Physician Health Programs: A Model for Recovery

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Disclosures

- Dr. Merlo receives salary support as Director of Research from the Professionals Resource Network, Inc., an integral arm of the Florida Medical Association

- Special thanks to my collaborator, Robert DuPont, MD, who created some of the following slides

SUDs in Healthcare Professionals

- Substance use disorders are considered an occupational hazard among physicians, pharmacists, dentists, nurses, and other healthcare providers
  - Baldisseri, Crit Care Med, 2007; 35(2), S106-116
- Physicians have been at greater risk of becoming addicted to narcotics than members of the general public
  - Hughes et al., JAMA, 1992;267:2333–9.
- The prevalence of psychiatric comorbidity appears to be increasing among physicians
  - Angres et al. J Addict Dis, 2003; 22(3):79-87
- Addiction can cause significant distress and impairment in the lives of physicians, their patients, and their loved ones

Physician Health Programs (PHPs)

How Did This Model Develop?

- It evolved over four decades, with roots in the employee assistance model
- Many early leaders were physicians who were themselves in recovery
- It maximized good long-term outcomes rather than minimizing costs
- It built on and extended the Minnesota Model of treatment
- It was committed to life-long abstinence from the use of any drug of abuse
- **It accepted that virtually all individuals with SUD began by denying their disorder and resisting treatment**
- It used the power of coercion without itself having any punishments to deliver for noncompliance

PHP Intervention

- Physician is referred to PHP
  - Physician undergoes comprehensive assessment by an addiction medicine specialist with expertise evaluating physicians (may require multi-day inpatient evaluation)
  - Treatment recommendations typically include 45-90+ days at a residential level treatment center with dedicated “healthcare professionals” track
- Upon completion of treatment, physician signs multi-year monitoring contract with PHP

Physician Health Program Characteristics

- MONITORING not TREATMENT
- “Compassionate coercion”
- Frequently confidential and separate from licensing board
- Provide weekly monitoring (groups +/- testing)
- 2-5 year contract for Psychiatric/Behavioral Problem
- 5 year contract for Substance Dependence

DuPont, McLellan, Carr, Gendel, & Skipper (2009). *J Subst Abuse Treat*.

Is "Coerced" Treatment Effective?

Referral to Treatment

Reasons for Referral to Treatment	% Endorsing Reason as Contributor to Treatment Referral	% Endorsing as MOST Important Contributor to Treatment Referral
Family/friends staged intervention	25.5	10.5
Arrested for substance-related crime	33.0	20.9
Involuntary referral to PHP	29.8	20.9
Spouse/significant other left	8.5	3.5
Fired from job or kicked out of school	25.5	10.5
Felt out of control	54.3	18.6
Financial problems	13.8	--
Attended AA/NA meeting	7.4	1.2
Health problems	14.9	1.2
Other	21.3	12.8

Note: "Other" responses included: Suicide attempt (n = 2); Overdose (n =2); Caught taking drugs from work (n = 2); Voluntary referral to PHP (n = 2); Self-loathing; Benevolent coercion; Realized life problems related; Interview by professional; Son overdosed and lived; Legal trouble; Pushed significant other during argument; Medicinal practice act; Patient complaint; Almost fired from job; Emergency Suspension Order on license; Caught forging prescription; Experienced withdrawal for first time; Teenage daughter concerned; Unable to quit by my own power; Affecting family life; Ex-wife wouldn't let me see my son; No one had to tell me—I knew

Merlo, Klingman, Conwell, & Rivenbark (2012). Poster presented at American Psychological Assn Meeting

PHP Efficacy Study

- *Chart review of 904 physicians with substance use disorders participating in impaired physician monitoring programs across 16 states*
- Typical 1-year abstinence rate for treatment within general population is 20-60% (Obrien, 1996)

- However, 78% of physicians completed **5 years** of monitoring with **NO** episodes of relapse (verified by random urine and/or hair testing)
- 80% of participants completed or extended their contracts
- 72% returned to the practice of medicine

DuPont, McLellan, White, Merlo, & Gold (2009). *J Subst Abuse Treat*.

Outcomes for Physicians with OUD

- Secondary analysis comparing outcomes for physicians with:
  - Alcohol use disorder
  - Opioid Use Disorder (OUD) +/- other drugs
  - Other [non-opioid] drug use disorder
- Demonstrated equivalent outcomes across all 3 groups
  - Also equivalent outcomes for individuals with history of IV drug use
- Use of MAT was very limited:
  - 40 physicians used naltrexone
  - 1 used methadone
  - 0 used buprenorphine (charts reviewed for physicians who began PHP monitoring 1995-2001; buprenorphine FDA approved in 2002)

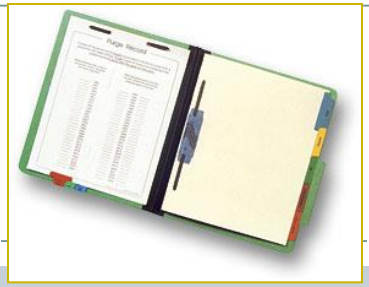
Merlo, Campbell, Skipper, Shea, DuPont. J Subst Abuse Treat. 2016;64:47-54

OUD, MAT, & PHPs

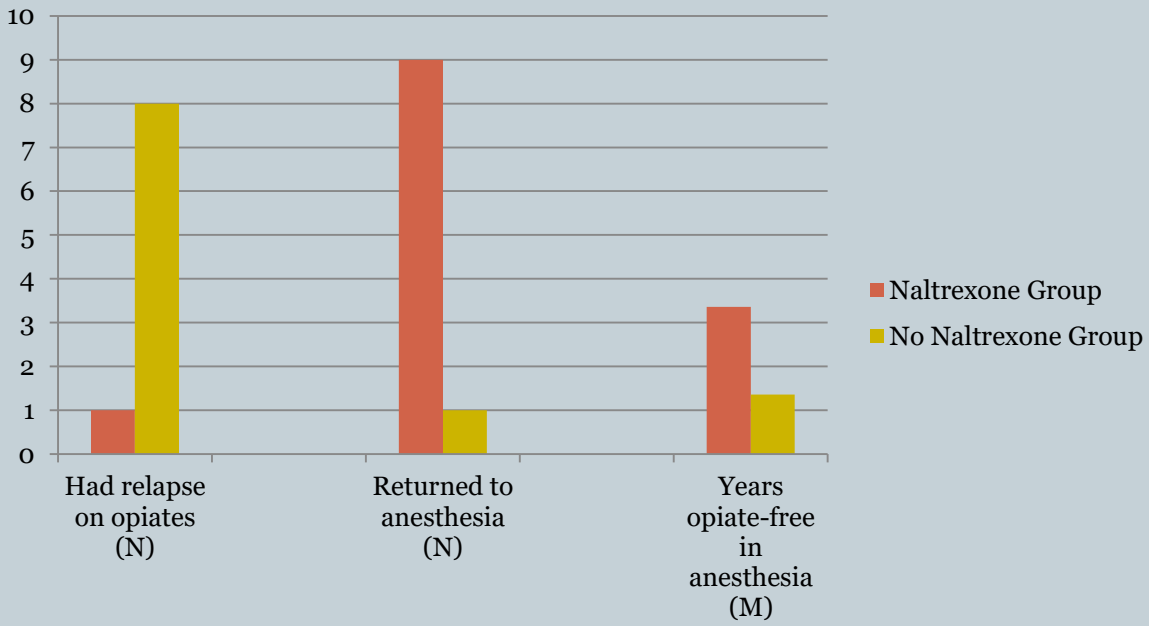
- Whereas some suggest that physicians and other HCPs should not receive OST
  - e.g., Hamza & Bryson (2012). *Mayo Clinic Proc.*)
- Others have recently suggested that physicians are being denied the "gold standard" of care
  - e.g., Beletsky, Wakeman, Fiscella (2019). *NEJM*.

- Given the safety-sensitive nature of the work, there remain concerns about the potential for neuropsychological impairment associated with OST
- The use of MAT with naltrexone is encouraged

Mandatory Naltrexone Study



- *Chart review of 18 anesthesiologists and 4 anesthesiology residents (N = 22; 95% male) under contract with PHP for opioid use disorder*
- ½ mandated to take naltrexone as part of contract, ½ not



Merlo, Greene, & Pomm (2011). *J Addict Med.*

Relapse (Naltrexone Group)

- The 1 anesthesiologist who relapsed on opioids despite naltrexone treatment did so after his wife's death. He admitted that he "didn't even get high."
- 1 other anesthesiologist taking naltrexone did relapse on an inhalant (Nitrous Oxide).
- It is noteworthy that 5 of the 11 anesthesiologists who took naltrexone had previously experienced a relapse on opioids or other drugs prior to beginning treatment with naltrexone.

Relapse (No Naltrexone Group)

- Of the 3 who did not relapse:
  - 1 left the field immediately and became a medical consultant
  - 1 indicated he was “terrified” of returning to anesthesiology, and instead went on Disability and then completed an Addiction Medicine fellowship
  - 1 returned to his anesthesiology residency

What do physicians and other healthcare professionals think about their PHP experiences?

Participant Experiences/Satisfaction

- *Online survey of participants/former participants from single state physician monitoring program*

TABLE 1.
Ways in which PHP participation was "Most Helpful" to physicians

Method of helping	Percent endorsing
Maintaining sobriety	85.9%
Job security	59.4%
Restoring healthy relationships	42.2%
Improving spiritual foundation	42.2%
Managing legal issues (not malpractice)	15.6%
Managing malpractice issues	6.3%
Other	2.5%
PHP Was NOT Helpful	4.7%

Merlo & Greene (2010). Am J Addictions.

Satisfaction with PHP

- Despite mandated participation in most cases, almost 80% “satisfied” with experience:
  - 44.6% Very Satisfied
  - 33.8% Satisfied
  - 6.2% Neutral
  - 4.6% Dissatisfied
  - 10.8% Very Dissatisfied
- Over 90% would recommend the program:
  - Helpfulness of monitoring
  - Advocacy/assistance in legal/licensure issues

PHP Participant Feedback

IN THE END, IT IS WORTH THE BURDEN/HASSLE TO PARTICIPATE:

–*It's been a journey and it's really…I can clearly say, now it's voluntary that I'm a member, and…prior membership was like mandatory and I was dragged in kicking and screaming.*

–*The bottom line is… if you're not in recovery, [the program's] a thorn in your ass. If you're in recovery, it's no big deal.*

IT EXPOSES HEALTH PROFESSIONALS TO PEERS WHO CAN HELP THEM:

–*The facilitator that we have is the greatest teacher of recovery that any person could want – sponsorship, non-sponsored, Twelve Steps, whatever. So, I, feel that it brought me closer to a Higher Power by being in the situation with the facilitator because of his recovery and his educational level about recovery, because it has really broadened me being here.*

–*[The program] has allowed me to be able to share very openly about my disease with other people that are like me. I don't feel alone, like I'm the only doctor out there that's like this.*

Merlo, Cummings, Cottler. (2010). College on Problems of Drug Dependence Annual Meeting.

THE PHP GIVES HEALTH PROFESSIONALS A CHANCE TO RECOVER:

–*I had like a moment of clarity and I felt like totally amazing that… someone else is gonna help me with the problem that I'm not able to do on my own. It was like a huge "ah-ha" moment, like finally, maybe this cycle, maybe these people won't let me keep doing this.*

–*The urine monitoring is very helpful in the beginning, you know, especially if you are at risk of relapsing.*

IT IS ONLY ONE COMPONENT OF A SUCCESSFUL RECOVERY PROGRAM:

–*The fear of getting caught keeps you sober for a while, but, eventually, if you don't have a program of recovery, fear alone will not keep you sober.*

–*[The program] gives you all the tools that you need, but you have to be willing to use them.*

How do healthcare professionals in recovery describe their recovery experiences?

Merlo, Conwell, & Rivenbark (2012). *American Society of Addiction Medicine Annual Meeting*. Atlanta, GA.

Quality of Life Following SUD Treatment

QOL Domain	% Improved	% Worsened
Physical health	86.2%	2.1%
Emotional/Psychological health	92.3%	2.1%
Romantic relationships	61.3%	14.0%
Sexual functioning/satisfaction	47.3%	14.0%
Family relationships	86.2%	5.4%
Social life	63.4%	20.4%
Work/career	72.0%	19.4%
Financial situation	50.0%	30.9%
Spiritual well-being	93.7%	1.1%

Changes in Quality of Life

- Increased length of time since signing a monitoring contract was correlated with greater improvements in:
  - family relationships ($r = .25$, $p = .02$)
  - work/career ($r = .31$, $p = .004$)
  - finances ($r = .33$, $p = .002$)

Five-Year Follow-Up Study

DuPont & Merlo (2016). Presented at FSPHP Annual Meeting

Method

- 8 PHPs attempted to contact past participants who had completed a contract for Substance Dependence and/or Substance Abuse at least 5 years earlier
- Physicians were invited to complete an anonymous online questionnaire regarding their experiences in the PHP, as well as the 5 years since their graduation

- **The PHPs contacted 42% of eligible physicians**
- **89% of those contacted agreed to participate**
- **N = 139**

Helpfulness of Components of Monitoring

Component	*M* (*SD*)	1	2	3	4	5	6	7	8
Initial contact/intervention w/PHP (n = 128)	**6.8** (1.8)	3%	8%	3%	2%	5%	11%	18%	52%
Formal Professional Assessment (n = 125)	**6.6** (1.8)	5%	7%	4%	4%	4%	10%	25%	42%
Substance Use Disorder Treatment (n = 124)	**7.2** (1.5)	5%	4%	2%	0%	1%	11%	15%	63%
Treatment for Comorbid Ψ Condition (n = 56)	**6.5** (1.7)	57%	2%	2%	0%	7%	9%	4%	19%
Signing PHP Monitoring Contract (n =130)	**7.2** (1.4)	0%	4%	1%	0%	3%	15%	19%	59%

1=Did Not Participate, 2=Extremely Unhelpful, 3=Moderately Unhelpful, 4= Somewhat Unhelpful, 5=Neither Helpful nor Unhelpful, 6=Somewhat Helpful, 7=Moderately Helpful, 8=Extremely Helpful

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Helpfulness of Components of Monitoring

Component	*M* (*SD*)	1	2	3	4	5	6	7	8
Random Drug & Alcohol Testing (n = 130)	**6.9** (1.6)	1%	4%	2%	1%	9%	11%	21%	51%
Worksite Monitor (n = 70)	**5.8** (1.4)	47%	2%	2%	2%	20%	11%	10%	8%
Attending 12-step Meetings (n = 127)	**7.2** (1.5)	2%	3%	4%	1%	3%	7%	15%	66%
Attending Caduceus / doctor "self help" meetings (n =117)	**6.4** (1.6)	10%	4%	4%	5%	6%	22%	19%	30%
Facilitated Monitoring Group Meetings (n = 90)	**6.6** (1.5)	30 %	3%	1%	2%	6%	14%	18%	24%

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MOST Valuable Elements of PHP

Component of PHP Participation	Rank	% Selecting as Most Valuable
12-Step Meeting Attendance	1	35%
Formal Substance Use Disorder Treatment	2	26%
Random Drug & Alcohol Testing	3	16%
Treatment for Comorbid Psychiatric Condition	4	8%
Caduceus / Doctor "self help" Group Meetings	5	7%
None of the Above (None were valuable)	6	5%
Other • "Counseling" • "12 step program" • "Being accountable to PHP Director"	7	2%

Item not selected: Worksite Monitor

Physician Outcomes

- 96% reported being licensed to practice currently
  - None of the non-licensed physicians (0%) reported that lack of licensure was related to substance use
- 91% of licensed physicians reported currently practicing medicine
  - 78% working full-time in medicine
  - 10% working part-time in medicine
  - 7% retired
  - 2% working in another field
  - 1% unemployed
  - 2% other
- 38% had voluntarily extended monitoring at some point
  - 20% were currently still being monitored

Relapse & Recovery

- 116 physicians (89%) reported completing contract without any relapse DURING MONITORING
  - 13 experienced 1 relapse
  - 1 experienced 2 relapses
  - 1 experienced 3 relapses
- 128 physicians (96%) reported they consider themselves to be “in recovery” now

Continued Recovery Supports: 12-Step

- 88% of respondents (n = 112) have attended 12-step meetings since completing their PHP contract
- Attendance during FIRST year post-PHP (n = 112):
  - < 1 time/month (n =7)
  - 1 time/month (n =7)
  - A few times/month (n =14)
  - Once a week (n =22)
  - A few times/week (n =42)
  - Most days/week (n=18)
  - Every day (n =2)
- Attendance during PAST year (n = 88, 69% of respondents):
  - < 1 time/month (n =17)
  - 1 time/month (n =7)
  - A few times/month (n =10)
  - Once a week (n =17)
  - A few times/week (n =29)
  - Most days/week (n=8)

Continued Recovery Supports: Religious

- 47% of respondents (n = 60) reported that participation in religious gatherings has been helpful in managing addiction and maintaining sobriety
- 56% of respondents (n = 73) currently participate in religious gatherings
  - < 1 time/month (n =8)
  - 1 time/month (n =10)
  - A few times/month (n =15)
  - Once a week (n =36)
  - A few times/week (n =3)
  - Most days/week (n=1)

Continued Recovery Supports: Other

- 25% of respondents (n = 32) have attended community/support meetings since completing their PHP contract
- Attendance during PAST year:
  - < 1 time/month (n =5)
  - 1 time/month (n =5)
  - A few times/month (n =2)
  - Once a week (n =9)
  - A few times/week (n =1)
  - Most days/week (n=2)

Views About Mandated Treatment

- 76% of respondents (n = 94) believe they would NOT have been able to maintain long-term abstinence without formal treatment (i.e., monitoring with random testing only)
  - 17/32 (53%) who believe they could have maintained sobriety reported they would not have experienced the same quality Recovery and personal growth/maturity without treatment

Support for Mandatory Treatment

- “Put simply: fear of being caught was not enough to keep me sober before participation in PHP, so I doubt it would have helped after. Without treating the underlying addiction, I would have tried to cheat the monitoring or take my chances of not being called for testing. The addiction itself must be treated.”
- “Treatment introduced me to AA, which remains necessary for me to remain sane and sober.”
- “I needed to be removed from my environment for an extended period of time before I was capable of choosing abstinence.”
- “I think because of treatment I could truly understand the idea that I had an illness and that it had distorted my thinking process. It was helpful to be amongst peers and to not feel so full of shame or alone. I think to have just a random testing program would have made the whole undertaking feel more punitive than therapeutic.”
- “Perhaps I could "white-knuckle" it, but the experience would not be as beneficial. I don't think I would be in genuine ‘recovery.’”
- “Addicts are inherently dishonest and manipulative, and I would have tried to continue my addiction somehow and fly under the radar. I tried to quit on my own many times….”
- “I would have remained isolated.”

Implications

- PHPs provide a national model for substance use disorder (SUD) care management
- Critics of the PHPs talk about the need for a "voluntary model"
  - Virtually no one with a SUD "wants" to stop using drugs or wants to go into treatment
  - When physician participants enroll in PHP care, most are resentful and critical
  - It is only when participants are in recovery that they say the PHP saved their lives and their medical practices
  - PHPs are "voluntary" – they help physicians maintain their medical licenses
  - PHPs have no punishment to deliver; they grant or withhold a safe harbor from consequences delivered by others
- PHPs, which expect **no use,** provide an alternative to the increasingly common harm reduction framework which mayb prolong drug use among individuals with SUDs

The Future of Substance Abuse Treatment

- The challenge facing drug policy is how to create and sustain lasting recovery

- The PHPs provide a template
  - Intensive, "brief" (typically 45-90 days) initial treatment committed to abstinence
  - Management of co-occurring conditions
  - Immersion in the 12-step recovery fellowships
  - Five-year intensive, comprehensive monitoring for any use of alcohol or other drugs – with serious consequences for noncompliance

Proof of Concept: Does it Work for Populations Other than Physicians?

- Two criminal justice system innovations validate the PHP care management model but lack some of its key features – in dramatically different populations
  - HOPE Probation for high-risk felony offenders
  - 24/7 Sobriety for repeat DUI offenders
- Similar programs have evolved in parallel for commercial pilots and attorneys, as well as for health care workers other than physicians

Looking to the Future

- The PHP model of care management sets the standard for treatment of SUD
  - DuPont & Merlo (2018). *The Judges Journal*
- This "New Paradigm" should be expanded and offered to all individuals suffering from SUDs
  - DuPont (2014). https://static1.squarespace.com/static/575830e0b09f958d96b6e4df/t/5759abb440261d4cd10b157d/1465494454305/IBH_New+Paradigm+for+Recovery+Report_March+2014.pdf
- The challenge is how to adapt this successful model to many other settings while maintaining its effectiveness
  - Access
  - Affordability
  - Contingencies

Thank You!

Questions?

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