ACMT Position Statement:
Allow Optimal Treatment for Healthcare Professionals With Opioid Use Disorder

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The position of the American College of Medical Toxicology (ACMT), is as follows:

The prevalence of opioid use disorder (OUD) in Healthcare professionals (HCP) is similar to that of the general population. Identification and treatment of OUD in HCPs is a public health and patient safety issue because HCP behavior impacts patient care. A person with OUD and active substance use may be impaired, that is unable to practice with reasonable skill and safety due to illness. However, when OUD is treated effectively, impairment may be resolved even though the diagnosis of OUD remains.

Opioid agonist therapy, specifically buprenorphine and methadone, are lifesaving treatments for OUD. HCPs should have access to the best treatments, including opioid agonist medications. There is a range of cognitive and psychomotor functional outcomes in patients receiving opioid agonists; the scientific literature does not support broadly categorizing HCPs receiving this therapy as impaired. Rather, fitness for work should be evaluated on an individual basis based on job requirements and the HCP's recovery status. We support the use of Physician Health Programs (PHPs), established by state medical boards to emphasize therapy over punitive action. When such programs offer all evidence-based treatments, including medications for opioid use disorder, they provide the best opportunity for HCPs to recover and serve their communities.

Healthcare professionals are not immune to opioid use disorder

There were more than 81,000 US overdose deaths in the 12 months ending May 2020, the largest ever in a 12-month period [1]. Illicit and (to a lesser degree) pharmaceutical opioids accounted for the majority of these deaths. HCPs, including physicians, pharmacists, nurses, and others, are neither immune to nor insulated from substance use. Although some medical specialties have higher rates of identified substance use disorders, rates of both substance use and addiction among HCPs generally parallel those of the general population [2,3]. Identification and treatment of substance use disorders in HCPs is a public health issue as their cognition and behavior impact the health of their patients. Provider impairment carries significant risk to patient safety.

Opioid use disorder does not equal impairment

The Federation of State Medical Boards (FSMB) states that substance use disorder causes impairment when the HCP is unable "to provide medical care with reasonable skill and safety." Impairment is considered to be a functional classification which exists on a continuum that can change over time [4]. A person with OUD who is engaged in active drug use may be impaired. However, with treatment, impairment may be resolved even while the diagnosis of substance use disorder (SUD) remains [4]. This model of illness aligns with the most current definitions of SUD and addiction [5,6].

Opioid agonist treatment should be available for patients with OUD

Accessible treatment for opioid use disorder (OUD) is required to address this cause of preventable morbidity and mortality. Opioid agonists, specifically methadone and buprenorphine, have been consistently demonstrated to reduce opioid-related harms [7,8,9]. Abstinence-based ("drug-free") and rapid-taper detoxification programs have been associated with increased relapse risk and increased risk of overdose death due to loss of tolerance [9,10]. Long-term opioid agonist treatment reduces risks of opioid-related mortality, all-cause mortality, treatment attrition, use of illicit drugs, and attendant health consequences.

Healthcare professionals should have access to the best treatments

Healthcare professionals deserve access to the same treatments that are considered best practice for their patients. Concerns around the effects of opioid agonist use in OUD have been used to justify only abstinence-based or antagonist-based approaches for HCPs. A blanket ban on agonist treatment (i.e., methadone or buprenorphine) cannot be justified given the evidence that agonist medication treatment is effective for the treatment of OUD and is compatible with current conceptualizations of recovery.

Opponents of opioid agonist therapy for HCPs have cited concerns about effects of opioids on cognitive or motor performance [11]. These concerns are reasonable, in consideration of the primacy of patient safety and the capacity for opioids to cause sedation and impair psychomotor task performance under certain conditions.

The scientific literature does not provide consistent evidence of impairment of task performance or functional outcomes in patients treated with opioid agonists for OUD. Patients treated for OUD with methadone or buprenorphine performed similarly to control subjects in most tests assessing driving aptitude, a complicated psychomotor task [12].There is overlap in functional outcomes (cognitive, memory, fatigue, occupational, social, and neurological) between patients treated with opioid agonists, untreated patients, and those without OUD [13].

Blanket practice restrictions for HCPs treated for OUD are inconsistent with our management paradigms for other health conditions. Practice restrictions are rare for other medications and health conditions that have the potential to cause impairment in some individuals. Rather than singling opioid use disorders and opioid agonists out from other health conditions or therapies, fitness should be evaluated on an individual basis based on specific duties required at work, the HCP's condition and their stage of recovery, and other special considerations such as practice environment. Fitness requirements for performing a surgical procedure are different from those

needed to conduct a patient interview. In some circumstances, access to opioids may play a role in determining fitness for return to work, depending on the overall course of the HCP's addiction. Individuals may be particularly vulnerable to relapse in practice environments with increased access to opioids, especially early in recovery. We advocate for functional evaluation to return to specialty-specific work, rather than wholesale rejection of opioid agonist therapy by HCPs.

Healthcare professionals should have access to Physician Health Programs that offer opioid agonist treatment

Physician Health Programs (PHPs) have been established in most states for oversight of HCPs with SUDs. Originally established for physicians only, some of these programs now offer support to other HCPs also. PHPs should provide a therapeutic alternative to disciplinary measures. These programs offer confidential monitoring, referrals to treatment, and advocacy. PHPs protect both HCPs and their patients. The available evidence shows that most physicians who access PHPs are able to practice medicine during 5 years of monitoring; only 1 in 10 had licensure revoked [14]. We support this management model, which emphasizes recovery over disciplinary action and allows HCPs to return to practice and serve their communities.

Despite this success, experts have expressed concerns that some PHPs do not use evidence-based treatments and are not transparent about outcomes or practices [15]. Many of these programs historically favored abstinence-based models, limiting the use of opioid agonist therapy [16,17,18]. If a PHP alternative is desired, the HCP should be treated in another setting by a physician (1) with expertise in managing addiction, (2) who is board-certified by the American Board of Preventive Medicine or American Board of Addiction Psychiatry, and (3) with monitoring capability similar to a PHP.

Some HCPs may select abstinence-based or antagonist (naltrexone)-based therapy as their most appropriate individualized treatment option. These approaches are unfortunately associated with greater risk of overdose due to loss of tolerance. Accordingly, no HCP should be compelled to choose abstinence or naltrexone in order to maintain the right to practice when an opioid agonist is indicated or preferable.

Recommendations

For the purposes of employment, a diagnosis of OUD should not be considered equivalent to impairment. With successful treatment for OUD, impairment is resolved or is prevented.

Fitness for employment in a healthcare position should be evaluated on an individual basis, based on specific duties required at work, the HCP's condition, and HCP's stage of recovery.

HCPs should have access to all evidenced-based therapies, including opioid agonist therapies.

HCPs should not be compelled to choose abstinence or antagonist therapy. These therapies may be the best choice for some patients, but raise the risk of opioid overdose for others.

PHPs, or similar return-to-work programs should be available to all HCPs. Effective PHPs should emphasize therapy over punishment and offer opioid agonist therapy, which is considered standard care and associated with a reduction in mortality.

Disclaimer

While individual practices may differ, this is the position of the American College of Medical Toxicology at the time written, after a review of the issue and pertinent literature.

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