Working With Impaired Residents: Trials, Tribulations, and Successes

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Impairment of physicians' ability to practice medicine safely and effectively is relatively common. Chemical dependency, the leading cause of physician impairment, has a lifetime prevalence of approximately 10%–15% among physicians. Statistics from physician health programs indicate that family physicians are overrepresented among impaired physicians. It is therefore important for family practice residencies to monitor for and deal with physician impairment. Over the past 11 years, we have worked with eight impaired residents: five with chemical dependency, two with cognitive impairment, and one with an affective disorder. Seven of the eight residents are currently practicing medicine, six in family practice. Based on our experience and the literature, we have developed an algorithm that includes the recognition, intervention, and aftercare of impaired residents. The long-term success of the majority of impaired residents with whom we have worked suggests that the trials and tribulations of working with this potentially difficult group of residents are well worth the effort.

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Physician impairment was defined by the American Medical Association (AMA) in 1973 as "the inability to practice medicine with reasonable skill and safety to patients by reason of physical or mental illness, including alcoholism and drug dependence."[1] Chemical dependency is the leading cause of physician impairment, with a lifetime prevalence of approximately 10%–15%, which is similar to that of the general population.[2-4] Compared to the general population, however, there is a higher rate of abuse of benzodiazepines and opiates due to self prescribing by physicians.[4,5] Another striking difference between the general population and impaired physicians is that female physicians have an alcoholism rate approximately equal to that of male physicians.[2] Other impairments, such as mental illness, cause physician impairment but at a much lower rate.[6-8]

Data from the California Physicians Diversion Program, which had 239 active participants as of December 31, 1998, showed that family practice was the second most common specialty behind anesthesiology for physicians involved in their program.[9] Statistics from Georgia's Impaired Physician Program about their first 1,000 physicians also indicated that family physicians and anesthesiologists were overrepresented among physicians participating in their program.[10] Given the prevalence of physician impairment and the overrepresentation of family physicians among impaired physicians (Table 1), it is important that the faculty of family practice residency programs be knowledgeable about working with impaired physicians.

Between 1989 and 2001, the JFK Family Practice Residency Program had the experience of working with eight residents who fit the AMA definition of an impaired physician. This article describes our residency's experience in working with these impaired residents and presents an algorithm to assist family medicine educators with the recognition, intervention, and subsequent aftercare of impaired residents.

JFK Family Practice Residency's Experience

Over the past 11 years, the faculty of JFK Family Practice Residency have worked with eight impaired residents (Table 2).

Residents 1 and 2 were identified as having impairments due to chemical dependency, resident 1 from

From the JFK Family Practice Residency, UMDNJ-Robert Wood Johnson Medical School.

prescription drugs and resident 2 from alcohol. Both of these residents were identified because of behaviors that included excessive work absenteeism, conflict with staff and peers, patient complaints, and poor academic performance. Resident 3 was identified as having an affective disorder and displayed symptoms of anxiety, depression, and mania in conjunction with weak academic performance and poor organizational skills. Residents 4 and 5 were identified with cognitive impairments, including varying degrees of learning disabilities. Their behaviors consisted of poor organizational skills, being unusually slow when seeing patients in the family practice center, and having trouble remembering assigned tasks. Based on a pattern of these suspicious behaviors, each of the residents, regardless of impairment, was confronted with a planned intervention.

The program director, with one other participant, conducted each of the interventions. The second participant was either the program's behavioral scientist, the resident's medical faculty advisor, or the program's administrative secretary. The director was always the primary spokesperson; the interventions occurred privately in the director's office. The goals of the intervention varied depending on the particular resident involved and ranged from further assessment to being required to enter a treatment program, with compliance required as a condition of remaining in the residency.

The beginning of each intervention consisted of reviewing the documented behaviors that precipitated the intervention. The interventions were always done from the perspective of genuine concern for the well-being

Table 1

Impairment by Specialty—Comparative Data From Two States

Specialty	*California Data*[9]		*Georgia Data*[10]	
Anesthesiology	40	(16.7%)	121	(12.1%)*
Family practice	38	(15.9%)	257	(25.7%)*
Internal medicine	32	(13.4%)	137	(13.7%)*
Psychiatry	24	(10.0%)	64	(6.4%)
Emergency medicine	16	(6.7%)	48	(4.8%)
OB-GYN	13	(5.4%)	61	(6.1%)
Orthopedics	10	(4.2%)	31	(3.1%)
Pediatrics	7	(2.9%)	32	(3.2%)
Surgery	6	(2.5%)	77	(7.7%)
Ophthalmology	6	(2.5%)	16	(1.6%)
General practice	5	(2.1%)	**	**
Dermatology	4	(1.7%)	—	—
Radiology	4	(1.7%)	32	(3.2%)
Cardiology	3	(1.3%)	—	—
Ear, nose, and throat	2	(.8%)	17	(1.7%)
Pathology	2	(.8%)	16	(1.6%)
Urology	2	(.8%)	—	—
Plastic surgery	1	(.4%)	15	(1.5%)
Neurological surgery	—	—	13	(1.3%)
Thoracic surgery	—	—	12	(1.2%)
Other	24	(10.0%)	51	(5.1%)
Total participants	239		1,000	

* In the Georgia study, the incidence of physician impairment in anesthesia and family practice was found to be greater than expected based on a comparison to the American Medical Association's database of the number of physicians in each specialty. The incidence of impairment for internal medicine was within the expected number.[10]

** Included in family practice (above)

Table 2

JFK Family Practice Residency's Experience With Impaired Residents (1989–2001)

Resident	*Identified by JFK*	*Impairment*	*Training Prior to JFK*	*Aftercare While at JFK*	*Completed JFK's Program*	*Long-term Outcome*
1	Yes	Chemical dependency	Yes	Relapsed	No	Completed training elsewhere, practicing, in recovery
2	Yes	Chemical dependency	No	Relapsed	No	Completed training elsewhere, practicing, in recovery
3	Yes	Affective disorder	No	Relapsed	No	Left medicine
4	Yes	Cognitive impairment due to organic disease	Yes	Successful	Yes	Practicing
5	Yes	Cognitive impairment	Yes	None	No	Practicing
6	No	Chemical dependency	Yes	Entered program during aftercare	Yes	Practicing, in recovery
7	No	Chemical dependency	Yes	Entered program during aftercare	Yes	Practicing, in recovery
8	No	Chemical dependency	Yes	Entered program during aftercare	Yes	Practicing, in recovery

of the resident, as well as for the safety of the patients and staff. Frequently, the director was in the role of disciplinarian, allowing the second participant to offer emotional support to the resident. As part of the intervention, the resident was told that the New Jersey Physicians Health Program would be contacted and that his/her cooperation with the program was mandatory for remaining in the residency.

Each resident's assessment, treatment, and aftercare program was unique to the individual's impairment and needs. Continuing care contracts were established with each resident that included verification of active participation in his/her treatment and aftercare programs. Remaining in the residency was contingent on compliance with his/her continuing care contracts. For residents with chemical dependency, there were additional parameters established by the State Board of Medical Examiners for the residents to continue in training. In addition, residents with chemical dependency had an active, random urine testing program that was administered by the New Jersey Physicians Health Program in conjunction with the residency.

Resident 4 was the only impaired resident identified within the residency who successfully completed JFK's program. This resident had a cognitive impairment due to an organic disease and was successful after undergoing a cognitive rehabilitation evaluation and treatment program. Resident 5 was also identified with a cognitive impairment but chose to leave the residency rather than cooperate with an assessment and treatment program. Residents 1, 2, and 3 all showed signs of relapse after their initial identification and treatment intervention. These relapses manifested themselves as poor compliance with their aftercare contracts and a continuation of suspicious behaviors. Some of the residents were also unable to overcome academic deficits as a result of their impairments. Each of the residents who failed to comply with his/her aftercare program was dismissed from the residency.

Residents 6, 7, and 8 entered our program at the recommendation of the New Jersey Physicians' Health Program because we were known as a residency willing to work with impaired residents. All of these residents had completed an inpatient rehabilitation program and were in various stages of their personal recovery. They entered the program with a continuing care contract from the New Jersey Board of Medical Examiners and the New Jersey Physicians Health Program. It was clearly established when they enrolled that they could remain in the residency only if they complied with their continuing care contract. Each of these residents fulfilled his or her contract and successfully graduated.

Overall, JFK had four impaired residents successfully complete the program and four who did not. It is important to note that the three residents with chemical dependency who completed the residency (residents 6, 7, 8) entered the program in a later stage of their recovery process than those chemically dependent residents initially identified by our residency (residents 1, 2). Even though the two residents identified with chemical dependency by our residency did not complete JFK's program, they did complete another family practice residency when they were further along in their recovery.

Algorithm for Working With Impaired Residents

We have found that the model of care developed for chemically dependent physicians has been equally applicable to residents impaired due to cognitive difficulties or mental illness. The "Algorithm For Working With Impaired Residents" draws from our own experience and from the literature about chemically dependent physicians[3,6] (Figure 1).

Recognition

The literature suggests many "red flags" that occur in the lives of chemically impaired physicians.[6] The first sphere of a person's life influenced by the addictive process appears to be the family, making recognition at the workplace difficult in the earliest stages of addiction.[11] Signs that appear in the family include withdrawal from family activities, hostile/abusive behavior, wide mood swings, and prolonged absences from home. Marital separation and divorce are more-public family disruptions.

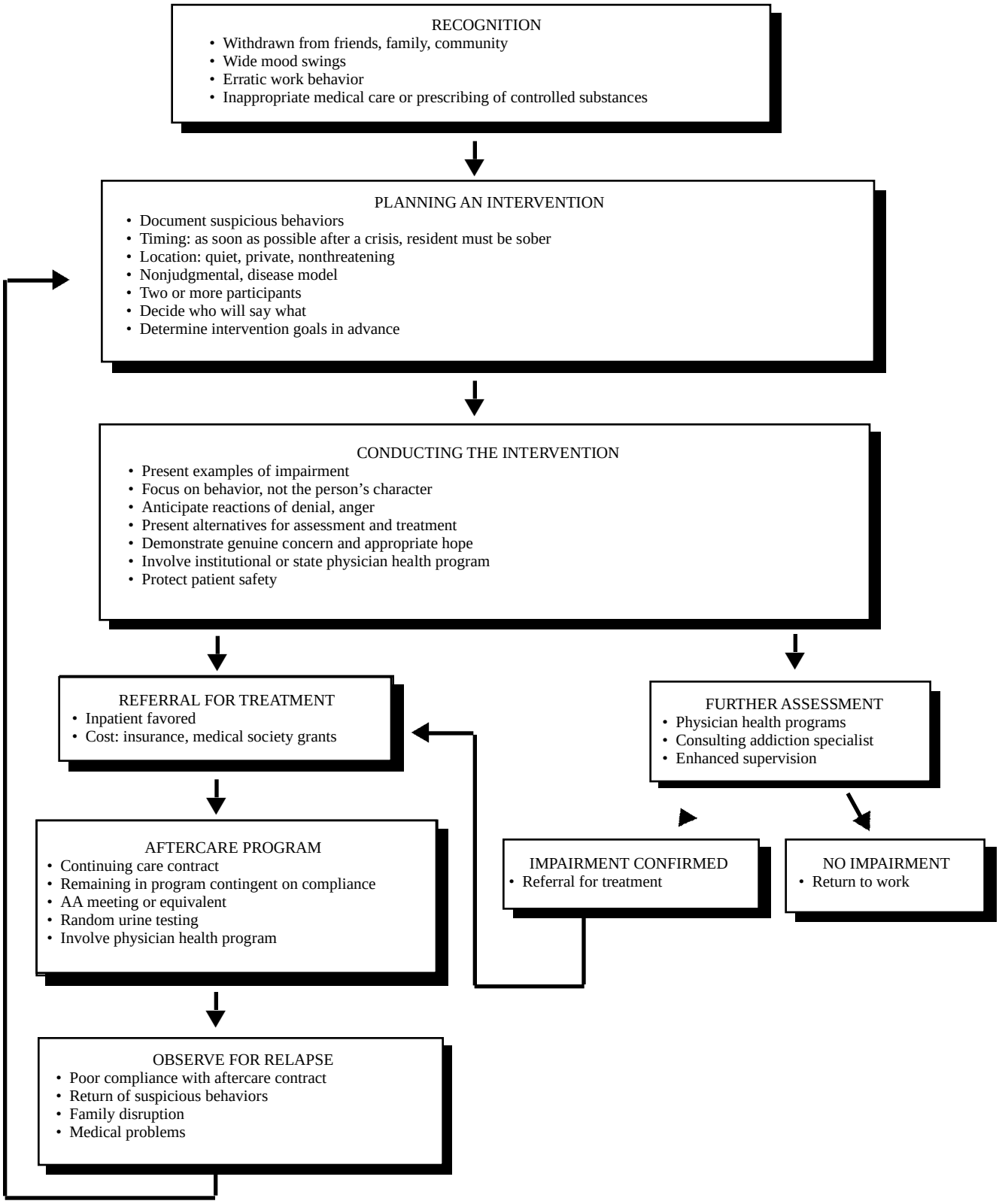
As the addiction progresses, the individual may withdraw from or neglect community activities or may publicly embarrass himself/herself due to intoxication. Loss of longstanding friendships, or at least a shift in peers, may be evident at this point. Arrests for driving while intoxicated (DWI) are also common at this stage. Personal health consequences soon follow and may include deterioration in appearance, medical complications of the addiction process, and outward signs of intoxication/withdrawal. Emotional crises and mood swings can also be seen.

Notably last, impairment begins to show up in the workplace.[3] For residents and attending physicians, this may be manifested as deterioration in work performance. Arriving late and/or leaving early is common, as are ever-expanding mood swings and argumentativeness. Patient complaints may increase, and inappropriate prescribing patterns may emerge, particularly with controlled substances. Physician functioning in the hospital often deteriorates; problem behaviors that may emerge include rounding at inappropriate times, writing/giving inappropriate orders, poor patient management, inappropriate response to phone calls, and even relocating one's practice or changing residency to avoid detection.[11]

Many barriers to recognition exist, most significantly denial by both the addicted physician and colleagues.[6,12] A code of silence may complicate the identification of

Figure 1

Algorithm for Working With Impaired Residents



impaired physicians/residents, as does lack of addiction training for most physicians.[3,11,13] The gradual progression of addictive diseases from family to community and then finally to workplace impairment creates a barrier to early recognition in the workplace.

Planning an Intervention

Once the functional impairment of the resident has been recognized, the next step is to plan an intervention in which the resident is confronted about problem behaviors. At least two people should be part of the intervention team. These participants should approach the intervention with a disease model perspective. They should be prepared to present specific, well-documented examples of suspicious behaviors. Intervention goals, including further assessment and/or treatment alternatives, should be clearly established prior to the meeting. This preparation must be accomplished in a timely manner, since the intervention should be done as soon as possible after a crisis. Ideally, the intervention is conducted when the resident is sober, and it should be done in a quiet, private, nonthreatening setting.

Conducting the Intervention

Both the literature and our experience suggest a model of intervention that combines both confrontation and concern.[6] First, pre-documented suspicious behaviors should be presented to the resident in a nonjudgmental fashion, focusing on the resident's behavior and not the resident's character. Faculty should demonstrate a genuine concern during the intervention. Reactions of anger and/or denial are common and should be anticipated.

A familiarity with the disease model of addiction is essential to being able to remain nonjudgmental because the impaired physician has often developed strong defenses and excuses for his/her behaviors, which may trigger reactions of anger/frustration during the intervention. It may also be necessary to report the resident's behaviors to state regulatory agencies. Appropriate state agencies to contact can be identified through the National Federation of State Physician Health Programs at the American Medical Association, Science Quality and Public Health, 515 North State Street, Chicago, IL 60610, phone: 312-464-4574.

Faculty must be able to clearly and calmly communicate the facts of the problem behaviors, their concern for the resident, and their concern for patient safety. Protection of patients must be the highest priority and may necessitate a summary suspension or immediate leave of absence pending further investigation. The intervention should result in either further assessment under enhanced supervision, consultation with an addiction specialist, or immediate referral for treatment.

Treatment Considerations

Physician health programs can sometimes offer concrete resources, including access to grant money to help fund treatment.[14] This is vital since treatment options are usually limited by current health insurance practices. Longer treatment is associated with greater success for addictive disorders.[2,6,15] There are physician-only inpatient treatment programs that have expertise in dealing with physician addicts, but general treatment programs have the advantage of reinforcing the fact that physicians are not unique people. There are no data to suggest that either approach is superior. However, there is a strong bias toward treating physician addicts in inpatient treatment programs.[2,6,16]

In the case of residents with other psychiatric or organic disorders underlying their impairment, consultation with or referral to mental health professionals, learning disability consultants, etc, is generally indicated.

Aftercare Program

A successful aftercare program is contingent on having a continuing care contract that clearly spells out the consequences for noncompliance.[4,17] Remaining in the residency and obtaining a medical license should be made contingent on fulfilling the contract.

Continuing care contracts are usually individualized to meet each physician's needs and vary from state to state. Comparative state regulations have not been published. A typical contract will usually include attendance at Alcoholics Anonymous meetings, random urine testing, and/or outpatient individual psychotherapy and/or family therapy when appropriate. Urine testing varies by state but is often similar to New Jersey's policy of twice per week for 6 months, then once per week for 18 months, followed by an individualized program for up to 5 years of testing. Personal face-to-face contact on a regular basis with the state physician health program is often required.

Signs of Relapse

Relapse is associated with strong and persistent denial of having a problem by the impaired physician, a dysfunctional family system, an untreated medical or secondary addiction, a weak aftercare contract, and a general inability to install alternative coping strategies for dealing with stress.[17] Often, the relapsing impaired physician will once again display suspicious behaviors that necessitate another intervention and treatment program.

Discussion

Five of our program's eight impaired residents were impaired due to chemical dependency. The success of each of these residents in the 3-year period of our residency correlated directly with his/her personal stage of

recovery. Those residents with chemical dependency who were initially identified by our program had a short-term failure rate but were ultimately successful in their recovery. While we had only one resident with an affective disorder and two with cognitive impairment, our experience raises the possibility that residents with these impairments may not have as successful a long-term prognosis as those physicians with chemical dependency. No literature addresses this issue, making it an area for further research.

State physician health programs that have published their experiences show successful outcomes. For example, New Jersey's Physicians Health Program experience for 1989 and 1990 included 80 chemically dependent physicians. They had a recovery rate of 83.8% with no relapses after 2 years and had a 97.5% 2-year success rate, when including the 13.8% of physicians who had one relapse.[14] They noted that in the chemical dependency field, one posttreatment relapse is considered part of the disease process and often seen as helpful to long-term sobriety and recovery. Physician relapse is often associated with a break in the recovery program and nonacceptance of the disease model.[17]

Overall, national statistics report physicians having an 83% total abstinence 1 year after receiving a comprehensive treatment program. In the nonphysician population, the figure drops dramatically to a 62% abstinence rate.[18] A 5- to 10-year follow-up study from Georgia of 100 physicians found that 77 had maintained documentable abstinence from all mood-altering substances.[17] It has been hypothesized that physicians do better than the general population because of (1) frequent, in-person contact with physician health program staff to monitor and update treatment plans, (2) formal, structured, addiction-informed outpatient psychotherapy, and (3) a highly structured urine monitoring program.[14,15] However, the frequent use of inpatient treatment may also contribute favorably to better physician outcomes. More study is necessary to firmly establish if this is true; if it is, it would have implications for the treatment of all addicts.

It is not clear why family physicians are overrepresented in physician health programs.[9,10] National statistics do not exist about the number of impaired physicians divided by the total number of physicians in a specialty. Therefore, we do not know if family physicians have a higher rate of impairment than other specialties or are just identified more frequently. Better identification of impaired family physicians could be due to the specialty's emphasis on the behavioral sciences, including addiction training, and is worthy of further study.

In dealing with impaired physicians, it is important to be aware of the American With Disabilities Act (ADA). The ADA does not apply to physicians who are currently using illegal substances. It does apply to physicians who are actively in a recovery program. When interviewing applicants for the residency program, it is illegal to inquire directly about an applicant's impairment. You can ask the applicant, "Do you require any job accommodations?" as well as ask for an explanation of any gaps in his/her CV. Reasonable accommodations that are not a burden to the program are required to be made. Medical drug testing can only be done when an offer to hire is pending but cannot be done as a prerequisite for offering a position.[20]

Most importantly, we have an obligation to protect patients when making decisions concerning impaired residents. When a program cannot ensure patient safety due to an impaired resident, that is the time to suspend or dismiss the resident from the residency. Ideally, this should be done with the support of a physician health program in conjunction with encouraging the resident to seek appropriate treatment that could help him/her return to the practice of medicine.

Conclusions

A long-range view of success is essential to working with impaired residents and physicians. It is important to recognize that suspension or dismissal may be only a temporary setback on the resident's long road to recovery. Short-term failure, including relapse, may in fact lead to long-term success.

Personality disorders, affective disorders, and cognitive impairment may represent a potentially more-difficult subset of impaired residents to deal with, compared with chemical dependency. Further research is needed on the long-term outcomes of physicians with these impairments. Overall, the rewards of working with impaired residents has outweighed the trials and tribulations, and we would encourage other residencies to be willing to work with this potentially rewarding group of residents.

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Editor's Note: The approach outlined in this article represents the approach recommended by the authors. The approach does not represent recommendations or endorsement by the editors or the Society of Teachers of Family Medicine. Residency directors and faculty responsible for dealing with residents who have suspected or known impairments should seek legal counsel to assure they are following all applicable provisions of the Americans With Disabilities Act.
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