

Evaluating and Treating Disabled or Impaired Colleagues

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Back in September 1999, I wrote a column about recognizing and dealing with impaired physicians.¹ This month, I'd like to talk about the processes and procedures associated with evaluating colleagues (we'll use physicians as the primary example) for such things as psychiatric disability and impairments that can affect their ability to practice safely and competently.

Disability

Many physicians carry disability insurance to protect themselves and their families from catastrophic loss of income. Some of these policies are quite expensive, and offer benefits that involve far higher monthly compensation than that found in ordinary policies (such as the Social Security disability benefits received by many chronically ill patients).

Some of the best physician disability policies insure one's practice of a specific specialty or subspecialty. That is, the claimant doesn't have to show that he or she cannot work at all, or even that he can't practice medicine at all, but merely that he can't practice the particular specialty that the policy covers. With the right policy, a neurosurgeon whose tremors don't allow him or her to operate is not required to try nonsurgical practice. In fact, the neurosurgeon in this situation could practice, say, radiology, and still collect disability for not being able to practice neurosurgery.

Insurance companies are understandably very careful about paying physicians and other high-end professional and executive claimants. In addition, they often require periodic proof of treatment compliance and continuing disability.

Dr. A, a subspecialty surgeon, suffered a manic episode in which he became delusionally grandiose, attempted to schedule complex surgeries in the middle of the night, threatened nurses who kept him from operating in his delusional condition, and eventually was hospitalized after assaulting a colleague. He had a history of two major depressive episodes (both successfully treated), had recently become depressed again, and had been placed on an

increased dose of antidepressant just before he became manic. He slowly improved, returning to near-baseline function after about 8 weeks, but the state licensing agency refused to reinstate his license, even with restrictions, until he could show that he was "no longer a threat to patient care or safety, nor prone to relapse of a condition likely to threaten patient care or safety." He reluctantly accepted the loss of his practice and applied for full disability, with tax-free payments of almost \$90,000 a year, while he continued his treatment.

Dr. B was reported to his state licensing agency for seeing patients while abusing fentanyl. This was his third drug-related reporting episode over a period of 12 years. His license was revoked and the revocation "stayed" with a practice suspension pending successful treatment for substance abuse. He spent 6 weeks in a residential recovery program, after which the state medical board refused to lift the sanctions on his license. His doctors and counselor recommended a 3-month sabbatical from medical practice in any event, so he closed his office and applied for disability through his private disability carrier, claiming full benefits of about \$80,000 per year.

Dr. C was sued by an adult patient whom he allegedly fondled during an examination. Soon after the allegation surfaced, criminal charges were filed. He immediately found and entered a residential treatment program where he was diagnosed as having a "sex addiction" and personality disorder. Dr. C remained in the inpatient program for several weeks prior to his criminal trial. He was allowed to plead guilty to misdemeanor assault and was

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placed on probation, after which his medical licensing board severely restricted his license. He could not find clinical employment that met the board's monitoring requirements and applied for disability payments based upon his "addiction," a subsequent claim of depression, and personality disorder.

Dr. A received his benefits almost immediately. Information from his treating psychiatrist was deemed sufficient to begin the payments, and an independent review of his records by a carrier-retained psychiatrist supported continuing them.

Dr. B received payment for his short-term disability (6 weeks in a residential rehabilitation setting), but the insurance company required more evidence before approving him for long-term payments. The company's position was that 1) neither loss of nor ineligibility for licensure in itself defines disability, and 2) the physician's substance abuse was voluntary, and voluntary impairment or inability to practice was not covered by his policy. His treating psychiatrist and substance abuse counselor, however, reported that his substance abuse was a disease outside his control (and thus involuntary) and that he was indeed disabled. After review and examination by an independent psychiatrist, the company allowed the claim and began his payments.

Dr. C was initially denied disability benefits. The company claimed that neither his sexual behavior nor his personality disorder was tantamount to a disabling condition, and his depression was insufficiently documented and treated to be defined as a chronically disabling condition. He appealed, and an independent psychiatric evaluation was scheduled. This evaluation revealed that there had been no complaints of depression and no indication of limitations from any personality disorder prior to his being caught. The personality disorder was not associated with psychosis or substantial mood instability, but with a tendency toward antisocial behavior. His depression was primarily self-described; it did not interfere significantly with his life, and he had not sought treatment "which could be expected to alleviate most or all depressive symptoms in most similar patients." His claim of sex addiction was examined and found to be "vague, and at best mixed with behavior which is simply self-gratifying and of poor judgement... even if shown to have some uncontrollable characteristics, his actual ability to diagnose and treat patients does not appear impaired. The main issue appears not to be that he cannot work, but that work within the Board's restrictions is hard to find." His appeal was denied.

In the case of Dr. A, about 3 years later independent evaluation revealed that his bipolar symptoms had not recurred and he was doing well on a regimen of an antidepressant and a mood stabilizer. He had successfully petitioned for reinstatement of his license, and it had been reinstated with restrictions, including a requirement that he have another clinician monitor all surgeries. Nevertheless, when he tried to return to practice he became overwhelmed with the stresses of acute care and soon stopped. He had considered seeking an administrative position or working in a non-acute physical medicine clinic, but had not done so by the time of the evaluation.

After reviewing the records and interviewing Dr. A, the evaluator spoke with his psychiatrist. The psychiatrist said that Dr. A. was quite frustrated at not being able to return to surgery and that, although he harbored fantasies of some other kind of practice, he had slowly come to accept a life outside the field of medicine. Dr. A was ambivalent about trying nonsurgical practice, but continued to travel and work in his garden rather than attempt it. The treating psychiatrist believed he had chronic subtle residual symptoms of his bipolar disorder, that his reluctance to return to medical practice served a protective function for him, and that his risk of relapse even with continuous medication precluded his being completely safe in an independent surgical practice.

The evaluator initially questioned Dr. A's motivation and the secondary gain associated with avoiding even simple medical work. Nevertheless, the insurance policy was clear that unless he could return to surgery, the policy would pay. He recommended that the disability rating continue indefinitely; the company agreed.

In the case of Dr. B, 2 years later it appeared to the company that his substance abuse problem was under control and that any future substance use would be "voluntary" rather than the result of an illness or disability. He had been sober for more than 2 years, was actively participating in a 12-step program, had completed all requirements of his licensing agency probation, and was socially stable, but had not returned to the practice of medicine. He was working as a non-physician counselor in the same residential substance abuse program he had attended a few years earlier.

During his interviews, Dr. B told the evaluator that both he and his counselor feared he would relapse if he returned to practice, citing in particular the availability of tempting abusable medications. He had thought about relatively less stressful clinical work, such as being a student health physician or doing physical

exams for a large correctional institution, but openly said that this would void his disability policy and pay about the same as his current insurance benefits. He then reiterated his fear of relapsing.

When the evaluator spoke with his counselor and monitoring physician, both said that returning to practice would increase his chances of relapse, citing examples of other patients who had returned unsuccessfully to stressful occupations. In this case, however, the evaluator came to the conclusion that avoiding the stresses of medical practice and potential return to drug or alcohol abuse were matters of the claimant's preference, and thus voluntary rather than conditions forced upon him by an illness. The carrier decided to give him 4 months' notice, then discontinue his payments.

In the case of Dr. C, several years later he again appealed to the disability carrier. By this time, he had worked briefly in a monitored setting before "retiring," and had opened a nonmedical business. His appeal was denied by the company and then by an independent mediator.

Licensure

Physicians being evaluated for possible license restriction or revocation usually present in a way that is the opposite of the situations described above. They do *not* want to be found impaired or practicing in a way that endangers patients. The evaluator may be an agent of the licensing agency (even if "independent" but acting at agency request), or may be retained by the physician's attorney.

Sometimes, physicians themselves request an evaluation; they may or may not mention that the request is associated with licensure, a legal matter, or some other kind of allegation. Unless the evaluation is strictly clinical (such as one in which a colleague is worried about symptoms but has not suffered any outside allegations or official criticisms), I strongly recommend against performing a psychiatric evaluation under such conditions. I almost always politely decline any detailed discussion and suggest that the potential evaluatee seek legal advice, after which I may work through his or her lawyer, licensing board, or a state-designated professional intermediary such as a "physicians' health committee." That creates much clearer professional roles, and less potential for bias, than working "for" the evaluatee himself.

In order to do licensure or other "fitness" assessments of physicians, one must be able to set aside personal loyalties and biases toward "salvaging" the colleague.

The evaluator must consider public safety, not merely symptoms, feelings, and competence. One should also be aware of the procedures that a licensing agency or similar body employs, and how to present one's findings in such a way that they are seriously and objectively considered.

Dr. D applied for a license to practice medicine in a western state, after having practiced for several years in New England. She was asked on the application whether or not she had ever been treated for a psychiatric disorder. She noted that she seen a psychiatrist during medical school, explaining that she had been treated for depression and briefly took antidepressant medication. She had graduated on schedule and the experience had never before interfered with her being licensed, credentialed, or clinically employed.

The state medical board delayed approving her application and required her to obtain a "forensic psychiatry evaluation." Taken aback, she nevertheless complied, spending many additional weeks and several thousand dollars before the evaluation was completed. The report opined that she had no apparent indications of current problems and, although depressions of the type she experienced may recur, there was no indication that she was unable to practice safely and competently.

The medical board approved her application but placed a 5-year restriction on her license which required annual re-evaluation at her own expense. She considered a legal appeal, but was discouraged by a local attorney. She is currently practicing without incident, but points out the unfair stigma associated with psychiatric treatment. Had she not sought the medical treatment we all would recommend, there might never have been a licensing question.

(Note that the same issue is occasionally raised for applicants who have been in psychoanalysis, including the training analysis required to become a psychoanalyst, or who have sought some form of counseling while in practice. Almost all licensing and credentialing bodies accept these things as not indicating any condition that might reasonably limit safety or competence, but a few sometimes require additional evaluation. In all states, not divulging the therapy or other treatment when required on an application or reapplication form creates substantial risk of being accused of fraud should problems arise later.)

Most licensing agencies, credentialing bodies, and the like are fair, and try to find a way for the evaluatee to practice if he or she can do so safely and competently. A few are not fair, however. Others are unduly fearful or misunderstand psychiatric diagnoses and symptoms. Still others may be influenced by political pressures, particularly if there have been recent media reports of incompetent or unscrupulous doctors, and the evaluatee may be caught in an unfortunate crossfire. This makes the evaluator's competence, objectivity, and ability to communicate the nuances of his or her findings all the more important.

Treaters, Monitors, and Evaluators

There are three general ways to participate in physician assessment and rehabilitation processes, whether as an agency volunteer/contractor or a private provider. One can be an *evaluator/reviewer*, a *monitor/chaperone*, or a *treating clinician*. Separating these roles is very important.

Evaluators/reviewers may be retained by a licensing agency or other government body, an insurance carrier, a private attorney, or (in unusual circumstances) by the physician him- or herself. They don't treat evaluatees, and usually don't monitor them after cases have been decided. They must be independent of evaluatees' personal and professional lives and may be from a different community altogether. Evaluators/reviewers should have no doctor-patient relationship with evaluatees and are expected to provide reports to the retaining entity.

Monitors/chaperones, who are often nonphysicians, are assigned by an agency or healthcare facility to observe or follow questionable or impaired physicians, but not to treat them. They may be continuously present, as in the case of some surgical observers or assistants and chaperones assigned to prevent inappropriate sexual behavior during patient interactions. Others have more peripheral roles, such as making unannounced visits or observations. Although monitors are often closely involved in their charges' day-to-day professional lives, they must be able to remain objective and free of bias, and thus should not have other close relationships (professional or personal, including doctor-patient relationships) with them. Monitors may be required to report periodically to a licensing agency or other body, and are expected to communicate about problems if they are observed.

Treating clinicians have a doctor-patient relationship with the physician/patient. The treatment is either involuntary (e.g., ordered by an agency or institution in

order to keep a license or privileges) or "pseudo-voluntary" (e.g., pursued because of external pressure from a pending license review, lawsuit, or criminal charge). The doctor-patient relationship creates the advantage of a relatively safe and confidential environment for improvement, outside most of the "administrative" or "legal" confines associated with independent evaluators and monitors. At the same time, treaters in these situations usually have some level of "dual agency," in which they may have to report periodically on patient status and progress and/or notify someone if they discover potentially serious threats to practice competence or safety.

Both treater and physician/patient must understand all of the requirements and limitations placed on the treatment and on the doctor-patient relationship, including those related to confidentiality, reporting, behavioral rules, choice of treatment modality, patient attendance, and compliance with treatment plans and regimens. This understanding should be clearly written down, provided to the patient, placed in the patient record, and filed with the agency or entity requiring the treatment.

The support and therapeutic value of a treatment milieu are considerable, but clinicians must not be naive about such patients. Psychiatrists and psychotherapists, especially, should remain aware that people whose licenses and careers are at risk are always motivated, to a greater or lesser extent, by factors related to their personal gain. They often do not report behaviors, impulses, symptoms, or problems as reliably as ordinary patients. This is not a job for inexperienced or immature clinicians. Even experienced ones often benefit from consultation or supervision.

Dr. E was convicted of misdemeanor voyeurism after placing a surreptitious video camera in his clinic dressing room. His medical license was suspended, then reinstated with the condition that, among other things, he receive psychotherapy for voyeuristic behaviors and urges. He made arrangements to see a licensed psychologist who specialized in intensive psychotherapy. On his first visit, he volunteered that he had "always wanted to be psychoanalyzed... I know there's a lot to learn about why I do things."

After about 3 months of what was described as twice-weekly psychodynamic psychotherapy, the therapist prepared a progress report for the licensing board. Before the report was finalized, she asked Dr. E to read it "as part of supporting his trust with-

in the therapeutic alliance.” Dr. E told the therapist that he disagreed with some parts of the draft and that his voyeuristic impulses were no longer a problem. They negotiated changes in the wording. Soon thereafter, they decreased the session frequency to once a week.

During the second 3 months of therapy, Dr. E. kept all of his weekly appointments. The therapy topics became a bit more superficial than they had been during the first 3 months, with portions of the sessions being spent on topics of mutual therapist-patient interest such as sailing and shooting. As the second report deadline approached, Dr. E. made it clear that he had not engaged in any voyeuristic activities, and that “the only urges I have are for my wife.” He asked the therapist to recommend that his psychotherapy become voluntary, “so we can work on the important stuff without having my license hanging over my head.” She agreed, and the licensing board dropped the requirement.

Soon after the board cancelled the therapy requirement, Dr. E began to miss appointments, then stopped coming altogether. He declined an offer

to continue long enough to address termination issues, and never paid his outstanding bill.

The Last Word

Make yourself available to help your state licensing agency review complaints and assess applicants and licensees. That kind of work is a public service and supports good decisions about colleagues whose practices are questioned. Most state licensing boards have lists or panels of volunteer reviewers who are paid a nominal fee when called upon. It won't make you rich, but you'll be doing something positive.

Know what you're doing, watch for conflict of interest and countertransference, and avoid biases that stand in the way of fairness and public safety.

References

1. Reid WH. Impaired colleagues. *Journal of Practical Psychiatry and Behavioral Health* 1999;5:291-3 (Can be accessed at www.reidpsychiatry.com/columns/Reid09-99.pdf).