

The USA Physician Health Program Experience with Monitoring Contracts.

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Physician health programs (PHPs) in the United States have been developing over the past 30 years in response to the recognition in the 1970's that physicians with health related illnesses, primarily substance use disorders, were not being adequately recognized, treated, and monitored. A significant aspect of the evolving of PHPs, has been the development of monitoring contracts which are aimed at ensuring that physicians comply with appropriate treatment and are compliant with contract obligations so that they can return or continue to practice medicine safely.

The Federation of State Physician Health Programs (FSPHP) has 47 state members, including the Washington District of Columbia. All of these state programs monitor physicians for substance use disorders. Many of these programs also monitor for mental health disorders, behavioral problems, and physical illnesses. The majority of the state programs have relationships with their state licensing boards and many with the state medical society. These relationships are usually positive, but not always stable, as the boards change members and the medical environment changes. The PHPs strive to ensure credibility and accountability with monitoring allowing the licensing boards to be assured that monitored physicians are safe to practice medicine. If there is non compliant, the board will be timely notified and if deemed necessary, the physician will come out of medical practice to allow for patient and public safety, as the physician is assessed for an exacerbation of illness and referred to treatment if needed.

In 2005, the FSPHP established program guidelines for the monitoring of substance disorders and psychiatric conditions. State programs are diverse with each state having its own medical licensing statutes and regulations and each program having its own mission, goals, and parameters. Many are non profit corporations affiliated with the state medical association, others are connected with the licensing board, and others are more independent. Thus the guidelines are not meant to set program standards, but rather, provide a set of guidelines with which the federation state members agreed.

Important parameters listed in the guidelines for substance use disorders are noted below:

An extended period of monitoring of 5 years for substance dependence with lesser years for substance abuse and diagnostic purposes. An agreement for

good faith participation between the PHP and the participant physician. An agreement for abstinence from all addictive substances including alcohol and to immediately report any use or relapse. Not to prescribe for neither one's self nor family members. To have a primary care physician who is informed of the monitoring and to not self diagnose nor treat. Attendance at self help groups such as AA/NA and facilitated support groups for physicians. Allowing communication with designated work place monitors. An understanding of the consequence of substance use or relapse, which may include withdrawal from medical practice, and reporting to the licensure board. Also the requirement for notifying the PHP of travel plans, address changes, work site problems, licensing board actions, and any criminal actions. Fitness for work guidelines are also provided. Regular reports as to recovery stability are also outlined

Of importance, substance use monitoring includes random testing of biologic specimens, commonly urine, and can include hair and blood, for substances of abuse. The testing is with qualified toxicology laboratories with chain of custody procedures.

Psychiatric or mental health contract guidelines are similar but without biologic specimen testing, unless the physician also has a substance use disorder. The psychiatric diagnosis is agreed upon. Regular meetings with a psychiatrist or therapist are required, along with an awareness of all prescribed medications.

Confidentiality is an essential and important aspect of these contracts. Physicians are more likely to seek assistance and early in their illnesses, if they can contact PHPs and engage in the assessment and treatment process, and be reassured of privacy. However, if the actions of the physician have caused patient harm or violation of the licensure board regulations, then the appropriate authorities are notified.

The outcomes of these monitoring contracts have been remarkably successful. Research efforts have intensified over the past few years to rigorously document such success.

The state of Washington PHP published a study in 2005 describing a 75 % success rate in substance use monitoring. The study also concluded that the risk of relapse was increased with abuse of a major opioid drug or had a coexisting psychiatric illness or a family history of substance use. The presence of more than one of these risk factors and a previous relapse further increased the risk of relapse.

The Massachusetts PHP published an outcomes study in 2007 for physicians being monitored with a substance use contract and those monitored for a mental and behavioral health contract. The success rate of 75 % was similar for both of the contracts. Successful completion of the substance contract was significantly associated with licensing board involvement. Women were less successful with

both of the contracts. The study demonstrated that physicians with mental and behavioral problems can be monitored in a similar manner to those with substance disorders. Also, that there is a need to provide greater attention to the services offered to female physicians.

A more recent study by independent researchers with data provided by the FSPHP of a composite of multiple PHPs is expected to be published soon which will provide outcome success rates and identify key aspects relating to monitoring of substance disorders, allowing for successful recovery of a high percentage of physicians and their ability to practice medicine safely.

In addition to the health disorders described above, many state PHPs are being referred physicians with occupational disruptive behaviors and workplace conflicts. Much attention is focused on how best to assess these behavioral problems, what treatment is effective, and whether monitoring is indicated and if so, how to monitor.

Physical and medical disorders are also included in the assessment and monitoring of many PHPs. Comprehensive evaluations often assist physicians in appreciating the importance of being cared for in addition to providing care for patients.

The assessment or monitoring of sexual disorders is controversial, with many PHPs reluctant to become involved, not having guidelines in place, and licensing boards taking disciplinary actions in preference to referral for treatment. The FSPHP has been including discussions of these disorders in its annual meeting to enhance understanding of the complexity of these problems.

In conclusion, the active involvement of USA physician health programs in assessing, referring to treatment, supporting and monitoring physicians in confidential programs is heartening and provides an opportunity for those with illnesses to move to wellness and health.

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