FIVE-YEAR OUTCOME AND THE SUCCESS RATE OF

IMPAIRED PHYSICIANS IN ALABAMA

Except where reference is made to the work of others, the work described in this thesis is my own or was done in collaboration with my advisory committee. This thesis does not include propriety or classified information.

Mary E. Burns
Mary Eugenia Burns

Certificate of Approval:

Peter Zachar, Ph.D.
Professor
Psychology

Steven G. LoBello, Ph.D., Chair
Professor
Psychology

James R. Stefurak, Ph.D.
Assistant Professor
Psychology

Janet S. Warren, Ed.D.
Vice-Chancellor
Academic and Student Affairs

FIVE-YEAR OUTCOME AND THE SUCCESS RATE OF IMPAIRED PHYSICIANS IN ALABAMA

Mary Eugenia Burns

A Thesis

Submitted to

The Graduate Faculty of

Auburn University Montgomery

In Partial Fulfillment of the

Requirements for the

Degree of

Master of Science

Montgomery, Alabama

December 15, 2007

FIVE-YEAR OUTCOME AND THE SUCCESS RATE OF

IMPAIRED PHYSICIANS IN ALABAMA

Mary Eugenia Burns

Mary E. Burns

Signature of Author

December 15, 2007

Date of Graduation

VITA

Mary Eugenia Burns, daughter of Alan Burns and Jane Wynn Hartley, was born July 22, 1978, in Mobile, Alabama. She graduated from Saint James High School in 1996. She attended Judson College in Marion, Alabama, for two years, then entered the University of Montevallo in August, 1998, and graduated with a Bachelor of Science degree in Biology in December, 1999. She entered Graduate School, Auburn University Montgomery, in August, 2004. She married Adam Hill, son of Thomas and Betty (Smith) Hill, on May 20, 2006.

THESIS ABSTRACT

FIVE-YEAR OUTCOME AND THE SUCCESS RATE OF IMPAIRED PHYSICIANS IN ALABAMA

Considerations of public safety and welfare requires that society develop strategies for addressing the problem of substance-abusing and disruptive physicians. The five-year outcome for substance-abusing and disruptive physicians monitored by three specific agencies in Alabama (Alabama Board of Medical Examiners, Medical Licensure Commission, and Alabama Physician Health Program) is described. Outcome is defined as practicing versus not practicing medicine five years after sanction. Nearly 85% of physicians who have been disciplined for substance abuse and/or disruptive behavior are practicing medicine five years after their first sanction. Results indicate that most physicians were monitored by the Alabama Physician Health Program only. Those monitored by the PHP only or the Alabama Board of Medical Examiners only had the highest success rates (93.8% and 100%, respectively). The lowest success rates were those physicians who were monitored by the Medical Licensure Commission only or who were monitored by all 3 monitoring agencies. There was insufficient data to determine if the success rate was better for any single offense or the combination of the two offenses. Of the 109 cases, 98 (89.9%) were monitored for chemical dependency problems without any indication of disruptive behavior. No significant relationship was found between the psychiatric diagnosis (affective disorder, personality disorder, or substance-use disorder) and outcome, considering both single diagnosis and multiple diagnoses.

ACKNOWLEDGEMENTS

The completion of the research project was made possible by numerous individuals. I would like to thank Dr. Steven G. LoBello for his guidance and patience through this investigation and my committee for their insight. Amy Dorminey, Jim Hulett, Mary Leigh Meredith, and Pat Shinn and have provided several hours of exceptional aid and flexibility throughout this difficult research process. Thanks also to Larry D. Dixon, Executive Director of the Alabama Board of Medical Examiners and Greg Skipper, M.D., Medical Director of the Alabama Physician Health Program. Without their support and insight this project would not have been possible. Thanks are also extended to Terri E. Brewer, Psy.D. and David S. Kantra, Psy.D. who provided valuable encouragement through this project.

On a personal note, I would like to thank my family members, Jane, Alan, and Jemison, and friends, Anne Shiver and Amy Hood, for their support during the course of this investigation.

Finally, I would like to thank my husband, Adam, for his understanding and patience throughout this research project. His love and support have not only shed a positive light on this project, but also on our life in general.

STYLE MANUAL AND SOFTWARE USED

Publication Manual of the American Psychological Association

Microsoft Excel

SAS Computer Software

TABLE OF CONTENTS

LIST OF TABLES AND FIGURES

Five-Year Outcome and the Success Rate of Impaired Physicians in Alabama

Physician Impairment

Physician impairment is defined by the American Medical Association (2004) as, "any physical, mental, or behavioral disorder that interferes with the ability to engage safely in professional activities" (p. 2). This impairment includes disruptive behavior and chemical dependency. In order to prevent physician impairment, it is important to identify physicians at risk for disciplinary action (Clay & Conatser, 2003). Research has documented that physicians develop addiction and dependence to drugs and alcohol just as often as the general population (Pomm & Harmon, 2004). This dependency may lead to a number of negative outcomes, including behavioral changes.

Troubled physicians fear that admitting a problem will place them at the mercy of state licensing boards (Pomm & Harmon, 2004). Physicians addicted to alcohol or drugs face many social, economic, and professional consequences and avoid seeking help (Stoudemire & Rhoads, 1983). For these reasons, many states have developed confidential assistance programs for physicians in need. These confidential programs guard the public interest while helping the impaired physician (Pomm & Harmon, 2004). If the physician follows the requirements set by the program, the information concerning the physician remains confidential. Some physicians believe that they could not develop a problem that warrents treatment and this defensiveness hinders the operation of assistance programs (Pomm & Harmon, 2004).

Disruptive Physician

Disruptive behavior may be defined as interactions among all participants in the healthcare setting (physicians, patients, hospital staff, or family members) that could hinder patient care (American Medical Association, 2004). Whether verbal or nonverbal, disruptive behavior results in negative outcomes. Bohigian et al., (2005) list the following eight actions that characterize the disruptive physician:

> (1) Employs threatening or abusive language, directed at nurses, hospital personnel, or other physicians; (2) Makes degrading or demeaning comments regarding patients, families, nurses, physicians, hospital personnel, or the hospital; (3) Uses profanity or other grossly offensive language while in a professional setting; (4) Utilizing threatening or intimidating physical contact; (5) Makes public derogatory comments about the quality of care being provided by other physicians, nursing personnel, or the hospital; (6) Writes inappropriate medical records entries concerning the quality of care provided by the hospital or any other individual; (7) Imposes idiosyncratic requirements on ancillary staff, which have nothing to do with better patient care and serve only to burden staff w/ "special" techniques and procedures; (8) Creates a hostile environment, which can increase risk management problems and decrease morale (p. 21).

The American Medical Association (2004) recognizes several disruptive behaviors that could lead to substandard care. The behavior falls on a continuum that begins with an arrogant attitude that may lead to disputes between colleagues and/or patients resulting in substandard care (American Medical Association, 2004).

Disruptive behavior in the hospital environment may include a variety of inappropriate behavior (Harmon & Pomm, 2004). Examples include, the use of explicit and abusive language, verbal threats to colleagues and staff, outwardly criticizing associates, and the notion of utilizing intimidation to obtain what is desired (Harmon & Pomm, 2004). The disruptive physician rarely realizes the effects of his/her behavior (Bohigian et al., 2005). The behavior is most noticed or felt by colleagues, staff, patients, and family members.

Many nurses bear the brunt of physicians' disruptive behavior. Cook, Green, and Topp (2001) studied the severity and occurrence of verbal abuse by physicians directed toward perioperative nurses. Ninety-one percent of perioperative nurses reported experiencing verbal abuse by a physician within the preceding year. Of these, 29% reported being abused at least once per week. The specific type of verbal abuse that occurred repeatedly was abusive anger and condescension (Cook et al., 2001).

Verbal abuse of nurses causes negative relations between nurses and physicians (Cook et al., 2001). Such abuse also affects nurses' job satisfaction and staff cohesiveness. Animosity as a result of disruptive behavior accounts for unwillingness of the nurse to ensure the highest quality care for patients. Nurses in these circumstances may hesitate to call a physician regarding changes in a patient's status and fail to offer suggestions about better care to the physician (Cook et al., 2001).

Why are some physicians allowed to display disruptive behavior without suffering any consequences (Pfifferling, 1997)? Other physicians may be reluctant to report colleagues' disruptive behavior because it may jeopardize a referral source. Other reasons some physicians avoid sanctions because (1) they have the reputation of being

the best doctor in the hospital, (2) they are known as the doctor who demands excellence, or (3) they blame the nursing staff (Horty, 1998).

Pfifferling (1997) reported that stress might be a factor in disruptive episodes. Some physician stressors include trying to maintain an ever-faster pace without sacrificing patient satisfaction. Increased rules and regulations from insurance and non medical personnel in the healthcare profession might also contribute to stress felt by physicians. Disruptive behavior can damage the professional medical setting in a number of ways. For example, productivity of the staff and other physicians may decrease, staff turnover may increase, and standards of patient care may decline (Pfifferling, 1997).

In the past, staff under the leadership of disruptive physicians would absorb the abuse without visible protest (Pfifferling, 1997). Now, abused staff terminate employment and many take legal action. Many physicians who practice with a disruptive colleague are also concerned about being named in such a suit for unprofessional conduct or a quality of care issue. A disruptive colleague may become very costly for other physicians, staff, and patients (Pfifferling, 1997). Staff may be afraid to ask questions, express opinions, and may withhold patient information. Administrators in both hospitals and private practices may spend their time apologizing to upset patients and listening to the complaints of staff instead of managing their operations.

Efforts are made, in many professional settings, to develop preventative measures for handling disruptive physicians before they become unmanageable. Many healthcare facilities and private practices are adopting prevention programs that demonstrate how negative conduct hinders the progress of patients and how to manage or eliminate the problem (Harmon & Pomm, 2004).

When behavior problems cannot be resolved within the physician's place of employment, then the physician may be referred to a treatment program. If local intervention is inadequate or fails, state agencies such as physician health programs may intervene. Many physicians do not appreciate the seriousness of their behavior until their license to practice medicine is threatened by state medical boards (Pfifferling, 1997).

Treating Disruptive Behavior

Many hospitals have established local guidelines and policies for handling disruptive physicians. These guidelines should specify a fair and speedy intervention and should also give the disruptive physician an opportunity to discuss the matter and change behavior (American Medical Association, 2004). However, many physicians do not perceive themselves as disruptive. Disruptive physicians may only respond to threats of disciplinary action. Such discipline could range from loss of staff privileges to being reported to the Board of Medical Examiners.

Once identified, the physician with disruptive behavior may be evaluated by interview consisting of work history, conduct within the work place, psychiatric evaluation, psychological testing, drug testing, interviews with staff and colleagues, and cognitive testing (Harmon & Pomm, 2004). Treatment of disruptive physicians consists of educational programs, anger-management, and monitoring. Changes in behavior are usually only accomplished through major financial and/or public sanctions (Kirkland & Skipper, 2002).

In order to effectively treat disruptive behavior, the source of the problem must be identified. Inappropriate anger has been linked to a number of interpersonal problems (Kirkland & Skipper, 2002) which, in turn, may be linked to health and/or psychological

distress syndromes. The disruptive physician may suffer from Personality Disorder (Antisocial, Paranoid, Borderline, Histrionic, or Narcissistic), a combination of these traits, or organic disorders (Kirkland & Skipper, 2002; American Medical Association, 2004). A physician may be experiencing high levels of stress. Substance abuse or withdrawal may present as different forms of disruptive behavior, such as aggressiveness, argumentativeness, and/or irritability (American Medical Association, 2004).

One type of treatment for "anger-management" is Cognitive Behavior Modification (CBM) (Kirkland & Skipper, 2002). CBM teaches a set of skills to manage angry outbursts. Treatment techniques are centered on learning to correctly identify emotions, such as differentiating anger from fear. Techniques also focus on decreasing physiological and emotional arousal, and on learning new social skills (Kirkland & Skipper, 2002).

Substance-Abusing Physician

Physicians face an array of stressors that may lead to career damage. For example, many physicians become dependant of drugs and alcohol, which may not immediately affect daily functioning (Pomm & Harmon, 2004). By the time many physicians admit a problem with drugs and/or alcohol the addiction has been long established. Dependency can mask occupational stressors typical of many physicians because of the blunting of emotions that occurs with alcohol and some drugs. Drug-induced emotional and cognitive impairment may affect the decision-making ability of physicians, which may affect patient care. In addition, financial problems may surface as an added stressor (Pomm & Harmon, 2004).

Alcohol and drug addiction can contribute to a number of behavior and social problems (Rotunda, Scheere, & Imm, 1995). Such problems include dysfunctional marriage, poor job performance, legal issues, abuse (verbal and physical), and difficulty parenting children. Physicians may be vulnerable to substance abuse because of high levels of occupational stress and limited time for leisure pursuits (Stoudemire & Rhoads, 1983). Many physicians must work long hours with little time off. When physicians try to engage in leisure pursuits, many report preoccupation with the work and patients they left behind (Stoudemire & Rhoads, 1983).

Is the physician more apt to become addicted to one type of drug over another? Hughes et al. (1992) mailed questionnaires to a random sample of physicians to assess the use of thirteen substances. Respondents reported that the most often consumed prescription medications were opiates and benzodiazepines. Alcohol was reported as the most commonly used substance. Respondents were more likely to consume alcohol compared to an age and gender matched cohort from the general population (Hughes et al., 1992). Physicians in this sample reported using illicit drugs (marijuana/cocaine) for recreation. However, the main reason for the use of prescription drugs (benzodiazepines/opiates) was for self-treatment (Hughes et al., 1992).

With all the daily demands on physicians, Felton (1998) noted that burnout might be a contributing factor to chemical dependency among physicians. Burnout is described as exhaustion (emotional or physical) caused by stress of work related activities. A component of burnout is having the feeling of never being caught up with work. Those working in human services were the most likely to suffer from stress related burnout. Felton (1998) reported that specific occupations, including physicians, were "at risk" for

such burnout. Certain components of a physician's job may make him vulnerable to burnout. For example, many physicians begin their careers with the expectation of helping others. However, many rarely receive a "thank-you", and are surprised to encounter disgruntled employees and/or patients. More specifically, Felton (1998) noted that physicians have been targets of legal actions by patients and insurance companies. Fear of being investigated has lead to a defensive mode of practice which negatively affects the physician-patient relationship. Physicians must also stay current with rapid advances in their fields, which may consume part of their family time. Physicians are fatigued by being on-call, working long hours, handling life and death situations, and by interruptions at the hospital, the office, and the home (Felton, 1998).

Treating Substance-Abusing Physicians

One important aspect of treating the substance-abusing physician is to establish uniform measures that ensure public safety while helping substance-abusing physicians (Voelker, 1994). The Federation of State Medical Boards (1995) has put much effort into establishing guidelines to specify the most effective treatment for substance-abusing physicians. The Federation supports strengthening the relationship between state licensing boards and treatment programs. Such relationships have been established in several states, including Alabama, and make it possible for physicians to enter programs before their problem becomes an issue for state licensing boards (Voelker, 1994). Awareness of the substance-abusing physician increased in the 1970's and has led to the creation of a number of treatment options (Gastfriend, 2005). Most states now have Physician Health Programs (PHP) that advocate for physicians with various impairments (including substance-abuse) and to provide nonpunative interventions.

Substance-abusing physicians benefit from the support of rehabilitation by most states (Pomm & Harmon, 2004). Many states have established confidential programs to identify, intervene, evaluate, treat, and monitor substance-abusing physicians. One major obstacle in treating such physicians is denial of the problem. The confidential programs established to help those physicians cannot be effective if the impaired physician denies the problem (Pomm & Harmon, 2004).

Physicians who deny addictions and inappropriate behavior may encounter additional problems (Bosch, 2000). The untreated physician is not only putting his career at risk, but the well-being of patients, families, and co-workers. Many physicians do not ask for help because they fear jeopardizing their careers and opt to self-treat their problems (Bosch, 2000). Colleagues, staff, patients, family, and friends may also deny that any problem exists. They may also believe they are protecting the addicted physician from social and professional embarrassment (Stoudemire & Rhoads, 1983).

Substance-abusing physicians deny their problem because of social, economical, and professional concerns (Stoudemire & Rhoads, 1983). Physicians as a group have garnered high social status which the addicted physician may fear losing. Physicians treated for alcoholism or chemical dependency may fear loss of referrals and sanctions by state licensing boards. Professional treatment is costly and lengthy inpatient treatment also precludes earning income for the duration of treatment. Many physicians and their families must cope with a reduced standard of living if work is interrupted for an extended period of time.

The substance-abusing physician may also fear resentment from the physician community (Stoudemire & Rhoads, 1983). Physicians have large investments (financial,

emotional, and intellectual) in professional identity and status. An illness as serious and stigmatizing as addiction may pose a threat to the physician's identity and sense of self worth, which reinforces the denial (Stoudemire & Rhoads, 1983). The physician must realize he is not perfect or invulnerable and is subject to the risks of developing chemical dependency. Once a physician confronts the realization of addiction, he must then accept who he has become: not only a recovering physician, but a recovering individual as well (Leavenworth, 1994).

When treating alcoholics and their families it is important to understand that alcohol plays a substantial role in the lives of all family members. Treatment should aim for achieving sobriety, but also defining new coping skills. These skills are especially needed to repair the lack of trust and negativity within the family (Rotunda et al., 1995). Many recovery centers have been established to solely treat recovering physicians (Leavenworth, 1994). One such center is the Maplesgroove Center for Chemical Dependency in West Bloomfield, Michigan. At this center, physicians are not placed on a pedestal by staff or other patients. Because this center only treats physicians, physicians and their peers learn about recovery and how it must become a major facet of their lives (Leavenworth, 1994).

Several program components are necessary to help the substance-abusing physician (Gastfriend, 2005). For example, individual monitoring plans should be established with personalized treatment contracts. Extended post-treatment monitoring is one vital key to successful treatment of a substance-abusing physician (Pomm & Harmon, 2004). Most monitoring contracts for chemical dependency are five years in length, which is standard for the Alabama Physician Health Program (American Medical

Association, 2005). The physicians must agree to random urine drug screening and a mandatory weekly urine drug screen during the first year of the contract. Typically, in the second through fourth year the physician is asked to supply a urine drug screen at least once per month.

Another component of the monitoring contract is participation in support or self help groups. These groups include Alcoholics Anonymous (AA), Narcotics Anonymous (NA), Caduceus, or group psychotherapy. The physician is typically required to attend meetings at least three times per week from their first through third year of the contract (American Medical Association, 2005). According to Pomm and Harmon (2004), 90% of physicians will not relapse within this period of monitoring. Substance abuse treatment programs have reported up to 70% of physicians and other health care providers successfully complete treatment and return to the practice of medicine (Domino et al., 2005).

One main goal of physician health programs is to monitor physicians to prevent relapses. Domino et al. (2005) reported one of every four substance-abusing physicians has at least one relapse. The authors define relapse as, "the resumption of substance use after initial diagnosis and completion of primary treatment for chemical dependency (p 1454)." Domino et al. (2005) conducted a study using information from the Washington Physician Health Program to determine the specific factors that lead health care professionals to relapse after treatment. This study was designed to see if physicians addicted to an opioid (fentanyl, sufentanil, morphine) were at a higher risk for relapse than physician addicted to another drug of choice. Domino et al. found the relapse rate was almost doubled if the drug of choice was an opioid, rather than other drugs. The risk

of relapse was also twice as great if the physician was diagnosed with a psychiatric illness or if there was addiction among other family members. This study found that three important factors for predicting relapse are family history of a substance use disorder, dual diagnosis, and opioid use. This study also found that age, sex, medical training, smoking preference, or specialty were not significant risk factors for relapse (Domino et al. 2005).

Medical Licensure and Disciplinary Procedures in Alabama

Alabama Board of Medical Examiners

The brochure *An Information Guide for Alabama Medical Licensees* (2006) states that medical students who have completed the educational requirements, residency programs, and passed the required national tests are not guaranteed an Alabama medical license. The license to practice medicine is a privilege granted through a process directed by two related state government agencies. The Alabama Board of Medical Examiners (ABME) first examines physician's credentials and, if approved, the Medical Licensure Commission (AMLC) grants the license to practice medicine in the state of Alabama (*An Information Guide for Alabama Medical Licensees,* 2006).

The 15 licensed physicians who sit on the Alabama Board of Medical Examiners (ABME) monitor and guide physicians through the application process, gather information regarding physicians' credentials, and investigate complaints (*An Information Guide for Alabama Medical Licensees,* 2006). The main duties of the ABME are to certify that the applying physicians have met the educational standards to be a physician in Alabama, review complaints, and initiate legal action against licensed physicians within the state of Alabama. The second branch of body, Medical Licensure

Commission (AMLC), is composed of eight members who are responsible for granting and/or revoking licenses for physicians to practice medicine or osteopathy, hold legal hearings pertaining to formal allegations regarding physicians' ability to practice safely, and to deliver rulings and sanctions on such allegations (*An Information Guide for Alabama Medical Licensees,* 2006).

The ABME meets monthly to discuss any issues pertaining to the activities of licensed and unlicensed physicians (*An Information Guide for Alabama Medical Licensees,* 2006). More specifically, they review pending applications for medical licensure, investigate physicians who have complaints against their licenses. The ABME grants, monitors, restricts, or revokes the physician's Alabama Controlled Substance Certificate (ACSC), review malpractice suits, and review actions taken by another state or medical facility (*An Information Guide for Alabama Medical Licensees,* 2006). While the ABME has jurisdiction over the ACSC, the AMLC has jurisdiction over the medical license.

Applications received by the office staff of the ABME must meet certain criteria (*An Information Guide for Alabama Medical Licensees,* 2006). If an application lacks documentation, or if an applicant has noted problems on his application, the pending application is reviewed first by the Credential Committee then by the full board. Problem applications include those submitted by applicants who took an usually long time to complete medical school or residency program, past treatment for chemical dependence, behavioral problems while in medical school or in a residency program, or numerous attempts to pass national tests. Many of these applicants are asked to supply additional information while others may be asked to meet with the Credential Committee to discuss

the problems. This process gives each applicant full opportunity to support his or her application for an Alabama medical license (*An Information Guide for Alabama Medical Licensees,* 2006).

Once an application is accepted by the ABME, the physician is granted a Certificate of Qualification (COQ) by the board to practice medicine (*An Information Guide for Alabama Medical Licensees,* 2006). This is not the medical license, but rather a certification that the physician meets educational requirements to hold an Alabama medical license. The application is then sent to the AMLC which further reviews each application. Once the application is approved by the AMLC the physician is granted a license to practice medicine. The AMLC may also ask for additional information or may request to meet with an applicant for further review before a license is granted (*An Information Guide for Alabama Medical Licensees,* 2006).

Physicians who write prescriptions for controlled substances must have an ACSC and register with the Federal Drug Enforcement Agency (DEA) (*An Information Guide for Alabama Medical Licensees,* 2006). The ABME issues, monitors, restricts, and revokes the ACSC. The ABME investigates physicians who write too many prescriptions or write prescriptions for himself or others without a substantial medical reason. The board may penalize a physician by removing his ACSC, assessing fines, restricting his prescribing privileges, or requiring additional certified medical education hours (*An Information Guide for Alabama Medical Licensees,* 2006).

Complaints against a physician are received for a number of issues (*An Information Guide for Alabama Medical Licensees,* 2006). Such complaints may involve perceived inappropriate sexual or other behavior, suspicion of practicing intoxicated,

inadequate physical examination, or incorrect diagnosis. All complaints are reviewed and investigated by the ABME. An investigator is assigned to each individual case who visits the site of the complaint and conducts an investigation. Anonymous complaints are not investigated (*An Information Guide for Alabama Medical Licensees,* 2006).

After gathering the initial information, the investigator presents the findings to the physician under investigation (*An Information Guide for Alabama Medical Licensees,* 2006). The physician answers questions about the complaint and writes a formal response to the complaint to the ABME. The investigator continues to gather information from other sources including pharmacies, hospitals, and colleagues (*An Information Guide for Alabama Medical Licensees,* 2006).

When the investigation is complete, a member of the Credential Committee is assigned to the case and the investigator forwards all information to that member (*An Information Guide for Alabama Medical Licensees,* 2006). The committee member examines the material and gives a summary to the Credential Committee who then makes a recommendation to the ABME. The physician under investigation may also be asked to meet with the board to give a verbal explanation of the circumstance surrounding the complaint (*An Information Guide for Alabama Medical Licensees,* 2006).

The Credential Committee may take one of several actions (*An Information Guide for Alabama Medical Licensees,* 2006). The committee may recognize an unfortunate outcome for the patient, but determine that the physician was practicing safely. The physician may have been providing substandard care, but the patient was not harmed. In this case, no formal action is taken, but the physician may be required to attend a related

certified medical education course (*An Information Guide for Alabama Medical Licensees,* 2006).

If it is determined that the physician provided substandard care and harmed a patient, the ABME may proceed with formal allegations to the AMLC (*An Information Guide for Alabama Medical Licensees,* 2006). The board may ask for a number of actions against the physician's medical license such as restrictions, revocation, and fines. If the board finds that the doctor's practices are immediately threatening to patients, then the board may ask the AMLC to summarily suspend the physician's license until the AMLC has the opportunity to set a formal hearing (*An Information Guide for Alabama Medical Licensees,* 2006).

Informing the complainant of the outcome of her complaint is handled individually (*An Information Guide for Alabama Medical Licensees,* 2006). If the ABME determines that the physician was practicing safely then a formal letter is sent to both the physician and the complainant stating the ABME has investigated the case and can find no reason to take action against the physician's license. If the ABME determines the physician was providing substandard care, but no harm done, then a Letter of Concern may be written to the physician and the complainant is sent a letter stating the ABME has investigated the case and considers the matter closed. If the physician is determined to have harmed a patient and formal charges are brought against the physician, then the complainant may request from the legal department any information concerning the physician (*An Information Guide for Alabama Medical Licensees,* 2006).

Medical Licensure Commission

The AMLC is composed of eight members; seven are licensed physicians and one is a public member (*An Information Guide for Alabama Medical Licensees,* 2006). The AMLC approves applicant's credentials and grants the opportunity to have a medical license with the state of Alabama. The AMLC also sets formal hearings for those physicians who have been judged by the ABME to be unable to practice medicine safely. The AMLC hearing is conducted in the same manner as a court trial. Both prosecutors and defense attorneys present evidence and call witnesses for any case brought to the Medical Licensure Commission. The ABME's legal department, which formalizes the complaints, acts as the prosecution and the commission members act as the judge and jury. The physician has the right to an attorney and to present his case as in a trial. The commission hears evidence, asks questions, and rules on the outcome. The AMLC may dismiss the case, restrict or revoke licenses, or impose fines upon the physician (*An Information Guide for Alabama Medical Licensees,* 2006).

This two part system (AMLC and ABME) work together not only to grant an applicant the opportunity to practice medicine within the state of Alabama, but also to ensure the safety of the citizens from licensed physicians who may cause harm. The Board of Medical Examiners functions as the investigative body while the Medical Licensure Commission is the judicial body. Actions are taken against physicians whose conduct may cause harm to citizens of Alabama (*An Information Guide for Alabama Medical Licensees,* 2006).

Alabama Physician Health Program

The Alabama Physician Health Program (APHP) is contracted through the Alabama Board of Medical Examiners (Rehabilitation of Physicians and Osteopaths, 1975) to assist impaired physicians in Alabama in seeking help with their problems (*Alabama Physician Health Program*, 2004). APHP maintains a confidential relationship between the physician and the program, an arrangement supported by the ABME and AMLC. The APHP staff is experienced in dealing with issues of impairment. When an APHP staff member visits a physician in his office, the meeting is conducted as privately as possible with the intention of not interfering with that physician's patients (Skipper, 2001).

The APHP offers assistance with problems associated with chemical dependency and/or abuse, mental illness, personality disorders, problems associated with the aging process, and physical problems (*Alabama Physician Health Program*, 2004). APHP receives referrals from physicians, hospital administrators, private practice staff, family of physicians, treatments centers, and friends of physicians (*Alabama Physician Health Program,* 2004). The Rehabilitation of Physicians and Osteopaths Act (1975) states that information not limited to reports, interviews, and other statements learned by the APHP remains "privileged and confidential."

Although the APHP is contracted through the Alabama Board of Medical Examiners, information disclosed to APHP is not disclosed to the Board of Medical Examiners. Some physicians who sign monitoring contracts with the APHP find this to be beneficial in developing a healthier lifestyle. Participation in the APHP may also be used as a means of establishing, maintaining, and/or restoring a physician's license.

A contract for physician behavior is one method used by the APHP for monitoring disruptive physicians and physicians with chemical dependency issues. Other methods include psychological evaluations, interviews with medical and hospital staff and administrators, drug screening, continued membership in help groups, and continued therapy sessions.

Investigations Act (1975) states that if physicians enrolled in the APHP are not compliant, and the APHP believes there may be a threat to the public safety the APHP must report the physician to the Alabama Board of Medical Examiners (*Alabama Physician Health Program,* 2004). Once this report is made, physicians may be investigated by the ABME. At this time a file may be opened by the ABME and the rules of regulations for impaired physicians may go into effect.

Current Research

The current stage of research is concerned with the number of disruptive physicians and the effects of such behavior may have on others. Rosentein (2002) conducted a study to see how nurses, physicians, and hospital executives perceive the relationships between nurses and physicians. In this survey, disruptive physician behavior was operationally defined as, "any inappropriate behavior, confrontation, or conflict, ranging from verbal abuse to physical and sexual harassment" (p 27). Of the participants who responded (n = 1,177), 92.5% reported they had seen disruptive behavior displayed by a physician. The most frequently reported behaviors were yelling, use of foul language, and disrespect toward colleagues and patients. Respondents also noted disruptive behavior by physicians was a reason many nurses left or changed jobs.

Bohigian, Bondurant, and Croughan (2005) conducted a study of the Missouri Physician Health Program (MPHP) from 1995-2002. In this study, Bohigian et al. (2005) found an increase in the number of psychiatric referrals from a previous study conducted from 1990-1994 for the same MPHP program. In the original study only 8% of physicians were referred for psychiatric reasons, while in the more recent study, 32% of impaired physicians were referred for psychiatric reasons. One possible explanation reason for the increase in psychiatric referrals is because of the increase in reporting of behaviorally disruptive physicians. In the original study 92% of physicians were referred for alcohol/chemical dependence, while in the current study, 68% of impaired physicians were referred for alcohol/chemical dependence.

Purpose

The main purpose of this study is to determine the five-year outcome for substance-abusing and disruptive physicians monitored by the ABME, AMLC, or the APHP. Specifically, the goal is to determine the success rate of these interventions, and to determine if rates of successful outcome differ among physicians with disruptive behavior, substance abuse, or a combination of these problems. Success is defined as completion of the intervention contract and status of licensure (unrestricted, restricted, suspended, revoked) five years after the initial sanction. The years 1995 -1999 are the program-initiated points for each 5-year monitoring period.

Another purpose is to establish the incidence of alcohol and drug abuse and disruptive behavior within the medical community that rises to the level requiring significant agency intervention. Cumulative incidence and incidence density are determined for each year 1995-1999. Cumulative incidence is calculated by dividing the number of new cases of disruptive or substance-abusing physicians identified in a given year by the number of physicians practicing medicine in Alabama during the same year. Incidence density is calculated by dividing the number of physicians in a given year by the person-years of medical practice for the entire cohort of practicing physicians during that year. Incidence density is a more precise estimate of the rate of occurrence of disruptive behavior and substance-abuse because the denominator takes into account the varying amounts of time that members of cohort were exposed to risk. Based on previous research (Rosentein, 2002), it is hypothesized the incidence of substance-abusing and disruptive physicians will increase between the years 1995-1999.

Another purpose of this study is to determine the relationship between the five-year outcome for physicians sanctioned or monitored by the AMLC, ABME, and APHP. Another purpose of this study is to determine the association between psychiatric diagnosis (substance abuse, personality disorder, and/or affective disorder) and outcome five years after the first sanction. It is hypothesized that those receiving dual or multiple psychiatric diagnoses will have poorer outcomes (revoked or restricted license) compared to those who have no diagnosis or a single diagnosis.

Method

Design

This is a retrospective outcome study. The outcome variable of interest is status of medical license five years after the date of first sanction.

Participants

This study was approved by the Executive Director of the ABME, the Medical Director of the APHP, and the Institutional Review Board of Auburn University Montgomery (Appendix A and B). The cohort were all sanctioned or monitored cases of disruptive behavior, substance abuse, or both that occurred between 1995-1999 identified in the archival data of the Alabama Board of Medical Examiners, the Medical Licensure Commission of the State of Alabama, and the Alabama Physician Health Program. Physicians who had an investigated action against their licenses before 1995 or after 1999 were excluded from the study. Physicians who engaged in boundary (sexual) issues were also excluded, although it is recognized that those cases sometimes also involve substance abuse and other forms of disruptive behavior. Those reprimanded for inappropriate prescribing or for quality of care issues not resulting from chemical dependency or disruptive behavior were also excluded from this study.

Procedures

This study began by obtaining archival date from the AMLC of the State of Alabama's year-end reports from 1995 through 2003. Physicians were identified as cases if sanctioned for chemical dependency and/or disruptive behavior. The next step was to identify cases of disruptive behavior and/or chemical dependency from the ABME physician database. Similar procedures for case ascertainment were followed for the records of the APHP. Information gathered from each source permitted the identification of cases that had been sanctioned or monitored by more than one agency. When this occurred, information was combined so the data base contained only one data record for each physician. Information concerning each physician's medical specialty, years of medical practice, date of sanction, sanctioning agency, action taken, and outcome at five years was recorded. Information concerning each physician's date of sanction, body of sanctioning board, action taken, and outcome at five years were recorded (Appendix C).

Some physicians are under monitoring agreements but do not have any record of public action against their licenses to practice medicine. These cases of disruptive behavior and/or chemical dependency are not included in the usual public data bases because the physicians entered into non reportable voluntary agreements with ABME or the AMLC of the State of Alabama. These cases are available through internal agency databases and these data bases were searched for additional cases that were included in this study.

No personal identifying information was used in constructing the data base for this study. Name, license number, date of birth, location of practice, social security number, location of home, or medical school attended were not recorded. Year of birth,

year of licensure, and year of disciplinary action were recorded in order to calculate age and person-years of medical practice.

All information was abstracted from paper records or electronic databases and entered into an Excel spreadsheet for analysis. The five-year study intervals that delimit the year of sanction and the fifth year of treatment monitoring include the years from 1995 through 1999, 1996 through 2000, 1997 through 2001, 1998 through 2002, and 1999 through 2003. Physicians included in the database are believed to be all physicians who have been subject to review by the ABME, AMLC, or APHP during the specified years of study except for exclusions as noted above. This data set is not representative of all physicians who are substance-abusers or who display disruptive behavior. Many physicians face reprimand or sanction from employers or resident hospitals and do not come to the attention of the ABME, AMLC, or APHP. The physicians monitored by ABME, AMLC, or APHP are those who potentially threaten public safety or who did not respond to local sanctions. Therefore, the identified cases represent the most serious cases.

Results

SAS was used for all data analyses. Table 1 depicts the demographic and background characteristics of the identified cohort. The sample consisted of 109 cases whose ages ranged from 24 to 82 years (mean age 45.2, s = 10.8). Twenty-seven (24.8%) of theses physicians specialized in Family Medicine and 24 (22%) in Internal Medicine. These specialties accounted for more than half of the cases. Ninety-nine (90.8%) were men and 10 (9.2%) were women. Seventy (64.8%) were Board Certified in their specialty. The majority of the cases graduated from an allopathic medical school, receiving a M.D. degree (92.7%), as opposed to only eight (7.3%) who earned a D.O. degree from an osteopathic medical school. Of the 109 cases, 98 (89.9%) had been monitored for issues involving only chemical dependency; four (3.7%) of the cases had been monitored for only disruptive behavior and seven (6.4) had been monitored for a combination of chemical dependency and disruptive behavior.

Table 1

Demographic and Background Information for Physicians with Substance Abuse, Disruptive Behavior, or Both (n=109).

	n	Percent
Age		
24 – 33	13	11.9
34 – 43	38	34.9
44 – 53	35	32.1
54 – 63	17	15.6
64 +	6	5.5
Sex		
Men	99	90.8
Women	10	9.2
Board Certified		
Yes	70	64.8
No	38	35.2
Degree		
MD	101	92.7
DO	8	7.3
Specialty		
Family Medicine	27	24.8
Internal Medicine	24	22
Radiology	8	7.3
Anesthesiology/Pain	7	6.4
Obstetrics/Gynecology	7	6.4
Surgery	7	6.4
Orthopedics	4	3.7
Emergency	4	3.7
Other	21	19.3
Offense		
Chemical Dependency	98	89.9
Disruptive Behavior	4	3.7
Both	7	6.4

Table 2 shows the total number of cases under observation, the number of physicians practicing each year, the total number of practice years among all physicians, the cumulative incidence, and the incidence density for each studied year. The cumulative incidence describes the occurrence of new cases during each year compared to the total number of physicians practicing within that year. The incidence density takes into account the number of incident cases per total number of person-years of practice for each year. This analysis showed that over the five-year period there were 20-25 physicians monitored and/or sanctioned per year, for a cumulative incidence of 14-18 cases per 10, 000 physicians. The incidence density is slightly more that once case monitored and/or sanctioned per 10,000 practice years.

Table 2

Incidence Rate and Incidence Density for Physicians with Substance Abuse, Disruptive Behavior, or Both

	n	Percent	n of Physicians	Cumulative Incidence
Year of Action				
1995	22	20.2	12,195	18/10,000
1996	20	18.4	12,714	15.7/10,000
1997	24	22	14,050	17.1/10,000
1998	23	21	13,769	16.7/10,000
1999	20	18.4	14,034	14.3/10,000
Year of Action		Practice Years	Incidence Density	
1995	22	154,650	1.4/10,000 practice years	
1996	20	162,944	1.2/10,000 practice years	
1997	24	170,857	1.4/10,000 practice years	
1998	23	178,767	1.3/10,000 practice years	
1999	20	186,509	1.1/10,000 practice years	

Table 3 depicts the relationship between the five-year outcomes for physicians sanctioned or monitored by the AMLC, ABME, and APHP. The outcome categories of license revocation, voluntary surrender, indefinite suspension, and license inactive were combined to represent all cases where the five-year outcome was the loss of the medical license. The remaining outcomes, which included full and unrestricted licensure, restricted license, continued monitoring, indefinite probation, and others were combined into a single category of individuals who were still practicing medicine. In analyses where the expected cell frequency was less than five, the significance test employed was Fisher's Exact Test. When the expected cell frequencies were all greater than five, the chi-square test was used. These analyses excluded three cases where the outcome was unknown, the licensee moved, or the license status at five years was simply listed as inactive. The Fisher's exact test shows a significant relationship between monitoring agency and outcome ($p = .00017$). Most physicians were monitored by the APHP program only. Those monitored by the APHP only or the ABME only had the highest success rates (93.8% and 100%, respectively). The lowest success rates were those physicians who were monitored by the AMLC only or who were monitored by all 3 agencies. Of the 104 physicians with known or classifiable outcomes, almost 85% were still practicing medicine after five years.

Table 3

Relationship Between the Five-Year Outcomes for Physicians Sanctioned or Monitored by the AMLC, ABME, and APHP for Problems Concerning Substance Abuse, Disruptive Behavior, or Both.

Monitoring Agency	n	% Total	Practicing Medicine	Not Practicing Medicine	% Success
Medical Licensure Commission	7	6.7%	4	3	57.1%
Board of Medical Examiners	5	4.8%	5	0	100%
Physician Health Program	65	62.5%	61	4	93.8%
Two Agencies	17	16.4%	13	4	76.5%
Three Agencies	10	9.6%	5	5	50%

All cases were reviewed to determine if a psychological or psychiatric evaluation had been ordered. Eighty-four cases received a psychiatric diagnosis. These cases received a variety of diagnoses and, to facilitate analysis, they were grouped together to form three diagnostic categories. The alcohol and drug category included all diagnoses related to substance abuse and dependence (n=74). Most of these cases were alcohol dependence. The personality disorder category included personality disorder diagnoses such as Narcissistic and Paranoid Personality Disorder, as well as Personality Disorder, NOS, and identified personality traits associated with personality disorder diagnoses (n=18). The final category included Affective Disorders such as Major Depression, Bi-polar Disorder, and Dysthymia (n=21). Those without formal diagnoses or who had not been referred for evaluation comprised the no diagnosis category (n=25). Table 4 depicts

the crude relationship between five-year outcome and psychiatric diagnosis categories. Because of dual diagnoses, the numbers presented in Table 4 exceed the total number of cases.

Table 4

Relationship Between Five-Year Outcomes (practice vs. no practice) and Psychiatric Diagnosis.

Diagnosis	Practicing Medicine		Not Practicing Medicine	
	n	Percent	n	Percent
Alcohol and Drug	63	85.1	11	14.9
Personality Disorder	13	72.2	5	27.8
Affective Disorder	14	66.7	7	33.3
No Diagnosis	19	79.2	5	20.8

Table 5 presents a more accurate portrayal of the sample with respect to psychiatric status. In this table, those with no diagnosis are included, as well as the number of cases with a single diagnosis and every possible combination of diagnoses. The analyses that follow compare outcomes among physicians with the various combinations of psychiatric diagnoses to outcomes for physicians who were not diagnosed.

The association between the outcome (practicing vs. not practicing) in physicians who had a single diagnosis of alcohol/drug disorder to those who had no diagnosis was not significant (Fisher's Exact Test, $p = .09$). Among those with no diagnosis, 20.8% were not practicing medicine after five years and 8.3% of those with an alcohol or drug diagnosis were out of medicine at the end of the five-year period. Physicians with a single diagnosis of alcohol/drug disorder and those who had alcohol/drug disorder combined with either an affective disorder or a personality disorder were combined into a

single group and compared to the no diagnosis group. In this analysis, there were 11.4% of the diagnosed group not practicing medicine at the end of five years and the same 20.8% not practicing among the undiagnosed group. The relationship between diagnosis of alcohol/drug problem and practice status at five years was not significant (Fisher's Exact Test, $p = .13$). Finally, the physicians with all three psychiatric diagnoses were added to the alcohol dependent group to determine if there was a significant relationship between outcome and any substance use outcome. At the end of five years, the percentage of physicians with an alcohol diagnosis, either alone or in combination with other diagnoses, was 14.9% compared to 20.8% for the no diagnosis group. The relationship between any diagnosis of alcohol/drug disorder and practice status at five years was not significant (Fisher's Exact Test, $p = .19$).

The number of physicians with an Affective Disorder only was insufficient (n=4) to compare to the no diagnosis group. All cases of Affective Disorder were combined for this analysis and 33.3% of those with any affective disorder diagnosis were not practicing medicine five years after beginning their program. However, when compared to the no diagnosis group, the relationship between affective disorder diagnosis and outcome was not significant (Fishers Exact Test $p = .172$).

The outcome (practicing vs. not practicing) of physicians with a personality disorder diagnosis was compared to those physicians with no diagnosis. There were 18 cases that received some form of personality disorder diagnosis, most in combination with some other diagnosis. There were insufficient numbers to analyze isolated cases of personality disorder diagnoses. Approximately 28% of the personality diagnosis group were not practicing medicine compared to 20.8% of the no diagnosis group. The

relationship between personality disorder diagnosis and outcome was not significant (Fisher's Exact Test $p = .25$).

The number of cases with all three diagnoses was small (n=4). Comparing outcome for cases with three diagnoses versus no diagnosis was not significant (Fisher's Exact Test $p = .058$; OR = 11.4, 95% CI = .97 – 134.5). There was no difference in outcome for those with two diagnoses versus those with no diagnoses ($X^2 = 0$, $p = 1$; OR = 1, 95% CI = .25 – 4.03). The relationship between any single diagnosis and outcome was also not significant (Fisher's Exact Test, $p = .12$, OR = .31, 95% CI = .08 –1.3). No relationship was found when all cases with diagnoses were combined and outcomes for this group were compared cases that were not diagnosed (Fisher's Exact Test $p = .55$; OR = .71, 95% CI = .22 – 2.24).

Table 5

Relationship Between Five-Year Outcome (practicing vs. not practicing) of Physicians with Single or Multiple Psychiatric Diagnosis.

Diagnosis	n	%	Practicing	Not Practicing
None	25	22.9%	19	5
Single Diagnosis				
Alcohol/Drug	51	46.8%	44	4
Affective	4	3.7%	4	0
Personality	1	.9%	1	0
Two Diagnoses				
Alcohol/Drug and Affective	11	10.1%	8	3
Alcohol/Drug and Personality	11	10.1%	10	1
Affective and Personality	2	1.8%	1	1
Three Diagnoses				
Alcohol/Drug-Affective-Personality	4	3.7%	1	3

Discussion

One research question addressed the five-year outcome for physicians being monitored by two sanctioning entities of the state of Alabama (AMLC and ABME) and one confidential state program (APHP). Results found the combined success rate of 84.6%. This number shows that nearly 85% of physicians who have been disciplined for substance abuse or disruptive behavior will be practicing medicine five years after the first sanction. The majority of cases were monitored by the APHP and accounted for a large proportion of the successful outcomes. This study is comparable to research by Domino et al., (2005), which reported substance abuse treatment programs have reported up to 70% of physicians and other health care providers successfully complete treatment and return to the practice of medicine.

One reason for such a high success rate among this group may be the means by which APHP monitors physicians. This program requires a psychological or psychiatric evaluation, attendance at self-help groups and/or therapy, and regular urine drug screening. While the APHP has a set contract that incorporates these requirements, both the ABME and AMLC vary in their approach to monitoring. The ABME and AMLC determine monitoring aspects on an individual basis. Physicians may be required to pay fines, sign an APHP contract, complete an evaluation, attend inpatient treatment, and/or attend outpatient treatment or therapy. The AMLC was shown to have the lowest success rate among the three agencies. The AMLC typically deals with the most severe cases or repeat offenders whose sanctions are more severe. Also, because the AMLC is the governing agency that has the power to remove a physician's license, more physicians

will involuntarily lose their license by the ruling of the AMLC. The APHP can refer a physician who has not been in compliance to the ABME or the AMLC.

This study also addressed whether the success rate was different for physicians sanctioned for chemical dependency, disruptive behavior, or both. There were insufficient data to determine whether the success rate was better for any offense or the combination of the two offenses. Of the 109 cases, 98 (89.9%) were monitored exclusively for chemical dependency problems.

Cumulative incidence rate reveals that for each year, the cumulative incidence remained reasonably consistent (14-18 new cases per year per 10,000 physicians). The same trend was observed for the incidence density. Throughout the five-year period, the number of new monitored cases remained reasonably consistent; only 1.1-1.4 cases per 10,000 practice-years were reported. Since the 1970's when the awareness of substance-abusing physicians began to rise (Gastfriend, 2005) and, more recently, the recognition of the disruptive physician (Rosentein, 2002) many more programs designed to rehabilitate physicians have been established. Increased awareness and intervention with many unaddressed cases when the programs were new may partially account for the stability of the incident cases.

This study also addressed whether outcomes for substance-abusing physicians and physicians displaying disruptive behavior were related to diagnosis of substance abuse or dependency, personality disorder, or affective disorder. Of the 85 (78.7%) cases that received a psychiatric diagnosis, 74 were diagnosed with substance abuse and dependence, 18 received a diagnosis of a personality diagnosis, and 21 were diagnosed with an affective disorder. There was no relationship between the number of psychiatric

diagnoses and the outcome (practicing medicine versus not practicing). More specifically, it did not matter if a physician had received diagnoses in one, two, or all three broad categories of psychiatric disorder. The numbers for some diagnostic categories and combinations of categories were small and this could be a factor in the lack of significance. The implication is that perhaps formal evaluation and diagnosis is not necessary for case management. However, it is possible that evaluation and diagnosis serves other valuable functions in the process, although it is not relevant to the license status at five years. Also, many, if not all, of the undiagnosed cases might have been diagnosed with a psychiatric disorder had they been evaluated, which raises the possibility that psychiatric disorder pervaded both the diagnosed and undiagnosed groups. A recent study by Bohigian, Bondurant, and Croughen (2005) showed a rise in psychiatric referrals to medical disciplinary boards, which is congruent with the high number found in the present study. Such problems may be linked to the behavior of disruptive physicians and/or those suffering from a substance-abuse problem (Kirkland & Skipper, 2002).

Between 1991 and 2001, 780 (50%) physicians were referred to the APHP for substance abuse problems; while, 208 (13%) physicians were referred to the APHP for disruptive behavior issues (Kirkland & Skipper, 2002). In this current study, 98 physicians were referred for substance-abuse problems, four physicians were referred for disruptive behavior, and seven were referred for a combination of substance-abuse and disruptive behavior. Kirkland and Skipper (2002) reported on cumulative referrals, whereas this study focused only on cases that were serious enough to warrant an intervention. Taken together, both studies indicate that many complaints are filed by the

public, but most complaints do not rise to a level that requires intervention and monitoring.

Study Limitations

The present study was concerned with only the physicians who are substance-abusers and/or who display disruptive behavior. Physicians who engaged in boundary (sexual) issues were excluded, although it is recognized that those cases sometimes also involve substance abuse and other forms of disruptive behavior. This data set is not representative of all physicians who are substance-abusers or who display disruptive behavior. Many physicians face reprimand or sanction from employers or resident hospitals and do not come to the attention of the ABME, AMLC, or APHP. The physicians monitored by ABME, AMLC, or APHP are those who potentially threaten public safety or who did not respond to local sanctions. Therefore, the cases identified in this manner represent the most serious cases.

A limitation of the present study is not being able to compare all disciplinary actions physicians may receive. This current study was limited to substance abusing and disruptive physicians whose behavior was reported to one of the three main reporting agencies. Throughout the five-year monitoring period, the number of cases for physicians being monitored or sanctioned for disruptive behavior was very small. Results showed that a few of the physicians suffering from substance abuse were also acting in a disruptive manner. There was no indication of an increase in purely disruptive behavior, despite the increased awareness of the problem during the timeframe of the study. Perhaps substance abuse may be related to disruptive behavior, and substance abuse as viewed as potentially more harmful and more in need of formal notification of

state agencies and treatment. If substance abuse is believe to precede and cause disruptive behavior, then it may be assumed that successful treatment of the substance abuse disorder will also resolve any disruptive behavior issues. It is also possible that disruptive behavior cases, uncomplicated by substance abuse or dependence, are more likely to be handled locally and without recourse to programs operating at the state level. Future research that evaluates the incidence and prevalence of disruptive behavior addressed in hospitals would be helpful in determining the burden of disruptive behavior in medical settings.

References

Alabama Code. (1975). Investigations. Section 34-24-361b. http://www.legislature.state.al.us/CodeofAlabama/1975/34-24-361.htm

Alabama Code. (1975). Rehabilitation of Physicians and Osteopaths. Section 34-24-400 to 406. http://www.legislature.state.al.us/CodeofAlabama/1975/34-24-400to406.htm

Alabama Physician Health Program. (2004). *A confidential, effective, compassionate approach of assistance for medical professionals with substance abuse or mental health problems* [Brochure]. Montgomery, AL: Author.

American Medical Association: Code of Ethics. (2004). Physicians and disruptive behavior. Available at: http://www.ama-assn.org/ama1/pup/upload/mm/21/disruptive_physician.doc. Accessed June 15, 2005.

American Medical Association: Code of Ethics. (2004). Physician impairment. Available at: http://www.ama-assn.org. Accessed June 15, 2005.

American Medical Association: AMA (FSPHP) Alabama. (2005). Available at: http://www.ama-assn.org/ama/pub/category/6021.html. Accessed June 15, 2005.

Bohigian, G.M., Bondurant, R., & Croughan, J. (2005). The impaired and disruptive physician: the Missouri physicians' health program – an update (1995-2002). *Journal of Addictive Diseases, 24(1),* 13-23.

Bosch, X. (2000). First impaired physician therapy program appears to be successful in Spain [Electronic Version]. *Journal of the American Medical Association, 283(24),* 3186-3187.

Clay, S.W., & Conatser, R.R. (2003). Characteristics of physicians disciplined by the state medical board of Ohio [Electronic Version]. *JAOA, 103(2),* 81-88.

Cook, S.K., Green, M., & Topp, R.V. (2001). Exploring the impact of physician verbal abuse on perioperative nurses. *AORN Journal, 72(3),* 317-331.

Domino, K.B., Hornbein, T.F., Polissat, N.L., Renner, G., Johnson, J., Alberti, S., et al. (2005). Risk factors for relapse in health care professionals with substance use disorders [Electronic Version]. *Journal of the American Medical Association, 293(12),* 1453-1460.

Federation of State Medical Boards of the United States. [Electronic Version] *Report on Physician Impairment.* Euless, Tx: Federation of State Medical Boards, 1995.

Felton, J.S. (1998). Burnout as a clinical entity – its importance in health care workers [Electronic Version]. *Occupational Medicine, 48,* 237-250.

Gastfriend, D.R. (2005). Physician substance abuse and recovery: what does it mean for physicians – and everyone else [Electronic Version]. *Journal of the American Medical Association, 293(12),* 1513-1515.

Harmon, L. & Pomm, R.M. (2004). Evaluation, treatment, and monitoring of disruptive physician behavior [Elecrtonic Version]. *Psychiatric Annals, 24(10),* 770-774.

Horty, J. ed. (1998). When conduct crosses the line. *Medical Staff Monthly, 4,* 1-3.

Hughes, P.H., Brandenburg, N., Baldwin, D.C., Storr, C.L., Williams, K.M., Anthony, J.C., et al. (1992). Prevalence of substance use among US physicians. *Journal of the American Medical Association, 267(17),* 2333-2339.

Kirkland, K. & Skipper, G.E. (2002). Anger management for Alabama physicians. *Journal of Medical Licensure and Discipline, 88(1),* 19-24.

Leavenworth, R. (1994). Recovering physicians groups [Electronic Version]. *Behavioral Health Management, 14(5),* 26-29.

Pfifferling, J.H. (1997). Managing the unmanageable: the disruptive physician. *Family Practice Management, 4(10),* 77-92.

Pomm, R.M., & Harmon, L. (2004). Evaluation and posttreatment monitoring of the impaired physician [Electronic Version]. *Psychiatric Annals, 34(10),* 786-789.

Rosenstein, A.H. (2002). Nurse-physician relationships: impact on nurse satisfaction and retention. *American Journal of Nursing, 102(6),* 26-34.

Rotunda, R.J., Scherer, D.G., & Imm, P.S. (1995). Family systems and alcohol misuse: research on the effects of alcoholism on family functioning and effective family interventions [Electronic Version]. *Professional Psychology: Research and Practice, 26(1),* 95-104.

Skipper, G.E. (2001. Fall). Why refer an impaired physician to the Alabama physician health program [Electronic Version]? *Alabama Board of Medical Examiners Newsletter, 16(4),* 1-4.

Stoudemire, A., & Rhoads, J.M. (1983). When the doctor needs a doctor: special considerations for the physician – patient [Electronic Version]. *Annals of Internal Medicine, 98(1),* 654-659.

The Board of Medical Examiners and the Medical Licensure Commission. (2006). *An information guide for Alabama medical licensees* [Brochure]. Montgomery, AL: Author.

Voelker, R. (1994). Finding effective treatment for impaired physicians [Electronic Version]. *Journal of the American Medical Association, 272(16),* 1238.

ALABAMA STATE BOARD OF MEDICAL EXAMINERS
LARRY D. DIXON, EXECUTIVE DIRECTOR

P.O. BOX 946
MONTGOMERY, ALABAMA 36101-0946
848 WASHINGTON AVE.
MONTGOMERY, ALABAMA 36104

TELEPHONE: (334) 242-4116
E MAIL: ldixon@albme.org

September 12, 2006

To Whom It May Concern:

This letter to the Institutional Review Board (IRB) of Auburn University Montgomery affirms that I approve of the study being conducted by Mrs. Genie Burns under the supervision of Dr. Steven LoBello of the Department of Psychology. The study is a retrospective follow-up of physicians who were monitored or sanctioned by the Medical Licensing Board and/or the Alabama Physician Health Program because of disruptive behavior and problems related to substance abuse. The purpose of the study is to determine the outcomes associated with the interventions on behalf of these impaired physicians. The results should inform medical boards about the likelihood of success of these interventions and indicate if modification of current practices is indicated.

The primary concern arising from a retrospective record review is for the privacy of our licensees and the confidentiality of the records which deal with very sensitive and personal information. I have reviewed the proposal for this study and I am satisfied that appropriate measures will be taken to ensure the complete anonymity of current or previously licensed physicians in the State of Alabama. According to the proposal, no personal or identifying information will be used in this study. Any personal identifying information (names, addresses, cities/counties of residence, license numbers) will be excluded from the data base that is being constructed. I intend to monitor the study as it progresses and will immediately halt the study if the privacy of licensees or the confidentiality of their records is compromised.

The proposed study conforms to my expectations for ethical research involving physician's records that are maintained by our agency. If you have any additional questions, please do not hesitate to contact me.

Sincerely,

Larry D. Dixon
Executive Director
Alabama Board Medical Examiners

September 12, 2006

Gregory E. Skipper, MD
Medical Director
Alabama Physician Health Program
19 S Jackson Street
Montgomery, AL 36104

To Whom It May Concern:

This letter to the Institutional Review Board (IRB) of Auburn University Montgomery affirms that I approve of the study being conducted by Mrs. Genie Burns under the supervision of Dr. Steven LoBello of the Department of Psychology. The study is a retrospective follow-up of physicians who were monitored or sanctioned by the Medical Licensing Board and/or the Alabama Physician Health Program because of disruptive behavior and problems related to substance abuse. The purpose of the study is to determine the outcomes associated with the interventions on behalf of these impaired physicians. The results should inform medical boards about the likelihood of success of these interventions and indicate if modification of current practices is indicated.

The primary concern arising from a retrospective record review is for the privacy of our licensees and the confidentiality of the records which deal with very sensitive and personal information. I have reviewed the proposal for this study and I am satisfied that appropriate measures will be taken to ensure the complete anonymity of current or previously licensed physicians in the State of Alabama. According to the proposal, no personal or identifying information will be used in this study. Any personal identifying information (names, addresses, cities/counties of residence, license numbers) will be excluded from the data base that is being constructed. I intend to monitor the study as it progresses and will immediately halt the study if the privacy of licensees or the confidentiality of their records is compromised.

The proposed study conforms to my expectations for ethical research involving physician's records that are maintained by our agency. If you have any additional questions, please do not hesitate to contact me.

Sincerely,

Gregory E. Skipper, MD
Medical Director
Alabama Physician Health Program

Appendix C

Variables abstracted from records and recorded in the data set.

Physician Information Recorded
Age at time of Sanction, Year of Licensure, Year of Birth, Year of sanction
Offense (chemical dependency, disruptive behavior, or both)
Primary Specialty
Board Certified (primary specialty)
Gender
Outcome at 5 years Completion of behavioral contract Status of medical license
Medical Doctor/Doctor of Osteopathy
Action by ABME examples include: voluntary restriction on COQ, voluntary restriction on ACSC, voluntary agreement, voluntary surrender of ACSC, stipulation and consent
Action by AMLC examples include: voluntary restriction on license, license suspended, license revoked, licensed issued with restrictions, voluntary agreement on license
Action by APHP examples include: original contract, physician completed contract, new contract physician moved out of state, physician retired