

## **Report of the Ad Hoc Committee on Physician Impairment**

### **Federation of State Medical Boards of the United States, Inc.**

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.

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#### **Section I. Introduction**

In May 1993, Federation President Hormoz Rassekh, MD, established a special Ad Hoc Committee on Physician Impairment to evaluate current concepts regarding physician impairment and to develop medical board strategies for the regulation and management of such physicians.

After discussion of several forms of physician impairment, the committee elected to focus primarily on chemical dependency, because of its prevalence. In May 1994, Federation President Gerald J. B, champs, MD, expanded the charge to include other impairments to be addressed immediately after guidelines are established for regulating and managing chemically dependent physicians. Other sections on psychiatric and physical impairments will be forthcoming, as well as an additional report on sexual boundary issues.

The ad hoc committee was composed of the following members: Barbara S. Schneidman, MD, MPH, Chair; Roy J. Ellison, Jr., MD; Alexander F. Fleming, JD; Ruth Horowitz, PhD; George J. Van Komen, MD; Maurice J. Martin, MD; Karen W. Perrine, JD; Julie F. Pottorff, JD; Hormoz Rassekh, MD; Nicholas E. Stratas, MD; Gerald L. Summer, MD; John J. Ulwelling; Andrew Watry. Rendel L. Levonian, MD, was consultant, and Gerald J. B, champs, MD, and Robert E. Porter, MD, were ex-officio members.

#### **Section II. Committee's Goals and Outcomes**

The committee discussed at length the specific goals and outcomes they want to achieve. Subsequently, three goals were identified as follows:

1. Develop elements of a model impaired physician program (IPP) to be recommended to state medical boards along with guidelines to promote uniformity in rules/regulations regarding impaired physicians.
2. Enhance the protection of the public through communication with and education of citizens about physician impairment. Communication with the American Medical Association, state medical boards, state medical societies, Administrators in Medicine, as well as providing appropriate articles to the press, were also cited as avenues of disseminating information to the public.
3. Pursue federal and state legislative initiatives, when appropriate, to provide improved powers to state medical boards for the supervision of impaired physicians.

#### **Section III. Development of Survey Instrument**

In order to provide the committee with the information necessary to develop a model IPP, a survey instrument was developed by the committee and distributed to all state medical boards. This survey requested information on IPPs currently available to the state medical boards. Committee recommendations

were derived from both previous board experience and the information received from the questionnaire. Out of 66 surveys mailed, 70% responded. The bulk of the responses received from the state medical boards are incorporated into the following report. Data from the survey is in the appendix.

#### **Section IV. Definitions**

1. Impairment-The inability of a licensee to practice medicine with reasonable skill and safety by reason of:
  - a. mental illness; or
  - b. physical illness or condition, including but not limited to those illnesses or conditions that would adversely affect cognitive, motor, or perceptive skills; or
  - c. habitual or excessive use or abuse of:
  - d. drugs defined in law as controlled substances,
  - e. alcohol, or
  - f. other substances that impair ability.
2. Impaired Physician Program (IPP)-A program approved by the state medical board and charged with the management of physicians who are in need of evaluation and/or treatment. Each state medical board should have available to it a program either under its own auspices or through a formalized contract with an independent entity whose program meets the standard set by the state medical board.

#### **Section V. Model Program**

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:
  - a. 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.
  - b. 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.
  - c. 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. Investigation 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 Section X.
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 Section XI.
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 to state 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.

1. 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.
2. 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.
3. The IPP does not deny services based on a physician's specialty, medical degree, or membership affiliations.
4. The IPP accepts all indigent physician patients and is available for all referrals by state medical boards.
5. The IPP must provide arrangements for emergency evaluations.
6. The IPP must have an aftercare contract consistent with physician rehabilitation and patient safety.

## **Section VI. 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.

## **Section VII. 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.

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

## **Section VIII. 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:

1. 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.
2. 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.
3. 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.
4. 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.
5. The psychiatric history and mental status examination should be performed by a psychiatrist knowledgeable in addictive disease.
  6. 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.
  7. Upon completion of the evaluation, release of all evaluation results will be made to the IPP.
  8. 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.

1. 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.
2. 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.
3. When assessment for mental illness requires residential or hospital inpatient care, it should be for an appropriate period of time.
4. The individual should undergo a complete medical evaluation, including appropriate laboratory and physical examinations. Laboratory examinations should include appropriate urine and blood drug screens.
5. The psychiatric history and mental status examination should be performed by a knowledgeable psychiatrist.
6. 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.
7. Upon completion of the evaluation, release of all evaluation results will be made to the IPP.
8. All physicians who refuse recommended treatment will be subject to state medical board notification by the IPP medical director.

### **Section IX. Treatment Program Criteria**

#### **Chemical Impairment**

1. 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.

2. 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.
3. 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.
4. All physicians who leave treatment against medical advice will be subject to state medical board notification by the IPP.

### **Mental Impairment**

1. 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.
2. 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.
3. 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.
4. All physicians who leave treatment against medical advice will be subject to state medical board notification by the IPP.

### **Section X.**

#### **Follow-Up Care/Discharge Planning for Impaired Physician Program**

##### **Chemical Impairment**

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. 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.

## **Section XI.**

### Relapse Management

#### Chemical Impairment

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. Reevaluation 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.

## **Section XII. Physical Impairment**

The committee recognizes that many competent physicians have a physical disability prior to their medical education and training and have appropriately adapted their medical practice to accommodate their disability. The committee also recognizes that a practicing physician may experience the onset of a physical disability and should be presumed to self-limit or suspend his practice in accordance with his ability to safely practice medicine. However, for some physicians who are unwilling or unable to recognize limitations due to a physical impairment, the board must be able to intervene in order to protect the public. The committee recommends that state medical boards develop capabilities that would allow state medical boards to respond to such physicians with physical impairment. The committee recommends the following:

1. A board should develop the capabilities to have physicians with physical impairments evaluated or assessed by experts in the appropriate field.
2. If the assessment reveals a physical impairment, the board should be informed about the nature and prognosis of the impairment, including whether the condition is treatable.
3. The assessment should apprise the board of the impact of the impairment on the performance of the practice of medicine.
4. Any restrictions or limitations placed on the licensee should be narrowly tailored to reflect the impact of the impairment on the physician's ability to practice with reasonable skill and safety.
5. To the extent possible, resolution of these physical impairment issues should be through informal negotiation rather than formal proceedings.
6. The board should develop mechanisms to allow intervention to occur outside of the board.

## **Section XIII. Allied Health Practitioners**

Impairment programs for allied health professionals should be available for referrals by medical boards. These impairment programs should meet the same criteria for approval as established by the medical board. If the state medical board has jurisdiction over allied health practitioners, appropriate impairment programs should be available

## **Section XIV.**

### **Appendix**

#### The Survey of State Medical Boards Regarding Impaired Physician Programs Summary

On October 22, 1993, a survey instrument was mailed to all member medical boards, requesting information on impaired physician programs (IPPs) available to each board. In November 1993, Federation staff faxed reminders to those state medical boards who had not responded and as of December 30, 1993, 70% of all state medical boards had mailed in their responses.

Question #1: Does your board have a program available that allows the board to deal with impaired physicians? 89% of responding boards indicated they had an IPP available and 11% indicated they did not.

Question #2: Who runs the impaired physician program (IPP)? 48% of boards affirmatively responding to Question #1 reported that the state medical association ran the IPP. 28% reported the state medical board was responsible for the operation of the IPP. 20% indicated some form of joint relationship with another organization, and 8% reported that the IPP was operated by another private contractor.

Question #3: Does your program address other areas of impairment besides chemical impairment? If so, what areas? 85% of responding boards address other areas of impairment besides chemical dependency and 15% indicated they did not. The other areas of impairment that state medical boards address include psychological, physical impairment, and age-related cognitive deficits. 20% of those boards who address other areas of impairment indicated that sexual misconduct is also addressed by their board as an impairment.

Question #4: How is the IPP funded? 35% reported that the IPP was fully funded by the state medical board's budget. A large percentage of IPP budgets come from licensure fees, both initial and renewals. 28% reported that the state medical association is responsible for all costs associated with the IPP. 9% of the medical boards indicated that the IPP was jointly funded by monies received from either a state medical association or program participant in conjunction with monies from the state medical board, and 7% indicated that the program participant is wholly responsible for funding of the IPP. The remaining 21% of responding boards indicated that funding for the IPP is obtained from additional sources, such as insurance companies, federal grants, and hospitals.

Question #5: Does the impaired physician program employ a full-time physician medical director? If not, what percentage of time does the physician medical director devote to the impairment program? 33% reported employment of a full-time physician medical director. Of the remaining 67%, 18% indicated the medical director devotes at least 50% of his time to the IPP, 9% said 25%, 12% said 0%-10%, and 18% did not know how much time the medical director devoted to the IPP.

Question #6: List the major elements of your impaired physician program and identify which of these elements are most effective. Identification of physician impairment was one of the most common elements identified. Evaluation, treatment, and aftercare monitoring were also identified as major elements for a successful and effective IPP. Other program elements that boards felt were effective included intervention, random urinalysis, the 12-Step Program, and trained staffing.

Question #7: If a physician comes before the state medical board, what criteria is used in order to recommend evaluation by the impairment program director? 87% of the responding boards indicated that suspicion of impairment alone was grounds for ordering a suspected impaired physician in for evaluation by the impairment program director or rehabilitation facility. Methods of identifying physicians suspected of being impaired include reports received from medical societies, hospitals, formal complaints, and relatives. Some states have identified specific criteria that must be met before ordering an evaluation. They include:

- a. Is there documented diversion of drugs?
- b. Is there documented consumption of drugs or alcohol?
- c. Are there quality of care issues?
- d. Is there any evidence to deem the physician a potential threat to public safety?

Question #8: Does your state's impairment physician program director have the sole authority to determine if impairment exists? 13% responding indicated that the program director has sole authority to determine if impairment exists, and 85% responded that determination of impairment was made by someone else besides the program director. Usually the board or a specific committee established to address physician impairment will make the decision to refer for further evaluation. In order to protect against conflict of interest, evaluators are required to provide only diagnosis and treatment recommendations. They will not provide the actual treatment and they must not have any personal, legal, or financial relationship to the individual being evaluated.

Question #9: What is the average length of monitoring and who manages follow-up care? 40% of responding boards indicated the average length of monitoring is 3-5 years, 35% said 5 years, and 4% reported that the length of monitoring is indefinite and is determined on a case-by-case basis. The remaining 21% reported monitoring varied from 1-7 years. Overall, most of the boards responding have monitoring contracts that average 3-5 years in length.

The management of follow-up care is predominantly handled by the state medical boards and IPPs. If the board is not responsible for follow-up care, then the IPP medical director is. The responses received to this question indicate that there is a concerted effort between the IPPs, state medical associations, and medical boards to effectively monitor impaired physicians.

Question #10: Does your program have a monitoring contract? For how long? 78% of the responding boards use monitoring contracts, and the most common response to length was 5 years.

Question #11:

- a. Who administers the urinalysis testing? 58% reported that independent laboratories administered the urinalysis testing, 20% use board investigators to handle urine screening, 15% indicated that the IPP is responsible for administering the urinalysis testing, and 7% did not answer.
- b. Who observes the process (urinalysis testing)? Responses to this question were similar to those received in question #11a. The main objective of observing this process is to make sure the samples received are not compromised. The "chain of custody" must be maintained.
- c. Who pays for this monitoring (urinalysis testing)? 87% responded that the program participant is responsible for paying for the urinalysis screenings. If the participant cannot afford to pay for screenings, many times payment may come from alternative sources, ie, insurance companies, medical board, medical society.
- d. Who is responsible for the monitoring during follow-up care? This question is similar to question #9 in that it addresses managing follow-up care. Over 50% of the boards responding indicate that the IPP is responsible for monitoring follow-up care. The medical board and the IPP often work in conjunction with each other in monitoring impaired physicians.

Question #12: Who develops the criteria that identifies physician impairment? 39% of responding boards indicate that the state medical board was solely responsible for the development of criteria that identifies physician impairment, 25% responded that the medical board and IPP share the responsibility of developing the criteria, and 20% responded that the IPP director alone developed the criteria. Expert treatment professionals are being retained by state medical boards to assist in the development of their board's criteria.

Question #13: How are relapses managed? Most of the responding boards indicate that relapses would be dealt with expeditiously, on a case-by-case basis. Circumstances surrounding the reason for relapse, physician's chemical dependency history, and protection of the public are issues that are thoroughly examined before dealing with an impaired physician. The medical boards can order a reevaluation or take formal disciplinary action against a relapsing physician.

Question #14: Does the board have trigger mechanisms that will enable the state medical board to take formal disciplinary action if needed? If so, what are they? If a physician is noncompliant with the terms of his/her monitoring contract, the IPP contacts the state medical board. There are also mandatory reporting requirements for health care providers. Impairment can also be determined by questionable prescribing practices and various other practices that would trigger the board about suspected physician impairment.

Question #15: Do you treat out-of-state applicants for licensure with a history of impairment differently than you do your current licensee population? Please describe how you handle out-of-state applicants with a history of impairment. 61% of responding boards indicated that both out-of-state applicants and in-state licensees are treated the same, and 37% responded that out-of-state applicants are handled differently than current licensees. Most states require an updated assessment of the physician, as well as receipt of the physician's treatment history in the other state. Depending upon how recent the impairment problem was prior to applying for a license will determine if the physician is granted a full and unrestricted license, restricted license, or denial of application. If license is restricted, the physician may also be required to participate in an IPP.

Question #16: What impact will the Americans with Disabilities Act (ADA) have on your program or ability to deal with impaired physicians? Explain. Most state medical boards are in the process of evaluating the ADA and are closely monitoring the New Jersey suit. 59% of responding boards said they are watching what is happening in New Jersey and noted how that case will set a precedent for future actions taken by the boards regarding impairment. Most anticipate only minor impact as it relates to application questions. 20% feel that the ADA will put considerable strain on their ability to handle impaired physicians, and 15% feel that the ADA will have no impact on their program or their board's ability to deal with physician impairment.

Question #17: Do you believe the ADA will infringe upon the effectiveness of the board in dealing with disciplinary matters relating to impairment? Explain. Until further clarification is made regarding the ADA and how it will effect state medical boards, many of the responding boards felt uncertain as to whether the ADA will infringe or not.

## **Section XV. References**

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