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RANDOM DRUG TESTING OF PHYSICIANS: A QUESTION OF SAFETY

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Precis: In this paper, we examine the legal history and current state of mandatory random drug testing of physicians in the U.S. and explore the future prospects thereof. We discuss the extent of physician impairment and its associated costs, examine the opinions of major medical associations on physician drug testing, and discuss the arguments for and against the random drug testing of physicians.

Keywords: Drug testing, substance abuse, physician impairment

Introduction

The prospect of mandatory random drug testing of physicians in the U.S. has been the subject of active discussion for well over three decades.[1] To this day, however, such programs remain the exception rather than the rule.[2] In this paper, we examine the state of mandatory random drug testing of physicians in the U.S. and explore the future prospects thereof.

It was a 1986 Executive Order (*Drug-Free Federal Workplace*) of President Reagan that saw to it that physicians in the employ of the federal government were to be subjected to mandatory random drug testing.[3] This development was attributable to the edict that "the head of each Executive agency shall establish a program to test for the use of illegal drugs by employees in sensitive positions."[4] The aforementioned initiative was further expanded by the enactment of the Drug-Free Workplace Act of 1988 (DFWA) which required some federal contractors and all federal grantees to maintain drug-free workplaces as a precondition to receiving a federal grant or a contract.[5] Health care enterprises, many of which are federal grantees, were inevitably affected. It follows that the lion's share of the federal physician workforce that is required to submit to mandatory random drug testing is deployed by the U.S. Departments of Defense, Veterans Affairs, and Health and Human Services (HHS).

Mandatory random drug testing of physicians in the employ of private not-for-profit health care systems, in contrast, is limited to the Cleveland Clinic and UCHealth.[6] Note is also made of the special case of the Departments of Anesthesia at the Massachusetts General Hospital (MGH), the Cleveland Clinic, and Vanderbilt

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[1] *See generally* Susan Tamborini-Martin, Dominic O. Vachon & Kevin V. Hanley, *Substance Abuse in the Workplace: Creating a Responsible Policy*, HEALTH PROGRESS, Nov. 1988, at 30 (illustrating that the discussion surrounding drug testing of physicians has been around since at least the 1980s).
[2] Ethan Cumbler & Jean S. Kutner, *Random Drug Testing of Physicians: A Complex Issue Framed in 7 Questions*, J. HOSP. MED., Jan. 2019, at 56, 57.
[3] Exec. Order No. 12,564, 3 C.F.R. 224 (1987).
[4] *Id.*
[5] *See* 41 U.S.C. §§ 1802-1803.
[6] Cumbler & Kutner, *supra* note 2.

University Medical Center wherein staff physicians and residents-in-training are the subject of ongoing random drug testing.[7]

It would thus appear that physicians who are not in the employ of the federal government are being held to a different standard than other safety-sensitive professionals who are obliged, by federal law, to submit to random drug testing. Examples include, but are not limited to, airline pilots, ship captains, train engineers, subway operators, truck drivers, and school bus drivers.

I. The Impaired Physician

The notion of the impaired physician, one well known to Sir William Osler and his 19th century contemporaries, was carefully delineated as early as 1892.[8] The prevalence of substance use disorders among U.S. physicians at the dawn of the 21st century was estimated at 6-8%.[9] The corresponding rate for alcohol use disorders was estimated at ≤14%.[10] Both incidence figures mirrored those noted for the population at large.[11] In contrast, the rate of use of prescription drugs (especially benzodiazepines and opiates) by physicians, was found to markedly exceed that of lay counterparts.[12] This latter differential is due, in all likelihood, to the ready access of physicians to controlled substances.[13] Family medicine practitioners, general internists, anesthesiologists, emergency medicine physicians, and psychiatrists, all professionals with ready access to controlled substances, are deemed especially vulnerable to the fallout of drug abuse.[14]

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[7] Michael G. Fitzsimons, Mark J. Rice & Keith Baker, *Drug Testing in Anesthesia: "Prevention and Protection" or "Major Risk for Minimal Gain"*, 132 J. ANESTHESIA & ANALGESIA 916, 916 (2021).
[8] Mark W. Millard, *Can Osler Teach Us About 21st-Century Medical Ethics?*, 24 BAYLOR UNIV. MED. CTR. PROC. 227, 232 (2011).
[9] Marie R. Baldisseri, *Impaired Healthcare Professional*, 35 CRITICAL CARE MED. S106, S108 (Supp. 2007).
[10] *Id.*
[11] *Id.*
[12] Patrick H. Hughes et al., *Prevalence of Substance Abuse Among U.S. Physicians*, 267 J. AM. MED. ASS'N 2333, 2334 (1992).
[13] Robert L. DuPont et al., *Setting the Standard for Recovery: Physicians' Health Programs*, 36 J. SUBSTANCE ABUSE TREATMENT 159, 166 (2009).
[14] *Id.* at 162.

The Drug Enforcement Administration (DEA) recognizes five classes of drugs that are frequently abused: narcotics, depressants, hallucinogens, stimulants, and anabolic steroids.[15] A major driver of drug diversion is opioid abuse, which in recent years has reached epidemic proportions.[16] Fentanyl, one of the most potent opioids and the most commonly diverted drug, constitutes a frequent cause of death due to overdosing.[17] Diversion of opioids in injectable and oral forms is commonly seen across all levels of health care organizations. Staff should be empowered to "stop, question and act."[18]

The recognition of the impaired physician is all too often compromised by the familiarity of medical professionals with the signs and symptoms of drug abuse.[19] It follows that physicians, unlike lay counterparts, are highly adept at concealing their addiction disorder for longer periods of time.[20] This reality is not without consequences. By the time an impaired physician seeks and/or receives therapy, the severity of his/her of affliction is likely to be more consequential than that of non-physician counterparts.[21] The recognition of the impaired physician is further complicated by the apparent reluctance of peers to report potentially compromised colleagues.[22] In one such survey, 17% of physicians reported direct personal knowledge of an impaired, or otherwise compromised colleague.[23] Most (67%) of the physicians in the know proceeded to

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[15] U.S. Drug Enf't Admin., *Drugs of Abuse, A DEA Resource Guide* 45 (2020), https://www.dea.gov/sites/default/files/2020-04/Drugs%20of%20Abuse%202020-Web%20Version-508%20compliant-4-24-20_0.pdf.

[16] A. Simon Pickard & Todd A. Lee, *Combating the Opioid Epidemic in the United States*, DRUGS CONTEXT, Dec. 15, 2021, at 1, 1 (2021), https://doi.org/10.7573/dic.2021-10-7.

[17] Nora D. Volkow, *The Epidemic of Fentanyl Misuse and Overdoses: Challenges and Strategies*, 20 WORLD PSYCHIATRY 195, 195 (2021).

[18] The Joint Commission, *Drug Diversion and Impaired Health Care Workers*, QUICK SAFETY, Apr. 2019, at 1, 1.

[19] DuPont et al., *supra* note 13, at 166.

[20] *Id.*

[21] *Id.*

[22] Catherine M. DesRoches et al., *Physicians' Perceptions, Preparedness for Reporting, and Experiences Related to Impaired and Incompetent Colleagues*, 304 J. AM. MED. ASS'N 187, 188 (2010).

[23] *Id.* at 191.

report the presumptively affected colleague to the relevant authority.[24] However, about a third of the physicians surveyed took no action. The most frequent reason given for failing to take action was the presumption that "someone else was taking care of the problem."[25] Other physicians who refrained from reporting an impaired colleague were swayed by the conviction that "nothing would happen as a result of the report."[26] Yet other physicians in the know took no action for fear of retribution.[27] As little data as exists relative to the rates of drug abuse by physicians, virtually no credible quantitative data is available on the safety implications thereof. One can only assume that impaired physicians account for an indeterminable proportion of the annual iatrogenic harm and death toll attributable to medical errors.[28]

II. The View of Organized Medicine

It was not until 1958 that the Federation of State Medical Boards called for a model probation and rehabilitation program for impaired physicians to be adopted by its constituent state medical boards.[29] By 1973, the American Medical Association (AMA) formally recognized physician impairment in a landmark policy paper titled *The Sick Physician: Impairment by Psychiatric Disorders, Including Alcoholism and Drug Dependence*.[30] It was the AMA report that prompted the creation of local, state, and national

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[24] *Id.* at 187.
[25] *Id.*
[26] *Id.*
[27] *Id.*
[28] *See* John T. James, *A New, Evidence-based Estimate of Patient Harms Associated with Hospital Care*, 9 J. PATIENT SAFETY 122, 122 (2013) (discussing limitations to estimates of errors made by impaired physicians); Julius Cuong Pham, Peter J. Pronovost & Gregory E. Skipper, *Identification of Physician Impairment*, 309 J. AM. MED. ASS'N 2101, 2101 (2013); LINDA T. KOHN, ET AL., TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM 30, 169 (2000).
[29] Baldisseri, *supra* note 9, at 106.
[30] *See* Council on Mental Health, *The Sick Physician: Impairment by Psychiatric Disorders, Including Alcoholism and Drug Dependence*, 223 J. AM. MED. ASS'N 684 (1973).

programs intent on assisting impaired healthcare workers.[31] The AMA report also took the view that physicians have an ethical obligation to report impaired colleagues as appropriate.[32] On the matter of random drug testing of physicians, however, the AMA did not take a stand.[33] It was the view of the AMA that drug testing should be "limited to pre-employment examination for those positions that affect the health and safety of others" or to "situations in which there is reasonable suspicion that an employee's (or physician's) job performance is impaired by alcohol and/or other drug use."[34] The AMA further endorsed "monitoring as part of a comprehensive program of treatment and rehabilitation of substance use disorders."[35] The AMA also noted the reality that "drug testing does not provide any information about pattern of use of drugs, dose of drugs taken, physical dependence on drugs, the presence or absence of a substance use disorder, or about mental or physical impairments that may result from drug use."[36]

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) took the view that matters of drug diversion and of impaired health care workers are to be addressed via its Sentinel Event policy.[37] The Accreditation Council for Graduate Medical Education (ACGME) limited its involvement with the random drug testing of physicians to the expectation that "Programs and Sponsoring Institutions" create and maintain systems for the "identification of…substance use disorders."[38] The American

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[31] *Id.*
[32] *Id.*
[33] Council on Scientific Affairs, *Issues in Employee Drug Testing*, 258 J. AM. MED. ASS'N 2089, 2094 (1987); David Orentlicher, *Drug Testing of Physicians*, 264 J. AM. MED. ASS'N 1039, 1040 (1990).
[34] *Issues in Employee Drug Testing H-95.984*, AMA POLICY FINDER, https://policysearch.ama-assn.org/policyfinder (2023); *Drug Testing H-95.985*, AMA POLICY FINDER, https://policysearch.ama-assn.org/policyfinder (2023) [hereinafter cited together as AMA Drug Abuse].
[35] *Id.*
[36] *Id.*
[37] *See* The Joint Commission, *supra* note 18 (noting in the footer that the newsletter is not a substitute for a Sentinel Event Alert).
[38] *Common Program Requirements (Residency)*, ACCREDITATION COUNCIL FOR GRADUATE MED. EDUC. 41 (July 1, 2023), https://www.acgme.org/globalassets/pfassets/programrequirements/cprresidency_2023.pdf.

Hospital Association (AHA) management advisory (*Substance Abuse Policies for Health Care Institutions*), first articulated in 1987 and further revised in 1992, calls for policies that include "pre-employment," "for cause," and "post-accident" drug testing.[39]

III. Federally Mandated Random Drug Testing

Random drug testing in the U.S. workplace dates back to 1981. The triggering event was a fiery crash aboard the aircraft carrier USS Nimitz where six of the 14 servicemen who lost their lives tested positive for marijuana.[40] It was in the wake of this tragedy that the Navy implemented broad scale random drug testing of all Navy personnel.[41] Random drug testing of enlistees in other branches of the U.S. Armed Forces followed suit.[42] In 1983, following a series of railroad accidents involving impaired employees, the Federal Railroad Administration (FRA) of the U.S. Department of Transportation instituted workplace-based random drug testing of employees who were involved in train accidents or who violated safety rules.[43] The U.S. Customs Service followed suit in 1986.[44] We discuss legal challenges to these programs below.

Not long thereafter, upon the enactment of the Omnibus Transportation Employee Testing Act of 1991 (OTETA), random drug testing was extended to drivers of commercial motor vehicles (trucks and buses) with an eye toward enhancing "commercial motor carrier safety."[45] The airline industry was to be markedly affected as well. As per the statute, the Federal Aviation Administration (FAA) of the Department of Transportation was to

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[39] M.R. Levine and W.P. Rennie, *Pre-Employment Urine Drug Testing of Hospital Employees: Future Questions and Review of Current Literature,* 61 OCCUPATIONAL AND ENV'T MED. 318, 319 (2004).
[40] UPI, *Navy Reports 6 of 14 Killed Aboard Nimitz Had Used Marijuana,* WASH. POST, June 19, 1981, at A12.
[41] Kirstin Downey Grimsley*, Like it or Not, Here's the Cup,* WASH. POST*,* May 10, 1998, at H1.
[42] *Id.*
[43] *See* J. Michael Walsh, *Development and Scope of Regulated Testing*, *in* DRUG ABUSE HANDBOOK 729, 730 (Steven B. Karch ed., 1998).
[44] *See id.*
[45] Department of Transportation and Related Agencies Appropriations Act, Pub. L. No.102-143, 105 Stat. 917 (1992).

"establish a program which requires air carriers and foreign air carriers to conduct preemployment, reasonable suspicion, random, and post-accident testing of airmen, crewmembers, airport security screening contract personnel, and other air carrier employees responsible for safety-sensitive functions for use . . . of alcohol or a controlled substance."[46] A comparable program was to be established for FAA employees as well.[47] The Nuclear Regulatory Commission followed suit all but concurrently.[48]

Legal challenges to the federal random drug testing programs on the grounds that they violate the Fourth Amendment to the U.S. Constitution (the provision referring to a right against "unreasonable searches and seizures" by the state) followed soon after the first federal initiatives. There are two particularly important Supreme Court cases that considered the issue. In 1989's *Skinner v. Railway Labor Executives' Association*, the U.S. Supreme Court held that random drug testing of employees of private railroads did not violate the Fourth Amendment. Importantly, the Court reached the conclusion that a warrant or individualized suspicion was *not* required as a prerequisite for such a search, because this fell into the category of "special needs beyond the normal need for law enforcement" as the reason the search was undertaken.[49] While acknowledging that urine testing, in particular, was an invasive intrusion, the court reasoned that "expectations of privacy of covered employees are diminished by reason of their participation in an industry that is regulated pervasively to ensure safety, a goal dependent, in substantial part, on the health and fitness of covered employees."[50] It held that these workers held "safety-sensitive" positions where such searches were permissible in that their role is "fraught with such risks of injury to others that even a momentary lapse of attention can have disastrous consequences."[51]

In a companion case, *National Treasury Employees Union v. Von Raab*, the U.S. Supreme Court held that essentially the same

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[46] *Id.*
[47] *Id.*
[48] *See* 10 C.F.R. § 26.31 (2022) (Nuclear Regulatory Commission regulations on drug and alcohol testing).
[49] Skinner v. Ry. Exec. Lab. Ass'n, 489 U.S. 602, 619, 624 (1989).
[50] *Id.* at 627.
[51] *Id.* at 628, 633.

analysis applied to a program that randomly tested United States Customs Service employees involved in drug interdiction or enforcement of related laws, or were required to firearms.[52] One again, the Court analyzed the question under the special needs exception to the requirement of a warrant or individualized suspicion. The court held that "because successful performance of their duties depends uniquely on their judgment and dexterity, these employees cannot reasonably expect to keep from the Service personal information that bears directly on their fitness."[53] The court held that the governmental interest in testing "outweigh[ed] the privacy interests of those who seek promotion to these positions, who enjoy a diminished expectation of privacy by virtue of the special, and obvious, physical and ethical demands of those positions."[54]

While the U.S. Supreme Court has not explicitly considered physicians in its cases, the lower courts have considered the applicability of the same analysis to them. In general, they have concluded that those who are subject to a state or a federal employment contract to constitute "safety-sensitive" employees who may be subject to random drug screens. For example, the U.S. District Court for the Northern District of California applied the same Fourth Amendment analysis to a varied set of healthcare employees (a physician, pharmacist, nurse, and two medical technician supervisors) involved in patient care at the Palo Alto Veterans Administration Hospital may be subject to random drug testing.[55] The court reasoned that "[t]he maintenance of professional and personal integrity in the execution of their mission, the care and treatment of inpatients and outpatients, is of compelling concern."[56] The paramount consideration of safety of members of the public who are eligible to use Veterans Administration hospitals and facilities is apparent on its face. Hospitals must exist for precisely that purpose. The gravity of the responsibilities of such medical professionals is at least as great as that of locomotive engineers,

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[52] Nat'l Treasury Emps. Union v. Von Raab, 489 U.S. 656, 664 (1989).
[53] *Id.* at 672.
[54] *Id.* at 679.
[55] Am. Fed'n of Gov't Emps. V. Derwinski, 777 F. Supp. 1493, 1499 (N.D. Cal. 1991).
[56] *Id.* at 1498.

flight attendants, and pipeline workers, and the risks associated with drug-impaired performance equally catastrophic. Random drug testing, as compared with other forms of testing, offers the best potential deterrent to drug use. This factor, coupled with the possibility of catastrophic accident, is sufficient to show a strong governmental interest in random testing.[57]

The same court reached a similar conclusion in a case regarding employees of the Federal Bureau of Prisons.[58] The court held in relevant part that "those licensed physicians and dentists in primary law enforcement positions who, in the regular course of their duties, must diagnose, treat, or directly supervise the diagnosis or treatment of patients on a daily or weekly basis may be subject to random urinalysis."[59]

Although it did not concern a random drug test in the medical profession a more recent decision of the U.S. Court of Appeals, Fifth Circuit, also lends some support. The court upheld the right of the Texas Tech University Health Science Center to test an emergency medicine resident physician who because of her behavior was suspected to be impaired.[60] In so doing, the court concluded that the status of the emergency medicine resident physician in question as a "student-employee . . . diminished her legitimate expectations of privacy vis-à-vis the search at issue."[61]

IV. State-Mandated Random Drug Testing

State laws on the matter of random drug testing remain highly heterogenous. Whereas a number of states enacted laws relevant to the random drug testing of public or private sector employees, other states (such as Massachusetts) have yet to do so. Arizona law, for its part, permits the conduct of random drug testing of all employees in both the private and public sector.[62] At one point, Florida state law limited the conduct of random drug testing of

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[57] *Id.*
[58] Am. Fed'n of Gov't Emps. v. Barr, 794 F. Supp. 1466, 1477 (N.D. Cal. 1992).
[59] *Id.* at 1473.
[60] Pierce v. Smith, 117 F.3d 866, 866 (5th Cir. 1997).
[61] *Id.* at 874.
[62] ARIZ. REV. STAT. ANN. § 23-493.04ok (2024).

public employees to safety-sensitive positions, though that is no longer the case.".[63] Private employers, in contrast, are explicitly empowered to set up drug-free workplace programs and conduct random drug testing of their employees.[64] Minnesota law, for its part, authorizes random drug testing of those in "safety-sensitive" positions.[65] California law, on the other hand, only allows that "peace officers…will be subject to random drug and alcohol testing."[66] Although the California constitution guarantees employees the right to privacy, a ruling of the State Court of Appeal, Fifth District, established that even private employees in safety-sensitive positions may be subjected to random drug testing.[67] Yet other state courts, such as the U.S. District Court for the Southern District of Mississippi and the Court of Civil Appeals of Alabama, not unlike federal counterparts, upheld that random drug testing may be applied to health care employees in direct patient contact.[68] Rhode Island and Vermont, in a departure from the aforementioned trends, prohibit random drug testing of any and all employees inclusive of those who are in safety-sensitive positions.[69]

Apart and distinct from the foregoing, some states saw to the enactment of laws mandating random drug testing of healthcare personnel in response to widely publicized drug diversion scandals. Stung by reports of unsafe conditions in one of its state-run psychiatric hospitals, the New Jersey Legislature mandated that all healthcare employees at state psychiatric hospitals, homes for the developmentally disabled, and veterans memorial homes, be subject to "random drug testing for controlled dangerous substances performed at such intervals as the Commissioner of Human Services deems appropriate."[70] In the wake of an investigation of the state-

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[63] FLA. STAT. § 112.0455 (2023).
[64] FLA. STAT. § 440.101 (2021).
[65] MINN. STAT. § 181.951 (2023).
[66] CAL. CODE REGS. tit. 2, § 599.960 (2024).
[67] Smith v. Fresno Irrigation Dist., 84 Cal. Rptr. 2d 775, 775 (App. Ct. 1999).
[68] Kemp v. Claiborne Cnty. Hosp., 763 F. Supp. 1362, 1368 (S.D. Miss. 1991); *see also* State Pers. Bd. v. State Dep't of Mental Health & Mental Retardation, 694 So. 2d 1367, 1367 (Ala. Civ. App. 1996).
[69] 28 R.I. GEN. LAWS § 28-6.5-1 (2022); VT. STAT. ANN. tit. 21, § 513 (2023).
[70] N.J. STAT. ANN. § 30:4-3.27 (West 2010); *see also* Susan K. Livio, *N.J. Psychiatric Hospital Workers Would Undergo Drug Testing Under Senate Bill*,

run Delaware Psychiatric Center by the Delaware Attorney General, the Delaware General Assembly mandated that "supervisory personnel, may also conduct a drug test based on a reasonable suspicion that a Delaware Psychiatric Center employee is impaired by an illegal drug."[71] Propelled into action by the prosecution of a dentist accused of practicing under the influence of alcohol, the Michigan Legislature rendered it a misdemeanor for a licensed health care professional to practice under the influence of alcohol or a controlled substance.[72] Moreover, law enforcement personnel were granted the authority to require that licensed healthcare professionals submit to chemical analysis subject to "reasonable cause."[73] The New Mexico Legislature, for its part, mandated that a "health care provider . . . in a state health care facility who is reasonably suspected of abusing illicit or prescription drugs or alcohol . . . shall undergo drug testing without prior notice . . .."[74] More recently, in response to a Hepatitis C outbreak attributable to a drug-abusing radiologic technician, the New Hampshire State Legislature saw to the enactment of HB 597 which mandated licensed health care facilities to "conduct random drug testing at least four times per year on all health care workers employed by the facility."[75] Under pressure from private health care organizations who were to underwrite the newly mandated drug screening program, HB 597 was amended to replace "random drug testing" with "drug testing which shall include, at a minimum, testing where reasonable suspicion exists."[76] It is of note that none of the aforementioned state laws singled out physicians for mandated

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NJ.COM (Dec. 7, 2009, 10:59 PM), https://www.nj.com/news/2009/12/nj_psychiatric_hospital_worker.html.

[71] DEL. CODE ANN. tit. 16, § 5137 (2012); *see also A Timeline of Scandal at DPC*, DEL. ONLINE (Aug. 7, 2014, 10:08 PM), https://www.delawareonline.com/story/news/local/2014/08/07/timeline-scandal-dpc/13755993/ (last updated Aug. 8, 2014, 1:02 PM).

[72] 2003 Mich. Pub. Acts 1239.

[73] MICH. PENAL CODE § 750.430 (1931).

[74] N.M. STAT. ANN. § 9-7-18 (West 2011).

[75] H.B. 597, Gen. Ct., Reg. Sess. (N.H. 2013); *see* Mark A. Abramson, Jared R. Green & Lindsey B. Gray, *Exposing the 'Dirty Little Secret': Random Drug Testing of Health Care Workers in the Wake of the Hepatitis C Outbreak*, 54 N.H. BAR J., Spring/Summer 2014, at 10, 13.

[76] *Id.*

random drug testing. Rather, consistent reference was being made to the broader category of healthcare workers. It is also of note that comparable legislative efforts in other states proved altogether unsuccessful. Efforts at enacting similar bills by the legislatures of the states of Texas, Mississippi, and Virginia failed to materialize.[77]

The most recent effort to implement mandatory random drug testing of physicians at the state level took place in California in 2014. Sweeping in its scope, this element of Proposition 46 sought to mandate hospitals to randomly "test physicians for alcohol and drugs."[78] Proposition 46 further stipulated that a physician be tested in the wake of an "adverse event" if and when "a physician was responsible for the care and treatment" of the patient in question.[79] Moreover, hospitals were to "report any positive test results, or the willful failure or refusal of a physician to submit to the test" to the Medical Board of California.[80] The latter, for its part, was to determine if "a physician was impaired by drugs or alcohol while on duty or during an adverse event, or that a physician refused or failed to comply with drug and alcohol testing[.]"[81] When indicated, the Medical Board of California was to "take specified disciplinary action against the physician. This action may include suspension of the physician's license."[82] Finally, Proposition 46 also required "physicians to report to the Board any information known to them that appears to show another physician was impaired by drugs or alcohol while on duty or that a physician who treated a patient during an adverse event failed to follow the appropriate standard of care."[83]

Whereas the notion of mandatory random drug testing of physicians was the subject of significant public support, other

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[77] *See generally* Michael Scott & Karen S. Fisher, *The Evolving Legal Context for Drug Testing Programs*, 73 ANESTHESIOLOGY 1022 (1990) (discussing state attempts at legislation); H.B. 1061, 2003 Leg., Reg. Sess. (Miss. 2003); S.B. 557, Gen. Assemb., Reg. Sess. (Va. 2000).

[78] CAL. OFF. OF THE ATT'Y GEN., PROPOSITION 46: DRUG AND ALCOHOL TESTING OF DOCTORS. MEDICAL NEGLIGENCE LAWSUITS. INITIATIVE STATUTE. 28-29 (2014).

[79] *Id.* at 29.

[80] *Id.*

[81] *Id.*

[82] *Id.*

[83] *Id.*

elements of the ballot were broadly opposed. Much of the opposition was directed at an effort to reform medical injury compensation (i.e. increase the malpractice cap) on the grounds that it would dramatically increase the overall state health care spending.[84] Buffeted by these and other controversial elements of the ballot, Proposition 46 was soundly defeated by the voting public on November 4, 2014.[85]

The California ballot stood out from earlier state efforts to institute random drug testing in a number of ways. For one, Proposition 46 would have required hospitals to test *physicians* rather than *all* healthcare workers who are "affiliated with the hospital."[86] In yet another departure, the California measure would have required that physicians who have been the subject of random drug testing assume responsibility for defraying the costs involved.[87] Finally, the California measure would have required hospitals "to report any positive test results, or the willful failure or refusal of a physician to submit to the test, to the Board."[88] The Medical Board of California, in turn, would be required to "take specified disciplinary action against the physician[,]" which "may include suspension of the physician's license."[89] In so doing, the ballot stood apart from the common national practice of affording physicians who tested positive for controlled drugs the option of voluntarily submitting to treatment and thereby foregoing a referral to the state medical board for discipline.[90]

V. The International Backdrop

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[84] *Id.*
[85] Tracy Seipel & Jessica Calefati, *California Voters Reject Propositions 45, 46, 48; Pass 47*, MERCURY NEWS, https://www.mercurynews.com/2014/11/04/california-voters-reject-propositions-45-46-48-pass-47/ (Aug. 12, 2016, 6:30 AM).
[86] Cal. Off. of the Att'y Gen., *supra* note 78, at 28.
[87] *Id.* at 29.
[88] *Id.*
[89] *Id.*
[90] *Policy on Physician Illness and Impairment: Towards a Model that Optimizes Patient Safety and Physician Health*, FED'N STATE MED. BDS. (Apr. 2021), https://www.fsmb.org/siteassets/advocacy/policies/policy-on-physician-impairment.pdf.

The state of random drug testing of healthcare workers, including physicians, the world over, remains highly variable. The United Kingdom, for its part, sought to implement random drug testing of its National Health Service (NHS) workforce as far back as 2001.[91] However, opposition from the British Medical Association (BMA) and the Royal College of Nursing (RCN) all but doomed the initiative.[92] More recent calls to revisit the NHS initiative have yet to materialize. It remains the position of the NHS that "random drug testing does not need to be enforced."[93] Early interest in establishing a random drug testing program for physicians in Australia remains limited to "health practitioners with a history of substance misuse who have restrictions placed on their registration."[94] New Zealand's Employment Court, for its part, has gone as far as to authorize random drug testing of safety-sensitive employees.[95] A random drug testing program for physicians, however, has yet to materialize. In yet other locales, random drug testing is all but prohibited. Examples include, but are not limited to Canada, wherein the Supreme Court all but banned random drug testing of all safety-sensitive employees.[96] Significant constraints on the random drug testing of physicians also apply in the European continent. In Finland, under the Occupational Health Care Act, only a Medical Review Officer (MRO) can determine if a drug test is

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[91] Nick Walsh, *Random Drug Tests for Doctors*, GUARDIAN (Mar. 11, 2001), https://www.theguardian.com/society/2001/mar/11/nhsstaff.health1.
[92] *Id.*
[93] *Job Sectors and their Workplace Drug & Alcohol Testing: Procedures and Policies*, DNA LEGAL (Nov. 17, 2020), https://www.dnalegal.com/sectors-and-workplace-testing.
[94] *National Drug Screening Protocol*, AUSTL. HEALTH PRAC. REGUL. AGENCY (Nov. 18, 2015), https://www.medicalboard.gov.au/news/2015-11-18-nat-drug-screening-protocol.aspx; *accord* Julia Medew, *Subject Doctors to Random Drug Testing, Expert Urges*, AGE (May 16, 2012, 3:00 AM), https://amp.theage.com.au/national/act/subject-doctors-to-random-drug-testing-expert-urges-20120515-1ype8.html.
[95] *NZ Amalgamated Engineering Printing and Manufacturing Union Inc v Air New Zealand Ltd* EmpC Auckland ARC 42/03, 13 April 2004 at [261]; *Electrical Union 2001 Inc v Mighty River Power Ltd* [2013] NZEmpC 197 at [76-85].
[96] *Communications, Energy, and Paperworkers Union of Canada, Local 30 v Irving Pulp & Paper, Ltd*. [2013] 2 S.C.R. 458, 464 (Can.).

needed.[97] Moreover, any and all workplace drug testing policies must be approved by the very employees who would be the subject of the random drug testing program.[98] An inventory of relevant European statutes reveals that the very approval of any and all drug testing programs is contingent on the accedence of an MRO.[99] All told, it would appear that the scope of random drug testing in Europe is markedly more limited in scale when compared with that of its U.S. counterpart.[100]

VI. The Case for and Against Random Drug Testing of Physicians in the U.S.

The panoply of judicial forays into mandatory random drug testing programs for U.S. physicians constitutes a faithful microcosm of the ongoing national debate. Most non-federal health care organizations have yet to implement random drug testing of physicians due, in part, to objections by members of the discipline.[101] Opponents of the random drug testing of physicians emphasize the costs inherent in the institution of any and all random drug testing programs.[102] Further counterarguments cite studies according to which more research is needed in that "the expansion of workplace drug testing initiatives is not supported by the current evidence base."[103]

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[97] Pirjo Lillsunde et al., *Finnish Guidelines for Workplace Drug Testing*, 174 FORENSIC SCI. INT'L 99, 101 (2008), https://doi.org/10.1016/j.forsciint.2007.03.006.
[98] *Id*. at 100-01.
[99] *See generally* COUNCIL OF EUROPE EXPERT COMMITTEE ON ETHICAL ISSUES AND PROFESSIONAL STANDARDS, DRUG TESTING IN THE WORKPLACE: INVENTORY OF EUROPEAN NATIONAL LEGISLATIONS (Jun. 15, 2007), https://rm.coe.int/1680745fba.
[100] *Id.*
[101] Stephen J. Lemon, Dean G. Sienko & Patrick C. Alguire, *Physicians' Attitudes Toward Mandatory Workplace Urine Drug Testing*, 152 ARCHIVES INTERNAL MED. 2238, 2241 (1992).
[102] *Id.*
[103] Ken Pidd & Ann M. Roche, *How Effective is Drug Testing as a Workplace Safety Strategy? A Systematic Review of the Evidence*, 71 ACCIDENT ANALYSIS & PREVENTION 154, 164 (2014).

Others have suggested that random drug testing is inefficient when compared to other forms of testing in that its utility as a deterrent is contingent upon higher testing frequency.[104] A related argument has been offered by Berge and McGlinch who point to the experience of two anesthesia departments who implemented random urine drug screening, which was complex and costly, yet found that "neither program was able to demonstrably reduce [Substance Use Disorder]."[105] They also argue that because random drug testing is a screening test for a rare event, there would likely be a false positive rate greater than 25%.[106] While it is true that any false positives would be rooted out by confirmatory tests, the authors argue that:

> Confirmatory retesting takes many days to obtain results, with subsequent clearance from the Medical Review Officer for return to work. When an anesthesia provider suddenly goes missing from the workplace for days, with inquiries to supervisors from concerned colleagues being met with stony silence, the assumption among many will be that their colleague was diverting workplace drugs. The damage to their reputation is done, without a word being spoken.[107]

While these authors do not make this point, one might worry that the burden of suspicion might fall harder on minoritized populations or other populations for whom stereotypes are more common about substance use disorder. These authors also argue that drug testing can be circumvented by intelligent and highly motivated people, and that most hospital systems lack the ability or wherewithal to impose the much stricter and more intrusive forms of drug testing used in the U.S. military or in the professional sports context.[108] When all

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[104] Abramson et al., *supra* note 75, at 13-14.
[105] Keith Berge & Brian McGlinch, *The Law of Unintended Consequences can Never be Repealed: The Hazards of Random Urine Drug Screening of Anesthesia Providers*, 124 ANESTHESIA & ANALGESIA 1397, 1397 (2017), www.doi.org/10.1213/ANE.0000000000001972.
[106] *Id.*
[107] *Id.*
[108] *Id.* at 1397-98.

of this is taken into account (the cost of false positives and confirmatory testing, the cost of implementing more secure systems), the argument is that hospitals systems might better use these funds instead to employ stricter methods of control and accounting for drugs of abuse, such as automated dispensing cabinets, and achieve better results. Ethical objections have been raised as well,[109] in particular as to physician autonomy and privacy,[110] with some arguing that imposing random drug testing on physicians is the trampling on civil liberties.[111]

Proponents of mandatory random drug testing of physicians, for their part, often point out that random drug testing is cost-reducing by preventing the theft and the illicit use of controlled substances (i.e. "drug diversion") as well as by precluding the downstream consequences thereof. Savings include but are not limited to labor turnover, tardiness, absenteeism, accidents, property damage, and lost productivity. There is also the prospect of lawsuits related to impaired physicians. Cautionary tales along these lines abound. The New Hampshire Department of Public Health is reported to have spent an estimated $384,000 in the course of its response to a widely reported Hepatitis C outbreak due to systematic drug diversion.[112] A private settlement related to a similar, if more expansive case of Hepatitis C outbreak due to drug diversion at the Texas-based Mid-Cities Surgi-Center, was estimated to top $100 million.[113]

Most importantly, however, proponents argue that mandatory random drug testing of physicians is (or should be) all about enhancing patient safety.[114] This point was made by former

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[109] Timothy Christie, *A Discussion of the Ethical Implications of Random Drug Testing in the Workplace*, 28 HEALTHCARE MGMT. F. 172, 174 (2015).

[110] *See* Cumbler & Kutner, *supra* note 2.

[111] Joseph Swani & Martin R. Miller, Correspondence, *Should Random Drug Testing be Applied to the Medical Profession?*, 382 LANCET 1174 (2013).

[112] Abramson et al., *supra* note 75, at 14.

[113] Meg Heckman, *N.H. Hep C Cluster Not The First: Medical Techs Were Suspected Before*, CONCORD MONITOR, July 29, 2012.

[114] Johns Hopkins Medicine, *All Hospitals Should Require Drug, Alcohol Tests for Physicians*, SCI. DAILY (May 7, 2013), https://www.sciencedaily.com/releases/2013/05/130507124813.htm.

HHS Inspector General Daniel R. Levinson in 2014 in a *New York Times* op-ed.[115] It is in this "first, do no harm" context of patient safety that the random drug testing of physicians comes to the fore as a Hippocratic derivative, if not a directive.

Absent legal mandates for the random drug testing of non-federal physicians or other healthcare workers, some private health care facilities proceeded to implement a drug-testing program on their own. In 1990, citing a desire to "set an example for the medical profession and to ensure the public's confidence in doctors," the Johns Hopkins Hospital proved to be the first teaching hospital to require random drug testing of its staff physicians.[116] However, the initiative in question was discontinued before too long.[117] A 1999 study of 30 large (500 or more beds) U.S. teaching hospitals, revealed 13% of the institutions involved to conduct random drug testing of their staff.[118] By 2015, the Cleveland Clinic announced that it will be expanding its own random drug testing program of physicians to all hospital employees with access to drugs.[119] A 2016 national survey of healthcare employers established that only 7% of the physician employees were subject to a random drug testing.[120] A full 45% of the healthcare employers surveyed noted the complete absence of any program that would subject physician employees to random drug testing.[121]

Examples of random drug testing of physicians are presently in evidence in select Departments of Anesthesiology across the U.S.

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[115] Daniel R. Levinson & Erica T. Broadhurst, *Why Aren't Doctors Drug Tested?* N.Y. TIMES, Mar. 13, 2014, at A27.
[116] Veronica T. Jennings, *Hopkins Doctors to Take Drug Tests: Mandatory Program Reportedly First in Nation for a Hospital*, WASH. POST, Feb. 9, 1990, at B1; Tamar Lewin, *Baltimore Hospital to Start Drug Tests on Its Physicians*, N.Y. TIMES, Feb. 10, 1990, at 9.
[117] Jennings, *supra* note 116.
[118] Isaac D. Montoya, Jerry W. Carlson & Alan J. Richard, *An Analysis of Drug Abuse Policies in Teaching Hospitals*, 26 J. BEHAV. HEALTH SERVS. & RSCH. 28, 34 (1999).
[119] *Expansion of Random Drug Testing Program*, CLEVELAND CLINIC (Nov. 18, 2015), https://my.clevelandclinic.org/-/scassets/files/org/graduate-medical-education/drug-testing-general-faq.ashx?la=en.
[120] HEALTHCARE EMPLOYMENT SCREENING TRENDS REPORT, PRECHECK PULSE 4 (2016 ed.).
[121] *Id.*

It was 2004 when the Department of Anesthesia, Critical Care, and Pain Medicine at the MGH instituted a first of its kind random drug testing program with resident trainees in mind.[122] Prior to the implementation of the MGH program, the departmental incidence of substance abuse was estimated at 1%.[123] No cases of substance abuse are presently apparent.[124] Residents-in-training are randomly tested once or twice during their first year, then once per year thereafter for the remainder of the residency training program.[125] Staff physicians are subject to random drug testing as well.[126] A comparable Cleveland Clinic program, established in 2008, is testing residents-in-training up to twice per year.[127] Fellows-in-training are being randomly tested once per year.[128] Staff physicians and support team members, in turn, are randomly tested every two years.[129] Both the MGH and the Cleveland Clinic programs test for an expanded panel of drugs that are rarely abused by the general public but are the subject of abuse by healthcare employees (e.g. fentanyl and benzodiazepines). Both programs also saw to the removal of potential bias and the maintenance of confidentiality by having all testing done off-site and reviewed by independent MROs. Employees who test positive are placed on paid medical leave and afforded professional evaluation. Those diagnosed with a substance abuse disorder are referred to the state Physician Health Program for treatment.

Fitzsimmons et al. notes that present-day norms deem certain occupations (e.g. airline pilots, ship captains etc.) as "safety-sensitive" in that "they are responsible for the well-being of the public."[130] These "safety-sensitive" occupations "have been drug

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[122] Michael G. Fitzsimons et al., *Random Drug Testing to Reduce the Incidence of Addiction in Anesthesia Residents: Preliminary Results from One Program*, 107 ANESTHESIA & ANALGESIA 630, 631 (2008), www.doi.org/10.1213/ane.0b013e318176fefa.
[123] *Id.* at 632.
[124] *Id.*
[125] *Id.* at 631.
[126] Fitzsimons, *supra* note 7, at 917.
[127] John Tetzlaff, et al., *A Strategy to Prevent Substance Abuse in an Academic Anesthesiology Department,* 22 J. CLINICAL ANESTHESIA 143, 145 (2010).
[128] *Id.*
[129] *Id.*
[130] Fitzsimons, *supra* note 7, at 918.

testing their ranks for nearly 40 years."[131] Whether this drug testing will continue to expand among physicians remains to be seen.

[131] *Id.*