Resource Document on Physician Health Programs in the Treatment of Substance Use Disorders in Physicians

The findings, opinions, and conclusions of this report do not necessarily represent the views of the officers, trustees, or all members of the American Psychiatric Association. The views expressed are those of the authors.

In 1974, the American Medical Association (AMA) acknowledged physician impairment from alcoholism and drug dependence occurs, and recognized alcoholism and addiction as illnesses. Physician illness and impairment exist on a continuum with illness typically predating impairment, often by many years. This is a critically important distinction. Illness is the existence of a disease. Impairment is a functional classification and implies the inability of the person affected by disease to perform specific activities.

The treatment of physicians and other licensed healthcare professionals occurs with the knowledge that substance use disorders, mental health conditions, or other medical diseases and other potentially impairing conditions can be chronic, relapsing disorders; and without appropriate treatment and ongoing support, individual health and public safety may be at risk.

With this in mind and with the advice and consent of the AMA and the Federation of State Medical Boards (FSMB), plans were launched for the development of therapeutic alternatives in lieu of automatic discipline of physicians who needed assistance. By 1980, many state licensing boards and state laws supported the establishment of state-based Physicians Health Programs (PHPs). In 1985, the AMA published its Model Impaired Physician Treatment Act, and in the 1990s the FSMB had also issued its own model guidelines. Currently, 46 States, in addition to Washington D.C., have PHPs. The States not listed include California, Delaware, Wisconsin and Nebraska (although in 2016 the Governor of California signed legislation reinstituting their PHP).

PHPs are a confidential resource for physicians, other licensed healthcare professionals, or those in training suffering from addictive, psychiatric, medical, behavioral or other potentially impairing conditions. PHPs coordinate effective detection, evaluation, treatment, and continuing care monitoring of physicians with these conditions. This coordination and documentation of a participant's progress allows PHPs to provide documentation verifying a participant's compliance with treatment and/or continuing care recommendations. In 1990 the professional, educational and nonprofit corporation Federation of State Physician Health Programs (FSPHP) was established to provide consistent and objective guidance and advocacy for state PHPs and currently has a membership of 47 state PHPs.

Recommendations:

1. The diagnosis and treatment of substance use disorders is an essential part of medical and psychiatric care of physicians. Physician

patients with identified substance use disorders must be educated about the condition and offered or referred for appropriate treatment. Physician patients should be educated about the presence and value of evaluation and treatment referrals offered through PHPs.

2. Psychiatrists and other involved healthcare providers should screen for substance use and co-occurring psychiatric disorders in physicians and encourage the development of integrated treatment strategies.

3. Careful attention must be given to evaluating psychosocial stressors that may contribute to increased risk of substance use disorder in physicians (e.g., retirement, financial stressors, loneliness, medical problems, etc.).

4. Physicians must recognize that colleagues may be more vulnerable to developing substance use disorders due to their professional proximity to often misused substances (opioids, sedatives) and the unique stresses incumbent upon physicians by virtue of being care providers. Assessment of these risk factors should be considered routinely in management of physician patients, particularly when considering prescribing controlled substances or when managing substance use disorders.

5. The goal of a PHP should be the rehabilitation of physicians with substance use disorders in a non-disciplinary, non-discriminatory, peer-based therapeutic program environment. The care provided should be confidential, evidence-based, and provided by well-trained and competent clinicians, appropriate to the level of impairment.

6. PHP participant fees should be fair and equitable with full disclosure at intake.

7. PHP enrollment may be mandated by a medical board, physician employer, or voluntary. Efforts to destigmatize substance use disorders and their treatment in physicians should be supported to increase voluntary participation in PHPs.

8. When referring physicians, PHPs must have a comprehensive range of available substance use services, including medication assisted treatment, evidence-based psychotherapies for addictions (e.g., motivational enhancement, relapse prevention, cognitive behavioral therapy, twelve step facilitation, group based treatments), self-help groups (e.g., alcoholics anonymous, narcotics anonymous, SMART), medical detoxification, intensive outpatient and partial hospitalization programming and residential treatment—all based on well-established clinical referral parameters (e.g., The American Society of Addiction Medicine Placement Criteria, SAMHSA Tip 45: Detoxification and Substance Abuse Treatment). Referrals should not be onerous and should be in accord with standard clinical practice guidelines, such as VA/DoD Clinical Practice Guidelines: Management of Substance Use Disorders.[1] Recommendations regarding unique physician-specific needs in substance use treatment should continually be adjusted in light of an ever-evolving evidence-base. Treatment should not be influenced by the perceived or actual financial status of the referred physician. Because of the potential for conflicts of interest, a mechanism for routine transparent either internal or external auditing or review of the relationship between state PHPs and the treatment programs they recommend should be established. Programs should also provide concurrent assessment and treatment referrals for co-occurring psychiatric disorders.

9. The full range of evidenced-based medication assisted treatment options for substance disorders should be incorporated into evaluation and treatment planning. (Including, but not limited to, consideration of (and ability to prescribe or refer for) buprenorphine, methadone, naltrexone, acamprosate, disulfiram, nicotine agonists, varenicline, and bupropion.)

10. Treatment referral processes should be transparent to the physician client, and a formal second opinion

[1] See: http://www.healthquality.va.gov/guidelines/MH/sud/

process should be available.

11. Cognizant of the need to preserve the integrity of the profession and protect public safety (including those patients being treated by physicians who are receiving treatment through a PHP), appropriately confidential and intensive mechanisms for monitoring of physician enrollees in PHPs is imperative, with well described and transparent processes for determining the need for professional sanction should concerns about a physician's clinical status arise.

12. Training at the level of medical school, residency and fellowship must be provided to develop competency in the diagnosis, treatment, and prevention of substance use disorders in physicians.

13. More research is needed on the unique evaluation and treatment needs of physicians with substance use disorders and co-occurring psychiatric disorders, as well as research to better identify those antecedents that may predispose a physician to developing a substance use disorder in the first place.

14. Individual physician training program Graduate Medical Education (GME) offices should avail themselves of collaboration with local state PHPs to ensure effective, equitable and evidenced-based treatment of physicians-in-training with SUDs or mental health concerns.

15. Public policy efforts should help:

- Reduce the stigma of substance use disorders and substance use disorder treatment, to best optimize voluntary participation in PHPs;
- PHPs develop formal discussions and ultimately guidelines for addressing possible financial or other real or perceived conflicts of interest between the various stakeholders involved;
- Reduce legal, contractual, or regulatory requirements that impede state PHPs from implementing all FSPHP guidelines;
- Facilitate insurance coverage of PHP services;
- Streamline referral processes for enrolling physicians in PHPs, as well as standardize evaluation/treatment/appeals processes within PHPs;
- Ensure confidentiality and appropriate monitoring parameters for physicians enrolled in PHPs, with procedures and processes for managing those whose clinical status poses concerns for their ability to execute the duties of their profession, or threatens the integrity of the profession;
- Educate medical students, residents, fellows, and physicians regarding the occurrence of substance use disorders among physicians and the avenues for engaging in effective, confidential, evidence-based treatments through PHPs;
- Inform and develop effective strategies for educating the public regarding the presence of PHPs and their functioning, acknowledging the complexity of on one hand advocating for the work done in PHPs, and on the other hand managing concerns about public safety (including those patients being treated by physicians who are receiving treatment through a PHP)