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Physician Views Regarding Substance Use-Related Participation in a State Physician Health Program

Lisa J. Merlo, PhD^{1,2} and William M. Greene, MD¹

¹Department of Psychiatry, University of Florida, Gainesville, Florida

²Department of Psychiatry, Washington University, St. Louis, Missouri

Abstract

Physician Health Programs (PHPs) safeguard the public by monitoring impaired physicians, but participation is not always voluntary, and many physicians resist referral. In this study, 80 physicians (85.1% male) who were referred to a state PHP for substance use-related problems completed an anonymous online survey regarding their experiences in the program. Results indicated that 78.1% of program completers had a 5-year contract, with 100% including random drug screening. In addition, 84.8% continued participation in 12-step fellowships after the required monitoring period. Participants were generally satisfied with the program, and 92.5% indicated that they would recommend it to others. They provided suggestions to increase the acceptability and efficacy of PHPs for physicians.

Introduction

For several decades, it has been recognized that physician impairment results from addiction more than any other disease.¹ Several factors are thought to contribute to physicians' vulnerability to substance use disorders, and particularly prescription opiate addiction,² including genetic predisposition, increased access, high-stress careers, long work hours, and secondhand exposure to potent drugs.^{3–6} However, the consequences of substance use disorders may be more severe among physicians than other individuals. Untreated physician addiction puts public safety in jeopardy and puts the physician's colleagues and employers at increased risk.⁷ The addicted physician is also at increased risk for suicide⁸ and other health problems. Despite these consequences, several barriers may prevent physicians from obtaining treatment.⁹ For example, physicians may experience significant denial of their addiction, or feel they can manage the symptoms personally.¹⁰ Due to their extensive medical knowledge and training, they may mistakenly believe that they can diagnose and manage their own substance use problems. In addition, though physicians have moral, ethical, and legal obligations to report a colleague who is putting patient safety at risk,¹¹ many have concerns about the potential ramifications of making a report.¹²

In order to address these concerns, most states have developed Physician Health Programs (PHPs) to assist with the monitoring of impaired physicians.¹³ In general, these programs mandate participation in formal treatment, as well as long-term monitoring, to ensure that the physician is adhering to program requirements. Physicians who cooperate with the PHP generally avoid more punitive measures. Many states also allow confidential participation in

Address correspondence to Dr. Merlo, Department of Psychiatry, University of Florida, P.O. Box 100183, Gainesville, FL 32610-0183. lmerlo@ufl.edu.

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their programs, and do not require reporting to the Board of Medicine. This promise of confidentiality is viewed as a critical component of the PHPs, as it allows physicians to avoid many of the feared consequences of obtaining treatment (e.g., loss of status in the community; diminished patient trust; licensure restriction or suspension; loss of employment). However, confidentiality may be broken in cases of uncooperative or non-adherent physicians. As a result, the ability to retain the medical license often becomes a primary motivator in helping the physician to maintain sobriety.¹⁴

Physicians who are referred to a PHP undergo an extensive evaluation before developing a personalized contract.⁹ Though there is some variability between states, elements of contracts in most states include a combination of residential or partial-hospitalization treatment, participation in a 12-step recovery program, psychotherapy, weekly group meetings with other professionals in recovery, and urine testing-based contingency management.¹⁵ In the majority of cases, the contracts extend 5 years, with random drug screening included for the duration of the contract. Treatment outcome for physicians who participate in these programs is generally much better than for the general public.¹⁶⁻¹⁹ Indeed, PHPs report 5-year sobriety (as verified by random drug screening) with return to employment for over 70% of participants.²⁰ However, participation in a PHP may be viewed as an undue burden by some, and the ethics of what may be considered “coerced treatment,” even when socially-sanctioned,²¹ are not supported by all. In addition, no data currently exist regarding physicians' opinions of program participation in general, or of the usefulness of specific components of PHP participation in particular. Thus, the goal of the present study was to examine physicians' views regarding their experiences in one state PHP. Specifically, we assessed participation in common program requirements (e.g., 5-year contract period, frequent randomized urine drug screening, participation in a 12-step fellowship, and weekly monitoring meetings), and examined physician opinions regarding satisfaction/dissatisfaction with the program and suggested areas for improvement.

Method

Procedure

All procedures were approved by the University of Florida Institutional Review Board and the state Physician Health Program (PHP) under study with a waiver of documentation of informed consent. Physicians who had a history of substance use-related involvement with the PHP between 1994-2008 (N = 640) were sent an informational letter describing the study and inviting them to participate. However, 238 letters were returned due to incorrect address or because the individual was deceased, leaving 402 potential participants. In the letter, the physicians were provided with a website URL address, directing them to an anonymous online survey website. The survey was comprised of a set of questions developed for this study and took 20-30 minutes to complete. Items covered demographic information and psychosocial history, substance use history, aspects of participation in the PHP, satisfaction with PHP involvement, and suggestions for improvement of the program. Participants completed the survey online, anonymously, and at a time that was convenient for them. There was no compensation provided for the time required to participate. Efforts were made to improve participation rates by sending reminders to all physicians who had been invited to participate in the study, and the physicians received 3 notices regarding the study during the four months that the survey was available online.

Participants

Of the 402 potential participants, 80 physicians (20%) completed the survey. This included 58 physicians who first signed a PHP contract between 2004-2008, 17 who first signed a contract between 1999-2003, and 5 who began their involvement with the PHP prior to

1999. Of those who completed the demographic questions ($n = 67$), 85.1% were male ($n = 57$). Participants ranged in age from 29-76 years ($M = 49.8$, $SD = 9.8$). The majority self-reported as Caucasian (90.9%), with others self-reporting as Hispanic/Latino (6.1%) and Asian American (3.0%). Participants in the study endorsed a number of medical specialties prior to their involvement with the State PHP. The most highly represented specialties included Anesthesiology (15.7%), Family Practice (12.9%), Surgery (10.0%), Internal Medicine (8.6%), and Pediatrics (8.6%). A total of 21 participants (26.6%) self-reported a lifetime psychiatric diagnosis. The most common psychiatric comorbidities, based upon self-report, included: depressive disorders ($n = 16$, 20%), anxiety disorders ($n = 8$, 10%), bipolar disorders ($n = 2$, 2.5%), sleep disorders ($n = 2$, 2.5%), and eating disorders ($n = 2$, 2.5%).

Results

Description of PHP Contract Components

The majority of participants (63.8%) reported signing only 1 contract with the state PHP ($M = 1.49$, $SD = 0.80$, range = 1 to more than 5). Of those who reported the length of their most recent contract ($n = 64$), most indicated signing a 5-year contract (78.1%); with a range of 1 to 8 years ($M = 6.01$ years, $SD = 1.46$ years). Sixteen individuals (20% of the total sample) reported being “still under contract,” rather than reporting the length of their contract. Fully 100% of participants reported that their contract included random urine drug screening, with most indicating that they engaged in urine drug screening once per week (66.7%) for at least the first 6 months of their contract. Another 9.4% reported urine drug screening 2 or more times per week, and 15.4% reported urine drug screening once every other week. Only 7.7% reported random urine drug screening less than every other week.

Participants also reported significant involvement with 12-step fellowships (e.g., Alcoholics Anonymous [AA] or Narcotics Anonymous [NA]) as part of their most recent contract. The overwhelming majority (94.9%) of participants reported attending 12-step meetings regularly, with 6.3% attending meetings daily, 78.5% attending meetings more than once per week, and 10.1% attending meetings on a weekly basis. Of those who reported completing their contract, 84.8% endorsed continued attendance at 12-step meetings, with all but 1 of these individuals reporting at least weekly attendance.

Satisfaction with PHP Participation

In this sample, 44.6% of physicians indicated that they were “very satisfied” with the PHP, and an additional 33.8% indicated that they were “satisfied,” for an overall 78.4% satisfaction rate. Of the remaining individuals, 6.2% reported feeling “neutral,” 4.6% reported being “dissatisfied,” and 10.8% reported being “very dissatisfied.” When asked whether they would recommend PHP involvement to others, 92.5% ($n = 74$) responded affirmatively. It is noteworthy that all of the physicians who reported dissatisfaction were currently under contract and/or had had their contracts extended at least once; similarly, all physicians who indicated they would *not* recommend PHP participation were still under contract.

Reasons given by participants for recommending the PHP to others included the helpfulness of monitoring/accountability provided by the program ($n = 23$), the advocacy and assistance provided by the PHP related to legal/licensure issues ($n = 18$), the overall quality of the program ($n = 15$) and staff ($n = 15$), the opportunity to interact with other professionals in Recovery ($n = 6$), and the confidentiality of the program ($n = 2$). Reasons for not recommending PHP involvement included feeling that physicians might be mis-identified as an addict and unfairly “punished” by program requirements ($n = 3$), and feeling that program

involvement is too confusing ($n = 1$). Participants were asked to endorse as many ways as PHP participation had been “most helpful” to them. Results are listed in Table 1. Fewer than 5% of responders reported feeling that the PHP had not been helpful to them. A free-response item was also included for participants to describe the “best thing” about PHP participation. The top 2 themes included the provision of social support/fellowship with professional peers ($n = 21$), and advocacy related to legal or licensing concerns ($n = 21$). An additional 15 participants reported that accountability to the PHP provided them with an added incentive to stay sober, and 7 participants described validation and support of Recovery as the best aspect. Four participants identified the opportunity to access treatment, and 2 participants noted specific aspects of the program, including anonymity and the convenience of the monitoring system.

Finally, several participants had recommendations regarding ways to improve PHP involvement for impaired physicians. The most common theme dealt with the strong desire for frequent and detailed communication ($n = 9$). Physicians suggested the provision of various written materials (e.g., newsletters, informational articles/books), as well as regular contact with case managers and PHP administrators. Another common theme surrounded making contracts as individualized as possible, based on the physician's personal needs ($n = 8$). The recommendations included making contract length more dependent on the specific individual's situation, monitoring prescription drug users more closely, allowing “transfer credit” of monitoring from other states, and educating physicians about alternative Recovery groups (in addition to 12-step fellowships). Next, 7 physicians provided recommendations for improving the urine drug screening procedures. The primary suggestion was to allow call-ins (to determine whether they were randomized to testing) the evening beforehand, so that the physicians could go to sleep before midnight, knowing whether they would need to fit the testing into their schedule the next day. Others suggested using a lab company with hours and locations that would be more convenient for practicing physicians, and having less frequent urine tests with intermittent hair tests. Some physicians recommended more focus on mental health issues independent of substance use ($n = 5$), improvements to the weekly facilitated groups ($n = 5$), and general concerns about staff interactions ($n = 5$). Finally, 4 physicians indicated that participation in the PHP was too expensive. It is noteworthy that 12 physicians wrote that they were satisfied with their PHP participation and had no recommendations for improvement.

Discussion

The present study assessed the experiences of participants from only one State PHP; however, the data highlight several important findings that may be applicable to all state PHPs, as the study confirms that participants in the PHP under study actually do complete the monitoring components assumed to be standard for most state programs (i.e., contract, a period of monitoring for approximately five years, regular and frequent urine drug testing, weekly support groups, and mandatory 12-step participation).¹⁵ Research on PHPs across the nation has demonstrated that these elements are quite consistent across programs.^{20,22}

Of note, the overwhelming majority (78.4%) of participants reported satisfaction with their participation in the PHP; whereas, only 15.4% of respondents expressed dissatisfaction. This result was somewhat surprising, given the fact that most participants were, on some level, mandated or forced into program participation. Furthermore, these programs require a significant time commitment, are often quite expensive, and typically employ a group therapy setting to pry into the most personal aspects of participants' lives. Despite functioning in a capacity which could reasonably be expected to be seen as imposing, authoritarian, harsh, or unforgiving, participants actually seem to *like* these programs. In fact, 92.5% would recommend PHP participation to others, and less than 5% found the PHP

to be unhelpful. Of note, only physicians who were still under contract expressed dissatisfaction with the program, suggesting that the imminent frustration associated with the aforementioned inconveniences may wane over time as physicians gain perspective on their experiences in the PHP. Indeed, all physicians who had successfully completed their involvement in the program indicated that they would recommend it to others. Reasons for recommending PHP participation included primarily a) the helpfulness of monitoring/accountability and b) the advocacy and professional assistance provided. Certainly, these two factors have long been regarded as the dual primary missions of PHP organizations: monitoring (to protect the public) and advocacy (for continued employment or licensure of the participant).

Beyond the components mentioned above, a top reason for recommending the program, or subjective “best thing” about PHP participation, was the fellowship and social support of professional peers. Several barriers to physician participation in group treatment have been identified previously (e.g., difficulty accepting the patient role, the experience of shame, and personality characteristics common to physicians).²³ Presumably, these professionals are more comfortable sharing about aspects of their addiction that relate to the practice of medicine in the company of their peers. Many of the common experiences verbalized in this group would be ill-received or quite unsettling if shared in a more public recovery forum (e.g., community 12-step meeting), but would more likely be met with open acceptance and empathy in a PHP setting. Participation also appears to impart lasting behavioral change beyond completion of the contract. The vast majority (84.8%) of participants reported voluntary continued attendance at 12-step recovery meetings after completing the contractual period of obligation.

With respect to participants' opinions on the “most helpful” aspects of the PHP participation, four top responses stand out above the rest: maintaining sobriety, enhancing job security, restoring healthy relationships, and improving spiritual foundation. Not surprisingly, maintaining sobriety was listed as the single most helpful aspect by respondents in this survey, and may also be viewed as a prerequisite for the other benefits of the program to come to fruition. Helping participants to maintain sobriety is a primary target/endpoint of virtually any treatment program directed at patients with addictions. Indeed, it has been identified as a necessary, though not sufficient, condition for achieving “Recovery.”²⁴ As a result, the monitoring provided by PHPs may facilitate Recovery by mandating and verifying sustained sobriety.

Respondents in this study also indicated several aspects of the program that might be improved, primarily with respect to a) improved communication, b) enhanced contract individualization, and c) improved convenience of submitting specimens for testing. Some of these suggestions were program specific (i.e., specific methods of communication, concerns about the specific urine testing lab company, etc.), but other suggestions could likely be extended to other state PHPs as well. As to communication, the suggestion for more written materials is easily attainable, and the PHP under study has implemented changes in this arena on the basis of the recommendation. Other state PHPs may consider offering a similar comprehensive orientation packet for new participants, which includes a list of “frequently asked questions,” to alleviate confusion about participation in the PHP. Intermittent, case-manager-initiated telephone contacts with PHP participants may also provide a forum to address problems before they arise, and to enhance overall communication. Although beyond the scope of this study, it is the authors' understanding that most state PHPs currently strive to individualize participants' contracts to the degree feasible. However, as state PHPs become more homogenous, perhaps consideration could be given to more readily allow “transfer credit” for physicians moving between states. With respect to the convenience of submitting urine and/or hair specimens, there appears to be

some discontent regarding how far in advance participants may call to find out if they have been selected for testing. Of course, the sooner a participant finds out they are *not* selected for testing, the more potential exists for illicit substance use circumventing detection. Thus, the issue of participant convenience must be weighed against maintaining the integrity of the system.²⁵ Perhaps as testing techniques improve, windows of detection increase (as with ethyl glucuronide [EtG] testing),²⁶ and hair testing is used with increasing regularity,²⁷ more consideration could safely be given to making testing more convenient for busy practicing physicians. Taken together, these suggestions imply that PHP participants, although generally satisfied with the program, would prefer that the monitoring process acknowledge and adapt to individual needs and circumstances wherever possible. As PHP programs across the nation continue to evolve, these concerns may be recognized, and suggestions judiciously implemented where appropriate, toward the goal of optimizing overall effectiveness of these programs.

Of course, the results of this study should be interpreted within the context of some limitations. For example, the data were from a relatively small sample ($N = 80$), based on a low response rate (i.e., 20%) for the survey. This was somewhat expected, given that the study included many known barriers to survey response, including: a) the population under study consisted of physicians, who historically provide lower response rates to surveys, b) anonymous participation, c) lack of telephone reminders, d) lack of financial compensation for participation.²⁸ In addition, other barriers to participation included: a) the length of the survey, b) the personal nature of the questions, and c) the requirement that participants access the survey online. Indeed, the response rate was comparable to other studies employing similar methodology with physician respondents.²⁹ However, given the low level of participation, response bias may have affected the study results, and the findings may not be generalizable to the population as a whole. Another limitation is that the questionnaire was designed for this study, so data regarding reliability and validity were not available. In addition, all collected data were based on self-report, and there was no way of verifying physician responses with programmatic data due to the anonymous nature of the study. However, given that we were most interested in physicians' personal views and opinions, the negative impact of utilizing self-reports was likely minimal. Despite these limitations, the data provide important preliminary information that may be used to improve state PHPs and to develop future studies.

In conclusion, physician health programs are now being recognized for their unmatched effectiveness in facilitating long-term remission of substance use disorders.²⁰ Five-year abstinence rates in these programs typically exceed 70%²²; a success rate rarely seen in the treatment of addicted populations. By furthering the understanding of what makes these programs so uniquely effective, physician health and patient safety may be better protected. In addition, key elements of these monitoring programs may be more widely applied to other populations affected by addiction.

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Table 1
Ways in Which PHP Participation Was “Most Helpful” to Physicians

Method of Helping	Percent Endorsing
Maintaining Sobriety	85.9%
Job Security	59.4%
Restoring Healthy Relationships	42.2%
Improving Spiritual Foundation	42.2%
Managing Legal Issues (Not Malpractice)	15.6%
Managing Malpractice Issues	6.3%
Other	12.5%
<i>PHP Was NOT Helpful</i>	<i>4.7%</i>