

Editor's Notes

Diverting California's Physician Diversion Program

By Stephen Jackson, M.D., Editor



California's Physician Diversion Program (Diversion) has been a valuable—and arguably even a lifesaving—resource for physicians, particularly for those in our specialty who must confront their most destructive occupational hazard, chemical dependence. Diversion, an enlightened, humane and effective program, has permitted addicted anesthesiologists to participate in a process that has preserved their professional careers and enhanced their personal well-being, while concomitantly safeguarding the public safety. Diversion has offered addicted physicians the opportunity to confront their demon directly and therapeutically as the disease that it truly is, such that they can pursue treatment while their future ability to practice medicine is simultaneously being protected. Despite the low prevalence of chemical dependence amongst CSA members, this issue casts a wide shadow. It is highly likely that every one of us personally knows of at least one colleague afflicted with it.

Unfortunately, the Medical Board of California has determined that it no longer is capable of effectively administering the 27-year-old Diversion Program that was authorized by an enlightened State legislature in 1980. As such, as of June 30, 2008, the MBC will eliminate Diversion, its unanimous decision citing five externally *conducted* audits, which identified operational and management flaws that were significant enough to conclude that the administration of the program was negligent. To be sure, Diversion has been a target for criticism because of unfavorable publicity instigated by consumer watchdog/advocate groups and the public's lack of understanding that addiction, like other mental illnesses, is a disease, not a crime. At this juncture, it is uncertain whether or for how long Diversion will continue to accept new applicants, and it remains unknown what will happen to those physicians who currently are Diversion participants. The MBC has not yet indicated how it will handle this newly created void, but it is aware that *all* other states have physician diversion programs.

The CMA, CSA, California Society of Addiction Medicine, and others in the medical community, who believe that closure of Diversion would have an adverse impact upon patient safety, opposed the MBC's decision. Having no option other than to face discipline and enforcement, addicted and mentally ill

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physicians historically have gone underground, hiding their disabilities and practicing despite them. Diversion *had the ability to force* impaired physicians to cease their practice immediately; however, loss of a physician's license to practice was not necessarily a precondition for participation in Diversion.

Most physicians, I believe, do not have a full grasp of Diversion, which was created to enable "the MBC [to] seek ways and means to identify and rehabilitate physicians" with impairment due to drug or alcohol abuse, or mental or physical illness, while concomitantly mandating protection of the public health and safety. Diversion is a Statewide five-year monitoring and rehabilitation program. Physicians enter it by one of three pathways: 1) self-referral, usually the result of encouragement by concerned colleagues or family members to seek help (the majority of participants); 2) referral by the Enforcement Unit of the MBC in lieu of pursuing disciplinary action (about one-fifth of participants), and 3) direction by the MBC to participate as part of a disciplinary order (another one-fifth of participants).

In this first and most common scenario for addicted anesthesiologists, the MBC does not know that a physician is in Diversion if no complaint has been filed. However, if a physician is unsuccessfully terminated from Diversion and determined to be unsafe to practice medicine, then the MBC is duly notified. Confidentiality of those who enter voluntarily is mandated, whereas for those who have been ordered into Diversion as part of a disciplinary action, it is a matter of public record. The costs associated with the administration of Diversion are funded by the MBC through physician licensure fees and renewals, but participants are fully responsible for any treatment, monitoring, and recovery related expenses.

Following completion of the initial evaluation, acute treatment and plan for extended treatment, most Diversion participants are enrolled in an individually (customized) planned program of recovery. Based on a five-year Diversion Participation Agreement that contains the specific provisions to which the participant must strictly adhere, their course of recovery is marked by an extensive and thorough system of supportive monitoring. The DPA may include an agreement not to practice medicine if requested, but if and when the physician is permitted to return to practice, the monitoring is focused upon ensuring patient safety.

All Diversion participants are assigned to a locally based Case Manager who coordinates and monitors the physicians' compliance with the DPA, which includes inpatient/outpatient medical and psychiatric evaluation and treatment with ongoing psychotherapy as indicated; work site (hospital and non-hospital) monitors; two Diversion Group meetings per week facilitated by

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licensed psychologists, therapists, or certified drug and alcohol counselors; abstinence from alcohol and psychotropic drugs; antagonistic medications as indicated; random, observed customized body fluid testing at least twice monthly; attendance at several Alcoholics and/or Narcotics Anonymous (or other) 12-Step meetings per week; progress reports by therapists, monitors and treating physicians; and, semiannual reports for the Diversion Evaluation Committee meetings. Absences from any of the DPA's prescribed activities, such as vacations or professional meetings, must be reported in advance and approved.

The DEC determines the appropriateness for participation in Diversion, the terms of participation, and the successful completion or termination from Diversion. Each MBC-appointed DEC is composed of five experts in addictive disorders and mental illness, of which three are physicians (usually including at least one psychiatrist). Each of these appointees must have the expertise and experience to advise Diversion staff on all matters relating to the program. To successfully complete Diversion, a participant must be drug and alcohol free for a minimum of three years and also must have demonstrated a lifestyle that will support ongoing sobriety. In mental health cases, a participant must have been compliant with treatment recommendations and have demonstrated a lifestyle that will maintain well-being.

Obviously, the Case Managers are crucial to the successful administration of Diversion, as they ensure that the participants comply with their DPAs and are well established in their recovery process. They are in contact with participants every one to two months and coordinate all of the information from the various monitoring and treatment sources, while also keeping in close contact with a participant's DEC.

The ASA's *Guidelines for the Ethical Practice of Anesthesiology*, **the only ASA document to which all ASA members are bound** (all ASA members sign onto this yearly when renewing their membership—check your membership card!), state that anesthesiologists have ethical responsibility to themselves to maintain their health (Section IV.2): *The practice of quality anesthesia care requires that anesthesiologists maintain their physical and mental health and special sensory capabilities. If in doubt about their health, then anesthesiologists should seek medical evaluation and care. During this period of evaluation or treatment, anesthesiologists should modify or cease their practice.* Anesthesiologists also have ethical responsibilities to their medical colleagues (Section II.4): *Anesthesiologists should advise colleagues whose ability to practice medicine becomes temporarily or permanently impaired to appropriately modify or discontinue their practice. They should assist, to the extent of their own abilities, with the reeducation or rehabilitation of a colleague who is returning to practice.* Moreover, anesthesiologists have

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ethical responsibilities to the health care institutions in which they practice (Section III.2): *Anesthesiologists share with all medical staff members the responsibility to observe and report to appropriate authorities any potentially negligent practices or conditions which may present a hazard to patients or health care facility personnel.*

Well over 1,000 California physicians have participated since Diversion's inception, and the success rate is approximately 80 percent. Your CSA leadership, along with all of our colleagues in organized medicine, will persist in efforts to maintain Diversion because it is in the best interests of the citizens of California.

CSA/UCSD Annual Meeting & Clinical Anesthesia Update

Mark the Date!
May 30-June 1, 2008

Hilton Los Angeles
Universal City, California

The full program—faculty, lecture titles and objectives—is available on the CSA Web Site at
www.csahq.org.