Physician Health Programs in the United States: Historical Context

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Presentation Goals:

1. Present a Brief History of Modern Physician Health Programs (PHPs)
2. Identify the distinguishing ingredients of PHPs that likely contribute to their exceptionally high recovery rates (70-90+%)(Guggenheim, 2001; Welsh, 2001; Gastfriend, 2005)

Context for the Emergence of PHPs

- Alcoholics Anonymous (1935) & International Doctors in AA (1949).
- Modern Alcoholism Movement, e.g., RCPA, Yale, NCEA
- Resurgence in hospital- and community-based alcoholism treatment resources (1935-1970).
- Rebirth of Addiction Medicine (1954)
- Early Industrial Alcoholism Programs to advent of “broadbrush” Employee Assistance Programs (1945-1975)

Birth of Physician Health Programs (PHPs)

- Federation of State Medical Boards calls for model physician assistance program (1953)
- AMA's Council of Mental Health report addresses physician impairment (1972)
- AMA's 1973 report on "The Sick Physician"
- Disabled Doctors Act of 1974 (mandatory reporting, whistleblower immunity)
- AMA's conferences on impaired physician (1975 & 1977)

Evolution of Physician Health Programs (PHPs)

- State Medical Society Physician Health Committees established (1970s)
- Rapid growth of formal PHPs (1970s)
- Specialized programs for treatment of health care professionals (1980s)
- Federation of State Physician Health Programs, Inc. (1990)
- Expanded scope of problems addressed within PHPs

Structure of PHPs Involves:

- Educational Programs
- Consultation Services
- Early Detection (early referral)
- Preliminary Assessment
- Professional Intervention Services
- Linkage to Comprehensive, Formal Evaluation
- Secondary Intervention (prn)
- Linkage to Clinical Treatment and Recovery Support
- Assistance in Developing an Aftercare Plan
- Sustained Professional Monitoring
- Advocacy

8 Key Ingredients of PHPs

1. Motivational fulcrum linked to personal identity, social/professional status and future financial security

   --Intervention teams, trained leaders, clearly defined intervention goals focused on evaluation

2. Comprehensive (Global) assessment and treatment
3. Peer-based recovery coaching

8 Key Ingredients of PHPs

4. Recovery-enhancing practice modifications, e.g., shift in specialty, prescribing restrictions, altered work setting or work schedule
5. Assertive linkage to recovery support groups

   --Caduceus meetings, Physician online therapy groups (Therapeutic Monitoring Groups)
6. Sustained (5+ years) monitoring, support and, when necessary, early re-intervention.

   --Periodic interviews and random drug testing

8 Key Ingredients of PHPs

7. Re-interventions move to higher level of treatment intensity

8. Integration of ingredients into personalized, comprehensive and sustained program.

--Continuity of contact over time

Sources: JAMA, 2005, 293(12), 1513-1515; White, DuPont & Skipper, in press.