



ASAM

American Society of Addiction Medicine

Public Policy Statement on Relapse in Healthcare and Other Licensed Professionals

(This is the eleventh in a set of eleven policy statements of the American Society of Addiction Medicine addressing Healthcare and Other Licensed Professionals with Addictive Illness)

Definitions

- a) For the purposes of this document “relapse” is defined as the recurrence of behavioral or other substantive indicators of active disease after a period of remission in a healthcare or other licensed professional with the disease of addiction
- b) Addictive illness is a biochemical, psychosocial, genetically-influenced primary illness hallmarked by loss of control or continued use of mind and/or mood altering substances, regardless of negative consequences frequently accompanied by a powerful denial of the existence and effects of the illness.

Background

Addictive illness is a stigmatized malady misunderstood and encumbered by myth and misinformation based on antiquated beliefs from the 18th, 19th and early 20th centuries. Today, science teaches us that addiction is a primary illness – a neurobiochemical brain disease manifest by disturbances of motivation and reward. Addiction treatment programs (ATPs) and Physician Health Programs (PHPs) work to assist their professional patients with the critically important step of moving beyond the moral “good versus bad” view of their illness into the healthier “illness vs. wellness” disease model supported by evidence based research. ATPs and PHPs understand that the recovering healthcare or other licensed professional who remains emotionally entrapped in the moral model of addiction is at an increased risk of relapse as a result of this erroneous view of the illness. The associated reliance on self-will of the moral model is less therapeutic and efficacious than the disease model which emphasizes honesty and reliance on others including peers, sponsors in recovery, treatment professionals, advances in treatment methods and the healthcare professional’s PHP.

Historically, many regulatory agencies and the healthcare community have viewed addictive illness from the moral model perspective; reacting to the illness based on resulting behaviors occurring during active illness. Naturally, this has kept regulatory agencies (RAs) in a

disciplinary approach to addiction and relapse as “bad behavior” warranting censure. Outdated beliefs hold that punishing the professional sends a message correcting aberrant behavior while serving as a warning to others. For example, public consent orders have referenced “moral turpitude” and “behavior intended to deceive, defraud, and harm the public”. Human beings, including healthcare and other licensed professionals, with active addictive illness sometimes behave in ways contrary to societal norms and professional expectations. Disease-driven aberrant behavior typically resolves following successful intervention and treatment. Ironically, public orders referencing such historical and now obsolete information re-enforces the moral model of addiction. These are the very ideas and attitudes the PHPs and ATPs work so diligently to extinguish during treatment and continuing care phases of recovery. Toxic shame is not conducive to sustained remission or public safety.

Addiction like many other chronic illnesses, such as asthma and diabetes, is a relapsing illness. Fortunately, healthcare and other licensed professionals receive excellent treatment and state of the art continuing care resulting in significantly fewer relapses than seen in other populations (See Domino and McLellan). Notwithstanding, stakeholders working with professionals with addictive illness do see relapse and manage their occurrence. In fact, relapse in healthcare and other licensed professionals with addictive illness can be a therapeutic event leading to the elimination of lingering reservations or residual denial so common with addictive illnesses. With this broader understanding, all stakeholders benefit by the adoption of an effective treatment and monitoring response benefiting the professional’s recovery and the public health, safety, and welfare.

Through effective PHP monitoring, relapse is typically discovered behaviorally prior to readministration of addictive substances or during the early phase of attempted “controlled use” and most commonly outside the context of active professional duties. At this point of early detection, the illness has not typically progressed to functional impairment. The once held common fear that patients would be harmed has proven to be unfounded. The Domino and McLellan studies failed to demonstrate patient harm in over 12,000 cases studied of recovering physicians in monitoring, including those who experienced relapse. Healthcare and other licensed professionals preserve their function in the workplace, remarkably well until later stages of the disease manifests. Lastly, anecdotal reports from malpractice carriers support the lack of evidence of patient harm reporting allegations of both active impairment and patient harm due to addiction as being extremely rare. These facts warrant a paradigm shift in viewing the phenomenon of relapse.

The American Society of Addiction Medicine recommends:

- 1) Healthcare and other licensed professionals with addictive illness and especially those who experience relapse have an obligation to obtain any necessary evaluation, treatment, and continuing care monitoring and should fully cooperate with RAs, ATPs, and PHPs through this process.
- 2) PHPs must have effective mechanisms in place for the early detection and expedient addressing of relapse before illness progresses to overt impairment.

- 3) With the understanding of the potential of relapse, PHP continuing care contracts should contain a clause of portability enabling the PHP to report to another state PHP and/or RA any relocation of a monitored healthcare or other licensed professional.
- 4) The PHP and RA should, within their memorandum of understanding, clearly articulate a mutually agreeable therapeutically effective management and reporting process to be followed in the event of relapse.
- 5) PHPs must understand, respect and support the mission of the RA to protect the public. Any concern of continued active use should prompt the PHP to demand immediate withdrawal from practice pending further evaluation. Failure of the physician to fully immediately cooperate must result in an immediate report from the PHP to the RA.
- 6) RAs should understand that relapse is not willful misconduct but a recognized part of addictive illness warranting further intervention; additional treatment; and/or enhanced monitoring. RAs are encouraged to consider relapse in the context of the illness and understand that public disciplinary action is not routinely indicated and can prove counterproductive.
- 7) RAs are encouraged to work closely with the PHP regarding all aspects of monitoring and rely on the PHPs professional opinion regarding relapse, level of intervention indicated, and the ability of the professional to subsequently engage in their profession safely with or without restrictions.