

Regular article

How are addicted physicians treated? A national survey of physician health programs

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Abstract

Introduction: Physicians with substance use disorders receive care that is qualitatively different from and reputedly more effective than that offered to the general population, yet there has been no national study of this distinctive approach. To learn more about the national system of Physician Health Programs (PHPs) that manage the care of addicted physicians, we surveyed all 49 state PHP medical directors (86% responded) to characterize their treatment, support, and monitoring regimens. **Results:** PHPs do not provide substance abuse treatment. Under authority from state licensing boards, state laws, and contractual agreements, they promote early detection, assessment, evaluation, and referral to abstinence-oriented (usually) residential treatment for 60 to 90 days. This is followed by 12-step-oriented outpatient treatment. Physicians then receive randomly scheduled urine monitoring, with status reports issued to employers, insurers, and state licensing boards for (usually) 5 or more years. Outcomes are very positive, with only 22% of physicians testing positive at any time during the 5 years and 71% still licensed and employed at the 5-year point. **Conclusion:** Addicted physicians receive an intensity, duration, and quality of care that is rarely available in most standard addiction treatments: (a) intensive and prolonged residential and outpatient treatment, (b) 5 years of extended support and monitoring with significant consequences, and (c) involvement of family, colleagues, and employers in support and monitoring. Although not available to the general public now, several aspects of this continuing care model could be adapted and used for the general population. © 2009 Elsevier Inc. All rights reserved.

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1. Introduction

Among physicians, there is a lifetime prevalence of substance use disorders (SUDs) of approximately 10% to 12%, very similar to the general population rate (Flaherty & Richman, 1993; SAMHSA, 2006). Specialty care and supervision for addicted physicians were initially proposed

and initiated in 1973 by the American Medical Association to help physicians and to protect the public with the publication of "The Sick Physician: Impairment by Psychiatric Disorders, Including Alcoholism and Drug Dependence." That document encouraged the growth of specialized, state Physician Health Programs (PHPs) in 49 states, managed via authority typically granted under charter from the state Licensing Boards, "...to provide advocacy for physicians and ... to protect the public" (www.ama-assn.org/go/fsphp; White, DuPont, & Skipper, in press).

Given the potential public health and safety issues associated with addiction among physicians, it is surprising that despite the many studies of single-state PHPs (e.g., Bohigan, Croughan, & Bondurant, 2002; Domino et al.,

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2005; Fletcher, 2001; Reading, 1992; Selander & Epstein, 1983), there has been no study describing the national program of PHPs or the nature of treatment and monitoring provided. In this regard, it might be expected that physicians with a SUD receive essentially the same type and duration of treatment that other addicted individuals receive. This is generally the case in all other areas of health care. If so, there is reason for concern because studies of addiction treatment in the general population have consistently shown relapse rates of 40% to 60% following treatment (Finney, Ouimette, Humphreys, & Moos, 2001; Institute of Medicine, 2006; McLellan, O'Brien, Lewis, & Kleber, 2000; Project MATCH, 1997; Simpson, Joe, & Brown, 1997).

However, it appears that the care and management of addicted physicians, as coordinated through these PHPs, may be qualitatively and quantitatively different from the care available to the lay public (see Domino et al., 2005; Gold, Pomm, Kennedy, Jacobs, & Frost-Pineda, 2002; Skipper, 1997). Moreover, the available outcome studies of PHP-managed addicted physicians have reported remarkable results—much superior to those found in other populations of addicted patients or from other forms of addiction treatment. Specifically, one outcome study reported abstinence rates of 78% over 11 years (Domino et al., 2005), whereas another reported a 90+% success rate over 5 years (Shore, 1987).

Indications of qualitative differences in the way care is provided, coupled with indications of substantially better results, led us to several evaluation questions. How do these programs operate? What is their structure? Are the programs similar across states? and What are the factors potentially responsible for the widely reported better outcomes? With these questions in mind, we approached the Federation of State Physician Health Programs (FSPHP) to undertake a comprehensive, nationally representative evaluation of the structure and function of these PHPs. Here, we characterize the legal, financial, administrative, and clinical structure of 42 PHPs nationwide, with a description of the course of care, support, and monitoring provided by these programs. We report some of the more salient 5-year results here, but a second article (McLellan, DuPont, & Skipper, 2008) is devoted to a full report of the 5-year outcomes on a consecutive sample of more than 900 addicted physicians from 16 state PHPs.

2. Methods

2.1. Involvement of the FSPHP

The FSPHP was approached with a request for assistance in completing a descriptive survey of all state PHPs. A steering committee involving members of seven PHPs was formed to advise us on the content of the questionnaire and on the data collection procedures. The steering committee also encouraged all PHPs to participate in this independent evaluation.

2.2. Questionnaire development

Following Institutional Review Board approval, a 38-item questionnaire was sent to the Medical Directors of all 49 active PHPs in April 2005. The questionnaire, pretested by a small group of PHPs, was organized into three content areas: financial and legislative aspects of the organization, physician participant profiles, and types of services provided.

2.3. Survey procedures

Questionnaire submission was followed by telephone contact to promote participation, clarify questions, and assure understanding of responses. Complete questionnaires were received from 39 of 49 PHPs, and an additional three partially completed questionnaires were obtained from 3 others for an 86% response rate. All returned questionnaires were examined by independent research staff for completeness and consistency. Blank or confusing responses were resolved by calls from the authors to verify understanding of the question and the validity of the responses.

3. Results

3.1. PHP goals

All responding PHPs shared the common goals of early detection of SUDs, thorough assessment and evaluation of potential cases, referral to abstinence-based treatment, long-term contingency monitoring, and reporting monitoring results to credentialing agencies (i.e., medical groups, hospitals, malpractice companies, health insurance companies, and so on) concerned with assuring that physicians are able to practice with reasonable skill and safety. There was essentially complete uniformity of these goals across all surveyed programs.

3.2. Organization

Most PHPs were independent, nonprofit foundations (54%), and the others were components of the state medical association (35%) or the licensing board itself (13%). Regardless of the organizational charter, all PHPs had written operating agreements with their state licensing boards to act on their behalf in the management of addicted physicians, and 59% of these PHPs had independent legal authority based on specific state laws.

3.2.1. Personnel

The average number of paid, full-time equivalent employees per PHP averaged 5 (range = 1–19, *Mdn* = 3) including medical directors, clerical support, administrators, counselors, and case managers.

3.2.2. Budget

The average annual operating budget for a PHP was approximately \$538,000, although this varied substantially (range = \$21,250–\$1.5 million, *Mdn* = \$270,000). The sources for these operating funds included licensing boards (50%), participant fees (16%), state medical association (10%), hospital contributions (9%), malpractice companies (6%), and other (9%). These PHP budgets did *not* include most treatment or drug testing, which were borne by the participants themselves. About half of programs received at least part of their funding from participants, but the other half charged nothing to participants.

3.2.3. General services

All PHPs provided general addiction education programs for all physicians in their state, as well as consultation with hospitals and clinics, informal investigations, careful evaluation of addiction treatment programs as referral sites, and most importantly, long-term monitoring. As part of their general services (both to the state licensing boards as well as to the physician participants), all PHPs maintained records documenting participant abstinence (drug testing and work-site surveillance) and participation in the various therapeutic and monitoring aspects of the program. These records were regularly provided to the licensing boards, hospitals, and malpractice carriers who required this evidence as a condition of participants' continued ability to practice medicine.

3.3. Description of addicted physicians

PHPs reported admitting an average of 34 new physicians with SUDs per year, per program (range = 0–150 cases, *Mdn* = 21). PHPs reported an average active caseload of 138 physicians under monitoring contracts (range = 9–541, *Mdn* = 86). Although all PHPs dealt with SUDs, only 12% focused exclusively on those problems. Most also worked with physicians who have mental illness (85%), physical illness (62%), and other potentially impairing conditions (for example cognitive deterioration). About a third (36%) handled only physicians, whereas the remainder also dealt with other health care professionals such as dentists (51%), veterinarians (33%), and pharmacists (21%).

3.3.1. Referral sources and conditions

The four major sources of referrals to PHPs in 2005 were self-referrals (26%), clinical colleagues (20%), the state licensing board (21%), and the hospital medical staff (14%). Other referral sources (17%) included treatment providers, medical schools, law enforcement officials, family members, attorneys, and other PHPs. Regarding levels of coercion, it was interesting that only 31% entered care through a formal stipulation or mandate from a regulatory or licensing authority. It is safe to say that all were coerced, with the remainder entering care due to some combination of informal pressures by colleagues or family. Regardless of referral source or condition, all physician participants were required

to sign a contract specifying the nature and duration of their treatment and monitoring, as well as the consequences for failing to abide by the contract (see below).

3.3.2. Problems at admission

The most common primary drugs of abuse were alcohol (50%) and opioids (35%). The other 15% of cases reported stimulants, sedatives, marijuana, and other drugs. Across PHPs, an average of 31% of these physicians had problems with both drugs and alcohol. Programs reported that about half (48%) also had co-occurring psychiatric disorders and/or pain problems. However, the range was large (1%–75%), possibly reflecting the diversity of attention paid to these issues by the various PHPs.

3.4. Description of addiction care

The typical course of care for an addicted physician involved a progression through three stages: initial evaluation and intervention (i.e., convincing a physician to sign a contract and enter care when warranted), formal treatment (at a specialty treatment program), and finally, long-term support and monitoring.

3.4.1. Evaluation and intervention

The first phase of PHP involvement took place prior to any treatment and generally involved discussions with colleagues, family, or employers who were considering referring a physician with suspected SUD. An intervention with the identified physician followed. In these interventions, the medical director or other senior person from the PHP discussed the issues raised, with the identified physician leading to a formal evaluation. These formal evaluations generally included a full diagnostic interview with collateral assessment for substance use and other psychiatric and medical conditions. The results of that evaluation guide the next steps including a discussion of the options, referral for treatment as indicated, eventually followed by a formal PHP treatment and monitoring contract.

3.4.1.1. The contract. A specific and important feature of these PHPs was the development of a formal, signed contract that specified in detail the care, support, and monitoring activities that the participant would have to participate in over the (usually) 5 years of the program. In addition, this contract specified the consequences that would occur upon failure to comply with the plan and/or return to alcohol or drug use. These consequences were different depending upon the conditions of the referral and the severity of the addiction problem, but at the minimum, failure to comply resulted in the following: (a) further evaluation and/or treatment, (b) reporting to the state licensing board, and (c) more serious consequences that would be determined by that board based upon the nature of the noncompliance.

An important additional part of this contract was the “safe harbor” provision that most contracts held. Most physicians

were referred to the PHP because of some serious alcohol or drug related incident or infraction that might result in immediate censure or even loss of license. Thus, as an additional incentive to enter care and monitoring, entering treatment and signing the contract under the auspices of the PHP generally led to postponement or deferral of pending legal employment or family sanctions—as long as the conditions of the treatment and monitoring plan were adhered to—thereby providing the accountability and oversight necessary for public safety. PHPs stressed that they provide a supportive, collegial approach but with firm boundaries based on program policies throughout the period of PHP care.

3.4.2. Formal treatment

Working through the FSPHP, the PHPs network to identify the most appropriate and effective treatment centers around the country for these physicians. Most state PHPs refer to the same five to seven treatment programs. This arrangement brings these treatment centers into long-term relationships with the PHPs and creates accountability to PHP to established standards and outcomes. Despite differences in the duration, intensity, and the complement of addiction services used, all PHPs require total abstinence from alcohol use and from nonmedical drug use.

The first phase of formal addiction treatment for two thirds of these physicians (69%) was residential care often for 90 days. The remaining 31% began treatment in an intensive day treatment setting. The participants at this stage usually received multiple intensive sessions of group, individual, and family counseling as well as an introduction to an abstinence-oriented lifestyle through required attendance at Alcoholics Anonymous (AA), Narcotics Anonymous (NA), and Caduceus meetings (a collegial support association for recovering health professionals) and other mutual-aid community groups. Frequent status reports on treatment progress were required by most PHPs.

3.4.2.1. Pharmacotherapy. Use of pharmacotherapy as a component of treatment for SUDs was rare. Very few of the treatment programs or the medical directors of the PHPs used any of the available maintenance or antagonist medications. On the other hand, PHPs indicated that as many as one third of participating physicians received antidepressant and nonbenzodiazepine antianxiety medications during their care.

3.4.3. Long-term support and monitoring

After completion of initial formal addiction treatment, all PHPs developed a continuing care contract with the identified physician consisting of support, counseling, and monitoring for usually 5 years. Most PHPs (95%) also required frequent participation in AA, NA, or other self-help groups and verification of attendance at personal counseling and/or Caduceus meetings. Most PHPs (70%) also required work-site monitors (a neutral, nonsubordinate party in proximity to the physicians' work site) to provide regular reports to the PHP (Talbot & Wright, 1987).

3.4.3.1. Drug testing. Physicians were tested randomly throughout the course of their PHP care, typically being subject to testing 5 of 7 days a week. Procedurally, they were required to call a telephone number each workday and were then informed whether to report for testing that day based on a random selection. Even if they were tested the day before a call, they could be retested again the next day. Most PHPs subcontracted with third-party administrators to conduct random, witnessed, chain of custody drug testing. Physicians were typically tested an average of four times per month in the first year of their contracts for a total of about 48 tests in the year. By the fifth year, the average frequency of testing was about 20 tests per year.

Most PHPs (95%) reported using urine as the primary substance for drug testing; however, hair (50% of PHPs), breath (21%), saliva (18%), and blood (3%) were also used. Drug test panels varied, with about half (52%) using a 20+ "health professional drug panel" for each of their tests, and 30% reported fewer drugs tested, and only about 5% of PHPs tested only for the physician's specific drug(s) of choice. Two thirds of the PHPs (68%) routinely used ethyl glucuronide, a new test to better detect recent alcohol exposure.

3.4.3.2. Other monitoring activities. In addition to the drug testing, participating physicians were expected to attend appointments with the PHP for ongoing clinical care and evaluation. Unannounced visits to the work site were also included in monitoring plans. Depending upon the specifics of each individual contract, it was possible for PHPs to also receive regular reports from colleagues and family members.

3.5. Dealing with relapse

PHPs were uniformly aggressive in the management of relapse. Relapse was defined broadly beyond reuse of alcohol or drugs to include noncompliance with program requirements or poor reports from work-site monitors and dealt with using a variety of responses tailored to the specifics of the case. For example, a Level I relapse consisted of missing therapy meetings, dishonesty, or other behavioral concerns. Level II relapses involved reuse of drugs or alcohol, but outside the context of medical practice. Level III relapses involved substance reuse within the context of practice.

Level I relapses (generally failure to attend appointments or lying) were usually addressed by a combination of increased intensity of care and monitoring and by immediately informing family and colleagues of the physician to enlist their support in promoting compliance with the contracted behavioral changes. The most common response (88%) to a Level II relapse (detected alcohol or drug use) was to recommend discontinuation of work to undergo a reevaluation. For physicians whose care was formally stipulated, 65% of PHPs said they were required to report even the first relapse to the medical board or licensing agency.

PHPs were also asked about their responses when there was repeated evidence of relapse. Again, the most common

response (82%) was to conduct a reevaluation including a search for previously unrecognized co-occurring addictions or psychiatric illness, which could impede sustained recovery. This process often resulted in recommendations for additional treatment and monitoring. For formally stipulated physicians, 70% of PHPs reported the positive tests to the licensing board. This reporting was typically accompanied by intensified addiction treatment and drug test monitoring. Only about 50% of the PHPs reported positive drug tests to licensing boards for nonstipulated participants.

3.6. Relapse rates

As part of a separate outcome study of these programs and patients, we performed a retrospective 5-year follow-up on a 100% intent-to-treat sample of 904 physicians admitted to 16 of these programs in 2001 (McLellan et al., 2008). That study examined all urine testing records of those physicians throughout their 5-year period of monitoring to determine the prevalence of Level II relapses (detected drug or alcohol use).

Over the 5-year period, 22% of physicians had at least one detected instance of alcohol or drug use. As indicated, the detection of substance use usually resulted in more intensive treatment and monitoring, and among those whose substance use was detected, only 26% had a repeat positive test during the 5 years. At the 5-year follow-up, 71% of this sample were working and licensed; 18% had retired or had their licenses revoked, had retired, or died; and 5% had an unknown status (see McLellan et al., 2008).

4. Discussion

PHPs have been established in 48 states and the District of Columbia to prevent substance abuse problems among physicians and to detect, intervene, refer to treatment and continuously monitor recovering physicians with SUDs. These PHPs do not provide formal addiction treatment themselves but instead function as active, long-term case managers and monitors for physician participants. The significant public health and safety issues associated with physician addiction have been the subject of intense public and professional interest (see Hasemeyer, 2007; Wohlsen, 2007) and make an understanding of the structure, function, and effectiveness of PHPs a high priority for the medical community, for regulatory agencies, and for the public at large.

Despite the public health importance and the uniqueness of this model of treatment, published studies of recovering physicians have been performed by single-state PHPs (e.g., Bohigan et al., 2002; Domino et al., 2005; Fletcher, 2001; Selander & Epstein, 1983; Reading, 1992). With the cooperation and consent of the FSPHP, we undertook a nationally representative study of PHP (administrative, treatment, monitoring, support, and sanctioning procedures), collecting data from 42 of 49 active PHPs in the country.

An important part of our original intent in undertaking this study was to examine different organizational or procedural subgroups of programs to see if these differences accounted for outcome differences. However, the first and in some ways the most interesting finding was that despite some differences in their operating and reporting structures, virtually all of the PHPs examined reported common goals, treatment philosophies, and referral strategies and very similar monitoring and reporting procedures. In this regard, essentially all PHPs work directly with referring professional societies, medical centers, colleagues, and families to assess and intervene with affected physicians to convince them of the need for professional, long-term care. A second important and common feature all PHPs is the development of a signed contract between the PHP and the physician participant, specifying in detail the elements of care and monitoring as well as the reporting practices of the PHP and potential consequences for noncompliance. A third common feature is referral to formal, abstinence-oriented treatment, usually to carefully selected residential programs. Following formal treatment, all PHPs continue individualized care, support services, and particularly monitoring (through drug and alcohol testing and work-site monitoring) for usually 5 years. Recovering physicians in all the PHPs studied were encouraged to continue attendance at AA, NA, and Caduceus meetings. Return to the use of alcohol or other drugs leads to swift clinical reevaluation, usually intensification of treatment and monitoring and sometimes reporting to state licensing boards.

Although essentially all these physicians were coerced into signing a PHP contract and entering treatment, it was interesting that only about one third were formally stipulated by a licensing board. The remaining physicians participated due to significant but less formal pressures from colleagues, medical centers, or family. The power of this initial coercion coupled with the temporary “safe harbor” provided by the PHP from potential legal, family, or employment actions appeared to be effective in getting physicians to enter and to comply with initial recommendations for evaluation, treatment, and monitoring. There was also continuing involvement of the physician’s family, close colleagues, and employers during the course of the physician’s treatment and monitoring, receiving regular reports on progress and treatment expectations. It is likely that the combination of formal and informal social supports and pressures over the extended period of the PHP contract were significant contributors to the remarkable results seen (see McLellan et al., 2008).

This type of care and these results are not typically found in studies of public addiction treatment. To illustrate, a recent national study by the Department of Veterans Affairs found that greater than 90% of care offered is provided in outpatient programs operating from 3 to 20 hours per week, for an average duration of only 14 days and with very little systematic use of drug testing (Finney, Willenbring, & Moos, 2000; Finney et al., 2001). Similarly, a study of insured, employed, addicted patients treated within the Kaiser system

indicated little use of residential care or urine testing and average outpatient treatment durations that were generally less than 60 days. Although patients were encouraged to attend AA, there was essentially no continuing care or monitoring linked to significant consequences for noncompliance available (Weisner et al., 2000).

Even court-mandated treatments for addicted individuals typically do not include the intensity or duration of supports and monitoring seen in PHPs. For example, more than 5000 drug court programs for drug-affected, nonviolent offenders with SUDs offer the opportunity to complete a year of addiction treatment and monitoring in lieu of incarceration for their drug-related crimes. That treatment occurs in outpatient settings, employing group counseling and referral to AA/NA but also regular urine monitoring. At biweekly to monthly hearings, the presiding judge reviews the offender's attendance and urine test results, with graduated sanctions meted out in cases of poor response. Although individual and national evaluations of drug court programs have reported very favorable results during participation (i.e., no arrests or incarcerations, few positive urine test results), greater than 48% of these clients relapse and 31% are rearrested in the 1 year following the end of supervision (Belenko, DeMatteo, & Patapis, 2007). In contrast, our evaluation of outcomes among 904 addicted physicians treated in a subset of 16 of these PHPs found 78% had completely negative urine test results throughout 5 years and 71% were still practicing medicine at the 5-year point.

5. Conclusion

These findings suggest that affected physicians, the medical community, and the public at large are well served by these PHPs—and lead to many questions about the “active ingredients” that may be responsible for these results. Of course addicted physicians enjoy educational, employment, financial, and social benefits that are not typical of the population at large or of the population of addicted individuals in treatment. Some of these advantages are characteristic of the physicians themselves, but an additional advantage is health insurance and personal resources that make high-quality care possible for extended periods. It is likely that these benefits by themselves offer a substantially better prognosis than seen in other treated populations. However, it is difficult to dismiss the effects of the qualitatively and quantitatively enhanced care received by physicians in accounting for the very favorable and enduring benefits.

It is both gratifying and concerning that the treatment and management of addicted physicians are qualitatively and quantitatively different from the standard addiction care available to the public. Although some elements of the PHP approach to addiction treatment and management are likely to remain quite unique, several of these elements (e.g., intensive residential and outpatient treatment; involvement of family, close colleagues, and perhaps employers; frequent, long-term, random drug and alcohol testing with aggressive

therapeutic management of relapses) could be employed more broadly and should improve the outcomes of standard addiction treatments. Is it fair or even reasonable that only physicians and some other high social status groups should be eligible to receive truly comprehensive addiction treatment?

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