

What Can You Do to Help Your Colleagues in the Absence of the Diversion Program?

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Case Presentation

He had been the chief resident, and a good one. An excellent clinician, he was always stepping up to fill in for colleagues, doing extra call, seemingly always in the operating room. So it was natural to offer him a job on the faculty, even though toward the end of his residency he seemed more excited and excitable than usual. Soon after he joined the faculty, his behavior became odder—leaving the operating room frequently, and generally not being “his usual self”—but everyone cut him a lot of slack because, after all, he was a good guy. Finding him unconscious in the bathroom with a syringe of fentanyl in his arm was a shock. Fortunately, he recovered physically from this event, then went on to enter the Physician Diversion Program of the Medical Board of California (MBC), and is practicing to this day.

How Would He Be Managed Today?

Each one of us has heard some variation of this story; it is well known that doctors have an increased tendency to abuse both drugs and alcohol. More importantly, anesthesiologists who are affected by drug and alcohol addiction have four times the prevalence of other specialties—4 percent compared to 1 percent. Our colleagues with these and other problems need our help in treatment, and then effective and safe reentry into the workplace with sufficient steps and monitors in place to assure patient safety. In past years, the MBC’s Physician Diversion Program monitored the well-being of impaired physicians and ensured their continued safety to practice. However, this all fell apart in 2007 when the Diversion Program was closed without any provision for a substitute.

Drs. Lee Snook and Tom Specht, in a previous *CSA Bulletin* (Volume 60, Number 2—Spring/Summer 2011), described what has happened in California since the state legislature closed the Diversion Program. They also outlined the work of the California Medical Association (CMA) in laying the groundwork for California Public Protection and Physician Health, Inc. (CPPPH), an entity that would assist physicians who have diseases of addiction—or mental health issues—that prevent them from working in an unimpaired condition. Our colleagues with these and other problems need our help in getting treatment,

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and then effective and safe reintroduction into the workplace while assuring patient safety. In order for CPPPH to come into being, legislation is needed to secure funding from physician licensing fees. Unfortunately two attempts to establish and fund this substitute entity for the former diversion program have failed, but a third, SB 742 (Lee), sits, for now, as a placeholder. Meanwhile, our colleagues have no generally available resource.

The Well-Being Committee at UCD Medical Center

The remainder of this article describes what one hospital Physician Well-Being Committee, at the University of California, Davis (UCD), Medical Center, has done to fill the existing void. This is not the only such Well-Being Committee (WBC) to have done so, and there likely are other effective programs about which we personally do not know. The purpose of the Davis committee, on which the authors of this article serve, is to lay a framework upon which other committees can build. Anesthesiologists can and should take a lead on these committees, which every hospital must have for accreditation purposes, if only because our specialty is disproportionately affected by addiction.

For the past several years, our WBC has managed a number of impaired physicians' treatment and reentry into the workplace. The committee has based this aspect of its work on the WBC of the University of California, San Diego (UCSD). In this article, we will describe how the UCD committee is composed, how it works, and how it manages impaired physicians. Elements of this committee's functions could serve as a model for other institutions.

The UCD committee is made up of a broad range of members of the medical staff, many of whom expressed or demonstrated interest in the committee before appointment. They are appointed by the Chief of Staff (COS). The Chair is a psychiatrist and the Vice Chair is a psychologist—a skill set that is extremely important to the functioning of the committee. Psychologists may not be part of the medical staff in other institutions, but as we will show, a Chair or Vice Chair with psychiatric and/or psychological skills is important.

The committee has set itself two main goals. One is to maintain the health of the medical staff, thereby ensuring quality patient care. The other is to monitor the health of the medical staff members who have had a psychiatric or substance-related problem of sufficient severity that patient care has been or could be potentially at risk. During the demise of the Diversion Program, it was stated that 10 percent of physicians are expected to have some kind of psychiatric or substance abuse problem. This supposed statistic was bandied about, allegedly demonstrating a failure of the Diversion Program because there were only some hundreds in diversion, rather than the thousands that

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the statistic indicated should be the case. We disagree with this statistic as it does not conform to our experience: it has never been our experience that 10 percent of our colleagues are impaired. However, while the 10 percent is a recognized statistic in psychiatric circles, it is over the person's lifetime. It has also been stated that only about 1 percent of these physicians would have problems of a severity that could potentially endanger patient care (Peter Yellowlees, Chair UCDCM Well-Being Committee, personal communication). This we do believe is closer to the truth.

Referrals to the WBC come from department chairs and training directors for residents, or result from a report of some acute incident involving a physician. The Chief Medical Officer (CMO) or COS may also request a referral. At our medical center, there can be as many as two or three referrals a day on an unusual day. We have about 1,200 faculty and 700 residents in the health care system. Our referrals have so far always been made by a third person—the chair of the department or another senior member of the department—about physicians who have either been determined to be impaired or suspected of being impaired. They are evaluated by the Chair or Vice-Chair of the committee. The evaluation consists of a broad psychiatric evaluation, but no notes are kept, and the consultation remains confidential. However—and the physician in question is informed of this up front—confidentiality may be breached either for the person's safety or for the safety of patients. Most of the referred are judged not to be impaired or to pose no safety risk.

If our Chair thinks that the person needs hospitalization, for either chemical dependency or mental illness, then he makes this referral, and also communicates this information to the involved physician's primary care physician (if one exists) and spouse or other family members. If chemical dependency is at issue, referral is to a hospital that is able to make an inpatient assessment (e.g., Betty Ford Center). Note that this all is voluntary. If the physician refuses, and if there is judged to be a patient safety issue, then the CMO or COS is informed. Outpatient therapy is a possibility for a psychiatric problem. Meanwhile the physician involved is removed from clinical service. The physician in question is made aware that cooperation with the process is his/her best way to ultimately maintain their medical license and career. If they are impaired and do not avail themselves of therapy and monitoring, then there is no choice but to refer to the Medical Staff Executive Committee for possible punitive action, and to refer to the MBC if such action is deemed appropriate.

The determination is also made as to whether monitoring is needed after discharge from inpatient care. Generally, if the case is severe enough to require admission to a facility, then monitoring is obligatory. Monitoring contracts have to be agreed to and signed and follow that which is recommended by the

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Federation of State Medical Boards (FSMB), in force since April 2011 (http://www.fsmb.org/pdf/grpol_policy-on-physician-impairment.pdf). This policy does have a number of statements that fly in the face of the unfortunate direction in which California has moved, such as “through a formalized contract, each state medical board should have available to it a Physician Health Program [PHP] that meets the standards set by this document and the FSMB-PHP guidelines” and “it is recommended that boards have a non-disciplinary process for referral to PHP to encourage early detection and intervention.” Hopefully the proposed CPPPH program can one day function in the role of a PHP.

The monitoring program for the chemically dependent physician includes regular psychiatric appointments, a workplace monitor, random urine screens, and regular meetings with Alcoholics Anonymous or Narcotics Anonymous. We use the Pacific Assistance Group for support and monitoring services, but other services are available. There is a regular (at least quarterly) report from either Pacific Assistance Group or the treating psychiatrist to the Chair of the WBC, who makes confidential reports to the committee every six months, or more frequently as the need arises.

A full review for people with substance abuse occurs at three years, but it would be an exceptional person who was not monitored for five years. Physicians with mental health issues are monitored until their psychiatrist feels they are fit to return to work.

At the moment we are monitoring five out of 1,200 medical staff. Four others who have been monitored either have left the institution or have done well and are no longer monitored. We have not reached the expected 1 percent, however, so we have been looking at other pathways for referral to our WBC. We have instituted new medical staff policies that require all physicians who have a “driving under the influence” (DUI) citation to be referred to the committee. Since this policy began, we have seen a few referrals, largely residents driving home from a party. All have been assessed to not have a chemical dependency, but rather, poor judgment. All DUIs as a routine are forwarded to the MBC, which makes its own recommendations.

We are attempting to improve self-referrals. To do so the committee, through its education subcommittee, has developed a well-being website, has an education outreach, and meets with faculty and residents at Grand Rounds, faculty meetings and other venues. The website has links to examples of self-assessments for mental illness, substance abuse and burnout. The committee is discussing implementing a routine voluntary screening of medical staff for these maladies. This has already been implemented at UCSD. It consists of an on-line screening tool and requires a part-time psychiatric social worker or

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person with comparable skills. Through the screening tool, a member of the medical staff can confidentially and anonymously e-mail with questions and comments, and hopefully—this is the experience at UCSD—some medical staff will then feel confident enough to self-refer to the committee.

Even if every hospital did achieve success, this would still leave many of our colleagues who do not practice in a hospital setting on their own. Thus the CPPPH is the hope for all physicians in the state in regard to support and monitoring of mental health and substance abuse problems, and we should actively support their efforts.

Our motto as physicians is *Primum Non Nocere*—first do no harm. As we strive to live that ethic for our patients, as is prominent in the ASA Guidelines for the Ethical Practice of Anesthesiology, we also have the ethical responsibility to help each other.

We are available for advice if necessary. We are also aware that each institution has its own medical staff culture and variable support from the hospital's medical staff office. However, an approach such as we have outlined not only protects the physicians, but equally protects patients from harm. Such improvement in patient safety and the resulting reduction in medicolegal risk should be something every hospital should support.

**CMA Physician's
Confidential Assistance Line**

650-756-7787 or 213-383-2691