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Research Article

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Creating Parity in Standards of Care Between Physicians and Nurses: The Montana Professional Assistance Program

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Introduction

Alternative-to-Discipline Programs (ADPs) are monitoring programs that were created in 1980 in the United States for nurses with substance abuse [1]. ADP's were developed to reduce risk to public health caused by "impaired" healthcare professionals, specifically nurses. ADP's counterpart, Professional Health Programs (PHPs), were later created with the same objective but target the medical professional and the culture of medicine.

While the mission of ADPs and PHPs are the alike, not all operate structurally within the same standard of care. This article will detail the operational process that The Montana Professional Assistance Program, Inc. (hereafter known as MPAP) follows under best practice guidelines and are outlined in the newly published Federation of State Physician Health Programs (FSPHP) 2019 Guidelines. Patient safety is non-negotiable and therefore; developing awareness and solutions to the barriers that the nursing profession uniquely faces in light of rehabilitation compared to physicians is essential. This article will underscore the successful outcomes of a treatment-focused PHP model that the MPAP has utilized for thirty-five years that has have been proven to provide the most successful outcome for physicians. The question is: how can this recovery-focused model be applied successfully to the nursing profession considering the barriers and challenges common to the nursing field and its workers?

The Montana Professional Assistance Program Inc.

The MPAP function originated with the Board of Medical Examiners in 1986 with the hiring of a physician to manage cases of professional impairment. The function was transferred to a private nonprofit corporation under the provisions of Section 35-2-101, Montana Code Annotated formed on July 20, 1989 and organized exclusively for charitable, educational, or scientific purposes. The MPAP was established to coordinate rehabilitation support for licensed physicians and other licensed health care professionals who are found to be physically or mentally impaired by habitual intemperance or the excessive use of narcotic drugs, alcohol, or any other drug or substance. The MPAP services were extended to dentists in 1990. The MPAP expanded its services to include first responders in 2004 and acquired the Montana Nurses Assistance Program and the Impaired Pharmacists Program in 2017 and continues to promote best practices and improve outcomes for these safety sensitive healthcare professionals.

The MPAP is designated as the sole provider for the state of Montana as a physician health program (PHP) as well, as of 2017, an ADP. With exception of a few states, most states across the nation have monitoring programs designated specifically for medical licensees as well as separate, unrelated monitoring program for the nursing profession. Since acquiring the nursing and pharmacy profession in 2017, the combination of such PHP and ADP models have provided its fair share of trials and tribulations.

Physicians and Dentist have enjoyed successful outcomes with the MPAP for nearly thirty-five years. As the MPAP assumed the contract under the Montana Board of Nursing to provide alternative-to-discipline services to nurses in 2017 under provision 24.159.20, Montana Code Annotated formed on May 11, 2012, challenges and barriers to rehabilitation have become evident that are specific to the nursing population. Specific challenges and barriers will be discussed later in this article.

The Montana Professional Assistance Program's mission is based off a physician health program model that is treatment-focused while still protecting public safety. The Montana Board of Nursing states "The program shall be based upon the concept that early identification, intervention, and referral to treatment are paramount to

promoting public health, safety, and welfare in that it decreases the time between the nurse's acknowledgement of a substance use disorder or mental health problem or chronic physical illness and the time treatment is received...the purpose of the program is to protect the public by putting appropriate monitoring processes in place for nurses with impairments that result in the inability to practice with reasonable skill and safety" (ARM, 2020).

In accordance with the Montana Board of Nursing, the MPAP is able to successfully provide rehabilitative services and reassurance to all stakeholders that the professional is safe to practice clinically through the following:

- **Intervention**: Interrupting the situation allowing space and time for identifying appropriate resources for evaluation of needs.
- **Referral**: Assisting referral to treatment program known to skilled in working with the distressed healthcare worker.
- **Continuing Care**: Assistance with guided reentry of the professional back into the workplace and/or community, offering education for family members and assisting with relapse prevention.
- **Monitoring**: Maintaining records of random toxicology testing to verify the participant's continued recovery and serving as an accountability partner over a course of five years.
- **Advocacy**: Advocating for the participant with the licensing boards, insurance companies, hospital committees and other governing agencies.

The same quality treatment and aftercare expectations must be applied across all professionals so that they may enjoy the same successful outcomes physicians have enjoyed by following the PHP model illustrated within the Blueprint Study. Unlike most ADPs serving nurses, the MPAP follows a five year long monitoring agreement in accordance with the Blueprint Study's research determining that five years of monitoring and accountability possibly provides the most successful outcomes.

The Blueprint Study

In 2008 research was provided through a study known as the Blueprint Study which remains the prime study of state PHPs to date. The Blueprint Study provides vital research concerning PHPs that have influenced the treatment-focused approach that PHPs across the nation and the MPAP have modeled their program in accordance with in providing services to the potentially impaired healthcare professional.

The Blueprint Study studied a sample of 904 physicians admitted to 16 state physician health programs and were studied over a course of five years from 1995 to 2001. The study was comprised of two phases: PHPs and characterization of their care management and outcomes of the PHP study sample [2]. The Montana Professional Assistance Program was among the PHPs followed for sample data. The Blueprint Study measures outcomes based on the following program standards of care that are also outlined in the Federation of State Physicians' Health Program 2019 Guidelines. Standard of care consistent across these PHP's include requirement of complete abstinence from all mood-altering substances using detection and deterrence through randomly observed toxicology over the course of five years, close linkages to 12-step peer support meetings such as Alcoholics Anonymous and Narcotics Anonymous and the use of qualified healthcare professional specific residential and/or outpatient therapy [2].

Conclusions from the Blueprint Study show that only 155 out of 802 (19.3%) failed to successfully completed monitoring. Out of the remaining 647 participants who successfully completed treatment and resumed clinical practice under supervision and monitoring, alcohol or drug use was detected in only 126 (19%) over the course of five years. At a post five-year follow-up, 631 (78.7%) of physicians were still licensed and working in their chosen profession. Only 10.8% had their license revoked (3.5% had retired, 3.7% had died and 3.2% had unknown status). According to the Blueprint Study, it is concluded that "About three quarters of US physicians with substance use disorder managed in this subset of physician health programs had favorable outcomes at five years. Such programs seem to provide an appropriate combination of treatment, support, and sanctions to manage addiction among physicians effectively" [2].

Barriers and Challenges in Assisting the Nursing Professional Using the PHP Treatment-Focused Alternative-To-Disicplinary Approach

Intervention and Referral

According to the National Institution on Drug Abuse, addiction is defined as a chronic, relapsing brain disease that is characterized by compulsive drug seeking and use despite harmful consequences (NIDA, 2008) [3]. Early identification and intervention is necessary in combatting the chronic, progressive nature of addiction. The MPAP has witnessed that nursing professionals coming into the program, in contrast to their physician counterpart, are often further along in their disease process and negative consequences have already escalated. With fear of reaching out for help possibly due to social stigma, hospital policy or unsupportive state board legislature, early intervention does not take place. Self-reporting and early referral do not transpire. By this time, more intensive treatment is often necessary. Chances of board involvement, loss of license and/or employment are greater.

It is essential that state boards of nursing have legislature in place that is supportive of rehabilitation of the healthcare professional as a vital measure to further protect public safety within their alternate-to-disciplinary rules and regulations. This includes provisions for safe harbor through anonymous involvement for the healthcare professional, as law permits, allowing the individual to participate in an ADP without fear of punishment from their

respective state board. Self-referral and early reporting are essential in disrupting the progression of addiction as well as protecting the public. Without proper board legislature in place, the chances of timely identification, self-referral or early reporting by a concerned colleague, for instance, is diminished significantly and the risk to public safety is considerably increased.

Compared to the medical profession, the MPAP has witnessed that hospitals and organizations are less likely to refer directly to the MPAP before firing the nurse and filing a formal complaint directly to the state board of nursing. Successful rehabilitation is challenged when financial resources are dissolved and fear of loss of licensure is foreboding.

Treatment

When early reporting and referral does not occur due to the reasons stated above, the chances that the professional's disease process or source of impairment has amplified to a more significant nature that potentially requires a higher level of care. In accordance with the Blueprint Study and the FSPHP 2019 guidelines for appropriate treatment placement for healthcare professionals, the MPAP holds true to these standards and believes that the impaired nurse who may require treatment deserves the same quality of treatment as their physician counterpart. The FSPHP 2019 guidelines state "Physicians do best when treatment facilities and treatment providers have knowledge and experience in treating safety-sensitive workers in general and healthcare workers in specific" (FSPHP, 2019) [4].

As the MPAP has served the nursing profession, it has become evident that financial and accessibility barriers exist exponentially more than other professionals served through the MPAP. Qualified treatment centers are often more expensive as the level of care and follow-up as well as the trained staff experienced with working with safety-sensitive workers require more time, attention and training. With the lack of intuitional support for direct reporting and referral to an ADP such as the MPAP and instead a direct reporting to the state board, professionals have by that time been placed themselves in a work and home situation that possibly includes termination of employment and loss of financial support from loved ones. The longer the period of time between identification of the problem and referral for treatment, the higher the chance of insufficient financial means that could otherwise be applied to appropriate evaluation and treatment. This is exacerbated by the often-lengthy time it takes for a state board to resolve a complaint as the process requires gathering of data and potentially a long period of investigation. When the professional has finally been referred to the ADP, not only has the disease progressed to where a higher level of treatment may be warranted, but the professional as often already lost their employment, insurance and family financial support to be able to afford quality treatment specialized in working with healthcare specific professionals.

Accessibility to appropriate treatment can further be challenged for nurses in consideration of data showing shows that males make up only 9.1% of the nursing workforce in 2017 (NCSBN). There is a higher chance that female is faced with potentially the responsibility of co-occurring roles as a single mother and professional. Treatment accessibility is complicated when the nurse has the responsibility of this additional role and childcare is having to be considered.

Furthermore, the disease of addiction effects women differently. The disease of addiction manifests itself physically, mentally and spiritually. The difference in the physical make up of a woman's body compared to their male counterpart is one reason it is believed that the disease process is more rapid in females. With the nursing workforce being predominantly female, it is appropriate to recognize the importance of early identification and intervention.

Other Barriers

Additional barriers to treatment and self-referral in nursing include the very qualities that make nurses good at what they do and are possibly why they choose to work in the field of nursing in the first place. It is no secret that nurses are caretakers. They are trained to take care of others. As part of their desire to enter the field of nursing, there is a passion and mission to provide care for others. However, lack of self-care is a common side effect of this trait. The fallout is that the nurse is less likely to reach out and receive the help they may need before the source of possible impairment is advanced.

Caretaker mentality can sometimes lead to codependency if the professional has underlying unresolved issues or distresses. Codependency is prevalent in the nursing field. Codependency traits often correlate with adverse childhood conditions. A 1997 study of 91 nursing students indicated that 69% reported either alcoholism, sexual abuse, physical or family violence as present during childhood. Of the 91 nursing students sampled, 74% reported codependency traits as determined by the Friel Co-Dependency Assessment Inventory [5]. Codependency typically expresses itself through characteristics such as caretaking, perfectionism, denial and peer communication (able to indulge information of others but withholding information of self). These characteristics tend to foster over-commitment to other's needs and over-working. Importantly, the codependent nurse tends to express strong defense mechanisms, possibly due to childhood stress and the need to protect one's self. A strong defense mechanism may lead to denial of one's own pain or troubles and instead consciously or unconsciously choosing to ignore or repress one's difficulties or problems in life (Hall, Wray, 1989) [6].

Barriers and challenges to early identification, referral and treatment can be exacerbated in the nursing profession considering the prevalence of codependency. Denial, perfectionism, defense mechanisms and survival instincts

associated with a codependent nurse may impede early identification, referral and treatment.

In correlation with the trend of codependency seen throughout the nursing professional in general, trauma and related conditions, possibly as a side effect to one's adverse childhood, have been seen as a common denominator specific to the nursing professionals entering monitoring with the MPAP. This is important to note as it emphasizes the need, in some cases, for competent evaluations and informed treatment at a facility with staff and resources specialized in addressing such deep rooted conditions. Such causes and conditions are vital in addressing one's addiction and/or mental illness.

Conclusion

Of concern, organizations who become aware of an impaired professional (in their employment) may address the situation as an employment matter, with disciplinary actions up to and including termination of contractual employment rather than refer the impaired professional to the respective State professional licensure board or to the Montana Professional Assistance Program for intervention consideration as mandated in State Statute. It is essential for senior leadership in healthcare organizations to recognize that this failure of clinical intervention at early stages contributes to increasing complexity of issues for public safety as the professional with the unmitigated disease process continues clinical practice in an alternate venue without regulatory awareness.

The nursing profession is unique to other professions served. However, the standard of care remains the same. Creativity, community and institutional education, advocacy and supportive state board legislation is necessary to provide equal care (proven to provide best outcomes through PHP model research) from identification of the problem to effective intervention to referral to qualified treatment and follow-up through rehabilitative focused aftercare monitoring. The nursing profession is ubiquitous and the potentially suffering nurse deserves every opportunity for rehabilitation despite the circumstances, conditions and potential barriers. It is the MPAP's goal to do just that.

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