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COMMENTARY

A Call for National Standards and Oversight of State Physician Health Programs

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AQ1 **Objectives:** Many physicians are referred to state physician health programs (PHPs) for evaluation, monitoring, and treatment of mental health and substance use disorders. If the physician agrees to cooperate with the PHP and adhere to any recommendations it might make, the physician often can avoid disciplinary action and remain in practice. Despite their considerable power, many PHPs operate with little oversight.

Methods: I review recommendations that a co-author and I previously made regarding oversight of PHPs and then review some of the findings from a recent performance audit of the North Carolina Physicians Health Program by the North Carolina Auditor's Office.

Results: Physicians who might object to the conclusions and recommendations of PHPs in many states do not have the ability to appeal and lack due process. Additionally, given that many of the evaluation and treatment centers to which PHPs refer their clients also sponsor meetings of PHPs, there is significant potential for conflict of interest in the standard operations of PHPs.

Conclusions: National standards should be put in place for the day-to-day operation of PHPs and include avenues for appealing decisions and recommendations by them. Also, PHPs should be routinely audited to ensure the soundness and fairness of their practice.

Key Words: conflict of interest, impaired physician, medical ethics, physician health, physician health program

(*J Addict Med* 2015;xx: xxx–xxx)

Approximately 10 to 12% of physicians will develop substance use disorders over the course of their lives (Flaherty and Richman, 1993). Physicians who are suspected of having substance use disorders or other mental health issues are often referred to their state physician health program (PHP) for evaluation. These physicians often must pay large amounts of money for psychological evaluations, followed by 30 to 90 days of treatment, if they hope to continue practicing medicine. Physicians generally have little recourse but to comply with PHP recommendations, given that state boards of medicine usually mandate full compliance with PHP recommendations if a physician hopes to continue working, and there are often no effective avenues of appeal of mandates by the board of medicine or the recommendations of PHPs.

Physician health programs report high rates of success in their work with physicians—generally in the 75% to 80% range—rates that are far higher than those seen in other populations (DuPont et al., 2009). Some argue that these high rates of success justify any coercion employed by PHPs or lack of an appeals process (Gitlow, 2012).

In this journal, my colleague John Knight and I previously argued that despite their considerable power over physicians who have been referred to them, PHPs operate largely outside of scrutiny and oversight because many physicians know nothing about these programs (Boyd and Knight, 2012). And among those who do know about PHPs, most assume they are entirely benevolent organizations—doctors helping doctors, in the vernacular—operating only for altruistic motivations. In that paper, Knight and I highlighted a number of concerning practices by many PHPs and called for national standards for PHP operation and regular audits of PHPs. Although our paper was published almost 3 years ago, little seems to have changed in the day-to-day practice of most PHPs.

That is not the case in North Carolina (NC), however. After receiving complaints from physicians in their state about the NC Physicians Health Program (NCPHP), in 2013, the NC Auditor's Office undertook an audit of the NCPHP, which reviewed over 100 individual physician files, conducted numerous in-person interviews of participants in the PHP, as well as staff members of the NC board of medicine, the NC medical society, and the PHP. (Disclosure: I served as a consultant for this audit.) The audit produced 6 key findings (Wood, 2015).

First, although it found no indications of abuse by the NCPHP, ''abuse could occur and not be detected because the Program lacks objective, impartial due process procedures for physicians who dispute its evaluations and directives.'' The report went on to say that ''the lack of objective and independent due process procedures could prevent physicians from successfully defending themselves against potentially erroneous accusations and evaluations.'' The auditor recommended that the NCPHP develops an avenue for ensuring that physicians are able to appeal NCPHP recommendations and conclusions, and get a fair hearing.

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The second key finding in the NC audit was that ''abuse could occur and not be detected because the Program gave the CEO/Medical Director and the Clinical Director excessive influence over the process for reviewing physician complaints, and physicians were not allowed to effectively represent themselves when disputing evaluations.''

The third key finding stated that ''abuse could occur and not be detected because the NC Medical Board did not periodically evaluate the Program, and the NC Medical Society did not provide adequate oversight.'' To remedy this, the NC audit concluded that both the state medical board and the state medical society should develop plans for improved oversight of the NCPHP.

The auditor's report decried the appearance of conflict of interest between the NCPHP and the evaluation/treatment centers that it utilized in its fourth finding: ''The Program created the appearance of conflicts of interest by allowing treatment centers that receive Program referrals to fund its retreats, paying scholarships for physicians who could not afford treatment directly to treatment centers, and allowing the centers to provide both patient evaluations and treatments.'' The reason for this finding is that the NCPHP overwhelmingly referred physicians for (almost exclusively out of state) evaluations and treatment to centers that sponsored the NCPHP's biannual meeting through 2012. Although NCPHP instituted changes in 2012, many evaluation and treatment centers continue to sponsor the National Federation of State Physician Health Program's Annual Meeting, as well as regional PHP meetings. This funding creates a significant conflict of interest, where both entities might prioritize their relationship to one another over against fairness to individual physicians. The NC auditor recommended that the NCPHP should not allow these centers to fund its retreats and stop directly paying scholarship money to these centers.

The fifth finding states that ''Program procedures did not ensure that physicians received quality evaluations and treatment because the Program had no documented criteria for selecting treatment centers and did not adequately monitor them.''

The final key finding states that ''The Program's predominant use of out-of-state treatment centers created an undue burden on physicians.'' The auditor recommended that the NCPHP cultivates in-state resources for evaluation and treatment.

The NC auditor's office will re-examine the NCPHP 18 months after its report was issued to ensure that the program has implemented its recommendations.

North Carolina might soon have company. A class action lawsuit by health care professionals against the Michigan PHP was recently filed, alleging a coercive, punitive process within the PHP (U.S. District Court Eastern District of Michigan, 2015). The complaint states that the Michigan PHP ''has turned into a highly punitive and involuntary program where health professionals are forced into extensive and unnecessary substance abuse/dependence treatment under the threat of the arbitrary application of prehearing deprivations,'' which includes suspension by the Michigan licensing board. It is too early to know if changes in Michigan will be forthcoming given this lawsuit. Although many physician health programs try hard to do what is in the best interests of the physicians with whom they work, as well as the general public, external oversight for all PHPs would ensure the procedures they are using are adequate to ensure fairness.

Many—if not most—facets of our healthcare system are subject to periodic audits and/or external review. Physicians have to apply for license renewal every several years, and, in so doing, subject themselves anew to scrutiny by their licensing board. Most hospitals in the United States are regularly inspected via unannounced visits and accredited by the Joint Commission. Analogously, medical residency and fellowship programs must conform to national standards set forth by the Accreditation Commission of Graduate Medical Programs and are periodically inspected to ensure compliance.

Given their power over the health and well being of physicians, PHPs should be no different. National standards ought to be established (including, but by no means limited to, allowing for avenues of appealing PHP decisions and recommendations that are timely and not cost-prohibitive), PHPs should be made to conform to those standards, and PHPs should be audited regularly. The NC State Auditor's report could serve as the basis for this nationwide reform. Implementing such standards would go a long way toward ensuring that PHPs are seen as transparent, benevolent entities that truly work toward promoting physician well being while also ensuring public safety.

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