

Physician Health Programs: A Model for Treating Substance Use Disorders

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Substance use disorders (SUDs) impact individuals and families from every socioeconomic status, racial/ethnic background, and level of education in every community across the United States. At a time when our nation faces a public health crisis—with overdose now the leading cause of death for Americans under age 50¹—there is an urgent push to identify and fund the most effective ways to treat and manage the disease of addiction. Opioid addiction, in particular, is ravaging communities. The effects of untreated opioid use disorders will have negative impacts for generations due to increased medical morbidities, premature deaths, diminished workforce, impaired parenting, economic strain, and increased burden on public servants and first responders.

The medical community is a necessary part of the solution to the opioid epidemic. Yet, physicians themselves are not immune to addiction. In fact, the rate of substance use disorders for physicians is similar to or exceeds that of the general population, and the heightened risk for opioid use disorders was apparent among physicians long before it spread among the general public over the past decade. Physicians' vulnerability to addiction is hypothesized to result from a number of factors, including their high-stress careers, personality factors (e.g., independence and difficulty seeking help from others), increased access and exposure to addictive drugs, tendency to self-medicate, and ability to successfully hide the symptoms and effects of their substance use, among others. Due to the safety-sensitive nature of their work, it is imperative that physicians suffering from SUDs are promptly identified and adequately treated.

Unlike the "standard of care" for individuals with SUDs in the general population, physicians and health care professionals with SUDs typically enter a comprehensive system of care management that produces the best long-term outcomes for these chronic, commonly fatal disorders. These programs are intended to protect patient safety and public health by ensuring an adequate dose of treatment and monitoring to prevent relapse. As a result, the state physician health programs (PHPs) serve as a model for how SUDs, including opioid use disorders, can be effectively managed routinely to produce long-term recovery. This model can also be applied to the criminal justice system, which already implements similar strategies.

The PHP System of Care Management

Physician health programs are resources for physicians, other health care professionals, and those in medical training who suffer from potentially impairing conditions, ranging from SUDs to a wide range of medical, behavioral, and psychiatric problems. The Federation of State Physician Health Programs concisely summarizes the role of the PHPs as coordinating the "effective detection, evaluation, treatment, and continuing care monitoring of physicians with these conditions."²

Physicians identified as having SUDs are referred to their state PHP to facilitate formal evaluation and assessment of treatment needs. Referrals may come from colleagues, medical boards, medical staff, medical schools, family members, or self-referrals. In working with physicians suffering from SUDs,

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the goals of the PHPs are to help the physician achieve long-term recovery, maintain his or her medical career, protect the public, and maintain patient confidence in their health care providers.

Many physicians referred to PHPs for SUDs face serious consequences of their substance use and related behaviors, including potential loss of their job or medical license. As a result, the PHPs often serve as diversion programs, providing opportunities for physicians to avoid these consequences through adherence to a comprehensive plan of care. Although participation in PHP care is voluntary, failure to adhere to the PHP contract obligations typically results in adverse actions by the Board of Medicine, hospital, insurance company, or family member(s) who referred them to the PHP and/or withheld consequences as a result of PHP participation.

A national study of PHPs outlined the care provided to physicians with SUDs who participate in a PHP. Following evaluation, physicians are referred to the appropriate level of SUD treatment, typically in a program with expertise in treating health care professionals with SUDs. Indeed, 69 percent of physicians undergo residential care for 30 to 90 days, and 31 percent receive intensive outpatient treatment. Following successful completion of their formal treatment, the physician signs a monitoring contract with the PHP.³ Participants are typically required to participate in the program for a period of five years, with consequences for noncompliance with the PHP's recommendations (ranging from reevaluation to additional treatment and possible reporting to the state licensing board). The PHPs oversee continued participation in professional and mutual-help care, which may include participation in psychotherapy, psychiatric care, and active participation in the 12-step fellowships of Alcoholics Anonymous and Narcotics Anonymous or other self-help recovery support groups. Participation in Caduceus meetings, which are specifically for physicians in recovery from SUDs, and monitoring groups facilitated by the PHPs also may be recommended. Most PHPs also require worksite monitors, who serve as neutral parties that report on the physician's behavior and work performance to the PHP.

Importantly, throughout the five-year contract, physicians are monitored closely for any alcohol and drug use through frequent, random drug and alcohol testing using an extensive drug testing panel. Physicians call a designated number or sign in to an online program every day to learn if they must submit to a drug test that day. The daily chance of being randomly drug tested is an important deterrent for participants, particularly in the early days of their sobriety.

Various levels of "relapse" or noncompliance range from missing appointments to dishonesty to return to drug or alcohol use, all of which result in prompt intervention by the PHPs to reengage physicians, evaluate the need for more intensive treatment and/or drug testing, and assess the need for reporting to state medical boards. A single missed test or positive test for alcohol or drug use is considered a serious violation and may lead to removal from medical practice for more intensive treatment.

PHP Outcome Studies

A national chart review of physicians from 16 PHPs showed that 64 percent of physicians completed their five-year contract without incident, 17 percent extended their contracts beyond the initial monitoring period (either voluntarily or due to PHP requirements), and 19 percent failed to complete the contract.⁴ At five-year follow-up, 78 percent of physicians were licensed and working, 11 percent had their licenses revoked, 4 percent had retired, 4 percent had died, and 3 percent had unknown status.

Perhaps most remarkably, over the course of five years of monitoring, 78 percent of physicians never had a single positive test for drugs or alcohol.⁵ Of the 22 percent of physicians who relapsed to alcohol or drugs, two-thirds had only a single positive drug test.

This national blueprint study of PHPs remains the largest PHP study to date. Subsequent analyses of these study data have shown that the impressive long-term outcomes are consistent among varying medical specialties including surgery, psychiatry, and emergency medicine and, notably, that outcomes are consistent among primary substances of abuse. No differences were found among physicians with opioid use disorders compared to their peers with alcohol or other SUDs, despite the fact that all participated in abstinence-based psychosocial treatment and opioid substitution therapy (e.g., methadone or buprenorphine) was not used.⁶

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Two unresolved questions from this large national study remained: (1) Do the impressive recovery rates persist after the mandatory monitoring period by the PHP has ended? and (2) What do the successful participants view as the essential components of PHP care in helping them achieve recovery? To explore these questions, an anonymous self-report survey was conducted among physicians who successfully completed SUD contracts with a PHP five or more years ago. Eight PHPs participated in this unfunded project. They successfully contacted 42 percent of eligible physicians, and 89 percent of those contacted agreed to participate.⁷

Survey participants rated elements of PHP care on a scale from “extremely helpful” to “extremely unhelpful.” Attending 12-step meetings was selected as the single most valuable component of PHP care by 35 percent of participants. Ranking next were participation in formal SUD treatment (26 percent) and random drug and alcohol testing (16 percent). When asked to rank the least valuable component of PHP care, 33 percent said all components were valuable. Observation by a worksite monitor was viewed as least valuable by 23 percent and Caduceus self-help meetings by 16 percent.

Five or more years *after* successful completion of a five-year SUD monitoring contract, 96 percent of participants were licensed to practice (none reported lack of licensure was related to substance use), and 91 percent were currently practicing medicine. Thirty-eight percent of participants voluntarily extended their monitoring at some point, and 20 percent reported currently being voluntarily monitored by a PHP.

The vast majority (89 percent) of participants reported completing the SUD contract without any relapse during monitoring, and about 10 percent reported only one relapse. Since SUD contract completion, 79 percent of participants reported no use of alcohol, 18 percent reported at least one occasion of alcohol use, and 3 percent declined to answer. A total of 95 percent reported no illicit or nonmedical use of drugs, 5 percent reported at least one occasion of drug use, and 1 percent declined to answer. Perhaps most encouraging is the fact that 96 percent reported they considered themselves to be “in recovery” at the time of the study.

Given the high ranking of 12-step meetings in contributing to their successful recovery, it was not surprising that use of recovery support since SUD contract completion was high. Eighty-eight percent of participants reported 12-step attendance after contract completion, and 69 percent reported past-year attendance.

Overall, the estimated personal cost of participating in the PHPs was \$250–321,000. The large majority—85 percent—of participants reported this was “money well spent.”

These outcomes, while encouraging, require more extensive follow-up studies of physicians, both while they are in PHP care and following successful SUD contract completion. The limitations of this first-ever follow-up study include the small sample that relied on self-reported data and the missing data from past participants who could not be located. The strengths of the study include its long-term scope, generalizability in terms of collecting data from several states with different programs, a good response rate (particularly for a physician sample), and the fact that 95 percent of participants reported that they were “completely honest” and 5 percent “mostly honest” in their answers to the survey.

Lessons Learned from PHP Care Management

The PHP system of care management and the outstanding recovery rates are somewhat unique in the realm of SUD treatment and care. Similar programs exist for commercial pilots and attorneys, which also display high rates of success, but these programs stand in stark contrast to the typical care provided to patients with SUDs in the general population. It has been argued that physicians are unrepresentative of the addicted population and that their treatment success results from personal factors such as high intelligence, financial resources, and family support. However, the data show that physicians with SUDs who receive treatment and care outside the PHP care management model have far less successful outcomes, similar to those seen among the general public.

It is important to recognize that one of the most fundamental problems inherent to treating addiction is that the vast majority (95 percent) of individuals diagnosed with an SUD do not perceive that they

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have a health problem, and most who do recognize the problem do not seek treatment.⁸ It is no surprise that general treatment outcomes are poor, with only about 40 percent of those admitted to treatment actually completing treatment and nearly half experiencing a relapse shortly after discharge. These disappointing treatment outcomes underscore the importance of the comprehensive approach to adequate treatment and aftercare that are inherent to the PHP care management system. The PHP uses its leverage as a diversion program to help individuals with SUDs enter and benefit from treatment in order to reliably achieve long-term recovery. Most physicians do not enter the PHP with enthusiasm. Rather, they often do it begrudgingly, as a way to avoid the serious adverse consequences they would otherwise face.

Three missing elements from SUD treatment that are emphasized in the PHP model of care management are (1) the clear goal of long-term recovery, (2) sustained monitoring and continued recovery support, and (3) insistence by those around the individual of sustained abstinence.⁹

There is a larger health context for the lessons of the PHP experience. In November 2016, in the midst of the national epidemic of drug overdose deaths, the landmark report *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health* was released. This report documented that treatment for SUDs is largely conducted in silos of specialty care that are disconnected from mainstream health care. Further, it documented that current SUD treatments, including the most intensive forms, are relatively brief, particularly considering that the disease of addiction is chronic and often life-long. This is a tragic mismatch. The surgeon general's report called for the full integration of SUD treatment into mainstream health care, from prevention to disease identification, intervention, treatment, and long-term monitoring to prevent/manage relapse. This new vision includes the integration of specialty addiction care providers into the full continuum of care, similar to the treatment of other serious chronic illnesses like diabetes and heart disease.

The PHP model of care management sets the standard for patients with SUDs by making sustained recovery the expected outcome of treatment. But it also does more; the PHP experience lights the path to an improved health future for all individuals diagnosed with SUDs. The PHPs do not themselves provide any treatment or drug testing. Instead, the PHPs manage the care provided by other health care practitioners, including specialty addiction treatment and long-term random drug testing. PHP care management also includes treatment and monitoring for other health needs such as comorbid physical health and mental health disorders.

PHPs are distinctive in that they may help physicians avoid the potential for serious professional and/or legal consequences of their SUD. For many physicians, this is a strong motivator that encourages them to enter SUD treatment. However, this model of care also has direct application within the criminal justice system, where the prospect of legal consequences can be used as leverage to promote treatment participation and recovery. A number of innovative criminal justice programs implement similar strategies as the PHPs, including frequent random drug and alcohol testing, the provision of immediate intervention in response to relapse and other program noncompliance, and linking of participants to long-term recovery support.¹⁰ These innovations (e.g., drug courts, HOPE probation, and 24/7 Sobriety) are part of what has been termed the "New Paradigm" for long-term recovery for high-risk drug and alcohol users.¹¹ They have demonstrated success in using the leverage of the criminal justice system to reduce drug and alcohol use, recidivism, and incarceration.

The Future of Addiction Care

A brighter, more ambitious, and more comprehensive future for the American health care system in combatting the epidemic of opioid addiction and other SUDs will not be quickly or easily achieved. But, thanks to the PHP experience over the past four decades, the template for the future of addiction treatment and management is now clear. In the context of the current, unprecedented, and bipartisan commitment to confront the national public health emergency of drug overdose deaths, the opportunity is now.

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