An Outsider Looks at PHP Care Management

The twin goals of the state Physician Health Programs are to help physicians achieve long-term recovery and to save their careers while also protecting the public and its confidence in physicians.[1, 2] The incentive for physicians to participate in this rigorous system of care management is that the PHPs validate the physicians' abstinence from the use of alcohol and other drugs and compliance with recovery-focused care. The only consequence for physicians who reject or fail to comply with PHP care management is that the PHP removes the safe haven it provides to the physician. Leaving the PHP can result in adverse actions by others such as state Boards of Medicine, hospitals, insurance companies or families who require PHP care. There is no adverse action taken by the PHPs.

The well-documented results of PHP care management speak for themselves.[3, 4, 5, 6, 7, 8, 9] These outcomes set the standard for the entire world by making long-term recovery, and not relapse, the expected outcome of the PHP intervention and treatment.[10, 11, 12]

This remarkable system has evolved over the past four decades, often led by physicians who are themselves in recovery. There is no one PHP model; instead each state program adapts the core approach to the individual state needs. It would be unfortunate to insist on a rigid format for all states not only because that ignores differences in the state regulations and laws that strongly affect the PHP programs, but also because it would stifle the ongoing innovations that have characterized the PHPs throughout their existence.

PHPs have adopted varying strategies to assist in the management of behavioral health problems among physicians, including serving physicians with alcohol and drug use disorders. The 2008 Joint Commission of Healthcare Association (JCOHA) publication 'Creating a Culture of Safety' (Issue 40)[13] empowered hospitals and practices to intervene when the behavior of physicians interferes with the optimal functioning of clinical teams. While PHPs have an admirable record of success helping physicians with addiction and other psychiatric illness, some physicians with concurrent substance use and mental illness can present difficult management challenges, a fact that those critical of PHPs often fail to reflect in their comments.

It is important to recognize that many physicians entering into PHP care are angry and feel beleaguered because they do not think they have problems or need treatment. This is not unique to physicians. It is common in all addiction treatment. About 95% of individuals with substance use disorders to not perceive that they have a problem or need treatment.[14] What is unique in my experience is that the large majority of physicians who leave their PHP experience are grateful to these programs. Even more impressive is that most participants remain in long-term recovery after their monitoring ends.

Not every participating physician succeeds in PHP care management. For as many as 10 to 20%, their illnesses prevent them from returning to the practice of medicine. Some of these physicians will return PHP care after initially failing and then succeed on their second or third tries. Some who fail feel betrayed by the profession of medicine and by the PHP.

I see PHP care management as inspiring a new way of thinking about addiction treatment which I have labeled the New Paradigm.[15, 16, 17] This new approach links high quality recovery-oriented treatment with long-term monitoring and support with the standard of no-use of alcohol or other drugs. It features immersion in community support, mostly but not always the 12-step fellowships. The random testing used by the PHPs is remarkable in identifying relapses quickly and permitting early intervention. The long-term wrap-around approach provided by PHP care has demonstrated its ability to regularly deliver recovery and satisfied, grateful participants. This is all the more remarkable given how unhappy and resentful most of these same physicians were at the time of their initial evaluations.

Legitimate concerns have been raised about the quality, objectivity and transparency of evaluations for physicians, for which guidelines and standards for the evaluation of physicians have been published by the American Psychiatric Association.[18] Those conducted by centers offering treatment have been criticized as biased but they may be less expensive than independent evaluations.

Physician suicide has been a concern long before the establishment of PHPs.[19] Stigma within the medical profession itself concerning mental illness and addiction has been cited as a factor contributing to suicide risk. A small outcome study by the Vanderbilt Comprehensive Assessment Program showed not surprisingly that being found unfit to practice and working in isolation were significant suicide risk factors.[20] Loss of income, loss of a professional role, and refusal to accept recommendations for care are other reasons physicians fail to seek treatment. Also important are the financial costs of treatment, maintaining practice and supporting a family. There is no insurance available that is suited to many of these needs. Because physicians regularly place themselves in a positive light even under these often desperately stressful circumstances, it should not be surprising that subsequent suicide was not readily predictable.

The PHP care management system deserves careful study because it holds great promise of improving the often frustrating enterprise of addiction treatment. PHPs also appear to be the best way to organize the difficult task of caring for physicians with other behavioral and mental health problems.

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Ten years ago, after more than three decades working in addiction treatment, recognizing the ubiquity of relapse after even the best treatment for alcohol and other drug addiction, I asked the question, "How good can long-term outcomes be for this cunning, baffling and powerful disease?"

The answer was in my practice. I had seen many physicians under the care management of physician health programs (PHPs) who did amazingly well. That observation let me to recruit

A. Thomas McLellan, PhD and Gregory Skipper, MD to help me conduct the first national study of PHP care with the active support of the Federation of State Physician Health Programs (FSPHP). We conducted the study with a small grant that Dr. McLellan obtained from the Robert Wood Johnson Foundation. To date, there have been seven professional articles published from that initial study of 904 physicians in 16 state PHPs.

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