Ethics and the Law - Warner-Greer

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This presentation is entitled Ethics and the Law: Principles and Implications. I will now pass it over to Dr. Carolyn Warner-Greer to begin our presentation.

00:10

Good evening, my name is Carolyn Warner-Greer. I am a physician at the Bowen Center, and I'm here to present on the topic Ethics and the Law: the Principles and Implications This presentation was authored by Dr. Westley Clark and I will be presenting his work today. Dr. Clark has no fin... or has two financial disclosures as listed. And I have no financial disclosures.

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So our objective today is just to really understand the ethical and legal considerations that impact the treatment of this population- patients with substance use disorder.

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And so we'll first we'll go on these basic ethics, ethical principles, which again, are very heavy on the boards review. Talk about informed consent, talk about privacy and confidentiality, how it's different when treating mental illness and substance use, talk about ethical prescribing, and then some special topics.

01:04

So there's four basic principles of ethics. The first one is autonomy. And that just simply is self determination, self governance, moral independence. This is just basically respect for the patient's ability to make a decision. They may decline treatment, they may take some of the things we're offering and not the other ones, but that ultimately is their decision.

01:26

Beneficence is actions that we do that should promote patient wellbeing. So when in general, do good, we're doing what's best for the patient. It should be noted that if you're too busy in your office to do what's best for the patient, you're not promoting beneficence. We're also minimizing harm for patients which will go to non-malfeasance.

01:47

The next one here, which is do no harm, or harm as little as necessary. Many things that we do in addiction medicine are balancing the risks and the benefits. And sometimes we cannot get perfect, doing good. And sometimes we will, there will be a little bit of acceptable harm to do the best thing for the patient. The most important thing is just to document how you balance those risks and benefits and came to the decision that you did.

02:16

And then the fourth main ethical principle is justice. And that's just means basically fairness. It's about not assuming anything about patients. A good example is pregnant women. Do we just assume that people who are of marginalized populations, so lower socioeconomic, those who are housing-insecure, that women of color, are they more likely to use drugs and therefore will do drug tests, but then a, you know middle class, white woman who's had multiple kids, we wouldn't do a drug test. And that's not promoting justice. You can make assumptions on age, race, gender, sexual identity. A good example, is distributing resources that might be limited, as well as new treatments. One thing that always comes up is you're working at a withdrawal management facility and there's only one bed left, do you give it to the person who's already been there 10 times, but is really, really sick? Or do you give it to the person who's never sought treatment before? These things come up. We are not, we have a limit on the number of patients we can see, about the resources, we have healthcare dollars. And so just trying to be fair, and promote equity among patients.

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Respect for people generally is just treating people in the manner that acknowledges their intrinsic dignity. And that's difficult sometimes when you get tired, and you get compassion fatigue, and you get worn out. But if you can enter every encounter with the patient, saying, "I'm going to, I'm going to respect this person, I'm going to understand that I don't understand- I'm going to seek to understand what I don't know." And then truth telling. "The patient should understand as much as I understand about what's going on with them."

04:00

There was a time in medicine where medicine was more paternalistic, and often people were not shared all the details, the prognosis, all the options for treatment, because they just you know, it was assumed they couldn't understand or it was too much. Now in the day of electronic health record, our patients are going to understand our truth whether we tell them or not because they have access to

everything we do. So the most important thing is to be honest with them face-to-face. So you don't have to explain why what you told them and what you documented or two different things, or what you did is different.

04:34

So informed consent. The main criteria for an informed consent is it has to be voluntary. You have to disclose all the information and the patient has to have decisional capacity to make informed consent. So being voluntary- they're freely given, need to make sure that they're not coerced by either punished if they don't pick what you want, or excessively rewarded if they do pick what you want. That there's some persuasion, because I think that's relationship with a provider and a patient is that you're using your degree of trust and relationship to help them direct to what you think is best, as well as some influence- but not, not overly. So the context is important in here. We just need to make sure that the information we give to our patients is the best information. In certain situations, patients may feel like they don't have a choice. Certainly anyone who's engaged in forensic diversion, such as a problem solving court, or even is actually incarcerated. Often patients feel like, and maybe they're explicitly told by non medical providers, "if you... this is what we recommend, if you don't do this, there'll be a punishment," or "I'm really proud of you for deciding to stop your treatment for opiate use." So we need to be very careful that when a patient exercises informed consent, that it's voluntary.

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You need to disclose all the information and generally what an informed consent was is, "I've diagnosed you with this, this is the proposed treatment, these are the risks of that treatment, these are the benefits of that treatment, these are the alternatives to this treatment. These are the consequences of not having treatment," and it's- you're held to a reasonable person standard. So I believe that in psychiatry and addiction medicine, that we have a very high standard of disclosure. Medicines that will produce dependency, medicines that have known adverse effects or medical medication accommodations that should be avoided. The malpractice standard is a reasonable person, but I think we should all shoot for a high standard of disclosure.

06:40

And then the patient has to have decisional capacity. There's a sliding scale to this. Patients who are intoxicated, patients who have underlying mental illness, they may have an acute mental health crisis- are not necessarily incapable of making decisions. And if their decision is not the same as ours, that doesn't mean that they lacked decisional capacity. So again, this is important about assessing patients and letting them exercise their autonomy, but also doing justice towards them as far as what they're allowed to pick and not pick.

07:15

So for those who lack capacity to make informed consent, there's measures that we have in place. A durable power of attorney for health care decisions is a form of identifying a surrogate decision maker if one becomes incapacitated. There's been some rumblings about durable power of attorney or

advanced directives for substance use. So we will talk later about involuntary commitment for substance use treatment. Having an Advanced Directive or living will, that's a written statement saying that there are specific wishes. That does not designate a healthcare power of attorney- that's just your wishes. It doesn't designate that this person gets to exercise those wishes. So those are two different documents. A guardianship or conservator is someone who's appointed generally by the courts to make a decision when the patient's incapacitated or ongoing for patients that are not anticipated of having a decision making capability.

08:15

So generally pearls: that there's various ethical principles that underlie medical addiction treatment that may come into conflict. And it's just really important to understand what these are, be able to use them in your vocabulary, be able to use them when you're discussing how we're going to proceed. The process of informed consent is, we're saying this again, voluntary information disclosure and decisional capacity, and then to the- always the awareness that certain treatment settings, forensic diversion, in-patient... can have the potential to infringe on voluntariness. So a good publication by ASAM was they took the ethics medical ethics from the American Medical Association and made an annotation specifically to addiction medicine. This is available on the website. When in doubt, look at these nine standards, it's very helpful in making those tricky ethical decisions.

09:06

So privacy and confidentiality. Privacy is the patient's right to protection of sensitive information like mental illness treatment, substance use diagnosis and treatment. Confidentiality is our responsibility to protect that sensitive information. 42 CFR Part 2 is the Confidentiality of Alcohol and Drug Abuse Patient Records. This is a federal code, and then HIPAA is the Health Information Portability and Privacy Act. And this proceeded... or actually 42 CFR Part 2 came before HIPAA. They are not the same thing even though the Department of Health and Human Services is trying to kind of merge those together.

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So the tricky thing about 42 CFR Part 2- The first thing you have to acknowledge is are you a covered program or a covered entity.

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This for... 42 CFR Part 2 was established when most substance use treatment was provided in standalone specialized facilities. Primary care did not address this. Hospitals did not address this. There was the alcohol detox unit. The first thing to understand is who's covered, the statute means, by a part 2 program. And it's basically any individual entity or identified unit within a general medical facility that provides substance use diagnosis, treatment or referral for treatment, and whose primary role is substance use diagnosis, treatment or referral. So general oral health care generally not included. Substance use only definitely included.

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The- to fall under the 42 CFR Part 2, the program must be federally assisted, that means it's conducted in a federal agency. It's supported by federal funds or distributed by a state or local government. The last part means that providers participating in Medicare who are authorized to conduct maintenance treatment or withdrawal treatment are covered under Part Two. This captures- Part Two captures most people who provide a substance use disorder treatment.

11:12

So the disclosure under Part Two implies that patients- any records that identify a patient as having or having had a substance use disorder require the patient's written consent before disclosure. There's exceptions, one of them is a bonafide medical emergency. And there's always, you know a discussion on what qualifies as a medical emergency. Error in manufacturing, labeling or product, research, a valid court order with a subpoena, crimes committed on a part two program premise or reporting suspected child abuse and neglect. And failure to adhere to these rules can result in a criminal penalty, which is generally a fine.

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HIPAA means that basically all protected- personal health information is protected. There's some exceptions related to medical operations. We have to disclose your diagnosis to your insurance company and then some with public interest and benefit. That's generally reporting of public illnesses. HHS, again, has proposed revisions to 42 CFR Part 2 but which have not quite been finalized. SAMHSA is working really hard to bring everybody together, things are evolving. The general feeling is is in the in the desire to protect patients privacy, we've limited sharing, which makes it difficult for different entities to take care of patients. And so I think they're trying to find that happy medium moving forward.

12:41

And um, substance use and definitely mental illness was so stigmatized when these laws were made. Less stigmatized now, more people trying to provide treatment, we want to make sure that we're good community partners to everybody, with also protecting our patients privacy or the right to privacy.

12:58

So the Controlled Substance Act of 1970. This basically instituted rules about prescribing and dispensing controlled substances. This is why we have a DEA registry- DEA registration, and it also scheduled drugs and chemicals based on their risk of addiction and potential for misuse.

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So the scheduling of medication: Schedule one is illegal and purportedly no medical use. And again, these are federal guidelines, not state guidelines. So this would include cannabis, GHB, MDMA, I

believe heroin is technically a schedule one medication. And then scheduled two through five- and some states even have added six- are based in, as the number increases, less addicting, and withdrawal and misuse potential. So cocaine and methamphetamine do have medical purposes, although they're very limited. Methadone, PCP, again, has some medical indications- often very, very limited. The idea that benzodiazepines are schedule four is sometimes interesting to to to look at. Lyrica or pregabalin is a schedule five. As of recently, gabapentin is not controlled under the Controlled Substance Act, but many, many states that were impacted by the opioid crisis have also made it a schedule five drug. Many other states have added it to their prescription drug monitoring program, which we'll talk about later. The DEA has explicitly requested to reschedule gabapentin as a schedule five as a federal rule.

14:44

So ethical prescribing: it it's important that when we prescribe medications that they're appropriate. That we screen for the risk of substance use disorder, the risk of diversion, and again, just weighing in. If it's exacerbating medical or psychiatric illnesses, so the one when we look at ethical prescribing is "What am I doing to mitigate the risks of misuse and diversion?"

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There's many things we do. Urine drug testing is a good way of evaluating for misuse and diversion. This isn't screening because we expect it to be positive for the medicines that are prescribed and we hope that it's negative for the medicines, or chemicals and compounds that can be negative, negatively impact what we're doing and make what we're doing more dangerous. Medication contracts in some cases are used, definitely using the prescription database for your state to look for overlapping prescriptions.

15:41

Other things that we can do are to write... When we feel like there may be a risk of misuse or diversion to write small prescriptions with refills, to talk about safe storage at every visit. Specifically, "I'm not worried about how you may misuse this medicine but kids or adolescents or people are visiting your house." Co-prescribing Naloxone with any opioid including medicines to treat opioid use disorder. At opiate treatment programs where methadone is prescribed there's overt diversion control, including having patients store their medicines in a locked box doing medication callbacks. Some people would believe that using for buprenorphine, naloxone- using tablets versus films as films are frequently diverted. And in the criminal justice system, as far as jails and prisons, not using the mono product of buprenorphine often will reduce the risk of diversion and misuse. But those are all kind of style points.

16:41

The universal precautions for prescribing controlled substances comes a little bit out of the CDC recommendations in 2016. These were never meant to say "stop prescribing opioids." They were only intended to support, not supplant medical judgment. It doesn't replace clinical judgment. But unfortunately, a lot of providers said, "Oh, I'm not allowed to do this treatment for you anymore."

That the biggest thing that it said was, please don't prescribe opioids to people without thinking about it. Those of you who've practiced in 2005, 2010 may know that it was not uncommon to write a prescription for a 30 year old for 180 hydrocodone tablets, send refills because you could put refills on it- it was a schedule four medicine then- and never ever write in your note why we're continuing to do this. So making a good diagnosis, doing a physical exam, looking and screening for the risks of substance use disorder, getting informed consent from the patient, what are the risks, benefits and alternatives? Agreeing with treatment, and the biggest thing is, is that "This is a trial and we're going to keep assessing your pain, we're going to assess 'are you being more functional, are the benefits of this medication intervention outweighing the risks,'" and documenting this and documenting this and documenting this.

17:58

They also need to concern with universal precautions which we've learned the risks of abruptly stopping opioids for patients too. So so the the legal consequences of not appropriate prescribing would be mis- just misprescribing. We don't have a good rationale, the dose quantity, lack of physical examination. The Controlled Substance Act says it's unlawful to knowingly or intentionally, those are the key words. The DEA traditionally uses what a reasonable or a good doctor would do

18:32

Now, if anyone's familiar with the Supreme Court's decision last June. They went more with a "good faith." "Is it possible the doctor didn't know?" And it's always tricky with the legal system in medicine that you know, it's not a crime to be a bad doctor. It's- it might be malpractice. It definitely is malpractice. You might get from a state level Medical Board sanctions, but it's not a crime to be a bad doctor. But if you knowingly, intentionally are a bad doctor than it is a crime.

19:01

So an interesting case this is the Supreme Court case from June of 2022, a pain management physician from Alabama was prescribing a very high quantity of opioid pain- specifically using intranasal fentanyl, and fentanyl lollipops which are only indicated in severe refractory pain for terminal cancer. This was a cash only clinic and the DEA viewed it as a pill mill. The physicians in this practice also got kickbacks from the pharmacy that was filling the prescriptions as well as pharmaceutical companies. They tried to donate those kickbacks once the initial complaint was fired and the physician was sentenced to 20 years. The lawyer for the state when this went before the Supreme Court basically said that the lawyers for the doctors were just asking the court to transform the DEA registrations, which are premised on the idea that at the very minimum doctors just need to act like a reasonable doctor. They said they want to be free of any obligations even to undertake the minimal effort to act like doctors when they prescribe dangerous, highly addictive, in one case lethal, doses of drugs to trusting and vulnerable patients. However, the Supreme Court basically said, you know, we don't know what his intent was. It's not completely, you know, impossible that these patients that these, these medications were indicated for these patients, and therefore his sentence was- his and another case were overturned. Since that ruling, I think there's been 15 cases of convicted physicians basically pill mills that have petitioned the court to have their sentence overturned.

20:45

So prescription drug monitoring programs: they are now as of two three weeks ago in all 50 states. Missouri was the lone holdout for a long time, as well as in DC and Guam. The goal was to mitigate abuse and diversion of medications. Some people say that the information isn't collected, it's not rock solid. Some people feel that it violates a patient's privacy that, you know, someone besides, you know, a pharmacist, law enforcement, there's a lot of people who have access to a prescription drug monitoring. Epidemiologists say that PDMPs- they help with better prescribing patterns, and they are helpful in understanding what everybody else is doing, recognizing physicians that tend to prescribe in a riskier fashion, those kinds of things.

21:32

So the pearls are: confidentiality- 42 CFR Part 2 and the HIPAA Privacy Rule, the Controlled Substances Act established a DEA classification of addictive drugs and criminal penalties for distribution of drugs. There's various models of ethical prescribing, I think it would be good to know those 10 points and responsible prescribing and PDMPs differ in implementation and effectiveness.

22:04

So special topics with the- first one is adolescents addiction and the law. So when can a minor provide informed consent for themselves? Well, definitely the age of majority, which is generally 18. Every state is different. There's generally minors who are emancipated, minors that are married or are in the military, minors that have children, minors who have graduated from high school, minors that are living away from their family and not dependent on their support generally are able to consent for treatment. Every state is different. States can allow consent for substance use treatment, mental health treatment and contraception and family planning as young as 12 year olds in some states.

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A good resource for looking at what your specific state laws is going to your children's hospital, going to their adolescent medicine program. Most of them will come up because even reading the laws can be somewhat nuanced. And so but they're obviously very good at this. That's what they do. So most of them have presented papers, I'm in Indiana. Riley's Children's Hospital provides us with invaluable information. They're also the consult team that's available to help us understand privacy and informed consent with minors. So.

23:29

Though, generally, so the pearls are here is that state laws vary for minor consent requirements. Adolescents do have autonomy. And they- we've shown over and over and over and literature that adolescents are able to report symptoms of substance use disorder just like they can with any other medical illness. And when we involve an adolescent they're, they feel more autonomy to take care of their their health care, in all things is when we're talking about wellness with adolescents that they can seek and report symptoms, report their concerns, report what's going on, be honest about their response to treatment, it's still- a skilled clinician can still engage parents, while still preserving the

adolescents confidentiality. The Guttmacher Institute is very good there to look- mostly contraception and family planning, but it also ties in individual state laws. And it's an ongoing document that can explain exactly what your state laws is. There's been many, many changes in adolescents and their treatment at the federal and the state level. It should be noted and this was on the boards when I took them that the American Academy of Pediatrics' position is doing a urine drug test without adolescents knowledge and consent is not recommended. They also recommend that with adolescents requiring drug testing to participate in sports or to drive your car to campus is also not recommended. It's not to be considered a good screening tool, but instead that all adolescents should be screened for substance use disorders and mental health, regardless if they want to play sports or drive a car.

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Pregnancy. So the legal consequences of pregnancy and substance use vary between states. And again, this is something to look at the Guttmacher Institute to understand what your specific state is. There are some states that consider substance use in pregnancy a criminal act and that they that can be involved in feticide charges. Some will call chemical endangerment of a child because of using substances during pregnancy. And some just have direct criminal child abuse laws. There's also civil penalties. Substance use equals child abuse in 24 states plus DC. Any substance use except not tobacco.

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And there's mandatory reporting to child welfare in many states as well as DC- about half of our states. In three states, you can simply commit a pregnant woman for treatment, simply because she's pregnant and has a substance use disorder. Reporting requirements: There are some states where it is mandated, mandated reporting for child abuse and neglect. The standard is usually just reasonable belief or suspicion for abuse. Noting that substance use does not always equate abuse and neglect. There are some states where prenatal drug use and substance expose newborns automatically trigger a report to the Department of Child Services. And there was a interesting article in The New York Times last week that talked about you know how this policy is probably harming our patients, especially the ones who've been an evidence based treatment for their substance use disorder. A known consequence may be opioid withdrawal in the in the newborn, and all of a sudden this triggers the DCS report.

27:04

So the guidelines generally with pregnant women, just know and tell your pregnant patients beforehand of their mandated reporting requirements and the limits of confidentiality according to your state laws, and always get informed consent before doing drug testing. The American College of OB/GYN's practice patterns which have been adopted in my state are that we screen every pregnant woman for substance use with a validated scoring tool such as the five Ps, CRAFFT, the TAs, different screening tools that are talked about at different parts in this conference, and use urine drug testing when appropriate, and when consented by the patient.

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The pearls: people who use substances during pregnancy can be subjected to criminal or even civil penalties. There are some mandated reporting requirements. And always get consent, including notifying the patient beforehand, that positive drug tests need to be reported in your state.

28:06

Justice-involved populations. So in 2020 5.5 million people are under correctional supervision in the United States. So that would be probation, parole, community corrections, local jails, federal prisons and state prisons. The history of incarceration in the United States is way outside anything else we see in any other country. We incarcerate a higher population of our citizens than any other country by far. The idea that substance use disorder's tied in with incarceration is well represented in the data. It's estimated over 65% of pat- or inmates, or people who are part of the criminal justice system have an active substance use disorder. 75% of women, but only about 10 to 15% actually receive appropriate treatment. So there's a need for to treat medicines for addiction and the correction situation.

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We know SAMHSA has published this and made quite a few guidelines, saying that 75% of people will relapse within three months of release from a controlled environment. And they are 100 times more likely to die of an overdose within two weeks from discharge. The barriers for corrections to provide evidence based treatment for those who have diagnosed substance use disorders are the general lack of education, the idea that, you know, you got through withdrawal, you're incarcerated, so you'll never use again, we're just substituting one drug for another, just some archaic mentality, but very per- per persuasive in the correctional population, the concerns about diversion, and I think always when talking to our community partners in the correctional thing that they have a different charge than we do.

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Their job is to make sure the law is upheld. And so even though we know most of the diversion of buprenorphine in the community is for people who need buprenorphine, to them that's, you know, distributing a scheduled drug. And that's- that's a felony in pretty much every state. So concerns about diversion within a correctional is concerning too because these medicines, while life saving for people who they're indicated in, can be dangerous in people that they are not indicated in and there's always a cost. And then the concerns that when they do discharge someone, that which one of us is going to take over their treatment for them, and continue their treatment, so... but we're seeing more and more pilots across the United States, Rhode Island, the Department of Corrections was first one in 2016 to implement statewide adoption of medicines to treat opiate use disorder. Their models immediately predicted a reduction in overdose overdose about 35%. In June of this year, the Bureau of Justice released a management withdrawal guideline for jails and prisons. So that's interesting, too. There were times where alcohol withdrawal, benzodiazepine withdrawal was met with indifference in the incarceration and now they understand that at least managing withdrawal is important in correctional medicine.

31:08

31:08

Problem solving courts, treatment courts... we have millions. Drug court, mental health court, DUI court, veterans court, reentry court. The idea is therapeutic jurisprudence. The judge is the leader in this. So in our treatment, the- the health care provider is leader. In a problem solving court, the judge is the leader, which is hard sometimes for medical people, because we're used to being in charge. And now we're going to answer to a judge. They have varying entry and eligibility. Some are pre-sentencing programs- that if they complete them successfully, the charges are dropped. Some are after sentencing- for a reduced sentence. They are are supposed to have very well delineated structure and a balance of incentives and sanctions with incentives outweighing the sanctions. Five to one is the recommendation. There is a great deal of efficacy as far as reducing recidivism, in promoting participants in achieving their goals in recovery. The treatment provider is often in a dual role when they're engaging with drug courts, meaning that you're trying to be part of the team and uphold some of their goals as far as basically law and order but also trying to do what's best for the patient.

32:31

It should be noted that the National Association of Drug Court Professionals or NADCP and ASAM worked very very, very closely together to develop best practices, their best practices for drug courts, and in by expansion, basically, treatment courts. There's the 10 general principles which are being adopted by ASAM and by NADCP. Those are not always followed in every county in every state. And so when helping to educate your drug courts, it's first to seek to understand before you tell them what you know, but then also to let them know about their own principles. So when your drug court team went to Nashville last week for the NAAC-, or NADCP conference and had a grand old time, but then it's not following the NADCP recommendations as far as treatment, sanctions, eligibility, that kind of thing, that you can help educate them, but also in an understanding way to try to remember to remain a valuable partner with the team.

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It also should be noted that problem solving courts that accept federal money cannot have a blanket prohibition on medicines for opiate use disorder. Unfortunately, often that just goes "Well they can patients can use naltrexone, but nothing else." So still working on that. So.

33:51

So final topics, civil commitments. The standard are for mentally ill or in some states substance use disorders and are dangerous to others or self or gravely disabled. So in 37 states, substance use disorders can have a civil commitment for treatment. The legal process includes a due process for everybody. It might not be immediate, but it has to be within a timely fashion. And then the judge generally will commit for a specific time. Some proponents of civil commitments would agree that this is helpful for patients that they are able to get into treatment where they may have not selected it on their own. And they can agree that maybe they're not making the best decisions. That's kind of the definition of substance use disorder.

34:49

Doctors surveyed in 2002 did not agree with civil commitment for substance use, but then in 2021, about 60% said "Yeah, I do believe that people can be civilly committed if they're an active addiction to receive treatment" That was on the assumption that everywhere that someone civilly gets committed to, that they're going to receive evidence-based treatment, specifically medicines to treat opioid use. When in reality, like less than 20% of people got. So basically they got committed. They're away from using substances, but they didn't get evidence-based treatment. And then the data shows that like less than 7% of people who are involuntarily committed for treatment for substance use actually followed up. 33% said they used the day that they were released, and that many of these places didn't even offer harm reduction.

35:36

There was a study in Massachusetts that said that patients who were civilly committed were two times more likely to die than people who voluntarily sought treatment for substance use. It's almost this reverse triage where those who want to get treatment sometimes can't because lack of availability, those who do not want treatment are forced to get treatment.

36:00

The American with Disabilities Act is coming into play a lot in the addiction medicine realm, because our patients have a diagnosed disability, because they meet the criteria, they have a physical or mental impairment that limits their major activities. They have a history of impairment, and and they're- they're regarded as having an impairment. Substance use is one of these. However, alcohol use disorder, no matter what stage of your illness you're in, you're covered by the ADA. With substance use, or other substance use disorders, the only ones who are protected are they're not using right now. But they are or have been in treatment and they're regarded as others as using drugs. So basically, people are in treatment with medicines, which mostly when this happens, or have a history of substance use disorder, but are not in active addiction, they're protected. If there's active substance use, then they're not really protected. So the casual user currently using drugs.

37:00

There are exceptions to recognizing the ADA. The main one is being religious organizations are exempt. So a church-based treatment facility can essentially discriminate against people who have a substance use disorder, alcohol use disorder, a history of or those who are in treatment.

37:24

Physician regulation and then impaired physicians. Physicians are generally regulated by medical malpractice and then the state medical boards. So civil and the state level. physician health programs are generally available in every state, they go by different names, the goals are generally to return a highly trained and important person to the community back to the workforce, as well as to prevent susceptible patients from an impaired physician who may not exercise the best clinical judgment. Often, physicians will enter treatment voluntarily, sometimes they can have mandated treatment. But generally the mandate is if you don't get treatment, you can't work. So it's kind of mandated. physician health programs have a very, very high success rate, like generally over 90% probably the

reason is, is that they are mandated or recommended. And you have to do a very high intensity level of treatment versus being allowed to, you know, I'm gonna go to a few meetings kind of thing so that they have very intensive follow up. So return to use even though the initial use is oftenly... not... physicians are usually identified late in the game as far as substance use, because of what they do and having a lot a great deal of autonomy. But once a physician is identified, they have very rigorous supervision so return to use is identified really quickly and addressed. And they have a lot on their- they have a lot to lose.

38:57

So the duty to report impaired physicians, if anyone identifies physical, mental or substance use, so it's not only substance use, if someone has a mental health or behavioral health concern or physical concern that inter- interferes with their ability to safely and competently perform virtual duties, then they should, it should be acknowledged. Most of us in this conference have a legal we have a duty to report a reason to believe if there's an ethical standard. The best way I think if you have a colleague who you believe is impaired, is to initially go to the colleague and be prepared on how to discuss with them your concerns. A lot of physician health programs if the patient or the colleague voluntarily... there's not necessarily reporting to the State Medical Board. So I think that we have that we can't we have a responsibility to make sure that it's being addressed but there's different ways to go about that.

40:02

Physicians being treated with medicines for opiate use is a tricky one. The Mayo Clinic did a study in 2012 that showed absolutely no impairment with health care professionals when being treated with buprenorphine. There are many and most physician health programs that say you can't enter our monitoring program thus can't get your license back while you're still being treated with buprenorphine. Some say you can't go back to work until you're tapered off of buprenorphine. So I'm hoping as time goes on, that we recognize the double standard there that we let our other patients participate in safety sensitive positions, but we don't let physicians look at this and hopefully, more research will be able to help that we can keep our colleagues in the workforce and still get appropriate treatment.

40:51

If you need to get in touch. We will have office hours that we'll talk about. Definitely reaching out to ASAM and the references that are included. Thank you very much for your time.