



the Reporter

TEXAS MEDICAL LIABILITY TRUST

September-October 2008



Physician impairment

a proactive approach

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Case study

Anesthesiologist A was a partner at XYZ Anesthesiology Associates and practiced at Hospital A. He was fired “with cause” from XYZ Anesthesiology Associates after he came to work in an impaired condition. (Anesthesiologist A was diverting and using Demerol) Subsequently, Anesthesiologist A was hired by Hospital B. During a routine tubal ligation at Hospital B, Anesthesiologist A prematurely extubated the patient while she was still under the influence of anesthesia and refused to call a code when the nurses noted the patient did not have a pulse. The patient has been in a vegetative state since the surgery. Anesthesiologist A was impaired by narcotics at the time of the surgery. The patient’s family sued Hospital B and Anesthesiologist A. Hospital B settled the case for several million dollars.

Hospital B then went on to sue Hospital A and XYZ Anesthesiology Associates alleging intentional and negligent misrepresentation. Hospital B’s request for information and references from Anesthesiologist A’s former employer failed to uncover Anesthesiologist A’s history of narcotic use. According to the complaint, two former colleagues of Anesthesiologist A and Hospital A failed to disclose relevant, material information. The two former partners had written positive letters of recommendation for Anesthesiologist A and Hospital A did not send complete credentialing information. Additionally, Anesthesiologist A was not reported to the National Practitioner Databank. This lack of “truthful communication” may have led to the hiring and

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credentialing of Anesthesiologist A at Hospital B. The jury found that intentional and negligent misrepresentations had been made and that these misrepresentations were the proximate cause of the patient's injuries. Accordingly, the jury found Hospital A and XYZ Anesthesiology Associates were responsible for 50% of the approximate \$8.2 million malpractice claim.¹

In the case described, it is not known if any actions were taken by XYZ Anesthesiology Associates to encourage Anesthesiologist A to enter a substance abuse treatment program. However, by terminating Anesthesiologist A, "the partners showed that they were unwilling to expose themselves and their patients to further risk/liability. They were concerned and confident enough about the impairment that they chose to terminate him 'with cause.' Is it justifiable to pass such risk along to other patients and providers?"¹

This article will discuss the signs and symptoms of physician impairment, the function of physician health committees and the Texas Medical Board's (TMB) nondisciplinary rehabilitation order, and what steps to take if a physician suspects a colleague may be impaired.

Physician impairment

The American Medical Association defines an impaired physician as one who is "unable to practice medicine with reasonable skill and safety to patients because of physical or mental illness, including deterioration through the aging process or loss of motor skill, or excessive use or abuse of drugs including alcohol."²

Though the exact rate is unknown, studies indicate that between 8% and 12% of physicians will develop a substance use disorder during their lives. This is the same rate found in the general population.² However, abuse of prescription drugs—particularly benzodiazepines and opiates—is more prevalent among physicians probably due to availability and familiarity with these drugs.³

An article published in the *Annals of Internal Medicine* estimated the incidence rates of physician impairment from mental illness, alcohol dependence and drug abuse, disruptive behavior, physical illness, and declining competencies and concluded that "When all conditions are considered, at least one-third of all physicians will experience, at some time in their career, a period during which they have a condition that impairs their ability to practice medicine safely; for a hospital with a staff of 100 physicians, this translates to an average of 1 to 2 physicians per year."⁴

Signs and symptoms

"For healthcare professionals, deterioration in clinical performance is usually one of the last signs of a substance abuse disorder. When the healthcare professional's work performance is affected, the problem is usually well advanced and severe. Professional performance of healthcare providers is often protected at the expense of other personal, social, and family obligations."³

Signs and symptoms of substance abuse that may be seen in physicians include:

- inaccessibility to patients and staff;
- completing rounds at odd hours;
- decreased chart performance;
- ordering large quantities of drugs;
- issuing inappropriate orders or prescriptions;
- forgetting oral orders;
- slurred speech during off-hour phone calls;

- heavy drinking at hospital or office functions;
- multiple prescriptions for family members;
- arriving late for appointments;
- increased absences and unexplained disappearances during work hours;
- increased patient complaints;
- increased secrecy;
- decreased productivity;
- decreased quality of care;
- increased conflicts with colleagues;
- vague letters of reference; and
- erratic job history that includes new jobs in different locations and unexplained time off between jobs.³

Signs of impairment from physical or mental illness may be similar to those listed above. "Disorders most commonly diagnosed in physicians include those of mood [major depression, dysthymic disorder, and bipolar disorder], cognition, chemical misuse, panic/anxiety and obsessive-compulsiveness. The most commonly encountered personality disorder traits are narcissism, obsessive-compulsiveness and antisocial."⁵ Physicians with a substance use disorder may have a coexisting psychiatric disorder, and if both conditions are not treated, the success rates of treatment will suffer for each.²

Physician health committees

"Historically, addicted physicians either went unnoticed or were treated punitively. In 1973, the American Medical Association recommended, in a landmark report entitled 'The Sick Physician,' that state medical societies establish programs to identify and treat impaired physicians. Since that time, every state has established a program or committee for that purpose."⁶

In Texas, the Committee on Physician Health and Rehabilitation (PHR) of the Texas Medical Association promotes the health and well being of physicians as well as the treatment and rehabilitation of those who have become impaired. "As advocates, the committee helps with intervention, referral for evaluation and treatment, monitoring upon return from treatment, and education for physicians, family members and support staff regarding possible impairments."⁵ The committee's activities include operating a 24-hour, toll-free number at 800-880-1640 to respond to referrals concerning physicians who may be impaired.

Types of impairments or conditions addressed by the TMA PHR Committee include:

drug or alcohol dependence	73%
disruptive behavior	4%
sexual misconduct	4%
depression/mood disorders	6%
stress/overwork	2%
other psychiatric disorders	11%

"The majority of cases referred to Texas county medical society PHR committees have involved substance abuse or dependence. However, as hospitals and medical societies are more aware of physician impairment, disruptive and dysfunctional behaviors of all types are being reported. Frequently, a psychiatric illness is at the root of the behavior, and these illnesses, although often difficult to identify, are treatable."⁵

In addition to state and county medical societies, hospitals and residency programs have also established physician health programs. In 2002, the Joint Commission and the Accreditation Council for Graduate Medical Education

mandated that training programs and hospitals “establish processes and programs designed to detect, intervene, treat, and rehabilitate the impaired physician that is separate from the medical staff disciplinary process.”³

“The purpose of separating health matters from disciplinary matters is to encourage the implementation of a process that will not damage the physician’s reputation as a result of impairment. The goal is to identify health-related problems at an early stage, put supportive services in place, and implement necessary safeguards to protect the safety of patients while (if possible) allowing the physician to remain in practice.”⁷

Reporting impaired physicians

Although the signs and symptoms of impairment can be obvious, many physicians are hesitant or unwilling to report impaired colleagues. “Many physicians are reluctant to confront behavioral or competence problems. Independence is so highly valued that physicians are loath to evaluate or confront a colleague whom they perceive as having a problem. Doctors abhor making judgments about colleagues who may also be personal friends or practice partners. Department chairs often lack the training and skills needed for managing doctors who perform poorly. The hospital may need the physician’s revenue stream.”⁴

A study reported in the *Annals of Internal Medicine* found that 96% of 1,662 surveyed physicians agreed that physicians should report impaired or incompetent colleagues to relevant authorities. However, 45% of those respondents with “direct personal knowledge” of an impaired or incompetent physician did not report that physician.⁸ A similar survey of physicians published in *Social Science and Medicine* found that physicians are more likely to report impairment due to substance abuse than impairment due to cognitive or psychological problems.⁹

In Texas, a physician’s duty to report an impaired colleague is spelled out in the Medical Practice Act. The Act specifies that any physician, medical student, resident, or medical peer review committee “shall report relevant information to the board [TMB] relating to the acts of a physician in this state if, in the opinion of the person or committee, that physician poses a continuing threat to the public welfare through the practice of medicine.”¹⁰

Accordingly, if in the physician’s opinion the colleague “poses a continuing threat to the public welfare through the practice of medicine” then that colleague must be reported to the board.¹⁰ Otherwise, the physician can report concerns to the local or hospital physician health committee and may also report these problems to the TMB.

“Contacting a PHP [physicians health program] can be done anonymously and is usually better than trying to confront the individual directly since most addicted physicians have high levels of denial . . . However difficult it might be to report a colleague, impaired physicians cannot be allowed to continue to put the lives of their patients at risk through negligence, misconduct, or avoidable harm.”⁶

It is important for physicians to realize that Texas physician-health and rehabilitation programs are designed to rehabilitate physicians, not punish them. Generally, reporting to the TMB is not required when the physician complies with treatment and rehabilitation guidelines.

The TMA PHR committee works through county medical society-based committees and state committee-appointed district coordinators, to investigate reports of potential impairment. Initially, the committee’s approach is one of “anonymity and advocacy.” If the investigation reveals suf-

ficient evidence to suggest a problem, an intervention will occur. The goal of the intervention is to have the physician agree to stop practicing, undergo an evaluation, and follow through with treatment recommendations. Upon the physician’s return from treatment, the committee enters an agreement with the physician for monitoring purposes. The physician can return to practicing medicine, provided that he or she adheres to the committee’s requirements.

If the physician refuses help or the committee believes that the physician “poses a continuing threat to the public welfare through the practice of medicine” the law requires the committee to report the physician to the TMB and any known health care entity in which the physician has clinical privileges. “This reporting obligation is often the final leverage utilized by the committee to persuade a physician to work with the physician health and rehabilitation committee.”¹¹

“At this point in the intervention, some physicians will insist that they can take care of the problem by themselves, but we tell them that if they do not agree to an evaluation or seek treatment, we have no alternative but to report them to the board and their hospital(s),” says John Jackson, MD, chair of the TMA’s PHR Committee.

Additionally, if the physician does not uphold the agreement with the committee—for example by not following treatment recommendations or by violating a post-treatment monitoring agreement—the committee may report the physician to the TMB. “We explain all this to the physicians so they know exactly what they are expected to do and what will happen if they don’t,” says Dr. Jackson.

The PHR committee’s response to physicians who are impaired follows the responsibilities outlined in the AMA Code of Medical Ethics. “Physicians’ responsibilities to colleagues who are impaired by a condition that interferes with their ability to engage safely in professional activities include timely intervention to ensure that these colleagues cease practicing and receive appropriate assistance from a physician health program. Ethically and legally, it may be necessary to report an impaired physician who continues to practice despite reasonable offers of assistance and referral to a hospital or state physician health program. The duty to report under such circumstances, which stems from physicians’ obligation to protect patients against harm, may entail reporting to the licensing authority.”¹²

For physicians who are uncertain if their suspicions mean a physician is impaired, Dr. Jackson recommends seeking assistance from the local or state physician health committee. These committees have experience in discretely looking into such issues and making decisions and recommendations. “I have often talked with concerned physicians without ever asking the name of the doctor about whom the concern exists. Once I can show that the committee’s interest is in helping the doctor, any reluctance to identify him or her is usually abandoned,” says Dr. Jackson.

Rehabilitation orders

The TMB also may take a “non-stigmatizing approach” toward physician impairment. According to the Medical Practice Act:

“(a) The board, through an agreed order or after a contested proceeding, may impose a nondisciplinary rehabilitation order on an applicant, as a prerequisite for issuing a license, or on a license holder, based on:

- (1) intemperate use of drugs or alcohol directly resulting from habituation or addiction caused by medical care or treatment provided by a physician;

(2) self-reported intemperate use of drugs or alcohol during the five years preceding the report that could adversely affect the reporter's ability to practice medicine safely, if:

(A) the reporting individual has not previously been the subject of a substance abuse-related order of the board; and

(B) the applicant or license holder has not committed a violation of the standard of care as a result of the intemperate use of drugs or alcohol;

(3) a judgment by a court that the applicant or license holder is of unsound mind;

(4) a determination of impairment based on a mental or physical examination offered to establish the impairment in an evidentiary hearing before the board in which the applicant or license holder was provided an opportunity to respond; or

(5) an admission by the applicant or license holder indicating that the applicant or license holder suffers from a potentially dangerous limitation or an inability to practice medicine with reasonable skill and safety by reason of illness or as a result of any physical or mental condition.

(b) The board may not issue an order under this section if, before the individual signs the proposed order, the board receives a valid complaint with regard to the individual based on the individual's intemperate use of drugs or alcohol in a manner affecting the standard of care.

(c) The board must determine whether an individual has committed a standard of care violation described by Subsection (a)(2) before imposing an order under this section.

(d) The board may disclose a rehabilitation order to a local or statewide private medical association only as provided by Section 164.205.¹³

Unlike other TMB disciplinary orders, rehabilitation orders are confidential and are not available to the public or managed care plans, and are not reported to the National Practitioner Databank.¹⁴ However, rehabilitation orders "can include the full range of actions of a disciplinary order, including revocation, cancellation, suspension, and various terms and conditions of probation. The most common rehabilitation order for a physician who self-reports is probation for a number of years under certain terms and conditions. These conditions are intended to not only monitor a physician in recovery, but also to rehabilitate the physician."¹⁵

Physicians can self-report impairments by sending a written report directly to the TMB or by filling out the online complaint form at the TMB web site. Physicians also have the option of reporting impairments on their annual license renewal form.¹⁴ In fiscal year 2007, the TMB issued 57 rehabilitation orders.¹⁶

Recovery rates for physicians

The outcome of substance abuse treatment is generally more favorable for physicians than for the general public. Reported abstinence rates for physicians vary from 70% to 90%. Treatment programs estimate that 75% to 85% of physicians return to work.³ This is likely due to close monitoring and "highly motivated physicians who have a tremendous amount to lose professionally and personally if they relapse."⁶

Resources

The TMA Committee on Physician Health and Rehabilitation

800-880-1640

<http://www.texmed.org/Template.aspx?id=4751>

The Texas Osteopathic Medical Association Physicians Health and Rehabilitation Committee

800-896-0680 or (512) 257-0927

The Texas Medical Board

(512) 305-7010

<http://www.tmb.state.tx.us/>

American Society of Addiction Medicine

www.asam.org

American Academy of Addiction Psychiatry

www.aaap.org

Alcoholics Anonymous

www.aa.org

Association for Medical Education and Research in Substance Abuse

www.amersa.org

Caduceus Groups

Caduceus groups are self-help groups for physicians and other health care professionals who are recovering from chemical dependence. TMA PHR staff can put you in contact with group members who can describe the structure and membership of their specific Caduceus group. Contact them at (800) 880-1300 or (512) 370-1300.

International Doctors in Alcoholics Anonymous

www.idaa.org

Smart Recovery

<http://www.smartrecovery.org/>

Physician health committees typically monitor physicians in recovery for five years, but some may monitor longer. A monitoring program includes random drug screens; written reports from counselors or therapists; self reports provided by the physician in recovery; and written verification of attendance at self-help or support group meetings.²

Conclusion

"Patients, family members, friends, and professional colleagues have a moral responsibility and obligation to identify healthcare professionals who are impaired. Once an impaired health care professional is identified, resources offering treatment interventions, rehabilitation, and assistance with reentry into clinical practice at the institutional, local, and state level are available. Timely identification, treatment, and follow-up care will allow impaired providers the opportunity to heal and to be successful in their clinical careers and personal lives."³

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