

Evolution of Physician Health Programs in the United States

Michael H. Gendel, MD

**Medical Director, Colorado Physician Health Program
Immediate past-president, Federation of State Physician
Health Programs**

Five forces of evolution

- ❖ 1. Clinical concern for sick physicians and the welfare of members of the medical profession
- ❖ 2. Interest/support of medical societies (AMA, CMA)
- ❖ 3. Interest of licensing boards and the public, controlled by laws of individual state governments, in protecting the public from physicians whose ability to practice safely may be impaired by illness

Five forces of evolution

- ❖ 4. Need for individual state physician health programs to work together to discuss and promote best practices and influence national public policy
- ❖ 5. Creation of private industry devoted to treating health care personnel/professionals

Five forces of evolution

- ❖ In the history that follows you will see the unfolding of the forces at work:
- ❖ 1. Clinical concern – focus on addiction gradually growing to all health and workplace problems
- ❖ 2. AMA office support; International research meetings
- ❖ 3. Regulatory involvement and public awareness – development of formal relationships with licensing boards and subsequent interdependence

Five forces of evolution

- ❖ 4. Formation of a national federation of PHP's (FSPHP) which has no authority but provides a platform for consensus strategies and public policy recommendations
- ❖ 5. Competition among private addiction treatment centers, psychiatric centers, laboratories; relationships to PHP's and FSPHP

Factors specific to U.S.

- ❖ Medical practice is regulated state by state, not nationally
- ❖ National bodies whose certification of health care organizations and programs effect medical practice – e.g. The Joint Commission

(Model) (Scope) (Structure)
(Protections) (Confidentiality)
(Authority) (Staffing)

(3) (6) (3) (4) (6) (2) (4)=1728

Don't forget: Laws, funding

“The Sick Physician”

- ❖ 1973 AMA article – product of an AMA committee
- ❖ Argued that physicians were subject to illnesses in ways different from the general population
- ❖ Included cancer, heart disease, depression, suicide, addiction
 - Not true, for the most part, that physicians afflicted at different rates than the general population

“The Sick Physician”

- ❖ Concluded that physicians have to do a better job of helping sick physicians
- ❖ Factors to overcome
 - Poor identification of illness
 - Lack of knowledge and competence about how to help
 - “Conspiracy of silence”

Early programs – Impaired Physician Programs

- ❖ “The Sick Physician” encouraged the development of programs to help sick physicians
- ❖ This development was welcomed by those physicians who were in recovery from addictive illness
- ❖ Specialized private treatment center for addicted physicians arose in the early 70’s
- ❖ Those who had been successfully treated were eager to help fellow physicians with similar problems.

Early programs

- ❖ Late 1970's
- ❖ Programs were staffed by physician volunteers
- ❖ Committees within medical societies
- ❖ Emphasis almost strictly on addictive illness
- ❖ Intervention, sending of physician to lengthy residential treatment programs, emphasis on Alcoholics Anonymous and other 12-step programs

Early programs

- ❖ Programs had unclear, informal relationship to state licensing boards and hospitals.
- ❖ Programs “advocated” for addicted physicians by supporting their return to practice if they remained abstinent
- ❖ Drug and alcohol testing

1980's: Physician Health Programs

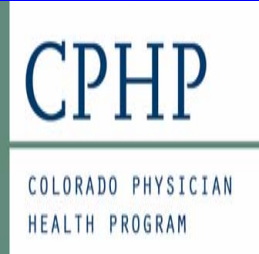
- ❖ Colorado first program to call itself a “Physician health program”
- ❖ Legislation creating the program passed in 1985
- ❖ Program opened 1986
- ❖ Also first program to specifically state that it would evaluate physicians with any health problem

Colorado Program

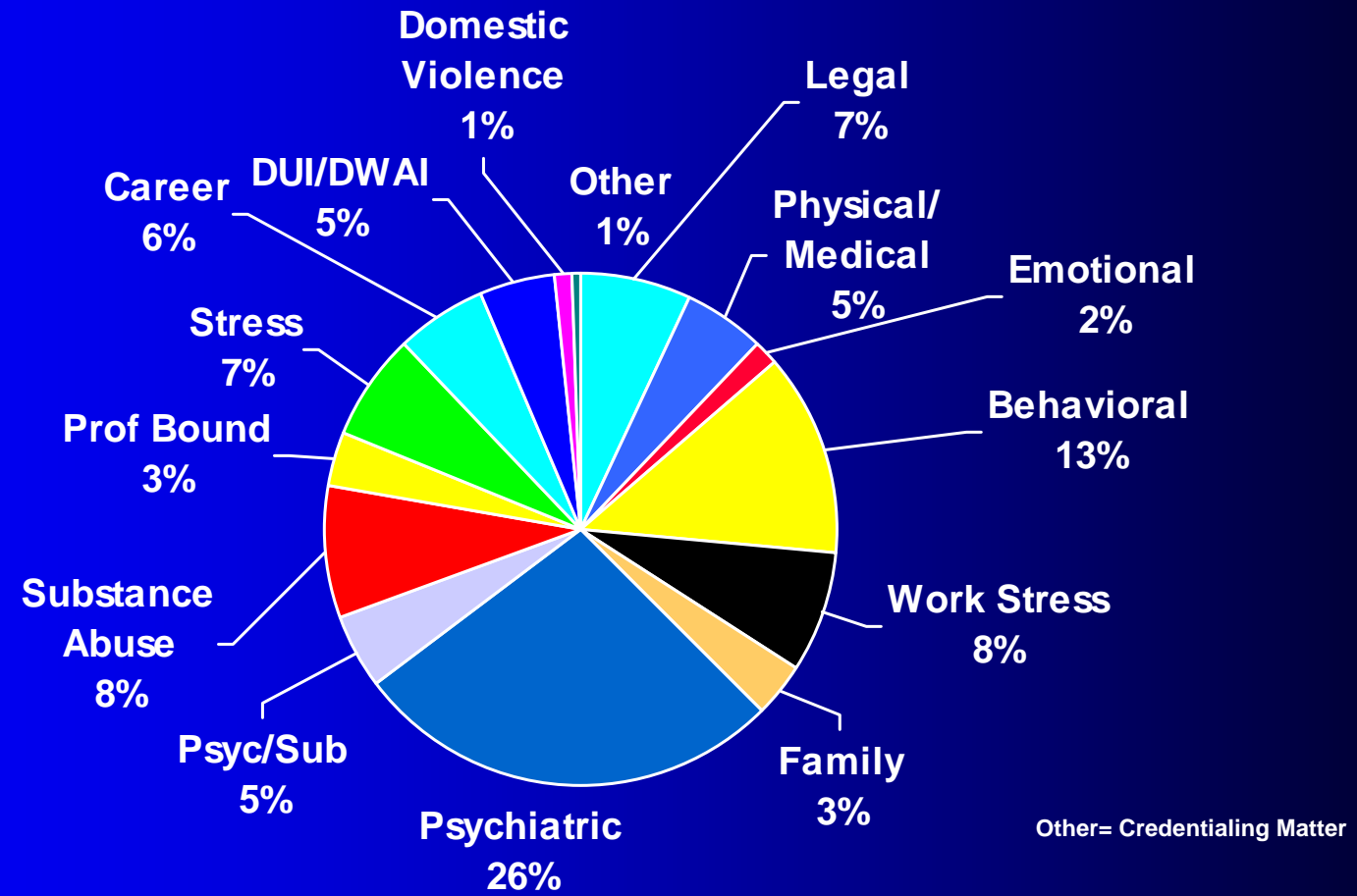
- ❖ >3000 evaluations
- ❖ 20% seen more than once, usually for a different problem
- ❖ 300 new evaluations per year
- ❖ 40% self referral, 20% suggested, 40% mandatory
- ❖ 20% of cases known to medical board

Colorado Program

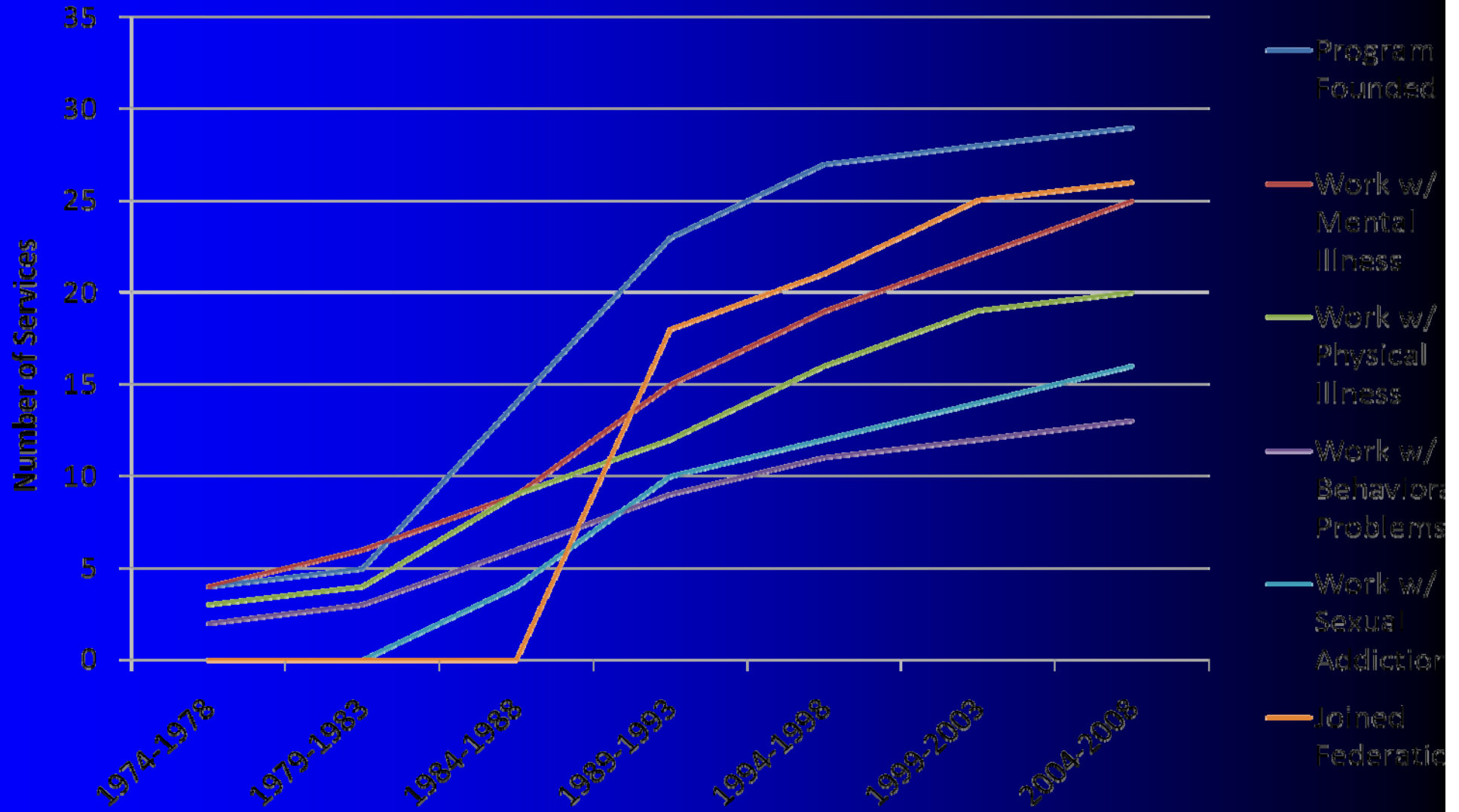
- ❖ Need for group consultation model
- ❖ Problems in treating physicians
 - Many physicians unskilled in treating physicians
 - Overidentification – fear or unwillingness of treating the doctor with sufficient seriousness
 - Challenged – treating the physician with no deference to their profession or specialness



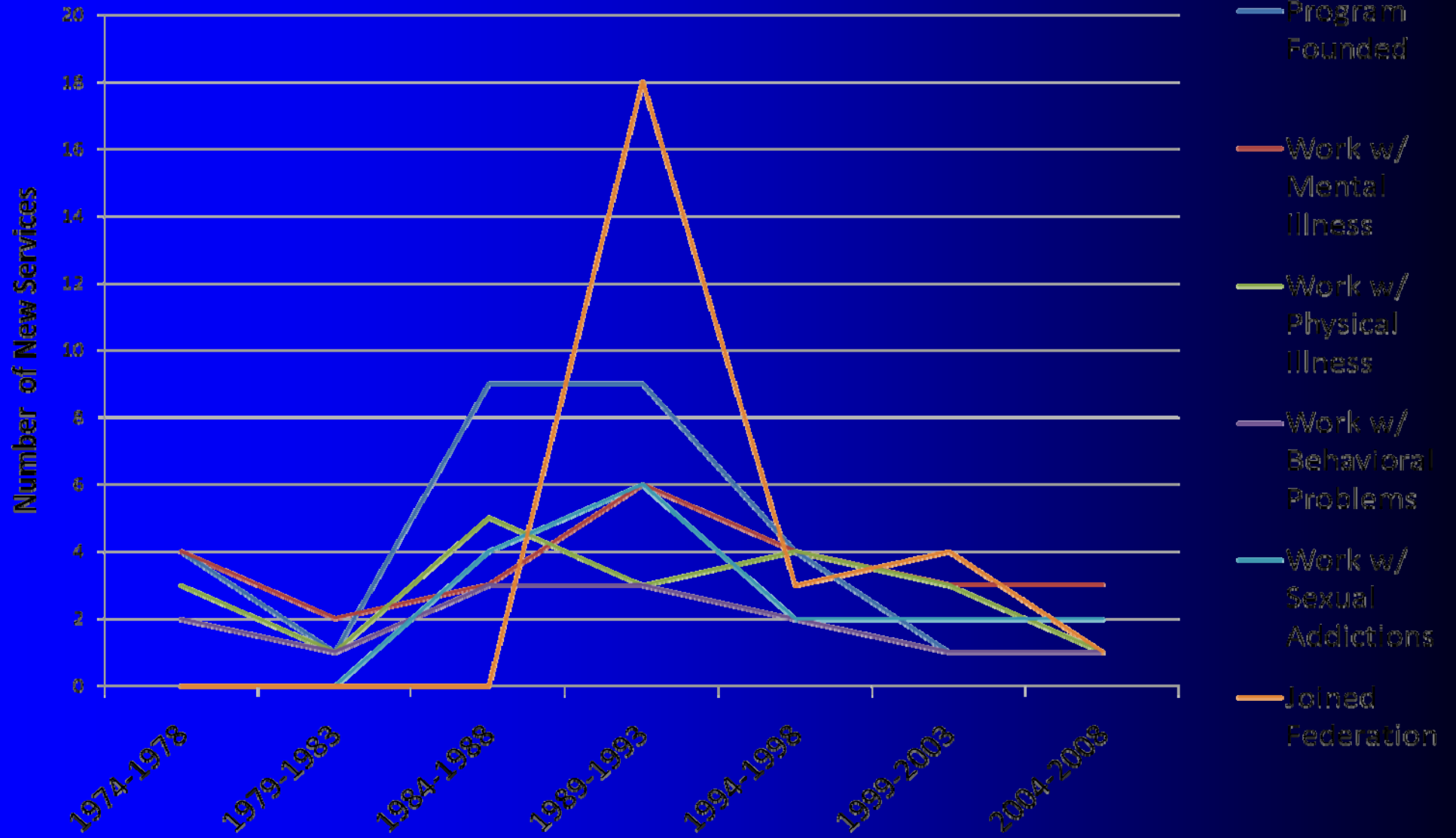
Problem Areas Served 2007-2008



Increase in Services Offered Over Time



Number of New Services over Time



1980's: Physician Health Programs

- ❖ Several programs “professionalized” during the 1980's, shifting away from volunteer staffing
- ❖ Medical, administrative, case management, clerical
- ❖ Reflected the concept that special knowledge and skill is required in working with physicians
- ❖ Health, workplace, career, family issues

1980's: Physician Health Programs

- ❖ Beginning to create clear relationships with licensing boards
- ❖ Atmosphere of distrust
- ❖ PHP's: Licensing boards are punitive
- ❖ Licensing boards: PHP's are only interested in advocating for sick physicians and may protect doctors with poor skills

1980's: Physician Health Programs

- ❖ Increasing need to be able to address workplace problems including angry behavior and sexual harassment
- ❖ Increasing need to be able to address physician/patient boundary violations
- ❖ Much debate about whether and how to do so

1980's: Physician Health Programs

- ❖ Beginning of published research for physician addiction
- ❖ Treatment center outcomes
- ❖ Licensing board outcomes
- ❖ New treatment strategies, e.g. contingency contracting (Crowley/Anker)

1990's: Sharing problems and solutions

- ❖ Creation of the Federation of State Physician Health Programs – need for input and ideas
- ❖ Provided a forum for discussing how to do PHP work
- ❖ Led to appreciation of the vast differences between programs
- ❖ Little funding, but commitment to communication and meetings
- ❖ Initial public policy statements

1990's: Sharing problems and solutions

- ❖ Slowly developing emphasis on working with all health conditions
- ❖ Importance of wellness, self-care, stress and stress management
- ❖ Apparent mushrooming of need to work with “disruptive” (angry) and boundary-violating physicians

1990's: Sharing problems and solutions

- ❖ Increasing complexity of PHP cases
- ❖ Multiple medical, psychiatric, and addictive diagnoses
- ❖ Importance of evaluating and opining about fitness-for-duty

1990's: Sharing problems and solutions

- ❖ Education of licensing boards
- ❖ Cooperative, respectful working relationships
- ❖ Clarity of disparate roles: PHP's – diagnosis and treatment – offer the only remedy to problematic physician behavior that is caused by illness
- ❖ Discipline, other than revocation of license, is unlikely to be a remedy

1990's: Sharing problems and solutions

- ❖ Consumer movement among the general public pushing licensing boards for more accountability
- ❖ Threat to privacy of records of sick physicians

1990's: Sharing problems and solutions

- ❖ AMA providing office and personnel for FSPHP
- ❖ Advent AMA/CMA international physician health research conferences (also Oslo meeting)
- ❖ Published research on many aspects of physician health and illness, self-care, wellness, work
- ❖ 1996 national research conference – Estes Park

1990's: Sharing problems and solutions

- ❖ Burgeoning private industry to evaluate and treat addicted physicians
- ❖ Development of interdependence of this industry on PHP's for referrals, and of FSPHP on the industry for funding of meetings
- ❖ Industry-based speakers at FSPHP national meetings

2000's: PHP's as Institutions

- ❖ Development of FSPHP guidelines for assessing and monitoring of addiction and mental health disorders
- ❖ Research publications by PHP's regarding addiction and mental health monitoring
- ❖ Licensing boards and PHP's developing institutionalized interdependence

2000's: PHP's as Institutions

- ❖ Hiring of FSPHP executive director to promote and professionalize the organization
- ❖ Development of e-group for quick and open communication between PHP's
- ❖ AMA formal recognition of physician health problems and their importance in statements and in structure

2000's: PHP's as Institutions

- ❖ Further development of private industry, now to evaluate and treat a variety of mental disorders including “process” addictions (certain sexual disorders, eating disorders) among physicians
- ❖ Industry to “educate” or treat physicians with boundary problems or behavior problems
- ❖ Private laboratories competing for PHP referrals
- ❖ Further interdependence with PHP's, FSPHP

2000's: PHP's as Institutions

- ❖ Large multisite study of PHP structure and function and of addiction outcomes, working with “outside” researchers (“Blueprint”)
- ❖ PHP and FSPHP leaders addressing national news regarding sick physicians (e.g. Cheney's doctor) and more local controversial issues

2000's: PHP's as Institutions

- ❖ Formation of working relationship between FSPHP and Federation of State Medical Boards (FSMB) and FSPHP presentations at FSMB meetings
- ❖ National FSPHP meeting becoming a place for education and research finding reports, less simple sharing of how each program works

2000's: PHP's as Institutions

- ❖ Transparency movement among the general public
- ❖ Further threat to privacy of records of sick physicians
- ❖ Joint Commission standards on physician illness and behavior in healthcare organizations, recognizing PHP role

2000's: PHP's as Institutions

- ❖ New abrasion and distrust in certain states between licensing boards and PHP's
- ❖ “Audits” by state government authorities
- ❖ California – dissolving the PHP (2007-8)
- ❖ Thoughtful creation of new PHP's utilizing the experience of expertise of FSPHP members

Evolution of Practice

- ❖ U.S. PHP's have evolved to improve physician health through:
 - Educating about the need to seek appropriate care
 - Fostering voluntary, early assessment in order to address problems before impairment occurs
 - Referring to those skilled in treating doctors
 - Enhancing outcomes through the monitoring of treatment

Future course

- ❖ U.S. PHP's will evolve to become:
 - The educators in the field of physician health
 - Expert in assessing fitness to practice
 - Expert in addressing illness and injury unique to the occupation – occupational hazards
 - E.g. – Bad outcomes, workplace trauma, malpractice and other work stress
 - Expert in counseling physicians regarding their occupation and its “life cycle”, and the physician workplace

Future course

❖ FSPHP

- Continue to educate regarding best PHP practices
- Encourage and catalogue relevant research
- Enhance its capacity to be a voice for rational public policy
- Strengthen relationships with national agencies
- Develop assistance packages for political crises at the state level