

2012 SAEM ETHICS CURRICULUM

Module 9: Physician Impairment and Wellness

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ACGME EM Milestones:

- *PROF1: (Professional values)*
- *PROF2: Accountability*

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Learning Objectives:

1. Define physician impairment.
 2. Discuss the various types of physician impairment.
 3. Discuss the causation, risks, treatments, and solutions of physician impairment.
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Case Study 9.1.1 – keeping awake on night shift:

A 35-year-old emergency medicine physician is halfway through her third consecutive night shift in a busy urban emergency department. By 3:30 a.m., the boost from several sodas and a large cup of espresso have long since worn off. In a scene that takes place all too frequently, the physician downs a few caffeine pills to aid her through the remainder of the night.

Case Study 9.1.1 Questions for Discussion:

1. How common is the above scenario? Should excessive fatigue be considered physician impairment?
 2. What if your colleague was cognitively impaired/incompetent? Should that situation be handled differently?
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Case Study 9.1.2 – consultant smelling of alcohol:

You work in an emergency department in a small community that has only one surgeon within 50 miles. He is well respected in the community and has always been regarded as competent. On two occasions when you have been working the night shift, he has come in to evaluate patients dressed in evening clothes. Although he has seemed to care for the patients appropriately, you believe you smell alcohol on his breath.

Case Study 9.1.2: Questions for Discussion:

1. If one of your colleagues were impaired by alcohol or drugs, how would you handle it? To whom (if anyone) should the person be reported?
 2. Does it matter that this is the only surgeon within 50 miles?
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Case Study 9.1.3 – working when ill:

You've had a terrible cough for a week now and continue to have fevers. You haven't had an appetite all week and have barely been drinking enough fluids to keep hydrated. You feel tired and lousy as you get ready for your twelve hour shift and think about giving yourself a bolus of IV fluids prior to your shift to make it through the day.

Case Study 9.1.3 Questions for Discussion:

1. If you were your own patient, would you recommend going in to work?
 2. How are the expectations that physicians expect of themselves and their colleagues different than those of their patients? Should there be a difference, and if not, what can be done to change this?
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Background Information:

The above situations are myopic views of physician impairment that overlook several key aspects of the topic. Physician impairment is defined as any condition that adversely affects a physician's professional performance. This includes substance abuse disorders, but also psychiatric disorders, incompetence, physical or mental disabilities, inappropriate prescribing, and unprofessional conduct. When viewed from this larger perspective physician impairment is encountered with more frequency than we may think.

A 1992 *JAMA* article reports that as many as 10% of US physicians use alcohol daily. In a 1992 study of resident substance abuse by specialty, emergency medicine residents had more current use of cocaine and marijuana than resident physicians in other specialties. In addition to illicit substances, physicians also abuse prescription drugs, including benzodiazepines and opiates that are often self-prescribed. Unfortunately, most physicians with an abuse problem rarely recognize their addiction as a problem until secondary consequences occur in their professional or private lives.

According to a report to the Georgia Composite State Board of Medical Examiners, approximately 4% to 10% of physicians are brought to the attention of licensing boards because of impairment related to major psychiatric disorders. In addition, some states report that 12% of referrals to physician well-being programs can be classified as "disruptive" physicians that exhibit compulsive behavior or excessive rage. Add to these statistics unreported cases of sexual misconduct, physical disabilities, and age-related impairments and the issue of physician impairment takes on a larger scale.

Not all examples of physician impairment are related to substance abuse, mental disorders, or other disruptive behaviors. The issue of clinical incompetence is one that is difficult to detect but has significant implications. Poor communication, lack of cognitive reasoning, or deficient knowledge base can all have negative impacts on a physician's patients and hospital environment. As with other forms of physician impairment, incompetence needs to be confronted and addressed to reduce risks and find solutions.

Hospital and department administrators need to work with physicians to develop effective ways to deal with impairment. Policies should be developed that are directed toward both prevention and management of these problems. The ability to detect and treat physician impairment in a non-threatening environment is of paramount importance. Instances of physician impairment should be addressed with minimal delay but with the utmost fairness and respect for fellow physicians. Access to mental health counselors, regular reviews of the work environment, and open communication among colleagues are just a few ways to prevent physician impairment.

The absence of physician impairment does not always imply physician wellness, however. Much of the literature to date has focused on lack of physician wellness such as fatigue and burnout. Shanafelt et al. described the positive aspects of wellness in their 2003 article: "Wellness goes beyond merely the absence of distress and includes being challenged, thriving, and achieving success in various aspects of personal and professional life."

Although we all strive to be well, wellness can be a difficult goal to achieve. Physicians often fail to take time off from work when they feel ill, neglect health-maintenance measures like physical examinations, and neglect to seek help when battling mental health issues such as depression. Emergency physicians often work in stressful environments for long periods of time, sometimes without appropriate nutrition, hydration, or bathroom breaks. This can lead to fatigue which can adversely affect patient care. Management of stress either via counseling or stress-reduction programs have been shown to have beneficial effects on both physicians and their patients. One study by Jones et al. demonstrated that after the initiation of a stress-management program, there were reductions in both medication errors and malpractice claims and another by Rø et al. showed reductions in emotional exhaustion at a one year follow-up after a counseling intervention.

As physicians we have an obligation to take care of ourselves and our colleagues as we would our patients. The lives of patients, the quality of hospital care, and the well-being of physicians and their families all hang in the balance.

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