

Impaired Colleagues

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This month, I will discuss recognizing, and properly dealing with, impaired professional colleagues. Many clinical organizations have guidelines about such issues. Licensing boards* go a step further, with rules that carry the force of law. Most boards not only require you to report when you are *certain* about colleagues' impairments or dangerous behaviors, but also when you have reasonable *suspicions*. This may sound heavy-handed (and hard to define), but it is important to remember that licensed clinical practice is a privilege, not a right. States regulate it and are generally entitled, within boundaries, to dictate your duty in both practice and reporting. If you fail to report unsafe or incompetent colleagues or those who are acting illegally, you can hurt both patients and your profession and become vulnerable to liability and licensure sanctions yourself.

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Your state may allow for initial reporting to a professional organization (e.g., a "physician health committee") rather than a licensing board. If so, the professional organization probably has a formal agreement with the board

* "Licensing board" refers to your state professional licensing agency. It may be called something else, such as a "Board of Healing Arts."

to act in certain ways to protect the public while trying to help the colleague. This kind of arrangement is often more private and collegial than government reporting, but has clear rules and safeguards. When referring colleagues to smaller organizations, such as subchapters of professional societies, be certain the organization's procedures are indeed blessed by the licensing agency and are not merely a local custom.

What is "reasonable" likelihood of danger to patients when considering whether or not to report a colleague? The rules in your state probably require a report if you reasonably suspect that the (therapist, counselor, physician) is not able to practice safely and competently, or that his or her behavior is such that it is likely to create a danger to patients or clients. Some boards want to hear about every suspicion and sort them out with their own investigations. Others are more liberal. Do not assume yours is liberal; call the Board and ask, especially if you are treating a colleague who may be impaired.

What about liability for reporting? What if the colleague sues me? That's where "good faith" comes in. You are almost certainly protected from suit so long as you have made a reasonable effort to ensure that your concerns are legitimate and it is clear that your interest is in protecting patients, even if you might benefit personally from reporting the individual. Be certain you have carefully documented the foundation for your concerns.

A surgeon's hospital privileges were suspended because of questions regarding his competence in the operating room. He sued the staff committee that recommended suspension, accusing them of slander, libel, and restraint of trade. He alleged that the people who assessed his medical competence also competed

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with him for patients, and that they had colluded to remove him for their personal gain. The hospital called expert witnesses who testified that, based on operative reports, medical charts, and nurses' statements, the hospital and its medical staff were correct in their concern, and were entitled, even required, to remove the surgeon from the operating room.

Do you have a duty to report to an employer, clinical staff, or licensing board if you learn that a colleague has been censured by his or her professional organization? Probably not, unless you are in a licensing, credentialing, or supervisory position with respect to the colleague. Such reporting might be construed as an unnecessary personal attack. However, if you believe there is a danger to patients and an organization's public sanction supports your point, it is appropriate to mention it. Note that if the organization's action is public, you have a good defense (the truth), so long as you stick to the published wording.

Should I report issues related to safety, incompetence, or illegality that I discovered while serving on a peer review committee? Information discovered or discussed within a *duly constituted* peer review process must not be revealed to anyone except persons authorized to receive the information, within the rules and purpose of that process. The law recognizes the fact that strict confidentiality in these settings is necessary to their effectiveness, and state and federal statutes regulate who can receive information from them. Be certain, though, that you understand the official definition of "peer review" in your state.

The circumstances under which peer review information (often conclusions or summaries rather than details) can be shared with specified bodies are carefully defined in the law. It is very important that everyone associated with peer review (or organization ethics committees, for that matter) understand the strict rules under which they operate, so that those protections are not threatened. Committee members can be, and have been, sued for divulging damaging information outside those rules, even when the information was available from other sources (such as a medical record).

What about reporting clinicians of a different profession, such as psychologists reporting physicians or social workers? Licensing boards usually have jurisdiction only over the people whom they license (e.g., medical boards can't tell psychologists what to do). Many states have broad licensing agencies that cover more than one profession, however, and some have statutes that require professionals to report unsafe or illegal practices to whatever agency has jurisdiction over the clinician.

Virtually all licensing agencies have some way of receiving complaints from the public; any clinician may use this vehicle to report a colleague, and may have a duty to do so.

I work in the same facility as a colleague who may be impaired. May I simply report my concerns to my boss? Perhaps, and especially if the person you tell is a senior clinician-administrator. Many licensing agencies, however, place the reporting burden on *any* clinician with reasonable concerns, and specify that you report to the Board (or a professional organization empowered to receive the report) regardless of other actions you may take. If you communicate with, for example, the clinical director of your facility, you should receive some assurance that he or she will follow the appropriate procedure.

If I want to talk with the colleague first, how do I broach the subject without hurting his feelings or endangering our relationship? The subject has already been broached, by virtue of the damage or danger he or she is causing patients. Your highest duty is to those patients, with pretty high duties to your profession and your colleague's potential survival as well. However, it is reasonable to have some concern about the person's reaction to being discovered. Your recognition or suspicion of his serious problem may be followed by an optimistic comment that there is probably a way to get things back on track, and (if you mean it) an offer of support.

You should not accept a colleague's promise to reprove himself or change his behavior. Such promises are not reliable enough to risk injury to patients, and sometimes to the colleague's own life or health. If you wish to give the person a chance to report himself, gently but firmly say that the matter really must be reported, and that you are willing to accompany him or her if he chooses to do it himself (by telephone may be sufficient, by listening on the extension).

A clinician who abused alcohol was confronted by his colleagues on the professional staff of a mental health clinic. They strongly recommended that he seek treatment and mentioned that the licensing board might have some ways of helping without suspending his license. In deference to his past experience and career, they accepted his promise that he would "seriously look into treatment and maybe report myself. . . I sure don't want to hurt anybody." They decided not to report him and did not follow up on his promise to "look into" it.

Less than a week later, the clinician committed suicide while intoxicated, leaving a note that said, in effect, that he could not stand the embarrassment of losing his license and seeing his career end in humiliation. Had he been reported (or reported himself),

there would have been a good chance for rehabilitation, and he might not have "seen his career end in humiliation."

Treating a fellow clinician without reporting a patient-threatening condition may seem humane, but is usually a real mistake. You must not subvert the proper reporting mechanism by privately assuming the roles of evaluator, judge of practice safety, treater, and monitor. Even if the colleague reveals a current impairment during a social or clinical visit (as contrasted with a confrontation about his behavior, for example), it is usually inappropriate—and may be dangerous—to keep the matter to yourself.

What if I am the colleague's supervisor or employer?

It is unwise to mix roles of supervisor/employer with those of friend or caregiver. If you are his or her boss, you should almost certainly refer any therapeutic or personal issues to someone else. The more complex the organization, the more this caveat applies.

A senior clinician-employee was reported to a company executive, also a clinician, because of poor judgment and erratic behavior. The executive attempted to get additional information from the clinician's family, and suggested treatment (but did not offer it himself). The clinician-employee was eventually fired because of his behavior, and sued the executive for some sort of breach of confidentiality. A judge determined that the clinician-executive had acted solely as a company agent and had not become a "therapist," thus precluding any duty of confidentiality. The suit was dismissed.

What happens to colleagues who are reported? Most states and licensing agencies have provisions for the rehabilitation of professionals who abuse substances or have mental illness. Some allow professionals to participate in an agency-sanctioned treatment program (especially one sponsored by a peer organization) without being reported, so long as the person cooperates in treatment and there is reasonable assurance of safe practice. Clinicians who treat professionals should be aware of relevant laws and ethical guidelines, however, and watch for conditions that are likely to place patients or the public at risk.

Many licensing boards and agencies may postpone or modify their actions when the licensee reports himself and/or seeks sanctioned treatment voluntarily. In Texas, for example, physicians who abuse substances and report

themselves to the Board of Medical Examiners are almost always offered confidential treatment and supervision without a public Board action. Those who are reported by someone else (or who do not adhere to the Board's conditions of treatment and monitoring) are dealt with much more harshly.

If you are treating a colleague under an order from a licensing board, must you report every detail of the therapy, or supply copies of your notes to the licensing board? Generally not, but be certain this has been agreed upon in advance. If you have an opportunity to influence the reporting rules, try to be sure they are consistent with good treatment and a therapeutic environment. Board orders may require great detail, perhaps because some lay board members do not understand the need for reasonable privacy in treatment. Even clinician-members may bring unnecessary fears and stereotypes about rehabilitation and public safety to the process.

A mental health professional was censured for stalking and harassing a patient's wife. The licensing board required, among other things, that she be treated by a psychoanalytically-trained therapist for not less than 3 years, with the therapist's notes to be available to the board upon demand. The professional asked the Board to reconsider both the arbitrary therapy duration and the complete loss of confidentiality, eventually convincing them that such requirements would undermine the therapeutic effort. Indeed, she had been unable to find a therapist willing to treat her under those conditions.

If you are treating someone under a Board mandate, resist the temptation to subvert the treatment-reporting requirement. Acknowledge the conflict of agency between your role of therapist and that of monitor for the board, then try to be as honest as you can. The Board can dilute the "double-agent" conflict by appointing a third party to evaluate the clinician-patient from time to time. Incidentally, if urine drug screening is required, it is best done by a representative of the Board or impaired-clinician committee rather than the therapist (who should, however, receive a copy of the results).

The Final Word

Your state licensing agency rules about impaired clinicians help both patients and colleagues. Understand and follow them.