American Academy of Addiction Psychiatry

Translating Science. Transforming Lives.

January 12, 2021

VIA EMAIL-dtakanis@hawaii.edu

Danny Takanishi, Jr., MD
John A. Burns School of Medicine, Department of Surgery
University of Hawaii
Queen's University Tower
1356 Lusitana Street, 6th Floor
Honolulu, HI 96813

Dear Dr. Takanishi:

We are writing on behalf of the leadership of the American Academy of Addiction Psychiatry (AAAP), the foremost professional association for addiction psychiatrists in the United States.

We applaud the FSMB for guidance that encourages treatment rather than punishment for impaired physicians and believe overall that the guidance sets the right tone in dealing with these issues.

However at times the language is sufficiently vague and will allow for misinterpretations or applications that could have devastating consequences to physicians considering seeking care, whether impaired or not.

We submit the following recommendations, somewhat in order of importance:

1. The section on Reporting, beginning at line 142, seems at odds in both tone and content with much of the rest of this document. Compelling treating clinicians to report colleagues to the board may in some cases only have the effect of driving physicians away from treatment. Moreover, the very next section of this paper focuses on voluntary mechanisms of engagement with Physician Health Programs (PHPs) as a way of encouraging treatment. We suggest that this section should indicate that, in the absence of an imminent threat to the safety of patients, colleagues—including treating physicians—should encourage self-enrollment in a PHP program, in lieu of reporting to the Board. Otherwise the language as currently written could directly imperil the liberty and best interests of physicians in need of treatment.

400 Massasoit Ave, Suite 307 East Providence, Rhode Island 02914
www.aaap.org • Phone: 401-524-3076 • Fax: 401-272-0922

2a. While we applaud the FSMB for opening the door to MOUD in this proposed revision, the text is not reflective of the current evidence base or standard of care for treating OUD. MOUD is the gold standard of care for persons with OUD. The text that MOUD is, “generally recognized as being an important component of quality treatment” is not accurate. In actuality, the ASAM practice guideline says: “All FDA approved medications for the treatment of opioid use disorder should be available to all patients.” Likewise the 2019 NASEM report states “there is no scientific evidence that justifies withholding medications from OUD patients in any setting.” The guidance should be written to emphasize that treating clinicians should have access to prescribing the full armamentarium of medications to treat OUD (including agonist and antagonist based medications), as some patients respond better to one versus another medication. We strongly encourage the FSMB to take a clearer stand on enhancing and ensuring access to these lifesaving medications, including all physicians in treatment irrespective of PHP or Board involvement. We remain disappointed that PHPs in many states have a blanket ban on agonist MOUD (e.g. buprenorphine and methadone). We see opportunity in these revised guidelines to address this problem.

2b. We suggest moderating several claims about the supposed dangers of MOUD (for instance there is no high quality evidence that methadone’s “characteristics include the potential for cognitive impairment”). Fear of cognitive impairment from opioids is greater than the reality of the risk, and can be mitigated by routine, ongoing cognitive monitoring or simple testing, which is a part of standard monitoring. Many other commonly prescribed medications that are not addictive are more frequent causes of cognitive problems (e.g. anticonvulsants).

3. Lines 199-200 say that one of the situations that should trigger referral for assessment is “information or documentation of excessive use of alcohol or other potentially impairing drugs with addictive potential.” That emphasized phrase is unnecessarily limiting. A physician who excessively used psychedelic drugs, though they are not “addictive,” should be referred for assessment. Further as currently written, the text confuses an important distinction between the general use of psychoactive substances and the presence of impairment and/or addiction. We would suggest dropping those last three italicized words.

4a. We have concerns about the equivocating use of the term "impairment." A clear distinction is needed between an individual physician’s loss of function versus impairment that may imperil patient outcomes. Impairment should be kept as a clear concept that implicates patient care. The other matters could be simply categorized as loss of function due to illness. That is, for instance, "Loss of function due to illness exists on a continuum. At the more severe end of that continuum loss of function due to illness may cause impairment."

4b. At lines 34-35, impairment is defined as being caused by “mental illness, physical illnesses, including but not limited to deterioration through the aging process, or loss of motor skill…” The italicized phrase represents an outdated notion that aging per se causes deterioration, particularly mental deterioration. If the intent here, as we suspect, is to point to neurodegenerative conditions as a cause of impairment, a better way to phrase this—consistent with DSM-5 nomenclature—would be, “including but not limited to neurocognitive disorders…”

5. The cost of care for physicians when under PHP contract remains a concern in the field. Physicians should have equal access to affordable community-based care and should not be required to pay tens of thousands on specific programs or very high-cost testing that is far beyond ordinary care needs. This current practice places undue stress on physicians (and their families) attempting to recover good health while concurrently unable, in many cases, to sustain usual income sources. PHPs need to cultivate high-quality collaborative community care options as a main approach to care, rather than mandating people out of state, or requiring burdensome levels of high-cost tests. While those programs may have their place in the menu of options for some individuals, there should be affordable and local alternatives for those for whom this poses a true hardship.

6. While the FSMB priority under this guidance may be preventing and addressing impairment and the charge of state regulatory boards, it would be a welcome addition to expand sections on other pertinent topics that PHP's could address such as physician education, mental health, addressing burnout, retirement planning/life transitions, and suicide risk. The purpose of PHPs is not simply to prevent or address impairment, but to be a resource for the promotion of physician health and well-being. This is much more than "wellness" as many think of it. Receiving timely evaluations and help for common problems will help physicians become more likely to seek such help once sick and earlier in the disease course. It's the ongoing relationships with individual physicians and the physician community that enhance PHPs impact.

We thank you for taking our submissions under consideration. Please contact AAAP directly with any additional questions.

Sincerely

Kevin Sevarino, MD, PhD
President