

Ethics opinion: The practitioner in need of care

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The generally used way of defining impairment when referring to medical practitioners is the inability to practice medicine with reasonable skill and safety for patients. This may be due to progressive physical or mental illness of the practitioner, loss of motor skills, deterioration through ageing or excessive use or abuse of alcohol or drugs, be it high schedule medication or illicit drugs (AMA 2011, Dhali 2006). It is important to note that the entire projection of the statement is towards the patient, care of the patient and safety aspects of the patients. A practitioner who may be impaired would internalise the dilemma but the reality is that the interest of the patient is paramount and that dictates the dealings with the practitioner.

Impairment

Impairment exists under medical practitioners and will continue to exist. Over time it will affect up to 15% of medical practitioners. The worldwide top reasons for impairment are alcohol abuse and psychiatric illness (AMA 2011).

A look from a distance at medical practitioners may reveal that doctors form a particular risk group for impairment:

- Doctors have a high risk for suicide
- Doctors frequently have burn-out and suffer from chronic stress and fatigue
- Doctors need help or incentives to relax
- Doctors often have problematic work-life relationships
- Doctors often see some of the worst aspects of life
- Doctors are in unexpressed competition with one another

In summary, doctors are conscientious, compulsive perpetual achievers who need to stay in control. To worsen this scenario, doctors also have access to opioids and other medication. The high stress and high strain of the job are the chronic companions. Fatigue and emotional bluntness occurs practically in every practitioner. Even amongst medical students burn-out has been recorded in a quarter of senior students (Van Rooyen 2006) and depression is common starting from school days and continuing through medical school and then into practice. This state of affairs can be regarded as Pre-impairment.

Pre-impairment

Pre-impairment should be detected when it hits the medical practitioner. Self diagnosis is highly unlikely to change habits and practice. The medical practitioner is known for perseverance and continuing with the job at hand. Fatigue, adverse occurrences, law suits, excessive workload all do not detract the doctor from carrying on with work, all under the banner of doing this for the patient. Therefore there is a big responsibility resting on the shoulders of the peer group (Hudley 1985). The peers are however often blinded to the process and in many cases stands back in non-intervention. Matters that could have been corrected at pre-impairment level thus often worsen until impairment occurs.

If peer group intervention could have taken place as a soft and gentle approach some matters could even be prevented. It is recognised that such interference is very difficult on a one-on-one basis.

Managing impairment

Once impairment has become apparent or seriously suspected a standardised approach should be followed:

- Suspicion and detection
- Diagnosis
- Care and management of the practitioner
- Reporting of the practitioner
- Follow-up and re-integration of the practitioner

Suspicion and detection

Once impairment has struck the practitioner may demonstrate several traits:

- Subtle personality changes
- Mood swings and outbursts or irritability
- Paranoia, euphoria, hyperactivity
- Absenteeism and poor performance
- Conflict with staff, colleagues and patients
- Declining personal hygiene
- Progressive isolationism (Boisaubin 2001, Mossman 2011)

It is clear that only those who know the medical practitioner either personally or in the workplace will be able to detect such changes. Suspicion and detection must therefore lead to a definitive step namely diagnosis.

Diagnosis

This is of course very difficult. A senior person in the workplace or from a professional Society or a friend will have to conduct a talk session about the possibility of impairment having struck. Complex

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issues such as “smell of alcohol”, “absent minded and wrong”, or suspicious behaviour should be talked about. More information obtained may lead to a real problem being confronted by the doctor and may help the medical practitioner considerably to move towards the next step which is Care.

This is not fool proof. This is however the preferred option as care will invariably follow a diagnosis. If suspicions persist then reporting will often take place and care may be postponed.

Care and management of the practitioner

The underlying priority is that the practitioner is in need of care and help and that should be the first step rather than censure, this will follow at a later stage. Often the responsibility of care and support programmes rest with psychiatrists. Care is aimed at improvement and stability and rehabilitation to avoid future damage. There is no possibility of self care. Medical practitioners with impairment need help and care from specialist practitioners knowledgeable in this field (Hulse 2004).

Care also includes help with day to day problems where the practice, finances and intercollegial contact and conduct must be addressed.

Reporting of the practitioner

As in practically all countries, referral to the registration authority is mandatory and outlined in law. In South Africa this will mean referral to the Health Committee of the HPCSA (HPCSA 2012). The registration authority has several responsibilities or options:

- Cancelling or suspending the registration of a practitioner
- Planning for monitoring and supervision including progress reports and reassessments
- Planning for reintegration into the profession

If a medical practitioner diagnosed with impairment is allowed to continue with practice it will have to be supervised by a senior person. If over time the progress reports indicate favourable response and the reasons for the impairment may have terminated (such as alcohol abuse) then the impairment will be regarded as being non-permanent and the practitioner may be declared competent to carry on with practice.

Follow-up and reintegration

Care should be continued as long as found to be necessary by the caregiver. Once a person who had a temporary reason for impairment has been found to have been rehabilitated then the practitioner will be able to carry on with practice.

Prognosis

The prognosis of impairment depends on many factors, mostly the underlying diagnosis. Strang (1998) pointed out that a good prognosis depends on

- Nondelayed entry into care programmes
- Shielded care being offered away from patient cohorts
- Strict adherence to supervision and monitoring

Good prognosis and functioning rates of around 75% even after extended follow up over two decades have been reported (Marshall 2008, Shore 1987).

Physician health and wellness

The American Medical Association opinion 9.0305 on physician health and wellness holds several strong messages. This includes

- Own responsibility of a physician to prevent impairment as much as possible
 - Own health lifestyle and avoidance of all substances or usage styles that could lead to own impairment
 - Treatment for won acute and chronic conditions
 - Management of own disabilities and stress
 - A reflective lifestyle and practice
 - Must have an own independent personal physician
- Responsibility and role towards colleagues
 - We share a collective responsibility to ensure the care to patients remains uncompromised
 - We need to refer an impaired colleague to the relevant authorities
 - We must help the impaired individual as far as we can through detection, intervention and care programmes
 - We must ensure that a colleague follows suspension or restricted practice while under care and we must assist reintegration once that is completed (AMA 2011).

Clinging to normality

Normality would include interpersonal support and respect. All medical practitioners go through bad moments and in some this turn to bad long periods. Normality would imply that those who know should support the troubled and pre-impaired practitioner in times of personal loss, personal illness, emotional or financial or other disasters, severe stress and work overload leading to absence or rest, severe work related matters such as loss or injury of a patient, serious complications, claims and complaints, and even imminent retirement.

Each practitioner should have someone to speak to. In the Medical School all students are called on to have a Buddy. Mentorship programmes exist in medical schools. Solo practice is a lonely situation and a Buddy is necessary. In group practices comfort times and discussions should be incorporated in the workplace scenario. Awareness of pre-impairment, impairment and rehabilitation processes will add considerably to better day to day practice.

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