

# Presented by

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# 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 / WVMPHP
- THE MESSAGE / Resources / Sources

## objectives

# APPLICABILITY

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

Healthcare & other Licensed Professionals

## HUMANESS - STIGMA

# 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)

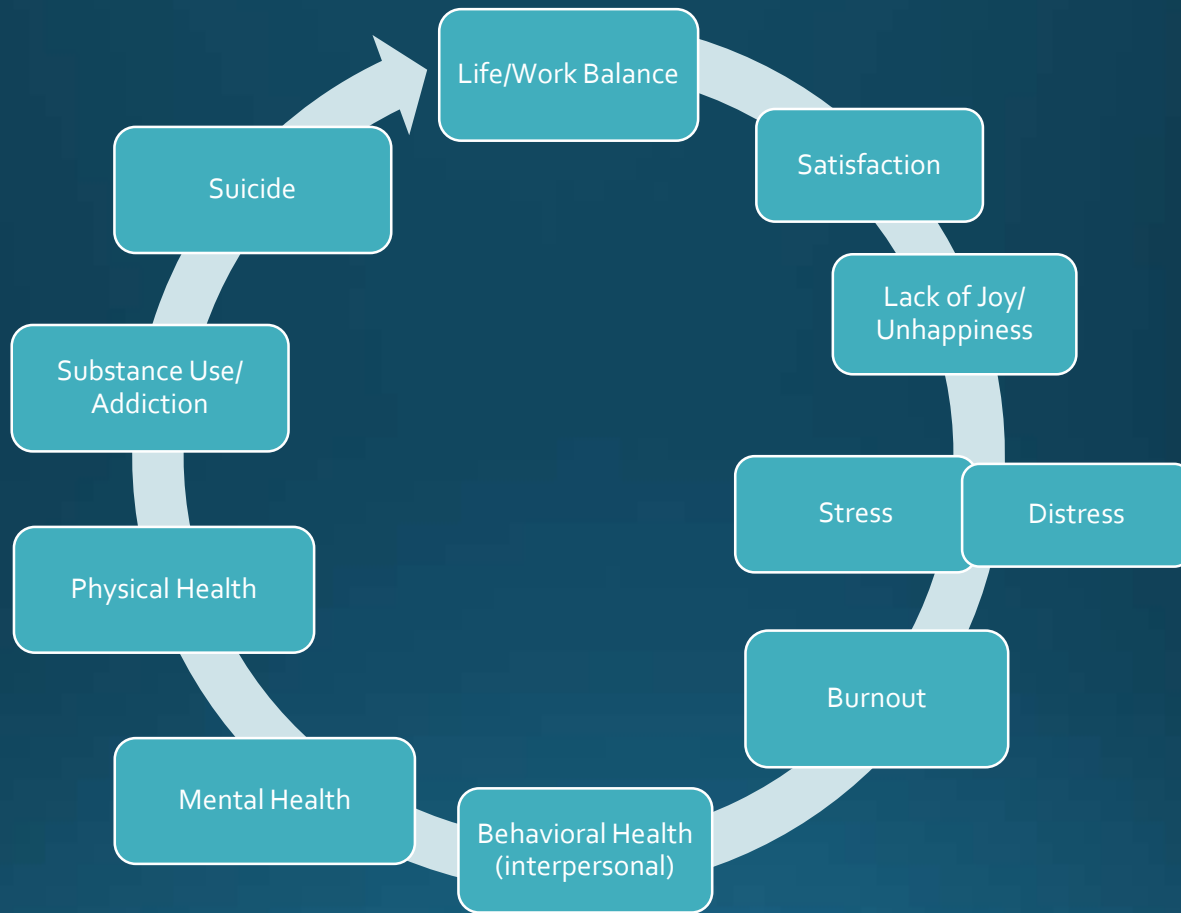


# Health and Wellbeing Issues

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

\* Professionalism/Boundaries

# An example of unhealthy cycle that healthcare professionals may experience



PHPs can intervene and help at any point!

# Finding Balance in the Medical Life

Lee Lipsenthal, M.D.

# Individual Wellness: Key Targets

- Awareness
- Self-Care
- Resilience
- Engagement

# Physician Wellness



“Wellness goes beyond merely the absence of distress and includes being challenged, thriving, and achieving success in various aspects of personal and professional life.”

Shanafelt TD, Sloan JA, Haberman TM. The well being of physicians. *Am Med J* 2003; **114**: 513–17.

# 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

# 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: Demands, Resources, Control





# Healthy Physicians Give Better Care!

- Decreased medical errors
- Increased patient satisfaction
- Better treatment recommendations
- Increased treatment adherence
- Lower malpractice risk
- Better attitudes toward work
- Higher team functioning
- Lower turnover

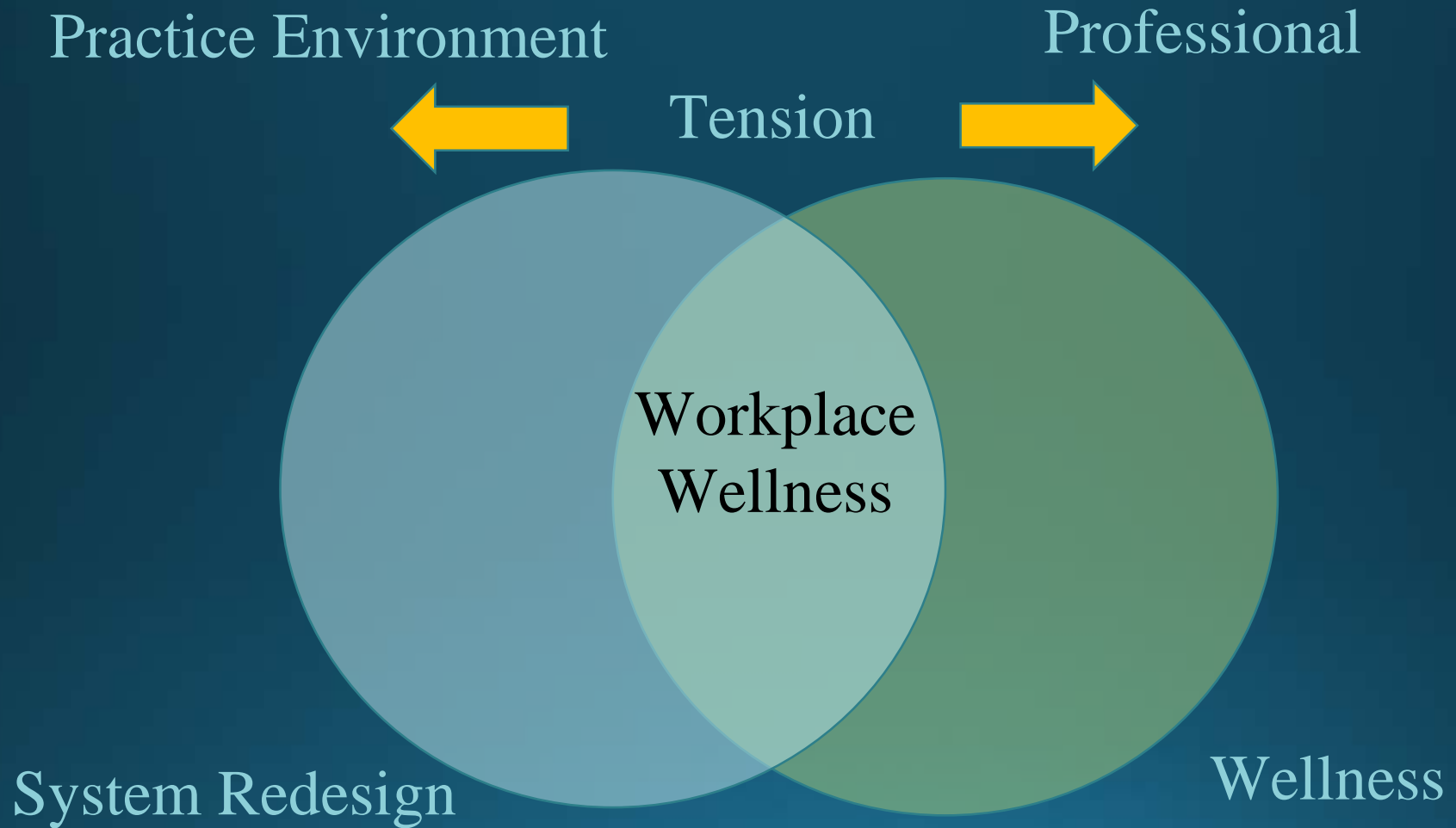
# Individual Drivers of Physician Burnout

- Perfectionism
- High achievement orientation
- Difficulty setting boundaries
- Intellectualization
- Delay of gratification
- Compartmentalization
- Materialism

# Environmental Drivers of Physician Burnout

- Workload and time constraints
- Inefficiencies/frustration (EHR)
- Lack of autonomy/control
- Ineffective leadership
- Mission/values mismatch (loss of meaning)
- Culture of incivility
- Perception of fairness and respect
- Diminished rewards

# Building Wellness into the Practice Environment





# How Do You Prevent Burnout?

- Accept **shared responsibility** for burnout
- Elevate personal wellness to a core professional value, starting in medical school
- Make wellness and satisfaction a quality outcome and incentivize it accordingly
- Muster the will to address burnout generators and **ask for help**
- Create opportunities for peer support and decrease isolation
- Nurture the brain through meditation and application of mindful practice to clinical work

# 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-Awareness & Self-Monitoring

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



# Self-Regulation & Resilience

- Cognitively
- Emotionally
- Somatically
- Spiritually

# 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

# 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”.

# Stigma

- Illness resistant
- God complex
- Knowledge is not protective
- Training how and who to ask for help

\*Education is the key

# 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

# Prevention

- Primary Prevention - avoid the development of disease \*\*
- Secondary Prevention- diagnose and treat an existing disease in its early stages before significant morbidity and patient harm
- Tertiary Prevention - treatments aim to reduce the negative impact of established disease by restoring function and reducing disease-related complications

\*\*Cultural shift through education

# Relationships

- 1 – Listen to understand, not to reply. This allows understanding of others' perspective and open mindedness to new knowledge.
- 2 – The most dangerous opinion is the highest opinion we hold of our own opinion. This is particularly true to that which we are sure about.
- 3 – Lack of knowledge of what we don't know is not our biggest problem, it is the knowledge of what we do know....with certainty, that's the bigger potential problem.
- 4 – Unity is best represented in a group with multiple variances among individuals. The very attribute of human variability is what makes organizations successful. Lack of acceptance of this variability in fulfilling a unified, common mission can be our biggest vulnerability.



# The Sick Physician and the PHP

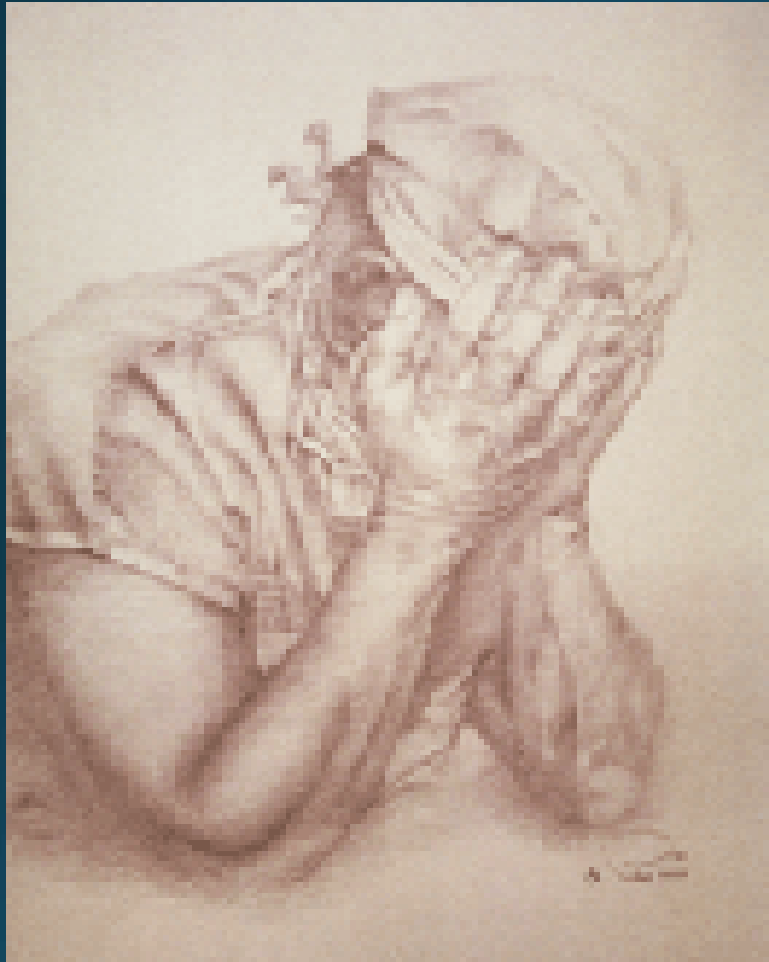
- The continuum of illness versus impairment
- Potentially impairing conditions
  - Substance Abuse, Mental Illness & Co-morbidities

## 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](http://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 – 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)

\*Cultural Shift



# 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

# 2019 FSPHP Annual Meeting

April 24-27, 2019 - Worthington Renaissance Fort Worth  
Hotel Fort Worth, Texas

# 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](http://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 <sup>a</sup>		DSM-IV Dependence <sup>b</sup>		DSM-5 Substance Use Disorders <sup>c</sup>	
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 <sup>d</sup>	–		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	

<sup>a</sup> 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.

<sup>b</sup> Three or more dependence criteria within a 12-month period.

<sup>c</sup> Two or more substance use disorder criteria within a 12-month period.

<sup>d</sup> 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

# 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

- 44.7 million (18.3%) age 18 or older had AMI
- 10.4 million (4.2%) age 18 or older had SMI
- 3.1 million (12.8%) adolescents had MDE
- 2.2 million (9%) 12-17 with MDE with severe impairment

2016 NSDUH

# Substance Use Disorders

- 20.1 million (7.5%) aged 12 or older had an SUD
- 19 million (21.7%) aged 18 or older had an SUD
- 1.1 million (4.3%) aged 12-17 had an SUD

2016 NSDUH

# 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

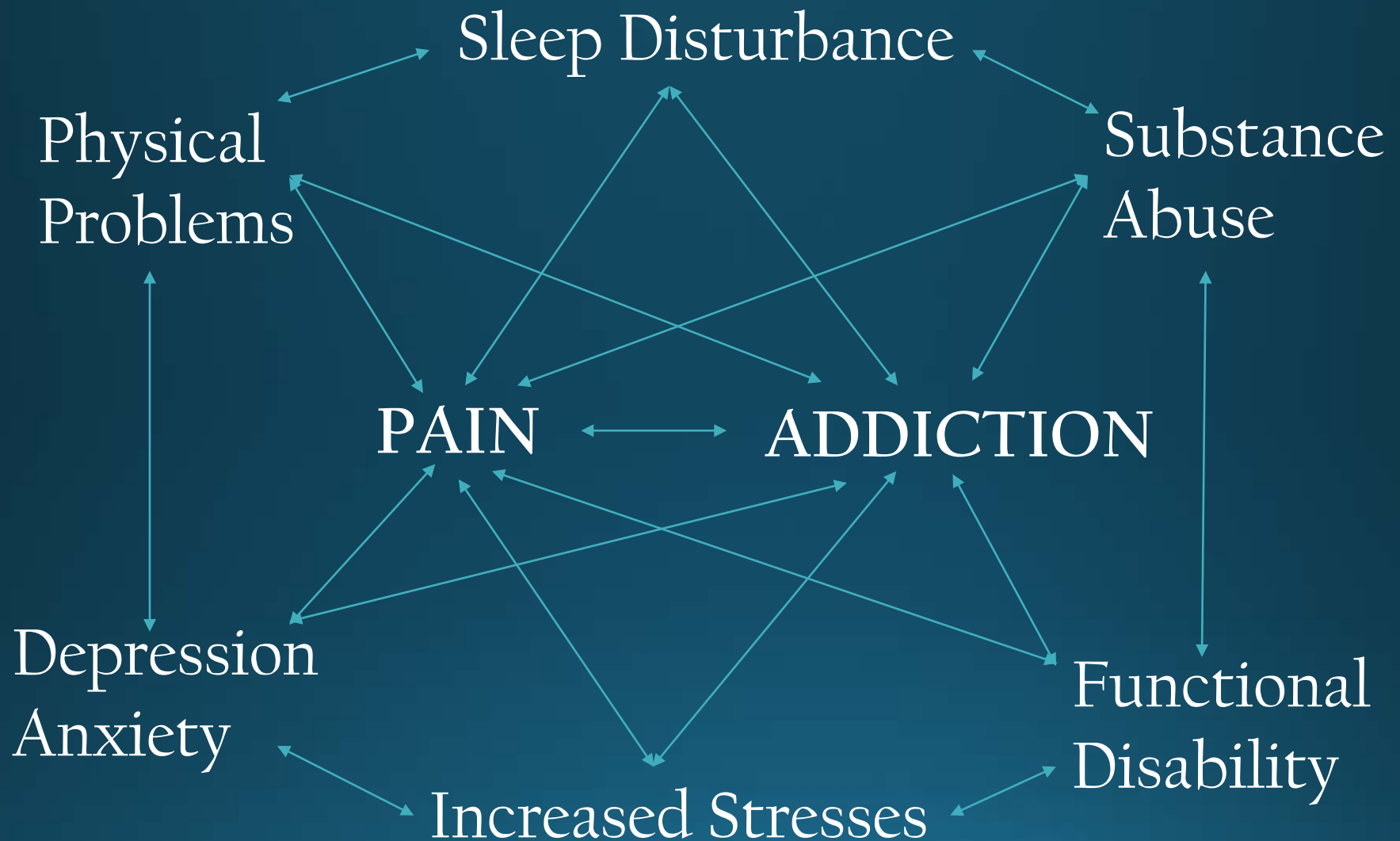
# Medical Specialty and Addiction

- 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

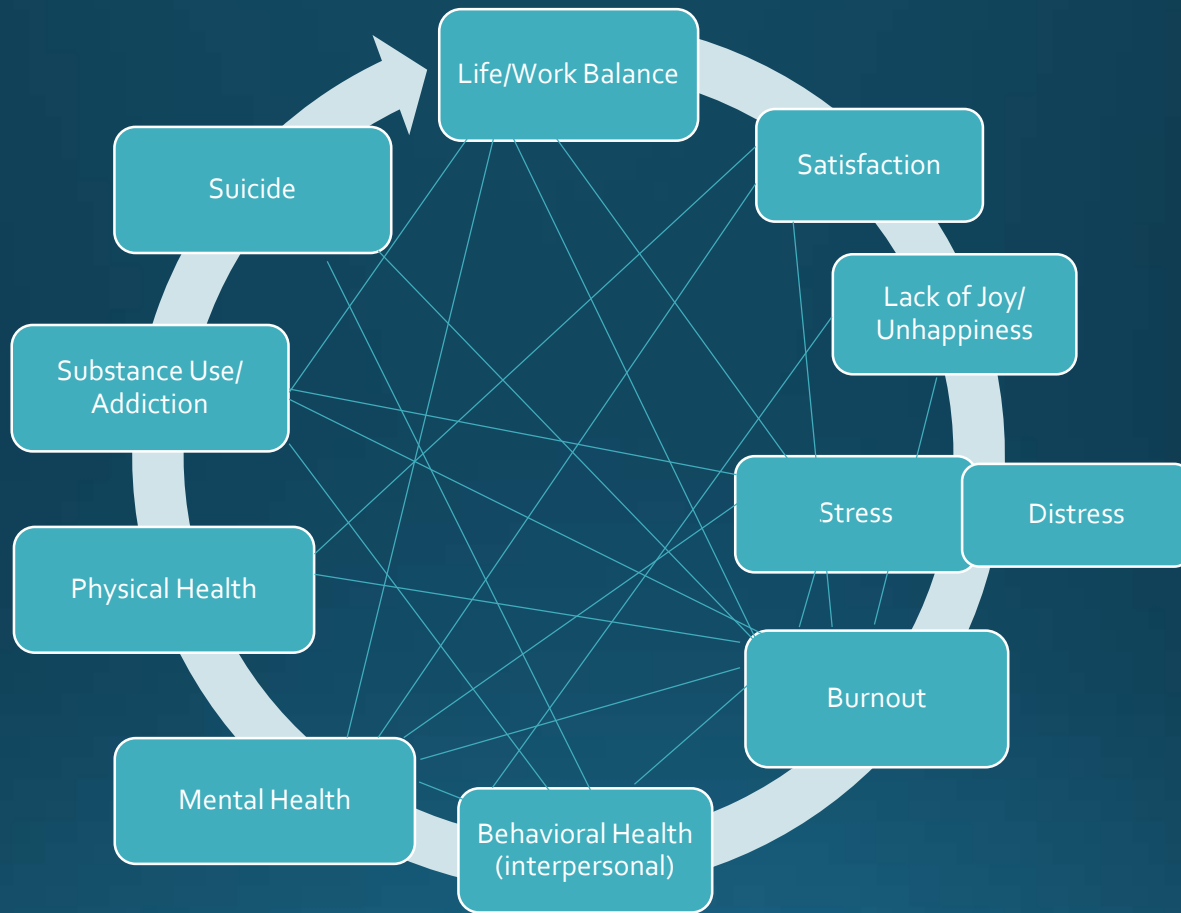
# Suicide Risk Factors

- 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

# An example of unhealthy cycle that healthcare professionals may experience



PHPs can intervene and help at any point!



# WHOSE DOMAIN ?

- HOSPITAL ?
- WVMPHP ?
- LICENSING/DISIPLINARY AGENCY ?

# The Sick Physician and the PHP

- The continuum of illness versus impairment
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- What is a PHP / PAP?

## objectives

# Physician Health Programs

From PREPARED

Thru *POTENTIALLY*  
*IMPAIRED*

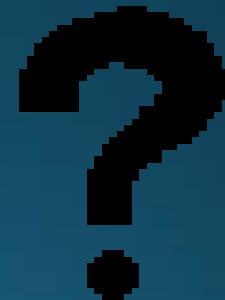
To *REPAIRED*

"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



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**

# PHP and Board Balance

PHP

Licensing Board

Confidentiality



Public protection

Illness



Impairment

Treatment



Sanctions

# 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

# 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

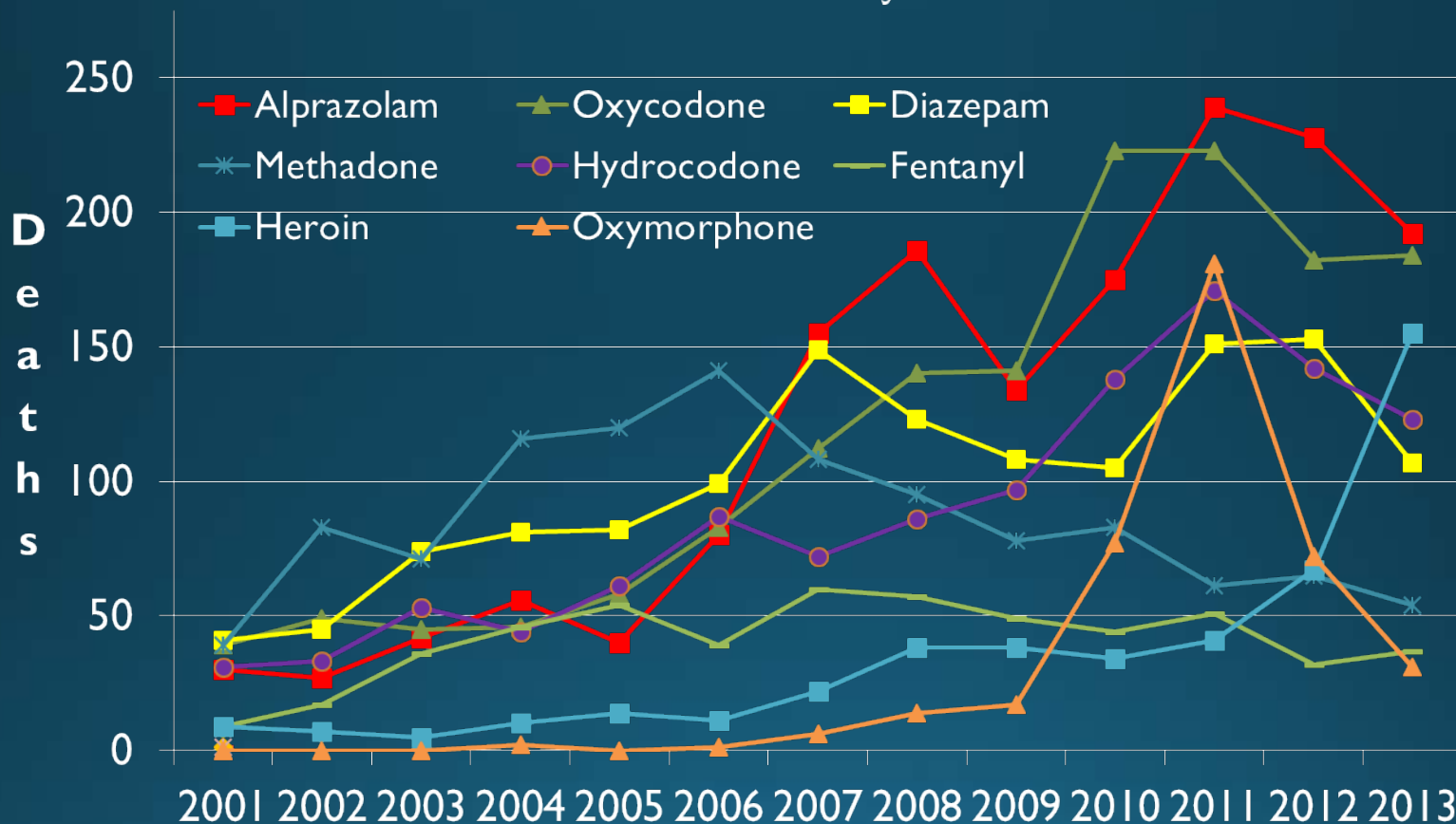
## THE DEADLY SILENCE

# 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

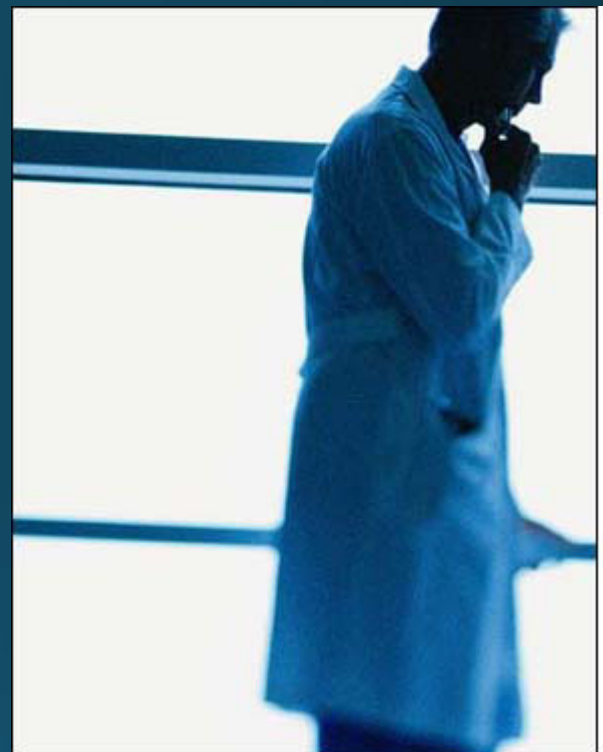
# DEADLY SILENCE

- 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

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# 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 WVMPHP 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.

Addiction & Mental Illness  
are

**NON-DISCRIMINATORY  
&  
POTENTIALLY IMPAIRING**

# THE SIX “I” S

# HOW TO IDENTIFY A TROUBLED COLLEAGUE

# BEHAVIORAL INDICATORS OF IMPAIRMENT

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



This Presentation is  
available at:

[www.wvmpHP.org](http://www.wvmpHP.org)

**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**  
(**A**lcohol **O**n **B**reath) 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

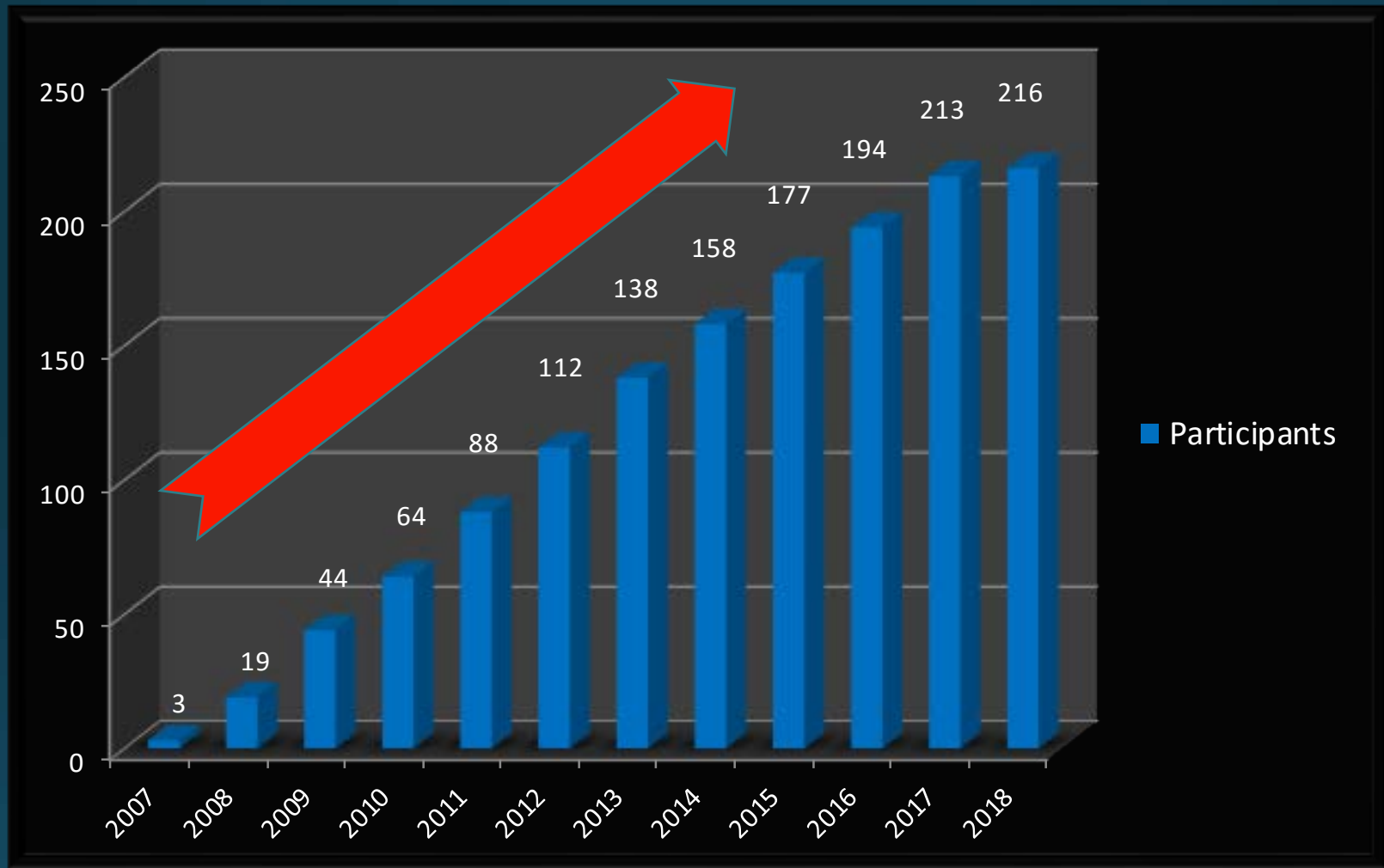
- The continuum of illness versus impairment
- Potentially impairing conditions
  - Substance Abuse, Mental Illness & Co-morbidities
- What is a PHP / PAP?
- Barriers to detection and assistance
- Humanness (Occupational hazard)
- Statistics / characteristics of PHPs / WVMPHP

## objectives

# Program Statistics

Growth 1000%+  
Success rate 90%

# WVMPHP Program Volume

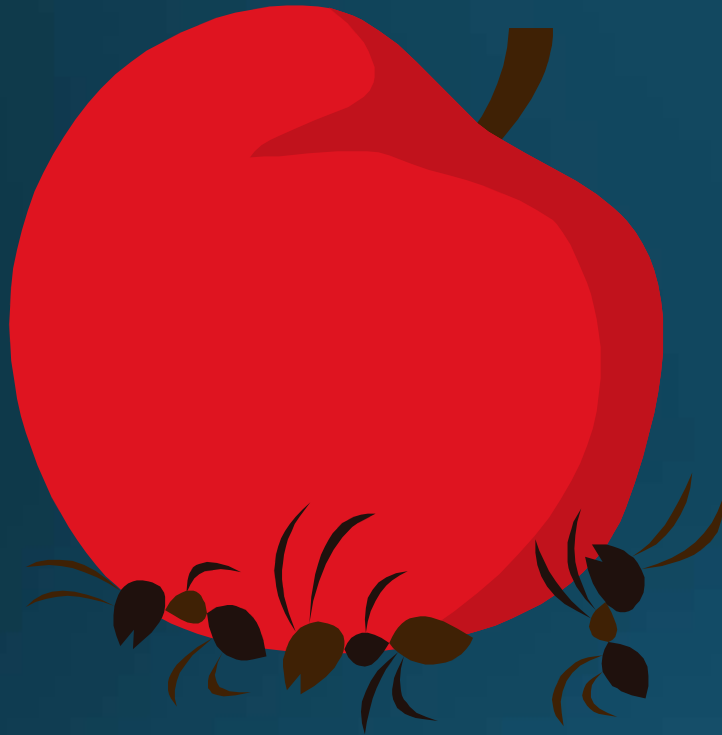


# Ineffective System

- 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
- ◆ Joint Commission MS 11.01.01
- ◆ Continuing Medical Education
- ◆ Conflict of Interest
- ◆ Malpractice Liability
- ◆ Patient Care Continuity
- ◆ Medical Practice Act
- ◆ Exposure
- ◆ Recruiting Expenses
- ◆ Public Safety



# Joint Commission

## 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

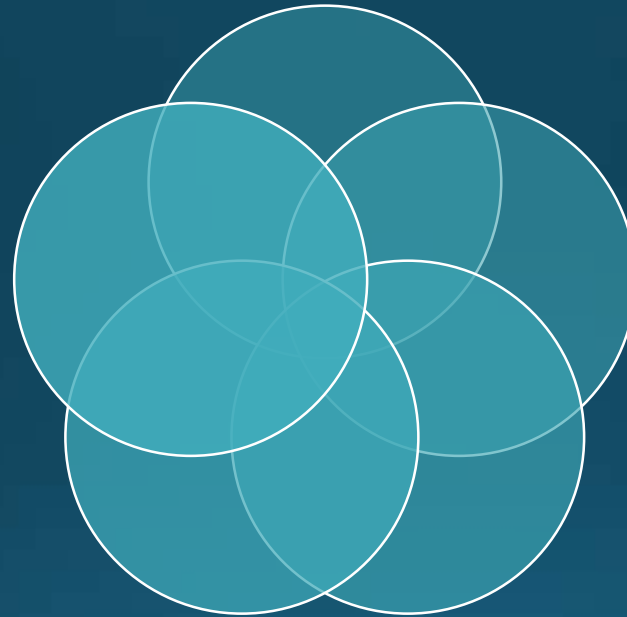
Physicians

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"><li>• Alcohol &amp; Drugs</li></ul>	<ul style="list-style-type: none"><li>• Random</li><li>• Frequent</li></ul>	<ul style="list-style-type: none"><li>• 4 times a month 1<sup>st</sup> year</li></ul>	<ul style="list-style-type: none"><li>• 5 th Year</li></ul>
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%)

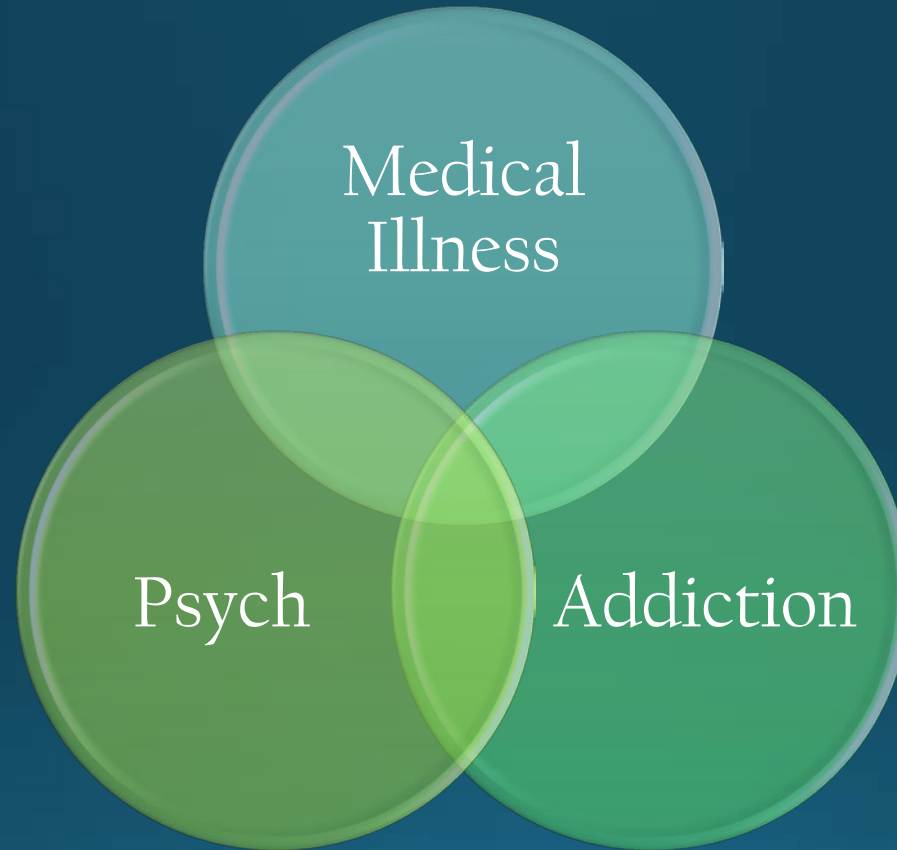
Bi-Polar – 6 (12%)

ADD – 1 (2%)

MULTIPLE DX – 23 (45%)

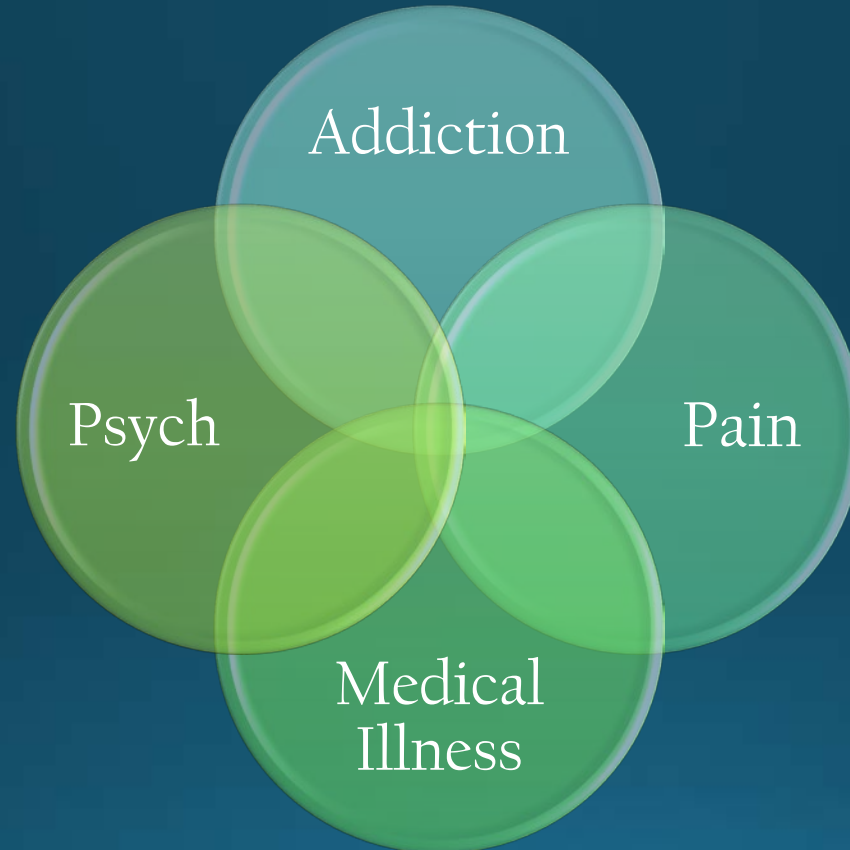
\*Active Participants

# Common Triad of Disorders





# Intersecting Diagnoses and other underlying issues



# Complexity Becomes More than Additive

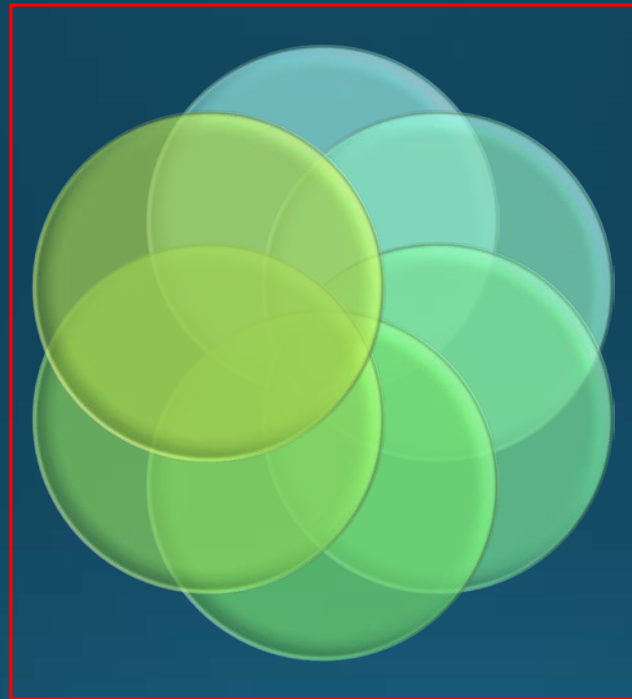
Addiction

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%)

# 2016 NSDUH Report Illicit <30 days 28.6 Million Adults (10.6%)

- Marijuana – 24 million (8.9%)
- Prescription Drugs – 6.2 million (2.3%)
- Prescription **Pain Relievers** – 3.3 million (1.2%)
- Cocaine – 1.9 million (0.7%)
- Hallucinogens – 1.4 million (0.5%)
- Inhalants – 0.6 million (0.2%)
- Methamphetamines – 0.7 million (0.2%)
- Heroin – 0.5 million (0.2 %)

# 2016 NSDUH Report Illicit <30 days 2.0 Million Adolescents (7.9%)

- Marijuana – 1.6 million (6.5%)
- Prescription Drugs – 0.4 million (1.6%)
- Prescription **Pain Relievers** – 239 thousand (1%)
- Cocaine – 28 thousand (0.1%)
- Hallucinogens – 149 thousand (0.6%)
- Inhalants – 175 thousand (0.7%)
- Methamphetamines – 9 thousand (<0.1%)
- Heroin – 3 thousand (0.1%)

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.

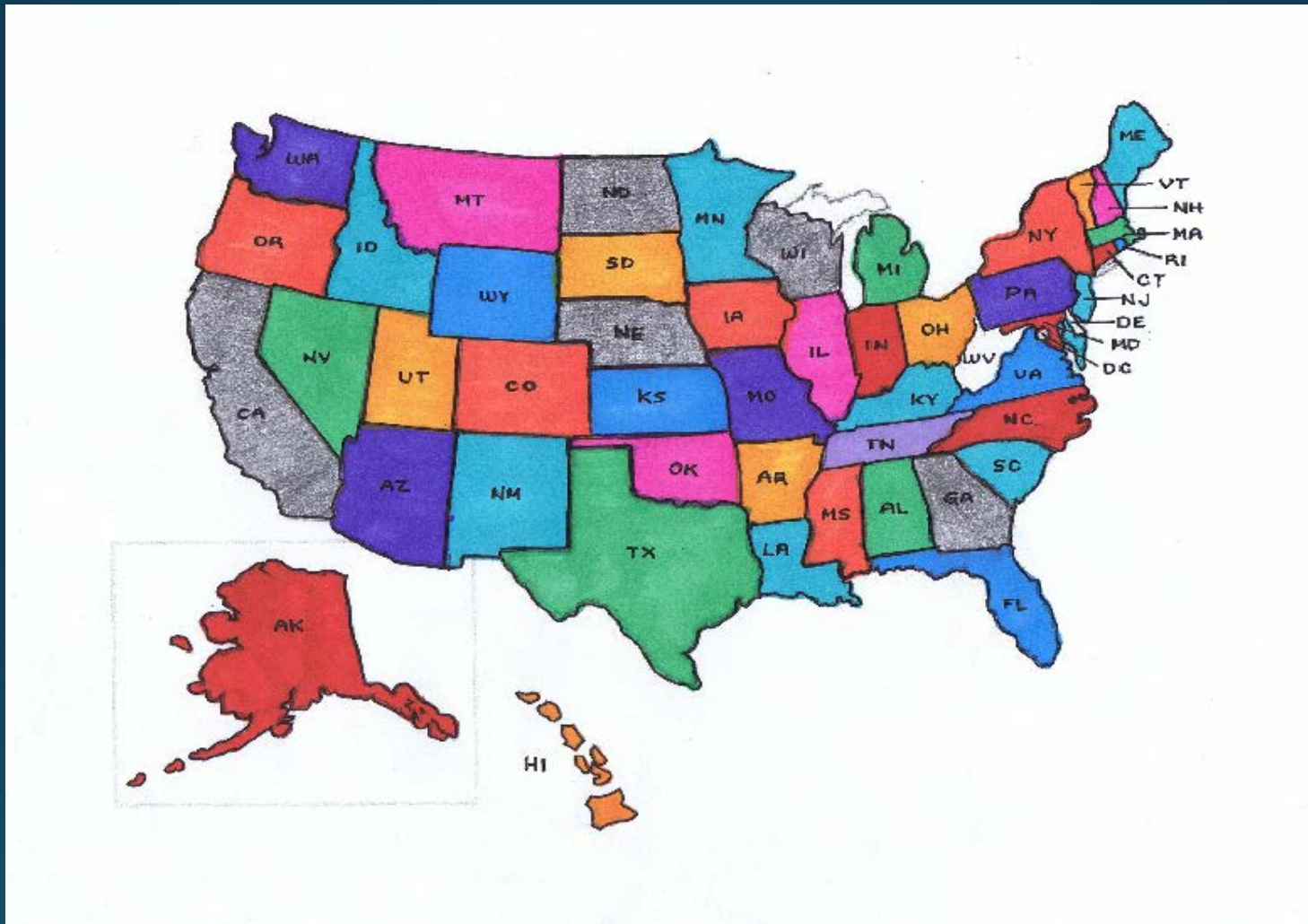
**YOU**

# Relocations & RTW

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



# 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 18 – 20, 2018  
Embassy Suites  
Charleston WV

# Websites:

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

This Presentation is  
available at:

[www.wvmpHP.org](http://www.wvmpHP.org)

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Website: [www.wvmphp.org](http://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.**



# Sources

- Federation of State Physician Health Programs Guidelines – [www.fsphp.org](http://www.fsphp.org)
- 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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- DuPont, et al. How are Addicted Physicians Treated? Journal of Substance Abuse Treatment, March 2009
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- American Society of Addiction Medicine, Physician Health Policies – [www.asam.org](http://www.asam.org)

[www.wvmp.php.org](http://www.wvmp.php.org)

# Sources

- National Survey on Drug Use and Health (NSDUH) <https://nsduhweb.rti.org/respweb/homepage.cfm>
- 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>