Physician Impairment: Is It Relevant To Academic Psychiatry?

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Objective: *This article examines the relevance of physician impairment to the discipline of academic psychiatry.*

Method: *The author reviews the scientific literature, the proceedings of previous International Conferences on Physician Health, and held discussions with experts in the physician health movement, department chairs, program directors, and residents.*

Results: *Psychiatric illness and impairment in physicians impact academic psychiatry in several ways. Mental illnesses in physicians are being studied by some researchers, but the subject requires more scholarly attention. Training directors are interested in resident well-being and illness and how to reach out to symptomatic residents in a more timely way. Leaders in psychiatry are eager to learn the first steps in identifying colleagues at risk and the route to assessment and care. They are especially concerned about disruptive behavior in the workplace, including harassment and boundary transgressions in doctor-patient and supervisor-supervisee relationships. Academic psychiatrists wish to be more responsive to nonpsychiatrists appealing to them for guidance with impaired members of their departments.*

Conclusions: *Physician impairment is an emerging field of study and interest to psychiatrists in academic settings.*

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> "Impairment should be defined as the inability of a licensee to practice medicine with reasonable skill and safety by reason of:
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> • Mental illness;
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> • Physical illness or condition, including, but not limited to, those illnesses or conditions that would adversely affect cognitive, motor or perceptual skills; or
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> • Habitual or excessive use or abuse of drugs defined by law as controlled substances, or alcohol or of other substances that impair ability" (1)

Impairment in physicians has many definitions, with the one presented above cited most often. Mental illness in physicians is not synonymous with impairment (2). In fact, the vast majority of physicians who are in treatment with a mental health professional are not impaired. They are working and practicing medicine safely and competently, although they may be working at reduced capacity or curtailing the full range of their services until they are well. They are accepting treatment voluntarily and their identities and illnesses are unknown to their state licensing board, employers, and colleagues.

There are several reasons why the subject of physician impairment and mental illness in physicians is germane to academic psychiatry; research on and teaching about mental illnesses are the bedrock of scholarly activity of academic psychiatrists. The biopsychosocial dimensions of mental illness in physicians, especially etiology and barriers to treatment, warrant empirical study (3). Residents may develop a mental illness and/or become impaired and chief residents and training directors need to know how to respond (4). Disruptive behavior in the workplace by physicians (5, 6) is currently a 'hot topic' in the world of physician health. Sometimes the disruptive physician is an academic psychiatrist. Psychiatrists, including academic psychiatrists, represent a small, but significant, cluster of physicians who transgress doctor-patient and supervisor-supervisee boundaries (7, 8). Some of these doctors are impaired by mental illness. Finally, nonpsychiatrists not uncommonly contact their confreres in academic psychiatry for advice about another faculty member in trouble.

Having a working knowledge of the more common illnesses in physicians—and how best to help out—can be salutary. Psychiatrists in leadership positions, especially chairs and division chiefs, sometimes struggle with how to reach out to colleagues in distress.

Mental Illness in Physicians: Academic Inquiry

Doctors, like the rest of humankind, may develop any illness in DSM-IV-TR. However, the most common are mood disorders, substance use disorders, anxiety disorders, adjustment disorders, eating disorders, and mental disorders due to a general medical condition. Physicians have higher rates of depression than the general population (3), including its worst outcome, death by suicide (9–12). Women physicians, unlike females in general, kill themselves at rates equivalent to male physicians, although this has been questioned (10, 13). Regarding substance use and dependence, alcohol continues to be the most frequently abused chemical, followed by benzodiazepines and opiates, then other street drugs (14). Many physicians are genetically vulnerable to substance abuse; they have one or more first degree relatives with alcoholism or other forms of drug dependence (15). Finally, psychiatrists may be prone to mood disorders and/or substance abuse or dependence (unpublished 2004 paper of MF Myers).

Despite the prevalence and seriousness of mental illnesses in physicians, there is a dearth of evidence-based research. There are no large studies of mood disorders in male physicians; we know much more about women physicians (13). We have good research on physicians with substance dependence (14–16). Recent data on trainees have found depression in up to 25% of medical students (17) but this is a hard group to study (18–20). In contrast, we have no up-to-date information on mood disorders in residents and studies that found depression in one third to a quarter of residents are old (21, 22). Within medicine, there are health studies about the unique challenges of minority physicians or international medical graduates (23), but not mental health vulnerability or resilience parameters.

Future Directions

Physicians warrant rigorous study by academic psychiatrists because they pose such challenging questions. Why are physicians prone to depression? How much is genetic and developmental versus the stressfulness of a medical career? Is this vulnerability analyzable in a medical student population? Stigma in the house of medicine is believed to reinforce psychiatric morbidity and mortality in physicians. Can this be quantified? Given the significant divorce rate in physicians (24), what role might mental illness play in marital demise? When physicians become suicidal, what are precipitating and protective factors unique to being a doctor? How can we reduce the numbers of physicians who kill themselves each year? These are some of the many questions that beg answers—answers that would greatly enhance the scientific basis of physician health, especially in primary and secondary prevention.

The Resident in Trouble

Some individuals who choose psychiatry as a career have personally experienced mental illness in the past. Many of those who have not manifested symptoms before entering residency have a genetic predisposition—they have first-degree relatives with a psychiatric illness. For those individuals becoming a psychiatrist is appealing, not only to fulfill a need for mastery over something but also to serve others with the same or a similar malady. And having learned through training that doctors are not always understanding and forgiving of each other, residents hope for acceptance by medical colleagues in psychiatry.

Internalized stigma, however, sometimes exists in psychiatric residents and in faculty members. If a resident becomes depressed, he or she may not directly disclose the illness. Attending physicians may not recognize that the resident is struggling and fail to reach out. There may be a dance of denial and deception. Something seems amiss—the resident's functioning decreases, motivation falls, tardiness and absences occur, and conflicts with staff or fellow residents arise. Inattention to the resident's plight enhances the risk of his or her impairment, chance of making a medical error, harming a patient (or upsetting the patient's family), obtaining a poor in-training evaluation, and attempting suicide.

Broquet and Rockey (4) have designed a curriculum in one medical center to educate junior residents and program directors about physician impairment. They found residents very receptive to its content, its therapeutic potential, the gained coping skills, peers helping peers, and normalizing the need for professional help. Institutional buy-in was fundamental to its acceptance and success.

Psychiatrists in Leadership Positions: Roles and Responsibilities

Today's department chairs, vice-chairs, program directors (medical student and resident), and other administrative psychiatrists are increasingly aware that some individuals on their watch are developing mental illnesses. Mentally ill faculty and residents are embracing treatment earlier than a generation ago. What follows are some pre-

scriptive steps to ensure that a mentally ill faculty member or trainee gets appropriate care.

1. Become aware of how a mood or anxiety disorder may manifest itself in the workplace. Subtle presentations can occur. Absenteeism, lateness, irritability, altered appearance, weight loss, forgetfulness, and other symptoms and signs may suggest alcoholism, other drug abuse, or a dual diagnosis (with a mood or anxiety disorder).

2. Act quickly to get as much information as possible about the changes in the person, from as many sources as possible, including residents. However, be mindful of confidentiality and always respect the privacy of the individual. Most symptomatic physicians feel deeply ashamed and guilty, especially at the height of the illness and before treatment.

3. Someone needs to approach the individual on a one-to-one basis in a kind, nonjudgmental, and open manner. The best person is a trusted colleague. Many ill physicians will welcome the gesture and accept assistance in obtaining medical care. A significant segment of physicians know that they are unwell but cannot ask for help directly. If the person reaching out is rebuffed and/or threatened for meddling, it is time for the next step.

4. Contact the physician health program in your institution, county, or state. The program's staff are the experts at intervention with physicians, whether the diagnosis is chemical dependency or nonchemical mental illness. They will offer guidance about how to intervene or set it up and do it themselves.

5. Be informed about other resources in your community. Is there anything onsite, like employee assistance programs (25)? Is there a hospital or departmental physician well-being service? Are there mental health resources (psychiatrists, addiction medicine specialists, clinical psychologists, and social workers) locally who are interested and skilled in looking after physicians?

6. If the individual is off work on medical leave, try to obtain consent from him or her for you to communicate with the treating physician—and vice versa. Respect your boundaries at all times and limit your questions to the health/work interface. What is a reasonable expected date of return to work? What occupational duties can be safely performed in a graduated return to work plan? What is best, if feasible, is a face-to-face meeting with the treating physician in the presence of the person.

Disruptive Behavior in the Academic Setting

Some psychiatrists charged with being disruptive at work may or may not be impaired by a psychiatric illness. Examples of disruptive behavior include the following: crude language toward and swearing at residents; not being available when on call; drinking or using drugs on duty; discriminatory remarks toward minority colleagues; sexually harassing comments or actions with colleagues, staff, and trainees (unwanted sexual advances, offensive language, turning others against the person); unprofessional words and interventions with patients; lying about a colleague's integrity and swaying others against that person; splitting the treatment team; passive-aggressively not meeting academic responsibilities, expectations, and promotion standards; excessively using projection and threatening litigation during performance reviews or when confronted with complaints that have been filed about his or her behavior.

Disruptive behavior is always upsetting to the milieu and arouses high emotion in all of those affected. Why is this psychiatrist behaving like this? Is this new behavior or is there a pattern here, such as in previous academic settings where he or she has worked? What is the context of the behavior? Are there systemic factors that are provoking or reinforcing the disruptive acts of this psychiatrist? Are there factors in the psychiatrist's personal life—medical illness, difficult divorce, death of a loved one, a disabled child—that are spilling into the workplace? How much rests with his or her personality—or is he or she ill?

All psychiatrists deemed disruptive require a thorough medical and psychiatric assessment. Leaders who propose this to their faculty member may or may not get cooperation. He or she may already have an attorney. Some will tentatively or ambivalently accept the recommendation. Many will resist and begin a long process of employment litigation.

Harassment of trainees, medical colleagues, and staff is assessed in most medical schools today by associate deans of equity or harassment policy offices of the university. Boundary transgression, whether it is a psychiatrist-patient dyad or a faculty-trainee dyad, occasionally occurs in academic departments of psychiatry. Some of these individuals have unrecognized, untreated, undertreated, or self-treated illnesses on Axis I. Some have personality disorders or significant traits (narcissistic, borderline, or antisocial) on Axis II. Some have both. This is a huge subject with significant literature (7, 8, 26, 27). Axis I illnesses that most commonly cause impairment are mood disorders and substance use disorders.

The best approach to boundary crises in professionals is prevention. Didactic seminars and workshops on this subject should begin in medical school and continue throughout residency (28). Psychiatry residents in particular need

both the intellectual knowledge and the experiential dimensions of this subject. Close supervision of their patients' care, especially psychotherapy, helps. But there needs to be trust and safety in the supervisee-supervisor relationship so that the resident can freely discuss countertransference matters. This includes both the recognition of affectionate and erotic feelings and what to do about them in the best interest of patient care. Personal psychotherapy is key and should be available, and affordable, for trainees.

Learning of a colleague's boundary crossing demands action. One needs to be aware of local responsibilities and obligations to medical licensing authorities. There may be mandatory reporting. If there is a question of psychiatric impairment, the local physician health program should be contacted immediately. The program's staff will know the next steps, which will include full assessment and treatment. The fallout from boundary violations—for the patient, for the psychiatrist, and their respective families—is huge. Suicide is not a rare ending and this in itself dictates that all of us must be our brothers' and sisters' keepers in the house of medicine.

When Non-Psychiatrist Academic Colleagues Call for Advice

Sometimes academic colleagues call for assistance regarding someone in their department about whom they are concerned. He or she suspects a possible psychiatric problem in the resident or faculty member and hopes that an academic psychiatrist can give him or her some guidance. Here are some examples:

• A member of the department has been found to be spending much of the day surfing pornographic sites on the Internet. "What should we do? He's neglecting his work. This is out of character and I'm shocked and worried about him."

• Residents have raised concerns that their training director is behaving inappropriately. He has started dating their chief resident. "What kind of role-modeling is this?"

• A chief of anesthesiology suspects that one of his anesthesiologists is diverting Fentanyl. The nurses are concerned that his patients are not receiving adequate pain relief despite common post-op dosing. "I'm really angry. Should I call the physician health program or the police?"

• One of the internal medicine residents has complained that his attending has called him at home when he is not on call. This is often late at night, her speech is slurred, and she's wondering if he's adjusting satisfactorily to his new program (29). "The resident is afraid of her. If he charges her with harassment, will she give him a poor evaluation?"

• A surgeon attempted suicide last weekend and has been hospitalized. Members of the department are asking questions. "What should the chief tell them? How much is acceptable and not a breach of confidentiality? Is it okay to thank them for their concern and simply say that she's on medical leave for awhile?"

• Several faculty members are concerned about the chief of their division. He seems "demented"–forgets meetings, repeats himself, has emotional outbursts, and makes "off-color" remarks to them. It is rumored that he might be gay. They think he could have AIDS. "We think he needs a thorough medical and psychiatric assessment. How do we approach him about the importance of this without making him angry or paranoid?"

The task here is not to have answers to all of these questions but to listen. One can assist by trying to get cursory information in an open-minded and nonjudgmental way, enabling time to formulate what might possibly be going on. There may be a range of suggestions to offer the colleague: get complaints in writing if they are thus far only verbal; meet with the physician and apprise him or her of the concerns; contact the individual's spouse or partner; call the hospital employee assistance program; contact the local or state physician health program; consider an intervention for possible chemical dependency; or contact a psychiatrist colleague who is interested and experienced in physician health matters to see if he or she can assess the individual.

CONCLUSIONS

Physician health and well-being, and physician mental illness and impairment, do matter to academic psychiatrists. It is about individuals who are trainees and colleagues and how their illnesses impact their families and the workplace. Armed with knowledge and comfort with the subject, academic psychiatrists reduce departmental anxiety and bewilderment when illness strikes. Having diagnostic and treatment measures in place reduces confusion and indecision, aborts protracted morbidity, and diminishes mortality. This is an overdue imperative.

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