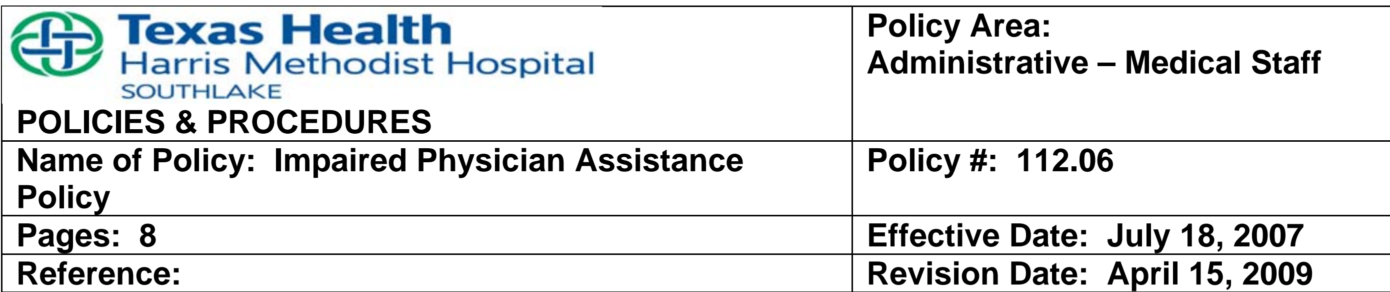


Texas Health Harris Methodist Hospital SOUTHLAKE **POLICIES & PROCEDURES**	**Policy Area:** **Administrative – Medical Staff**
Name of Policy: Impaired Physician Assistance Policy	**Policy #: 112.06**
Pages: 8	**Effective Date: July 18, 2007**
Reference:	**Revision Date: April 15, 2009**

DEFINITION

The problem of impairment is complex. To assist in the understanding of what constitutes an impaired physician the following definition applies. The American Medical Association defines the impaired physician as follows:

"A physician who is unable to practice medicine with reasonable skill and safety to patients because of physical or mental illness, including deterioration through the aging process or loss of motor skill, or excessive use or abuse of drugs including alcohol".

However, because the term, "impaired physician" includes a variety of problems from those associated with the aging process to substance abuse to physical or mental illness, the steps given will not be suitable in every circumstance. Specific needs and varying circumstances preclude a single inflexible mechanism for dealing with all impaired physicians. The number of incidents with the physician, for example, and their seriousness may dictate a different response by the hospital. The individuals conducting the inquiry will vary depending upon circumstances. Moreover, the risk of patient harm must be of paramount concern. Immediate action may be necessary.

The CEO plays a significant role in this process in conjunction with Medical Staff leadership because an impaired physician is a hospital concern, not merely a medical staff problem. One exception to this policy is impairment due to age and irreversible medical illness or other factors not subject to rehabilitation. In such cases, the sections of the policy dealing with rehabilitation and reinstatement of the physician are not applicable.

Because of the independent nature of most physicians' practices and the serious implications of any disability, impairment is often difficult to identify early and is always difficult for the impaired physician to acknowledge, and it is hard to face the problem with the physician. Nevertheless, it is the obligation of the hospital and medical staff leadership to address this problem whenever it arises. The following policy provides the framework within which to do it.

PURPOSE

1. To establish a process to identify and manage matters of individual physician health, separate from the medical staff disciplinary function, in compliance with JCAHO standards.

2. To establish a mechanism for any individual working in the hospital with a reasonable suspicion that a practitioner appointed to the HMSCDS Medical Staff is impaired.

3. To provide a process that offers support and compassion to the affected practitioner.

POLICY & PROCEDURE

If any individual working in the hospital has a reasonable suspicion that a practitioner appointed to the Medical Staff is impaired because of mental or physical disability, including substance abuse, the following steps should be taken:

1. A written report shall be given to the Chief of Staff, President, and the Director of Quality. The Vice Chief of Staff will substitute and hear complaints if the impaired practitioner should be the Chief of Staff or Quality Director. The report shall include a description of the incident(s) that lead to the belief that the physician may be impaired. The report must be factual. The individual making the report does not need to have proof of impairment, but must state the facts leading to the suspicions. If all possible, that individual should provide the names of two (2) other contacts who have observed or who have knowledge of the incident(s) and can corroborate the report.

2. The Chief of Staff of his/her designee shall discuss the report with the individual filing the report and the practitioner involved. A standard flow sheet of questions to ask/information to obtain in these meetings will be formulated by the Quality Review Committee to ensure consistency and uniformity of information collected. The Chief of Staff shall then discuss his/her findings with the President and Director of Quality or their designees, to determine if there is enough information to warrant further inquiry. If no further inquiry is felt to be necessary the practitioner should be informed by the Chief of Staff and/or the President that there was a potential problem and that he/she was exonerated with no further action required, with documentation to this effect to be kept in the separate file referenced in Item #8. If further inquiry is felt to be necessary the chief of Staff and/or President shall pursue at least one of the following:

   (a.) Form a standing committee of the medical staff, which shall be called the Medical Staff Health and Well Being Committee.
   (b.) Engage an outside consultant.
   (c.) Direct a review by another individual or individuals appropriate under the circumstances, such as a psychiatrist.
   (d.) Take immediate action regarding the practitioner's privileges if patient health and/or safety are felt to be jeopardized.

If, after the inquiry, the report documents sufficient evidence that the practitioner is impaired, the POS and/or CEO shall meet personally with that practitioner or designate another appropriate individual to do so.

3. The Chief of Staff and/or President, at their discretion, may order any practitioner who is under inquiry or for whom there is reasonable cause to believe that he or she is

chemically impaired, to immediately submit to a urinalysis or blood test for substance abuse.

4. Appropriate laboratory testing of the practitioner shall be conducted by a reference laboratory certified by CAP, NIDA, or other acceptable certifying agency chosen by the hospital, with confirmation by GCMS, Testing procedures shall follow portions of the Mandatory Guidelines for Federal Workplace Drug Programs as published in the Federal Register Volume 53, Number 69, of April 11, 1988. The applicable portions are Subpart A 1.2, Subpart B 2.2, 2.34, 2.4 (a)-(g)(5), 2.4(g)(8), 2.4(h)(i)(k), 2.7.

The following cut off levels are established; levels above which are considered positive for reporting purpose.

(a.) Alcohol 50 milligram/dl (blood alcohol)
(b.) Marijuana Metabolites 100 ng/ml
(c.) Cocaine Metabolites 300 ng/ml
(d.) Opiate Metabolites 300 ng/ml
(e.) Phencyclidine 25 ng/ml
(f.) Amphetamines 1000 ng/ml
(g.) Benzodiazepine 300 micrograms/mL
(h.) Barbiturates 300 micrograms/mL
(i.) Demerol – There is not present screening procedure available so the presence of the drug is considered positive.

Testing for other drugs may be performed as deemed appropriate under the circumstances of the suspicion. Cut off levels for drugs not listed here shall be determined by the Chief of Staff and/or President in consultation with hospital counsel.

3. The practitioner should be told if the results of an inquiry indicate that the practitioner suffers from an impairment that affects his or her practice. The practitioner may be told who filed the report, with permission of the individual providing the information. If the provider of the information wants identification protected the practitioner will not be told. It is appropriate to share the specific incidents contained in the report with the practitioner.

4. Depending upon the severity of the problem, and the nature of the impairment, at least one of the following options should be exercised:

(a.) Require the practitioner to undertake a rehabilitation program as a condition of continued appointment and clinical privileges. Leave of absence may be permitted in lieu of suspension for physicians who voluntarily enter a rehabilitation program.

(b.) Impose appropriate restrictions on the practitioner's hospital practice.

(c.) Immediately suspend the practitioner's privileges in the hospital until rehabilitation has been accomplished if the practitioner does not agree to discontinue practice voluntarily.

(d.) The Practitioner may make a self-referral or be referred by the Medical Staff Health and Well Being Committee.

(e.) Referral for evaluation and treatment may be made to an external source.

(f.) If the practitioner refuses referral, the matter will be referred for corrective action as provided for in the Medical Staff Bylaws.

5. If the matter cannot be handled internally, or jeopardizes the safety of the practitioner or others, the hospital shall seek the advice of hospital counsel to determine whether any conduct must be reported to law enforcement authorities or other governmental agencies and what further steps must be taken.

6. The original report and a description of the actions taken by the Chief of Staff and/or President should be included in the physician's QI/QA file, unless the inquiry reveals that there is no merit to the report, in which cases, for purposes of this policy, a separate file is kept. A summary describing what occurred should be kept in this file. If the inquiry reveals that there may be some merit to the report, but not enough to warrant immediate action, the report shall be included in a confidential portion of the practitioner's QI/QA file and the practitioner's activities and practice shall be monitored until it can be established that there is, or is not, an impairment problem. Monitoring may include the following: chart review, physician consultation for each patient, interviews with staff working in direct relationship with the practitioner, or any other monitor which may be deemed appropriate by the MEC.

7. The Chief of Staff and or President shall provide a written report on outcome of the inquiry to the practitioner, and provide appropriate follow-up to the complainant within (forty-five) 45 days of receipt of the complaint.

8. Throughout the process, all parties should avoid speculation, conclusions, gossip, and any discussions of this matter with anyone outside those described in this policy.

9. The Medical Executive Committee (MEC) shall be fully apprised of the report and recommendation. If the report and recommendation are accepted by the MEC and the MEC recommendation to the Governing Board results in "adverse" action to the practitioner, as defined in the Medical Staff Bylaws, the practitioner shall be notified of his or her right to a hearing.

10. Confidentiality will be maintained in all written and verbal communications and materials regarding the practitioner seeking referral or being referred for assistance, except as limited by law enforcement agencies or other governmental or regulatory agencies. The hospital will comply with all reporting requirements imposed on it by law.

REHABILITATION

Hospital and medical staff leadership should assist the practitioner in locating a suitable rehabilitation program. A practitioner shall not be reinstated until it is established, to the hospital's satisfaction, that the practitioner has successfully completed a program which the hospital has approved.

REINSTATEMENT

1. Upon sufficient proof that a practitioner who has been found to be suffering an impairment has successfully completed a rehabilitation program, the medical staff in consultation with the hospital may consider that physician for reinstatement to the Medical Staff.

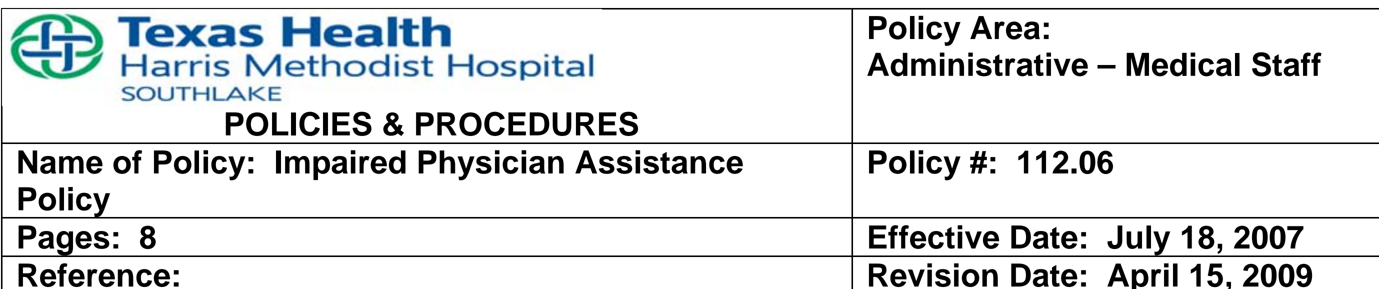
2. In considering an impaired practitioner for reinstatement, the hospital and its medical staff leadership must consider patient care interests paramount.

3. The hospital must first obtain a letter from the physician director of the rehabilitation program where the physician was treated.

The physician must authorize the release of this information. The letter shall state:

(a.) whether the practitioner is participant in the program
(b.) whether the practitioner is in compliance with all of the terms of the program
(c.) whether the practitioner attends AA meetings regularly (if appropriate)
(d.) to what extent the practitioner's behavior and conduct are monitored
(e.) whether, in the opinion of those doctors, the practitioner is rehabilitated
(f.) whether an after care program has been recommended to the practitioner and, if so, a description of the after care program
(g.) whether, in his or her opinion, the practitioner is capable of resuming medical practice and providing continuous, competent care to patients

4. The practitioner must inform the hospital of the name and address of his or her primary care physician, and must authorize that physician to provide the hospital with information regarding his or her condition and treatment. The hospital has a right to require an opinion from other physician consultants of its choice.



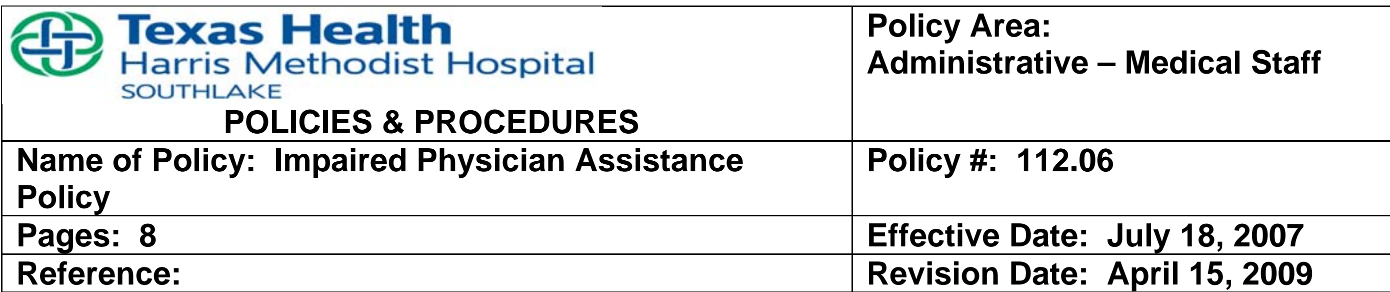
5. The hospital needs to know from the primary care physician the precise nature of the practitioner's condition, and the course of treatment as well as the answers to the questions posed above in (3.e and 3 g).
6. Assuming all of the information received indicates that the practitioner is rehabilitated and capable of resuming care of patients, the hospital must take the following additional precautions when restoring clinical privileges:
   (a.) The practitioner must identify two physicians who are willing to assume responsibility for the care of his or her patients in the event of his or her inability or unavailability.
   (b.) The practitioner shall be required to obtain periodic reports for the hospital from his or her primary physician – for a period of time specified by the President and the Chief of Staff – stating that the practitioner is continuing treatment or therapy, as appropriate, and that his or her ability to treat and care for patients in the hospital is not impaired.

7. The practitioner's exercise of clinical privileges in the hospital shall be monitored, which may include consultation with another physician on patients or checking with the department head when arriving at work each day, by the department chair, or by a physician appointed by the department chair.

8. The practitioner must agree to submit to an alcohol or drug and screening test (if appropriate to the impairment) at the request of the Chief of Staff, Quality Director and/or President of a designee of the above who suspects that the physician may be under the influence of drugs or alcohol.
9. All requests for information concerning the impaired practitioner shall be forwarded to the Chief of Staff and/or President for response.

MEDICAL STAFF PHYSICIAN ASSISTANCE COMMITTEE

1. The Medical Staff Physician Assistance Committee shall be established to receive all reports from monitors of impaired physicians, meet with the affected practitioner for discussion/assessment, access the quality and adequacy of the recovery/monitoring program, report to the Medical Executive Committee, and assist all impaired physicians to re-integrate into the Medical Staff. The committee shall coordinate education on impairment for the Medical Staff.
2. The Medical Staff Physician Asistance Committee shall be composed of no less than three (3) but no more than seven (7) active members of the medical staff, a majority of whom, including the chairman, shall be physicians. The Chairman will be appointed by the President of the



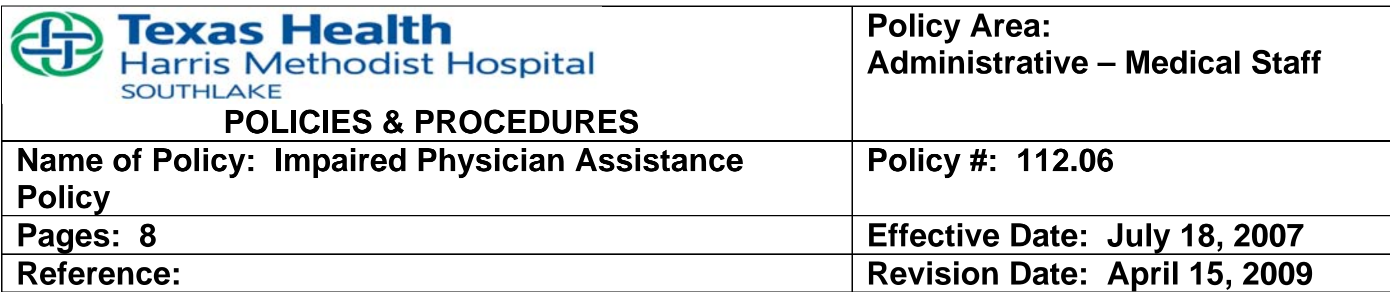
Medical Staff with members appointed on an ad hoc basis that may include: distinguished senior medical staff members; an addictionist; a psychiatrist; a high-risk area representative (anesthesiology, surgery, emergency medicine), and a physician with substantial personal recovery experience. For purposes of confidentiality and avoidance of conflict, the committee generally should not include: any hospital board members, the President of Staff, any medical executive committee members, any President or nurse, QI / RM committee member or legal counsel. Each member shall serve a term of two (2) years. The President of the Medical Staff shall have the option of sustaining the composition of the Committee in order to maintain continuity.

RESPONSIBILITIES, DUTIES, AND AUTHORITY

1. Responsibilities, Duties and Authority. It is recognized that medical staff members face unique stresses involving professional or personal matters that may affect all aspects of their lives, and accordingly may impact the quality of care they render. It is the medical staff's responsibility to enhance quality care and protect patients from harm. It is this committee's goal to act as physician advocate by providing provide valuable resources to assist medical staff members in dealing with these unique stresses in a confidential and compassionate manner which is separate and apart from the medical staff disciplinary process. This committee shall keep all information confidential, (i.e., not accessible to either the hospital administration or the medical staff.) The goal is to gain the trust of the medical staff members, impaired or not.

2. This committee shall address issues of practitioner health including the prevention of physical, psychiatric or emotional illness. It shall be responsible for facilitating confidential diagnosis, treatment and rehabilitation of practitioners who suffer from a potentially impairing condition. The committee shall focus on assistance and rehabilitation, rather than discipline, to aid a practitioner in retaining or regaining optimal professional functioning, consistent with the protection of patients. If at any time during the diagnosis, treatment, or rehabilitation phase of the process it is determined that a practitioner is unable to safely perform the privileges he or she has been granted, the matter shall be forwarded to the Chief of Staff or his or her designee for appropriate corrective action. Reporting of such corrective action shall be in accordance with State and Federal reporting requirements. The committee shall be empowered to rule whether the disciplinary process or the physician health route best addresses a physician problem.

3. The committee may receive reports, through self-referrals or referrals by hospital staff or medical staff, related to the health, well-being or impairment of medical staff members. The committee may, as it deems appropriate, investigate such reports for the credibility of the complaint, allegation, or concern. With respect to matters involving individual medical staff members, the committee, or a designee of the committee, may confront the individual and provide advice, counseling, or referrals to the appropriate professional internal or external



resources for the diagnosis and treatment of the condition or concern. Such activities shall be confidential to the extent that the affected practitioner voluntarily participates in any recommended programs and monitoring. In the event that the affected practitioner refuses such referral and the committee determines that further action is necessary, than the committee may forward its recommendation to the Chief of Staff for corrective action. To assure patient safety, the committee shall monitor the participating practitioner and the care provided to the patients he or she diagnoses or treats, until the rehabilitation or any disciplinary process is complete.

4. The committee shall also consider general matters related to the health and well being of the medical staff and develop educational programs or related activities about illness and impairment recognition issues specific to medical staff members for the hospital and medical staff. Education may include but not be limited to: medical staff presentations, training of department heads, training of nurses, and regular ongoing publicity through bulletin boards, newsletters and staff notices.

5. The committee shall report to the Medical Executive Committee on at least an annual basis the following summary information:

   a. The number of referrals received for evaluation in the current reporting period;

   b. The number of those referrals accepted for monitoring;

   c. The total number of individuals currently being monitored;

   d. The number of individuals released from monitoring in the current reporting period;

   The number of individuals referred for corrective action in the current reporting period