33rd Gulf Coast Conference on Alcohol and Drug Abuse
Gulf Shores, Alabama
October 6-7, 2016

Illness, Impairment and the Distressed Physician

Jim Harrow, M.D., Ph.D.
Medical Director
Alabama Physician Health Program
DISCLOSURES

Dr. Harrow has no disclosure of real or apparent conflict related to the content of this presentation.

CONTENTS

1. Physician health programs
2. Physicians as patients
3. Substance and alcohol use disorders
4. Mental health
5. Disruptive behavior
6. Burnout
7. Professional sexual misconduct
8. Alabama Physician Health Program

PHYSICIAN HEALTH PROGRAMS
**THE GOLDEN AGE**

- Physicians with alcohol and drug use disorders.
- Medical boards were punitive.
- License suspension or revocation.
- Physicians moved to other states.
- No intervention or treatment.

**HISTORY OF PHYSICIAN HEALTH PROGRAMS**

1958
American Medical Association alcoholism is a disease.

1958
Federation of State Medical Boards suggested development of programs for physician health.

1968
Federation of State Medical Boards made a resolution for nation wide programs.

1980’s
AMA encouraged Physician Health Programs.

1990
Federation of State Physician Health Programs formed.

2016
Most states have programs (all except WI, NE, CA).
JCAHO MS 4.8 STANDARD

• 2001 – JCAHO established requirement that all accredited hospitals have a Physician Health Program.
• Clinical – Non-Disciplinary
• Requires
• Education of staff regarding signs of impairment and how and who to report to about concerns.
• Process for intervention, referral for evaluation, treatment and monitoring, as needed.

JCAHO MS 4.8 STANDARD

• Bylaws – should contain a description of process.

• Partner with state Physician Health Program to create physician health standard.

• Physician Health Officer or committee to liaison with Physician Health Program.

ILLNESS VERSUS IMPAIRMENT

Federation of State PHPs public policy:

Physician illness and impairment exists on a continuum with illness typically predating impairment, often by many years.

Illness is the existence of a disease.

Impairment is a functional classification implying the inability of the person affected by disease to perform specific activities.

www.fsphp.org
**Impairment:** “inability to practice with reasonable skill and safety”

**THE PROBLEM.......**

- Regulatory entities have tended to equate “illness” with “impairment” (unprofessional conduct, moral turpitude, behavior intended to deceive, defraud and harm the public, etc.)

- They have viewed addiction through the lens of behavioral, moral or ethical conduct, a professionalism issue, addressed through discipline.

- Some states have been less than fully supportive of healthcare professional rehabilitation.

- Officials believe that it is their duty to take **disciplinary action** in the face of an addicted professional to “protect the public.”

- Uneducated and dogmatic approach exists within some disciplines and **physicians** have led the way.
POTENTIALLY IMPAIRING CONDITIONS

• Substance and Alcohol Use Disorders
• Mental Illness
• Neurocognitive Decline
• Physical Disease
• Disruptive Behavior
• Psychosexual Disorder
• Incompetence/Dated
• Stress Disorder/Burnout
• Unethical Behavior

~20-30% LIFETIME PREVALENCE

PHYSICIANS AS PATIENTS

• Difficulty accepting the patient role.
• Less than objective medical treatment.
• Potential or real loss of status and authority.
• Myth: having knowledge protects them from illness.
Physicians seek medical care less often and tend to wait longer.

- Tendency to self diagnosis and treatment.
- “Hallway” medical consultations.

- INVULNERABLE.

MDEITY SYNDROME

The typical physician is “an obsessive compulsive neurotic with a dominant super ego who is consciousness driven and depression prone”. They suffer from MDEITY SYNDROME and we see omnipotence on one hand and omnipotence on the other. Add to that baseline addiction, early recovery and narcissistic personality and there is plenty of rope with which one may hang oneself!

SUBSTANCE AND ALCOHOL USE DISORDERS
KING ALCOHOL

MOTHER'S LITTLE HELPER
What a drag it is getting old
"Kids are different today,"
I hear ev'ry mother say
Mother needs something today to calm her down
And though she's not really ill
There's a little yellow pill
She goes running for the shelter of a mother's little helper
And it helps her on her way, gets her through her busy day

The Rolling Stones, Aftermath, 1966

PREVALENCE OF SUBSTANCE USE DISORDERS

• For physicians drugs > alcohol (Compared to the general population).

• National Institute of Health: Lifetime prevalence 16%. 
DEFINITION OF ADDICTION

American Society of Addiction Medicine:
Addiction is a primary, chronic disease of brain reward, motivation, memory and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors.

ADDICTION
Compulsive drive to take a drug despite serious adverse consequences.

NOT AS:
• Bad choice made voluntarily.
• Moral or ethical failure.
• A personality disorder.
• Secondary to another psychiatric illness.
• Inability to handle stress without use.

CATEGORIES OF DRUGS OF ADDICTION
• ALCOHOL
• OPIOIDS
• SEDATIVES
• HYPNOTICS
• STIMULANTS
• NICOTINE
• COCAINE
• CANNABIS
• INHALANTS
• HALLUCINOGENS
THE ADDICTED PHYSICIAN

- Typically, the hospital/practice is the last place addiction manifests symptoms.
- Disruptions in family, personal health, community, social, spiritual and leisure life can all occur while the work place remains relatively unaffected.
- Even very small intrusions of addiction into the workplace should be taken extremely seriously in physicians.

THE DOCTOR AND ADDICTION

Barriers to seeking help:
- Addiction as a primary biogenetic and psychosocial disease.
- Denial is the common feature of alcoholic/drug addicted physicians.
- Knowledge of the effects of drugs and alcohol.
- Alcoholic/addicted physicians do not accept ADDICTION as a disease.
- Family members and colleagues contribute to denial.

DON’T EVEN KNOW I AM LYING

- Not Lying
- Subconscious
- Defense mechanism
- Is protective
MEDICAL SPECIALTY AND ADDICTION

There is no specialty that is not affected although incidence varies in different series, certain specialties are generally over-represented:

- Anesthesiology
- Obstetrics/Gynecology
- Family Medicine/General Practice
- Emergency Medicine
- Physicians (all specialties) in Academic Medicine

INTOXICATION in a Medical professional in purely social settings should be IGNORED since it DOES NOT OCCUR DURING NORMAL WORKING HOURS? WRONG
On the JOB A O B (Alcohol On Breath) is almost always an ominous sign, even when noted on a single occasion? YES

Aberrant workplace behavior caused by chemical dependency should be addressed rapidly because it usually indicates progression beyond early-stage disease? YES
MENTAL HEALTH

PREVALENCE OF PSYCHIATRIC DISORDERS

• Major depressive disorder – 16.

• Any psychiatric disorder – 46%.

• Burn out – almost all physicians at some point in their career.

CLUSTER A: PARANOID, SCHIZOID, SCHIZOTYPAL

• Distrustful, suspiciousness, suspects exploitation or harm or deceit from others, doubts about the loyalty of others, reluctant to confide in others due to unwarranted fear, reads hidden demeaning or threatening meanings into remarks or events, bears grudges, perceives attacks on character or reputation that are not apparent to others.
CLUSTER B: BORDERLINE

- Pervasive pattern of instability of relationships, self-image, mood, and marked impulsiveness.
- Frantic avoidance of real or imagined abandonment (“I Hate You, Don’t Leave Me”).
- Intense unstable relationships: extremes of idealization and devaluation.

I'm selfish, impatient & a little insecure.
I make mistakes, I'm out of control & at times hard to handle.
But if you can't handle me at my worst,
then you sure as hell don't deserve me at my best.

-Marilyn Monroe
CLUSTER B: ANTISOCIAL

- Pervasive pattern of disregard for others.
- Failure to conform to lawful behavior.
- Deceitfulness, lying, impulsive.
- Lack of remorse, indifferent to the pain of others.

"Anti-social behaviour is a trait of intelligence in a world full of conformists."
- Nikola Tesla

CLUSTER B: NARCSSTIC

- Grandiosity, self-importance, preoccupied with success, power, brilliance, beauty, or ideal love, believes that he or she is “special” and unique and can only be understood by, or should associate with, other special or high-status people.
- Need for admiration.
- Lack of empathy, arrogant.
- Entitlement, exploitative, envious.
CLUSTER C:
AVOIDANT, DEPENDENT, OBSESSIVE COMPULSIVE

- Preoccupation with orderliness, rules, lists, order.
- Difficulty in accepting change.
- Perfectionism interferes with task completion.
- Controlling, rigid, stubborn.
- Excessively devoted to work.

I have CDO

It's like OCD but all the letters are in alphabetical order as they should be.
MENTAL DISORDERS AND SUBSTANCE USE DISORDER RISK

• All Mood disorders 32%
• Bipolar I disorder 61%
• All Anxiety disorders 23.7%
• Schizophrenia 47 %
• Personality disorders: Antisocial personality disorder 83.6 %, borderline personality disorder 50%
DISRUPTIVE BEHAVIOR

- Intimidation
- Abusive language
- Unprofessional conduct
- Sexual harassment
- Racial or ethnic slurs
- Threats of violence, retribution or litigation

The presence of intimidating and disruptive behaviors:

- Erodes professional behavior in the workplace.
- Creates an unhealthy or even hostile work environment.
- Readily recognized by patients and their families.

- Can foster medical errors.
- Contribute to poor patient satisfaction.
- Contribute to preventable adverse outcomes.
- Increase the cost of care.
Overt and passive behaviors undermine team effectiveness and can compromise the safety of patients. All intimidating and disruptive behaviors are unprofessional and should not be tolerated.

CAUSES OF DISRUPTIVE BEHAVIOR

• Burnout, cynicism, depersonalization, exhaustion.
• Substance or alcohol related disorders.
• Physical health (multiple disease states).
• Affective disorders.

INDIVIDUAL FACTORS

• Stresses and fatigue of dealing with high stakes, high emotion situations.
• Physicians who exhibit characteristics such as self-centeredness, immaturity, or defensiveness.
• They can lack interpersonal, coping or conflict management skills.
SIGNS AND SYMPTOMS

- Formal complaints from nurses or staff.
- Poor attendance at meetings or CME.
- Change in appearance.
- Mood swings.
- “Midnight rounds.”
- Financial problems.

BURNOUT
SYMPTOMS

- Emotional exhaustion
- Withdrawal, cynicism
- Poor judgment
- Perfectionism, rigidity
- Impaired job performance
- Alcohol and drug use
- Physical and emotional complaints

HOW IS BURNOUT IDENTIFIED?

- Overwhelming physical and emotional exhaustion.
- Feelings of isolation and detachment.
- Sense of ineffectiveness and lack of accomplishment.
- Irritability and hypervigilance.
- Perfectionism, rigidity, poor judgement.
- Professional and personal boundary violations.

PHYSICIANS MORE VULNERABLE?

- Changing external realities of medical practice today.
- Decreasing autonomy and control over workplace.
- Unrealistic expectations of self and others.
- Reluctant to delegate work to others and ask for help.
- Conscientious, inflexible, perfectionistic.
- Increasing time pressures.
HOW ARE PHYSICIANS IMPACTED?

• 37.9% of US physicians had high emotional exhaustion (no emotional response to positive stimuli).
• 29.4% had high depersonalization (cynical patient detachment).
• 12.4% low sense of personal accomplishment (low self-esteem, worthlessness).
• 45.8% of US physicians are burned-out.


PHYSICIAN SEXUAL MISCONDUCT

I was lookin' for love in all the wrong places
Lookin' for love in too many faces........
don't know where it started or where it might end
I'd turn to a stranger just like a friend.

Johnny Lee, Urban Cowboy, 1980
“When is sex with a patient acceptable”

NEVER

HIPPOCRATIC OATH:

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

ORIGINAL VERSION: 5th Century: “In every house where I come I will enter only for the good of my patients, keeping myself far from all intentional ill-doing and all seduction and especially from the pleasures of love with women or men, be they free or slaves.”

EXCUSES DOCTORS GAVE JUSTIFYING SEX WITH A PATIENT

• To demonstrate a “normal” partner.
• To demonstrate lack of physical cause for decreased libido.
• Assist with determination of sexual orientation.
• Relieve frustration in widows/divorces.
• To demonstrate desirability.
• To teach sexual anatomy.

(Seagriff, 1993)
PREVALENCE

- Male Physicians: 9 – 10%
- Female Physicians: 3%
- Highest risk specialties:
  - Psychiatry
  - Obstetrics and gynecology
  - Family practice/general practice

AMA CODE OF ETHICS

“SEXUAL CONTACT THAT OCCURS CONCURRENT WITH THE DOCTOR-PATIENT RELATIONSHIP CONSTITUTES SEXUAL MISCONDUCT.”

MISCONDUCT CONSEQUENCES

- Personal – majority not reported.
- Malpractice – time dependent.
- Loss of hospital privileges/reputation.
- Ethics complaint/Board complaint.
- Civil Suit: negligence/loss of consortium, breach of contract, battery, fraud.
- Criminal prosecution.
YOUR LICENSE

Medical Licensure Commission

This is Your Medical License.....Sex with Patients!

THE ALABAMA PHYSICIAN HEALTH PROGRAM
History Of Alabama's Physician Health Program

1980
Volunteer committee with no authority.

1988-1991
Legislative Authority - Statute - AL Code Sec. 34-24-400-406
Requires BME to offer program to assist troubled physicians
Confidential except under certain circumstances.
Immunity - protects program.

1991
Dr. Gerry Summer first Medical Director.

ALABAMA CODE
1975; §34:24:400

The term ‘impaired’ shall mean the inability of a physician or osteopath to practice medicine with reasonable skill and safety to patients by reason of illness, inebriation, excessive use of drugs, narcotics, alcohol, chemicals, or other substances or as a result of any physical or mental condition.

ALABAMA STATUTES
PROVIDE
A CONFIDENTIAL Conduit for Evaluation and/or Treatment, Monitoring and Earned Advocacy
REPORTING OF IMPAIRED PHYSICIANS

- AL Code 34-24-361b
  - "Any physician who is aware of another physician who cannot practice safely or is a risk to patients has a duty to report to the Medical Board. The reporting physician is provided immunity from liability."
- AL Code 34-24-405
  - "A report to the Alabama Physician Health Program satisfies the requirement AL Code 34-24-361b"

CONFIDENTIALITY OF APHP

All information resulting from the investigations, interventions, treatment, or rehabilitation, or other proceedings of such committee are declared to be privileged and confidential.

All records and proceedings of such committee shall be confidential and shall be used by such committee and the members thereof only in the exercise of the proper function of the committee and shall not be public records nor available for court subpoena or for discovery proceedings.

WHOSE DOMAIN?

- HOSPITAL?
- ALABAMA PHP?
- BOARD OF MEDICAL EXAMINERS
APHP SERVICES

• Available to licensed/non-licensed allopathic and homeopathic physicians.
• Physician Assistants.
• Medical students and residents.

APHP REPORTS TO THE BOARD

• Imminent danger to the public.
• Failure to respond to treatment.
• Non-compliance with contract.

FUNDING

• Board of Medical Examiners 67%
• Participant Fees 24%
• Malpractice Insurance Companies 3%
• State Schools of Medicine 6%
**REFERRALS TO APHP**

![Bar chart showing referrals over the years from 00 to 16.]

**REFERRAL SOURCES**

- Families and Spouses: 20%
- Friends: 12%
- Nurses: 14%
- Other: 17%
- Fellow Physicians: 20%
- Boards of Medical Licensure: 21%
- Hospitals: 14%

**PHYSICIAN PARTICIPANTS 2016**

<table>
<thead>
<tr>
<th>Substance and Alcohol Use Disorders</th>
<th>Mental Health</th>
<th>Physical Diseases</th>
<th>Sexual Boundary Violations</th>
<th>Disruptive Behavior</th>
<th>Out of State</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>237</td>
<td>19</td>
<td>3</td>
<td>5</td>
<td>6</td>
<td>21</td>
<td>291</td>
</tr>
</tbody>
</table>

* Senior Monitoring 96
* With Board of Medical Examiners 9

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substance and Alcohol Use Disorders</td>
<td>81%</td>
</tr>
<tr>
<td>Mental Health</td>
<td>6.5%</td>
</tr>
<tr>
<td>Physical Diseases</td>
<td>1%</td>
</tr>
<tr>
<td>Sexual Boundary Violations</td>
<td>1.7%</td>
</tr>
<tr>
<td>Disruptive Behavior</td>
<td>2%</td>
</tr>
<tr>
<td>Out of State</td>
<td>7.2%</td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
</tr>
</tbody>
</table>
## INITIAL BEHAVIOR REPORTED

<table>
<thead>
<tr>
<th>Total New Referrals</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015 Total</th>
<th>1st Quarter of 2016</th>
<th>2nd Quarter of 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substance Use Disorders</td>
<td>24</td>
<td>21</td>
<td>36</td>
<td>32</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td>Psychiatric</td>
<td>10</td>
<td>4</td>
<td>5</td>
<td>9</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Disruptive Behavior</td>
<td>9</td>
<td>10</td>
<td>12</td>
<td>7</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Sexual Boundaries Issues</td>
<td>0</td>
<td>5</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Other (Physical/Cognitive Health)</td>
<td>10</td>
<td>1</td>
<td>2</td>
<td>5</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>ABME Licensure Application</td>
<td>17</td>
<td>21</td>
<td>14</td>
<td>19</td>
<td>5</td>
<td>22</td>
</tr>
<tr>
<td>Total New Referrals</td>
<td>70</td>
<td>65</td>
<td>72</td>
<td>74</td>
<td>15</td>
<td>25</td>
</tr>
<tr>
<td>Current Active Contracts</td>
<td>295</td>
<td>284</td>
<td>291</td>
<td>284</td>
<td>279</td>
<td>281</td>
</tr>
</tbody>
</table>

## DISPOSITION OF REFERRALS

<table>
<thead>
<tr>
<th>Referrals</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>1st Quarter of 2016</th>
<th>2nd Quarter of 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Referrals</td>
<td>76</td>
<td>72</td>
<td>74</td>
<td>15</td>
<td>25</td>
</tr>
<tr>
<td>Referred for Evaluation</td>
<td>21</td>
<td>27</td>
<td>26</td>
<td>5</td>
<td>8</td>
</tr>
<tr>
<td>Referred for Treatment</td>
<td>24</td>
<td>28</td>
<td>11</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>New Monitoring Contract Initiated</td>
<td>54</td>
<td>45</td>
<td>40</td>
<td>5</td>
<td>18</td>
</tr>
<tr>
<td>Not Recommended for Licensure</td>
<td>6</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>No Action Required</td>
<td>7</td>
<td>9</td>
<td>18</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

## INITIAL EVALUATION

- Interview conducted by the Medical Director and clinical staff.
- Collateral information.
- Medical, psychiatric, treatment records
- Prescription Drug Monitoring Program
- Urine, blood and hair testing as indicated.
- Referral for evaluation and/or treatment.
PHYSICIAN EVALUATION
• Facilities with the expertise in evaluating and treating health care professionals.
• Medical and psychiatric examinations.
• Addictions evaluation.
• Neuropsychological testing.
• Family evaluation.
• Collateral information.

APHP AGREEMENTS
• Chemical Dependence Assistance Agreement
• Diagnostic Monitoring Agreement
• Mental Health Assistance Agreement
• Behavior Assistance Agreement
• Physical Health Assistance Agreement
• Out of State Assistance Agreement

COMPLY WITH THE APHP’s RECOMMEDATIONS
• Confidential
• Continue practice
• Advocacy
• Patient safety
• Prevent BME involvement
### Outcomes

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total referrals (includes repeats)</td>
<td>2999</td>
<td>215</td>
<td>190</td>
<td>198</td>
<td>225</td>
<td>188</td>
</tr>
<tr>
<td>New referrals (new names)</td>
<td>1750</td>
<td>75</td>
<td>62</td>
<td>62</td>
<td>78</td>
<td>52</td>
</tr>
<tr>
<td>Interventions</td>
<td>1397</td>
<td>124</td>
<td>60</td>
<td>70</td>
<td>72</td>
<td>32</td>
</tr>
<tr>
<td>Evaluations</td>
<td>955</td>
<td>64</td>
<td>51</td>
<td>60</td>
<td>68</td>
<td>32</td>
</tr>
<tr>
<td>BME Reported</td>
<td>341</td>
<td>51</td>
<td>11</td>
<td>15</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>Active Contracts</td>
<td>NA</td>
<td>252</td>
<td>279</td>
<td>254</td>
<td>296</td>
<td>259</td>
</tr>
<tr>
<td>Contracts Signed (new)</td>
<td>521</td>
<td>40</td>
<td>29</td>
<td>44</td>
<td>38</td>
<td>36</td>
</tr>
<tr>
<td>New Chemical Dependence Dxs</td>
<td>528</td>
<td>28</td>
<td>13</td>
<td>16</td>
<td>22</td>
<td>18</td>
</tr>
<tr>
<td>Relapses: Level III</td>
<td>134</td>
<td>6</td>
<td>2</td>
<td>5</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Level II</td>
<td>8</td>
<td>9</td>
<td>8</td>
<td>7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level I</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>Annual Relapse Rate</td>
<td>1.6%</td>
<td>1.4%</td>
<td>2.1%</td>
<td>2.1%</td>
<td>2.2%</td>
<td>2.1%</td>
</tr>
</tbody>
</table>

### Outcomes

- The prognosis of the adequately treated physician alcoholic/addicts/other disorders is excellent, if the physician engages in the recovery process.
- Recovery is a long term (lifelong) process.
- Continuing engagement in a mutual help program and in peer-group support has proved to be an essential component.
- Random alcohol/drug screens assist in maintaining successful recovery.

---

ALABAMA PHYSICIANS
HEALTH PROGRAM

CALL 334-954-2596 OR 800-239-6272

STAFF@ALAMEDICAL.ORG

FOR ASSISTANCE OR ASSESSMENT
ALL CALLS ARE **CONFIDENTIAL**