I SUSPECT PROVIDER IMPAIRMENT: WHAT SHOULD I DO?

Natasha N. Bray, DO, MSEd, FACP, FACOI

Visiting Associate professor of Rural Health

Oklahoma State University College of Osteopathic Medicine

DISCLOSURE

I HAVE NO RELEVANT FINCANCIAL RELATIONSHIP OR AFFILIATIONS WITH COMMERCERICAL INTEREST TO DISCLOSE

Objectives

- By the end of this activity, participants should be able to:

1. Define physician impairment and delineate how this differs from physician illness.
2. List the signs and symptoms of physicians with substance use disorders.
3. Describe a structured strategy for intervening when physician impairment is suspected.
4. Describe the recommended activities for monitoring of physicians with substance use disorders.

American Medical Association (AMA)

Defines Impairment As:

"The inability to practice medicine with reasonable skill and safety due to:

1. Mental Illness
2. Physical Illness, including but not limited to deterioration through the aging process
3. Excessive use or abuse of drugs, including alcohol"

AMA Code of Ethics

Illness versus impairment

- Illness:
  - The existence of a disease
  - Illness is not always synonymous with impairment
- Impairment:
  - Functional classification that impedes ability to perform specific activities
- Represents a continuum with illness potentially predating impairment by years

Federation of State Medical Boards. Policy on physician impairment. 2011

Examples

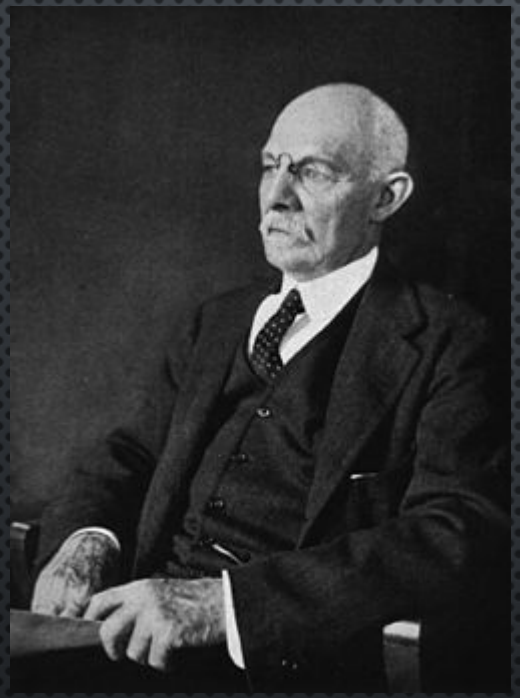
1. Mental Illness:
   - Major Depression, Generalized Anxiety, Specific Phobias, Bipolar Disorder
2. Physical Illness:
   - Chronic vs Acute, Medication Side Effects, Chronic Sleep Deprivation
3. Substance Use Disorders:
   - Opioids, Alcohol, Cocaine, Benzodiazepines

SYMPTOMS OF PHYSICIAN IMPAIRMENT

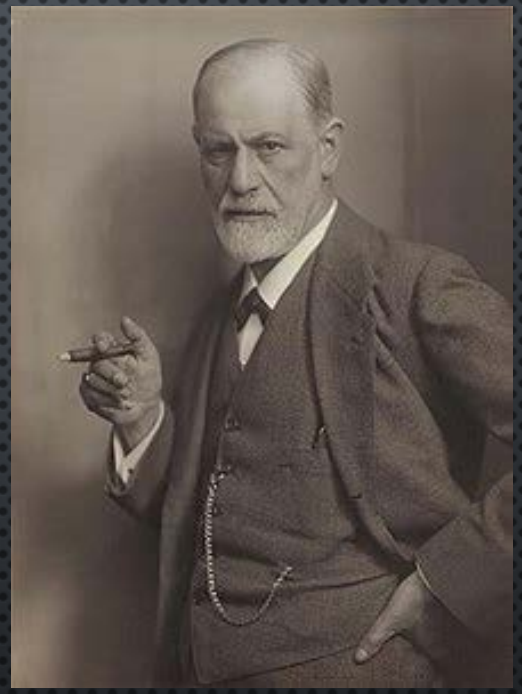
Signs/Symptoms in the Workplace	
Deteriorating personal hygiene	Emotional lability
Frequent Absences or Tardiness	Appearing sleep-deprived
Increased professional errors -inappropriate orders, prescriptions, clinical judgment -decline in bedside manner	Inaccessibility for Patients or Staff -not responding to calls/pages -rounding at odd hours -missing appointments
Decreased concern for patient well-being	Conflicts with Co-Workers or patients
Disorganized Schedule or Missed Deadlines	Multiple Prescriptions for Family Members
Heavy Drinking at Social Functions	Many 'accidental' injuries

Baldisseri MR. Impaired healthcare professional. Crit Care Med. 2007; 35: S106-116.

Famous Addicted Doctors



- Dr. William Halstead – Father of modern surgery
  - Addicted to cocaine, then morphine



- Dr. Sigmund Freud – Father of psychoanalysis
  - Addicted to cocaine and tobacco

http://www.latimes.com/local/california/la-me-doctors-addiction-20170720-story.html accessed April 24, 2018
http://www.modernhealthcare.com/article/20160514/MAGAZINE/305149988

The New York Times

Opinion

OP-ED CONTRIBUTORS

Why Aren't Doctors Drug Tested?

By Daniel R. Levinson and Erika T. Broadhurst

March 12, 2014

"Hospitals can do more to protect patients. Improved security, such as surveillance of drug storage areas, tighter chain of custody on drugs, and better tracking of controlled substances are obvious areas to target.

But we should go further. We believe hospitals should be required to perform random drug tests on all health care workers with access to drugs. The tests should be comprehensive enough to screen for fentanyl and other commonly abused drugs and must keep up with evolving drug abuse patterns."

https://www.nytimes.com/2014/03/13/opinion/why-arent-doctors-drug-tested.html

Prevalence of Substance Use Disorders (SUD)

- Prevalence of SUD in physicians between 6-15%
  - Similar to general population
- Alcohol – Most commonly abused drug
- Illicit drugs – less commonly abused than the general population
- Rates of benzodiazepine and opiate use are up to 5X higher than general population
- Physicians in solo practice, anesthesiology, emergency medicine and psychiatry may be more impacted
  - Lowest Risk – Pediatricians, pathologists, radiologists, obstetricians, surgeons

1. Flaherty JA, Richman JA. Substance use and addiction among medical students, residents, and physicians. *Psych clin North Am*. 1993; 16: 189-197.
2. Hughes PH, Brandenburg N, Baldwin DC Jr. et al. Prevalence of substance use among US physicians. *JAMA*. 1992; 267: 2333-39.
3. Hughes PH, Storr CL et al. Physician substance use by medical specialty. *J Addict Dis*. 1999; 18(2): 23-37
4. Oreskovich MR, Shanafelt T, Dyrbye LN, et al. The prevalence of substance use disorders in American physicians. *Amer J Add*. 2015; 24: 30-38.

Prevalence of Substance Use Disorders (SUD)

- Fentanyl abuse = 95% are either anesthesiologists or surgeons
- 43% of opioid-using doctors had been using opioids for more than 2 years before detection
- Impaired Female Physicians
  - Slightly Younger (40 vs 44 years old)
  - More likely to abuse sedative-hypnotics (11.4% vs 6.6%; OR = 1.87)
  - More likely to have a comorbid psychiatric disorder (42% vs 27%)
  - More likely to report past (51.8% vs 29.9%; OR = 2.51) or current (11.4% vs 4.8%; OR = 2.54) suicidal ideation

Wilson et al. Psychiatrically impaired medical practitioners. Australasian Psychiatry. Vol 17, No 1 . February 2009
Garcia-Guasch et al. Substance use disorders in anaesthetists. Current Opinion in Anesthesiology. 25: 2, April 2012
Wunsch et al. Women phsyicians and addiction, Journal of Addicitve Disease, 2007. 26:2; 35-43.

Risk Factors

- Family history of substance abuse
- Stress at work and home
- Emotional problems
- Untreated psychiatric condition
- Sensation seeking behaviors

1. Flaherty JA, Richman JA. Substance use and addiction among medical students, residents, and physicians. *Psych clin North Am*. 1993; 16: 189-197.
2. Hughes PH, Brandenburg N, Baldwin DC Jr. et al. Prevalence of substance use among US physicians. *JAMA*. 1992; 267: 2333-39.
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SYMPTOMS OF PHYSICIAN IMPAIRMENT

Signs/Symptoms of Dependence	
Changes in sleeping or eating patterns	Discrepancy in drug orders or charting
Poor physical condition or hygiene	Inconsistent drug wasting procedures
Fatigue	Never returning waste at the end of a case
Consistently dilated vs. pinpoint pupils	Excessive volunteering for extra cases or shifts
Bloodshot or watery eyes	Strained communication
Mood swings	Defensiveness, apathy, or lack of discipline
Personality changes	Manipulative
Post op pain out of proportion to opioid dose	

1. Baldisseri MR. Impaired healthcare professional. *Crit Care Med*. 2007; 35: S106-116.
2. Berge KH. Et al. Chemical dependence and the physician. *Mayo Clin Proc.* 2009; 84(7): 625-631.

Dr. Marvin Seppala – CMO Hazelden Betty Ford Foundation

"There's an invulnerability: 'Well, I'll just do this the right way, and it'll never be a problem. I'll just do this the right way and I'll never overdose,' "

"Somehow they believe their knowledge is going to be more powerful than addiction."

"That's where the risk lies, because these people are really bright, and because they know illnesses and do all these things to try and hide it … the obvious things are always really late"

Injecting drugs → wear long-sleeved shirts

Abnormal Pupil Size → Eye drops to counteract

http://www.latimes.com/local/california/la-me-doctors-addiction-20170720-story.html. Accessed April 24, 2018

ADDICTION

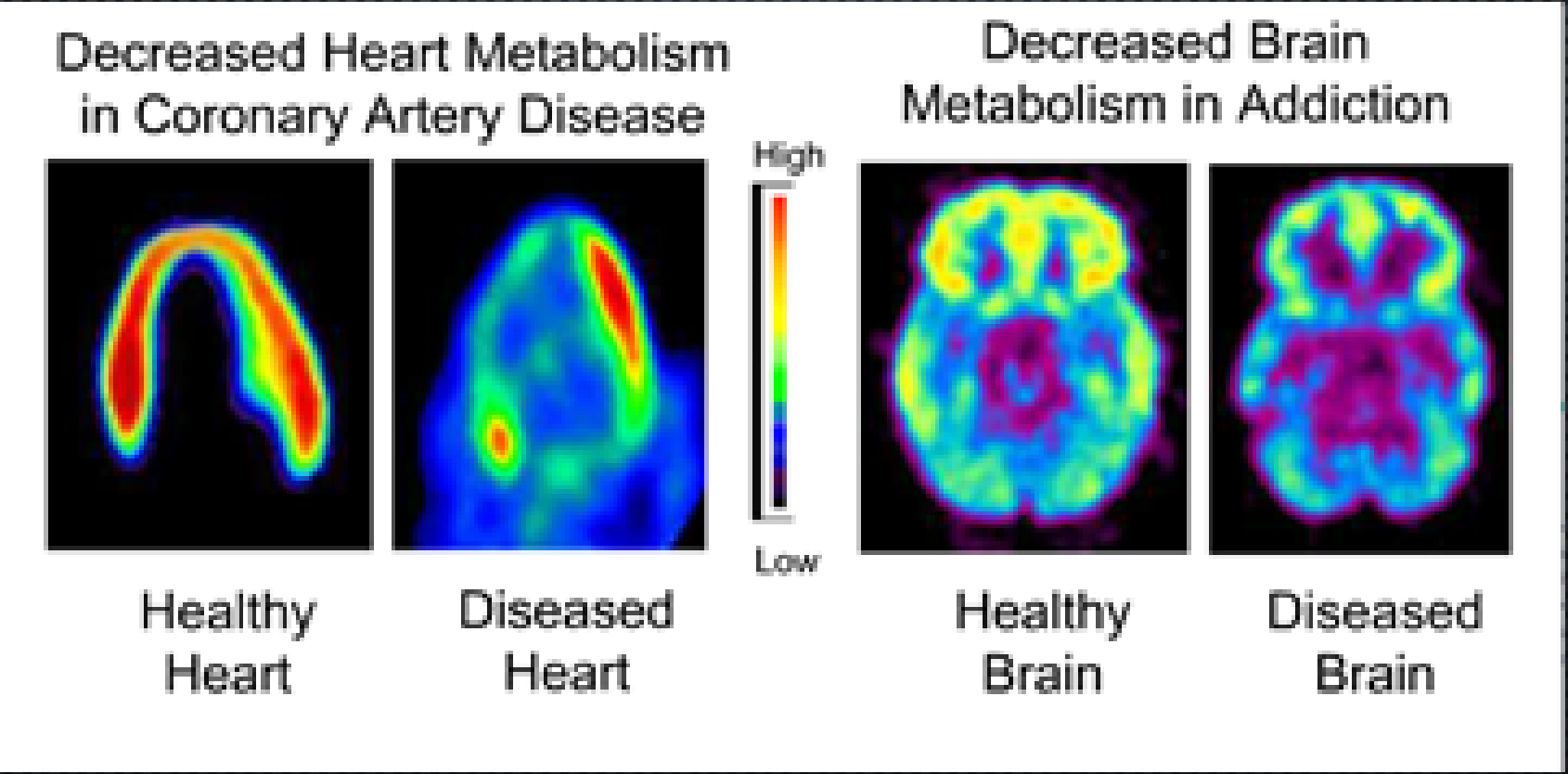
The 4 C's of Addiction:

- **Loss of** Control
- Compulsive **use or** Craving
- **Continued use despite adverse** Consequences

- PRIMARY, **CHRONIC BRAIN DISEASE** CHARACTERIZED BY **COMPULSIVE DRUG SEEKING** AND USE **DESPITE HARMFUL CONSEQUENCES**
- INVOLVES CYCLES OF RELAPSE AND REMISSION
- 40-60% GENETIC
- WITHOUT TREATMENT, ADDICTION IS PROGRESSIVE AND CAN RESULT IN DISABILITY OR PREMATURE DEATH

American Society of Addiction Medicine. April 12, 2011. www.asam.org
NIDA. August, 2010. http://www.drugabuse.gov/publications/science-addiction

ADDICTION CHANGES BRAIN STRUCTURE & FUNCTION



Barriers to Seeking Care

1. Stigma
2. Fear of disciplinary action
3. Aversion to the patient role
4. Denial

"You're on a pedestal as a physician, and you've got all these societal expectations ... in some ways it's harder to ask for help because nobody expects you to want or need help"

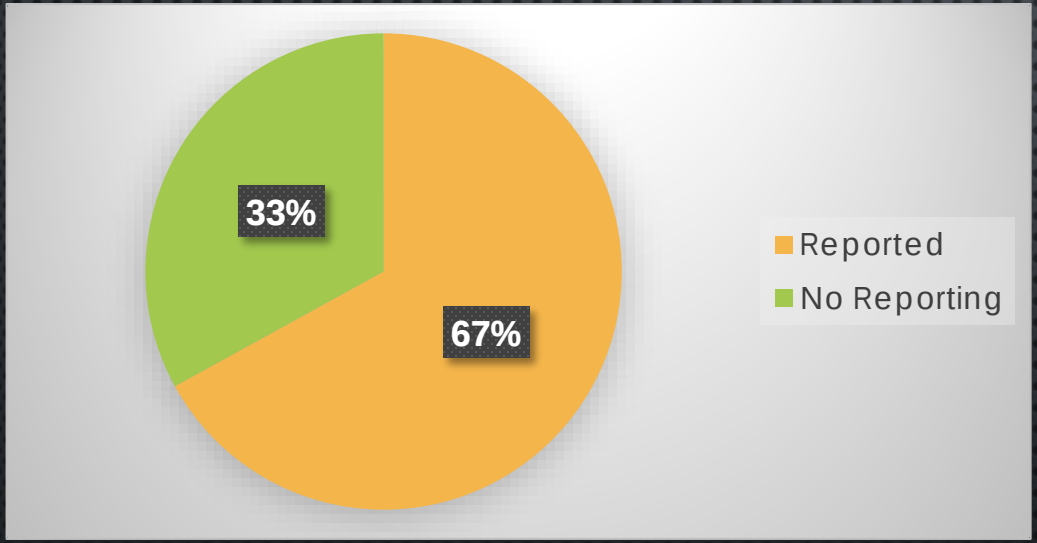
- Dr. Peter Grinspoon, Boston
- Vicodin Addiction

"The issue with physicians or anyone involved with public safety is that addiction is so stigmatized that the risk of losing your job or your practice is very great"

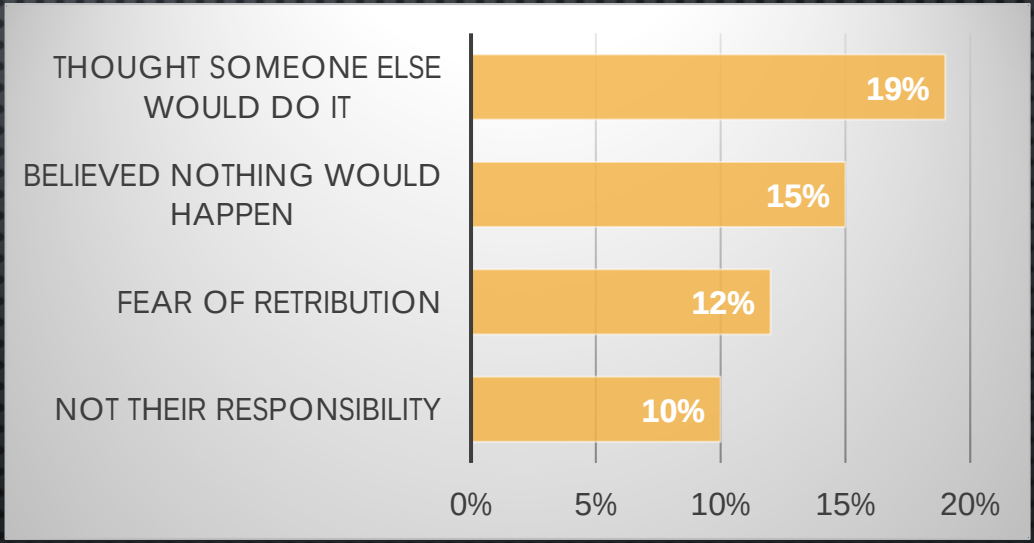
- Dr. Michael Lowenstein

BARRIERS TO REPORTING

KNOWN COLLEAGUE IMPAIRMENT



REASONS FOR NOT REPORTING



DesRoches CM et al. Physicians perceptions, preparedness for reporting and experiences related to impaired and incompetent colleagues. JAMA. 2010; 304(2): 187-193.

Report Physician without impairment

- Patients
  - Loose access to competent physician
  - Limit access to care
- Physician
  - Board of Medicine Investigation
    - Loss of income
    - Public ignominy
    - Strained personal & professional relationships
    - Legal bills
- Colleagues
  - Overwhelmed with coverage responsibilities

Failure to report an impaired physician

- Patients
  - Harm - Death - Safety
- Physician
  - Does Not Seek Help/treatment
  - Death
  - Harm to physician family

DesRoches CM et al. Physicians perceptions, preparedness for reporting and experiences related to impaired and incompetent colleagues. JAMA. 2010; 304(2): 187-193.
Federation of State Medical Boards. Policy on physician impairment. 2011.

American Medical Association

Policies related to physician health:

- Duty to practice medicine unimpaired
  - H-30.960: Physicians engaging in patient care should have no significant body content of alcohol and should avoid situations that create a "hangover effect"
- Ethical obligation and duty to report impaired colleagues
  - H-275.952
- Duty to preserve our own personal health and performance
  - H-140.886

Physicians' responsibilities to colleagues who are impaired by a condition that interferes with their ability to engage safely in professional activities include timely intervention to ensure that these colleagues cease practicing and receive appropriate assistance from a physician health program (PHP)….

Ethically and legally, it may be necessary to report an impaired physician who continues to practice despite reasonable offers of assistance and referral to a hospital or state physician health program.
The duty to report…may entail…reporting to the licensing authority

American Medical Association. Opinion 9.031 Reporting impaired, incompetent, or unethical colleagues. Code of Medical Ethics. http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion9031.page. Accessed December 1, 2013.

ACGME: Common Program Requirements

- VI.B Professionalism
  - VI.B.4 Residents and faculty members must demonstrate an understanding of their personal role in the:
    - VI.B.4.c) Assurance of their fitness for work, including:
    - VI.B.4.c).(2) Recognition of impairment, including from illness, fatigue, and substance use, in themselves, their peers, and other members of the health care team.

ACGME Common Program Requirements. availble at:
http://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/CPRs_Section%20VI_with-Background-and-Intent_2017-01.pdf

OKLAHOMA

- **Oklahoma Administrative Code – Title 435**
- 435:10-7-4. Unprofessional conduct
  - The Board has the authority to revoke or take other disciplinary action against a licensee or certificate holder for unprofessional conduct. Pursuant to 59 O.S., 1991, Section 509, "Unprofessional Conduct" shall be considered to include:
  - (21) Aiding or abetting the practice of medicine and surgery by an unlicensed, incompetent, or impaired person.
  - (40) The inability to practice medicine and surgery with reasonable skill and safety to patients by reason of age, illness, drunkenness, excessive use of drugs, narcotics, chemicals, or any other type of material or as a result of any mental or physical condition. To enforce this paragraph, the Board may, upon probable cause, request a physician to submit to a mental or physical examination by physicians designated by it. If the physician refuses to submit to the examination, the Board shall issue an order requiring the physician to show cause why he will not submit to the examination and shall schedule a hearing on the order within thirty (30) days after notice is served on the physician. The physician shall be notified by either personal service or by certified mail with return receipt requested. At the hearing, the physician and his attorney are entitled to present any testimony and other evidence to show why the physician should not be required to submit to the examination. After a complete hearing, the Board shall issue an order either requiring the physician to submit to the examination or withdrawing the request for examination. The medical license of a physician ordered to submit for examination may be suspended until the results of such examination are received and reviewed by the Board.
  - (42) Failure to inform the Board of a state of physical or mental health of the licensee or of any other health professional which constitutes or which the licensee suspects constitutes a threat to the public.
  - (43) Failure to report to the Board unprofessional conduct committed by another physician.

1. http://www.okmedicalboard.org/download/457/MDRULES.pdf. Last amended 12/1/2015

OKLAHOMA

- **The Oklahoma Osteopathic Medicine Act - O.S. Title 59 Sections 620 – 645; 650**
  - **Section 637 - Refusal, Suspension, or Revocation of License - Witnesses and Evidence**
  - A. The State Board of Osteopathic Examiners may refuse to admit a person to an examination or may refuse to issue or reinstate or may suspend or revoke any license issued or reinstated by the Board upon proof that the applicant or holder of such a license:
    - 8. Is incapable, for medical or psychiatric or any other good cause, of discharging the functions of an osteopathic physician in a manner consistent with the public's health, safety and welfare;
    - 12. Has been guilty of habitual drunkenness, or habitual addiction to the use of morphine, cocaine or other habit-forming drugs;
    - 13. Has been guilty of personal offensive behavior, which would include, but not be limited to obscenity, lewdness, molestation and other acts of moral turpitude; and
    - 14. Has been adjudicated to be insane, or incompetent, or admitted to an institution for the treatment of psychiatric disorders.

1. https://www.ok.gov/osboe/documents/The%20Oklahoma%20Osteopathic%20Medicine%20Act.pdf


STOP

MODEL FOR INTERVENTION

1. EVALUATE AVAILABLE INFORMATION
2. UNDERSTAND YOUR INSTITUTIONAL POLICIES
3. UNDERSTAND YOUR STATE MEDICAL BOARD POLICIES
4. DECIDE IF IT SHOULD BE A GROUP OR INDIVIDUAL INTERVENTION
5. PREPARE BEFORE THE INTERVENTION – HAVE A PLAN
6. PROBLEM IDENTIFIED → REFER TO A PHP

The American Medical Association's (AMA) *Code of Medical Ethics*

Physicians' responsibilities to colleagues who are impaired by a condition that interferes with their ability to engage safely in professional activities include timely intervention to ensure that these colleagues cease practicing and receive appropriate assistance from a physician health program (PHP)….

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2. **Berge KH et al. Chemical dependency and the physician. Mayo Clin Prac. 2009; 84(7): 625-631.**
3. American Medical Association. Opinion 9.031 Reporting impaired, incompetent, or unethical colleagues. *Code of Medical Ethics.* http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion9031.page. Accessed December 1, 2013.

Model for Intervention

1. Evaluate available information
2. Understand your institutional policies
3. Understand your state medical board policies
4. Decide if it should be a group or individual intervention
5. Prepare before the intervention – have a plan
6. Problem identified → refer to a PHP

1. **VandenBos GR and Duthie RF. Confronting and supporting colleagues in distress. Professionals in Distress, Washington, DC: American Psychological Associaton (1986), 211-232.**
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INTERVENTION

- GOAL – GET INDIVIDUAL A FORMAL EVALUATION
  - STRESSFUL, DELICATE, NEVER SIMPLE!
- NEVER JUST SEND THEM HOME (HIGH SUICIDE RISK)
- SUSPECTED ACUTE INTOXICATION?
  - IMMEDIATE REMOVAL FOR THE PATIENT CARE ENVIRONMENT
  - FOLLOW POLICY FOR INSTITUTION
- REFER FOR TREATMENT

Table 2 Steps for intervening if physician addiction is suspected

1. Contact the state PHP; take advantage of your access to this important resource
2. Recruit others to assist you; avoid confronting the physician alone
3. Express positive regard for the physician's abilities; demonstrate your respect for the individual
4. Describe specific, observable problem behaviors of concern; consider using a script to assist with this step
5. Avoid accusation or blame; be kind and empathic
6. Avoid negotiating, arguing, or bargaining; do not engage the individual in attempts to avoid the intervention
7. Present a specific plan of action for assessment and treatment; consider working with the state PHP to develop a plan first
8. Indicate clearly the consequences of not following through with the plan; do not be afraid to use coercion—it works!
9. Insist on immediate action; do not consider requests for "one more chance"
10. Provide for safe transition and transportation to the next step in the plan; typically, assist the physician in attending a professional assessment

PHP, Physician Health Program.

1. Boisaubin EV, Levine RE. 2001. http://www.ncbi.nlm.nih.gov/pubmed/11465244
2. *Berge et al. Chemical dependency and the physician. Mayo Clin Proc. 2009;84(7):625-631*
3. *Merlo et al. Successful treatment of physicians with addictions. Psychiatric Times. Vol. 26 No. 9*

Provider Health Programs (PHP)

- Federation of State Medical Boards:
  - Provides guidelines on referral, evaluation, treatment and long term monitoring
- All but 3 states (California, Nebraska and Wisconsin) have PHP
- Dual Purpose
  - Promote the health and well-being of physicians (especially those with substance use and mental health issues)
  - Protect the public from physicians who might be impaired.
- Reporting to the appropriate regulatory agency for anyone not able to cooperate
- Public interest best served if:
  - There is a "confidential process allowing for early intervention, evaluation, treatment and monitoring."

Federation of State Medical Boards. Policy on physician impairment. 2011

STATE MEDICAL BOARD VS. PHYSICIAN HEALTH PROGRAM

State Medical Board	Physician Health Program
Mission: Protect Public	Mission: Protect Public, Health, and Careers of Physician
Public Proceedings	Confidential Proceedings
Reports to National Practitioner Data Bank (NPDB)	Many report to Medical Board; Does not report to NPDB

MODEL FOR PHP

- Medical Evaluation for Impairment
- Problem Identified
- Inpatient vs Outpatient Treatment
- Safe Return to Work Recommended?
- Contract with PHP for Monitoring

Federation of State Medical Boards. Policy on physician impairment. 2011

Monitoring of SUD

Required

- Abstinence from all drugs of abuse
- Psychiatric care and individual psychotherapy
- Group therapy
- Self help meetings (12-step program)
- Monitoring meeting with the PHP
- Random and for cause drug screening
- Workplace monitor

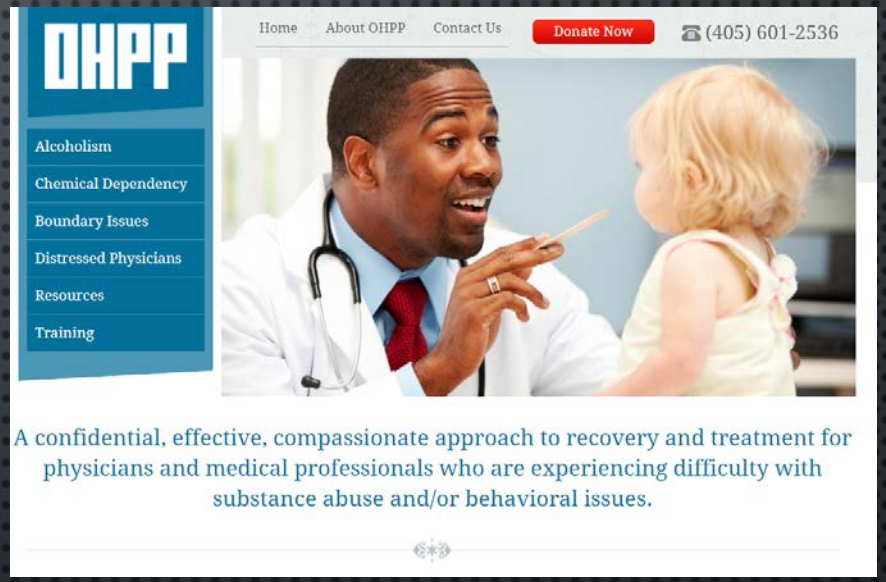
Potential

- Restricted work hours (particularly in the beginning to meet required elements)
- Workplace limitations
- Prescribing limitations
- Neurocognitive testing

1. Federation of State Medical Boards. Policy on physician impairment. 2011
2. *Berge et al. Chemical dependency and the physician. Mayo Clin Proc. 2009;84(7):625-631*

OKLAHOMA HEALTH PROFESSIONALS PROGRAM (OHPP)

- Established 1983
- Served > 900 physicians & health care providers with drug and chemical dependence
- Support and Monitor
  - Medical & Allied Health Professionals in Oklahoma
  - Substance Abuse, Mental Health, Disruptive Behavior, Boundary Issues, Stress Management
- Funding Sources
  - State medical society
  - State licensing agency
  - Malpractice insurance companies
  - Hospital and private contributions
  - Participant Fees



http://www.okhpp.org/

- ✓ Operated by state medical society
- ✓ Formal contractual relationship with state medical board

Caduceus Meeting

- Physicians seeking Support from other physicians in recovery

- **Oklahoma City** – Robert Westcott, MD
  405-650-6681
  Medical Director
  Caduceus – Every Monday 7:00 p.m.
- **Tulsa** – Merlin Kilbury, MD
  918-605-5716
  Associate Director
  Caduceus – Every Thursday 7:30 p.m.
- **Lawton**
  Caduceus – Every Tuesday 6:00 p.m.
  Lawton, Oklahoma
- **Enid** – Paul Cheng, MD
  405-412-1233
  Caduceus – Every Tuesday 6:00 p.m.
- **Ada**– Lynn Baddett, MD
  405-201-8165
  Caduceus – Every Tuesday 6:00 p.m
- **Muskogee** – David Whatley, MD
  918-351-9323
  Caduceus – Every other week 6:00 p.m.

Prognosis for sobriety in PHP

For physicians completing a 5-year monitoring period:

- 78% were still licensed and practicing medicine
- 11% had medical license revoked
- 19% tested positive during drug or alcohol monitoring
- No significant differences between surgeons vs non-surgeons

1. McLellal AT. et al. Five year outcomes in a cohort study of physicians treated for substance use disorders in the United States. BMJ. 2008; 337: a2038.
2. Buhl A. et al. Prognosis for the recovery of Surgeons from Chemical Dependency. Arch Surg. 2011; 146(11): 1286-1291.
3. Journal of Substance Abuse Treatment. 2009

Prognosis

Impaired Practitioners Program, Florida, 1991-96

- 68 physicians (59 males, 7 females), ages 25-63
- 32% IVDU, 12% crack, 7% both

- Five-year outcomes based on facilitator reports, physician/psychiatrist evaluations, AA/NA attendance, return to work, negative drug tests
  - 88% positive outcomes
  - Coercion equally effective as voluntary treatment

Gold et al. Urine testing confirmed 5 year outcomes in impaired physicians. World Psychiatric Association, Florence Italy , Nov 2004

Importance of Random Urine Testing

- 1-800 number a physician calls daily, he/she is randomized to urine test or no test but given at least 1 urine test weekly
- Success with urine testing = 96% sobriety
- Without urine testing = 64% sobriety

Shore et al. The Oregon experience with impaired physicians on probation. JAMA. 1987 Jun 5;257(21):2931-4.

RISK FACTORS FOR RELAPSE

Risk Factor (Univariate Analysis)	HR (95% CI)
Family History of SUD	2.29 (1.44 – 3.64)
Drug of Choice = Major Opioid	1.80 (1.03 – 3.13)
Parenteral Drug Use	4.36 (2.55 - 7.44)
Dual Diagnosis (93% Axis I Disorder)	2.12 (1.33 – 3.36)
Major Opioid Use + Dual Diagnosis	5.79 (2.89-11.42)
Major Opioid Use + Dual Diagnosis + Family History of SUD	13.25 (5.22-33.59)

Factors not associated with increased risk: Sex, Age, Resident Status, Specialty

Domino KD et al. Risk factors for relapse in health care professionals with substance use disorders. JAMA. 2005; 293(12): 1453-1460.

Ethical Considerations with PHP

1. Concerns for potential coercion
2. Cost
3. Funding of PHP potentially tied to the State Medical Boards
   - Conflict of interest?
4. Illness vs. Impairment
5. Voluntary vs. Mandated Participation

Boyd JW and Knight JR. Ethical and managerial considerations regarding state physician health programs. J Addict Med. 2012; 6(4): 243-246
Lenzer J. Physician health programs under fire. BMJ; 353: i3568.

PHP Problems

- Physician have no real option but to comply if they hope to continue practicing
  - Medical boards defer to PHPs
  - Failure to comply with any aspect of contract and licensing board likely will be notified, often requiring physician to stop practicing medicine
- Often no effective means of appealing a PHP recommendation

Boyd JW and Knight JR. Ethical and managerial considerations regarding state physician health programs. J Addict Med. 2012; 6(4): 243-246
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PHP PROBLEMS

- Often have no external oversight
- PHPs often have financial ties with evaluation and treatment centers, creating potential for significant conflict of interest
- Little to no scrutiny, given that most physicians don't know about PHPs until they are referred
  - Complaints about PHPs then are often seen as not legitimate.

Boyd JW and Knight JR. Ethical and managerial considerations regarding state physician health programs. J Addict Med. 2012; 6(4): 243-246
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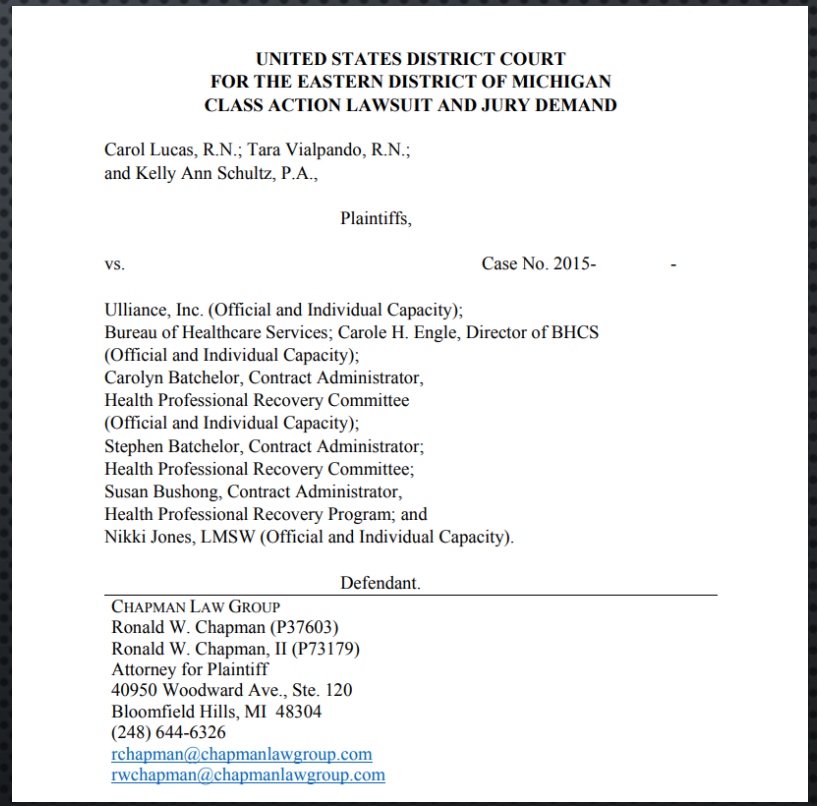
FEDERAL CLASS ACTION LAWSUIT AGAINST MICHIGAN PHP

HEALTH CARE PROFESSIONALS "ARE FORCED INTO EXTENSIVE AND UNNECESSARY SUBSTANCE ABUSE/DEPENDENCE TREATMENT UNDER THE THREAT OF THE ARBITRARY APPLICATION OF PRE-HEARING DEPRIVATIONS," WHICH INCLUDE SUSPENSION BY THE MICHIGAN LICENSING BOARD.



UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF MICHIGAN
CLASS ACTION LAWSUIT AND JURY DEMAND

Carol Lucas, R.N.; Tara Vialpando, R.N.;
and Kelly Ann Schultz, P.A.,

Plaintiffs,

vs. Case No. 2015- -

Ulliance, Inc. (Official and Individual Capacity);
Bureau of Healthcare Services; Carole H. Engle, Director of BHCS
(Official and Individual Capacity);
Carolyn Batchelor, Contract Administrator,
Health Professional Recovery Committee
(Official and Individual Capacity);
Stephen Batchelor, Contract Administrator;
Health Professional Recovery Committee;
Susan Bushong, Contract Administrator,
Health Professional Recovery Program; and
Nikki Jones, LMSW (Official and Individual Capacity).

Defendant.

CHAPMAN LAW GROUP
Ronald W. Chapman (P37603)
Ronald W. Chapman, II (P73179)
Attorney for Plaintiff
40950 Woodward Ave., Ste. 120
Bloomfield Hills, MI 48304
(248) 644-6326
rchapman@chapmanlawgroup.com
rwchapman@chapmanlawgroup.com

PHP PROBLEMS

- Often have no external oversight
- PHPs often have financial ties with evaluation and treatment centers, creating potential for significant conflict of interest
- Little to no scrutiny, given that most physicians don't know about PHPs until they are referred
  - Complaints about PHPs then are often seen as not legitimate.

NEED –
- External Scrutiny
- National Standards
- Audits

Boyd JW and Knight JR. Ethical and managerial considerations regarding state physician health programs. J Addict Med. 2012; 6(4): 243-246
Lenzer J. Physician health programs under fire. BMJ; 353: i3568.

Prognosis for sobriety in PHP

For physicians completing a 5-year monitoring period:

- 78% were still licensed and practicing medicine
- 11% had medical license revoked
- 19% tested positive during drug or alcohol monitoring
- No significant differences between surgeons vs non-surgeons

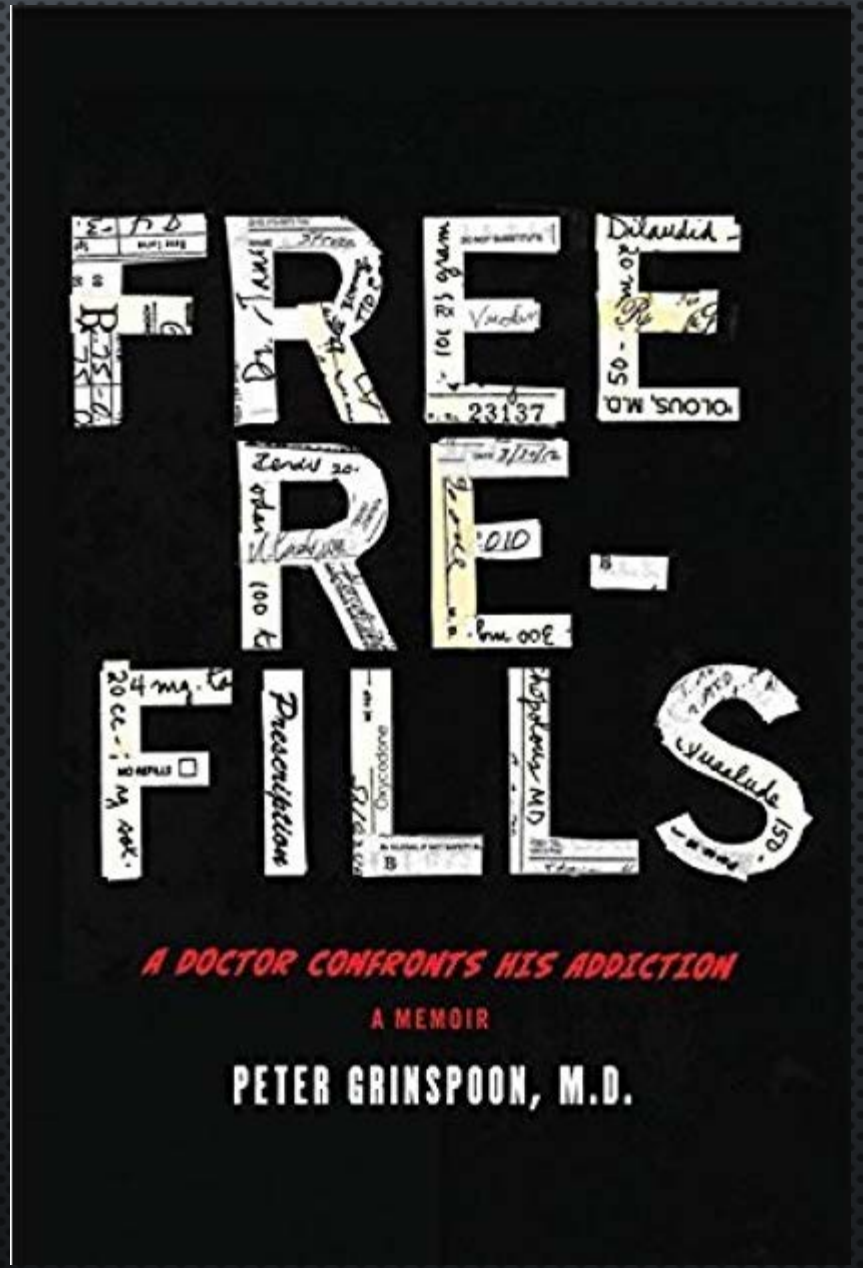
1. McLellal AT. et al. Five year outcomes in a cohort study of physicians treated for substance use disorders in the United States. BMJ. 2008; 337: a2038.
2. Buhl A. et al. Prognosis for the recovery of Surgeons from Chemical Dependency. Arch Surg. 2011; 146(11): 1286-1291.
3. Journal of Substance Abuse Treatment. 2009

"WHAT WE END UP DOING IS PRETENDING THESE PROBLEMS DON'T EXIST"

"BUT WHAT'S REALLY UNSAFE IS A PHYSICIAN THAT NOBODY KNOWS IS ADDICTED ... IT'S THE UNTREATED PHYSICIAN WHO'S REALLY DANGEROUS."

DR. PETER GRINSPOON

http://www.latimes.com/local/california/la-me-doctors-addiction-20170720-story.html
http://www.modernhealthcare.com/article/20160514/MAGAZINE/305149988
Dr. Peter Grinspoon – *Free Refills: A Doctor Confronts His Addiction.*



PUBLIC POLICY AND AWARENESS

The first legal and ethical obligation of a clinic or hospital is to safeguard patients

by removing the physician from practice

and counseling the physician

to take a leave of absence for treatment.

Final Thoughts

"If we don't police ourselves, someone else is going to do it, and they'll do it more harshly than we might. It's a matter of professional pride, as well. I don't want bad doctors to give all doctors a bad name."

"In the end, we will remember not the words of our enemies, but the silence of our friends."

- *Martin Luther King Jr.*