The Impaired Professional, Part III: Understanding Addicted Physicians

Gregory E. Skipper, MD, FASAM

Understanding the historical and political issues surrounding the identification and management of addicted physicians is important to effectively work with them. These issues in many ways reflect the continued ambivalence in our society regarding whether we regard addiction as an illness or a moral failing. Physicians hold a place of esteem in our society and the patient-physician relationship involves a transference necessary for patients to relinquish their privacy to get care. Patients tell their secrets, share their fears, face their mortality, expose their bodies to physicians, and follow the physician's directions to undergo procedures and take medications only because of the special relationship and trust placed in them. This is why there is a cognitive dissonance associated with physicians having problems with substance abuse, and why it is newsworthy to hear about physicians admitting their addiction or being arrested for a drug problem. We have a morbid curiosity about how this could happen. Furthermore, the problem of addiction among physicians is common—studies show that about one in ten physicians become addicted during their lifetime (Flaherty & Richman, 1993).

Medical boards, whose members are usually appointed by the governor of each state, are assigned the responsibility to protect patients by assuring that practitioners are qualified and ethical. So it makes sense that medical boards would be concerned about addiction and other mental health issues among licensed physicians. Stories regarding addicted physicians are in the news and lawyers see the opportunity to capitalize on the anger of patients who feel betrayed. These events garner negative publicity for the boards.

Most medical boards are funded through state budgets and they must continually demonstrate their need for funds. Going after addicted physicians is relatively easy compared to seeking to discipline physicians who are greedy, overutilizing procedures or who have poor communication skills leading to medical errors. Medical boards are legal entities established through legislation; they are not designed for diagnosis and treatment of illnesses. Additionally, medical board investigators are essentially a police force—in fact, many board investigators are actually ex-police. The medical board process, like other legal processes, is slow. From the time of reporting a violation of a medical practice act to actual disciplinary action such as citation, fine, suspension or revocation can take years.

As an addiction professional there is nothing more bizarre and frustrating than to see a board pursuing an addicted physician. First there is a complaint, usually from a hospital or patient. The legal process of the board first

involves a board investigator making a preliminary investigation to see if more in-depth investigations and interviews are needed. If so, the next step is usually to invite the physician for an informal interview. All this usually takes a few months, during which time the doctor may continue to use drugs or alcohol, except the doctor is now aware that the board is cognizant of the problem, which prompts the doctor to intensify his or her hiding. When the interview occurs, the doctor is essentially invited to come up with alternative explanations, which he or she will have had months to concoct. If the board decides to proceed, the investigators conduct interviews, gather data (such as DEA and pharmacy records) and eventually if there is enough evidence the physician is summoned for a formal hearing that resembles a trial. The physician usually brings his or her own attorney, one specializing in administrative law. This "trial" can occur before the board itself or a proxy, such as an administrative law judge, usually hired by the board. It's obvious to any observer that this is not the best way to identify and obtain treatment for someone with an illness.

To rectify this bizarre situation, the concept of the physician health program (PHP) evolved over the past thirty years. The purpose of the PHP is to provide a "clinical arm" for the board. In its ideal form the PHP identifies physicians with addiction problems early, prior to overt impairment, and intervenes. Physicians are directed to proper evaluation and treatment and then, if they are deemed fit to return to practice, they are closely monitored for many years. The beauty of this approach is that it is not a legal, but a clinical process. If symptoms are identified, an intervention can be conducted and a thorough evaluation performed. There is no need for a police level investigation and there is no provision for "due process." Thus, if physicians exhibit signs of addiction (e.g., showing up at work with alcohol on the breath), an intervention can be conducted immediately and the doctors can be asked to stop working and undergo prompt evaluation. The leverage to get physicians to cooperate is that if they fail to comply a report will then be sent to the medical board. Almost 100 percent of physicians comply because of the dread they appropriately have of dealing with the board.

The concept of the PHP is logical and effective; however, successful implementation has been mixed and continues to be controversial. The media sensationalize news of physician addiction and challenge the effectiveness of the medical boards. Questions, continually arise, such as "Why is the addicted physician allowed to keep a medical license?" and "Shouldn't patients have the right to know which doctors have an addiction history?" Organizations such as Public Citizen publicize the ranking of states regarding their per capita disciplinary actions. The assumption is that the boards with a higher disciplinary rate are doing a better job. Having an effective PHP decreases the number of disciplinary actions. This information is sent to state newspapers and leads to headlines, such as that in the *MinnPost* titled, "Minnesota ranked 'worst in the country' at disciplining physicians" (Perry, 2012).

Tension can then develop between the PHP and the medical board. Ambivalence regarding whether to treat or to punish addicted physicians varies year to year and state to state. The largest state for population of physicians, California, disbanded their PHP in 2008 following ongoing criticism regarding its effectiveness. Ironically, this has left the state of California now essentially prosecuting all addicted physicians and taking sometimes years to do so. Sadly many physicians are prosecuted after they have been in good recovery for a year or more. So, states vary considerably regarding the way the PHP works in each with varying degrees of trust and functionality.

Points to Consider

- When working with addicted physicians it is important to investigate—in every state in which they are licensed—the status of the PHP regarding its functionality.
- All physicians will have to respond to license renewal questions. It's important to help them decide how they will respond to questions such as, "Since your last license renewal have you undergone treatment for a substance use problem?" Failure to address this question in treatment can lead to the physician fraudulently answering the question, a far worse offense than being in recovery.
- Since physicians who are not involved with PHPs will eventually need to reveal their history of addiction, it is important that they be monitored in the interim with regular drug testing and other methods to document their recovery.
- When and how to advise a physician to self-report a history of addiction, which can often be the best tactic, must be carefully considered. Someone knowledgeable regarding the particular state medical board and PHP should be involved. C

Gregory E. Skipper, MD, FASAM, *is head of the Alabama State Physician Health Program.*

References

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