ASAM
American Society of Addiction Medicine

Public Policy Statement on Healthcare and Other Licensed Professionals with Addictive Illness—An Overview

Healthcare professionals, like all individuals, are human, fallible and subject to medical illnesses, including addiction. The public—and too often the healthcare community itself—views addiction and its prognosis for remission in a negative light. This view represents an antiquated but long standing stigma about addiction, a lack of sufficient longitudinal addiction care, sparse treatment outcome data, and inadequate dissemination of evidence-based treatment into the healthcare community and the public at large. Healthcare professionals are a unique cohort, with distinctive characteristics that come into play in the development of the illness, the course of treatment, legal and ethical ramifications and eventual outcomes. Our best data regarding licensed professionals comes from research on over three decades of physician-specific addiction treatment and monitoring. These programs were initially recommended by the American Medical Association and the Federation of State Medical Boards. Nationally, the membership organization for the majority of Physicians Health Programs (PHPs) is the Federation of State Physician Health Programs (FSPHP). These programs have continued to evolve and mature; the majority of such programs now provide assistance for other licensed healthcare professionals in addition to physicians, and some address other professionals with addictive disease such as attorneys, judges, or healthcare administrators.

Physicians treated for addiction have recently become the focus of high quality, evidence based outcome research published in peer-reviewed journals (see Domino et al[1] McLellan et al[2], DuPont et al[3]). The results of this research indicate the treatment of physicians is profoundly effective when properly executed. ASAM has adopted a series of public policy statements addressing knowledge gained from such research and three decades of experience on physician-specific treatment, post-treatment monitoring and continuing care. *This evidence-based research, over a period of decades, has implications for care and policy development in the future. Throughout these documents the authors use the term "**Healthcare and other licensed professionals**" as an inclusive term of applicability*. While these public polices, by definition, address physicians, ASAM believes the overarching principles communicated through these policies are equally applicable to all healthcare professionals, other licensed professionals, and non-licensed professionals in safety sensitive positions. The breadth of the collection of policy statements reflects this orientation. The eleven public policy statements surrounding this topic are as follows:

1) Healthcare and other Licensed Professionals with Addictive Illness - An Overview

2) Illness versus Impairment in Healthcare and other Licensed Professionals
3) Discrimination and the Addicted Professional
4) Coordination between Treatment Providers, Professionals Health Programs and Regulatory Agencies
5) The Evaluation, Treatment and Continuing Care of Addiction in Healthcare and Other Licensed Professionals
6) Credentialing in Healthcare and Other Licensed Professionals with Addictive Illness
7) Confidentiality in Healthcare and Other Licensed Professionals with Potentially Impairing Illness
8) Public Action by State Medical Licensure Boards and Comparable Regulatory Agencies Regarding Healthcare and Other Licensed Professionals with Addictive Illness
9) Public Safety and the Healthcare and Other Licensed Professional with Addictive Illness
10) Recovering Physicians, Medical Licensure Boards, Specialty Board Certification and Professional Society Membership
11) Relapse in Healthcare and Other Licensed Professionals

Although healthcare and other licensed professionals have the potential to develop many types of psychiatric, psychological and behavioral illnesses, this group of policies focuses on substance use disorders (SUDs), especially addiction. This collection of public policy statements is not intended to be a complete compendium on the subject of addiction in healthcare and other licensed professionals. There are many research papers, review articles and textbooks on the topic of addiction and even on addiction among physicians. These public policies focus on three important areas of addiction among healthcare and other licensed professionals, including issues related to stigma (*see Public Policies 2 and 3*), the effective response to the problem of addiction among professionals (*See Public Policies 4, 5 and 11*), and the interrelation and integration of medical, legal, and sociologic issues regarding addiction in this particular population (*see Public Policies 6, 7, 8, 9 and 10*).

Several factors are involved in the etiological differences of addiction as it manifests in the "special populations" of healthcare and other licensed professionals. First, one group of professionals—healthcare providers—have greater access to addictive drugs in their workplace, which can accelerate and complicate the onset and progression of the disease. Secondly, healthcare professional training creates a level of comfort and an associated false sense of immunity to the dangers of drug use. Having technical knowledge about the pharmacology of drugs does not protect susceptible individuals from becoming addicted to such drugs and, in fact, may actually predispose susceptibility. Thirdly, all healthcare and other licensed professionals with addictive illness face tremendous prejudice based on stigma and fear which make them hesitant to admit a problem or seek assistance. Lastly and importantly, as with other safety-sensitive occupations, healthcare and other licensed professionals with untreated, potentially impairing conditions have the potential to place the public at risk.

Many individuals and agencies play a role in the care and coordination of the addicted healthcare and other licensed professionals. For the purposes of these policy statements, we have focused on four critical entities: the population of healthcare and other licensed professionals with the disease of addiction; the specialty treatment programs where these persons receive clinical care; the various Physicians / Professionals Health Programs (PHPs) which provide continuing care monitoring and earned advocacy; and state-specific licensure and other comparable regulatory agencies. These entities, as defined, have an interrelated and often symbiotic role in both the successful rehabilitation and recovery of the addicted professional, and the safety and welfare of the public.

The Addicted Professional

The disease of addiction produces characteristic behaviors. The characteristics and circumstances of the patient who is, himself or herself, a professional are unique. These issues must be considered and managed during treatment and post-treatment recovery. These policies address physician patients who are part of a professional cohort; but include other licensed professionals including, but not limited to, nurses, physician assistants, pharmacists, psychologists, commercial pilots, attorneys, law enforcement officials, as well as any cohort which provides a public service that could impact the public health, safety, and welfare. Each of these groups is unique in the perception of their disease, their experience of addiction-induced shame, and the necessary coping skills to ensure successful long-term recovery. Some of these professional groups share strong similarities; however, each specific group should be treated by providers knowledgeable, skilled and experienced in understanding the distinctive educational background, psychological characteristics, work environment, professional culture, social factors, and specific licensure and regulatory agency processes related to each particular cohort of addiction treatment recipients.

Addiction Treatment Programs (ATPs) for Healthcare and Other Licensed Professionals

Addiction Treatment Programs for healthcare and other licensed professionals specialize in the diagnosis and treatment of addictive and/or mental illnesses in healthcare and other licensed professionals. These clinical programs possess expertise in dealing with issues specific to these populations of ill individuals; some ATPs have expertise in one or more subsets of professionals. ATPs provide a multi-disciplinary spectrum of therapeutic services, addressing the biologic, psychosocial, family, and spiritual components of these disease states. One important element in specialized Addiction Treatment Programs is the presence of a cohort of like-professionals. This “peer relating” during treatment decreases the isolation and enhances the interdependent learning necessary for effective treatment. ATPs for professionals have extensive experience with and knowledge of the stressors and triggers in the work and home environment specific to the professional cohort being treated. This information is used to focus the treatment on cohort-specific issues, encourages reintegration into a healthy home and work environment, and ultimately promotes a sustained successful recovery. The most comprehensive programs manage multiple psychiatric diseases, complex medical conditions, psychological co-morbidities along with a broad spectrum of addictive disorders.

Many facilities that treat addicted professionals provide comprehensive evaluation services as well. Some evaluation programs are organized as separate entities from ATPs, while others are integrated with treatment facilities. Evaluation centers must exhibit a proven track record in understanding the complex multifactorial and insidious nature of addiction among healthcare and other licensed professionals. They should utilize a multi-disciplinary team of individuals with specific expertise in distinct but interrelated specialties. The multi-disciplinary evaluation process is essential to a truly thorough and comprehensive evaluation. They collect outside data and collateral information, investigate the workplace environment and associated risks, complete psychological and neurocognitive testing and perform intricate drug screen testing tailored to the specific individual. These centers communicate regularly with and release reports (with appropriate consent) to referral sources such as the Professionals Health Programs, regulatory agencies and/or other need-to-know entities.

Professionals Health Programs (PHPs)

A Professionals Health Program has mutually symbiotic dual roles of enhancing public safety and facilitating the successful rehabilitation and practice re-entry of healthcare and other licensed professionals with potentially impairing medical conditions. Professionals Health Programs (PHPs) provide a confidential conduit for ill professionals to access a comprehensive evaluation and any necessary subsequent treatment. When a professional with a potentially impairing illness becomes involved with a Professionals Health Program (PHP) and no harm to the public has been identified, he or she is ideally enrolled in an alternative pathway to professional discipline. PHPs provide the availability of a non-disciplinary alternative with rehabilitation and accountability being emphasized, facilitated, and carefully documented over time. The PHPs continuous, skilled and documented monitoring of the professionals recovery status and associated earned advocacy further promotes the public safety (*see Public Policy 9*). PHPs are exceptionally distinct in their ability to provide early identification, intervention, and referral for evaluation and/or treatment. They also conduct three types of post-treatment monitoring: behavioral, chemical, and worksite evaluations. Their success is largely attributable to this tri-partite model of recovery monitoring. The intervention, referral and post-treatment monitoring services offered by PHP's are generally conceptualized as being distinct from the clinical services offered by ATPs. PHPs educate the medical community about addiction among professionals, the risks of addiction in professionals and the recognition of the subtle signs and symptoms of addiction in the workplace. Such education and prevention services further enhance public safety by encouraging earlier detection and referral to treatment when appropriate. PHPs are uniquely qualified to advocate for program enrollees with potential employers and regulatory agencies when enrollees have successfully engaged in an ATP and are compliant with PHP monitoring requirements.

Regulatory Agencies (RAs)

These are agencies of state government charged with credentialing and granting licenses to professionals and assuring to the public at large that the conduct of the professional meets professional and statutory standards. State statutes mandate the regulation of

selected professions to ensure the delivery of quality healthcare or other services necessary to the public health, safety, and welfare. They investigate the practice of licensees and have authority to address those who violate the state's professional practice acts or comparable legislation. Their primary mission is to protect the public. Regulatory agencies, through the charge given them by the state legislature, focus on public safety, while Professionals Health Programs focus simultaneously on public safety and the health of the licensed professional. This is complementary to the focus of Addiction Treatment Programs, which attend to the health of the addicted professionals under their care and the fitness for duty of such professionals. Addiction rehabilitation requires an understanding of the inter-organizational complexities along with associated expertise in the interrelated management of addicted professionals to the benefit of the public we serve. This understanding of addiction rehabilitation among professionals facilitates the interaction by and between Addiction Treatment Programs, Regulatory Agencies, and the Professionals Health Programs. (*See Public Policy 4*).

Accordingly, ASAM Recommends the following, aligned with this Overview of issues related to Physicians and Other Licensed Professionals with Addictive Illness:

a) The healthcare community, general public, and public policy makers be assisted in the understanding of the reality that addiction occurs in healthcare and other licensed professionals like any other group of human beings. The addicted professional deserves the same professional, compassionate, respectful and confidential care as is offered to any other person in need of addiction treatment.

b) The recommendations set forth in this interrelated set of policies become the basis for standards of care for all healthcare and other licensed professionals promulgated by Professional Health Programs, Regulatory Agencies and others. Addicted professionals warrant compassionate care, state of the art disease management, safe reentry into the workplace, skilled long-term monitoring and appropriate advocacy on their behalf. Addicted professionals, appropriately managed, should retain the ability to engage in the professional activities for which they have been trained without unnecessary restrictions on their licensure. Such professionals deserve the earned advocacy of competent Professionals Health Programs (PHPs) upon successful and cooperative treatment by qualified Addiction Treatment Programs (ATPs).

c) Treatment providers who treat addicted professionals have a strong working knowledge of the professionals' educational background, psychological, social, work and environmental issues. These treatment providers have extensive experience in the regulatory issues, subtleties of the presentation and clinical management of addiction in the populations specific to the professional cohorts of patients they serve.

Furthermore, ASAM Recommends the following which comprise a Summary of the major Recommendations of the other ten public policy statements on Healthcare and Other Licensed Professionals with Addictive Illness:

Policy 2) All relevant entities with an interest in healthcare and other licensed professionals with addictive illness should recognize addiction is a potentially impairing illness, while "impairment" is a functional classification. Professionals diagnosed with addictive illness may or may not evidence "impairment". The term "impaired professional" used to signify professionals in recovery is pejorative, and should be replaced with the term "recovering professional". An addicted professional is a person diagnosed with an illness. That person may be impaired, may be in recovery, or may not be either. Individuals with addictive illness, their families and the community at large are best served when addicted professionals are identified early, referred to treatment and appropriate post treatment monitoring before their illness becomes an impairment.

Policy 3) All parties involved, including regulatory agencies, should assiduously avoid direct or indirect discrimination against any and all healthcare and other licensed professionals who develop an addictive illness. Any restriction of access to the rights and privileges of membership in a professional organization or serving in a professional role should be based on just cause only, not solely on the presence of a particular diagnosis. Those in remission who have had appropriate evaluation, treatment and are being monitored or have successfully completed such monitoring should not be unnecessarily scrutinized or discriminated against.

Policy 4) Addiction Treatment Programs (ATPs), Professionals Health Programs (PHPs) and Regulatory Agencies (RAs) should coordinate their efforts and work in concert to enhance the health and safety of healthcare and other licensed professionals with an addictive illness to the benefit of the health and safety of the public they serve.

Policy 5) The evaluation and treatment of addicted and recovering healthcare and other licensed professionals is best performed by a PHP-approved multi-disciplinary team of clinicians with extensive knowledge and experience regarding the unique manifestations of illness and recovery within the framework of the licensee's professional cohort. Continuing care should be conducted by competent PHP Professionals.

Policy 6) Credentialing processes must be fair, reasonable, unbiased, and performed in good faith, and should utilize accurate, current documentation that reflects the current state of active disease or disease remission and an accurate assessment of current impairment. When a recovering healthcare or other licensed

professional in sustained remission from an addictive illness is credentialed, the credentialing body should not discriminate against such professionals for any reason, and specifically as it relates solely to a past history of addictive illness.

Policy 7) Healthcare and Other Licensed professional's who have health problems, including addictive illness, should have the same rights to privacy as do other patients in clinician-patient relationships. Professionals with addictive illness should be afforded confidential and compassionate care. Health status information, *per se*, about licensed professionals, should not be publicly disclosed. Addiction Treatment Providers, Professional Health Programs and Regulatory Agencies must work together to ensure confidential quality care is balanced with the imperative for public safety.

Policy 8) Automatic and publicly-disclosed adverse disciplinary actions by Regulatory Agencies in response to potentially-impairing illnesses in professional licensees are not beneficial to the recovering professional and are not necessarily in the best interest of the professional or the public. Regulatory agencies should have extensive knowledge of the addictive behaviors that occur in healthcare and other licensed professionals – typically via interface with their PHP. Public Action should be limited whenever possible to actions clearly indicated for the enhancement of public safety.

Policy 9) When considering healthcare and other licensed professionals with addictive illness, the public health, safety and welfare are paramount. The public health, safety and welfare are best served when an otherwise competent professional with a potentially impairing illness is managed with a cohesive effort among all involved entities. Such management leads to earlier identification, appropriate evaluation, any indicated treatment, competent monitoring through a Professionals Health Program (PHP) and the safe return to the active practice of their profession. Barriers to these goals must be removed.

Policy 10) Professional and Specialty Societies, Specialty Certification Boards, and State Regulatory Agencies should support recovering healthcare and other licensed professionals.Unjustifiable impediments to society membership, specialty certification, and board certification on the basis of recovery from addictive illness alone is counterproductive, pejorative, and should not occur.

Policy 11) Relapse is not indicative of willful misconduct but a reality of the illness indicating the need for further evaluation, treatment, and monitoring. A subset of healthcare and other licensed professionals with addictive illness will experience relapse. When relapse does occur, decisions regarding response to and management of the relapse should be clinically driven and guided by the PHP.

REFERENCES:

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Public Policy Statement on Illness versus Impairment in Healthcare and Other Licensed Professionals

(This is the second in a set of eleven policy statements of the American Society of Addiction Medicine addressing Physicians and Other Licensed Health Care Professionals with Addictive Illness)

Background

Well structured Professionals Health Programs (PHPs) have a dual mission. They are committed to the outreach, treatment and rehabilitation of healthcare and other licensed professionals who are ill, while also being dedicated to the enhancement of public safety. The PHPs refer healthcare and other licensed professionals who may be ill to highly skilled specialists for evaluation and/or treatment. The PHPs then provide continuing care monitoring and earned advocacy once clinical stability or remission of their Illness is achieved.

Healthcare Professional "impairment" definitions generally align with the AMA definition of physician "Impairment" which is "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."

This language has been adopted by most state regulatory agencies and is a part of many state Medical Practice Acts. Unfortunately, some regulatory agencies equate a state of "illness" (i.e., addiction or depression) as synonymous with a state of "impairment". Healthcare and other licensed professional illness and impairment exist on a continuum with illness typically predating impairment, often by a period of years. This is a critically important distinction. Illness is the existence of a disease. Impairment is a functional classification and implies the inability of the person affected by disease to perform specific activities.

Most healthcare and other licensed professionals who develop an illness are able to function effectively and safely even during the earlier stages of their illness due to their rigorous training and their professional dedication. In most cases, this is the time for referral to a state PHP. Even if illness progresses to cause impairment, treatment usually results in remission of disease and restoration of functioning. PHPs are then in a position to monitor clinical stability and the person's continuing progress in recovery.

In some jurisdictions the regulatory process addresses all ***ill*** healthcare professionals as if they were ***impaired***. When the regulatory process automatically disciplines licensed professionals

who are ill but are not impaired, such professionals may, find they are no longer fully able to engage in professional services. This automatic regulatory decree and sequelae is not usually conducive to the professional's recovery and, indeed, can have unintended consequences not necessarily beneficial to the public.

Clinicians recognize it is always preferable to identify and treat illnesses early in their course, before they have become severe and complex and lead to secondary complications. There are many obstacles to an ill healthcare and other licensed professionals seeking care including: denial, aversion to the patient role, practice coverage issues, stigma, and fear of disciplinary action. Fear of disciplinary action and stigma are powerful disincentives to healthcare and other licensed professionals referring their colleagues or themselves to medically necessary addiction treatment. When early referrals are not made, healthcare and other licensed professionals with illness often remain without treatment until overt impairment manifests in the workplace.

The interest and safety of the public are best served when state regulatory agencies and the PHPs work in concert to develop a confidential process allowing for early intervention, evaluation, treatment and monitoring of the ill healthcare and other licensed professional. The model of a PHP working in close cooperation with its state licensing board/regulatory agency can succeed in treating ill healthcare and other licensed professionals with potentially impairing conditions. This model allows for accountability and quality case management, resulting in long term clinical outcomes vastly superior to usual treatment without monitoring or a legal / disciplinary approach and at the same time enhance public safety (*See Public Policies # 4-Coodination between Treatment Providers, Professionals Health Programs and Regulatory Agencies; Public Policy # 8-Public Action by State Medical Boards and other Regulatory Agencies; and Public Policy #9 Public Safety and the Healthcare and Other Licensed Professional with Addictive Illness*). When this occurs, the public is better protected and a highly trained professional continues to be available to provide services for the benefit of the public they serve.

The American Society of Addiction Medicine recommends:

1. All relevant entities with an interest in Healthcare and Other Licensed Professionals with Addictive Disease should recognize that addiction is a potentially impairing illness, while "impairment" is a functional classification. Professionals who suffer from addiction may or may not evidence "impairment". An Addicted Professional is thus a person diagnosable with an illness, and that person may be impaired, may be in recovery, or may not be either..

2. Professional Health Programs (PHPs) should be recognized for their expertise in supervising intervention, evaluation, treatment, and monitoring of professionals who are ill, and therefore potentially impaired, consistent with guidelines promulgated by the Federation of State Physician Health Programs.

ASAM
American Society of Addiction Medicine

Public Policy on Discrimination and the Addicted Professional

(This is the third in a set of eleven policy statements of the American Society of Addiction Medicine addressing Healthcare and Other Licensed Professionals with Addictive Illness)

Background

As seen in the general population, a significant portion of healthcare and other licensed professionals are impacted by the disease of addiction. As presented in the second policy statement in this series, addictive illness is a potentially impairing condition which, left unaddressed, may eventually impair job performance and interfere with the public health, safety and welfare. Addictive illness is a primary, progressive illness that can result in disability; yet it is highly amenable to treatment and chronic disease management. Professional organizations should not discriminate on the basis of race, religion, age, gender, disability, national ancestry, sexual orientation, or economic conditions. This includes discrimination based on an individual having a chronic medical illness such as addiction. It is important that all involved do their part to eliminate arbitrary and capricious discrimination against recovering healthcare and other licensed professionals.

Employers may have little interest in, or understanding of, the complex illness of addiction. In fact, employers may not view it as an illness but as a behavioral matter - a manifestation of personal irresponsibility and nothing more - or an issue of moral turpitude warranting scorn, discipline or job dismissal. Additionally, employers may inadvertently be hesitant to hire a recovering professional based on their own lack of education, fear, prejudice and stigma. Recovering people generally, and the recovering professional particularly, face discrimination in a number of ways. This discrimination carries over into the pursuit of life, health, disability, malpractice and other insurance coverage. Specialty boards often discriminate on the basis of a history of addictive illness or a related regulatory agency disciplinary action. Hospitals or professional associations may choose to revoke credentials or memberships of recovering professionals based on prior disciplinary actions or a long-past medical history irrespective of associated treatment history, current stability and sustained remission of illness. In some cases honesty regarding past treatment generates discriminatory responses on the part of an employer or potential employer. Professional colleagues may hire an otherwise less-qualified, non-recovering applicant based on the recovering applicant's history of addictive illness or treatment.

Examples of these and other forms of discrimination are well known and all too common. Like the recovering public, healthcare and other licensed professionals recovering from addictive illness face local, state, federal and private-sector policies that impose barriers to reintegration into the workplace during recovery. These include, but are not limited to, policies that restrict access to appropriate healthcare, employment, public benefits, education and training, parental rights, and housing. Discriminatory policies discourage recovering professionals and the public from seeking treatment. Such discrimination inhibits disease remission, restricts hope for recovery, and ultimately costs society untold billions of dollars in future preventable expenses.

Healthcare and other licensed professionals hold a position of public trust. Many occupy safety-sensitive positions. Regulatory agencies have an obligation and duty to see that such individuals are capable of conducting their professional duties in a manner consistent with promoting the health, safety and welfare of the public. Early identification, evaluation, treatment, and monitoring with contingency management for healthcare and other licensed professionals with addictive illness are an effective and important means to enhance the public health, safety and welfare. Any and all barriers to the goal of facilitating public safety through early identification, evaluation, treatment, and monitoring are counterproductive and must be eliminated.

The American Society of Addiction Medicine recommends:

1) All parties should regard addiction as a chronic, potentially impairing, progressive, yet highly treatable illness.. Discrimination based solely on a person having a history of addictive illness is inappropriate and should not be tolerated. Any restriction of access to the rights and privileges of membership or certification in a professional organization or serving in a professional role should be based on just cause only, irrespective of any particular diagnosis (See *Public Policy #10 –Recovering Physicians, Specialty Society Standing, and Specialty Board Certification*).

2) "Safe harbor" should exist whereby healthcare and other lic**e**nsed professionals who seek, or are motivated to accept, assistance and guidance to address their addictive illness. Such individuals should not be subject to automatic discriminatory actions such as professional sanction, public disclosure, dismissal or other punitive actions related to their behavior which directly resulted from untreated addictive illness.

3) Employers should adhere to the Americans with Disabilities Act and carefully avoid discrimination based on a history of Addictive Illness. Appropriate non-discriminatory policies would include requirements of healthcare and other licensed professionals with addictive illness having an obligation to comply with recommendations for evaluation, treatment, and continuing care monitoring with earned advocacy r**e**ports sent to employers, regulatory agencies and other entities as may be indicated. .

4) Professional Organizations should actively engage the legislative process, educational institutions, and the general public to improve public and private sector policies in a

manner supportive of recovering healthcare and other licensed professionals. Policies should also address discrimination against persons who have received addiction treatment. Laws, regulations, and policies that sanction discriminatory practices under the guise of appropriate deterrence or sanction are counterproductive, unacceptable, outmoded and should be eliminated.

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Public Policy Statement on Coordination between Treatment Providers, Professionals Health Programs and Regulatory Agencies

(This is the fourth in a set of eleven policy statements of the American Society of Addiction Medicine addressing Healthcare and Other Licensed Professionals with Addictive Illness)

INTRODUCTION

Professionals Health Programs (PHPs), Addiction Treatment Programs (ATPs), and Regulatory Agencies (RAs) are separate entities with distinct though often overlapping, complimentary and interdependent missions and roles. Each has a different relationship with the licensed professional who has a potentially impairing illness. Optimal cooperation among these three entities is necessary to achieve the proper balance between a professional's rehabilitation and protection of the public.
In the best case scenario, a highly trained professional with addictive illness is safely and successfully rehabilitated and retained as a practicing member to the benefit of the profession, the individual and his/her family, and the public.

An introductory description of these entities appears in the first policy statement in this set, entitled – *Healthcare and Other Licensed Professionals with Addictive Illness – An Overview*.

DESCRIPTION

PROFESSIONALS HEALTH PROGRAMS (PHPs)

PHPs are organizations that have the dual roles of facilitating the rehabilitation of healthcare and other licensed professionals who have potentially impairing medical conditions and enhancing public safety. These roles are symbiotic in their effect. As a result of this dual role, PHP's are often positioned between Addiction Treatment Programs and Regulatory Agencies. PHPs provide a confidential conduit for ill professionals to access comprehensive evaluation and treatment as their condition may require. PHPs ideally constitute an alternative pathway to professional discipline in cases where no harm to the public has occurred. PHPs are unique in their ability to provide

early identification, intervention, and referral for evaluation and/or treatment and continuing care. They conduct post-treatment behavioral, chemical, and worksite monitoring. Their success is largely attributable to this tripartite model of continuing care monitoring coupled with contingency case management and appropriate levels of confidentiality.

Monitoring is a key role of PHPs. Monitoring is not prevention, diagnosis or treatment; although it includes elements of each. Monitoring is the oversight of the disease status/remission/health of an individual assuring that the individual's clinical condition is stable. Technically, case management is the oversight function applied for persons under active treatment or continuing care including low-intensity chronic disease management of a clinical condition. Monitoring must be credible, reliable and accurate in order to provide the PHP with the evidence upon which to base its advocacy role on behalf of healthcare and other licensed professionals who have completed treatment and are, indeed, in remission.

Most PHPs do not engage in clinical services. Typically, PHPs do not conduct comprehensive clinical evaluations or offer clinical treatment but arrange for such services to be provided by qualified professionals. The monitoring function of the professional's remission of addictive or other disease state is a unique function promoting the ongoing health of the treated individual. This allows the PHP to engage in responsible advocacy on behalf of the professional who is in remission. Earned advocacy facilitates non-discriminatory re-entry into the practice of his or her profession. Advocacy on behalf of the compliant PHP participant is appropriate with various entities including, but not limited to, a hospital or clinic medical staff, credentials committee, other credentialing bodies, employers, business partners, professional colleagues, provider networks and regulatory agencies. The role and responsibility of the PHP in providing earned advocacy for the program enrollee who has adhered to all case management and monitoring functions of the PHP cannot be overemphasized.

Another critical function of PHPs is to evaluate ATPs in developing a list of "qualified and approved treatment programs". Approved ATPs demonstrate expertise in meeting the clinical needs of healthcare and other licensed professionals with addictive or other potentially impairing health conditions. PHPs provide this list of "qualified and approved treatment programs" to the participant when referring for evaluation or indicated treatment. Participants should not be allowed to select an addiction or mental health treatment provider/facility that is not PHP-recognized. The provider of treatment should be a "qualified and approved" program to assure that the treatment received shall have the sophistication and comprehensive multi-disciplinary nature to enhance the probably of treatment success.

ADDICTION TREATMENT PROGRAMS (ATPs)

ATP applies to all evaluation and treatment entities for ill healthcare and other licensed professionals.

Treatment for addictive illness should be preceded by and based upon a comprehensive multidisciplinary evaluation. Some Evaluation Centers provide only evaluation services. The majority are also qualified to provide indicated treatment. "Evaluation" and "Treatment" are two distinct processes. Centers that provide both services must always ensure any professional evaluated, and in need of treatment, is provided with treatment alternatives acceptable to the PHP, the RA, and the ATP. The availablitility of alternatives minimizes perceived or alleged conflict-of-interest between the evaluation and the treatment processes.

ATPs are clinical centers specializing in the diagnosis and treatment of addictive and/or mental illness in healthcare and other licensed professionals. These programs possess expertise in dealing with issues specific to professionals with addictive illness and its associated co-morbidities. They provide a spectrum of therapeutic services which addresses the biological, psychosocial, and spiritual components of these disease states. An ATP's primary purpose is to provide healthcare and other licensed professionals with potentially impairing illness with state of the art clinical care facilitating the remission of the active disease state and long-term recovery.

REGULATORY AGENCIES (RAs)

RAs are branches of State government charged with credentialing and licensing of healthcare and other licensed professionals. State statutes mandate the regulation of these professions to insure delivery of quality healthcare or other services to the public. They investigate and address licensees who violate the state's practice acts or other comparable legislation. Their primary mission is to protect the public.

CONSIDERATIONS

ASAM is aware of the significant variability that exists among ATPs, PHPs, and RAs from state to state. ASAM also recognizes that some ATPs differ in their philosophical and operational approaches. ASAM acknowledges the political nuances, funding levels, state statutes, and other factors influencing how effectively these entities function individually and collaboratively. Where impediments to optimal functioning exist, they should be challenged by all involved. This ASAM policy statement on Coordination among these three entities provides a broad-based generalized vision. Its recommendations reflect an attempt to express parameters to be followed under ideal conditions. Those PHPs which have established trust and credibility with their Regulatory Agencies appear to function at highly effective levels. Those RAs which provide a safe and effective alternative to discipline by a confidential conduit through their PHPs also appear to be the most effective. Having an established alternative to discipline enhances the willingness of colleagues and others to report concerns regarding professionals with potentially impairing illness, and lessens resistance from ill professionals in need of assistance. ATPs that specialize in evaluation and treatment of healthcare and other licensed professionals provide particular expertise in addressing those issues specific to this population of ill individuals.

COORDINATION AMONG ALL THREE ENTITIES

Interagency communication and cooperation are critical in achieving optimal results. Healthcare and other licensed professionals occupy safety-sensitive positions and every effort should be directed to ensure their ability to practice their profession with reasonable safety.

PHPs are unique in their ability to provide early identification, intervention and referral before the public is compromised by actual on-the-job impairment. They should refer to only qualified ATPs and periodically assess the status of those programs. Unless specifically structured to do so, PHPs should avoid making diagnoses or providing direct primary treatment. They should facilitate case management and the establishing of continuing care when appropriate. The main focus of a PHP should be their participant's fitness-for-duty from the standpoint of disease remission, while leaving to RAs the role of determining the licensed professional's competency and skills. Under no circumstances should a PHP misrepresent itself as speaking for an RA. If membership requirements are met, PHPs should join and actively participate in the Federation of State Physician Health Programs (FSPHP), taking advantage of this organizations collective experience and wisdom. PHPs should utilize the FSPHP Guidelines unless the circumstances of a particular case dictate otherwise. They should demonstrate accountability by submitting periodic reports to their stakeholders, and embrace transparency and accountability by inviting independent audits.

An additional role of PHPs is education. PHPs work to provide evidence-based education to all involved regarding addiction and other potentially impairing illnesses. PHP's interface with RAs, state legislatures, hospitals, clinics, professional associations, public groups, professional liability insurance carriers and others. PHPs educate these entities on the role of the PHP, ATPs, RAs, and the importance of coordination among the three to the benefit of individual licensees and the public. PHPs can also respond in an informational manner, educating on all of these issues, to licensed professionals, family members, colleagues, or the media.

ATPs should periodically report patient progress to PHPs, solicit secondary interventions from them when necessary, and invite participation in discharge planning. This is especially important with respect to return-to-work considerations and stipulations. The repository of all clinical records is the ATP, and should remain in that domain unless otherwise expressly authorized by the patient (See Public Policy *"Confidentiality"*). ATPs should carefully coordinate discharge planning with the PHP and provide discharge summaries to PHPs immediately after discharge. ATPs should maintain financial and administrative independence, avoiding all conflicts of interest with PHPs.

When legislative reform is indicated, RAs should endorse the adoption of statutes that provide rehabilitative alternatives to discipline for a licensed professional when there is no evidence of public harm. RAs assistance via regular review of PHP reports and PHP

policies and procedures enhances the accountability and relationship by and between PHPs and RAs. This accountability and relationship is facilitated by mutually acceptable periodic performance audits. Effective PHPs can thus be provided public advocacy by RAs parallel to the way PHPs provide advocacy for the ill professional who has been accountable and compliant. RAs should avoid unintentional undermining of PHPs in failing to support the PHP in the event of participant non-compliance. RAs should utilize their PHP as the *licensing Board's expert consultant* in all matters relating to licensed professionals with potentially impairing illness.

SUMMARY

The structure and functioning of ATPs, PHPs and RAs are clearly circumscribed yet overlapping. It is in the best interest of all parties to understand and respect the boundaries between them. Ideally they should function effectively through collaborative mutual respect for each other's clinical, therapeutic, and legal expertise. This requires an understanding and consideration of the primary mission, operational constraints, and complimentary goals of each. Maintaining appropriate boundaries does not preclude meaningful effective cooperation and coordination. The conjoint effort among ATPs, PHPs, and RAs can successfully foster rehabilitation of healthcare and other licensed professionals while simultaneously protecting the public. In the attainment of these dual goals, well-coordinated ATPs, PHPs and RAs are not only collegial but rather interdependent and symbiotic in meeting the needs of individuals, families, professions, and society at large.

The American Society of Addiction Medicine recommends:

PROFESSIONALS HEALTH PROGRAMS (PHPs)

- Embrace and incorporate Federation of State Physician Health Programs (FSPHP) guidelines into core operations.
- Provide immediate intervention, initial assessment, appropriate triage, rapid referral for evaluation &/or treatment, and post-treatment laboratory, workplace and behavioral monitoring.
- Establish a written contractual relationship with recovering program Participants which, among other things:
    - requires total abstinence from all unauthorized and/or non-prescribed mind and/or mood altering addictive and/or addiction potentiating substances, including alcohol.
    - delineates all parameters of case-management and monitoring (laboratory monitoring, workplace monitoring, and behavioral monitoring).
    - emphasizes the expectation of compliance with the PHP contract, and defines non-compliance.
    - includes written consent for release of information, authorizing the PHP to send periodic written and verbal reports, as indicated, to need-to-know parties.

    - defines the sending of compliance or non-compliance reports to appropriate external entities regarding a Participant's participation.
- Ensure that program Participants are aware that PHP advocacy is contingent upon compliance, and ceases with:
    - failure to respond to treatment.
    - non-compliance with case management or monitoring as outlined in the Participant's contract.
    - behavior by the Participant which constitutes an imminent danger to the public and thus requires immediate referral of the case outside of the PHP and into the purview of the appropriate Regulatory Agency.
- Conduct extensive education about addictive and mental illness as well as the behavioral indicators of possible or potential impairment for a wide range of stakeholders in professional health, patient/public safety and related areas.
- Widely publicize the availability of the PHP and contact information.
- Adhere strictly to confidentiality as required by State Statutes, Federal Regulations, and internal PHP policies.
- Emphasize that while rehabilitation for individuals with potentially impairing illness is critical, protection of the public is paramount.
- Build trust with RAs through mutual open, honest, direct communication.

ADDICTION TREATMENT PROGRAMS (ATPs) FOR PROFESSIONALS

- Recognize addictive illness as a primary disease state requiring lifelong total abstinence from all unauthorized and/or non-prescribed mind and/or mood altering addictive and/or addiction-potentiating substances, including alcohol.
- Have the ability to provide comprehensive, multidisciplinary evaluation for possible addictive illness, mental illness, and co-morbid disorders. The evaluation must include collateral information in addition to the self reports of the healthcare or other licensed professional undergoing evaluation and/or treatment. Evaluations should include ancillary, neuropsychological and neurocognitive testing as indicated. Any diagnosis made by an outside entity must be validated though the clinical activities of the ATP.
- Offer the choice of alternative treatment sites acceptable to the ATP, the PHP, and the RA in those cases when the ATP has conducted a comprehensive, multidisciplinary evaluation that has established a diagnosis and recommended treatment.
- Secure written authorization from the licensed professional so that the results of the evaluation and treatment services offered by the ATP may be released to appropriate entities. Authorization to the licensed professional's PHP should be a condition of successful treatment completion.
- Have the ability to provide comprehensive, multidisciplinary treatment for alcohol and other substance use disorders, addressing the physical, psychosocial and spiritual dimensions of the disease of addiction.
- Utilize best practices with evidence-based treatment protocols.

- Orient patients to the 12-Step approach to personal recovery and support patients in exploratory involvement in such activities during the treatment process.
- Work closely with the licensed professional's PHP throughout the evaluation and treatment process.
- Secure and maintain accreditation from a nationally recognized accreditation entity.

REGULATORY AGENCIES (RAs)

- Clearly understand the distinction between illness and impairment by recognizing that illness does not necessarily equate to actual or functional impairment, i.e., a diagnosis does not establish the inability to practice a profession with reasonable skill and safety (See Public Policy #2 in this set of policy statements, *"Illness vs. Impairment in Healthcare and other Licensed Professionals"*).
- Embrace a rehabilitative and less punitive, philosophy in those cases where the ability to practice safely can be monitored by the PHP and there has been no demonstrated harm to patients or the general public.
- Enter into a formal contractual agreement with PHPs to define roles and responsibilities and have open lines of communication in order to lessen the inevitable occurrence of misunderstandings and potential conflicts of interest.
- Support PHP policies and procedures.
- Allow PHPs sufficient clinical latitude in case management. Understand and respect confidentiality restrictions imposed on PHPs by State Statutes and Federal Regulations (See Public Policy #9 in this set of policy statements, *"Public Safety and the Healthcare and Other Licensed Professional with Addictive Illness ").*
- Build relationships and trust with the PHP through mutually open, honest, direct communications.
- Allow the PHP in their jurisdiction to function as the licensing Board's expert consultant in all matters relating to healthcare and other licensed professionals with potentially impairing illness.

ASAM
American Society of Addiction Medicine

Public Policy on the Evaluation, Treatment and Continuing Care of Addiction in Healthcare and other Licensed Professionals

(This is the fifth in a set of eleven policy statements of the American Society of Addiction Medicine addressing Healthcare and Other Licensed Professionals with Addictive Illness)

Background

Healthcare and other licensed professionals with addictive illness occupy a unique position in society. The public depends upon them for the provision of professional services and may unwittingly consider professionals "immune" to developing a potentially impairing illness. Healthcare and other licensed professionals are human beings and thus subject to the same illnesses as the public they serve.

The public, policy makers, regulatory agencies, and professional associations expect and deserve safe competent service from healthcare and other licensed professionals. All parties involved with professionals who have an addictive illness or another potentially impairing health condition should have reassurance that such professionals have been appropriately evaluated, adequately treated, and have received or are receiving state of the art continuing care and monitoring. This helps ensure a) the professional recovering from addiction or another potentially impairing health condition is in sustained remission of their health condition or, b) any relapse to active illness is quickly detected before actual on-the-job "impairment" occurs (See Public Policy Statement #2; *"Illness versus Impairment in Healthcare and other Licensed Professionals"*).

Healthcare and other licensed professionals with addictive illness are faced with cultural factors predisposing them with difficulty in seeking or accepting assistance and guidance. Their training teaches them – both overtly and covertly - to place their patients first, often denying or minimizing personal and family needs. This training emphasizes mastering skills necessary to be "providers of care" while deemphasizing the learning of self-care skills. Experience has shown it is difficult for a healthcare provider to become the patient – the "recipient of care." When the issue is addictive illness, fear of professional sanction, loss of career and reputation, and the stigma of addictive illness may be compounded; making evaluation, treatment and

continuing care even more challenging. In addition, healthcare and other licensed professionals who spend their career "being in charge and in control" may have greater difficulty adapting to the demands of monitoring and accountability required of recovering professionals.

Over the last three decades Addiction Treatment Programs (ATPs) have evolved which specialize in healthcare and other licensed professionals with addictive illness. ATP professionals have developed the expertise, art and science equipping them to address the unique challenges of evaluating and treating this special clinical population of patients who are themselves licensed professionals. Concurrent with the evolution of this specialized clinical expertise in evaluation and treatment, Professionals Health Programs (PHPs) — such as those within the Federation of State Physician Health Programs (FSPHP) -have developed expertise in continuing care management and monitoring of healthcare and other licensed professionals (see Public Policy Statement #4; "*Coordination between Treatment Providers, Professionals Health Programs and Regulatory Agencies*"). The PHP model of accountability, monitoring, and earned advocacy involving contingency management exemplifies the state-of-the-art PHP operations which continues to evolve and mature. Studies of PHPs [Domino (*JAMA 2005*) and Dupont (*Journal of Substance Abuse Treatment, 2009*)], demonstrate remarkable PHP effectiveness in working with physicians with potentially impairing illness. Available evidence indicates this success is adaptable to other professional groups.

With state of the art evaluation, treatment, continuing care and monitoring, sustained remission is the expected outcome for healthcare and other licensed professionals with potentially impairing illness including addiction. When healthcare and other licensed professionals attain and maintain a state of disease remission; the ill professional, family, community, profession and the public all benefit. This model of specialized care, support, monitoring, and accountability involving contingency management has proven successful and is applicable to all licensed professionals. Furthermore, this proven methodology has the potential to serve as a paradigm for state-of-the-art clinical treatment and case management approaches to addiction for any patient population.

The American Society of Addiction Medicine Recommends:

1) Healthcare and other licensed professionals with addictive illnesses should receive a comprehensive multidisciplinary evaluation and any indicated treatment by PHP-approved Addiction Treatment Programs (ATPs) with experience and expertise in working with this population. (see Public Policy Statement #4; "*Coordination between Treatment Providers, Professionals Health Programs and Regulatory Agencies*").

2) Recognizing the importance of associated co-morbidities, ATPs providing evaluations should carefully assess for co-occurring addictions and psychiatric illnesses..

3) All referring PHPs or similar entities should be kept apprised throughout the evaluation and treatment process.

4) Evaluation, treatment, continuing care providers and PHPs should be familiar with the ASAM Patient Placement Criteria as well as FSPHP Guidelines in the evaluation and treatment of healthcare and other licensed professionals with addictive illness.

5) The public's safety being paramount; both ATPs providing clinical services and PHPs providing monitoring and advocacy services must be respectful and mindful of Regulatory Agencies (RAs) primary mission to protect the public (see Public Policy Statement #4; "*Coordination between Treatment Providers, Professionals Health Programs and Regulatory Agencies"*).

6) Regulatory Agencies must understand disciplinary action is not always indicated or beneficial to either the professionals sustained remission or public safety.

7) Recovering professionals with addictive illness or other potentially impairing health conditions recognize and accept the responsibilities of PHPs and RAs of ensuring the public's safety. These accountability requirements support the recovering professional and are vital for PHP long-term viability, availability and credibility. PHP credibility is necessary for effective earned advocacy on behalf of the recovering healthcare and other licensed professional.

8) Healthcare and other licensed professionals in the evaluation, treatment, or continuing care phase of recovery should be supported and afforded the legally required and appropriate levels of confidentiality (see Public Policy Statement #7; "*Confidentiality in Healthcare and Other Licensed Professionals with Potentially Impairing Illness*").

9) Discrimination against recovering professionals solely on the diagnosis of medical illness is antiquated and unjustified (see Public Policy Statement #3; "*Discrimination and the Addicted Professional*").

ASAM
American Society of Addiction Medicine

Public Policy Statement on Credentialing in Healthcare and Other Licensed Professionals with Addictive Illness

(This is the sixth in a set of eleven policy statements of the American Society of Addiction Medicine addressing Healthcare and other licensed professionals with Addictive Illness)

Background

The appropriate and effective credentialing of healthcare and other licensed professionals is an extensive and necessarily confidential process. In recent years, the credentials verification process related to healthcare and other licensed professionals has experienced increasing centralization with movement toward streamlining the procedure. As a result of this movement, there have been a greater number of agencies charged with various aspects of the credentialing process. The concern; in this multi-layered approach to the granting of hospital privileges, health plan network membership, and related efforts is the sharing of confidential information among a number of diverse agencies potentially involving re-release of information. Such centralized credentialing processes may contribute to an increased likelihood of inadvertent exposure of the healthcare providers' confidential personal medical information (PMI) into the public domain.

The American Society of Addiction Medicine acknowledges the potential value of a formal centralized credentialing process readily accessible to healthcare facilities, organizations, and systems of care. ASAM recognizes the process needs to address areas of public interest while simultaneously respecting the privacy of healthcare and other licensed professionals who have received, are currently receiving, or will be receiving medical treatment. This includes treatment and/or continuing care monitoring of potentially impairing illness by participation in a recognized monitoring program such as a Professionals Health Program (PHP). Given the favorable prognosis for healthcare professionals engaged in treatment and monitoring through a PHP, it would be inappropriate and unethical to deny them the same rights of confidentiality as that provided the general public experiencing similar illnesses (see *Public Policy Statement #7; Confidentiality in Healthcare and other Licensed Professionals with Potentially Impairing Illness).*

ASAM is concerned the recovering healthcare and other licensed professional may be inappropriately excluded from or denied; clinical privileges, provider panel membership and/or

other credentials to practice when a credentialing decision is based on outdated credentialing information of past behavior occurring during the acute phase of the professional's illness. Information utilized in credentialing decisions should be based on the professional's current level of health and future prognosis. Issues of prejudice, misguided fear and misinformation should never enter into credentialing decisions. When the healthcare and other licensed professional with a potentially impairing illness has entered into a phase of sustained remission of his or her disease state, and there is no evidence of current impairment of functioning; the denial of clinical privileges, provider panel membership, or related issues is without basis. Most importantly, credentialing information must be kept current, confidential and protected.

ASAM is particularly sensitive to the potential public safety issues regarding healthcare and other licensed professionals with any undiagnosed potentially impairing illness such as addiction. ASAM strongly endorses the significant benefits of early detection; qualified evaluations; accurate diagnoses; effective, evidence-based treatment; appropriate chronic disease management; with monitoring and documentation of the status of disease remission. Professionals Health Programs have demonstrated expertise and effectiveness in providing these services. With these recommended proven principles, ASAM reiterates the fact that addiction is a treatable illness. Recovering healthcare and other licensed professionals in remission of a potentially impairing illness and compliant with treatment, case management and monitoring, should receive fair and unbiased review of their credentialing applications.

The American Society of Addiction Medicine recommends that:

1) Any credentialing process must be sensitive to the special circumstances of healthcare and other licensed professionals in treatment and recovery from a potentially impairing illness such as addiction and /or psychiatric illness. Such processes should utilize accurate, up-to-date documentation reflective of current status of disease and must be fair, reasonable, unbiased, and performed in good faith.

2) All credentialing entities must remain acutely aware that illness does not equate to past or predict future impairment (see Public Policy Statement #2; "*Illness versus Impairment in Healthcare and other licensed Professionals"*).

3) Credentialing decisions should be confidential and protected from unauthorized disclosure. In the case of an adverse credentialing decision, healthcare and other licensed professionals should have equal rights of appeal utilizing due process and the assurance of fair and unbiased hearings.

4) A healthcare or other licensed professional in recovery from a potentially impairing illness, who has demonstrated compliance with all aspects of recommended treatment, should not routinely be the subject of credentialing restrictions based on behavior occurring during the acute phase of illness. This would be contingent on the illness being in remission, stable and having no residual functional impairment potentially impacting the ability of the professional to safely, diligently and responsibly perform their duties.

5) Credentialing personnel should be sensitive to and understand that relapse can be a manifestation of the illness. A history of relapse does not equate to evidence of

defiance or functional impairment as evidenced by many other relapsing chronic medical illnesses (see Public Policy Statement #11; "*Relapse in Healthcare and Other Licensed Professionals").*

6) Personal medical information (including treatment and PHP monitoring records) obtained through the course of an investigation by a credentialing and accreditation review board of a healthcare or other licensed professional must meet the same privacy and fiduciary standards of confidentiality as any other privileged and private information learned in the physician/patient relationship as that of the general public in similar circumstances.

7) Personal medical information obtained by a credentialing entity should not be disclosed to third parties. Re-release of health records by credentialing entities is unethical and should be prohibited by law in the absence of the appropriate written consent.

ASAM
American Society of Addiction Medicine

Public Policy Statement on Confidentiality in Healthcare and Other Licensed Professionals with Potentially Impairing Illness

(This is the seventh in a set of eleven policy statements of the American Society of Addiction Medicine addressing Physicians and Other Licensed Healthcare Professionals with Addictive Illness)

Background

Confidentiality of medical information has been recognized as an important component of medical care since the time of Hippocrates. If patient-specific medical information were made available to the public, many persons in need of care would resist seeking and receiving medical attention resulting in their untreated illness progressing to a much more serious stage. This issue is even more relevant with respect to healthcare and other licensed professionals with a potentially impairing illness. Addiction and psychiatric illnesses are associated with public and peer misunderstanding, prejudice and stigma. Fear of judgment, the desire to protect one's privacy, the real threat of professional consequences and public discipline may encourage professionals to avoid the formal health care system or to seek alternative care. Care for an addictive illness through peer-support organizations such as Alcoholics Anonymous can be extremely helpful; however, self-help groups alone may prove insufficient. Healthcare and other licensed professionals who avoid care or seek misguided private assistance deprive themselves of the proven benefits available through professional evaluation, treatment and PHP monitoring. PHP-orchestrated accountability oversight and support has been proven to promote accountability via the PHP enhances positive outcomes.

Since early diagnosis and intervention are unquestionably beneficial goals, it is of paramount importance for healthcare and other licensed professionals with potentially impairing illnesses to confidently seek - or be receptive to - confidential assistance without fear of unwarranted professional sanction. The alternatives to discipline that are available via PHPs promote the utilization of proven, reliable and available resources to assist the ill professional. The confidentiality of PHP processes is vital in promoting early detection, intervention, treatment and monitoring for professionals with potentially impairing illnesses, thereby enhancing public safety.

Healthcare and other licensed professionals, like other human beings, develop illnesses requiring appropriate diagnosis and treatment. As with other occupations potentially impacting public safety, such as Department of Transportation regulated CDL drivers and commercial airline pilots, early diagnosis and successful treatment of potentially impairing illness prior to the actual "functional impairment", is an important issue of public concern and safety (see Public Policy Statement #2; *Illness versus Impairment in Healthcare and Other Licensed Professionals*).

Physicians providing diagnosis and treatment to their medical colleagues should not be required to report any aspects of their healthcare and other licensed professional patient's medical history to governmental or judicial bodies in any manner not consistent with that of other patients. When Regulatory Agencies such as Licensure Boards have a need for information from a clinician, such information should be released only with the appropriate written consent direct from the clinician from whom the information is being sought. Treatment providers should provide clinical information in a summation letter of the issues, in lieu of releasing the patient's entire medical record. These letters/reports should be reviewed by qualified personnel with expertise in matters of professional health, such as staff of the applicable state PHP. Where necessary, laws should be adopted to allow for the use of appropriately detailed summation letters.

Historically, there has been an effort to require that healthcare and other licensed professionals with a potentially impairing illness reveal excessively detailed personal medical information to Regulatory Agencies and frequently the general public. This level of public disclosure surrounding healthcare and other licensed professionals with potentially impairing illness violates the rights to privacy and the basic tenants of confidentiality. Such disclosure may actually have the unintended consequence of compromising public safety by deterring the ill healthcare and other licensed professional with potentially impairing illness in seeking assistance. While the public has a right to some information gathered by a Regulatory Agency about demonstrable functional impairment resulting in public board disciplinary action, the disclosure of a recovering professional's excessively detailed personal medical information is neither beneficial nor appropriate.

The American Society of Addiction Medicine recommends:

1. Healthcare and other licensed professionals experiencing potentially impairing health problems should have the same rights of privacy as do other patients in clinician-patient relationships. Personal health status information, *per se,* about healthcare and other licensed professionals, should not be publicly disclosed.

2. When applying for medical staff membership, managed care provider panel participation, or other employment related maters, a recovering professional should not be required to reveal non-essential personal medical information in any manner not required of all other non-recovering professionals.

3. A confidentiality clause for recovering professionals provided by specific state legislation via participation with a state's Professionals Health Program is preferable. Regardless of legislative status confidentiality should be respected.

4. The confidentiality inherent in Professionals Health Programs should be recognized as an essential feature of such programs. ASAM acknowledges and supports the importance of confidentiality of PHP participants with a mechanism in place allowing immediate notification of the Board whenever a professional with potentially impairing illness is felt to be an imminent threat to the public.

5. Application forms for medical licensure, medical staff privileges, provider panel membership and related items should be constructed in a way allowing recovering professionals with a potentially impairing illness to maintain their confidentiality when under a contract of participation with a state PHP. Questions on such forms should be limited to current medical conditions potentially impacting the applicant's ability to safely perform their duties. .

ASAM
American Society of Addiction Medicine

Public Policy Statement on Public Actions by State Medical Licensure Boards and Comparable Regulatory Agencies Regarding Healthcare and Other Licensed Professionals with Addictive Illness

(This is the eighth in a set of eleven policy statements of the American Society of Addiction Medicine addressing healthcare and other licensed professionals with Addictive Illness)

Background

Healthcare and other licensed professionals with addictive illness, like the general population with addictive illness, have a chronic, relapsing and potentially impairing disease. Such professionals have been a concern of state medical licensure boards and other comparable Regulatory Agencies (RAs). Licensure boards are agencies of state government and their primary mission is to protect the public. As agencies of government, their proceedings and decisions generally fall under the provisions of "open meetings" laws: their actions are a matter of public record. There is consensus among the professional societies which comprise organized medicine, treatment providers, monitoring professionals who work in state Professionals Health Programs (PHPs), and public policy makers that a healthcare and other licensed professional who is functionally "impaired" poses a potential risk to the public. Similarly, a healthcare and other licensed professional who is non-compliant with the recommendations of a PHP to participate in indicated intervention, evaluation, treatment, case management and ongoing monitoring, also poses a potential risk to the public and should be dealt with by the PHP and/or the RA in a timely and effective manner.

Historically, Regulatory Agencies viewed their only alternative to protect the public to be public disciplinary action against professionals, including those they understood to have an addictive illness. The belief was that without such disciplinary action, the public would be placed at risk. Newer research, however, is reassuring and supports a more effective process and questions the singular alternative of the discipline-only approach. Studies such as Domino (*JAMA*, 2005) and Dupont (*Journal of Substance Abuse Treatment,* 2009) indicate PHP-monitored physicians have excellent clinical outcomes and are able to practice their profession safely. PHPs are specialized programs of continuing care management that actively screens for relapse and/or loss of remission of illness through a model of tripartite monitoring. Recognizing relapse may occur in a subset of monitored recovering professionals with addictive illness, the goal is early detection

and intervention prior to illness progression to overt functional impairment. This approach has led to high success rates and minimization of risk to patients. It is well established with evidence-based medicine that PHP monitoring makes a difference and should be actively supported. Strong anecdotal evidence indicates these approaches are applicable and effective in other professional populations. In reality, disciplinary action as a primary means of addressing addictive illness in healthcare and other licensed professionals may actually place the public at increased risk by impeding the early detection and treatment of potentially impairing illness. The fear of disciplinary action is a powerful disincentive for the ill professional in need of assistance. (see Public Policy Statement #7; "Confidentiality for Healthcare and Other Licensed Professionals with Potentially Impairing Illness").

Public Regulatory Agency disciplinary action often led to unintended, onerous and permanent consequences for both the recovering professional and the public they serve. Inadvertently, these consequences can include constraints on healthcare and other licensed professionals' ability to practice their profession effectively in the best interests of the public. Examples include 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. Reportable disciplinary actions often have the unintended effect of leaving the professional unemployable. Disciplinary action, in and of itself, is not therapeutic and does not promote long term remission of illness. The potential for reportable disciplinary action actually deters licensed professionals from seeking appropriate assistance. In management of the healthcare and other licensed professionals with addictive illness, the most advantageous process for all concerned is one that promotes the early identification of the ill professional prior to progression of "illness" to overt "impairment" (see Public Policy Statements #2; "Illness versus Impairment…" and #4 "Coordination Among Addiction Treatment Programs, Professionals Health Programs and Regulatory Agencies").

Where Regulatory Agencies are required to publicly disclose reportable disciplinary decisions, PHPs operate without such constraints therefore encounter less resistance from a professional with a potentially impairing illness. Additionally, Regulatory Agencies must operate under a time consuming "legal burden of proof" before they are able to intervene. Conversely, PHPs can immediately and effectively intervene and interrupt professional duties when a potentially impairing illness is suspected. In the event of relapse to active illness, PHP case management includes contingency management, with explicit and swift intervention for non-adherence to the PHP agreement. State Medical Licensure Boards and other comparable regulatory agencies must be cognizant that addictive illness is a chronic and therefore potentially relapsing disease. Relapse does not constitute treatment failure, intentional professional disobedience, or defiance. PHPs and RAs expect abstinence. They must, however, recognize that relapse more often indicates an unintentional lapse of focus on the elements required for successful quality recovery, the presence of an unidentified co-existing addiction, and/or the presence of undiagnosed co-morbid psychiatric illness, rather than indicating intentional recalcitrance on the part of the PHP participant. As with other chronic medical diseases relapses occur and need to be managed therapeutically in order to minimize the potential of functional impairment. Disciplinary action on the part of the RA, in response to relapse, is not necessarily beneficial to the individual or the public. Clinical re-evaluation and/or intensification of active treatment and monitoring is warranted and effective. The addicted professional in active relapse should be required to

suspend their professional activities until the illness is stabilized. Treatment and PHP professionals should be relied upon to determine remission and state resumption of professional activities.

Finally, many states, where the regulatory boards work closely and collaboratively with their associated Professionals Health Program, have witnessed a dramatic increase in the number of addicted professionals identified with addictive illness. Under such conditions a concerned party with information is much more willing to come forward and report a licensee to a PHP. This is further facilitated with the awareness the professional will be assisted by the PHP and the associated decreased fear of automatic and publically-disclosed discipline by a State Medical Board or other comparable Regulatory Agency. This collaborative and coordinated process, described in detail in Policy #4, encourages the early identification of illness and clearly promotes public health, safety and welfare.

The American Society of Addiction Medicine recommends:

1- State Medical Licensure Boards and other comparable Regulatory Agencies recognize the diagnosis of addictive illness does not equate with impairment. "Impairment"- is a functional classification.

2- State Medical Licensure Boards and other comparable Regulatory Agencies carefully consider the alternatives available to them in addressing professionals with addictive illness. In all cases competent, qualified and experienced professionals, such as those working for the state PHP, should be utilized in the intervention, evaluation, treatment, case management and monitoring of recovering healthcare and other licensed professional.

3- Automatic publicly-disclosed adverse disciplinary actions by State Medical Licensure Boards and other comparable Regulatory Agencies in response to relapsed healthcare and other licensed professional are not necessarily in the best interest of the professional or the public. . Public action should be limited whenever possible to actions clearly indicated for the protection of public safety.

4- For the public welfare, regulatory agencies and PHPs should work collaboratively with each other to better ensure the early identification, evaluation, treatment and monitoring of healthcare and other licensed professionals with addictive illness.

ASAM
American Society of Addiction Medicine

Public Policy Statement on Public Safety and the Healthcare and other Licensed Professional with Addictive Illness

(This is the ninth in a set of eleven policy statements of the American Society of Addiction Medicine addressing Healthcare and other licensed Professionals with Addictive Illness)

Background

The American Society of Addiction Medicine is aware healthcare and other licensed professionals with addictive illness have the potential to adversely impact public safety. Regulatory Agencies (RAs), Professionals Health Programs (PHPs), professional organizations, credentialing agencies, malpractice carriers, the professional community and the general public all have a vested interest in this important issue. Each desires the otherwise competent but ill professional to be rehabilitated, providing the public is protected in the process. Addiction is a primary, multifactorial disease which impacts the entire general population. The disease involves complex genetic, biochemical and psychosocial factors. Healthcare and other licensed professionals are no less susceptible to this disease than persons from other segments of society (see Public Policy Statement #1; "Healthcare and Other Licensed Professionals with Addictive Illness—an Overview").

The diagnosis of addictive illness should no longer imply incompetence and does not, in and of itself, equate to functional impairment (See Public Policy Statement No. 2; *"Illness versus Impairment…").* Healthcare and other licensed professionals with addictive illness, particularly doctorate-level professionals such as physicians, can have difficulty transitioning from the provider role to that of patient. They have a propensity to self-diagnose and self-treat; therefore represent a unique population. Fortunately, early diagnosis, treatment and monitoring have proven successful in the vast majority of cases. This success benefits not only the professional with a potentially impairing illness but also professional organizations, regulatory agencies and, most importantly, the public.

Preventive efforts, education, research and evidence-based strategies incorporated into public policies are important and efficacious. The issue of addictive illness and public safety has been recognized and addressed in organized medicine policies, similar professional policies and in many state and federal laws. This is exemplified in the criminal justice systems' diversion programs, DOT 49 CFR Part 40, the Drug Free Workplace Act of 1980, regulatory agency Medical Practice Acts, the Federation of State Physician Health Program (FSPHP) guidelines,

and other formal documents and policies. Regulatory agency responses to an ill professional are too often automatically punitive; a consequence of the fear, prejudice, stigma of earlier times and is not reflective of current evidence-based knowledge. Adaptations to and incorporation of new research in the field of healthcare and other licensed professionals with addictive illness is too often delayed which can be detrimental and counterproductive for all.

Research-based proven strategies must replace outmoded approaches to the professional with potentially impairing illness such as addiction. Despite technical challenges, legal limitations, methodologies, and privacy considerations, we are witnessing the dawn of a new "ERA" of effective strategies for working with these ill professionals. Addictive illness in healthcare and other licensed professionals is best addressed through interagency cooperation with utilization of Professionals Health Programs (PHPs) and Addiction Treatment Programs (ATPs). The ultimate goal is to ensure that healthcare and other licensed professionals serve the public effectively and safely (See Public Policy Statement #4; "*Coordination Between Treatment Providers, Physician Health Programs and Regulatory Agencies*"). Treatment professionals should coordinate with state PHPs to determine illness severity, recovery needs, remission stability, relapse risk and medical fitness for duty. Professionals Health Programs (PHPs) have clearly demonstrated excellent results thereby assisting Regulatory Agencies in protecting the public. There are over 30 health professional regulatory agencies including Physicians, Nurses, Dentists, Veterinarians, Psychologists, Counselors, Social Workers and others. The Federation of State Physician Health Programs (FSPHP) has developed guidelines to effectively and safely address licensees with potentially impairing illnesses. This PHP model is recommended for all professions.

Research and anecdotal experience - including reports from malpractice carriers and others - indicate the once feared situation of professionals with addictive illness causing harm to the public is actually quite rare. In reality, identification and intervention occur earlier along the continuum of illness before there is actual on-the-job impairment. Post treatment tripartite behavioral, chemical, and worksite monitoring is highly effective in obtaining sustained disease remission. With well coordinated interface between Professional Health Programs, Regulatory Agencies and Addiction Treatment Programs, the public is best protected. PHPs utilizing best practices in evaluation, treatment and monitoring with contingency management have achieved excellent outcomes with minimization of risk to the public. The typical and expected outcome for the professional with a potentially impairing illness is sustained recovery (See Public Policy Statement #4; *"Coordination between Treatment Providers, Physician Health Programs and Regulatory Agencies").*

Ultimately, healthcare and other licensed professionals with potentially impairing illness must receive state of the art treatment and post-treatment monitoring because hospitals, malpractice carriers, professional organizations, regulatory entities, health insurance companies, friends, families, colleagues, and the public have the highest expectations of professionals in safety sensitive positions.

The American Society of Addiction Medicine recommends:

1. When considering healthcare and other licensed professionals with addictive illness, the public health, safety and welfare are paramount.

2. The public health, safety and welfare are best served when an otherwise competent healthcare or other licensed professional with a potentially impairing illness is identified early, receives appropriate evaluation and/or indicated treatment, is monitored competently through a Professionals Health Program (PHP) and, when ready, returned to the safe, monitored practice of their profession.

3. To the further enhancement of public safety, ASAM recommends the continued support of evidence-based research in the education, evaluation, treatment and monitoring of potentially impairing illness, such as addiction, in this unique population.

ASAM
American Society of Addiction Medicine

Public Policy Statement on Recovering Physicians, Medical Licensure Boards, Specialty Board Certification and Professional Society Membership

(This is the tenth in a set of eleven policy statements of the American Society of Addiction Medicine addressing Healthcare and Other Licensed Professionals with Addictive Illness)

Background

In the United States, a medical license issued by a state regulatory agency/ licensure board assures the public a physician has met competency requirements to diagnose and treat patients. Licensure Boards are Regulatory Agencies of state or territorial governments, and independent from jurisdiction to jurisdiction. Medical specialty boards are responsible for setting the standards of quality practice in a particular medical specialty. Board Certification by a medical specialty board assures the public and other stakeholders that a physician in that specialty has successfully completed an approved educational and residency training program in that specialty. Additionally, a peer evaluation and testing process has occurred which included components designed to assess the medical knowledge, judgment, professionalism, as well as the clinical and communication skills required to provide quality patient care in a designated specialty. Board certification represents a statement of peer review endorsement to other professionals, organized medicine and the public. It is an important consideration for potential employers, malpractice carriers, insurance payors, credentialing organizations, managed care and others of the physician's good standing within their chosen field of specialization. Similarly, professional society membership reflects good standing within the medical community.

Recovering physicians who have sought assistance and been treated for potentially impairing illness such as addiction and psychiatric disorders are occasionally faced with public disciplinary action taken on their license by a Regulatory Agency (such as a State Medical Licensure Board). Licensure restrictions, suspensions, revocations, and other public Licensure Board actions are reportable to the National Practitioner Data Bank. In some instances, this reportable event resulted from actions or behaviors on the part of the now- recovering physician which occurred during their undiagnosed, untreated active stage of illness (e.g., drug diversion for self-use). In some instances, Regulatory Agencies have automatically taken public action based solely on the existence of an addictive and/or psychiatric illness. Unfortunately, Professional Societies and Specialty Boards occasionally use the history of a publicly reportable adverse action(s) by a Licensure Board to declare physicians unworthy of and ineligible for: membership, certification,

recertification, or continued participation in maintenance of certification programs. Fortunately, some Licensure Boards have become more proactive and take into account addiction as a treatable, chronic medical illness amenable to treatment and successful remission. Knowledge that a once-actively-addicted physician is engaged with a PHP evaluation/treatment/monitoring process provides the Regulatory Agency with greater discretion regarding reportable board disciplinary action. Notwithstanding, the existence of a Regulatory Agency public order related to a history of addiction or psychiatric illness should not automatically disqualify eligibility for Specialty Board certification or Society membership.

Professional Medical Specialty Societies are membership organizations of physicians (and others) whose clinical focus is within a special area of medical practice. Membership is voluntary and members must apply and pay dues to retain membership in good standing. Professional/Specialty Societies may also use a history of publicly reportable adverse actions by a Regulatory Agency to declare physicians ineligible for membership. The existence of a Regulatory Agency public order related to a history of addiction or psychiatric illness should not automatically disqualify eligibility for Specialty Society membership.

Recovering physicians experiencing loss of their Specialty Society membership standing and/or Specialty Board certification status find their professional life and continued recovery complicated in many ways. There is potential loss of hospital credentialing, insurance provider panel membership, and all too often employment/employability. There may be denial of participation in managed care contracts or other insurance provider panels. Professional liability insurance carriers may place a higher premium rating status or cancel existing coverage. At the time of a recovering physician's greatest need for support, the good will of their specialty and healthcare community; the recovering physician can be left disenfranchised and feeling despairingly alone. Facing such stresses, the ability and even the opportunity to effectively treat patients can be adversely impacted.

Barring other factors such as inadequate training, diminished skills, or other features of demonstrated incompetence to practice, recovering physicians are not "impaired" (See Public Policy Statement # 2*; "Illness versus Impairment in Healthcare and other Licensed Professionals*"). These professionals have been carefully evaluated, received indicated treatment, and are ideally participating in the monitoring and scrutiny of their state's Professionals Health Program to ensure their illness remains in remission. As such, they warrant the continued respect and support of their colleagues, Professional Societies and Specialty Boards. It should remain the purview of the physician's Regulatory Agency /Licensure Board to determine their ability to practice medicine with reasonable skill and safety. Should the Licensure Board/Regulatory Agency determine continued licensure – with or without restrictions – is warranted, recovering physicians should receive from their physician colleagues the same consideration we afford our patients – our support, encouragement, compassion, and care.

Specialty Societies and Specialty Boards should work with their state PHP to develop processes regarding their physician colleagues with addictive and/or psychiatric illness or other potentially impairing health conditions that have been reported to the National Practitioner Data Bank. Consideration of the remedial efforts the physician has made since the events leading to the report should be taken into account in their deliberations. Recovering Physicians who have

earned the advocacy of their state PHP should be accorded full privileges of the profession of medicine and not limited in their activities solely on the basis of past behavior or the existence of a disease that is now in remission.

A Specialty Society or Specialty Board considering suspension, revocation of membership or inhibition of board certification, based on a limitation imposed on a medical license should undertake appropriate due process in ascertaining the warranting of privileges removal, membership or board certification. Individual cases should be provided consideration of the opinions of treatment professionals and appropriate others including Professionals Health Programs.

The American Society of Addiction Medicine recommends:

1) Professional and Specialty Societies, Specialty Certification Boards and State Regulatory Agencies /Licensure Boards understand addictive and psychiatric illnesses are not issues of moral turpitude, personal character or professionalism. They are chronic medical illnesses to which physicians are susceptible, just as are their patients.

2) Barring other substantive issues, successful completion of the administrative process of a Regulatory Agency and associated re-licensure - with or without restriction - should obviate the need for Specialty Boards, Professional Societies and Specialty Societies to undertake denials of certification, eligibility for recertification, and/or membership.

3) Physicians who are or who have been successful participants in a Professionals Health Program should be recognized to be in a state of fitness for duty rather than an automatically "unfit" status representing a risk to the public that they serve.

4) Specialty Society membership, Specialty Board certification should not be withdrawn retrospectively based solely upon a diagnosis of a potentially impairing illness, such as addictive and/or psychiatric illness. Specialty Boards should not withdraw, prevent, prohibit or otherwise interfere with a physician's board Certification based solely on these same issues. In the absence of cause beyond illness, continuation of Specialty Society membership and privileges and board certification should be maintained.

5) Professionals Health Programs and other experts in the evaluation, treatment and continuing care of physicians should be utilized and input respected in all specialty society membership and/or board certification decisions related to appeals of adversarial rulings of physicians recovering from addiction and/or psychiatric illness.

6) Continued discriminatory loss of specialty society membership and/or specialty board certification is not reflective of the philosophical principles and practice of medicine in general, is a dated carryover of an antiquated moral model of addiction and is no longer appropriate based on current knowledge and efficacy of addictive and/or psychiatric illness treatment and chronic disease management.

ASAM
American Society of Addiction Medicine

Public Policy Statement on Relapse in Healthcare and Other Licensed Professionals

(This is the eleventh in a set of eleven policy statements of the American Society of Addiction Medicine addressing Healthcare and Other Licensed Professionals with Addictive Illness)

Definitions:

a) For the purposes of this document "relapse" is defined as the recurrence of behavioral or other substantive indicators of active disease after a period of remission in a healthcare or other licensed professional with the disease of addiction

b) Addictive illness is a biochemical; psychosocial, genetically-influenced primary illness hallmarked by loss of control or continued use of mind and/or mood altering substances regardless of negative consequences frequently accompanied by a powerful denial of the existence and effects of the illness.

Background

Addictive illness is a stigmatized malady misunderstood and encumbered by myth and misinformation based on antiquated beliefs from the 18th, 19th and early 20th centuries. Today, science teaches us that addiction is a primary illness – a neurobiochemical brain disease manifest by disturbances of motivation and reward. ATPs and PHPs work to assist their professional patients with the critically important step of moving beyond the moral "good versus bad" view of their illness into the healthier "illness vs. wellness" disease model supported by evidence based research. ATPs and PHPs understand that the recovering healthcare or other licensed professional who remains emotionally entrapped in the moral model of addiction is at an increased risk of relapse as a result of this erroneous view of the illness. The associated reliance on self-will of the moral model is less therapeutic and efficacious than the disease model which emphasizes honesty and reliance on others including peers, sponsors in recovery, treatment professionals, advances in treatment methods and the healthcare professional's PHP.

Historically, many regulatory agencies and the healthcare community have viewed addictive illness from the moral model perspective; reacting to the illness based on resulting behaviors occurring during active illness. Naturally, this has kept RAs in a disciplinary approach to addiction and relapse as "bad behavior" warranting censure. Outdated beliefs hold that punishing the professional sends a message correcting aberrant behavior while serving as a warning to

others. For example, public consent orders have referenced "moral turpitude" and "behavior intended to deceive, defraud, and harm the public". Human beings, including healthcare and other licensed professionals, with active addictive illness sometimes behave in ways contrary to societal norms and professional expectations. Disease-driven aberrant behavior typically resolves following successful intervention and treatment. Ironically, public orders referencing such historical and now obsolete information re-enforces the moral model of addiction. These are the very ideas and attitudes the PHPs and ATPS work so diligently to extinguish during treatment and continuing care phases of recovery. Toxic shame is not conducive to sustained remission or public safety.

Addiction like many other chronic illnesses, such as asthma and diabetes, is a relapsing illness. Fortunately, healthcare and other licensed professionals receive excellent treatment and state of the art continuing care resulting in significantly fewer relapses than seen in other populations (See Domino and McLellan). Notwithstanding, stakeholders working with professionals with addictive illness do see relapse and manage their occurrence. In fact, relapse in healthcare and other licensed professionals with addictive illness can be a therapeutic event leading to the elimination of lingering reservations or residual denial so common with addictive illnesses. With this broader understanding, all stakeholders benefit by the adoption of an effective treatment and monitoring response benefiting the professional's recovery and the public health, safety, and welfare.

Through effective PHP monitoring, relapse is typically discovered behaviorally prior to readministration of addictive substances or during the early phase of attempted "controlled use" and most commonly outside the context of active professional duties. At this point of early detection, the illness has not typically progressed to functional impairment. The once held common fear that patients would be harmed has proven to be unfounded. The Domino and McLellan studies failed to demonstrate patient harm in over 12,000 cases studied of recovering physicians in monitoring, including those who experienced relapse. Healthcare and other licensed professionals preserve their function in the workplace, remarkably well until later stages of the disease manifests. Lastly, anecdotal reports from malpractice carriers support the lack of evidence of patient harm reporting allegations of both active impairment and patient harm due to addiction as being extremely rare. These facts warrant a paradigm shift in viewing the phenomenon of relapse.

The American Society of Addiction Medicine recommends:

1) Healthcare and other licensed professionals with addictive illness and especially those who experience relapse have an obligation to obtain any necessary evaluation, treatment, and continuing care monitoring and should fully cooperate with RAs, ATPs, and PHPs though this process.

2) PHPs must have effective mechanisms in place for the early detection and expedient addressing of relapse before illness progresses to overt impairment.

3) With the understanding of the potential of relapse, PHP continuing care contracts should contain a clause of portability enabling the PHP to report to another state PHP and/or RA any relocation of a monitored healthcare or other licensed professional.

4) The PHP and RA should, within their memorandum of understanding, clearly articulate a mutually agreeable therapeutically effective management and reporting process to be followed in the event of relapse.

5) PHPs must understand, respect and support the mission of the RA to protect the public. Any concern of continued active use should prompt the PHP to demand immediate withdrawal from practice pending further evaluation. Failure of the physician to fully immediately cooperate must result in an immediate report from the PHP to the RA.

6) RAs should understand that relapse is not willful misconduct but a recognized part of addictive illness warranting further intervention; additional treatment; and/or enhanced monitoring. RAs are encouraged to consider relapse in the context of the illness and understand that public disciplinary action is not routinely indicated and can prove counterproductive.

7) RAs are encouraged to work closely with the PHP regarding all aspects of monitoring and rely on the PHPs professional opinion regarding relapse, level of intervention indicated, and the ability of the professional to subsequently engage in their profession safely with or without restrictions.