Introduction

One of the tasks facing hospital leadership today is promoting a culture of patient safety. Only recently has the Joint Commission acknowledged that a cornerstone of patient safety is physician health. An unhealthy or impaired physician, either mentally or physically, cannot provide optimal patient care. Impaired concentration, memory or mood may reduce a physician's diagnostic and communication skills potentially leading to poor patient care or, even worse, medical errors and adverse events.

Ironically, the same traits that make a great physician whittle away at the physician's health and well-being. Hospital administrators and staff often value and reward physicians who see a large number of patients, are obsessive about details and are compulsive with habits. Some physicians exhibit an exaggerated sense of responsibility, chronic feelings of not doing enough and an inability to find personal and professional balance. These traits may cause burn out, putting the physician at risk for numerous health problems ranging from cardiovascular disease and obesity to chronic anxiety, depression and addictive disorders.

The general public honors and admires physicians, sometimes forgetting that they are also human. Physicians, like everyone else, are not immune to physical and emotional stressors. Illness of a family member, marital discord or divorce, conflict at work, financial problems, children's tuition payments and physical and mental illnesses can all contribute to overwhelming stress. Stress is a known cause
of physical and emotional break downs. Although not all stress is controllable, the stress that is manageable must be addressed.

The condition of being “stressed out” means the human stress response via the autonomic nervous system has been overworked. It is usually experienced when work and home responsibilities exceed personal and social resources. Situations in which you find yourself with little or no control may exacerbate stress. A certain amount of stress can be exhilarating, but unrelenting, chronic stress may render you unable to cope and diminish your ability to practice medicine optimally.

The Dream vs. the Reality

The practice of medicine is changing quickly. In the past, physicians spent more time caring for the patient. Now HMOs and large practice business models increasingly place the physician in a more removed and impersonal role. Physicians are now called providers who service clients. The practice of medicine can become an obstacle course of electronic charting, completing paperwork, rounding on patients, returning phone calls, and all the while maintaining certification, licensure and yearly CMEs. Add longer hours, productivity standards, decreasing compensation, government and insurance regulations and threats of malpractice claims and even the most devoted practitioner may become disillusioned.

What the Joint Commission says...

On January 1, 2001, The Joint Commission issued medical staff standards that focused on the health and behavior of physicians and staff as contributors to patient safety. Specifically, the element of performance mandated that “Leaders create and implement a process for managing disruptive and inappropriate behaviors.” This standard opened the floodgates for discussions about disruptive and inappropriate behaviors exhibited by physicians and other healthcare providers and staff. In 2008, the element of performance was re-written as “Leaders create and implement a process for managing behaviors that undermine a culture of safety.”

While the wording has been revised, the implications remain the same. Human behaviors that may impact patient safety must be managed by the organization. The Joint Commission describes disruptive behaviors as either active or passive. Active behaviors are overt actions such as petty verbal outbursts or even throwing things, while passive activities include refusing to perform assigned tasks, or quietly exhibiting uncooperative attitudes. Disruptive behaviors can be an indicator of deteriorating physical or mental health or impairment and certainly do not contribute to a culture of safety!

Ironically, the overt actions are easier to identify as safety issues that can be dealt with. Outbursts, addictions and frustration flare-ups are straight forward and, while not acceptable, at least definable. The more difficult scenarios to recognize and mitigate involve human beings dealing with human behavior. These examples are not as easily recognizable as a sign of a stressed out clinician or as having an impact on patient safety.
This scenario might result in a deteriorating patient situation and potentially a malpractice claim. The etiology of both clinicians' actions should be investigated. Is the on-call clinician overly stressed? Burned out? Perhaps even impaired? What about the night staff? Has the staff received adequate education on how to manage difficult situations, reinforcement training on their reporting responsibility? Positive interventions by the on-call and night staff alike are required to resolve the situation and ensure appropriate patient interventions in the future.

Consider the overworked, stressed clinician who cannot disguise the impatience he or she displays when dealing with emotional patient or staff situations - or even having to deal with patients/family with limited literacy skills. These encounters may send a message to the patients that they are using up the clinician's valuable time. Throughout the exchange, the clinician's mind is racing with all the things on today's “to do” list. How many more patients must be seen? How far behind schedule are they running? The non-verbal (or even verbal) expression of impatience results in a chilled interaction that has a negative impact on patient safety. The patient or family member or staff shut/down or cut/off questions because they may feel they are taking up too much of the clinician's time. Discussions that have the potential to impact decisions about care are cut short because the patient/family or staff is inhibited from pursuing the discussion.

Education is stunted, knowledge is limited and the patient’s safety is jeopardized. Instructions on post care follow-up, medication use and side effects, and common complications become casualties of the physician impatience.

**From Disruptive to Impaired?**

An encouraging outcome of the debate on what constituted disruptive behavior was increased institutional concern for physician health and potential for impairment and how this directly relates to patient safety. It was finally acknowledged that 36 hour shifts and 80 hour workweeks contributed not only to errors from fatigue, but a medical and emotional hazard for the physician. Finally, the physician's frailty was recognized as a contributing factor to patient safety.

Years ago, a physician exhibiting disruptive behavior would not have fit any description of impairment. Hospital staffs used to tolerate physicians who acted out with chart throwing, desk or computer whacking, and door slamming. Additionally, certain physicians could bully staff and colleagues with veiled or explicit legal or administrative threats. Deference was given and excuses were made for those physicians who helped fill the hospital beds. This was not recognized as impairment. If the physician's behavior did not ostensibly affect patient care, then staff simply ignored it. This created an unsafe power differential that adversely affected patient care.
Investigating the situation from a physician perspective, a national survey of 1,627 physician members of the American College of Physician Executives helped clarify issues regarding disruptive doctors.

- 36% of the executives surveyed said most behavior problems stem from conflicts between physicians and staff members, including nurses.
- 43% said the behavior problems were not linked to alcohol or substance abuse.
- 50% of the executives surveyed said problems are only reported when a doctor is completely out of line and a serious violation occurs.
- 83% said problems with physician behavior involve disrespect.
- 95% of executives surveyed said their organization had met with a disruptive physician in the last two years to discuss behavior problems.

Note: Percentages are rounded.
Source: American College of Physician Executives
September-October 2004

Recognizing the Early Signs of Impairment

Some early warning signs may include:

- Deterioration of personal hygiene
- Yelling, foul or abusive language
- Threatening gestures
- Malicious gossip
- Hostile avoidance or the “cold shoulder” treatment
- Sarcasm
- Increased absence from professional functions or duties
- Emotionally labile
- Appears sleep-deprived
- Increased incidence of professional errors, i.e., prescriptions, dictations, clinical judgment, non-responsive to pages or telephone calls
- Shows a decreased concern for patient well being and unexplained “personal problems” to mask his or her deficits in concentration and /or patient care
- Increased patient complaints about the quality of care and bedside manner

What the AMA says...

In 1973, The American Medical Association (AMA) formally recognized physician impairment as a serious problem and issued its landmark policy paper entitled “The Sick Physician: Impairment by Psychiatric Disorders, including Alcoholism and Drug Dependence.” The AMA defines an impaired physician as one unable to fulfill professional or personal responsibilities because of psychiatric illness, alcoholism or drug dependency. AMA studies indicate that tobacco and alcohol use and abuse problems appear to occur in physicians at about the same rate as the general population when compared to their age, sex, and income-matched controls. However, drug use, abuse, overdose, and addiction appear to occur more often among the physicians profession.
Physician impairment is more than just drug abuse and dependence, but also includes psychiatric illnesses, and physical ailments associated with aging. The definitions of an impaired physician are consistent between the AMA and the Joint Commission.

Prevention is key - the earlier the detection, the better the rate of recovery and the quicker the return to practice. Notably, short term impairments such as those associated with the stress of a malpractice lawsuit, impending divorce, family illness or any one of a variety of life crises can affect a physician's ability to deliver adequate care. Early intervention and support can sometimes prevent a temporary short-term situation from becoming a more serious threat to physician health.

AMA policy # H-275.952 states that physicians have an ethical obligation to report impaired, incompetent and unethical colleagues. Physicians should be familiar with the reporting requirements in their own state and hospitals and comply accordingly. (See the “Resource” section at the end of this article)

Having direct knowledge of an impaired colleague can weigh heavily upon a physician. It’s difficult to report a colleague who may also be a friend, mentor or partner. The implications are huge and risks are enormous.

AMA policy H-95.968 on substance abuse states that it is the policy of the AMA (1) not to establish a substance abuse hotline, but to continue to respond to inquiries about all physician health issues, including substance abuse issues, on an individual basis; (2) to encourage physicians with substance use disorders to contact their state physician health program since that program is probably best able to render assistance; and (3) to publicize the existence and availability of the Drug Abuse Information and Treatment Referral Hotlines as an alternative and secondary source of referral information.

Physician recovery rates for substance abuse treatment are generally more favorable than those of the general public. Studies on successful treatment outcomes and recovery conducted in Maryland and Rhode Island reported abstinence rates for physicians after treatment vary from 70 to 90%. Treatment programs estimate that 75 to 85% of physicians return to work. This may be due to close monitoring and motivated physicians who have an enormous amount at stake professionally and personally if they relapse.

**Signs and symptoms of Substance Abuse sometimes seen in Physicians:**

- Inaccessibility to patients and staff
- Completing rounds at odd hours
- Decreased chart performance
- Issuing inappropriate order or prescriptions
- Forgetting verbal orders
- Slurred speech during off-hour phone calls
- Heavy drinking at hospital or office functions
- Multiple prescriptions to family members
- Arriving late for appointments
- Erratic job history that includes new jobs in different locations and unexplained time off between jobs.
How do the Joint Commission Requirements Protect Me?

The Joint Commission requires the hospital develop a code of conduct that defines acceptable behavior and behaviors that undermine a culture of safety. The code of conduct adopted by the hospital is for all hospital employees, not just physicians. All team members should be held accountable for modeling the desirable behaviors, and the code should be enforced consistently and equitably among all staff.

What staff perceives as unacceptable or disruptive behavior should be determined prior to developing the code of conduct. Keep in mind perceptions of what constitutes unacceptable behavior may vary by region, culture or clinical area of the hospital. These perceptions will provide a baseline from which physicians, nurses, staff and administrators may create a collaborative organizational process for addressing intimidating and disruptive behaviors.

The Joint Commission has stated that hospitals are required to design a process that provides education and prevention of physical, psychiatric, and emotional illness. Furthermore, hospitals must have a method for reporting, mitigating and resolving issues related to physician health. Facilitating confidential diagnosis, treatment, and rehabilitation of potentially impaired physicians is the ultimate goal. The focus of this process is rehabilitation, rather than discipline, and helping a physician to retain or regain optimal professional functioning. Confidential, professional resources should be available to physicians who are referred. However, the standards also direct that if, at any time, the physician relapses and becomes unsafe, the hospital administration take action. Such action includes, but is not limited to, strict adherence to any state or federally mandated reporting requirements.

According to the Joint Commission, points addressed in administrative policy should include:

- **“Zero tolerance”** for intimidating and/or disruptive behaviors, especially the worst such as assault or other criminal acts. The zero tolerance policy should be incorporated into medical staff bylaws, employment agreements and the code of conduct. The medical staff policies should complement the non-physician staff policies.
- Reducing fear of intimidation or retribution and protecting those who report or cooperate in the investigation of intimidating or unprofessional behavior.
- A system of reporting/surveillance (possibly anonymous) should be developed and implemented for detecting unprofessional behavior. While focusing on addressing the disruptive or undesirable behavior, it should also concentrate on maintaining the privacy and dignity of the accused. This should be supported with non-confrontational strategies. These interventions should initially be non-adversarial in nature, with the focus on building trust, placing accountability on and rehabilitating the offending individual and protecting patient safety.

Implementation strategies for reporting may vary from one hospital to another depending upon facility size, region, medical staff make-up and state regulations. One strategy implemented by hospitals is the formation of “well-being committees” to address staff concerns.
**Barriers to Reporting**

A recent study published in the Journal of the American Medical Association found that two-thirds of physicians with direct knowledge of an impaired or incompetent physician colleague reported them to a medical board, hospital, clinic, professional society or other body. Of the one-third of physicians who had never reported an incompetent or impaired colleague, almost 20% claimed that they thought “someone else was taking care of the issue.” Other common barriers included fear of retribution and the belief that nothing would happen as a result of the reporting.

**How Can I Help Myself?**

While the Joint Commission can raise the bar for workplace recognition of physician health issues, the individual physician shares responsibility for his/her self. Physicians sometimes delay personal and pleasurable interests until more important goals are achieved. This can result in neglect of significant relationships and jeopardize a healthy work-life balance.

Several strategies may help in identifying negative influences or uncovering actual or potential problems:

- Listen to your “self talk.” Are you always complaining to yourself? Monitor the level of optimism and hopefulness contained in the internal dialogue in your mind. A simple activity such as positive affirmations or smiling in the mirror can impact overall outlook. Negativity or depressed feelings can be reinforced with negative “self talk” and may be helped by speaking with a professional.

- Are you content and satisfied? What makes you happy? Are you happy? Asking these questions honestly and openly may help identify sources of discontent. Identifying the cause and effect of happy feelings can help you to replicate these feelings. It can also serve as an exercise to excise happy feelings from the midst of more diffuse emotions.

- What causes you to feel stress? Are you irritable? Anxious? Depressed? Stress management techniques such as meditation, yoga, and walking can help alleviate some of the physiological responses to stress. Finding a supportive friend, colleague or even professional therapist can help channel negative feelings and frustrations into an area where they can be dealt with in a positive manner.

- How are your relationships going? Is your practice going well? Is it what you expected? Neglecting relationships allows them to deteriorate rapidly and

**AMA policy encourages all physicians to have a personal physician whose objectivity is not compromised through income or referral relationships. Those physicians caring for colleagues should not disclose any aspects of their medical care without the physician-patient’s consent, except as required by law, by ethical and professional obligations or when it is essential to protect patients from harm. Even then, only the minimum amount of information required by law or to protect patient safety should be disclosed.**
destroy the family and community support system that is crucial to a healthy work-life balance. Active problem solving can help to regain that loss of control that threatens to overwhelm. Decisions that could help might include engaging in a hobby, plan a vacation with family, hire extra help at the office or cut back on your hours. Creative problem solving breeds hopefulness – what you have decided to do can have a positive impact on your situation.

- What is your body telling you? Are you tired? Do you get enough sleep? Do you have headaches? Back pain? Physical aches and pains can be contributing factors to alcohol or prescription drug use. In general, the etiology behind physician substance abuse and impairment is no different than the causes found in the general public. However, personality characteristics and easy access to potent agents are most often cited as contributing factors in physician substance abuse.

Physician health and impairment is a very real concern in modern day medicine. The community expects and deserves safe and competent health care providers. Every physician has a moral and ethical obligation to make sure that they and their colleagues are healthy both physically and emotionally. Not just for their sake, but also for their patients' safety.

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**Resources**

**States**

**Louisiana**
Physicians’ Health Foundation of Louisiana, Physicians Health Program /888.743.5747  

**Texas**
Committee on Physician Health and Rehabilitation of the Texas Medical Association  
24 hour toll-free number at 800-880-1640

**Arkansas**
Arkansas Medical Foundation: Physician Health Committee Office Hours M-F 8:30am-5pm  
Phone: 501-224-9911

**National**

Federation of State Medical Boards Directory - [http://www.fsmb.org/directory_smb.html](http://www.fsmb.org/directory_smb.html)


The Center for Substance Abuse Treatment's (CSAT) Drug Information, Treatment, and Referral Hotline: 1-800-662-HELP, 1-800-66-AYUDA (Spanish) Provides confidential information and treatment resources in your area.
Bibliography

Web links are provided as a convenience and are subject to change. If the link does not work, web-search the document by title at the time of use.


“Physicians' Perceptions, Preparedness for Reporting, and Experiences Related to Impaired and Incompetent Colleagues,” Journal of the American Medical Association, July 14, 2010

