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Information

Treatment of Impaired Physicians/The California Board of Medical Quality Assurance Program

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Professional impairment is not a rarity and the hazards for health professions can be many. The California Board of Medical Quality Assurance has instituted a treatment and rehabilitation program for impaired physicians in which, at the completion of the program, a treated physician's records are purged. Although it is too early to evaluate the effectiveness of the program, preliminary data have been useful in pointing out the types of impairment that are being seen. Impaired physicians tend to have a higher than normal incidence of substance (tranquilizers, sedatives and stimulants) abuse, to be young (about 44 years) and to have had barren childhoods. Women physicians may be especially vulnerable to the stresses of the profession.

THE PREEMINENT RESOURCE of any society is its people. In the United States a significant and increasing portion of the gross national product is expended on maintaining the health of this resource. In a highly technologic environment, the stresses on each person to adapt to a rapidly changing milieu are considerable. The health care system then becomes the container for many who cannot adapt or, more frequently, who maladapt to their life circumstances and have physical or mental disorders (or both). What happens, though, when healers themselves become impaired?

ABBREVIATIONS USED IN TEXT

BMQA = Board of Medical Quality Assurance
DEC = Diversion Evaluation Committee
DMQ = Division of Medical Quality

Impaired Physicians

The American Medical Association Council on Mental Health published a report, "The Sick Physician," in 1973[1] that dealt with the importance of recognizing professional impairment and of assisting a disabled physician in obtaining appropriate treatment. The depth of the problem was underscored by a rate of 125 disciplinary cases per year in California alone at that time; most of these cases involved the use of narcotics. Recommendations included a stepwise program of assisting impaired physicians into treatment, progressing from approaching a person with evidence of impairment by colleagues, hospital staff, medical society committees on well-being and, finally, the state licensing board.

A seven-year study at the Mayo Clinic involving psychiatric hospital admissions of 93 physicians found the mean age of those presenting for treatment to be 54 years old, with 73 percent having no previous psychiatric history and 63 percent being admitted to a closed unit.[2] A wide spectrum of psychiatric diagnoses was found, with a low incidence of organic brain syndrome and a high incidence of drug and alcohol abuse. In interviews with 98 recovered alcoholic physicians abstinent for a minimum of a year, self-reports of academic achievement identified these persons as doing remarkably well through medical school.[3] Often it is several years after the completion of training that habitual substance abuse develops. Approximately half those interviewed had abused other drugs in addition to alcohol.

Vaillant and co-workers[4] did a 20-year longitudinal study of 45 physicians and 90 controls addressing the use of psychoactive drugs. All of the subjects had been selected during their undergraduate years for indices of physical and mental health. The use of tranquilizers, sedatives and stimulants was greater among physicians than

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controls, though both groups equally used alcohol and cigarettes. In addressing the physician as patient, the authors warned that the "patient's tendency to deny illness will make a diagnosis difficult; secondly, the patient's virtue of not troubling his doctor may lead to the wish to self-prescribe; and thirdly, the patient's willingness to care selflessly for others may conceal a greater than average need to be given to." A person's use of denial, reticence to seek treatment and underlying unmet psychologic needs must then be considered when addressing the problem of impaired physicians.

Characteristics of Impaired Physicians

The defenses used by disabled physicians frequently include denial, avoidance and rationalization. Retrospective accounts have found substantial familial difficulties in the childhood and adolescence of these physicians that may be a prime mover in their motivation to enter the helping professions. In a further report of the long-term study mentioned above, Vaillant and colleagues[5] noted that physicians, especially those in primary care specialties, tended to have more marital maladjustments, abuse of substances and use of psychotherapy than controls. Physicians most vulnerable to becoming impaired have been seen as those having a barren childhood and surrounding themselves with needy patients. Overwork per se was not found to lead to impairment, though commonly cited by disabled physicians as the reason for their difficulties. Possibly the stress of giving to patients who tend to be dependent by those who themselves have histories of unmet nurturant needs predisposes to professional dissatisfaction and ill-being. These personality traits are based on psychoanalytic theory, however, and have not been shown definitively to be causative factors.

A 15-year study of 65 patients treated for narcotics addiction at the Menninger Institute involved 30 physician addicts.[6] Data at time of admission on the 25 physicians who continued in the study group showed the mean age to be 41 years old, the average length of addiction to be three years and that most physicians had been admitted to hospital for addiction at least twice previously. This group is younger and with a significantly higher previous use of psychiatric services than those in the Mayo Clinic study.[2]

Where Vaillant and associates describe the typical impaired physician's childhood as barren, Modlin and Montes[6] reported a common finding of sickness in the early years. The physicians were often studious and ambitious throughout adolescence. Parents were often seen as unavailable. Fathers were described as stern and depriving, passive and indifferent, volatile and flamboyant or irritable and withdrawn and most fathers had problems with alcohol abuse. Mothers were seen as nervous, pushy, demanding, dominating, depressive, perfectionistic, harsh, distant, protective or alcoholic. Hence, the family backgrounds that impaired physicians develop in are perceived by them as lacking in warmth and caring. It then may come as little surprise to find that these persons have difficulties with their spouses, lack interest in child-rearing and have a 75 percent incidence of sexual dysfunction.

Physicians themselves report overwork, fatigue and disease as precipitants for their use of drugs and alcohol. The authors, however, postulate that unmet professional expectations lead to disillusionment and regression. Psychiatric disability develops later in these professionals than in many other addicted and alcoholic patients. A possible explanation for this is that the structured environments of medical school, internship, residency and entry into practice become alternative family settings that allow the attainment of adulthood to be postponed. On being confronted with the reality of being independent and not magically provided for by the profession, these physicians retreat to more primitive oral-dependency gratification.

A subsequent study of drug- and alcohol-addicted doctors (43 with MD degrees and 7 dentists) at the Menninger Memorial Hospital showed a mean age in the study population of 46.5 years, with 76 percent practicing medicine till the time of admission.[7] Diagnostically, those under 40 years of age were felt to have more serious psychopathology, often of a severe characterologic sort, whereas those over 40 had a greater incidence of organic brain syndrome and depression. Again, the use of denial, both in the need for admission to hospital and possible impairment in treating patients, was observed.

Female physicians may be especially vulnerable to the stresses of the profession.[8] Of 751 deaths of women physicians over a five-year period (1967 to 1972), 49 were due to suicide, with an annual rate of 40.7 per 100,000 population. This is higher than the suicide rate for male physicians and four times that for nonphysician women

matched for race and age. Though Stevens and Shore[9] disagree with the study's extrapolation of the 65 percent prevalence of affective disorder in female physicians, the high suicide rate is a finding not easily dismissed. A comparison of women health professionals found fourfold the amount of affective disorder in physicians compared with psychologists.[10] The reluctance to seek professional help is revealed by a fifth of the depressed physicians having treated themselves with antidepressant medication. In both populations, depressed persons tended to report more job discrimination than nondepressed professionals, and women with children experienced more career disruption. There may be some common stresses that health providers are subject to and respond similarly to, yet physicians may be more at risk than other helping professionals.

Colleagues' Attitudes Toward Impaired Physicians

Aside from a physician's family, peers may be the first to recognize a deterioration in clinical skills and means of interacting with others. Physicians should be most aware of indications of mental or physical ill-being, however subtle. Yet, the denial that an impaired person functions under can operate for colleagues who identify with the compromised physician. Duffy and Litin[2] noted behavior among impaired physicians' colleagues that included a reluctance to intervene, a propensity to overprotect and a stance of rejection toward disabled physicians. Chappel[11] has more recently addressed physicians' attitudes toward professional impairment. He identifies negative responses as silence, avoidance and permission versus the more positive responses of confrontation, assistance into treatment and education regarding the risks of the profession. Recommendations were made for the development of confrontational skills in all physicians and the involvement of paraprofessionals and formerly impaired physicians in a disabled physician's care.

Certain state legislators have recognized the extent of the problem of physician impairment and have enacted laws to assist in the recommendations that investigators such as Chappel have made. Talbott and co-workers[12] have reported on the disabled doctors' plan in Georgia, which has been in operation since 1975. The Medical Association of Georgia, in cooperation with the state board of licensure, developed a program with clear treatment objectives and well-delineated phases of treatment (that is, residential care, outpatient services, physician's apprenticeship and reinstitution of professional activities). After 18 months of operation, the Georgia program had assisted in returning 62 percent of those entering treatment back to their professional positions.[12] Bloom[13] emphasizes the ubiquitous nature of the impaired physician syndrome and mentioned the Johnson Institute of Minnesota model of intervention used by the California Medical Association. The California situation is one testing

TABLE 1.—*Status of Referrals to the Diversion Program for Physicians (February 1980-March 1, 1981)**

Status	*Program Referrals*	
	number	*(percent)*
Active (n=80)		
Seeking admission or participating in the diversion program		
Participants in program and in treatment	52	(47.3)
Potential participants accepted by the Diversion Evaluation Committees and awaiting treatment programs	13	(11.8)
Awaiting evaluation before a Diversion Evaluation Committee	15	(13.6)
Inactive (n=30)		
Terminated from diversion program participation	1	(0.9)
Referrals not resulting in diversion program admission		
Accepted by the Diversion Evaluation Committee but became ineligible before initiating treatment	2	(1.8)
Determined by the Diversion Evaluation Committee to be unacceptable for the program	3	(2.8)
Lack of interest in entering program	15	(13.6)
Ineligible/did not meet entry criteria	9	(8.2)
TOTAL REFFERALS	110	(100.0)

*From the report of the diversion program for physicians, State of California Board of Medical Quality Assurance, 1981.

TABLE 2.—*Types of Disorders in Physicians in Active Status in California Diversion Program**

Disorder	Men	Women	No. of Physicians	Mean Age
Alcohol abuse	18	0	18	47.1
Drug abuse	28	3	31	39.1
Alcohol and drug abuse	12	1	13	44.2
Mental illness	5	1	6	47.3
Mental illness and substance abuse	8	1	9	48.3
Physical illness	1	0	1	52.0
Physical illness and substance abuse	2	0	2	55.0
TOTAL	74	6	80	43.9

*From the report of the diversion program for physicians, State of California Board of Medical Quality Assurance, 1981.

ground for treatment of this group of professionals.

California Diversion Program for Physicians

In California, with more than 50,000 doctors, a diversion program was instituted for physicians in January 1980 to address the problem of physician impairment. In the previous year the state legislature had directed the state's Board of Medical Quality Assurance (BMQA) to establish means for the identification and treatment of impaired physicians. The goal of the program is to rehabilitate those doctors with dysfunctions attributable to alcohol or drug abuse, mental dysfunction or physical illness that interfere with competence in treating patients.

Application for the program is reviewed by one of five Diversion Evaluation Committees (DEC) consisting of five experts in the treatment of mental illness, drug abuse and alcoholism. If accepted in the program, a person is asked to adhere to a written treatment contract that varies in each case. While in the program, there is no disciplinary action by the Division of Medical Quality (DMQ) of the BMQA regarding licensure. A DEC member is designated as case consultant and a compliance officer is assigned to check alcohol and drug use. Review of cases is made by the DEC. At the end of the rehabilitation period, envisioned as three to five years, the DEC then determines whether unsupervised practice can be reinstituted. If so, a treated physician's records are purged. Initial unacceptability or noncompliance at any point can result in a person's case being dropped from the program.

First Year of Operation

In its first 13 months of existence, 110 physicians have been referred to the diversion program, 80 were on active status with 52 in treatment as of March 1981 (see Table 1). Of the total population, 68 were referred either by the BMQA or the office of the Attorney General; 17 more had DMQ investigations in progress and 25 were self-referrals. The need for an external impetus into treatment is apparent and has been noted previously by those who treat disabled physicians.[7]

Of the 80 physicians who have presented for treatment, 74 were men and 6 women. Drug and alcohol abuse are present in most of the program population, with seven persons having mental or physical illness or both, without evidence of substance abuse. The drug abuse category of disability involved the largest number of physicians and had a mean age of 39.1 years, compared with the mean of the total of 43.9 years (see Table 2). In all diagnostic categories 52 physicians used drugs and the three most popular substances were meperidine hydrochloride (Demerol) (23), cocaine (15) and amphetamines (10). Other substances frequently used included pentazocine hydrochloride (Talwin) (9), diazepam (Valium) (8), marijuana (7) and Percodan (a combination of oxycodone hydrochloride and terephthalate, aspirin, phenacetin and caffeine) (7). Physicians have been noted in clinical reports over the last two decades to preferentially use narcotics, stimulants and tranquilizers. This pattern seems to hold today with the continued use of drugs such as meperidine; the additional use of cocaine and marijuana can be attributed to the change in our society's drug use pattern. Diazepam abuse is representative of newer medications with widespread use and abuse potential.

Conclusions

In its first year of operation, the diversion program has received more referrals than expected. It is too early to know the long-term results of the program, though elsewhere a 64 percent abstinence rate has been reported in addicted physicians 9 months to 4½ years following treatment.[7] These preliminary data point to the types of impairment seen in one professional group today. As more physicians enter "diversion," are treated and follow-up data become available, the results of the program can be assessed. A system

that uses public regulatory powers and peer pressure to bring impaired physicians into treatment may well be the most effective force in rehabilitation versus punishment.

As evidenced by the mean age of the physicians on active status in the program, an impaired physician can be seen as a resource with many potential years of service to society remaining following treatment. The rewards and gratification for physicians brought to treatment, their families, the health providers involved in caring for physicians seeking diversions and those patients treated by rehabilitated professionals warrant the continuation of the California Diversion Program. It is hoped that diversion will prove to be efficacious and become a model for assistance to impaired professionals.

Finally, questions that remain unanswered regarding the diversion program's effectiveness include what becomes of those physicians who apply and are considered unacceptable by the DEC, have a lack of interest in entering the program or do not meet entry criteria. Of interest to evaluation and redesign of the program would be the reasons that 15 applicants did not enter owing to "lack of interest." A delicate balance no doubt must be struck in meeting the needs of individual physicians versus those of the program as an organization. Here, too, the issue of coercive as opposed to voluntary treatment leads to the use of confrontative techniques with persons, who retain the option of not entering treatment.

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Information

Diabetic Retinopathy

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DIABETIC RETINOPATHY is one of the most feared complications of diabetes mellitus. The fear is justifiable, since diabetic retinopathy is the leading cause of new blindness in adults, and 84 percent of blind diabetic persons are blind due to diabetic retinopathy (see Table 1).

Retinopathy is divided into nonproliferative (sometimes called *background*) and proliferative varieties. Background retinopathy consists of hemorrhages, microaneurysms, hard exudates, cotton wool spots and macular edema. It is found more often in maturity-onset diabetes. Proliferative changes, seen more often in juvenile-onset diabetes, include flat and elevated neovascularization, both on and away from the optic disc. Neovascularization causes recurrent vitreal hemorrhages and sometimes retinal detachment.

The frequency of retinopathy is related more closely to duration of diabetes than to any other single factor, and approaches a 90 percent incidence after 25 years of diabetes. The relationship between metabolic control and retinopathy is somewhat speculative, however; Kohner's data[1] and Engerman's work[2] in Alloxan-diabetic dogs suggest that "good control," especially in the first five years after diagnosis of diabetes, can delay the onset of retinopathy for several years. After retinopathy is present, control to euglycemia may be of some benefit in retarding the progression. It is a clinical fact that severe retinopathy is observed not infrequently in patients alleged to have been in "good control" all their lives, and likewise the converse.

Current therapy, apart from whatever role might be played by careful medical management,

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