

Ethical and Managerial Considerations Regarding State Physician Health Programs

J. Wesley Boyd, MD, PhD and John R. Knight, MD

Many physicians are referred to state physician health programs (PHPs) for evaluation, monitoring, and treatment of mental health and substance use disorders. Most PHPs are “diversion” or “safe haven” programs, meaning that physicians who suffer from alcohol or drug problems can have their case diverted to the PHP in lieu of being reported to the state licensing board. If the physician agrees to cooperate with the PHP and adhere to any recommendations it might make, the physician can avoid disciplinary action and remain in practice. These programs are therefore quite powerful and yet, to our knowledge, there has not been any systematic scrutiny of the ethical and management issues that arise in standard PHP practice. Given our 20 years of service as associate directors of one state PHP we analyze and evaluate the standard operating procedure of many PHPs and offer ethical critique as well as suggestions for improvement.

Key Words: physician health, physician health program, impaired physician, medical ethics, conflict of interest

(J Addict Med 2012;6: 243–246)

Approximately 10% to 12% of physicians will develop substance use disorders (Flaherty & Richman, 1993) at one point over the course of their lives. Either voluntarily or otherwise, physicians with substance use disorders often seek the assistance of a physician health program (PHP). A small handful of states do not have PHPs, and physicians in those states presumably find other avenues for assistance. Physician health programs meet with, assess, and monitor physicians who have been referred to them for substance use or other mental and behavioral health problems. When a PHP determines that a physician could benefit from having his treatment and well-being monitored, it offers a monitoring contract that mandates random drug testing and alcoholics anonymous attendance (for those with substance use disorders), regular appointments with medical and psychiatric caregivers, periodic meetings with a PHP associate, and other specific provisions. A detailed

description of standard PHP practices is available elsewhere (DuPont et al., 2009b). Physician health programs then report the results of compliance including drug test results to licensing boards, credentialing agencies, employers, and others who need to know that the physician is sober, compliant with treatment, and capable of practicing medicine safely.

Physician health programs have evolved over the last several decades from often-humble origins in which physicians, some with substance use histories themselves, volunteered their time to reach out to other physicians who were in need. From these roots, PHPs have evolved into incorporated agencies that have formalized agreements with their state licensing boards specifying the exact content of their monitoring agreements and how noncompliance is handled. A handful of PHPs are themselves subsidiaries of state licensing boards, some are run out of state medical societies, whereas the majority are independent entities. They are funded through a variety of means, including grants from state licensing boards, fees charged to participants, contributions from their state medical association, or a “per capita” assessment from malpractice insurers. Staffing at PHPs usually includes a director (who may or may not be a physician) and associate directors or case managers, and a program manager and other administrative support staff. Some PHPs are large enough to have a development officer and/or a staff attorney.

Many PHPs are “diversion” or “safe haven” programs, meaning that physicians who suffer from alcohol or drug problems can have their case diverted to the PHP in lieu of being reported to the state licensing board. Some states such as Massachusetts allow for this kind of “diversion” only when there have been no allegations of patient harm and no laws have been broken. Some states also require physicians to acknowledge that they are in a PHP when they renew their licenses. Nonetheless, when a physician agrees to cooperate with the PHP and adhere to any recommendations it might make, it decreases the probability that the physician will be subject to disciplinary action and increases the likelihood that he will be able to remain in practice.

Although some physicians enter PHPs on their own, many are compelled to do so by their hospitals or medical groups. Still others are referred by the state licensing board and instructed to comply with any PHP recommendations or else face disciplinary action. Thus, for most physicians, participation in a PHP evaluation is coercive, and once a PHP recommends monitoring, physicians have little choice but to cooperate with any and all recommendations if they wish to continue practicing medicine (DuPont et al., 2009a).

From the Department of Psychiatry, Harvard Medical School and Cambridge Health Alliance, and Boston Children’s Hospital (JWB), Cambridge, MA; and Department of Pediatrics, Harvard Medical School, Boston Children’s Hospital (JRK), Boston, MA.

Received for publication July 7, 2011; accepted June 3, 2012.

Send correspondence and reprint requests to J. Wesley Boyd, MD, PhD, 1493 Cambridge Street, Cambridge, MA 02139. E-mail: jwboyd@cha.harvard.edu.

The authors declare no conflict of interest.

Copyright © 2012 American Society of Addiction Medicine

ISSN: 1932-0620/12/0604-0243

DOI: 10.1097/ADM.0b013e318262ab09

Contracting physicians are not the only ones who might feel coerced to comply with PHP recommendations. The same may very well apply to chief medical officers, department chairs, or any other individual who refers a physician to a PHP. No matter how "soft" the referral might have been from the perspective of the referrer, once the PHP meets with the physician and returns a list of formal recommendations, the referring entity might be on shaky ground legally if it does not mandate full compliance with the PHP recommendations.

Despite their coercive nature, PHPs are among the most effective modalities for treating addictions, a fact that many believe justifies coercion (Nace et al., 2007; Sullivan et al., 2008). Just how successful are they? Abstinence rates among substance abusing physicians who engage with PHPs are in the 75% to 80% range, far higher than almost any other form of substance abuse treatment (McLellan et al., 2008). The effectiveness of PHPs in dealing with mental health disorders is still being established, but early evidence suggests a similar high degree of effectiveness (Knight et al., 2007).

The high success rate of these programs is likely multifactorial. First, the structured nature of the treatment and monitoring programs is, no doubt, partly responsible for their effectiveness. The physician clients of these programs are demographically different from most who enter rehabilitation programs: tending to be better educated, more professionally accomplished, and of a higher socioeconomic status, differences that might also contribute to the high rates of recovery among physicians. Furthermore, for physicians, the rewards of maintaining sobriety and the costs of relapse are often quite high, a fact that likely further contributes to the successful nature of PHP involvement. Although these various factors likely play a role in PHP success rates, at present there is insufficient evidence to speculate about the exact contribution of each.

Physician health programs' high success rates notwithstanding, impressive results do not obviate the need for scrutiny. Although there have been a number of descriptions of PHP configuration, standard practice, success rates, and variability among different state programs (Brooks et al., 2012; Knight et al., 2002, 2007; McLellan et al., 2008; DuPont et al., 2009a, 2009b) to our knowledge, there has not yet been any systemic analysis of the ethical and management issues that arise in standard PHP practice.

Collectively, the authors of this commentary have more than 20 years of experience as associate directors of a PHP, which included working with many other state programs (to arrange interstate transfers or joint monitoring of clients), and through our teaching, research, and national professional society activities, we have reviewed the extent scientific literature and networked with PHP leaders throughout the United States. We believe that because of the power of PHPs over physicians and the coerced nature of their services, such an examination is both warranted and overdue.

CONFLICT OF INTEREST IN REFERRALS FOR EVALUATION AND TREATMENT

Some PHPs perform their own evaluations of physicians and only refer the most complicated cases out for external

review. Other PHPs refer every physician who enters their program for an initial evaluation. Also, if a physician who is being monitored tests positive for a substance of abuse, is known to have relapsed otherwise, or has a significant recurrence of a psychiatric disorder, the PHP may require an outside "independent" evaluation. Although they perform an important function, these evaluations carry with them ethical dilemmas.

First, evaluations are usually not covered by insurance and they are costly (as high as a \$4500 minimum charge for a 96-hour evaluation) (Boyd, personal communication, 2010). If the evaluators recommend treatment, clients are given the opportunity to go to various centers for treatment, but they often elect to stay at the same site where they obtained their evaluation (with costs as high as \$39,000 for a standard 90-day length of stay [LOS]; some even more costly). This expense can be prohibitive, especially for physicians in training and for those who are not working. For example, an out-of-work physician received a grant from his state medical society's "benevolent fund" to obtain an evaluation but could not afford to pay for treatment when it was recommended, so instead of staying he simply left the center. If treatment is priced so high that it is out of the reach of potential physician patients, it does not serve the purpose for which it was created and thus represents an administrative and management failure on the part of the PHP.

Furthermore, it is not clear to us why, for many PHP clients, the LOS should be so much longer than the LOS on average for non-PHP patients. Although individuals who remain in treatment do better than those who drop out, we could find no studies supporting a specific LOS for health care professionals. Thus, the only guarantee for requiring physicians to remain in treatment for 90 days compared to the more standard 21- to 28-day LOS is that it will cost more, perhaps prohibitively so for some physicians.

Also, because many centers that specialize in evaluating health care professionals also provide costly treatment, can anyone ensure that financial incentives did not play a role in the recommendation? In our experience, it is far more common for physicians to simply stay at the same facility for treatment rather than packing up and moving elsewhere.

To further complicate matters, many evaluation/treatment centers depend on state PHP referrals for their financial viability. Because of this, if, in its referral of a physician, the PHP highlights a physician as particularly problematic, the evaluation center might—whether consciously or otherwise—tailor its diagnoses and recommendations in a way that will support the PHP's impression of that physician. Adding to the potential conflict of interest, evaluation and treatment centers often sponsor or exhibit at PHP regional and national meetings, thus supporting PHPs financially. The relationships between PHPs and evaluation/treatment centers are thus replete with potential conflicts of interest.

DRUG AND ALCOHOL TESTING

Laboratory testing for substances has become exceedingly sensitive. Routine urine testing can detect minute levels of morphine and ethyl glucuronide (EtG), a metabolite of

ethanol that provides a 3-day window of detection. For example, we have seen low-level positive EtG results in individuals who have done nothing more than use alcohol hand wash, rinse their mouths with alcohol-based mouthwash, or used asthma inhalers with ethanol propellants. (We have also seen positive morphine tests in individuals who had consumed only poppy seed bagels or crackers.) Because of its extreme sensitivity, the Substance Abuse and Mental Health Services Administration has issued an advisory cautioning that EtG testing be used for clinical purposes only and not used solely as the basis of reports in forensic programs (Center for Substance Abuse Treatment, 2006).

Nonetheless, some state PHPs report any and all positive tests to the licensing board. Each PHP is different in its reporting requirements, depending on the nature of the relationship between the PHP and its respective board. We have seen many physicians reported to the board for positive laboratory results that did not indicate either substance use or relapse. The fact is that merely being reported to one's licensing board can produce inordinate anxiety, shame, and fear for the physician and his family, and it also carries significant economic and professional costs, given that once reported, physicians often need to retain legal counsel and/or are asked not to work while the positive test result is being investigated. We do not believe that an ethically sound argument can be made for reporting positive tests that do not indicate relapse to state medical boards. We, therefore, disagree strongly with the practice of some PHPs of reporting all positive tests to licensing entities and others.

To avoid having physicians test positive at low levels for EtG, some PHPs advise their clients to avoid ethanol-based handwash. Given the availability of isopropyl-alcohol-based handwashes that do not cause a positive EtG result, this statement seems feasible. But the standard handwash in many, if not most, hospitals is ethanol based, and many require alcohol-based handwashing without providing an isopropyl-based alternative, making a PHP recommendation for a physician to avoid alcohol handwash ethically indefensible, given that the careers of physicians being monitored by PHPs are almost always already in jeopardy.

Analogously, we are aware that some PHPs make recommendations to physicians about treatment for their medical conditions, specifically pertaining to acute pain management, asthma treatment, and surgery and postoperative care. When this has occurred, the motivation to do so by the PHP has been to simplify the PHP's ability to interpret test results—namely to avoid medications such as opioids that cause physicians to have positive tests—rather than what might be in the best health interests of the physician. We believe that the physician's health and well-being should be paramount to all other considerations. Physician health programs should not take any steps that could interfere with a contracting physician's right to the best medical care, including, for example, contacting his treating physicians to discuss the difficulties of monitoring while under legitimate, warranted treatment with opioid medication. In the short term, these treatments may be better handled with temporary increases in testing, support group attendance, and more frequent communication with workplace monitors.

RESEARCH BY PHPs

A number of state PHPs collect data about their participants and, either individually or in collaboration with other PHPs, publish data about physician outcomes or other aspects of their work. The first principle of the Nuremberg Code of Medical Ethics states, "The voluntary consent of the human subject is absolutely essential. This means that the person involved should . . . be able to exercise free power of choice, without the intervention of any element of force, . . . duress, over-reaching, or other ulterior form of constraint or coercion" (Nuremberg Code of Medical Ethics, 1947). Physician health program standard practice often flouts this principle because even if PHPs inform their participants about the possibility of having their data tabulated (as some do) and even if the data collection receives approval of an institutional review board, we do not believe that PHP participants could easily decline to be research subjects. Physician health programs could, of course, respond by saying that physicians, as a group, are also naturally curious, and they might, therefore, volunteer for research studies for the common good out of a sense of altruism. Although this may be true, we believe that most PHP participants are just too vulnerable professionally to risk displeasing those who run their PHP by declining to participate as research subjects.

INTERTWINED RELATIONSHIPS WITH STATE LICENSING BOARDS

A majority of PHPs in the United States (30 of the 43 PHPs that reported) receive a substantial portion of their funding from their state licensing board (Federation of Physician Health Programs, 2009). Thus, even if they are not run by their licensing boards, most PHPs are beholden to the licensing board and might act in ways to keep the board satisfied, rather than risk loss of financial support or even closure. After running afoul of its licensing board, for example, the PHP in California was shut down (California Physician Advocacy Group, 2009). Most PHPs thus have a potential conflict of interest anytime they communicate with their licensing boards about any physician. To further complicate matters, the physicians on staff at PHPs are themselves licensed by their state boards and, as such, could be compromised in any dealings with their licensing board. As an example, Massachusetts regulation 243 CMR 1.03 requires any licensed health care professional to report any physician suspected of being impaired (Massachusetts Board of Registration in Medicine, 2010). Therefore, physician members of PHPs could be professionally vulnerable if they do not report such colleagues, even though most PHPs would cease to exist if they fully adhered to this mandate.

CONCLUSIONS

Physician health programs often provide quality, effective addiction and/or mental health-related services aimed at treating physicians' illnesses in an evidence-based and respectful manner (Brooks et al., 2012; DuPont et al., 2009a, 2009b; Knight et al., 2007; McLellan et al., 2008), thereby helping physicians to better position themselves to retain their careers. However, there is substantial variability in individual states'

PHP policies and practice, often raising serious ethical and managerial questions.

Because PHP practices are unknown to most physicians before becoming a client of the PHP, many PHPs operate outside the scrutiny of the medical community at large. Physicians referred to PHPs are often compromised to some degree, have very little power, and are, therefore, not in a position to voice what might be legitimate objections to a PHP's practices. We recommend that the broader medical community begin to reassess PHPs as a whole. Consideration should be given toward the implementation of independent ethical oversight and establish an appeals process for PHP clients who feel they are being treated unfairly, to ensure that PHPs fulfill their mission in an ethical manner. Also, we believe that the relationships of PHPs to evaluation and treatment centers and their respective licensing boards be as transparent as possible and openly communicated to all PHP clients. We call upon national organizations such as the American Society of Addiction Medicine and the American Association of Addiction Psychiatry to review PHP practices and recommend national standards that can be debated by all physicians, not just those who work within PHPs. We recommend a system of national licensing and periodic auditing of PHPs to ensure that they continue to provide a valuable service to the community, while doing so on a more nationally consistent basis (eg, ensuring minimal credentials of those who run PHPs, consistent practices around overseeing clinical care and drug testing, adopting standardized clinical outcomes metrics for quality assurance, etc), while also ensuring that PHP services are financially accessible to all physicians, students, and trainees and ethically sound in their implementation.

Authors' Disclaimer: The opinions expressed herein are solely those of the authors and do not necessarily reflect those of any state PHP, any state medical society, or ASAM. Our aim is to stimulate widespread discussion about standard PHP practices and to effect positive changes in the way that PHPs are currently administered.

REFERENCES

- Brooks E, Early SR, Gundersen DC, et al. Comparing substance use monitoring and treatment variations among physician health programs. *Am J Addict* 2012;21:327-334.
- California Physician Advocacy Group. 2009. Available at: <http://www.cpag.org>. Accessed July 9, 2012.
- Center for Substance Abuse Treatment. Substance Abuse Treatment Advisory: The role of biomarkers in the treatment of alcohol use disorders. 2006. Available at: http://www.kap.samhsa.gov/products/manuals/advisory/pdfs/0609_biomarkers.pdf. Accessed December 21, 2009.
- DuPont RL, McLellan AT, Carr G, et al. How are addicted physicians treated? A national survey of Physician Health Programs. *J Subst Abuse Treat* 2009a;37:1-7.
- DuPont RL, McLellan AT, White WL, et al. Setting the standard for recovery: physicians' health programs. *J Subst Abuse Treat* 2009b;36:159-171.
- Federation of Physician Health Programs. State programs. 2009. Available at: http://www.fsphp.org/State_Programs.html. Accessed July 9, 2012.
- Flaherty JA, Richman JA. Substance use and addiction among medical students, residents, and physicians. *Psychiatr Clin N Am* 1993;16:189-197.
- Knight JR, Sanchez LT, Sherritt L, et al. Outcomes of a monitoring program for physicians with mental and behavioral health problems. *J Psychiatr Pract* 2007;13:25-32.
- Knight JR, Sanchez LT, Sherritt L, et al. Monitoring physician drug problems: attitudes of participants. *J Addict Dis* 2002;21:27-36.
- Massachusetts Board of Registration in Medicine. Mandated reporting on physicians. 2010. Available at: <http://www.mass.gov/cohs/provider/licensing/occupational/physicians/mandated-reporting/>. Accessed July 9, 2012.
- McLellan AT, Skipper GS, Campbell M, et al. Five year outcomes in a cohort study of physicians treated for substance use disorders in the United States. *BMJ* 2008;337:a2038.
- Nace EP, Birkmayer F, Sullivan MA, et al. Socially sanctioned coercion mechanisms for addiction treatment. *Am J Addict* 2007;16:15-23.
- Nuremberg Code of Medical Ethics. *Doctors of Infamy: The Story of the Nazi Medical Crimes*. New York: Schuman; 1947:xxiii-xxv. Available at: <http://www.cirp.org/library/ethics/nuremberg/>. Accessed October 15, 1949.
- Sullivan MA, Birkmayer F, Boyarsky BK, et al. Uses of coercion in addiction treatment: clinical aspects. *Am J Addict* 2008;17:36-47.