Practicing What We Preach — Ending Physician Health Program Bans on Opioid-Agonist Therapy

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The ongoing overdose crisis has spared no demographic, professional, or geographic stratum. Although efforts to bring substance use disorder and its treatment out of the shadows have made substantial inroads, outdated thinking, policies, and practices persist.

Recently, two nurses were found dead from overdoses involving opioids in employee bathrooms at Clements Hospital in Dallas. These deaths occurred just 16 months apart at the same facility. The precise toll of opioid use disorder (OUD) and overdose among clinicians has not been quantified, but clearly this issue deserves far more attention.

Opioid-agonist therapy is the standard treatment for OUD.[1] Maintenance with methadone or buprenorphine sharply reduces the risks of relapse, overdose, and death, making it possible for patients to regain control of their personal and occupational functions. Despite the well-documented effectiveness of such treatment, however, it remains vastly underutilized in the United States and elsewhere.[1]

Clinicians and their professional organizations have been at the vanguard of advancing the expansion of opioid-agonist therapy to bring the overdose crisis under control. A 2019 report from the National Academies of Sciences, Engineering, and Medicine concluded that "there is no scientific evidence that justifies withholding medications from OUD patients in any setting" and stated that such practices amount to "denying appropriate medical treatment."[1] It is therefore ironic that clinicians, who are better positioned than most people to acquire and afford opioid-agonist therapy, are often denied it.

Health practitioners who identify themselves as having — or are determined by their employers or oversight boards to have — OUD are usually required to enroll in physician health programs (PHPs). These state-level programs routinely mandate abstinence-based models of substance use treatment as a condition of maintaining professional licensure. With rare exceptions, this arrangement implies a blanket ban on opioid-agonist therapy.

Such practices date back to the early 1970s, when physicians banded together to help their colleagues who had problems related to alcohol use, drug use, or mental health. By 1973, the American Medical Association formally endorsed state-run specialty treatment for physicians. All but three states (California, Nebraska, and Wisconsin) operate PHPs. The programs "promote early detection, assessment, evaluation, and referral to abstinence-oriented (usually) residential treatment for 60 to 90 days," followed by random urine toxicology screening for roughly 5 years.[2]

There are two primary rationales for banning opioid-agonist therapy in PHPs: physician exceptionalism and concerns about impairment. Traditionally, PHPs have been viewed as yielding substantially better outcomes than abstinence-only programs for the general public. Accepted wisdom suggests such programs are singularly effective because physicians (and, by extension, other licensed health care professionals) are exceptional. The purported success of PHPs is widely attributed to their intensive regimens and mandated, long-term monitoring as well as the threat of severe sanction, coupled with high motivation among participants to continue practicing in their field. We believe, however, that statements heralding the success of PHPs warrant closer scrutiny. Without knowing the true number of clinicians with OUD, it's impossible to determine the extent of the selection bias that may shape PHP outcomes. It's unclear, for instance, how many people who could benefit from treatment don't enroll in PHPs because of pervasive stigma, criminalization of substance use, and rigid adherence to an abstinence-only approach and are therefore forced to abandon the practice of medicine.

What's more, available evidence on the effectiveness of PHPs lacks sufficient rigor and transparency. There have been no carefully designed studies that adequately matched participants in PHPs who did and did not receive opioid-agonist therapy in terms of their OUD severity and other characteristics. The numbers of fatal overdoses, suicides, and lost licenses among clinicians that might be averted by increasing access to opioid-agonist therapy is an area in dire need of research. Even when taken at face value, data from PHPs suggest

that nearly 25% of physicians (and a substantially higher proportion of nurses) are not "successful" in their recovery. Certainly, some of these patients would stand to benefit from the standard of care: opioid-agonist therapy.

People who support bans on opioid-agonist therapy for practicing clinicians also argue that the neurocognitive side effects of such medications substantially interfere with clinical practice. Given ongoing concerns about high rates of medical errors, minimizing workplace impairment among clinicians is of vital importance. But the contention that calibrated opioid-agonist pharmacotherapy automatically results in substantial impairment in cognition, psychomotor tasks, and memory is far from settled science.[3] Available evidence doesn't demonstrate that people receiving opioid-agonist therapy show meaningful differences in performance as compared with those receiving nonmedication treatment for OUD. A 2019 meta-analysis found significant neurocognitive differences between healthy controls and patients with OUD, but the average raw scores in the patient group typically fell within the normal range, and many studies didn't include patients receiving maintenance agonist treatment.[4] A recent RAND overview conducted at the request of the U.S. Department of Defense concluded that "weaknesses in the body of evidence prevent making strong conclusions about . . . effects [of opioid-agonist therapy for OUD] on functional outcomes."[5]

The assumption that opioid-agonist therapy may pose a unique threat in the workplace until proven otherwise also ignores neurocognitive effects caused by a number of other medications and health conditions. Clinicians being treated for depression, anxiety, heart disease, and other common issues are routinely prescribed medications that may affect cognition and mood, but they don't face restrictive policies. There is little empirical support for this double standard.

There is, however, an extensive body of research linking excessive fatigue, stress, and sleep deprivation to both cognitive impairment among practitioners and harm to patients. The principal source of such impairment isn't medication, but structural dysfunction within the health care sector. Among the sequelae of this dysfunction are burnout and untreated physical and emotional pain. When combined with ready access to psychoactive substances, these factors all contribute to an elevated risk of OUD and other substance use disorders among clinicians. We believe that with provider health as their stated focus, PHPs must do far more to address well-documented, modifiable, systems-level drivers of clinician impairment.

There are also legal and ethical reasons to jettison bans on access to opioid-agonist therapy in PHPs. Unduly restricting access to one class of medications for OUD among employees or members of professional organizations may violate provisions of the Americans with Disabilities Act. Imagine if the medical profession barred anyone being treated with pharmacotherapy for depression from returning to practice, insisting that only physicians who had achieved remission with cognitive behavioral therapy were fit to practice; the medical community would revolt.

Bans on opioid-agonist therapy within PHPs codify the very antiquated attitudes and stigma toward medication treatment for OUD that the health care community is fighting so hard to eliminate. Such bans signal that opioid-agonist therapy represents second-class care not worthy of health care professionals and that health professionals receiving agonist treatment cannot be trusted with patient care or medication stewardship. This message not only hurts clinicians with OUD but is detrimental to public health because it undermines efforts to make this lifesaving care mainstream in our communities.

We believe the debate regarding clinicians' fitness to practice while receiving opioid-agonist therapy is less substantive than ideological. The best scientific evidence available suggests that the benefits of such therapy extend to all patients. Systematically denying clinicians access to effective therapy is bad medicine, bad policy, and discriminatory. We call on the health care sector to practice what it preaches by discarding this antiquated norm in all its policy and practice variants.

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Health Care Autonomy of Women Living with HIV

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In sub-Saharan Africa, more than 60% of all adults living with HIV in 2018 were women, according to the Joint United Nations Programme on HIV and AIDS (https://aidsinfo.unaids.org). Largely as a result of early access to HIV testing and antiretroviral treatment (ART) at antenatal clinics, women were the first to benefit from "Treat All" approaches to ART; with the introduction of Option B+ policies starting in 2011, all pregnant and breastfeeding women were offered immediate ART initiation and lifelong treatment, regardless of their CD4+ T-cell count or clinical staging. Women accounted for 67% of the 13.5 million adults receiving ART at the end of fiscal year 2018 in programs supported by the President's Emergency Plan for AIDS Relief (PEPFAR) globally (www.pepfar.gov).

Providing the best available ART regimens to women requires complex decision making related to their childbearing potential, including weighing women's health needs and experiences with medications, along with possible safety concerns for infants exposed to HIV medications during any current or future pregnancy. When a potential association with neural-tube defects (NTDs) in infants born to women receiving dolutegravir (DTG)-based ART was identified in May 2018, the risks of possible adverse outcomes for infants exposed to DTG became a major focus of HIV policy discussions.[1] Yet such discussions should include consideration of all the risks, including those for women who might receive inferior ART regimens, if we are to ensure the best achievable access to treatment options and improved health outcomes for women living with HIV.

Before May 2018, global HIV programs were poised to transition the preferred first-line ART regimen rapidly from tenofovir, lamivudine, and efavirenz to tenofovir, lamivudine, and DTG, which poses a lower risk of treatment failure and causes rapid viral suppression.[2,3] The momentum behind this shift waned, however, after the release of interim World Health Organization (WHO) guidance in July 2018 that included a note of caution advising that adolescent girls and women of childbearing potential be given a DTG-based regimen only if it was used in tandem with a consistent and reliable form of contraception; other regulatory bodies followed with similar statements of caution. Despite the release of more permissive WHO guidance in December 2018, the response to the NTD safety signal has varied among countries, with a limited number allowing women to make an informed decision, some providing access to the regimen only for patients using contraception, and others not offering access to DTG-based regimens for any women of childbearing potential.

Policy discussions have focused primarily on the possible increased risk of having a child with an NTD — largely overlooking the importance of shared decision making between a woman and her health care provider and the possible risks of adverse outcomes for pregnant women who might receive inferior ART regimens and their infants. When global policymakers and national HIV programs make recommendations that restrict women's access to medications on the basis of uncertain — or even known — safety concerns related to childbearing potential, women's ability to make their own decisions about treatment options that best fit their life circumstances and beliefs is severely limited. By contrast, nondirective counseling is a key strategy for ensuring that women are empowered to participate in their own health care decisions. Health care providers taking this approach lay out information and clearly describe all the risks as they are currently known, along with options for avoiding or mitigating these risks.

Respecting the autonomy of women to participate actively in their own health care decision