Resource Document: Guidelines to District Branches for a Policy on Physician Impairment

Approved by the Joint Reference Committee, 1990
Approved by the Council on Psychiatry and Law, 1990

This resource document was written by the Committee on the Impaired Physician, Council on Medical Education and Career Development.

1. Purpose

The American Psychiatric Association has resolved to promote the mental and physical health of all physicians toward the goal of insuring optimum care of patients, protecting the public from possible harm by an impaired physician, preventing loss of valuable medical manpower, and helping the impaired physician regain health and productivity.

The APA recognizes that psychiatrists, like other physicians, are at risk for impairment by mental and physical disorders, including addiction (or substance abuse). All physicians have an ethical obligation to assist colleagues who are impaired, including those who avoid and resist treatment.

There is now a body of knowledge demonstrating the effectiveness of therapeutic alternatives to punishment as a solution to the problems of impaired physicians.

The APA recognizes that much of the work—early recognition, referral, evaluation, treatment, and re-entry into practice—must be done with individual physicians at the local level.

State medical societies now have programs, many of which are prepared to aid impaired physicians at various stages of development. These programs typically interact with hospital boards and medical staff organizations, state medical boards and other institutions concerned with the problems of impairment.

The following are essential components of programs to aid impaired physicians:

(a) Facilitating anonymous reporting of physicians suspected of being impaired. Such reports come from a variety of sources, including colleagues, families, hospital staff, administrators and, patients.

(b) Offering information, consultation, and advice to those seeking help for impaired physicians.

(c) Receiving and evaluating referrals from all sources, including physicians, family, friends, and patients.

(d) Planning and developing strategies for intervention, within the context of state and local regulations, which are designed to limit denial and persuade the impaired physician to accept referral for psychiatric evaluation. These strategies may include limit-setting and coercion. (While the District Branch itself has no power to discipline physicians, the threat of action by the state licensing board is often sufficient to coerce unwilling physicians to comply with treatment programs.)

(e) Promoting the impaired physician's acceptance of appropriate available treatment for impairing conditions. When the impaired physician agrees to enter treatment and comply with a treatment plan, he or she enters into a contractual relationship which allows the matter to be handled in a confidential manner by the impaired physicians committee. Disciplinary action is not needed in such cases, but could follow if the physician does not comply with the contractual agreement. Typically, records of a medical society impaired physicians committee are confidential, while those of state boards of medical examiners are public documents. Participation in a program to aid impaired physicians may or may not provide protection from reporting, depending on state and local regulations.

(f) Monitoring and reinforcing compliance with treatment—particularly in the case of substance abuse—and supporting the impaired physician's rehabilitation and return to work.

(g) Aiding re-entry into professional activity with career counseling or retraining if needed.

(h) Serving as an advocate for the impaired physician with ethics committees, boards of licensure, hospital administration, and law enforcement agencies, at the request of the impaired physician as long as the physician continues in the program.

(i) Maintaining separation of the program's intervention, treatment and advocacy functions whenever possible.

(j) Maintaining confidential records of proceedings, without individual identifiers, so that data can be available for research about effectiveness of the program.

(k) Promoting adequate insurance coverage for medical students, residents and physicians, including psychiatric health insurance coverage and disability insurance.

(l) Providing education and consultation to licensing bodies.

Other recommended functions of an impaired physicians program include:

(a) Providing financial support in the form of loans or gifts for impaired physicians during treatment.
(b) Seeking ways to improve the mental health of medical students and residents by providing information, education, and treatment and advocating these reductions in training programs.
(c) Providing educational programs for physicians and their families other professionals, state licensing bodies, and the public about physician impairment.
(d) Working with legislators to enact laws which will facilitate the above goals.

The APA recommends that District Branches take an active role in the provision of the above services. Moreover, the APA recommends that District Branch efforts be joined or coordinated with those of the state medical society to increase effectiveness and efficiency. Such collaboration will prevent unnecessary duplication of effort and may provide immunity for those District Branch members participating in the program. Many state medical society programs have already worked out methods of maintaining confidentiality and of relating to the ethics committees and licensing bodies. It is imperative that the District Branch be thoroughly familiar with the Impaired Physician Program of the state medical society. State laws and the procedures of state licensing boards vary, so activities of the Impaired Physician Programs must conform to the regulations in each state.

The APA recommends that District Branches ensure representation and active participation by psychiatrists on the state medical society impaired physician committees. Psychiatric expertise is essential in early recognition and prevention programs, not only for addictive disorders, but also for other psychiatric disorders; and particularly dual diagnoses, (e.g., affective disorder and alcohol dependence; cocaine addiction and borderline personality disorder). Psychiatric representation is necessary in developing recommendations regarding treatment, monitoring re-entry, and aiding in the assessment of situations in which ethical complaints are compounded by impairment problems (e.g., sexual abuse of patients by a physician impaired with a bipolar disorder, manic phase).