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Chemically Dependent Physicians and Informed Consent Disclosure

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ABSTRACT. Developments in law, professional guidelines, and public attitudes support informed consent disclosure by physicians who have been treated for chemical dependency. This view is built on the apparent materiality of the risk of relapse to informed treatment decisions by patients. Several considerations undercut this position. The probability is remote that a patient will be injured by a recovering physician who suffers an undetected relapse while being properly monitored. Monitoring by impaired physicians programs provides a more sensitive and specific mechanism for detecting relapsed physicians. Moreover, compromise of the privacy and employment rights of recovering physicians by consent disclosure is not justified if programs provide rigorous monitoring that protects the welfare of patients. Finally, required consent disclosure will reduce referrals of chemically dependent physicians to impaired physicians programs, thereby increasing the danger to patients. Limiting demands for required consent disclosure necessitates effective operation of impaired physicians programs. *[Article copies available from The Haworth Document Delivery Service: 1-800-342-9678.]*

The health problems of physicians may affect the effectiveness and safety with which they practice medicine. Despite this fact, most physicians demur at the suggestion that they might be obligated to disclose these problems to patients. Yet legal and policy

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developments are building the case for this proposition. While the argument for disclosure was initially marshalled in regard to physicians with HIV infection, it involves moral and legal principles now being applied to physicians who have been chemically dependent.

The discussion begins with a review of these developments. In subsequent sections, it is argued that required informed consent disclosure by physicians recovering from chemical dependency unjustifiably compromises their rights and welfare and does not serve the public's interests. However, it will be suggested that these arguments are decisive only if there is rigorous professional monitoring of recovering physicians.

THE BURGEONING CASE FOR DISCLOSURE

The argument for disclosure of the physician's personal health problems to patients is anchored in informed consent doctrine. Ethical and legal standards of informed consent require physicians to disclose those risks which a patient would need to know in order to make a decision about the proposed treatment.[1] These are designated "material risks." According to the argument, when the personal health problems of the physician may endanger the welfare of the patient, this is a material risk about which a patient would want to know in reaching a decision about treatment. The materiality of this risk is reinforced by the fact that the patient can easily avoid it by switching to another physician.

For example, in the case of *Hidding* v. *Williams* the patient underwent a decompressive laminectomy that resulted in permanent bladder and bowel incontinence.[2] The negligence suit brought by the patient claimed that the surgeon had failed to disclose nerve damage as a risk of surgery and had failed to disclose his chronic alcohol abuse. The court ruled that because chronic alcohol abuse increases the potential for injury during surgery, it represents a material risk. Moreover, the court held that had this risk been disclosed, a reasonable patient would have chosen a different course of treatment. Therefore, it ruled that the surgeon's failure to disclose his chronic alcohol abuse violated informed consent law.

Soon after this case, the Superior Court of New Jersey ruled that a medical center may require physicians to disclose their HIV seropositivity to patients as part of informed consent to surgery.[3] The latter case involved Dr. William Behrenger, who practiced otolaryngology and plastic surgery. When the Princeton Medical Center learned that he was HIV-positive, his surgical privileges were suspended and the hospital trustees voted to require that HIV-positive surgeons use a special consent form revealing their serostatus to patients. Dr. Behrenger's estate brought an employment discrimination suit against the medical center. However, the court found that the risk of transmission of the infection and the risk of months or years of HIV testing for an accidentally exposed patient both met the condition of "materiality." It therefore concluded that the medical center policy was justified and outweighed the claim regarding employment discrimination.

In another case in which the author was retained as an expert witness by the defendant physician, the patient suffered a complication after surgery. The defendant was asked to perform emergency surgery when the problem was discovered the following day. Despite the intervention, the plaintiff later required an amputation. In the subsequent negligence suit, the plaintiff maintained that the consulting surgeon violated informed consent requirements by failing to disclose that he was recovering from a previously treated chemical dependency. Moreover, it was claimed that a different surgeon would have been selected if the patient had received the information. Although the claim was later dismissed, it is noteworthy that the plaintiff drew upon the *Hidding* case and policy developments related to HIV-infected physicians in constructing the suit.

These legal developments have been reinforced by policy guidelines of the American Medical Association and the Centers for Disease Control related to physicians with HIV infection. The 1991 guidelines of the CDC assert that HIV and HBV-infected physicians should not perform "exposure-prone procedures" unless they have been counseled by an expert review panel about the circumstances under which these procedures might be performed, which "would include notifying prospective patients" of their infection.[4] Similarly, the AMA maintains that "Physicians who are HIV positive have an ethical obligation not to engage in any professional activity which has an identifiable risk of transmission of the infection to the patient." Moreover, it asserts that "In cases of uncertainty about the

risks to patient health, the medical profession, as a matter of medical ethics, should err on the side of protecting patients." Therefore, "until the uncertainty about transmission is resolved . . . HIV infected physicians should abstain from performing invasive procedures which pose an identifiable risk of transmission or disclose their seropositive status."[5]

The latter policy statement suggests general conditions for informed consent disclosure that are easily applied to recovering physicians. First, the medical problem must be such that the performance of professional activities poses an "identifiable" risk of causing a harm of significant magnitude to the patient. Second, there must be uncertainty as to the probability of this harm actually occurring to patients. In the case of physicians who have been treated for chemical dependency, there are certainly identifiable risks. That is, we can imagine many errors, resulting in serious harm to patients, that a recovering physician might make after suffering an undetected relapse. Moreover, the probability that such events might occur is uncertain. Thus, the same reasoning can be used to assert that recovering physicians should make informed consent disclosure of their medical problem to patients, or refrain from engaging in professional activities involving these risks. In the case of the patient undergoing the amputation, the plaintiff's attorney drew this precise analogy to the AMA's policy on HIV-infected physicians.

These policy developments have mirrored public opinion. In a recent survey of public attitudes about HIV-infected physicians, 93% of the respondents indicated that HIV-infected physicians should be required to disclose their serostatus to patients. Moreover, 37% indicated that they would switch from an HIV-positive physician.[6] These same attitudes were reflected in the United States Senate in July, 1991 when it passed, on a vote of 81-18, a resolution which would have made it a crime for HIV-infected physicians to treat patients without disclosing their serostatus. Unfortunately, there are no similar surveys of public attitudes about physicians recovering from chemical dependency. Responses would undoubtedly reflect various factors that affect the risk assessments of lay persons–the newness of the risk, the ease of imagining its adverse consequences, and the extent of media attention.[7] However, the survey regarding HIV-infected physicians suggests that most persons want to know about the health problems of their physicians which may expose them to serious risk of harm.

These developments in law, professional guidelines and public opinion strongly support the proposition that physicians are sometimes obligated to disclose personal health problems to patients. They are directly applicable to physicians recovering from chemical dependency. Nevertheless, there are strong reasons for maintaining that recovering physicians should not be obligated to disclose their medical status to patients, provided that impaired physicians programs implement comprehensive services for identification, treatment and monitoring.

CLAIMS OF MATERIALITY

The claim that a physician's status as a recovering individual is material to a patient's decision about treatment merits critical scrutiny. Material risks are a subset of all relevant risks posed by a particular medical intervention. A risk is not *ipso facto* material merely because it is "identifiable." One strategy for determining the materiality of a risk is to ask whether the degree of risk is such that a reasonably prudent person might utilize the information to avoid the risk.

Degree of risk is determined by both the probability and magnitude of the harm that might occur. The magnitude of harm about which we are concerned is any serious injury to a patient caused by a recovering physician who suffers an undetected relapse, resulting in a critical error in judgment or technique. The likelihood that a patient, visiting a physician whose health status is unknown, might suffer harm of this sort can be specified by multiplying the probabilities of several events: the physician is a recovering person; he or she has suffered a relapse; the patient visits before the relapse is detected; and a serious medical error is made. Thus,

$$p(H) = p(\text{recovering}) \times p(\text{relapse}) \times p(\text{visits while undetected}) \times p(\text{serious error}),$$

where p(H) is the probability that a serious harm occurs to the

patient. In assigning a tentative value to p(H), we must estimate the value of each subsidiary probability. For the sake of the illustration, it is assumed that effective impaired physicians programs are operative.

The probability of the patient encountering a recovering physician is approximately 1/10, if we accept the high estimate that 10% are chemically dependent and assume that most will eventually undergo treatment.[8] Results from the most effective impaired physicians programs suggest a relapse rate after initial treatment for chemical dependency that is approximately 2/10.[9]

The other probabilities are more difficult to ascertain. Estimate of the risk of visiting a relapsed physician prior to detection requires some background assumptions. The first concerns the period of time during which a relapse will be undetected. In comprehensive impaired physicians programs, recovering physicians undergo rigorous monitoring. This includes random drug screening several times a month, frequent meetings with a physician monitor, and regular required attendance at Alcoholics Anonymous or similar therapy groups. Under these circumstances, it is likely that a relapse would be discovered within two weeks.[9] Another assumption concerns the median period of time between the resumption of practice by a recovering physician and the occurrence of relapse. Since no good data are available, we might stipulate for purposes of the illustration a median period of one year. If a recovering physician sees 20 patients per day, five days a week, for fifty weeks a year, then there are 5,000 patient visits per year. During the time in which the relapse is undetected, the physician would have 200 patient visits. Given these assumptions, the patient's likelihood of seeing the physician during the period after a relapse and prior to its detection would be 200/5,000, or 1/25.

Estimate of the probability that a relapsed physician will make an error in judgment or skill, resulting in serious harm to a patient, is also complex. Little data exists about the correlation between chemical dependency and workplace error.[10] We do know that many chemically dependent physicians are able to sustain their professional competence, even when other aspects of their lives have seriously deteriorated. On the other hand, a chemically impaired physician is clearly capable of a serious error in judgment or skill.

In order to complete the illustration, we might stipulate that the likelihood that a relapsed physician makes an error resulting in serious harm to a patient at 1/20 patient visits (one per day). This is almost certainly a high estimate because most clinical judgments are relatively routine and the competence of a recently relapsed physician is not likely to have seriously deteriorated. For purposes of the illustration, however, it is important that the risk of serious injury to patients not be underestimated. Thus, when a patient visits a physician whose health status is not known, the probability of suffering serious harm due to an undetected relapse of the physician's chemical dependency can be estimated as

$$p(H) = (.1) \times (.2) \times (.04) \times (.05), \text{ or approximately } 1/25{,}000.$$

In assessing the materiality of a risk of this magnitude and probability for a reasonably prudent person, we must ask whether this information would be used to avoid the risk. An indirect measure is provided by considering whether persons typically shun similar risks in daily life or in the medical context. The estimated risk posed by recovering physicians is equivalent to the risk of accidental death from taking a four-hour canoe ride while on vacation, letting one's child ride a bicycle to school two miles each way for four months, or flying 40,000 miles on commercial airlines.[11] We are four times more likely to die in an automobile accident in a given year. Moreover, the risk of death from taking contraceptive pills for two years is the same, while the risk of dying from anesthesia on the operating table is 2.5 times greater.[12,13] Yet none of these risks, whose probability is similar to or greater than the estimated risk of being seriously harmed by a relapsed physician, typically evokes avoidance behavior by average persons.

Of course, the estimated risk of being seriously harmed by a recovering physician who has suffered an undetected relapse is highly conjectural. However, the illustration allows some measure of comparison to other risks of harm that persons make little effort to avoid. This exercise at least raises doubts about whether a reasonably prudent person would consider the degree of risk sufficiently material to affect a decision about receiving treatment from a recovering physician.

However, some critics contend that the "reasonably prudent per-

son" standard is inappropriate for determining what information is material to the treatment decisions of patients. According to this view, informed consent disclosure is designed to allow patients to make decisions in terms of their own values and goals, not those of the "reasonably prudent person." In particular, patients have a right to determine what risks are pertinent to their decisions and what risks are worth taking. If the physician's health status poses risks to patients, they have a right to receive this information and decide its relevance for themselves. The remote probability of being harmed or their failure to avoid similar risks in daily life is not pertinent, if they choose to assign greater importance to the risks posed by recovering physicians.[14]

The problem with this approach is that it leads to absurd demands for personal information about the physician. The logic of this position would allow no time restrictions on required disclosure. Unless it could be proved that the risk of relapse falls to zero after a certain period of years, recovering physicians who have achieved ten, twenty or thirty years of relapse-free recovery would still be required to disclose their health status. Patients would also have a right to know their physician's sleep patterns, work habits and marital stresses, because each may affect health status and pose some risk of diminished quality of care. Indeed, legitimate inquiries would not be restricted to the physician's health status. Patients might also inquire about the racial attitudes of physicians of different ethnic background, or the social attitudes of physicians regarding patients of less fortunate economic status. These factors might also pose remote risks of less than optimal care that some patients might regard as relevant to treatment decisions.

These implications suggest that information about the physician's health status is not material simply because some patients would want to know it. The right of patients to make informed decisions must be limited by a standard of what disclosures are reasonable. Otherwise, the privacy rights of physicians get swallowed up by the whims of patients for any information they find pertinent. Moreover, physicians would be exposed to much broader legal liability for incomplete disclosure. Rather than being required to satisfy community practice or reasonable person standards of disclosure, they would be required to disclose any information

about their health status that individual patients might find pertinent to their risk assessments.

CONSENT DISCLOSURE AND PROFESSIONAL MONITORING

The claim that the status of a physician as a recovering individual should be disclosed hinges not just on the materiality of the risk, but also on the issue of what social mechanisms are best utilized to ensure that physicians do not harm their patients. While those who favor consent disclosure appeal to the right of patients to make their own decisions, they also contend that consent disclosure is a useful social mechanism for protecting patients from the dangers posed by relapsed physicians. This approach would radically revise the usual understanding of the function of informed consent.

As originally devised, the informed consent process was intended to enable patients to assess the nature of a medical intervention, as well as the benefits, risks and alternatives, in the light of their own values and goals. Allowing patients to make this assessment acknowledges their status as self-determining persons and provides a buffer against paternalistic decision making by physicians that might reflect very different values and goals. Factors extraneous to the nature and consequences of the treatment itself were not encompassed by this doctrine.[15]

Assessment of the competence of physicians to safely practice medicine has traditionally been assigned to professional regulatory and oversight groups. Licensing exams, specialty certification, peer review organizations and other professional mechanisms provide public assurance that physicians have sufficient knowledge and skill to not endanger the welfare of their patients. Members of the profession have the knowledge and experience to formulate appropriate standards of professional practice and to evaluate the performance of their colleagues. By contrast, patients are not usually knowledgeable enough to assess the technical competence of their physician. Assignment of this function to patients would have two adverse moral consequences. One is that the assessment by patients would be less effective than peer review in identifying all physicians whose performance fails to meet appropriate standards of

technical competence. Protection for the welfare of patients as a group would therefore be compromised. The other consequence is that some physicians would be unfairly judged incompetent by patients using informal criteria that do not identify only those physicians who might endanger their welfare.

The same considerations support professional oversight of recovering physicians. Comprehensive impaired physicians programs can provide the resources and expertise to specify aftercare requirements for and to closely monitor the progress of recovering physicians. By contrast, suppose that the AMA promulgated guidelines, like those for HIV-infected physicians, recommending that recovering physicians abstain from patient care or make informed disclosure of their health status to patients. Required disclosure would provide patients with little useful information about the ability of their physician to safely practice medicine, because few patients have the knowledge and skill to determine whether their physician has active chemical dependency. On one hand, it would not empower patients to identify and avoid all physicians who have relapsed, even if all patients switched to other practitioners. Some recovering physicians might violate the rule and fail to disclose their history of chemical dependency. Patients might also switch to physicians who have untreated chemical dependency, or who have relapsed but fail to disclose their health status. If patients chose not to switch, they might be treated by physicians who have, in fact, relapsed. On the other hand, patients would not be able to pick out only those physicians who have relapsed. Many physicians making satisfactory recovery and safely practicing medicine might have their livelihood unfairly compromised if patients engage in extensive switching. Thus, the primary obligation for assessing the capacity of recovering physicians to practice medicine safely should reside with state impaired physicians programs, provided that they have the resources and personnel to implement rigorous monitoring protocols.

Critics might respond that we should combine professional oversight with informed consent disclosure as complementary mechanisms for protecting the welfare of patients. This suggestion might be defensible if the protective consequences of using both mechanisms equaled the sum of their individual strengths. However, it will be suggested subsequently that required informed consent disclosure is likely to seriously undermine the effectiveness of impaired physicians programs in facilitating identification and treatment of chemically dependent physicians. Thus, required disclosure would dilute overall efforts to protect the welfare of patients as a group.

PRIVACY AND EMPLOYMENT RIGHTS OF PHYSICIANS

Physicians are sometimes patients. As such, they are due the same moral rights possessed by other patients, including the right to confidentiality of their medical record. Disclosure of this information to third parties is generally allowed only with the patient's permission. A policy requiring informed consent disclosure by recovering physicians would usurp this right generally accorded to patients.

However, the moral right to medical confidentiality is not absolute. Confidential medical information may be disclosed without the patient's permission under certain narrowly defined conditions. These conditions obtain when (a) medical information suggests that another person may be seriously harmed by the patient; (b) disclosure of the information will likely avert this harm; and (c) there is no alternative for preventing the harm less violative of the patient's right to confidentiality.[16] In order to justify compromising the medical confidentiality of recovering physicians, proponents of required informed consent disclosure must show that these conditions are satisfied. That is, the medical status of recovering physicians must pose a substantial threat of harm to patients. Required disclosure to patients must be likely to avert this harm. In addition, there must be no alternative policy option that will both protect patients from harm and preserve the medical confidentiality of recovering physicians.

Condition (b) might be met by a required disclosure policy, if patients frequently choose to avoid the danger by switching to other physicians. However, conditions (a) and (c) are not satisfied. Given the exceedingly low probability that a patient will be seriously harmed by a recovering physician who relapses while being properly monitored, it is difficult to argue that recovering physicians pose a substantial threat. More importantly, there is a clear alternative to

informed consent disclosure that is less violative of the right of recovering physicians to medical confidentiality and more effective in protecting the welfare of patients. This alternative is rigorous monitoring of recovering physicians by state impaired physicians programs, using random drug screening, assigned individual monitors, and mandatory participation in group therapy. Thus, the conditions for usurping the physician's right to confidentiality are not met.

Required informed consent disclosure would, for similar reasons, violate the moral right of recovering physicians to gainful employment. Recent developments in employment discrimination law suggest narrow conditions under which persons may be fairly denied employment due to handicapping conditions. Drawing on the decision of the Supreme Court in School Board of Nassau County v. Arline,[17] the Americans with Disabilities Act (ADA) specifies that terminating the employment of a person with a disability is nondiscriminatory if that person poses "a direct threat to the health or safety of other individuals in the workplace" and such risk cannot be eliminated through some "reasonable accommodation" of the disabled person.[18]

It is unlikely that the ADA would apply to required informed consent disclosure by recovering physicians. Required disclosure is not necessarily tantamount to denial of employment. Whether it infringes on the opportunity for gainful employment by recovering physicians depends on the actual percentage of patients who would switch to other physicians. Moreover, many physicians are not employees and the provisions of the ADA would not apply to them.

However, it is the spirit of the employment discrimination law on which I want to focus here, beacuse it suggests two moral rules that must be satisfied if an individual's right to gainful employment is not to be unfairly compromised. First, the person's condition must constitute a "significant risk to the safety of others." For example, in the legislative history of the ADA, it is clear that a "speculative or remote" or a "merely elevated risk of injury" would not be significant. Moreover, a "case-by-case" assessment of the risk posed by a worker is deemed necessary. The evaluation of risk "must be based on the behavior of the particular disabled person, not merely on generalizations about the disability."[19] As suggested above, the probability is remote that a patient will be seriously

harmed by a recovering physician who, while being properly monitored, suffers a relapse of his or her chemical dependency. In addition, required informed consent disclosure reflects a generalization about the potential danger of recovering physicians that is less individualized than professional monitoring of the safety with which each recovering physician is able to continue practice.

Second, the ADA suggests that a person's right to be gainfully employed is unfairly constrained by restrictions that are more severe than other "reasonable accommodations." This rule is an instance of the general moral requirement that, if a basic right of a person is to be restricted in order to prevent harm to others, then the restriction must not be more severe than necessary to accomplish the intended goal. In the case of recovering physicians, required informed consent disclosure would impair their right to gainful employment to the extent that patients decided to switch physicians. By contrast, protection of patients might be secured by careful monitoring of recovering physicians by state impaired physicians programs. This alternative would also protect the employment opportunities of physicians so long as they maintain their recovery. Thus, rigorous professional monitoring of recovering physicians would constitute a "reasonable accommodation" of their medical condition that is less violative of their right to be gainfully employed.

The upshot is that insufficient moral grounds exist for violating the privacy and employment rights of recovering physicians through a policy of required informed consent disclosure. If recovering physicians are stringently monitored, the danger that potential relapse poses to patients does not reach the threshold of significance sufficient to justify usurpation of their moral rights. More importantly, even if the danger is considered significant, there is the alternative of effective professional monitoring. This alternative mitigates the potential danger to patients, while protecting the privacy and employment rights of recovering physicians.

PROTECTING THE WELFARE OF PATIENTS AS A GROUP

Impaired physicians programs protect the welfare of patients as a group by facilitating the identification, treatment and oversight of

chemically dependent physicians. They encourage identification by providing a treatment resource physicians may contact when they suspect that a colleague is chemically dependent. They facilitate treatment by utilizing physicians skilled in investigation, intervention and diagnostic assessment of addicted physicians. Finally, effective impaired physicians programs possess the authority and resources to implement rigorous monitoring protocols to insure that physicians are maintaining recovery. These features of comprehensive impaired physicians programs significantly reduce the dangers to the welfare of patients posed by chemically dependent physicians.

Prior to the development of impaired physicians programs, there was a professional conspiracy of silence regarding the problem of chemically dependent physicians. Except for addicted physicians who egregiously violated norms of professional competence, few came to the attention of professional licensing boards. An important reason for the lack of intraprofessional self-policing was the momentous consequences of reporting a chemically dependent colleague. With no treatment option available, identification might result in professional disciplinary action, including revocation of the legal privilege of practicing medicine. Few colleagues who suspected a physician's chemical dependency were willing to initiate proceedings that might lead to the termination of his or her medical career.

With the expansion of impaired physicians programs, the perceived consequences of identifying an impaired colleague are being gradually altered. First, evaluation and treatment of the reported physician are now provided confidentially through these programs. Second, physicians treated for chemical dependency have the opportunity to resume their medical careers if successfully treated. Disciplinary proceedings by state licensing boards occur only if chemically dependent physicians fail to accept treatment recommendations or maintain recovery. The opportunity to resume their medical careers becomes dependent on their own commitment to the work of sobriety. Thus, physicians who report colleagues suspected of being chemically dependent are not initiating disciplinary proceedings with seriously adverse professional consequences. Rather, they are facilitating a confidential treatment process that may result in

recovery of personal health and resumption of professional practice for the chemically dependent physician.

Required informed consent disclosure by recovering physicians would seriously undermine these new incentives for reporting physicians suspected of being chemically dependent. Required disclosure assures that the medical condition of recovering physicians will become widely known in their community. Furthermore, required informed consent disclosure means that the practice opportunities of recovering physicians may be severely impaired by patients' decisions to switch to other physicians. Physicians who contemplate reporting a colleague to the impaired physicians program will know that these devastating consequences await chemically dependent physicians, even if they undergo treatment and achieve long-term remission of their disease. Thus, many physicians may be unwilling to seek intervention by impaired physicians programs.

Indeed, the disincentives to report colleagues are more severe under a required disclosure policy than prior to the inception of impaired physicians programs. In the past, reporting addicted physicians to licensing boards resulted in revocation of medical licensure or lesser practice restrictions only in the most extreme cases of professional incompetence. However, under a legal policy of required informed consent disclosure, serious adverse consequences will befall all recovering physicians. Even if they have willingly entered treatment and achieved a strong recovery, all will be compelled to disclose information that will be widely disseminated in the community and will impair their ability to retain a satisfactory panel of patients. The conspiracy of professional silence–typical of the period prior to the institution of impaired physicians programs–will likely reappear.

This loss of protection for the welfare of patients as a group, deriving from the decreased effectiveness of impaired physicians programs, must be balanced against the gain in self-protection for patients resulting from required informed consent disclosure. However, as argued earlier, there is little protection for patients to be gained from required disclosure. Provided that recovering physicians are being properly monitored by an impaired physicians program, this assessment of their ability to practice medicine safely is likely to be far more sensitive and specific than the evaluation by

individual patients. The only advantage of informed consent disclosure is that the patient might choose to switch to another practitioner in a case where the recovering physician has suffered an undetected relapse. This minimal gain for the protection of patients resulting from informed consent disclosure is purchased at the cost of substantially diminishing the likelihood that other physicians will report their chemically dependent colleagues to impaired physicians programs.

Thus, required informed consent disclosure would undermine the ability of impaired physicians programs to protect the welfare of patients as a group, without producing offsetting benefits for patient self-protection.

THE ROLE OF IMPAIRED PHYSICIANS PROGRAMS

The public policy grounds for rejecting required informed consent disclosure by recovering physicians depend in several crucial ways on the effective operation of impaired physicians programs. First, when recovering physicians are properly monitored, the risk of undetected relapse is sufficiently marginal to minimize the materiality of this information for patient decision making. Moreover, rigorous monitoring by impaired physicians programs provides a more sensitive and specific mechanism than informed consent for determining whether recovering physicians are able to safely practice medicine. Second, the moral rights of recovering physicians to the protection of medical confidentiality and the opportunity for gainful employment cannot be justifiably overridden by required informed consent disclosure if an effective alternative exists for protecting the welfare of patients. This alternative can be provided by the role of impaired physicians programs in monitoring recovering physicians. Finally, the fact that required informed consent disclosure will reduce the willingness of colleagues to report chemically dependent physicians undermines the protection of patients as a group only if impaired physicians programs already operate effectively in facilitating identification and treatment of chemically dependent physicians.

Unfortunately, definitive evidence regarding the performance of

impaired physicians programs is not available. Useful data would include the percentage of practicing physicians identified as chemically dependent, the portion who relapse after treatment, the mean time to relapse, and the average period between relapse and discovery through the monitoring process. Anecdotal information suggests that some state impaired physicians programs operate very effectively according to these parameters, while others exhibit obvious shortcomings. Comprehensive data that allows comparative assessment of individual state programs is necessary for establishing a sound judgment of their operational strengths and weaknesses.

Because the effectiveness of impaired physicians programs undergirds the argument against required informed consent disclosure, any inadequacies in their operation enhances the legitimacy of demands for disclosure by recovering physicians. Establishment of this latter approach as public policy would have deleterious consequences for the welfare of patients and the rights of recovering physicians. Thus, avoiding these unfortunate developments requires strong public and professional support for improving the critical role of impaired physicians programs.

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Comparison of DSM-III-R Symptoms for Alcohol Dependence Between Patient Self-Report and Clinician Interview or the Structured Clinical Interview for DSM-III-R

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ABSTRACT. This study sought to determine which Diagnostic and Statistical Manual of Mental Disorders, Third Edition, Revised (DSM-III-R), symptoms of alcohol dependence were most sensitive to under-reporting by 78 inpatients from alcohol treatment programs. We hypothesized that patients would be more reluctant to report social/behavioral symptoms (lost time, hazardous behavior or major role interference, and reduced activities) than psychological or physiological symptoms. Patient endorsement of symptoms on a self-administered diagnostic questionnaire was compared with parallel items on the Structured Clinical Interview for DSM-III-R (SCID) and clinician interview. Bias and Prevalence Adjusted Kappas for

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