CHALLENGES IN REGULATING PHYSICIAN HEALTH THE OREGON EXPERIENCE

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The passion for truth is silenced by answers which have the weight of undisputed authority.

- Paul Johannes Tillich, 1886-1965

AMA House of Delegates 2011 Meeting
REPORT 2 OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH (A-11)
Physician Health Programs
(Reference Committee D)

- EXECUTIVE SUMMARY

- Objective. To provide an historical overview on the development and operation of physician health programs (PHP) and briefly discuss what is known about the barriers to use of PHPs and the effectiveness of their confidentiality safeguards. Additionally, to review some key studies on the effectiveness of PHPs in order to identify best practice characteristics.

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- Conclusion.

  The medical profession has an obligation to ensure that its members are able to provide safe and effective care. All PHPs aim to protect the public and to help physicians maintain their own health and effectiveness, while protecting physicians same right to privacy and confidentiality of their medical records as anyone else seeking medical help or treatment. It is important that a state PHP have a strong collaborative relationship with the medical board in the state. The AMA recognizes the importance of developing new model guidelines to assist states in developing high quality programs that will **benefit their clients**.

Physician Health Issues

- Physical illness
- Stress and burnout
- Substance use disorders
- Psychiatric/psychological problems
- Aging and retirement

Illness ≠ Impairment

(Disciplinary Issues)

- Incompetence
- Professional misconduct
  - Disruptive behavior
  - Sexual misconduct and boundary issues
  - Criminal behavior
  - Ethical violations
  - Working while intoxicated or recovering from the effects of intoxication (hung over)

Who are the *clients* of PHP's?

Physicians!

Other major stakeholders

- The public
- Employers
- FSMB and state regulatory entities
- HHS and other federal health agencies
- AMA and other professional organizations
- *The addiction treatment industry*

The Addiction Treatment Industry Vendors

- Private addiction treatment centers (business entrepeneurs)
  - Intervention
  - Treatment
  - Education
  - Research
  - Public policy
- Professional "experts"
  - Addictionology (individuals and institutions)
  - Public policy (individuals and institutions)
  - Public relations and sales
- AA, NA, and other 12-step programs

The Addiction Treatment Industry Middle-Men

- Criminal justice system (includes professional licensing boards, FSMB, AIM)
- Consumer advocacy organizations
  - Citizen Advocacy Center
  - Public Citizen
  - The Joint Commission (formerly JCAHO)
- Managed behavioral healthcare corporations
  - Employee Assistance Programs, private insurance, Medicare/Medicaid
- Public media

The Addiction Treatment Industry Middle-Men (continued)

- Government
  - Bureaucrats
  - Politicians
  - Regulators and attorneys
  - DEA, NIH, NIDA, NIAAA, SAMHSA, …
- Independent Accreditors
  - The Joint Commission, Inc. (formerly JCAHO)
- Professional Organizations
  - ASAM, FSPHP, NAADAC, NAATP, NAPHS, AMA, APA, …

The Addiction Treatment Industry Customers (Patients)

- Voluntary
- Involuntary or coerced
  - Court-mandated
    - Prisoners, parolees, minors, persons with mental illness
  - Licensing board mandated
    - Healthcare professionals
      - Physicians
      - Nurses
      - Dentists
      - Pharmacists
      - Psychologists, marriage and family therapists, licensed clinical social workers, licensed professional counselors, massage therapists, laboratory technicians, phlebotomists,…
    - Pilots
    - Attorneys
    - Other professionals in safety-sensitive positions

Components of Business Success in the Addiction Treatment Industry

- Market was untapped
  - Nobody else wanted to deal with this problem
- Labor is cheap
  - Addicts/alcoholics in AA/NA/12-step recovery share a huge personal commitment to spread these programs to maintain their own "sobriety"
  - Treatment is provided by CADC's and other medical laypersons
  - Training is easy/cheap (most have already learned this on their own)
  - AA/12-step groups are free and widely available (but treatment centers can and do charge for them)
- Supply and demand can be manipulated
  - Disease/recovery model can be marketed
  - Definition of disease state can be controlled/expanded (DSM-5)
  - Treatment can be coerced
    - Early commercial successes with adolescent care
    - Later success with physicians and others in "safety-sensitive" positions
- Liability can be reduced or eliminated by statute
  - Yes, malpractice reform is theoretically possible in the United States!

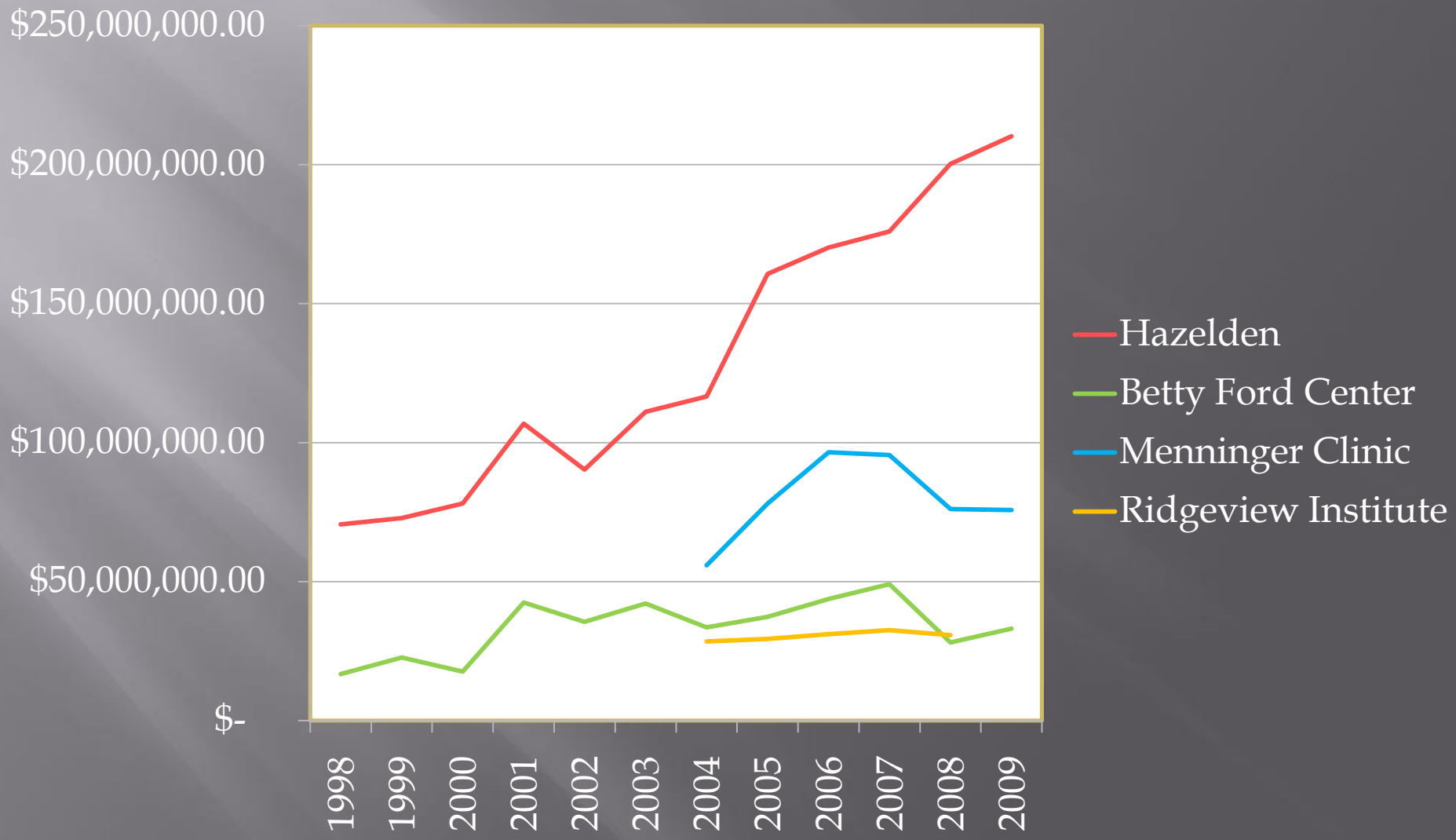
Commercialization of AA through the Minnesota/Hazelden Model

- Ridgeview Institute
  - Founded in 1976
  - Impaired professionals program added in 1977
  - Study of first 1000 physician-patients published in 1987
- Anchor Hospital and Talbott-Marsh Recovery Campus
  - Founded in 1986 to treat physicians with addiction
  - Later expanded to include dentists, nurses, pharmacists, pilots, clergy, lawyers, pro athletes and other public figures
  - $20,000,000/year gross revenue by 1995
  - Acquired by Charter Behavioral Health (Magellan Health Services) in 1997

Added Commercial Value of Stigma

- "Addiction" is a lifelong brain disease
  - Natural disease progression results in "jails, institutions (insanity), or death"
  - All addicts/alcoholics are liars, it's part of the disease
- Physicians have unlimited access to drugs and believe they are invulnerable to addiction
- Physicians are unwilling/unable to access help for addictions without coercion
- Physicians who are addicts/alcoholics are by definition "impaired professionals" who endanger public safety
- Physicians who dispute the diagnosis of addict/alcoholic or refuse AA/12-step programs as treatment for this condition are "impaired professionals "who are "in denial" , and who endanger public safety
- "Impaired professionals" can only practice safely while in a tightly controlled and monitored "recovery" program
- "Recovery" from alcoholism/addiction can *only* be attained through AA/12-step programs.

Commercial Success of the AA/Minnesota/Hazelden Model



THE TWELVE STEPS OF ALCOHOLICS ANONYMOUS

1. We admitted we were powerless over alcohol—that our lives had become unmanageable.

2. Came to believe that a Power greater than ourselves could restore us to sanity.

3. Made a decision to turn our will and our lives over to the care of God *as we understood Him.*

4. Made a searching and fearless moral inventory of ourselves.

5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.

6. Were entirely ready to have God remove all these defects of character.

7. Humbly asked Him to remove our shortcomings.

8. Made a list of all persons we had harmed, and became willing to make amends to them all.

9. Made direct amends to such people wherever possible, except when to do so would injure them or others.

10. Continued to take personal inventory and when we were wrong promptly admitted it.

11. Sought through prayer and meditation to improve our conscious contact with God, *as we understood Him*, praying only for knowledge of His will for us and the power to carry that out.

12. Having had a spiritual awakening as the result of these Steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs.

Religious components of 12-step (AA/NA, etc.) meetings

- Reverence for a "higher power"
- Steps and slogans with references to "God"
- Ritual group recitation of prayers
  - Serenity Prayer
  - Lord's Prayer
- Confessions/forgiveness
- "The Big Book" ("AA Bible")

No. 06-15474. - *INOUYE v. KEMNA* US 9th Circuit, 2007

- Establishment Clause of the First Amendment of the US Constitution - "Congress shall make no law respecting an establishment of religion."

- "We do not hold that AA/NA is itself a religion. We hold only that, for the purposes of reviewing the grant of summary judgment and on the facts alleged, the AA/NA program involved here has such substantial religious components that governmentally compelled participation in it violated the Establishment Clause."

- "While we in no way denigrate the fine work of AA/NA, attendance in their programs may not be coerced by the state."

"The greatest dangers to liberty lurk in the insidious encroachment by men of zeal, well-meaning but without understanding."
Omstread vs United States, 1928 Justice Lewis Braindeis

History of Oregon's PHP

- Prior to 1989: Separate from medical board
  - Peer support (addiction, 12-step recovery)
  - Independent medical society program
- 1989-2010: In-house by medical board (HPP)
  - Staff of two (one admin, one MD addictionologist)
  - Supervisory Council (5 MD's, one PhD, one MA)
  - Roughly 100 participants (addiction, + MH in 2009)
- 2010-present: HPSP - Outsourced from medical board to State DHS, who outsources to "private monitoring program" (Reliant BH) and "private monitoring entity"/"independent third party auditor" (Acumentra Health), "substance abuse" + "mental disorder"

OAR's adopted 4/8/2011 by Oregon Medical Board

- OAR 847-005-065(12) "Mental disorder" means a clinically significant syndrome identified in the current DSM that is associated with disability or with significantly increased risk of disability.

OAR's adopted 4/8/2011 by OMB (continued)

- OAR 847-005-065(18) "Substance abuse" means a disorder related to the taking of a drug of abuse (including alcohol); to the side effects of a medication; and to a toxin exposure, including: substance use disorders (substance dependence and substance abuse) and substance-induced disorders (including but not limited to substance intoxication, withdrawal, delirium, and dementia, as well as substance induced psychotic disorders and mood disorders), as defined in DSM criteria.

Historical Composition of Oregon's PHP Enrollees

- 1/3 Board Ordered
  - Board staff investigate physician
    - Medical laypersons, criminal justice background (retired cops)
    - Lack experience or formal training in addictions or mental health (informed by media and public perceptions, which are informed by industry)
    - Comb through licensee's medical, psychiatric, and psychotherapy records (including psychotherapy notes) for incriminating information
  - Board staff and legal counsel determine course of action, draft Board Order, and submit to Full Board for approval
  - Full Board votes (usually unanimously) to approve Board Order
- 1/3 Self-Referred
- 1/3 Other (referred by hospital or colleague)

Oregon HPSP Program Components

- 5-year contract
- Complete abstinence from alcohol and/or unapproved drugs, including many OTC's, even when appropriately prescribed and used as directed (based on rules of AA/NA)
- Cease practice if ordered by the program
- Enter treatment if ordered by the program
- Noncompliance with any term of the contract may result in termination from the program and referral to board for ***disciplinary action***

Oregon HPSP Program Components (continued)

- Random drug testing
  - Daily call-in (7 days/week for 5 years or more)
  - Witnessed collection
  - Work interruptions
  - Travel restrictions
- Required twice-weekly "mutual self-help" (AA/NA) meetings
  - Meetings are free, widely available, often public
  - Must document attendance and participation
    - Participation includes acceptance of diagnosis
    - "Denial" (disagreement with diagnosis) is treated as program noncompliance
  - SMART Recovery rarely approved as alternative "when client unable to accept 12 steps approach of AA/NA"

Oregon HPSP Program Components (continued)

- Required unlimited medical releases/disclosures
- Required worksite monitor/disclosure
- Required hospital monitor/disclosure
- Required weekly "non-therapy compliance consultation group meetings"
  - Separates monitoring and treatment
  - Reduces dual-agency of therapists, treatment monitors
  - Reduces medical malpractice liability of State and program staff/consultants by reducing the appearance they are providing treatment
  - Reduces political liability of program by reducing the appearance they are liable for program failures

Oregon HPSP "Contingency Management" for "Noncompliance"

- Multidisciplinary evaluation
  - To "assess commitment to recovery" and "clarify diagnoses"
  - Physician pays cost, $3000-$20,000
  - Board investigation tool to acquire more information to use against physician
    - Lie detector tests
    - Private psychotherapy notes
  - Treatment programs get more referrals for residential treatment
    - Historically evaluators self-referred (practice is changing)
    - Referral to other members of treatment monopoly (10-12 private AA/NA/12-step programs who claim special experience with physician impairment) is growing standard
- Additional residential treatment
  - Physician pays cost, $30,000-???

Oregon HPSP "Contingency Management" for "Noncompliance" (cont.)

- Public disclosure of private medical information about stigmatizing illnesses (Board Orders)
  - Boards improve public image
    - Public Citizen's role (informed by industry)
    - Citizen Advocacy Center's role (informed by industry)
    - FSMB's role (informed by industry)
    - Local media's role (informed by industry)
    - Public's role (informed by industry)
  - Physicians are harmed (public humiliation, professional harm, financial and legal burdens)
- License restrictions, suspension, revocation – report to NPDB and reflex disciplinary action in other states
- Loss of malpractice insurance, personal disability insurance
- Loss of personal income
- Loss of personal health insurance
- Loss of specialty board certification
- Loss of employability in healthcare

Oregon HPSP Cost to Participants

- Licensure fees
- Program enrollment costs
- Evaluation and treatment costs
- "Non-therapy compliance consultation group meetings" costs
- Drug testing costs
- Missed time from work
- Missed time from family and community life
- Loss of privacy, autonomy, freedom of religion
- Professional stigma
- Public stigma
- Self-stigma

Evaluation and Treatment Costs to Physician-Patient*

Facility	# of Days for evaluation	Cost for evaluation	# of Days for treatment	Cost for treatment
Betty Ford Center	3	$4000	90	$50,000
COPAC	5	$6000	90	$32,000
Hazelden	5	$6400	30-120	$30-62,000
Pine Grove	3-5	$3000-5380	45	$37,500
Sierra Tucson	4	$9900	30-45	$46-67,000
Talbott Recovery Campus	4	$4500	90	$40,000
The Farley Center	4	$3500*	90	$40,000
The Meadows	0	Incl. in Tx. Cost	35	$42,200

* Staff estimates provided by phone survey, June 2011

Oregon HPSP Impact on Physician Health Program Model

- 10-20% "have no business being there" (no clinically significant substance use disorder, primarily Board referrals)
- No more self-referrals
- No more colleague or hospital referrals
- "We've cured addiction among Oregon physicians"

Board Control of Oregon HPSP Design/Implementation

- Board must *pre-approve* evaluators, consultants, and treatment programs (decisions informed by industry)
- Physician *must* comply with evaluator's recommendations
- Evaluator Qualifications
  - Addictions (always, often with financial/personal/professional ties to AA/NA/12-step programs and treatment facilities/Board members/Board employees)
  - Mental Health (sometimes)
  - Medicine (usually not)
  - Must be willing to provide qualifying diagnosis(es) for mandating HPSP and to recommend residential AA/NA/12-step treatment at Board-approved facility

Board Control of Contractors/Subcontractose

- If you want to do business with us, you'll do it the way we tell you to do it (methods informed by industry)
- "Independent" private 3rd party evaluators must be pre-approved by Board (will deny approval of any evaluator who does not support the Board's approach)
- "Pre-approved" consultants and treatment programs (will deny approval of any consultant or treatment program who does not support the Board's approach)

Board control of Oregon HPSP design/implementation

- Evaluator Training
  - AA/NA/12-step model (with coercion if necessary) is medical standard of care
  - Generally have no other formal medical training besides AA/NA/12-step model of addictions (LCSW's, LPC's, CADC's, MSW's, …)
  - Goal of evaluation is to get physician into treatment
- Evaluator Incentive
  - Provide requested diagnosis/treatment plan in order to obtain more financially lucrative Board referrals
- Evaluator Protection
  - Insulated from professional liability by statute (extension of Board's state immunity from criminal/civil liability)

State's reactions to physician complaints/lawsuits

- No more "safe harbor" for physicians in treatment
- Change of statutory requirement for "chemical dependency" diagnosis
- Change of statutory definition for "substance abuse" and "mental illness"
- Statutes and administrative rules to remove most physician-patient rights
  - Informed consent
  - Healthcare privacy (including psychotherapy)
  - Healthcare quality (no liability for program malpractice)
- Consents require signing away future rights (because enrollees complained about signing new contracts on HPP conversion to HPSP)

Ethical and legal issues in developing a Model PHP

- Informed consent
- Program elements
  - Religion issue (mandatory AA/NA/12-step)
  - Abstinence issue (abstinence standard of AA/NA)
- Cost to participants
- Privacy protections
- "Contingency management"
- Managing conflicts of interest
- Suicide issue – personal and professional

Evidence-based alternatives to the AA/Minnesota/Hazelden Model

- Motivational Interviewing/ Motivational Enhancement Therapy
- Cognitive Behavioral Therapy
  - SMART Recovery
  - Rational Recovery
- Relapse Prevention Therapy
- Behavioral Couples Therapy
- Project MATCH

Controversies in the Abstinence Standard promoted by AA/NA

- Medication for withdrawal
- Medication for relapse prevention
- Medication for psychiatric disorders
  - Depression, anxiety, bipolar, ADD/ADHD,…
- Medical comorbidity
  - Pain, itching, allergy/asthma, cough, congestion, nausea, diarrhea, insomnia,…
- Caffeine and nicotine

Criticisms of Current PHP model

- No evidence of public protection
  - Helps those who want to be helped
  - Does not adequately monitor
  - Iatrogenic harms (one-size-fits-all)
    - Level of care same regardless of seriousness of problem
    - Same treatment approach regardless of physician needs or preferences (no non-12-step options)
    - Same contingencies regardless of seriousness of "noncompliance"
    - Contingencies for inadvertent exposures/dilute urines
- No evidence of long-term success
- Some evidence of increased physician suicide rates
  - Imposes significant financial burdens
  - Interferes with social support (family, community, co-workers)
  - May conflict with religious beliefs and/or psychological coping mechanisms
- Perpetuates stigma, exploits the stigmatized for profit

AMA Challenges in Developing a New PHP Model

- Informed consent (information/risks/benefits/alternatives)
  - Consent must be given freely, coerced treatment is not OK
- Healthcare privacy
  - Steven Miles, MD, Professor of Medicine and Bioethics
- Program accountability
  - Protect public safety by defining professional standards
  - Protect the nation's supply of qualified, experienced, dedicated physicians by protecting patient rights for physicians
- Help overcome the stigma of addictions and mental illness
- Advocate for physicians as healthcare consumers
- Promote physician health and wellness