WPHP Report: Medications for Opioid Use Disorder in Monitored Health Professionals

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In August 2019, the New England Journal of Medicine (NEJM) published an opinion piece that accused physician health programs (PHPs) of a blanket ban on opioid agonist therapy for physicians under monitoring agreements.[1] The authors went on to speculate as to the causes and consequences of this supposed ban despite the fact that there was no systematic data to support their conclusions, the authors had no experience working in physician health programs, and no effort was made to communicate with the Federation of State Physician Health Programs (FSPHP) to learn about PHP practices.

The article ran alongside another NEJM story about a medical student with opioid use disorder (OUD) who lost his life to an opioid overdose.[2] The moral of this second story might easily have been about how referral to a PHP could have saved the student's life. Instead, the implication was that PHPs were denying physicians lifesaving care with tragic consequences.

A firestorm of self-righteous, polarized, PHP bashing ensued on social media, signaling to the larger media outlets that PHPs might be up to something nefarious. National Public Radio picked up the story and in short order I found myself being interviewed for *All Things Considered*. In my letter to the editor of the NEJM, published somewhat later, I expressed concern that physicians would be discouraged from seeking PHP assistance because of such misinformation, that the article might have done more harm than good.

Fast forward to March of this year when the Department of Justice (DOJ) ruled that the Indiana Nursing Board violated Title II of the Americans with Disabilities Act (ADA) by prohibiting nurses who have been prescribed medications for opioid use disorder (MOUD) from participating in the Indiana State Nursing Assistance Program. That decision put regulators and monitoring programs on notice that blanket policies banning MOUD would probably not hold up under legal challenge. In my opinion, the DOJ was right in its decision. Policies that preclude the use of specific medications are undesirable and difficult to defend.

However, in its ruling, the DOJ overstepped by going out of its way to spotlight methadone and buprenorphine as "safe and effective when taken as prescribed." In so doing, the DOJ risked giving these medications special legal status, perhaps even protection, without the requisite expertise. For example, the ruling failed to acknowledge that opioid agonist/partial-agonist medications are often *not* taken as prescribed and that these medications have unique monitoring risks and challenges compared to long-acting injectable naltrexone (LAI naltrexone, an opioid antagonist). MOUD options are not all created equal when it comes to safety-sensitive workers and the decision often involves consideration of multiple medical and occupational variables. Uninformed opinions and policies, driven by attorneys, regulators, and medical pundits can interfere with sound medical decision-making.

In January of this year, the FSPHP published its position statement, "Safety Considerations for Medication Treatment of Opioid Use Disorders in Monitored Health Professionals." It was developed by a special advisory panel chartered by the FSPHP Board of Directors and involved an extensive review of the literature as well as internal and external reviews and feedback. The position statement provides clarity and guidance to support the rehabilitation and safe practice of physicians with OUD and includes the following conclusions:

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1. FDA-approved medications for the treatment of OUD should be available to all patients including healthcare professionals.
2. PHP participants with OUD experience excellent outcomes with and without medication treatment.
3. A treatment provider and patient must always make case-specific, shared decisions that consider the risks, benefits, and alternatives of proposed treatment options for opioid use disorders, including opioid antagonist and agonist/partial agonist medications.
4. Effective communication, collaboration, and accountability among the participant, treatment providers, and the physician health program are critical to addressing the health needs of the medical professional while decreasing the risk of impairment.
5. LAI naltrexone is the preferred medication for monitored health professionals from the perspective of clinical performance and safety to practice. It has an established record of safe and effective use in this population. LAI naltrexone has no abuse potential, adherence is easily verified, there is no evidence to suggest cognitive or functionally impairing side effects, and it is highly protective against a return to opioid use, opioid-related impairment, and overdose.
6. Further research investigating the safety and efficacy of FDA-approved medications and non-pharmacologic treatment modalities for OUD in monitored healthcare professionals is needed.
7. Additional education and outreach is recommended to assist the treatment providers of monitored health professionals to address the unique needs and circumstances of this population.

For a time, I was perturbed by the unfair characterization of PHPs in the NEJM article. However, in retrospect, it did galvanize the FSPHP, its member PHPs, and others to set the record straight. Some programs needed to look carefully at their policies, evaluate the rationale of their practices, and confront some biases. While there never has been a systematic prohibition against opioid agonists among PHPs, there was a lack of clarity and communication regarding best practices that might have prevented a misleading idea from taking hold.

WPHP does not have policies that ban any specific medications for OUD and we strongly support the use of medications for opioid use disorder (MOUD) for all program participants with OUD. We work closely with our participants and their treatment providers to ensure that treatment and monitoring plans are tailored to individual needs. We recognize that LAI naltrexone can be cost-prohibitive for some, cause intolerable side effects, or otherwise may not be the best MOUD option. In those cases, participants can be successfully monitored on buprenorphine without compromising their safety to practice.

Nothing here is intended to suggest the inferiority of buprenorphine for the treatment of OUD in the general population. Without question, buprenorphine is an excellent treatment choice. It decreases the risk of death from overdose, reduces communicable disease transmission from injection drug use, and decreases incarceration for drug-related offenses. In addition, patients are often more successful in initiating treatment with buprenorphine than naltrexone because the latter requires full opioid detoxification prior to starting. However, for health professionals with OUD who usually initiate MOUD in a structured, high-intensity treatment setting, LAI naltrexone induction is highly successful. Once successful induction has occurred, LAI is as effective as buprenorphine. So, for this group, the risk/benefit profile usually favors LAI naltrexone. Recognizing the advantages of LAI naltrexone from a monitoring perspective should not diminish or stigmatize buprenorphine or methadone. That makes about as much sense as saying that wearing gloves stigmatizes mittens.

While I cannot speak for all PHP policies or practices, experience tells me that, like WPHP, most PHPs and other monitoring programs embrace MOUD. In the coming months, FSPHP will be partnering with the American Medical Association and the Federation of State Medical Boards to further study and characterize MOUD practices among PHPs and regulators. Such data can help us evolve best practices and promote consistency and excellence in the management of this complex problem. I look forward to having data, rather than speculation, to guide us forward.

WPHP can provide help and hope for physicians and PAs struggling with opioid addiction. With fentanyl replacing the U.S. heroin supply, resulting in record-high opioid overdose deaths, now is the time to get help and treatment for opioid addiction. Remember, we are always just a click or phone call away.

Web: www.wphp.org

Toll-free: 800-552-7236 (24/7)

1. Beletsky L, Wakeman SE, Fiscella K. Practicing What We Preach — Ending Physician Health Program Bans on Opioid-Agonist Therapy. *New England Journal of Medicine*. 2019;381(9):796-798. doi:10.1056/NEJMp1907875

2. Lucey CR, Jones L, Eastburn A. A Lethal Hidden Curriculum — Death of a Medical Student from Opioid Use Disorder. *New England Journal of Medicine*. 2019;381(9):793-795. doi:10.1056/NEJMp1901537