

The Impaired Physician: Lessons for Chairs

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Case Scenario

- A few weeks before starting your new role as chair, your predecessor (Interim Chairman) informs you that, several months ago, he received multiple complaints about a senior faculty member in the department
- The complaints raised suspicion of possible alcohol abuse, and the Interim Chairman contacted both Human Resources and the Chief of Staff Office
- A formal meeting occurred with the faculty member, Interim Chairman and Chief of Staff
- The faculty member adamantly denied alcohol abuse, but was given a formal written warning for his behavior



The Complaints to the Interim Chair

Signs of physician impairment

Deteriorating personal hygiene
Increased absence from professional functions or duties
Emotional lability
Appearing sleep-deprived
Increased professional errors (eg, prescriptions, dictations, clinical judgment)
Not responding to pages or telephone calls
Decreased concern for patient well-being
Citing unexplained "personal problems" to mask deficits in concentration or patient care

Current Psychiatry 2011; 10: 67-71



Case Scenario, Continued...

- You assume your new role in July, and hear no formal complaints about the faculty member
- In December, the same complaints resurface: lack of availability, frequent call-offs from work, smell of alcohol, concern of impaired medical judgment, and not completing his required documentation
- Around the same time, the Chief of Staff contacts you to ask about the status of this physician, and whether the previous investigation could be considered closed
- What should you do? What are your options?



Reporting Impaired Physicians

Options for reporting impaired colleagues

Impairment in hospital-based physicians may be reported to the hospital's in-house impairment program, the hospital's chief of staff, or another appropriate supervisor (eg, a chief resident)
Impairment in physicians with office-based practices may be reported to hospitals where they have privileges or to the state's physician health program
Colleagues who continue to practice despite offers of assistance and referrals for treatment or for whom the above options are not available should be reported to the state licensing board

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State medical board rules on reporting physician impairment: 3 examples

State	Rules
California ⁸	California's Medical Practice Act contains no mandatory reporting requirement. "However, ... the Board clearly is concerned about physicians who potentially present a danger to their patients. Reporting an impaired colleague to the Medical Board will allow the Board to ensure adequate protections are in place so a colleague who requires assistance will not harm the public. The Board keeps the sources of complaint information confidential."
Montana ⁹	"[E]ach licensed physician ... shall ... report to the board any information ... that appears to show that a physician is' impaired. However, "[i]nformation that relates to possible physical or mental impairment connected to [substance misuse or illness] may be reported to' Montana's physician rehabilitation program' in lieu of reporting directly to the board."
Ohio ¹⁰	"Any Board licensee having knowledge' that a physician is impaired because of substance misuse' is required ... to report that information to the Board. ... [h]owever, ... the [impaired] physician's colleagues may be excused from reporting the physician's impairment ... if the [impaired] physician has completed treatment with a Board approved treatment provider and maintained uninterrupted sobriety, and violated no other provisions of the Ohio Medical Practice Act."

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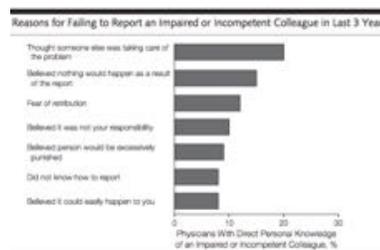


The Pros and Cons of Reporting

- Con: What if you're wrong?
 - Possibility of damaging the career of the physician
 - If falsely accused, physician could bring legal action
- Pro: Early identification
 - Will protect a greater number of patients from harm
 - Increased probability that the physician's health will benefit from earlier diagnosis and treatment



Why Reporting Doesn't Happen



What I Actually Did...



The UCMC Policy

- The evaluation of the alleged impaired physician may be performed by either the Clinical Chief or by the Chief of Staff
 - The evaluation is confidential and focuses on protecting patient care
 - It is not intended to be a disciplinary investigation
- The Clinical Chief or Chief of Staff may recommend:
 - No action
 - Continued monitoring of practitioner
 - Advise the practitioner to initiate a voluntary therapeutic program
 - Require initiation of a voluntary therapeutic program
 - Request the practitioner to voluntarily restrict or resign privileges until satisfactory rehabilitative progress is demonstrated



Case Scenario, Continued...

- I met with the faculty member, with the Director of HR and the Chief of Staff in attendance. The physician again vehemently denied alcohol or drug use, but admitted to depression and a cervical spine problem
- The physician was strongly encouraged to take a medical leave of absence via FMLA, and was referred to the UC Employee Assistance Program for help
- The physician agreed to use FMLA, but postponed it by 6 weeks and declined to use the EAP
- After taking only 1 month of FMLA, the physician returned to work
- Two days after his return, I was called by several CRNAs who felt that his conduct threatened patient safety: not answering calls, mental status not normal, ill-appearing, etc.



Case Scenario, Continued...

- I called the AOD and had the physician removed from clinical duty
- I called the physician and demanded a meeting in my office
- Again, the physician denied substance abuse, insisting that his behavior was secondary to the effects of antidepressants
- The physician was given 2 options: termination, or return to FMLA with the promise to obtain appropriate treatment, and a requirement for fitness for duty evaluation prior to return
- The physician agreed to Option 2
- I contacted HR and the COS Office to assist with the process
- Six weeks after starting the second medical leave, the physician was admitted to the hospital with acute alcoholic liver failure, with a MELD of 40



Another Option: Physician Health Programs

Medical associations' official positions on reporting impairment

American Medical Association (Policy H-275.952)²	'Physicians have an ethical obligation to report impaired, incompetent, and unethical colleagues.'
Federation of State Medical Boards³	Physician health programs have 'a primary commitment to [help] state medical boards ... protect the public ... [These] programs [should] demonstrate an ongoing track record of ensuring safety to the public and reveal deficiencies if they occur.'

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Physician Health Programs

- Most states have PHPs
 - No national standards
 - Structure, size and quality of programs varies
- PHPs offer physicians a route to fulfilling their reporting obligations and receiving help for their condition, without the stigma of board sanction
- PHPs are typically separate from state medical boards
 - Generally administered by state medical societies
- The goal of PHPs is early detection of impairment
- PHPs have had good success: 75-90% of US physicians treated for substance abuse are licensed and working at 5 year follow-up



Ohio Physicians Health Program

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Mission: To facilitate the health and wellness of healthcare professionals in order to enhance patient care and safety.

SERVICES

Confidential Resource

OPHP serves as a confidential resource for healthcare professionals who may be affected by mental, emotional and behavioral illness, substance-related and addictive disorders, or other illnesses.

Monitoring & Advocacy

Monitoring and advocacy services are available for healthcare professionals. OPHP specializes in providing assistance to healthcare professionals voluntarily seeking treatment and who qualify for the One-Size Rule allowing for confidential participation.

Educational Outreach

Presentations are delivered on the prevention of mental, emotional and behavioral illness and substance-related and addictive disorders - and stress, burnout, suicide, and statutory guidelines for medical professionals.

Wellness Program

OPHP is broadening its scope of services by developing resources, tools, and program services to support your wellness efforts. A Wellness Program will be launched in 2018! Learn more here.

Table 3. Selected Characteristics and Outcomes of Anesthesiologists and Other Physicians in State Physician Health Programs for Substance Use Disorders, with Adjusted and Unadjusted Odds Ratios^a

Characteristic/outcome	Anesthesiologists (n = 83)	Other physicians (n = 697)	Unadjusted univariate odds ratios		Adjusted multivariate odds ratios ^a	
			OR (95% CI)	P	OR (95% CI)	P
Gender						
Male	71 (86)	599 (86)	1.1 (0.6-2.0)	0.87	1.1 (0.5-2.0)	0.88
Primary drug of abuse						
Alcohol	23 (28)	361 (52)	0.4 (0.2-0.6)	<0.001	0.4 (0.2-0.6)	<0.001
Opioids	46 (55)	217 (32)	2.8 (1.7-4.4)	<0.001	2.9 (1.8-4.6)	<0.001
IV drug use history						
Yes	32 (41)	64 (10)	6.3 (3.8-10.7)	<0.001	5.7 (3.4-9.8)	<0.001
Number of substances						
Multiple	40 (48)	358 (51)	0.9 (0.6-1.4)	0.63	0.9 (0.6-1.4)	0.61
Prior treatment						
Yes	25 (30)	273 (39)	0.7 (0.4-1.1)	0.12	0.7 (0.4-1.1)	0.15
Enrollment status						
Mandatory	49 (59)	393 (57)	1.1 (0.7-1.8)	0.73	1.2 (0.8-2.0)	0.76
Positive drug test						
Yes	9 (11)	156 (23)	0.4 (0.2-0.9)	0.02	0.4 (0.2-0.8)	0.01
Reported to board						
Yes	15 (18)	140 (20)	0.9 (0.5-1.6)	0.77	0.8 (0.5-1.5)	0.72
Program status						
Completed contract	59 (71)	445 (64)	1.4 (0.9-2.3)	0.23	1.5 (0.9-2.5)	0.17
Contract extended	15 (18)	112 (16)	1.2 (0.6-2.1)	0.64	1.1 (0.6-2.1)	0.69
Failed to complete	9 (11)	140 (20)	0.5 (0.2-1.0)	0.05	0.5 (0.2-0.9)	0.05
Occupational status						
Licensed or practicing medicine	63 (76)	508 (73)	1.2 (0.7-2.0)	0.60	1.2 (0.7-2.1)	0.57
License revoked	6 (7)	78 (11)	0.6 (0.3-1.5)	0.35	0.6 (0.2-1.4)	0.28
Died	5 (6)	24 (3)	1.8 (0.7-4.8)	0.22	1.7 (0.6-4.7)	0.30

Anesth Analg 2009; 109: 891-6

Lessons Learned

- Be aware of the signs of physician impairment, and act immediately when they are recognized
- Expect your faculty member to deny the problem
- Do not act alone. Take advantage of institutional and state resources to help impaired physicians:
 - Human resources
 - Chief of Staff office
 - State Physician Health Program
- Your obligation is not just to the health of your patients; it is also to the health of your faculty member
- Managing this is not comfortable for anyone, but you must act decisively. Think of it as an act of tough love

