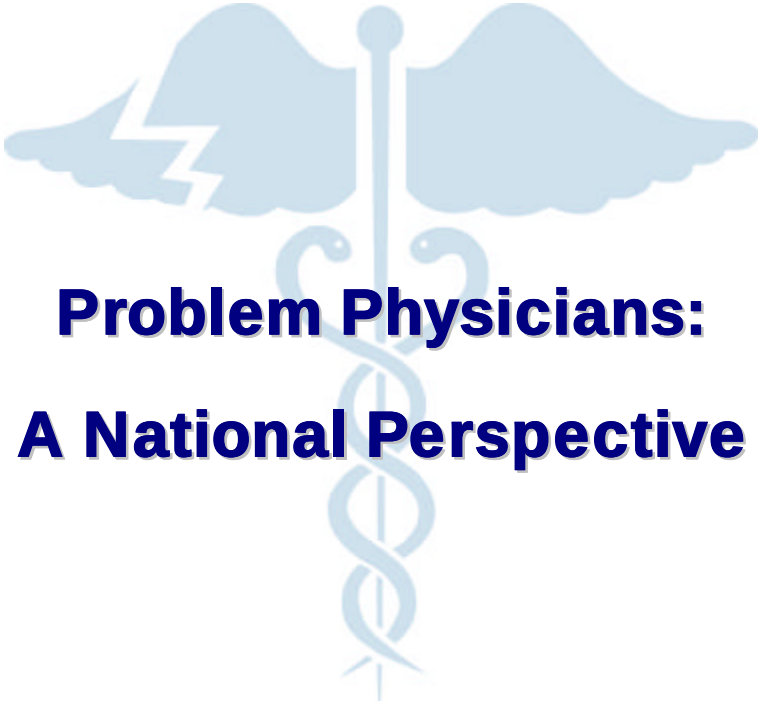

Problem Physicians:

A National Perspective

A Report to the Georgia Composite State Board Of Medical Examiners

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Table of Contents

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G. Douglas Talbott, M.D., F.A.S.A.M., F.A.C.P., Editor

Preface

This work was developed from the 1995 edition of the book published by the Georgia Composite State Board of Medical Examiners Problem Physicians: Guidelines for Licensing/Credentialing Boards. Many individuals contributed their time and effort to the first edition, but Dr. Douglas Talbott and Andy Watry, then the Executive Director of the Georgia Board, guided the effort to develop and publish the Guidelines. This edition includes chapters from a more geographically diverse group of respected authors in their fields and demonstrates the general applicability of common medical Board concerns and ways of dealing with them. Each chapter is written from the diverse perspective of the education, training and experience of the individual author. It serves as a valuable resource to Medical Boards-their members, staff and investigators as Boards grapple with the tough issues facing them in the licensure and regulation of problem physicians.

Each state's Medical Practice Act is unique and Board resources vary widely. The relationships among state medical Boards, physician well-being organizations and treatment facilities differ significantly. Patient protection is the primary purpose of all medical Boards, but the problem physician must be treated with compassion and the Boards' aim is, when possible, to rehabilitate the physician and allow a return to practice when reasonable skill and public safety can be expected.

Complex interactions among substance abuse, personality disorders, psychiatric illnesses, cognitive impairment and the other problems discussed in this book require that any treatment plans be based on an initial comprehensive assessment. Established behavior and practice patterns are difficult to alter without intensive intervention, which often requires the involvement of the medical Board.

For example, in some states, first time self-reported substance abuse problems in which the physician voluntarily seeks treatment may not result in license suspension and may be handled by a private consent order with the Board. If the Medical Board, during the course of its investigation, gathers evidence that illegal or fraudulent activities by the impaired physician occurred, then a public consent order or suspension may be warranted. Also, if there has been patient harm or provable unprofessional conduct, public action may be appropriate.

Relapses into problem behavior, while not unexpected, usually result in public suspension or other action. Also, many Medical Boards impose progressively stricter sanctions on physicians who continue to exhibit problem behaviors. Revocation of the physician's medical license is the strictest sanction that may be imposed by the Board.

Our hope is that this book will further the development of "best practices" in the diagnosis and treatment of problem physicians, and allow medical Boards to deal consistently with the related goals of public protection and physician rehabilitation.

Introduction

In April of 1995, in the first edition of Problem Physicians: Guidelines for Licensing/Credentialing Boards, the goal was to provide the Georgia Composite State Board of Medical Examiners, physician members, with a handbook for dealing with the various problem physicians they encountered. These guidelines would provide consistency and allow Georgia Board members standardization in their decisions on how to deal with these physicians. Experts in the first edition were chosen from the local Atlanta area to author the individual chapters along with Georgia Board representatives.

In this update related to problem physicians we have selected physicians throughout the United States who have established themselves as directors of their State Physicians Well-being Programs. We have expanded the categories to include management of the pain disabled physicians and physicians with infectious disease. The overall goal continues to be provision of standardization and consistency of protocols for handling problem physicians.

The principal audience for this report is the Georgia Composite State Board of Medical Examiners, its administrative staff and legal personnel. These Board members and personnel should benefit from this work and it is hoped that it will also be useful to other health professional Boards (i.e. nurses, dentists, pharmacists, counselors, etc.). The guidelines presented in this monograph may serve as a template for related healthcare Boards in establishing policy and protocol.

A variety of terms have been used to describe the organization, programs and committees of State Medical Societies and Medical Boards that address problem physicians. The Federation of State Medical Boards uses the term "Physician Health Program". Alternative terms include: Impaired Physicians Program, Physician Well Being Program (PWP), Physician Rehabilitation Program (PRP), Physician Recovery Network (PRN, and others. For the purposes of this document, the authors will follow the convention of the Medical Association of Georgia, which has adopted the term Physicians Well-being Program (PWP) to describe intervention, treatment facilitation and monitoring efforts of problem physicians.

G. Douglas Talbott, M.D., F.A.S.A.M., F.A.C.P., Editor

Editorial Note:

It is the editors' and authors' intent that these guidelines may serve as a basic paradigm for each state's Medical Board. However, it may be tailored or expanded according to the needs of individual states. Hopefully, these protocols will be useful to all the Boards in the United States and Canada. The ultimate judgment for any specific action regarding a problem physician must be made by the Medical Board with consideration of all pertinent information, and in light of diagnostic and treatment options (where applicable). For purposes of ease of reading, the terms he/his is used throughout the monograph, but may also connote she/her.

I

Substance Abuse Related Disorders

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General Considerations

In the general U. S. population, the lifetime prevalence of any substance abuse or dependence disorder has been estimated to be 26.6%. The lifetime incidence of alcohol dependence is 14.1% and of drug dependence is 7.5% (Kessler et al., 1994).

Experts suggest that physicians have a greater lifetime probability of developing a substance-related disorder than the general population. Physicians have an occupational hazard of becoming dependent on controlled substances due to access to drugs during the course of medical practice, particularly when drugs are dispensed or administered by the physician himself. (Lutsky, 1993, Bohigian, 1994).

Substance dependence is a primary biogenetic, psychosocial disease. Although the substance addict may focus his attention on different substances with varied toxic effects, addiction specialists view substance dependence as a singular disease with multiple and varying presentations. Substance dependence disorders are chronic with genetic, psychological, social, family and environmental factors influencing both their inception and course over time.

Substance dependence can occur as a single problem, but commonly appears with other medical or psychiatric illnesses and develops a complex interaction with these concomitant diseases. Left untreated, substance dependence is progressive and often fatal.

Substance dependence is characterized by:

- Continuous or periodic loss of control over drinking or drug use-compulsivity is a primary symptom of the disease
- Preoccupation with the drug or alcohol, use of alcohol or other drugs despite adverse or lethal consequences
- Distortions in thinking, most notably denial

The physician rarely recognizes addiction as a problem until secondary consequences occur such as professional, family, legal or health problems. Even at this point, most impaired physicians view their substance use as a product of other difficulties, rather than the other way around.

Patterns of Substance Use and Addiction in Physicians

Literature indicates that the proportion of female physicians hospitalized for substance-related disorders has increased in recent years (Nance, 1995). Hughes, et.al. (1992,1999) have suggested that among medical residents, Emergency Medicine and Psychiatry residents show higher rates of substance use than other specialties. ER physicians use more illicit drugs and psychiatrists use more benzodiazepines than other specialties.

The relation between substance use and addiction is not linear, but increased substance use in physician populations is likely to correlate with an increase in addictive disease. Accessibility to certain drugs may also play a crucial role in the type of drug used/abused. The specific drugs of abuse also characterize a slightly different course of the disease both in how the disease appears and in its rate of progression. For example, anesthesiologists often appear in treatment addicted to the synthetic opioid agent Fentanyl or its relatives. Fentanyl is a drug commonly used by anesthesiologists/anesthetists in their practice and Fentanyl addiction appears to progress more rapidly than other substance dependence. Physicians addicted to Fentanyl develop intense tolerance and drug seeking behaviors over a series of months rather than years. Recent research by Paris and Canavan report the relapse rate of anesthesiologists as

comparable to relapse rates of other physicians who are also participating in a well-designed Physicians Health Program (1999).

Protocol

Collaborative multi-center outcome studies on the treatment of physicians with substance dependence have established that with satisfactory completion of primary treatment and extended physician-specific comprehensive monitoring, the vast majority of physicians maintain an extremely high rate of recovery. Most physicians are able to eventually re-enter the practice of medicine and practice with competency and, at the same time, maintain a high level of public safety. Physicians who complete comprehensive treatment and enter an abstinence-based recovery process often report that their skills post treatment (especially those related to the art of medicine) are more astute than any other time in their life.

The care of substance-abusing physicians involves three key elements:

1. Comprehensive assessment
2. Detoxification, medical stabilization and primary treatment
3. Long-term Continuing Care and monitoring

1. Comprehensive Assessment

A comprehensive assessment by one or more professionals experienced in the evaluation of addiction and its concomitant problems in physicians and approved by the Board or the PWP should be required to determine if professional impairment or potential impairment is present. If there is controversy or contention over the events leading to intervention, and professional impairment is suspected, assessment by a team approved by the Board and/or PWP is recommended to include evaluations by specialists in addiction medicine, psychology and neuropsychology, and psychiatry. If the assessment referral comes from the PWP or the Board, the physician must agree to provide a written authorization for full disclosure of information from the assessment to the Board or PWP and in some cases both. Failure to comply with this request will precipitate an immediate report to the Medical Board. Physicians who self report for assessment or treatment will be referred to the PWP during the course of treatment. Depending on the severity of the addictive disease and concomitant morbidity, some physicians may need to report directly to the Board as well as the PWP.

Upon the completion of the initial assessment, if all parties agree that substance dependence is present and the physician agrees to proceed with treatment, that patient may choose to begin treatment immediately at the assessment facility. All physicians have the option of beginning treatment at a facility other than where the assessment takes place, as long as that facility has been approved by the Board as appropriate for the care of physicians with addictive disease.

When substance use is totally or substantially denied and the first professional (or assessment team) who assess the patient believe substance dependence is present in the physician or when the physician disagrees with the results of the initial assessment, the physician may proceed to a second independent assessment. In cases not involving complaints or reports to the Board, the Medical Director of the PWP will be directly involved determining where the second assessment will occur. In cases involving the Medical Board, the Board will be involved as a concerned party as to the time and place for the second opinion.

The assessment should determine, with a reasonable degree of medical certainty, whether the physician is impaired or potentially impaired due to the habitual or excessive use of: controlled substances; of alcohol; or of other substances. Physical and mental conditions in addition to substance dependency /abuse should also be reported, including an opinion as to whether they may have contributed significantly to the events leading to assessment. Mental disorders and substance use diagnoses are made using DSM IV criteria. The assessment team should determine whether issues involving public health and safety or violations of ethical standards require the physician be reported to the Board if a report has not been made. The assessment results should be given to the Board with the physician's written consent whenever a case has reached the level of the Board.

2. Detoxification, Medical Stabilization and Primary Treatment

Multidisciplinary addiction treatment is aimed at reducing denial, increasing self-care, treating the comorbid family, medical and psychiatric problems, and educating the physician to learn to protect himself from his disease. Comprehensive substance abuse treatment requires an interplay between group therapy, 12 step groups, spiritual programs, individual therapy, medication management, written assignments, psycho-educational sessions, family education and therapy, and workplace / lifestyle restructuring.

In cases involving impairment or potential impairment at the time of assessment, the physician will be required to satisfactorily complete primary treatment in a program approved by the Board and the PWP. The existence of comorbid conditions involving physical or mental health may prolong primary treatment.

If the physician remains professionally impaired or potentially impaired at the completion of primary treatment, extended treatment may be required. In any case, when the patient is discharged from treatment, he must sign written authorization to provide full disclosure of treatment records to the Medical Board, or PWP as determined during the assessment. Failure to comply with this request will precipitate an immediate report to the Medical Board.

The treating facility will use the ASAM PPC-2R (American Society of Addiction Medicine Patient Placement Criteria) to guide the treatment level of care. It is generally accepted, however, that physicians require a more extensive time in treatment, preferably in a treatment milieu that cares for physicians and other health care professionals. The reasons for the more extensive length of time in treatment are numerous, several of these are:

- Physicians are held to a stringent recovery standard, due to issues of public welfare.
- The credibility of the physician community is endangered by a singular physician's relapse.
- Physicians are quite clever at concealing their illness and mimicking good recovery skills - a somewhat more prolonged treatment process assists the physician to incorporate and internalize recovery skills.

3. Long term continuing care and monitoring.
Peer group meeting attendance, body fluid analysis and recovery-based therapy and support are crucial to the treatment of the physician. The physician's support groups most commonly center around 12 step mutual help groups such as A.A. and N.A., with additional spiritual support systems as indicated. Therapy in continuing care is tailored to the individual physician needs. Individual, group and family therapy may be indicated. Group therapy, some of which involving physician peers, has been shown to be the most effective method of reducing denial and orienting the physician to a lifestyle that reduces the risk of subsequent relapse.

Upon successful completion of primary treatment and, when necessary, extended residential care, the physician will sign a continuing care and monitoring contract. The monitoring contract covers (at a minimum):

- Continuing care therapy
- Mutual help group attendance
- Body fluid analysis protocol
- Modifications in the professional practice
- Practice monitoring by peers/others
- Additional continuing care assignments
- Protocols should the physician require mood-altering drugs for a legitimate medical problem.
- Contingencies that will occur should a patient return to substance use.
- Names of individuals who will support the physician in his or her ongoing recovery.

When the physician is determined not to be currently impaired, and has not been reported to the Board, the contract will be between the physician and the PWP. In all other cases, the contract will be under the purview of the Medical Board as well as involve the PWP. Failure to comply with this contract will be addressed in the next section of this document, the physician with a substance related disorder associated with relapse.

It is advisable to provide structured post-treatment monitoring for recovering physicians under the framework of Continuing Care Contracts for a minimum of five years. When the physician is determined to have a co-morbid mental disorder, additional contractual provisions may be necessary as defined in other sections of this document, particularly under section III, the physician with Psychiatric Disorder.

Board Considerations

The Medical Board's first priority is to assure patient safety. In addition, the Board may encourage the physician to seek professional help and rehabilitation. Physician well-being programs or other types of therapeutic programs geared to this type of problem manage many cases in which a physician seeks help with substance abuse, at least initially. When the impairment rises to the level that a physician must cease practicing temporarily and seek either inpatient or intensive outpatient treatment, the impaired physician is obliged to self-report this treatment to the Board.

If impairment is the only issue, and the physician self-reports, then the physician may be asked to sign an agreement not to resume practice without the approval of the treatment team and the Board. Usually, the physician will need to appear before the Impairment Committee of the Board and submit advocacy that he can practice with reasonable skill and safety. A private, non-disciplinary consent order may be entered into with the Board to ensure patient safety prior to the resumption of practice. This generally involves five years of monitoring with specific terms and conditions.

If there are complaints that the physician has violated the law or harmed patients in the course of impairment, then a full investigation is initiated. If the evidence supports the allegations, appropriate public sanctions may be in order.

II

Substance Abuse Relapse

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General Considerations

An addicted physician who returns to practice does so with assurance that he can practice with skill and public safety. A relapse, while a component of this primary, chronic, relapsing disease, offers severe consequences particularly from the legal and public safety standpoint.

Currently, DSM-IV categorizes re-use of chemicals or behaviors in three categories:

- sustained full remission;
- early partial remission (a slip)
- sustained partial remission (a full relapse)

The return to the use of addicting substances is the final incident in a series of events that defines a relapse. Prior to chemical relapse, the addicted physician commonly exhibits characteristic behaviors that signal a subsequent return to chemical use. Therefore, any use of addicting chemicals by an addicted physician probably indicates a significant reoccurrence of illness in many and needs to be carefully scrutinized.

Denial, shame, and fear of consequences, following return to use of mood altering substances, prevents many relapsing physicians from seeking help once chemical use has begun. Anecdotal evidence suggests that physicians who relapse frequently exhibit a very rapid downhill course in their disease. Swift intervention often prevents dire consequences including risk to public health and safety, and even suicide.

In characterizing a relapse, it is essential to consider the following facts:

- Abnormal, and often diagnostic, emotional behavior abnormalities precede interruption of remission (AA language - "stinking thinking").
- Relapse may be partial (a slip) with limited consequences or maybe fully defined as sustained partial remission.
- Relapse is forever; it can occur any time in an individual afflicted with addictive disease.
- The more comprehensive the monitoring for at least the first five years, the less the chance of relapse.

It is imperative that a relapsing physician be detected and helped as soon as possible. Shame and fear will quickly build into incredible denial. The continued practice of relapsing physicians will not only put the patient and the public at risk, but may lead to serious physical and emotional consequences to the relapsing physician. Too often relapsing physicians commit suicide or die inadvertently from an overdose as tolerance to their drug of choice has changed.

The key to both prevention and early detection of relapse in the physician lies in close monitoring. A sixteen point check list (see Appendix) conducted by a monitoring team of, ideally, a physician and therapist on a timely basis, will detect interruption of remission. It is important to emphasize, as with any other relapsing disease such as diabetes and rheumatoid arthritis, proactive guidelines should be developed at the time of treatment. A relapse contract (see Appendix) needs to be completed by the

patient, the family, and significant others, as well as other members of his support system. Once relapse is detected, the patient needs to be evaluated by a multidisciplinary team. This team should consist of medical, psychiatric and addiction medicine physicians as well as, a neuropsychologist, and family therapist. The team then makes determination whether this is a partial or full interruption of remission.

Following detection of the relapse, a Physicians Health Committee and/or program-monitoring physician needs to make a decision whether or not to notify the licensing Board. Many states have current contracts with the treatment facilities and the monitoring physicians who dictate that such relapses sustain partial remission will automatically be reported to the Board.

Protocol

The following protocol is advisable:

1. When members of the physician's support system suspect relapse, an immediate informal conference should occur between the PWP and the supervising physician (if appropriate). During this conference this evaluation group must decide:

- Should immediate action be taken to encourage, or when necessary, insist the physician leave his medical practice pending further assessment?
- Should the physician be sent directly to an inpatient setting for assessment or treatment to prevent the untoward consequences of relapse, including the need for medical detoxification and observation for possible suicidal behavior?
- Immediate analysis of appropriate body fluids (blood, urine, breathalyzer or hair analysis) should be considered.
- Should the Medical Board be informed of the relapse, if the physician is not known to the Medical Board? Who should inform the Medical Board of the relapse (in the case of the physician under an active consent order)?

2. The evaluation group, or when appropriate, the assessment team, should carefully consider:

- the relapsed physician’s emotional state
- recovery program prior to relapse,
- his length of sobriety and extent of relapse
- the psychological dynamics of the relapse (e.g., - was the relapse triggered by poor recovery skills, emerging unresolved emotional traumas, or character pathology).

Once the evaluation criteria are considered, the relapsed physician is presented with the findings, and given several options as to where he may be treated. If it is determined that the physician has "slipped" (short-term chemical use with little or no psychological or physical damage), the treatment team may suggest a correction in physician's recovery plan.

Consideration of legal consequences or potential patient safety risks needs to be considered. Significant relapse, however, warrants treatment in a relapse specific treatment program.

3. The treatment team also should provide recommendations to the Medical Board for its deliberation. Their report should include the following information:

- The longest length of time the physician had in recovery prior to relapse.
- The length of time the physician was in relapse.
- The effect the relapse had on others, including his or her patients.
- The physician's response to the intervention (i.e., the degree of personal accountability for the relapse).
- The drugs used in the relapse.

Physicians in high-risk positions who have ready access to, and relapse on high potency synthetic narcotics (i.e., fentanyl citrate) may need reassignment to another branch of medicine to decrease the risk of recurrent relapse.

- Any known professional boundary violations or improprieties that have occurred as part of or separate from chemical relapse.
- Whether the physician followed his or her continuing care and monitoring contract (see Appendix) developed in his or her prior treatment.
- Other factors affecting relapse such as family, job, stress, physical illness, particularly pain.
- DEA privileges should be voluntarily surrendered or held in suspension.
- Determination of drug(s) used in relapse should be determined if different from the initial drug(s) of choice.

4. Once the physician successfully completes the treatment recommended by the evaluation group or assessment team, and recovery activities outlined in the Continuing Care Plan and Behavioral Contract, the recovering physician must petition the evaluation group and the Medical Board for lifting of suspension. This petition must include:

- A general statement of the physician's quality of recovery.
- Written summaries from the physician's treatment program, and the evaluation team.
- Evidence of attendance at physician-specific support groups (in compliance with the Continuing Care and Monitoring Contract).
- Evidence of Twelve-Step group attendance.
- Copies of random body fluid screens, as obtained under chain of custody provisions, as dictated by the evaluation group and Medical Board. Testing must be performed by a NIDA certified laboratory.
- Careful consideration should be addressed as to the specifics of returning control substance licensure.

Board Considerations

Substance abuse relapse will, in general, result in progressively more severe sanctions, including public suspension. The physician, the monitor or the treatment program must report relapse to the Board as soon as possible. Lifting of the suspension occurs only after the physician has entered and completed treatment and has advocacy to return to the practice of medicine and the physician has appeared before the Impairment Committee and obtained the Board's approval to resume practice under a consent order. There may be progressively longer suspensions result after multiple relapses.

III
Psychiatric Disorders

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General Considerations

In the United States, anxiety disorders, substance-related disorders and affective disorders are the most commonly encountered mental disorders in the general population (Robins, et al, 1984; Kessler et al, 1994).

It is estimated that 4 to 10% of physicians come to the attention of licensing Boards because of problems related to non-substance-related major psychiatric disorders. Major psychiatric disorders (Axis I disorders of Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV) may or may not cause impairment in a physician's ability to safely treat patients. Sexual disorders (also Axis I disorders of DSM-IV) are discussed separately in Section V of this monograph. Some personality disorders (Axis II disorders of DSM-IV) may manifest as behavioral disruption (see Section IV) and antisocial, unscrupulous, or unethical behavior (see Sections VII and VIII). The most common psychiatric disorders in physicians, other than substance-related disorders, are the Mood Disorders (depressive and bipolar disorders), anxiety disorders and Cognitive Disorders.

Cognitive Disorders and Bipolar Disorders were the two most common types of major mental illness (after substance-related disorders) seen in physicians who came to the attention of the Oregon Board of Medical Examiners (Bloom et al, 1991). The experience of the Georgia Medical Board is similar.

Other major psychiatric disorders, such as Psychotic Disorders and Dissociative Disorders, may also present in practicing physicians. Primary Psychotic Disorders that are undetected during training may present during later adulthood after a physician begins to practice and may be resistant to treatment. More commonly in physicians, psychotic symptoms are secondary to an affective illness, neurocognitive impairment, or other primary psychiatric disorders that require appropriate treatment.

Substance-related disorders (Sections I and II) often coexist with other Axis I and Axis II disorders, complicating the complete disease progression and course of treatment. Patients with coexisting disorders need integrated, sophisticated evaluation and treatments.

Most Affective Disorders and Anxiety Disorders are very responsive to effective treatments, and patients usually resume their previous level of functioning. Cognitive Disorders may be primary or secondary to underlying medical illness. In fact, many physicians have experienced and recovered from major psychiatric disorders without ever reaching the attention of a licensing Board. Having an Axis I or Axis II disorder does not necessarily lead to impairment. Untreated, inadequately treated or treatment-resistant psychiatric disorders are more likely to cause impairment.

- A physician impaired by a psychiatric disorder may or may not be safe to practice medicine. Examples of physicians who may not be able to safely practice include:
- A physician with active Bipolar Disorder in a manic phase who is showing poor judgment and insight and is refusing treatment;
- A physician with Panic Disorder resistant to medications who is so phobic that work duties and patient care duties are avoided and neglected;
- A physician who becomes psychotic as a sign of incipient schizophrenia, does not respond completely to medication, and is unable to work;
- A physician who exhibits marked irreversible memory impairment from early Dementia.

Similar examples in which patient safety would probably not be compromised include:

- A physician with Bipolar Disorder in a somewhat depressed state who is compliant with treatment, maintaining appropriate therapeutic lithium levels, and showing good insight and judgment
- A physician with Panic Disorder who responds well to treatment and avoids certain situations that do not interfere with work
- A physician who becomes psychotic while severely depressed, but retains insight about symptoms, responds well to medication treatment and slowly returns to the previous level of functioning
- A physician with reversible memory impairment from a severe depression that responds to treatment

Protocol

When a mentally disordered physician comes to the attention of a licensing Board, consultation with a psychiatrist experienced in treating and monitoring impaired physicians is essential. The DSM-IV diagnosis must be considered along with the physician's current and past levels of functioning, concurrent medical disorders, complicating factors such as substance-related disorders, compliance with treatments, response to treatment, prognosis, and stage of recovery from the illness.

Psychiatric consultation to the Medical Board can facilitate effective assessment and monitoring of the mentally disordered physician. A psychiatric consultant can assist with the treatment plan review, identify appropriate treatment resources, give feedback regarding the impact of specific psychiatric treatments or Board disciplinary actions, and systematically evaluate rehabilitation effectiveness (Shore, 1980, 1982).

Assessment

A complete psychiatric, neuropsychological and medical assessment is necessary for the psychiatrically ill physician, or the physician for whom psychiatric impairment is suspected. Additional opinions and expert evaluations may also be helpful. A full evaluation should include:

1. Psychological assessment
2. Descriptive psychiatric formulation and diagnosis (with emphasis on past psychiatric history, stressors, and potential destructive behavior)
3. Recommendations for further treatment and evaluation (including medication recommendations)
4. Evaluation of a physician's safety to practice
5. Evaluation of any impairments in functioning
6. Long-term prognosis

Treatment and Monitoring

Most psychiatrically impaired physicians may safely return to medical practice, if they are effectively treated, are compliant with treatment and continue to respond to treatment. The mentally disordered physician must be expected to follow the treatment recommendations of the expert evaluators. A primary treating psychiatrist should be the coordinator of treatment. Components of treatment can include psychopharmacologic, cognitive-behavioral, and other psychotherapeutic interventions.

Psychotropic medications may be necessary for the recovery of a mentally disordered physician. When optimally prescribed and taken as prescribed, psychotropic medications do not interfere with the safe practice of medicine. Addicting psychotropics should be avoided when there is a current or past history of substance-related disorders.

The goal of all monitoring activities is to insure patient safety as well as safe, uninterrupted recovery from illness and impairment. The mentally disordered physician should enter a monitoring relationship with cooperative psychiatric input. Privileged communications of the ill physician are confidential, yet the psychiatrist and physician can still cooperate with ongoing monitoring. Ideally, the ill physician will have a primary (treating) psychiatrist, a monitoring physician (preferably a psychiatrist) and a workplace supervisor.

Monitoring should be individualized considering the severity of illness, complicating conditions, compliance with treatment, response to treatment, and other factors. Testing the blood or urine can monitor many psychotropic medications; this monitoring is essential for non-compliant physicians, and may be recommended for others. Additionally, psychiatrically impaired persons are at increased risk for substance-related disorders so initial and continued body fluid screening for drug and alcohol use is important in this group, even when there is no known history of substance-related disorders. A suggested monitoring plan for physicians with psychiatric disorders may be found in the Appendix.

Board Considerations

The Board may addresses major psychiatric disorders when issues such as patient care or harm and unprofessional conduct arise. When evidence suggests that impairment may exist most Boards have the statutory authority to order a physician to undergo a mental and physical evaluation.

A comprehensive assessment by an approved facility is the first step in determining if a physician can practice with reasonable skill and patient safety. If the assessment indicates that a physician has a major psychiatric disorder, but can practice safely if he complies with treatment recommendations, the physician generally enters into an agreement with the Board. The agreement usually involves five years of monitoring and specific terms and conditions. If no patient care or harm issues are found, a private consent order may be appropriate. If there is evidence the physician cannot practice with reasonable skill and safety, the Board will take the necessary steps to prevent him from practicing.

IV
Disruptive Behavior

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General Considerations

In recent years there has been a marked increase in the less clearly defined category of "disruptive" or "behaviorally handicapped" physicians. Some states report that 12% of recent referrals to physician well-being programs can be categorized as disruptive physicians.

While it is difficult to precisely define "disruptive behavior", it may be described as a chronic pattern of contentious, threatening, intractable, litigious behavior that deviates significantly from the cultural norm of the peer group. This behavior creates an atmosphere that interferes with the efficient functioning of the health care staff and the institution.

The use of the word "chronic" in this definition implies a habitual pattern of behavior as opposed to the rare or occasional outburst on the part of the acutely fatigued or stressed physician, which is usually recognized even by the offending physician as exaggerated and inappropriate.

As reported by Waring (1974), Krell and Miles (1976), Rhoads (1977), Krakowski (1982), and Gabbard (1985, 1988), compulsivity is the hallmark of the physician's personality and the first factor of assessment in the disruptive physician.

Gabbard (1985,1988) lists the five essential criteria for diagnosis of a compulsive personality as follows:

- Restricted ability to express warm and tender emotions.
- Perfectionism.
- Insistence that others submit to one's way of doing things.
- Excessive devotion to work and productivity to the exclusion of pleasure and interpersonal relationships.
- Indecisiveness.

Another psychological factor to consider is that some physicians have been raised in an abusive home environment that, for some, is replicated in medical school, as they may have been the object of physical, verbal and mental abuse. This type of negative "cultural" influence leaves a significant "imprint" that the abuser had not only status and genius but also power. The medical training, for many physicians, has also emphasized intellectual capacity at the expense of fostering learning and practicing interpersonal skills. Rarely, if ever, is the question of competence regarding body of knowledge or technical expertise at issue for the behaviorally disruptive physician.

The behaviorally disruptive physician often exhibits compulsive personality traits to a highly exaggerated degree. Compulsive traits operate as a psychological defensive style of living useful in defending against feelings of shame and guilt. Guilt is a positive emotion in that it promotes civility within the human condition. Shame is a negative emotion that demands a hiding place. The greater the store of shame, the more likely it is to use dysfunctional psychological defensive mechanisms to hide it.

Physicians who may be predisposed for the behaviorally disruptive category may use alcohol in a socially acceptable manner, but they do not use or abuse other substances. They also usually profess low to zero tolerance for those who use/abuse mood altering substances which reduces the opportunity that they might receive help/support from the chemical dependency program available through most PWPs.

The most distinguishing characteristic of this physician is varying degrees of chronic malcontent and frequent outbursts of anger. When the compulsive traits fail, anger becomes the next level of psychological defense guarding the shame. The result is inappropriate outbursts of anger, often approaching the level of rage towards nurses, technicians, employees, and patients.

Inappropriate behaviors of the disruptive physician may include:

- intimidation
- abusive language
- demeaning other staff
- blaming or shaming others for adverse outcomes
- threats of violence, retribution or litigation

Inappropriate words or actions directed towards another person

- sexual comments, jokes or innuendo
- flirtation, sexual harassment
- seductive, aggressive or assaultive behavior
- racial, ethnic or socioeconomic bias or slurs
- lack of regard for personal comfort and dignity of others

Inappropriate responses to patients needs or staff requests

- uncooperative, defiant, rigid, inflexible
- avoidant, unreliable
- late or unsuitable replies to pages and calls
- unprofessional demeanor or conduct
- arrogant, disrespectful
- inadequate communication in quantity, quality and promptness
- recurrent conflict with others, particularly authority figures, irrational, oppositional

Behaviorally disruptive physicians are a singular form of impairment distinguished by the following criteria:

1. Previously ignored and therefore not included in rehabilitation opportunities
2. Associated with an exaggerated degree of compulsive personality traits
3. Not associated with substance abuse
4. Competence and technical expertise acceptable
5. Malcontent and anger outbursts frequently bordering on rage attacks

*Not all disruptive physicians exhibit each of these behaviors

Protocol

Disruptive professionals rarely seek help. They characteristically lack insight into the nature or severity of their problematic behavior. When it is necessary to proceed with intervention and depending on the severity of the situation two or more senior medical staff and administration should perform the initial intervention. As with any physician intervention, the general guidelines are:

a. Establish a clear goal for the intervention
b. Plan intervention for a private neutral setting
c. Assure for privacy, confidentiality and adequate time to address needs
d. Present information in a clear non-judgmental manner, including dates and times of situations
e. Extend option of assessment to the physician, if situation warrants
f. State expectations clearly regarding any future occurrences
g. State consequences of non-compliance with expectations
h. Document summary of meeting in physicians personnel file

Assessment

The Physician Wellness Program is an excellent resource for initial assessment and referral for formal assessment of the behaviorally disruptive physician. As discussed Sections I, II, II, the assessment

should be multidisciplinary and conducted at centers which are approved for assessment and treatment of physician health disorders.

The purpose of the assessment is to determine if psychiatric disorders (Section III) are at the base of this behavior, particularly substance dependence and Axis II Cluster B personality disorders such as *Narcissistic, Histrionic, Borderline,* or *Paranoid*. Other psychiatric problems may be: *Bipolar, Dementia, Major Depression or Schizoid Personality.* As discussed under assessment, each disruptive physician may exhibit unique symptoms requiring individualized care planning and Continuing Care Contracts.

The Continuing Care Contract is an integral part of the assessment/treatment process and specifies that the physician agree to cease this disruptive behavior.

Recommendations for this agreement may include:

- Therapy recommended by assessment team
- Focused education on:
  - anger management
  - conflict resolution
  - sensitivity training skills
  - communication
  - behavioral modification
  - impulse control training
- Peer Monitoring
- Leave of absence
- Partial loss of privileges/temporary suspension of privileges with a clear plan and requirements for re-entry, suspension of privileges, revocation of privileges
- Denial of appointment or reappointment
- In many states prolonged changes in privilege status are reportable to the licensing Board.
- Failure to do so would be equated with relapse behavior that would dictate reassessment of diagnostic criteria and treatment methodology.

Historically, medical Boards have not recognized disruptive behavior as a form of impairment but state physician well-being programs are currently addressing this category of impairment.

Board Considerations

Disruptive physicians can make the lives of those around them miserable. The Board is primarily concerned, however, with whether the physician can practice with reasonable skill and safety. While patients or coworkers may be disturbed by disruptive behavior, it is often difficult to gather evidence that a physician's actions escalate to the level of violating the Medical Practice Act. Informally, investigative interviews for physicians with multiple complaints may serve as a "wake-up call".

V
Sexual Misconduct

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General Considerations

The Hippocratic Oath taken by physicians includes:

"I will come for the benefit of the sick, remaining free of all intentional injustice, of all mischief and in particular of sexual relationships with both female and male persons."

The Council on Ethical and Judicial Affairs of the American Medical Association indicates that the sole purpose of a physician's treatment of a patient is for the patient's welfare.[1]
Sexual misconduct between the physician and patient seriously compromises the patient's welfare because "the emotional factors that accompany sexual involvement may effect or obscure the physician's medical judgment, thus jeopardizing the patient's diagnosis or treatment. Sexual contact or relationships between patient and physician are unethical because the physician's gratification inappropriately becomes part of the professional relationship." In other words, sexual misconduct by a physician is, in part, for the gratification of the physician, and therefore not for the exclusive benefit of the patient.

The Georgia Medical Board's primary function is to protect the safety and welfare of the public it serves. Medical Boards typically view physician sexual misconduct as a violation of the public trust and therefore a detailed evaluation is needed and disciplinary action may be taken against the physician. The Federation of State Medical Boards has reviewed the issue of physician sexual misconduct, behavior that exploits the physician relationship, because it involves non-diagnostic and non-therapeutic behavior that may include "expressions of thoughts and feelings or gestures that are sexual or that reasonably may be construed by a patient as sexual.[2]"

The Federation divides sexual misconduct into two categories: sexual improprieties and sexual violations.

The less severe is *sexual improprieties, which* may include:

- Seductive, sexually suggestive or sexually demeaning acts or expressions that may include disrobing or draping practices that fail to respect the patient's privacy;
- Intimate examinations in the presence of others (such as students or third parties) without the explicit consent of the patient or when consent is withdrawn;
- Genital examination or genital touching without the use of gloves;
- Inappropriate statements regarding the patient's body or sexual orientation;
- Sexual questioning (except when the examination is for the specific purpose of evaluating the sexual function or dysfunction of the patient
- Soliciting dates
- The physician initiating comments regarding the physician's sexual problems or the physician's sexual preferences or fantasies
- Sexual kissing or examining the patient without consent is also seen as sexual improprieties.

Sexual violations are considered more serious than sexual improprieties and include physician sex (whether initiated by the patient or the physician) or involvement in sexual contact with the patient that can be reasonably interpreted as sexual in nature.
Sexual violation encounters may include:

- Genital to genital intercourse
- oral to genital contact, oral to anal contact, genital to anal contact, oral to oral contact (excluding CPR), touching breasts, genitals or any sexualized part of the patient's body for any purpose other

than an appropriate examination or treatment (or when the patient has refused or withdrawn consent)
- encouraging the patient to masturbate in the presence of the physician or masturbation by the physician while the patient is present
- offering an exchange of practice-related services for sexual favors (such as an exchange of drugs for sexual activity with a patient).

Protocol

Physicians accused of sexual misconduct may seek assessment through a variety of channels. In Georgia, when the Medical Board receives a complaint, an investigator gathers information to evaluate the veracity of the complaint and if the physician is considered a threat to his or her patients' welfare, immediate disciplinary action against the physician's practice of medicine may occur. In the majority of cases an independent medical evaluation (IME) is requested of the physician prior to the physician appearing in a formal hearing with the Georgia Medical Board. In other cases, physicians involved in sexual misconduct seek out the Physicians Well-being Program that may subsequently seek an evaluation to determine the need for treatment of the physician. Still other physicians are self-referred when they, their business partners or their hospital administrators have sought out an independent opinion regarding possible sexual misconduct. A final source of referral may be the physician's attorney following the filing of a malpractice lawsuit against the physician or, in some cases, criminal charges resulting from sexual misconduct.

A critical aspect of the assessment involves a clarification of the confidentiality of records and the potential consequences of other parties seeking out the assessment results. When the Medical Board refers the physician they must be informed that anything discussed during the assessment could appear in a summary advanced to the Medical Board. When referred through other sources the physician being evaluated should be provided confidentiality of his assessment but with two qualifiers:

1. First, most state Boards can yield considerable force when concerns about the physician's license are raised and, as a consequence, the Georgia Medical Board may pursue access to any assessments completed on the accused physician.

2. Second, the evaluator has an ethical responsibility to report any physician who is currently considered dangerous to his or her patients. Although the second case is unusual, it occasionally occurs during assessment of a physician involved in professional sexual misconduct, and the evaluator may have to report the impaired physician due to this potential danger.

Assessment

The evaluation process begins with a complete review of the specific allegations made against the physician, the results of the licensing Board's investigation and any other collateral information available from third parties familiar with the accusations.

An independent multidisciplinary assessment team experienced in the evaluation of possible sexual misconduct should undertake the assessment. Assessment necessitates the completion of a psychiatric history including a mental status evaluation, family, social, medical and substance abuse history, a medical history and physical examination including laboratory measures and drug screening, neuropsychological screening, psychological testing and the measurement of possible paraphilic (deviant) sexual interest.

A summary of the physician's assessment should include:

- Diagnosis based upon the five axial diagnoses of the current Diagnostic and Statistical Manual of Psychiatric Disorders of the American Psychiatric Association (DSMIV)
- The extent of the professional's impairment or potential impairment

- Whether rehabilitation is possible and, if the professional is recommended to return to practice, what practice plan would be required before or concomitant with the physician returning to practice so as to protect the safety of the public.

If and when the physician returns to practice, what type of supervision and check and balance system would be required to ensure patient safety and what is the frequency of ongoing reports from the treatment agent to the Georgia Medical Board to ensure the maintenance of the physician's safe practice of medicine. The treating agent is always obliged to agree that if it is believed the physician has become dangerous to the welfare of his or her patients, the treating agent would immediately contact the Georgia Medical Board and inform them.

When physicians involved in sexual misconduct have received a formal Axis I DSM diagnosis, it usually includes one of the following diagnostic considerations:

- Sexual Dysfunction NOS; the physician's sexual behavior includes a compulsive, recurrent driven quality that is unlikely to lead to closeness and intimacy with a sexual partner.

- Various categories of paraphilias; voyeurism (preoccupation with surreptitiously observing a patient undress), frottage (sexual gratification obtained by sexual touching of the patient), fetishism or partialism (the physician is sexually attracted to overly eroticized parts of the patient's anatomy, such as breasts, feet and hands) and pedophilia (sexual attraction to children). Paraphilic behavior is usually a sexual interest beginning in the mid-teens and extending throughout the physician's lifetime.

Axis II diagnoses of the DSM classification refer to various personality disorders, enduring, sustained ways an individual physician interacts with others over his or her life time. These personality disorders are not considered Axis I diagnoses but the inclusion of diagnosable Axis II personality disorders is complimentary to the understanding of those factors contributing to a physician's sexual misconduct.

Personality disorders are not considered Axis I diagnoses but the inclusion of diagnosable Axis II personality disorders if believed they are special, has a sense of entitlement and is personality disorders most frequently seen in physicians involved in sexual misconduct include:

- Narcissistic Personality (the physician has a grandiose sense of self-importance)

- Bipolar disorder (the physician demonstrates periodic poor impulse control, irritability, hyperactivity, insomnia and sexual impulsivity)

- Male sexual dysfunction due to general medical conditions (such as hyperthyroidism or Cushing syndrome) or substance induced sexual dysfunction (such as cocaine, marijuana or hallucinogenic induced sexual dysfunction).

- Impulse Control Disorder NOS in which a physician's sexual impulsive disorder is a chronic, recurrent sexual impulsiveness.

- Adjustment Disorder with Disturbance of Conduct

- Occupational Problem

The Federation Ad Hoc Committee on Physician Impairment has examined whether sexual misconduct should be considered a form of impairment resulting from a mental disorder and has concluded that sexual misconduct usually is not caused by physical or mental impairment, but instead is a violation of the public's trust.

It is critical that the independent medical evaluation clarify precisely how the Axis I DSM-IV diagnosis

leads specifically to sexual misconduct by the physician.[2]

The Ad Hoc Committee has also emphasized that the term *sexual addiction* although frequently used, is not a recognized disease in the Diagnostic and Statistical Manual of Mental Disorders (DSM).

Treatment
A new development in the treatment of physicians involved in professional sexual misconduct has been:
1. The effectiveness of treatment that combines the cognitive-behavioral approaches originally developed for the treatment of paraphilic disorders

2. Psychopharmacological intervention (in selected cases), especially with the newer specific serotonin reuptake inhibitors that reduce sexual compulsivity and sexual drive

3. Self-help programs to reduce stress and bring balance to the physician's life (such as Caduceus programs and impaired professional programs;

4. Checks and balances report forms that incorporate training of the physician's administrative staff regarding the specifics of his sexual harassing behavior and feedback from the physician's staff and patients regarding early signs of sexual harassment.[4] In some cases polygraphs are also used to ensure the safety of the public.

All of these treatment components, when combined with the supervision from the Georgia Medical Board, have been effective at reducing recidivism to less than one percent of treated physicians. The occurrence of professional sexual misconduct is approximately 6%, nationwide. Since recidivism rates post-treatment are considerably less than 6%, returning treated physicians to practice reduces the likelihood of sexual misconduct in the general public.

Not all physicians with sexual misconduct can be effectively returned to the practice of medicine. This is often the case when the physician has organic brain involvement or when sexual misconduct is interconnected with substance abuse. Additionally, not all physicians should be evaluating other physician involved in sexual misconduct. The Federation Ad Hoc Committee on Physician Impairment explicitly clarifies that those physicians who have themselves formerly been sexual misconduct offenders should not conduct such evaluations.[2]

Prevention
Medicine has always stressed the importance of prevention. Sexual misconduct can be reduced by:

- Improving physician training regarding the issues of sexual misconduct and sexual boundary violations
- Continuing medical education and awareness programs throughout the physician's professional career, training by medical specialty societies,
- Peer review and staff education in the hospital setting and educational efforts by impaired professional program throughout the United States.

Physicians and trainees should clearly understand what constitutes sexual misconduct, boundary violations as well as the potential repercussions of sexual misconduct upon the victims and the potential consequence of such violations on the physician's ability to practice medicine.

Disciplinary action for physician sexual misconduct cases should continue to be public so that the physicians, patients and the general public can be aware and work together to reduce and eliminate sexual misconduct.

Board Considerations
Most Boards consider sexual misconduct cases as very serious and places a high priority on investigating them. Due to the confidential, often intense, nature of the patient-physician relationship,

patients are vulnerable to becoming intimately involved with their physicians, to the detriment of the patient. In more egregious cases, sexual violations may rise to the level of committing illegal acts beyond those related to the Medical Practice Act. When there is reasonable evidence to support allegations of sexual misconduct, the physician may be required to undergo a comprehensive assessment at an appropriate facility to establish the nature of the problem.

Sexual impropriety allegations are often more difficult to investigate than sexual violations, but investigation often reveals multiple patient complaints. When sufficient evidence exists that physicians have committed sexual improprieties, sanctions can be imposed.

Board orders in sexual misconduct cases generally are public and surveillance of behavior for further violations may require the assistance of staff and patients through the use of survey forms. In sexual violation cases, sanctions should require a monitoring physician experienced in treating such cases. Some sexual misconduct cases may result in suspension or revocation of the physician's license in order to protect the public.

VI
Dyscompetence

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General Considerations

Concerns regarding physician competence generate more complaints to medical licensing Boards than any other problem. This is not surprising when you consider that the primary function of a regulatory licensing agency is to protect the public by assuring that physicians are qualified and able to practice medicine with skill and safety. In fact, the reason the other categories of physician problems in this book are of concern to medical licensing Boards is that they can and do cause impairment of competence. In this section we will discuss dyscompetence, an abnormality of competence that is not secondary to illness but appears to be primary. Complaints usually focus on some aspect of the practice of medicine with concerns about quality of care. All the other problems in this book, e.g. chemical dependence, do not appear to be present. Of course, there can be an overlap between dyscompetence and other problems mentioned in this text including, "The Inappropriately Prescribing Physician" (Chapter VII), "The Unethical Physician" (Chapter VIII), "The Elderly Physician" (Chapter X), and others. Dyscompetent physicians are often found to have a broad range of medical practice problems and difficulties, ranging from the doctor with a mild and circumscribed focal knowledge base deficiency to a broader pattern of dyscompetence and unacceptable practice behavior in numerous spheres of practice setting and patient types. Dyscompetence can be divided into one or more of the following areas:

- problems with medical knowledge base,
- reasoning, communication skills, or charting.

Medical licensing Boards in the United States have undergone a profound evolution since their beginnings in the 1800's. Several broad eras have been described. The first, the era of qualification, involved the licensing of physicians based on documentation of graduation from legitimate medical schools. This was an attempt to eliminate charlatans and imposters from practicing medicine. The second, the era of examination, followed the development of standardized testing. Tests such as the National Board Exams, now the United States Medical Licensing Exam (USMLE) became popular. This was a further attempt to assure that physicians achieve a standard knowledge base in order to practice safely. Finally, since the 1970's we have entered the era of disciplinary action. This era places pressure on physicians to comply with standards of care and ethical behavior. Disciplinary action may include revocation, suspension, stipulated agreements, public reprimand, fines, or other action. Medical licensing Boards receive complaints, investigate, hold hearings, evaluate, and determine if discipline or other remedial action is required to protect the public.

Concurrent with the era of discipline has been the development of Physician Health Programs. These programs have been established in most states to provide a mechanism for early detection, rehabilitation, and monitoring to avoid the necessity of disciplinary action for remedial problems, especially regarding chemical dependence. Likewise, concerns regarding competence are beginning to be better analyzed by Boards and in-depth evaluation is helping determine if rehabilitation is possible.

Complaints to medical licensing Boards regarding competence come from numerous sources but primarily from patients, their families, and other health professionals. The complaints often occur following an incident or catastrophic event usually preceded by a history of other episodes of concern. Often the local hospital staff has attempted to deal with the problems unsuccessfully. As managed care organizations have established standards of care more physicians are reported because of action from these organizations. Sometimes the primary concern of the managed care company is regarding over utilization that leads to increased cost as well as patient safety and quality care concerns. A relatively

new source of complaint, that has lead to disciplinary action[1], involved the medical director of an HMO who was disciplined for denial of coverage of needed medical care that resulted in harm to the insured patient.

Once a medical Board investigates and usually following or during due process proceedings the Board may refer the physician for further evaluation. This is an underutilized step and is important to understanding the details of a physician's situation. Too often a Board will attempt to evaluate a physician in a committee setting. It is much better when possible to have the physician evaluated in a formal evaluation program. Various programs for physician evaluation have been developed. One well-known program, the Colorado Physician Evaluation Program, CPEP, has evaluated many physicians. Recently the Federation of State Medical Boards, FSMB, has developed a program utilizing the CPEP experience and has formed an evaluation program for competence called the Institute for Physician Evaluation, IPE. This program promises to be an important resource for competence evaluation for medical licensing Boards and other organizations. The ultimate goal of the FSMB is that there will be several IPE sites situated in various geographical sites around the United States.

Protocol

A thorough professional practice history must be performed to develop a physician practice profile. The profile provides an overview of the physician's patient population and scope of practice. This includes information on staffing, certification, office procedures performed, hospital description and privileges, and long-term care activities. Collateral information from Boards, hospitals, or other organizations that led to the referral must be obtained and reviewed. It is important to obtain verification of training, documentation of recent continuing education, licensure, malpractice cases, professional affiliations and personal interests. It is also important to obtain any previous history of problems (e.g. failure or marginal performance in medical school or residency, previous Board disciplinary action, etc.).

Deficiency of Knowledge Base

The assessment of medical knowledge is particularly important. To accomplish this, standardized tests such as the Special Purpose Exam (SPEX) may be utilized. Additionally, and more importantly, professional peer assessment should be performed. One or more specialists in the same field should be retained to conduct a detailed interview with the physician based upon chart review. The evaluation should, however, go beyond the usual chart review and should include evaluation of clinical thought process, differential diagnosis, depth of clinical knowledge, and charting practices. Actual or hypothetical cases may be discussed regarding understanding of the specific field of medicine. A report is generated that details the findings. Further testing and interviews may be conducted. Observation or description of surgical or procedural technique may be important during this process.

Defective Ability to Reason

An important part of evaluation is cognitive testing. Screening may be performed with computer-based systems or other standardized tests. Recent memory, attention, response time and abstract logic as well as other parameters may be assessed. More sophisticated testing may be necessary to define deficits. Formal neurologic or neuropsychological testing should be done if this is a suspected area of concern or if screening shows problems. Reports should be issued indicating the exact deficits, their probable etiologies, and whether they are treatable or remediable. Follow-up examination may be important.

Poor Communication Skills

Thorough evaluation should include assessment of communication and interview skills. Information regarding communication skills can be developed from interviews with assessment personnel. This is best performed with mock patient encounter sessions. These sessions are best performed with trained actors in a videotaped session. Analysis of the physician's communication and interview skills can then be performed with the evaluation staff including the actors themselves. Physicians can view these

[1] Texas Board of Medical Examiners Bulletin, 4/2000

interviews on videotape and often gain insight into communication difficulties. There are also programs and institutes in some states for patient-physician communication. These programs are available for training and assessment of physicians. Negotiation skills and listening techniques can sometimes be learned.

Poor Charting Skills
Sometimes a major problem is present with a physician’s charting techniques. Inattention to detail, poor handwriting, or disorganized notes may be found. Review of records usually reveals this deficiency.

Board Considerations
Complaints regarding dyscompetent physicians are often difficult for the Boards to resolve. An investigation of alleged dyscompetence must obtain admissible evidence, which is then peer reviewed. The reviewer must determine that the care fell below the minimum standard of practice for the treatment rendered. A comprehensive assessment may be required to rule out an organic basis for the problem and the physician may be required to undergo testing of his medical skills and knowledge. Based on this information, appropriate retraining may be needed. Unfortunately, with the complexity of today's medical environment, restricting the physician to "General Practice" does not ensure adequate patient safety.

VII
Inappropriate Prescribing

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General Considerations

It is amazing in this high tech age of computer-enhanced imaging, teleconference diagnosis, organ transplantation and daily surgical innovations, that one of the most powerful tools of medicine is still the ink pen. A physician's signature on a prescription pad holds the key to the treatment of many/most illnesses. That signature is also the impetus for a multi-billion dollar industry.

Despite this substantial power, most physicians take prescribing for granted and actually have had little training about the process. For many reasons, a surprisingly large number of practitioners find themselves in trouble with medical regulatory agencies, including Medical Boards and the Drug Enforcement Agency. Worse, is the occasional physician who finds himself facing criminal diversion charges.

It seems such an enigma that highly respected, fully trained physicians could lose sight of their prescribing responsibilities to the point that their careers are lost or threatened and/or they end up facing serious legal consequences.

One of the most common problems facing medical Boards each year is the inappropriately prescribing physician. A high percentage of practitioners "invited" for Board interviews have had prescribing irregularities. Most of the problems involve controlled drugs, but sometimes, it is the erratic and excessive prescribing of even non-controlled drugs that draws the attention of authorities. This is especially true if a doctor prescribes for himself or a family member. In fact, in 1995, 30% of physicians interviewed by the North Carolina Medical Board had prescribing problems. That same year, 30% of formal Board actions in North Carolina were for irregular prescribing.

There are many reasons why busy doctors may have problems stemming from their prescribing patterns. Four major categories have been described as: Deficient; Duped; Deliberate and Drug Dependent.

Deficient(Dated)

- Too busy to keep up with CME
- Unaware of controlled drug categories- limits, call-ins, refills
- Not aware that Methadone is only for chronic pain or for use in Methadone Clinics
- Prescribing "pet " drugs that were once said to be" non-addictive" but have proven otherwise
- Prescribing for friends or family without a patient record

Duped

- Always assumes the best about his patients and is gullible
- Too trusting and leaves script pad lying around
- Buys sad story of patient being from out of town, on vacation, left medication at home
- Strangers come in with cast on arm or leg complaining of pain
- Stranger presents with "kidney stone" or severe migraine
- Stranger asks for a specific medication (" Percocet really works for me")
- Hydrophilic medicine- fell into toilet or down the sink
- Patient announces that he is an addict and is scheduled for treatment next week –" need enough for 4 days until I get there"

Deliberate (Dealing, Diverting)

- Practitioner becomes a mercenary
- Office becomes a "pill factory"- full of drug seekers

Sells controlled samples and all controlled scripts are for sale
Prescribes for known addicts who will likely sell drug to others
Splits the take or gets “favors” in return for scripts- money, sex, street drugs, etc.

Drug Dependent (Addicted)

Starts by taking controlled samples (often to relieve a hangover or keep going without much sleep)
Progresses to diverting or diluting injectables in office drug locker
Calls in scripts for family members or fictitious patients and picks them up himself/herself
Asks staff to pick up medications in their name as a favor
Asks patient to return to office for medication instruction and switches or diverts some of the medication
Uses another doctor’s DEA number
Becomes more brazen and careless as addiction progresses.

Protocol

Years of inappropriate prescribing may be the rule for some physicians before a report is generated to raise concern. Sometimes, a disgruntled patient complains to a pharmacist or to the Medical Board that the doctor is taking some of his medication or is switching it altogether. It is not unusual for a pharmacist to see an emerging pattern of over prescribing. More often, Board investigators during routine pharmacy prescription surveys discover excessive or inappropriate prescribing. Likewise, Medicare/Medicaid pharmacy inspectors discover excessive controlled prescriptions for a handful of patients written by the same provider. Another good source of information is the DEA review of mail order drug invoices for individual practitioners or office practices. Collaboration between the Medical Board investigative staff, the DEA and the state physician well-being program/committee can hasten the process toward confirming the existence of a problem, confronting the physician, and determining the appropriate help, if indicated.

1. The approach to the *deficient (dated*) *physician* and the *duped physician* is primarily education, but the types of instruction are likely to be different. Initially, these two groups can be combined, because it is imperative to know if the doctor is capable and /or willing to learn the new material required to practice quality medicine. A physical examination is a good starting point since most physicians do not get examined on a regular basis. A mental examination is necessary and it is quite likely that cognitive testing may be required to see if the physician is thinking correctly.

   If it appears that the physician is deficient (dated), then the Special Purpose Examination (SPEX) will give some indication how much remedial education is needed. Some practitioners benefit greatly by taking a course on “Prescribing of Controlled Drugs “, usually a 5-7 day course with a year’s worth of continuing medical education (CME). If, however, the preliminary indications are that the physician is *duped*, he will need assertiveness training to learn to say “no” to aggressive patients and may need co-dependency treatment to overcome enabling/people-pleasing behaviors. Additionally, a prescribing course would also help this group. If aging is an apparent issue, then following the protocol set forth in Section X (*The Elderly Physician*) would also be indicated.

2. The *drug dependent* physician is often in the worst physical/mental condition when discovered, but often, has the best chance to fully recover. After a comprehensive multidisciplinary assessment, the discovery of chemical dependency requires treatment first before any other factors are considered. Once sober, the recovering physician can better deal with the chaos he has created. Depending on the degree of motivation the “treatment” may range from monitored Twelve Step recovery to long term inpatient treatment lasting three months or longer. After treatment, enrollment with the state physician well-being program/committee is a necessity to monitor day–to–day compliance, obtain random drug screens, and provide other focused activities, including quarterly progress reports. Reentry to the practice of medicine is usually possible under a tightly structured agreement with State PHP and /or the State Medical Board.

3. The *deliberate physician* who flagrantly disregards the Hippocratic Oath usually has a psychiatric diagnosis. Despite the presence of an Anti-social Personality Disorder or worse, these individuals generally know the difference between right and wrong and need to fully face legal consequences for their wrongdoing. However, it is necessary to do a thorough psychiatric evaluation with neuropsychometric testing to rule out organic disorders.

Education

In cases where the over prescribing is marginal and is, perhaps, the result of naiveté without seeking personal gain, an educational approach is warranted. As mentioned previously, there are a number of good to excellent prescribing courses. In the Southeast there are courses at Mercer University (Atlanta, GA), the University of South Florida (Tampa, FL), The University of Kentucky (Lexington, KY) and Vanderbilt University (Nashville, TN). If over prescribing is significant and is done for personal gain, a measured disciplinary response is indicated, including criminal prosecution. The specific approach depends on a careful assessment of the physician's practice situation and consideration of all factors that may have contributed to the pattern of inappropriate prescribing.

If a physician continues in practice with restrictions, a period of monitoring should be part of the program of rehabilitation. A local "designated monitor" may be identified to meet with the problem physician at regular intervals to review patient records, indications for medications prescribed, and general rationale for treatment decisions .A Medical Board review of a random selection of patient records may precede each return visit to the Board. In many cases the State Physicians Health Program/Committee can monitor the physician as well.

Restrictions

In some instances, a physician may have to have a modification of the drug schedules that he is allowed to use. This restriction is usually conveyed to the DEA and the physician may have to keep a log of all controlled prescriptions written for a period of months to years. A copy of the log is sent quarterly to the Medical Board and the DEA. Board investigators and DEA agents can track compliance with the DEA modification. Overall, the Medical Board must get the practitioner's attention and ongoing scrutiny is the key.

Board Considerations

Inappropriate prescribing runs the gamut form incompetence to drug diversion. The investigation must gather admissible evidence including existing patient medical records, and the actual prescriptions. Possible impairment must be documented. Prescribing patterns that do not violate any specific parts of the Medical Practice Act, or other applicable laws or rules, may still be unprofessional conduct. Board actions may appropriately range form suspension or revocation to probation. The terms of probation may include requiring the physician to obtain CME or a mini-residency in appropriate prescribing, to have his prescribing privileges for controlled or non-controlled drugs restricted and to submit triplicate prescriptions and a prescription log to the Board.

VIII
Ethical Violations

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General Considerations

A small number of physicians engage in unethical and sometimes criminal activities. Reasons for unethical behavior in physicians include greed, need for power, dysfunctional family of origin with unethical role models, Antisocial Personality Disorder, and/or untreated chemical or behavioral addictions.

Antisocial Personality Disorder may present in a physician with disruptive behavior (Section IV) and/or with unethical behavior. A person with an Antisocial Personality Disorder exhibits:

> a "pervasive pattern of disregard for and violation of the rights of others occurring since age 15 years" as evidenced by a combination of the following: failure to conform to social norms regarding lawful behaviors, deceitfulness, impulsivity, irritability, and aggressiveness, disregard for the safety of self and other, consistent irresponsibility, and lack of remorse. [1]

Society has difficulty in perceiving and reconciling unethical behaviors in physicians, and other professionals, where there is an explicit power relationship and inherent sense of trust between the professional and those seeking help, e.g., the clergy.

Denial is often present in the family and significant others of the unethical physician rendering early intervention unlikely. Recognition of the unethical physician usually ensues after a civil suit has been filed against the physician or an investigation is initiated by a state medical Board. In today's litigious environment, it is critical to identify the unethical physician to reduce liability to patients and professional peers.

The unethical physician's behavior may present in a variety of ways, almost all dependent on the physician's desire and drive for money, power, or the need to satisfy an underlying addiction. Common examples of unethical behavior encountered by physicians of both genders are:

- Forty-six year old physician selling prescriptions for controlled substances after a perfunctory or absent examination of the patient. This had evolved into a very lucrative practice; patient came to the office by "word of mouth"

- Fifty-three year old physician found to be writing controlled substance prescriptions in payment for sex to prostitutes. After a prostitute overdosed and was taken to the Emergency Room, the revelation of the source of the controlled substances became known from the prostitute after her recovery.

- A family practitioner was performing sexual acts on patients after sedating them in the examining room. A number of patients over a period of three years experienced this unethical practice, but were unwilling to openly disclose their trauma.

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[1] DSM-IV

- A physician and the physician's lawyer spouse practicing near the Mexican border were operating a pain clinic. Numerous patients from Mexico were prescribed exaggerated doses of narcotics, which were then taken across the border.

- A physician in one of the central states was over charging patients for medications and submitted fictitious bills on patients. Having been identified as an alcohol abuser, the physician's defense that these acts were secondary to the disease of alcoholism was not valid. However, the claim of the disease of alcoholism was substantiated.

- A northeastern physician was found to have committed major fraudulent billing in a home-care company for equipment, nurse's services, and home visits. The claim that opioid addiction to Percodan was responsible for the illegal behavior was not valid or substantiated.

- A physician in an academic setting was the recipient of large research grants. As additional large grants were pending, documentation of dates, research funding, and conclusions were fabricated. The physician's defense was "a severe endogenous depression" which attempted to explain the behavior. This was not substantiated on an assessment.

The differentiation and separation of the unethical physician from the other problem physicians is crucial to the credibility and the reliability of the state medical Boards or well-being programs. The unethical physician, in the Georgia experience, will often attempt to legally hide in the treatment programs; thus a careful multidisciplinary assessment program is critical.

The unethical behavior category, as is that of the disruptive physician, is one of exclusion. Once it is established that there is unethical and/or illegal behavior, the physician must then be held accountable and responsible for their behavior to fulfill their legal and other obligations. Participation in a rehabilitation program may be indicated if the physician is found to have features that justify placement in one of the other categories.

Protocol

1. Adhering to specific state mandatory reporting statutes, state medical Boards should be notified as soon as possible. Most state physician well-being programs are designed to help in the prevention, identification, and referrals to treatment, as well as guiding and monitoring the recovery of sick physicians. In so doing, they protect the public. The unethical physician does not fit into the category of "sick physician" and yet does represent a threat to the safety of patients. The consumers of healthcare expect the medical profession to deal fairly, but swiftly with an unethical physician. It is advisable, that statute permitting, the physician be requested to stop practicing immediately and the state medical Board be notified in order to effect any legal or licensure adjudicating proceedings which are appropriate. Associates, colleagues and patients who are mindful of, or have witnessed the alleged behaviors should be urged to report the physician to the state medical Board directly.

2. A multidisciplinary team assessment is critical because the unethical physician often desperately seeks refuge under legitimate psychiatric or addiction medicine diagnoses to rationalize and excuse their behavior. Access to collateral material and investigative materials, as well as records from past disciplinary or corrective actions is essential for an adequate assessment. (see also Assessment under Section I)

The unethical physician may muster a tremendous amount of "advocacy" on their behalf, including favorable documentation to hide from scrutiny. It is essential, with appropriate consents to release information, to obtain additional data from as many sources as possible; e.g., patients, pharmacists, peers, hospital personnel, legal, and law enforcement agencies.

3. Legal charges both filed and pending, must be considered and appropriate action encouraged. The physician should be assisted in obtaining appropriate legal counsel, if not already represented.

Board Considerations

Because unethical behavior spans such a broad range, the investigation must be appropriate to this area of misconduct. It must determine if a comprehensive evaluation is required and what steps must be taken to rehabilitate or sanction the physician. In general, unethical behavior is very difficult to modify and requires strict monitoring if the physician is to practice medicine. The Board's considerations are usually related to whether the behavior is related to the practice of medicine or could impact patient care.

IX
Physically or Medically Disabled

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General Considerations

Physicians are no different than the general population regarding their susceptibility to physical and/or medical conditions. However, secondary to the nature of the profession, when a physician is afflicted by a serious physical/medical condition, its impact is potentially felt by multiple other individuals and groups. The very fact that a physician's condition can affect his ability to practice the profession, with skill and safety resulting in potential risks to the health, safety and welfare of the public, raises the standard by which these conditions must be assessed.

Two factors lay the framework within, which is made a comprehensive assessment of the physician's condition and its impact upon the public:

1. The medical Board is ultimately accountable for decisions regarding a physician's ability to practice within the profession.

2. The Americans with Disabilities Act (AWDA) protects the potentially disabled physician while allowing continued practice within the realm of their functional ability.

There are multiple parameters that outline the standard for assessment of a physician's physical/medical condition:

- The evaluator(s) must not only be Board certified in a related field but also have expertise in evaluating conditions similar to those presented. Evaluators must fully understand and be able to evaluate the potential impact of the condition upon the physician's ability to practice his profession with skill and safety.

- The results of this evaluation must clearly delineate: the natural course of the presenting condition (acute, chronic, progressive, etc.); the extent of the physician's physical and/or cognitive disability that pertains to the practice of his profession; the prognosis; the treatment plan; and, any recommendations regarding reasonable accommodations that would allow for the physician's continued safe and skillful practice.

Rules governing the medical Board's response to conditions that potentially impair physicians are most effective when not generalized. The real and potential manifest impairment(s) exhibited by each condition assessed will vary as determined by multiple physical, psychological, genetic and environmental factors. Therefore, each physician must be evaluated on an individual basis.

Protocol

Identification

1. Source of referral for assessment
   Self, family
   Co-workers, partners
   Hospital or other institutions
   Regulating and/or investigating agency that has received a complaint that the alleged problem might be secondary to a physician's medical/physical condition.

2. Referring Information
   Verbal report of concerns

When possible, written documentation detailing the symptoms (physical, cognitive and/or behavioral) that are presently or potentially affecting the physician's ability to practice with skill and safety.

Evaluation *

- Choice of expert(s) to be determined by presenting symptoms and/or diagnosed condition

- Complete history and physical

- Specialized examination of diagnosed condition(s) yielding the following information:
    1. Extent of disability
    2. Course of the diagnosed condition
    3. Treatment plan
    4. Prognosis
    5. Impact upon ability to practice with skill and safety

- Etiology of symptoms determined because of a blood-born, potentially infectious pathogen: (i.e. HIV disease)
    Evaluation by an infectious disease specialist
    Determination if the infected physician performs invasive procedures and if so;
    1. Risk to patients
    2. Evaluation of physician's knowledge and adherence to safe practice standards
    3. Statement as to the need for limitations and/or change in practice procedures performed, if indicated

- When manifest behavioral and/or psychiatric symptoms are secondary to the condition:
    1. Evaluation by a Board Certified Psychiatrist
    2. Complete psychological testing when indicated

- When manifested cognitive deficits are secondary to the condition, neuron-psychological testing should be performed

Monitoring Requirements (if indicated)

- The diagnosed condition has been determined to be of such a nature that there has been manifest and/or potential impairment in the physician's ability to practice with skill and safety. However, parameters have been established which would allow for continued safe practice.

- Monitoring parameters to be determined
    1. Duration
    2. Frequency of reassessments if required
    3. Need for indirect versus direct supervision
    4. Reporting requirements by supervisor and/or expert(s) performing reassessment function

* When multiple evaluators are utilized, a team leader should be identified to assist in arranging all components of the evaluation and be the recipient of all materials. The team leader should be responsible for submission of the materials to the Medical Board, including a written, comprehensive report summarizing the essentials of the history, diagnosis, prognosis, and treatment including practice recommendations.

Board Considerations

The Medical Board must balance the rights/needs of the physically or mentally disabled physician with the responsibility not to allow an unsafe physician to practice. A comprehensive assessment indicating

limitations must be followed by an agreement that adequately addresses the physicians' abilities without being unnecessarily restrictive.

X
Age Related Issues

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General Considerations

Many physicians are able to practice safely and effectively well into their 70's or beyond; however, a significant number will begin to display the physiologic changes of aging as well as signs or symptoms of illnesses which occur with advancing age.

Since these physiologic and pathological changes most often occur slowly along a continuum, the line where safe and effective practice ends may long have been crossed before coworkers, colleagues and friends notice. The physician himself is almost never aware of a deteriorating level of ability, especially when cognition is the primary or even a secondary problem. The physician with movement disorders i.e. Parkinson disease, degenerative or rheumatoid arthritis and other neuromuscular diseases are not usually difficult to note and assess; however, slow progressive changes in vision, hearing, and mental capacity may go on for considerable time before intervention is even considered. Coworkers and colleagues often "enable" the process to continue, as they are reluctant to confront an aging physician with a long and distinguished record of service.

Special care must be taken to consider medical disorders, which are treatable and could allow the physician to return to safe practice. If the physician cannot be treated and rehabilitated to maintain a safe level of practice, restrictions must be imposed or practice completely curtailed. The decisions about competent practice should not be considered on the basis of chronological age, but only on the physician's functional capacity. At all times, the elderly physician must be treated with compassion, respect and dignity. The current loss of cohesiveness between hospitals, health care agencies and their medical staffs may jeopardize the handling of these matters in a sensitive and empathetic manner and the outcomes may be disastrous.

Protocol

Reports of possible impairment and resultant unsafe practice in the older physician are generally reported either to the State Board of Medicine or the Physicians' Health Programs. Reports most often come from nurses, colleagues, and occasionally from friends and family. They are sometimes anonymous.

When such a report is made, the physician must then be approached either by a representative of the PHP or most often by the chairman of the hospital's medical staff health committee. The physician is then offered a comprehensive multidisciplinary assessment at a convenient location and if at all possible at no cost to the physician.

If the physician is unwilling or unable to comply voluntarily, a report to the State Board of Medicine may be necessary to suspend or restrict practice until such assessment can be done. Often, simply having the physician's hospital privileges suspended until he complies may preclude such reporting.

The multidisciplinary assessment should be accomplished at a center where qualified specialists in internal medicine, psychiatry, neurology, neuropsychology and geriatric medicine are available. Standard guidelines for functional capacity and safety should be utilized. One person on the assessment team should coordinate the assessment, collect the data and opinions from the other team members and finally produce a document of findings, conclusions and recommendations. This document must clearly state whether or not with reasonable medical certainty impairment exists and whether or not the physician can return to medical practice.

The assessment results are then presented to the physician with recommendations regarding practice, treatment, rehabilitation or the suggestion for retirement and license inactivation. The results of the assessment should, with the consent of the physician, be forwarded to the medical director of the PHP, the chairman of the hospital physicians' health committee, or both.

If only practice restrictions, treatment and later reassessment are recommended, an effective monitoring agreement must be put in place to assure compliance. This is most effectively accomplished through the PHP. If the physician refuses the assessment, disagrees with the findings, will not comply with treatment or a monitoring agreement, a formal report to the State Board of Medicine will be necessary.

It is imperative that all involved treat the physician with compassion and support. Should the assessment indicate a threat to patient safety, all efforts should be made to encourage voluntary retirement. Activities not involving direct patient care should be sought whenever possible in order for the physician to maintain a sense of worth and dignity.

Board Considerations

The aging physician who is losing his ability to practice safely is often the last one to admit that this is happening. The investigation can often be handled in a non-adversarial way that allows the physician to place his license on inactive status, if he chooses. If this is not agreeable, and the investigation shows reasonable evidence of decreased ability to practice with reasonable skill and safety, then a comprehensive assessment must e obtained. The Board's actions can be tailored to the results of this examination.

XI
Pain Disability

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General Considerations

Pain is a universal, personal, and unique sensory and emotional experience, and is difficult to quantify. Millions of Americans suffer chronic daily pain. While a multitude of conditions may cause pain, often the underlying cause is not easily identifiable. Perhaps the most common causes of chronic pain arise from conditions associated with headache, mechanical spine problems, arthritis and related illnesses, and neuropathies. Moreover, chronic pain is not inevitably proportionate to tissue damage. Often the "signal" becomes "invalid", no longer serving as a useful warning system, but the pain itself is no less valid. Increasing attention to the treatment of chronic pain, and the corresponding liberalization of the prescription of opioids for the treatment of pain, implies that a number of physicians in the United States are actively being treated for pain (some with opioids).

The International Association for the Study of Pain, defines pain as "an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage." Nociception, or the complex series of events that occur between the area of tissue damage and ultimately perception, is by definition, only one part of the experience of pain. Loeser noted that chronic pain is the result the interplay of nociception, perception, suffering and pain behavior. The experience of pain is also modulated via descending pathways, and further influenced by socio-cultural factors, beliefs, emotions and more. Pain is most often considered as acute or chronic. Acute pain can be self-limited as in a bone fracture, or recurrent as with sickle cell crisis. Chronic pain is often described in terms of progressive (malignancy) or non-progressive disease (inflammatory bowel disease).

Over the past few years, it has been widely acknowledged that pain, particularly in its chronic and persistent form, may be a regarded as a disease in and of itself. This paradigm exists in part because of two main factors: 1) The underlying cause is at times not known, or not amenable to treatment and 2) Under treated or untreated pain has consequences in its own right.

Recent surveys suggest that moderate to severe pain interferes with a number of basic quality of life issues that in turn are likely to affect human performance:

- Interference with ability to engage in exercise
- restful sleep
- recreate
- perform daily chores
- socialize
- concentrate
- maintain relationships with family and friends
- Nearly forty percent of people suffering moderate to severe pain also perceive a significant interference with their ability to perform their job.
- Emotional impact also includes listlessness, irritability, depression, a sense of uselessness and inability to cope.

- Direct medical effects include (in addition to higher risks of depression and suicide): exacerbation of hypertension, increased risk of myocardial infarction, increased tumor burden, immune function changes, hormonal imbalances and more.

Physician groups as well as patient advocacy groups acknowledge that pain complaints should be taken seriously, and treatment should be applied early and aggressively. At both State and Federal levels, pain initiatives have been undertaken to improve care of patients suffering pain. The California Medical Association is taking an aggressive stance in training health professionals to treat pain, and optimal pain control in lieu of assisted suicide is being widely advocated. The American Pain Society, The American Academy of Pain Medicine, The American Medical Association, The Federation of State Medical Boards, The American Society of Anesthesiologists, and other organizations too numerous to list are all giving a great amount of attention to improving the treatment of pain in this country.

Physicians as Patients

Given the ever-present nature of pain, it is not unreasonable to assume that a significant number of physicians suffer from chronic pain. In the interest of public safety, it is important to consider the nature and duration of pain, the emotional and cognitive impact, and the effects of the treatment itself. It is paramount that a nonjudgmental environment of care exists for all health care professionals.

This is in the best interest of the patients they serve for any number of reasons:

1) Physician training is costly to society and the removal of the physician from practice may not be in the best interest of the community.

2) A physician not plagued by the impairments of pain and its consequences would be expected to be more vigilant, emotionally stable, capable of exercising good judgment; and functioning in an efficient and compassionate manner.

3) In the sub population of physicians that may be considered for medication management of pain including opioid therapy, an open and caring environment will reduce the likelihood of a maladaptive response with impairment. Careful assessment and monitoring of the effects of pain and its treatment would of course be required.

Two Case Studies

1. *Elaine B., a 33-year-old pediatrician had a family history of alcoholism. Four years ago, she developed severe generalized muscle pain, fatigue, a low-grade fever and elevated sedimentation rate. Following the establishment of the diagnosis of polymyositis rheumatica she was started on cortisone and hydrocodone for the pain. Although cortisone was increased to almost toxic levels, the pain incapacitated this pediatrician until the doses of hydrocodone were significantly elevated. With a history of chemical dependency in her family, her attending physician was reluctant to increase and maintain her hydrocodone. The rheumatologist who was consulting with her family doctor suggested calling in pain specialist who was also certified in addiction medicine. He placed her on oxycontin, which resulted in her becoming symptom-free, effectively functional with no signs of addiction. It was felt that this would not be possible with codeine or hydrocodone based on her self-report of compulsive urges that she experienced with codeine derivatives.*

2. *A 49-year-old orthopedic surgeon with a history of codeine addiction suffered a severe spinal fracture in an automobile accident while he was in college. Two years of post-traumatic back pain relieved by oral codeine resulted in an opioid addiction. He was successfully treated in a four-month program for physicians. He had remained abstinent and in good recovery for the past 27 years. Driving to work two months ago, chauffeured by his wife (a former ER nurse), this physician suffered classical substernal chest pain with radiation to the left jaw. Driving to the University Emergency Room, the physician*

explained that he had an opioid addiction and the ER physician ordered a ridiculously low dose of Demerol 15 mg. because he was afraid of re-addicting the physician patient. The patient's wife protested loudly and the attending physician became annoyed with her and had security escort her from the ER. The physician's wife called the addiction medicine specialist who spoke with the chief resident in the ER and the patient was then given 150mgs of Demerol, due to the patient's high tolerance for opioids. This was an educative experience for the ER physicians concerning the high tolerance level that the opioid addict carries with him for the rest of his life.

Treatment

Pain should be treated early and aggressively, preferably in a multidisciplinary environment. Pain may be amenable to any number of therapies, either alone or in tandem. Cognitive-behavioral strategies, biofeedback and progressive muscle relaxation, physical therapy, structured goal and pace setting exercises, nerve blocks, neuroalblative techniques, neuromodulatory techniques and more advanced surgical or interventional techniques may be effective. In the usual and customary treatment of pain, medications, including antidepressants, anticonvulsants, oral local anesthetics, anti-inflammatories, antispasmodics, antihistaminic agents, stimulants, neuroleptics and opioids are either used as definitive treatment, or as a means to facilitate the other therapies. All reasonable efforts to treat the pain should be brought to bear, allowing for the physician as patient to be afforded the same autonomous decision making process after informed consent and risk benefit analysis.

The presence of opioids, prescribed under the direction of another physician, does not automatically indicate that impairment is present. Perhaps more importantly, abstinence from opioids does not guarantee normal cognitive function or performance. Untreated pain affects performance, as may the underlying illness. In particular, the use of non-opioid medications with the presumption that performance is protected is based upon faulty logic. Certain antidepressants, anticonvulsants, antihistaminic agents and more have the potential to cause more prolonged periods of impairment. Recent evidence suggests that treatment of pain with stable doses of opioids may actually improve cognitive and psychomotor performance.

Information regarding the medical treatment of pain is often incorrectly extrapolated form the chemically dependent population. The behaviors, neurochemistry, and indeed the very response to psychoactive substances are different in patients with a history of, or familial propensity for, chemical dependency. Pain modulates the neurochemical changes that ordinarily occur in the active addict. Physicians with a history of chemical dependency and co-morbid chronic pain must be handled with special care. Multidisciplinary care, behavioral contracts, careful follow-up, and an intact social support group are essential. Lastly, physicians with overt impairment, whether previously chemically dependent or not, should be immediately removed from practice, have medications optimized and stabilized. Subsequently, cognitive testing and assessment of psychomotor function should be undertaken. The use of simulated medical environments is becoming popular for real time assessment of judgment and psychomotor function.

Board Considerations

The Medical Board investigates pain disability most often when impairment due to narcotics abuse is suspected. While the Board recognizes that the use of opioids in a chronic pain situation may be appropriate and the physician may be practicing with reasonable skill and safety, it must be determined if the physician is abusing narcotics or violating applicable laws and rules. Repeated self-prescribing of controlled substances, forging prescriptions or diverting drugs may all indicate abuse, even in the presence of pain disability and require Board intervention to address the addictive or illegal behavior.

XII
Infectious Disease

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General Considerations

Physicians with HIV and other bloodborne infectious diseases including Hepatitis B and C, present complex questions and challenges to medical Boards. Issues that arise related to human immunodeficiency virus (HIV), acquired immune deficiency syndrome (AIDS) and Hepatitis present three concerns:

1. Potential infectious risk to others
2. Potential effects of the illness on the function of the physician (cognition, coordination and ability to comply with risk reduction techniques).
3. Special consideration and the need for referral of a professional with infectious disease who is also impaired by alcohol or other drugs.

In a 1991 report the CDC indicated that infected HCWs (health care workers) who do not perform invasive procedures pose no risk for transmitting HIV or HBV, HCV (Hepatitis B and Hepatitis C) to patients. Prevention of infections has been quite successful and is based on scrupulous adherence to universal precautions and strict infection control mandates.

Infected HCWs who adhere to universal precautions and who perform certain exposure-prone procedures pose a small risk for transmitting HBV to patients. The task of the medical Board is to balance the physician's ability to effectively practice medicine, while limiting potential risk to patients. It is clear that restriction of practice is the most undesirable method of decreasing the transmission of HIV, HBV or HCV.

Physicians with HIV infection or Hepatitis should be under the care of a physician with expertise in infectious disease. Periodic assessments should be performed to ensure that the disease remains asymptomatic or that if symptoms occur, they do not affect the physician's ability to practice effectively. A thorough assessment should be performed and decisions should be made on a case-by-case basis since there are a myriad of variables that will factor into a physician's ability to practice medicine.

Currently there are various protocols to treat HIV disease and Hepatitis. There is some consensus about treatment recommendations, but treatment regimens have not become standardized as to: when to start treatment, which drugs to use and when drug regimens should be adjusted. Prompt assessment and treatment by a physician knowledgeable about HIV or Hepatitis is an essential part of care.

For all physicians, especially those in recovery from drug addiction, HIV and Hepatitis bring up a constellation of psychosocial issues that must be addressed in order to remain professionally effective. Grief and loss, anxiety and depression are some of the issues for HIV/HVB physicians. Family members may also benefit from counseling interventions, as well as significant others that may also be sexual partners of the infected physician.

A physician with active tuberculosis may pose a health risk to patients. This individual should not practice until there is evidence that the individual is not contagious (e.g. negative sputums).

Protocol

The AMA (American Medical Association, 1999) advises that a physician who knows that he or she has an infectious disease, which if contracted by the patient would pose a significant risk to the patient, should not engage in any activity that creates an identified risk of transmission of that disease to the patient. The precautions taken to prevent the transmission of a contagious disease to a patient should be

appropriate to the seriousness of the disease and must be particularly stringent in the case of a disease that is potentially fatal.

The CDC recommends surgical technique modifications and use of devices to prevent percutaneous injury. Surgeons with HIV or Hepatitis B infection (especially if Hbe-Antigen is positive) should pay special attention to high-risk "invasive procedures". HCWs who are infected with HIV or HBV (and are HbeAg positive) should not perform exposure prone procedures unless they have sought counsel form an expert review panel and been advised under what circumstances, if any, they may continue to perform these procedures.

- Digital palpation of a needle tip in a body cavity
- The simultaneous presence of a health care worker's fingers and a needle or other sharp instrument or object (e.g. bone spicule) in a poorly visualized or highly confined anatomic site.

Invasive procedure is defined by CDC as "surgical entry into tissues, cavities, or organs or repair of major traumatic injuries" associated with any of the following:

- An operating or delivery room, emergency room or outpatient setting including both physicians and dentists offices
- Cardiac catheterization and angiographic procedures
- A vaginal or cesarean delivery or other invasive obstetric procedure during which bleeding may occur
- The manipulation, cutting or removal or any oral or perioral tissues, including tooth structure, during which bleeding occurs or the potential for bleeding exists. (MMWR 1987:36(suppl no.2S): 6S-7S.

The CDC (1991) reported that there was no data to provide rationale for recommendations to restrict the practice of HCWs infected with HIV/HBV/HCV who perform " invasive procedures" **not** identified as exposure prone, provided the infected HCWs practice recommended surgical/dental technique and comply with universal precautions and current recommendations for sterilization/disinfections.

HCWs who perform exposure prone procedures should know their HIV antibody status and those who perform exposure prone procedures and who do not have serologic evidence of immunity to HBV from vaccination or from previous infection should know their HbsAg status and, if that is positive, should also know their HbeAg status.

The CDC Guidelines and AMA Guidelines advise that any HIV-infected physician should disclose his/her serostatus to a state public health official or local review committee. Ideally, the committee would include the patient's physician, an infectious disease specialist not involved in the care of the patient, an epidemiologist, and others as appropriate. Committee members should be unbiased and at least some of the members should be familiar with the performance of the infected physician. The question of whether HCWs infected with HIV, especially those who perform invasive procedures, can adequately and safely be allowed to perform patient-care duties or whether their work assignments should be changed must be determined on an individual basis.

This review committee may recommend to the appropriate authority restrictions on the physician's practice, if they believe there is significant risk to patients' welfare. The review committee is also responsible for monitoring adherence to universal precautions and must also monitor the physician's clinical competency; Those who do not abide by recommended restrictions should be reported

to the appropriate authorities, such as the state licensure Board. (AMA House of Delegates Policies, 1999).

Board Considerations

The Federation of State Medical Boards (1996) has adopted a policy statement which directs that the medical practice act and other appropriate statutes/rules of the state medical board include provisions dealing with preventing the transmission of HIV, Hepatitis B and Hepatitis C. The FSMB recommendations include:

I. Persons under the jurisdiction of the Board should comply with CDC guidelines for preventing the transmission of HIV and Hepatitis (B and C) to patients.

II. State Medical Boards should have the following powers and responsibilities

- To encourage physicians and other health providers to know their HIV, HBV and HCV status
- To require reporting to the state medical board and/or the state public health department of HIV/HBV/HCV infected practitioners.
- To ensure confidentiality of those reports received
- To establish practice guidelines for HIV, HBV and HCV infected practitioners
- To monitor or assist the state public health department to monitor the practices and health of HIV/HBV and HCV infected practitioners.

The state medical board should be authorized to discipline all persons under its jurisdiction who violate the statute(s) or rules establishing or otherwise implementing requirements related to preventing transmission of HIV, HBV, HCV to patients.

In Georgia, failure to adhere to the Center for Disease Control guidelines published in the MMWR 1991 (40(RR08) is considered unprofessional conduct.

XIII
Resources for Assessment of Competency

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General Considerations

For various reasons a physician may not practice clinical medicine for an extended period of time. This may be due to personal choice or as a result of Medical Board actions, such as license suspension. It may be prudent at times for the Medical Board to assess a physician's general knowledge base. The Special Purpose Examination (SPEX) is a suitable assessment for physicians for whom there is no indication of problems with their clinical performance. Questions used in SPEX focus on a core of clinical knowledge and relevant underlying basic science principles deemed necessary to form a reasonable foundation for the safe and effective practice of medicine. Content of SPEX is intended to reflect the knowledge and cognitive abilities of physicians who are five years or more beyond medical school graduation. SPEX is constructed around two primary dimensions reflecting experience in medical practice: clinical encounter categories and physician tasks.

There are other times when more serious knowledge deficits are possible. It is not uncommon for physicians who are of questionable competence to be brought to the attention of the Medical Board. As noted by Gregory Skipper, M.D. in section VI, there may be questions ranging from relatively mild to circumscribed problems to unacceptable standards in all spheres of clinical practice. Peer reviews have become more standard in the medical community, and consequently, more marginal physicians have come to the attention of various agencies. It is incumbent upon the Medical Board to ascertain in a fair and impartial manner, the relative competency of those questionable physicians.

It is important to first rule out obvious causes of impairment such as described in previous sections. For the physician who is not impaired by psychiatric or substance use/abuse disorders, specialized assessment for competency is indicated. A thorough evaluation should include the following:

1. An external assessment of a physician's skill in a variety of practices settings.
2. An objective evaluation of the physician's strengths and weaknesses by experts in the physician's field.
3. Constructive alternatives to sanctions by hospitals or other organizations.
4. Assistance in redirecting of patterns and scope of practice.
5. An atmosphere of professional collaboration and encouragement to address specific areas of educational need to promote correction of deficiencies.
6. Delineation of specific areas outside the physician's ability or expertise.

Unfortunately, there are few resources available in the USA that adequately assess physician competence. Of the programs that were contacted by this author, one program stood out as a leader in this type of evaluations of physicians. The "Colorado Personalized Education for Physicians" (CPEP) has been conducting physician assessments under a contract with the Nation Board of Medical Examiners.

There are a number of programs offering assessments around the country. Some of them include: East Carolina School of Medicine in Greenville, North Carolina; Colorado Personalized Education for Physicians in Aurora, Colorado; Oregon Medical Association Individualized Physician Renewal Program in Portland, Oregon; State University of New York in Syracuse, New York and University of Wisconsin Medical School in Madison, Wisconsin.

Protocol

Key elements of the assessment include:

1. Physician Practice Profile: This provides a general overview of the physician's patient population and scope of practice. Hospital privileges office staffing, office procedures and policies are reviewed. Additionally, the physician provides a record of his/her education, CMEs, licensure, and malpractice cases.
2. Intake Interview: The CPEP Medical Education Director (MED) completes an in-depth interview that reviews the physician's practice profile and reasons for the evaluation.
3. Multiple Choice Questions: The physician completes an objective test in his/her field to assess general knowledge.
4. Chart Simulated Recall: The physician sends at least 15 complete charts from their practice to CPEP. At least two physician assessors will review the charts. This provides an opportunity for evaluation of clinical thought processes, differential diagnoses, dept of clinical knowledge, and charting practices as well as communication skills.
5. Simulated Patients: The physician is videotaped interviewing three "simulated patients". The CPEP communication consultant and the physician view the taped sessions focusing on interpersonal skills, communication style, and interviewing technique.
6. Myers-Briggs Type Indicator: This test provides a basic understanding of the participant's personality style. It gives information about the physician's view of himself/herself and others, as well as the physician's relative strengths and weaknesses in interacting with patients and peers.
7. Assessment of Cognitive Functioning: Psychological testing is performed to assess cognitive functioning, which includes recent memory, attention, response time, and abstract logic. The test was developed by the Harvard Risk Management Foundation and is used as a screen to determine if further neuropsychological testing is indicated.
8. Physical Exam: The participant is asked to provide a recent general physical exam or an exam is performed during the course of the evaluation.

At the discretion of the evaluation team, other testing activities can be performed:

1. Computer-based Clinical Simulations: This exam is designed to assess the physician's patient management and diagnostic skills. For example, the general practitioner's exam consists of ten cases that reflect acute and chronic problems at varying degrees of urgency in ambulatory and hospital settings. The simulations are used to stimulate an in-depth clinical discussion of the participant's medical knowledge and decision-making processes.
2. Electrocardiogram Interpretation: This is a written exam in which the participant is asked to describe the abnormal findings and give an interpretation of each.
3. Fetal Monitoring Strip Interpretation: The physician is asked to interpret ten fetal monitoring strips and provide treatment plans for each.
4. Psychiatric Screening Interview: A psychiatric and/or substance abuse screen may be included at the request of the evaluation team for physicians suspected of having psychiatric or substance abuse problems that could interfere with successful completion of the exam or with patient care. Physicians who may be experiencing such difficulties may be referred to their State Medical Societies' Physician Help Program. Check on this

Formulation of an Education Plan

A personalized education program may be designed following the Assessment through phone contacts and written correspondence. Education Plans are completed while the physician continues to maintain his normal clinical practice activities. Every effort is made to use educational resources within the home state of the participant.

The Education Plan for each physician varies in length of time, as well as breadth of activities. The plan includes educational objectives (the specific goals to be obtained), performance objectives (the activities to be undertaken) and evaluation methods.

Examples of activities that may be included in an Education Plan are:

1. Preceptor –Mentor Activities: Preceptor activities provide a basis for the participant to work directly with a peer to improve clinical performance, documentation, office practices, and interpersonal skills. The participant may spend from two hours to several days per week in the preceptor's office.

The preceptor reports to CPEP and the participant is responsible for maintaining a weekly log of preceptor activities. Preceptor activities are evaluated every three months to assess progress and revise educational objectives if necessary. The participant and preceptor may also discuss cases via phone, e-mail, or FAX as the need arises.

2. Mini-Residencies: Mini-residencies provide concentrated, hands-on educational experiences in a hospital or clinic setting. The participant is assigned to a supervisor in a hospital or residency program who provides input into the training activities and educational objectives.

3. Professional Reading: The participant may be assigned to regularly read specific journals or tests to update the physician in specified areas of practice.

4. Home Study and Self-Assessment Courses: These courses provide structured self-testing and home study activities that can be completed over a period of several months at the physician's own pace.

5. Videotapes: With the wide range of videotapes available in clinical and interpersonal skills, the participant may be assigned videotapes for at home viewing and study.

6. Specialty Field updates and Clinical Courses: Many medical school and specialty societies offer annual weeklong updates or clinical reviews of specific topics. CPEP may recommend the physician enroll in such a course and submit a summary evaluation of the sessions.

7. Communication Activities: Educational objectives relating to communication or interpersonal skills may be addressed through a variety of resources, including communication workshops, communication skills coaching, or accent modification training.

Monitoring
The CPEP Medical Education Director (MED) will maintain monthly contact with the physician to help ensure successful completion of the educational objectives, revise or update the Education Plan as necessary, and provide assistance with any problems that may impact completion of the plan. If requested by the participant, the MED will also submit quarterly reports of the participant's progress to appropriate organizations.

Follow-up Evaluations
At the completion of the Education Plan, the MED will evaluate the physician's progress according to the objectives and methods defined in the Education Plan. The MED may also recommend that the participant return to CPEP for a one-day interim or final evaluation in order to determine whether the participant has been able to integrate what he/she has learned into daily practice.

Based on the outcome of the evaluation, the participant may either be found to have completed all educational objectives satisfactorily or assigned additional activities in subsequent segments. Results of the evaluation, as well as a description of the entire process, are incorporated into a final report that is provided to the physician and to appropriate organizations identified by the participant.

Board Considerations
The need for competency assessment has been increasingly recognized as the practice of medicine has become more complex and the demands of the public to protect it from dyscompetent physicians have grown. Developing programs to assess competence have been hindered by the difficulty in marshalling resources to conduct such in depth exams and the significant expense-both to the program and to the physician being evaluated. Currently, physicians who have not practiced clinical medicine in 2 or more years and who wish to have a medical license granted, or a suspension lifted, may be required to satisfactorily complete a SPEX examination or an in-depth competency evaluation such as PLAS. A physician with an unrestricted medical license is entitled to due process before the Board can require competency assessments. The resources available in the U.S. that can assist Medical Boards in such evaluations are listed in the Appendix.

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Appendices

A. Sixteen Points : Assessing Progress in Recovery

G. Douglas Talbott, M.D., F.A.S.A.M.
Talbott Recovery Campus, Atlanta, Georgia

1. Meetings
2. Sponsor
3. Monitoring
4. Emotional Traps (anger, guilt, depression, anxiety, insomnia, etc.)
5. Additions/subtractions to addiction history (secrets)
6. Compulsive behavior (sex, food, nicotine, gambling, theft, spending)
7. Current therapy/treatment/medications (prescribed, OTC)
8. Relationships (family, spouse, MSO, parents, children, friends)
9. Physical health-exercise program
10. Leisure time-fun
11. Work (professional status, duties, attitudes)
12. Financial status
13. Legal-licensure status
14. Additional training and/or continuing medical education
15. Spiritual program
16. "Soft" part of your recovery program

B. Sample Relapse Contract

I. I, _____, agree to perform the following within 24 hours should I use any alcohol or other mood altering drugs:

- Contact my sponsor
- Attend an AA/NA meeting and pick up a white chip when applicable
- Contact my monitoring professional in my area to inform him/her of my relapse
- Contact the Continuing Care Associate at my treatment center to inform him/her of my relapse.

II. I, _____ , a member of the family or significant other, agree to encourage the patient to contact the monitoring professional to inform him/her of the relapse. I agree to contact my sponsor and home Al-Anon group for additional suggestions. I agree to contact the monitoring professional and Continuing Care associate at the treatment center as outlined above, if the patient is unwilling to do so.

III. I, _____, will complete and return this contract to my treatment provider within 30 days of my discharge.

_____ _____

Patient Signature Date

_____ _____

Family member/S.O. Signature Date

_____ _____

Monitoring Professional Signature Date

_____ _____

Continuing Care Associate Signature Date

C. Sample Continuing Care Contract

DISCHARGE DATE: _____

NAME: _____

HOME ADDRESS: _____

_____

TELEPHONE: (H): _____ (W): _____

The following continuing care plan is a set of recommendations that have been developed by the clinical treatment team at Talbott Recovery Campus. It utilizes the expertise gained from years of treating chemically dependent individuals. Our experience is that patients who follow these guidelines significantly enhance their recovery. Where appropriate, impaired networks, boards, employers, families and referral sources have provided input regarding the recommendations presented in this plan. It is not meant to be a binding legal agreement, but a recommended recovery plan. We recommend the adherence to this plan for a period of 5 years.

I agree to abstain completely from taking any mood-changing chemical except when cleared by my primary physician and monitoring physician (and when appropriate, in consultation with an Addictionologist). I also agree to have my primary physician and monitor clear any and all medications (prescribed, over the counter, or herbal/ nutritional/health food store). I agree not to self prescribe. Listed below are any and all current medications prescribed/cleared by my TRC attending physician:

_____
_____
_____
_____

I will ask my primary care physician and/or monitor to assist me with care or follow-up of the medical conditions listed below.

_____
_____
_____

I agree to follow the terms of the family and the continuing care relapse plans.

If I change address, I agree to notify the Continuing Care Director at least two weeks before such a move in order to develop a new support network.

I agree to complete, submit for review to my monitoring professional, and mail the Talbott Recovery Campus Continuing Care Quarterly Monitoring Reports every 3 months for 5 years.

Listed below are any and all current legal/licensure issues: _____

_____
_____
_____

Relapse prevention suggestions for return to work include: _____

_____

_____

I will be returning to work at the following location:

Company: _____

Address: _____

Phone: _____

My return to work date is: _____

It is suggested that I work no more than 40 hours per week, unless agreed on and cleared by my monitor.

Until I return to work, I will be following a schedule that will include the following:

_____

_____

_____

The following is my primary physician. I agree to execute a continuing care release to my primary physician including full address prior to my discharge.

Name: _____

Address: _____

Phone: _____

I will utilize the following as my monitor/monitors. I agree to execute a continuing care release to each member of my monitoring team (including full address) prior to my discharge.

Monitor Name: _____ Phone: _____

Address: _____

_____

Other Name: _____ Phone: _____

Address: _____

_____

I agree to contact my monitor/monitors the Monday following discharge and then as directed.

I agree to random/observed urine/blood monitoring drug screens to be set up by my monitor and agree to pay for these urine/blood drug screens.

Plan:

Frequency: _____

Drop Site: _____

I have asked the following person to be my sponsor. I agree to utilize my sponsor to continue to work a daily recovery program.

Name: _____ Phone: _____

Address: _____

_____

I agree to the following living recommendations:

_____

_____

I understand that the recommendation is that I attend daily meetings for 90 days and then 4-7 meetings per week for the duration of this continuing care plan. I understand that my aftercare/monitoring groups can count in that total if my monitor approves. I have obtained a home group and will develop a regular plan for meeting attendance.

Home Group: _____

Meeting Schedule:

Monday: _____

Tuesday: _____

Wednesday: _____

Thursday: _____

Friday: _____

Saturday: _____

Sunday: _____

The day, time and location of my Health Professionals group is:

Day: _____

Time: _____

Location: _____

The day, time and location of my continuing care group is:

Day: _____

Time: _____

Location: _____

I agree to participate in recommended therapy as indicated below. I also agree to complete a continuing care release, including full address, for all therapeutic parties listed below:

Family Therapist: _____ Phone: _____

Address: _____

Individual Therapist: _____ Phone: _____

Address: _____

_____

Medication Management: _____ Phone: _____

Address: _____

_____

Recommendations for return visits include:

3 Month Return Visit: _____ 6 Month Return Visit: _____

Annually for 5 years thereafter. If I am unable to attend a scheduled return visit, I will contact the Continuing Care Director in writing with reason for absence.

In addition to this plan, I will be under contract with the following:

_____

_____

_____

I have identified the following barriers to maintaining a drug free life-style:

_____

_____

_____

In addressing the preceding barriers, I would like to commit to the following recovery activities:

Spiritual: _____

Leisure/Social: _____

_____

c. Physical Health: _____

_____

d. Other: _____

_____

I will comply with the treatment center Business Office agreement.

The above continuing care plan has been explained to my satisfaction, and I understand its contents.

_____

Patient Name (Printed)

_____ _____

Patient Signature Date

_____ _____

Continuing Care Director Signature Date

D. Sample Quarterly Monitoring Agreement

Name _____**Occupation/Profession**_____ **Specialty** _____

Street _____ **City**_____ **State** _____ **Zip** _____

Home Phone _____ **Daytime/Office phone** _____

Today's Date _____ **Discharge Date** _____ **Sobriety Date** _____

Part I. Status Changes (Please circle YES or NO and write where needed.)

1. Has your sobriety date changed since your last treatment at TRC?.....YES NO

   a. If YES, did you seek help?.....YES NO

   b. If YES, are you back in recovery? .....YES NO

      Your new sobriety date, if applicable _____

2. Your marital status is (circle) Single Married Divorced Separated Widowed

   a. Changed since discharge?.....YES NO

   b. Have you ever been divorced?.....YES NO

3. Are you smoking now?.....YES NO

4. Is your life out of balance in any of these areas?.....YES NO

   a. If YES, (circle) Sex Food Gambling Spending Work Other _____

5. Are you taking any prescribed medications? .....YES NO

   a. IF YES, please list _____

6. Any trouble with your licensure status now? .....YES NO

   a. If YES, please explain _____

7. Any legal status troubles now (i.e., traffic, civil actions)?.....YES NO

   a. If YES, please explain _____

8. Any employment status or job location change? .....YES NO

   a. If YES, please explain _____

Part II. Recovery Activities

Please indicate how many **TIMES PER MONTH** you engage in the following activities. If the item does not apply, write "N/A" in the appropriate bracket. Please do not leave any blank spaces.

____ 9. Attend 12 Step Group meetings

____ 10. Contact 12 Step sponsor

____ 11. Done 12 Step service work

____ 12. Attend professional group meeting

____ 13. Contact professional monitor

____ 14. Attend Continuing Care Group meeting

____ 15. Individual therapy or counseling sessions

____ 16. Exercise for 30-60 minute sessions

____ 17. Take time for regular meditation/reflection

____ 18. Contact your primary physician

____ 19. Attend therapy/counseling sessions with family/spouse/other persons

____ 20. Spend an hour or more in recreational or social activities

____ 21. Attend continuing medical education or other training

OTHER ACTIVITIES (note frequency change)

____ 22. How many hours working **PER WEEK**

____ 23. How many random urine/blood monitoring, drug screenings **THIS QUARTER**.

E. CDC Recommendations for Preventing Transmission of Human Immunodeficiency Virus and Hepatitis B Virus to Patients During Exposure Prone Invasive Procedures

(MMWR 40(RR08); 1-9, 7/12/1991

The recommendations outlined in this document are based on the following considerations:

Infected HCWs who adhere to universal precautions and who do not perform Invasive procedures pose no risk for transmitting HIV or HBV to patients.
Infected HCWs who adhere to universal precautions and who perform certain exposure-prone procedures (see page 4) pose a small risk for transmitting HBV to patients.
HIV is transmitted much less readily than HBV.

In the interim, until further data are available, additional precautions are prudent to prevent HIV and HBV transmission during procedures that have been linked to HCW-to-patient HBV transmission or that are considered exposure-prone.

RECOMMENDATIONS

Investigations of HIV and HBV transmission from HCWs to patients indicate that, when HCWs adhere to recommended infection-control procedures, the risk of transmitting HBV from an infected HCW to a patient is small, and the risk of transmitting HIV is likely to be even smaller. However, the likelihood of exposure of the patient to an HCW's blood is greater for certain procedures designated as exposure-prone. To minimize the risk of HIV or HBV transmission, the following measures are recommended:

1. All HCWs should adhere to universal precautions, including the appropriate use of hand washing, protective barriers, and care in the use and disposal of needles and other sharp instruments.

2. HCWs who have exudative lesions or weeping dermatitis should refrain from all direct patient care and from handling patient-care equipment and devices used in performing invasive procedures until the condition resolves.

3. HCWs should also comply with current guidelines for disinfection and sterilization of reusable devices used in invasive procedures.

Currently available data provide no basis for recommendations to restrict the practice of HCWs infected with HIV or HBV who perform invasive procedures not identified as exposure-prone, provided the infected HCWs practice recommended surgical or dental technique and comply with universal precautions and current recommendations for sterilization/disinfection.

Exposure-prone procedures should be identified by medical/surgical/dental organizations and institutions at which the procedures are performed. HCWs who perform exposure-prone procedures should know their HIV antibody status. HCWs who perform exposure-prone procedures and who do not have serologic evidence of immunity to HBV from vaccination or from previous infection should know their HBsAg status and, if that is positive, should also know their HBeAg status.

HCWs who are infected with HIV or HBV (and are HBeAg positive) should not perform exposure-prone procedures unless they have sought counsel from an expert review panel and been advised under what circumstances, if any, they may continue to perform these procedures.* Such circumstances would include notifying prospective patients of the HCW's seropositivity before they undergo exposure-prone invasive procedures. Mandatory testing of HCWs for HIV antibody, HBsAg, or HBeAg is not recommended. The current assessment of the risk that infected HCWs will transmit HIV or HBV to patients during exposure-prone procedures does not support the diversion of resources that would be

required to implement mandatory testing programs. Compliance by HCWs with recommendations can be increased through education, training, and appropriate confidentiality safeguards.

*The review panel should include experts who represent a balanced perspective. Such experts might include all of the following:
a) the HCW's personal physician(s),
b) an infectious disease specialist with expertise in the epidemiology of HIV and HBV transmission,
c) a health professional with expertise in the procedures performed by the HCW, and
d) state or local public health official(s).

If the HCW's practice is institutionally based, the expert review panel might also include a member of the infection-control committee, preferably a hospital epidemiologist. HCWs who perform exposure-prone procedures outside the hospital/institutional setting should seek advice from appropriate state and local public health officials regarding the review process. Panels must recognize the importance of confidentiality and the privacy rights of infected HCWs.

HCWS WHOSE PRACTICES ARE MODIFIED BECAUSE OF HIV OR HBV STATUS
HCWs whose practices are modified because of their HIV or HBV infection status should, whenever possible, be provided opportunities to continue appropriate patient-care activities. Career counseling and job retraining should be encouraged to promote the continued use of the HCW's talents, knowledge, and skills. HCWs whose practices are modified because of HBV infection should be re-evaluated periodically to determine whether their HBeAg status changes due to resolution of infection or as a result of treatment.

NOTIFICATION OF PATIENTS AND FOLLOW-UP STUDIES
The public health benefit of notification of patients who have had exposure-prone procedures performed by HCWs infected with HIV or positive for HBeAg should be considered on a case-by-case basis, taking into consideration an assessment of specific risks, confidentiality issues, and available resources. Carefully designed and implemented follow-up studies are necessary to determine more precisely the risk of transmission during such procedures. Decisions regarding notification and follow-up studies should be made in consultation with state and local public health officials.

Definition of Invasive Procedure
An invasive procedure is defined as ``surgical entry into tissues, cavities, or organs or repair of major traumatic injuries'' associated with any of the following:

1) an operating or delivery room, emergency department, or outpatient setting, including both physicians' and dentists' offices
2) cardiac catheterization and angiographic procedures
3) a vaginal or cesarean delivery or other invasive obstetric procedure during which bleeding may occur
4) the manipulation, cutting, or removal of any oral or perioral tissues, including tooth structure, during which bleeding occurs or the potential for bleeding exists.''

Reprinted from: Centers for Disease Control. Recommendation for prevention of HIV transmission in health-care settings. MMWR 1987;36 (suppl. no. 2S):6S-7S.

http://aepo-xdv-www.epo.cdc.gov/wonder/prevguid/p0000286/p0000286.htm

F. Federation of State Medical Boards of the U.S.
"Prevention of HIV/HBV/HVC Transmission to Patients"

The Federation has adopted as policy the following position statement related to the prevention of HIV/HBV/HVC transmission:
The medical practice act, other appropriate statutes and/or the rules of the state medical board should include provisions dealing with preventing the transmission of human immunodeficiency virus (HIV), hepatitis B (HBV), and hepatitis C (HVC) to patients. These statutes or rules should implement or be consistent with the following Federation recommendations:

A. Persons under the jurisdiction of the Board should comply with the guidelines established by the Centers for Disease Control (CDC) for preventing transmission the human immunodeficiency virus (HIV), hepatitis B virus (HBV) and hepatitis C virus (HVC) to patients.
B. The state medical boards should have the following powers and responsibilities:
    1. to encourage physicians and other health care providers to know their HIV, HBV and HVC status;
    2. to require reporting to the state medical board and/or the state public health department of HIV, HBV and HVC infected practitioners;
    3. to ensure confidentiality of those reports received by the state medical board and/or state health department under number 2 above;
    4. to establish practice guidelines for HIV, HBV and HVC infected practitioners
    5. to monitor or to assist the state publish health department to monitor the practices and health of HIV, HBV and HVC infected practitioners.

C. The state medical board should be authorized to discipline all persons under its jurisdiction who violate the statute(s) or rule(s) establishing or otherwise implementing requirements related to preventing the transmission of HIV, HBV, and/or HVC to patients.

April 1992
Revised 1996

G. AMA Policy Statement on Infected Physicians
AMA Code of Ethics, 9.131 (updated 1996)

Source: AMA Ethical Opinions on HIV/AIDS Issues

Physicians and Infectious Disease
A physician who knows that he or she has an infectious disease, which if contracted by the patient would pose a significant risk to the patient, should not engage in any activity that creates an identified risk of transmission of that disease to the patient. The precautions taken to prevent the transmission of a contagious disease to a patient should be appropriate to the seriousness of the disease and must be particularly stringent in the case of a disease that is potentially fatal.

HIV-Infected Patients and Physicians
A physician may not ethically refuse to treat a patient who se condition is within the physicians current realm of competence solely because the patient is seropositive for HIV. Persons who are seropositive should not be subjected to discrimination based on fear or prejudice.
When physicians are unable tot provide the services required by an HIV-infected patient, they should make appropriate referrals to those physicians or facilities equipped to provide such services.

A physician who knows that he or she is seropositive should not engage in any activity that created an identified risk of transmission of the disease to others. A physician who has HIV disease or who is seropositive should consult with colleagues as to which activities the physician can pursue without creating a risk to patients. (March 1992, updated June 1996).

www.ama-assn.org/special/hiv/policy/amapol.htm

H. Federation of State Medical Boards of the U.S. Model Program

The Federation of State Medical Boards of the US, Inc., accepted this Report of the Ad Hoc Committee on Physician Impairment as policy in April 1995. The Model Program is an excerpt of this policy.

The purpose of an IPP is to evaluate licensees with possible impairment and recommend appropriate management. The IPP should also monitor the progress of licensees in after-care programs, whether the referral is voluntary or board-mandated. In addition, programs should make periodic reports to appropriate individuals, committees, or organizations; develop intervention programs, intervenors' training programs, research programs; and serve as a resource for inquiries of physicians and the public. An IPP should have the following elements:

1. Administration: Ability to adequately and appropriately manage and administer the program. Staff should include:
   Physician Medical Director: A medical director with appropriate background in chemical dependency and general understanding of mental illness. The IPP should provide for funding of a full-time physician medical director. The committee believes that a full-time physician medical director is better equipped with the clinical knowledge necessary to effectively evaluate the investigative information surrounding the impaired physician, both those who voluntarily refer and those who are board-mandated. The committee recognizes that smaller state medical boards may not have the available resources necessary to employ a full-time physician medical director. Therefore, the committee recommends that smaller state medical boards might wish to establish consortiums so that the employment of a full-time director may be feasible.

   Executive Director: An individual with the responsibility to oversee the administrative and operational aspects of the program. Some programs may wish to combine the functions of the physician medical director with the executive director.

   Support Staff: The program should include adequate clerical and other staff to support the physician medical director and executive director.

2. Investigation: Authority to investigate a report of possible impairment. The purpose of the investigation is to determine if the report can be substantiated and if intervention is warranted. Investigations should be conducted by professionals with training in the area being investigated.

3. Intervention: Authority to intervene if the investigation indicates a reasonable probability that the physician is impaired. The individuals conducting the intervention should be appropriately trained for the specific type of intervention, particularly in the areas of chemical dependency and mental illness.

4. Evaluation/Assessment: Authority to coordinate an evaluation to determine the nature and extent of the impairment. The committee recommends that, whenever possible, the evaluation of the physician be conducted by an independent evaluator to avoid the appearance of conflict of interest. Therefore, the program should have a number of resources that have been reviewed and found to be acceptable for referrals. The program should use the criteria set forth in Section VII to determine if a physician should be referred for an evaluation. In addition, the program should meet the criteria set forth in Section VIII, particularly in selecting an evaluator and obtaining evaluations.

5. Treatment: Ability to analyze information received from the evaluator and make recommendations for treatment, if necessary. The program should meet the criteria set forth in Section IX, particularly to determine if a facility or practitioner is acceptable for referrals.

6. Discharge/Follow-Up Care: Ability to develop and implement a discharge or monitoring plan that is designed to ensure that the impairment does not adversely effect the ability to practice with reasonable skill and safety and that the physician remains in recovery or is otherwise able to cope with his impairment. The program should also have the authority to ensure compliance with follow-up care and should meet the criteria set forth in Treatment Programs.

7. Relapse Management: Methods should be designed for the early recognition of relapse and should have the ability to respond timely and effectively. This response will include a report to the board, in most circumstances. For chemical dependency, the program should meet the criteria set forth in Treatment Programs.

8. Confidentiality: The committee recognizes the need for confidentiality of program participation; however, it recommends to state medical boards the need for a non-board member, preferably an agency staff member, to be notified by the IPP medical director of a physician's participation, voluntary or not. Also, the committee affirms that the IPP medical director should, if warranted by a participant's noncompliance, communicate with the state medical board regarding this same physician. The committee recognizes that a method of confidentially protecting a program participant needs to be developed by the state medical board. The committee has determined that aggregate program data is considered public information and may be disclosed to all medical board members, but only a designated agency staff person should be apprised of the actual identity of the program participant. The committee has identified and recommends stating medical boards the utilization of the following criteria in determining state medical board approval of an IPP. It is recommended that a formal contract be executed, setting forth the relationship between the two bodies, and that such contract be based on mutual trust.
    a. Mutual interaction between the state medical board and the IPP. There must be a Commitment between both parties in regard to open lines of communication.
    b. The IPP must be aware of and understand the issues involved, relative to the licensure and disciplinary responsibilities of the board in its mission to protect the public.
    c. The IPP does not deny services based on a physician's specialty, medical degree, or membership affiliations.
    d. The IPP accepts all indigent physician patients and is available for all referrals by state medical boards.
    e. The IPP must provide arrangements for emergency evaluations.
    f. The IPP must have an aftercare contract consistent with physician rehabilitation and patient safety.

Tracks for Referral to IPP

The ad hoc committee identified two pathways, or tracks, by which impaired physicians are referred to an IPP. Track "A" physicians are those who voluntarily enter the IPP without the state medical board's mandate and who do not expose patients to the possibility of patient harm. These physicians are usually considered self-referred, even though, most often, they are confronted by peers with the warning that disciplinary action may be taken if compliance is not forthcoming. Other violations of the medical practice act will be dealt with separately by the board. Track "B" physicians are mandated by the state medical board to participate in an IPP.

Criteria for Referral

While all programs should have mechanisms that allow a physician to self-refer, it is recognized that most physicians will enter the IPP voluntarily or by board mandate. While it is appropriate for physicians to refer themselves to the program, there should be an evaluation of all suspected physicians and the following criteria should be used as the basis for referral. The committee recommends that when intervention or investigation uncovers one or more of the following criteria, a physician should be referred for evaluation/assessment.

There is information or documentation of excessive or habitual alcohol or other drug consumption.

There are sufficient indications of current alcohol or other drug use that may include positive body fluid analysis for mood-altering chemicals.
The physician's behavioral, affective, and/or thought disorder manifestations represent a threat to public safety.
Information or documentation of mental illness that is not being treated or that impairs the ability to practice.

Evaluation/Assessment Program Criteria

- Chemical Impairment

The committee recommends that an approved IPP employ the following criteria in selecting providers to whom referrals will be made for evaluations/assessments of physicians:
Providers performing evaluations/assessments should have demonstrable expertise in the recognition of the unique characteristics of health professionals involved in the disease of chemical dependency. To avoid the appearance of conflict of interest, a member of the health professional/impaired physician committee should have no vested interest in the provider offering the evaluation/assessment.
Admission for evaluation of chemical dependency should be contingent upon agreement of the patient to release to the health professional/IPP any records pertaining to the identity, diagnosis, prognosis, or treatment of such patient that are maintained in connection with the performance of any program or activity relating to substance abuse education, prevention, training, treatment, rehabilitation, or research.
When assessment for chemical dependency requires residential or hospital inpatient care, it should be for an appropriate period of time to observe for withdrawal and to complete the evaluation, generally a minimum of three days.
The individual should undergo a complete medical evaluation, including appropriate laboratory and physical examinations. Laboratory examinations should include appropriate urine and blood drug screens and should be conducted by a physician with demonstrable knowledge of chemical dependency.
The psychiatric history and mental status examination should be performed by a psychiatrist knowledgeable in addictive disease.
A comprehensive psychological assessment should include neuropsychological testing performed by a qualified clinical psychologist. Testing shall give an indication of personality structure, including, but not limited to, assessment of memory and cognitive understanding. The assessment instrument(s) used should be specified in the psychologist's report.
Upon completion of the evaluation, release of all evaluation results will be made to the IPP.
All physicians who refuse recommended treatment will be subject to state medical board notification by the IPP medical director.

- Mental Impairment

The committee recommends that IPPs approved by a state medical board employ the following criteria in selecting providers to perform evaluations/assessments of physicians referred by the IPP.
The providers performing evaluations/assessments should have demonstrable expertise in the recognition of the unique characteristics of health professionals involved in the disease of mental illness. To avoid the appearance of conflict of interest, a member of the health professional/impaired physician committee should have no vested interest in the provider offering the evaluation/assessment.
Evaluation of mental illness should be contingent upon agreement of the patient to release to the health professional/IPP any records pertaining to the identity, diagnosis, prognosis, or treatment of such patient that are maintained in connection with the performance of any program or activity relating to mental illness education, prevention, training, treatment, rehabilitation, or research.
When assessment for mental illness requires residential or hospital inpatient care, it should be for an appropriate period of time.
The individual should undergo a complete medical evaluation, including appropriate laboratory and physical examinations. Laboratory examinations should include appropriate urine and blood drug screens.
The psychiatric history and mental status examination should be performed by a knowledgeable psychiatrist.
A comprehensive psychological assessment may include neuropsychological testing performed by a qualified clinical psychologist. Testing shall give an indication of personality structure, including, but not

limited to, assessment of memory and cognitive understanding. The assessment instrument(s) used should be specified in the psychologist's report.
Upon completion of the evaluation, release of all evaluation results will be made to the IPP.
All physicians who refuse recommended treatment will be subject to state medical board notification by the IPP medical director.

Treatment Program Criteria

- Chemical Impairment

The provider of treatment should have demonstrable expertise in the recognition of the unique characteristics of health professionals involved in the disease of chemical dependency and have the ability to offer an inpatient treatment program of at least thirty (30) days. To avoid the appearance of a conflict of interest, a member of the health professional/impaired physician committee should have no vested interest in the provider offering treatment.
Admission for treatment of chemical dependency should be contingent upon agreement of the patient to release to the health professional/IPP any records pertaining to the investigation, identity, diagnosis, prognosis, or treatment of such patient that are maintained in connection with the performance of any program or activity relating to substance abuse education, prevention, training, treatment, rehabilitation, or research.
Providers conducting the treatment must agree to release the results of the treatment to the IPP.
Physicians undergoing treatment should agree to adhere to the recommendations of the treatment provider.
All physicians who leave treatment against medical advice will be subject to state medical board notification by the IPP.

- Mental Impairment

The provider of treatment should have demonstrable expertise in the recognition of the unique characteristics of health professionals involved in the disease of mental illness and have the ability to offer an inpatient treatment program. To avoid the appearance of a conflict of interest, a member of the health professional/impaired physician committee should have no vested interest in the provider offering treatment.
Admission for treatment of mental illness should be contingent upon agreement of the patient to release to the health professional/IPP any records pertaining to the investigation, identity, diagnosis, prognosis, or treatment of such patient that are maintained in connection with the performance of any program or activity relating to mental illness education, prevention, training, treatment, rehabilitation, or research.
Providers conducting the treatment must agree to release the results of the treatment to the IPP.
Physicians undergoing treatment should agree to adhere to the recommendations of the treatment provider.
All physicians who leave treatment against medical advice will be subject to state medical board notification by the IPP.

Follow-Up Care/Discharge Planning for Impaired Physician Program
Chemical Impairment-Introduction
Two closely related models for follow-up/discharge planning are available: Track "A" for those who enter treatment through an IPP and Track "B" for those who enter treatment through board proceedings. Physicians who have engaged in conduct that the board determines constitutes a violation of the public trust should be routed through Track B.

1. Length: The IPP must have an aftercare contract consistent with physician rehabilitation and patient safety. While medical boards may be called upon to individualize aftercare contracts, the committee recommends that all physicians involved in an IPP should be supervised for a minimum of five years.
2. Follow-up Criteria:
    a. Monitoring physician familiar with the addiction process
    b. Personal primary-care physician. Self-treatment is prohibited.
    c. Supervisory physician with oversight of impaired physician while practicing medicine
    d. Attendance at AA, NA or other equivalent program
    e. Support group attendance, including a weekly meeting with peers

f. Strong encouragement that a physician's personal and family support system be included in the recovery process
g. Urine Screening:
1. Obtain witnessed urine screens by a same-sex observer
2. Use of an approved laboratory for screening urine samples
3. Establish a chain-of-custody for urine samples
4. Screen for all commonly abused mood-altering chemicals
5. Screen at intervals appropriate to drug(s) of abuse
h. Progress reports
i. Psychiatrist or psychologist, if needed

3. Portability: All aftercare contracts must have the provision to allow IPPs to notify IPP/medical boards in other states of the physician's participation and current status.
4. Reporting: The IPP should report to the state medical board's designated representative on all cases of physician impairment. If the impaired physician enters treatment voluntarily, the IPP should submit "blinded reports" to the state medical board on a periodic basis, which report on the status of the impaired physician in regard to compliance with the provider's treatment recommendations. The periodic "blind reports" also should include a report on the monitoring of the workplace. IPPs reporting on those physicians who are board-mandated should report to the state medical board on a quarterly basis and include detailed reports on aftercare compliance.

Mental Impairment

1. Follow-Up Criteria:
a. Monitoring psychiatrist
b. Personal primary-care physician. Self-treatment is prohibited.
c. Supervisory physician with oversight of impaired physician while practicing medicine
d. Strong encouragement that a physician's personal and family support system be included in the treatment process
e. Progress reports

2. Portability: All aftercare contracts must have the provision to allow IPPs to notify IPP/medical boards in other states of the physician's participation and current status.
3. Reporting: The IPP should report to the state medical board's designated representative on all cases of physician impairment. If the impaired physician enters treatment voluntarily, the IPP should submit "blinded reports" to the state medical board on a periodic basis, which reports on the status of the impaired physician in regard to compliance with the provider's treatment recommendations. The periodic "blind reports" should also include a report on the monitoring of the workplace. IPPs reporting on those physicians who are board-mandated should report to the state medical board on a quarterly basis and include detailed reports on aftercare compliance.

Relapse Management

Chemical Impairment-Introduction

The medical licensing board's response to relapse may vary, depending upon the physician's recovery program and the circumstances surrounding the relapse. It is important to remember that the occurrence of relapse may not be with the initial or primary drug of choice. Monitoring recovery groups and random urine drug screening provide opportunity for early detection of relapse.

1. The board recognizes three levels of relapse behavior that have the potential to impact public safety.
Level 1: Behavior that might indicate relapse, without chemical use, should be reviewed by the physician medical director or designated representative who may make treatment recommendations that may include individual counseling or a return to a more intense monitoring protocol.
Level 2: Relapse, with chemical use, that is not in the context of active medical practice may be reported to the medical board.
Level 3: Relapse, with chemical use, in the context of active medical practice, which may include a positive blood or urine specimen, should be immediately reported to the state medical board.

2. The board underscores the need for prompt management of relapse to ensure public safety. There is a need to understand that the drug involved in the relapse may not be the primary drug of choice present in the initial chemical abuse process. Furthermore, it is important that management of a relapsed physician be within the realm of the IPP. If relapse is permitted to be managed outside the program, there may develop a loss of control in the recovery process that tends to produce isolation and recurrent relapse.

Relapse management should consist of the following:

a. Re-evaluation should be conducted by the IPP medical director, with immediate investigation, intervention, and notification to the state medical board.

b. The recommendation should depend on the circumstances and the behavior surrounding relapse in consultation with the appropriate treatment provider.

c. An emergency suspension of the physician's license to practice medicine may be indicated if there is a danger to the public.

d. Noncompliance with the aftercare contract will result in a report to the board.

Mental Impairment

Relapse management should consist of the following:

1. Reevaluation by the IPP medical director, with immediate investigation, intervention, and notification to the state medical board.

2. The recommendation should depend on the circumstances and the behavior surrounding relapse in consultation with the appropriate treatment provider.

3. An emergency suspension of the physician's license to practice medicine may be indicated if there is a danger to the public.

4. Noncompliance with the aftercare contract will result in a report to the state medical board.

I. Sample Agreement Not to Practice

Georgia Composite State Board of Medical Examiners

I, _____ holder of license No. _____

To practice medicine in the State of Georgia pursuant to O.C.G.A. Ch.34, T.43, as amended, hereby freely, knowingly and voluntarily agree as follows:

I will follow all treatment recommendations of _____
(insert name of treatment program) as established by my treating physician.

I will not practice medicine in the State of Georgia until I have the written permission of the Composite State Board of Medical Examiners; and

I hereby consent to and authorize _____
(insert name of treatment program) to immediately notify the Medical Coordinator of the Composite State Board of Medical Examiners if I fail to comply with the treatment recommendations OR return to the practice of medicine in the State of Georgia without the prior written permission of the Composite State Board of Medical Examiners.

Agreed to this ___day of, 2001. _____ _____

_____

Name: _____

Witnessed by: _____

Treating Physician
Name: _____
License No._____

J. Resources for Physician Evaluation for Competence

East Carolina School of Medicine
Clinical Enhancement Program
Brody Medical Sciences
Lakeside Annex 6
600 Moye Blvd.
Greenville, NC 27835-4353
Dr. Stephen Willis
252-816-2601
252-816-3040 FAX

Colorado Personalized Education for Physicians
14001 E. Lleff Avenue, Suite 206
Aurora, Colorado 80014
Debbie Waugh, L.C.S.W.
Assistant Director for Assessment Services
303-750-7150 FAX 750-7171

Oregon Medical Association
Individualized Physician Renewal Program
5210 Corbett Avenue
Portland, Oregon 97219
Dr. Roy Skoglund
503-226-1555
503-241-7148 FAX

State University of New York
Department of Family Medicine
Health Science Center at Syracuse
475 Irving Avenue, Suite 200
Syracuse, NY13210
315-464-6997
315-464-6982 FAX

University of Wisconsin Medical School
Department of Continuing Education
2715 Marshal Court
Madison, WI 53707
Dr. Thomas Myer
608-263-2852
608-262-8421 FAX