THE EFFECTS OF AN INTENSIVE EDUCATIONAL SEMINAR ON PHYSICIANS' AWARENESS OF AND ATTITUDES ABOUT COLLEAGUE IMPAIRMENT

Andrea Gibson Summer

Certificate of Approval:

Sami Gulgoz, Assistant
Professor, Psychology

Carolyn K. Long, Chair
Assistant Professor
Psychology

Stephen LoBello, Assistant
Professor, Psychology

Guinevera A. Nance
Director
Graduate Studies

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VITA

Andrea Gibson Summer, daughter of Thomas Cushman Gibson and Sarah (Knowlton) O'Donnell, was born June 11, 1956, in Philadelphia, Pennsylvania. She graduated from the High Mowing School, Wilton, New Hampshire, in 1974. In August, 1975, she entered Bucks County Community College and received the degree of Associate of Arts (Journalism) in May, 1978. For the next ten years, she worked in management and operated a small service-oriented business. She changed career goals and entered Palm Beach Atlantic College and received the degree of Bachelor of Arts (Psychology) in May, 1990. She entered graduate school at Auburn University at Montgomery in September, 1991. She married Gerald Leland Summer in June, 1987. They have two daughters, Lynn Ann and Carrie Elizabeth.

THESIS ABSTRACT

THE EFFECTS OF AN INTENSIVE EDUCATIONAL SEMINAR ON PHYSICIANS' AWARENESS OF AND ATTITUDES ABOUT COLLEAGUE IMPAIRMENT

Andrea Gibson Summer

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This study was designed to determine if an intensive educational seminar would have an effect on physicians' awareness of and attitudes about colleague impairment, specifically resulting from chemical dependence. Surveys were distributed in an educational packet at various seminar locations in Alabama. The seminars contained the following topics: (a) the impaired physician; (b) legalities concerning impairment; and (c) Alabama's impaired physician program, the Physicians Recovery Network (PRN). Physicians attending the seminars were randomly assigned to complete either a pre-test or a post-test survey which contained six scenarios. Following each of the six scenarios, the same

three questions were asked to determine: (a) ability to recognize colleague impairment; (b) reported willingness to intervene by speaking to a colleague suspected of impairment; and (c) reported willingness to intervene by calling the Alabama Impaired Physicians Program (PRN - Physicians Recovery Network). Analysis of 1966 completed surveys showed significant differences between pre- and post-test surveys in the areas of recognition of impairment and reported willingness to call the Alabama PRN about a colleague suspected of impairment. Follow-up surveys indicated a stability of effect over a nine-month period.

TABLE OF CONTENTS

LIST OF TABLES

I. INTRODUCTION

"Physician, heal thyself." This frequently quoted phrase takes on a special meaning in the area of physician impairment. According to the Council on Mental Health (1973):

> It 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 or drug dependence....When exhortations by family and friends are ineffective and when the physician is unable to make a rational assessment of his ability to function professionally, it becomes essentially the responsibility of his colleagues to make that assessment for him, and to advise him whether he should obtain treatment and curtail or suspend his practice (P 684).

Despite this mandate, physicians traditionally have taken a "hands off" approach when confronted with colleague impairment, whether due to alcohol and substance abuse, psychiatric disorders, sexual impropriety, or physical deterioration. Most states now require licensed physicians and osteopaths to report information on any physician or osteopath practicing medicine in a manner which endangers the health of patients. These laws protect the reporting physician from liability as a result of any reporting statement made in good faith. Physicians who report a

colleague suspected of impairment are also protecting themselves from future litigation because physicians who knowingly allow an impaired colleague to continue practice may be liable for punitive damages (Larkin, 1991).

Recently, organized medicine has become alarmed at the waste of medical resources and the human loss represented by impaired and suicidal physicians (Sargent, 1979). In spite of a high potential for recovery from impairment due to chemical dependence (90 percent), many physicians are lost each year through suicide or loss of license to practice. Since most of those who do recover from chemical dependence do so because of intervention by colleagues, this tragedy occurs in part because of failure of unimpaired physicians to recognize early warning signs and to intervene (Bates, Burton, DeWitt, Mandell, & Sargent, 1979).

Because chemical dependence is the type of impairment seen most often in the medical profession (AMA Council on Mental Health, 1973), the focus of this review and subsequent study is physician impairment due to chemical dependence. This review of the literature looks at the impaired physician movement from the viewpoint of the unimpaired colleague to examine: (a) the reasons physicians are reluctant to become involved with an impaired colleague, (b) the educational efforts to raise awareness of physician impairment both in medical school and through continuing medical education (CME), (c) educational efforts which aim

to change physicians' attitudes, and (d) the need for more educational programs directed not only to medical students but more specifically to practicing physicians in the community.

II. REVIEW OF LITERATURE

The Conspiracy of Silence

The reasons physicians are reluctant to report colleagues suspected of impairment have been studied extensively. Some attribute the reluctance to: (a) fear of how the impaired colleague would react, (b) fear of having to interact afterwards, or (c) the belief that colleagues would perceive the intervention as an attack (McCrady, 1989). Others cite reasons such as: (a) patient confidentiality, (b) fear of retaliation by the accused colleague, (c) lack of awareness of the potential harm caused by the impaired colleague, and (d) a lack of confidence in the committee to which the information is reported (Gartrell, Herman, Olarte, Feldstein, & Localio, 1987). Other factors discouraging reporting were the unpleasantness of the task and fear of litigation (Wood, Klein, Cross, Lammers, & Elliott, 1985) as well as: (a) ignorance about impairment, (b) lack of awareness of intervention and treatment alternatives, or (c) the reluctance of many physicians to "label a friend as ill, nor to confront him unnecessarily" (Scheiber & Doyle, 1983, p 131).

Denial is one of many factors inherent in physicians' reluctance to report a colleague suspected of impairment. Talbott and Benson (1980) spoke of peers and colleagues who were not only unaware of the fact that 12% to 14% of their colleagues were impaired but who denied that the problem could exist in their community.

The medical profession has an image to protect. It is an image of infallibility, omnipotence, omnipresence, and prestige (Crosby & Bissell, 1989). These expectations subject the profession to public scrutiny and, in recent years, increasing criticism. When threatened by public disclosure, the medical profession has traditionally banded together to protect their own from anything that could tarnish the positive image (Crosby & Bissell, 1989).

In addition, physicians have traditionally placed a high value on assuming personal responsibility and exercising individual authority in making professional decisions (Chappel, 1991). The philosophies of "live and let live" and "there but for the Grace of God go I" are also excuses for inaction. And lifelong friendships or loss of referral sources may be factors which deter a physician from initiating intervention (Green, Carroll, & Buxton, 1978). Finally, the punitive and emotional nature of a "substance abuser" label can make physicians unlikely to confront their colleagues or report suspected substance abuse to hospital,

state, or professional organization authorities (Martin & Mazmanian, 1990).

Substance Abuse and Impairment Education

Given that early intervention and the subsequent treatment of physicians impaired by chemical dependence have been shown nationwide to be effective in returning the impaired physician to productive practice (Bates, Burton, Dewitt, Mandell, & Sargent, 1979; Green, Carroll, & Buxton, 1978; Shore, 1982, 1987; Talbott, Gallegos, Wilson, & Porter, 1985), what is being done to educate and increase the awareness of the medical community? Educational efforts to date can be broken down into two main categories: those directed toward the medical student and those directed toward the practicing physician through continuing medical education (CME) credit. Within these groups, efforts are specifically aimed either at recognition of and attitudes toward the chemically dependent patient or recognition of and attitudes toward the impaired physician. To date, educational efforts directed toward the practicing physician about impaired colleagues have been given the least attention.

Impairment Education: Medical Schools

In 1976, substance abuse instruction represented 0.6% of the total core curriculum in medical schools (Helwick, 1985). In a recent survey of medical students, 64% of the

students reported that there was some teaching about substance abuse and 45% remembered there was also some teaching about physician impairment. The study concludes that while a majority of schools are teaching substance abuse, they are less likely to teach about physician impairment or have clear substance abuse policies or programs in place (Baldwin, Hughes, Conrad, Storr, & Sheehan, 1991).

It has been recommended that medical school instruction in alcohol abuse should begin early, continue throughout medical school and be unambiguous (Talbot, 1989). The program at the Medical College of Wisconsin Affiliated Hospitals (MCWAH) demonstrates that an institution-wide program for impaired residents is feasible in spite of the problems of faculty and staff attitudes toward impairment, misconceptions about the program, and a lack of authority to enforce the program (Lohr & Engbring, 1988). A study by Marchand (1988) on the effects of an educational program on the desire for treatment among impaired medical students showed retrospectively that medical students who attended educational lectures on impairment were more likely to seek help for their own problems. The need for formal procedures for identification of impairment as well as the course of action after identification has been suggested (Lamb, 1987).

Greater attention to the diagnosis and care of addiction will make medical students and practicing

physicians more aware of their own vulnerability (Lewis, 1986). This need has been clearly shown in a study about hospital house officer responses to impaired physicians in which medical house officers were found to rely on more senior physicians when faced with an impaired attending physician (Reuben & Noble, 1990). One medical school program which involves medical students in the treatment of impaired physicians is the Disabled Doctors Program conducted at various treatment centers in Georgia, using junior medical students from Emory University School of Medicine. The students interview impaired physicians at the treatment centers, meet with impaired physicians in group settings, and, with their "significant others", meet with recovering "graduates" of the treatment programs and their spouses (Talbott, 1982).

The problem with substance abuse curriculum in medical school is that it has: (a) traditionally focused limited time on the subject, (b) used a narrow, biomedical approach, and (c) lacked student involvement and exposure to both early diagnosis and current models of diagnostic treatment. The Weekend Intervention Program (WIP) was developed at the School of Medicine at Wright State University to present medical students with an educational experience designed to overcome the above deficiencies by teaching medical students to: (a) identify early chemical dependence, (b) understand the dynamics of the chemically dependent patient and family,

(c) increase awareness of treatment models, and (d) examine personal drinking and drug use (Siegal & Rudisill, 1983; Siegal, Markert, & Vojtech, 1986).

In a 28-hour course on substance abuse at the University of Nevada School of Medicine, it was found that changing students' attitudes about substance abuse can be achieved in medical education provided that the course is based on attitudinal learning through emphasis on clinical problems and small group discussion; and that the course does not displace the heavy load of the basic scientific courses in the medical school curriculum (Chappel, Jordan, Treadway, & Miller, 1977; Chappel & Veach, 1987). Neither of the above studies included a specific course on the topic of physician impairment, although students reported that they had begun to examine their own drinking habits as a result of the course (Siegal & Rudisill, 1983). In a study done at the Johns Hopkins University School of Medicine concerning their Model Alcohol Curriculum (MAC), the authors suggest that experiential sessions, elective programs, and greater emphasis during the clinical years on substance abuse issues are needed to maintain positive educational outcomes (Gopalan, Santora, Stokes, Moore, & Levine, 1992).

Impairment Education: Continuing Medical Education

Teaching medical students and residents to recognize symptoms of early impairment is an effective way to ensure

that new physicians are not only good physicians but also healthy physicians. However, that does not solve the problem of the physician already practicing in the community. The typical alcohol-impaired physician has been in practice and interacting with unimpaired colleagues for 15-18 years prior to intervention (Green, Carroll, & Buxton, 1978). Those colleagues need to be the target audience of CME programs designed to change physicians' awareness of and attitudes about physician impairment.

In 1975, the AMA sponsored a national conference entitled, "The Disabled Doctor - Challenge to the Profession" (Steindler, 1975). For the first time, the AMA presented the problems of impaired and incompetent physicians as well as the proper procedures for state and local authorities to follow in dealing with them (Green, Carroll, & Buxton, 1978). Since then, other conferences about physician impairment have been sponsored by the AMA, the American Society of Addiction Medicine (ASAM), and state and local medical societies. Many of these CME courses have addressed individual state programs (Casper, Dills, Soter, Lupoll, & Shore, 1988; Gallegos, Lubin, Bowers, & Talbott, 1991; Shore, 1982, 1987;) or consist of retrospective surveys about physician impairment (Bissell, & Jones, 1976; Estep, Novack, & Helsel, 1989; Gallegos, Veit, Wilson, Porter, & Talbott, 1988; McAuliffe, Rohman, Santangelo, Feldman, Magnuson, Sobol, & Weissman 1986; McAuliffe,

Santangelo, Magnuson, Sobol, Rohman, & Weissman, 1987). Other courses have examined treatment and outcome studies of the impaired physician (Galanter, Talbott, Gallegos, & Rubenstone, 1990; Herrington, Benzer, Jacobson, & Hawkins, 1982; Logan, 1989; Morse, Martin, Swenson, & Niven, 1984;).

The issue is not one of a lack of continuing medical education (CME) about substance abuse and physician impairment. Rather, the question that needs to be asked continually is whether or not the CME being presented to physicians is effective in changing their awareness and attitudes about substance abuse and physician impairment. It is in these areas that the available literature is lacking.

One study that evaluated a CME program for primary care physicians on the management of alcoholism, attempted to change the behaviors of physicians in their management of alcoholic patients. The authors failed to find any substantiation for behavior change, although there was a consensus that participation in the program was worthwhile and enjoyable. The results suggested that, since CME on substance abuse is not mandatory, educators must offer physicians stimulating CME experiences to illustrate the importance of the topic. A suggested method of teaching utilized a computer-simulated patient, individualized feedback, a brief follow-up reading, and a bibliography (Brown, 1988).

In another study, family physicians were surveyed to determine how information about impairment was obtained, which sources were valued, and how exposure to impairment relates to attitudes and beliefs. A significant relation was found between involvement in group-oriented programs and recognition of risk factors unique to the profession. All physicians surveyed had exposure to the topic from an average of three sources. Older physicians who graduated from medical school before the implementation of a substance abuse curriculum were more likely to hold judgmental attitudes about physician impairment. The authors believe that this study offers encouraging evidence that efforts to educate practicing family physicians about physician impairment are successful (Butler, & Wolkenstein, 1991).

The need to reach practicing physicians through continuing medical education is clear. Needed changes in attitudes will not result unless the profession as a whole commits to a fundamental change. This reeducation of attitudes must: (a) create an awareness of high risk, (b) create a willingness to help, (c) be based on personal and professional respect, and (d) be incorporated into the physician's professional image (Martin & Mazmanian, 1990).

Several strategies have been utilized to affect attitudinal and/or behavioral changes as a result of CME presentation. Some studies have shown that a physician who has direct contact with the target population (i.e., a

physician working directly with alcoholic patients) can favorably influence attitudes toward those populations (Robins & Wolf, 1989; Talbott, 1982; Butler & Wolkenstein, 1991). One study made use of commitment cards, in which respondents were asked to write three changes that they proposed to make as a result of attending a CME symposium. Two months later, the cards were mailed back to the respondents asking if those changes had been implemented. Ninety-three percent of the respondents reported making at least one change. The benefit of this technique is that the commitment for change instrument provides a reinforcement of learning and identifies the major teaching points which had the greatest impact (Purkis, 1982).

In assessing the effectiveness of a CME program, the following factors must be taken into consideration: (a) the target behaviors must be changed during the course of the evaluation, (b) the evaluation method must be able to detect behavioral change, and (c) attitudinal and environmental variables should be examined (Ferguson, Caplan, & Williamson, 1984). In particular, CME presentations about substance abuse and physician impairment, as well as emotional and behavioral aspects of physical illness need to focus on the psychosocial attitudes of the physician attending the CME presentation (Dornbush, Singer, Brownstein, & Freedman, 1984; Marcotte & Held, 1978).

Recommendations in the Literature

The medical profession has recognized the need for greater educational efforts in the areas of substance abuse and physician impairment. More specific recommendations have been made concerning educational objectives to include both knowledge and attitude changes involving affective, interpersonal, and experiential learning groups. Attitudinal objectives should focus on high-risk signs, self-awareness, and willingness to ask for help when indicated as well as altered values and sensitivity in the recognition and appropriate intervention with colleagues in denial. Training materials and methods need to be developed to meet these goals (Scheiber & Doyle, 1983). Additionally, substance abuse and physician impairment materials should be presented by an authoritative presenter who introduces the subject matter with respect and regard for the target audience (Scheiber & Doyle, 1983).

This review has shown that considerable progress has been made toward promoting the education of physicians about substance abuse and physician impairment. But if the goal of physician education is to change and enhance physicians' repertoire of knowledge, skills, and attitudes, including those related to self-examination and life management (Martin & Mazmanian, 1990), then the profession has a long way to go toward meeting those goals. More studies are needed, especially in the area of continuing medical

education, to reach those physicians who could be the first to recognize early impairment in colleagues. Medical schools must participate by rigorously alerting and educating students. Intervention through CME must be designed to change deeply rooted attitudes that dictate the behaviors that physicians develop through years of practice (Martin & Mazmanian, 1990). And, where possible, follow-up studies need to be done to ensure that knowledge gained and modified attitudes are translated into action through behavioral change.

The Present Study

This study was designed to determine if a CME program about physician impairment had an effect on physicians' awareness and attitudes about impaired colleagues. Utilizing some of the above suggestions, the educational program was presented by authoritative presenters with a high regard for the sensitivity of the material; and the program was designed to enhance physicians' knowledge and awareness of potential impairment problems, while attempting to change long-held attitudes and beliefs about colleague impairment. Physicians who attended the educational seminars in various Alabama locations were randomly assigned to complete either a pre-test or post-test survey containing six scenarios. Following each of the scenarios, the same three questions were asked to determine: (a) ability to

recognize colleague impairment, (b) reported willingness to intervene by speaking to a colleague suspected of impairment, and (c) reported willingness to intervene by calling the Alabama Impaired Physicians Program (PRN - Physicians Recovery Network). In addition, follow-up surveys were mailed to all members of the Medical Association of the State of Alabama nine months after the first seminar had been presented. Analysis of the completed surveys is expected to show that: (1) physicians who attended the seminar would be more likely to report a recognition of professional impairment than those who did not attend the seminar; (2) physicians who attended the seminar would be more likely to report a willingness to intervene anonymously on an impaired colleague by calling the Alabama Physicians Recovery Network (PRN) than those who did not attend the seminar; (3) those physicians who reported that they had received some training in chemical dependence in medical school would be more likely to report a willingness to intervene either personally or anonymously by calling the Alabama Physicians Recovery Network (PRN) than those who reported that they had not received chemical dependence training in medical school; and (4) follow-up surveys will show that the effects of seminar attendance on recognition of professional impairment and reported willingness to call the Alabama PRN will be sustained over time with some drift.

IV. METHOD

SUBJECTS

The Mutual Assurance Company, a medical malpractice insurance company in Alabama, sponsored 16 risk management seminars about physician impairment throughout the state of Alabama from January to September, 1993. Eight of the 16 seminars were included in this study. The eight seminars not included were specialty seminars with low attendance. The eight seminars used in this study yielded 906 surveys, of which 97 were eliminated because they were incomplete. Follow-up surveys were sent to 5400 members of the Medical Association of the State of Alabama. Of the 1424 follow-up surveys returned, 101 were eliminated because they were incomplete. In addition 166 surveys were eliminated because the follow-up group contained retirees, a group that was not represented in the pretest or posttest groups. For that reason, 166 surveys reporting an age of 70 or above were eliminated to remove retirees from the sample. The total number of surveys used in data analysis was 1966.

There were four groups of surveys: (1) seminar attendees completing a pretest survey, (2) seminar attendees completing a posttest survey, (3) follow-up survey: no

seminar attendance, and (4) follow-up survey: attended a seminar. The demographic and personal data for the four groups were similar and were combined into one group. Age ranged from 27 to 69 years-old with a mean age of 46 years. Subjects were predominantly male (88%), white (82%), and Christian (91%). The majority of physicians completing the surveys attended medical school in Alabama (48%), although 199 medical schools were represented. Internal medicine and family practice were the most frequently cited specialties (38%). Forty-two percent of the subjects were in a small group practice of less than six doctors and 33% had a solo practice. Twenty-nine percent were raised in a rural area and 21% currently reside in a rural area. Table 1 on page 19 shows the demographic profile of the 1966 participants.

Table 1

Demographic Profile of Study Participants.

Variable	Percentage
Gender	
Male	88
Female	12
Race	
White	82
Black	3
Hispanic	<1
Asian	3
American Indian	<1
Other	12
Religion	
Christian	91
Non-Christian	6
Other	3
Area Raised	
Urban	38
Suburban	33
Rural	29
Area of Current Residence	
Urban	36
Suburban	42
Rural	21
Medical School Location	
Alabama	48
Other U.S.	46
Foreign	3
Other	3
Specialty	
Internal Medicine	21
Family/General Practice	17
Surgery	12
OB/GYN	9
Pediatrics	7
Radiology	5
Anesthesiology	5
Other	24
Practice Type	
Solo	33
Small Group < 6	42
Large Group > 6	23
Other	2

MATERIALS

The survey consisted of six brief scenarios followed by the same three questions (see Appendix B). Demographic and background information were also requested. A cover sheet indicating pretest or posttest survey (see Appendix C) was included and the surveys were sealed with a staple. The follow-up survey included an indication of which seminar, if any, the subject attended (see Appendix D).

Because there were no prior studies of this type using scenarios, the survey instrument was designed using the following criteria: (a) the scenarios were written by an acknowledged expert in the field of physician impairment, (b) the scenarios represent actual case studies and the diagnoses of the physicians in the scenarios were confirmed by a treatment center specializing in the treatment of physician impairment, and (c) any identifying characteristics have been changed to protect the identities of the physicians used in the scenarios. Five of the six scenarios represented physicians who had been diagnosed with chemical dependency. One of the scenarios concerned a physician who was diagnosed as not being impaired at that time.

The three questions asked after each scenario are to determine; (a) ability to recognize possible colleague impairment; (b) reported willingness to intervene personally by speaking to a colleague suspected of impairment; and (c)

reported willingness to intervene anonymously by calling the Alabama Impaired Physicians Program (PRN - Physicians Recovery Network).

Possible responses to the scenario questions range from strongly agree to strongly disagree on a Likert-type scale. The ideal responses would entail high recognition of potential impairment, low reported willingness to respond on a personal level, and high reported willingness to respond by calling the Alabama PRN.

PROCEDURE

Each seminar lasted for three hours and consisted of one hour about the definition and prevalence of impairment and the treatment of impaired physicians, one hour about the legalities concerning impairment, and one hour about the Alabama State Impaired Physicians Program. The content of the lectures was virtually the same throughout the series, although there were several presenters and a video tape of a presenter was occasionally used (See Appendix A).

A survey was given either before or after the lecture series, depending on the group to which the physician was assigned. A follow-up survey was mailed to all members of the Medical Association of the State of Alabama (MASA) approximately nine months after the first seminar. A reminder to return the survey was printed in the Alabama MD weekly newsletter approximately three weeks after the

surveys were mailed. Previous surveys by MASA have had a response rate of 25%. The response rate for this study was 26%.

A variation of the Pretest-Posttest Design was used in which an identical lecture was given to groups of physicians with half of each group randomly receiving either a pretest or a posttest survey. The randomization occurred by the placement of either a pretest or posttest survey in the front of the seminar's educational packet. These packets were prepared ahead of time and were placed on each chair prior to the physicians' arrival at the meeting site. In this manner, each physician choosing a seat had an equal chance of receiving either the pretest or the posttest survey. Each survey had a cover sheet with instructions. The surveys were folded in half and stapled shut.

Because the physicians paid for these seminars and received a CME credit and a reduction in their malpractice insurance premium as a result of attendance, it was not possible to have a control group at the time of the seminars. However, returns from the follow-up survey provided a control group consisting of those MASA members completing a survey who had not attended any seminar. Overlap between seminars was not a problem because there was no benefit for attending more than one seminar. Response problems included removal of the cover sheet identifying

pretest or posttest, forgetting to return the survey, and refusal to participate.

At the beginning of each program, a representative from Mutual Assurance made an announcement concerning the surveys. Physicians with the pretest survey were instructed to fill out the survey before the seminar began. At the end of the seminar, the announcer instructed those physicians with the posttest surveys to fill out the survey before leaving. Both groups were asked to return the surveys and course registration certificates to the registration desk. A potential problem was physicians who disregarded the instructions. Surveys were collected in a box and marked with the date and seminar location.

V. RESULTS

Data were analyzed for each scenario to determine the relation between seminar attendance and correct answers. Correct answers were defined as those: (1) in agreement that professional judgement may be impaired, (2) disagreeing with the response to talk to the physician personally, and (3) agreeing with the response to call the Alabama PRN. Each scenario was analyzed using the Chi-square for a 2 X 2 design (attendance/non attendance at seminars and correct/incorrect answers).

It was predicted that seminar attendees would report a higher recognition of physician impairment than those physicians who had not attended a seminar. Results were calculated by frequency but are reported by percentage for clarity.

Because more than 86% of the physicians in all four groups reported an ability to recognize physician impairment, the differences between those who attended a seminar and those who did not attend seminar, while statistically significant in four of the six scenarios, is of little practical significance. However, the differences in recognition of possible impairment between those who

attended the seminar and those who did not attend a seminar in Scenarios 1 and 6 indicated that there was some variable within those scenarios that was affected by the educational material presented in the seminars. Table 2 shows the chi-square comparisons of correct and incorrect responses for each scenario.

Table 2

The effects of seminar attendance on recognition of impairment by scenario as determined by Chi-square calculations.

Scenario	Response	Seminar	No Seminar	p=	Phi
1	Correct	92%	86%	.001	.10
	Incorrect	8%	14%		
2	Correct	98%	96%	.05	.05
	Incorrect	2%	4%		
3	Correct	98%	96%	.25	.03
	Incorrect	2%	4%		
4	Correct	96%	93%	.001	.08
	Incorrect	4%	7%		
5	Correct	96%	95%	.50	.02
	Incorrect	4%	5%		
6	Correct	97%	89%	.001	.15
	Incorrect	3%	11%		

The next hypothesis was that reported willingness to call the Alabama PRN would increase as a result of seminar attendance. For all scenarios, this reported willingness did increase significantly. While these data do not show

that the seminars are the only reason for the increase in reported willingness to call the Alabama PRN, the results suggested that physicians who attended the educational seminar reported more of a willingness to call the PRN than physicians who did not attend the seminar. Table 3 shows the comparison of correct and incorrect responses for each scenario.

Table 3

The effects of seminar attendance on reported willingness to call the Alabama PRN by scenario as determined by Chi-square calculations.

Scenario	Responses	Seminar	No Seminar	p=	Phi
1	Correct	54%	24%	.001	.30
	Incorrect	46%	76%		
2	Correct	91%	73%	.001	.22
	Incorrect	9%	27%		
3	Correct	92%	85%	.001	.11
	Incorrect	8%	15%		
4	Correct	86%	66%	.001	.23
	Incorrect	14%	34%		
5	Correct	92%	78%	.001	.19
	Incorrect	8%	22%		
6	Correct	90%	71%	.001	.23
	Incorrect	10%	29%		

The third hypothesis concerned the effects of chemical dependence education in medical school on reported willingness to intervene either personally or anonymously.

There was no difference between those who reported having received training in chemical dependence in medical school and those who reported having received no training in medical school with regard to reported willingness to intervene personally. Table 4 shows the comparison of correct versus incorrect responses for each scenario.

Table 4

The effects of prior chemical dependence training on reported willingness to intervene personally by scenario as determined by Chi-square calculations.

Scenario	Responses	CD Training	No CD Training	p=	Phi
1	Correct	19%	17%	.50	.02
	Incorrect	81%	83%		
2	Correct	15%	15%	.95	.003
	Incorrect	85%	85%		
3	Correct	17%	16%	.75	.01
	Incorrect	83%	84%		
4	Correct	25%	22%	.25	.04
	Incorrect	75%	78%		
5	Correct	22%	22%	.90	.01
	Incorrect	78%	78%		
6	Correct	19%	20%	.75	.01
	Incorrect	81%	80%		

The second part of that hypothesis was that those physicians who had received chemical dependence training in medical school would be more likely to report a willingness

to call the Alabama PRN than those physicians who had not received such training.

In four of the six scenarios there were no differences between those physicians who had received chemical dependence training in medical school and those physicians who had not received such training. However, in scenarios 4 and 6, physicians who reported that they had not received any chemical dependence training in medical school were more likely to report a willingness to call the Alabama PRN than those physicians who reported that they had received chemical dependence training in medical school. The lack of meaningful differences, as shown by phi coefficients, indicates that physicians' perceptions of having received chemical dependence training in medical school had no significant effect on reported willingness to call the Alabama PRN about a colleague suspected of impairment. The chi-square and phi coefficients showing no significant effects of prior chemical dependence training on reported willingness to call the Alabama PRN are shown in Table 5 on page 29.

The last hypothesis concerned the stability of the effects of the seminars over a nine month follow-up period. Recognition of impairment over time was not calculated because, as stated above, the floor was so high that there was very little room for meaningful variation in responses.

Table 5

The effects of prior chemical dependence training on reported willingness to call the Alabama PRN by scenario as determined by Chi-square calculations.

Scenario	Responses	CD Training	No CD Training	p=	Phi
1	Correct	38%	37%	.75	.02
	Incorrect	62%	63%		
2	Correct	81%	81%	.95	.002
	Incorrect	19%	19%		
3	Correct	87%	89%	.50	.03
	Incorrect	13%	11%		
4	Correct	68%	77%	.005	.09
	Incorrect	32%	23%		
5	Correct	81%	85%	.10	.06
	Incorrect	19%	15%		
6	Correct	76%	80%	.05	.05
	Incorrect	24%	20%		

The stability of reported willingness to call the Alabama PRN was analyzed by scenario and by seminar date. The frequency of correct/incorrect responses reported by the posttest group was compared to the frequency of correct/incorrect responses reported by the follow-up: specific seminar groups. The time elapsed from the first seminar (January 18, 1992) to the mailing of the follow-up surveys was approximately nine months. The time elapsed from the last seminar (May 31, 1992) to the mailing of the follow-up surveys was approximately five months. Returned surveys were analyzed by seminar date and by

scenario using the chi-square statistic. Posttest survey responses were pooled and a modified Bonferroni test was used to determine an alpha level of .001 for the 48 planned comparisons.

It was expected that there would be no significant differences between the posttest and follow-up surveys if the seminar had an effect on reported willingness to call the Alabama PRN and if that effect was stable over time. Significant differences between the posttest and follow-up surveys indicated that the effects of the seminar on reported willingness to call the Alabama PRN were not stable over time.

Scenario 1 showed the least stability over time, with significant differences in reported willingness to call the Alabama PRN occurring between the posttest and follow-up surveys at six months and nine months follow-up. In general, the effects of the seminar on reported willingness to call the Alabama PRN remained stable across scenarios 2, 3, 4, 5, and 6 throughout the nine-month follow-up period.

V. DISCUSSION

The medical profession has come a long way in the recognition of impairment among its own ranks. It is the practicing physician who is in the best position to observe impaired judgement in a colleague. Few studies have been done to research physician's awareness of and attitudes toward their impaired colleagues. This study showed that recognition of impairment is not the problem which needs to be addressed. The four groups in this study all scored a high percentage of correct answers in the area of recognition of physician impairment indicating that recognition of the problem is not what keeps physicians from reporting their impaired colleagues.

Scheiber and Doyle wrote (1983) that the problem is: (a) ignorance about impairment, (b) lack of awareness of intervention and treatment alternatives, and (c) the reluctance of many physicians to confront a colleague. As a result of this study, perhaps ignorance needs to be redefined. Ignorance of physician impairment is not a lack of recognition of the problem but rather a lack of understanding of the solutions. The answer then lies in educational objectives aimed not just at the acquisition of

knowledge, but also the willingness to change long-held attitudes toward impaired colleagues.

Is a reported willingness to pick up the phone and call the Alabama PRN evidence that attitudes are changing? Not at all. The significant differences between those physicians who attended the seminars and those who did not are impressive. But, with a sample size of 1966, significant differences are to be expected. It is true that reported willingness to call the Alabama PRN increased with seminar attendance. But it may not have increased as a result of seminar attendance. There may be other variables that contributed to the increase. At the time the seminars were conducted, the medical director of the Alabama PRN was giving lectures to hospitals and county medical societies and publishing articles in the Alabama medical journal to educate physicians about colleague impairment. Physicians in the state of Alabama were most likely exposed to information about physician impairment from one or more of these other sources.

Between scenarios, there were differences in the recognition of possible impairment and reported willingness to call the Alabama PRN which suggested effects of other variables within the scenarios. Because the survey instrument has not been validated and because the variables in the scenarios were not systematically varied, it is not possible to say exactly what those variables are.

In scenario 1, there was a statement "This was an isolated episode. He said it would not happen again." The philosophies of "live and let live" and "there but for the Grace of God go I" discussed in the introduction may have been important factors within this scenario. Scenario 1 had the lowest recognition and least reported willingness to call the Alabama PRN among those physicians who did not attend a seminar, when compared to the other scenarios. In addition, responses to scenario 1 concerning reported willingness to call the Alabama PRN had more deterioration over time than the other scenarios. While physicians responded well initially to the acquisition of the knowledge that the physician in scenario 1 may be impaired and may need help, a long-term change in attitude does not appear to have occurred.

Scenario 3 was the only scenario that mentioned a physician in trouble because of narcotics. This scenario had the highest overall recognition despite representing the only physician in the six scenarios who had been diagnosed as not having a problem with chemical dependence. Physicians may be more willing to recognize a physician in trouble with drugs because the physician in trouble with drugs may be less threatening to a colleague than the physician who abuses alcohol.

One variable not mentioned in any of the scenarios was the degree of friendship between the physician in the

scenario and the physician who was being asked to report a willingness to call the Alabama PRN. Reported willingness to call may have been elevated because the physicians did not perceive a threat to a personal relationship.

If attitudinal changes are one of the goals of impairment education, how can attitudinal changes be measured in terms of behavioral change? To answer this question for the purposes of the current study, referrals to the Alabama PRN were counted from the inception of the program on October 1, 1991. Referrals to the PRN increased during the period of the seminars and decreased following the completion of the seminars. Because the program only has a one year history, this data will only become meaningful if the number of referrals are tracked for another year to see if seasonal changes, rather than the seminars are the factor which affected the number of referrals to the PRN. The increase in referrals during the period of the seminars is an encouraging sign, however, that a reported willingness to call the Alabama PRN is translated to the behavioral change of picking up the phone and actually making a call. Another follow-up survey could be sent inquiring if those physicians who attended a seminar had ever called the Alabama PRN.

The predictions about physicians who had prior chemical dependence training in medical school also deserves further investigation. As shown in the literature, medical schools

are addressing the problem of physician impairment. For the purposes of this study, it appears there was no relationship between chemical dependence training in medical school and current attitudes about colleague impairment. Because the question about chemical dependence training relied on physicians' perceptions and memory of medical school curricula, a yes or no response was not descriptive enough to provide meaningful data. More specific questions could have been asked regarding the type, duration, and time elapsed since such training occurred.

There are several conclusions that can be drawn as a result of this study. First, recognition of impairment and reported willingness to call the Alabama PRN increased following seminar attendance, although they may not have increased because of seminar attendance. Second, reported willingness to call the Alabama PRN remains stable for at least a nine-month period. Lastly, referrals to the Alabama PRN increased during the seminars, followed by a gradual decline, suggesting a behavioral change.

The lack of empirical studies in the area of physician awareness of and attitudes about colleague impairment make this an area wide open to further research. This particular study was the first of its kind and, as such, there are many changes that could be made to enhance a study of this type in the future. As mentioned previously, scenarios in future studies could be systematically varied in order to determine

specific characteristics that help or hinder an attitudinal change in physicians regarding their impaired colleagues. Also, questions following the scenarios do not need to include a reported willingness to intervene personally. Rather, a question which seeks to determine the physician's attitude toward his colleague would be more useful. Responses to the questions should be forced choice to more accurately reflect correct versus incorrect responses. Lastly, space should be provided and comments encouraged for each scenario in order to better understand what specific attitudes are being confronted.

Recommendations for future research include educational objectives that: (1) involve both knowledge and attitudinal change; (2) attempt to change deeply rooted attitudes that dictate behaviors developed through years of practice; (3) utilize evaluation methods that detect behavioral change; and (4) contain a plan for follow-up to ensure that knowledge gained and modified attitudes are translated into action.

This study has shown a practical need to continue educational efforts aimed at changing physician's attitudes toward their impaired colleagues. From a theoretical viewpoint, evaluative responses which seek to measure those attitudes include cognitive, affective, experiential, and even physiological aspects. The nature of attitudes and attitudinal change are such that reinforcement is needed at

the time of the educational effort and again at a later date (Chappel & Veach, 1987). CME courses about physician impairment need to address these attitudinal issues in order to affect a long-term behavioral change in physicians.

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APPENDIX A

SEMINAR CONTENT

SEMINAR TITLE: THE IMPAIRED PHYSICIAN
COMPLETED CONTENT OUTLINE

TIME: 8:00 a.m.- 9:15 a.m.
FACULTY: Talbott/Groper/Keppler
Teaching Methods: Lecture/Discussion

OBJECTIVES

1. Define Impairment

2. Discuss the prevalence of impairment among physicians and review common reasons for impairment.

3. Outline characteristics of impaired physicians and discuss early warning signs of problems.

4. Review appropriate interventions and treatment modalities, exploring the various components of selected modalities.

5. Describe the processes for re-entry into practice and monitoring techniques after re-entry.

AGENDA

I. Prevalence of impairment among physicians.
   A. percentages of physicians who have been, are, or will be addicted to alcohol and/or drugs.
   B. the "Conspiracy of Silence".
   C. the problem of self-deception.
   D. reasons for impairment.

II. Identification of impaired physicians.
   A. six characteristic behaviors.
   B. sequential progression of symptoms.
   C. early warning signs.

III. Interventions.
   A. denial characteristics of physicians.
   B. difficulty in reaching out for help.
   C. characteristics and requirements of physician intervenors.
   D. selection/control of intervention strategies and intervenors.

IV. Treatment modalities and components.
   A. initial assessment.
   B. four phases of treatment.
      1. inpatient treatment program.
      2. outpatient therapy/ supervised living.
      3. counselor trainee with supervision - "mirror image".
      4. re-entry.

V. Re-entry and monitoring.
   A. 20-month aftercare contract.
   B. AA/NA meetings.
   C. relapse guidelines.
   D. support network contacts - "Caduceus Club" and others.

TIME: 9:15 a.m.- 10:00 a.m.
FACULTY: Attorneys
Teaching Methods: Lecture/Discussion

OBJECTIVE

6. Review and discuss case examples of lawsuits involving impaired physicians.

AGENDA

VI. Operating under the influence.
   A. problems defending a malpractice case involving an impaired physician.
   B. individual physician's duty to report an impaired colleague.
   C. case presentations.

TIME: 10:30 a.m. - 11:15 a.m.
FACULTY: Gerald Summer
Teaching Methods: Lecture/Discussion

OBJECTIVE

7. Introduce and describe Alabama's Impaired Physician Program.

AGENDA

VII. The Alabama Physicians Recovery Network (PRN)

TIME: 11:15 a.m. - 12:00 p.m.
FACULTY: All

AGENDA

Questions and Answers
Summary and Evaluation

APPENDIX B

SURVEY

Have you completed this survey before today? Y____N____

Age: _____ Male___ Female___ Race: _____

Medical School: _____ Year 19____ Specialty: _____

Type of practice: Solo____ Small group (<6)_____ Large group (>6)____

Primary area raised? Urban _____Suburban _____ Rural_____

Area of current residence: Urban _____Suburban _____Rural_____

The religion in which you were raised:_____

Have you ever been evaluated for chemical dependency? Y___ N___

Did you receive any training in chemical dependence or professional impairment while attending medical school? Y___ N___

PLEASE READ EACH OF THE FOLLOWING SCENARIOS AND RESPOND TO THE STATEMENTS BY CHOOSING ONE OF THE FOLLOWING RESPONSES:

1	2	3	4	5
STRONGLY AGREE	**AGREE**	**UNDECIDED**	**DISAGREE**	**STRONGLY DISAGREE**

A 42-year old emergency room physician arrived late for his shift in the emergency room with alcohol on his breath. Another physician took his shift. This was an isolated episode. He said it would not happen again.

1. BASED ON THE INFORMATION GIVEN, I BELIEVE THIS PHYSICIAN'S PROFESSIONAL JUDGEMENT MAY BE IMPAIRED.

1 2 3 4 5

2. I WOULD SPEAK TO THIS PHYSICIAN ABOUT HIS POSSIBLE IMPAIRMENT.

1 2 3 4 5

3. I WOULD CALL THE STATE IMPAIRED PHYSICIANS PROGRAM ABOUT THIS PHYSICIAN.

1 2 3 4 5

A 51-year old surgeon was reported by nurses to the hospital administrator for making rounds at 11:00 p.m. with alcohol on his breath. Recently, both his marriage and his professional partnerships have split up. He denies any problem.

1. BASED ON THE INFORMATION GIVEN, I BELIEVE THIS PHYSICIAN'S PROFESSIONAL JUDGEMENT MAY BE IMPAIRED.

1 2 3 4 5

2. I WOULD SPEAK TO THIS PHYSICIAN ABOUT HIS POSSIBLE IMPAIRMENT.

1 2 3 4 5

3. I WOULD CALL THE STATE IMPAIRED PHYSICIANS PROGRAM ABOUT THIS PHYSICIAN.

1 2 3 4 5

1	2	3	4	5
STRONGLY AGREE	AGREE	UNDECIDED	DISAGREE	STRONGLY DISAGREE

A 37-year old anesthesiologist was reported by the hospital pharmacy to the hospital administrator for recurrent gross inadequacies in the narcotic logs for which he had been previously counselled. He denies drug use.

1. BASED ON THE INFORMATION GIVEN, I BELIEVE THIS PHYSICIAN'S PROFESSIONAL JUDGEMENT MAY BE IMPAIRED.
1 2 3 4 5

2. I WOULD SPEAK TO THIS PHYSICIAN ABOUT HIS POSSIBLE IMPAIRMENT.
1 2 3 4 5

3. I WOULD CALL THE STATE IMPAIRED PHYSICIANS PROGRAM ABOUT THIS PHYSICIAN.
1 2 3 4 5

A 44-year old family practitioner was accused by nurses of sexual harassment over the telephone. Recently, he has been making rounds late at night and has been having multiple consultants care for his patients. Nurses say his eyes look "glassy". He denies their allegations.

1. BASED ON THE INFORMATION GIVEN, I BELIEVE THIS PHYSICIAN'S PROFESSIONAL JUDGEMENT MAY BE IMPAIRED.
1 2 3 4 5

2. I WOULD SPEAK TO THIS PHYSICIAN ABOUT HIS POSSIBLE IMPAIRMENT.
1 2 3 4 5

3. I WOULD CALL THE STATE IMPAIRED PHYSICIANS PROGRAM ABOUT THIS PHYSICIAN.
1 2 3 4 5

A 56-year old psychiatrist was reported by a mental health district employer for repeated failure to see scheduled patients. Nurses say he is "bizarre" and changes jobs frequently. He is rumored to drink heavily.

1. BASED ON THE INFORMATION GIVEN, I BELIEVE THIS PHYSICIAN'S PROFESSIONAL JUDGEMENT MAY BE IMPAIRED.
1 2 3 4 5

2. I WOULD SPEAK TO THIS PHYSICIAN ABOUT HIS POSSIBLE IMPAIRMENT.
1 2 3 4 5

3. I WOULD CALL THE STATE IMPAIRED PHYSICIANS PROGRAM ABOUT THIS PHYSICIAN.
1 2 3 4 5

A 49-year old family practitioner was involved in an alcohol-related auto accident in which he fractured his cervical spine. He was charged with DUI. His ex-wife says alcohol was a problem in their marriage. He has never been noted to be impaired while working.

1. BASED ON THE INFORMATION GIVEN, I BELIEVE THIS PHYSICIAN'S PROFESSIONAL JUDGEMENT MAY BE IMPAIRED.
1 2 3 4 5

2. I WOULD SPEAK TO THIS PHYSICIAN ABOUT HIS POSSIBLE IMPAIRMENT.
1 2 3 4 5

3. I WOULD CALL THE STATE IMPAIRED PHYSICIANS PROGRAM ABOUT THIS PHYSICIAN.
1 2 3 4 5

APPENDIX C

COVER INSTRUCTIONS FOR SURVEYS

PRETEST SURVEY

PLEASE OPEN THE PRETEST SURVEY BOOKLET AND COMPLETE THE SURVEY NOW. WHEN YOU HAVE FINISHED THE SURVEY, PUT IT IN FRONT OF YOU ON THE TABLE AND IT WILL BE COLLECTED BEFORE THE PROGRAM BEGINS. PLEASE DO NOT DISCUSS THE SURVEY AT ANY TIME. THANK YOU.

POSTTEST SURVEY

PLEASE DO NOT OPEN THE SURVEY BOOKLET UNTIL THE LAST SPEAKER HAS FINISHED PRESENTING. AT THAT TIME, OPEN THE BOOKLET AND COMPLETE THE SURVEY. WHEN YOU HAVE COMPLETED THE SURVEY, LEAVE IT ON THE TABLE IN FRONT OF YOU FOR COLLECTION. PLEASE DO NOT DISCUSS THE CONTENTS OF THE SURVEY AT ANY TIME. THANK YOU.

APPENDIX D

FOLLOW-UP SURVEY

Have you completed this survey before today at one of the Mutual Assurance Seminars? Y____N____

Please indicate what Mutual Assurance Seminar you attended:
Mobile 1/18/92____ Birmingham 2/1/92____ Montgomery 3/21/92 ____
Huntsville 4/4/92____ Florence 4/25/92____ Birmingham 5/2/92 ____
Montgomery 5/23/92____ Gulf Shores 5/31/92____ Other specialty seminar____ I did not attend a Mutual Assurance seminar____

Age: _____ Male___ Female___ Race: _____

Medical School: _____ Year 19____ Specialty:_____

Type of practice: Solo____ Small group (<6)_____ Large group (>6)____

Primary area raised? Urban _____ Suburban _____ Rural _____

Area of current residence: Urban _____ Suburban _____ Rural _____

The religion in which you were raised:_____

Have you ever been evaluated for chemical dependency? Y___ N___

Did you receive any training in chemical dependence or professional impairment while attending medical school? Y___ N___

PLEASE READ EACH OF THE FOLLOWING SCENARIOS AND RESPOND TO EACH STATEMENT BY CHOOSING ONE OF THE FOLLOWING RESPONSES:

1	2	3	4	5
STRONGLY AGREE	**AGREE**	**UNDECIDED**	**DISAGREE**	**STRONGLY DISAGREE**

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1 2 3 4 5

2. I WOULD SPEAK TO THIS PHYSICIAN ABOUT HIS POSSIBLE IMPAIRMENT.
1 2 3 4 5

3. I WOULD CALL THE STATE IMPAIRED PHYSICIANS PROGRAM ABOUT THIS PHYSICIAN.
1 2 3 4 5

1	2	3	4	5
STRONGLY AGREE	AGREE	UNDECIDED	DISAGREE	STRONGLY DISAGREE

A 51-year old surgeon was reported by nurses to the hospital administrator for making rounds at 11:00 p.m. with alcohol on his breath. Recently, both his marriage and his professional partnerships have split up. He denies any problem.

1. BASED ON THE INFORMATION GIVEN, I BELIEVE THIS PHYSICIAN'S PROFESSIONAL JUDGEMENT MAY BE IMPAIRED.

1 2 3 4 5

2. I WOULD SPEAK TO THIS PHYSICIAN ABOUT HIS POSSIBLE IMPAIRMENT.

1 2 3 4 5

3. I WOULD CALL THE STATE IMPAIRED PHYSICIANS PROGRAM ABOUT THIS PHYSICIAN.

1 2 3 4 5

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1. BASED ON THE INFORMATION GIVEN, I BELIEVE THIS PHYSICIAN'S PROFESSIONAL JUDGEMENT MAY BE IMPAIRED.

1 2 3 4 5

2. I WOULD SPEAK TO THIS PHYSICIAN ABOUT HIS POSSIBLE IMPAIRMENT.

1 2 3 4 5

3. I WOULD CALL THE STATE IMPAIRED PHYSICIANS PROGRAM ABOUT THIS PHYSICIAN.

1 2 3 4 5

A 44-year old family practitioner was accused by nurses of sexual harassment over the telephone. Recently, he has been making rounds late at night and has been having multiple consultants care for his patients. Nurses say his eyes look "glassy". He denies their allegations.

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1 2 3 4 5

2. I WOULD SPEAK TO THIS PHYSICIAN ABOUT HIS POSSIBLE IMPAIRMENT.

1 2 3 4 5

3. I WOULD CALL THE STATE IMPAIRED PHYSICIANS PROGRAM ABOUT THIS PHYSICIAN.

1 2 3 4 5

1 STRONGLY AGREE	2 AGREE	3 UNDECIDED	4 DISAGREE	5 STRONGLY DISAGREE

A 56-year old psychiatrist was reported by a mental health district employer for repeated failure to see scheduled patients. Nurses say he is "bizarre" and changes jobs frequently. He is rumored to drink heavily.

1. BASED ON THE INFORMATION GIVEN, I BELIEVE THIS PHYSICIAN'S PROFESSIONAL JUDGEMENT MAY BE IMPAIRED.
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2. I WOULD SPEAK TO THIS PHYSICIAN ABOUT HIS POSSIBLE IMPAIRMENT.
1 2 3 4 5

3. I WOULD CALL THE STATE IMPAIRED PHYSICIANS PROGRAM ABOUT THIS PHYSICIAN.
1 2 3 4 5

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2. I WOULD SPEAK TO THIS PHYSICIAN ABOUT HIS POSSIBLE IMPAIRMENT.
1 2 3 4 5

3. I WOULD CALL THE STATE IMPAIRED PHYSICIANS PROGRAM ABOUT THIS PHYSICIAN.
1 2 3 4 5