



VOLUME 82
NUMBER 3
1995

F E D E R A T I O N B U L L E T I N

- 122 Information for Authors
- 123 President's Message ■ Robert E. Porter, MD
- 125 Editorial: *The Philosophy of Rehabilitation for Impaired Physicians*
- 127 The Alabama Physicians Recovery Network ■ Gerald L. Summer, MD
- 131 The Florida Impaired Practitioners Program ■ Roger A. Goetz, MD
- 134 Kentucky Physicians Health Foundation Impaired Physicians Program
■ Burns M. Brady, MD
- 141 Missouri Physicians' Health Program ■ Angela M. Allen, BJ
- 146 The North Carolina Physicians Health Program ■ Robert C. Vanderberry, MD
- 151 The Physicians' Health Programs of the Educational and Scientific Trust
of the Pennsylvania Medical Society ■ Penelope P. Ziegler, MD
- 155 Tennessee Medical Foundation Impaired Physician Program ■ David T. Dodd, MD
- 158 Washington Physicians Health Program ■ Lynn Hanks, MD
- 164 Confessions of an Alcoholic ■ Anonymous
- 168 From Our International Exchanges: *Manitoba, Canada; New Zealand*
- 171 From Our Member Board Exchanges: *Colorado, Minnesota, North Carolina, Ohio*
- 177 Medicolegal Decisions
- 183 Letters to the Editor: *Responses to Sandra G. Boodman's article, "What do the
Certificates on Your Doctor's Wall Really Mean?"* Michael H. Claphan, CAE;
James F. Callahan, DPA

FEDERATION BULLETIN

THE JOURNAL OF MEDICAL LICENSURE AND DISCIPLINE

Published Continuously Since 1913

Volume 82

Number 3

1995

All articles published, including editorials, letters, and book reviews, represent the opinions of the authors and do not reflect the official policy of the Federation of State Medical Boards of the United States or the institutions or organizations with which the authors are affiliated unless clearly specified.

Editor

Linda C. Chandler, MA

Editors Emeritus

Ray L. Casterline, MD
Dale G. Breden

Editorial Board

Ronald C. Agresta, MD
2990 Johnson Road
Steubenville, OH 43952

Ruth Horowitz, PhD
401 Rockwood Road
Wilmington, DE 19802

Patrick W. Russell, DO
Elkhart Clinic
PO Box 201
Elkhart, IN 46515

Barbara S. Schneidman, MD, MPH
American Board of Medical Specialties
1007 Church Street, Suite 404
Evanston, IL 60201

Thomas J. Scully, MD
1400 Ferris Lane
Reno, NV 89509

Daniel J. West, PhD
RD #1, 101 Birch Street
Gouldsboro, PA 18424

Contributing Editors

David S. Citron, MD
Bryant L. Galusha, MD
John H. Morton, MD
Deborah Lewis Rodecker, JD

Editorial Assistant

Linda F. Vernale

Archives/Mail List

Nannette York

©Copyright 1995 The Federation of State Medical Boards of the United States, Inc.

Federation Officers

President: Robert E. Porter, MD*
President Elect: James E. West, MD*
Vice President: Susan M. Spaulding*
Treasurer: Bruce H. Hasenkamp, JD*
Secretary: James R. Winn, MD

Federation Board of Directors

Gerald J. Béchamps, MD*
Leroy B. Buckler, MD*
Ray Q. Bumgarner, JD
William H. Fleming, III, MD
John T. Hinton, DO, MPH
Philip M. Margolis, MD
Dinesh Patel, MD
Alan E. Shumacher, MD
George Van Komen, MD

*Executive Committee

Federation Executive Staff

Executive Vice President:
James R. Winn, MD
Deputy Executive Vice President:
Dale L. Austin, BSN, MA
Assistant Vice President,
Exam and Board Action Services:
I. Kathryn Hill, MEd
Assistant Vice President,
Public Relations/Publications/Education:
Carol A. Clothier, BA
Assistant Vice President,
Member Support Services:
Deborah Modesette, MPA

The Federation Bulletin: The Journal of Medical Licensure and Discipline (ISSN 0114-9306) is published quarterly by the Federation of State Medical Boards of the United States, Inc.; 400 Fuller Wiser Road; Suite 300; Euless, TX 76039-3855. Telephone 817-868-4000. Fax 817-868-4099. Printed by The Ovid Bell Press, Inc.; Fulton, Missouri. Second-class postage paid at Fort Worth, Texas, and additional mailing offices.

Change of address: POSTMASTER, send all address changes to *Federation Bulletin: The Journal of Medical Licensure and Discipline*, 400 Fuller Wiser Road, Suite 300, Euless, TX 76039-3855.

Subscriptions and correspondence about subscriptions should be addressed to the *Federation Bulletin: The Journal of Medical Licensure and Discipline*, Attention: Subscription Department, 400 Fuller Wiser Road, Suite 300, Euless, TX 76039-3855. Subscription price is \$35 per year, single copy is \$10. Notification of change of address should be made at least six weeks in advance. Enclose new and old addresses, including zip code.

Authorization to photocopy material under circumstances not within fair use as defined by the United States Copyright Law is granted by the Federation of State Medical Boards of the United States, Inc., provided that a fee of \$1 per article plus 10 cents per page is paid through the Copyright Clearance Center, 222 Rosewood Drive, Danvers, MA 01923. Phone 508-750-8400. Such photocopies may not be used for advertising or promotional purposes, for creating new collective works, or for resale. This publication is available in microform through University Microfilms International, 300 North Zeeb Road, Ann Arbor, MI 48106. Phone 313-761-4700.

Submissions: Manuscripts, letters to the editor, and other materials to be considered for publication should be addressed to Linda C. Chandler, Editor, *Federation Bulletin: The Journal of Medical Licensure and Discipline*, 400 Fuller Wiser Road, Suite 300, Euless, TX 76039-3855.

The nature and strength of the feelings which we call regret,
shame, repentance, or remorse depend apparently
not only on the strength of the violated instinct,
but partly on the strength of the temptation,
and often still more on the judgment of our fellows.

—Charles R. Darwin (1809–1882)
The Descent of Man (1871)

Information for Authors

The Editorial Board accepts original manuscripts for consideration of publication in the *Federation Bulletin: The Journal of Medical Licensure and Discipline*. The *Bulletin* is a refereed journal, and all manuscripts are reviewed by Editorial Board members and/or appropriate consultants. (The review process takes six to eight weeks.) Manuscripts should focus on issues of medical licensure and discipline or related topics of education, examination, postgraduate training, ethics, peer review, quality assurance, and public safety. Queries and manuscripts should be sent to the attention of the *Bulletin* Editor, Federation of State Medical Boards, 400 Fuller Wiser Road, Suite 300, Euless, TX 76039-3855.

Manuscripts should be prepared according to the following guidelines:

1. A cover letter should introduce the manuscript, name a corresponding author, and include full address, phone, and fax information. The letter should disclose any financial obligations or conflicts of interest related to the information to be published.
2. The title page should contain only the title of the manuscript. A separate list of all authors should include full names, degrees, titles, and affiliations.
3. The manuscript (including references and tables) should be typed double-spaced, with ample margins, on standard white paper. All pages should be numbered, and the length of the text should not exceed 5000 words.
4. References should follow the format of the *AMA Manual of Style*, including journal abbreviations from *Index Medicus*, and should be numbered in the order cited. The number of references should be appropriate to the length of the text.
5. Tables and figures should be submitted on separate pages. Note their placement within the text and number tables and figures separately in order of citation. Include appropriate titles or legends. Figures must be legible; black and white line drawings or photos are preferable. Any table or figure from another source must be referenced. Photos should be marked by label on the reverse side and up direction noted.
6. Commentary, letters to the editor, and reviews are accepted for publication, subject to review of the Editorial Board. Such submissions and references should be concise but should conform to the format of longer submissions.
7. Four copies of the manuscript (including references, tables, and figures) and a computer disk copy should be submitted. The word processing program and the title of the appropriate file(s) should be indicated.
8. Manuscripts are reviewed in confidence. Editorial changes will be submitted to the corresponding author for approval. The original copy and disk will be returned if the submission is not accepted for publication.

President's Message

Federation Meets Challenges Affecting Boards

There's a chill in the air in New England, and as we return to the work of the fall, the Federation Board of Directors has completed some of its summer charges. A busy four days in Chicago in the heat of July resulted in a fruitful AIM/FSMB leadership liaison session and an exciting annual meeting program for April 1996, the content directed by the board survey conducted in June. The last project of the summer meeting was the assemblage of an SAI work group to refocus on a service-oriented, customer-driven instrument. I think all boards will appreciate the efforts of this group.

The 1996 Annual Meeting will be at the Sheraton Chicago Hotel and Towers, an outstanding convention facility. Put the dates—April 11-13—on your calendar.

We now know that the Clinton health plan is off the table; nevertheless, change is in the air. House Speaker Gingrich, in an address to the AMA House of Delegates in June, reminded everyone that there are some hard medical choices ahead but assured us that "choice" will be available. Federation leaders and staff will monitor federal initiatives and their potential effects on state boards and will report to the Federation during the Annual Meeting.

The HMO influence continues to increase its impact on health care delivery. According to a 1994-1995 survey, patient enrollment varies by state from 4% to 32%. The private sector, the AMA, the Congress, and the Federation are all working in their own areas to cope with the challenges. At the Annual Meeting in Chicago, a session moderated by President-elect James E. West, MD, will be devoted to managed care and its effects on board activity.

We also will hear from Dr. Lee Buckler's Ad Hoc Committee on Telemedicine about telemedicine's impact on state medical boards. The committee will have developed a model legislative package dealing with the interstate licensure issues generated by this growing practice. Dr. Bill Fleming's ad hoc committee's report on fraudulent practices in medicine also will be featured in Chicago. The Bylaws Committee will present an integrated, updated report that suggests bylaws changes for consideration at the April House of Delegates session.

*Robert E. Porter, MD.
President, Federation
of State Medical Boards
of the United States, Inc.*

I also want to comment on the Physician Impairment Committee and its expanded charge dealing with sexual boundary issues. Dr. Barbara Schneidman has done an outstanding job in keeping the committee focused and productive. The problem surfaces in almost every medical publication, and its ramifications are international in scope. Dr. Schneidman has spoken about physician impairment in Canada and Australia. A northeast consortium addressing this issue is on the table, and Federation-sponsored regional seminars are being considered. Sexual boundary issues also will be on the April program.

The fall promises to be a busy time. Eight state medical boards have scheduled visits for Federation board representatives and staff to discuss issues of concern. As we near the end of another year, ask yourself whether your board is fulfilling its charge in the licensure and discipline arena. Are you doing your part to make its work successful? If not, why? If your answers suggest areas of need that can be met by Federation services, contact the Federation staff, officers, or directors with your ideas and give us the opportunity to help you make your work more effective.

Editorial

The Philosophy of Rehabilitation for Impaired Physicians

In May of 1980, Crawshaw, et al¹ published a special communication in the *Journal of the American Medical Association* titled "An Epidemic of Suicide among Physicians on Probation." This article described the extreme distress experienced by the Oregon Board of Medical Examiners in 1977, when eight of approximately 40 physicians on probation or under investigation for probation committed suicide, and two additional physicians were recovering from serious suicidal attempts. These suicides occurred during a 13-month period from June 1976 to July 1977. This unfortunate experience forced the Board to study the phenomenon and ask for advice and recommendations about methods to avoid repetition of such devastating incidents.

This article, along with others, including the 1972 report from the American Medical Association on "The Sick Physician,"² gave impetus to and growing recognition for the need for effective rehabilitation for the impaired physician, instead of punitive actions. Medical boards have responded to this need with increasing referrals to and support for physician health and diversion programs. Unfortunately, medical boards are still seen as the "enforcers," whose job is to revoke or restrict licenses. Most medical boards would prefer rehabilitation to probation or revocation, so long as the public is protected from imminent danger from the actions of impaired physicians.

The articles in this issue of the *Bulletin* outline a sampling of programs from across the United States, initiated to address the dilemma of physician impairment. Some have expanded their scope to include numerous impairments in addition to chemical dependency. Some have stretched their arms to embrace other professions as well as physicians. All are conscientiously applying principles of rehabilitation, and the success rates of the programs and others like them approach 90%. Diversion programs in many states have allowed impaired physicians to get necessary treatment without board involvement, necessitating board intervention only if the physician in treatment violates his contract or becomes a danger to the public. The 10% of participants who fail in the programs are referred to the licensing boards for disciplinary action.

This nonpunitive environment should be in place as students begin their medical school careers and should extend into residency training. If students or

Barbara S. Schneidman, MD, MPH, Chair of the Ad Hoc Committee on Physician Impairment and Past President of the Federation of State Medical Boards of the United States, Inc.

residents seek psychiatric assistance or treatment for problems with chemical dependency, they should not be penalized or discouraged from seeking such treatment. Conversely, medical educators and residency training directors should honestly evaluate trainees, so licensing boards do not receive glowing recommendations or written evaluations silent on seriously troubled students and residents. Also, when a resident openly seeks help, the training program should be supportive and should assist that individual with appropriate call schedules to permit the resident to attend Alcoholics Anonymous meetings, other support groups, or psychotherapeutic treatment mandated by the medical board or other treatment modalities.

The 1977 Oregon experience highlights the need for a comprehensive psychological/psychiatric assessment prior to board action. The Oregon committee chosen to study the suicides reported a high incidence of serious diagnosed psychopathology demonstrated prior to contact with the board as well as abuse of alcohol and other mind-altering drugs. Although this data is almost 20 years old and involved only a small number of physicians, it points out the importance of first assessing the psychological needs of the individual impaired physician before any medical board intervention.

Cooperation and communication between the medical boards and the physician health programs must occur in an effort to protect the public while assisting impaired physicians in their recovery. In addition, medical boards must educate their licensees from the time of initial licensure through continued licensure reregistration to inform them of the availability of treatment resources and well as the philosophy behind treatment, which should be rehabilitation, not revocation.

References

1. Crawshaw R, Bruce JA, Eraker PL, et al. An epidemic of suicide among physicians on probation. *JAMA*. 1980;243:1915-1917.
2. Council on Mental Health. The sick physician: impairment by psychiatric disorders, including alcoholism and drug dependence. *JAMA*. 1973;223:684-687.

Editor's Note—Special thanks to Gerald L. Summer, MD, for his assistance in coordinating contributions for this issue.

—Linda C. Chandler, Editor

The Alabama Physicians Recovery Network

GERALD L. SUMMER, MD

The Medical Association of the State of Alabama (MASA) for many years has recognized the need to assist the sick physician. MASA, in a contractual relationship with the Alabama Board of Medical Examiners (BME), developed the Alabama Impaired Physicians Committee (AIPC) in 1988 to promote early identification of the physician who may be ill as the result of substance abuse or mental or emotional illness. Allegations of professional sexual misconduct are also addressed by AIPC.

Development of the Physicians Recovery Network

Act 88-536 of the 1988 regular session of the Alabama legislature enabled the BME to contract with MASA for the creation of the AIPC. This legislation promotes early identification of the impaired physician, thereby protecting the consumer while offering the physician opportunity for rehabilitation. In some cases, this legislation provides a therapeutic alternative to the disciplinary process. In other cases, it allows therapeutic intervention and treatment concurrent with disciplinary action. This legislation recognizes that illness and recovery are mitigating factors in board disciplinary procedures and offers an incentive for early intervention and treatment. It also provides the licensee an opportunity to reenter practice after completing treatment and participating in a documented monitoring process.

Under the direction of MASA, the AIPC develops the policies and procedures for the impaired physicians program, known as the Physicians Recovery Network (PRN). The BME funds the activities of the AIPC and PRN. The AIPC has directed PRN as a full-time program since October 1, 1991. In establishing the PRN, MASA and the BME affirm that drug and alcohol dependence and mental/emotional illnesses are diseases which can cause physician impairment, that these diseases can be successfully treated in most cases, and that, following successful treatment, physicians can continue or resume practicing medicine with care and safety. The PRN process is consistent with the recommendations of the Federation of State Medical Boards' ad hoc committee on physician impairment.¹

The PRN works with county medical societies, medical specialty societies, hospitals, medical schools, self-help groups, and other concerned organizations to achieve its goals. Hospitals, clinics, medical schools, and other institutions

*Gerald L. Summer, MD,
Medical Director, Physi-
cians Recovery Network,
Medical Association of
the State of Alabama,
Montgomery, Alabama.*

are encouraged to develop their own impaired physician policies and programs with which the PRN can cooperate by accepting referrals. These entities are made aware that referrals are considered confidential, and the process assures that public record will be avoided and the possibility of litigation significantly reduced.

Scope of the Program

All Alabama-licensed physicians, those working in Alabama but not licensed, residents, medical students, and physician assistants are within the scope of PRN. Physicians identified to PRN are referred by fellow physicians, friends, families, hospital administrators, nurses, or others. Self-referrals are encouraged. The BME may also refer physicians who are predisposed to an impairment in medical practice. AIPC assistance in achieving recovery can be instrumental in these circumstances in preserving the physician's medical license and assuring patient safety.

Some 8186 physicians currently are in active practice in Alabama. From the beginning of the full-time program October 1, 1991, through June 15, 1995, 700 physicians have been identified to PRN. Some of those identified to PRN are inappropriate referrals and are promptly referred to the BME. Others are identified with insufficient information to proceed and are placed in long-term observation. Sufficient information was available on 256 physicians to warrant an intervention and recommendation for evaluation. Sixty-five percent of the evaluations have resulted in a diagnosis of chemical dependency/abuse, and 35% in mental/emotional illness. Ten percent of these interventions have involved allegations of professional sexual misconduct.

Evaluation and Treatment Processes

When it is determined that the physician is troubled, the physician is urged to become involved in evaluation and treatment. Intervention may be conducted by a local volunteer physician, coordinating with the medical director of PRN, members of the AIPC, a representative of the BME, and others as may be appropriate to the case. Some issues to be explored during intervention/evaluation include:

- Does the physician have an alcohol, drug, mental, or emotional problem requiring evaluation?
- Is the problem causing impairment in the individual's ability to practice medicine? If so, is there evidence of imminent danger to the public?
- Is there a history of previous treatment?
- Is the physician motivated to enter or resume treatment and to participate in the impaired physicians program?
- What is the potential for involvement by family members in the rehabilitative process?
- Is there imminent danger of suicide?

If the physician agrees to join the PRN, the medical director or his designee will formulate an action plan based in part on the suggestions of the

This legislation recognizes that illness and recovery are mitigating factors in board disciplinary procedures and offers an incentive for early intervention and treatment.

Sixty-five percent of the evaluations have resulted in a diagnosis of chemical dependency/abuse, and 35% in mental/emotional illness.

provider performing the evaluation and/or treatment. This may include further medical or psychiatric evaluation to clarify the diagnosis or to make more specific treatment recommendations. Direct referral to inpatient or outpatient treatment may be recommended. Special medical examinations may be requested to determine the nature, presence, and extent of impairment. Results of this evaluation will be used to determine the level of program participation and to develop treatment and monitoring plans.

Although the PRN does not engage in treatment per se, a recovery or rehabilitation program will be prepared and updated for each program participant by the medical director or his designee in consultation with the reported physician, those treating him, his close associates, and others as appropriate.

Treatment may include inpatient or outpatient services for detoxification, rehabilitation, psychiatric care, and/or attendance at self-help and peer support groups. Urine drug screens will be required for documentation of continued recovery, as may be needed for the BME, hospitals, other physician groups, and liability insurance companies. Changes in treatment must be approved by the medical director of PRN. Treatment providers will be part of the treatment plan if they are willing to cooperate with the impaired physicians advocacy program by reporting continued attendance and participation in treatment.

Reporting Issues

Alabama law expressly exempts the AIPC from the requirements of reporting impaired physicians. PRN reports activities to the BME, but physicians' identities are not revealed initially except under the following circumstances:

- if it is determined that the physician presents an imminent danger to the public
- if the physician is believed to be impaired and refuses to cooperate with the AIPC after sufficient committee efforts
- if, during treatment, the physician does not follow the treatment plan and/or does not respond to treatment
- if upon annual renewal of the physician's license to practice medicine in Alabama, the PRN participant acknowledges to the BME his illness and involvement with PRN

The emerging experience of the AIPC shows encouraging results. Currently, 90% of PRN program participants are compliant to monitoring requirements and are stable in recovery, with documentation to ensure that they are practicing medicine with care and safety. This favorable prognosis is consistent with that reported for other state impaired physicians programs.²

Conclusion

The Alabama PRN is a positive example illustrating that organized medicine and the regulatory board understand that it is more cost effective to rehabilitate a sick physician than it is to train another one. For the majority of

Although the PRN does not engage in treatment per se, a recovery or rehabilitation program will be prepared and updated for each program participant

Alabama law expressly exempts the AIPC from the requirements of reporting impaired physicians.

impaired physicians, cooperation can result in the assurance that they can practice medicine with care and safety.

References

1. Report of the Federation's Ad Hoc Committee on Physician Impairment. *Fed Bull: J Med License Discipl.* 1994;81:229-242.
2. Summer GL, Physician impairment: current concepts. *Fed Bull: J Med License Discipl.* 1994;81:121-122.

The Florida Impaired Practitioners Program

ROGER A. GOETZ, MD

Failure, fear, frustration, and fragmentation of care—all of which may have endangered the public, the profession, and the physician—ultimately led to the Florida system for the management of impaired practitioners. Florida's system is the logical and necessary extension of the efforts begun in 1979 by the Florida Department of Professional Regulation (DPR) and the Florida Medical Association (FMA). After futile attempts by the DPR and concurrent, independent attempts by practicing physicians to form an impaired practitioners program, the DPR and FMA joined efforts in 1985 to develop the policies and procedures presently administered by the nonprofit Physicians Recovery Network (PRN). Prior to the collaboration, the regulatory agency's program was misperceived as too public and punitive, and the medical association's program was misperceived as secretive and an extension of the "conspiracy of silence."

Funding

PRN is funded by charitable contributions and through a contract with the Florida Agency for Health Care Administration, the successor to DPR, to implement the statutorily required Impaired Practitioners Program. Physicians and other health care providers are not charged for PRN services. The PRN program has no financial relationship with any treatment program, provider, or individuals. All money for the Agency for Health Care Administration is obtained through licensing fees, and no tax revenue is involved. The program does not provide medical services. Physicians pay for their own medical care, and a loan fund and charitable services are available for those individuals without resources.

Participants

Confidentiality of medical records and participation in impaired physician programs is essential to the successful protection of the public. Confidentiality permits open and honest communication and early treatment prior to public harm. The Florida Medical Practice Act permits the confidential treatment of physicians with impairments. Approximately 84% of all referrals to the PRN occur prior to any violation of the Medical Practice Act or any evidence of patient harm. Participation is confidential unless there is failure to progress in recovery. The PRN program provides treatment, support, and referral for physicians in lieu of discipline, prior to discipline, or during discipline and

*Roger A. Goetz, MD.
Medical Director, Physicians
Recovery Network.
Fernandina Beach, Florida.*

post-discipline. The PRN is a "broad brush" program handling physical disorders (including HIV), mental disorders, substance abuse, and chemical dependency. Physicians with alleged sexual boundary violations in the practice of medicine are provided a full range of psychiatric services and monitoring should they be permitted to reenter the practice of medicine.

Networks for Therapy

Florida is the fourth largest state in the Union. It has an ethnically and geographically diverse population. It is a major population growth center with a complex influx of physicians of various nationalities, training, and political backgrounds. To ensure adequate, cost-effective, and comprehensive coverage, the Physicians Recovery Network includes three cooperative groups:

1. Committees of organized professional associations that formally provide the political basis for the organization's interaction with PRN (Examples of organizations include the Florida Medical Association, the Florida Pharmacy Association, the Florida Dental Association, and the Florida Veterinary Medical Association.)
2. Treatment experts who provide a network to actively manage participants (Examples include physicians and hospitals.)
3. Recovering community volunteers who assist in monitoring, identification, and communication and provide a continuum of contact and assurance to program participants.

Additional identification and assistance is provided by informal cooperation among various field offices of regulatory agencies. Each of these statewide networks interacts through the Physicians Recovery Network offices in an overlapping vertical and horizontal communication system to protect the public and provide a net to the falling professional.

The Florida PRN has a network of local group therapy meetings. These meetings are in addition to required attendance at 12-step groups for chemically involved physicians and other appropriate diagnostic groups. The therapy groups are self-supporting, paying their own therapist. The therapist is approved by and accountable to PRN. In addition to its monitoring functions, the group assists in forming a bond within the recovering community. This has been an extremely successful method of early detection of impending problems in group members and other health care workers. The advantage of this system is the constant interaction between participants in the PRN program and the practicing medical community.

Psychotherapy may be recommended for both chemical dependency and psychiatric conditions. Psychotherapy by a psychiatrist or other therapist under the direction of a psychiatrist is required for all non-chemical abuse or addiction participants. PRN does not interfere with psychotherapy but requests that the psychotherapist report progress and cooperation. If the physician fails to progress, discontinues medication, alters therapeutic patterns, or becomes a danger, the psychiatrist is expected to engage the services of the PRN office to mandate reestablishment of the psychotherapeutic relationship.

The therapy groups are self-supporting The therapist is approved by and accountable to PRN.

The Florida PRN now reviews its policies, procedures, and actions for the public at open meetings of overseeing boards, while confidentially managing individual physicians

PRN is totally confidential from the medical society and board members. Initially, impaired practitioner committees of the board or the medical society discussed and attempted to manage individual cases. This practice presented certain risks because membership of the committee changed, compromising confidentiality, or levels of expertise varied. Philosophies were divided, and issues of transference and counter-transference interfered. The Florida PRN now reviews its policies, procedures, and actions for the public at open meetings of overseeing boards, while confidentially managing individual physicians with a professional staff. This has been a source of reassurance to prominent physician participants.

Public Protection

Florida has a "snitch law." The law recognizes treatment prior to public harm as an exception if the treatment is under PRN direction. Should other problems or patient harm occur, discipline may be imposed concurrently. The disciplinary process remains confidential unless the licensee waives confidentiality or probable cause is found. However, if a complaint concerns a matter of immediate and serious threat to the public, an emergency suspension may be requested by the director of the PRN. This power has been used successfully as a motivational factor to participants. The public nature of the process works as a control of the PRN. Every case that does not progress becomes disciplinary, and the entire record of the impaired physician is open to review by the public and the press.

HIV Issues

The only alleged documentation of transmission of HIV to patients occurred in Florida in a dental practice. This event assumed national attention and received extensive study. The populace urged regulatory management of HIV-positive practitioners in Florida. All agreed that the HIV-infected health care worker had a physical condition which could interfere with the public safety. There also was concern about the mental status of practitioners with HIV infections. The PRN program assumed responsibilities in this matter and provided a confidential, credible, accountable system for management of HIV-infected health care workers. This program has been successful in maintaining the confidentiality of the HIV-infected practitioner who presents no danger in practice, while assuring regulatory authority and control should conditions deteriorate.

Scope of the Program

The Florida PRN has grown from a program designed for only physicians to one that covers the entire spectrum of health care workers. The success with health care workers has led to the institution of similar programs for attorneys and educators. The result of this growth has been communication among the legal, medical, and health care teams. Referrals from knowledgeable members of all disciplines ensure that the entire professional system in Florida can provide help to otherwise qualified individuals and protect both the individual and the public from the consequences of untreated or unrecovered impairments.

Every case that does not progress becomes disciplinary, and the entire record of the impaired physician is open to review by the public and the press.

The success with health care workers has led to . . . similar programs for attorneys and educators.

Kentucky Physicians Health Foundation Impaired Physicians Program

BURNS M. BRADY, MD

The Kentucky Physicians Health Foundation Impaired Physicians Program came into being in 1976 as a standing committee of the Kentucky Medical Association in response to a directive by the American Medical Association that all states should have such a committee.

The initial committee of the Kentucky Medical Association consisted of eight members, all psychiatrists and none of whom were in recovery. During the past 19 years, the committee has grown to 24 members, 14 of whom are in recovery. Of these, five are addictionologists certified by the American Society of Addictive Medicine. In addition, four psychiatrists, one of whom is in recovery, currently serve on the committee. A permanent representative of the Women's Auxiliary and the chief residents in psychiatry from both the University of Kentucky and the University of Louisville residency programs are also included.

At the inception of the Impaired Physicians Program in 1976, the mission statement was to be available for those physicians who asked for help, and no advocacy position was taken. No monitoring was instituted, and intervention techniques were not used at that time. The current mission and procedures of the Kentucky Physicians Health Foundation Impaired Physicians Program are outlined below.

Mission and Procedures

The following process will be used by the Kentucky Physicians Health Foundation Impaired Physicians Program in dealing with impaired physicians. This process should be used as a guideline. Each separate case will dictate individual variations, and each participant should be considered separately. Nor will this process cover all contingencies that may arise.

The Impaired Physicians Program will provide total oversight of this process on a routine basis. Within the dictates of timeliness, the medical director will be required to implement these steps autonomously or with the input of the chairman, individual committee members, or ad hoc groups of members, as individual circumstances dictate.

*Burns M. Brady, MD.
Medical Director, Kentucky
Physicians Health Foundation
Impaired Physicians Program.
Louisville, Kentucky.*

Staff shall act as a central information-receiving and coordinating source under the direction of the chairman/medical director.

Information/Reporting

Information about suspected impaired individuals will be received from various sources. Common recurring sources are the Board of Medical Licensure, colleagues/peers, hospital staff/administrators, coworkers, spouses, and other family members. Routinely, the information will be received by the medical director, chairman, individual committee members or staff. Reasonable efforts should be made to acquire as much objective information as possible regarding the nature of the impairment, its manifestations, substances in question, and duration of abuse.

Confirmation/Documentation

The medical director, chairman, committee member, or staff shall attempt to acquire confirmation or documentation of the abuse issue from the reporting source, the Board of Medical Licensure investigators, local contacts, and other credible sources. In some instances, adequate confirmation may not be obtained, and the process may be postponed or terminated.

Intervention

If the situation dictates, intervention may be arranged by the medical director in cooperation with colleagues, family members, licensure investigators, and other principals. Some instances will not require intervention. Where intervention is appropriate, the medical director will be included or consulted.

Assessment/Evaluation

Depending on the situation, the medical director shall arrange for assessment of the individual participant by a psychiatrist, counselor, therapist, or neuropsychologist. Circumstances may require that assessment be conducted at an off-site facility on an inpatient basis, or assessments may be made by the medical director or intervenor on the spot.

Acute Treatment

If acute treatment is indicated, the medical director shall either make or be involved in determining arrangements for acute care in an appropriate facility or on an outpatient basis. In the acute treatment phase, the nature and duration of treatment will be determined by the facility principals, and the medical director shall seek continuing information during the treatment phase. Choice of facility will be determined, in part, by coordination with the committee regarding family involvement and aftercare referral.

Aftercare

Following acute treatment, the committee will be the primary determining body for continuing care. Facets of aftercare will include liaison with and routine reporting to the licensure board, when appropriate; development of a

Reasonable efforts should be made to acquire as much objective information as possible regarding the nature of the impairment, its manifestations, substances in question, and duration of abuse.

So long as the individual is compliant with the terms of the aftercare agreement and its intent, the committee shall act . . . as an advocate with the licensure board, liability insurers, health insurance carriers, hospital medical staffs, and colleagues.

viable aftercare contract; involvement with a physician therapy group and/or an individual therapist; arrangement for random biological fluid testing; attendance at self-help group meetings and selection of a sponsor; and assignment of a committee member as a regular contact. Routine contact with the committee should be the responsibility of the individual participant. Aftercare efforts for information exchange should be coordinated between the committee and affected hospital medical staff or other local groups.

Excluding legal or prior contractual demands, information shall not be released to any party without the express signed consent of the individual involved.

Advocacy

So long as the individual is compliant with the terms of the aftercare agreement and its intent, the committee shall act in a responsible manner as an advocate with the licensure board, liability insurers, health insurance carriers, hospital medical staffs, and colleagues. This responsibility may require routine written or verbal reports on an individual's progress as well as meetings with specific agencies.

Relapse

If a relapse occurs, the committee, through the medical director, chairman, or a member, shall seek confirmation. As soon as is reasonable, a critical assessment of the individual's recovery program and nature of the relapse will be made and additional treatment or recovery modification will be determined. Agencies to which the committee is an advocate will be advised of the relapse.

Record Maintenance

Records on each individual participant will be maintained by the committee. These records will contain clinical as well as anecdotal information and are considered the sole property of the committee. Under KRS 311.619, these records are not considered to be discoverable, and their use will remain at the discretion of the committee and its director within the boundaries of any legal reporting requirements. These records also may include contracts for assessment, treatment, and aftercare.

Information Release

Excluding legal or prior contractual demands, information shall not be released to any party without the express signed consent of the individual involved. A signed general information release will be considered adequate consent except for individuals or agencies seeking only specific items of data. Anecdotal information will be released only at the discretion of the chairman, medical director, or the committee. Any information acquired without written consent of the individual shall be considered formally to be anecdotal.

Compliance

While overall recovery may be apparent, individual facets may not be quantifiable. A total recovery program, ideally, is attitudinal and cannot be objectively measured. It shall be the responsibility of the chairman, medical director,

A total recovery program, ideally, is attitudinal and cannot be objectively measured.

and the committee, using practical and personal experience, to define individual recovery facets and determine compliance. Compliance can be supported through random biological fluid testing, which shall be at the individual's expense, and through formal reports from designated therapists. Overall compliance, however, remains a subjective determination.

Operations

Staff

Currently, our staff consists of a physician medical director who is an addictionologist. This is a full-time salaried position. A full-time administrative assistant is also on staff, and a part-time employee works approximately 12 hours per week, with a range of job functions.

Our relationship with the Kentucky Board of Medical Licensure is defined as a consultant role.

Funding

The funding for the Kentucky Physicians Health Foundation is derived from various sources. The principal funding is derived from a portion of the state license and reapplication fees generated by the Kentucky Board of Medical Licensure. This revenue totals \$200,000 per year. Donations from medical malpractice groups in Kentucky are contributed into the 501(c)(3) under which the Kentucky Physicians Health Foundation Impaired Physicians Program operates. Our current budget is \$250,000 per year.

Relationships

Our relationship with the Kentucky Board of Medical Licensure is defined as a consultant role. Moneys from the license fees are dispensed as a budget item of the Kentucky Board of Medical Licensure to the Kentucky Physicians Health Foundation Impaired Physicians Program.

Our relationship with the Kentucky Medical Association is currently in an advisory role. This relationship has changed within the past 12 months. As noted earlier, the Impaired Physicians Committee previously was a full standing committee of the Kentucky Medical Association. With the assistance of the Kentucky Board of Medical Licensure and the Kentucky Medical Association, the Kentucky Medical Malpractice Act was opened in the past Kentucky legislative session, and through statute definition, we now have immunity from discovery of records and protection in liability issues commensurate with the Kentucky Board of Medical Licensure.

... we now have immunity from discovery of records and protection in liability issues....

With the full assistance of the Kentucky Medical Association, 501(c)(3) foundation status was obtained, and the Kentucky Medical Association's Impaired Physicians Committee evolved into the Kentucky Physicians Health Foundation Impaired Physicians Program.

The Treatment Program

Admissions

Individuals are referred to us from various sources, including the Kentucky Board of Medical Licensure, hospital staffs, individual referrals, Louisville Metro Narcotics, and the court systems. As noted in the Mission Statement, the full process then involves confirmation, intervention, evaluation, treatment, after-care, advocacy, reentry, and monitoring.

Dismissal can occur at anytime due to breach of contract or the individual's choice.

Monitoring in our program consists of a five-year contract. Individuals may elect to continue in our program, and they are invited to do so beyond the five-year contractual basis. Dismissal can occur at anytime due to breach of contract or the individual's choice. If dismissal occurs, the groups with which we have advocacy relationships are notified.

The Kentucky program has handled approximately 300 cases since 1976. The program consists of 150 active cases with a new intake of approximately five cases per month. Our success for the past 150 physicians approximates 90%.

Treatment

In the evolution of the Kentucky Physicians Health Foundation Impaired Physicians Program, we have found components that work both efficiently and economically. We have developed two evaluating teams consisting of a board-certified psychiatrist/addictionologist and a certified chemical dependency counselor (CCDC). They are geographically located to service the state in its eastern and western distribution. At the time of documentation and intervention, the individual physician is referred to the evaluating team in closest proximity. The evaluation is done on a fee-for-service basis. The psychiatrist and/or CCDC interviews the physician separately before discussing the case. All the information that we have is at their disposal. Following their conclusions, they contact the medical director, and a decision is made about the best treatment to be instituted for the individual in question.

We also have insisted that the program doing the intensive inpatient evaluation not be the program that will be doing the treatment, if inpatient treatment is recommended.

Intensive outpatient treatment is done at various locations within our own state, and intensive inpatient residential programs used are ones that we have found to be particularly effective and cost-efficient. Should intensive inpatient evaluation be recommended by the on-site evaluating team, we refer these cases to programs with cost-efficient and effective histories. We also have insisted that the program doing the intensive inpatient evaluation not be the program that will be doing the treatment, if inpatient treatment is recommended.

At the completion of treatment, the individual is enrolled in one of the physicians therapy groups situated in various geographic locations in Kentucky. These cofacilitated therapy groups meet weekly, and the physician returning from treatment will be involved in these groups for six months to two years. Group therapy is not a precedent set by the State of Kentucky, but we have developed it into a distinct and highly productive component of our recovery process.

The cost of the evaluations and the therapy group is the responsibility of the individual in recovery. Through the benevolent endeavors of the Kentucky Medical Association, the Kentucky Physicians Health Foundation Impaired Physicians Program has access to a benevolent fund for any individual unable to pay for the treatment program. Interest-free loans are available, and the loan is monitored by the Kentucky Medical Association.

Recovery and Monitoring

As with any successful program, the basis for successful recovery is a major spiritual component. We consider the latitude of the spirituality to include Alcoholics Anonymous, which is our primary recommendation. The number of meetings attended is established by the medical director of the program in full concert with the recovering individual, the significant others of the recovering individual, and the treatment team for the physicians therapy groups. Approximately 2% of monitored recovering physicians have elected to use the church as their spiritual recovery, and two individuals have selected Rational Recovery as the supportive mechanism.

Nine physicians on the Impaired Physicians Committee are located strategically throughout the state. When an individual returns from treatment, he is assigned to one of these monitoring physicians, and this relationship constitutes an integral part of our monitoring system. Other integral parts of the system are the monthly reports from the physicians therapy groups and documentation from responsible significant members of the support system. Random drug screens are done within the confines of this monitoring system.

Successes and Challenges

The success we have had from our physicians therapy groups has been monumental. This is measured not only in the quantity of recovery but in the quality. Perhaps our biggest disappointment has been the inability to initiate consistent structure in spousal treatment, aftercare, and general involvement. We did try monthly Couples in Recovery meetings, but they were not successful. In conjunction with other state physicians assistance programs, we have begun preparation for an annual group retreat.

Our experience has revealed that nine of ten physicians with whom we are involved present chemical dependency problems. However, we have had increasing success with the other 10% who have various difficulties such as physical and/or emotional problems. We are seeing significant increases in disruptive physician referrals and in cases of sexual impropriety not involving chemical dependency. Our network of evaluation, treatment, and reentry in these cases has been greatly facilitated by a diligently working regional Federation of Physicians Health Programs. Information exchanged at these meetings has been invaluable to our program, and certainly every intent is directed toward continuing such meetings. Through the sedulous effort of a few physicians over the past five to ten years, the National Federation of Physicians Health Programs has matured and has become a valuable asset to the

Perhaps our biggest disappointment has been the inability to initiate consistent structure in spousal treatment, aftercare, and general involvement.

... nine of ten physicians with whom we are involved present chemical dependency problems. However, we have had increasing success with the other 10% who have various difficulties

Kentucky Physicians Health Foundation Impaired Physicians Program. Cross-state communication is an invaluable tool for studying our individual successes and failures as well as in transferring and monitoring individual physicians.

Missouri Physicians' Health Program

ANGELA M. ALLEN, BJ

It is estimated that approximately one of 100 physicians will suffer from some sort of impairment due to substance abuse and dependence annually.¹⁻⁴ The Missouri State Medical Association (MSMA) recognized the need for assisting the impaired physician and, in 1985, established the Missouri Physicians' Health (MPH) Program. The MPH Program deals with issues of impairment among Missouri physicians suffering from alcoholism, drug dependence, psychiatric problems, and/or physical impairment. The program is designed to treat the problem of impairment with compassion and understanding while providing the impaired physician with essential tools needed to work toward a strong personal and professional recovery.

The Missouri State Board of Registration for the Healing Arts also is concerned about the rehabilitation of impaired physicians. "The Board has been involved for years with trying to rehabilitate doctors who are impaired. Comparing the statistics to the number in treatment, it means there are a lot of impaired physicians not seeking treatment,"⁵ said August W. Geise, MD, president of the Board.

For many years, the MPH Program and the Board operated without a sense of cooperation. Communication between the program and the Board was limited, and the two organizations tended to work independently rather than with one another. The Board and the MPH Program recently recognized that they shared a common vision: the successful rehabilitation of the impaired physician. It was because of this shared belief that the "Memorandum of Understanding" (MOU) was created. This document ended an era of mistrust and created a new age of cooperation.

"The spirit under which the MOU was created is clearly visible in the opening paragraph: . . . 'to develop a cooperative relationship between the two organizations that will both safeguard the public and provide the physician with the opportunity to return to practice through a system of detection, early intervention, effective treatment and monitoring,'" said Robert Bondurant, RN, LCSW, program coordinator for the MPH Program.

One of the greatest fears of impaired physicians is the loss of licensure. They worry that if they seek assistance for their problems they may face disciplinary action by the Board of Healing Arts. The MOU consistently stresses

*Angela M. Allen, BJ,
Managing Editor,
Missouri Medicine,
Jefferson City, Missouri.*

One of the greatest fears of impaired physicians is the loss of licensure.

the need for confidentiality. It requires the MPH Program to make reports on voluntary clients when they initially join the program and then at quarterly intervals. Each client is reported to the Board by a code number. The report consists of information concerning compliance with the program, such as results of urine drug screenings, attendance of group psychotherapy meetings or AA/NA meetings, and any other information that may detail progress. The mandatory client, who is already known to the Board, is also reported quarterly using a code number.

The new relationship with the Board of Healing Arts has strengthened the MPH Program's role as an advocate for impaired physicians. Through monitoring its participants, the MPH Program creates a record of recovery for the impaired physician that is used to advocate for the physician. If the mandated client is found to be in noncompliance, the program is required to report him to the Board. The Board confers and determines the disciplinary action. The MPH Program advocates on the client's behalf before the Board. The program will help to formulate a plan of recovery that will work in conjunction with the Board's action. The client is not judged solely on his current state of noncompliance but also on his overall participation in the program. This allows both organizations to determine how to strengthen the client's recovery plan in order to facilitate a return to rehabilitation.

The MOU offers a sense of security both to the impaired physician and to the people involved with impaired physicians. Colleagues, friends, and family members of an impaired physician can facilitate participation in the program and be assured that their referral will not ruin that person's professional career. Mr. Bondurant expresses the benefits of the MOU:

Because the Board is encouraging rehabilitation rather than discipline, there should be less fear and concern about joining the program. We also hope that those who are concerned about someone will feel more comfortable referring him because he will not lose his license. Spouses, family members, peers and administrators—those who see the impairment—can feel better about contacting the program if they know it will make a positive improvement in the person's life, profession, and future.

The Board of Healing Arts licenses more than 12,000 physicians each year to practice in the state of Missouri. It is estimated that 1% of these professionals are impaired. The MPH Program reported 31 referrals for 1994 and a total of 75 participants. With heightened awareness, more professionals impaired by chemical dependency or psychiatric illness can arrest the problem before it puts them, their loved ones, or their practice in jeopardy. The MPH Program hopes that the MOU will create a new outlook on the problem of impairment.

Memorandum of Understanding

The Memorandum of Understanding has developed a cooperative relationship between the MSMA Physician Health Program, the Missouri Association of Osteopathic Physicians and Surgeons Physician Health

The client is not judged solely on his current state of noncompliance but also on his overall participation in the program.

Program, and the Board of Healing Arts that will safeguard the public and provide the physician the opportunity to return to practice through a system of detection, early intervention, effective treatment, and monitoring.

Two types of clients are created for the physician health program:

1. **Mandatory:** an individual who enters an impairment program either as a conditional requirement of a formal disciplinary agreement with the Board of Healing Arts or in lieu of possible formal disciplinary action by the Board. Mandatory participants are required to sign the program's contract. If a participant fails to comply with any provision of the contract, the executive committee and/or the MPH will report the individual to the Board.
2. **Voluntary:** any individual who decides to participate in the impairment program either on his own or through referral. The identity of the participant is not known by the Board of Healing Arts and is referred to only by code number. If a voluntary participant fails to comply with any provision of the contract, the executive committee and/or the MPH will report the individual by code number to the Board of Healing Arts.

Colleagues, friends, and family members of an impaired physician can . . . be assured that their referral will not ruin that person's professional career.

Guidelines Specific to Mandated Clients

1. The Board agrees to provide to the MPH a copy of the signed order for all mandated clients within 14 days of the date signed.
2. The MPH agrees to provide the Board a copy of the signed impairment agreement for all mandated clients within 14 days of the date signed.
3. The MPH agrees to provide to the Board a program evaluation report for all mandated clients within 14 days.
4. The MPH agrees to provide the Board quarterly progress reports as specified.
5. The MPH agrees to notify the Board the next working day by telephone and to follow up in writing within 14 days of positive urine or blood tests, failure to submit to screening, habitual absence (leaving the program), substantiated complaints of relapse, or other physical or mental indicators observed by the MPH staff.
6. The MPH agrees to have the director or designee and an attorney (at the client's discretion) to accompany the client to meetings of the Board should the Board have reason to believe that the client is not complying with terms of the agreement.

The identity of the [voluntary] participant is not known by the Board of Healing Arts and is referred to only by code number.

Guidelines Specific to Voluntary Clients

1. The MPH agrees to provide the Board a program evaluation report by code number within 14 days of the client's joining the program. When this is not possible, the MPH agrees to provide a preliminary report within 14 days followed by a complete program evaluation within a reasonable period of time.
2. The MPH agrees to provide the Board quarterly progress reports (including any noncompliance) by code number.

3. The Board may request and the MPH may recommend that certain coded clients be revealed because of a pattern of noncompliance with the contract.
4. The Board agrees that when a voluntary client's name has been released by the MPH because of a pattern of noncompliance with the contract, the Board will consult with the director of the program about the patient's stability before initiating its investigation.

... the Board will consult with the director of the program about the patient's stability before initiating its investigation.

Reports

An evaluation report that details the initial examination of the client includes the following information: the reason for referral to the program (if applicable), clinical history and diagnosis, treatment, and aftercare plan and return-to-work recommendations.

A quarterly progress report provides a statement of compliance. If the client has experienced any form of noncompliance (including, but not limited to, updated information on results of drug screenings, aftercare performance, monitoring meetings, AA/NA meetings and record of attendance, or therapy), recommended revisions and information regarding any outside legal action will be provided.

General Guidelines

The MPH agrees to use comprehensive drug screenings when initially testing all clients, whether mandatory or voluntary, and will continue comprehensive tests if the results of the initial test are positive. If the results of the initial test are negative, the MPH will use the simpler test. It is also agreed that if a client has a positive urine drug screen, it will be followed initially by a comprehensive drug screen. If the screen is negative, the client then will be subject to the simpler test.

The MPH agrees to provide the Board a directory of all hospitals and clinics used by the program and to notify the Board when a hospital or clinic or other health facility is added or deleted. When the hospital, clinic, or other health care facility is deleted, the MPH agrees to notify the Board in writing the reason(s) for terminating the relationship.

Should such condition arise that might require or lead to discipline of a client's license, the Board agrees to take into consideration the client's participation and compliance in the program before final discipline is decided. The MPH agrees that the Board reserves the right to evaluate the program.

The MPS agrees to use comprehensive drug screenings when initially testing all clients, whether mandatory or voluntary....

References

1. Brewster JM. Prevalence of alcohol and other drug problems among physicians. *JAMA*. 1986;255:1913-1920.
2. Shore JH. The impaired physician: four years after the problem. *JAMA*. 1982;248:3127-3130.
3. Talbott DG, Gallegos KV, Wilson, Porter TL. The medical association of Georgia's impaired physician program. *JAMA*. 1987;257:2927-2930.
4. Arnes JF. Substance abuse: one anesthesiologist's perspective. *Am Coll Surg Bull*. 1993;78:10-14.
5. The board and the MSMA physicians health program share rehabilitation goal for impaired physicians. *Mo Med*. 1995;92(2):78-79.

The North Carolina Physicians Health Program

ROBERT C. VANDERBERRY, MD

The state of North Carolina is fortunate that its two major health care organizations—the North Carolina Medical Society (NCMS) and the North Carolina Medical Board (NCMB)—are keenly interested in the health of its physicians as well as their patients. In other states, it sometimes seems that such organizations are diametrically opposed to one another, with the licensing board solely interested in the welfare of the patient and the medical association solely interested in the welfare of the physician. The NCMB and the NCMS still have differences of opinion on many issues, but the issue of physician impairment is not one of those. Since 1986, these two bodies have collaborated to establish a statewide impaired physicians program, and the program has been operational since December 1988.

North Carolina has benefitted from good luck and good timing as well as good planning. Despite the wishes of the NCMS Physicians Health and Effectiveness Committee (PHEC) to have a full-time impairment program, a breakfast meeting between a NCMB member and pioneer in the field of physician impairment did as much as anything to start the impaired physicians program in North Carolina. Harold L. Godwin, MD, of the NCMB, discussed the merits of having a full-time program with David Canavan, MD, Medical Director of the New Jersey Impaired Physicians Program since 1982, at a one-on-one meeting in September 1986. Dr. Godwin was so impressed that he wrote the NCMB and the *North Carolina Medical Journal* about his strong belief that North Carolina needed such a program.

At about the same time, the PHEC had to convince the entire NCMS delegation that an impaired physicians program was in the best interest of organized medicine. Coincidentally, resolutions through the NCMS Aging Committee and the NCMS PHEC came to the NCMS House of Delegates at the same time in 1986, both seeking a full-time impaired physicians program. In an unusual move, John Foust, MD, president of the North Carolina Medical Society, stepped down from his seat at the head of the House of Delegates and came to the floor to speak in favor of the resolution. Initially, it seemed that the resolution was defeated by a loud voice vote, but Jonnie McLeod, MD, of Charlotte, alertly requested a roll-call vote. When the roll call was tabulated, the resolution had passed. The NCMS thereby endorsed the concept of establishing an impaired physicians program.

*Robert C. Vanderberry, MD,
Medical Director, North
Carolina Physicians
Health Program,
Raleigh, North Carolina.*

Establishment of the Program

With the resolution in place, the PHEC began collaborating with members of the NCMB to seek statutory authority for an impaired physicians program. As a state agency, the NCMB was unable to lobby for itself, but the PHEC did so very effectively. In August 1987, State Statute 90-21.22 was passed to amend the Medical Practice Act. This peer review statute allowed the NCMB to set up an impaired physicians program and to give the operation of the program to the NCMS. While rules and regulations were being worked out for this interaction between the NCMB and the NCMS, a task force was created to select the first medical director of the North Carolina Physicians Health Program (NCPHP). Robert C. Vanderberry, MD, a pediatrician/addictionologist and retired US Navy officer, was chosen for the position.

On December 1, 1988, Dr. Vanderberry was given the 23 cases that had been handled by the PHEC. That same morning, he met with the North Carolina Medical Board and received his marching orders. In truth, no one knew how many cases of impairment existed in North Carolina, and no one was sure how an impaired physicians program really would or should be handled. On December 8, 1988, the first new case was reported. Over the course of the first year, Dr. Vanderberry and his administrative assistant, Kimberly McCallie, dealt with 93 new cases in addition to the 23 initial ones. Toward the end of the first year, an alcoholism counselor, Lynn Anderson, was named assistant program director. Dr. Vanderberry examined all the new cases, and Mr. Anderson monitored all the old cases through 1989 and 1990.

Growth and Funding

During 1990, it became apparent that the increase in the number of referrals and the geographic limitations were too much for Dr. Vanderberry and Mr. Anderson to handle. It was obvious that a field coordinator to handle western North Carolina would be necessary. However, a new source of funding would be needed to underwrite this new position. Heretofore, the funding of the program had come primarily from medical licensure fees, with additional contributions from the NCMS and from Medical Mutual Insurance Company of North Carolina. It was decided that the NCPHP should solicit money from hospitals for whom services had been rendered, where malpractice suits had been prevented and physicians had been rehabilitated and returned to their communities and their hospitals. With the blessing of the Board of Trustees of the North Carolina Hospital Association, the NCPHP began a full-scale marketing effort to make hospitals aware that the impaired physicians program was providing risk management services. Forty percent of hospitals began contributing to NCPHP in 1990, with contributions based on hospital bed capacity. Since that time, more than 50% of the hospitals in North Carolina have consistently contributed 35% to 40% of the NCPHP budget annually. NCPHP added not only a field coordinator but another clerical assistant to keep pace with the increasing number of cases coming into the program.

In truth, no one knew how many cases of impairment existed in North Carolina, and no one was sure how an impaired physicians program really would or should be handled.

Since that time [1990], more than 50% of the hospitals in North Carolina have consistently contributed 35% to 40% of the NCPHP budget annually.

... confidentiality can be maintained for the person referring an individual to the program as well as for the individual referred.

Participant Statistics

Over the past six years, NCPHP has worked with more than 500 physicians. Consistently, 70% of the physicians who have been enrolled have had chemical dependency problems. Other conditions have included psychiatric problems, dual diagnosis problems (chemical dependency plus psychiatric illness), sexual misconduct, behavioral disruption, and problems secondary to aging. Because of the wisdom of the initial legislation, confidentiality can be maintained for the person referring an individual to the program as well as for the individual referred. Cases are presented by case number and case scenario, and in the majority of cases, anonymity is maintained. A Compliance Committee of the NCPHP Board of Directors ensures that there is no undue influence on the Board of Directors by the North Carolina Medical Board and that the NCPHP staff will not be inclined to "sweep something under the rug." A majority vote of the Compliance Committee members is required before anyone's anonymity is broken to the NCMB. In November 1994, physician assistants were brought under the NCPHP umbrella, and a physician assistant was added to the NCPHP Board of Directors.

When the 500th participant was enrolled in January 1995, statistics were tabulated to determine the NCPHP success rate over the past six years. Of the 500 cases, 338 were chemical dependency cases; 59 were psychiatric disorders; 38 were sexual misconduct; 54 included a collection of problems such as physical handicaps, behavioral problems, aging, and cognitive difficulties; and 11 cases were unsubstantiated. (See Table 1.)

Table 1.—NCPHP, the First 500 Cases

Chemical Dependency	338
Psychiatric Disorders	59
Sexual Misconduct	38
Miscellaneous*	54
Unsubstantiated	11
Total	500
*physical handicaps, behavioral problems, aging, cognitive difficulties, etc.	

Combined, 91.7% of the chemical dependency cases are still actively practicing and in good recovery.

Of the chemical dependency cases, 265 individuals have had continuous sobriety from the time of the enrollment, which represented 78.4% of the entire chemical dependency number. Forty-five cases (13.3%) had relapsed but were re-treated and were able to continue practicing. Combined, 91.7% of the chemical dependency cases are still actively practicing and in good recovery. Three individuals died sober (0.9%). Unfortunately, 23 individuals (6.8%) continued to relapse and were unable to maintain their recoveries. All of these physicians lost their licenses. Two individuals (0.6%) were victims of overdose deaths. (See Table 2.)

Table 2.—Chemical Dependency Cases, the First 338

Continuous Sobriety	265	(78.4%)
Relapsed, Retreated, Continued Practice	45	(13.3%)
Died Sober	3	(0.9%)
Total	313	(92.6%)
Continued Relapses, Lost Licenses	23	(6.8%)
Overdose Deaths	2	(0.6%)
Total	25	(7.4%)

With a sharply increasing workload of sexual misconduct cases as well as behaviorally disruptive cases, it is anticipated that the associate medical director will have a full workload

Plans for Future Operations

During 1995 and beyond, it is anticipated that there will be many new cases and new trends of referral of those cases. Funding has been approved for an associate medical director, and a psychiatrist/addictionologist has been hired. With a sharply increasing workload of sexual misconduct cases as well as behaviorally disruptive cases, it is anticipated that the associate medical director will have a full workload dealing with those cases as well as the standard chemical dependency cases. For now, it is anticipated that the NCPHP will continue to have three-year treatment plan contracts for monitoring physicians. Although many states are implementing five-year monitoring contracts, the NCPHP has decided to adopt another monitoring procedure between the third and fifth years of recovery. The NCPHP has chosen to use a Post-contract Agreement whereby the physician will continue to send in meeting attendance logs for 12-step recovery meetings, will agree to continue with Caduceus meetings, and will have a working relationship with an AA/NA sponsor. Because going to meetings and having a sponsor seem to be the real keys to recovery, the Post-contract Agreement would seem to satisfy this need. Likewise, physicians who have completed their third year of recovery will be chosen as monitors for other recovering physicians. This will keep them in contact with the NCPHP office, as they send quarterly reports and interact frequently with the office about the persons they are monitoring.

Over the coming years, the NCPHP hopes to become more self-sufficient financially. It has received 501(c)(3) tax-exempt status. The NCPHP began charging participating physicians \$100 monthly and physician assistants \$50 monthly in July 1995. Also it is anticipated that an annual campaign will be established this year whereby former participants and friends of the program can contribute to the program annually or can consider a contribution to the program through their estate planning. It is obvious that the North Carolina Medical Board has its own increasing expenses and cannot continue to contribute substantial sums to the program on an ongoing basis. That is why this

. . . this program and others like it . . . will need to become more self-sustaining while providing high quality services to its participants.

program and others like it across the country will need to become more self-sustaining while providing high quality services to its participants.

Value of the Investment

People often ask whether we are spending too much time and resources trying to rehabilitate impaired physicians. Unfortunately, some people still believe that impaired physicians are a blight on medicine and do not deserve an opportunity for rehabilitation. However, it should be understood that physicians are fallible human beings just like anyone else, despite the fact that they may have more advantages and more education. If afforded the opportunity to recover, each of these individuals can affect the lives of thousands of patients over the course of their careers. Considering the fact that untreated chemical dependency is nearly 100% fatal and that recovery among physicians can be as high as 92%, the time and resources spent to rehabilitate impaired physicians is more than worth the expenditure. To see a physician regain his dignity, his family and the respect of his peers and patients is gratifying. The naysayers are certainly wrong in belittling the efforts of those working in the field of physician impairment. Those licensure boards and those medical associations that help physicians recover deserve our gratitude.

... the time and resources spent to rehabilitate impaired physicians is more than worth the expenditure.

The Physicians' Health Programs of the Educational and Scientific Trust of the Pennsylvania Medical Society

PENELOPE P. ZIEGLER, MD

Since the mid-1970s, the Pennsylvania Medical Society has had an interest in assisting impaired physicians through a peer support system of doctors helping doctors. This activity began as a committee of volunteer members of the Society who had professional expertise and/or personal experience in alcohol and other drug dependencies and recovery. Committee members devoted time to intervene with impaired colleagues, offer support and direction to physicians entering treatment and reentering practice, and educate the profession about the risks of professional impairment.

In 1985, the Pennsylvania Medical Society determined to develop a professionally staffed program for the purpose of identification, intervention, referral, monitoring, and advocacy of impaired physicians. The Society hired its first full-time medical director, Robert McDermott, MD, in 1986. The Physicians' Health Programs (PHP) have expanded rapidly since that time, adding professional and support staff and broadening the population served to include physicians whose professional and/or personal lives have been disrupted by any health issue. Educational programs for medical students, residents, and practicing physicians have been implemented, and special support systems have been developed for physicians experiencing difficulty coping with stress related to professional liability litigation and other job-related stressors.

Staffing

The current staffing pattern of the program is as follows:

Medical Director—a full-time position filled by an addiction psychiatrist board-certified in Psychiatry with Added Qualifications in Addiction Psychiatry and certified in Addiction Medicine by the American Society of Addiction Medicine

Associate Director—a full-time master's level employee assistance specialist with extensive experience in drug and alcohol counseling as well as administrative, budgeting, and fund-raising training and experience

*Penelope P. Ziegler, MD.
Medical Director, Physicians' Health Programs of the Educational and Scientific Trust of the Pennsylvania Medical Society. Harrisburg, Pennsylvania.*

Coordinator of Case Management—a full-time addiction counselor who oversees the monitoring program for recovering physicians

Administrative Assistant—a full-time position coordinating and managing the data system, planning meetings and mailings, and handling documentation and correspondence

Volunteer Monitoring Network—a statewide network of 25 to 30 physicians who devote varying amounts of time for face-to-face monitoring of the progress of physician participants, assessing their progress in recovery, their commitment to ongoing treatment and recovery activities, and their abstinence status via random observed body fluid screenings

[A] statewide network of 25 to 30 physicians [devotes] . . . time for face-to-face monitoring of the progress of physician participants.

Operations

In 1989, the PHP became a part of the Pennsylvania Medical Society's Educational and Scientific Trust, a 501(c)(3) charitable foundation that also administers the Society's student loan programs, leadership training institute, and public health initiatives. This relationship has permitted the PHP to expand the fund-raising activities needed to finance its ongoing work.

The PHP is overseen by a nine-member Physicians' Health Committee composed of members of the Pennsylvania Medical Society who have expertise and experience in professional impairment. The Committee meets six times a year and holds telephone conference calls on an as-needed basis to address funding issues; organizational and staffing concerns; relationships between the PHP and the Pennsylvania Medical Society, State Board of Medicine, and other organizations; philosophy and scope of the program; and other issues. It is not involved in the management of individual cases.

The PHP Advisory Committee, consisting of 25 to 30 members appointed by the trustees of the Educational and Scientific Trust, provides expert consultation in the management of specific cases and in the overall approach to various types of impairment and distress. Members of this committee represent a broad range of clinical specialty areas, including addiction medicine, psychiatry, neurology, physical medicine and rehabilitation, infectious diseases, and pain management. This committee meets yearly, but its individual members are available for consultation on an as-needed basis.

Funding for the program comes from contributions and grants from organized medical systems, health care delivery organizations, hospital medical staff organizations, and individual contributors. A major grant is received yearly from the Pennsylvania Medical Society Liability Insurance Corporation, which recognizes the preventive value of early detection and intervention and strongly supports the Litigation Stress Program. The PHP has received generous support from some large insurance plans and health maintenance organizations, including Pennsylvania Blue Shield and HealthAmerica. For the past six years, the PHP has conducted an intensive fund-raising campaign with hospitals, encouraging medical staffs and administrations to make matching contributions for the ongoing support of PHP activities. At the present time, no financial support is received from licensure fees or via any other governmental agency.

At the present time, no financial support is received from licensure fees or via any other governmental agency.

There is no formal relationship between the PHP and the State Board of Medicine or the State Board of Osteopathic Medicine. However, we have worked cooperatively with both regulatory bodies and, since 1989, have been recognized by the State Board of Medicine as an approved impaired professional monitoring program. Approximately 12% to 15% of our referrals come from licensing boards that have received complaints but have elected to divert cases from disciplinary to rehabilitative disposition and require the licensee to enroll in the PHP for ongoing monitoring as needed.

Referral and Monitoring

Services of the PHP are available to any physician or medical student in Pennsylvania, regardless of membership in the Pennsylvania Medical Society or current licensure status. A recent review of our data base showed the primary sources of referral indicated in the table.

Treatment Provider	22%
Concerned Colleague	19%
Hospital	17%
Self	16%
State Board of Medicine	12%
Other State IPP	6%
Family	5%
Other	3%

There are no direct charges to participants for the referral, monitoring, and advocacy services provided by the PHP. Participants are responsible for the costs of treatment, laboratory fees, and other costs related to recovery from impairment.

Monitoring agreements are written and individualized to meet the needs of the particular participant. In general, they include regular documentation of attendance at and progress in treatment; body fluid screens; attendance at 12-step (eg, Alcoholics Anonymous) meetings, support groups, and/or self-help services; reports from the assigned PHP monitor relating to progress, compliance, and other issues; regular telephone contact, and as-needed meetings with PHP staff. The written monitoring agreement contains language describing the consequences of noncompliance, including discussion of the case with the consultant on impairment to the State Board of Medicine in the event of persistent noncompliance, untreated relapse, and/or other issues which present an actual or potential threat to the public safety.

The initial monitoring agreement is for a period of three years. It can be extended as recommended by the PHP medical director or as required by the employer, State Board of Medicine, or other authority. A voluntary, less intensive monitoring agreement is offered to participants who have demonstrated three or more years of stable recovery and wish to remain in the

Approximately 12% to 15% of our referrals come from licensing boards that have received complaints but have elected to divert cases from disciplinary to rehabilitative disposition

Participants who have been referred to the State Board of Medicine because of noncompliance and/or active impairment may be maintained in the active caseload or placed on inactive status

... the programs rely heavily on the concept and practice of peer support....

program for continued support and advocacy. Participants who have successfully completed a monitoring agreement and do not wish to maintain an active file are placed on inactive status. Participants who have been referred to the State Board of Medicine because of noncompliance and/or active impairment may be maintained in the active caseload or placed on inactive status as determined by the medical director and PHP staff.

Since 1986, the PHP has offered services to more than 1300 physicians, medical students, and physician assistants. At the present time, the active caseload of physicians enrolled in the program is approximately 530. A recent outcome study indicated that, of those physicians referred because of professional impairment, 84% experience uncomplicated recoveries with no relapses. Of the 16% who do experience relapse to active addictive disease or recurrence of acute psychiatric symptoms, most are able to reestablish stable recovery. More than 90% of the participants are able to reenter the practice of medicine. Those who do not include treatment failures, physicians with static or deteriorative conditions such as dementia, and those who have had lengthy license suspensions or revocations.

One special aspect of the Pennsylvania PHP is its reliance on volunteer physician monitors, most of whom have completed the monitoring program themselves, to provide day-to-day support and monitoring services to physicians entering the program. Training seminars for new monitors orient them to their role and responsibilities and offer an opportunity to explore possible scenarios through case discussions and role playing. Compensating for the geography of the state and the limited size of the professional staff, this system allows for face-to-face contact with a representative of the PHP on a monthly basis, or more frequently. A network of support groups, known as Caduceus meetings, or medical 12-step meetings are available in the larger metropolitan areas. However, many participants living in rural areas are unable to attend these groups on a regular basis and depend on the monitoring system for support in their local areas. A similar network of supportive colleagues is used in the Litigation Stress Program, which attempts to pair physicians being sued with others in their specialty who have "survived" the litigation experience. Thus, the programs rely heavily on the concept and practice of peer support, which is both cost-effective and attractive to physicians in need of services.

Tennessee Medical Foundation Impaired Physician Program

DAVID T. DODD, MD

During the 134-year history of the Tennessee Medical Association (TMA) preceding 1978, organized efforts were directed at the politics of medicine and continuing medical education. As was characteristic of organized medicine in general, little emphasis had been placed on the mental and emotional health of its membership. In April 1978, the House of Delegates resolved that the TMA would formalize and operate an Impaired Physician Program. Its charge would be to identify and triage rehabilitation for physicians impaired by mental/emotional illness and/or alcohol or other drug addiction. Oversight was relegated to an Impaired Physician Peer Review Committee (IPPRC). The relationship between the TMA IPPRC and the Tennessee Board of Medical Examiners (BME) is an informal one based upon mutual respect, mutual support wherever possible, and credibility. Herein, the evolution of this program is summarized, services currently being provided are described, and early outcome data are presented.

Chemical Dependence

Our early experience with chemical dependence, using quality of recovery as a guideline, demonstrated a direct relationship between successful outcome and length and type of treatment. We settled for approximately 120 days out of practice with inpatient or residential treatment as the standard for obtaining advocacy from the IPPRC. This formula has consistently provided a 93% favorable outcome for chemical dependence treatment. Furthermore, we came to recognize the core pathology among chemically dependent physicians to be endogenous "toxic shame" and unresolved feelings of guilt in this population occurring in two "layers"—that which preceded the onset of addiction and that secondary to the addiction itself. For solid recovery, both layers must be resolved.

Toxic shame (fear of not measuring up to the profession's standards) leads one to be acutely sensitive to feelings of guilt (fear of doing an inadequate job) within the healers' arena of being all things to all people. In susceptible individuals, these feelings of inadequacy take root in certain families of origin and are magnified by medical education and postgraduate training. Such vulnerability, combined with other personality characteristics of physicians—obsessive/compulsive traits, perfectionism, chronic self-doubt, exaggerated

*David T. Dodd, MD.
Medical Director,
Tennessee Medical
Foundation Impaired
Physician Program.
Nashville, Tennessee.*

sense of responsibility—set a groundwork for all sorts of dysfunction, including impairment.

At the outset of the TMA IPP, chemical dependency was prevalent and the incidence seemed to be increasing. Early experience with this population served as a gateway to a better understanding of the psychology of physicianhood and presented the key to more diverse services.

A Unifying Theory

Alcohol dependency is known to be associated with both genetic and developmental factors in susceptible individuals. In our experience, developmental factors dictate the choice to use, while genetic factors promote abuse, increase the likelihood of dependency, and dictate its rate of progression. For some physicians, other legal mood-altering drugs constitute a substitute for alcohol for various reasons. Toxic shame and unresolved feelings of guilt are major developmental factors leading to use of all mood-altering substances. If chemically dependent physicians have a double dose of shame and guilt, are there not many other physicians in possession of the developmental factors who act them out in various ways leading to adverse consequences, including double-dosing with shame and guilt? Our experience dictates an unqualified “yes” answer to this question. Upon this theory, our program has expanded to provide a variety of services to physicians.

Diversity of Services

Workaholism

Work can become an addiction destructive to wholeness within a physician and his nuclear family. Burnout, depression, and anger are its hallmarks. Intervention and appropriate counseling promote resolution in almost every case.

Overprescribing Mood-Altering Substances

Overextension and the inability to say “no” without feelings of guilt frequently underlie a physician’s prescribing habits and may make him vulnerable to patients who ask for particular substances. For such physicians, we have designed a seminar given twice annually. Participants learn to say “no” without guilt and to be wary of becoming a victim through trying to be all things to all people. Within our program, more than 100 physicians have participated in this service with no repeat offenders to date.

Disruptive Physicians

Some physicians act out their unresolved shame and guilt in a disruptive fashion. In the absence of fixed personality disorders, intervention and appropriate counseling have proven effective in 90% of two dozen such cases.

Dysfunctional Professional Associations

A group of physicians can become dysfunctional in a fashion similar to a family. Here again, one or more members may be acting out shame and guilt,

Toxic shame and unresolved feelings of guilt are major developmental factors leading to use of all mood-altering substances.

Work can become an addiction destructive to wholeness within a physician and his nuclear family.

and the effects ripple outward. Intervention and counseling have proven effective in a dozen or more such groups.

Post-malpractice Stress Syndrome

Nothing promotes shame and guilt feelings in a physician more than charges of malpractice. It especially compounds these feelings in a susceptible host. We promote support groups for such individuals, with statutory immunity from subpoena of the group content.

Psychosexual Misconduct

Sexual boundary violations, in the absence of gross predatory behavior, is frequently symptomatic of shame, guilt, and low self-esteem. Intervention, education, and counseling have proven effective in a dozen or more cases, and demand is growing.

Mental Illness

Endogenous depression, the various types of bipolar disorders, and fixed personality disorders are the most common mental disorders among physicians. Adult form of attention deficit disorder is being recognized with increasing frequency. Appropriate intervention and referral for therapy will maintain physicians at a functional level in the majority of cases.

Conclusion

The TMF IPPRC is charged with rehabilitation of physicians impaired by mental/emotional illness and/or the disease of chemical dependence. Experience gained while carrying out this charge has revealed to us a theoretical "final common pathway" not only to various forms of impairment but also to other degrees of dysfunction among physicians. Using a similar approach to both, we have demonstrated that we can assist in the quality of life for many physicians and thus enhance their ability to provide better quality healthcare to the public. In this way, the TMF Program protects the public. Several categories of such service have been described.

The BME is charged with protection of the public from physicians who pose a danger. Once the BME has issued a license to an individual physician, thereafter, it reacts to complaints against the licensee. This process is tedious, is often delayed until after the fact, and may be hampered by long legal processes.

The TMF Program, under the aegis of peer review statutes, can proceed in a preemptive fashion, potentially preventing later consequences from impairment. Furthermore, the TMF Program can intervene in dysfunction that would not be within the purview of the BME.

The BME and the TMF Program act synergistically to protect the public through an informal relationship based upon mutual respect, mutual support, and credibility. It is our belief that a similar process could be instituted between all state medical boards and their impaired physician programs.

Nothing promotes shame and guilt feelings in a physician more than charges of malpractice.

The TMF Program . . . can proceed in a preemptive fashion, potentially preventing later consequences from impairment.

Washington Physicians Health Program

LYNN HANKES, MD

The Washington Physicians Health Program (WPHP) evolved from the Committee on Personal Problems of Physicians of the Washington State Medical Association. It came into existence in 1986 and is an independent not-for-profit corporation with a paid, full-time physician/addictionist director, administrator, clinical coordinator counselor, administrative assistant, and secretary. The Washington State Medical Association retains philosophical control over WPHP, appointing its board of directors, which consists of five physicians, an administrator, a certified public accountant, and an attorney. The program serves all allopathic and osteopathic physicians, physician assistants, podiatrists, and veterinarians and provides the following services: intervention, screening assessment, treatment referral, recovery monitoring, quality assurance, and educational programs. It deals with impairment caused by chemical dependency, psychiatric illness, and dual diagnosis. It is initiating family, stress management, and disruptive behavior components.

Funding

Sixty percent of WPHP funding is derived from a \$25 surcharge on annual license renewal fees. Forty percent is obtained through client fees that cover some program administrative costs, facilitated continuing treatment, recovery monitoring, and all urine toxicology testing. We believe that it is important for clients to participate financially as well as other ways in their recovery and to demonstrate fiscal responsibility.

Operational Policies

The program occupies a detached, autonomous position, and potential physician-clients perceive us as an independent entity unconnected to either organized medicine or the state regulatory agencies. However, we contract with the State Department of Health to capture the license surcharge fees. That contract stipulates the conditions under which the program operates and reflects the provisions in the state statutes which legislate our existence. These statutes allow WPHP to provide a confidential conduit for medical professionals to access an assessment and/or treatment. If a prospective client voluntarily enters the program, completes the evaluation process, successfully completes primary treatment, and enters into a five-year contract, WPHP can maintain the client's confidential status, provided the client responds to treatment and is

*Lynn Hankes, MD.
Director, Washington Physi-
cians Health Program.
Seattle, Washington.*

Table 1.—Washington Physicians Health Program: 1993–1994 Relapse Data

Number of Clients	1993	1994
Average total number of clients	109	126
Average number of mandated clients	34	24
Average number voluntary clients	75	102
Relapses		
Total	12	13
Mandated	3	4
Voluntary	9	9
Percentages		
Total	11%	10%
Mandated	9%	17%
Voluntary	12%	9%
Method of Relapse Detection		
Self-reported	4	2
Behavioral monitoring	3	3
Chemical monitoring	1	3
Workplace monitoring	2	1
Other (spouse/client/physician/outside agency)	1	4
Board report	1	0
Year in Program		
One	4	4
Two	2	5
Three	3	2
Four	1	1
Five	0	0
Six	0	0
Seven	2	0
Eight	0	1
Disposition		
Re-treatment	7	5
Discharge	3	3
Intensify monitoring	1	5
AWOL	1	0
MQAC/Board Report		
Multiple relapse	2	3
Noncompliance	2	5
Multiple relapse/noncompliance	1	0
Total nonresponse rate	4.6%	6.3%
Voluntary	4	4
Mandated	1	4
Levels of Protocol		
I	0	0
II	0	1
III	1	3
IV	4	3
V	1	2
VI	4	2
VII	2	2

compliant to the contract. The five-year contract requires, among other things, total abstinence, behavioral monitoring, chemical monitoring, workplace monitoring, and attendance at meetings of Alcoholics Anonymous, Narcotics Anonymous, Rational Recovery, or Secular Organization for Sobriety.

Referrals

Clients are referred to WPHP primarily from the medical community, specifically by colleagues, partners, medical staff members, peer review committees, hospital wellness committees, the county medical societies, the state medical association, nurses, nurse practitioners, and physician assistants. Reports also are received from nonmedical sources such as attorneys, judges, spouses, and other family members. To date, we have not received a single report from a patient.

To date, we have not received a single report from a patient.

At the time of initial contact, the potential client is placed in a "Case in Development" category on the basis of urgency. In rare instances, an emergency Board referral is accepted if an individual is of imminent danger to himself or others and will not enter "safe harbor." Those rare occasions usually result in a Summary Suspension by the Board. The "Under Active Review" category means that some data is available but additional corroborating reports are needed to reach the threshold which constitutes reasonable suspicion or probable cause for suspecting impairment. In a "Pending Further Data" category are individuals with a single report and no collaborative data. The last category comprises those "In Abeyance," usually individuals who are moving to Washington from other states.

Monitoring Criteria

Clients are not enrolled in our program unless a clear diagnosis has been established and primary treatment has been successfully completed. The five-year contract is divided into two phases. During Phase I, the first two years, clients attend a weekly monitoring/therapy group facilitated by a credentialed therapist employed by the program. Upon entry into the program, clients perceive the monitoring aspect to be dominant, but with time and growing trust in the program, their focus shifts to therapy. These behavioral monitoring/therapy groups are conducted throughout the state by therapists whose credentials range from Chemical Dependency Counselor with extensive field experience to individuals with academic degrees up to the doctorate level. In the last three years of the program, Phase II, meetings are conducted on a monthly basis.

Clients are not enrolled in our program unless a clear diagnosis has been established and primary treatment has been successfully completed.

Chemical monitoring is truly random. Each day, each client calls a 1-800 number and hears the color recording of the day. If it corresponds to a predesignated color, the client has a 12-hour window in which to appear at an independent collection site for a witnessed micturition. Proper chain-of-custody is followed, and chemical determinations include both screening and confirmatory tests. Reports are sent by modem to our central office. For the first two years, urines are tested at least three times a month, and for the last three years, at least twice a month.

Each client must designate a worksite monitor. That individual is usually in the same medical specialty but could be the Vice President of Medical Affairs or the Chief of Staff at a given facility. The worksite monitor is charged with reviewing clinical competence. This review can be accomplished by an on-site visit within the workplace, a chart review, or formal meetings, but not

Table 2.—WPHP Protocol for Perceived Relapse Behavior and/or Full Relapse

Level I:	Relapse Prodrome (Relapse behavior without chemical use) Action: Review and confrontation by group facilitator and client redirection.
Level II:	Persistent Prodrome (Persistent relapse behavior, without chemical use) Action: As in Level I, plus consultation with and/or confrontation by clinical coordinator. Increase intensity of recovery program.
Level III:	Program Lapse (Little or no relapse behavior, brief chemical use, with good program contact) Action: As in Level II, plus consultation with and/or confrontation by the Director. Intensify program. Board report on mandated clients.
Level IV:	Partial Relapse (Relapse behavior, episodic or limited chemical use, with fair program contact) Action: As in Level III, plus consultation with Clinical Staffing Committee. Evaluation and/or re-treatment. Design new recovery program.
Level V:	Relapse (Relapse behavior, more than episodic or limited chemical use, and little or no program contact) Action: As in Level IV, plus re-treatment. Possible Board report on voluntary clients.
Level VI:	Relapse with Impairment (Severe relapse behavior and extensive chemical use within the context of active practice) Action: As in Level V, plus re-treatment or discharge from the program. Board report on all clients.
Level VII:	Persistent Noncompliance (Uncertain behavior, unknown use, little or no program contact, and resistance to redirection) Action: As in Level VI.

by telephone contact alone. Communication between the worksite monitor and the program occurs on a regular basis. Support meeting attendance is not monitored, but if it becomes apparent that a client is unfamiliar with these programs, he may be required to maintain an attendance log similar to that used in a DUI deferred prosecution program. This log lists the date and time of the meeting, the name of the group, its location, and the topic discussed. It must be initialed by the leader of each meeting.

We also have a Phase III for clients who desire ongoing advocacy. Those who successfully complete a standard five-year contract can then enter this phase annually on a truly voluntary basis. It calls for quarterly meetings and urine tests.

Communication between the worksite monitor and the program occurs on a regular basis.

	Relapse Behavior	Chemical Use	Program Contact	Action Taken		
				Intensify	Evaluation/ Treatment	Board Report
I Relapse Prodrome	+	-	+++++	+	-	-
II Persistent Prodrome	++	-	++++	++	-	-
III Program Lapse	-/+	+	++++	+++	-	- Vol + Man
IV Partial Relapse	+++	++	+++	-	Evaluation/ Treatment	- Vol + Man
V Relapse	++++	+++	+/-	-	Treatment	-/+ Vol + Man
VI Relapse w/Impairment	+++++	++++	N/A	-	Discharge/ Treatment	+ Vol + Man
VII Persistent Noncompliance	?	-/?	-/+	-	Discharge/ Treatment	+ Vol + Man

Statistics and Success Rates

In 1994, the program received 122 inquiries, one every three days. As of July 1, 1995, WPHP had 276 program participants, 140 under contract and 136 cases in development. The contract clients are split evenly between Phase I and Phase II.

The program success rate is high. The relapse rate in 1993 was 11%, and in 1994, 10%. We gauge the overall success rate of the program by the non-response rate. In 1993, this was 4.6%, and in 1994, 6.3%, corresponding to success rates of 95.4% and 93.7% respectively. One of the unique aspects of this program is a seven-level protocol defining the entire spectrum of relapse activity: I Relapse Prodrome, II Persistent Prodrome, III Program Lapse, IV Partial Relapse, V Relapse, VI Relapse with Impairment, and VII Persistent Noncompliance.

Most relapses are detected through self-report, behavioral monitoring, or chemical monitoring. Occasionally, a relapse is detected by a workplace monitor or is reported from an external source. The vast majority of relapses occur

One of the unique aspects of this program is a seven-level protocol defining the entire spectrum of relapse activity....

in the first two years of the program, with some in year three but a drastic reduction thereafter. Most clients required re-treatment, some were discharged as having reached maximum benefit, and others required intensified monitoring.

Relation to the Medical Boards

We believe that 89% of our clients are voluntary because we function independently of organized medicine and the Medical Quality Assurance Commission (the Board). We have an extremely close relationship with the Board. If the Board receives an initial report on a prospective client, and there appears to be impairment only, with no pending civil litigation, no criminal activity, and no quality of care issue, the Board will defer its action and refer that case to us for disposition. Having trust and credibility with the Board is crucial to the success of our program. The Board is critically aware that we will not hide clients in our program nor allow clients to seek refuge under our mantle, hoping to avoid disciplinary action. In 1993, five clients were reported to the Board, and an additional eight were reported in 1994. This sends a clear message to our clients that the program is "fair but tough." Each client realizes that we will not lie for them or to them. While we believe that it is vitally important that a therapeutic alternative to discipline exists, our primary mission, nevertheless, is always the protection of the public.

The Board is critically aware that we will not hide clients in our program nor allow clients to seek refuge under our mantle, hoping to avoid disciplinary action.

Confessions of an Alcoholic

ANONYMOUS

The physical and laboratory findings of alcoholism are well known to this readership; however, understanding of the underlying addictive process is limited. This endeavor does not purport to explain addictive behavior but attempts to describe the progressive deterioration, emotional symptoms, and deranged behavior which often appear long before the physical examination becomes abnormal and/or suggestive laboratory findings appear.

Because of a mirroring effect, a recovering alcoholic can often quickly and reliably diagnose another in the early stages of the disease process (a sort of "takes-one-to-known-one" situation). Because the course of chronic alcoholism is one of progressive deterioration, by the time of clinical diagnosis, the sufferer may have literally devastated his life as well as the lives of those about him. As in most areas of medicine, early diagnosis is of utmost importance, and the physician who knows the emotional symptoms and the progressive nature of the disease may frame several symptoms into a picture highly suggestive of alcoholism.

Alcoholics Anonymous (AA) transcends all racial, social, and geographic boundaries and brings together people from all walks of life who have suffered a common peril. I have noticed in the rooms of AA a profound similarity of emotions and attitudes in otherwise vastly different people. This manuscript is an effort to put the reader in touch with a possible syndrome of emotional characteristics in an effort to aid early diagnosis and perhaps lead to earlier intervention. In addition, there may be a reader who will note similarities between this description and his own behavior. I hope this would lead to an interest in a recovery program. This is not an effort to determine how many drinks a day or how many DWIs constitute alcoholism. It is an attempt to paint a verbal picture of an alcoholic's feelings and habits, retrospectively using my personal history as a model, so the reader may gain insight into alcoholism with a view toward intervention before the horrible nadir with which we are all so familiar.

It is said that alcoholism is a disease of feelings. There was not much closeness or unity in my family. We never discussed our feelings but talked about our goals and/or the need for achievement (ie, performance). I never felt emotionally supported or understood by my family. I always felt apart. That feeling of separateness haunted me. I could feel absolutely alone in a crowd.

*Reprinted with permission
from the Dallas Medical
Journal; 1992; 78(7) 282-283.
Because of the nature of this
article, it was accepted from
a Dallas County Medical
Society member for anonymous
publication.*

I would describe myself as an over-achiever who felt compelled to be as near the top as possible in all endeavors. This obsession led to the development of an excellent medical practice, which in turn led to an abundance of material things and development of a god-like ego. High school athletics had helped develop a competitive spirit, which was most certainly a valuable trait in college and medical school. For a very competitive person, there was simply no way of keeping score as to how I compared to my peers in the practice of medicine, so I placed an inordinate emphasis on the accumulation of things to enhance my self-esteem. Sheer drive and willpower resulted in more material achievement than I had ever expected possible.

As success evolved and materialism grew, I deviated from my original course and became lost in the morass of "things." I seemed to discover a new way to live and attempted to transfer my aggressive, controlling, self-righteous behavior to my family with devastating results. Perhaps as a compensatory mechanism because of my childhood feelings of detachment, I ordained that when children arrived, we would become a very close, loving family. Obviously, I didn't know how to effect this goal, and the more I tried, the worse it became. I felt personal achievement as well as achievement by my children to be the sole reasons for existence. It was always necessary for me to be right. I would rather have been right than happy.

I thought that every challenge must be conquered or I was a failure. I thought that loved ones must meet my needs or they did not love me. I lived with a single answer to every situation—win. All relationships were based on competitive terms. Life was something to be conquered rather than enjoyed, a game with only winners and losers. Living in that manner, one is destined to feel like a loser eventually.

Retrospectively, I recognize that this attitude is a set-up for failure, and as the behavior failures increased, I got emotional relief only through the use of alcohol and the exercise of more self-will. All my time and effort was directed toward attempting to control others' behavior by judging and manipulating them.

Early on, alcohol was definitely a social lubricant for me. It enhanced my limited social skills. It allowed me to engage in activities that I would have skirted otherwise. It made me fit in and feel comfortable. I loved what it did for me.

I now realize that, from the beginning, I drank differently from "normal" people. I could never have only one drink. Even the thought of alcohol, and certainly the taste, set off a craving that made me continue drinking, often to the point of oblivion. I considered this behavior a lack of willpower or a kind of weakness and tried every maneuver I could to allow myself to continue drinking and functioning.

I never considered stopping drinking, even though perhaps everyone close to me knew something was wrong. It never occurred to me there may have been a problem. Reality had fled my life. I tried all kinds of alcohol and all kinds of mixes and just couldn't realize that I simply could not consume alcohol. I don't know when I crossed the invisible lines between social drinking,

... as the behavior failures increased, I got emotional relief only through the use of alcohol and the exercise of more self-will.

I never considered stopping drinking, even though perhaps everyone close to me knew something was wrong.

heavy drinking, and chronic alcoholism, but my feeling is that I was alcoholic from the beginning. However, early on, I was able to control and/or curb the use of alcohol periodically.

As I became restless, irritable, discontent, and filled with subconscious guilt and shame, the only ease or comfort resided in the bottle. Therefore, through the years, I depended increasingly on alcohol. Even though I had recurrent blackouts and memory loss, I had an inexplicable lack of respect for the lethal power of alcohol. As my drinking progressed, repeated efforts to stop for more than a few days at a time were unsuccessful. I continued to believe that I could stop at any time it became necessary, but the reality was that I could not.

The denial process does not allow one to look at oneself in a realistic manner, and I deteriorated to the point that I started each day remorseful and promising myself I wouldn't drink but, almost invariably, concluded the day drinking. I thought circumstances drove me to drink. When I tried to correct these conditions and found that I couldn't to my satisfaction, the drinking got out of hand. I lost touch with reality and had no idea of the magnitude of the problem or even that a serious problem existed. Alcoholism is the only disease I know that tells you that you don't have it. I pictured myself and presented myself as just a nice guy who, unfortunately, drank too much.

I could never see my part as relationships deteriorated, and I spent all of my time working or attempting to fix the other parties. Before recovery, I could not examine my role, probably because of low self-esteem issues. I could not be honest with myself. Self-deception, a form of dishonesty, led me constantly to judge others and avoid judging myself. This behavior led to progressive isolation because no one could understand me. I could think only about me. I manufactured my own misery. The painful obsession with self bound me to the bottle for greater than half my life.

Because of my preconception that alcoholism implies weakness and lack of willpower, I had considerable difficulty accepting the disease concept, and I believed myself to be a bad and weak person rather than a sick person. Negativism generated by these feelings and the frustration related to the absolute inability to have any sort of personal objectivity led to feelings of self-pity, resentment, and anger. These emotions then became problems. As I look back, I understand that I sought resolution of these negative feelings through the use of alcohol. Impaired thinking was accompanied by global and indefinable fears and more than a little depression. I was incapable of any sort of self-examination and turned to drink.

My frustration at not being able to get people to do what I thought they were supposed to do resulted in anger and resentment. I developed a pattern of blaming, and it became important to notify others of their mistakes and deficiencies. I was operating with alcohol as a temporary solution. There was nothing positive about my life, and I didn't understand what was happening.

The last days of drinking were horrible. Nothing was functional in my life except the anger and resentment I directed at those who were trying to help. In the late stages, the will to resist alcohol had fled, and I had no choice but to

Before recovery, I could not examine my role, probably because of low self-esteem issues.

... I had considerable difficulty accepting the disease concept, and I believed myself to be a bad and weak person rather than a sick person.

drink. The "creature" alcohol literally hammered me to my knees. No choices were left, and I had to admit complete defeat to alcohol.

This picture of emotional deterioration is common in alcoholics. Some develop it rapidly, while in others, it is progressive. The alcohol which previously "handled" or soothed feelings eventually stops working. At "the bottom," the drinker has no choice but to drink. An adage in AA says, "The man takes a drink, and then the drink takes a drink, and then the drink takes the man."

Finally, so many horrible things were happening that I was forced to surrender and to enlist medical help. I thought that a treatment center could be the answer, but before going there, filled with denial even that I was an alcoholic, I attended an AA meeting. At that first meeting, I recognized that inpatient treatment centers were OK for stabilization, but my long-term recovery, if any, would occur through the fellowship of Alcoholics Anonymous. For the past 5 years, I have been free of alcohol and believe that AA has made the difference.

Thankfully, the simple but difficult program of 12-step living has led to critical self-examination, and with the support of a group of people just like me, my self-respect and self-esteem have been restored. I no longer think that it's necessary to be the smartest, strongest, or any other "est." Life has become much easier since I have stopped trying to conquer every moment and instead have tried to flow with the situation. It is OK just to be me. I am learning acceptance of myself and the fact that just being genuine is more fulfilling than being great. A changed outlook and a measure of humility have resulted in more tolerance and less judgment of others.

Relationships have been restored, with stronger foundations and firmer bonds than I have ever known. I am learning the futility of trying to change others and the absolute necessity of examining and changing myself. Most important, the recovery program has given me an "owner's manual for living" which has allowed engagement in a process that has led to the discovery of a higher power and a quality of life that I never knew was available to me. Five years ago, I never would have believed that my life would be like it is today.

I recognize that alcoholics can be extremely difficult and deceitful people to deal with, but if physicians can better understand the dysfunctional emotional processes at work, then perhaps earlier intervention can occur. Until the final stages of my drinking, to my knowledge, no one even suggested to me that there may have been a problem, and I certainly couldn't recognize the problem in myself. Therefore, I offer this suggestion to my physician colleagues: If, in your day's work, you encounter a story that sounds even remotely like mine, please offer to help.

This picture of emotional deterioration is common in alcoholics. Some develop it rapidly, while in others, it is progressive.

... the recovery program has given me ... a quality of life that I never knew was available to me.

FROM OUR INTERNATIONAL EXCHANGES

MANITOBA, CANADA

PRESCRIPTIONS FOR MORE THAN ONE PATIENT

It has been brought to our attention that pharmacists are being asked to dispense a single prescription for use by two or more patients.

*From the College, College of Physicians
and Surgeons of Manitoba newsletter
July 1995*

Prescribing for more than one patient on a prescription is not in the patient's best interests (especially the unnamed consumers of the prescription), and it makes it impossible for the pharmacist to maintain accurate patient medication profiles, monitor for compliance, and keep accurate records. Neither the prescriber nor the pharmacist can be confident that each patient is taking the prescribed amount of medication for the prescribed length of time.

Specific faults of this practice include:

- The entry of information on patient medication profiles is either nonexistent or necessarily vague, further reducing the benefits of the profile and of monitoring compliance and interaction.
- There is often no space on a prescription label to type full directions in the case of varying dosages for several patients. In some cases, the prescriber may have indicated only one dosage in the instructions, but has given verbal directions for other intended recipients. This practice is both unsafe and illegal. Most studies have shown that verbal instructions not accompanied by written directions are frequently confused or forgotten.

- All intended recipients may not always be at the same locations, which may lead to the transfer of contents to inappropriate, unlabeled, or mislabeled containers.

If your motive is to protect your patient from financial hardship, a more appropriate and safe approach would be to ask the pharmacist to assist with payment arrangements which would ensure that essential medications are obtained.

STATEMENT: CLINICAL RESEARCH

Background: [Excerpts from CMA Code of Ethics]

An ethical physician will recommend only those diagnostic procedures that are believed necessary to assist in the care of the patient and therapy that is believed necessary for the well being of the patient. The physician will recognize a responsibility in advising the patient of the findings and recommendations and will exchange such information with the patient as it is necessary for the patient to reach a decision.

An ethical physician will first communicate to colleagues, through recognized scientific channels, the results of any medical research, in order that those colleagues may establish an opinion of its merits before they are presented to the public.

An ethical physician will recognize a responsibility to give the generally held opinions of the profession when interpreting scientific knowledge to the public; when presenting an opinion which is contrary to the generally held opinion of the profession, the physician will so indicate and will avoid any attempt to enhance his/her own personal professional reputation.

An ethical physician will avoid advocacy of any product when identified as a member of the medical profession.

An ethical physician will avoid the use of secret remedies.

What is "Necessary"?

The term "necessary" has implications with respect to insurability in that "necessary services" are generally regarded as insurable services within the terms of provincial legislation. The use of the word "necessary" suggests that some arbitrary cutoff is being applied with respect to which procedures or therapies may be insured and which are not. This decision is usually based on cost effectiveness.

Noninsured services may also be considered valid if they are scientifically acceptable and have appropriate clinical indication.

The Concept of "Scientific Acceptability"

This term means that a particular procedure or therapy can be supported as effective in the peer-reviewed literature. It must be reliable, reproducible, and safe.

Procedures or therapies which do not meet this description are considered "experimental" or "developmental." A procedure remains experimental until it has been established as reliable and reproducible. With respect to safety issues, a procedure or therapy remains developmental until associated risk is significantly reduced below the adverse effect of the condition being managed.

Procedures or therapies which are proven to be unsafe, or which are unreliable, nonreproducible are referred to as "not scientifically acceptable."

Approved Research Project

This term applies to any project which has been considered acceptable for the use of human subjects by an Ethics Committee of the University of Manitoba.

Procedures or therapies not yet "scientifically acceptable" may be performed by a physician only as part of "an approved research project." Patients participating in such a process must provide a fully informed consent regarding the experimental nature of the process. No fees can be assessed to the patient, nor can the patient be asked to contribute to research costs.

Clinical Activities

Developmental - When a procedure or therapy is considered developmental, then the physician may perform it, but only within the conditions recognized by the College of Physicians and Surgeons. The patient must be provided with a fully informed consent regarding the "developmental status." Fees may be assessed by the Manitoba Medical Association; however, items with this status are not acceptable as insurable services.

NEW ZEALAND

COMMENTS FROM THE CHAIR

KEN THOMSON, MD

Chair, The Medical Council of New Zealand

The recent discharge of a Hamilton anaesthetist charged with manslaughter has again focused attention of Section 155 of the Crimes Act and the dangers doctors face of prosecution for what may be considered minor errors but which contribute to the death of patients.

*From MCNEWZ, Medical Council
of New Zealand newsletter
July 1995*

The Medical Council has lent its support to the Medical Law Reform Group in its campaign to have this section of the Act modified. This is not because it wishes doctors to escape the consequences of their actions, but because it believes neither the profession nor the public is well served by the current legislation. It is in the interest of all parties to have full disclosure of any errors of judgement or procedure in any situation regardless of the outcome. That is the way to minimise future errors, but the threat of prosecution is a powerful disincentive. When there are demonstrable deficiencies in knowledge or competence, there are remedies available even under the existing Medical Practitioners Act. The new bill, with its provisions for competence reviews and recertification, will certainly address those areas.

The use of the Crimes Act to charge health professionals should be confined to cases where there is gross negligence or reckless disregard for the patient's safety. Doctors attempting procedures in which they have insufficient training or skills should also be at peril, except in emergency situations where there are no reasonable alternatives.

The current approach has led to the demise of the Anaesthetic Mortality Review Committee. During its existence, the Committee made a valuable contribution to patient safety in its assessment of anaesthetic deaths of all types throughout the country, and both the public and the profession lose from its collapse.

The argument is advanced by some members of the legal profession and the public that doctors and other health professionals should not be treated any differently from other people when death occurs as a result of their actions. This approach neglects the obvious. Medicine by its very nature involves the management, from time to time, of very sick

people who would certainly die without intervention. Instead of persecuting doctors over the few patients who die, society should be grateful for the many that recover and foster a climate where the profession and the community can learn from those who do not. It is New Zealand law which is out of step, not the rest of the Commonwealth. As late as 1994, the United Kingdom Law Commission described our legislation in most unfavourable terms, and it is pleasing to see that the Minister of Justice has appointed Sir Duncan McMullin to examine it and make recommendations.

The suggestion by Justice Hammond that the police refer all potential prosecutions to the Solicitor-General for expert assessment is a necessary interim step. The Crimes Act must, however, be modified if the full benefits of the new Medical Practitioners Act are to be realised.

FROM OUR MEMBER BOARD EXCHANGES

COLORADO

SUNSET REVIEW RESULTS IN CHANGES TO MEDICAL PRACTICE ACT

*From The Examiner, published
by the Colorado Board of Medical Examiners,
Department of Regulatory Agencies,
State of Colorado
Volume 4, Number 1, June 1995*

“Sunset” is the term used to describe the process by which each board residing under the umbrella of the Department of Regulatory Agencies is periodically reviewed to determine if an agency should continue to exist. It is an opportunity for the public, board members, licensees, and representative groups to review their licensing statutes and to suggest changes to the practice acts from which the boards derive their authorities and responsibilities. During the last two years, the Medical Board and its staff have been reviewing the Medical Practice Act (MPA) in order to make suggestions for its own sunset bill which was introduced in January for consideration by the 1995 Colorado legislature. There were a few significant changes to the law as well as some simple updates to the nomenclature. House Bill 95-1002 was signed by Governor Romer on May 31, 1995, and goes into effect on July 1, 1995. The Medical Board's authority to exist has been continued to the year 2010. The more important changes of which all licensees should take note are listed below with the applicable statutory citations following. Copies of the “new” MPA will soon be available and may be received by sending a written request to the Medical Board office.

Changes Regarding Licensing

In the past, a number of physicians have been licensed via the “fifth pathway” route, allowing an international medical graduate who did not have a medical degree conferred, to complete a residency and become licensed in Colorado. The provision allowing licensing via this “path” has been removed from the MPA. [12-36-107.6(2)]

With respect to the reinstatement of lapsed licenses, two changes have been made. First, the Board shall defer any action on the pending application for reinstatement of a license if it is believed that the physician has committed unprofessional conduct or is in violation of the MPA. The Board shall proceed with a hearing on such charges as may be filed in accordance with the statutes regarding disciplinary action. Second, the Board shall not reinstate any license to practice medicine which has lapsed for more than two years unless the applicant demonstrates continued professional competence in a manner prescribed by the Board. [12-36-123(2)(a)]

The Medical Board may now refrain from issuing a license, or may grant a license subject to probationary terms, if an applicant has not actively practiced medicine for the two-year period immediately preceding the filing of an application, or if the applicant has not otherwise maintained continued competency, as determined by the Board, during that two-year period. [12-36-116(1)(d)]

Changes to the Definition of Unprofessional Conduct

A physician may now be found in violation of the MPA if he/she resorts to fraud, misrepresentation, or deception in applying for, securing, renewing, or seeking reinstatement of a license to practice medicine in this state or any other state and in applying for professional liability coverage or privileges at a hospital. [12-36-117(1)(a)]

Any conviction of an offense of moral turpitude, a felony, or a crime that would constitute a violation of the MPA is

now unprofessional conduct. "Conviction" includes the entry of a plea of guilty or nolo contendere, or the imposition of a deferred sentence. [12-36-117(1)(f) & (h)]

Engaging in a sexual act with a patient during the course of patient care has been a violation of the MPA for some time. The MPA now requires a six-month "cooling-off" period following the termination of the physician's professional relationship with the patient, during which time a sexual act with a patient would still be considered unprofessional conduct. [12-36-117(1)(r)]

A single act or omission which fails to meet generally accepted standards of medical practice is now sufficient grounds for the Medical Board to proceed with disciplinary action. Previous to this change, in order to take action, the Board had to determine that two or more acts of substandard care or one act of grossly negligent medical practice had occurred. [12-36-117(1)(p)]

Failing to answer the renewal questionnaire accurately has now been specified in the MPA as unprofessional conduct. [12-36-123(1)(b)]

Failing to respond within 30 days to a complaint filed with or initiated by the Board or its inquiry panels is now unprofessional conduct. In the past, responses provided by or on behalf of a physician have been optional. The new legislation requires these responses, although they may still be made by a physician's legal counsel on her/his behalf. [12-36-117(1)(gg) & 12-26-118(4)(a)(I)]

"Advertising in a manner that is misleading, deceptive, or false." This very general standard replaces language which was specific to the advertising of board certification credentialing. [12-36-117(1)(hh)]

These standards are applicable to conduct or behavior occurring on or after July 1, 1995, and may not be applied retroactively.

Changes Applicable to Physician Assistants

Physician assistants may now access the peer assistance program currently available through the Colorado Physician Health Program. Physician assistants will also be assessed a fee in contribution to the peer assistance fund. [12-36-123.5]

Physician assistants will, upon adoption of rules by the Medical Board, be allowed to prescribe medications on the DEA controlled substance schedules II-V. The Board will be moving forward with steps to draft the implementing rules at its next meeting. Please note that until such rules are approved and in place, physician assistants will continue to be restricted to prescribing noncontrolled substances only. Be sure to check future editions of *The Examiner* for updates. [12-36-106(5)(a)]

MINNESOTA

PRACTICE BY PHYSICIANS NOT LICENSED IN MINNESOTA

A recent issue of the Minnesota Board of Nursing's newsletter, *For Your Information*, contained an article regarding the legality of Minnesota nurses carrying out orders issued by physicians who are not licensed in Minnesota.

*From Update, Minnesota Board
of Medical Practice newsletter
Spring 1995*

The position taken by the Board of Nursing is that for a Minnesota nurse to legally carry out orders for the medical care of a patient located in Minnesota, the orders must be issued by a physician holding a valid Minnesota license.

The Board of Medical Practice reviewed the article prior to its publication and concurred with the position taken by the Board of Nursing.

Since the publication of the article, both the Board of Nursing and the Board of Medical Practice have received a substantial number of inquiries and requests for clarification.

Some of the questions raised can be addressed and answered at this time, while others will require additional research or policy development.

Before starting the discussion of the questions, however, it may be useful to simply state that the sole reason the Board of Medical Practice, or any other professional credentialing or licensure agency, in Minnesota or any other state, exists is to protect the public from substandard practice. The only way the Board is able to do this is to have jurisdiction over the practitioner. The way this is accomplished under American law is for the practitioner to hold a license or other credential issued by the state.

This is a long and technical way of saying that the only way the Minnesota Board of Medical Practice can protect the public from substandard medical care is to make sure that the people practicing in Minnesota meet standards by holding a valid Minnesota license.

Far and away the most common question raised was "When did the law change?"

The answer is that it has not changed. For as long as physicians have been licensed in Minnesota, over 108 years now, the law has required anyone who "undertakes . . . to treat in any manner or by any means, methods, devices or

instrumentalities, any disease, illness, pain, wound, fracture, infirmity, deformity or defect of any person . . . ” to carry a valid Minnesota license.

Some have suggested that as long as the physician is never in Minnesota, a license is not needed. The fact is, it is the location of the patient which makes the license necessary. If the patient is in Minnesota, the treating physician must have a valid Minnesota license.

The most common setting for questions to arise is border communities in Minnesota where patients are residents in health care facilities. Nursing staff in these facilities have been asked to carry out orders from physicians in other states, who do not have Minnesota licenses.

The Board has advised these facilities to seek arrangements with the clinics in the bordering state to have a Minnesota licensed physician either issue the order, or have the order countersigned by a Minnesota licensed physician. In the instances where the clinic does not have a Minnesota licensed physician, the Board has advised the Minnesota facility to seek arrangements with a Minnesota physician, for example, the Medical Director, to review and countersign the order.

This has been satisfactory in most instances, and is supported by the fact that Minnesota rules require facilities, such as nursing homes, to designate a licensed physician for the “supervision of the care and treatment of the patient or resident during the person’s stay”

It is noteworthy that the reverse is also true. That is, a physician licensed in Minnesota cannot treat patients in a bordering state without holding a valid license in that state.

Another area of question has dealt with out-of-state residents who attend camps in Minnesota. Such settings are governed by the Minnesota Child Camp laws (M.S. 144.71 [1994]). A rule promulgated under this statute requires campers to undergo a physician examination prior to admittance to the camp. Each camper must present a certificate of health based on a physical examination conducted by a licensed practitioner not more than 90 days prior to admittance. (Minn. R. 4630.4300) This certificate of health is to include instructions relative to the limitation of a camper’s participation in camp activities. However, the rule is silent regarding any orders for medical care the camper may bring from an out-of-state physician.

These same Minnesota Child Camp laws require that the camp operator designate a practitioner as the camp’s physician. The solution is for the out-of-state physician to establish a formal consultation relationship with the physician designated as the camp physician and to issue orders or order changes through the camp doctor. This formal “actual consultation” relationship is one which is recognized by

Minnesota law and does not require the out-of-state physician to carry a Minnesota license.

Other questions have been asked about the legality of filling prescriptions written by out-of-state physicians. The Pharmacy Board has long held that a Minnesota pharmacist may legally fill the prescription for a legend drug written by any practitioner holding a valid license which allows the practitioner to prescribe such a drug, regardless of the state of origin of the license.

A law signed this session, H.F. 1363, Session Laws Chapter 66, extends that to prescriptions for controlled substances in Schedules II, III, and IV.

There are other questions left unanswered, including who should bear the costs of consultation or review and countersignature of orders by a Minnesota licensed physician; how those costs should be assessed and administered; the apparent differences in approaches to this question by the regulatory systems in place for differing health care professions; how this relates to the reality of the regional nature of the economics and delivery system for health care; and how this relates to interstate aspects of telemedicine and other portions of the delivery of health care.

For these answers, more work, research, and perhaps legislation will be necessary.

For now, suffice it to say: The practice of medicine in Minnesota requires a valid Minnesota medical license, and has for nearly 109 years.

COURTS UPHOLD BOARD AUTHORITY

During the course of the past year and one-half, the Minnesota judicial system has reviewed and upheld the Board of Medical Practice’s authority to order a respondent physician to undergo a mental and physical examination pursuant to M.S. 147.091, subd. 6(a).

In the course of reviewing numerous complaints against a respondent physician, the Board’s Complaint Review Committee issued an order for the physician to undergo a mental and physical examination, as authorized by the Medical Practice Act.

The respondent physician, through counsel, filed in District Court for declaratory relief as well as a temporary and permanent injunction against execution of the order, alleging that the statutory authority was unconstitutional, and that execution of the order would cause irreparable harm to the respondent.

District Court Judge Kenneth J. Fitzpatrick found against the respondent and denied injunctive relief, stating that there was no evidence that the respondent would be irreparably harmed, and that the arguments of unconstitutionality of the statute were “without merit.” Judge Fitzpatrick wrote:

There is a strong public interest in protecting the citizens of Minnesota from incompetent treatment from doctors much like the interest in keeping the roads safe from drunk drivers. Just as a drunk driver is subject to the implied consent automobile license revocation provisions of Minn. Stat. 169.123, an incompetent physician is subject to the physician discipline process under Minn. Stat. 147, *et seq.* A license to practice medicine is a privilege which requires from the holder a certain level of competency. In exchange for the privilege, the physician is subject to review when questions as to competency arise. The physician disciplinary process, including the mental and physical examination, is needed to ensure the public's safety and confidence.

The Court of Appeals upheld the Board's authority and Order. The Minnesota Supreme court denied further review.

NORTH CAROLINA

NCMB POSITION STATEMENT ON THE PHYSICIAN-PATIENT RELATIONSHIP

BRYANT D. PARIS, Jr.
Executive Director, North Carolina Medical Board

At its meeting on July 22, 1995, the North Carolina Medical Board adopted the enclosed position statement: The Physician-Patient Relationship, the Physician, and the North Carolina Medical Board. This reaffirmation of principles that are fundamental to sound medical practice and are as old as the profession of medicine is necessary in the current health care environment, an environment of change that could, by its complex nature, lead some to neglect the primacy of the physician-patient relationship. The ethical heart of medicine is found in that relationship. Professionalism is defined by it. The public's trust is dependent on it.

The NCMB is not responsible for the universe of medical activity, but it is responsible for those it is charged to regulate: physicians, physician assistants, and nurse practitioners in North Carolina. Whatever the setting in which they practice, they must always be aware of the essential principles stated here. Their continuing awareness will certainly aid in keeping the health care system focused on the human and humane purposes of medicine.

We hope other medical licensing authorities will consider this effort carefully and explore the possibility of drafting

similar positions for their respective jurisdictions. Needless to say, the members and staff of the NCMB would welcome comments on this position statement at any time.

The Physician-Patient Relationship, the Physician, and the North Carolina Medical Board

A Position Statement by the North Carolina Medical Board

The North Carolina Medical Board recognizes the movement toward restructuring the delivery of health care and the significant needs that motivate that movement. The resulting changes are providing a wider range and variety of health care delivery options to the public. Notwithstanding these developments in health care delivery, the duty of the physician remains the same: to provide competent, compassionate, and economically prudent care to all his or her patients. Whatever the health care setting, the Board holds that the physician's fundamental relationship is always with the patient, just as the Board's relationship is always with the individual physician. Having assumed care of a patient, the physician may not neglect that patient nor fail for any reason to prescribe the full care that patient requires in accord with the standards of acceptable medical practice. Further, it is the Board's position that it is unethical for a physician to allow financial incentives or contractual ties of any kind to adversely affect his or her medical judgment or patient care.

Therefore, it is the position of the North Carolina Medical Board that any act by a physician that violates or may violate the trust a patient places in the physician places the relationship between physician and patient at risk. This is true whether such an act is entirely self-determined or the result of the physician's contractual association with a health care entity. The Board believes the interests and health of the people of North Carolina are best served when the physician-patient relationship remains inviolate. The physician who puts the physician-patient relationship at risk also puts his or her relationship with the Board in jeopardy.

Elements of the Physician-Patient Relationship

The North Carolina Medical Board licenses physicians as a part of regulating the practice of medicine in this state. Receiving a license to practice medicine grants the physician privileges and imposes great responsibilities. The people of North Carolina expect a licensed physician to be competent and worthy of their trust. As patients, they come to the physician in a vulnerable condition, believing

the physician has knowledge and skill that will be used for their benefit.

Patient trust is fundamental to the relationship thus established. It requires that

- there be adequate communication between the physician and the patient;
- there be no conflict of interest between the patient and the physician or third parties;
- intimate details of the patient's life shared with the physician be held in confidence;
- the physician maintain professional knowledge and skills;
- there be respect for the patient's autonomy;
- the physician be compassionate;
- the physician be an advocate for needed medical care, even at the expense of the physician's personal interests; and
- the physician provide neither more nor less than the medical problem requires.

The Board believes the interests and health of the people of North Carolina are best served when the physician-patient relationship, founded on patient trust, is considered sacred and when the elements crucial to that relationship and to that trust—communication, patient primacy, confidentiality, competence, patient autonomy, compassion, selflessness, and appropriate care—are foremost in the hearts, minds, and actions of the physicians licensed by the Board.

This same fundamental physician-patient relationship also applies to mid-level health care providers such as physician assistants and nurse practitioners in all practice settings.

OHIO

COADMINISTRATION OF PHENTERMINE AND FENFLURAMINE FOR WEIGHT LOSS

Your Report, *from the State Medical Board of Ohio newsletter*
Summer 1995

Many patients have approached their physicians in recent months requesting weight-loss treatment using a combination of phentermine and fenfluramine (Schedule IV controlled substances), a treatment approach featured in several recent publications and programs in the popular media. Because all phentermine and fenfluramine products are controlled substances, their use is governed by Rule 4731-11-04, Ohio Administrative Code. It is essential for

physicians to be familiar with this rule before prescribing these drugs.

The Board adopted Rule 4731-11-04 in 1986 to address a serious and growing substance abuse problem. At the time, U.S. Drug Enforcement Administration (DEA) statistics showed Ohio among the top five states in per capita consumption of Schedule II controlled substance stimulants. The Board ultimately adopted a rule banning those drugs for weight reduction. Although numbers were not kept to show levels of distribution of substances in Schedules III and IV, the experience of the State Medical Board, the Board of Pharmacy, the DEA, and law enforcement agencies throughout the state was that stimulant drugs such as phentermine, phendimetrazine, and benzphetamine constituted a major diversion and abuse problem. Testimony at the Board's 1986 rules hearing revealed that controlled substance stimulants in Schedules III and IV were widely sought "on the streets," and were even diverted and abused by impaired health care professionals.

While much evidence in 1986 showed that controlled diet drugs present a serious substance abuse problem, no acceptable studies had been done showing them to be effective at achieving long-term weight loss. In fact, the medical literature showed that patients who lost weight with anorexiants, with or without behavior therapy, later gained the weight back faster than patients who had lost weight using behavior therapy alone.

Based on the available evidence, the State Medical Board adopted Rule 4731-11-04, setting stringent standards for the use of controlled substances to assist in weight reduction. The rule prohibits use of these drugs as a first line of treatment, requires that they be used only accordance with their FDA approved labeling, prohibits continued use if the patient develops tolerance or stops losing weight, and prohibits their use in the presence of a contraindication, in the treatment of a pregnant patient, or in the treatment of a patient who has a history of or shows a propensity for alcohol or drug abuse. The rule sets other technical requirements, which a physician should learn before prescribing these drugs.

Rule 4731-11-04 has traditionally been viewed as prohibiting coadministration of multiple controlled substances to assist in weight reduction, because coadministration of two CNS stimulants violates the "recognized contraindication" prohibition of the rule. Fenfluramine, however, is unique in that it is the only controlled substance approved by FDA as a weight loss aid that does not usually act as a CNS stimulant. Thus, its use together with another controlled diet drug does not violate the "recognized contraindication" prohibition, and the State Medical Board has not ruled that a

physician may not coadminister fenfluramine and phentermine.

In 1992, Dr. Michael Weintraub of Rochester, New York, published a study reporting long-term success in achieving and maintaining weight loss using fenfluramine and phentermine in combination. Almost immediately, the State Medical Board began receiving inquiries from physicians excited over the possibilities this treatment approach offered for their obese patients. The Board has had to caution inquiring physicians that, while the coadministration of fenfluramine and phentermine may not constitute a violation *per se*, the provisions of Rule 4731-11-04 still apply:

- Either or both drugs can still be used only in accordance with their FDA approved labeling, and the labeling for both still limits use to "a few weeks."
- The rule still requires cessation of treatment using either or both drugs if (1) the patient develops tolerance or (2) fails to lose weight over a 14-day period.

MEDICOLEGAL DECISIONS

Recent medicolegal decisions involving or of interest to medical boards. Reprinted from *THE CITATION*.

SECTION 1: MEDICAL BOARDS

Preferred Provider Application Denied . . . A managed health care company did not violate the Virginia Any Willing Provider statute in denying a physician's application to become a preferred provider, ruled a federal trial court for Virginia.

. . . the company had a policy of rejecting the application of any physician who had been disciplined by a state medical board.

In 1993, the managed health care company sought to set up a preferred provider network in northern Virginia. In October of that year, an orthopedic surgeon read and signed the company's provider agreement. In March 1994, she was informed by the company her application to become a preferred provider had been denied. The reason given for the denial was the company had a policy of rejecting the application of any physician who had been disciplined by a state medical board. The surgeon had been disciplined three years before. When she learned of the denial of her application, she brought an action against the company under the state Any Willing Provider statute.

At trial, the federal court found for the managed care company. The company's credentialing policy, the court held, did not discriminate unreasonably against the physician. It was permissible for the company to rely upon the conclusions of the state medical board in determining whether a physician applicant was suitable to be granted preferred provider status.—*Richter v. Capp Care, Inc.*, 868 F. Supp. 163 (D.C., Va., Nov. 1, 1994)

License Suspension Upheld . . . The Supreme Court of Hawaii upheld a lower court and the Board of Medical Examiners when the latter suspended the license of a physician who had been convicted of sexual abuse and kidnapping.

The high court also decided [that] the absence of patient involvement did not alter the importance of the physician's fitness for licensure.

A physician hired a medical assistant to perform typical office duties. A few months later, he asked the employee to come to his home rather than the office to do some paperwork on medical files and records. Upon her arrival, the physician made verbal and physical advances, physically restrained her, and attempted to force himself upon her against her will. These events led to an indictment and ultimate conviction on the charges of attempted first degree sexual abuse and kidnapping. Sentence included probation, community service, and a \$3500 fine. The physician appealed the conviction.

While the appeal was pending, the Department of Commerce and Consumer Affairs filed a disciplinary action against the physician. Following a hearing, the hearing officer recommended license suspension for one year and a \$1000 fine. The Board adopted the proposed sanctions, whereupon the physician appealed to the circuit court, which reversed the fine but let stand the license suspension. The physician appealed again.

The Hawaii Supreme Court reviewed the case and several claims of judicial and Board error presented by the physician. These included (but were not limited to) a condition of double jeopardy and the position of the physician that the attempted sexual assault was not related to the qualifications, duties, or functions of a physician since there was no patient involvement.

The court decided the penalty levied by the Board, license suspension, was not double jeopardy because it served to protect the public from an unfit physician, thus qualifying as a "legitimate nonpunitive governmental objective." Only the fine was punitive, and it had been reversed by the lower court. Double jeopardy, the court said, related to a second punishment.

The high court also decided [that] the absence of patient involvement did not alter the importance of the physician's fitness for licensure. In several paragraphs taken from judicial and ethical statements, the court quoted the following:

Physicians hold a position of public trust. As such they have an ongoing duty to maintain the highest standards of professional conduct. This duty extends not only to the patients whom they are treating but to society as a whole.

The conduct need not have occurred during the actual exercise of professional or occupational skills, nor need the conduct raise general doubts about the individual grasp of those skills. . . . Conduct may indicate unfitness to practice medicine if it raises reasonable concerns that the individual may abuse the status of being a physician in such a way as to harm members of the public or if it lowers the standing of the medical profession in the public eyes.

The court determined the circuit court had decided the issues properly and affirmed the lower court ruling.—*Louisiana State Board of Medical Examiners*, 889 P.2d 705 (Hawaii Sup. Ct., Feb. 21, 1995)

Board Members May Not Be Deposed . . . A physician against whom disciplinary proceedings were brought by the State Board of Medical Examiners was not allowed to depose Board members prior to his hearing, ruled a Louisiana appellate court.

The physician was not entitled to pursue discovery proceedings . . .

The physician was disciplined by the Board of Medical Examiners for his improper care of two patients upon whom he performed abortions. Afterward, he allegedly violated conditions of his probation, and the Board opened disciplinary proceedings against him. Prior to his disciplinary hearing, he sent deposition notices to each member of the Board, seeking to interrogate them on their opinions about abortion. The Board quashed the deposition, and the physician filed a request in trial court for a review of the decision to quash.

Before the trial court the physician argued he would be denied the opportunity for a fair and impartial hearing if he were not allowed to depose the Board members. The Board countered by arguing it was inappropriate for triers of fact to be witnesses as well. The trial court reversed and ordered the Board members be deposed.

On appeal, the court reversed. If the physician had any reason to believe a Board member was motivated by bias or prejudice, it held, he could file a motion to recuse. The physician was not entitled to pursue discovery proceedings to determine whether grounds for recusation existed.—*Louisiana State Board of Medical Examiners v. Golden*, 645 So.2d 690 (La. Ct. Of App., Sept. 29, 1994; rehearing denied Dec. 13, 1994)

Physician's License Suspended for Bank Robbery . . . The suspension of the license of a physician convicted for bank robbery was affirmed by a Louisiana appellate court.

. . . none of the alleged acts of prosecutorial misconduct made any difference in the outcome . . . The fact remained the physician had been convicted of a felony.

In 1986, the physician was convicted of stealing \$2000 from a savings and loan. The conviction later was reversed based on the trial court's refusal to admit expert testimony concerning the process used to identify the thief. The physician was retried and once again convicted. On appeal, the conviction was affirmed. Subsequently, the State Board of Medical Examiners filed an administrative complaint against the physician. After a hearing at which the physician was represented by counsel, the Board decided to suspend the physician's license for three years, effective from the date upon which he would be released from prison. The physician appealed this ruling, asserting misconduct on the part of the Board's prosecutor.

The court affirmed the license suspension. It found none of the alleged acts of prosecutorial misconduct made any difference in the outcome of the hearing. The fact remained the physician had been convicted of a felony. Under the Medical Practice Act, the court pointed out, the Board acted in the appropriate manner in response to the physician's conviction.—*Alexander v. Louisiana State Board of Medical Examiners*, 644 So.2d 238 (La. Ct. Of App., Sept. 29, 1994; rehearing denied Nov. 15, 1994)

Physician Guilty of Overprescribing . . . The appellate court of Tennessee affirmed a Board of Medical Examiners' suspension of a physician's license because he habitually prescribed Schedule II drugs for weight loss indications.

... some of his patients had not exhibited a benefit from his therapy even though he maintained them on drugs in excess of one year.

A physician came to the attention of two state agencies, the Pharmacy Board, which performed audits of his prescriptions in one pharmacy, and the Division of Health Related Boards, which conducted audits in several pharmacies. The findings in each case were similar; the physician was the high volume prescriber in the entire state of Tennessee of Schedule II stimulant drugs including Desoxyn, Preludin, Biphedamine, and Dexedrine.

In addition, the Drug Enforcement Administration, a federal agency, procured records which showed the physician had obtained a substantial amount (12,500 dosage units) of dextroamphetamine sulfate for dispensing in his practice in addition to the prescriptions he had written.

The physician nominally specialized in Obstetrics and Gynecology but stated he had intended for some time to phase out of this specialty and concentrate on weight reduction. He admitted some of his patients had not exhibited a benefit from his therapy even though he maintained them on drugs in excess of one year. According to his testimony, these patients felt better while receiving the medication. In one instance cited by the investigators, the physician prescribed a stimulant which caused the patient to become agitated and then ordered Valium to calm her.

After being charged, the physician did not challenge audit results presented to him. The Board accused him of unprofessional conduct, gross malpractice, and dispensing a controlled substance without a legitimate purpose. The Board imposed a six month license suspension and other requirements to be met preceding a return to practice. The physician appealed to the Chancery Court, where he failed to obtain any relief, and then to the appellate court.

He claimed the statutes under which he was charged were unconstitutionally vague and the Board had heard no expert testimony which indicated his prescribing habits were abnormal.

The court affirmed the Board and lower court actions. It said the Board of Medical Examiners, made up of physicians, was expected to use their experience and did not require expert testimony to reach decisions involving medical practice issues. With regard to the physician's claim, the

statute was too vague to be understood. The court said, "It should be clear to anyone that giving stimulants to obese patients for long periods of time just to help them feel better is a dangerous practice."—*Williams v. Department of Health and Environment*, 880 S.W.2d 955 (Tenn. Ct. of App., March 9, 1994)

Licensure Action Affirmed . . . A physician's license suspension was affirmed by a Louisiana appellate court.

In denying the right of cross examination, the physician was not precluded from due process, the court said.

Following a State Board of Medical Examiners hearing, a physician's license was suspended because he had prescribed excessive amounts of controlled substances to at least eleven patients, some of whom were known to be addicted to the drugs. Immediately thereafter, the physician sought and obtained a judicial review which affirmed the Board action. Subsequently, the physician appealed to a higher court.

He claimed denial of due process rights because he was not permitted to be present during the Board's deliberations on two proposed consent orders he had submitted for consideration as a settlement offer. The appellate court found the physician had no right to be present when the Board discussed his proposals.

The physician sought to cross examine Board members, but the appellate court indicated no such right existed since the Board was an adjudicatory body, free to use its expertise and experience as necessary. In denying the right of cross examination, the physician was not precluded from due process, the court said.

A Board expert reviewed the records of eleven patients and found three had prescribing violations in every instance. Witnesses for the physician, among them some who were familiar with the patients, presumably were in a better position to discuss treatments, but even they did not concur completely with the accused physician's practices. Finally, deposition testimony of the physician contained an admission he may have prescribed excessive amounts of medicine in at least one instance.

In review of the evidence presented and available, the court determined the Board had acted appropriately and affirmed its conclusions and those of the lower court.—*Reynolds v. State Board of Medical Examiners*, 646 So.2d 1244 (La. Ct. Of App., Nov. 30, 1994; rehearing denied Jan. 18, 1995)

SECTION 2: OTHER HEALTH PROFESSION BOARDS

Board of Nursing Upheld in Nurse Licensure Ruling . . .
A ruling against a nurse accused of habitual intoxication was upheld by the Supreme Court of Iowa.

. . . the Supreme Court wrote that a professional licensing board has "extremely broad authority" to impose sanctions against licensees.

After determining a nurse was guilty of habitual intoxication, the Iowa Board of Nursing imposed several conditions of probation. These included a requirement she was to undergo inpatient treatment for her disability followed by after care treatment. Also, she was required to attend Alcoholics Anonymous, submit to random blood and urine testing, and undergo a psychiatric examination.

A judicial review sought by the nurse ended with reversal of the Board's findings because substantial evidence was lacking to prove the case. The Board appealed to the Supreme Court of Iowa which reversed the lower court determination. In its opinion, the Supreme Court wrote that a professional licensing board has "extremely broad authority" to impose sanctions against licensees. Since the purpose of licensing is to protect the public, the court said, it was reasonable to construe licensing statutes liberally. The claim by the nurse that the Board had exceeded its authority by imposing stringent probation was not realistic since she had been found guilty of habitual intoxication.

Deciding Board action was reasonable and justified by the circumstances, the court upheld the Board.—*Burns v. Board of Nursing of Iowa*, 528 N.W.2d 602 (Iowa Sup. Ct., March 29, 1995)

Denturist Action Against Board Rejected . . . Dismissal of claims by a denturist against the State Board of Dentistry in connection with an injunction the Board attempted to obtain against him was affirmed by the Montana Supreme Court.

The denturist responded by maintaining TMJ evaluations were within the scope of the practice of dentistry.

The denturist placed a notice in a local newspaper advertising he would perform temporomandibular joint dysfunction (TMJ) evaluations at his office. A local dentist responded to the advertisement by writing a letter to inform the Board

of Dentistry the denturist was involved in the unauthorized practice of dentistry. The Board informed the denturist of the complaint and requested a response. The denturist responded by maintaining TMJ evaluations were within the scope of the practice of dentistry. One week later, the Board asked the county attorney to file criminal charges against the denturist for practicing dentistry without a license. The county attorney decided not to prosecute, and the Board filed a complaint with the trial court seeking to enjoin the denturist from practicing dentistry without a license.

The trial court granted summary judgment for the denturist. There was no evidence the denturist had performed dental work on natural teeth. The trial court also granted summary judgment for the Board on the denturist's counterclaims of violation of his right of privacy, wrongful injunction, slander and libel, wrongful civil litigation, abuse of process, outrage and intentional infliction of emotional distress, intentional interference with business and patients, and negligence. The denturist appealed.

On appeal, the court affirmed. It held the claim for wrongful injunction was inappropriate because there was never any injunction issued. There was no invasion of privacy in the Board's efforts to obtain a list of the denturist's patients through discovery. Again, the Board had never obtained such a list, so even if an attempt had been made to obtain one, there was never any actual invasion of privacy. Lastly, the denturist could not prevail on an interference with business claim because he could offer no evidence the Board had acted to damage his business without justification.—*State Board of Dentistry v. Kandarian*, 886 P.2d 954 (Mont. Sup. Ct., Dec. 16, 1994; rehearing denied Jan. 12, 1995)

SECTION 3: OTHER ISSUES OF INTEREST

Sexual Assault Charges Reinstated Against Gynecologist . . . A decision dismissing criminal sexual assault charges against a gynecologist was reversed by the Illinois Supreme Court.

The physician argued that many examinations conducted by a gynecologist met the law's requirement for assault . . .

A physician was indicted by a county grand jury for several sex offenses including eight instances of criminal sexual assault which arose from his conduct of physical examinations. The physician moved to have the charges dismissed, claiming the statute used by the prosecution to accuse him was unconstitutionally vague. The physician argued that

many examinations conducted by a gynecologist met the law's requirement for assault (sexual penetration, absence of consent, or inability to understand the nature of the act) even though there was an exemption in the statute for legitimate gynecologic examinations.

On appeal from the dismissal charges, the state argued the law was not vague. The supreme court agreed. It said the wording and intent of the law was sufficiently clear that "men of common intelligence" would not have to guess at its implication or meaning. The medical exemption which used the terminology "reasonable medical standards" was sufficient, the court stated.

The case was remanded for further proceedings.—*People v. Burpo*, 647 N.E.2d 996 (Ill. Sup. Ct., Feb. 17, 1995)

Medical Student Reinstated . . . The decision for a medical student expelled from a medical school for cheating on an exam was upheld by a Texas appellate court.

The due process requirement that the school confront the student with the charges against him in a timely manner was not met.

The student took his medical board exam in surgery in February 1991. The exam proctors observed him repeatedly looking at the answer sheet of the student sitting next to him and later reported this behavior to the medical school's associate dean for student affairs. A statistical analysis of the test results of the two students was performed in order to assess the likelihood the student had cheated. The analysis proved inconclusive but the student was informed in early April that he had been charged with academic dishonesty in connection with the exam. A hearing was held two weeks later. The hearing officer found sufficient evidence of cheating and recommended expulsion.

The student, subsequently expelled, appealed his expulsion to the school president. When the expulsion was upheld, the student responded by filing suit against the medical school, the associate dean, and the president. He claimed violation of his due process rights and breach of contract. The breach of contract claim eventually was disposed of by summary judgment, but the student was able to obtain a temporary injunction allowing him to continue his studies pending a decision on whether to issue a permanent injunction. The school appealed the grant of the temporary injunction.

The appellate court upheld the grant of the temporary injunction. One year later, a trial court signed a permanent injunction, allowing the student to complete his education. The school again appealed.

On appeal, the court rejected the school's contention the student was not entitled to due process in connection with an academic dismissal. The court found the dismissal had not been academic but disciplinary in nature. The student was entitled to due process. In this case, though, his due process rights were violated. The due process requirement that the school confront the student with the charges against him in a timely manner was not met. He was not informed officially of the charge of cheating until eighteen days after the exam had passed, at which point most potential witnesses had forgotten where they were seated during the exam. In addition, the student was provided with copies of documents to be used as evidence against him only five days before the disciplinary hearing was to take place. Under the circumstances, the court upheld the permanent injunction.—*University of Texas Medical School at Houston v. Than*, 874 S.W.2d 839 (Tex. Ct. Of App., April 7, 1994; rehearing denied May 5, 1994)

Psychiatrist Guilty of False Billing . . . A psychiatrist and his wife who billed the federal government for treatment of Medicare and Medicaid patients were found by a federal trial court in the District of Columbia to be in violation of the False Claims Act and ordered to reimburse the government.

On at least two occasions, the psychiatrist and his wife billed for more than 21 hours of services in one day.

The psychiatrist treated seriously mentally ill patients on Medicare and Medicaid. In January 1993, the federal government brought an action against him and his wife, who was responsible for overseeing his billing operation, for false Medicare and Medicaid billing. The government alleged two types of misconduct: (1) submission of bills for a service with a higher level of reimbursement than the psychiatrist actually provided, and (2) the submission of bills for medically unnecessary services. The damages sought were triple the actual alleged damages of \$245,000 and \$10,000 for each of the 8002 allegedly false reimbursement claims.

At trial, the court considered the extreme difficulty of assessing the validity of 8002 claims and decided to try the case on the basis of 200 claims submitted for seven patients. It found there was no basis for the government's claim the physician had performed medically unnecessary services. In addition, it found unreasonable the government's contention the physician should not have billed for a 40-50

minute session when he spent fewer than 40 minutes in actual face-to-face contact with a patient. Expert testimony at trial established it was common for psychiatrists to use part of a 40-50 minute session for other purposes than face-to-face therapy, as, for example, to prescribe medication or to consult with a patient's spouse.

The court looked with more favor on the other of the government's allegations. It found the psychiatrist's billing practices constituted reckless disregard as to the truth or falsity of the billing submissions being made. On at least two occasions, the psychiatrist and his wife billed for more than 21 hours of services in one day. Such practices were in violation of the False Claims Act. The court determined the proper remedy for the violation was for the psychiatrist to be made responsible for reimbursing the government for any bills submitted in excess of nine hours of services in one day. The government also would be entitled to try to prove the psychiatrist submitted incorrect bills when he had billed for fewer than nine hours of services in one day, the court said.—*United States v. Krizek*, 859 F. Supp. 5 (D.C., July 19, 1994)

Candidates Denied Board Certification . . . Dismissal of the claim of two psychiatrists who sued a board after they were denied certification was affirmed by a federal appellate court for Illinois.

Rather than pursue an internal appeal with the Board, the psychiatrists chose to bring a lawsuit in federal court.

The psychiatrists passed written examinations to become eligible for certification by the American Board of Psychiatry and Neurology. However, both of them failed their oral exams. Rather than pursue an internal appeal with the Board,

the psychiatrists chose to bring a lawsuit in federal court. They alleged violations of the Sherman Act, the due process clause of the Fourteenth Amendment, and numerous principles of state law.

The trial court dismissed the claims for failure to state a claim. In its ruling, it pointed out [that] as part of their application for certification, the psychiatrists agreed to resolve any disagreements about the decision on certification through the Board's internal processes.

On appeal, the psychiatrists argued the Board lacked the power to condition an application on a promise not to sue. The court disagreed. Contrary to what the psychiatrists contended, it found the Board must be considered a private association and not a "state actor." It also found the psychiatrists had not stated an antitrust injury under the Sherman Act. Their claim was the Board's oral exam discriminated against physicians whose first language was not English. It did not constitute a claim for antitrust violation, the court said.—*Sanjuan v. American Board of Psychiatry and Neurology, Inc.*, 40 F.3d (C.A.7, Ill., Nov. 21, 1994)

LETTERS TO THE EDITOR

Responses to Boodman's Article "Certificates on Your Doctor's Wall"

To the Editor—Volume 82, Number 2, 1995, of the *Federation Bulletin* contains an article on page 83 by Sandra G. Boodman. Ms. Boodman originally wrote this article for the *Washington Post* and it was published in July 1994. In the second paragraph of this article, Ms. Boodman refers to the American Board of Medical Specialties (ABMS) as "the sole widely accepted authority on board certification." It is understandable that a reporter might overlook the other widely accepted authority on board certification, the American Osteopathic Association (AOA). However, it is disturbing that the *Federation Bulletin* should reprint this misinformation, thus perpetuating it and giving it a wider audience. It is even more disturbing that your audience probably ascribes greater credibility to the *Federation Bulletin* than most do to the *Washington Post*. Furthermore, your readers are more likely to be in policymaking positions affecting health care providers.

Of the fully licensed physicians in the United States, 37,000 are osteopathic physicians (DOs). While some DOs choose to be certified through ABMS, many are certified through AOA. This article completely fails to recognize these physicians and their qualifications. It leaves readers with the impression that osteopathic physicians certified by one of the AOA boards are among the "self-designated subspecialty boards" which may or may not be indicative of quality care.

Michael H. Claphan, CAE
Executive Director
Indiana Association of Osteopathic
Physicians and Surgeons
Indianapolis, Indiana

Editor's Response—As policy, we do not apply our red pen to reprints. Obviously, those who grant us permission to reprint would object. Soon we would acquire a reputation for such editing and would be less likely to secure reprint permissions, preventing our use of some relevant and thought-provoking work.

However, Mr. Claphan's points are well-taken, and, an editorial note deemed insufficient, we have invited him to submit a manuscript outlining AOA specialty certification procedures and listing the AOA boards. We hope its publication will further educate our readers and will be considered equitable by our friends and colleagues in the osteopathic field. Pending receipt and processing time, we plan to bring this information to the *Bulletin* within six months.

To the Editor—I recently received a copy of the enclosed article from the 1995 issue (Volume 82, Number 2) of *Federation Bulletin*, "What do the Certificates on Your Doctor's Wall Really Mean," which includes the "American Board of Alcoholism and other Drug Dependencies (AMSAODD)" in a list of "self-designated boards" (page 85). AMSAODD (American Medical Society on Alcoholism and Other Drug Dependencies) is the former name of the American Society of Addiction Medicine (ASAM). ASAM offers certification in addiction medicine to physicians who meet the credentialing criteria, which are requirements for education and training, and who then pass a six-hour written examination. Recertification is required after 10 years.

ASAM is explicit in helping members and the public understand the distinction which your article discussed: the difference between those certifying groups which are Boards recognized by the ABMS and those which are not so recognized. All of ASAM's information about its certification program states, "ASAM is not a member of the American Board of Medical Specialties, and ASAM certification does not confer Board certification." ASAM does not call itself a "Board."

To our dismay, there does exist an "American Board of Addiction Medicine" headquartered in Palm Beach, Florida. It confers certification upon psychiatrists who meet its criteria. ASAM is in no way affiliated with the group, nor does ASAM endorse it.

ASAM's commitment is to educating physicians about appropriate diagnosis and treatment of alcoholism and drug dependencies. The certification program is an integral part of our educational efforts.

Thank you for reprinting the article from the *Washington Post* and for your efforts to inform your readers about the important distinctions among the different entities called "self-designated boards" and the fact that they vary widely in their requirements and their significance.

May I ask that you would draw your reader's attention, in a future issue of *Federation Bulletin*, to the error regarding AMSAODD (ASAM) that appeared in the 1995 issue?

James F. Callahan, DPA
Executive Vice President/CEO
American Society of Addiction Medicine
Chevy Chase, MD

Editor's Response—Mr. Callahan's clarification is appreciated. According to ASAM publications enclosed with his letter, the name change occurred in 1989, five years before the article we reprinted was written.

The fact that many organizations offer certifications—despite forthrightness about their not being "board certifications"—is a continuing cause for confusion among members of the general public, who have difficulty researching such distinctions with the limited information they see on the certificates on physicians' walls.

Federation Publications

Any of the Federation publications listed below may be ordered by writing to the following address:

Federation Publications
Federation of State Medical Boards of the US
400 Fuller Wiser Road, Suite 300
Euless, Texas 76039-3855

All orders must be prepaid by cashier's check or money order payable to the Federation. **Personal checks cannot be accepted.** Foreign orders must be accompanied by an international money order or the equivalent payable in US dollars through a US bank or a US affiliate of a foreign bank. Prices are subject to change without notice. (Texas residents must add 7.75% state sales tax except for subscriptions to the *Federation Bulletin* or the *FSMB NewsLine*.)

Federation Bulletin: The Journal of Medical Licensure and Discipline
(ISSN 0014-9306)

The world's only journal devoted exclusively to medical licensure and discipline.
quarterly: \$10 per issue/\$35 annual subscription

FSMB NewsLine
(ISSN 1062-5380)

A newsletter focused on current issues of interest to medical licensing and disciplinary authorities.

monthly: \$4 per issue/\$35 annual subscription

FSMB Handbook
(ISSN 0888-5656)

A compendium of information about the Federation, including its history, purposes, leadership, committees, membership, and bylaws.

annual: \$15

A Guide to the Essentials of a Modern Medical Practice Act (ISSN 0888-6768)

A set of basic recommendations for use in the development, evaluation, or revision of state statutes governing the practice of medicine.

triennial (1992 edition): \$8

Exchange
(ISSN 0888-5648)

Detailed information on examination and licensing requirements in all US jurisdictions and on medical board structure and disciplinary functions.

biennial (1995-1996 edition): 3 sections: \$25 each/\$60 per set

Section 1: USMLE and M.D. Licensing Requirements

Section 2: USMLE and D.O. Licensing Requirements

Section 3: Licensing Boards, Structure and Disciplinary Functions

SPEX Guidelines, Strategies, and Sample Items

Descriptions and samples of the content guidelines on which the Special Purpose Examination is based, testing-taking suggestions, and practice items.

1995 edition: \$20 US/\$25 foreign