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CLAIMS Rx

RISK MANAGEMENT PERSPECTIVES

Impaired Physicians:
Risks, Insights, and Considerations

ProAssurance
PART OF The Doctors Company

CLAIMS Rx
RISK MANAGEMENT PERSPECTIVES

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Impaired Physicians:
Risks, Insights, and Considerations

INTRODUCTION

"As an ethical responsibility, competence encompasses more than medical knowledge and skill. It requires physicians to understand that as a practical matter, in the care of actual patients, competence is fluid and dependent on context. Each phase of a medical career, from medical school through retirement, carries its own implications for what a physician should know and be able to do to practice safely and to maintain effective relationships with patients and with colleagues. Physicians at all stages of their professional lives need to be able to recognize when they are and when they are not able to provide appropriate care for the patient in front of them or the patients in their practice as a whole."[1]
—AMA's Code of Medical Ethics, Opinion 8.13

According to the American Medical Association (AMA), an impaired physician is one who is unable to fulfill professional responsibilities with reasonable skill or safety due to a physical or mental condition or disorder.[2] Studies indicate that 10-15% of physicians in the United States experience an impairment during their careers. Contributing factors to physician impairment can include the demanding and intense work physicians engage in, the high rates of stress and burnout experienced by healthcare providers, and achievement-oriented personality traits such as perfectionism, self-criticism, independence, and high personal standards and expectations.[3,4]

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The following list includes possible signs and symptoms of impairment, in both the professional and personal arenas of a physician's life.

Professional concerns:[4]

- Increased and unexpected work absences
- Frequent appointment lateness
- Atypical rounding schedules, such as unusually early or very late
- Secret or evasive behavior
- A rise in complaints from patients
- Poor clinical judgment or declining quality of medical care
- Errors in documentation or prescription writing
- Reduced productivity or capability
- Growing conflicts with team members
- Heightened frustration or aggressive behavior
- Visible intoxication
- Inconsistent job history

Personal concerns:[5]

- Withdrawal from family or social activities
- An increase in accidents or injuries
- More frequent medical appointments
- Escalating agitation and conflict at home
- A decline in self-care
- Emotional changes such as depression or anxiety
- Financial problems
- Legal issues

This *Claims Rx* issue explores the medical professional liability risks and patient safety implications of impaired physicians. The article's closed claim studies will examine physician impairment in the following three areas:

1. impairment by a physical or psychological medical condition or illness;
2. impairment by advanced age; and
3. impairment by substance use or abuse.

Each closed claim includes accompanying risk reduction strategies intended to prevent similar events from occurring elsewhere.

In addition, each case includes strategies that address both direct and vicarious liability risks for clinicians and healthcare administrators. Direct liability involves a person or organization being held legally responsible for their own actions, while vicarious liability involves responsibility by a third party, such as an employer, for the actions of another, such as an employee.[6]

Some employer risk reduction strategies include creating a culture of safety in which staff feel empowered to voice concerns, modifying clinician duties and responsibilities as needed for patient safety, and reporting physician impairment promptly as required by state law. Strategies for physicians include engaging in regular and routine competency screenings and voluntarily self-reporting any deficits or limitations that may arise throughout their careers.

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CASE ONE:

Physician's Medical Condition Contributes to Delay in Diagnosis and Infant's Death

In this first case, a physician's medical condition may have affected his ability to properly care for his patient throughout her pregnancy.

As you read through the facts of this case, consider the best way to manage an adverse event that you or your colleague's impairment may have contributed to or caused. How would you begin the discussion?

A 31-year-old patient presented to an obstetrics-gynecology clinic early in her pregnancy with her third child. Her two prior deliveries were noted at approximately 38 weeks gestation, with each infant delivered vaginally and weighing close to nine pounds. The patient's height and weight were recorded at 5'7" and 160 pounds during the visit.

During her second visit to the clinic, the patient informed the obstetrician-gynecologist (ob-gyn) that she had been diagnosed with gestational diabetes during her previous pregnancy. She also indicated she had been seen and monitored as high-risk throughout the pregnancy. The patient further told the physician that she had multiple family members who had been diagnosed with diabetes. The ob-gyn informed her that the test for gestational diabetes would be completed at the 28-week pregnancy mark.

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When the patient presented for her standard fetal anatomy ultrasound at week 20, the ultrasound detailed a normal anatomic survey of a male fetus. The ultrasound also found greater-than-average amniotic fluid volume—a sonographic finding commonly associated with gestational diabetes. However, the patient did not receive education materials, diet or exercise modification recommendations, or any additional maternal/fetal screening or surveillance related to her risk for gestational diabetes at this time.

During her next three visits with the ob-gyn, which included the 28-week mark, the patient indicated there was no mention of her known gestational diabetes risk or the need for lab testing or screening.

At 34-weeks gestation, the patient's weight was recorded at 275 pounds, with an almost 40-pound weight gain over the last two to three months. Again, the physician did not discuss screening for gestational diabetes with the patient, and no paperwork for lab testing was provided to the patient by the physician or his staff during the visit.

At 36-weeks gestation, the patient presented for an ultrasound to evaluate fetal biometry, and fetal weight was estimated at almost 11 pounds. Because she was worried about the baby's size, the patient said she asked the ob-gyn to induce her or otherwise remove the baby. However, since she still had four weeks remaining in her pregnancy, the physician recommended waiting another two weeks. The patient was screened for vaginal Streptococcus B, but again, there was no mention of gestational diabetes risk or screening during the visit. The patient left the appointment visibly upset and reported feeling the ob-gyn was dismissive of her concerns.

One week later, the patient presented to the hospital after noticing a significant decrease in fetal movement. Her point-of-care blood glucose level was elevated at 200 mg/dL, indicative of gestational diabetes. The lack of fetal heart activity and fetal demise were subsequently confirmed by ultrasound.

The patient sued the ob-gyn and the ob-gyn's medical practice. She alleged that misconduct, failures, departures, and breaches of their duty of care resulted in her unborn baby's death, causing her physical and mental pain, suffering, anguish, and disability.

DISCUSSION

There were multiple problematic issues that compromised the defense in this case. To start, experts all agreed that the care and treatment of the patient fell below the applicable standards of care. Gestational diabetes is one of the most prevalent disease states in pregnancy, and standard obstetrical care for screening and treatment is widely established.[7] The ob-gyn's failure to appropriately screen and treat the patient for gestational diabetes was evident and indisputable.

Experts were also critical of the physician's failure to properly inform, educate, and communicate with the patient throughout her pregnancy. In addition, following the patient's final ultrasound and delivery, timely disclosure did not occur. When the patient asked the ob-gyn why he had not come to speak with her following the delivery, he responded that he had a full office of patients that needed to be seen first.

It was further discovered during the case investigation that the ob-gyn had early signs of Alzheimer's disease and wore a medicated transdermal patch to help minimize his symptoms. During discussions with his defense team, the physician had trouble recalling words and remembering recent conversations and events.

Finally, the defense team discovered that the ob-gyn had several prior complaints and settlements against him. Although not part of this lawsuit, the ob-gyn's medical practice should have already been aware of his limitations and ended his employment.

Due to negative standard of care reviews, inadequate patient safety practices, and the physician's contributing medical condition, the case was settled.

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RISK REDUCTION STRATEGIES FOR ADMINISTRATORS

Consider the following strategies:

- Conduct National Practitioner Data Bank (NPDB) queries for information regarding any previous clinical privilege actions taken against a physician.[8]
- When competency concerns arise, consider a focused professional practice evaluation to assess a clinician's ability to safely perform essential functions.[9]
- Modify a physician's duties and responsibilities, limit scope, or require medical care as needed to help ensure patient safety.
- Report physician impairment issues to the medical board as required by state law to allow for appropriate intervention, treatment, and referral.
- Develop, review, and update policies and procedures to establish safe and uniform care throughout the practice.
  - ► Policies should include, but not be limited to, medication management, test tracking and follow-up, informed consent, adverse event disclosure, and reporting of incompetent or unethical behavior.
- Conduct periodic medical record audits to verify clinical findings are managed according to policies and promptly address any practice gaps.

RISK REDUCTION STRATEGIES FOR CLINICIANS

Consider the following strategies:

Self-Directed

- Inform clinic leadership of your own medical diagnoses that may impact patient care and safety.
  - ► Request support and accommodations as needed.
- Regularly consult with your personal physician for the continued assessment and treatment of your medical condition.

Patient-Directed

- Communicate thoroughly with patients about their condition and care. Use plain language and practice closed loop communication.
  - ► Closed loop communication involves the patient repeating care instructions and the physician then confirming the instructions, to ensure accuracy.
- When educating patients, utilize the teach-back method to aid in patient understanding and comprehension.
  - ► The teach-back method involves asking patients to explain their treatment plan back to the physician.
- Review medical record documentation with patients to confirm correctness, further inform them of their condition, and remind them of any impending care.

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DISCLOSURE

Research conducted at Vanderbilt University found that physicians who are unable to establish trust and rapport with their patients have a higher incidence of both adverse patient events and malpractice claims. Proper disclosure and transparency can help maintain and salvage the physician-patient relationship following an adverse event or complication.[10]

Consider the following strategies:

- After an adverse or unexpected event, ensure that open, sincere, and timely communication takes place with the patient and family.
  - ► Actively listen, use clear and concise language, show empathy, and foster trust through respectful interactions.
- Document disclosure conversations with patients.
  - ► Include the date, time, and location of the discussion, as well as the parties and the relationships of those present.

PROASSURANCE DISCLOSURE RESOURCES

2 Minutes: What's the Risk? Adverse Event Disclosure[11]
Guidance on communicating with patients and their families after an adverse event

Unexpected Outcomes: Investigate, Communicate, Document[12]
Includes discussion techniques for properly disclosing an adverse situation to patients and families

Deciphering Disclosure[13]
Provides key principles that guide effective disclosure

Medical Error: A Defense Attorney's Perspective on Disclosure[14]
Techniques for satisfying patient needs while protecting and enhancing the defensibility of liability claims

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CASE TWO:

Advanced Age Contributes to Surgical Error and Patient's Vision Loss

This second case describes a surgical error caused by a physician's age-related hand impairment and highlights the importance of ensuring that senior surgeons can safely perform surgery.

As you read through the facts of this case, consider how other members of the healthcare team could have helped prevent the patient's injury.

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A 41-year-old patient presented to his ophthalmologist with a raised, fleshy growth on the surface of his right eye, identified as a pterygium. Also called "surfer's eye," a pterygium is a noncancerous triangular excrescence arising from the conjunctiva that begins in the corner of the eye but may eventually extend over the cornea. A pterygium can be caused by prolonged exposure to ultraviolet light, wind, and dust. Due to the patient's continued eye redness, dryness, and irritation, the ophthalmologist recommended surgical removal of the pterygium and scheduled it for the following week.

As scheduled, the patient presented to the ophthalmologist's practice for right eye pterygium removal surgery. The ophthalmologist administered a local anesthetic and began the surgical resection of the pterygium using a crescent blade. During the resection, the ophthalmologist's hand slipped, increasing the intended depth of the dissection and leading to a perforation of the patient's cornea. Postoperatively, the patient developed significant right eye pain, swelling, and vision loss. He subsequently underwent a corneal patch graft surgery with a different ophthalmologist to seal the hole left by the corneal perforation. While the patient's vision improved after the patch graft surgery, his visual acuity remained permanently diminished. Of note, prior to the initial surgery, the patient's vision was 20/20 in both eyes.

The patient sued the ophthalmologist. He alleged negligent right eye pterygium removal surgery, which resulted in permanent vision loss, pain, suffering, and additional surgery.

DISCUSSION

The ophthalmologist was 78 years old at the time of the surgical incident. During their investigation, the defense team asked the ophthalmologist to explain the pterygium resection procedure. Although asked only to describe the procedure, the physician raised his hand to illustrate his movements during surgery, and it visibly shook. When asked about his hand, the ophthalmologist admitted his hand tremors had worsened over the last few years. However, he indicated he would rest his hand on a patient's cheek or brow during surgery to help stabilize his hand and control the shaking. Experts opined that this was a difficult case to defend due to the physician's admitted and visible age-related impairment.

In addition, there were concerns related to the informed consent process. According to the patient, the physician told him the pterygium resection procedure was a simple operation considered elective in nature. The patient denied that the physician informed him of any possible surgery complications or risks, and documentation of a thorough informed consent discussion prior to surgery was lacking in the medical record.

The defense team believed the physician's age-related hand impairment would reflect poorly in front of a judge or jury and compromise his defense. The case was settled.

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RISK REDUCTION STRATEGIES FOR ADMINISTRATORS

Consider the following strategies:

- Conduct periodic assessments of surgeons' cognitive and psychomotor skills, including hand stability, hand-eye coordination, eyesight, and hearing.
- Encourage a culture of safety where colleagues and staff are empowered to voice patient safety concerns, including a physician's age-related decline.
- Adhere to state reporting obligations in regard to age-related physician impairments.

RISK REDUCTION STRATEGIES FOR CLINICIANS

Self-Directed

As recommended by The American College of Surgeons:[9]

- Voluntarily self-report any age-related concerns or deficiencies.
- Limit or modify affected activities or practices.
- Initiate transition planning mid-career to proactively prepare for roles outside the operating room, such as administration, research, or training.

Patient-Directed

Consider the following strategies:

- Engage in thorough informed consent discussions with patients, outlining the risks, benefits, and alternatives to recommended treatments and procedures.
- Explain procedures in detail and encourage patients to ask questions or clarify any concerns they have about the procedure.
- Establish the patient's understanding of the information provided and document the specifics of the informed consent discussion in the medical record.
- Document thoroughly to provide evidence of the care that was given and to facilitate communication among all team members.

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CASE THREE:

Substance Abuse History Impacts Defense in Patient Death Case

This case highlights the impact of a physician's substance use history on the defense of a case involving a patient's death following a procedure.

As you read through the facts of this case, consider the role that perceptions can play in the defense of a case. How can knowledge of a physician's substance abuse history influence a judge or jury's perception of the physician's competence?

A 48-year-old patient presented to a pain management clinic for the evaluation and treatment of lower back pain. His medication list included trazadone and bupropion. He admitted to heavy alcohol use. The patient had a medical history of Cushing's disease and previous spinal injections approximately six months prior. The anesthesiologist diagnosed the patient with spondylosis without myelopathy or radiculopathy in the lumbar, sacral, and sacrococcygeal regions. He prescribed 50 mg diclofenac, a home stretching program, and ordered diagnostic facet injections in two weeks.

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The patient presented to the Ambulatory Surgical Center (ASC) on multiple occasions over the course of the next five months where he underwent right and left facet joint injections under anesthesia. The facet joint injections were not successful in relieving the patient's pain, and a radiofrequency ablation (RFA) was scheduled.

The patient presented to the ASC for bilateral medial branch RFA under general anesthesia as scheduled. The anesthesiologist, in his role as the pain management specialist, would perform the procedure, while a certified registered nurse anesthetist (CRNA) would administer the anesthesia. This arrangement was similar to what had taken place during previous procedures without complication.

The CRNA administered a sedative dose before the procedure began, and the patient was placed face down on the operating surface. While the anesthesiologist administered the injections as part of the procedure, the patient stopped breathing. However, the respiratory arrest went unnoticed until he was rolled over once the procedure was completed. When he was rolled over, the patient was blue in color, had no heartbeat, and was not breathing. The anesthesiologist and CRNA began trying to revive the patient. The CRNA attempted to insert a breathing tube to reestablish the airway, but the patient did not respond. A staff member called 911.

First responders described the scene as chaotic and disorganized when they arrived. Their documentation indicated that the anesthesiologist was agitated and yelling at the staff, and that instruments to restore the patient's airway were not attached.

At the hospital, the patient was diagnosed with a severe brain injury due to lack of oxygen. He began having uncontrolled seizures. Although sent to a second hospital with more complex care capabilities, the patient could not be saved. He was removed from life support after testing confirmed he had no brain activity.

An autopsy revealed the patient had sustained an injury to his spinal column in the area where the anesthesiologist had placed the injections. His death was the result of brain damage caused by hypoxia during the rhizotomy procedure.

The patient's family filed a malpractice lawsuit against the pain management practice, anesthesiologist, and CRNA, claiming their separate and combined negligent acts caused and contributed to the patient's death. Significantly, one of their allegations was that the practice failed to prevent a physician with a history of substance abuse infractions from coming into contact with its patients.

DISCUSSION

Upon investigation, records indicated that the anesthesiologist had been previously charged with substance abuse impairment while working at two area hospitals. He was fired from both hospitals. At the first hospital, the anesthesiologist displayed slow and slurred speech, unsteady equilibrium, and confusion. The second hospital's administration found the doctor's symptoms—blank stare, rapid and involuntary movements, and inability to communicate—so concerning that they sent him to the emergency room for treatment.

The defense team also discovered that the anesthesiologist had previously falsified employment records, and that he had been referred by a colleague to the medical board's physician health program for drug and alcohol abuse. During deposition, the anesthesiologist was not forthcoming about his previous suspensions of privileges. He also could not fully explain why he refused to take a drug test after he was taken to the emergency room following his removal from the second hospital.

Experts were unsupportive of both the anesthesiologist's and CRNA's care and noted they failed to appropriately respond to the airway emergency. Although there was no evidence that the anesthesiologist was under the influence during the patient's treatment, members of the defense team believed the case would be especially difficult to defend due to its damaging optics, including the anesthesiologist's history of substance abuse charges, suspensions of privileges, and employment record falsification.

Due to the lack of expert support of care and treatment, the lack of emergency preparedness, and the previous substance abuse issues identified, this case was settled.

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RISK REDUCTION STRATEGIES FOR ADMINISTRATORS

Consider the following strategies:

- Verify that practice policies and procedures are followed related to the credentialing, hiring, and training of providers.
- Conduct queries of the NPDB for information regarding previous suspensions of privileges.
- Maintain evidence of physician competency and training.
- Regularly reassess provider skills and competencies.
- Follow respective state laws to ensure impaired physician reporting requirements are met.
- Conduct mock code drills to prepare for emergencies.
- Routinely test equipment to confirm it is in working order and to verify staff proficiency.
- Develop, review, and update clinical policies and procedures to support safe and uniform care throughout the practice.
  - ► Policies should include, but not be limited to, patient monitoring standards, medication administration, airway management, staff roles and scope of practice, and emergency readiness.

RISK REDUCTION STRATEGIES FOR CLINICIANS

Consider the following strategies:

Self-Directed

- Prioritize your health and engage in behaviors and habits that improve wellbeing and reduce stress.
  - ► Regular exercise, a balanced diet, adequate sleep, and stress management or relaxation techniques can all contribute to a healthy lifestyle.[15]
- Do not use illicit drugs and avoid alcohol consumption that may affect your ability to provide safe and effective patient care.
- Regularly assess your personal wellness and seek care or counseling as needed.

Patient-Directed

- Follow policies and procedures related to the handling of emergencies.
- Communicate effectively with other providers throughout procedures to maintain the standard of care and help ensure patient safety.
- Allow emergency medical services personnel to intervene as a patient moves to the next care level, ensuring respect for established roles and a smooth handoff process.

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CONCLUSION

"A healthcare provider with an alleged impairment often must defend more than the medical care at issue when a lawsuit is filed. The fact is, much of defending good medicine involves managing the optics of information presented about the provider to a judge or jury. Whether the provider's alleged condition is associated with advanced age, an addiction, or other illness, the provider will likely need to provide objective evidence that his or her condition did not compromise the quality of care provided to the patient."
—Laura Ekery, JD, ProAssurance Regional Claims Executive, on defending an impaired physician

"First do no harm" from the Hippocratic Oath is a foundational principle of medicine.[16] And while the issue of impaired physicians may at times be sensitive in nature, patient safety must remain at the core of medical care and treatment. Implementing the risk reduction strategies outlined throughout this article can help physicians and medical practices appropriately and effectively address physician impairment, contributing to safer patient care and reducing medical liability risk.

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ENDNOTES

The ProAssurance resources referenced in this article, along with many other risk management resource documents and past editions of *Claims Rx*, are available on the ProAssurance website, by calling Risk Management at 844-223-9648, or by email at RiskAdvisor@ProAssurance.com.

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