Commentary: Quality Improvement and Psychiatric Fitness-for-Duty Evaluations of Physicians

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A physician's fitness for duty is of great importance to a variety of parties, including the general public, yet it is not often addressed in the professional literature. Requests for mental health evaluations of a physician's fitness for duty originate from state medical boards, hospital medical staffs, human resource departments of hospitals, impaired-physician or other diversion programs, or individual physicians and their attorneys. Some evaluations are voluntary, and others are mandatory. Litigation at the medical board level regarding a physician's medical license is often hotly contested, given the high stakes of a medical license sanction. Thus, the publication of the American Psychiatric Association's Resource Document on the Guidelines for Psychiatric Fitness-for-Duty Evaluations of Physicians[1] is a welcome contribution.

Referrals for evaluations of allegedly impaired physicians relate to a variety of matters. Although comprehensive data regarding the frequency of various referral questions are unavailable, evaluations conducted on referrals to Alabama's Physicians Recovery Network between 1991 and 1997 yielded primary clinical diagnoses of chemical dependency (55%), chemical abuse (6%), affective disorders (29%), and personality disorders (10%).[2] In Georgia, of the 1000 physicians evaluated between 1975 and 1986 for suspected impairment, 92 percent had a primary diagnosis of chemical dependence, and 6 percent had a psychiatric diagnosis, with or without chemical dependence.[3]

Existing literature and practice in this area reveal that recognition of impaired physicians is often challenging because of their varied presentations.[4] Health care professionals, especially physicians, greatly value their careers and work and therefore attempt to mitigate, delay, deny, or hide their work impairment from others. Thus, personal and family relationships are usually affected before impairment affects work. Hospital nurses can become expert at concealing hospital drug diversion, given that hard evidence of such is typically unavailable. The physician with a personality disorder is skilled at externalizing responsibility for behavior. Physicians are notoriously considered to be poor patients and not infrequently attempt to diagnose and treat themselves and family members, often because they have no personal physician for themselves.[5] They may seek special status and privilege and demand to be treated differently from others. Beyond this, outrageous or abnormal behavior is often tolerated in physicians due to their professional, economic, or social status in the community or health care organization. There may be rationalization of disruptive behavior, with faulty attribution to sleep deprivation, stress, or overwork. Yet, the prognosis for substance-abusing physicians is described as generally good, when the patient is adequately motivated and treatment is available and accepted.[6,7]

The guidelines are also useful for evaluators of health care professionals other than physicians. Nurses greatly outnumber physicians and are not immune to mental disorder and substance abuse. Other health care providers, such as psychologists, respira-

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tory therapists, dentists, podiatrists, and chiropractors, also come to the attention of hospital employers and state boards.

Initially, it should be noted that guidelines are recommended practices and are distinguishable from standards that are regarded as mandatory or required. Nevertheless, guidelines are intended to assist the evaluator in conducting the evaluation and preparing the report, to make the procedure more uniform across evaluators, and to assist the less experienced evaluator.

Existing empirical literature on the quality of forensic evaluations generally indicates that the work of forensic and nonforensic specialists is deficient in data sources, extrapolation of the data, and provision of detailed support for expert opinions in the evaluation report.[8,9] Further, the quality of forensic evaluations conducted by nonforensic specialists is especially lacking.[10] In many hospital and general medical settings, increased volume of patient care activity is sometimes associated with improved quality of care as measured by morbidity and mortality.[11,12] In psychiatry, there is a similar association between volume of mental health services and its quality.[13] General psychiatrists, as well as psychiatrists with forensic training and expertise, conduct fitness-for-duty evaluations. It is expected but unknown whether adoption and implementation of these practice guidelines would ultimately increase the quality and reduce the variability of fitness-for-duty evaluations of physicians conducted by nonforensic or forensic mental health specialists.

The evaluation approach adopted by the APA fitness-for-duty guidelines is that of a general forensic evaluation. Yet, some differences exist and should be discussed. As noted in the document, evaluations differ depending on the referral source. An evaluation of a physician for diversion to an impaired physician's program can be quite different from an evaluation for discipline of a physician by a state medical board.

Though practice guidelines are desirable and can improve the quality of evaluation and treatment in health care, many problems with practice guidelines have been described.[14,15] Organizations that create and publish them do not uniformly articulate and execute a development process.[16] Guidelines are often not empirically based, but only assemble the collective wisdom or opinion of the sponsoring group and development committee, as in the present fitness-for-duty guidelines. Physicians may not agree with the guidelines' recommendations. Guidelines can be oversimplified or written generally with limited specificity, depending on the topic area. They can become outdated in a few years, especially in rapidly changing practice areas.[17] Practice guidelines are not conclusive with regard to determining the standard of care in professional liability cases, but can be used as inculpatory or exculpatory evidence.[18] Dissemination of the guidelines is often lacking, and many practitioners may not even be aware of their existence. Practice inertia makes it difficult for many physicians to alter their practices, despite the presence of the guidelines. Other barriers to implementing guidelines include financial cost and intrusion into physician autonomy. Application of the guidelines may also be cumbersome.

With this in mind, it is important that the resource document be adequately publicized, and we welcome its present publication in the *Journal*; it should also be distributed electronically. The Agency for Health Care Research and Quality (AHRQ) publishes professional health care practice guidelines through the website of the National Guidelines Clearinghouse, and the guidelines should be accessible through that website.[19,20] A strategy to implement and operationalize the guidelines is lacking and would be welcome.

All practice guidelines are works in progress. At this stage in the development of the APA fitness-for-duty guidelines, they are not evidence- or empirically based guidelines. We have no empirical data on the frequency of fitness-for-duty evaluations of any health care providers, the resources (i.e., time, funding) needed to conduct these evaluations, and the types of interviews and testing procedures typically used in practice or their results. We do not know what fitness-for-duty evaluators actually do, or what they say that they do, or what they think should be done. We do not have data regarding the quality of such evaluations as assessed by the referral sources or anyone else.

Additional specificity in the guidelines would be useful. While we note that special expertise is needed to conduct such evaluations, we deem it especially important in conducting evaluations of physicians that the evaluator have experience in evaluating and treating other physicians. Evaluators must understand that protection of the public is the most important underlying principle of fitness-for-duty evaluations of physicians, whether for diversion or discipline.[21]

Evaluators may too easily overidentify with another physician and thereby lack the necessary objectivity required by the Ethics Guidelines of the American Academy of Psychiatry and the Law (AAPL). Those evaluators who are readily intimidated by antagonistic or narcissistic personality pathology in physicians may also have difficulty conducting an objective evaluation. In addition, evaluators should be familiar with substance-abuse problems in physicians and have specific knowledge of available treatment, rehabilitation, and diversion programs in the respective geographic areas.

Evaluators may too easily accept the evaluee's self-report of symptoms, functioning, or drug use as valid. Additional expertise may be necessary in bipolar, personality, and endocrine disorders and their comorbid illnesses. Evaluators must be able to assess the evaluee's treatment to determine if it is appropriate and likely to control the evaluee's symptoms adequately and render him or her capable of the safe practice of medicine.[21]

Other important substantive areas omitted from the guidelines are relapse; recidivism; prognosis of psychiatric disorders, including substance abuse and dependence; and time until reentry into the work place. Fitness-for-duty evaluators should be familiar with the growing empirical literature in these areas. Last, the guidelines do not detail what psychological instruments, symptom validity testing, or other tests are useful or valid in these evaluations.[22,23]

It is to be hoped that publication of these guidelines will improve the quality of fitness-for-duty evaluations of health care professionals. Medical boards and other groups should become familiar with this document, distribute the guidelines to their evaluators, and expect evaluators to adhere explicitly to them in their contracted work. Further refinement of the guidelines, with greater specificity and empirical base, should be undertaken.

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