CENTRAL IOWA HEALTH SYSTEM
GRADUATE MEDICAL EDUCATION COMMITTEE

POLICY ON IDENTIFICATION, INTERVENTION, ASSISTANCE, AND RESOLUTION OF THE IMPAIRED RESIDENT

I. Purpose. This policy provides guidelines for proper response to performance problems by resident physicians associated with alleged or actual substance abuse, physical disability, mental illness, or emotional impairment.

II. Definition. An impaired resident physician shall be defined as any resident who, by virtue of substance abuse, physical disability, mental illness, or psychological impairment, is unable or potentially unable to care for patients with reasonable safety and skill

III. Background. If any Central Iowa Health System (CIHS) employee, medical staff member or resident has knowledge, substantiated concerns, or convincing reasons to suspect that patient care is, or may be, affected by any resident due to the resident being impaired, it is his or her duty to report this expeditiously to the program director.

Confidentiality of Information

Confidentiality is extremely important in situations involving suspected resident impairment and/or any intervention with and treatment of an impaired resident. However, the Director of Medical Education must be notified when a resident has been diagnosed as being impaired and must be kept apprised of the intervention process and the resident's progress. The nature of the impairment, the actions taken and the progress of the resident's treatment and rehabilitation must be documented. With the exception of the Director of Medical Education, information will remain confidential as a part of the resident's permanent file. The Iowa Board of Medicine will be notified pursuant to the applicable Iowa Code.

IV. Policy. The following details the impaired resident identification, intervention, assistance and resolution process. This policy is designed to provide guidance and consistency in assessing and handling resident work related performance problems associated with alleged or actual substance abuse, physical disability, mental illness or emotional impairment.

Step 1. Program director receives work related performance problem information. The program director may receive reports of alleged or actual impairment related work performance problems. Prior to approaching the resident with the work related performance problem information, it is recommended that the program director consult the Director of Medical Education and Iowa Health System (IHS) legal counsel. These individuals will identify resources available to conduct an investigation, if necessary. In the event that a resident voluntarily identifies impairment related work performance problems, the program director should follow the procedures outlined in this policy beginning with Step 3.

Step 2. Program director discusses work related performance problems with resident. The program director will meet with the resident to discuss the allegations of impairment, framing the discussion in the context of information received related to work performance problems. The program director has the discretion to determine that an impairment problem does not exist and what, if any, further action is warranted. If the resident indicates a desire to terminate discussions of this nature with the program director, he or she may do so at any time during the conversation. The program director will document the resident meeting(s) and /or document unsuccessful attempts to meet with the resident to discuss work related performance problems.

Step 3. Program director assesses the acceptance or denial of the alleged impairment problem exists. Step 4 or Step 5 is then followed as appropriate.

Step 4. Acceptance. The Resident agrees that he/she may have an impairment problem.	**Step 5. Denial.** The Resident denies that he/she has an impairment problem.
A. Program director notifies the Director of Medical Education**.** B. The program director, in consultation with the Director of Medical Education and IHS legal counsel, encourages the resident to follow all impairment self-reporting requirements as stipulated by the Iowa Physician Health Program (IPHP). After the resident self-reports, the IPHP will notify the program director. If the resident fails to self-report to the IPHP within two business days of agreeing that an impairment problem exists, the program director will report the resident to the Iowa Board of Medicine. C. Resident seeks intervention**.** The resident is referred to a treatment program. Collaboration occurs with the Human Resources Department to ensure that the resident understands his/her medical insurance coverage. (If not covered by medical insurance, the residency will not bear expenses incurred by the resident in the treatment process.) If the resident self-reports and fails to notify the program director in a timely fashion, the resident's status in the residency program may be affected per this policy. D. Program director makes work re-entry decision. The program director may decide whether or not to allow the resident to return to the residency program contingent upon considerations such as the nature of the work related performance problem, assurance of patient safety, and evidence from the treatment program that the resident is safe to return to work and interact with patients. The program director must present documentation to the Director of Medical Education that the resident's treatment has been effective, that the program director has received reports on the resident's progress in the	A. The program director documents the discussion with the resident including the resident's denial that a problem exists. B. The program director provides copies of all relevant information to the Director of Medical Education and IHS legal counsel. C. The program director shall not require the resident to submit to diagnostic testing without first consulting IHS legal counsel to determine if sufficient evidence exists to require such testing. D. Program director makes employment decision**.** Termination based upon impairment is an option only if (1) the resident is required and refuses to submit to diagnostic testing; (2) the resident agrees to diagnostic testing, the testing results in a diagnosis that an impairment exists and the resident refuses to enter treatment; (3) the resident does not successfully complete a treatment program; or (4) sufficient information exists regarding impairment related work performance problems to terminate the resident.

treatment program, that the resident is in compliance with the treatment program, and that the resident is willing to adhere to an after-care program. E. Program director monitors resident's compliance with the after-care program. The program director monitors the resident's compliance with all components of the after-care program, as set forth by the prescribed treatment program. F. Resident compliance with after-care program and/or recurrence of impairment related work performance problems. The program director may terminate the resident's training if the resident does not comply with all components of the after-care program and/or if impairment related work performance problems persist.	

Step 6. Program director determines if the resident should be terminated. If terminated follow Step 7. If not, follow Step 8.

Step 7. Resident's Training is Terminated	**Step 8.** Resident's Training is not Terminated.
If the program director terminates the resident's training, the program director must notify the Director of Medical Education. IHS legal counsel should also be notified and, as appropriate, the Iowa Board of Medicine. The resident will be afforded due process as outlined in the CIHS *Appeals Procedure for the Resident*.	Program director monitors work related performance**.** If the resident has denied the existence of an impairment problem and the program director does not have sufficient grounds to request entry into a treatment program or termination, no further action will be taken. However, the program director will continue to monitor the resident's work performance. If suspected impairment related work performance problems persist or if further allegations emerge, the program director will return to Step 2.

Resources. Attached to this policy are three appendices which provide a description of contributing factors to chemical dependency, identify risks of substance abuse in physicians and describe the signs, symptoms and considerations in identifying potential chemical dependency.

Approved by the Graduate Medical Education Committee on February 9, 2010.

APPENDIX A: CONTRIBUTING FACTORS TO SUBSTANCE ABUSE

Substance abuse carries significant personal risk to residents and their patients. Chemical Dependency (Substance abuse) is a medical disease, and some clinical departments may have greater risks because of the availability of potent drugs[1].

A 7% prevalence of alcoholism among physicians implies a clear need for careful crisis intervention[2]. Within the estimated population of 15-20,000 chemically dependent American physicians, one in 100 will become addicted to narcotics, with one in ten of this committing suicide. However, abstinence "cure rates" approximate 90% for ethanol abuse and 75% for fentanyl abuse[3]. The magnitude of substance abuse in American Society makes a clear policy essential to the function of the Hospital in the University setting.

The following policy is designed to provide guidance and consistency to assessing and handling of House Staff Member work related performance problems associated with substance abuse.

[1] Ware, C. F. et al., "Drug Abuse among Anesthesiologists," JAMA 250:922, 1983.
[2] Krizek, Thomas K., "Substance Abuse: An Issue for Faculty and House Staff." Minutes of the Society of University Urologists pp. 34-40, Oct. 11, 1990.
[3] Krizek, Thomas K., "Substance Abuse: An Issue for Faculty and House Staff." Minutes of the Society of University Urologists pp. 34-40, Oct. 11, 1990.

APPENDIX B: RISKS OF SUBSTANCE ABUSE IN PHYSICIANS

Residents who have access to addictive drugs are at risk for substance abuse. Several factors contribute to the development of chemical dependency:

- Drugs are available in hospitals and operating rooms and their potential misuse is influenced by a culture of moderate to heavy drinking where alcoholic beverages are a way of life;
- Experimentation with mood-altering drugs is pervasive; they are available to all members of our society;
- Job stress is common in highly skilled and achievement oriented specialties;
- An "ain't got no respect" syndrome may exist where there can be a low recognition of intense work effort;
- A "chemical" way of life and a cultural need for instant gratification may lead to rote or mechanical ways of dealing with psychological pain, stress, fatigue, worry and physical discomfort.

Fraly, W.J. and Talbott, G.D., "Editorial: Anesthesiology and Addiction", Analgesia 62:465-6, 1983.

APPENDIX C: SIGNS, SYMPTOMS & CONSIDERATIONS IN IDENTIFYING POTENTIAL CHEMICAL DEPENDENCY

The early clinical and behavioral characteristics of alcohol and/or substance abuse impairment may be subtle and difficult to recognize, especially when substance use is intermittent and the resident is not yet dependent or impaired. Clues that could raise suspicion include behavioral changes, deterioration in work performance, tardiness, irresponsibility, or anti-social conduct as well as overt manifestations such as drunkenness, hallucination, euphoria, depression, anxiety and even traffic violations related to driving while intoxicated (DWI).

Social behavior, health and work performance may be variably affected by chemical dependence. Social dysfunction may manifest itself in any of the following categories:

- Withdrawal from leisure activities, friends and family;
- Uncharacteristic or inappropriate behavior at social gatherings, impulsive behavior. These may include:
  - gambling or overspending;
  - mood swings;
  - frequent illness;
  - prominent desire to work alone and undisturbed;
  - hostility; and/or
  - refusal to eat lunch or to take breaks
- Domestic turmoil (e.g., separation from spouse, child abuse, sexually inappropriate behavior);
- Change in behavior of children or spouse; and/or
- Legal problems (e.g., DWI)

Changes in health status may be manifest as follows:

- Deterioration in personal hygiene;
- Striking sensitivity to temperature (may mask the desire to wear long sleeves to cover puncture sites);
- Increased number of accidents; and/or
- Number of health complaints and/or increased need for medical attention.

Changes in professional relationship, particularly deterioration of work performance, include:

- Unreliability:
  - missed appointments;
  - inappropriate responses to emergencies;
  - absences;
  - poor record keeping; and/or
  - anesthesia mishaps
- Complaints by patients or other staff;
- Inappropriate drug requests:
  - over-prescription of medications;
  - excessive ordering of drugs from mail-order houses; and/or
  - heavy use of adjuvant drugs
- Unstable employment history (e.g., relocation to several institutions or hospitals); and
- Working at a level of professional responsibility below that consistent with the physician's qualifications.

Ward, C.F., et al., "Drug Abuse Among Anesthesiologists", JAMA 250:925, 1983.