

Potential Impairment in the Healthcare Professional and the Physicians Health Program

P. Bradley Hall, M.D.

Executive Medical Director, WVMPHP

West Virginia University-Resident Orientation

Presented by

P. Bradley Hall, M.D., DABAM

Executive Medical Director,
West Virginia Medical Professionals Health Program,
(WVMPHP)

President,
West Virginia Society of Addiction Medicine (WVSAM)

President,
Federation of State Physician Health Programs, (FSPHP)

CONFLICT OF INTEREST DISCLOSURES

Name	Commercial Interests	Relevant Financial Relationships: What Was Received	Relevant Financial Relationships: For What Role	No Relevant Financial Relationships with Any Commercial Interests
P. Bradley Hall MD				X

The Sick Physician and the PHP

- The continuum of illness versus impairment
- Potentially impairing conditions
 - Substance Abuse, Mental Illness & Co-morbidities
- What is a PHP / PAP?
- Barriers to detection and assistance
- Humanness (Occupational hazard)
- Statistics / characteristics of PHPs / WVMPPHP
- THE MESSAGE / Resources / Sources

objectives

APPLICABILITY

- Federation of State Physician Health Programs – www.fsphp.org
- Federation of State Medical Boards, Impaired Physician Policy – www.fsmb.org
- American Society of Addiction Medicine, Physician Health Policies – www.asam.org
- American Board of Medical Specialties – www.abms.org
- Physicians, Nurses, Pharmacists, Dentists, etc.
- Conscious awareness
- Patients

Healthcare & other Licensed Professionals

HUMANESS

Why I Do What I Do

- 1 versus 10
- 2 paths
- Making a difference in the lives of the addicted patient

INTENTION versus EFFECT

Physician Role In The Epidemic

- Prescribing
 - Acute versus chronic pain
 - Psychiatric illness
 - Recovering patient
- Patient education
- Prescription monitoring programs
- Barriers
 - Business of medicine
 - Medical legal climate
 - “POS”
- Society – pill fix

Physician Role..... (con't)

Pill mills

- Greed

The Antidote Is a Cultural Change In Medicine and Therefore Changing Behavior in our Patients (Society)

Health and Wellbeing Issues

- Life / Work Balance
- Satisfaction
- Lack of joy / unhappiness
- Stress
- Distress
- Burnout
- Behavioral Health (interpersonal)
- Mental Health
- Physical Health
- Substance Use / Addiction
- Suicide

* Professionalism/Boundaries

Finding Balance in the Medical Life

Lee Lipsenthal, M.D.

Burnout

- Emotional exhaustion
- Loss of meaning in work
- Feelings of ineffectiveness
- Depersonalization - viewing people as objects rather than human beings

Burnout impacts the quality of care physicians provide and physician turnover.

Burnout

AMA / Mayo Clinic –
6,880 physicians surveyed 2011 & 2014

- At least one symptom of burnout increased 2011-2014 (45.5-54.4%)
- Work / Life balance satisfaction declined 2011-2014 (48.5-40.9%)
- Burnout rates higher for all specialties in 2014
- Nearly a dozen specialties increased greater than 10%
- More prevalent when compared to the general US working population even when adjusted for age, sex, hours and educational level

Resilience

The ability of an individual to respond to stress in a healthy, adaptive way such that personal goals are achieved at minimal psychological and physical costs..... the “Bounce-Back”.

Resilience

Wellbeing of clinician
workforce, quality of care and
healthcare costs are linked.

Resilience

- Self-awareness and self-monitoring
- Self-regulation and resilience
- Public accountability, communities of care and healthcare institutions

Self-Regulation & Resilience

- Cognitively
- Emotionally
- Somatically
- Spiritually

Self-Awareness & Self-Monitoring

- Recognizing stressed-ness
- Fatigue & irritability
- Outside comfort zone
- Emotional, mental & physical “temperature”

Public Accountability, Communities Of Care And Healthcare Institutions

- Training programs
- Hospitals
- Employers
- Patients
- Public

Attending To Self

- Resilience is about wholehearted engagement with and not withdrawal from the often difficult realities of the workplace.
- Paradoxically the loss of resilience can result from seemingly energy saving measures of withdrawal.

The way out is to get all in

Education is the Key

- Addiction is a chronic relapsing disease
- Voluntary versus Involuntary Usage
- Addiction – drugs versus alcohol
- Addiction stigma
- Addiction is non-discriminatory
- Addiction is treatable
- Addiction recovery is possible
- Professional Health Programs Work

The Educational Pyramid

Children / Parents

College

Medical Students

ALL HEALTH CARE PROVIDERS

Residents

Practicing Physicians

Patients

The Sick Physician and the PHP

- The continuum of illness versus impairment
- Potentially impairing conditions
 - Substance Abuse, Mental Illness & Co-morbidities

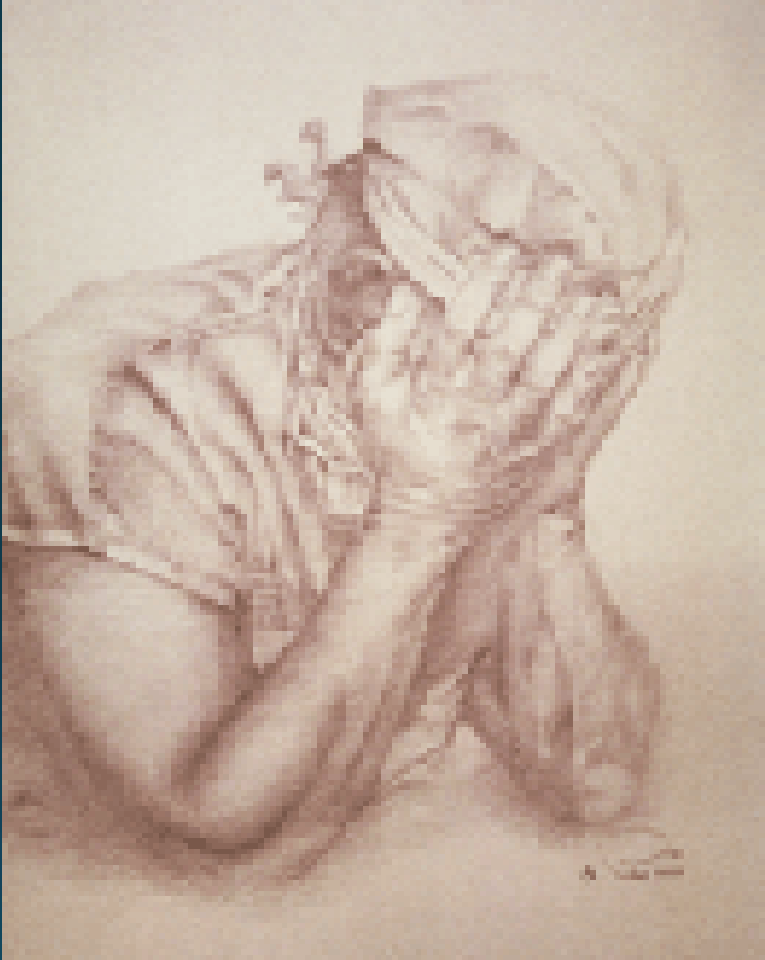
objectives

RECOGNITION: ???

Signs & Behaviors of Potential Impairment Indicating Possible Referral to the Medical Professionals Health Program and “What is that?”

Reality

- Most chemically dependent physicians are untreated or unrecognized and are still practicing medicine.



Illness VS. IMPAIRMENT

- FSPHP Public Policy on Illness vs. Impairment
Physician illness and impairment exists on a continuum with illness typically predating impairment, often by many years.
- Illness is the existence of a disease
- Impairment is a functional classification implying the inability of the person affected by disease to perform specific activities

www.fsphp.org

Impairment:
“inability to practice
with reasonable skill
and safety”

American Medical Association definition -

“IMPAIRMENT” - “the inability to practice medicine with reasonable skill and safety due to:

- 1) mental illness
- 2) physical illnesses, including but not limited to deterioration through the aging process, or loss of motor skill, or
- 3) excessive use or abuse of drugs, including alcohol”

Historical Perspective

- ❖ 1700 's – Benjamin Rush promoted the “Disease Concept of Alcoholism”
- ❖ 1870 – American Association for the Cure of Inebriety
- ❖ 1929 – The College on Problems of Drug Dependence
- ❖ 1935 - Alcoholics Anonymous
- ❖ 1953 - FSMB calls for model physician assistance programs
- ❖ 1956 – American Medical Association recognized Alcoholism as a “Disease”.
- ❖ 1973 – “The Sick Physician: Impairment by Psychiatric Disorders, Including Alcoholism and Drug Dependence” by AMA Council on Mental Health



Historical Perspective

- ❖ 1975 and 77' – AMA held Physician Health Conferences
- ❖ 1980 – almost all state medical societies had authorized or implemented a state PHP and PHPs were communicating.
- ❖ 1987 – American Medical Association recognized drug dependence as a “Disease”
- ❖ 1990 - Several state Physician Health Program's organized the Federation of State Physician Health Programs
- ❖ 1995 – FSMB published guidelines for a model Physician Health Program
- ❖ 2004 – Federation of State Physician Health Programs (FSPHP) Guidelines



Historical Perspective

- ❖ 2007 – West Virginia State Medical Assoc. Senate Bill No. 573 West Virginia's Medical Professionals Health Program
- ❖ 2010 – Licensure Fee
- ❖ 2011 – American Society of Addiction Medicine 11 Policies on Physician Health
- ❖ 2012 - FSMB updated the guidelines for a model Physician Health Program
- ❖ 2012 - Appalachian Addiction & Prescription Drug Abuse Conference was born under the auspices of the WV State Medical Association



Historical Perspective

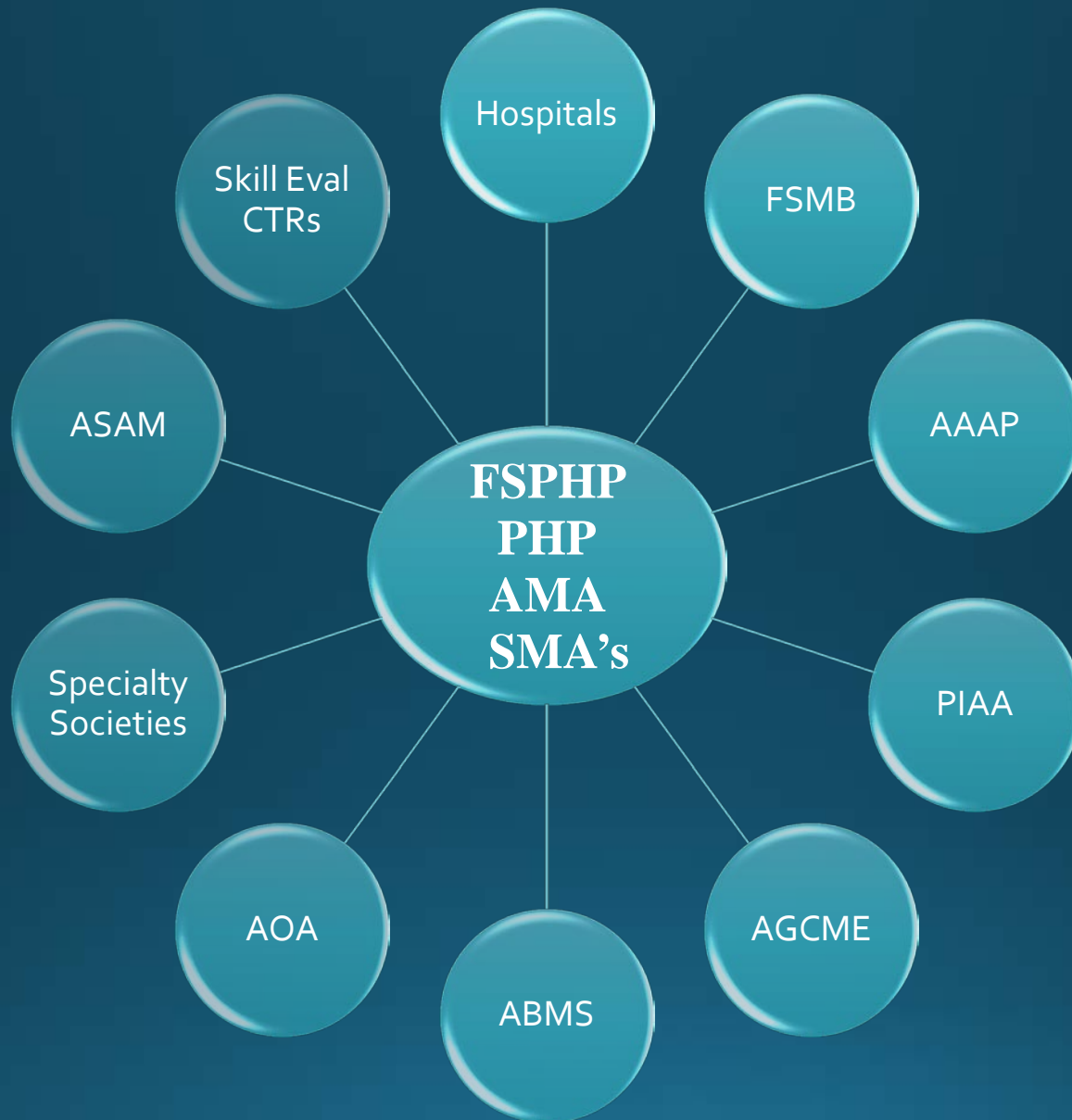
- ❖ 2016 – World Medical Association, Physician Wellbeing Policy
- ❖ 2016 – AMA Model Physician Health Program Act (1985 policy revision)
- ❖ 2016 – FSPHP Guidelines Update (in process)
- ❖ 2016 – ACGME – Symposium on Physician Wellbeing
- ❖ 2016 - The AMA Council on Medical Education Report 1-I-16, Access to Confidential Health Services for Medical Students and Physicians, was adopted as amended at I-16 and the final recommendations are now official AMA policy (H-295.858)

FSPHP Collaboratives

- Federation of State Medical Board & Federation of State Physician Health Program Conferences
- American Society of Addiction Medicine's Drug Testing Appropriateness Document
- Federation of State Medical Board's Burnout Task Force
- Federation of State Medical Board's Ethics and Professionalism Committee
- Coalition for Physician Enhancement, CPE
- American Osteopathic Association, AOA
- Coalition of Physician Education, COPE
- American Medical Association, AMA
- ASAM Text (6th Edition) Chapter on PHPs & Physician Addiction (Paul Earley, M.D.)
- Physician Mental Health and Well-Being: Research and Practice Textbook (28 authors)
- FSPHP Guidelines update
- California Legislation SB1177– Physician Health Program enabling legislation
- The Council on Medical Education Report 1-I-16, Access to Confidential Health Services for Medical Students and Physicians, was adopted as amended at I-16 and the final recommendations are now official AMA policy (H-295.858)

AMA Physicians Health Program Act

- Dual Purpose
- Early Detection
- Mitigate Barriers
- Confidentiality / Public Safety / Discrimination
- Funding
- PHP Model Endorsement
- Principles of Accountability, Communication, Collaboration & Transparency



2017 FSPHP Annual Meeting

April 19-22, 2017 - Worthington Renaissance Fort Worth Hotel Fort Worth, Texas

PHPs Restoring Physician Satisfaction and Wellness in an Era of Burnout, Mental Illness, Addiction & Suicide

- FMA – CME Provider

- Objectives:

Burnout Prevention & Satisfaction in Medicine

Mental Health & Suicide Prevention

PHP Best Practices

PHP Funding Strategies

The Aging Physician Population

- Guest Speakers Pending

- Kurt Mosley, Vice President of Strategic Alliances for Merritt Hawkins, Staff Care, companies of AMN Healthcare, the innovator in **healthcare workforce** solutions.
- Christine Moutier, MD, Chief Medical Officer, American Foundation for Suicide Prevention
- Art Hengerer M.D., FSMB
- Suzie Brown, MD, “My Life as a Guitarologist” (Cardiologist, singer songwriter)

2018 FSPHP Annual Meeting - April 24 - 28

What Is Addiction

- Seems So Self Evident
- DSM IV/**V**
- Dependence - Physical & Psychological
- Negative Effects On Life
- Out Of Control
- Pattern Of Use

What is Addiction?

Progressive, Incurable, and Fatal Disease: a Chronic, Relapsing Medical Condition

- ✓ Progressive - Illness rarely gets better without intervention / treatment.
 - ✓ Incurable - Chronic condition. No such thing as a “cure”. There are no **ex-addicts** or **ex-alcoholics**.
 - ✓ Fatal - Overdose, car accident, suicide, liver disease, heart disease, homicide
- ➔ Definition of Addiction: Continuing behavior despite suffering negative consequences as a result of that behavior.

www.asam.org = definition of addiction

Four “C’s” of Addiction

- Involves loss of Control- taking more of the medication than prescribed, taking the medication when pain is well-controlled.
- Compulsion -Inability to Cut down on dose despite attempts, promises...can't stop.
- Continued use despite adverse Consequences
- Cravings -constant thoughts about (obsession) or intense desire for (compulsion) drug

Symptoms of Substance Use Disorders (SUD)

	DSM-IV Abuse ^a		DSM-IV Dependence ^b		DSM-5 Substance Use Disorders ^c	
Hazardous use	X	} ≥1 criterion	–	} ≥3 criteria	X	} ≥2 criteria
Social/interpersonal problems related to use	X		–		X	
Neglected major roles to use	X		–		X	
Legal problems	X		–		–	
Withdrawal ^d	–		X		X	
Tolerance	–		X		X	
Used larger amounts/longer	–		X		X	
Repeated attempts to quit/control use	–		X		X	
Much time spent using	–		X		X	
Physical/psychological problems related to use	–		X		X	
Activities given up to use	–		X		X	
Craving	–		–		X	

^a One or more abuse criteria within a 12-month period *and* no dependence diagnosis; applicable to all substances except nicotine, for which DSM-IV abuse criteria were not given.

^b Three or more dependence criteria within a 12-month period.

^c Two or more substance use disorder criteria within a 12-month period.

^d Withdrawal not included for cannabis, inhalant, and hallucinogen disorders in DSM-IV. Cannabis withdrawal added in DSM-5.

Symptoms of Substance Use Disorders (DSM-5)

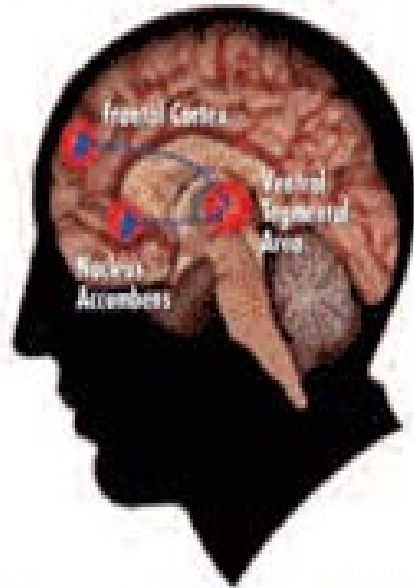
1. Using larger amounts or over a longer period than was intended
2. Desire to cut down or unsuccessful efforts to control use
3. Great deal of time spent obtaining, using or recovering from use
4. Craving, or a strong desire or urge to use substance
5. Failure to fulfill major role obligations at work, school, or home
6. Continued use despite recurrent social or interpersonal problems
7. Giving up social, occupational, recreational activities due to use
8. Recurrent use in situations in which it is physically hazardous
9. Continued use despite physical or psychological problem caused or exacerbated by use
10. Tolerance
11. Withdrawal

Diagnosing SUD in DSM-5

- 11 criteria
- Criterion eliminated: recurrent legal problems
- Criterion added: **craving** or strong desire to use
- Severity
 - Mild: 2-3 symptoms
 - Moderate: 4-5 symptoms
 - Severe: 6 or more symptoms

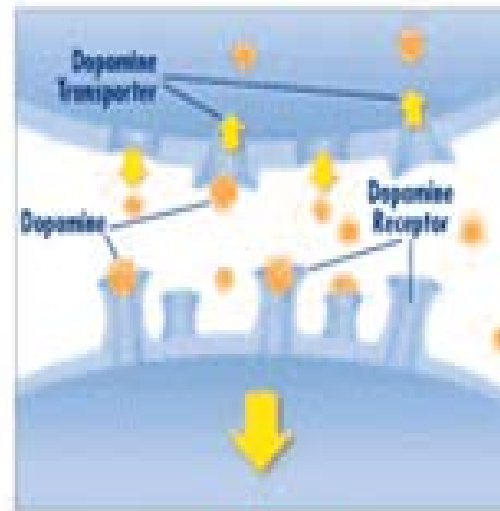
ALL DRUGS OF ABUSE TARGET THE BRAIN'S PLEASURE CENTER

Brain reward (dopamine) pathways



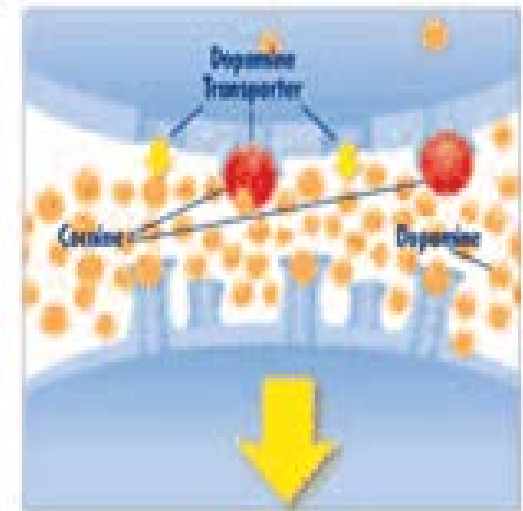
These brain circuits are important for natural rewards such as food, music, and art.

All drugs of abuse increase dopamine *



FOOD

Typically, dopamine increases in response to natural rewards such as food. When cocaine is taken, dopamine increases are exaggerated, and communication is altered.



COCAINE

Brain Reward Pathway: Dopamine Release

What Happens when Intoxicants are used?

- All intoxicant chemicals interact with the brain's reward system
- These drugs impact on brain levels of the neurotransmitter (chemical messenger)
dopamine
- Depending on the class of drug, they also interact with other brain neurotransmitters

Addiction Progression

- Recreation and Fun ➡ Need to
- Need to ➡ Have to
- Have to ➡ Bad stuff

LOSS OF CHOICE

Mental Illness

- 43.4 million (17.9%) age 18 or older had AMI
- 9.8 million (4%) age 18 or older had SMI
- 3 million (12.5%) adolescents had MDE
- 2.1 million (70.7%) 12-17 with MDE with severe impairment

NSDUH 2015

SUBSTANCE USE DISORDERS

- 20.8 million (7.8%) aged 12 or older had an SUD
- 19.5 million (22.2%) aged 18 or older had an SUD
- 1.2 million (5.0%) aged 12-17 had an SUD

NSDUH 2015

AAFP This Week (vol. 4, #36, 9/9/03)

- “Patients with drug or alcohol dependence or abuse problems will be hard to detect unless the physicians ask them about their use
 - 94% of the 22 Million people with these problems fail to recognize these problems in themselves

Initially, a person takes a DRUG hoping to CHANGE their MOOD, PERCEPTION, or EMOTIONAL STATE.

Translation.....

.....HOPING TO CHANGE THEIR BRAIN

Report of the Council of Mental Health of the American Medical Association (1972)

- "It is a physician's **ethical responsibility to take cognizance** of a colleague's inability to practice medicine adequately by reason of physical or mental illness including alcoholism and drug dependence"

CAGE

Cut down
Anger
Guilt
Eye Opener

+2 = 60-90% sensitive

The Addicted Physician

- Typically, the hospital/ practice is the last place addiction manifests symptoms
- Physicians hold the workplace sacred
- Disruptions in family, personal health, community, social, spiritual and leisure life can all occur while the workplace remains relatively unaffected
- Even very small intrusions of addiction into the workplace should be taken extremely seriously in physicians

The *Psychology of the Physician

- Haunted by our failures
- Perfectionistic: “Society’s meat is the physician’s poison” (Gabbard, 1985)
- The vulnerability factor for depression, burnout, suicide, and anxiety (Beevers and Miller, 2004)
- Low childhood self-esteem is additive
- Relief from intra-psychic torment and conflict is a learned phenomenon

***Adapted from Myers and Gabbard: The Physician as Patient, 2008**

Medical Specialty and Addiction

- There is no specialty that "protects" a physician from a substance use disorder
- Although incidence varies in various series, certain specialties are generally over-represented:
 - Anesthesiology
 - Obstetrics/Gynecology
 - Family Medicine/General Practice
 - Emergency Medicine
 - Physicians (all types) in Academic Medicine
 - Early identification and diagnosis are critical.
- Barriers to early diagnosis:
 - "conspiracy of silence"
 - denial on the part of family, friends, colleagues, even patients

Medical Specialty and Addiction

- These barriers are the products of a lack of education concerning the true nature of addiction as a primary biogenetic and psychosocial disease.
- Tenacious denial is the common feature of alcoholic/addict physicians
- Knowledge of the effects of drugs and alcohol create the delusion that special insight provides immunity
- Alcoholic/addict physicians cannot see themselves as sick; do not accept dependency as a disease
- Family members and colleagues contribute to the denial by covering up/making excuses for the physician, don't demand he/she seek help

Subtlety

- Any change from known practice/ personal style
 - Will be attributed to anything else (but addiction)
 - It could well be both (e.g.. Divorce and addiction)
- Even very small intrusions of addiction into the workplace should be taken extremely seriously in physicians
 - Tip of the Iceberg



Coronary Artery Disease

- Hypertension
- Diabetes
- Hyperlipidemia
- Exercise
- Smoking
- Diet

Addiction

- Depression
- Anxiety
- Pain
- PTSD
- Physician Illness
- Co-dependency

Co-Morbidities

Potentially Impairing Conditions

- Chemical Dependency
- Mental Illness
- Dual Diagnosis
- Stress Disorder
- Disruptive Behavior
- Psychosexual Disorder
- Incompetence/Dated
- Unethical

Suicide / SUD / AMI

- 3.9 % of adults with AMI had serious thoughts of suicide in the past year.
- 1.1% / 2.7 million adults made suicide plans
- 0.6% / 1.3 million attempted suicide
- Patients with an ETOH use disorder 20x more likely to complete suicide than general population.

Suicide

400

physicians

Suicide Risk Factors

- Previous suicide attempts
- History of **mental** disorders, particularly depression
- History of **alcohol** and substance abuse
- Family history of suicide
- Family history of child maltreatment
- Feelings of hopelessness
- Impulsive or aggressive tendencies
- **Barriers to accessing mental health and/or addiction treatment**
- Loss (relational, social, work, or financial)

Suicide Protective Factors

- **Effective** clinical care for mental, physical, and substance abuse disorders
- Easy **access** to a variety of clinical interventions and support for help seeking
- Family and community **support**
- Support from **ongoing** medical and mental health care relationships
- Skills in **problem solving**, conflict resolution, and nonviolent handling of disputes
- Cultural and religious beliefs that discourage suicide and support self-preservation instincts

WHOSE DOMAIN ?

- HOSPITAL ?
- WVMPHP ?
- LICENSING/DISCIPLINARY AGENCY ?

The Sick Physician and the PHP

- The continuum of illness versus impairment
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 - Substance Abuse, Mental Illness & Co-morbidities
- What is a PHP / PAP?

objectives

Physician Health Programs

From PREPARED

Thru POTENTIALLY
IMPAIRED

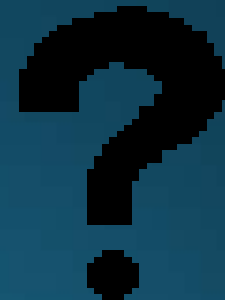
To REPAIRED

"Try to remember that though God has wrought miracles among us, we should never belittle a good doctor or psychiatrist. Their services are often indispensable in treating a newcomer and in following his case afterward."



~Alcoholics Anonymous, 4th Edition,
The Family Afterward, pg. 133~

What is a Physicians Health Program?

and What it is NOT



What the WVMPHP is NOT...

-  a “Provider of treatment”
-  a place of refuge
-  simple or easy
-  tolerant of unwillingness,
dishonesty or denial
-  the decision maker of
diagnoses or impairment

What a PHP is...

- ❑ Receives reports of professional impairment, investigates, collects collateral information and refers appropriately
- ❑ Supportive, structured, monitored environment of recovery to a total abstinence model
- ❑ It is a State wide, multifaceted rehabilitation and monitoring program with twin goals of protecting the public and helping physicians with substance abuse disorders and mental illnesses improve their lives and careers
- ❑ Safe haven alternative to licensure restriction leading to early detection of potentially impairing conditions
- ❑ Reasonable way out of a difficult problem

What a PHP is... (con't)

- ❑ Honest, concerned and compassionate
- ❑ Recovery monitoring and documentation
- ❑ Supportive of physician and their families
- ❑ Networking opportunities with colleagues experiencing similar issues
- ❑ Advocacy via documentation of recovery activities, abstinence and compliance
- ❑ Confidential
- ❑ Helps protect the public

Balancing Act



Our Delicate Balancing Act

Confidentiality



Public protection

“Illness”



“Impairment”

Treatment



Discipline

73

OBSTACLES to State PHPs

- The Regulatory Entity
- The Professional Association
- State Law (or lack thereof)
- The State Legislature
- Disgruntled and connected former clients
- CAC / Watchdog groups
- Human Resources
- The Press
- Evolving Others....

FUNDING

Physicians have a right and an obligation to ask for help when they are struggling with impairment. When they request assistance, they deserve the same care and respect they give their own patients everyday.



Recovery Progression

- Bad stuff ➡ Have to
- Have to ➡ Need to
- Need to ➡ Fun & Recreation

REGAINING OF CHOICE

Potentially IMPAIRED

- Chemical Dependency
- Mental Illness
- Dual Diagnosis

POSSIBLY IMPAIRED

- Stress Disorder

NOT IMPAIRED

- Sexually Exploitive
- Incompetent/Dated
- Unethical
- Disabled

PROBLEM PHYSICIANS

• Chemical Dependency	PHP
• Mental Illness	PHP
• Dual Diagnosis	PHP
• Stress Disorder	?
• Disruptive Behavior	HOSPITAL
• Psychosexual Disorder	BOARD
• Incompetent/Dated	BOARD
• Unethical	BOARD

WV STATUTES PROVIDE A *CONFIDENTIAL* CONDUIT for Evaluation and/or Treatment, Monitoring and earned Advocacy

The Sick Physician and the PHP

- The continuum of illness versus impairment
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 - Substance Abuse, Mental Illness & Co-morbidities
- What is a PHP / PAP?
- Barriers to detection and assistance

objectives

BARRIERS TO REPORTING

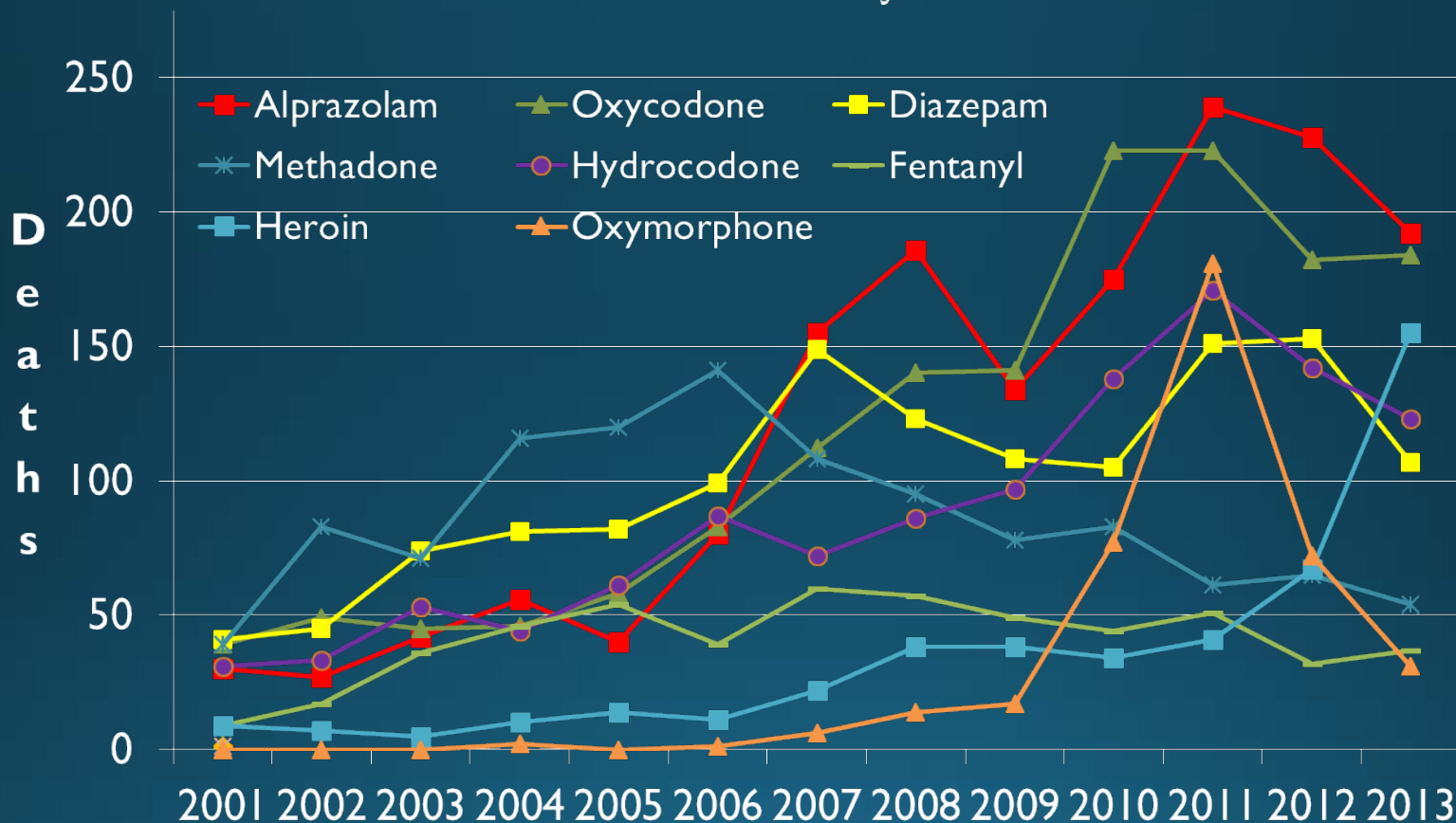
THE DEADLY SILENCE

CAVEATS

- The Patient
 - Denial is great
 - Insight is poor
- The clinician
 - Ignorance
 - Avoidance
 - Oversight

Trend Analysis – 8 Commonly Involved

WV Drug Overdose Deaths by Selected Drug Involved
2001-2013 Occurrences by Year



Data Source: WV Health Statistics Center, Vital Statistics System

* - 2012 and 2013 Preliminary

Barriers to Help



Conspiracy
of
Silence

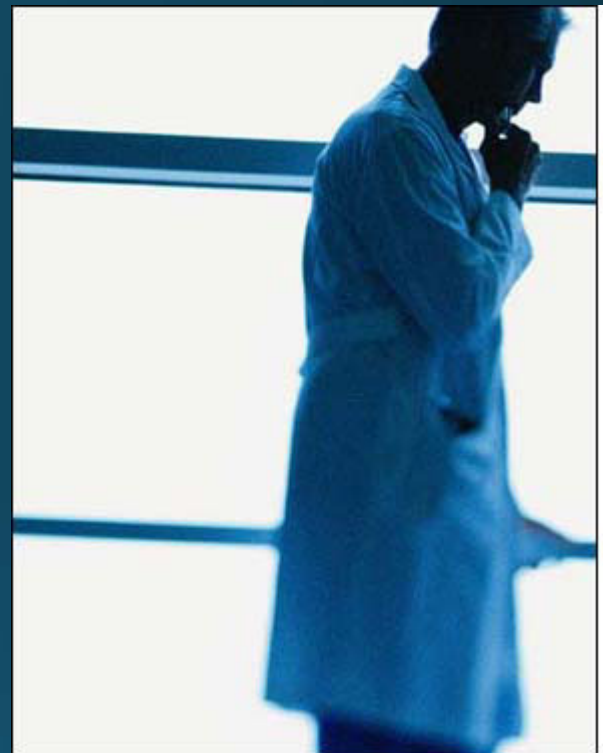
DEADLY SILENCE

- DENIAL
- FEAR
- IGNORANCE
- AMBIVALENCE
- MYTHS

Don't
Even
Notice
I
Am
Lying

DENIAL

- NOT = LYING
- SUBCONSCIOUS
- DEFENSE MECHANISM
- IS PROTECTIVE



*Most Treatment programs easily address this issue – if
ABLE TO PROVIDE **ADEQUATE PEER GROUP
AVAILABILITY**

MD

DO

Malignant

Denial

Denial

Obstructive

DENIAL

- PERSONAL
- FAMILY
- COLLEAGUES
- COMMUNITY
- FEAR BASED

FEAR – III Physician

- PROFESSIONAL CENSURE
- DISCIPLINARY SANCTION
- CAREER DISRUPTION
- FINANCIAL

FEAR - OBSERVER

- BEING WRONG
 - INACCURATE “DIAGNOSIS”
 - RELIABILITY OF REPORT
 - VINDICTIVE “EX”-LOVER
 - DISGRUNTLED EMPLOYEE
 - POLITICAL ENEMY
 - RUTHLESS COMPETITOR

FEAR - OBSERVER

- “PRIMUM NON-NOCERE”
 - PROFESSIONAL CENSURE
 - DISCIPLINARY SANCTION
 - CAREER DISRUPTION

FEAR - OBSERVER

- BEING WRONG
 - OVER-REACTING
 - NEED MORE DATA
 - NEED MORE TIME

False Evidence Appearing Real

FEAR - OBSERVER

- REPRISAL
 - LOSS OF A FRIEND
 - OVERT RETALIATION
 - HARM
 - LAWSUIT

If you are wondering if you have a problem, that is a **BIG RED FLAG**. Social users don't wonder if they have a problem, they know they do not. If you are still wondering you might want to cut down on whatever you are doing. If you are unable to cut down call the WVMPHP. **YOU**

IGNORANCE

- UNDERLYING DISEASE STATE
- PROGRESS TO LATER STAGE
- TREATMENT SUCCESS
- INTERVENTION

IGNORANCE

- LEGAL OBLIGATIONS
- ETHICAL CONSIDERATIONS
- EXISTENCE OF PHPs
- PHP NOT = DISCIPLINARY BD
- PHPs WORK

AMBIVALENCE

- OSTRICHITIS
 - “IT’S NOT THAT BAD”
 - “IT’S NOT TRUE”
 - “IT WILL GO AWAY”
- HASSLE FACTOR
- STIGMA

MYTHS

- MUST WANT HELP
- MUST HIT BOTTOM

Incidence of Physician Impairment

- “An estimated **30% of Physicians** will have a condition that impacts their ability to practice with reasonable skill and safety at some point in their career.” (AMA)
- Addiction, alone, impacts 10-15% of the general population. Slightly **higher** in health care professions.

**What about the other 70%
that never have a
condition impairing their
ability to practice
medicine safely?**

QUIETLY INQUIRE TO SUBSTANTIATE AUTHENTICITY

ARRANGE AN INTERVENTION WITH WVMPPH GUIDANCE

GOAL → EVALUATION

INTERVENTION

- Definition:



The initial discussion with the individual in an effort to educate them and thereby encourage participation in a formal chemical/alcohol dependency/psychiatric evaluation by qualified experts.

Why Doctors use Drugs

- Access to pharmaceuticals (availability)
- Family history of substance abuse (genetics)
- Personality factors (e.g., grandiosity, guilt)
- Stress at home and/or at work
- Thrill-seeking
- Self-treatment of pain, sleep patterns, emotional disorders
- Chronic fatigue
- Social/economic status

Self-Medication

- Emotional Pain
- Physical Pain

Instrumental or Implemental Use

- Use of Drugs in Order to Fulfill a Demanding Work Role Is a Risk Factor for Developing a SUD Among Physicians

(McAuliffe et. al. 1987).

Identification

- As a SUD Progresses in a Physician
 - First Marital, Financial, Social and Legal Difficulties
 - Last Effected by the Illness Is the Practice Setting
- The Most Important Is Personality Change
 - Very Rapid in Opiate and Cocaine Addiction
 - Slower and More Difficult to Perceive in Alcohol Dependence As It Develops Slowly Over Many Years.

As SUD Progresses

- The Physician Frequently Explains That the Financial, Legal and Family Problems Are Causing All the Difficulties
- In Reality the SUD Is the Origin of Most of the Difficulties
- Intoxication at Social Functions
- Arrests for a Drinking and Driving Offense or for Behavior
- Finally Withdrawal From Social Activities and Isolation From Colleagues and Social Support Systems.

Fact

- A medical professionals addiction is typically advanced before identification and intervention.



THE SIX “I” S

HOW TO IDENTIFY A TROUBLED COLLEAGUE

Addiction & Mental Illness
are

**NON-DISCRIMINATORY
&
POTENTIALLY IMPAIRING**

BEHAVIORAL INDICATORS OF IMPAIRMENT

- Irritability
- Irresponsibility
- Inaccessibility
- Inability
- Isolation
- Incidentals

IRRITABILITY

- Mood Swings
- Negative Attitude
- Argumentative
- Inappropriate Anger
- Overreaction to Criticism

IRRITABILITY

- Verbal Altercations with
 - PATIENTS
 - STAFF
 - PEERS
- Other Disruptive Behaviors
- “PERSONALITY CHANGE”
especially after bathroom break

IRRESPONSIBILITY

- Shifts Work Load
- Manipulates Schedule
 - E R
 - O R
 - ON-CALL
- “HURRY UP-CATCH UP”
 - Hasty Rounds
 - Short Cuts

INACCESSIBILITY

- Frequent Tardiness
- Frequent Absence
- “MIA”-MISSING IN ACTION
 - Frequent Trips to Bathroom
 - Frequent Trips to Parking Lot
 - Prolonged Lunch Breaks
 - UNAVAILABLE When On-Call
 - UNAVAILABLE For Discussions

INACCESSIBILITY

- Frequent Beeper Failure
 - “Forgot to Turn it On”
 - “Batteries were Dead”
- Frequent Illness
 - Monday Morning
 - Post-Holiday

INACCESSIBILITY

- Early Departure
 - Friday Afternoon
 - Pre-Holiday
- “NODDING OFF”

INABILITY

- Inadequate Orders
- Inadequate Charting
 - QUALITY
 - QUANTITY
 - TIMELINESS
 - Q A OUTLIERS
 - OFTEN ON THE “HIT LIST”

INABILITY

- Difficulty with Complex Cases
- Deviation from Standard Protocol
- Deviation from Drug Procedures
 - UNWITNESSED WASTING
 - EXCESSIVE AMOUNTS
 - INSUFFICIENT ANALGESIA
 - XS SPILLAGE / BREAKAGE

INABILITY

- Decreased Performance
- Frequent “FORGETFULNESS”

ISOLATION

- Odd Hours for Rounds
- Absent from Doctor's Lounge
- Eats Alone
- Avoids
 - DEPARTMENTAL MEETING
 - CME EVENTS
 - MEDICAL SOCIAL EVENTS

INCIDENTALS

- EYES
- EARS
- NOSE
- OTHER

EYES-THEIRS

- RED
- BLACK & BLUE
- YELLOW
- PUFFY
- GLASSY
- PUPILS
- NO CONTACT



EYES-YOURS



- DISHEVELED APPEARANCE
- TREMORS
- BRUISES
- NEEDLE TRACKS
- HEAVY DRINKING
 - AT STAFF FUNCTIONS
 - AT SOCIAL FUNCTIONS
- OFF-DUTY INTOXICATION

EARS

- Raspy Voice
- Gargling in Bathroom
- Complaints from
 - STAFF
 - PATIENTS
 - PEERS
- Phone Speech
 - SLURRED
 - INCOHERENT

EARS

- Black Outs
- Fatalistic Comments
 - (“SCREAM SILENTLY”)
- Hospital Gossip
 - MARITAL DISCORD
 - FINANCIAL PROBLEMS
 - “PARTY” REPUTATION
 - DUI-DWI

NOSE-THEIRS

- RED
- ORANGE PEEL
- RUNNY



NOSE-YOURS

- Mask the Odor of Alcohol
 - MINTS
 - MOUTHWASH
 - XS COLOGNE
- Alcohol (AOB)

OTHER

- Prescription Requests
 - NEW Rx
 - LOST Rx
 - “MY DOG ATE THE Rx”
 - “For MY WIFE” Rx
 - “For MY KIDS” Rx
 - “For A FRIEND” Rx
 - Any Other EXCUSE Rx

INTOXICATION in a Medical Professional in purely social settings should be IGNORED since it DOES NOT OCCUR DURING NORMAL WORKING HOURS ???

On the JOB A O B
(Alcohol On Breath) is
almost always an ominous
sign, even when noted on
a single occasion???

**Aberrant workplace BEHAVIOR
caused by chemical dependency
should be ADDRESSED rapidly
because it usually indicates
progression beyond early-stage
disease???**

While several SIGNS of IMPAIRMENT, or a CLUSTER of them, usually suggest TROUBLE, a pattern of aberrant behavior is almost always indicative of POTENTIAL or ACTUAL IMPAIRMENT.

**Normal behavior following
an episode of Aberrant
Behavior usually means
that no significant problem
exists???**

BROTHER/SISTER'S KEEPER

CALL WVMPHP

TO

DISCUSS THE “SITUATION”
WITHOUT IDENTIFYING DATA
(Anonymity)

What next?

- Refer medical professional to the WV Medical Professionals Health Program
- A comprehensive evaluation will be done.
- A treatment plan is constructed based on the evaluation and treatment recommendations of treatment professionals.
- A contract with the WVMPHP is signed.
- The individual is monitored throughout the contract and provided support and **EARNED ADVOCACY**.

Why Do What the WVMPPHP Says ?

- Confidentiality
- Continued Practice
- Special Advocate
- PHPs Work
- Patient Safety

WVMPHP REPORTS TO BOARD

- IMMINENT DANGER TO THE PUBLIC
- FAILURE TO RESPOND TO TREATMENT
- NON-COMPLIANCE WITH CONTRACT

The Sick Physician and the PHP

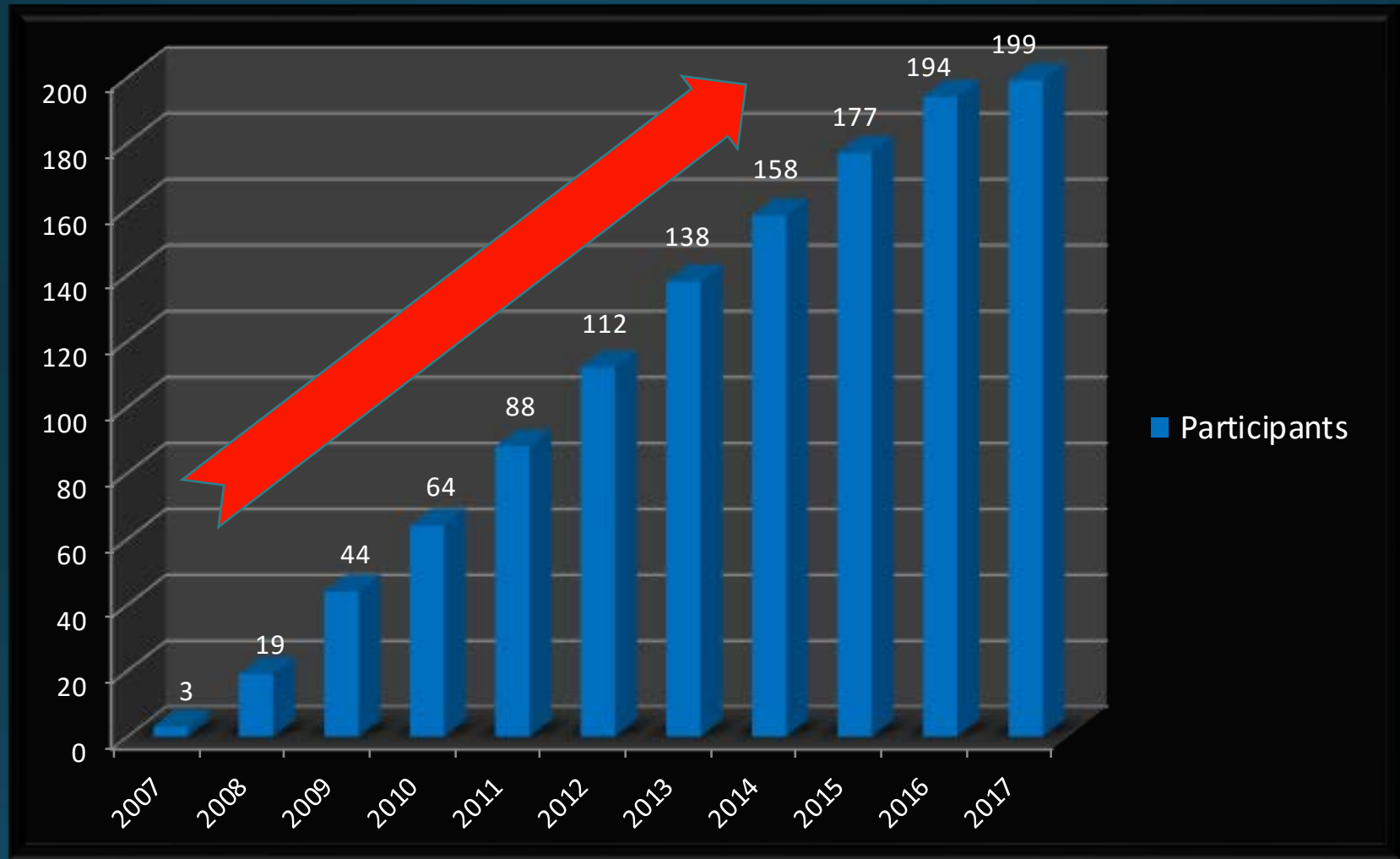
- The continuum of illness versus impairment
- Potentially impairing conditions
 - Substance Abuse, Mental Illness & Co-morbidities
- What is a PHP / PAP?
- Barriers to detection and assistance
- Humanness (Occupational hazard)
- Statistics / characteristics of PHPs / WVMPHP

objectives

Program Statistics

Growth 1000%+
Success rate 90%

WVMPHP Program Volume

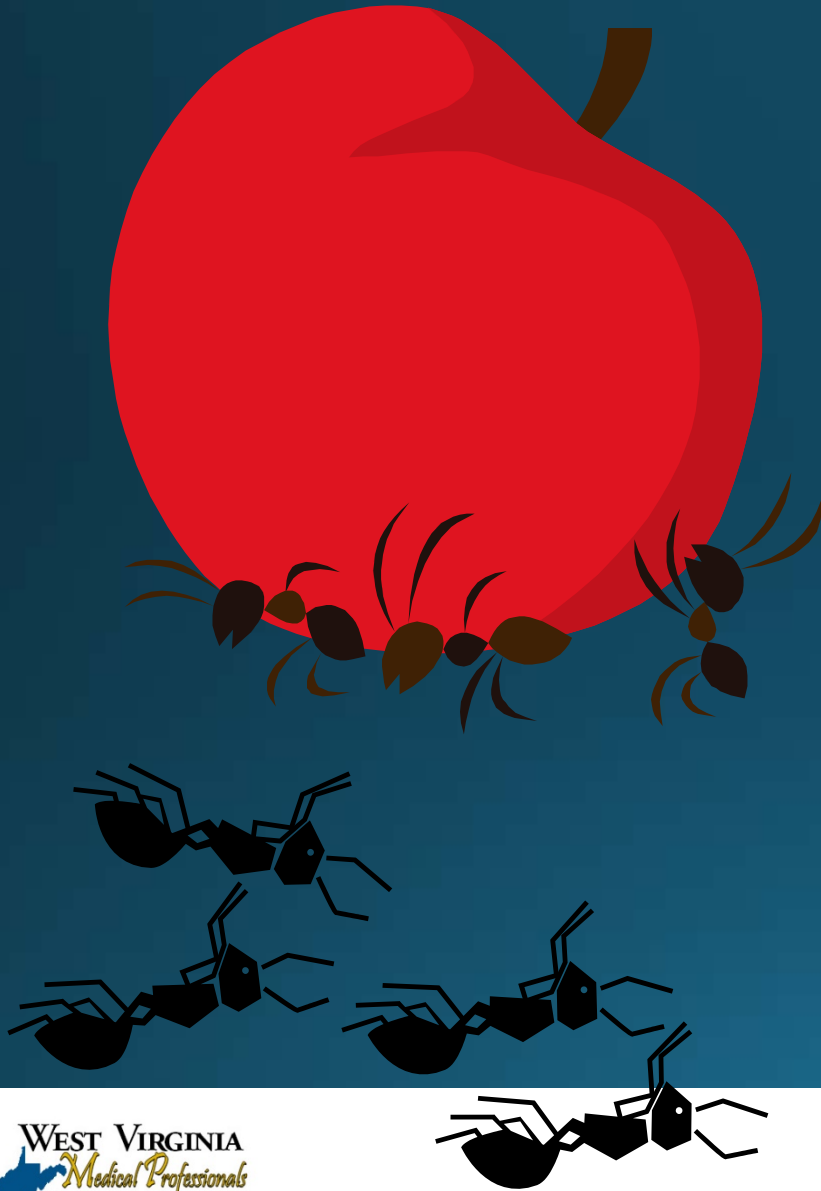


Ineffective System

- Independence
- Hospitals need REVENUE
- Groups need PARTNERS
- Spouses need their SPOUSES
- Families need INCOME
- Doctors LAWYER up
- State Boards Discipline AFTER the fact

Hospitals

- ◆ Legal Expenses
- ◆ Monitoring Expenses
- ◆ JCAHO 2.6
- ◆ Continuing Medical Education
- ◆ Conflict of Interest
- ◆ Malpractice Liability
- ◆ Patient Care Continuity
- ◆ Medical Practice Act
- ◆ Exposure
- ◆ Recruiting Expenses
- ◆ Public Safety



JCAHO MS 11.01.01

- ✓ Mandates... 'the medical staff implement a process to identify and manage matters of individual physician health that **is separate from the medical staff disciplinary process**'
- ✓ *Robert Wise, MD, JCAHO, Vice President of Standards, Division of Research states,*
"Many states have specialized programs that deal with these matters. JCAHO accepts delegation to existing external programs as a means to meeting the standard."

Board Consent Order

❖ A MAJOR ACTION –

- Can't participate with many provider panels, i.e. BCBS
- Harder to effectively treat patients
- Trouble getting malpractice
- Data Bank Report
- Can't sit for Board Recertification
- Harder to be hired
- Harder to get a residency
- Plaintiff Attorneys attempt to use against doc in unrelated matters – Years later
- Problems with Hospital Privileges
- Hard to retain call partners



West Virginia Medical Professionals Health Program Mission Statement:

To protect healthcare consumers through seeking the early identification and rehabilitation of physicians, surgeons, and other healthcare professionals with potentially impairing health concerns including abuse of mood altering drugs including alcohol, mental illness or physical illness affecting competency so that physicians, surgeons, and other healthcare professionals so afflicted may be treated, monitored and returned to the safe practice of their profession to the benefit of the healthcare profession and the patients we serve.

Collaboration Communication Accountability Transparency

Funding

- **Fall 2005 – PHP Task Force**
- **March 8, 2007 – Passage of Senate Bill # 573**
- **July 1, 2007 – Effective date of SB # 573**
- **August 17, 2007 – WVMPHP Incorporated as an Independent Not-for-Profit 501(c) 3**
- **November 2007 – WVMPHP / WVBOM /WV Bd Osteo operating under Agreement s “to be signed”**
- **Spring, 2008 – WVMPHP / WVBOM / WV Bd Osteo Agreements signed**
- **May 1, 2010 – Licensure Fee partial funding**
- **January 2014 – Osteopathic & Allopathic agreements renewed (5-yrs)**

WV Chronology

Legislation

Senate Bill # 573 – March 8, 2007

- Voluntary / Confidential
- Provided PHP existence
- Protected Records
- Immunity
- Funding

Structure & Function

- WVMPHP Board of Directors – Fiduciary
- WVMPHC Case Management - Participants

WVMPHP Board of Directors

- ◆ WV State Medical Association
- ◆ WV Mutual Insurance Company
- ◆ WV Hospital Association
- ◆ WV Podiatric Medical Association
- ◆ WV Society of Addiction Medicine
- ◆ WV Association of Physician Assistants
- ◆ WV Society of Osteopathic Medicine
- ◆ WV Citizen – WVMPHP Board Appointed

WV Medical Professionals Health Program Committee

- ◆ WVMPHP Board Approved
- ◆ Addiction Psychiatry
- ◆ Psychiatry
- ◆ Addiction Medicine
- ◆ Family Medicine
- ◆ Recovery
- ◆ Physician Assistant
- ◆ Podiatry
- ◆ Geography
- ◆ Personal Experience

Populations Served

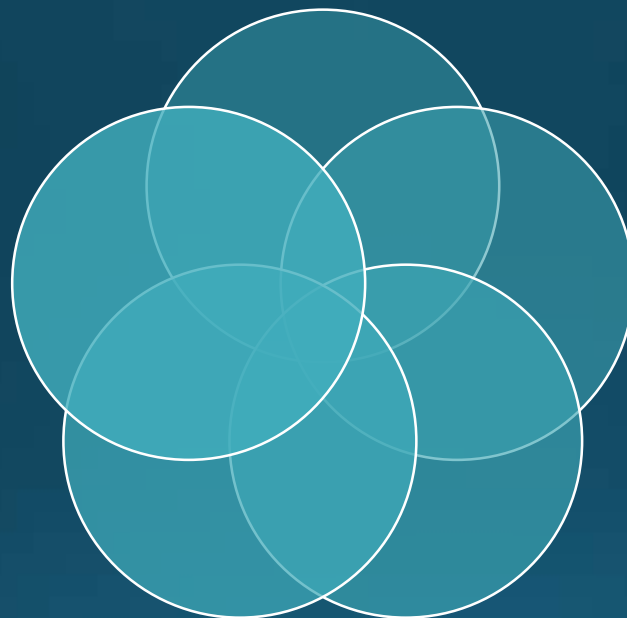
Physicians

Physician
Assistants

Podiatrists

Licensees

Others



Non-discriminatory

Board Agreements

- ◆ *January 14, 2008 – West Virginia Board of Medicine officially signed an agreement with the West Virginia Medical Professionals Health Program. (Renewed x5 yrs Jan. 2014)
- ◆ *May 16, 2008 – West Virginia Board of Osteopathic Medicine officially signed a similar agreement. (Renewed x5 yrs Apr. 2014)

*** Licensure Renewal Applications –Grant confidentiality**

Services for Problems

Substance Abuse *

Mental Illness *

Behavioral Health, Leadership, & Boundaries

Stress and Burnout

Physical Illness

Neurological Deficits

Other Disorders

Intervention *

Education *

Advocacy *

Treatment Outcome Comparisons

- Alcoholism ... 50-70% abstinent
- Opioid Dependence ... 50-80% abstinent
- Cocaine Dependence ... 50-60% abstinent
- Nicotine Dependence ... 20-40% abstinent
- Diabetes (relapse) ... 30-50% stable
- Hypertension (poor control) ... 50-60%
- Asthma (multiple ER visits) ... 60-80%

(Gaber, Davidson, 1992; McLellan 2002)

TREATMENT WORKS

- ❖ Full Treatment Experience
(Detoxification; Rehabilitation; Maintenance)
- ❖ General Population relapses at 40-60% @ 1 yr
- ❖ Physicians Recover at 92% @ 1 year
- ❖ Detoxification Alone at < 10% @ 1 year

Drug Testing

<ul style="list-style-type: none">• Alcohol & Drugs	<ul style="list-style-type: none">• Random• Frequent	<ul style="list-style-type: none">• 4 times a month 1st year	<ul style="list-style-type: none">• 5 th Year
100 %	Witnessed	48/ year	20/ year

- *52% use 20+ health professionals panel
- *5% only drug of choice
- *68% use EtG

Effective System



Physicians with potentially impairing conditions who come forward are given the opportunity for evaluation, rehabilitation, treatment and monitoring without disciplinary action in an anonymous, confidential and respectful manner.

WVMPHP GOALS

Early detection

Thorough assessment & evaluation

Abstinence based treatment

Long-term monitoring

Documentation (abstinence, compliance, etc.)



HIPAA
CFR 42

Credentialing

DEA

FMLA
ADA

Medical
Boards

Insurance
Payors

Malpractice

Legal
System

Hospitals

Employers

OIG

Participant

Sponsor

Psychiatrist

PCP

Work
Monitors

Counsel
or

Drug
Tests

Hospital

12-Step
Meetings

Malpractice
Carrier

Board

Family

Financial Disarray

LIFE

Disciplines

	Active	All
Students/Residents	14 (20%)	21 (19%)
Physician Assistants	8 (12%)	12 (11%)
Allopathic Physicians*	42 (62%)	68 (61%)
Osteopathic Physicians*	4 (6%)	10 (9%)
TOTAL PHYSICIANS*	46 (68%)	78 (70%)

*PGP

Specialty - 24

	Active	All
Family Practice	13 (19%)	23 (21%)
Emergency Medicine	6 (9%)	9 (8%)
Internal Medicine	6 (9%)	8 (7%)
General Surgery	6 (9%)	8 (7%)
Radiology	6 (9%)	7 (6%)
Anesthesia	5 (7%)	6 (6%)
OB-GYN	4 (6%)	6 (6%)
Other	22 (32%)	44 (39%)

Qualifying Illness

	Active	All
ADDICTIVE	62 (91%)	100 (90%)
MENTAL	6 (9%)	11 (10%)

*41 (66%) of active participants were PG physicians with addictive illness.

*68 (68%) of all participants were PG physicians with addictive illness.

*91% of all participants with mental illness were PG physicians

WVMPHP Referral Sources

	Active	All
Licensure Boards	19 (28%)	46 (41%)
Employer	7 (10%)	8 (7%)
Hospital	11 (16%)	14 (13%)
School/Residency	10 (15%)	13 (12%)
Other PHP	7 (10%)	10 (9%)
Other	14 (21%)	20 (18%)
(Family, colleague, treatment provider)		

Addictive Illness with

51 (82%) had co-morbid psychiatric illness*

Depression – 37 (73%)

Anxiety – 21 (41%)

PTSD – 8 (16%)

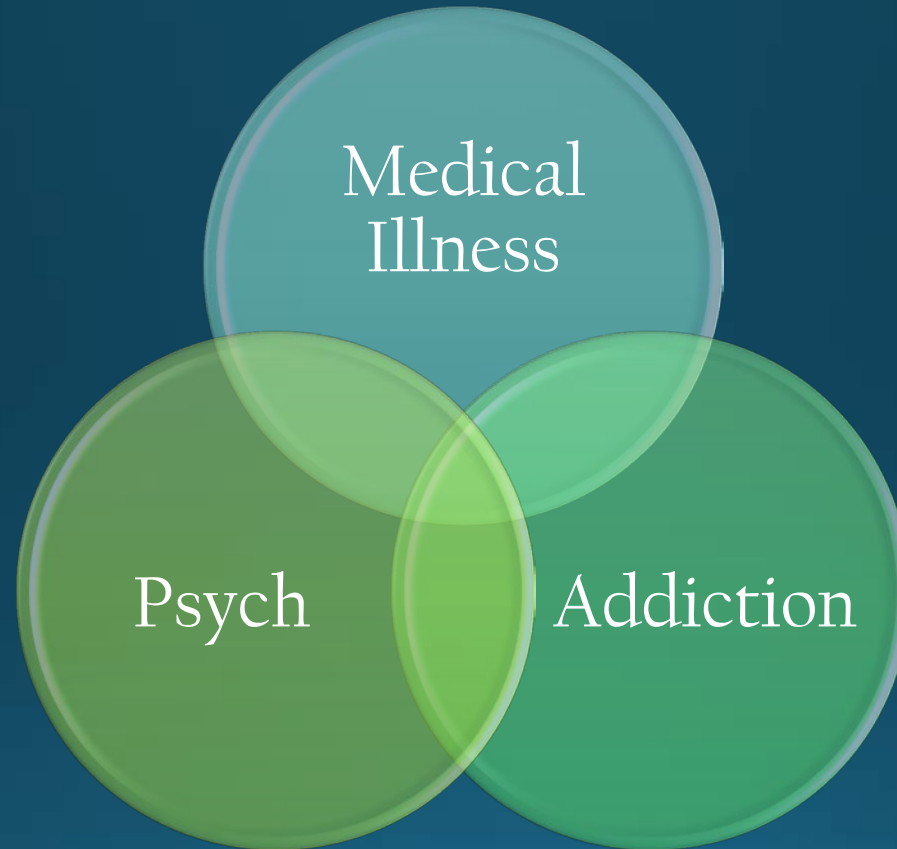
Bi-Polar – 6 (12%)

ADD – 1 (2%)

MULTIPLE DX – 23 (45%)

*Active Participants

Common Triad of Disorders



Intersecting Diagnoses and other underlying issues



Complexity Becomes More than Additive

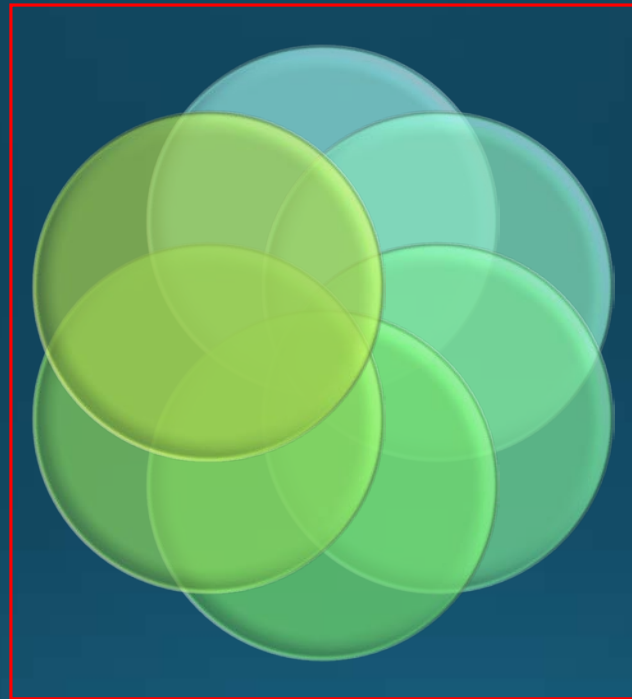
Addiction

Marital Discord

Pain

Co-Dependency

Financial Disarray



Psychiatric

*Professional
Regulatory Agencies

Substance of Choice

	Active n=62	All n=100
Alcohol	25 (40%)	46 (46%)
Alcohol + Drugs	21 (34%)	32 (32%)
Drugs Alone	16 (26%)	22 (22%)

Drugs of Abuse

	Active n=16	All n=22
Opiates	7 (44%)	9 (41%)
Marijuana	2 (12%)	3 (14%)
Amphetamines	0 (0%)	1 (4%)
Benzodiazepines	0 (0%)	0 (0%)
Polysubstances	7 (44%)	9 (41%)

2015 NSDUH Report

27 Million Adults (10.1%)

- Marijuana – 22.2 million (8.4%)
- Prescription Drugs – 6.4 million (2.4%)
- Prescription **Pain Relievers** – 3.8 million (1.4%)
- Cocaine – 1.9 million (.7%)
- Hallucinogens – 1.2 million (.5%)
- Inhalants – .5 million (.5%)
- Methamphetamines – 897 thousand (.3%)
- Heroin – .3 million (.1%)

2015 NSDUH Report

2.2 Million Adolescents (8.8%)

- Marijuana – 1.8 million (7%)
- Prescription Drugs – 492 thousand (2%)
- Prescription **Pain Relievers** – 276 thousand (1.1%)
- Cocaine – 53 thousand (.2%)
- Hallucinogens – 121 thousand (.5%)
- Inhalants – 175 thousand (.7%)
- Methamphetamines – 13 thousand (.1%)
- Heroin – 21 thousand (.1%)

If you are wondering if you have a problem, that is a **BIG RED FLAG**. Social users don't wonder if they have a problem, they know they do not. If you are still wondering you might want to cut down on whatever you are doing. If you are unable to cut down call the WVMPHP.

YOU

Previous Issues related to Qualifying Illness

	Active	All
Illness /Sentinel Events	40 (59%)	55 (50%)

TREATMENT PROVIDERS

Relocations & RTW

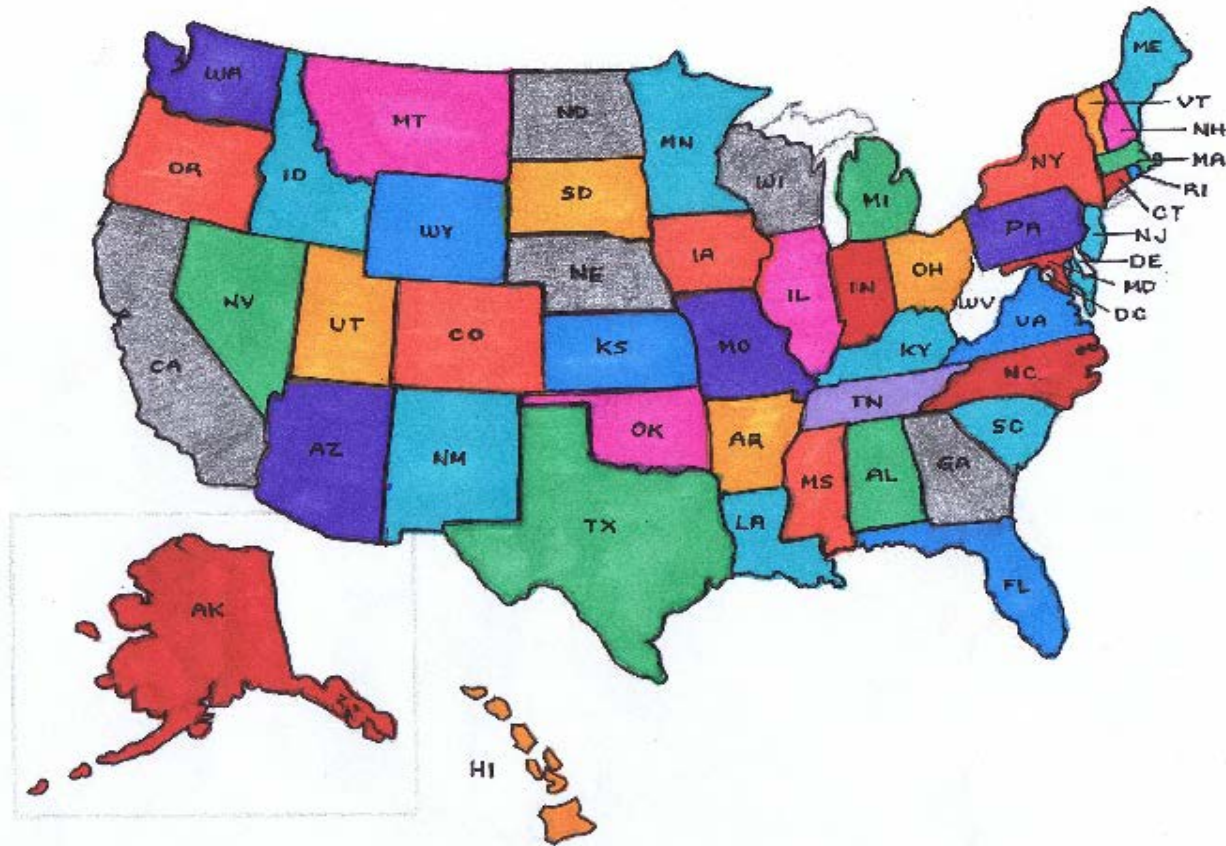
	Active	All
Inter-state	11 (16%)	20 (30%)
Continued working or Returned to work	56 (82%)	87 (78%)

Other activities

- Federation of State Physician Health Programs – www.fsphp.org
- Federation of State Medical Boards, Impaired Physician Policy – www.fsmb.org
- American Society of Addiction Medicine, 11 Physician Health Policies – www.asam.org
- Governor's Advisory Council on Substance Abuse (GACSA)
- Clinician's Pocket Guide
- WVMPHP Brochure
- FDA testimony – Hydrocodone rescheduling
- American Board of Medical Specialties – www.abms.org
- World Medical Association – Physician Wellness Committee
- Appalachian Addiction & Prescription Drug Abuse Conference
- Students/Practitioners (Physicians, Nurses, Pharmacists, Dentists, Counselors, therapists, social workers, psychologists etc.)
- Healthcare and other licensed professionals
- Public/Patients

HUMANS

If you have seen 1 PHP, you have seen...ONE PHP



SUCCESSFUL

***Three agencies, the WVMPHP and Boards with committed individuals who work collaboratively, have a continuous, ongoing relationship since program inception to the benefit of the licensees and the public they serve.

1 PHP + 2 Boards = 4

REMEMBER !

Even very small intrusions of addiction into the workplace should be taken extremely seriously in physicians

THE “MESSAGE”

- REHABILITATE
- DON'T TERMINATE



APPALACHIAN ADDICTION & PRESCRIPTION DRUG ABUSE CONFERENCE

October 19-21, 2017

Websites:

- WV Medical Professionals Health Program – www.wvmphp.org
- WV Board of Medicine – www.wvbom.wv.gov
- WV Board of Osteopathic Medicine - www.wvbdosteo.org
- WV State Medical Association – www.wvsma.org
- WV Osteopathic Medical Association – www.wvoma.org
- Federation of State Physician Health Programs – www.fsphp.org
- American Society of Addiction Medicine – www.asam.org

This Presentation is
available at:

www.wvmpHP.org

P. Bradley Hall, M.D.
DBAM, AAMRO, MROCC
Executive Medical Director

WV Medical Professionals Health Program

4013 Buckhannon Pike

Mount Clare, WV 26408

Phone: 304-933-1030

Cell Phone: 304-677-9283

Email: bhallmd@wvmphp.org
wvsam@hughes.net

Website: www.wvmphp.org

THANK YOU !

It has been a great day with a great audience and I thank you for your time and attention to this most important issue.

The cat herder is tired and is going to be taking a long nap.



The Sick Physician and the PHP

- The continuum of illness versus impairment
- Potentially impairing conditions
 - Substance Abuse, Mental Illness & Co-morbidities
- What is a PHP / PAP?
- Barriers to detection and assistance
- Humanness (Occupational hazard)
- Statistics / characteristics of PHPs / WVMPHP
- THE MESSAGE / Resources / Sources

objectives

THE “MESSAGE”

- Addiction = A Disease
- Medical Professionals =
No Immunity
- Denial = Chief Symptom
- Denial = Obstacle to Tx

THE “MESSAGE”

- Medical Professionals
Won't Seek Help
- Intervention is Necessary
- Treatment Works
- Medical Professionals are
Different

Why?

The challenge of keeping up appearances and presenting a strong, balanced mind set must be met in order to determine a medical professional's success, production numbers, and to meet the expectations held of him/her by colleagues, patients, the physician's family, and the general public.



Why?

- The level of importance that is placed on work by those in the health professions is often very high.
- As a result, social, financial and interpersonal decay often occur before the addiction interferes with the job.
- Families, partners, and friends are much more likely to have been impacted by the effects of addiction long before it is noticed at work.

THE “MESSAGE”

- Early detection is important
- High long-term success rate
- Recovering medical professionals can be a very important part of the medical community

THE “MESSAGE”

- Modify the Treatment
- Outcomes Are Favorable
- Monitoring Is Critical

THE ‘MESSAGE’

- ✦ Mental illness and substance use disorders (SUDs) are diagnoses, not necessarily equating with impairment
- ✦ The incidence of addiction in the general population is 10% and potentially higher in physicians due to access, knowledge of drugs and comfort of prescribing
- ✦ Medical professionals are humans too, don't think “it will never happen to me”
- ✦ When encountered in your career, call the professionals health program.... You will encounter the addicted colleague
- ✦ The WVMPHP dual roles are to protect the public and provide successful rehabilitation and re-entrance into the safe practice of medicine



THE “MESSAGE”

- Social stigma for medical professionals with an alcohol or drug abuse disorder is at least double that held for the general public with the same disorder.
- Alcohol is the drug of choice for most physicians.
- Anesthesiologists prefer potent IV opioids such as fentanyl and sufentanil.
- Nurses prefer fentanyl, morphine, percocet, and other easily diverted opioids.

THE “MESSAGE”

- Recovery is a long term (lifelong) process
- Continuing engagement in a mutual help program and in peer-group support has proved to be an essential component
- Random alcohol/drug screens assist in maintaining successful recovery

THE “MESSAGE”

- The delay in diagnosis relates to the medical professional's tendency to protect their workplace performance and image well beyond the time when their life outside work has deteriorated and become chaotic.
- Maintaining access to the drug of choice may be dependent upon being in that workplace, providing incentive to stay at work.

THE ‘MESSAGE’

- ✦ Physician health programs have 80 – 90+% success rate over 5 years
- ✦ According to the AMA, 30% of physicians will have a condition which may impair their ability to practice medicine with reasonable skill & safety
- ✦ Recovering addicted patients (medical professionals)
CANNOT CONTROL MEDICALLY NECESSARY MEDICATION BY THEMSELVES

If you are wondering if you have a problem, that is a BIG red flag. Social users don't wonder if they have a problem, they know they do not. If you are still wondering you might want to cut down on whatever you are doing. If you are unable to cut down call the WVMPHP.



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- McLellan, et al. Drug Dependence, a Chronic Medical Illness. JAMA, October 2000
- Domino, et al. Risk Factors for Relapse in Health Care Professionals with Substance Use Disorders. JAMA, March 2005
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- American Society of Addiction Medicine, Physician Health Policies – www.asam.org

www.wvmp.php.org

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- National Center for Health Statistics (NCHS) <http://www.cdc.gov/nchs/>
- Epidemiologic Catchment Area (ECA) <http://downloadily.com/docs/epidemiologic-catchment-area-study.html>
- National Co-Morbidity Survey (NCS) <http://www.nimh.nih.gov/health/topics/ncsr-study/nimh-funded-national-comorbidity-survey-replication-ncs-r-study-mental-illness-exacts-heavy-toll-beginning-in-youth.shtml>
<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4005614/>
- National Epidemiologic Survey on Alcohol and Related Conditions (NESARC) <http://www.niaaa.nih.gov/research/guidelines-and-resources/epidemiologic-data>
- Drug Abuse Warning Network (DAWN ED) <http://www.samhsa.gov/data/DAWN.aspx>
- Monitoring the Future Survey (MFS) <http://www.drugabuse.gov/monitoring-future-survey-overview-findings-2013>
- National Vital Statistics System, Mortality File ; <http://www.cdc.gov/nchs/deaths.htm>
- National Institute of Drug Abuse (NIDA); <http://www.drugabuse.gov/>

Burnout Busters

- <http://www.ama-assn.org/ama/ama-wire/post/beat-burnout-7-signs-physicians-should>
- <http://www.ama-assn.org/ama/ama-wire/post/7-steps-prevent-burnout-practice>
- <http://www.ama-assn.org/ama/ama-wire/post/burnout-busters-boost-satisfaction-personal-life-practice>
- <https://www.stepsforward.org/modules?sort=recent&category=well-being>
- <https://www.stepsforward.org/>
- <http://www.ama-assn.org/ama/pub/physician-resources/physician-health/international-conference-physician-health.page>