Public Policy Statement on Physicians and Other Healthcare Professionals with Substance Use Disorder (SUD)

Background

Physicians and other healthcare professionals, like all people, are susceptible to developing SUD. In some, but not all cases, addiction may impair a healthcare professional's ability to practice and present a risk to patient safety. The Federation of State Medical Boards (FSMB) defines impairment as the "inability of a physician to provide medical care with reasonable skill and safety due to illness or injury," and "also applies to other healthcare providers in instances where state medical boards license multiple types of healthcare professional."

Importantly, the FSMB definition goes on to clarify that:

> Illness, per se, does not constitute impairment […]. Impairment is a functional classification which exists dynamically on a continuum of severity and can change over time […]. At one end […] can be found mild loss […]. At the other end […] can be found more substantial loss of function such as that associated with […] severe SUD […]. An instance of loss of function only merits regulation by a state medical board if it meaningfully limits (and therefore impairs) a physician's ability to provide safe care to patients. […] Each instance of impairment should also be considered according to its severity and functional impact. In many cases, impairments can be improved through effective management.[1]

Many healthcare professionals who develop SUD can function effectively, but this depends on their stage of illness. If it progresses to cause impairment, treatment usually results in remission of disease and restoration of functioning, particularly if appropriate monitoring and continuing care is put in place.[2]

The public, policymakers, regulatory agencies, and professional associations expect and deserve safe and competent care from all healthcare professionals, and should be assured that healthcare professionals with SUD have been appropriately evaluated, adequately treated, and have received or are receiving evidence-based continuing care and monitoring to ensure they are in sustained remission and unimpaired in practice.

State laws and regulations vary in how they define impairment and address potential cases of impairment among healthcare professionals.[3,4] Most states mandate that healthcare professionals report fellow healthcare professionals who are impaired by illness. In some states, clinicians who have knowledge of a fellow clinician's impairment because they are treating the impaired clinician may be exempt from such reporting. Some states have statutes or rules that satisfy reporting requirements if a referral is made to a state's Physician Health Program (PHP) in lieu of reporting to the regulatory agency (i.e., licensing board).

Physician Health Programs (PHPs) are organizations whose purpose is to provide a therapeutic alternative to discipline for healthcare professionals with potentially impairing illnesses,

including SUD. While PHPs provide referrals for evaluation and treatment services, their key role is monitoring of health status. Based on the results of this monitoring, PHPs advocate for physicians with licensing boards, employers, and other entities. Due to their knowledge of state regulations and experience in advocating for healthcare professionals, PHPs may offer advantages to those who are under investigation or have received actions from state licensing boards.

Non-disciplinary referral tracks aid healthcare professionals without disciplinary action on the professional's license. ASAM encourages non-disciplinary referral to PHPs or clinicians with expertise in the treatment of addiction in healthcare professionals to facilitate early detection, evaluation, treatment, and monitoring before potentially impairing illness progresses to actual impairment. Non-disciplinary tracks also encourage self-referrals and more referrals by concerned colleagues, family members and patients.

ASAM recognizes that, for a variety of reasons, treatment of healthcare professionals with SUD may occur with or without oversight by a PHP. PHPs have been established in many states to provide a non-disciplinary, confidential conduit for professionals to access comprehensive evaluation, any necessary treatment, and monitoring of health status. In retrospective studies, reported outcomes for SUDs in PHP participants are among the best in addiction medicine.[2] However, such studies should be considered in light of limitations commonly found in retrospective studies, such as selection bias and limited characterization of illness severity.

Public interest and safety are best served when state regulatory agencies, PHPs, and, when involved, clinicians with expertise in the treatment of SUD in healthcare professionals, work in concert to develop a confidential process allowing for early intervention, evaluation, treatment and return to practice with subsequent monitoring of the professional with SUD. A non-disciplinary, confidential process results in more referrals and self-referrals for assistance with SUD.

Public regulatory agency disciplinary action often leads to unintended, onerous, and permanent consequences – for both recovering professionals and the public they serve. Such consequences can include inadvertent constraints on healthcare professionals' ability to practice effectively in public's best interests (e.g., restrictions on the practitioner's ability to prescribe or dispense indicated medications, and barriers to the practitioner's ability to participate with provider panels or maintain active certification from a specialty certification board). Moreover, professional societies and specialty boards occasionally use the history of a publicly reportable disciplinary action by a regulatory agency to declare physicians unworthy of and ineligible for membership, certification, recertification, or continued participation in maintenance of certification programs. These reportable disciplinary actions and their consequences often have the unintended effect of rendering the professional unemployable and therefore, unable to serve patients – even when the professional's treatment has been successful and their illness is in full remission.

This policy statement articulates the ASAM's recommendations for promoting the health of healthcare professionals with SUD, and thereby, contributing to their safe practices.

Recommendations

The American Society of Addiction Medicine recommends:

1. All relevant entities with an interest in healthcare professionals with SUD should recognize that while SUD is a potentially impairing illness, "impairment" is a functional classification and illness *per se* does not constitute impairment. Healthcare professionals who suffer from SUD may or may not be functionally impaired. The healthcare professional with SUD is a person with an illness, and that person may be impaired, may

be in recovery, or may not be either.

2. Public health, safety, and welfare are best served when an otherwise competent healthcare professional with a potentially impairing illness is identified early and receives appropriate evaluation and indicated treatment and, when ready, returned to the safe, monitored practice of their profession. PHPs have demonstrated the capability to provide these service components; as could other clinicians experienced in the treatment of SUD in healthcare professionals. Clinicians who treat healthcare professionals outside of PHPs should thoughtfully appraise their ability to provide credible assurance of safety to practice for professionals in their care and understand their legal and ethical requirements for public safety within the context of the therapeutic relationship. Clinicians experienced in the treatment of SUD in healthcare professionals should understand when participation in a PHP may offer an advantage to a patient and suggest this as an additional support.
3. Although specialized treatment programs for professionals may provide the benefit of extensive staff experience in working with this population, treatment for healthcare professionals should be individualized to the needs of each professional as well as to the available resources.
4. Healthcare professionals should be offered the full range of evidence-based treatments, including all FDA-approved addiction medications, in whatever setting they receive treatment, in compliance with the Americans with Disabilities Act (ADA).[5] Regulatory agencies (including state licensing boards), professional liability insurers, and credentialing bodies should not discriminate against the type of treatment an individual receives based on unjustified assumptions that certain treatments cause impairment.
5. Recurrence of use is a recognized characteristic of SUD. Once a healthcare professional fulfills all formal monitoring requirements, it is recommended a clinician experienced in treatment of SUD in healthcare professionals provide ongoing chronic disease management to maintain recovery and intervene clinically should active illness reoccur.
6. Diversion of controlled medications for personal use is not uncommon in healthcare professionals who develop SUD. The proper management of such cases should maximize early identification, proper treatment, and monitored recovery. A drug diversion episode should not result in automatic disciplinary action and such disciplinary responses should be proportionate to the harm caused by the episode of diversion.
7. Healthcare professionals have the same rights of privacy and confidentiality of personal health information as other persons and should not be required to reveal their personal medical histories to patients, prospective patients, or to the public.
8. The reporting of healthcare professionals with potentially impairing conditions should result in efforts to restore health rather than disciplinary action whenever possible. Therapeutic rather than disciplinary responses result in more self- and peer-reporting.
9. Physicians and other health care professionals should not be discriminated against in the areas of professional licensure, clinical privileges, specialty certification, or inclusion in managed care or health maintenance organization provider panels, solely due to a past diagnosis of SUD when that professional has demonstrated sustained disease remission. Participation in and/or completion of a monitoring agreement with advocacy from a state PHP or other recognized monitoring agency may be especially valuable in the following circumstances: (1) when a professional with a history of SUD or other potentially

impairing illness is applying for licensure in a new state; (2) for employment, privileges or credentialing by a healthcare organization or managed care entity; (3) for certification or re- certification by a specialty board or other certifying organization; or (4) for membership in a professional association.

10. Barring other substantive issues, successful completion by a healthcare professional of a regulatory agency's administrative requirements and associated re-licensure – with or without license restrictions – should suffice for specialty boards and professional societies to affirm certification, eligibility for recertification, and/or membership. When a professional is practicing within the boundaries of such a restriction, they are practicing safely. PHPs and other experts in the evaluation, treatment, and continuing care of the treatment of SUD in healthcare professionals should be consulted and input respected in all specialty society membership and/or board certification decisions related to appeals of adverse rulings on healthcare professionals recovering from SUD.
11. PHPs need further study to see if positive outcomes are replicated in more rigorous, prospective studies and to determine which factors are most important for producing good outcomes, whether such outcomes are sustained after PHP monitoring ends, and whether the PHP model of treatment and monitoring is feasible and effective for non-physician healthcare professionals. Despite the need for more rigorous PHP outcomes research, states without PHPs and clinicians treating SUD in healthcare professionals outside of PHPs would do well to study PHP practices.[6] It would be valuable to study healthcare professionals with SUD who are treated and monitored outside of PHPs to determine whether outcomes are comparable, including participant experience of the treatment and monitoring.
12. Healthcare professionals should be educated about occupational risk factors for SUD given healthcare professionals' unique access to controlled medications and legal authority to write prescriptions. They should also receive training in healthy self-care and stress management practices to promote health and prevent unhealthy use of medication or drugs such as alcohol. Healthcare professionals should be able to recognize signs of SUD in colleagues and know how to help colleagues connect with non-disciplinary assistance.

Adopted by the ASAM Board of Directors on February 6, 2020, revised December 12, 2024.

© Copyright 2024. American Society of Addiction Medicine, Inc. All rights reserved. Permission to make digital or hard copies of this work for personal or classroom use is granted without fee provided that copies are not made or distributed for commercial, advertising or promotional purposes, and that copies bear this notice and the full citation on the first page. Republication, systematic reproduction, posting in electronic form on servers, redistribution to lists, or other uses of this material require prior specific written permission or license from the Society. ASAM Public Policy Statements normally may be referenced in their entirety only without editing or paraphrasing, and with proper attribution to the society. Excerpting any statement for any purpose requires specific written permission from the Society. Public Policy statements of ASAM are revised on a regular basis; therefore, those wishing to utilize this document must ensure that it is the most current position of ASAM on the topic addressed.

References

1. Federation of State Medical Boards House of Delegates. Policy on Physician Illness and Impairment: Towards a Model that Optimizes Patient Safety and Health. Published online April 2021. https://www.fsmb.org/siteassets/advocacy/policies/policy-on-physician-impairment.pdf

2. McLellan AT, Skipper GS, Campbell M, DuPont RL. Five year outcomes in a cohort study of physicians treated for substance use disorders in the United States. *BMJ*. 2008;337:a2038. doi:10.1136/bmj.a2038

3. Lawson ND, Boyd JW. How broad are state physician health program descriptions of physician impairment? *Subst Abuse Treat Prev Policy*. 2018;13(1):30. doi:10.1186/s13011-018-0168-z

4. Lawson ND, Boyd JW. Do state physician health programs encourage referrals that violate the Americans with Disabilities Act? *International Journal of Law and Psychiatry*. 2018;56:65-70. doi:10.1016/j.ijlp.2017.12.004

5. Siepman K. DOJ Emphasizes Need for Individualized Assessments in Finding Indiana Nursing Board Violated ADA. Ogletree. April 15, 2022. Accessed November 6, 2024. https://ogletree.com/insights-resources/blog-posts/doj-emphasizes-need-for-individualized-assessments-in-finding-indiana-nursing-board-violated-ada/

6. FSPHP. Home. Federation of State Physician Health Programs. Accessed November 6, 2024. https://www.fsphp.org/