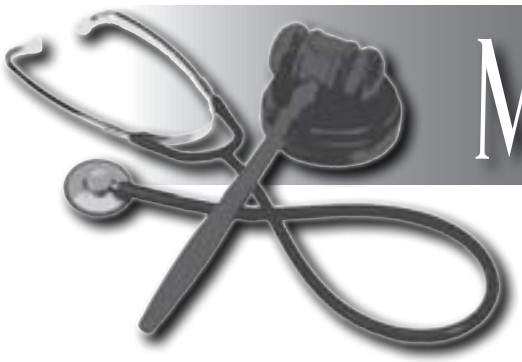

MEDICAL-LEGAL

What Happens When A Physician Is Suspected of Abusing Drugs or Alcohol?

Daniel M. Avery, MD
Kathy T. Avery, RN, BA, MT (AMT)

Abstract

Physicians suspected of abusing drugs or alcohol are reported by a multiplicity of mechanisms. The vast majority of complaints today are sent to the state impaired-physician program. Physicians suspected of abusing drugs or alcohol are usually sent for a residential evaluation and assessment by a team of professionals trained in addiction. Most physicians today are treated at state medical society and licensure commission approved residential treatment facilities. There is life and the practice of medicine after successful treatment, depending on a compliance contract with the state, a treatment plan, and urine drug screens. Most hospitals today are recovery-minded. Relapse of physicians after quality treatment is rare, but, when it occurs usually results in death or prison.

Introduction

Physicians suspected of abusing drugs or alcohol are reported via several mechanisms. A patient, who suspects a physician, may register a complaint with a hospital administrator. Many hospitals have physician wellness or physician impairment committees that will then investigate the complaint. Often, a group of colleagues intervene with a physician about whom they are concerned. A concerned physician, nurse, or pharmacist may express concern about a specific physician. Suspected medical students are usually dealt with by the medical student affairs office. Residents and fellows in training usually become involved with the program director. On rare occasion, a patient or concerned party may register a complaint with the licensure board or state medical society. Self-reports to state medical societies and physician health programs are few and far between. The physician in trouble is usually the last to know. The thought of his/her calling the state impaired-physician program and expressing concern over himself/herself is usually unheard of. Table 1 lists the possible ways a physician is reported.

Table 1: How are physicians reported?

- **Report to hospital administrator**
- **Intervention by colleagues**
- **Complaint to licensure board**
- **Complaint to state medical society**
- **Self-report to psychiatrist for other reasons**
- **Attempt at "private treatment"**
- **Report by suspicious pharmacist**
- **Report by nurse**
- **Report by fellowship or residency director**
- **Report by medical school student affairs office**
- **Referral from the legal system**
- **Self-reporting by the physician himself/herself is very rare**

Report to Impaired Physician Programs

No matter what the point of entry of the concern, ultimately the complaint makes it to the state impaired-physician program, usually an agency of the state medical society. Physicians never self-report, because addiction alters their thinking process; they are the last to know that they are in trouble. In Alabama the appropriate agency is the Alabama Physician's Health Program or "APHP" headed by Dr. Greg Skipper. The program was founded by the late Dr. Gerald Summer as the Physicians Recovery Network or "PRN." Alabama has a very progressive program aimed at rehabilitation, a far cry from the original punitive approach. Records are protected by the Code of Alabama and not discoverable by subpoena. The Program is run by a number of appointed physicians from around the state. Local monitors are usually psychiatrists or addictionologists, who regularly meet with impaired physicians and assist Dr. Skipper with interventions.

The APHP compliance is protective of a physician's medical license, unless that physician does not comply, and then his license is in jeopardy. Failure to comply with recommendations in Alabama, like most states, results in licensure revocation.

Evaluation of Suspected Addiction

The vast majority of complaints about physician addiction are directed to the APHP. All reports are anonymous. Dr. Skipper then investigates the complaint and interviews the physician in question. An evaluation by an addictionologist is almost always recommended. A health professional evaluation and assessment consists of a one-to-four day residential assessment by a team of professionals, including addictionologist, psychiatrist, psychologist, social worker, neurologist, and counselor. A comprehensive history and physical is performed along with urine and blood screens and hair samples for toxicology. The physician-patient is observed in a situation where there is no access to drugs or alcohol. After the assessment is completed, a recommendation is rendered to the state impaired-physician program, consisting of any medical diagnoses, psychiatric diagnoses, and opinion about whether the physician is abusing or addicted to drugs or alcohol, and, if so, a recommended course of treatment. A physician may be abusing drugs or alcohol but not yet addicted. A physician may be neither and simply doing things that are "stupid," such as going to the hospital with alcohol on his breath. If a diagnosis is not clear, a period of monitoring may be recommended.

Diagnoses of Addiction, Abuse, or Neither

For those physicians who are diagnosed with alcohol or drug addiction, almost all states and licensure boards demand residential treatment at an approved treatment facility. In Alabama, diagnosed physicians meet with Dr. Skipper, and they usually decide on a treatment facility. The physician is usually given a choice of several possibilities. Compliance with the APHP protects a physician's license. However, non-compliance means revocation of license, which is not a good choice. Basically, the licensure commission holds a physician's license over his head to get treatment, which in the long run is a good thing.

Residential Treatment

Once a treatment facility is selected, the physician requests a leave of absence from his hospital administrator, training program, if he is a fellow or resident, or medical school, if he is a student. Practicing physicians make arrangements to be away from their practice for a period of time, ranging from thirteen weeks to one year. As stated above, there is no current effect on license with compliance.

Physicians are usually given a choice of several approved treatment programs. Not all states have approved treatment programs. Talbott-Marsh Recovery Campus in Atlanta was one of the first treatment facilities designed primarily for healthcare providers. It is considered the "gold standard" of care, and physicians from all over the world go there for treatment. No other program boosts the success rate of Talbott-Marsh, which is greater than 90%. In some cases, detoxification may need to be performed first, before actual treatment. This may be performed locally or at a treatment center.

The term "residential treatment" means, in essence, that you live there, apart from medicine, family, problems, and stresses of life, and completely relearn how to live. One lives with

Table 2: Residential Treatment

- **Detoxification if needed**
- **Living with recovering physicians**
- **Good nutrition**
- **Sleep**
- **Exercise**
- **Group therapy**
- **Individual therapy**
- **Specific counseling**
- **Marital & couples counseling**
- **Psychological testing**
- **Psychiatric testing**
- **Treatment of psychiatric diagnoses**
- **Alcoholic Anonymous**
- **Narcotics Anonymous**
- **Caduceus**
- **Family Week**
- **Discharge Planning**

three to seven other recovering physicians, varying in length of treatment and recovery. There is a complete restructuring of life with good nutrition, sleep, exercise, group, individual and family therapy, specific counseling, treatment of psychiatric diagnoses, Alcoholic Anonymous, Narcotics Anonymous, Caduceus, and Family Week (Table 2). It can be a wonderful experience, but it is also life-changing.

Life After Treatment

Most physicians complete treatment because the state licensure commission holds their license over their head. Physicians see treatment as a means to a new life and the ability to return to practice. The success rate for quality treatment is greater than 90%. The recidivism rate is low among healthcare professionals. Most physicians do well, regain their practices, their self-esteem, and do well professionally. Most serve as a knowledgeable resource about addictions to their patients and colleagues. Most will end up helping others. Ninety-nine percent of patients are understanding, glad to see their physician returned, and gladly acknowledge their honesty.

The real work begins after treatment. Treatment provides the tools for the job ahead – recovery. All state medical societies and licensure commissions require at least a five-year advocacy contract. In reality, *RECOVERY IS FOREVER!* There is no magic pill that keeps a physician from using drugs and drinking alcohol. As the "Big Book" of Alcoholics Anonymous says, "It is a simple program but not an easy one. Don't drink, don't do drugs, go to meetings, talk to people in recovery, read the "Big Book," avoid old playmates and playgrounds." Life after discharge consists of a number of factors outlined in Table 3. They include integration back into family and work, work restrictions of 60 hours per week, proctoring, mentoring, AA, NA, Caduceus, group therapy, After Care, family therapy, urine drug screening, self-assessment, relapse prevention, and an advocacy contract with state impaired-physician program and state medical society. Also essential is a primary care physician and dentist, who have knowledge of addiction, and treatment center revisits. The physician must also meet with the hospital administrator, physician health committee, and malpractice insurance carrier.

Advocacy Contract with State

Every state in this country requires that a physician completing treatment sign an advocacy contract with the state impaired-physician program and/or state licensure commission. This contract is essential for hospital privileges, malpractice insurance, and most practices. While most states only require a contract for five years, hospitals, health insurance carriers, and malpractice companies require such a contract and advocacy for the duration of a physician's practice life. The contract with the state requires the items listed in Table 3. Thereby, most recovering physicians today participate with the state forever. Most malpractice carriers will allow one treatment for addiction but usually consider that physician high risk with a higher premium rate.

Table 3: Treatment After Discharge

- **Integration back into family**
- **Integration back into work**
- **Work restrictions (60 hours/week)**
- **Proctoring**
- **Mentoring**
- **Alcoholics Anonymous**
- **Narcotics Anonymous**
- **Caduceus**
- **Group therapy**
- **After care**
- **Family therapy**
- **Urine drug screening**
- **Self-assessment**
- **Relapse prevention**
- **Advocacy contract with state**
- **Primary care physician**
- **Primary care dentist**
- **Treatment center revisits**
- **Meeting with hospital administrator**
- **Meeting with the physician health committee**
- **Meeting with the malpractice carrier**

Urine Drug Screening

Urine drug screening is an integral part of state and licensure contracts and recovery. Most drug screens are random. Initially screens are once a week, progressing with time to once a month. After five years, most advocacy contracts go to every quarter. Screens may also be used for bad outcomes and any suspicion of drug or alcohol use. Drug screens are observed and follow the "chain of command." They are reviewed by a certified medical review officer or the state director of the physicians' health program. A positive drug screen must be investigated. Urine drug screens can only be performed at an approved collection site.

"Can I go back to my old practice and hospital?"

After all of the above is done, the question remains whether a physician can go back to his old job and practice at his old hospital. Most of the time, it is possible but not always. It depends heavily on how much damage was done. Usually 99%

of patients are glad to have the physician back, are understanding, and will use the physician as a resource; 1% are not and they will go elsewhere. Most hospitals today are very recovery-minded, provided the physician does what he is supposed to do and is compliant with his contract.

Relapse

Despite quality treatment, approximately 1% of physicians will relapse at some point in time, usually early most of the time. Relapse is often disastrous. Recurrent relapse has very deleterious results on license, privileges, and practice. Untreated, the end result of addiction is long-term impairment, loss of license, loss of income, loss of family, loss of health, loss of everything, and, ultimately, loss of life or life in prison.

Conclusion

Most physicians do well with treatment, return to a normal life, family, and practice, and are compliant with advocacy contracts. Most of their patients are understanding and forgiving and will use them as a valuable resource for themselves.

Daniel M. Avery, MD, is the Associate Professor and Chair of Obstetrics/Gynecology at the University of Alabama School of Medicine in Tuscaloosa, AL.

Kathy T. Avery, RN, BA, MT (AMT), is Clinical Nursing Supervisor for the University of Alabama Student Health Center.

Potential Financial Conflicts of Interest: By AJCM® policy, all authors are required to disclose any and all commercial, financial, and other relationships in any way related to the subject of this article that might create any potential conflict of interest. The authors have stated that no such relationships exist.