



Notable Grand Rounds
of the
Michael & Marian Ilitch
Department of Surgery

Wayne State University
School of Medicine

Detroit, Michigan, USA

Carl Christensen, MD, PhD, D-FASAM, cMRO

**PHYSICIAN IMPAIRMENT: DISRUPTIVE,
DISABLED, DUPED & DEPRESSED**

October 6, 2021

About Notable Grand Rounds

These assembled papers are edited transcripts of didactic lectures given by mainly senior residents, but also some distinguished attending and guests, at the Grand Rounds of the Michael and Marian Ilitch Department of Surgery at the Wayne State University School of Medicine.

Every week, approximately 50 faculty attending surgeons and surgical residents meet to conduct postmortems on cases that did not go well. That “Mortality and Morbidity” conference is followed immediately by Grand Rounds.

This collection is not intended as a scholarly journal, but in a significant way it is a peer reviewed publication by virtue of the fact that every presentation is examined in great detail by those 50 or so surgeons.

It serves to honor the presenters for their effort, to potentially serve as first draft for an article for submission to a medical journal, to let residents and potential residents see the high standard achieved by their peers and expected of them, and by no means least, to contribute to better patient care.

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Physician Impairment: Disruptive, Disabled, Duped & Depressed

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October 6, 2021

This paper is a summary of Dr. Christensen’s telepresentation at Wayne State University Surgical Grand Rounds on October 6, 2021.

Literature references are available on request to ab7059@wayne.edu

To the Joint Commission¹ and the board of medicine, "impairment" means that a doctor is essentially unsafe. Being unsafe can be due to a lot of different factors—drugs, alcohol, mental illness, an underlying personality disorder, and medical issues. A lot of people in monitoring in our program have had brain injuries or currently have dementia.

When speaking of impairment in doctors, we often use the “five D” mnemonic:

- Disruptive,
- Disabled,
- Duped,
- Dishonest, and
- Depressed.

1. *Disruptive doctors.* You have heard of a surgeon throwing things in the OR, or a physician throwing an object around in the wards and being generally violent. But there are a lot of different levels of disruption (Fig 1). Besides the aggressive

disruption just described—with anger, profanity, sexual harassment, racial jokes, ethnic jokes — there is also passive-aggressive disruptive behavior, for example: Derogatory comments about the hospital or medical practice, or simply refusing to do tasks.

Another actual example was a physician making rounds at a local hospital who found out that the patient that he came to see had gone for massage therapy. The physician was upset because this patient had been non compliant with his rec-

Aggressive	Passive Aggressive	Passive
Anger Outbursts	Derogator comments about hospital/group	Chronically late
Profane/Disrespectful Language	Refusing to do tasks	Not responding to calls
Demeaning Behavior		Inappropriate chart notes*
Physical Aggression		
Sexual Comments or Harassment		
Racial/Ethnic Jokes		

Fig. 1. Spectrum of Disruptive Behaviors

¹ JCAHO, the Joint Commission on Accreditation of Healthcare Organizations.

ommendations. He then asked the staff: "Can I get a massage too?" That sounds harmless, but the physician was called to answer for it in front of the executive committee—and it was not his first time. He was a chronic relapsing provider.

Then there are clinicians who make inappropriate chart notes. In these days of electronic records, such things can never be taken back. I remember from my days as a resident at the Detroit Medical Center (DMC), a nutritionist consult once recommended a calorie count. My attending wrote on the chart: "Above stupid comment noted." This went right to the top, and is one of the reasons that the attending stopped working at the DMC.

JCAHO does not even talk about disruptive physicians anymore. Instead, they talk about a "culture of safety" (Fig. 2). So whenever you hear that term, take it as a code word for someone being disruptive. If things are not resolved at the hospital level, the hospital may be required to report a disruptive physician to the National Practitioner Data Bank (NPDB), a more or less permanent repository of information on medical malpractice.

2. *Disabled doctors.* Addiction affects healthcare providers just like everybody else. It is due to either genetics or trauma or being exposed to a drug. About 15% of us are going to have some type of addictive disorder sometime during our lives, though not necessarily while we're practicing.

The things to watch out for in a colleague who may be suffering from an addiction are signs of change over time: They become socially removed, their work performance goes down, they may actually spend more time at work because that's where they're getting their drugs, their hygiene may decline, they have absences, they are defensive and irritable and bite your head off when confronted. They may start writing very unusual drug orders, they may commit domestic abuse or violence, they may become sexually promiscuous, they may get extremely drunk at social events, and they may be arrested for drunk driving.

At work, they seem to be agitated, they may be sweating or tremulous (either from stimulant intoxication or opioid or benzodiazepine withdrawal) and they may isolate in their office with "locked door syndrome." One minute they're not

looking good and the next minute they disappear in the bathroom and come out 15 minutes later looking great—not because they had a bowel movement but because they used whatever their drug of choice was. They may exhibit classic signs of intoxication—ataxia, slurred speech, tremors—and they may start

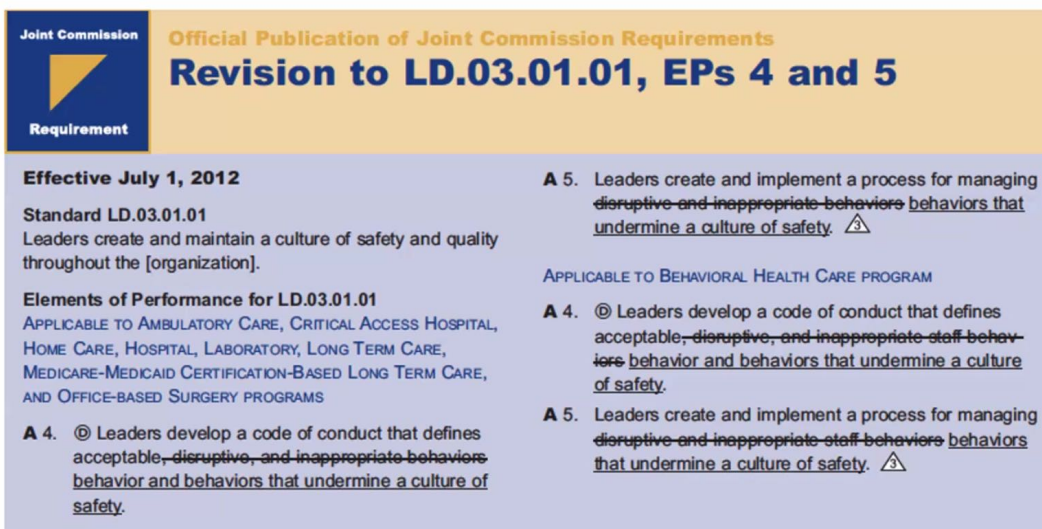


Fig. 2. Disruptive = "Culture of Safety"

disappearing on Mondays and, if things get bad enough, on Fridays too.

Another category of impairment is over-prescribing, which frequently leads to legal issues. And these are classically the duped docs and the dishonest docs, as well as disruptive and disabled. One of the first such cases I was ever aware of was a DMC physician who was presented to law enforcement and Medicare or Medicaid for excessive prescribing. He was prescribing so much that in the mornings, when they opened the clinic, there was a line all the way around the street. I've been practicing for a long time and I have never known of lines going out of a physician's office down the street.

At his trial, prosecutors said that he was not the number one prescriber in Michigan. He was the number two prescriber—right behind the University of Michigan hospital system!

3. Dishonest doctors: There are schemes going on between pharmacies, DME (durable medical equipment) providers, and doctors to provide either non-existent medication or selling pills. Eventually, such schemes will wind up coming to the attention of the DEA (Fig. 3). I am an expert witness for the DEA and tenacity does not begin to describe them. Doctors who are running pill mills and discover that they are being observed will start requiring an X ray of a patient in order to prescribe oxycontin. It doesn't really matter what the X ray shows—any X ray will do.

Fig. 4 is an X ray presented by a "patient" who came in complaining of pain. The doctor said he could tell from the X ray that the patient must be in a lot of pain and asked what the patient wanted. The patient wanted oxycontin. The X ray probably shows some right hip dysplasia, but it also shows a very, very long coccyx, which most of us would also call a tail. It is, in fact, an X ray of a dog. The prescriber was arrested and lost his medical license.



Fig. 3. The Embodiment of "Tenacity"

This is just one of the things providers will do to try and appear legitimate when they are not. Another one is that doctors can be out of date. Some doctors simply don't fulfill their CME requirements and just don't know that there's an opioid crisis going on and don't know about the risks of benzodiazepines.

Impaired Physicians (see above): Even though a doctor may be addicted and not deliberately trying to sell pills, when you have addiction, your brain is simply not functioning, your judgment is gone, and you're a very easy mark. So even though you're not trying to run a criminal enterprise, you wind up doing so because you simply can't filter out what patients are trying to get from you.



Fig. 4. Chronic Pain?

4. *Duped doctors*. These comprise the biggest category. Many doctors are people-pleasers—one reason we go to medical school is so people will like us. You will never see a happier patient than someone who leaves your office with a prescription for Norco, Xanax, and Soma. And you'll never see somebody unhappier than someone who leaves your office with nothing. We quickly learn that we can please people by writing prescriptions and get in trouble that way. Addiction physician Anna Lembke's book *Drug Dealer, MD* (Fig. 5), is about how this can happen.

In one case in Huntsville, Alabama, in which I was involved, a doctor who was not trying to be a criminal but simply started writing anything anybody wanted was cautioned and sanctioned, but she would not stop and finally wound up in federal court. This was a tragic loss of a physician's practice for no reason that could not have been corrected.

Dr. Lembke espouses a sixth "D": Defamation in the social media. You know that if you see a doctor today and you don't like the kind of care you got, you can go out in the parking lot, log on to [vitals.com](https://www.vitals.com) and write a scathing review, which is going to be there as long as the Internet is there. Here are some examples:

- He was rude and wanted me to jump through hoops.
- He walked out in the middle of the interview, even before I asked for pain meds.
- The worst doctor I've ever seen.
- I'll never go back to him.
- He's a horrible doctor.

If you haven't guessed already, these are all about me. As an addiction physician, I don't expect to be wildly popular. But if I were new faculty member at a medical center or a medical practice, you can bet that these comments could be career ending. Just keep in mind that you have to please the public, but that can lead to bad prescribing.

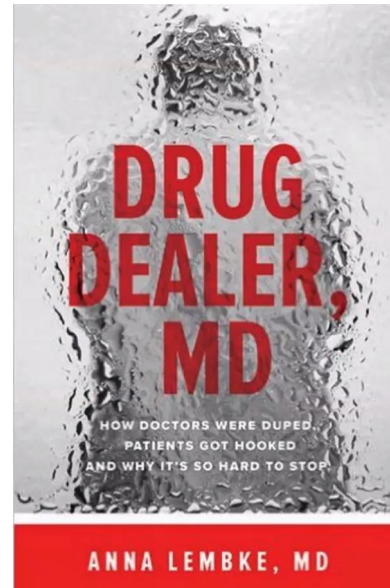


Fig. 5.

Here's my favorite, on [vitals.com](https://www.vitals.com):

"He's a complete asshole.... He is a controlling son of a **** who bases his decisions without completely listening to you."

5. *Depressed doctors*. Depression is a major issue now, along with burnout in medicine. Depression can lead to suicide. Suicide is almost always the result of depression or mental illness that may or may not include alcohol or substance abuse. It is a major problem currently in medicine.

Dr. Pamela Wible (Fig. 6) is the best known physician in the country dealing with physician suicide. She is a primary care doctor who has presented to AAMC and the AMA and has a very active Internet blog. She holds herself out as being available 24 x 7 to any healthcare

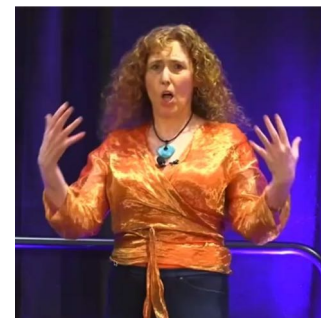


Fig. 6. Dr. Pamela Wible

provider who is thinking about suicide.

Physicians do not necessarily have a higher attempt rate. But we do have a higher completion rate—between 1.4 to 2.3 times more successful than non-physicians. Female doctors are less likely to attempt suicide but even more successful (2.4 - 4 times) at completing it. These numbers are probably underreported—sympathetic underreporting can occur when a physician has to give a colleague an autopsy diagnosis.

Of those physicians who commit suicide, the most common diagnoses (as you would expect) are depression, bipolar disorder, alcoholism, and drug abuse. The most common techniques they use are medication overdose and firearms.²

Who Do You Call?

If you are in trouble yourself, what can you do about it? You can call your Employee Assistance Program (EAP). Your EAP is prevented from communicating directly with your employer. You can call a colleague or faculty or you can call Dr. Wible at (541) 345-2437. But you need to realize that if you express a plan for hurting yourself, they may call the police and you may wind up in the emergency department. That is simply the law. They may be forced to contact somebody if it appears that you are going to hurt yourself or hurt somebody else.

What about when one of your colleagues is in trouble? These are examples of things that you might see that should lead you to worrying about this:

- Your colleague tells you that s/he is depressed and is not sure s/he "wants to keep on going."
- They come to work with alcohol on breath or odor of cannabis. (Remember that even though cannabis is legal in Michigan, in pretty much every healthcare institution you must *not* test positive for THC.)

- Their work becomes erratic. They begin missing work. They won't answer your calls.
- You find out that something's happened to them academically—perhaps they have been placed on academic probation.
- If they are a fellow or resident or student, you get strange calls from them that they're being stalked, they're being watched, they're being plotted against,... quite frankly, they are paranoid.
- You find out that they experienced an overdose. They will have a very rational explanation—"It's because of the Seroquel," but in reality, they're abusing opioids and benzodiazepines.

The issue is that even though you'll want to try and figure out what's going on you probably won't be able to, because you're not going to have enough information and your colleague is not going to be forthcoming. You will probably not be able to tell whether the problem is a mood disorder, drugs, alcohol, or some combination.

The bottom line is the safety of your colleague. Obviously—and this is the bottom line for most providers—you don't want to intervene, you don't want to report them because you don't want to damage their medical license. Even though somebody is in a lot of trouble, colleagues tend to do nothing. But remember, while you are responsible for your colleague's safety to some extent, you are most certainly responsible for public safety and the public may be at risk because of your colleague.

You can report to your division chief, your chair, your hospital, you can go on up the line, or you can try and intervene and refer yourself—which is very difficult to do and almost always unsuccessful. You need to figure out if they need a psychiatrist, an addiction doctor, a therapist, a psychologist,... and you really are not going to be able to do that. That's where the physician health programs (PHP) come in.

² Austin, AE. Physician suicide. J Forensic Sc 2011 Jan 58 suppl 1:591-3



- Legislatively mandated 1993 (initiated 1994)
- Covers >300,000 HCP
- Covers 29 HCP disciplines
- MD/DO, DDS, RN/LPN, RPh acc't for > 93% of referrals.
- >750 HCP in contract
- Approx. 30 referrals /mo.
- > 4000 to date

Fig. 7. HPRP

There is one in every state. In Michigan it is called the HPRP (Health Professional Recovery Program) which monitors impaired physicians and also nurses and pharmacists. It was formed in 1994. I have been a provider for HPRP since 2009. We currently have about 700-800 health-care professionals, which is probably about 5% or less than the number it should be. The most common referral we get is from nurses because they are the most numerous in terms of health care professionals. We get about one referral a day. (Fig. 7 refers.)

This may sound as though if somebody refers you to the HPRP you're going to wind up being arrested and taken to hospital. But in the majority of cases, when there's an evaluation done, there is no diagnosis made and there is no monitoring done. The most common referral we get, as you might expect, is a drunk driving arrest or conviction. If you have a drunk driving conviction, the state of Michigan requires you to report it within 30 days of your conviction. If you don't, your license can be suspended.

A lot of people will not report it, because they don't want to have to go through an evaluation and the attorney they paid a lot of money for will tell them not to. I've seen, time and time again,

folks getting their licenses suspended just because they didn't contact the state of Michigan.

If they do find a diagnosis, it is either going to be an addiction diagnosis, which we call substance use disorder, or some mental health diagnosis. Our monitoring programs go from one year to three years in most cases.

This is very effective. Over 1,000 physicians have been monitored and the success rate is about 80 to 90%. More than 90% of those who completed the program continue practicing in their specialty, but that goes down to less than 30% for those who do not complete the program. The success rates for regular addiction treatment, in comparison, are somewhere between 3-60%. In sum: The HPRP program is very structured, lasts for several years, is very comprehensive, and is very successful in terms of people keeping their license and keeping their practice.

Before I present some actual cases, I want to mention some bizarre articles that appeared in the *New England Journal* in 2019 concerning a medical student who died from an overdose be-



Perspective
AUGUST 29, 2019

A Lethal Hidden Curriculum — Death of a Medical Student from Opioid Use Disorder

Catherine R. Lucey, M.D., Lee Jones, M.D., and Abigail Eastburn, M.D.

PERSPECTIVE

PRACTICING WHAT WE PREACH

Practicing What We Preach — Ending Physician Health Program Bans on Opioid-Agonist Therapy

Leo Beletsky, J.D., M.P.H., Sarah E. Wakeman, M.D., and Kevin Fiscella, M.D., M.P.H.

Fig. 8. Don't You Believe It!

cause he chose not to share his diagnosis with anybody. (See Fig. 8.) The authors recommended that anybody who has a history of opioid addiction and is going to practice medicine should be on methadone. Please be advised: That is wrong!

Case presentations

These are all true stories. All except one happened at the Detroit Medical Center.

Case 1: A 28 year-old intern was arrested driving home drunk during Match Day and convicted of DWI. Evaluation showed that this was a one time episode. Probably the intern got drunk to celebrate getting the match of their choice. There was no diagnosis and no further action was taken. The case is closed. But if the intern had chosen not to report it to the state of Michigan, it could have meant a license suspension and being reported to the databank.

Case 2: An anesthesia resident was referred to me because she had multiple narcotic medications withdrawn in the OR for her patients. She would take out medication at the beginning of the day for use on cases, withdrawing and using more dilaudid and fentanyl than any attending in the hospital, which didn't make a lot of sense. I saw her and another addiction specialist saw her. She denied there was a problem and explained her behavior as due to osteoarthritis and tiredness. We told her hospital, which referred her, that we had no diagnosis. There was really nothing that could be done. Six months later, she was found overdosed in the bathroom outside an OR with no pulse and no respiration. She was resuscitated. She had been injecting herself with fentanyl. She initially did not want to be involved with the HPRP, claiming she did not have much of a problem. But we convinced her and she enrolled in HPRP, which she completed successfully. She is now a faculty at an out of state university.

Case 3: A 50 year old psychiatrist was referred to HPRP for having alcohol on his breath. The

HPRP could not complete its evaluation because the referring institution would not cooperate. They said there was no problem and the case was closed without any diagnosis being made. The psychiatrist had a history of liver disease from his job and should not have been drinking anyway, but he continued to drink. Two years later, he was presenting at a national organization and failed to show up for his presentation. Hotel security broke into his room and found him unconscious. He had a very high alcohol level. His colleagues declined to refer him for an evaluation because they said this was a one-time incident, even though this had been going on for 10-20 years. He continued to drink. Four years later, he was admitted for a medical complication of his drinking, left the hospital AMA so he could go home, and was admitted later in septic shock and died. He was a friend of mine. This was an entirely preventable episode.

Case 4: Twenty-two years ago, a 45 year-old physician was reported to his chair for having alcohol on breath and strange behavior at work. He had actually had a previous intervention during residency, but it was dropped. The chair referred him to a psychiatrist but he stopped going after a while and the psychiatrist discharged the physician from his practice. Because there was no release of information, they could not notify anybody—nothing was done, there was no follow up, and the physician just went back to drinking.

He was again brought before his chair and convinced the chair that there was no problem, which is very common—alcoholics and drug addicts become adept at explaining things away. Again, nothing was done. Two years later, he was referred back to the administration, this time for deteriorating performance, hygiene issues such as never taking a shower, living in his office, being disheveled, and having alcohol on breath. In addition, he was found unconscious under his desk by a nurse. On top of all that, an empty wrapper that appeared to have contained cocaine was found in the OR right after he had gone to the bathroom.

He was intervened on yet again. He demanded a lawyer, which is not uncommon for alcoholics and drug addicts. Instead of being given an on-the-spot drug screen, he was allowed to take two weeks off and told he had to do the drug screen when he came back. This was obviously an attempt to give him a last chance to straighten up rather than be fired, but it really simply enables somebody if they are using.

Instead of being gone two weeks, he was gone for six. When he returned, the drug screen was positive for cocaine. In this situation, the hospital is normally obliged to either to refer to the HPRP or to report to the board of medicine, which would result in a license suspension. He was allowed to call the HPRP, went for another evaluation, and was recommended for 4-month residential treatment, which he completed successfully. On return to the DMC, he signed a lifetime last chance agreement with his hospital that said that if he relapsed and reported it to us, he would be simply suspended; otherwise, he would be terminated for life from the DMC hospital system. (See Fig. 9, at the end of this document.)

The signature on the bottom of that agreement is mine. I am a recovering alcoholic and a cocaine addict. I was sent to treatment in 1999, after my last intervention. My first intervention was in 1983. The DMC had no reason to offer this to me and I will always owe them a debt of gratitude. Eventually they let me start seeing patients again, and I wound up switching from my previous specialty of GYN oncology to Addiction Medicine and became involved with the HPRP, of which I am currently the medical director and a previous chairman.

The nurse who found me unconscious under my desk married me four years later. Things *do* turn out better.

I present this not because I think that many of you are going to wind up being hopeless drug addicts, but about 15% of you are going to have an addiction problem or already do. The hospital is responsible for monitoring you and you are responsible for reporting it. In any state you work in when you're done with your residency, you will have a physician health program that can monitor you if this is diagnosed. It will keep everything confidential. HPRP is a confidential program and your records are destroyed once you are five years out. There are actually no records of my involvement with HPRP other than what I talk about in public

My cell phone number is 734-218-5317. My email address is ab7059@wayne.edu. HPRP can be reached at a number nobody wants to use: 800-453-3784. But it is worth it.

Conclusion

Let me reiterate the main points of this presentation:

1. Impairment may be a result of addiction, mental illness, or medical issues.
2. Disruptive behavior is considered impairment (JCAHO "culture of safety").
3. The hospital is responsible for monitoring; the healthcare professional is responsible for cooperating and reporting.
4. EVERYONE reading this will encounter an impaired/depressed/suicidal physician.
5. Whatever state you practice in, you will have a physician monitoring program (PHP) that can monitor (= protect) you if impairment is diagnosed.

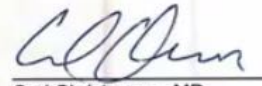
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Detroit Medical Center Professional Recovery Return to Work Agreement

NAME: Carl Christensen, MD
 HOME ADDRESS: 633 W. Hancock, Detroit, MI
 HOME PHONE: 313-999-1656
 EMPLOYMENT: Hutzel Hospital - OBGYN Department
 WORK ADDRESS: 4707 St. Antoine, Detroit, MI 49201
 WORK PHONE: 313-966-0149

I, Carl Christensen, hereby agree to following terms as a condition of my continued employment and/or staff privileging with the Detroit Medical Center. I understand that non-compliance with any terms of this agreement could result in disciplinary action up to and including termination, loss of staff privileges with the Detroit Medical Center (DMC), and reporting to the Michigan Health Professional Recovery Program (HPRP), the State of Michigan Department of Consumer and Industry Services (MDCIS), the National Practitioners Databank and/or any other relevant agencies as is considered appropriate by the DMC.

1. I agree to maintain lifelong sobriety.
2. I shall comply with all provisions of my HPRP Recovery Monitoring Agreement. (Exhibit A)
3. I shall comply with all provisions of my West Michigan Addiction Consultants (WeMac) Professional Recovery System Continuing Care Contract. (Exhibit B)
4. In compliance with my HPRP Recovery Monitoring Agreement, drug specimen collection is to be performed at the DMC Occupational Health Services (DMC OHS) clinic located at UHC-4K or at another "drop site" location as designated by the DMC OHS coordinator. In the event that the DMC OHS clinic is not open for business on a collection day (e.g. clinic closed for holiday), then an alternate site specifically approved for my use by HPRP shall be used. It is my responsibility to establish this alternate site with HPRP and arrange for HPRP to provide documentation of the approved drop sites to the MRO, which shall specify the DMC OHS clinic as the primary drop site, and their approved alternate as a back up. In the event that I am out of town, either on business or vacation, I shall follow the HPRP requirements for drug collections. In the event that unforeseen clinical duties preclude my being able to present by 10:00 am (e.g. emergency surgery), I shall provide documentation from my Worksite Monitor regarding the inability to have the collection performed on time, and regarding the time at which I should be expected to be available for testing. I shall present to the drop site as soon as possible following the completion of those clinical duties which have precluded my presence at the drop site. On drug screening days, as randomly established by HPRP (i.e. "purple days"), I shall present to the drop site by 10:00 a.m. for urine specimen collection (notwithstanding the HPRP requirement that the collection be performed by 6:00 p.m.) I agree to undergo observed collections on a random basis as determined by the DMC.
5. I agree to a full release of information from HPRP, WeMac, my Department Chair, my Worksite Monitors (currently Dr. Gene McNeely and Dr. Leonard Dorey) to the DMC OHS Medical Review Officer (MRO, currently Dr. Mark Upfal).
6. I agree that the MRO shall be notified immediately by my Worksite Monitor of any possible signs of relapse behavior.
7. In the event of actual relapse (i.e. use of any controlled substance), I shall immediately consider myself to be on medical leave and without medical center privileges for the performance of any clinical or other occupational duties until formally cleared by the MRO. I shall immediately contact my Worksite Monitor to arrange for coverage of my clinical and other occupational duties. I shall contact the MRO directly, if this contact has not already been made by my Worksite Monitor. I recognize that reporting to the DMC Worksite Monitor and/or the DMC MRO does not fulfill my reporting requirements to HPRP and WeMac. I may be required to report similar information directly to all three institutions.
8. I agree to indemnify and hold harmless the DMC, the MRO, my Worksite Monitors, my employer(s) any DMC representatives from any liability to me that may result from any actions taken in good faith to protect my patients, the interests of the DMC, the interests of the community and my sobriety.
9. I will be solely responsible for all costs incurred while complying with the terms of this agreement.


 Carl Christensen, MD (date) 11/16/19

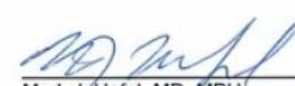

 Mark J. Upfal, MD, MPH (date) 11/16/19
 Medical Review Officer
 Corporate Medical Director
 DMC Occupational Health Services

Fig. 9. Last Chance Agreement

