

Physician Health vs. Impairment: The North Carolina Physicians Health Program

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Consider these scenarios:

- Colleagues in a large medical practice believe they smell alcohol on a physician's breath in the workplace.
- A physician with back pain reads an article in the North Carolina Medical Board Forum about the North Carolina Physicians Health Program (NCPHP), becomes concerned about her use of opiates, and realizes she needs help.
- A hospital reports a physician to the North Carolina Medical Board (NCMB) and to NCPHP because of ongoing sexual harassment of other staff.
- A physician assistant self-reports to NCPHP before his practice dismisses him for continual abusive comments and actions towards patients.

While the actual cases monitored by NCPHP are not usually this simple, all of these examples have in fact been seen many times. This is because the North Carolina General Assembly and a number of other visionary leaders in this state fought strong opposition to establish a peer assistance program in the 1980s for physicians who needed help.

The North Carolina Physicians Health Program is proud of its over 20 years of service. Since its founding on December 1, 1988, over 2,000 physicians, physician assistants, veterinarians, and registered veterinary technicians have been seen for substance abuse assessment. As a result, numerous practitioners seeking recovery are now visited regularly by field coordinators for urine drug screens and supportive services.

The first movement toward a physician's health program began in 1978 through the work and foresight of pioneers in this field. Dr. Ted Clark, Dr. Jonnie McLeod, Dr. Harold Godwin, and many others started the Physicians Health and Effectiveness Committee, part of the North Carolina Medical Society, in the mid-1970s. These individuals believed that many physicians suffering from substance use or mental health problems deserved help and treatment, not solely sanction or loss of a medical license. Significant resistance was encountered from many in the profession who did not understand that recovery

from mental health and substance abuse problems is possible through treatment and monitoring. However, Ted Clark and his colleagues believed that the doctors who found recovery could be of greater service to patients, in part *because* they had suffered from a chronic but treatable disease.

From 1978 until 1988, Dr. Clark operated the Committee out of his home. It was during this time that attitudes toward treatment began to change. By 1987, the North Carolina General Assembly authorized the North Carolina Medical Board and the North Carolina Medical Society to create a peer-review process. Senate Bill 204, later to become part of NC General Statute 90-21.22, formalized the work of the Committee. NCPHP, first known as the Physicians Health and Effectiveness Program, was born.

Physicians and physician assistants (PAs) may seek services from NCPHP on their own or through a referral. Though many referrals come from the NCMB and hospitals, others come from a wide range of sources including residency directors,

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colleagues, treatment centers, and spouses. The types of interventions are related to the types of problems and they are broadly classified into five types (see Table 1).

Analysis of the chemical dependence files shows that NCPHP has an approximate 90% positive outcome rate at five years after intake. This exceeds or matches the national standard for chemical dependence monitoring.¹ These results speak for themselves.

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Table 1.
NCPHP Assessments 1988-2007

Chemical Dependence and Dual Diagnosis	59%
Psychiatric (Axis I)	12%
Behavioral (Axis II)	12%
Unsubstantiated and Other	12%
Professional Sexual Misconduct	5%

Dr. Jonnie McLeod, writing in the *North Carolina Medical Journal* in 1996, reflected on the first decade of work. She said, "...a large fraction of the medical community still insists that impaired physicians ought to be punished rather than helped to recover. Those of us who have seen the results know that despite the years of struggle, this program is more than worth it."²

So what *has not* changed in the last 20 years? The following problems remain largely unresolved:

- Physicians/PAs suffer from addiction at the same rate, or perhaps only slightly higher, as the general population.
- Denial and fear often prevent physicians/PAs from getting early treatment.
- Physicians/PAs continue to encounter external obstacles to treatment.
- A significant amount of the illness suffered by physicians and PAs results in relapse.
- Society remains ambivalent as to whether some conditions (especially substance abuse and perhaps depression) represent moral failing, weakness, or illness. This is an especially sensitive issue as it relates to health care professionals.

Many of the issues that have made it difficult to estimate the prevalence of psychiatric illness in the general population^{3,4} also affect the accuracy of information about prevalence in professionals.⁵ In addition, denial and fear of professional consequences in physicians not only interferes with access to treatment, but also makes the issue very difficult to study. The definition of a "good outcome" has been hotly argued. Some say that a single slip, relapse, or even the minimal presence of addiction in health care professionals is unacceptable. Others point to the 1956 and 1987 declarations by the American Medical Association that alcoholism and drug dependence are illnesses; they argue that addiction treatment should be approached like diabetes or heart disease, and be treated using a chronic disease management model. This dichotomy has existed in various forms throughout NCPHP's history.

What things *have* changed in the last 20 years?

- Physician health programs (PHPs) have become widespread throughout the US and Canada, now existing in some form in most states and provinces.

- Many PHPs have begun to address other psychiatric diagnoses, behavioral issues, and professional sexual misconduct.
- More research is available on factors leading to favorable addiction outcomes in physicians/PAs.⁶
- The definition of "acceptable risk" has shifted and/or narrowed.
- Regulatory, legal, and financial pressures in medicine have increased greatly, with increased calls for transparency in the regulatory process and greater pressure on medical boards and other regulatory bodies.
- Computers and the internet have markedly changed the collection and dissemination of information.
- Tension in medicine between "high-touch" and "high-tech" has increased.
- Use of medications for treatment of psychiatric illness and addiction has become more widespread and accepted.
- There is a greater understanding of the anatomy and physiology of addiction.
- Drug screening technology has advanced, as have methods for evasion of detection.
- Programs now exist for many other professionals in North Carolina, including nurses, attorneys, pharmacists, and dentists.

None of these changes have occurred overnight; all represent the evolution of trends that have developed over many years. While this slow process often makes it hard to see "the forest for the trees" at any given point in time, we ignore the trends at our peril.

Physician health programs throughout the US and Canada have operated under many different models: some have been operated by medical boards, some by medical societies, and others as independent programs. NCPHP was set up early in its history to be independent but with internal "checks and balances" involving the NCMB, NCMS, and other stakeholders. The underlying idea was to maximize both patient safety and physician/PA health.

NCPHP monitoring contracts are structured so that (for cases not known to the NCMB) anonymity is maintained as long as the participant is safe to practice. However, if the participant constitutes an imminent danger to the public or themselves, refuses to cooperate with the program, refuses to submit to treatment, is still impaired after treatment, or if it reasonably appears that there are other grounds for disciplinary action, their status is made known to the NCMB. Pursuant to longstanding NCPHP policy, and now due to changes in the NC General Statutes, professional sexual misconduct cases are only monitored with mandatory involvement of the NCMB.

Impairment has been defined by the Federation of State Medical Boards as, "the inability of a licensee to practice medicine with reasonable skill and safety by reason of: mental illness; physical illness or condition, including but not limited to those illnesses or conditions that would adversely affect cognitive, motor, or perceptive skills; habitual or excessive use

or abuse of drugs defined in law as controlled substances, alcohol, or other substances that impair ability.”⁷ By this definition, illness can lead to impairment but is not the same thing as impairment.

There will always be tension between the goal of getting practitioners to self-identify illness early and to seek help versus the desire of the public to know when their doctor is ill or impaired. The former emphasizes protection of the public through prevention, while the latter speaks to the empowerment of patients as consumers.

The lessons of the last 20 years have taught that PHPs must address both illness and impairment and, ideally, even conditions predisposing to illness. A prevention model will only work if practitioners feel safe in getting early preventive treatment and monitoring of illness through the PHP. If the definitions of illness and impairment become confused, that perception of safety will be eroded. The PHP will then get more and more referrals of those in late-stage addiction and hence those who are more likely to be impaired in the workplace. This becomes a vicious cycle that ultimately results in the inability of the PHP to function effectively, to the detriment of public safety.

Furthermore, if the bar to return to practice after addiction treatment is set too high, physicians and PAs will be even more reluctant to get treatment. If the bar is set too low, physicians

and PAs will return to work too early and/or with inadequate treatment. NCPHP’s role, in part, is to assess the severity of illness, help determine appropriate length of treatment, and to assess the potential to practice safely, and to do so in as unbiased and objective a manner as possible. The question is one of balance. A recent NCPHP participant was told by a colleague during his intervention, “You can make the decision to go to treatment now, or you will reach a point where others are making decisions for you, and you *won’t* like the outcome.”

In achieving this balance, physician health programs have a responsibility to carry out our mission as consistently and competently as possible. While it is not realistic to expect the complete absence of errors, policies must be in place to minimize the chance of errors taking place and to identify and correct mistakes when they occur.

How society treats its physicians and PAs will determine how those practitioners treat their patients. We, as physicians and PAs, have a responsibility to ourselves, our profession, our colleagues, and to our patients to assist each other in getting timely help. NCPHP has helped the profession do just that for 20 years and looks forward to the next 20 years and beyond. As an NCPHP participant recently said, “The value of a benevolent act such as this cannot be underestimated, and I continue to be grateful to those who made this miracle possible.” **NCMJ**

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