

## THE IMPAIRED PHYSICIAN: WORKPLACE DRUG TESTING OF PHYSICIANS

by Daniel M. Avery, MD

**ABSTRACT:** Drug testing deters drug taking behavior and protects society from its adverse effects both direct and indirect.

As a young boy I regularly accompanied my uncle to the large railroad yard where he was foreman, and I remember one occasion when he took two cases of beer to a crew which had worked unusually hard. The crewmen stopped work, drank the beer and returned to work.

As a teen-ager I worked in a men's clothing store. The owner had several bottles of bourbon stashed about from which he drank periodically throughout the day, frequently sharing a drink with his "special" customers when they made a purchase.

Later I worked in a medical laboratory during college. A couple of the techs would make a punch spiked with reagent grade ethanol on holidays and most employees would imbibe during the lunchtime party. Some would become intoxicated but after the party everyone returned to work including medical technicians, supervisors, managers and physicians.

Also during college I worked nights in a funeral home where the embalmers regularly drank alcohol while preparing bodies for burial. Several claimed it improved the quality of their work.

During medical school I remember a neuropathologist who regularly drank alcohol late in the afternoon before going home. Occasionally he invited his medical students to join him in his office for a drink.

During my residency an attending stormed in one Friday afternoon and ordered all of us to meet in his office immediately. Fearing the worst we stopped work and went into his office where he shut the door. He then opened a large briefcase full of iced beer and thanked us for a job well-done that week. Everyone shared the beer.

(CONTINUED ON PAGE 9)

HAPPY NEW  
serve as

THE PRESIDENTIAL BOX

Dan Avery, President

YEAR! I am pleased to  
President of the

## THE MEDICOLEGAL OB/GYN NEWSLETTER VI.1, JANUARY 1998

Society for a second term in our sixth anniversary year. We organized the Society of Forensic Obstetricians and Gynecologists in 1992 with ACOG officially recognizing us in 1993 and granting status as a Special Interest Group in 1994. Last year we changed our name to the American Society of Forensic Obstetricians and Gynecologists.

I greatly appreciate the hard work of our outgoing President, Dr. Ben Harer. Having such an influential College Fellow serve as our President has been a great asset to the Society.

The success of the Society is due to the efforts of Dr. Doug Daniel of Buckhannon, West Virginia. He served as our second President and currently is both Executive Director and Newsletter Editor. His untiring efforts have made the Society a reality. The increasing membership, expansion of the Newsletter to its present form and our current programs are the result of his hard work and dedication to the Society. I suspect he has spent as much time with the Society and its Newsletter as he has with his own obstetrics and gynecology practice. It was his idea to create the Newsletter's Editorial Board.

Addressing the medicolegal aspects of obstetric and gynecology practice was the basis for founding the Society, and education about medical malpractice and prevention of litigation remains fundamentally important. Dr. Sidney Wilchins initiated the idea of review of expert witness testimony by a three-person review panel in each ACOG District and Dr. Daniel contributed the ideas of medical expert witness certification, our Impaired Physician Program, and provision of AA and Caduceus Meetings at the ACM each year. We have many more great ideas for 1998.

The Society will hold its yearly meeting along with the other Special Interest Groups at this Spring's ACM in New Orleans. I hope to see all the Society's members there as well as any other interested physicians who attend.

During 1998 we must increase our membership in order for the Society to grow plus we need active members to participate, write items for the Newsletter and pay the meager dues. Doug cannot do all the work, so we need your help. Those interested should contact either of the following:

William D. Daniel, MD, FACOG  
Post Office Box 536  
Buckhannon, West Virginia 26201-0536

or

Daniel M. Avery, MD, FACOG  
Post Office Box 1230  
Winfield, Alabama 35594

## THE WITNESS BOX

Doug Daniel, Editor

*"Change happens when the status quo becomes more painful than making a change."*

Richard L. Scott, Chairman and CEO,  
Columbia/HCA Healthcare Corporation.

In case you haven't noticed, there have been some rather dramatic changes in the Newsletter. Hopefully for the better but perhaps not. First of all your last issue and this one were unusually late due to the changeover to a new computer system including CPU, printer and desktop publishing software. If you've never made such a change, don't. It was my worst nightmare from Hell. Nothing seemed to work properly, and I didn't know how to use those that would. But now we're back to the future, boldly going where no man has gone before, blazing a trail into the 21st Century, etc. The Newsletter will have a somewhat primitive look, similar to the January 1996 issue, until I finish the tutorial on the new software. Perhaps by the next issue.

On a related note, I need input on which format you the readers prefer, i.e. 8 1/2" X 11" like this issue or 7" X 8 1/2" like the July 1997 issue. I've had recommendations for both but the important question is which you prefer. There will be some exceptions in the JULY 1998 issue due to the demands of a planned special project, but otherwise it's your choice.

Oh by the way, we now have a Toll Free telephone number available on Fridays only for voice communication, no fax. The idea is to make it easier for you to communicate with the office. I know, snail mail is a real drag and who has time for it anyway. But now you can ring us up; no fuss, no bother, no charge. The number is 1-800-304-4728. Write it down because it's not on our letterhead and its not in Toll Free Information. It's easy to remember though because you just dial 1-800 and then our letterhead number, 304-472-8594.

So far our dues-paying membership has decreased by 29, a 43% drop from December 1997. This is in spite of picking up 18 new members in 1997. Perhaps there will be some renewals later this month, but it is more important than ever that we beat the drum and recruit new members aggressively.

Plans for the Society's meeting at the New Orleans ACM are still incomplete, mostly due to our planning further ahead than the College regarding Special Interest Group meetings. But right now it looks like we will be having open and closed AA meetings, Caduceus meetings, and a meeting of the membership. Ben Harer has agreed to address the membership regarding the Society's role within the College and within the specialty. I can promise you it will be a dynamite presentation. Ben is not one to pull his punches and although you may not always like what he says or agree with it, he tends to be right-on and even a little bit ahead of the rest of us in his thinking. The exact location of the membership meeting should be available in the April Newsletter but the College has us in the Preliminary Program as an ancillary meeting Sunday evening, 10 May, 5:30 PM to 7:30 PM. You can even look it up! It's on page 75!

Dan Avery's installment this month on impaired physicians addresses the confusing controversy surrounding and obscuring random drug screening. Before you get all riled up and start flying around the room, stop to objectively think about it for a moment. Yes, random drug screening of all healthcare professionals is a theoretical invasion of privacy, but the constitutional issues have been extensively addressed and resolved in regard to testing of commercial airline pilots and other transportation workers. In case you still oppose the concept after reading Dan's

article, ask yourself whether you're afraid of failing the screen. If that's the problem, give me a call. You're probably chemically impaired.

This issue's Book Box has nothing whatsoever to do with forensics or obstetricians or gynecologists. It reviews an excellent book on medical and Civil War history I happened on in the National Park Service Gift Shop at Gettysburg National Battlefield. History buffs, Civil War aficionados and true Sons of the South will find it well worth their time to find and read it.

There's a new feature debuting this issue, The Litter Box. The idea, for those of you non-cat owners, is to provide a convenient receptacle for mental droppings which are interesting but unrelated to anything else. Let me know how you like it.

Included in the back of this issue are copies of two articles from the November/December 1997 issue of *Physician's Practice Digest*, published by Magazine Works, Incorporated, for Johns Hopkins Medicine. Ken Heland at ACOG's Department of Professional Liability has been saying for over a year that there would eventually be a backlash to the liability protection provided managed care companies under the federal ERISA laws. Seems like Texas has started the ball rolling. Hopefully the other states will get on board as soon as possible or maybe the Feds will rescind their allegedly unintended protection. We'll see. In the meantime, these articles were reprinted with the permission of *Physician's Practice Digest*, a bimonthly practice management magazine published in sixteen states. You may contact the magazine via snail-mail at

Physician's Practice Digest  
100 South Charles Street  
13th Floor  
Baltimore, Maryland 21201.

E-mail address is [ppdinfo@aol.com](mailto:ppdinfo@aol.com) and they have a Web site at [www.ppdnet.com](http://www.ppdnet.com). If you ask real nice and mention that you're an ASFOG member, they might put you on their complimentary mailing list. Then again they might not. But like Dad used to say, "It never hurts to ask."

The Society got some very good coverage in the December 1997 issue of *OBG Management* on page 21. It's generated about 25 requests for information packets and four new members so far. If you missed it, send me a SASE and you'll get a copy.

Several of you were interested in receiving *The Forum*, published by the North Carolina Board of Medicine. I lost all the names except Tom Gruszynski's. Please either call or write if yours was one of those names I lost.

As usual we encourage submission of letters to the editor and articles for publication consideration, letters subject to editing only for space requirements with articles typewritten and double-spaced. Free reprints of individual past Newsletter articles are available to members at no cost upon submission of a SASE, back issues for \$10.00 each or \$20.00 per volume of four issues.

SEE YOU IN THE QUEEN CITY!

## THE BOOK BOX

Doug Daniel, Editor

**JOHNNY REB, MD**

Doctors in Gray: The Confederate Medical Service  
 By H. H. Cunningham  
 Illustrated. 339 Pages. Baton Rouge and London:  
 Louisiana University Press.  
 Paper, \$14.95

Most of the Society's membership either hails from or lives north of Mr. Mason and Mr. Dixon's famous line. To the best of my knowledge none are currently practicing military medicine, though most in my age group probably did at some time in the past, perhaps only briefly and unwillingly. These will be interested in Professor Cunningham's book purely as it relates to the history of medical and surgical practice in the middle-to-late 19th century. There is the occasional mention of gallant men in blue and their practice of medicine, but events and conditions are primarily viewed from a southern exposure. If on the other hand you are a true Son of the South and consider it an abomination to eat grits dressed with anything other than butter, salt and/or pepper, an in depth study of your medical heritage awaits. Either way this is an educational and obviously well-researched historical work on 19th century medicine, specifically focusing on the War of Northern Aggression.

Cunningham was teaching history at Elon College in Elon, North Carolina, in 1958 when his book was published. A second edition was printed in 1960 and reprinted in 1993. Statistics abound, such as the Confederate States of America (CSA) mobilizing over 600,000 soldiers and sailors, including almost 3000 medical officers plus contract physicians, each experiencing illness and wounds an average of six times during the War. Cunningham says that of these, probably 200,000 were killed in action or died secondary to wounds or disease.

All this makes the horror of our modern Vietnam pale in comparison. For instance, the First Tennessee Regiment fielded about 3200 men during the War, only 65 of whom survived to see the Appomattox surrender. According to Cunningham only one quarter of the Confederate military deaths were attributable to the results of battle, about 50,000. The remaining 150,000 died of disease. On the Union side, 110,070 died in or as a result of battle while 224,586 died of disease. Many on both sides died in overcrowded prisoner of war camps.

A recent interview with Mr. Alan Hawk, Collections Manager, Historical Collections, National Museum of Health and Medicine, revealed that 60-90% of deaths among Federal and Confederate forces during the War were due to infectious diseases such as typhus, typhoid, malaria, yellow fever, cholera, influenza, measles, mumps, chicken pox, tetanus, etc. The current official US Government statistics are as follows:

**CIVIL WAR COMBATANT DEATHS**

	Confederate (Approximate)	Federal	
		White	Black
KIA	94,000	106,796	3,279
Homicide	Unknown	1,205	58
Disease	164,000	195,374	29,212
<b>TOTALS</b>	<b>258,000</b>	<b>303,375</b>	<b>32,544</b>

COMBINED TOTAL = 594,000 (Approximate)

**KILLED TO WOUNDED RATIO**

CIVIL WAR	50%
WORLD WAR II	33%
VIETNAM	17%.

The remarkable improvements in killed-to-wounded ratios are obvious when you think about it. World War II had battlefield supplies of human plasma and

antibiotics with banked blood at the field hospital, usually only a short ambulance ride from the front. There were also Medics and Corpsmen immediately available who were scientifically, if not technically, more proficient than the medical officers of the 1860's. Vietnam saw improved antibiotics and even better trained paramedical personnel immediately available in addition to much improved techniques in surgical treatment of battle wounds and intensive care life support. But the biggest advance by far was immediate aeromedical evacuation from the battlefield to MASH units, hospital ships and trauma centers.

The deadliest enemy for both Yankee and Rebel was disease. Green recruits quickly learned to become effective soldiers and stay alive on the battlefield, but they could never conquer the chronic and acute illnesses endemic to the soldier's daily life. Measles, malaria and typhoid were epidemic. Lister had yet to preach the virtues of carbolic acid and antiseptics.

Major contributors to the flood of communicable diseases were poor personal hygiene, lack of vaccinations, careless disposal of animal slaughter and food preparation waste, uncontrolled pests such as insects and vermin, exposure (even frostbite), malnutrition (occasionally starvation) and recruits conscripted from isolated rural areas with no prior exposure to common illnesses. The biggest problem by far was failure to construct adequate field sanitation facilities, and when constructed the troops wouldn't use them. Some soldiers wrote of waking at dawn to find they had spent the night sleeping in prior troops' excrement. Considering the above plus the carnage of the battleground, it is not difficult to understand how drinking water from streams and wells was constantly contaminated.

At the beginning of the War most of the CSA's medical officers had been trained in northern medical schools and resigned commissions in the United States Army or Navy Medical Corps to join the Confederate forces, just as most of her General Staff had been West Pointers or graduates of Annapolis and career officers in the United States Army or Navy. There were only 21 southern medical colleges of limited enrollment in 1861 but they compared favorably in every respect with their northern sisters. All but one were forced to close soon after Fort Sumter. The Medical College of Virginia remained open throughout the War and even shortened its sessions in order to graduate two classes a year, producing about 400 physicians for the South during these four years.

Stories have abounded about the Confederacy's shortage of medical supplies and drugs for civilian and military use, but many drugs and remedies were compounded from available plants when unable to be imported from European suppliers. Chloroform was the preferred anesthetic for both sides, and the Confederate Medical Department insured that adequate supplies were imported past blockades and kept in inventory. Most shortages were due to failures in the distribution system.

During Vietnam the major advance in infantry weaponry was the Soviet AK-47 or Kalashnikov rifle and Colt's AR-15. Both used rounds designed to deliver a high degree of torque upon striking the target, and they were capable of unbelievably large and extensive volumes of tissue destruction. Battlefield wounds took a giant leap forward.

The same thing happened during the Civil War. Prior to the 1860's muskets with ball and powder were in use with the cap and ball rifle being fairly new. The minie ball, a larger and heavier conical lead projectile, was increasingly issued while the War continued. Winchester repeating rifles came into use after the War. As with the AK-47, gunshot wounds suddenly became more traumatic and extensive. One strategy for riflemen was to aim for the enemy's feet or legs. A chest, head or abdominal wound would usually be quickly fatal, the victim quickly buried, and his replacement quickly put into action. Extremity wounds on the other hand required commitment of much more extensive human and materiel resources over a prolonged treatment and convalescent period, thereby depleting the enemy's medical stores and his finances.

There's some interesting sidelights here, too. In 1835 the Dean and faculty of my alma mater, the Medical College of Georgia, recognized the need for a national medical organization dedicated to improving medical education and establishing

minimum standards of practice, but their efforts to establish such a professional society failed. The American Medical Association was finally founded in 1847 by the efforts of the New York State Medical Society, and southerners played a vital role in its administration with the above mentioned Dean, Paul Fitzsimmons Eve, serving as president 1857-1858. Incidentally, he is also credited with being the first American surgeon to successfully perform a hysterectomy. And just as interesting, Bernard Baruch's father, Simon, joined the CSA Medical Corps fresh out of medical school.

The appendix is packed with statistical information gleaned from surviving CSA records, but the most interesting to me was the list of Confederate hospitals. If you live in the South you'll recognize several of the locations as close by, in both large cities and small towns, and oftentimes local historians can direct you to the sites.

You'll probably have to get your bookseller to order a copy unless you're near a Civil War National Parks Service gift shop such as Gettysburg. It was a great read for me, and I hope it will be for you also.

## THE LITTER BOX

Doug Daniel, Editor

From *USAA Magazine*, November/December 1997

"Statistically speaking, talking on a cellular phone behind the wheel is about as risky as driving while nearly legally drunk, according to a Canadian study reported in the *New England Journal of Medicine*. University of Toronto researchers found that driver use of cell phones quadrupled the risk of a collision...The study involved 5,980 Canadian drivers who had been in collisions resulting in substantial property damage but no personal injury...It may be that cell phones merely decrease a driver's ability to avoid a collision caused by someone else...Brazil, Israel, Switzerland and two Australian states have passed laws against using hand-held phones while driving."

"Alcohol-impaired individuals are at risk in many situations, according to the Coalition for Consumer Health and Safety...36% of pedestrians over the age of 14 who were killed in accidents during 1987-1991 tested positive for alcohol. And as many as 60% of fatalities in boating accidents, including persons who fall overboard, had been drinking...Some 28% of high school seniors (according to a 1995 study by the National Institute on Drug Abuse) in 1994 said they had consumed five or more drinks at one sitting during the preceding two weeks, and one-third did not see the consumption of four or five alcoholic drinks nearly every day as entailing 'great risk'."

From *Your Healthy Practice*, Winter 1998

"If confronted by law-enforcement officers with a search warrant knocking at the door of your medical practice, will your staff know how to respond?"

As a preventive measure, you should have a policy for staff to follow if this occurs at your practice. A policy statement and detailed procedures will allow staff to act in a responsible and professional manner.

The following suggestions were given by legal counsel at a recent corporate compliance program and could serve as the basis for your policy development.

- Establish one staff member who will take charge of the situation. This might be the office manager, practice manager or executive director.
- Send employees home or off the premises.
- Get a copy of the search warrant. It may contain important information for your attorney.
- Get the names of all agents and personnel involved in the search.
- Get an inventory of all records taken and, if possible, get copies of records before they are seized.
- Videotape the search, if possible.
- Send a letter to all employees after the search detailing their legal rights as employees. (You should seek legal counsel on the appropriate wording of the letter.)

- Write notes immediately after the search detailing everything that happened, including who was present and what occurred.

You should review the preceding suggestions with your attorney to determine unique areas specific to your individual practice."

Don't forget to explain to the patients present in your office, preferably personally, that you will be unable to see them for their appointment while at the same time expediting their departure. Also have a trusted staff member start phoning to cancel later appointments and station another staff member outside the office to intercept any patients you are unable to contact.

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**THE IMPAIRED PHYSICIAN, Continued from page 1**

Over many years of private practice there have been numerous hospital Christmas parties at which alcoholic beverages have been served to and consumed by medical staff members, including those on call.

But the times they are a'changing. Alcohol and drug use are no longer acceptable in the workplace. The impact of mandatory and random employee drug testing is summarized in the introduction to Medical Review Officer Handbook by Shults and St. Clair:

"Drug testing has made this country a safer place to live. Drug testing has been effectively implemented by both private initiative and federal regulation to mitigate one of the inherent dangers of widespread drug abuse, that is, danger to public safety. Drug testing has been successful in detecting and removing individuals at risk, as well as serving as an effective deterrent. The growth of testing has been fueled by the fact that drug testing deters drug taking behavior. This deterrent effect has perhaps been drug testing's most important contribution to societal well-being. This deterrent effect is an immeasurable benefit that drug testing has yielded. ...Drug testing has a direct impact on reducing claims. ... Preemployment drug testing results...in a dramatically improved applicant pool which eventually results in a lower turnover rate and a good return on investment."<sup>1</sup>

Several years ago the University of Alabama at Birmingham (UAB) and University Hospital implemented employee drug testing, agreeing that the health and safety of employees and patients were of paramount importance, plus the hospital workplace would obviously be safer and far more effective without employee use/abuse of illegal street drugs, prescription controlled substances or alcohol. No one could argue that impaired hospital employees were not dangerous to themselves, their fellow workers and especially their patients.

Now UAB is committed to a drug-free workplace. As a condition of employment everyone must be free of illegal drugs, controlled substances and alcohol on the job. A policy and procedure has been developed for mandatory and random alcohol and drug testing of employees including preemployment screening and reasonable cause screening when employee behavior suggests impairment, failing job performance or inattention to safety.

The individual of concern is requested to submit samples for blood alcohol and urine drug testing when managers or supervisors have reasonable cause to believe that he is impaired while on the job. Refusal to submit the specimens results in termination. Approved procedure includes private confidential interview of the possibly impaired individual, testing of body fluid samples in a laboratory certified by the National Institute on Drug Abuse, and review of the results by a medical review officer plus implementation of treatment and rehabilitation when indicated.<sup>2</sup>

Rehabilitation of professionals valuable to society has become a priority over the past several years. For instance, at one time a single episode of alcohol use during flight status excluded a commercial pilot from the cockpit for the rest of his life. The Federal Aeronautics Administration (FAA) would permanently revoke his commercial license resulting in immediate unemployment. In 1979 the AirLine Pilots Association (ALPA), essentially a guild or union composed of professional commercial pilots, developed their Human Intervention and Motivation Study.<sup>3</sup> Known as the HIMS Program, it enabled impaired pilots to receive early intervention and treatment which usually saved their jobs and careers.

The FAA has an obvious interest in airline safety and ALPA has an obvious interest in member employment. In cooperation with the airline companies they have rehabilitated over 2600 impaired commercial pilots and returned them to flight status with a recidivism rate of only 10%.<sup>4</sup>

The FAA policy regarding alcohol use by flight crews is called the "Bottle-to-Throttle" Rule and prohibits consumption of alcohol for at least eight hours before entering the cockpit. All airline companies require at least twelve hours' abstinence from alcohol before entering the cockpit, and some require twenty-four.<sup>4</sup> Compliance is checked via random Breathalyzer® testing of 25% of aircrews upon check-in and reasonable cause screening.

Companies have the discretion of rehabilitation or termination for Blood Alcohol Concentrations (BACs) between 0.02% and 0.04%. The FAA enforces mandatory license revocation for BACs over 0.04% and has a zero tolerance rule for illegal street drug use. Most federal, state and foreign standards for automobile driver intoxication used to be BAC 0.10% or greater. In a trend initiated by Scandinavian countries, the definition of intoxication is steadily decreasing.

Flight status while taking legitimate prescription or over-the-counter medications is determined on a case-by-case basis by FAA flight surgeons. According to Dr. Donald Hudson, Air Medical Director of the ALPA, these same standards are in his opinion reasonable for all healthcare workers with responsibility for patient care and safety.<sup>4</sup>

So why not have workplace drug testing for all professionals responsible for the public's care and safety, including physicians? Who could reasonably oppose the above rules, regulations and policies used by UAB, FAA, ALPA and the airline companies being applied to all clinical and diagnostic physicians as well? Furthermore, don't forget that the same or similar restrictions already apply to commercial truckers, bus drivers, railway crews, subway crews and merchant mariners.

In Principles of Addiction Medicine Dr. Westley Clark discusses various types of drug testing. Employers regulated by government agencies routinely perform preemployment, periodic, postaccident, reasonable cause, random and return-to-duty drug testing.<sup>5</sup> All are easily adapted to physician testing. Routine preemployment BAC and urine drug testing may be utilized prior to hospitals or medical groups granting staff privileges to or employing any physician including postgraduate trainees, and is recognized as "application for privileges" drug testing.

Periodic and random BAC and urine drug screening may be performed at any time or upon renewal of medical staff privileges. Postaccident drug testing can be utilized after operating room catastrophes or in quality assurance evaluations of adverse patient care outcomes. Reasonable cause drug testing should be required at any time by the hospital administrator, department chair or credentials committee chair in instances of the following:

- Obvious impairment
- Inability to reach a physician on call
- Failure of a physician on call to respond
- Recurrent tardiness or absence
- Falling asleep at work, at the operating table or between surgical cases.

Return-to-duty testing is useful after treatment and rehabilitation when a previously chemically impaired physician re-enters practice. Those monitored by

Impaired Physician Programs or Physician's Recovery Networks are required to submit to mandatory periodic and random drug testing.

It really doesn't seem unreasonable to require physicians to abstain from beverage alcohol while on call and for at least twelve hours before assuming patient care responsibility. BACs between 0.02% and 0.04% while on call or on duty justify investigation by the credentials committee while BACs of 0.04% or more require intervention. Even use of mood altering substances properly and therapeutically prescribed by another physician can impair cognitive processes and performance, requiring temporary or permanent reduction or revocation of medical privileges.

Zero tolerance of physician use of illegal and recreational street or controlled drugs whether on call, on duty, on vacation or on his own time likewise seems logical. Patients are shocked when they learn that physicians can be users, abusers and addicts just like anyone else, but there is essentially no provision for routine monitoring to deter, detect and debar such behavior.

The goal of any drug screening program is prevention of substance use, abuse and addiction with their subsequent harm to the individual. Workplace screening additionally strives to protect the general public from risks and adverse consequences directly or indirectly attributable to the substance use, abuse and addiction of others. These goals cannot be overemphasized, and mandatory drug screening of those in other safety sensitive jobs requires that physicians voluntarily submit to the same. This position is highly controversial among physicians with many adamantly opposed, but it is universally endorsed by our patients.

Several years ago I remember a nonaddicted, nonalcoholic colleague meeting only token opposition when he proposed at a medical staff meeting that our hospital institute random drug and alcohol screening of its physicians. Institution of such a policy never happened and perhaps he was ahead of his time, but today I firmly believe our patients expect and demand treatment by unimpaired physicians.

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