IMPAIRED PHYSICIANS

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THE IMPAIRED PHYSICIAN

Because the topic of the impaired physician is rarely considered for Grand Rounds, and because the topic involves house staff and faculty, I have chosen to discuss it here.
I have three main points to make:

1. What defines impairment?
2. How is impairment recognized?
3. What is available here for our medical staff (house staff and faculty)?

In discussing impairment, I shall focus on substance abuse, because it is the most common reason for referral to peer review committees. At the end, I shall discuss the disruptive physician, because it has become a prominent issue, and, while it causes impairment, is usually purely behavioral.

The AMA defines impairment as "The inability to practice medicine with reasonable skill and safety to patients by reason of physical or mental illness, including alcoholism or drug dependence."[1] It is our ethical duty not to practice if we are impaired.[2] It is also the hallmark of the causes of impairment to prevent us from recognizing our own impairment. It becomes the duty of all of us to protect the public and help the sufferer. This is what professionalism demands of us. It is also our legal responsibility, as stated in the JCAHO Standards: "The medical staff implements a process to identify and manage matters of individual practitioner health that is separate from the medical staff disciplinary function."[3] Since the 1970's physician health committees have emerged to address this issue. They have the ability to aid in recognition and treatment of impaired physicians apart from the regulatory and licensing authorities. This has become more and more refined, and there is growing data collection and reporting, which, while still anecdotal and frequently limited geographically, allows us to begin to understand addiction, other impairments and the value of monitoring.

At this institution, The Committee on Practitioner Peer Review and Advocacy (COPPRA) provides the mechanism for referral, evaluation, treatment recommendations, and monitoring of recovery for house staff, faculty with clinical responsibilities, and other practitioners credentialed at Parkland (PA's, CRNA's). I shall discuss in detail the workings of this committee.

The prevalence and types of impairment are not different from the general population. In Texas, as reported by the Physicians Health and Recovery Committee of the Texas Medical Association, substance abuse is the most common impairment.

Types of Impairment Addressed by the PHR Committee	
Type	**% of Cases**
Drug & alcohol dependence	90%
Depression/mood disorders	6%
Other psychiatric disorders	2%
Sexual misconduct	<1%
Disruptive behavior	<1%
Stress/overwork	<1%
Organic brain syndrome	<1%
(TMA PHR Quarterly Reports 2003)	

To put this in perspective, the following chart represents actual numbers of consultations with the committee over several years:

Referrals via Hotline and CMS PHRC (1996-2000)

Nature of Referral	Total Number	Percentage
Alcohol	138	27%
Drug	121	23%
Alcohol & Drug	142	27% (77%)
Organic	2	<1%
Anxiety	1	<1%
Depression	24	5%
Stress/Overwork	23	5%
Other Psychiatric	25	5%
Other	40	8%

In North Carolina, the first 500 cases were distributed as follows:

Cause	Number	Percent
Chemical Dependency	338	68
Psychiatric Disorders	59	12
Sexual misconduct	38	8
Miscellaneous*	54	10
Unsubstantiated	11	2

*physical handicaps, behavioral problems, aging, cognitive difficulties, etc.[4]

In New Jersey:[5]

Diagnosis	Number	Percent
Alcohol only	144	24.5
Primary alcohol and other	54	9.2
Total alcohol	198	33.7
Drug only	131	22.3
Primary drug and other	67	11.4
Total drug	198	33.7 (67.4)
Psychiatric only	129	21.9
Primary psychiatric and other	16	2.7
Total psychiatric	145	24.6
Dementia only	14	2.4
Physical only	21	3.6
Other	12	2.0
TOTAL	588	100

While I shall be discussing addiction in detail, I must emphasize that there are many causes of impairment, including medical conditions such as neuromuscular diseases, cognitive disorders, and metabolic diseases; psychiatric diseases such as mood disorders, anxiety disorders, and behavioral disorders.

There are two guiding principles in dealing with physicians who are impaired and are of equal importance. The first is that patients and the public must be protected. The second is that rehabilitation is possible for the great majority of impairments and that these physicians continue to be successful in their practices and in their lives as long as they are in remission. The good news is that, in terms of substance abuse, the recovery rate for physicians is much better than for the general public. Rates of abstinence are gleaned from various reports, but the average recovery rate for practitioners who are followed by a monitoring system, such as COPPRA, or state agencies is about 86%. If persons with one relapse and then recovery again are counted the rate is in the mid 90%'s. This is compared with a 50 – 60% recovery rate in the general population.[6, 7, 8] This is attributed to the usually longer active treatment phase, the high stakes associated with relapse, and the careful follow up by committees. In a recent article, a retrospective analysis of physicians in recovery in the state of Washington, the risk of relapse was increased when there was a family history of addiction, a coexisting psychiatric disorder, or the use of a major opioid as the drug of choice.[9]

Recognizing impairment is crucial to the protection of the public and the recovery of the physician. It is frequently the case that when a member of the medical staff (house staff and/or faculty) here is sent away for treatment, we hear that "everybody knew" of the problems suffered by the physician. It is painful to know that months to years have gone by while we covered for our colleagues. Most people in recovery recognize that they wish they had been intervened upon at an

earlier date, although at the time, they would have denied any problems and would have resented comments from and by their colleagues.

Some behaviors which should alert us to possible problems include:

- Missing Work
- Irritability
- Outbursts
- Incomplete Charts
- Deterioration in hygiene/dressing habits
- Obvious intoxication
- Frequent hospitalizations and/or visits to physicians and dentists
- Accidents
- Mood swings
- Poor concentration
- Confusion
- Allegations among staff of inappropriate behavior

If one is worried about a colleague, our instinct is first to deny it! Our second thought is to discuss it with the colleague with offers to help. This, although intuitive, is often incorrect. It is necessary to report the possible problem to an expert, in this case, COPPRA. When that happens, there is an investigation, and the physician is usually asked to appear before the committee. This is in the form of an intervention. The purpose of an intervention is to break down the barriers of denial to the extent that the physician is at least willing to be evaluated by an expert. The committee does not diagnose the physician referred to it. All diagnosis, treatment and rehabilitation recommendations are made by consultative experts both on and off campus. We now understand that there is sometimes more than one diagnosis, and we are beginning to understand how to tailor follow up more appropriately. After the evaluation, a treatment plan is proposed. This is usually inpatient or intensive outpatient treatment and frequently requires a medical leave. After this phase, there is the follow up monitoring. Depending on the impairment, this may require attendance at 12 step program, random drug screening, evidence of adherence to psychiatric treatment, etc. The physicians here sign a contract with the committee. Some basic principles include designation of a primary care provider who prescribes all non specialty medication and knows all medications being used, designation of a treating specialist, no self prescribing, permission for the committee to receive reports from the treating specialist and reports from supervisors about job performance. Specific items might include limitation of duties for specified times or procedures (e.g., no OR duties for anesthesiology physicians for some period of time).

COPPRA

COPPRA was formed in the early 1990's. It is a formally constituted peer review committee. This means that proceedings and decisions are protected from disclosure. It is currently comprised of 9 members. It is important to appreciate that the two goals of the committee, patient safety and provider recovery and advocacy are equally important. The committee has the ability to recommend suspension of hospital privileges if it is believed that the provider or patients are in imminent danger. This "clout" is what makes intervention possible. For most people, and physicians in particular, the threat of job and career loss is the most important factor in breaking through. If the physician chooses not to accept the recommendation of the committee, his or her job is at stake.

As mentioned earlier, the purpose of the intervention is to break down denial of the problem by the sufferer. This is done by reporting the behaviors and causes of concern about the physician. The physician is told that the institution and their department want them to be successful, and that we believe that evaluation and treatment will lead to their return to health and work. The persons who report concern about behavior are protected by Texas law from retaliation, unless it can be proved that the report is malicious or fraudulent. When people are reported to a duly constituted peer review committee, and they comply with the recommendations of the committee, the Texas Board of Medicine considers them to have self-reported. This usually means that the agreements with the Board which ensue from discovery and treatment remain confidential.

After the physician has been evaluated and a treatment plan is in place, the work of the committee is to monitor the treatment and serve as an advocate for the physician. This involves frequent meetings, and treatment specific oversight. In the case of addiction, this includes random drug screening. We have a formal system set up with Occupational Health at Parkland. A missed screen is considered a positive result. In the case of psychiatric illness, it would include regular communication with the treating psychiatrist that the physician is participating in the treatment and is able to work. We do not request content material from the sessions.

The committee also requests regular communication from the physician's department about job performance.

If the physician does not adhere to the treatment plan, one would obviously worry about relapse. The relapse rate among physicians followed by peer review committees is quite low, but it does happen. At that point, depending on the consequences of the relapse, retreatment is required. I must remind you that addiction is a disease and relapse is expected. If you consider a glucose >200 a "diabetic relapse" or a systolic blood pressure >160 a "hypertensive relapse", you understand that all treatments need monitoring and assessment. The obvious

difference is that the consequences of relapse in substance abuse is more immediately dangerous to the physician and patients. The number of times that relapse is tolerated by the institution is variable, but repeated frequent relapse has a grave prognosis.

The Committee is obliged to report the physician to the Medical Board if that physician does not agree to the terms of the contract recommended by the Committee.

THE DISRUPTIVE PHYSICIAN

It would appear to some that this is a new condition, having come to discussion in the early 1990's. When one reflects on this, however, it is clear that the behavior has been going on for a long time. Disruption is defined as verbal or physical abuse in the workplace.[10] The stereotypical disruptive behavior is throwing surgical instruments in the operating room. Behaviors which constitute disruption in the workplace include anything that creates a hostile environment. It would include sexual harassment, belittling of colleagues or staff, derogatory remarks about other providers or the institution, etc. In the olden days, not so long ago, we used to excuse bad behavior by physicians, especially at the faculty level. We even encouraged many of the personality traits which can lead to disruptive behavior, namely, self-confidence, specialized knowledge, expectation of deference, etc. Now we understand that this behavior is not acceptable. There is a great impact on patient care and safety. While there are a number of similarities between disruptive behavior and other impairments, this category requires specific discussion because there is not always a treatable medical condition.

There are a number of conditions associated with disruptive behavior, including addiction, stress, and psychiatric disorders. It is unusual for physicians with addiction to display disruptive behavior, but this possibility should be considered. Stress is rarely the cause of the behavior, although increased stressors could precipitate it. Psychiatric illnesses or disorders include major depressive episodes which can be characterized by irritability. More commonly, manic or hypomanic episodes with grandiosity can manifest as disruption, although other behaviors usually lead to the diagnosis earlier. Personality disorders, especially narcissism, results in a sense of entitlement, and the expectation that all behaviors are to be accepted. Finally, learned behavior which is maladaptive and not any diagnosable mental disorder may be at the base of the behavior.

Recognizing disruptive behavior is not a diagnostic dilemma. The following are possible presenting symptoms: physically assaultive or intimidating; verbally abusive or threatening; publicly berating or demeaning displays; throwing objects; yelling or condescending speech; excessively argumentative or insulting; and sexually intrusive, harassing or abusive speech or behavior.[10] Two other

characteristics are that the behavior is usually long standing and everyone around the physician is extremely frustrated.

It is advisable to refer disruptive physicians to the peer review committee. The committee has the authority to insist on evaluation, and, if there are treatable conditions, these should be addressed. If not, this is a purely disciplinary procedure. The institution must have strict guidelines and policies in place to guide the behavior of the medical staff. Principles of dealing with disruptive physicians have been well delineated and are found in medical economics and physician management journals. Sotile and Sotile describe seven steps to solving the disruptive physician problem:

1. Provide protection.
2. Listen and empathize, and avoid communication triangles.
3. Confront offenders with data, authority, and compassion.
4. If needed, get outside help.
5. Offer workplace training and experiences that foster positive relationships.
6. Follow-up.
7. Practice what you preach and get support for yourself.[11]

At this institution, it is made quite clear that inappropriate behavior will not be tolerated. The balance between corrective actions and disciplinary consequences is not easy and is very important. There are some behaviors which are so grossly inappropriate that immediate termination is the only response. More often, a series of interventions and contracts about behavior can restore proper behavior. It is very common that the disruptive physician is stressed, angry, and believes that he or she is the only one who really cares about the care of the patients. They are often quite intelligent and hard working, and we sometimes believe that we cannot expect changes in their behavior. Just as denial is the hallmark of addiction and some mental illnesses, it is characteristic of the disruptive physician that there is absolutely no understanding of how their behavior is perceived by other people. There is often a kernel of truth to their complaints, but it is usually because their behavior is so provocative, that they manipulate others into bad behavior. Changing bad behavior is a complicated process and there are frequently burned bridges. There needs to be a new balance between increased supervision and protection of the physician from retaliation of the staff. Assigning a mentor can be very useful. We have come to see that participation in self-help groups is extremely useful for behavioral problems; it's too bad there isn't a "disruptives anonymous" organization.

FINAL THOUGHTS

This leads me to my final recommendation. An algorithm, if you like. This institution and particularly this department have always been supportive of the medical staff. We should understand that bad behavior is not acceptable, but our

approach to remediation should include assessment of the possible causes of the behavior. As part of our counseling of colleagues and house staff, we should raise the possibility of treatable conditions. It would be wise to involve the Committee on Practitioner Peer Review and Advocacy early on. There are several reasons. It is frustrating to the committee to get a referral that essentially says, "find something to fix, or this physician will be fired". It is unwise and perhaps unethical for those of us who are required to discipline to act as diagnosing and treating physicians. The committee can be an ally to the department by being separate from it, but also by endorsing the commitment to patient safety as well as physician health.

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