ETHICS IN ACTION

THE IMPAIRED PHYSICIAN

Ethan Cowan, MD, MS
Department of Emergency Medicine and Epidemiology & Population Health – Albert Einstein College of Medicine

CASE PRESENTATION

One of your colleagues and close friends, an emergency medicine physician, was recently involved in a serious motorcycle accident. He sustained multiple orthopedic injuries and was out of work on disability for 5 months. Upon returning to work you notice that he is irritable, easily provoked and argumentative. Some of his outbursts have resulted in formal patient complaints and write-ups by hospital staff. Although he had always been highly sociable and engaged, he now seems to be withdrawn. He has had several episodes at work where the staff described him as being "out of it" and sleepy. At first you attribute his behavior to the stress of returning to work after such a long absence, but as his behavior becomes more erratic you become concerned. One day you get a distressed call from your colleague's wife, who believes her husband has become addicted to pain medications. She tells you that, over the last few months, he has visited multiple physicians, each of whom has prescribed a generous dose of opioid pain medications. Today she happened to be looking through his closet and found hundreds of tablets of hydrocodone and OxyContin.

DISCUSSION

The American College of Emergency Physicians defines physician impairment as occurring "when a physician's professional performance is adversely affected by mental or physical illness, aging, alcoholism, chemical dependence or any other circumstance that interferes with his or her ability to engage safely in patient care."[1] Drug and alcohol abuse are among the most well-recognized causes of physician impairment, but other issues, such as mental illness and cognitive disorders, can also result in a significant decline in one's ability to carry out normal patient care responsibilities. In regard to substance abuse, multiple studies have documented that approximately 10-12% of all physicians will develop a disabling substance abuse problem at some point in their career, similar to rates in the general populace.[2,3]

The case vignette brings up both ethical and legal issues surrounding physician impairment. Two issues that must be assessed when confronting a possibly impaired physician is the degree of danger, if any, the impairment presents to patients, and whether or not to confront and disclose. In most cases of drug and alcohol abuse, it is almost impossible for the affected physician to prevent their addiction from eventually encroaching on and ultimately affecting the care they provide to patients. Even if the physician never shows up to work intoxicated, the long-term effects of both drug and alcohol abuse can take a significant toll on cognitive function and impair one's ability to provide quality patient care. If, as in the case presented, the physician's work behavior is suspicious for abuse and addiction, there can be no doubt about the potential harm that this physician poses to patients. Once there is a reasonable suspicion of physician impairment, there is both an ethical and a legal obligation to report it. The one caveat is that a physician must be immediately reported if they show up to work intoxicated and pose an immediate threat to patients.

From an ethical standpoint, disclosure can be justified by the "harm principle." In the case of physician impairment, the potential harm to patients from being treated by an impaired provider overrides the physician's right to privacy. From a legal standpoint, the legal obligation to report an impaired physician varies from state to state, and it's important to know your own state's reporting requirements. An intermediate option between reporting and not reporting to state licensing boards that is available in most states is having the impaired physician voluntarily enroll in a physician's health program (PHP). These programs are established by state medical societies to assist impaired physicians. They offer a way for the physician to undergo treatment and rehabilitation without being subjected to formal disciplinary action. PHP programs tend to be rigorous. Almost all require post-treatment random drug and alcohol screening, sometimes for years, after the physician completes the rehabilitation program. So long as the physician complies with the PHP's procedures, they can avoid formal reporting to the state's medical board for disciplinary action such as loss of a medical license.

Although many physicians have fears about reporting a colleague, an important thing to remember is that reporting, more often than not, turns out to be the best course of action

Continued on Page 9

JOINING AN SAEM ACADEMY: A RESIDENT'S PERSPECTIVE

Marie Carmelle Tabuteau, DO, MBA
PGY 3 Emergency Medicine – Emory University
Chair - ADIEM Resident Subcommittee

Why should a resident join an SAEM academy? How much can a person at the resident member level contribute to its work?

Marie Carmelle Tabuteau, DO, MBA

As the chair of the Resident Subcommittee of the SAEM Academy for Diversity and Inclusion in Emergency Medicine (ADIEM), I feel it is good to pause and reflect on the value of ADIEM and on why such an academy is crucial to our specialty. Interview season has been in full swing, and the need to recruit and retain residents from diverse backgrounds and interests should be a key driver for success. Why should this matter? From my perspective, the most meaningful memories are the experiences I have had and the knowledge I have gained from my patients, attendings, and fellow residents. I am honored to train in a large metropolitan hospital, in an emergency department that sees patients from many different cultures, patients whose individual perspectives affect the way they interact with emergency department staff and must inform the way we as physicians interact with them. My residency program too is inclusive of people from diverse backgrounds and experiences. Simply put, we strive to mirror the community in which we live. On any given shift, for example, I have worked with residents that have had medical training in the Middle East, as well as with a new intern from the Midwest caring for their first patient in the South. As an African American woman whose family is from Haiti, I have grown and have been motivated to be a better physician by sharing my personal background and experiences with my patients and my colleagues and learning about theirs. Each of us brings our unique contributions to the tapestry of experience and understanding woven by each encounter with the variety of individuals and cultures represented in the emergency department every day, combining in strength and unity that have inspired me to strive to be a better and more aware person.

One of the vehicles SAEM uses to address specific concerns within our specialty is its academies. The mission of ADIEM, the academy with which I am involved, is to increase and ensure inclusion and diversity of the physician workforce at all levels, eliminate disparities in clinical care and outcomes, and encourage the training of EM physicians to deliver culturally appropriate health care. Residents can share their own valuable experiences and insights, as well as their time and talents, to help all SAEM academies fulfill their missions and contribute to the development of academic emergency medicine. I am proud to be a member of ADIEM and to be making my own contribution; I encourage all residents to discover their own interests and passions and to join SAEM academies to help create the future of our specialty.

Please visit SAEM's academy landing page at www.saem.org/saem-community/academies for more information; feel free to contact me at contact me at m.c.tabuteau@emory.edu for more information on ADIEM. ◗

Continued from Page 8

for the physician as well as the patients. If the physician agrees to undergo treatment and enrolls in a PHP, they have a high likelihood of having a successful rehabilitation and re-entry into the workforce.

CASE OUTCOME AND LESSONS LEARNED

After the call from your colleague's wife and his pattern of recent behavior, there was no doubt that he was suffering from an addiction that was significantly impairing his ability to provide safe patient care. You felt you had an ethical, professional and legal obligation to report him. You informed your chairman and hospital administration of your suspicion and the evidence you believed supported ongoing impairment. Your chairman called your colleague into his office and presented the evidence to him. Your colleague was given the option of either voluntarily enrolling in a physician's health program or arguing his case before the state medical board. Upon being confronted with the suspicion of impairment from drug abuse, your colleague admitted his addiction and agreed to voluntary treatment.

The main lesson from this case is that physician impairment is a common, albeit under-recognized problem. Although the legal obligation to report varies by state, it can be argued that once you have identified impairment in a colleague, you, as a physician, have both an ethical and a professional obligation to report. Ultimately, reporting with subsequent treatment can save a colleague's career and protect patients from harm. ◗

BIBLIOGRAPHY

1. American College of Emergency Physicians (ACEP): Policy Statements. Physician Impairment. Retrieved November 5, 2013, from http://www.acep.org/Clinical---Practice-Management/Physician-Impairment/
2. 1. Hughes PH, Brandenburg N, Baldwin DC, Jr, et al. Prevalence of substance use among US physicians. JAMA 1992; 267(17):2333-2339.
3. 2. McLellan AT, Skipper GS, Campbell M, DuPont RL. Five year outcomes in a cohort study of physicians treated for substance use disorders in the United States. BMJ 2008; 337:a2038.