



The impaired practitioner – scope of the problem and ethical challenges

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Practitioner impairment occurs when a physical, mental or substance-related disorder interferes with his or her ability to engage in professional activities competently and safely. The Health Professions Council of South Africa makes reporting of impaired colleagues and students mandatory. The ethical dilemma faced by many colleagues on the issue of reporting an impaired practitioner is that of having to choose between protecting the privacy of the practitioner and the safety

of patients. However, medicine as a profession with an acknowledged fiduciary relationship has a clear responsibility to assure the public, and all patients, that its practitioners and institutions are trustworthy. An awareness of and sensitivity to physician vulnerability and early detection and prevention of impairment is important.

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While recognition of the impaired physician as a distinct problem in medicine emerged in the 1970s,¹ and has been the subject of attention for over 35 years, insufficient attention has so far been given to ensuring that these practitioners obtain the services that they themselves provide for others. Practitioner impairment occurs when a physical, mental or substance-related disorder interferes with his or her ability to engage in professional activities competently and safely² (and unpublished HPCSA document, 2005, obtained directly from Itumeleng Maloa, Committee Co-ordinator – Health Committee). Professional activities refer to those situations where there is direct involvement in patient care, i.e. the practitioner-patient relationship. Conditions causing impairment can affect anyone in the general population and health practitioners, who have a fiduciary relationship with patients, are not immune. The purpose of this paper is to highlight dilemmas concerning mental and substance-related disorders causing practitioner impairment.

Scope of the problem

The prevalence of illnesses causing impairment in physicians is not known, but it has been estimated that as many as 1 in 6 may be affected.² Anxiety, depression and mental illness occur commonly among health practitioners, especially doctors. Depression is seen in 10 - 20% of doctors and about 21% who report work-related stress have contemplated suicide. The suicide rate among doctors is reportedly 50% higher than

that of the general population.³ Chemical dependency is an important cause of physician impairment, with a lifetime prevalence approaching 10 - 15%, and alcohol dependence varies from 8% to 15%. The most common drug of abuse is alcohol, followed by opiates.⁴ Abuse of benzodiazepines and opiates has been shown to be facilitated by self-prescribing.^{5,6}

Of concern is that physicians as a group deviate from the norm when seeking treatment when they fall ill. They may not seek help for mental problems because they do not recognise the problems; they may be in denial; they may recognise the problems but believe they do not require professional care; or they may recognise the problems and realise that treatment is needed but nevertheless do not seek help. In addition, physicians have a tendency to diagnose and treat themselves, and if they do seek care they often do not use the usual programmes of the health service, choosing instead to seek the advice of colleagues.⁷ This is possibly due to the complexity of establishing a therapeutic relationship between the impaired practitioner and the treating one, as well as the reversal of roles from practitioner to patient.

The Health Professions Council of South Africa approach

In October 1998, the Interim National Medical and Dental Council of South Africa added two new rules to the existing set of Ethical Rules. The following would be regarded as acts of omissions in respect of which Council may take disciplinary steps:

Failing on the part of a student or practitioner to –

- (a) Report impairment in another student or practitioner to the Council if he or she were convinced that such other student or practitioner was impaired as defined in the Act;
- (b) Self-report his or her impairment or alleged impairment to the Council if he or she was aware of his or her impairment or had been publicly informed of being

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impaired or had been seriously advised by a colleague to act appropriately to obtain help in view of an alleged or established impairment.⁸

Because impaired practitioners are not usually able to recognise their own impairments and therefore do not voluntarily seek help, these rules place a positive duty on students and practitioners in terms of the Health Professions Act⁹ to report colleagues to the Health Professions Council of South Africa (HPCSA) whom they are 'convinced' are impaired in terms of the Act. It also requires them to report their own impairments if they are 'publicly informed' or 'seriously advised by a colleague to act appropriately or obtain help'. 'Publicly informed' would seem to mean that the student or practitioner must have been informed by somebody in public, as opposed to in confidence (e.g. being seriously advised by a colleague) – in other words more than one person was present at the time the information was given.¹⁰

In 2002 there were 30 cases of impaired physicians reported to the HPCSA, and in 2003 there were 33. Over 50% were because of substance abuse (Itumeng Maloa, Committee Co-ordinator, Health Committee, HPCSA – personal communication). Because of the increase in substance abuse, in 2004 the Health Committee of the HPCSA embarked on establishing mechanisms and procedures to oversee the implementation of treatment programmes for such individuals. The approach of this Committee is non-punitive, with a focus on rehabilitation. The essential components of these programmes include comprehensive medical and psychiatric assessment as well as treatment and active long-term follow-up. The Committee has assumed the role of promoting support to such practitioners in effectively managing their impairment rather than penalising them for it. Where necessary, practitioners are restricted to supervised practice while undergoing suitable treatment, or in more severe cases management is by means of temporary suspension linked to specific measurable achievements in treatment. Urgent and speedy action by the Committee is provided where there is an immediate risk to the patient and/or he or she is not compliant with the management proposed.¹¹ In this manner assistance and rehabilitation rather than discipline is employed so as to aid the impaired practitioner in retaining or regaining optimal professional functioning consistent with the safeguarding of patients.

Practitioner vulnerabilities

The non-punitive approach adopted by the Health Committee probably reflects awareness of and sensitivity to physician vulnerability. Health practitioners experience high levels of stress in their professional roles and responsibilities, where expectations are high and room for error small. Their responsibilities not only take a great deal of professional time but also impact on family and personal time. Hence personal

relationships can be strained, with the physician often being caught in a conflict between commitment to the patient and all his or her other responsibilities. In addition fears of being perceived as 'weak' are pervasive, with practitioners tending to maintain the belief that their patients and not themselves are the ones with the problems, hence perpetuating resistance and denial.¹² When confronted with the stresses of clinical practice and the expectations of unblemished behaviour, every practitioner is at risk of substance-induced or mental impairment. Such personal risk cannot be underestimated. Moreover, controlled substances are more readily accessible to health practitioners than to the lay public. In addition, it is difficult to identify practitioners with substance abuse, especially as physicians are adept at disguising their addictions and often manifest exceptionally rationalised denial and sophisticated resistance. Professional colleagues and family members are also very trusting and rarely recognise even very obvious signs of addiction.¹³

Reporting – ethical issues

The ethical dilemma faced by many colleagues on the issue of reporting an impaired practitioner is that of having to choose between protecting the privacy of the practitioner on the one hand and the safety of patients on the other. Failure to report the impaired colleague may be because of the potential for adverse social, financial and legal consequences. Although physicians may acknowledge a duty to report impaired colleagues, they can be reluctant to do so because of the potential social stigmatisation of both the impaired practitioner and the accusing physician.⁵ Hence there are two sets of outcomes that are typically considered by reluctant witnesses to physician impairment: concerns about the personal consequences for the informant, and concerns about the consequences for the impaired.¹³ While there is a need for patient protection, physicians need to feel safe in reporting an impaired colleague and to be assured that the impaired practitioner will be helped rather than harmed. The situation is complex and fraught with conflicts of interest.

Nevertheless, medicine as a profession with an acknowledged fiduciary relationship has a clear responsibility to assure both the public, and all patients, that its practitioners and institutions are trustworthy. Justice and fairness demand that the vulnerability of patients is addressed. This is achieved when practitioners can be trusted to promote their patients' best interests. The privilege of one's calling requires a dedicated and competent fulfillment of responsibilities, and the fiduciary aspect of the relationship is eroded when patients lose confidence and trust in their practitioners. Moreover, the perception that medicine is failing to live up to the terms of its social covenant is further reinforced.

Impairment generally leads to decreased or altered clinical judgement, or diminished technical skills with consequent



implications for patient safety. The risks to patients as a result of practitioner impairment far outweigh the risks to the person reporting such impairment. When clinical responsibilities are not being appropriately addressed, patient protection becomes paramount.¹³ Moreover, altered judgement could have far-reaching implications for one's family, institution and wider community. Impairment can also result in significant problems with others in the medical community.¹⁴ Professionals who are silent with regard to a colleague's impairment are guilty of perpetuating the problem and resultant dangers to patients, institutions and society at large. Hence, they become part of the problem itself.

Some recommendations

If medicine's fiduciary relationship with society is to be truly honoured, and if society is to be assured that patient safety is to be preserved, early detection and management of practitioner impairment is critical and of paramount importance. When the stresses of training and clinical practice become too great, every physician should seek professional assistance to minimise the risk of personal substance abuse and other potential consequences. Formal workplace programmes need to be instituted, or when already established, to be strengthened in order to assure impaired practitioners that they will receive empathic and supportive care. Furthermore, their anxieties and fears over punitive consequences will be allayed. In addition, institutional support should include educational programmes on impairment. While there are many accounts in the literature of the scope of physician impairment problems, there is a paucity of information regarding effective ways to educate practitioners about impairment.¹⁵ A shift in practitioner attitude, i.e. a move away from the 'all powerful' to recognition of their own human frailty and hence vulnerability, is necessary as well. Perhaps the current reactive approach to physician performance problems should be replaced with a routine, formal, proactive system of monitoring that uses validated measures to focus strictly on clinical and behavioural performance with the goal of identifying problem practitioners early, before patient safety is jeopardised. Such a system would need to be objective, fair and promptly responsive.¹²

It has recently been shown that disciplinary action against practising physicians by a medical board is often associated with unprofessional behaviour by those practitioners when they were in medical school, pointing to the need for professionalism to play a central role in medical education and throughout one's medical career. The earliest signs of problems often emerge during the training years when it may be possible to take remedial preventive action.¹⁶⁻¹⁸ Robust preventive programmes at an undergraduate level, focusing on the recognition of early warning signs of impairment in oneself and one's fellow students and stressing management that enhances coping skills and problem-solving abilities, are imperative. These could include confidential peer assistance

programmes run by students, support services established by psychiatrists, and regular formal and informal seminars on mental health and substance abuse.¹⁹

Despite the increase in substance abuse among impaired practitioners, and the resultant harmful impact on patient care, the impaired practitioner and in particular the impaired student are under-researched. This problem should be recognised as a research priority. Finally, while impairment that interferes with practitioner ability to engage in professional activities competently and safely applies to those situations where there is direct involvement in patient care, the possibility of broadening the scope of the definition to incorporate practitioners who, although not directly involved in managing patients, engage in activities that impact on patients, should be investigated. The profession's rules on the impaired practitioner should pertain equally to all practitioners, including those servicing the profession at the level of professional bodies and institutions. It is imperative that the image of medicine as a profession is upheld and that public confidence in the profession is preserved.

Conclusion

A health practitioner's primary duty is towards his or her patient, and patients are required to be treated with reasonable skill and care. Any practitioner who is unable to provide appropriate medical services because of physical or mental impairments should only be allowed to treat patients to the extent that their ability is not restricted by their impairment. Any practitioner servicing the profession at a macro level of decision making should only be allowed to do so to the extent that his or her ability is not restricted by any form of impairment. Treatment of patients by impaired practitioners beyond their competence as a result of such impairment could result in medical malpractice and professional negligence claims against them. There is also a duty on members of the medical profession to uphold the standards of the profession in order to protect the public. Accordingly, they have an obligation to inform the HPCSA when they become aware of colleagues who are a danger to their patients. Not doing so could be perceived as an act of omission that could result in a disciplinary process.

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HIV-positive status among surgeons – an ethical dilemma

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HIV/AIDS is a manageable disease with a reasonable expectation that affected individuals might be able to experience both reduced mortality and morbidity. Within the socio-political context of the illness there has been a very strong emphasis on human rights issues, especially in relation to discrimination, which has seemingly been influenced more by emotion than science. This article explores and addresses the potential risk of an HIV-positive surgeon transmitting

the virus to a patient. We argue that the Centers for Disease Control (CDC) and Health Professions Council of South Africa (HPCSA) guidelines are too restrictive, especially against a background of limited transmission risk, and hence that these guidelines could be more harmful than beneficial to our health systems.

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The emergence of HIV/AIDS has had a powerful impact on society, in both the developed and developing worlds.¹ South Africa has the highest estimated number of people living with HIV/AIDS in the world (5.3 million as of the end of 2003), with a prevalence rate of 21.5% compared with a global rate of 1.1%, and with an estimated 370 000 South Africans having died of HIV/AIDS in 2003.² Enormous scientific energy and funding has seen the emergence of an AIDS industry dedicated to both prevention and treatment. Such efforts have yielded tremendous advances that have turned a killer disease into a condition that is manageable, with a reasonable expectation that affected individuals might be able to experience both

reduced mortality and morbidity, even those with advanced AIDS.³ Within the socio-political context of the illness there has been very strong emphasis on human rights issues, especially in relation to discrimination, which has seemingly been influenced more by emotion than science. To some extent the issue of discrimination in South Africa would appear to be addressed in Section 9 of the Bill of Rights of the Constitution of the Republic of South Africa⁴ and in the Employment Equity Act,⁵ which censure unfair discrimination. However discrimination remains, even within the scientific community where the risk of infection has resulted in reluctance to treat HIV-positive individuals.⁶ Aside from moral arguments, scientific evidence has not been able to support such a position. But what of the HIV-positive health care worker (HCW), such as a surgeon? Here we are confronted with a somewhat different scenario, but involving the same issue, i.e. the risk of HIV transmission during a procedure. Does the patient have a right to know the status of the surgeon? Does the employer have a right to know? Is the surgeon obliged to disclose, and to whom is the surgeon expected to disclose his/her status?

With regard to the Employment Equity Act,⁵ although in chapter II Section 6(1), discrimination on the basis of HIV status is technically unlawful, Section 6(2)(b) states that excluding

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