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Physicians Health Programs: What Counselors Can Learn from These Remarkable Programs

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Despite their advanced training, physicians are not immune to the perils of addiction. The prevalence of substance use disorders among physicians is similar to that in the general population, and substance-related problems continue to be among the chief reasons physicians are referred to their licensing boards for disciplinary action (Flaherty & Richman, 1993; Brewster, 1986; Hughes, Brandenburg, Baldwin, et al., 1992). Obviously physicians do not fit the typical, and erroneous, stereotype of addicts (i.e., poorly educated and from lower social classes); however, physicians have their own special risk factors, including easy access to controlled substances and, as a group, relatively high rates of alcohol consumption. Plus, physicians entering addiction treatment report particularly high rates of problem complexity, e.g., family histories of addiction, multiple drug choices, co-occurring medical/psychiatric conditions, and other significant obstacles to successful recovery (Domino, Hornbein, Pollissar, et al., 2005).

Despite these risk factors, the documented long-term recovery rates for physicians are among the highest reported--between 70-96% (Talbot, Gallegos, Wilson, & Porter, 1987; Gastfriend, 2005; Domino, et

al., 2005). This article explores the sources of such high recovery rates, including active case management, aggressive and prolonged monitoring, contingency management linked to contractually stipulated and clearly defined consequences (not only for return to alcohol or other drugs but also for leaving the monitoring system), plus the requirement of active participation in 12-step programs or other community recovery fellowships. We believe that this comprehensive system of care is worthy of careful examination for components that might be emulated by the addiction treatment system at large (DuPont, McLellan, Skipper, & White, 2006).

Addicted Physicians: The Early History

Health care professionals have a long and colorful history of substance abuse in America. Addiction touched the lives of some of the nation's most prominent physicians, including Dr. William Halsted (1852-1922), the father of scientific surgery in America. The nation's early medical journals included essays on the treatment of addicted physicians (Mattison, 1883; Crothers, 1899), and recovering physicians played an important role in the birth of

addiction medicine, particularly as practiced within late nineteenth century private addiction cure institutes (White, 2000). Although there were physicians, such as Dr. J.T. Mattison, who specialized in the treatment of addicted physicians, there was no larger response to this problem by early medical societies until the late 1800s when medical boards increased in number and developed programs to assure physician competence.

Concern about addicted physicians increased after the repeal of alcohol prohibition, but so did the hope for recovery following the co-founding of Alcoholics Anonymous (1935) by Dr. Robert Holbrook Smith, a proctologist, and the subsequent founding of the International Doctors in A.A. (IDAA) (1949) by Dr. Clarence Pearson. Members of the IDAA played an unheralded role in the subsequent development of physician health programs and in the development of the broader field of addiction treatment in the twentieth century.

Three events set the stage for the development of physician health programs: the rise of formal industrial alcoholism programs, the development of private and public addiction treatment programs and the development of family-based and peer-based professional intervention technologies. The earliest physician health programs (known then as impaired physician programs or physician assistance programs) were modeled after the industrial alcoholism programs that predated modern employee assistance programs. Many of the core elements of these early programs, such as personalized contact on the jobsite with co-workers who are in recovery with the explicit goal of saving the addicts career, were largely lost in the later evolution of EAPs. These features have been retained in physicians health programs (PHPs).

Although the Federation of State Medical Boards called for model physicians assistance programs as early as 1953, it was not until the 1970s that such programs began to emerge. Four events furthered the rapid growth of PHPs: 1) the American Medical Association's (AMA) Council of Mental Health's 1974 report that addressed

physician impairment, 2) the AMA's 1973 report on "The Sick Physician," 3) the U.S. Disabled Doctors Act of 1974 that promoted mandatory reporting of impaired physicians and whistleblower immunity, and 4) the AMA's 1975 and 1977 conferences on impaired physicians. As a result of these events, State Medical Society Physician Health Committees were established in most states in the 1970s and were followed by the rapid growth of formal PHPs and the development of specialized treatment programs for addicted physicians. In 1990, the nation's PHPs were linked organizationally by the formation of the Federation of State Physician Health Programs.

The PHP Model

Modern PHPs typically provide a range of services including: 1. Educational programs that promote early referral, 2. Professional intervention services, 3. Referral to formal evaluation, 4. Referral to formal treatment, and 5. Long-term monitoring.

Educational Programs: Educational programs are provided by PHPs for numerous reasons and there are usually ample opportunities since the Joint Committee on Accreditation of Healthcare Organizations, and others, require all accredited hospitals to provide Continuing Medical Education for their doctors and other staff regarding physician impairment. Educational programs provide an excellent opportunity for "marketing" and for the PHP staff to become known and trusted, and to explain who, how, and when to refer. Early referral of physicians with substance use problems before actual impairment and patient harm occurs is obviously desirable. Providing copious education to every willing hospital, medical group, county medical society, etc, is an excellent way to spread the word about the program, and PHPs take advantage of these opportunities.

Professional intervention services: When a physician is referred to a PHP, a preliminary assessment is performed to verify that the referral is legitimate and

appropriate. Illegitimate referrals are rare but can occur from disgruntled spouses, political enemies, etc. If a referral is deemed legitimate and warranted, a professional intervention is conducted. A professional intervention is simply one in which the physician is presented with information about the program, the fact that concerns have been raised, that the concerns appear legitimate (even if not accurate), and the procedures and policies of the PHP are explained. These procedures and policies provide protection and advocacy for the physician if the physician voluntarily follows recommendations.

Referral to formal evaluation: PHP policies usually specify that a formal evaluation at an approved evaluation site is the next step. If the evaluation fails to identify a problem, this fact can be used to exonerate the physician by the PHP and to squelch the original complaint—a situation that is rare but does happen. Either way, the PHP can assist the physician by documenting the results of the evaluation as well as how the findings have been handled.

Referral to formal treatment: PHPs assure that the physician receives credible care by referring to an approved treatment center.

Long-term monitoring: PHPs include long-term monitoring that includes regular random drug testing, reports from a worksite monitor, group attendance with documentation of attendance, and other recovery oriented activities.

Outcomes: Treatment outcome studies of addicted physicians suggest both high success rates (Shore, 1987; Talbott, et al., 1987; Smith & Smith, 1991; Domino, et al., 2005) and that PHP participation is the likely key to high abstinence rates (Gastfriend, 2005).

Key Ingredients

So what are the key ingredients of PHPs that lead to their successes? Studies have yet to be conducted that isolate the most potent ingredients of PHPs; however, we propose they include many practices that

addiction counselors and the treatment programs that employ them could incorporate into their own work. Eight such practices are detailed below.

1. Find a motivational fulcrum. The PHP utilizes a crisis-induced window of opportunity to transition those they serve from the experience of pain to the experience of hope. The common message is, “You are in a bind, and we can help because we represent a legitimate process and a group of physicians who have escaped the very pain that you are now experiencing.” The PHP intervention focuses on the arena in which the person’s identity is most enmeshed, in this case the status-imbued practice of medicine and the potential loss of identity, income and social standing that would follow license revocation. Even where contact with the PHP is voluntary, these potential realities remain an omnipresent sub-theme of the assistance process. What counselors can take from this is the importance of contingency management, i.e. linking recovery to meaningful positive rewards and relapse to negative consequences. Establishment of a clear behavioral contingency agreement, on paper, signed by the physician and the PHP director, clearly identify required aftercare activities and commitment to regular drug testing—a tangible measure of sobriety and of relapse. This reinforces important mediums of continued recovery and provides a source of support and re-motivation during early recovery. The stakes involved in this contingency are best if they are specific and serious, for example, loss/retention of intimate relationship, job/career, children, freedom, or privileges. Counselor folklore is replete with admonitions that no one can get sober except for themselves, but lighting the sobriety fire requires kindling and a source of ignition that is specific to each client. Contingency management techniques are becoming more widely accepted as their effectiveness is confirmed in traditional treatment settings (Petry, et al., 2006).

2. Provide comprehensive assessment and treatment. Another key component used effectively by PHPs is the

provision of comprehensive formal evaluation and treatment that address the full scope of problems identified in the evaluation. What the mainstream treatment system can take from this is the need to move from categorical to global evaluation protocols and the need to widen the menu of available services. What distinguishes the settings in which doctors are treated from the mainstream treatment system is not that the treatment for physicians is more expensive (a factor that does not always translate to better quality), but that it is far more intensive and comprehensive, e.g., more likely to be prolonged (if needed) and to include concurrent psychiatric evaluation and treatment plus rigorous family programs and treatment of any other problematic condition (i.e. chronic pain, sexual disorders, etc) (Skipper 1995).

3. Provide viable role models and peer-based recovery coaching. PHPs rely on physician-to-physician identification and communication, provide positive role models of physicians in long-term recovery, and provide peer-based recovery coaching into and throughout the recovery process. In most PHPs, there is a staff member or case manager who fills the role as a recovery coach who solicits input from the family and professional peers and offers the physician a regular report card, e.g., “Here’s where you are very strong right now, and here are some areas in which you could do better.” Such feedback coming from other physicians also in recovery and tested allies and advocates provides a potent vehicle of support that could be matched by few other sources. As counselors, we would be well served by asking ourselves, “How does this person define himself or herself at the most fundamental level (age, gender, race/ethnicity, family, sexual orientation, drug choice, profession, geography, life-shaping event, etc.)?” With this information we can more effectively explore how to mobilize people in recovery who share those qualities in support of the client’s recovery. PHPs have done a brilliant job aligning comprehensive support for American physicians with substance use disorders.

4. Modify lifestyles to reduce relapse risk and enrich recovery. PHPs ask each physician to consider recovery-enhancing practice modifications and lifestyle changes. The former could include such options as a change in medical specialty, prescribing restrictions, external monitoring of prescribing practices, or a change in institutional affiliation or work schedule. The goal is to set the physician up for success—both in his/her recovery and his/her practice.

5. Assertively link to recovery support groups. PHPs rely on active (linkage to a particular person/group/meeting) rather than passive (verbal encouragement for participation) referrals to Twelve Step and other recovery mutual aid groups. They also link each member to professionally-directed group therapy with other physicians in recovery and monitor physician attendance at such meetings. The PHP encourages participation in peer-based recovery support groups, e.g., (Caduceus Meetings or International Doctors in Alcoholics Anonymous). The goal is to link each individual client with people who will reinforce their identity as a recovering physician and to lead these same individuals into relationship with the larger recovery community.

6. Sustain monitoring and support and, when necessary, re-intervene. Post-treatment monitoring and support enhances long-term recovery outcomes (Dennis, Scott & Funk, 2003), and PHPs are unique in the length of time they monitor and support persons in recovery. The monitoring function involves periodic interviews as well as random urine, saliva, sweat patch and hair testing for five years or more. PHP staff members respond to any positive drug screen with an appropriate level of re-evaluation of the physician, encouragement to seek further treatment if needed, and the ever present potential, if warranted, of referral to the licensing board if recommendations are not followed. Every physician knows that referral to the licensing board could result in loss of license.

Such surveillance and support does not completely eliminate relapse. Surveys reveal that up to 25% of physicians in PHPs

experience at least one relapse (Domino et al., 2005), but because of the monitoring and re-interventions, most physicians eventually establish stable recovery, avoid posing threats to the safety of their patients, and retain their license to practice medicine. Active and sustained monitoring insures early identification of relapses, which in PHPs typically lead to increased support and re-intervention. This may be the component that most distinguishes PHPs from many mainstream addiction treatment programs, other employee assistance programs, drug court and other criminal justice programs, and intervention programs in the child welfare system, all of which offer less rigorous, intensive and enduring systems of monitoring and support.

7. Re-intervene at a higher level of intensity. Another distinguishing feature of PHPs is that relapse and re-intervention are followed by reevaluation and the possibility of more intensive, prolonged, and specialized treatment rather than a re-admission and replication of the same treatment that was provided earlier. This blend of support and accountability, alliance and toughness distinguishes PHPs from other interventions that seek but too often fall short of creating and sustaining these important ingredients.

8. Integrate these elements, where possible, within a comprehensive program. Many persons achieving successful recovery experience elements of what we have described here, but the PHPs are distinguished by their inclusion of these elements within an integrated program. The level of cohesion and coordination that comes from such integration may itself contribute to the PHP's high long-term recovery rates. The best drug courts and the more innovative programs in the child welfare system share similar direction and integration. Where such elements are lacking, counselors could well serve their clients by providing the connective tissue and leadership within multi-agency intervention models that utilize an integrated service plan and contain the potent ingredients we have described here.

Summary

Addicted physicians involved in physicians health programs have exceptionally high long-term recovery rates. They recover in such high numbers not necessarily because they are physicians, but more likely because they participate in programs that differ significantly from standard treatment in the United States (Gold, Logan, Bruijnzeel, & DuPont, 2006). The seven components of PHPs that we consider to be the keys to quality enhancement are: 1) use of a motivational fulcrum, 2) comprehensive assessment and treatment, 3) peer-based recovery coaching, 4) lifestyle modifications, 5) assertive linkage to communities of recovery, 6) sustained monitoring, support and early re-intervention, and 7) service integration. These active ingredients of the care provided by Physicians' Health Programs merit serious study by those of us invested in improving the quality of addiction treatment for all Americans.

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