

Physician CONNECTION



Drugs, Alcohol and Physician Health Programs

By Diane L. Bellquist, J.D.

When you hear the term “impaired provider,” you may think of the medical doctor or physician assistant who practices under the influence or who has hit rock bottom to the point he or she can no longer hold a practice together. You may be surprised by just how encompassing the impaired provider label is for purposes of regulation by licensing boards.

What is Impairment?

A provider with the mere diagnosis of an addiction illness, despite no functional impairment, may be labeled an impaired provider and monitored accordingly. Boards aim to intervene early to prevent the illness from progressing along the continuum and later causing functional impairment.

The Federation of State Medical Boards’ stance is “[t]ypically, addiction that is untreated progresses to impairment over time. Hence, in addressing physician impairment, it makes sense to identify addiction early and offer treatment and recovery prior to the illness becoming an impairment” (FSMB Policy on Physician Impairment, adopted April 2011).

An untreated impairment can have negative consequences for a

provider’s health, family stability, patients and clinic practice. Impaired providers are at risk for running afoul with the law. The licensing boards, medical staff privileging and criminal arenas all can come into play when substance abuse impairments manifest. The licensing boards have the duty to protect the public and the profession from the risks of impaired providers.

Identifying Impaired Providers—Initial Applications for Licensure

Impaired providers may be identified at the time of initial entry into the profession through the licensure application process.

Case Example: A 25-year-old college student drove after drinking beer while tailgating at a football game. The student was arrested for driving under the influence. The charges were resolved without a conviction. The student successfully completed his professional degree without issue and applied for a state license to begin practicing. Five years elapsed since the charges. The applicant’s fitness to practice was questioned based on the incident, necessitating a fitness-to-practice evaluation.



If information in an initial application calls into question the applicant’s fitness to practice, licensing boards may request that the applicant obtain an evaluation. New graduates are often shocked to learn mistakes they overcame long ago can haunt them once again.

Many applicants will choose to voluntarily submit to an evaluation with the hope of expediting action on their applications so they can begin earning a living and avoid lengthy and costly litigation that carries the risk that licensure may be denied.

Continued on page 2

Continued from page 1

Identifying Impaired Providers—Complaints Filed with Licensing Boards

Impaired providers may also be identified through complaints filed with their respective licensing boards.

Case Example: A complaint from a competitor doctor is filed, alleging that Dr. X was observed at a social function having a drink, when Dr. X is known to be a recovering alcoholic. Dr. X's fitness to practice is called into question based on allegations alone, despite the existence of a factual dispute.

Allegations regarding substance use alone will likely trigger an immediate whirlwind of events for the provider. Depending upon the severity of the allegations and the amount of evidence, licensing boards may issue an emergency order immediately suspending the provider's license in order to protect the public while the facts are sorted out.

Often, licensing boards will request that the provider submit to a voluntary evaluation of his or her fitness to practice. If the provider does not submit voluntarily, then the board may exercise its authority to order the provider to submit to an evaluation. Generally, reasonable cause or probable cause is all that is needed to issue such an order. In light of this, providers often choose to submit to a voluntary evaluation.

Identifying Impaired Providers—Intervention by Hospital Staff, Partners, or Colleagues

Sometimes impaired providers opt to voluntarily self-refer to a physician health program after partners, colleagues, employers or hospital staff intervene.

Case Example: A surgeon arrived at the hospital. Staff observed signs of

impairment and believed he was under the influence of drugs. They take steps to prevent him from operating on the patient. Staff coordinated with the physician health program for further intervention.

When confronted in this situation, the provider may opt to voluntarily submit to and agree to comply with the requirements of the physician health program. This hospital scenario may nonetheless trigger licensing board action because a peer review incident report will likely be created with findings that would necessitate reporting to the licensure board.

Identifying Impaired Providers—Self-Reporting

Some providers with insight into their conditions who are internally motivated to change may self-refer to a physician health program for assistance.



Case Example: A physician assistant was experiencing burnout in her profession. What began as use of prescribed narcotics for a legitimate medical necessity developed into an addiction and abuse of narcotics. With the encouragement of her husband, she self-referred to a physician health program for assistance and the first step toward recovery.

When providers self-refer without an associated adverse event (i.e., criminal charges or patient care issues), they are afforded confidentiality regarding their

participation and may avoid action by the licensing board. Physician health programs do not typically report a self-referred provider who can safely practice with restrictions and monitoring unless the provider is noncompliant with the program requirements. This is the supportive role that physician health programs fulfill.

Often, licensure renewal applications will ask if the provider has ever been diagnosed with a condition that has the potential to impair his or her ability to practice. Some states require impaired physicians to answer that question affirmatively.

The licensing board may then contact the physician health program to confirm participation and status of compliance. The confidentiality of the program does not necessarily preclude the licensure board from confirming the provider's participation. Usually, no further action is taken by the licensing board if the applicant is compliant with the program. This incentivizes providers to take proactive steps toward self-care.

Identifying Impaired Providers—Criminal Matters

It is not uncommon for an addiction to lead to criminal activity, which may involve drinking and driving, diversion of prescription medications or prescribing to oneself unlawfully. When a provider is charged with a crime, law enforcement agencies tend to coordinate with the licensing boards. In some cases, the boards are aware of the matter through the media outlets before there is the chance to coordinate with law enforcement.

Case Example: A surgeon was intoxicated when he drove his Ford Mustang at a high rate of speed down a residential road, lost control and crashed into the side of a house narrowly missing the owner as she stood outside watering her plants.

How to Handle an Impaired Provider

Good practitioners can become impaired in their practice. You may encounter a partner or colleague who struggles with addiction. The very nature of the illness or impairment relating to substance use often precludes providers' insight about the condition or their desire for change absent intervention.

Fear of being wrong, resulting retaliation, ruining an individual's career or earning a reputation as a whistle blower is a deterrent for physicians to intervene when a colleague is suspected to be impaired. This may be especially true where the physician serves in a senior position, in a leadership role or in smaller groups where the financial impact is greater.

In the face of these fears, providers weigh their legal and ethical duty to report impaired colleagues. If you wait to intervene until your colleague has been arrested, injured a patient or caused reputational damage, you are actually doing a disservice to your colleague.

There is no clear rule regarding the legal duty to report a colleague suspected of being impaired. Nonetheless, there are limited scenarios where foreseeably allegations or even legal liability could result for failing to report an impaired colleague. Imposing liability



on a physician for failure to report is heavily dependent upon the facts of the situation.

In the civil arena, liability could result in the case of a supervising physician and an impaired subordinate physician. The extent of the supervising physician's knowledge and the actual severity of the impairment would be key factors to determining liability. In the licensure arena, the professional practice act may impose a duty

upon physicians to report known violations of the act. The issue of whether the physician can be disciplined for failing to report an impaired colleague would be dependent upon actual knowledge of practicing impaired versus a suspicion. The practical risk of having one's license disciplined for failing to report is typically reserved for only exceptional cases where actual knowledge of an impairment that posed a serious danger to the public existed.

The best step is to address the provider directly about your concern. This affords the provider the opportunity to take steps toward self-care, which may include self-referring to a physician health program. This approach affords the advantage of confidentiality to the fullest extent, thus minimizing the adverse employment and licensing effects. If the provider is not receptive, then you may feel the professional or moral obligation to report your concerns to the facilities where the provider practices. Reporting to the licensing board is usually viewed as a last resort option.

A Few Practical Tips:

- *Realize that, as a licensed professional, your consumption of alcohol must be moderated.*
- *Don't drink at work—not even after hours.*
- *If you realize you're struggling with substance use, get help before it is too late.*
- *Once you have participated in a physician health program, you should adopt sobriety as a lifestyle for the duration of your professional career.*
- *Intervene early when a partner or colleague may be struggling with substance abuse.*

Addiction exists among the general population, from which medical providers are not immune. The fact that a provider suffers an addiction, alone, is not a career killer. The medical community has recognized that there are inevitably providers that will suffer from addiction.

There has been a shift toward providing support for rather than penalizing such providers, which has operated to lessen the stigmas that once existed. Practitioners can take comfort knowing there are resources available to aid and support their continued practice. There are several inpatient and outpatient treatment programs that specialize in treating healthcare providers and addressing their specifically unique issues. Practitioners can take advantage of local caduceus meetings with other

professionals. Professional health programs can also connect individuals with physician sponsors who can identify with the practitioner's situation.

All of these established support structures tailored specifically to medical professionals convey a very important point—medical providers struggling with substance abuse disorders are never alone in their recovery process.

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Conclusions about an individual's symptoms of intended use, cravings and tolerance may be inferred by the evaluator from the amount of reported use.

Many physicians are surprised to learn that what they believed was responsible social drinking actually meets the criteria for alcohol use disorder. Even a diagnosis of alcohol use disorder (mild) may result in a referral to a physician health program for abstinence and monitoring of compliance. Where there is a justifying diagnosis, the provider may be required to abide by a monitoring contract with provisions geared toward rehabilitation for the purpose of ensuring that his or her continuation of practice is both possible and safe.

Physicians have sworn to uphold the Hippocratic Oath, which is to "first do no harm." Monitoring contracts with physician health programs are an extension of that social contract. They balance the needs of public protection with the needs of impaired physicians to be able to safely practice their profession. The programs have the dual-hatted responsibility of serving as an advocate for the physician and protecting the public.

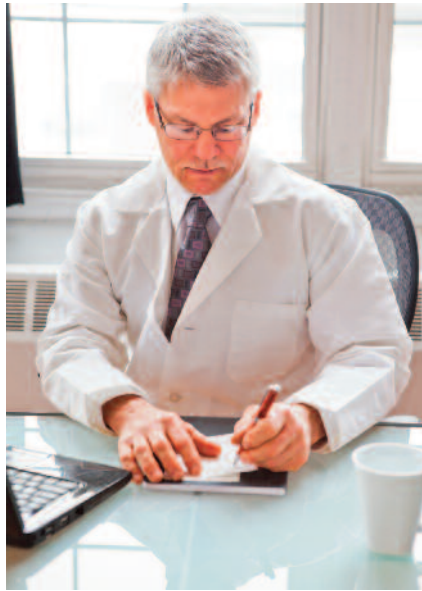
The confidential nature of physician health programs provides great incentive for early intervention—before impairment manifests itself to the point where disciplinary action by the regulatory board may be warranted.

Monitoring Contracts

If a medical provider receives a diagnosis necessitating abstinence and monitoring, then the provider will be required to enroll in a physician health program and sign a contract agreeing to follow the terms for participation.

What exactly are the terms of participation? They may include treatment and abstinence from all intoxicating substances, unless taken as prescribed by a treating physician. The provider's abstinence

will be verified through random urine screens, blood draws or hair testing. The provider is typically also required to participate in caduceus meetings (recovery groups specifically for healthcare professionals) and other support groups. It is fairly standard for monitoring contracts to range from three to five years.



Licensing Board Actions

If the licensing board discovers a provider's impairment in any manner other than the provider's disclosure of self-referral to a physician health program, some type of board action is likely to result. The licensing board action gives teeth to the provider's participation in the program.

Many licensing boards have authority to address impairment matters through a diversion program or nondisciplinary action. Some boards' diversionary actions are not public, while other boards issue public but nondisciplinary orders. Even when the action is public, the orders tend to be heavily redacted to protect confidential substance abuse information protected from disclosure by federal law. If the provider has related criminal proceedings, resulting patient injury or other aggravating factors, the licensing board may impose disciplinary action to redress those separate issues.

Even when board action is not disciplinary, there can be detrimental collateral effects. There are the obvious costs involving money, time and the emotional toll associated with addressing a licensing board action. While licensing boards may be restricted from disclosing confidential substance abuse information, insurance companies and other credentialing bodies may require the provider to submit an unredacted copy of the order.

There is no law that protects the physician from being required to disclose the information to private entities for credentialing consideration. Some insurance companies are beginning to take a harder look at these actions for insurability and credentialing purposes. Public orders, despite being nondisciplinary in nature, still carry a reputational risk.

Providers who are enrolled in a monitoring program must take the program seriously. Too often, providers approach the program with resistance or with the idea they can beat the system. Those are professionally fatal errors.

Case Example: A physician struggling with a cocaine addiction was enrolled in a physician health program. When the impaired provider's staff, along with the Board's investigator, visited the physician to collect hair for a drug test, he had informed them he had shaved his entire body and was therefore unable to provide a hair sample.

While most licensing boards are willing to give providers at least one chance in the program, second chances are not guaranteed. It is important to understand the perspective of the licensing boards, which is that regulated professionals are held to a higher bar than the rest of the public because of the privileges they hold to practice their profession. Sometimes circumstances mandate going the extra mile to maintain that privilege.

The surgeon was arrested for a DUI. The incident was covered heavily in the news with emphasis on the fact that he was a surgeon and identifying the practice group with which he was affiliated.

Case Example: An internist issued narcotic prescriptions to individuals who were not bona fide patients. The individuals would fill the prescriptions at various pharmacies in different cities and then give the internist the pills. The internist compensated the individuals by paying either cash or sharing the pills. The internist was charged and convicted of felony drug crimes.

When unlawful drug crimes are involved, often the provider's DEA registration is also at stake.

Case Example: A physician pled guilty to unlawful possession of a controlled substance after he was caught diverting fentanyl and self-medicating to relieve stress after completing a 24-hour shift at the hospital. The physician surrendered his DEA registration.

Administration of Physician Health Programs

Physician health programs can be administered by medical boards, state medical societies or other third parties. The programs strive to detect, intervene, rehabilitate and monitor providers with impairments that can impede the safe practice of medicine. Participation in the program is voluntary. While the licensing board has the authority to order providers' participation in the programs and impose discipline, the programs do not have any such authority.

After consultation with the program staff, a provider may be referred for an independent forensic evaluation. Physician health programs themselves do not perform evaluations or provide any treatment. An independent forensic evaluation is separate from a

treating provider role; there is no physician-patient confidentiality. The provider will be required to sign releases so that information can be shared between the evaluator, the physician health program, and in some cases, the licensing board. The evaluator can become an expert witness, so it is important to exercise due diligence in selecting the evaluator when provided options. The evaluations can cost thousands of dollars and days lost from practice.

The DSM-5 now integrates alcohol abuse and dependence (addictive illnesses) into a single disorder called "alcohol use disorder" with mild, moderate and severe subclassifications. Individuals will be diagnosed with alcohol use disorder if they have experienced at least two of the following symptoms:

Impaired Control Criteria

1. Consuming more alcohol than intended.
2. Worrying about stopping or failed efforts to control consumption.
3. Spending a large amount of time consuming alcohol.
4. Craving alcohol.

Social Impairment Criteria

5. Giving up or reducing other activities because of alcohol use.
6. Use detracts from fulfilling major obligations at home, work or school.
7. Continuing use despite negative effects upon personal relationships.

Risky Use Criteria

8. Continuing use despite detrimental ramifications to health.
9. Repeated use in dangerous situations.

Pharmacological Criteria

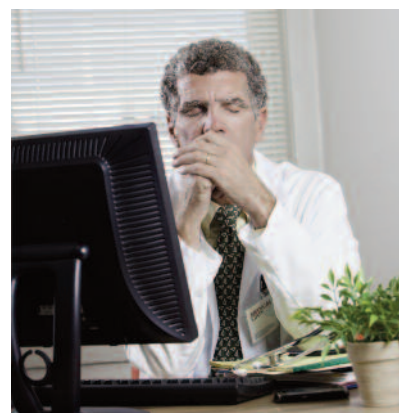
10. Building up "tolerance," which is defined by the DSM-5 as "either needing to use noticeably larger amounts over time to get the desired effect

or noticing less of an effect over time after repeated use of the same amount."

11. Experiencing "withdrawal" symptoms, which is defined by the DSM-5 as including "anxiety, irritability, fatigue, nausea/vomiting, hand tremor or seizure...."

Two of these symptoms indicate a "mild" substance abuse disorder, four to five symptoms indicate a "moderate" substance abuse disorder, and six or more indicate a "severe" substance abuse disorder. It may be noted that an individual's disorder is in remission.

The substance abuse evaluation does not simply rely upon the provider's conscious and voluntary self-admission or denial of the criteria. These symptoms may be concluded based on information gleaned from interviews, physical



examinations, lab tests, substance use screening tools such as SASSI and MAST instruments, and collateral evidence. The current Dietary Guidelines for Americans defines "moderate" drinking as up to one drink a day for women and up to two drinks a day for men. The Substance Abuse and Mental Health Services Administration (SAMHSA) defines "binge" drinking as four drinks for women and five drinks for men on the same occasion at least once in the last month. SAMHSA defines "heavy" drinking as binge drinking five days or more in the past month.

Sign up Today for Your Personal Risk Assessment

A Personal Risk Assessment (PRA) is essential to physician policyholders to help identify and manage risk that ensures patient safety and provider satisfaction.

The assessment helps:

- Identify potential areas of exposure in your practice
- Determine your risk tolerance level
- Identify needed risk management activities

Premium Discounts

Full-time physicians may qualify for a premium discount with a minimum overall score of 70 percent or better. The discount is based on the score achieved during the on-site PRA. Discounts are applied to policy renewals effective January 1 the following year and are valid for two years.



Assessment Topics

The goal of the PRA is a heightened awareness of risk areas in your practice and improved patient safety.

The topics covered during the assessment are:

- Documentation practices
- Medication management
- Staffing concerns
- Scheduling concerns
- Tracking of labs, diagnostic tests and referrals
- Patient education
- Communication practices

Getting Started

1. Complete the form found at <http://bit.ly/PRA2017>
2. A PSIC risk manager will contact you to schedule appointment
3. Assessment conducted in your office:
 - Participating physician and/or designated office personnel answer a series of questions (approximately 45 minutes)
 - Review of select policy and procedure documents is conducted (approximately 15-30 minutes)
 - Patient medical records for each physician are reviewed (approximately 30-45 minutes per physician participant)
 - Exit interview conducted to discuss findings of the assessment with the designated staff and/or providers
4. Report provided by PSIC Risk Manager

Additional Risk Management Resources

Physicians and their staff can also participate in other risk management programs offered through PSIC.

In collaboration with MedRisk® (Medical Risk Management, Inc.), we offer 18 courses through an online Continuing Medical Education Library. These courses are approved for premium discounts and cover a variety of topics on patient communication, documentation, office risks, informed consent, avoiding never events, and more.

You'll find additional information at <http://bit.ly/online-CME>.

Online webinars are also available to physicians and their staff. Our most recent ones covered the topics of:

- Avoiding communication breakdowns between providers
- Cultural and communication gaps
- Trends in cyber attacks/ransomware

To access the webinar library, visit <http://bit.ly/PSIC-webinars>.



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