# The impaired practitioner and role of the profession

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The American Medical Association has defined an impaired physician as — "One who is unable to practice medicine with reasonable skill and safety to patients becuase of physical or mental illness including deterioration through the ageing process, or loss of motor skill or excessive use of drugs including alcohol"[1].

This definition may appear at first glance to be clear-cut and uncontroversial but in practice one is often dealing with varying degrees of impairment. For instance an ageing practitioner may be unfit to undertake surgical procedures but be perfectly competent to perform non-procedural work. Another example is the degree of safety to patients of a practitioner who is infected with the HIV, hepatitis B or hepatitis C virus. Finally, where does one draw the line on mental illness? Should eccentric personalities who disadvantage their patients or practitioners who sexually abuse their patients be categorized as impaired physicians?

Accurate figures on the extent of the problem are unavailable because impairment is often concealed by the practitioner and is rarely brought to light by the practitioner's colleagues or patients. Thus what is available are rough estimates. In the U.S. a Mayo Clinic study showed that 7% of physicians surveyed were possible or probable alcoholics, a percentage similar to that found in general medical outpatients[2]. Abuse of prescription and illicit drugs, though less prevalent than alcohol abuse, is generally believed to be much commoner in pyhsicians than in the general population. A more reliable statistic is the annual loss in the U.S. of approximately 700 medical practitioners on account of suicide, and alcohol and drug abuse. Startling as this figure is, it still represents only the tip of iceberg.

Figure 1 details the nature of the common impairments. Major depression is a common psychiatric disorder in the medical profession as elsewhere but it rarely poses a problem with respect to patient-care as the practitioner usually withdraws from professional work when the depression becomes severe. The same cannot be said for hypomanic illness in which a career can be destroyed in the course of a few weeks. There is an unfortunate tendency for psychiatrists to avoid the diagnosis of schizophrenia and delusional disorder (paranoid psychosis) in their medical colleagues and instead to use such euphemisms as atypical depression or eccentric personality. Although this attitude may be motivated by the well-intentioned desire to avoid the stigma attached to schizophrenia and delusional disorder the end result is that the impaired practitioner is deprived of the chance of effective treatment.

**Nature of Impairment**

(a) Mental illness: major depression, mania, schizophrenia

(b) Drug/Alcohol abuse: narcotics, alcohol.

(c) Ageing practitioner: dementia, impaired visuo-motor skills, outdated.

(d) "Grey zone": some underperforming doctors, difficult characters.

(e) "Sexually-impaired": personality disorder.

**Figure 1**

In the category of substance abuse disorders, alcohol far exceeds all the other drugs combined, but is very rarely brought to the attention of Medical Boards because of the social tolerance to alcohol consumption as the following case vignette, abstracted from the Annual Report of the Medical Board of Victoria (1992/93) illustrates: Dr.X, anaesthetist on-call to a suburban hospital, received a call at 10.30pm to administer an anaesthetic. On the way to hopital he was found to have a blood alcohol reading of 0.11 on a random police check. The surgeon when informedd insisted that the anaesthetist be released to assist in urgent surgery. Dr. X was taken by police vehicle to the hospital where he proceeded to administer a general anaesthetic as planned. The surgeon commented afterwards that Dr X had administered the anaesthetic in his usual "perfectly competent" fashion.

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With respect to the ageing practitioner there have been concerns that a proportion of practitioners in this category are practising beyond their levels of competence. It has been proposed that after a certain age medical practitioners should submit themselves to a practice-audit and be re-certified. This may be harsh and even discriminatory especially in view of the fact that complaints against ageing practitioners are relatively infrequent, and because most older practitioners tend to modify their practice to accommodate for their failing perceptual abilities and motor skills.

The grey zone in Figure 1 refers to eccentric practitioners and practitioners with idiosyncratic styles of practice who on investigation by a Medical Board may reveal a greater or lesser degree of psychiatric impairment. The sexually abusing doctor is usually dealt with as a disciplinary matter and is denied the more lenient provisions available to the impaired practitioner, although rehabilitation programmes offered for this condition often refer to such practitioners as being sexually impaired.

**Table 1. Monitoring Program-Nature of Impairment**

| | |
|---|---|
| Drug Abuse | 48 |
| Psychiatric | 31 |
| Alcohol Abuse | 9 |
| Physical | 1 |
| Total | 89 |

Table 1 gives the nature of impairment of the 89 practitioners who were monitored during a 12-month period in 1993/94 by the New South Wales (Australia) Medical Board. The commonest cause of impairment was self administration of narcotic durgs and this condition was five times more frequent than impairment caused by alcohol dependence. This is a reversal of the presumed relative prevalence of the two disorders among medical practitioners, confirming the fact that alcohol is seldom reported

**Role of the Profession**

- protection of the community
- self-regulatory function
- self-protection and self interest
- caring function
- conserve human resources

**Figure 2**

The role of the profession (Figure 2) with respect to the impaired practitioner is first and foremost the protection of the community. A distinguishing characteristic of a profession is its self regulatory function. It is only by committing itself to this function that the medical profession can maintain its intergrity and retain its position of high standing in the community. Accodingly, notification of an impaired colleague becomes an important responsibility of every practitioner and should not be seen as a morally reprehensible act. The American Medical Association has emphasized this obligation to its members by incorporating the duty to inform in its ethical code of 1980. Section two of the Principles of Medical Ethics states "A physician shall deal honestly with patients and colleagues, and strive to expose those physicians deficient in character or competence, or who engage in fraud or deception". In many parts of the world, the reporting of an impaired practitioner who poses a serious risk to the public is a mandatory requirement. The Medical Practice Act 1994 of the State of Victoria, Australia goes even further by providing the reporting practitioner with statuory immunity from liability, provided the report is made in good faith

In the past two decades there has been a trend for Medical Boards to go beyond its traditional role of protecting the community and become involved in the rehabilitation of the impaired practitioner. In 1981 the General Medical Council of U.K. appointed the first Preliminary Screener for Health Procedures. His main functions are to place the doctor under appropriate medical care and if necessary to limit his practice. This is undertaken by the impaired doctor on a voluntary basis. The Council becomes directly involved only if the impaired practitioner fails to co-operate with the Preliminary Screener. This concept of a screener has now spread to other parts of the world and the experience up to date is that by this approach the problems of the impaired practitioner can be addressed in a less traumatic and more compassionate manner, and that the results are better than the previous approch of simply excluding the practitioner and leaving him to his own devices.

A variation of the above strategy are the Diversionary Programmes which have been adopted successfully by some states in the United States. An impaired practitioner may voluntarily enter such a programme for treatment and rehabilitation of drug dependence. Alternatively the practitioner may be referred to the programme by a Board. These diversionary programmes, which may have an

input from the Medical Association of that State, has discretionary powers with respect to notification of the Board if the practitioner poses a risk to the public.

Other treatment strategies which have been developed to assist impaired practitioners are: (a) regional referral programmes by which contact can be made by telephone with an advisory panel of practitioners who will direct the impaired practitioner for appropriate treatment, (b) the option of appointing a preliminary assessor who is not a member of the Medical Board, (c) establishing supernumary positions in hospitals where the inpaired practitioner can begin his rehabilitation under supervision, (d) confidential counselling on practice management by experienced medical practitioners, and (e) self-help groups. Much has been learnt in recent years of the treatment of the drug-dependent practitioner. The important lessons which have learnt are that (a) close monitoring is essential, a vital element of which is frequent random urinary drug-screening (b) the incidence of relapse can be minimized by placing appropriate restrictions and conditions on practice, (c) psychiatric follow-up must be for an extended period with gradual easing of conditions, (d) the prognosis is relatively favourable, and (e) early relapse is compatible with good long term outcome.

Only a passing comment will be made of the sexually abusing practitioner. There has been a recent epidemic of this disorder in the Western world and it is likely to spread to the rest of the world with a lag period of a few years. The general consensus is that the apparent increase in the frequency of this phenomenon is due mainly to increased reporting and not to changing sexual mores in the community. This has probably come about by changing community attitudes whereby patients are no longer willing to accept sexual abuse and exploitation by health providers. Medical Boards which have experience of investigating such complaints are beginning to take an attitude of "zero tolerance" to such professional behaviour because of the devastating effects it has had on the victims who are moved to complain.

**References**

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