Physician Impairment Policy

Scope: All residents and fellows participating in University of Washington graduate medical education programs (i.e., residencies or fellowships).

Background: Impaired physicians can put themselves and their patients at risk. Physicians are known to be at increased risk for completed suicide compared to the general population. The State of Washington recognizes this risk and provides a confidential resource through the Washington Physicians Health Program (WPHP) for identifying, referring for evaluation or treating, monitoring recovery and endorsing the safety of healthcare practitioners who have a condition, mental or physical, which could affect their ability to practice with reasonable skill and safety.

At the University of Washington, impairment is managed as a medical and behavioral illness. Implicit in this concept is the existence of criteria permitting diagnosis, opportunity for treatment, and with successful progress toward recovery, the possibility of returning to work in an appropriate capacity. However, untreated or relapsing impairment is not compatible with safe clinical performance.

To minimize the incidence of impairment, the University of Washington and WPHP have developed didactic programs to educate faculty and trainees about physician impairment, including problems of substance abuse, its incidence and nature, and risks both to the involved individuals and patients. Education also includes an explanation of the concerning signs and symptoms of impairment, and how to detect abnormal behavior associated with use of psychoactive drugs and alcohol abuse. Each Department should have a program in place to educate trainees about physician impairment, including the incidence of physician suicide and problems of substance abuse including risks both to the involved individuals and patients.

Definition: The definition for “impairment” in the State of Washington is the “inability to practice with reasonable skill and safety”. Impairment can be due to any physical or mental condition. Examples of conditions that may cause impairment are:
- Substance (drug or alcohol) abuse and dependence (see Appendix 1 for further detail)
- Mood disorders such as major depression with or without suicidal ideation and attempt
- Anxiety disorders such as PTSD, OCD, or phobias
- Sleep disorders
- Stress disorders and “burnout”
- Neurodegenerative disorders such as Multiple Sclerosis
- Traumatic Brain Injury
- Chronic non-malignant pain
- Behavioral changes from medical conditions, such as poorly controlled Diabetes Mellitus or thyroid irregularities

Goals: The primary goals of this policy are to:
1. Prevent or minimize the occurrence of impairment, including substance abuse, among University of Washington residents and fellows;
2. Protect patients from risks associated with care given by an impaired trainee. If there is a concern that a trainee may be impaired, he/she must be removed from
patient contact until approved to return to work by both the WPHP and the program.

3. Compassionately confront impairment and allow for diagnosis, relief from patient care responsibilities, treatment as indicated, and appropriate rehabilitation.

In achieving these goals, several principles are involved:

1. The safety of both the impaired trainee and his/her patients is of prime importance.
2. The privacy and dignity of the impaired trainees should be maintained as far as is possible in the context of safe patient care and departmental administration.
3. The program, GME Office, and WPHP will work together to facilitate the diagnosis and management of the trainee’s impairment.

**Policy:**

Program Directors and faculty must monitor residents and fellows for the signs of impairment, and especially those related to depression, burnout, suicidality, substance abuse, and behavioral disorders. Evidence of impairment is described in Appendix 2.

Further, it is also the responsibility of every individual—including Program Directors, faculty and trainees—licensed by the Washington State Department of Health (DOH) to report any licensed healthcare practitioner who may not be able to practice with reasonable skill and safety as a result of a physical or mental condition according to WAC 246.16.200. This reporting requirement applies to anyone who observes that a physician may be impaired. Actual evidence of impairment is not required. In the absence of patient harm, sexual misconduct, or professional misconduct, this reporting requirement may be fulfilled and confidentially reporting the individual to the WPHP. Trainees may make this report to the WPHP directly, or may make their concerns known to the Program Director, Chief of Service, GME Counseling Service, GME Office or another responsible individual.

For new trainees with a history of impairment as well as current trainees who exhibit evidence of impairment, evaluation, treatment and monitoring will be performed under the auspices of the WPHP or applicable physicians’ health program. When a trainee is referred to the WPHP for assessment, the trainee is required to sign a release allowing the Program Director and the GME Office to receive information on the outcome of the assessment and ongoing monitoring.

The UW GME conducts a thorough background check on all new trainees upon appointment to the UW residency or fellowship training program. If a history of DUI or other alcohol/substance abuse related crime(s) is revealed, a referral may be made to the WPHP in order to determine if ongoing evaluation, treatment and/or monitoring is required.

As a condition of appointment, all trainees are required to comply with the Program Director or faculty member’s decision to remove them from participation in clinical duties and other professional activities and to refer them to WPHP should impairment be suspected and/or confirmed.

The WPHP is solely authorized to determine fitness for duty and endorse the return to work (i.e., the resumption of training and clinical care responsibilities) of all trainees who experience and/or exhibit signs of impairment.

**Resources:**

**GME Office & GME Counseling Service:** Confidential counseling services are provided free of charge for residents, fellows and their spouses/life partners through the GME Wellness Service. More information concerning these services is available through the GME website under Resident & Fellow Wellness. The GME Office and counselors are also available to facilitate referrals to WPHP.
GME Wellness Service (counselors on-site at UWMC Monday – Thursday)
Mindy Stern, LICSW
Director of Resident & Fellow Wellness
(206) 543-6408, pager (206) 991-6756
mindywho@uw.edu

Kristina Schellie, LICSW
Assistant Director of Resident & Fellow Wellness
(206) 543-3484
Schellie@uw.edu

GME Office
Amity Neumeister, MBA
Assistant Dean, GME
(206) 685-6801
amity@uw.edu

WPHP: The WPHP provides assessment and counseling to impaired individuals, and also provides support to Program Directors and faculty by closely guiding them through the referral, evaluation, treatment and monitoring processes. Confidentiality is always preserved by both services to the limits that are legally permissible.

WPHP
(206) 583-0127 or 800-552-7236
Address: Suite 1010, 720 Olive Way, Seattle WA 98101
www.wphp.org

Intervention: Once concern is raised about a trainee, the Program Director should act quickly to perform a workplace intervention. In the absence of the Program Director, Department Chair, or Associate Program Director, any responsible faculty member may perform a workplace intervention. A detailed description on how to conduct a workplace intervention involving a trainee with suspected substance abuse is described in Appendix 3.

Program Status: If WPHP determines that the trainee is not impaired, mention of the concern shall be removed from his/her records and the trainee will be allowed to return to work without prejudice. However, should WPHP conclude that a trainee is suffering from impairment, the trainee may be required to complete outpatient treatment with WPHP and/or may be referred to an outside facility for further evaluation and potential inpatient treatment. In this case, the Program Director must immediately take appropriate action, which may include:

1. Suspension from Clinical Duties: This action will be considered if impairment may adversely affect the trainee’s ability to provide safe patient care or may otherwise put the individual at risk for hurting him/herself or others. The program may assign other educational/training responsibilities to the trainee during this time.
2. Leave of Absence: In inpatient treatment is indicated as a part of the treatment plan, the program may opt to place the trainee on a medical leave of absence and remove him/her from all patient contact and other program duties.

Leave Status: Trainees who must undergo inpatient treatment and rehabilitation at an outside facility will automatically be placed on medical leave during this period. This medical leave will be unpaid unless the trainee elects to use vacation or sick leave during this time; however, the trainee will continue to receive benefits including medical insurance. Depending on the duration of leave, the trainee may be required to extend his/her training in order to meet ACGME and/or Board minimum training requirements. The Residency/Fellowship Position Appointment (R/FPA) will not be renewed for the
Return to Work:

Trainees who have been treated for impairment will require a full endorsement from both the treatment center and the WPHP before consideration will be given to their return to training. The program will make the decision about accepting a trainee back into training only after full consultation with WPHP and after review of the trainee’s previous academic performance. Trainees will be required to agree to and sign a Return to Work Agreement, which outlines the terms under which the trainee is allowed to return to clinical and/or other training duties. In some cases, trainees may undertake limited duties as a part of the Return to Work Agreement. Due to the many risks to recovery inherent in the healthcare workplace, in some cases, return to training may not be recommended.

Trainees who are deemed able to return to training will be required to commit to a full monitoring program as determined by the WPHP. The WPHP will be responsible for arranging chemical, behavioral, and worksite monitoring that allows for the endorsement that the trainee is safe to practice. The program will allow reasonable accommodations for trainees to meet the requirements of this monitoring program.

An appropriate workplace monitor will be identified at each training site who will both provide and receive reports from the WPHP of the trainee’s progress. The workplace monitor(s) will be responsible for making sure the trainee reports for work as required and will be the point person for any concern regarding the trainee. The workplace monitor may need to notify other faculty members or chief residents of the situation, although confidentiality will be maintained wherever possible.

Diagnostic Monitoring Contract:

In some cases, the presence of an impairing condition may not necessitate treatment, but the need for close monitoring may also not be fully ruled out immediately. In these cases, individuals may be permitted to return to clinical duties, but may be required to participate in a Diagnostic Monitoring Contract with WPHP. The program will provide reasonable accommodations for individuals to meet the requirements of the Diagnostic Monitoring Contract.

Financial Considerations:

Evaluation by the WPHP is at no cost to the trainee or referring program. If the WPHP determines further assessment or evaluation is required, the trainee will be referred to a nationally recognized substance abuse or behavioral health treatment facility. The nearest drug and alcohol treatment facility is in Oregon. The cost of this evaluation ranges from $3000 to $5000 and is the responsibility of the trainee. In circumstances where no evidence of impairment is found, the Department may consider refunding the cost of the evaluation. This will depend on the circumstances under which the evaluation was requested. If the evaluation by WPHP or by another facility reveals evidence of substance abuse and/or other impairing condition(s), all costs for any additional assessment and subsequent treatment of the condition(s) will be the responsibility of the trainee. Medical insurance may cover some of these costs.

If a Diagnostic Monitoring Contract is required by WPHP for further evaluation, the costs associated with this contract will be the responsibility of the trainee.

In the event that an assessment or evaluation is requested by another agency (i.e., MQAC), all associated costs and subsequent treatment costs will be responsibility of the trainee. The Department will not be responsible for cost of the assessment, evaluation, or treatment, if required.

Disclosure:

The University of Washington and WPHP support full confidentiality to the extent allowed by university policy and law. Further, confidentiality of evaluation, treatment
and monitoring by WPHP is assured by the WPHP Confidentiality Assurance Policy. However, programs are required to disclose impairment and successful return to practice, if applicable, for hospital or medical licensing board training verification and/or credentialing inquiries.

The University of Washington expects that its faculty and trainees will adhere to the UW Medicine Professionalism Policy in all interactions with patients, the public, members of the University community and each other. This expectation extends to all interactions related to compliance with this Policy, including reporting concerns about a trainee’s possible impairment and a trainee’s response to any expression of concern regarding possible impairment and/or notice of a workplace intervention.

Final Comments: Stigma, shame, guilt, and an exaggerated sense of responsibility can make it very, very difficult for afflicted physicians to seek help on their own. It falls upon us to speak up. Whenever you have concerns about a trainee’s possible impairment, you are encouraged to discuss these concerns with the Program Director, GME Wellness Service, GME Office or WPHP. This can be done without identifying the individual about whom you are concerned. Sharing your concerns provides two major benefits: 1) it unburdens you, and 2) it may validate your concerns and make it easier to identify an individual who needs formal intervention. Our ultimate goal is to create a medical culture that values health and wellness for our patients as well as for our physicians. Be well!

With thanks to the following individuals, whose work was the basis for this policy:

Karen Souter, MB BS  Charles Meredith, MD
Vice Chair for Education & Residency Program Director  Medical Director
Department of Anesthesiology and Pain Medicine  Washington Physicians Health Program
### Appendix 1. “6 Is” for Suspected Substance Abuse

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<thead>
<tr>
<th>1. IRRITABILITY</th>
<th>2. INABILITY</th>
<th>3. INACCESSIBILITY</th>
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<td>Mood swings</td>
<td>Inappropriate orders</td>
<td>Frequent tardiness</td>
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<tr>
<td>Negative attitude</td>
<td>Inadequate charting:</td>
<td>Frequent absence</td>
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<tr>
<td>Argumentative</td>
<td>– Quantity,</td>
<td>MIA “missing in action”:</td>
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<td>Inappropriate anger</td>
<td>– Quality,</td>
<td>– frequent trips to the bathroom,</td>
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<tr>
<td>Overreaction to criticism</td>
<td>– Timeliness,</td>
<td>– frequent trips to the parking</td>
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<tr>
<td>Altercations with staff</td>
<td>– QA outlier</td>
<td>lot,</td>
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<td>Altercations with patients</td>
<td>Difficulty with difficult cases</td>
<td>– prolonged breaks,</td>
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<td>Altercations with peers</td>
<td>Deviation from standard procedures:</td>
<td>– unavailable when on call,</td>
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<tr>
<td>Other disruptive behavior</td>
<td>Un-witnessed wasting / excessive or insufficient patient analgesia,</td>
<td>– unavailable for discussions,</td>
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<td>Personality change</td>
<td>Spillage / breakage</td>
<td>Frequent beeper failure</td>
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<td>Decreased performance</td>
<td>Frequent illness</td>
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<td>Frequent malpractice action</td>
<td>Monday morning or Post holiday “flu”</td>
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<td></td>
<td>Frequent forgetfulness</td>
<td>Early departure on Friday afternoons or post-holiday</td>
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<td>Nodding off</td>
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<tr>
<th>4. IRRESPONSIBILITY</th>
<th>5. ISOLATION</th>
<th>6. INCIDENTALS</th>
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</thead>
<tbody>
<tr>
<td>Shifts work load</td>
<td>Odd hours for rounds</td>
<td>Eyes - red / puffy / glassy pupillary changes / avoids eye contact</td>
</tr>
<tr>
<td>Manipulates the schedule</td>
<td>Volunteers for graveyard shift</td>
<td>Disheveled - tremors / bruises / needle tracks / long sleeves / sweating</td>
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<tr>
<td>Hurry-up / catch-up rounds</td>
<td>Absent from DRs lounge</td>
<td>Complaints - patients/ staff / colleagues</td>
</tr>
<tr>
<td>Hasty rounds</td>
<td>Eats alone</td>
<td>Gossip - marital / financial problems</td>
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<td></td>
<td>Avoids departmental meetings,</td>
<td>Driving Under the Influence (DUI)</td>
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<td>CME events, Social events</td>
<td>Unexpected / frequent job changes</td>
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<td>AOB / excessive scent/ mints to mask</td>
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<td>AOB</td>
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Appendix 2. Evidence of Impairment

The following are signs and symptoms of possible impairment. Isolated instances of any of these signs and symptoms may not impair a trainee's ability to perform adequately, but if they are noted on a continued basis or if multiple signs are observed simultaneously, individual action is indicated. Warning signs and symptoms, although certainly not specific to problems of impairment and/or substance abuse, may include:

1. Physical signs such as excessive fatigue, deterioration in personal hygiene and appearance, multiple physical complaints, accidents, or significant change in eating habits and body weight.
2. Behavioral signs such as mood changes or mood lability, depression, slowness, lapses of attention, chronic exhaustion, risk taking behavior, manic behavior, flat affect, paranoid beliefs, and self-deprecating or fatalistic comments.
3. Unprofessional behavior patterns including unexplained absences, spending excessive time at the hospital, tardiness, decreasing quality or interest in work, avoidance of interaction with other staff, and inadequate professional performance.
4. Social changes including withdrawal from outside activities, isolation from peers, embarrassing or inappropriate behavior at parties, adverse interactions with police, driving while intoxicated, undependability and unpredictability, aggressive behavior, and argumentativeness.
5. Drug use may be associated with excessive agitation or edginess, dilated or pinpoint pupils, self-medication with psychotropic drugs, stereotypical behavior, alcohol on breath at work, uncontrolled drinking at social events, blackouts, binge drinking, or changes in attire (e.g., wearing of long sleeve garments by parenteral drug users).
6. Disturbances in family stability, relationships, and parenting.
7. Failure to comply with hospital narcotic and other controlled substance policies.
8. Writing prescriptions for oneself or family members.
Appendix 3. Practical Aspects of Dealing with a Case of Possible Substance Abuse

Guidelines for performing a workplace intervention for a trainee with suspected impairment due to substance abuse.

Introduction
A workplace intervention should be conducted by the Program Director or other faculty member as soon as possible for any trainee who has shown signs or symptoms consistent with substance abuse, for whom discrepancies in his/her narcotic counts are found, or about whom there is concern of possible impairment from any other physical or mental condition. This intervention is an opportunity to express concern, ensure the safety of and provide a “safe harbor” for the trainee, and protect the safety of patients.

1. Aims of the Intervention
   a. Protect the trainee from harm or death resulting from the effects of narcotics or other substances.
   b. Prevent patient harm as the result of being cared for by an impaired physician.
   c. Facilitate further evaluation and treatment in a manner that allows the trainee to protect his/her medical license and avoid disciplinary action by MQAC.
   d. Protect the identity of the trainee to the maximum extent provided by existing State and Federal law. See WPHP Confidentiality Assurance Statement at www.wphp.org for further information.

2. Planning an Intervention
   The Program Director and/or faculty member(s) undertaking a workplace intervention must be completely clear about the anticipated outcome of the intervention before embarking upon it. This requires some prior planning. If a faculty member is conducting the intervention, inform the Program Director of the intervention as soon as possible.
   a. Review the information that has raised the concern. Discuss the case with Amity Neumeister, Assistant Dean, GME, Mindy Stern, Director of the GME Wellness Service or Kristina Schellie, Assistant Director of the GME Wellness Service. If there is question about impairment, the program may refer the trainee to the GME Wellness Service for a preliminary evaluation.
   b. Consult the WPHP for advice on managing the situation before undertaking a workplace intervention. Scott Alberti, CCDC, WPHP Clinical Director or Charles Meredith, MD, WPHP Medical Director are the best contacts at WPHP. In most cases, WPHP will want to see the trainee with suspected impairment and will give advice on the time frame for this. This will usually be the same day.
   c. Arrange for the trainee to be relieved from assigned duties, as he/she will not likely be returning to work for at least a couple of days.
   d. Set up the workplace intervention for the earlier part of the day, ideally. This allows time for the trainee to go straight to WPHP afterwards. If possible, avoid doing the workplace intervention at the end of the day or on a Friday evening.
   e. Select a suitable office or room where the conversation will be private.
   f. Identify one other faculty member to keep notes of what happens during the intervention, if desired.
   g. Discuss what will be said during the intervention and what is the desired outcome of the intervention with the other faculty member.
   h. Understand that once a trainee found to be impaired, only the WPHP may determine if the trainee is safe to return to work and resume patient care responsibilities.
   i. Set an appointment for the trainee with WPHP for immediately after the workplace intervention (unless advised otherwise by WPHP). The time period between performing the workplace intervention and the trainee presenting for evaluation at WPHP must be minimal. This reduces the risk of self-harm by the trainee in the time between being confronted about a possible problem and being placed in a safe place for further evaluation and/or treatment. This is best accomplished by coordinating with WPHP before conducting the workplace intervention.
   j. In some circumstances especially if the resident is very distressed as a result of the intervention - a faculty member should be prepared to drive the trainee to WPHP. Or, if safety is a concern, the Program Director or faculty member may arrange for the trainee to take a taxi cab to WPHP.
Make sure the trainee can arrange for a ride home or has cab fare to get back to the hospital to retrieve his/her car, if appropriate, after the evaluation.

3. **Potential Outcomes**
   a. The workplace intervention should end with the trainee presenting for evaluation to the WPHP.
   b. If the trainee does not agree to an evaluation, he/she should be suspended from clinical activities. Washington statutes consider potential impairment to be any “condition, physical or mental, which may affect a physician’s ability to practice with reasonable skill and safety”. If the trainee appears to be impaired and will not submit to further evaluation by WPHP, then he/she is considered to constitute “a clear and present danger” to the public and must be reported to the MQAC by the Program Director or other responsible faculty member after consultation with the GME Office and WPHP.
   c. In contrast, WPHP is not obligated to report anyone to the MQAC as long as they are compliant with WPHP recommendations. While under treatment by WPHP, the trainee’s identity shall not be made known to the disciplinary authority as long as he/she remains compliant with WPHP recommendations and does not constitute a clear and present danger to the public. This protects the trainee from disciplinary action against his/her medical license.

4. **After the Intervention**
   a. Once the trainee has been evaluated, the WPHP clinical staff will advise about the next stage in the trainee’s care.
   b. If the trainee requires further evaluation, this will take at least one week to coordinate and conduct as most substance abuse and/or behavioral health treatment facilities are outside of Washington State.
   c. If the evaluation is positive for substance dependence, the trainee may be required to complete inpatient treatment for a minimum of 2 months. At this stage the Chief of Service(s), and Chief Resident(s) and hospital leadership, if applicable, should be notified that the trainee is on medical leave so the call schedule may be adjusted.
   d. It is not appropriate to give out details of the trainee’s condition. The term “medical leave” is sufficient detail. Remember this is a medical condition and appropriate confidentiality must be maintained.