illness progresses. In CA, the hospital Physician Wellness Committees have created their in-house sources of support, which are well-intended, and serve a useful purpose but carry the downside of privacy, and inconsistent approach across systems when a healthcare professional seeks care inside of their workplace. PHPs fill this gap effectively.
5. **Encouraging participation:** Punitive models deter physicians from seeking help. Overly harsh approaches reduce physician willingness to seek support, increasing risks to patients. The PHP model effectively balances patient safety with participant confidentiality, allowing more providers to seek help sooner. Every provider who seeks help through a PHP provides direct benefits to thousands of patients, who might otherwise be relying on an impaired provider for their own healthcare.

**The ABA's Model Rule Supports Monitoring Frameworks**

The American Bar Association's Model Rule on Conditional Admission to the Practice of Law offers a strong parallel to the PHP approach. Though it applies to law, its principles are consistent with the goals of AB 408:

- **Rehabilitation Focus:** Conditional admission supports those with past conduct risks who demonstrate rehabilitation.
- **Tailored Conditions:** Requirements must be narrowly tailored, time-limited, and professionally recommended.
- **Confidentiality Protections:** The rule ensures the privacy of medical information.
- **Compliance Oversight:** A designated authority monitors compliance, allowing professionals to work safely.

This model illustrates how a properly structured monitoring program—whether in law or medicine—can promote both public protection and ADA compliance.

**Uniform Standards**

Section 2341 (b) exempts the new program from imposing Uniform Standards whereas section (C) imposes them for terms of probation. This is problematic. California should allow the new program to operate under the guidelines of the new legislation, eliminating the outdated Uniform Standards for participants of the program. The Uniform Standards are misaligned with both AB 408 and current best practices in physician health. The Uniform Standards, as they exist, are outdated, contradictory, and difficult to implement. Worse,

these standards are even punitive. These factors combine to discourage participation and they undermine the effectiveness of the programs. By replacing these with a single set of best practices, California can ensure consistency, clarity, and accountability in case management, making the programs more accessible and effective for participants while maintaining public protection.

**Evidence, Not Fear**

Policy decisions, especially in regards to healthcare, must be guided by evidence—not by fear, and not by stigma. The Washington PHP ("WPHP"), like most PHPs, serves all impairing conditions, not just substance use disorders. The number of professionals served by WPHP was misstated; 408 professionals were served in 2024. More importantly, with an estimated 1% impairment rate, the WPHP serves approximately 70-90% of the overall need. This speaks to the importance of PHP availability: Like a fire or police department, the PHP stands ready to help when the need arises, and the readiness is critically important regardless of call volume.

**Conclusion**

FSPHP is the organization tasked with providing guidance and best practices to member PHP organizations. While those member organizations are diverse and multifaceted, certain common themes are important to consider as California decides whether to initiate another PHP for its providers:

- Referrals are based on observed impairment, not diagnostic assumptions.
- Disability and impairment are distinct: impairment is the relevant factor for patient safety.
- The legal system supports intervention when safety is at stake.
- PHPs are voluntary, and no physician is compelled to participate without recourse.

All the principles stated here are supported by the PHP model which is based on FSPHP PHP Published Guidelines established through a robust consensus process.

PHPs are structured to provide legal protections that prevent discrimination against providers in recovery by focusing on impairment (not diagnosis), ensuring confidentiality, offering voluntary participation, and complying with federal disability laws. These safeguards promote both patient safety and provider rights, fostering an environment where physicians can seek help without fear of unjust consequence.

Should California make the decision to embark on a new PHP, as contemplated in AB 408, FSPHP stands ready to educate and guide the new program. We welcome dialogue about how best to support physicians with disabilities and health concerns, and urge California to focus on the compelling evidence and the long, successful history of effective, lifesaving care provided by PHPs as the best approach to ensuring patient safety.

Respectfully,

Michael Baron, MD, MPH, DFASAM, FAPA,
FSPHP President
Medical Director, Tennessee Medical Foundation Physician's Health Program
*Board certified in Anesthesiology, Psychiatry, and Addiction Medicine*

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**Wilmington, MA 01887**
**Website: www.fsphp.org**

**References**


1. American Medical Association (AMA). (n.d.). https://www.fsphp.org/assets/docs/ama_physicians_health_programs_act_-_2016.pdf
2. Federation of State Medical Boards (FSMB). (2020). Policy on Physician Impairment and Physician Health Programs.
3. Federation of State Physician Health Programs (FSPHP). (n.d.). Guidelines and Best Practices for PHPs.
   A few state specific examples – there are many more:
4. Washington Mandatory Reporting- How and When to Report; https://app.leg.wa.gov/wac/default.aspx?cite=246-16-220 , Immunity from liability https://app.leg.wa.gov/RCW/default.aspx?cite=18.130.070 ; PHP Record Protection - https://app.leg.wa.gov/rcw/default.aspx?cite=18.130.175 ( .
5. Massachusetts General Laws, Chapter 112, Section 5F. (n.d.). Exemptions from Mandatory Reporting for Physicians in Approved Programs. ; https://www.massmed.org/Physician_Health_Services/Education_and_Resources/Exception_to_Mandatory_Reports_-_PHS/
6. MA PHS PEER Review protection (defined at MGL Ch. 111, s. 1 “Medical Peer Review Committee” and protections set forth at MGL Ch. 111, s. 204) https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXVI/Chapter111/Section1 https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXVI/Chapter111/Section204
7. The Alabama Medical Board authorization of the Alabama Physician Health Program - https://admincode.legislature.state.al.us/administrative-code/540-X-13 ; PHP Immunity - Section 34-24-403 Liability for Actions Within Scope of Committee Functions.
8. Florida: 456.076 Impaired practitioner programs.— To encourage practitioners who are or may be impaired to voluntarily self-refer to a consultant, the consultant may not provide information to the department relating to a self-referring participant if the consultant has no knowledge of a pending department investigation, complaint, or disciplinary action against the participant and if the participant is in compliance and making progress with the terms of the impaired practitioner program and contract, unless authorized by the participant.
9. Indiana: 844 IAC 5-2-8
   (b) A practitioner who voluntarily submits himself/herself to, or is otherwise undergoing a course of, treatment for addiction, severe dependency upon alcohol or other drugs or controlled substances, or for psychiatric impairment, where such treatment is sponsored or supervised by an impaired physicians' committee of a state, regional, or local organization of professional health care providers, or where such treatment is sponsored or supervised by an impaired physicians' committee of a hospital, shall be exempt from reporting to a peer review committee as set forth in subsection (a) or to the medical licensing board for so long as:
   I. the practitioner is complying with the course of treatment; and
   II. the practitioner is making satisfactory progress.
10. Ohio Confidential Monitoring Program https://codes.ohio.gov/ohio-revised-code/section-4731.25
11. South Dakota: 36-2A-6. Application to program--Admission evaluation.

b. An applicant that meets admission criteria shall be allowed access to the program by self-referral, board referral, or referral from another person or agency.

12. The TMF-PHP is intended to be a "Quality Improvement Committee" as defined in T.C.A. § 63-1-150 and T.C.A. § 68-11-272. Any and all actions of the TMF and the TMF-PHP are intended to come within the provisions and protections of T.C.A. § 63-1-150 and T.C.A. § 68-11-272 as contemplated in these statutes.
13. West Virginia - https://code.wvlegislature.gov/pdf/30-3D-2/
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