The Impaired Physician: Medical, Legal, and Ethical Analysis with a Policy Recommendation

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A young woman came in to see her obstetrician for an ultrasound during her prenatal treatment. This is her third child, so she knows what normal pregnancy is like. She informed the obstetrician that she has had cramping and some spotting, an abnormal occurrence during the first trimester of preg-
nancy. The doctor, who seemed harried and stressed, began the ultrasound and quickly viewed the machine’s monitor. The patient heard the fetal heartbeat and was placated by the doctor’s pronouncement that all seemed well. The doctor left as quickly as she had come in, calling over her shoulder that she would see the patient in three months. The patient dressed and went home. A week later the cramping became worse. The fallopian pregnancy, which the doctor had missed on her quick ultrasound and had been foreshadowed by the cramping, had progressed to a dangerous stage. The fallopian tube began to rupture under the pressure of the ectopic pregnancy. The patient was rushed to the emergency room where she was quickly transferred to emergency surgery. Because the fallopian pregnancy had not been diagnosed at an earlier stage and had not been treated in a timely fashion, an emergency hysterectomy had to be performed. The patient underwent three blood transfusions during her four-day hospital stay and returned home not only having lost the pregnancy, but also having lost the future capacity to have children.

A young man sat on the edge of an examining table in a hospital gown, waiting to be examined for minor back pain which began when he carried his child’s camp trunk up the stairs. When the doctor came in to perform the examination, he appeared disheveled and unkempt. After a brief disorganized examination, the doctor wrote a prescription for pain medication and moved on to the next patient. The pharmacist recognized the doctor’s signature. The doctor was an orthopedist highly respected in the medical community, and so the narcotic prescription was filled without question. The patient took the bottle of pills home and self-administered the medication. The pills, morphine, should have been one milligram each and the patient should have taken no more than two a day. The prescription had been written for ten milligram tablets and the doctor had simply instructed the patient to take them when the pain is bad. The patient woke in the middle of the night from the back pain. Following the doctor’s orders to “take them when the pain is bad,” the patient took two pills and laid back down. The two pills, a lethal dose of morphine, suppressed the patient’s respiratory drive and the young man never awakened.

A patient was wheeled into the operating room for coronary artery bypass surgery. The cardiac surgeon stuck his head in the operating room door and checked that the anesthesiologist was beginning to sedate the patient and gave him a ten-minute warning before the patient will be fully sedated. The cardiac surgeon is a seasoned physician who has earned the universal respect of his colleagues. He is tremendously popular with nurses and residents because he is a patient teacher, skilled surgeon, and has wonderful bedside manner, a skill many surgeons lack. On this morning he looked a bit ragged and seemed to be shaky. He excused himself to the doctor’s lounge to finish
his "breakfast." When he did not return to begin scrubbing for the operation, a resident was sent to retrieve him. The resident entered the lounge to find the doctor swigging from a silver flask before heading for the operating room. The resident, a direct subordinate of the surgeon, looked at him in shock. The surgeon responded to the resident's shock by flippantly replying that he just needs a little swig to steady his hands before surgery and he has done this for thirty years, there is no problem.

Each of the scenarios just described, and many more like them, are an all too frequent occurrence in the field of medicine. Physician addiction is taboo, but this silence injures both the physician and his patients.\(^1\) Alcohol and drug addiction interfere with multiple functions in daily life. There is no doubt, when the addicted individuals are physicians, the interference affects their ability to practice medicine, causing their patients to receive a lower standard of care than they would otherwise receive.\(^2\) In a retrospective study of impaired physicians performed by Murray, most impaired physicians admitted during the interviews that their impairment had negatively influenced their patient care.\(^3\) The cited lapses in care ranged from missing calls or rounds because they were intoxicated to negligently causing the death of a patient.\(^4\) The true surprise is in the number of physicians who are impaired by addiction.\(^5\) A research study performed by Birch and colleagues found that roughly two-thirds of young physicians drink in excess of recommended safe drinking limits.\(^6\) Some experts estimate the rate of addicted physicians to be between seven and twelve percent, similar to that found in the general population.\(^7\) Other experts state that a physician has a thirty percent greater risk of becoming addicted than a member of the general population.\(^8\) Irrespective of the frequency of addiction and relapse among physicians, the

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3. Murray, supra note 1, at 1538.
4. Id.
problem must be addressed with a universal policy. Even one impaired physician who is left practicing medicine is one too many.

Despite the prevalence of physician addiction and subsequent impairment, there is no universal approach to prevention, identification, treatment, or post-recovery follow-up. The purpose of this article is to address and analyze the issues of addiction that are distinct for physicians, culminating in a policy recommendation to address these problems. This policy recommendation addresses current flaws in the system that allow impairment to occur and continue in the medical field. Prevention will be addressed with a thorough education and continuing education requirement for all physicians. Identification, partially remedied by the education obtained in the prevention approach, must also include inducement for self-identification and greater protection for the identifying individual. Essential in both the treatment and follow-up stages of care is a universal approach. This must include confidentiality, if not anonymity, for the individual being treated and individualized care plans. These suggestions combine to create a policy recommendation believed to remedy the current problem of impaired physicians.

II. MEDICAL ANALYSIS

A. An Impaired Physician Is...

The impaired physician is a medical doctor who suffers from alcoholism, drug addiction, or mental illness. Physicians, like other professionals who are responsible for the life of another individual, bear an additional burden in their impairment. The American Medical Association's Council on Mental Health defines physician impairment as, “the inability to practice medicine adequately by reason of physical or mental illness, including alcoholism or drug dependency.” The ramifications of physician impairment go beyond the individual and his personal contacts, and place his patients at greater risk. It is this risk to patients that makes physician impairment incompatible with the practice of medicine. And it is this incompatibility that leads the impaired physicians to further conceal their addiction and continue to practice medicine while impaired. The nature of medicine as a profession emphasizes self-reliance and competence. These traits, ingrained in

9. Id.
12. See Gossop et al., supra note 6, at 162.
the physician from training and practice, make it more difficult for the physician to recognize or admit his own impairment. Impairment, particularly in the form of alcoholism and depression, inhibits the impaired physician's insight. Additionally, the impaired physician often conceals his addiction because the stigma attached to physician impairment makes seeking help significantly more difficult than for the general population. Potential punitive responses may also play a role in incenting concealment. Compound- ing the problems of self-denial and concealment is the fact that physicians have difficulty recognizing and addressing early signs of addiction in their colleagues, though the diagnosis may have been obvious if the addicted individual had been a non-physician patient.

Physicians have both a higher prevalence of impairment and more difficulty obtaining treatment than non-physicians. The high rate of impairment is generally attributed to two sources: the high stress inherent in medical practice and the access to chemical substances. It is clear that the practice of medicine has an intrinsic level of stress greater than that found in most professions. This stress stems from bearing the responsibility for the lives of patients and accountability to both the patients and peer organizations. This stress coupled with relatively easy access to a gamut of pharmacologic substances creates a dangerous temptation for those physicians who feel overwhelmed by their obligations and responsibilities.

13. See Brooke, The Addicted Doctor, supra note 11, at 150.
15. See id. at 31, 35; Gossop et al., supra note 6, at 162.
16. See Gossop et al., supra note 6, at 162–63.
17. Blondell, supra note 7, at 210.
18. Id. In addition to impairment, physicians are at a greater risk for both physical and mental health problems, according to Higgs in his published work on the health of health care workers. R. Higgs, Doctors in Crisis: Creating a Strategy for Mental Health in Health Care Work, 28 J. ROYAL C. PHYSICIANS LONDON 538 (1994).
19. Blondell, supra note 7, at 210. Impairment as a result of occupational stress is a phenomenon that extends beyond the practice of medicine. See Bissell & Jones, supra note 2, at 1142–43. In general, greater responsibility in a chosen field is attributable in part to the attainment of higher education and there is correlation between the attainment of higher education and alcoholism. Id.
20. See Deborah Brooke, Editorial, Why Do Some Doctors Become Addicted?, 91 ADDICTION 317, 317–18 (1996) [hereinafter Brooke, Doctors Become Addicted?]. Included in the concept of “stress” is the understanding that physicians work uncommonly high number of hours per work week. See W.L.M. Baird & M. Morgan, Editorial, Substance Misuse Amongst Anaesthetists, 55 ANAESTHESIA 943, 943 (2000). Attempts to control excessive work hours have been instituted during training in residency and fellowship programs by the Accreditation Counsel for Graduate Medical Education (ACGME). ACGME Highlights Its Standards on Resident Duty Hours—May 2001, http://www.acgme.org/acWebsite/positionpapers/pp_osaResponse.asp (last visited April 17,
gan describe an additional reason for the higher prevalence of impairment among physicians. They propose that physician substance abuse is not merely a result of access to opiates and other potent psychoactive drugs, but in part a result of the physician’s understanding of the intricacies of pharmacodynamics and pharmacokinetics.

Impairment affects the physician’s life both personally and professionally. The physician’s personal life is usually affected first, then his professional interactions with colleagues, and the last area to be affected by impairment is often the physician’s patient care skills. Impaired physicians who might recognize that their addiction is overtaking their personal life still might deny the existence of the problem in their professional life because they fear the stigma and disapproval of their peers, or loss of their ability to practice medicine. Loss of respect or approval by a physician’s peers may threaten their livelihood. One of the greatest fears cited by impaired physicians was the threat of loss of licensure. This is a realistic fear given the fact that the most common reasons for a doctor to appear before his professional disciplinary organization are alcoholism and mental disorder. The looming potential for formal discipline and stigmatization by peers leaves many impaired physicians feeling that they cannot seek help or treatment. The result is that the majority of physician suicides are attributable to alcoholism, drug dependence, and depression. In these and many other ways, impairment harms not only the physician, but also the physician’s family.

2010). The ACGME’s limitations restrict residents and fellows to an eighty hour work week (this includes patient care, administrative work, and academic time). Id. As of the writing of this article, there were no limitations by any governing body on the number of hours house staff and attending physicians can work. Thus the “stress” of medical practice results not merely from the inherent responsibility of medical practice, but also from the sheer quantity of time during which the physician must shoulder this responsibility. See Baird & Morgan, supra note 20, at 943. In a retrospective study of forty-one alcoholic physicians, one of the three primary catalysts for drinking was overwork. Murray, supra note 1, at 1537.

21. See Baird & Morgan, supra note 20, at 943–44.
22. Id. at 943.
24. Blondell, supra note 7, at 211.
25. Gossop et al., supra note 6, at 162.
26. Id.
27. Bohigian et al., supra note 23, at 1079.
30. Baird & Morgan, supra note 20, at 944.
31. See id.
B. Identification of the Impaired Physician

Identifying the impaired physician presents a tremendous challenge. The impaired physician resists identification because addiction carries stigma amongst his colleagues and, potentially, punitive action by the medical licensing body. Colleagues, too, will be reluctant to report an impaired physician because they are fully aware of the harsh ramifications of being labeled impaired. An impaired physician can be identified if his addiction leads to an interaction with law enforcement authorities. For physicians still in training, a supervisor may identify their impairment based on work performance. In most cases, the first people to become aware of the physician’s impairment are family and close friends.32

Many physicians hesitate to approach or identify a colleague. A suspecting colleague may question whether he is correct in assessing the impaired physician’s status. And more subtly, a colleague of an impaired physician does not wish to gain a reputation for “tattling.” In many cases, a colleague may hesitate to identify an impaired physician because he identifies with him, and can easily see himself in his colleague’s shoes. The reluctance to identify an impaired colleague is due in part to the attitude of the profession towards addiction. Only a short time ago in the history of medicine, smoking was socially acceptable despite the knowledge that smoking was unhealthy and even detrimental. Now, as smoking has fallen out of favor, few physicians would hesitate to tell a colleague not to smoke. The progression of alcohol in the attitude of medical professionals is following the same trend. It is progressively less acceptable to drink in excess, and it is not looked on favorably by colleagues.33 But attitudes have not yet progressed to the point where one colleague is likely to tell another that he should not have another drink.34 Although colleagues may hesitate to become involved or to meddle, the impaired physician often craves their assistance, fears asking for it, and wishes it were volunteered.35 A testimonial from one recovering physician states, “to help us the most . . . you must get to know us better and sooner.”36 Yet in the majority of documented cases, colleagues acted only

32. See Edwards, supra note 10, at 1297. As the addiction progresses the impaired physician’s symptoms will become more overt, to the extreme of endangering patients. See id. Before this point, the impaired physician will provide a progressively lower standard of clinical care. See id. This may manifest in forgetfulness, lack of effort, or apathy towards supervision of physicians in training. Id.
33. See Edwards, supra note 10, at 1297–98.
34. See Bissell & Jones, supra note 2, at 1145.
36. Id.
when the physician’s impairment posed great danger to patients. Gossop and his colleagues found that fifty-nine percent of the impaired physician’s colleagues knew of the addiction as a result of impairment at work.

The ramifications of addiction are not restricted to the impaired physician’s professional life. His addiction is likely to get him in trouble in all areas of his life. A physician who is caught driving under the influence may be arrested and convicted, but his trouble may not stop there. It is the practice of some court clerks to send a report to the medical licensing board for that state when there is any criminal proceeding that involves a physician. In some jurisdictions, such as California, the law provides that a physician who has been convicted of more than one alcohol offense is guilty of “unprofessional conduct.” In a study of ninety-eight recovered physicians, they “accumulated . . . 219 arrests and 170 jailings.” Yet in this same sample of ninety-eight recovered physicians, only fifty-eight had been admonished by a colleague, twenty warned by a medical licensing agency, twenty had lost hospital privileges, and nine had their medical license revoked or restricted. These statistics show that the people and their law enforcement representatives are stricter in identifying impaired physicians than is the medical profession. Closing the gap in identification between law enforcement and medical regulatory agencies could be one of many steps taken to assist in early detection and treatment of impaired physicians.

Physician impairment often begins, or is at least foreshadowed, in medical school. Many coping mechanisms that are developed to handle the stress of practicing medicine are developed as a student when the rigors of medical practice are first imposed upon the individual. Most substance use begins in medical school and serves as an ominous predictor of future

37. Murray, supra note 1, at 1538.
40. Id.
41. Id.
42. Id.
43. Bissell & Jones, supra note 2, at 1142–43, 1145.
44. Id. at 1145.
45. Id.
46. A more complete discussion of the laws surrounding impaired physicians is to follow in Part IV, and the discussion of potential solutions will be continued in Part V.
47. Blondell, supra note 7, at 210.
abuse. Yet medical schools traditionally neglect to address substance abuse. There is unifying consensus that early detection and intervention are by far the best approach, yet medical school curriculum does not reflect this. Only twenty-two percent of medical schools have a policy of teaching preventive measures for physician impairment. In one study of emergency medicine residency programs, only thirty-six percent involved instruction on recognition, progression, and treatment of physician impairment. In the same study, thirty percent of program directors had no formal education regarding physician impairment. It would be a vast improvement simply to inform all program directors that every state medical society has a physician impairment program. Program directors cannot bear the full burden of identifying impaired residents because their impressions are based on work performance. A resident’s work performance is largely dependent upon medical knowledge and skill, making it easy to mistake an impaired resident for an unprepared resident. Possible impairment could be attributed to lack of understanding for a specific disease etiology or insufficient training in a specific locus. The impaired student, resident, or fellow will exhibit symptoms in his behavior and interaction with family and friends long before impairment manifests into the work environment.

Identification of an impaired physician should be done using an objective standard. Most commonly used to identify alcohol abuse is a four question assessment called “The CAGE questionnaire” which reads as follows:

1. Have you ever felt that you should cut down on your drinking?
2. Have people ever annoyed you by criticizing your drinking?
3. Have you ever felt bad or guilty about your drinking?

49. Blondell, supra note 7, at 218.
50. Id.
52. Id.
53. Id. at 1074.
54. When the term “impaired physician” or “physician” is used, it is intended to encompass medical students, residents, and fellows.
55. McNamara & Margulies, supra note 51, at 1074.
4. Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover?

Answering yes to more than two questions is indicative of a serious alcohol problem. Identification of chemical abuse or addiction is most commonly based upon multiple symptoms in the following chart.

<table>
<thead>
<tr>
<th>EARLY SIGNS</th>
<th>LATE SIGNS</th>
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<tbody>
<tr>
<td>Alcoholic family members</td>
<td>Family dysfunction</td>
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<tr>
<td>Regular use of alcohol</td>
<td>Depression</td>
</tr>
<tr>
<td>Drinking while studying</td>
<td>Drinking while “on call”</td>
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<tr>
<td>Drinking to relax or to sleep</td>
<td>Auto accidents</td>
</tr>
<tr>
<td>Drinking alone</td>
<td>Poor hygiene</td>
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<tr>
<td>Frequent intoxication</td>
<td>Public intoxication</td>
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<tr>
<td>Blackouts</td>
<td>Memory impairment</td>
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<tr>
<td>Cigarette smoking</td>
<td>Needle marks</td>
</tr>
<tr>
<td>No religious affiliation</td>
<td>Missed work</td>
</tr>
<tr>
<td>Likable personality</td>
<td>Negativism</td>
</tr>
<tr>
<td>Good health</td>
<td>Poor health</td>
</tr>
<tr>
<td>Good grades and patient care</td>
<td>Poor patient care</td>
</tr>
</tbody>
</table>

57. In the McNamara and Margulies study, these were the four criterion presented to the program directors. McNamara & Margulies, supra note 51, at 1074. The report states that a "substantial number of program directors reported no or only slight knowledge of four key areas regarding impaired physicians." Id.

58. Blondell, supra note 7, at 211 (organizing data from David C. Clark et al., Alcohol-Use Patterns Through Medical School: A Longitudinal Study of One Class, 257 JAMA 2921, 2923 (1987)).
In order to utilize these two tools, medical institutions—medical schools, residency training programs, fellowship training programs, hospitals, and other medical institutions—must have policies and procedures in place to handle the impaired physician. These policies must include education on impairment, identification of the impaired individual, modes of intervention, requirements for treatment, policy on reporting to licensing agencies, and procedures for re-incorporating the recovering physician into the medical profession. Failure to have such a plan leads to an inappropriate response which ultimately results in an inferior outcome.\(^{59}\)

C. Intervention and Treatment of the Impaired Physician

There is no single right way to intervene and treat an impaired physician, but there are consistent elements that must be present in the treatment of every case. Each state has its own impaired physician program, all with similarities and differences. Many are affiliated with Alcoholics Anonymous or Caduceus, which aids continuity for the impaired physician when he completes the formal treatment program.\(^{60}\) First and foremost is the understanding that identifying and treating the impaired physician earlier in the course of their addiction is the action that has the most influence over the outcome.\(^{61}\) It is not adequate to wait until the impaired physician manifests the symptoms of full or severe addiction before intervening and treating.\(^{62}\) The professionals who intervene and treat the impaired physician must exude hope and potential for recovery or the impaired physician may view continued substance abuse or suicide as better options.\(^{63}\) It is essential that within the positive attitude there is no hint of condescension.\(^{64}\) Confidentiality is another key element to successful intervention and treatment. The impaired physician is likely to fear exposure to colleagues and thus deny addiction or refuse treatment.\(^{65}\) In general, the impaired physician does best when treated

\(^{59}\) See Blondell, supra note 7, at 211–212.


\(^{61}\) Nelson et al., supra note 7, at 34.

\(^{62}\) Blondell, supra note 7, at 217.

\(^{63}\) Id. at 215.

\(^{64}\) Steinbicker, supra note 35.

\(^{65}\) See K. Rawnsley, Helping the Sick Doctor: A New Service, 291 Brit. Med. J. 922, 922 (1985). It is commonly more effective to offer the impaired physician treatment outside of the medical community in which he works. Id. This option removes the possibility of colleagues developing a protective collusion that hinders recovery. Id. Additionally, the impaired physician may be more comfortable attending a facility in which none of his colleagues treat him. See id.
in an in-patient unit, particularly if the unit is dedicated specifically to the treatment of medical professionals so that the impaired physician is not being treated alongside non-medical professionals. The standard progression of treatment following the in-patient stay is a halfway house program that segues into an outpatient follow-up program.

There is universal consensus that early identification and intervention result in the best outcome. The first statewide diversion program officiated by the medical board began in 1989 in Oregon, and now serves as the model for other state medical boards to emulate. The Oregon diversion program "starts with a focus on early identification and active intervention." British journals cite the American practice of early intervention to stress the urgency of halting addiction before it escalates to a chronic level. The early stages of impairment tend to correlate with the early stages of a physician's career. It is during these early stages that physicians commonly adopt the habit of drinking in excess or using other chemicals as a means of escape. These students can be preliminarily identified by anxiety and stress during training. In the training period for a physician, which includes medical school, residency, and fellowship, the student is supervised and evaluated regularly. This observation by a senior physician provides a window of opportunity to identify and treat the impaired physician. If addiction is missed during training, the physician may progress through several years of medical practice and worsening addiction before the impairment is recognized by a colleague. Additionally, program directors are more likely to refer a physician-in-training to a treatment program than colleagues would be to refer another physician because the physician-in-training is not threatened with license sanctions or negative implications on their career. The hierarchy of medicine places an attending physician in a pedagogic position of authority, with little to no personal risk from reporting a subordinate as there would be.

67. Gossop et al., supra note 6, at 163.
68. Steinbicker, supra note 39.
69. Nelson et al., supra note 7, at 31–32.
71. See Gossop et al., supra note 6, at 160, 163.
72. Id. at 160.
73. Id.
75. Blondell, supra note 7, at 210–11.
76. Id.
77. Nelson et al., supra note 7, at 34.
if reporting a colleague. Despite these facts, the number of impaired residents being identified does not correlate to the number of residents who are impaired. McNamara and Margulies found that residency program directors identified one percent of their residents as impaired and intervened. The CAGE results for the same group of residents revealed that over twelve percent were either addicted or severely abusing chemical substances. 

Thomas, Santora, and Shaffer demonstrated the ability to identify potential impaired physicians during training by their stress level. Their retrospective study demonstrated that those physicians who were mid-life drinkers exhibited significantly more stress and anxiety than physicians who in mid-life are non-drinkers.

An important, yet generally lacking, element of early detection is education. Physicians must be taught how to identify the signs and symptoms of addiction both in themselves and their colleagues. In addition they must be taught how to help the impaired colleague, or how to help themselves. This training should begin in medical school, be reinforced in residency and fellowship, and be continually discussed during continuing medical education. In addition, medical institutions should form an “Impaired Physician Committee” that would be charged with educating all members of the staff about identification, available resources and access to resources.

The initial hurdle in treating an impaired physician is actually getting him to commit to a treatment program. There are two ways an impaired physician enters a treatment program: voluntarily or by referral. Impaired physicians who choose to enter a program voluntarily are rewarded with anonymity. This allows them to arrest the progression of their addiction and recover without public exposure, disciplinary action, restriction of privileges, or loss of license. Voluntary entrance into a treatment program does not usually occur until a relatively late stage of addiction. This is in part because the impaired physician is often not able to recognize the progression of their chemical dependency, and also in part because denial is a classic companion

78. McNamara & Margulies, supra note 51.
79. Id.
80. Id.
82. Id.; Brooke, Doctors Become Addicted?, supra note 20, at 317.
83. Blondell, supra note 7, at 211-12.
84. In a study published in the British Medical Journal, a retrospective examination of impaired physicians in the follow-up stage of recovery demonstrated that the degree of cooperation in treatment did not affect the outcome. Murray, supra note 1, at 1537-39.
85. Bohigian et al., supra note 23, at 1078.
to addiction. Thus, without external aid, the impaired physician is not likely to seek assistance "until late in the course of [his] illness." 

In cases of referral, knowledgeable physician colleagues are the preferred method of entering a treatment program. Often the referral of an impaired physician to a treatment program is either by a superior in his medical institution or by an accreditation or licensing board resulting from an investigation after a problem in the work environment. Approximately forty percent of referrals stem from poor work performance, and another thirty percent of referrals are catalyzed by some form of "disciplinary action or the threat of disciplinary action." A referral, irrespective of the source or cause, must be kept confidential. Most medical association treatment programs have a strict policy to keep impaired physician’s information confidential. Some go so far as to not retain records and to identify impaired physicians by a given number and not by name. The British Medical Association, quoting success in American programs, reported that health care professionals in treatment are entitled to the highest standard of confidentiality.

The burden of treatment for impaired physicians falls not only on the impaired physician’s shoulders, but on the shoulders of the greater medical community. Impaired physicians must be treated individually. Their treatment and recovery program must contain certain universal necessities, but those involved in providing treatment must tailor the program to the individual patient. Society in general has an expectation that medical professionals will not abuse chemical substances. This stems from the understanding that physicians guide and lead their patients by example as well as by treatment. Physicians are expected to set a healthy example by not smoking, exercising regularly, and seeking regular medical check-ups. This example cannot be imposed as moral judgment and may not be presented in a fashion of moral superiority. Such a negative approach will not aid the impaired physician in treatment or recovery, and may inhibit other impaired physicians from seeking treatment. The illness of one health care professional affects and reflects on the greater health care community. Colleagues who

86. Blondell, supra note 7, at 213.
87. Id.
88. Id. at 209.
89. Gossop et al., supra note 6, at 161.
90. Baird & Morgan, supra note 20, at 943.
93. Edwards, supra note 10, at 1297.
are supportive and compassionate without being judgmental are all integral parts of a positive outcome for the impaired physician.  

D. Prevention of Recovered Impaired Physician Relapse

Physical recovery from addiction is a quick and relatively small part of the impaired physician’s recovery; it is the mental recovery that lasts a lifetime. Addiction is a progressive and chronic disease in which the impaired person uses and abuses chemical substances, despite personal knowledge of the negative ramifications. The chemical substance progressively controls the addicted, both physically and mentally. Cessation of use, depending on the chemical, may cause physical withdrawal. The nature of addiction leaves the impaired subject vulnerable to relapse during any stage of recovery. Thus a significant portion of treatment effort must be funneled to ensuring that the impaired physician does not succumb to relapse.

Relapse is a significant concern, particularly when the impaired physician returns to patient care. Monitoring and follow-up care, like initial addiction treatment, does not have a specific recipe; rather, this stage must also be tailored to the individual in question. Shore studied the probationary periods of recovered impaired physicians and found that probation ranged in length from one month to one hundred and twenty months. In a focus group of his study, eighteen of the thirty-four physicians experienced a total of forty relapses. The Rand study, a study focusing on addicts with “serious dependency profiles,” reports a fifty-six percent relapse rate. Baird, who focuses on impaired anesthesiologists, cites a forty percent relapse rate during the first two years of recovery. He goes on to state that eighty percent of recovered impaired anesthesiologists successfully return to clinical practice. Ulwelling found that forty-nine percent of impaired physicians relapsed at an average of twenty-two months. The prognosis is not as dour

94. Baird & Morgan, supra note 20, at 944.
96. Blondell refers to relapse as a “common” occurrence. Blondell, supra note 7, at 209.
98. Id.
100. Baird & Morgan, supra note 20, at 944.
102. Ulwelling, supra note 70.
as it may seem; impaired physicians typically have more favorable outcomes than the general public. 103

Multiple factors contribute to the successful recovery of the impaired physician. Many impaired physician treatment programs cater directly to these needs, acknowledging that the ultimate goal is to reincorporate the impaired physician as a practitioner in the medical community. To attain and sustain this goal the impaired physician requires a combination of factors including, but not limited to, support of colleagues, support groups angled towards impaired physicians, outpatient follow-up care, and monitoring and advocacy during any probationary period of return to work.

The process of recovery is dynamic; the recovering impaired physician requires different resources as their recovery evolves. 104 In the beginning, most impaired physicians require the guidance and support of professional health care providers. 105 Ultimately, many recovered impaired physicians model their own practice of medicine to help and treat other addicts. 106 In testimonials provided by recovered alcoholic physicians, Doctors’ and Dentists’ Group of Alcoholics Anonymous and general Alcoholics Anonymous groups were pivotal and invaluable components of their recovery. 107 Alcoholics Anonymous provides continuity for the recovered impaired physician as they progress through the stages of recovery. 108 This is particularly important for physicians who traveled to treatment facilities in another geographical location for treatment, for whom continued care is often a stumbling block. Additionally, Alcoholics Anonymous endorses camaraderie amongst the participants, creating an environment that can be warm and accepting. 109 The comfort found in this environment is strikingly different from the more sterile and detached atmosphere found in most psychiatric facilities. 110 Research demonstrates that a cohesive support system, such as that found in Alcoholics Anonymous, serves to reinforce good behavior. 111

Toxicology testing is another common element of follow-up care. One approach is to use Alcoholics Anonymous in conjunction with random toxi-

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103. Blondell, supra note 7, at 216.
105. Id.
106. See Mark Galanter et al., Combined Alcoholics Anonymous and Professional Care for Addicted Physicians, 147 AM. J. PSYCHIATRY 64, 66, 68 (1990).
107. Id. at 66; Treatment for GPs with a Drink Problem, 8 PRACTITIONER 1059 (1989).
108. See Galanter et al., supra note 106, at 67.
109. Id.
110. See Jones, supra note 104, at 1122; Galanter et al., supra note 106, at 67–68.
Ulwelling found that random urine monitoring had a positive correlation with successful treatment outcome. He went on to show that if a recovered impaired physician does not relapse in the first four years, they are not likely to relapse. If the impaired physician arrived at treatment by referral, they will be followed upon release by the applicable medical board. Recovered impaired physicians who are followed closely in this manner have a high success rate. If a relapse occurs, close monitoring often allows detection before a positive drug screen demonstrates that relapse has occurred.

If the recovered impaired physician is returning to clinical treatment, medical facilities may institute additional requirements before granting practice privileges. Some examples are restrictions on access to controlled substances, and medications to be taken for any ailment must be done under the supervision of a physician who is aware of the individual’s recovery status. Some institutions may limit the scope of practice or the recovered impaired physician’s prescribing capacity. The arrangements between privilege granting facilities and the recovered impaired physician are similar to all the previous stages of treatment and recovery in that it must be individualized to each specific case.

## III. LEGAL ANALYSIS

### A. Impaired Physician Legislation

Every state in the union has an established treatment program for impaired physicians. In the early 1970s, the American Medical Association...
began to focus attention on the issue of impaired physicians.\textsuperscript{122} This began the national transformation that culminated in an impaired physician treatment program in each state.\textsuperscript{123} The first state medical board to establish a statewide impaired physician program was Oregon.\textsuperscript{124} The Oregon Senate, in 1989, passed Senate Bill 1032 which established funding and structure for the Diversion Program Supervisory Council and its medical director.\textsuperscript{125} In addition, the Accreditation Council for Graduate Medical Education mandates that program directors in certain medical fields, "identify impaired physicians and intervene appropriately."\textsuperscript{126} The effects of this obligation are evident in the most recent surveys which indicate that eighty-two percent of programs have a policy regarding impaired physicians.\textsuperscript{127}

The impaired physician's addiction has ramifications beyond their medical practice. The impaired physician, like any other substance abuser, is likely to come into contact with law enforcement.\textsuperscript{128} It is the practice in some states, and is the law in others, that when a physician is convicted of a criminal offense, the medical board is notified.\textsuperscript{129} In the year 2001, the Federation of State Medical Boards gave 335 disciplinary actions for non-medical related offenses.\textsuperscript{130} In the majority of jurisdictions, a conviction for driving under the influence will lead to a state board investigation to determine if the incident was isolated or evidence of impairment.\textsuperscript{131} Despite this practice, the public response to impaired individuals\textsuperscript{132} is harsher and more

\begin{itemize}
  \item \textsuperscript{122} Ulwelling, supra note 70, at 21.
  \item \textsuperscript{123} See Federation of State Physician Health Programs, History, http://www.fsphp.org/History.html (last visited Apr. 17, 2010); Gossop et al., supra note 6, at 160.
  \item \textsuperscript{124} John J. Ulwelling & John F. Christensen, Northwest Center for Physician Well-Being, 174 W. J. MEd. 70, 71 (2001).
  \item \textsuperscript{125} Id. The funding for the Diversion Program Supervisory Council and the medical director is funded by medical licensees' fees, which at time of publication were twenty five dollars each year. Ulwelling, supra note 70, at 21. Cumulatively, these fees raised roughly one hundred and sixty thousand dollars per year. Id.
  \item \textsuperscript{126} Dubovksy et al., supra note 8, at 447.
  \item \textsuperscript{127} McNamara & Margulies, supra note 51, at 1072. The Accreditation Council for Graduate Medical Education initially required this of emergency medicine residencies. Id.
  \item \textsuperscript{128} Bissell & Jones, supra note 2, at 1145. Contact with law enforcement refers to incidents such as driving under the influence and disorderly conduct.
  \item \textsuperscript{129} See Rice, supra note 39, at 88. Some states go so far as to notify the medical board if a physician is arrested. Id.
  \item \textsuperscript{130} Id.
  \item \textsuperscript{131} Id.
  \item \textsuperscript{132} Public response refers to arrests, jailing, revocation or suspension of driver's license. Bissell & Jones, supra note 2, at 1145. Medical society's response most often consists of warnings with proportionally low amount of medical license suspensions or loss of hospital privileges. Id.
\end{itemize}
frequent than the medical societies' responses. In a study of 100 impaired physicians, only three had their license revoked, fifteen had their license suspended, and nineteen had restrictions placed on their practice. This means that more than half of the impaired physicians in this study received no reprimand from the medical society. Blondell, in his article on impaired physicians, concludes that physicians must address the lack of response to impairment by medical societies or the legislature will do it for them.

B. **Legal Aspects of Reporting the Impaired Physician**

Many impaired physician treatment programs offer anonymity as an incentive to enroll voluntarily. Impaired physicians who do so and successfully complete the program may never come into contact with the licensing agency or medical board. Although the promise of anonymity acts as incentive to enroll in the treatment program with the ultimate goal of physician recovery, there is a little-discussed negative. An impaired physician who completes the treatment program and returns to clinical practice may do so without anyone else's knowledge. Specifically, it is possible for an impaired physician to voluntarily receive treatment and have none of his colleagues or superiors become aware that a problem existed. Given the high incident of relapse, significant risk to patients still exists. As noted in the discussion of treatment programs, follow up care and close monitoring are essential parts of a treatment and recovery program for an impaired physician. The impaired physician who maintains complete anonymity will not be followed or additionally supervised once he completes the treatment program.

Impaired physicians who self-refer to treatment programs may be required to expose themselves as impaired on license applications and renewals. Physicians must renew their license on an annual basis. One step in the license renewal process is answering a series of questions including ques-

133. *Id.*
135. Blondell, *supra* note 7, at 217–18. It is inherent in his writing that Dr. Blondell believes legislation, rather than response within the medical community, would not be a positive solution. *Id.*
136. Nelson et al., *supra* note 7, at 32.
138. As detailed in the previous section, multiple studies report the relapse rate for recovered impaired physicians is between forty and fifty-five percent in the first two to four years.
139. See discussion *supra*, Part II.C.
140. Peyser, *supra* note 137, at 517.
tions about substance abuse and treatment. The phrasing of the question and what information must be reported by mandate varies by state. Currently, many state psychiatric associations are lobbying to have the impairment and substance abuse questions reflect current impairment and not past history of impairment. This would allow the physician to move from state to state, receive license reciprocity in the new state, and then relapse. If the impaired physician continually enrolls in the treatment program voluntarily, it may be possible for him to transfer from state to state each time he relapses. This loophole has the potential to put patient populations at grave risk. The Federation of State Medical Boards has made a progression towards closing this loophole by creating the practice of information sharing between state medical boards. This progression, while a strong attempt to move in the right direction, does not address the full problem. State medical boards share information about disciplinary action taken against a physician, but as we have seen in the statistics, less than half the impaired physicians ever received formal discipline from their medical board. In addition, the extent of action taken may vary between states as well as the determination of what discipline is significant enough to report. Finally, most medical "boards do not report licensure denials."

The American Medical Association’s Council on Mental Health in its report on physician impairment states, “[I]t is the physician’s ethical responsibility to take cognizance of a colleague’s inability to practice medicine adequately by reason of physical or mental illness including alcoholism and drug dependence.” Despite this ethical obligation, many physicians hesitate to report a colleague for two primary reasons. First is the general perception among physicians that the counseling programs for impaired physicians are inadequate. Second is the fear of liability.

141. Id.
142. See id.
143. Id.
145. Id.
146. Id.
147. Id.
148. Id.
149. Kusserow et al., supra note 144, at 823.
The fear of liability for third parties\textsuperscript{153} can influence the decision to report an impaired physician in either direction.\textsuperscript{154} Fear of liability for slander may prevent a person from reporting a physician's alleged impairment. To date, there is no record of a successful slander suit against a reporter whose report can be justified with evidence even if the alleged impairment is ultimately unfounded. This can be interpreted as the court system protecting the honest reporter or it could simply be a function of out of court settlements driven by social pressures on the parties involved. Opposing the fear of liability for slander is the fear of liability for negligence.\textsuperscript{155} The impaired physician's employer can be held liable for negligence if a patient injury results from the impaired physician's practice of medicine.\textsuperscript{156} Thus, there is incentive for colleagues and employers to refer an impaired physician to a treatment program.\textsuperscript{157}

Impaired physicians who are referred to treatment programs may have a greater potential for successful recovery.\textsuperscript{158} When the impaired physician enters a treatment program by referral, the appropriate medical board is notified.\textsuperscript{159} As detailed in the medical analysis section of this paper, impaired physicians fear losing their license to practice medicine.\textsuperscript{160} If the impaired physician is known to the medical board, the incentive to participate and succeed in the treatment program increases.\textsuperscript{161} Additionally, when the impaired physician completes the inpatient and halfway house portions of their treatment and begins to reintegrate into the clinical environment, the medical board participates in the follow up care to help ensure patient safety.\textsuperscript{162}

In addition to self-reporting and colleague/employer reporting, a patient who believes that his physician is impaired may take action.\textsuperscript{163} The patient
has two venues in which he can file his complaint. One option is for the patient to sue the physician for malpractice. In a malpractice suit the patient will have the burden to prove four elements: duty, breach, damage, and causation. Another option is for the patient to file a complaint with the licensing board, in which case the patient need only prove duty and breach for the board to take action. There are significant distinctions between a malpractice suit and a complaint filed with the licensing agency. To begin, the patient does not need to have suffered injury at the hands of the allegedly impaired physician to file a complaint with the licensing agency. This narrower scope of investigation makes a complaint to the licensing board significantly easier to verify than a malpractice suit. In the case of a successful malpractice suit, the patient will likely receive monetary compensation for their injury. To the contrary, a complaint to the licensing agency that is found to be meritorious does not provide any tangible compensation to the complaining patient. Instead the patient acts altruistically because the tangible benefit of the complaint is to protect future patients from harm. A complaint filed with the licensing board is arguably the most effective means of prevention because it is the licensing board’s primary goal to protect patients from unqualified physicians.

C. Impairment in the Context of the Americans with Disabilities Act

Individuals who are deemed disabled under the Americans with Disabilities Act (ADA) are afforded protection from discrimination based upon their disability. The general rule, as defined in 42 U.S.C. § 12112 states, “No covered entity shall discriminate against a qualified individual on the basis of disability in regard to job application procedures, the hiring, advancement, or discharge of employees, employee compensation, job training, and other

164. See id.
165. In order to file a suit alleging malpractice, the patient must have the ability to claim some form of damage that resulted from the physician. See id. at 252.
166. Id.
167. Id. at 252, 254.
168. See ANNAS, supra note 163, at 254.
169. Id. at 252.
170. See id. at 254. A physician does not necessarily lose their license to practice medicine as a result of a successful malpractice suit. See id. at 253.
171. Id. at 254.
172. ANNAS, supra note 163, at 254.
173. See id.
To establish a prima facie case of discrimination that violates the ADA, the *McDonnell Douglas* framework is used. The plaintiff must establish: (1) he is disabled or regarded as disabled within the meaning of the ADA; (2) he is qualified to perform the essential functions of the job; and (3) he was subjected to an adverse employment action solely on account of his disability.

In accordance with the *McDonnell Douglas* framework, the foundational question is whether or not alcohol or substance abuse/addiction qualifies as a disability under the ADA. The court in *Burch v. Coca-Cola Co.* determined that alcoholism is not a per se disability as defined by the ADA. Irrespective of a disability's status under the ADA, the courts have held that if the employer treats the individual as though they are impaired, the disability automatically becomes considered a disability under the ADA. From this we must conclude that an impaired physician would be protected from discrimination—in the form of termination, restricted privileges, etc.—based solely on his impairment.

175. *Id.*
177. *Id.* at 802; see, e.g., Holbrook *v. City of Alpharetta*, 112 F.3d 1522, 1525 (11th Cir. 1997) (where a police officer injured in an accident claimed he was discriminated against as a result of his disability and the district court granted the city's motion for summary judgment because the officer was no longer able to perform the essential functions of the job but the city had maintained his job title, wages, and benefits); Aucutt *v. Six Flags Over Mid-Am., Inc.*, 85 F.3d 1311, 1320 (8th Cir. 1996) (where the court granted summary judgment to employer because plaintiff failed to establish that he was disabled within the meaning of the ADA); *Bacon v. Great Plains Mfg., Inc.*, 958 F. Supp. 523, 531 (D. Kan. 1997) (where a former employer was not held liable under the ADA because plaintiff did not show former employer knew of her disability, nor did she show that she had a disability that qualified under the ADA).
179. 119 F.3d 305 (5th Cir. 1997).
180. *Id.* at 316.
181. 42 U.S.C. § 12102(1)(C) (2006); see, e.g., Holihan *v. Lucky Stores, Inc.*, 87 F.3d 362, 363 (9th Cir. 1996). Holihan acted in an abusive, hostile and threatening manner towards several employees. *Id.* at 364. Holihan's supervisors inquired if he had any problems that they could help him with, which Holihan denied. *Id.* Holihan was transferred to a different store where he had multiple outbursts. *Id.* Holihan's supervisors offered him the choice of suspension pending investigation or a leave of absence if he contacted the company's employee assistance program. *Id.* The judge held that, "a reasonable jury could infer that Lucky regarded Holihan as suffering from a disabling mental condition that substantially limited his ability to work." *Holihan*, 87 F.3d at 366.
The prohibition against employment discrimination based on disability in the ADA sets precedent for changing the questions asked in the licensing and credentialing process. ¹⁸² The ADA prohibits questions about an individual’s past history of disability in the employment context because it is intrusive and would require an unnecessary disclosure of private information. ¹⁸³ The ADA does not apply directly to the licensing and credentialing process, but the rationale used when drafting the legislation lays the groundwork for changing the licensing and credentialing process to be held to the same standard as other employment activities. ¹⁸⁴

D. Informed Consent and Disclosure of Prior Impairment to Patients

The doctrine of informed consent is the principle that “[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body.”¹⁸⁵ This doctrine guides the physician-patient relationship. The physician must disclose a standardized amount of information before receiving consent to perform a procedure.¹⁸⁶ The physician must disclose the diagnosis, including further tests and evaluations and their nature and purpose.¹⁸⁷ The physician may emphasize which treatment modality he would recommend based on his expertise, but he must also disclose all the possible options.¹⁸⁸ The physician must also disclose the risks associated with each treatment option.¹⁸⁹ Informed consent is necessary prior to treatment.¹⁹⁰ If informed consent is not obtained, the treatment may be technically considered battery, and the physician could be held liable.¹⁹¹

The remaining question is whether an impaired physician has the obligation to disclose his addiction to a patient prior to performing a treatment. Some states have adopted a patient-centered standard for disclosure, requiring the physician to disclose any information that could be material to the

¹⁸². Peyser, supra note 137, at 517.
¹⁸³. Id.
¹⁸⁴. See id.
¹⁸⁷. Id.
¹⁸⁸. Id. at 83. Included in the treatment options must be the option to refuse care.  See Truman v. Thomas, 611 P.2d 902, 906 (Cal. 1980).
¹⁹¹. Id. (applying the rule in Gray v. Grunnagle, 223 A.2d 663, 674 (Pa. 1966)).
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patient's decision. Spielman states that "the test for determining whether a particular peril must be divulged is its materiality to the patient's decision: all risk potentially affecting the decision must be unmasked."193 This standard is troublesome to many physicians who do not tend to share information on their own competence when discussing informed consent. Rather, physicians are accustomed to controlling the quantity and content of information flow between themselves and their patients.194 Physicians do not expect, nor do they want, the patient expanding the topics of discussion during informed consent.195 The closest analogy is physicians informing a patient of a mistake they have made that caused the patient injury.196

In Kaskie v. Wright,197 an alcoholic physician performed emergency surgery on an injured child without informing the child's parents of his impairment.198 Although the statute of limitations had run before the case was filed, the court addressed the issue in their decision.199 The court, referencing Boyer v. Smith,200 stated that there must have been a "touching," but that negligence is not necessary for recovery.201 It described consent to treatment as a contractual arrangement by which any "contact with the patient's body must be agreed to."202 The court followed the precedent set out in Boyer and refused to expand the doctrine of informed consent "to include matters not specifically germane to surgical or operative treatment."203

In Ornelas v. Fry,204 a kidney transplant from one sibling to another failed.205 During the surgery, the kidney-receiving sibling "bucked," an ac-

192. Bethany Spielman, Expanding the Boundaries of Informed Consent: Disclosing Alcoholism and HIV Status to Patients, 93 AM. J. MED. 216–18 (1992). Two states specified in this study are Louisiana and New Jersey. Id.
193. Id.
195. See Roger W. Shuy, Three Types of Interference to an Effective Exchange of Information in the Medical Interview, in THE SOCIAL ORGANIZATION OF DOCTOR-PATIENT COMMUNICATION 17, 24 (Sue Fisher & Alexandra Todd eds., 2d ed. 1993); Spielman, supra note 192, at 216–18.
196. The issue of disclosing addiction is akin to the issue of a physician disclosing his HIV status. Few, if any, physicians disclose to a patient if they themselves are HIV positive. Spielman, supra note 192, at 216–18.
198. Id. at 214.
199. Id. at 214–15.
201. Kaskie, 589 A.2d at 216.
202. Id.
203. Id. at 217.
205. See id. at 820.
tion akin to coughing. The motion tore stitches from the recently attached kidney, and emergency suturing had to be done. The kidney was removed a few days later; ultimately the transplant recipient died. The family alleged that the "bucking" was a result of negligent anesthesia. They brought suit against the anesthesiologist alleging that he did not disclose his status as an alcoholic, which they believed to have been the proximate cause of their son's death. The court held that the anesthesiologist's status as an alcoholic did not in itself prove the claim of negligence. The court went on to say that negligence could only be proven if his alcoholism translated to a lower standard of care. The court concluded that the plaintiffs had not demonstrated evidence that the anesthesiologist's alcoholism played a relevant factor in the poor outcome of the surgery.

In Hidding v. Williams, the court found differently than the above cases. Mr. Hidding was operated on by an alcoholic physician. The physician neglected to disclose the risk of loss of control over bowel function. He also neglected to disclose his status as a chronic alcoholic. The court concluded that this doctor's failure to disclose his impairment vitiated the patient's consent to surgery. The court justified this decision by stating that had the patient known this piece of information, it is likely he would have elected to have the surgery performed by a different physician. Different forms of physician impairment should be compared in the analysis of what information should be disclosed to a patient about the provider. A common comparison is made between an alcoholic physician and an HIV-positive physician. If a provider has the obligation to reveal his HIV-positive status to a patient because there is risk of transmission, does the same obligation exist for an alcoholic physician to reveal his addiction because there is an increased risk of error and/or complication? In Estate of

206. Id.
207. Id.
208. Id. at 820–21.
209. Ornelas, 727 P.2d at 821.
210. Id.
211. Id. at 823.
212. Id.
213. Id.
215. See id. at 1198.
216. Id.
217. Id. at 1196.
218. Id.
219. Hidding, 578 So. 2d at 1196.
220. Id.
Behringer v. Medical Center at Princeton,\footnote{221} the Superior Court of New Jersey held that the Medical Center could suspend Dr. Behringer's surgical privileges based on his positive diagnosis of AIDS.\footnote{222} The court went further to say that the Medical Center properly conditioned the return of Dr. Behringer's surgical privileges on the mandate that he obtain informed consent, "as a physician with a positive diagnosis of AIDS" from every surgical patient.\footnote{223}

There is no clear consensus in the courts or in the medical literature about physician disclosure and the informed consent process. These opposing interests, the patient's interest in information and the physician's interest in privacy, are not calculable to an exact science.\footnote{224} Just as each patient is treated individually, each physician and each informed consent process must be taken individually.\footnote{225}

E. Policy for Impairment in Professions Outside the Medical Arena

Impairment from alcohol or drug addiction is a significant concern in any profession in which one individual is responsible for another human being. Physician impairment can be compared to pilot impairment and firefighter impairment, to name only a few. All professions which entail public safety share the same universal public policy initiative, to protect the public which the profession is there to serve. This shared goal creates a dichotomy of two competing interests—the interest of the public and the interest of the professional. In the case of impairment, these competing interests are multiplied.

In the case of a pilot, physician, or firefighter who is impaired, the public that each profession serves is placed in a precarious situation. The passengers on a plane, the patient in pre-operative preparation, and the innocent victim in a burning building or car accident do not know or have control over the abilities of the professional who is there to assist them. Yet, the outcome is less likely to be positive because an impaired professional is providing substandard services. From the perspective of the service consumer, it seems logical to ban impaired professionals. On the other hand, the impaired professional is also a person with inherent self-worth who is suffering from an illness beyond his control. Removing him from the profession or even publicly acknowledging his impairment, even for the sake of treatment, may cause great harm. The impaired physician may be the sole provider for his
family and removing him from work may adversely affect all the members of his family. In addition to the potential economic hardship, the impaired physician may suffer as a result of the stigma his illness carries.

Although many levels of assistance are available to the impaired professional, society ultimately places the public's interests above the professional's personal interests. We see this decision expressed in our legislative system with regulation of narcotics and opiates as well as age restrictions and activity restrictions on alcohol. In addition, a number of court cases have reiterated this point in decisions concerning impaired professionals. Each of these cases abided by the public policy notion that the safety of the general public outweighed the interests of the impaired professional.

IV. ETHICAL ANALYSIS

The ideal foundation for healthcare policy stems from the express values of society. In the field of bioethics, the predominant approach to the application of these values is through the theory of Principality. The economic hindrance may be short term or long term. In the short term, the family will have no source of income; in the long term, the professional may be shunned and lose his or her cliental or the endorsement of his peers, both of which may lead to his or her ultimate economic demise.

227. See, e.g., D'Amico v. City of New York, 955 F. Supp. 294 (S.D.N.Y. 1997); Montegue v. City of New Orleans, No. CIV. A. 95-2420, 1997 WL 327113 (E.D. La. June 12, 1997); Judice v. Hosp. Serv. Dist. No. 1, 919 F. Supp. 978 (E.D. La. 1996); Altman v. N.Y. City Health & Hosps. Corp., 100 F.3d 1054 (2d Cir. 1996). In D'Amico v. City of New York, a firefighter was terminated after multiple attempts and failures at treatment for his cocaine addiction. 955 F. Supp. at 297, 299. The court justified this termination based on the unique safety demands placed on a firefighter that could easily be compromised by cocaine use. Id. at 299. In Judice v. Hospital Service District No. 1, an impaired physician applied for reinstatement of his hospital privileges after recovering from an alcoholic relapse. 919 F. Supp. at 980. The hospital insisted on a second opinion from a specialist, which the physician refused to submit to claiming it violated his rights under the ADA. Id. The court ruled in favor of the hospital, saying it is reasonable to obtain a second opinion from a specialist prior to granting hospital privileges. Id. at 984. In Montegue v. City of New Orleans, a firefighter sought rehire after being terminated for cocaine and marijuana use. 1997 WL 327113, at *1. The court found for the department stating that it was not obligated to rehire him. Id. at *4. In Altman v. New York City Health & Hospitals Corp., the chief of internal medicine sought reinstatement as chief after treatment for alcoholism. 100 F.3d at 1055. The court found that the physician's history of treatment and relapse posed a sufficiently high public safety risk and that he was not qualified for the job. Id. at 1060–61.

Principalism provides a framework with which all bioethics dilemmas can be analyzed based upon four principles: autonomy, nonmaleficence, beneficence, and justice. Medical society has held this ethos since the origin of the profession, a fact demonstrated by the persistent use of the Hippocratic Oath for nearly two and half millennia. Society has since reinforced the ethos of the four prima facie principles in a codification of the Belmont Report. Thus, Principalism is the de facto standard for moral foundation in medicine.

Within the philosophical framework of Principalism, society values benefit to the patient over benefit to the physician. This hierarchical ranking is demonstrated by the policies limiting the physician’s autonomy in areas such as human research, refusal to treat, and treatment protocols. An impaired physician policy must be syntonic with these established policies. It must maximize the good for the patient within the framework of society’s chosen value system. Once the desired outcome is defined and the method of obtaining that outcome is determined, policy can be designed to ensure the desired outcome is reached. Thus it is essential to perform an ethical analysis of the potential responses to physician impairment prior to making a policy recommendation.

A. Autonomy

Autonomy, also referred to as “Respect for Autonomy,” is the principle of self-governance, the concept that an individual is free of controlling influence or limitations imposed by others on the individual’s decision making process. In the framework of physician impairment, the patient’s autonomy and the physician’s autonomy come into conflict. It must be clear in the policy that patient autonomy takes priority over physician autonomy. The physician may have the autonomy to self-destruct, namely to leave addiction untreated, but this right cannot be extended to be a right to damage a patient.

229. Id. at Part B.
230. See id. at Part B2. The Hippocratic Oath, written in 400 B.C.E. by Hippocrates, the Father of Medicine, is an oath taken by all physicians in which the physician pledges to ensure that the rights of all patients are respected. MedicineNet.com, Definition of Hippocrates, http://www.medterms.com/script/main/art.asp?articlekey=20908 (last visited Apr. 17, 2010).
231. See BELMONT REPORT, supra note 228, at Part A–D. The Belmont Report, issued by the Department of Health, Education and Welfare in 1979, is a codification of the “basic ethical principles” with which all human beings must be treated in medical research. Id. at Part B. These principles have since been extrapolated and applied to the practice of medicine. Id. at Introduction.
232. See id. at Part B2.
233. See id. at Part A–C.
234. BELMONT REPORT, supra note 228, at Part B.
Patient autonomy infers that the patient be fully informed because there is no opportunity for autonomy without knowledge. This analysis does not favor protection of the physician, but rather implies that the patient must be informed that the physician suffers from addiction. The problem raised by this analysis is that it creates incentive for the physician to hide his addiction. Policy on physician addiction must recognize the potential for this behavior and the additional risk of patient harm created by this potential. Practical policy must therefore create incentive for the addicted physician to self-identify and seek treatment. If the incentives include the opportunity for full rehabilitation and return to practice upon remission of the addiction, then the physician is more likely to self-report, obtain treatment, and return to medical practice unimpaired. Incentive, even in a non-punitive form, does not allow autonomy for the physician, but does create greater benefit to both the physician and his patients.  

B. Nonmaleficence

Nonmaleficence is the principle obligation to not inflict harm. This principle is a foundational concept universal to all ethical theories in medicine. It is summarized in the maxim, *primum non nocere*, first do no harm. In the circumstance of physician impairment, the principle of nonmaleficence is simple: protect the patient from the impaired physician who would likely do harm. Any policy addressing physician impairment must address the need to prevent an impaired physician from injuring a patient.

C. Beneficence

Beneficence, the natural extension of nonmaleficence, is the obligation to do good. Within Principalism, a physician has four obligations: “1. one ought not to inflict evil or harm . . . ; 2. one ought to prevent evil or harm; 3. one ought to remove evil or harm; [and] 4. one ought to do or promote good.” The first obligation is nonmaleficence and the remaining three obligations are beneficence. Thus, beneficence builds off of nonma-

238. *See id.*
239. *See id.*
240. BEAUCHAMP & CHILDRESS, *supra* note 236, at 114.
241. *Id.* at 115.
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leficence, taking the theory of first do no harm and extending it to preventing others from doing harm, removing the potential for harm, and ultimately doing good.\textsuperscript{242}

The potential for beneficence in physician impairment is maximized by offering the impaired physician non-punitive treatment options.\textsuperscript{243} If physician impairment is approached in a punitive fashion, the risk increases that an impaired physician will obscure and hide his addiction, ultimately creating risk of harm to the impaired physician's patients.\textsuperscript{244}

Within the principle of beneficence the patient's and physician's interests are not in conflict. Incentivizing treatment for physician impairment fulfills a universal good. Beneficence is accomplished for the patient by removing risk of harm and replacing it with treatment by a non-impaired physician—i.e., doing good. Beneficence is accomplished for the physician, who in this case is also a patient, by obtaining treatment for the impairment.

D. Justice

The principle of justice is attributed to Aristotle who summarized it as, "Equals must be treated equally, and unequals must be treated unequally."\textsuperscript{245} In the context of physician impairment, the comparison is best drawn as the rights of the individual—i.e., the physician—versus the rights of society—every member of society is a potential patient.\textsuperscript{246} As expanded upon before, the communal ethos in society is to place greater value on the rights of the members of society.\textsuperscript{247} Thus, society and the individual are not equals and are therefore not treated as equals. The needs of potential patients' safety trumps the impaired physician's needs, resulting in regulation of medical practice while impaired. Policy resulting from the principle of justice would emphasize its primary focus on removal of the impaired physician from practice, and secondarily address the treatment programs.

In the context of medicine, justice is often analyzed in the context of distributive justice.\textsuperscript{248} Distributive justice focuses on disparate levels of healthcare and health services for different groups within society.\textsuperscript{249} In the instance of physician impairment, there is no evidence that any one subset of

\begin{itemize}
\item \textsuperscript{242} See id.
\item \textsuperscript{243} See id. at 116.
\item \textsuperscript{244} See id.
\item \textsuperscript{245} BEAUCHAMP & CHILDRESS, supra note 236, at 227.
\item \textsuperscript{246} See BELMONT REPORT, supra note 228, at Part B3; see also BEAUCHAMP & CHILDRESS, supra note 236, at 226.
\item \textsuperscript{247} See BELMONT REPORT, supra note 228, at Part B3.
\item \textsuperscript{248} See BEAUCHAMP & CHILDRESS, supra note 236, at 226.
\item \textsuperscript{249} See id.
\end{itemize}
society is at greater risk for treatment by an impaired physician. Theories of disparate impact can be made for different socioeconomic classes, but again there is no proof that either of these theories is accurate. The first theory is that the poor population is disparately affected by physician impairment because this population generally receives care in large institutions in which an impaired practitioner could more easily slip through the cracks. In addition, members of lower socioeconomic classes do not necessarily have knowledge of or access to patient advocates to assist them. The second theory is that the rich population is disparately affected by physician impairment because members of upper socioeconomic classes tend to receive care in elite institutions where a physician with status may be able to avoid being reported for impairment by use of clout and influence. In addition, many physicians who choose not to practice in this elite environment, but rather choose to serve the underprivileged communities, may have a communal ethos of altruism and idealism. These practitioners are less likely to tolerate an impaired colleague who puts their patients at risk.

V. POLICY RECOMMENDATIONS

Despite the prevalence of physician addiction and subsequent impairment, there is no universal approach to prevention, identification, treatment, or post-recovery follow-up. Each of these four elements must be standardized for all physicians practicing in the United States. For all physicians in the United States, their careers began in a standardized format. Every student took specific pre-med requirements, the MCATs, standard medical curricula, core rotations, medical board examinations, and the same accreditation exam for their specialty. This ecumenical approach to medical education and training produces a consistent caliber of physicians. Yet once a physician’s official training years are complete, the national standard ends. Physicians are regulated by their state licensing agency. Each state sets its own requirements for continuing medical education and license renewal, and national continuity is lost. It is this loss of continuity in the system that allows impairment to occur and continue in the medical field. Creating a national standard for impaired physician programs and policies would return to the proven methodology of universal physician regulation.

This policy recommendation rests on a base of continuity. Each of the four elements of an impaired physician policy—prevention, identification, treatment, and post-recovery follow-up—must be standardized.

Prevention of physician impairment is the ideal approach to reducing the impaired physician problem. As the studies discussed in prior sections
have demonstrated, the majority of physician impairment starts during medical school.\textsuperscript{250} For this reason, it is essential that physician impairment be addressed during the first year of medical school. A standard curriculum should be taught in every medical school, the same way that anatomy and physiology are standardized in all medical schools. The curriculum must include key information such as how to recognize impairment in oneself and in others, what resources are available for an impaired physician, and what protection is afforded the impaired physician. After a detailed curriculum is taught in the first year of medical school, a truncated version of the course should be revisited at the end of second year, just before students begin to rotate on the wards. In addition to education during medical school, residency programs should incorporate at least one impaired physician lecture per year in the regular, mandatory conferences. Finally, all physicians must participate in a certain amount—varying by state—of continuing medical education to maintain their credentials and licensure. It should be mandatory that a portion of this education address physician impairment. This plan ensures that every physician is well versed in recognizing and addressing physician impairment and is knowledgeable about the resources available.

All the literature and studies are in agreement that the key to a successful recovery is the early identification of an impaired physician.\textsuperscript{251} The education discussed above will help physicians to recognize impairment in their peers. In addition, the continuing conversation about physician impairment throughout a physician's career will help to remove the stigma attached to physician impairment. The combination of lowered stigma and knowledge of resources will help to raise the portion of physicians who self-report or who report a peer.

Universality is most important during the treatment stage. Rather than having an impaired physician program in every state, there should be a number of nationally run and regulated physician wellness programs. Having a national impaired physician treatment center would help to vitiate a number of the current treatment deterrents. National treatment centers would help the impaired physician to seek treatment outside of their professional circles. This is particularly important in small medical communities where anonymity may be far more difficult to maintain. Additionally, this would ensure that physicians are treated in physician-only settings, which are proven to be more successful for recovery than programs that mix physicians and non-physicians. Additionally, the healthcare providers at these national treatment centers would be specialists in physician impairment, and thus more apt in

\textsuperscript{250} See Blondell, supra note 7, at 210.
\textsuperscript{251} See supra Part II.C.
approaching the treatment hurdles that are unique to physicians. A national impaired physician treatment center would encourage self-reporting by providing anonymity in combination with the optimal treatment environment.

The post-recovery follow-up must also be standardized. Every recovering physician should be followed in the same manner, for the same length of time, and by the same physicians as the treating physicians. This continuity helps provide stability for the recovered physicians as they re-enter the work environment. Additionally, a standardized follow-up program allows the recovered physicians to know what to expect and to not feel singled out for additional attention.

These suggestions combine to create a policy recommendation believed to better diminish the current problem of physician impairment. Continuity in each of these four stages will provide the backbone of support necessary to minimize physician impairment.