**Re: Physician Health Programs: Coercive or Supportive?**

**“Constricting” might be more descriptive**

I would like to thank EMNews for continuing to cover this emerging issue of critical importance to a subset of physician readers. As Katz reports, Physician Health Programs (PHPs) were indeed originally designed to offer peer support to physicians with substance abuse problems.

As the article correctly states, “When a physician agrees to cooperate with the PHP and adhere to ***any and all recommendations*** *(emphasis added****)***, it decreases the probability he will be subject to disciplinary action and increases the likelihood he will be able to remain in practice, PHP proponents say.” Even PHP detractors would not disagree with this. This is called in the trade a contingent management contract system, and it is universally used by PHPs. And *adherence* is a good term, because these are indeed “contracts of adhesion”.[[1]](#footnote-1)

However, as Boyd and Knight (former MA PHS Associate Directors) also correctly note, once a physician has been reported (by self or others) to a PHP, he or she is almost invariably coerced into cooperation with a finely tuned and well greased machine. The system originally designed for peer support in dealing with physicians with substance use disorders, is now being applied ever more broadly, to physicians with a history of pure or even remote and very common mental health issues (such as anxiety, grief, depression), those who are labeled as (or are) “disruptive”, those who are developing burnout, and those who for whatever reason find themselves complained about, often anonymously, and who may in fact be much better served by coaching or a true peer support system than by a lifetime drug abuse monitoring program which is backed by a highly profitable industry.[[2]](#footnote-2)[[3]](#footnote-3)

This scheme is buttressed by for-profit “monitoring contractors”, drug testing facilities, and “preferred” rehabilitation facilities (many owned or founded by recovering physicians, or former physicians). [[4]](#footnote-4) Failure to comply with **each and** **every** requirement put forth by the PHP--- as for example, providing proof by testimony of other participants of regular attendance at AA meetings (something that flies in the face of AA principles of anonymity) EVEN when diagnostic criteria for alcoholism are not met; submitting to random daily drug and alcohol screening for **years** when diagnostic criteria for alcohol or drug abuse have never been met; submitting to NON FDA approved diagnostic testing that is overly sensitive to alcohol that is encountered daily in hospital environments (such testing developed, patented and promulgated by recovering physicians or former physicians---and now used by 100% of PHPs)[[5]](#footnote-5), and that moreover is NOT recommended by federal agencies for use in forensic settings such as these [[6]](#footnote-6); forgoing even medically necessary prescription medications (for serious diagnoses such as asthma, sleep apnea and narcolepsy) because they might interfere with such testing; mandatory submission to polygraph testing (which has been debunked by all US courts as representing “junk science”); acquiescing to and making up front cash payments for extensive four day inpatient “evaluations” at “preferred centers” that almost inevitably lead to further expensive inpatient rehabilitation at these same or other “preferred/selected” out of state facilities--- can and does result in reporting “noncompliance” to the medical licensure board (MLB) which subjects the physician to the very real risk of loss of licensure and therefore livelihood.

Physician health programs generally do NOT report noncompliance to credentialing agencies and employers, but rather to medical licensing boards, (MLBs) which in turn report to varying entities including the Healthcare Practitioner Data Bank (which must by law be queried by credentialing agencies and employers prior to credentialing), as well as to the public via their newsletters and websites. One MLB was for a time tweeting results of disciplinary orders on physicians.[[7]](#footnote-7) However, there are instances of PHPs reporting the fact of current admissions of ostensibly impaired physicians to rehabilitation facilities to employers, immediately revealing the presumptive diagnosis of addiction, a disabling condition, something that is prohibited under several federal laws and most state laws.

Due to my longstanding concerns about physician mental health and suicide prevention, I was a very staunch supporter of PHPs[[8]](#footnote-8) until I started learning of such mismanagement/abuses of authority from ACEP members who came to me for advice in my capacity as chair of the WellBeing Committee. One, for example, experienced psychiatric side effects from medically indicated pharmaceutical treatment, and reported voluntarily to the employer as temporarily disabled, resulting in the employer’s demand for reporting to the MLB/PHP. Several clients, after self reporting to the PHP for “support” for stress, anxiety, grief reactions, or low level depression, have been forced into 12 step rehabilitation for nonexistent substance abuse disorders. Others who refused to comply with mandated abstinence-only faith based programs that are clearly irrelevant to their condition or are grossly overreaching, have either lost their licenses and/or their employability as a result of adverse publicity.

Robert DuPont, MD, quoted extensively in the article as an authority on PHPs, was the drug policy director under Nixon and Ford. He cofounded the sixth largest employee assistance program (EAP) in the US (Bensinger, DuPont and associates, now BDA Morneau Shepell) which promotes, manages, and profits from drug testing for over 10 million people including, of course, physicians. He also chairs the Advisory Board of and holds stock options in Psychemedics Corporation, which holds patents on hair follicle testing. He is hardly a disinterested person when it comes to his zealotry for drug testing and the new PHP paradigm to which drug testing is central. DuPont now runs a Behavioral Health Intervention service, which serves EAPs, including PHPs. Could he possibly exhibit a conflict of interest? Several published interviews with and addresses by DuPont make it clear that he is THE leading proponent of zero tolerance (based on frequent drug testing) abstinence-only lifelong faith-based programs for addictions management, and in fact any and all drug testing of almost any population, perhaps especially of the non FDA approved and overly sensitive alcohol tests now increasingly relied upon in abstinence-only programs including all PHPs.[[9]](#footnote-9)

Mike Sucher, a recovering EP who runs assessment and monitoring facilities in the western US, reports that “Certain alcohol containing disinfectants used in operating rooms and dental offices can be inhaled and produce a low level of EtG. ” (one of several such non FDA approved tests now uniformly adopted by PHPs) Other nondrinking sources of alcohol exposure include foods, over-the-counter medications, propellants in asthma medications and hairspray, aftershave and mouthwash.[[10]](#footnote-10) There is even something called “autobrewery syndrome” in which certain individuals through their own microbiome can produce enough alcohol to be “detected” in urine by these overly sensitive tests that are being used forensically to disprove abstinence.

And of course any test for substances of abuse that are conducted without forensic safeguards, such as non alcohol based disinfection before sampling of blood, refrigeration of urine, signing, sealing and immediate processing of forensic samples, increases the risk of a false positive result that can then be used against an individual whose license may be at risk. There is increasing evidence from individual clients that “clinical” rather than “forensic” drug testing is being used by many PHPs. These tests are adopted and widely used by PHPs nationwide to enforce abstinence (for all clients, not just those with substance use disorder diagnoses), despite warnings by the Substance Abuse Mental Health Services Administration (SAMSHA) that “false positive responses from such tests can be detrimental in medical and forensic settings where an individual’s freedom or career is in jeopardy.”[[11]](#footnote-11)

DuPont’s assertions that “Programs (PHPs) have no leverage. They have no punishment; they have no consequences” is specious. Although he has never led a PHP, DuPont knows perfectly well from his colleagues in the industry that PHPs have all the leverage they need in the readiness of associated MLBs to mete out discipline to “noncompliant” doctors.[[12]](#footnote-12) Noncompliance and “relapse” have also been redefined to promote these programs.[[13]](#footnote-13)

MLBs have over the past two decades suffered enormous pressure from consumer organizations such as Public Citizen to increase their quotas for doctor discipline[[14]](#footnote-14). Meting out discipline to ostensibly “noncompliant” PHP participants is harvesting low hanging fruit---a seemingly unassailable way to increase those quotas and answer criticisms by the likes of Public Citizen founder Sidney Wolfe (a frequent speaker at Federation of State Medical Boards meetings) about “too few disciplined doctors”.

An informal survey of typical treatment costs for physicians done by an Emergency physician in 2011 showed that DuPont’s figures in the Katz article were gross understatements. Five years ago the lowest cost for an inpatient treatment program was 32K and the average was about 45K. These were for stays as short as 30 days. While typical rehabilitation inpatient stays for **non**-physicians are dictated by insurance and average about **28** days, certain self interested organizations such as the American Society of Addictions Medicine (ASAM) and its nearly captive Federation of State Physician Health Programs (FSPHP) have recently been promulgating the notion that the “standard of care” for inpatient rehabilitation of physicians is now **90** days. Based upon a single, flawed study, by DuPont, and referenced by Katz[[15]](#footnote-15).

The article, which does not discuss the possible confounders of dropouts, physicians “lost to followup” (really? Doctors? Totally lost?) such as relapsed participants or suicides, touts the amazing success rates of physicians in recovery in PHPs and attributes these solely to prolonged inpatient “rehabilitation”. However, it has long been established that physicians are among the most often successfully rehabilitated of all chemically dependent persons. Common sense dictates that this success relates far more to the Damoclean sword of imminent revocation of licensure, than to the requirement of an extraordinary length of stay in even more extraordinarily expensive facilities.

Katz writes that “Reports argue that physicians charge a lot for their time and services, so they are financially able to pay more than a non-physician would for the same treatment.” This sentence was interpolated between two quotes made by Wes Boyd, a former associate PHP director and a medical ethicist. Boyd has confirmed that these were not his words nor his “reports”.

If such reports can be verified, the writing suggests that prices for physician clients are being fixed at a higher level than for “normal” persons. This would be an unjustifiable and illegal activity (price fixing) with any coexisting element of coercion (as is clearly the case in the PHP-MLB paradigm), and no opportunity for competition in pricing between facilities or comparison shopping by physicians between those dozen or so “preferred” facilities to which physicians are invariably mandated.

It would seem that this comment may have come from Warren Pendergast, former Exec Director/Chief Medical Officer of the NC PHP, also quoted extensively in the article (Pendergast was the official cited in the audit of the North Carolina PHP for compromised objectivity within his program[[16]](#footnote-16)), who was interpreting his own study of the NC PHP outcomes comparing Physicians’ Assistants and physicians. “physicians assistants as a whole don’t have the same ability to pay for long term treatment. They just don’t have as deep of pockets as the physicians when they get into trouble.”

Pendergast does admit, regarding the discrepancy, that another contributing factor may be that physicians have more to lose. “For a lot of physicians, if they are not able to keep their license or get their license back they don’t have a lot to fall back on. The prospect of losing one’s livelihood and identity as a physician is a major motivator.” [[17]](#footnote-17)

Indeed it is. And it is also an incredibly powerful inducement to submission to activity such as unwarranted “rehabilitation” and monitoring, leaving physicians who are cornered in this system incredibly vulnerable to abuse. Physicians who were interviewed by the auditors in NC alleged that they were intimidated into unnecessarily enrolling into alcohol and chemical dependency programs. Without any meaningful due process protections, to the extent that in NC physicians were being denied the right to even ***know what diagnoses they were being labeled with*** in order to justify inpatient treatment, a physician has little recourse but to comply to prevent a report of noncompliance to the MLB, which report would lead to licensure action. Even involuntarily committed psychiatric patients are treated more fairly. (It is not yet known whether these compromising policies uncovered by the state audit have been corrected as a result of the audit).

DuPont’s assertion that “My experience is that PHPs are certainly willing to work with physicians on cost issues” is belied by the experiences of many physician clients who have participated in these programs. They report having undergone something more akin to living financial autopsy than wallet biopsy when they arrive for admission at one of these facilities. Failure to make advanced arrangements to pay is considered grounds for a report to the licensure board of physician noncompliance with a PHP recommendation. Such enforcement measures are even codified in many of the “contingent contracts” dispensed by PHPs.

In sum, there is far more to the PHP issue than meets the eye or has yet met the mainstream press; and I firmly believe that more abuses will emerge as physicians who have previously submitted in silence to such abuses of authority become emboldened, through the realization that they are not disgraced and alone, to share their stories.

Given the close interrelation between the FSPHP and its alterego, the ASAM, and close collaboration (if not collusion) between certain PHPs and MLBs[[18]](#footnote-18), we are no doubt seeing only the tip of the iceberg in the first emerging stories of those who have been affected. Several class action, ADA, civil rights and antitrust suits are currently being filed against various PHPs and MLBs in several states. There may be many more in the pipeline.

Meanwhile, I would have to urge all readers to proceed VERY CAUTIOUSLY if they are either reported, or feel the need to self report to a PHP. Please do NOT assume for one minute that PHPs are “in your corner” unless you have personalized knowledge that your state program operates legally and ethically. I am afraid that the 2016 PHP waters are uncharted, muddy and filled with unexpected predators who represent themselves as allies. Get reputable legal representation, and don’t be lulled into thinking that you can safely “go it alone” merely because you have done nothing wrong.

*Louise B. Andrew MD JD FIFEM twice chaired the Personal & Professional WellBeing Committee of ACEP and was a longstanding senior member of the ACEP Medical-Legal Committee*. *She represented ACEP at the FSMB for many years and occasionally at FSPHP*. *She manages a website dedicated to the prevention of Physician Suicide* [*www.Black-Bile.com*](http://www.Black-Bile.com)*, and another dedicated to helping physicians deal with the stress of litigation,* [*www.MDMentor.com*](http://www.MDMentor.com) *She does NOT represent clients, but has a wide network of contacts with lawyers who do.*

1. A contract of adhesion is a contract between two parties, where the terms and conditions of the contract are set by one of the parties, and the other party has little or no ability to negotiate more favorable terms and is thus placed in a "take it or leave it" position. [↑](#footnote-ref-1)
2. See, e.g. Horvath’s documentary “The Business of Recovery” detailing abuses in this $34 B annual industry; trailer available at <http://www.thebusinessofrecovery.com/> [↑](#footnote-ref-2)
3. Excellent review of “The Business of Recovery” can be found at http://tinyurl.com/Bus-of-Recovery-TO-Review [↑](#footnote-ref-3)
4. Fletcher, A “The Wrong RX for Addicted Doctors” The Fix 1/23/13 https://www.thefix.com/content/whats-wrong-with-addicted-doctor-PHP-programs00389 [↑](#footnote-ref-4)
5. See Helliker, A Test for Alcohol and its Flaws, WSJ Aug 12,2006 (accessed at http://www.mapinc.org/drugnews/v06/n1069/a01.html [↑](#footnote-ref-5)
6. SAMSHA Advisory 2012 accessed 2/24/16 http://tinyurl.com/SAMSHA-Biomark-Adv- [↑](#footnote-ref-6)
7. Personal communication with a former chair of a state MLB who does not wish to be identified [↑](#footnote-ref-7)
8. See “PHPs are in Your Corner” Emergency Physician’s Monthly June 2006 http://epmonthly.com/article/phps-are-in-your-corner/ [↑](#footnote-ref-8)
9. e.g.DuPont, R “Addiction in Medicine” presentation to TACCA http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2394682/pdf/tacca119000227.pdf [↑](#footnote-ref-9)
10. Andrews, L JMLD 91:4; 2005 at 11 [↑](#footnote-ref-10)
11. The Role of Biomarkers in the Treatment of Alcohol Use Disorders 2012 SAMSHA Advisory, [↑](#footnote-ref-11)
12. Ibid, at 10 quoting Lyn Hankes, former PHP director WA: “All of our clients know while we get them in with a carrot, the stick is picking up the phone and calling the [medical] board.” Without the board’s clout behind it, the PHP loses its best **leverage**. [↑](#footnote-ref-12)
13. Noncompliance, according to the ASAM/FSPHP, is used somewhat interchangeably with relapse by some PHPs and can include such things as missed AA meetings, being late for appointments, or “dishonesty” ; FSPHP and FSMB also define Level 1 Relapse as “Behavior without chemical use that is **suggestive** of impending relapse” (emphasis added) 2011 FSMB policy on Physician Impairment http://tinyurl.com/FSMB-Policy-MD-Imp [↑](#footnote-ref-13)
14. See, e.g. annual rankings of MLBs reporting to the public http://www.citizen.org/Page.aspx?pid=700 [↑](#footnote-ref-14)
15. J Subst Abuse Treat 2009;37[1]:1 [↑](#footnote-ref-15)
16. NCOSA #8141 2014 acccessed 2/23/16 at http://www.ncauditor.net/EPSWeb/Reports/performance/per-2013-8141.pdf [↑](#footnote-ref-16)
17. Andrews, L JMLD 91:4; 2005 at 8 [↑](#footnote-ref-17)
18. See, e.g. Parker, J Whistleblower: Abuse and Neglect in USA Residential Treatment Centers, pp. 48-72, accessed 2/24/2016 http://www.heal-online.org/unjp2011.pdf [↑](#footnote-ref-18)