POLICY & PROCEDURE: MEDICAL STAFF IMPAIRED PROVIDER

POLICY SUMMARY/INTENT:

To define and establish a consistent, fair procedure for managing impaired providers including resident physicians.

DEFINITIONS:

MEC - Medical Executive Committee
CCC - Family Medicine Residency Clinical Competence Committee
DIO - Designated Institutional Official
GMEC - Graduate Medical Education Committee

AFFECTED DEPARTMENTS/SERVICES:

Medical Staff, Resident Physicians and Allied Health Professionals

POLICY: COMPLIANCE - KEY ELEMENTS

A. BACKGROUND:

1. The problem of impairment is complex, and the customary investigation and hearing process, as defined in the AHUV Medical Staff Bylaws, is not appropriate in this situation. The American Medical Association defines the impaired provider as "one who is unable to practice medicine with reasonable skill and safety to patients because of a physical or mental illness, including deterioration through the aging process or loss of motor skill, or excessive use or abuse of drugs including alcohol." This policy is intended to provide some overall guidance and direction when confronted with a potentially impaired provider.

2. However, because the term, "impaired provider" includes a variety of problems from age to substance abuse to physical or mental illness, the steps given may not be suitable in every circumstance. Specific needs and varying circumstances preclude a single inflexible mechanism for dealing with all impaired providers. The number of incidents with the provider, for example, and their seriousness may dictate a different response by the Medical Staff. If the "evaluation" suggested in this policy is carried out, the individuals conducting the evaluation may vary depending upon personalities and circumstances. Moreover, the risk of patient harm must be of paramount concern and immediate action may be necessary. There can be no one policy to cover all situations.
3. Situations may arise where this policy does not apply to the given circumstances or the impairment cannot be remedied by the reasonable application of its provisions. In such situations, the normal investigation and disciplinary policies of the Medical Staff or appropriate policies will be used to address the issue. Consultation with the Medical Staff attorney will be sought as needed.

4. Because of the independent nature of most providers’ practices and the serious implications of any disability, impairment is often difficult to identify early and is always difficult for the impaired provider to acknowledge. Nevertheless, it is the obligation of the medical staff and its medical staff leadership to address it in a timely manner. The following policy provides the framework within which to do it.

B. POLICY:

1. **Report & Evaluation** - If any staff working in the Hospital or a patient or patient's family, expresses a reasonable suspicion that a provider/resident appointed to the medical staff is impaired, the following steps should be taken:

   a. **REPORTING** - A written report is given to, or prepared by the Chief of the Medical Staff (COS), the Chief Medical Officer (CMO), the Program Director (PD), and/or the President of Adventist Health Ukiah Valley (President). The report includes a description of the incident(s) that led to the belief that the provider may be impaired. The report must be factual. The individual making the report does not need to have proof of the impairment, but must state the facts leading to the suspicions.

   b. **EVALUATION** - If, after discussing the incident(s) with the individual who filed the report, the COS, CMO, PD, or President believes there is enough information to warrant an evaluation, they will direct that an evaluation be instituted and a report be made by or to, as appropriate:

      i. the Chief of the Medical Staff; or,

      ii. the Program Director; or

      iii. A Physician Wellness Committee, at the request of the Chief of Staff/designee, or the MEC which may be comprised of multidisciplinary representatives of the Medical Staff, according to the potential problem(s) to be addressed. This Committee would not be asked to recommend any action but would gather information to facilitate the MEC’s determination of the scope of the problem; or,

      iv. If resident physician, the Clinical Competency Committee can assist in gathering information to facilitate the MEC’s determination of the scope of the problem. MEC should invite PD and/or DIO to participate in determining the scope of the problem; or

      v. an outside consultant; or,

      vi. another individual or individuals deemed appropriate under the circumstances.

   c. **INTERVENTION**

      i. **Alcohol or Substance Abuse** - If a provider or resident is believed to be under the influence of drugs or alcohol while on duty the provider/resident in question will be directed to wait until the COS, CMO, or designee arrives at which time a urine drug screen and blood alcohol level will be obtained in the clinic setting. Chain of custody procedure will be followed in the collection of the specimens. The COS, CMO, PD, President, or designee may at his/her discretion direct the physician to cease providing patient care pending the results of the testing, should the COS, CMO, PD, President or designee determine that such action is necessary to safeguard patient care. In such instance, the COS, CMO, PD, President or designee will arrange for immediate alternative...
care for the physician’s patient. Should the urine screen and/or the blood alcohol level be positive, or if it is negative and the COS, CMO, PD, President or designee determines the physician to be otherwise psychologically and/or physically impaired, the physician in question may be immediately suspended by the COS to safeguard patient care. The COS, CMO, PD, President or designee will make a full report of such matter for immediate review by the Medical Executive Committee (MEC) and in case of resident physician to the Clinical Competency Committee (CCC) and as appropriate to the Governing Board. The physician/resident in question will be notified of this procedure. Medical Staff Bylaws will be followed for Medical Staff members.

ii. Other Impairments - If the provider/resident displays conduct that raises suspicion of physical or mental impairment that could compromise patient care, any staff member is to immediately notify the COS, CMO, PD, President or designee, directly or in writing of such concern. The COS, CMO, PD, President or designee will review the circumstances of the complaint and may take statements from witnesses as appropriate. Types of conduct that may indicate impairment would include a pattern of questionable performance issues including, but not limited to:

A. An increase in number of medical errors;

B. Behavioral changes such as unprofessional approach to other physicians, staff, patients and/or families;

C. Frequent lateness, unavailability or inappropriate response to telephone calls and pages;

D. Reports of incoherent orders, slurred speech, etc.

Should the COS, CMO, PD, President or designee determine the physician to be psychologically and/or physically impaired, the physician in question may be immediately suspended by the COS, or designee in order to safeguard patient care. The COS, CMO, PD, President or designee will make a full report of such matter for immediate review by the Medical Executive Committee (MEC) and in case of resident physician to the Clinical Competency Committee (CCC) and as appropriate to the Governing Board. The physician/resident in question will be notified of this procedure. Medical Staff Bylaws will be followed for Medical Staff members.

d. ACTION - Based on the results of the report, one of the following actions will be taken by the MEC:

1. If the evaluation reveals that there is no merit to the report, the report is destroyed;

2. If the evaluation reveals that there may be some merit to the report, but not enough to warrant immediate action, the report is included in a confidential portion of the provider's/resident's file and the provider's/resident's activities and practice are monitored until it can be established that there is, or is not, an impairment problem; For resident physicians, these records will also be kept in the residency file, or

3. If, after the evaluation, it is found that sufficient evidence exists that the provider/resident is impaired, the COS (or PD if resident physician) meets personally with that provider or designates another appropriate individual to do so.

   a. The provider/resident is told that the results of an evaluation indicate that the provider/resident suffers from an impairment that affects his or her practice. The provider/resident is not told who filed the report, and does not need to be told the specific incidents contained in the report.
b. Depending upon the severity of the problem, and the nature of the impairment, the Medical Staff has the following options:

I. require the provider/resident to undertake a rehabilitation program as a condition of continued appointment and clinical privileges; or

II. impose appropriate restrictions on the provider's/resident's privileges.

c. The original report and a description of the actions taken by the MEC are included in the provider's/resident's file (and in the case of resident, included in residency file).

d. The Medical Staff seeks the advice of legal counsel to determine whether any conduct must be reported to law enforcement authorities or other government agencies and what further steps must be taken.

4. The COS, CMO, PD, President or designee informs the individual who filed the report that followup action was taken.

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

2. Rehabilitation - AHUV and medical staff leadership assist the provider in locating a suitable rehabilitation program. A provider may not be reinstated until the Medical Staff is satisfied that the provider has successfully completed a rehabilitation program in which the Medical Staff has confidence. A typical contract regarding drug/substance abuse remains in effect for five (5) years and may include, as appropriate, the following areas:

   a. Attendance at 12 step support groups;

   b. Random urine drug screen testing;

   c. Individual, family, and/or group counseling;

   d. Communication with all appropriate therapists and treating physicians;

   e. Attendance at support group for health care professionals;

   f. Regular meetings with an approved physician advocate;

   g. Other requirements deemed necessary to aid recovery;

   h. Approval to send regular reports to the appropriate personnel documenting contract compliance.

3. Reinstatement -

   A. Upon sufficient proof that a provider/resident who has been found to be suffering an impairment has successfully completed a rehabilitation program, the Medical Staff, in its discretion, may consider that provider/resident for reinstatement to the medical staff.

   1. Failures to comply with a request for evaluation or with the terms of any compliance or monitoring agreement will result in appropriate discipline and reporting under the Medical Staff Bylaws or otherwise as appropriate.

   2. All requests for information concerning the impaired provider/resident are forwarded to the COS or PD for a response.
3. The provider/resident must agree to submit to an alcohol or drug screening test (if appropriate to the impairment) at the request of a member of hospital management, a provider, or a nurse who suspects that the provider/resident may be under the influence of drugs or alcohol.

4. The provider's/resident's exercise of clinical privileges in the hospital is monitored by the MEC (and in the case of resident, by the CCC) or by a provider appointed by the MEC. The nature of that monitoring is determined by the MEC or CCC after its review of all of the circumstances.

5. Assuming all of the information received indicates that the provider/resident is rehabilitated and capable of resuming care of patients, the Medical Staff must take the following additional precautions when restoring clinical privileges:
   
   i. the provider/resident must identify two providers who are willing to assume responsibility for the care of his or her patients in the event of his or her inability or unavailability; and

   ii. the provider/resident is required to obtain periodic reports for the MEC/CCC from his or her PCP (or other designated physician after-care provider) - for a period of time specified by the COS or PD- stating that the provider/resident 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.

6. From the PCP (or other designated physician after-care provider) the Medical Staff (and in the case of resident physician, the GMEC) needs to know the precise nature of the provider's/resident's condition, and the course of treatment as well as the answers to the questions posed above in C, 1-7.

7. The provider/resident must inform the MEC (and in the case of residents, the CCC) of the name and address of his or her primary care provider (PCP) (or other designated physician after-care provider), and must authorize that provider/resident to provide the Medical Staff with information regarding his or her condition and treatment. The Medical Staff (and for resident physicians, the GMEC) has the right to require an opinion from other provider consultants of its choice.

8. The Medical Staff (and for resident physicians, the Family Medicine residency) must first obtain a letter from the director of the rehabilitation program where the provider/resident was treated. The provider/resident must authorize the release of this information. This letter must address whether:
   
   i. the provider/resident is participating in the program;

   ii. the provider/resident is in compliance with all of the terms of the program;

   iii. the provider/resident attends AA or other support meetings regularly (if appropriate);

   iv. to what extent the provider's/resident's behavior and conduct are monitored;

   v. if, in the opinion of those providing treatment, the provider/resident is rehabilitated;

   vi. an after-care program has been recommended to the provider/resident, and, if so, a description of the after-care program; and

   vii. if, in his or her opinion, the provider/resident is capable of resuming medical practice and providing continuous, competent care to patients.

9. In considering an impaired provider/resident for reinstatement, the Hospital and its medical staff leadership must consider patient care interests as paramount.
ATTACHMENTS:
(REFERENCED BY THIS DOCUMENT)
OTHER DOCUMENTS:
(WHICH REFERENCE THIS DOCUMENT)
FEDERAL REGULATIONS:
ACCREDITATION:
CALIFORNIA:
HAWAII: Not applicable
OREGON: Not applicable
WASHINGTON: Not applicable
REFERENCES: UVMC Medical Staff Bylaws, The Joint Commission
ADVENTIST HEALTH SYSTEM/WEST POLICY OWNER:
ENTITY POLICY OWNER: Director, Medical Staff Services
APPROVED BY:
ADVENTIST HEALTH SYSTEM/WEST: Not applicable
ADVENTIST HEALTH SYSTEM/WEST INDIVIDUAL:
ENTITY:
ENTITY INDIVIDUAL:
REVIEW DATE: 04/04/2016
REVISION DATE: 02/28/2013, 01/31/2018
NEXT REVIEW DATE: 01/30/2021

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