



January 21, 2005

Liz Figueroa, Chair  
Members Joint Committee on Boards, Commissions and Consumer Protection  
State Senate  
1020 N. Street, Room 521  
Sacramento, CA 95814

The Honorable Liz Figueroa and Committee Members,

The California Society of Addiction Medicine (CSAM) is grateful for the opportunity to speak with you and share with you our experience and expertise with regard to chemical dependence and the monitoring of physicians afflicted with alcoholism, addiction and or mental illness. Our goal is to help you understand the scientific basis of addiction and recovery so that you can objectively evaluate the Enforcement Monitor's report concerning the State of California Physician Diversion Program.

**Summary of Response to Enforcement Monitor Report**

**The Diversion Program is an essential option and must be maintained.** The idea of having no such alternative for physicians suffering this illness, would create enormous public safety issues, sending physicians needing treatment to go into hiding in order to protect their licensure and their livelihood. California law, in addition, supports the rehabilitation of physicians consistent with public protection.

**The Program has literally been starved – the root cause of the problems identified.** The EM's report identifies program deficiencies caused by insufficient staffing and resources that are required in order for the program to operate effectively to protect the public.

**Maintain the focus of the Program – the one for which it was initially created – to monitor physicians who seek treatment for substance abuse.** Inclusion of participants who have mental health illnesses is beyond the intended scope of the Program and should be halted unless there is proper funding and appropriate staffing to address the needs of this unique population.

**Confidentiality of voluntary participants is an essential element of the program and can draw participants who might not otherwise admit their illness.** We strongly urge separation of enforcement staff from diversion program staff in order to ensure confidentiality.

**That case managers caseloads must be held to manageable and appropriate levels.** Internal quality controls can be ensured when case managers workloads are held to appropriate levels.

**Random Drug and Alcohol Screening is an essential part of ensuring the quality of the program and protecting the public.** It must be properly implemented in order for the program to function as intended.

**We support a licensing fee increase.** However, any fee increase must be tied to the continuation and proper funding of the Diversion Program.

### **The California Society of Addiction Medicine**

CSAM is the California Chapter of the American Society of Addiction Medicine (ASAM), an association of physicians dedicated to improving the treatment of alcoholism and other addictions, educating physicians and medical students, promoting research and prevention, and enlightening and informing the medical community and the public about the issues.

ASAM serves its members by providing opportunities for education and sharing of experiences, and by promoting the development of a body of professional knowledge and literature to enhance the quality and increase the availability of appropriate health care for people suffering from addictions.

ASAM Certification (similar to board certification) generally requires Board Certification in another medical specialty, several years of experience or a 1-2 year addiction medicine fellowship, and successfully passing a rigorous addiction certification examination. There are approximately 3,000 ASAM-certified addictionists worldwide.

### **The Disease of Addiction**

In the State of California, the ability to practice the art and science of medicine is a privilege. The license of practice is granted only to those individuals who have passed those rigorous standards that have been established by the state and administered through the Medical Board of California.

Further standards have been established to protect the public. Despite meeting the requirements for licensure to practice medicine, physicians may still suffer from one or more afflictions that may impair their ability to actually practice. The public deserves protection from mental, emotional, or chemical dependency impairments, as well. Every state in this country, including California, has developed a diversion program whose job it is to protect the public from impaired physicians. California law, in addition, supports the rehabilitation of physicians consistent with public protection.<sup>1</sup>

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<sup>1</sup> California Business and Professions Code § 2340. It is the intent of the Legislature that the Medical Board of California seek ways and means to identify and rehabilitate physicians and surgeons with impairment due to abuse of dangerous drugs or alcohol, or due to mental illness or physical illness, affecting competency so that physicians and surgeons so afflicted may be treated and returned to the practice of medicine in a manner which will not endanger the public health and safety.

However, understanding the philosophy and operation of these diversion programs requires first at least a basic understanding of the nature of addiction. According to Alan Leshner, Ph.D., former Director of the National Institute of Drug Abuse:

“The United States is stuck in its drug abuse metaphors and in polarized arguments about them. Everyone had an opinion... People see addiction as either a disease or as a failure of will. None of this bumpersticker analysis moves us forward. The truth is that we will make progress in dealing with drug issues only when our national discourse and our strategies are as complex and comprehensive as the problem itself.

A core concept that has been evolving with scientific advances over the past decade is that drug addiction is a brain disease that develops over time as a result of the initially voluntary behavior of using drugs. The consequence is virtually uncontrollable compulsive drug craving, seeking, and use that interferes with, if not destroys, an individual’s functioning in the family and in society. This medical condition demands formal treatment.

We know in great detail the brain mechanism through which drugs acutely modify mood, memory, perception, and emotional states... thus, the majority of the biomedical community now considers addiction, in its essence, to be a brain disease; a condition caused by persistent changes in brain structure and function.

This brain-based view of addiction has generated substantial controversy, particularly among people who seem able to think only in polarizing ways. Many people erroneously still believe that biological and behavioral explanations use alternative or competing ways to understand phenomena, when in fact they are complementary and integratable. Modern science has taught that it is much too simplistic to set biology in opposition to behavior or to pit willpower against brain chemistry. Addiction involves inseparable biological and behavioral components. It is the quintessential bio-behavioral disorder.

Many people also erroneously still believe that drug addiction is simply a failure of will or of strength of character. Research contradicts that position. However, the recognition that addiction is a brain disease does not mean that the addict is simply a hapless victim. Addiction begins with the voluntary behavior of using drugs, and addicts must participate in and take some significant responsibility for their recovery. Thus, having a brain disease does not absolve the addict of responsibility for his or her behavior, but it does explain why an addict cannot simply stop using drugs by sheer force of will alone. It also dictates a much more sophisticated approach to dealing with the array of problems surrounding drug abuse and addiction in our society.

In updating our national discourse on drug abuse, we should keep in mind this simple definition: Addiction is a brain disease expressed in the form of compulsive behavior. Both developing and recovering from it depends on biology, behavior, and social context.

Addiction should be understood as a chronic recurring illness. Although some addicts do gain full control over their drug use after a single treatment episode, many have relapses. Repeated treatments become both necessary to increase the intervals between and diminish the intensity of relapses, until the individual achieves abstinence.

The complexity of this brain disease is not atypical, because virtually no brain diseases are simply biological in nature and expression. All, including stroke, Alzheimer's disease, schizophrenia, and clinical depression, include some behavioral and social aspects. What may make addiction seem unique among brain diseases, however, is that it does begin with a clearly voluntary behavior—the initial decision to use drugs. Moreover, not everyone who ever uses drugs goes on to become addicted. Individuals differ substantially in how easily and quickly they become addicted and in their preferences for particular substances. Consistent with the biobehavioral nature of addiction, these individual differences result from a combination of environmental and biological, particularly genetic, factors. In fact, estimates are that between 50 and 70 percent of the variability in susceptibility to become addicted can be accounted for by genetic factors.

Over time the addict loses substantial control over his or her initially voluntary behavior, and it becomes compulsive. For many people these behaviors are truly uncontrollable, just like the behavioral expression of any other brain disease. Schizophrenics cannot control their hallucinations and delusions. Parkinson's patients cannot control their trembling. Clinically depressed patients cannot voluntarily control their moods. Thus, once one is addicted, the characteristics of their illness—and the treatment approaches—are not that different from most other brain diseases. No matter how one develops an illness, once one has it, one is in the diseased state and needs treatment.

Moreover, voluntary behavior patterns are, of course, involved in the etiology and progression of many other illnesses, albeit not all brain diseases. Examples abound, including hypertension, arteriosclerosis and other cardiovascular diseases, diabetes, and other forms of cancer in which the onset is heavily influenced by the individual's eating, exercise, smoking, and other behaviors.

Does having a brain disease mean that people who are addicted no longer have any responsibility for their behavior? Of course not. Addiction begins with the voluntary behavior of drug use, and although genetic characteristics may predispose individuals to be more or less susceptible to becoming addicted, genes do not doom one to become an addict.

Moreover, as with any illness, behavior becomes a critical part of recovery. At a minimum, one must comply with the treatment regimen, which is harder than it sounds. Treatment compliance is the biggest cause of relapse for all chronic illnesses, including asthma, diabetes, hypertension, and addiction. Moreover, treatment rates are no worse for addiction than for these other illnesses, ranging from 30 to 50 percent. Thus, for drug addiction as well as for other chronic illnesses, the individual's motivation and behavior are clearly important parts of success in treatment and recovery.

Maintaining this comprehensive bio-behavioral understanding of addiction also speaks to what needs to be provided in drug treatment programs. Again, we must be careful not to pit biology against behavior. The National Institute on Drug Abuse's recently published Principles of Effective Drug Addiction Treatment provides a detailed discussion of how we must treat all aspects of the individual, not just the biological component or the behavioral component. As with other brain diseases such as schizophrenia and depression, the data show that these attend

to the entire individual, combining the use of medications, behavioral therapies, and attention to necessary social services and rehabilitation.

A growing body of scientific evidence points to a much more rational and effective public health/safety approach to dealing with the addicted offender. Simply summarized, the data shows that if addicted offenders are provided with well-structured drug treatment while under criminal justice control, their [relapse] rates can be reduced by 50 to 60 percent for subsequent drug use. Moreover, entry into drug treatment need not be completely voluntary in order for it to work. In fact, studies suggest that increased pressure to stay in treatment—whether from the legal system or from family members or employers—actually increases the amount of time patients remain in treatment and improves their treatment outcomes.

Diversion to drug treatment programs as an alternative to incarceration is gaining popularity across the United States. The widely applauded growth in drug treatment courts over the past five years—to more than 400—is another successful example of the blending of public health and public safety approaches. These drug courts use a combination of criminal justice sanctions and drug use monitoring and treatment tools to manage addicted offenders.

Understanding drug abuse and addiction in all their complexity demands that we rise above simplistic polarized thinking about drug issues. Addiction is both a public health and a public safety issue, not one or the other. Drug abuse and addiction are about both biology and behavior. One can have a disease and not be a hapless victim of it.

We also need to abandon our attraction to simplistic metaphors that only distract us from developing appropriate strategies. We are, after all, trying to solve truly monumental, multidimensional problems. To devalue them to the level of slogans does our public an injustice and dooms us to failure.

The message from the now very broad and deep array of scientific evidence is absolutely clear. If we as a society ever hope to make any real progress in dealing with our drug problems, we are going to have to rise above moral outrage that addicts have “done it to themselves” and develop strategies that are as sophisticated and as complex as the problem itself. Whether addicts are “victims” or not, once addicted they must be seen as “brain disease patients.

Moreover, although our national traditions do argue for compassion for those who are sick, no matter how they contracted their illnesses, I recognize that many addicts have disrupted not only their own lives, but those of their families and their broader communities, and thus do not easily generate compassion. However, no matter how one may feel about addicts and their behavioral histories, an extensive body of scientific evidence shows that approaching addictions as a treatable illness is extremely cost-effective, both financially and in terms of broader societal impacts. Thus, it is clearly in everyone’s interest to get past the hurt and indignation and slow the drain of drugs on society by enhancing drug use prevention efforts and providing treatment to all those who need it.”<sup>2</sup>

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<sup>2</sup> *Issues in Science and Technology*, “Addiction is a Brain Disease,” Spring 2002.

## **Legislative Intent of the Medical Board of California's Diversion Program**

Created by legislative statute in 1980, the California Physician Diversion Program is one of the leading programs of its kind in the U.S. The Diversion Program is a highly structured, multifaceted, five-year monitoring and rehabilitation program that has operated with a 74% success rate since its inception. Success rate requires compliance with the Program standards and a minimum of three years continuous sobriety. The statutes establishing the Diversion program require confidentiality of all participants who enter the program voluntarily. The Program, administered by the Division of Medical Quality of the Medical Board of California, operates to support and monitor the recovery of physicians who have substance abuse or mental health disorders.

The intent of the Legislature has been that the Medical Board of California seek ways and means to identify and rehabilitate physicians and surgeons with impairment due to abuse of dangerous drugs or alcohol, or due to mental illness or physical illness, affecting competency so that physicians and surgeons so afflicted may be treated and returned to the practice of medicine in a manner which will not endanger the public health and safety. Physicians enter the program by one of three pathways: by self referral, by encouragement from others, or by referral by the Enforcement Unit of the Medical Board in lieu of pursuing disciplinary action.

## **California Physician Diversion Program Sets the Standard for the Nation**

The California Physician Diversion Program has been the standard by which some other state physician diversion programs have been modeled and its philosophy of supervision, monitoring, and treatment has been adopted by more than 400 drug courts across the United States. As noted in a respected journal early in the Diversion Program's history:

“Since January 1980, following a change in California law, impaired physicians have been given the opportunity to be diverted from possible medical board discipline into a statewide treatment program financed by the Board of Medical Quality Assurance (BMQA). The success of the program has depended on a rapid response mechanism, an individualized treatment program, an ironclad confidentiality, and a multilevel monitoring program. This non-disciplinary approach has made it easier for physicians to encourage their sick colleagues to volunteer for treatment. The experience after 24 years indicates that impaired physicians are found and treated more quickly when legal restrictions against one's license are avoided.”

Throughout the Program's 24-year history, there have been no reported cases of harm to patients by physicians participating in the Diversion Program. However, patients could be endangered when the Program's staffing and resources are too low to ensure proper implementation of participant monitoring. By removing the impaired physician's fear of legal discipline and its attendant publicity, the California Diversion Program for Impaired Physicians has fostered a speedier recognition and treatment of the sick doctor.

The 24-year experience with the program has more than justified its cost and effort. Physicians who have been diverted from the possible BMQA discipline have not required an extensive

investigation or an expensive legal hearing. This has resulted in substantial budgetary savings for the BMQA.

The most surprising result from the program's experience is the negation of the prevailing idea that impaired physicians cannot safely practice medicine while undergoing treatment. When a physician's outpatient rehabilitation treatment is individually tailored to meet his needs, and an appropriate supportive monitoring system is in place, "impaired" physicians are not impaired, and can safely practice.

"Voluntary" coercion by the BMQA does not turn off physicians who are potential self-referrals. Also, hospital executive committees and department chairmen are now more inclined to urge an impaired colleague to voluntarily apply to the program in lieu of suspending his or her hospital privileges. The existence of a confidential Diversion Program has permitted many concerned physicians to encourage their sick colleagues to self-refer. Finally, the program has brought the medical profession one step closer to the goal of healing itself.<sup>3</sup>

## **Situational Analysis**

### **Budgetary and Staffing Crises**

Over the past few years, the Diversion Program has been faced with tremendous budgetary pressures and staffing shortages. As a result, some policies were modified to adapt to the availability of limited resources. For example, the Program Manager served as a Case Manager for a period of six months, due to a staffing shortage in one region. During this time, the Deputy Executive Director of the Medical Board of CA, took over the responsibilities of the Program Manager. This caused a "blurring of the lines" between the Diversion Program and the Enforcement side of the Medical Board and raised concerns about protection of confidentiality of physicians voluntarily involved in the program.

### **Physicians with Mental Illness Added to Program**

In addition, pressure was placed on the Program's staffing and resources in 2003 with the passage of legislation that required it to accept referrals from the Enforcement Division of physicians who had been diagnosed with mental illness. A representative of the CA Psychiatric Association was invited to join the Liaison Committee, however, no additional funding was provided in order to increase Diversion Program staffing levels or to recruit the clinical experts to serve this new group of participants. The addition of this group of participants added greater responsibility to the already overburdened Program that continued to operate with a staffing and resource shortage.

### **Selection of Biased Enforcement Monitor**

Previous to her position as the Enforcement Monitor, Julie D'Angelo Fellmeth has been a public interest advocate who has been publicly critical of the Diversion Program for almost a decade.

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3 Gualtieri, et al., Journal of the American Medical Association, v. No., January 1983,

She has taken a long-standing role of questioning the Program's ability to protect the public from impaired physicians. She was often quoted in newspaper articles attacking the Program and its effectiveness with regard to recidivism and recovery. Her well-known bias opposing the Program has raised many concerns about her ability to fairly evaluate the Program and issue a well-balanced report to the CA Legislature.

### **Program Manager Resignation**

During the course of the review by the Enforcement Monitor, the Program Manager, Laura Choate, tendered her resignation. Prior to her departure, she speculated that the Enforcement Monitor would raise issues such as: insufficient number of drug screenings, higher relapse rates, etc. Her resignation has resulted in an administrative loss to the Program. While deficiencies may have existed prior to her departure, often related to budgetary and staffing shortfalls as previously described, the management void created by Ms. Choate's untimely departure certainly contributed to the negative statistics quoted by the Enforcement Monitor's report.

### **Analysis of Enforcement Monitor's Report**

The California Society of Addiction Medicine appreciated the Enforcement Monitor's concerns. Certainly, shining a light on this important program can only help up to improve the process. Our goals are to:

1. Protect the Public.
2. Help afflicted physicians to recover from chemical dependency and mental illness.

### **General Overview**

Many viewed the prospect of having a team of experts in the science of addiction critically evaluating the Diversion Program as a wonderful opportunity to improve an already world class program. Unfortunately, that opportunity has been lost and substantial resources squandered in the process. Careful study of the report reveals that the writers had little or no knowledge of understanding of addiction, monitoring, or acceptable public safety standards. Clearly, the writers are unfamiliar with similar programs here in California or across the nation. The lack of understanding of statistical analysis contributes to the misinformed opinions throughout. In light of these facts, it is understandable that the report would be somewhat confused and biased. However, there is no excuse for the sarcasm, latent hostility and venom that repeatedly colors the writer's discourse.

For example, in the first paragraph, the reader is misled by the selective wording of the report to believe that the Diversion Program allows active drug or alcohol using physicians to continue to practice medicine. This is simply incorrect and untrue. In fact, participants are removed from work if there is evidence of impairment.

#### **1. Misinterpretation of Data**

(a). This misinformed, misinterpreted and hysterical overreaction to management errors sets the tone for all that follows. The "Initial Concerns of the MBC Enforcement Monitor" goes on to

list a series of operational errors, some of which do need attention and should be corrected. However, the sky is not falling and the emotional overreaction of the Enforcement Monitor is unprofessional, unwarranted, and uncalled for. However, I will address each of these in turn.

(b). Staffing insufficiencies have been a longstanding problem with the Diversion Program. Staffing insufficiencies should be corrected.

(c.) Monitoring is an important function the Diversion Program. Quality control is an ongoing process. Internal controls are necessary.

Random urine drug screening for monitoring purposes is a highly sophisticated scientific specialty for which specific national qualifications have been developed. The Medical Review Officer qualification sets the standard of knowledge in this highly specialized medical-scientific area. The Enforcement Monitor has no such qualification or training. Much of the EM's report is simply nonsense.

### **(1.) Urine Collection System**

Urine collection is only one facet of monitoring compliance with abstinence, albeit, an important one. Collection should be done in a timely manner and in accordance with the regulations. If recent staffing shortages have caused urine collection to be late, this should be corrected with proper staffing. Urine screening results should be recorded on the proper client's record.

### **(2.) Case Manager Attendance at Group Meetings.**

When case manager caseloads rose due to staffing shortages, some case managers may have lacked the time necessary to attend group meetings. This was a matter of balancing priorities and a matter of necessity, not a programmatic directive to lessen job responsibilities. If case manager attendance is in question, then this should be monitored. Correction of staffing shortages could easily correct this sort of problem. Condemnation of the entire program seems to be an overreaction to an easily solved problem.

### **(3.) Worksite Monitor Reporting**

Worksite monitors should file their reports in a timely manner. This is just one of the monitoring tools used by Diversion. However, it is widely accepted as a useful compliance and monitoring tool and is used nationwide.

### **(4.) Treating Psychotherapists Report**

If treating psychotherapists are not submitting their reports on time, this deficiency can easily be corrected.

(b.) Program staffing issues must be corrected for the Program to function correctly.

Again, this goes without saying. If our buses were always late because we did not have enough bus drivers, would the solution be to scrap all the buses? Of course not! We would hire enough bus drivers and the problem would be fixed.

The EM's clear lack of clinical experience or understanding of the monitoring process has unfortunately resulted in a document of little real value. Nobody has been surprised to find that

the Diversion Program is understaffed. We have known this for many years and the Liaison Committee to the Physician Diversion Program has repeatedly voiced concern, only to be informed that it was a budgetary matter. Perhaps, if there is good to come from this exercise, however, the public attention to these understaffing issues will result in improvements in the Program.

“The Program’s staff must be significantly augmented.” The California Society of Addiction Medicine cannot agree more with the EM. In fact, we have been suggesting adequate staffing levels for many years.

The EM’s railing about the Program “functioning without adequate internal controls for 24 years” is simply unsupported and unfounded. True, the science of addiction medicine is growing and evolving all the time. And, as we learn more, we may change way we think about the monitoring process. Certainly, information systems have progressed light years in the past 24 years, and upgrades in systems may need to be evaluated. In some cases, informational systems are developing so quickly that they seem to be outdated by the time installation is complete! Probably, one could make that case that almost any management system installed more than a year ago needs to be redesigned. But, these facts cannot logically lead to throwing out the baby with the bath water and throwing out the entire program, as the EM has recommended.

## **2. Enforceable Rules and Standards.**

Another glaring failure of the EM’s report resulting from the EM’s lack of clinical experience and understanding of the monitoring process is described in this section. The close clinical scrutiny and methodical case-by-case monitoring at the heart of the Diversion Program’s success is called “an unacceptable ‘case-by-case’ mentality” by the EM. Clinical medicine, indeed any evaluation of complex human behavior, is always performed on a case-by-case basis. In fact, it could not be successfully performed on any other basis.

The EM then goes on to attack the *Diversion Manual*, again failing to understand the relevance of guidelines as applied to clinical decision-making. The EM goes on to attack the case managers and Program Administrator for “not being aware of any of the problems we found with the urine collection system described above.” The pitfalls and limitations of any urine drug-screening program are well known and documented in the literature (in fact, the American Society of Addiction Medicine gives courses on just this!). One must wonder how this question was posed to the case managers and Program Manager, or if the question was posed at all.

The EM’s misinterpretation and misstatement of the statement “a participant will be considered for termination when the participant has more that three relapses while in the Program” is simply one more egregious example of the EM’s failure to seek professional help in understanding the science of addiction medicine. To describe this statement as a bumpersticker “three-strikes-and-you-may-be-out” policy is simply a corruption of any remaining attempt at even the appearance of objective evaluation.

The EM goes on to describe anecdotal evidence of a 1982 Auditor General report. Unfortunately, the interface between disciplines, such as between law and science, are fraught with potential pitfalls. Where complex concepts are misinterpreted and language is misused or

misunderstood, we open ourselves to grave errors in understanding. It is obvious to us that the EM fell into that trap.

### **3. Division of Medical Quality “Ownership” and Responsibility for the Diversion Program.**

The California Physician Diversion Program has been widely recognized as one of the finest in the nation for the past 24 years. It has been copied and modeled after by many others and its successful formula has been applied not only to helping physicians, but dentists, veterinarians, pharmacists, attorneys, nurses, physical therapists, and even commercial airline pilots. It is a formula that works and works well.

Could the Diversion Program be improved? Of course it could. Should staffing be improved? Yes. Should monitoring systems and information systems be reviewed periodically and updated as funds permit? Yes, of course these things should be done. But to suggest that the sky is falling just because the Enforcement Monitor was hit on the head by an acorn is just silly.

### **4. The Diversion Program is an integral part of the Medical Board, but requires a certain level of confidentiality to function properly in protecting the public.**

The majority of Diversion Program participants enter the Program voluntarily. This voluntary participation, and attendant public protection, would abruptly end if Program confidentiality were to cease. No longer would physicians with a self-recognized problem come to the Diversion Program for monitoring and help. No longer would fellow physicians encourage their peers to seek help for their problems. Clearly, the interest of the public would not be served.

The report acknowledges that pursuing the disciplinary route typically involves delays before a physician can be removed from practice. As the EM’s report states on page 11 of the Executive Summary, “The average length of time for a serious complaint to reach its disciplinary conclusion during 2003-04 was 2.63 years. Many cases take much longer. The total average time from the filing of a serious complaint to a judicially-reviewed disciplinary decision is thus 1,369 days or 3.75 years...” And, that is on top of the two, five, ten, or twenty years that the physician continued to practice before the complaint was filed. There is, therefore, clear and good reason to support the Diversion system that intervenes in a physician’s practice in far less time that will ever be possible in the disciplinary system.

No, we do not want to go back to the Dark Ages of physician chemical dependency treatment. Our current system, flaws notwithstanding, allows physicians to get into treatment early in their disease. This is the point at which both maximum public benefit can be derived as well as maximum therapeutic benefit to the physician him or herself.

### **5. The California Physician Diversion Program is proud of its 74% success rate.**

The EM recommends further and more extensive outcome studies. The California Society of Addiction Medicine supports funding for further studies. Let’s find out just what makes this program work so well and let’s find up how we can improve it still further.

## **Initial Recommendations of the MBC Enforcement Monitor**

**Recommendation #56: “Based on the information contained in this and prior reports on the Diversion Program, the Medical Board must reevaluate whether the “diversion” concept is feasible, possible, and protective of the public.”**

Unfortunately, the EM’s failure to understand even the basic terminology of addiction medicine creates even further confusion in this recommendation. Clearly, actively chemically dependent physicians should not be practicing—and they are not at the present time.

**Recommendation #57: “If the Board determines that it is possible to implement the “diversion” concept consistent with the public interest (which is presently demanded by sections 2001.1, 2229, and 2340), the Board must then determine whether to house the diversion program within the Medical Board or contract it out to a private entity.”**

The EM’s suggestion that the Diversion Program be contracted to a private entity does carry some precedent. The California Board of Registered Nursing Diversion Program is managed by a contracting private entity. The BRN Diversion Program is modeled after the California Physician Diversion Program and is also nationally recognized for its quality and success.

Having served as a BRN Diversion Program Diversion Evaluation Committee Member and Chair for eight years, under three different contracting entities, I can tell you that the same sorts of “problems” exist in the privately managed Nurse Diversion Program as the EM has pointed out in the Physician Diversion Program. Issues of inadequate staffing, outdated computer programs, urine collection irregularities, drug screening interpretation, case-by-case management of human beings, and imprecise guidelines abound. Despite the EM’s strident complaints, we are not dealing with a perfect world.

I do know that there was a detailed report, prepared two years ago by the Medical Board’s executive staff, which provided a comprehensive review of the private alternatives. After review of those alternatives by the Liaison Committee to the MBC’s Diversion Program, it was recommended that private outsourcing was not a viable or preferred option.

Private management or public, these are problems for which we work toward solutions every day. Many of us who work in this field of medicine have dedicated our professional lives to helping to protect the public and at the same time to helping the healers to heal. We struggle to find better ways of doing what we do all the time. But, none-the-less, it may be some time before we create the perfect program.

**Recommendation #58: “If the Medical Board decides that “diversion” is feasible and that administration of the Diversion Program should remain within the Medical Board, the Division of Medical Quality must spearhead a comprehensive overhaul of the Diversion Program to correct longstanding deficiencies that limit the Program’s effectiveness both in terms of assisting participant recovery and in terms of protecting the public.”**

Adequate financing and staffing are necessary for the Diversion Program to operate efficiently. Many of the EM’s recommendations are based on a faulty understanding of the disease of addiction. While they may make sense to the uninformed, they have little real value.

For example, if we asked a civil engineer, trained in building bridges and skyscrapers but with no aeronautical experience to build an airplane, he might suggest that we build it with steel and concrete. Within the scope of his experience, this would be a wonderful idea. But, it really does not take an engineer to realize that a concrete and steel plane would never get off the ground. So it is with many of the EM’s recommendations. While they may make great sense to the uninformed, it is easy to see that most of them would never allow our program to get off the ground.

**Recommendation #59: “The Division of Medical Quality must reclaim its authority and jurisdiction over the Diversion Program by abolishing the Liaison Committee as it is currently structured.”**

Again, the need for clinical experts goes without saying. The Liaison Committee is an essential component of the longstanding success of the Diversion Program. In fact, one of the fatal flaws in the EM’s report is the inability to understand the need for experts who can bridge the interface between law and science, between public safety and clinical medicine, between data management and data interpretation. Unfortunately, despite the time, effort, and wasted funding that went into creating this report, the EM still failed to make these connections. One must wonder why apparently professional evaluators never got the point.

**Recommendation #60: “The Division of Medical Quality must determine whether Program participation should be an “entitlement” for any and all impaired CA physicians, or whether its participation should be capped at a maximum that can meaningfully be monitored by the staff allocated to the Diversion Program.”**

We must correct the funding and staffing insufficiencies. Capping public protection and physician treatment and monitoring are not acceptable alternatives. The risk, once again, is to shut down physician self-referral and peer referral. The beauty of the Physician Diversion Program is that it allows the physician community to police itself. The public interest would not be served by destroying this valuable process.

**Recommendation #61: “Regardless of whether Diversion Program participation is deemed an entitlement or is capped to accommodate staffing and protect the public, the Diversion Program’s budget should be earmarked and separated from other MBC program budgets.”**

The Diversion Program's budget should be earmarked and separated from other MBC program budgets.

**Recommendation #62: “DMQ must establish enforceable standards and consistent expectations of participants and Diversion Program staff through legislation or the rulemaking process, oversee a comprehensive revision of the Diversion Program’s policy manual, and ensure that Diversion Program management is integrated into overall MBC management.”**

Once again the EM has made destructive recommendations. As the data shows, the California Physician Diversion Program is one of the finest in the nation. The sky is not falling. The EM's distorted view of the science of addiction, and misunderstanding and misinterpretation of the Diversion Program functioning, has resulted in a series of recommendations that would be clearly not in the best interest of the public.

The Diversion Program Manual does not need to be completely rewritten or codified into law. This has not been done with other similar administrative manuals and should not be done in this case. Science and medicine are evolving disciplines and flexibility for the future may be desirable for the introduction and application of new information, systems, and techniques as they are developed.

**Recommendation #63: “DMQ should explore various methods of assessing the long-term effectiveness of the Diversion Program in assisting physicians in recovery from substance abuse.”**

The DMQ should explore various methods of assessing the long-term effectiveness of the Diversion Program in assisting physicians in recovering from chemical dependency.

**Recommendation #64: “The Medical Board should continue its efforts to replace and upgrade the Diversion Tracking System.”**

The Medical Board should continue its efforts to re-evaluate and upgrade all Diversion Program systems.

**Recommendation #65: “The Medical Board’s Diversion Program should undergo a full performance audit by the Bureau of State Audits every five years.”**

The Medical Board's Diversion Program should undergo regular re-evaluation of its performance. Again, the EM confuses confidentiality with secrecy. Emotionally charged verbiage such as this just weakens any possible usefulness the EM's report might otherwise bring to the table.

## **CONCLUSION**

The California Physician Diversion Program, administered by the Division of Medical Quality of the Medical Board of California, operates to protect the public and to support and monitor the recovery of physicians who have substance abuse or mental health disorders.

Over the past few years, the Diversion Program has been faced with staffing shortages and high turnover. The State budget crisis has resulted in hiring freezes. There has been no increase in funding to the Diversion Program, and yet the program has expanded. In addition, pressure was placed on the Program's staffing and resources in 2003 with the passage of your bill, SB 1950, requiring the Diversion Program to accept referrals from the Enforcement Division of physicians who had been diagnosed with mental illness. However, no additional funding was provided in order to increase Diversion Program staffing levels or to recruit the clinical experts to serve this new group of participants. The addition of this group of participants added greater responsibility to the already overburdened Program that continued to operate with a staffing and resource shortage.

The elimination of the Diversion Program would cause physicians who require help for drug, alcohol or mental health disorders to seek out private programs to monitor their recovery. Under this scenario, it is very likely most will choose not to pursue this path. The result: Many may resort to hiding their problem, and thus, put the public at great risk. The report suggests areas for improvement mainly in systems and quality control that can be resolved with proper staffing and resources. However, these are not indicators or evidence of overall Program failure resulting in public harm.

Additionally, a key factor in the implementation of the Diversion is proper staffing of the Program Manager position. It is seriously under-classified and requires the clinical perspective of a physician in this role. Under the current classification/salary, it would be difficult to find a qualified physician who would be willing to fill the Program Administrator position. At the same time, it would be very helpful to create a requirement that the Program Manager be a licensed professional with experience in treatment or monitoring of chemical dependency. Such training and experience would greatly improve the program management. Additional staff may be necessary to accommodate program growth, particularly to address the area of participants entering the program with mental health disorders.

There have been suggestions to privatize the Diversion Program, however, we have no information on private programs regarding: outcomes data (relapse, etc.), quality assurance practices, oversight and reporting practices. All this information, currently provided by the existing State Diversion Program has been useful in understanding the impact and outcomes of the program.

**The California Society of Addiction Medicine recommends the following:**

- **That the State Diversion Program be maintained** in order to ensure public safety and the continuation of a proper practice to compel physicians to seek help for alcohol and drug abuse problems. If continuation of the existing program requires increased licensing fees, CSAM would support such a proposal. Other options for funding in order to maintain this worthwhile program include: monthly participation fees paid by participants and/or contributions from malpractice carriers and hospitals. CSAM supports these measures if it would ensure the continuation and improvement of a State-managed Physician Diversion program.

- **That the State allocate appropriate resources** in order to properly staff the program so that issues of confidentiality and proper monitoring/reporting can be implemented according to proper procedure, to ensure the proper management of the Program. We believe that confidentiality is absolutely critical to attracting participants to the Program. Any threat that enforcement, the public, or other entities and individual will be informed that an individual is participating in Diversion will clearly discourage many physicians from making contact. This is surely a critical issue for any monitoring program. We believe that, on balance, confidentiality of the program coupled with strict conditions of participation and monitoring better protects the public by attracting participants rather than driving them further underground or giving them no place to go.
- **That proposals to privatize the Program should be considered within the context of maintaining a program that meets the needs of the California public and physicians** and ensures collection of outcomes data (relapse, etc.), maintains proper quality assurance practices, and provides oversight and necessary reporting practices.

Thank you for the opportunity to present our response to the Enforcement Monitor's report.

Sincerely,

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