

Critical decision points in the management of impaired doctors: the New South Wales Medical Board program

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Alcohol and drug problems and psychiatric illness are the most common causes of impairment in doctors referred to the New South Wales Medical Board. In the late 1980s, the Board developed an informal program for managing impaired doctors and medical students in a constructive and non-disciplinary manner. In 1992, the Impaired Registrants Program was embodied in the Medical Practice Act. This program is designed to meet the Board's primary responsibility of protecting the public, while maintaining doctors in practice whenever possible. It provides an alternative to the disciplinary pathway for doctors whose practice of medicine is affected by their personal illness.

All other Australian states, as well as New Zealand, have similar non-disciplinary programs for impaired doctors, but the level of direct medical board involvement varies. For example, potentially impaired doctors are evaluated by Board-appointed doctors in NSW and Queensland, but by members of the Medical Boards in Western Australia and South Australia. The NSW program does not provide or direct treatment, but requires the doctor to comply with treatment delivered by their preferred clinician. In contrast, the Victorian Board has established a dedicated treatment program, albeit at arm's length from the Board.¹

The underlying philosophy of the NSW program is that

- The doctor's management must be individualised according to the type of illness.
- It is desirable for doctors (like any patients) to be well informed about their impairment, its likely course, outcome, and appropriate treatments, as well as their involvement with the Board.

The program is outlined in Box 1 and is now well established. However, the NSW Board has become increasingly aware of the need to provide a range of pathways,² individualised according to the impact of the specific disorder, and the registrant's career stage and stage of progress through the program. These pathways have been devised in consultation with experts on the most common impairments affecting doctors and their practice, and have been developed as policy and put into practice over the past 2 years.

Pathways at different career stages

Impairment problems that commonly present at various stages in a medical career are shown in Box 2.

Complaints: At all career stages, from medical student onwards, the most common complaints about impaired doctors are inappropriate behaviour in the clinical setting and impaired performance. For doctors in clinical practice, substance and alcohol misuse may become obvious.

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ABSTRACT

- The New South Wales Medical Board has developed the Impaired Registrants Program to deal with impaired registrants (doctors and medical students) in a constructive and non-disciplinary manner; the program is now well established.
- The Program enables the Board to protect the public, while maintaining doctors in practice whenever possible.
- Disorders that commonly lead to referral of impaired doctors include alcohol and drug misuse, major depression, bipolar disorder, cognitive impairment and, less commonly, psychotic and personality disorders and anorexia nervosa.
- Pathways in the program are individualised according to the impact of the specific disorder, the registrant's career stage, stage of involvement in the program, insight and motivation.
- Critical points in the program include entry, easing of conditions, breach of conditions, return to work after suspension, and exit from the program.
- Decision-making at these points takes into account the nature of the impairment, compliance, professional and personal support available and the registrant's insight and motivation.

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Who refers? An impaired medical student may be noticed by lecturers and supervisors, fellow students or the student's own doctor, but it is usually the Dean of the medical school who notifies the Board (about 2% of referrals to the NSW Board in 2003/2004). Once doctors are in clinical practice, impairment may be noticed by the doctors themselves or their families, resulting in self-notification (about 50% of referrals in 2003/2004). Indeed, the proportion of self-referrals has increased, from 10% in 2000. Other sources of notification are colleagues (22%), the doctors' own doctors (10%) and official complaints from bodies such as the Health Care Complaints Commission, the Pharmaceutical Services Branch or courts (about 12%). In addition, for novice doctors (25–34 years), impairment may be apparent to clinical supervisors and medical administrators.

Who assesses? The Board determines whether to appoint a clinician (usually a psychiatrist or drug and alcohol physician) to assess the registrant and advise whether there is an impairment and whether the registrant's involvement in the Impaired Registrants Program is required. In 80% of the cases heard by the NSW Impaired Registrants Panels in 2003/2004, the registrant and the Board agreed on the conditions to be placed on medical registration, while in 12% of cases no conditions were deemed necessary.

Who treats? Treatment is undertaken by the registrant's own clinician, with no Board involvement other than gaining the registrant's authorisation for the treating clinician to notify the Board if they are non-compliant, terminate treatment or fail to

1 Stages in the New South Wales Impaired Registrants Program

Notification and assessment

The Board's Health Committee reviews all notifications of potentially impaired registrants (doctors and medical students*) at its monthly meetings. Where there is an indication of impairment, the Committee refers registrants for assessment by a Board-appointed doctor, with a view to convening an Impaired Registrants Panel if sufficient cause is found.

Review

Two members of the Panel meet with the registrant and consider any medical reports and other relevant information to determine the most effective way of ensuring the registrant can continue to practise medicine while at the same time protecting the public.

Action

Actions that the Panel may recommend include:

- that the registrant agree to conditions on medical registration (the most common outcome) or suspension from practice for a specified period; or
- that the registrant undergo counselling.

The aim is to devise a monitoring and rehabilitation program that will allow the registrant to continue to practise in an appropriate environment.

Monitoring and review

The Health Committee monitors conditions placed on registration, which may include treatment by the registrant's nominated doctor, urine drug screening, restriction of prescribing authority, and regular review by a Board-nominated doctor and the Board.

Gradual lifting of conditions

As the registrant demonstrates progress in rehabilitation and recovery, the conditions are gradually relaxed, with return to full health and unconditional and safe practice being the goals of the program.

* In New South Wales, medical students must register with the Medical Board, which entitles them to access the Impaired Registrants Program.

on their part and increases the chances of early identification of illness or relapse, in addition to providing an environment in which recovery or stabilisation can occur. Personal support and engagement with the community are recognised as positive predictors of recovery, particularly from addiction.

Insight and motivation to change and to work with the program are critical. Doctors can be ill but insightful, and those who practise within their capability are not deemed to be impaired. Doctors who lack insight into the impact of their illness on their practice are considered to be impaired. This area is subject to the greatest potential variance in views between impaired registrants and those dealing with them.

Common problems and management

Alcohol and drug misuse and dependence

Alcohol and drug misuse has been the most common reason for referral to the Board (over 50% of referrals) (Dr V Manicavasagar, as above), but recently has been overtaken by psychiatric problems, generally mood disorders (now about 80% of referrals). Referral for alcohol misuse is often later in life (eg, registrants aged in their 50s), reflecting the unreliability of early signs and the degree of denial by registrants and those around them. A significant concern is alcohol-related neurological effects on cognitive function and fine motor skills.

Narcotics (notably pethidine) and sedatives (often self-prescribed benzodiazepines) are specific problems for doctors.³ Pethidine dependence tends to be the most treatment-refractory of all the dependence syndromes. Referral to the Board occurs most commonly when registrants are aged in their 30s to 40s. Although doctors aged over 40 tend to be fairly conservative in their use of "street drugs", a recent UK study of junior doctors revealed rising rates of regular use of recreational drugs, including cannabis, "ecstasy" and cocaine.⁴

In the early stages of involvement with the program for alcohol or drug misuse, the main issues are identifying precipitants and dealing with drug-seeking behaviour and withdrawal syndromes. The Board encourages registrants to take time off work to undertake a specific treatment program, as this improves outcomes.^{5,6} There are often difficulties in the early stages of treatment, with structured monitoring generally required over 3 to 5 years.

attend. The registrant's progress is monitored by a Board-appointed clinician, who reports regularly to the Board.

Critical decision points in the program

The program has defined critical points where the Board must decide about appropriate action: at entry to the program, when conditions are being eased, when conditions are breached, when referral to the disciplinary pathway is being considered, when the registrant wishes to return to work after suspension, and at exit from the program.

The parameters considered in decision-making at each critical point are shown in Box 3. They have been developed on the basis of the Board's experience with the program, advice from specialist consultants, and results of qualitative and quantitative research on the program commissioned by the Board (J Milne, Research Psychologist, commissioned report to the NSW Medical Board, 2002; and Dr V Manicavasagar, Clinical Psychologist, University of NSW, *The impaired registrants program: final report to the NSW Medical Board*, 2003).

Decisions are based on a consideration of the nature of the impairment (discussed in detail below), compliance, professional and personal support and insight.

Registrants are encouraged to discuss their impairment with their employers and selected colleagues. This demonstrates insight

2 Common problems, by career stage*

Medical student (17–24 years) Depression, bipolar disorder Substance misuse Anorexia nervosa Early psychosis Anxiety disorders Adjustment to course	Novice doctor (25–34 years) Depression, bipolar disorder Substance and alcohol misuse Anorexia nervosa Anxiety disorders <i>Balancing career with family and interests</i>
Mature doctor (35–54 years) Depression, bipolar disorder Alcohol and substance misuse or dependence <i>Balancing career with family and interests</i> <i>Marital problems</i>	Older doctor (55 years +) Depression Alcohol dependence Early physical and cognitive decline Delusional disorder <i>Lack of planning for life after medicine</i>

* Italics denote common problems that do not usually come to the attention of the Medical Board.

3 Parameters to be considered in decision-making at critical points in the program

Parameter	Entry to the program	Easing of conditions and approving employment
Nature of impairment	Is there agreement about the presence and nature of the impairment? Does the registrant have sufficient information and understanding of their condition? Is the registrant likely to gain from inclusion in the program? How can public protection be assured?	Are the conditions serving a useful purpose in terms of public protection and/or the wellbeing of the registrant?
Compliance with conditions	Does the registrant understand the issues?	Has the registrant been fully compliant?
Professional support	What is the career stage of the registrant? Has the registrant told key work associates; do they intend to do so?	Who has the registrant confided in? Will a suitable level of support be available?
Personal support	Has the registrant told family and friends about their condition?	Will a suitable level of personal support be available to the registrant?
Insight	Is there agreement about the effect on their work and personal life? What is the registrant thinking of doing or changing? What are likely barriers to recovery? How is the registrant planning to deal with these barriers?	What progress has the registrant made in understanding their illness? Are there realistic plans about their proposed employment?

*Decisions about progress in the program are usually made collaboratively with the registrant (clearly the most desirable course). However, there are times when the Board will need Referral to the disciplinary pathway may occur when there have been repeated breaches of agreed conditions, with no prospect of resolution.

Later concerns are the medical and social effects of longstanding use, with management issues similar to those in other remitting-and-relapsing illnesses.⁷ For some doctors with longstanding problems, low-level supervision is favoured over discharge from the program as a means of maintaining sobriety and safe work practices. Narcotic use carries the additional hazards of intravenous administration and sedation.

As doctors with substance-misuse problems pass through the program, they usually expect that their prescribing authority for narcotics will be returned. Many see this as their right, a reward for compliance and rehabilitation, while some have a real or perceived need. The Board's view is that the return of this authority will be considered only where there is a demonstrable need, and that registrants should demonstrate they have gained further knowledge in the area of pain management. Other options include limited prescribing of oral analgesic medication; authority to prescribe but not handle, possess or administer these drugs; or no return of the authority. It is now possible for a doctor to exit the Program with unconditional registration but limited prescribing authority.

Major depression

Doctors are at higher risk of depression than the general community because of factors such as personality characteristics (eg, perfectionism, dislike of conflict, high expectations of self),⁸ coupled with high levels of responsibility at work and sleep disruption. Most registrants who become depressed do not reach the Board's attention, unless the episode significantly affects work or leads to involuntary hospitalisation. Late-onset depression (after the age of 65 years) can herald emerging vascular disease, other ill health and evolving dementia.^{9,10}

In major depression, the Board aims to return registrants to work with appropriate support and monitoring, encourages them to address vulnerabilities that lead to relapse and, for late-onset depression, anticipates relapse and possible cognitive decline.

Bipolar disorder

Bipolar disorder has onset in the 20s and 30s. It typically has a relapsing course,¹¹ which may be very disruptive during early

career stages. Referral to the Board often follows significant social and work dysfunction, involuntary admission to a psychiatric unit or complaints about disinhibited behaviour during the manic phase, including sexual indiscretions, unwise decisions, irritability and being "disruptive".¹² After recovery from an episode, the longitudinal course and the registrant's insight into its impact should be assessed (Dr P Mitchell, Psychiatrist, presentation to the NSW Medical Board, 2002).

Cognitive impairment

The incidence of dementia rises rapidly with increasing age over 65 years, but is lower in doctors than in the general population. Mild cognitive impairment often presents with subjective, and some objective, memory loss. Conventional cognitive tests are not sensitive in detecting mild impairment, and well educated individuals with mild to moderate dementia can still score well.¹³ Given this, the Board often requires a full cognitive assessment by a neuropsychologist and advice from a Board-appointed geriatrician or psychogeriatrician about the advisability of continuing work. When there is clear evidence of cognitive impairment compromising work practice and patient safety, the aim is for a dignified retirement.¹³

Anorexia nervosa

Anorexia nervosa affects medical students and young doctors. Clinical work may be affected by subtle cognitive dysfunction, depression and the medical effects, such as osteoporosis, hypotension and fatigue.

The Board focuses on protecting the public, with goals determined by the functional consequences for patients and the need for objective outcome measures (such as body mass index [BMI] or workforce parameters). Should a registrant's BMI fall below 17.5 kg/m², monitoring in the Impaired Registrants Program while still in clinical practice is appropriate, while at a BMI of 15 kg/m² suspension from clinical practice may be required (Dr J Russell, Psychiatrist, presentation to the NSW Medical Board, 2002). A frequent problem is a significant difference between registrants' views of their function and those of the Board and its agents.

Breaches of conditions	Referral to the disciplinary pathway*	Allowing return to work after suspension
Was the breach anticipated at an early stage of involvement in the program? Is public safety compromised? How can public protection be assured, given the natural history of the illness?	How can public protection best be assured, given the natural history of the illness?	Can public protection be assured if the registrant returns to work? What treatment plan is in place?
Is the breach isolated or repeated? Where in the course of the illness is the registrant?	Are breaches serious and/or repeated? Are breaches wilful or an illness manifestation? Are there measures to ensure public protection?	What issues have arisen as part of the exiting process? Do any require action?
Who knows about the breach?	Has the registrant a support network? Have they been informed?	Who has the registrant confided in? Is there anyone in workplace aware of relapse prevention plan?
Who knows about the breach?	Has the registrant a support network? Have they been informed?	Is the registrant well supported in their personal life and in the workplace?
Is there agreement about the effect of their illness on their work and personal life? What progress has the registrant made in understanding their illness?	Is there agreement about the effect of their illness on their work and personal life? What progress has the registrant made in understanding their illness?	Is there agreement about the effect of their illness on their work and personal life? What progress has the registrant made in understanding their illness?

* to consider the safety of the public and the registrant and make decisions without the full agreement of the registrant.

The concern about extreme weight loss may overshadow other issues related to distressing early life experiences, including childhood abuse. These issues can affect motivation for recovery and doctor–patient interactions and should be borne in mind by the Board-nominated psychiatrist to ensure a holistic approach to management (Dr J Russell, as above).

Personality disorder

Registrants with personality disorder, particularly “cluster B” (borderline, antisocial, narcissistic, and obsessional), often present as “disruptive”¹² rather than impaired doctors. They are usually identified by patient or staff complaints. Others come to notice because of alcohol or substance misuse, depression or suicide attempts. The behaviours of concern are usually longstanding but more pronounced during periods of stress or substance misuse. Depression tends to be part of unstable mood control rather than discrete clinical episodes. As in anorexia nervosa, some affected registrants have had difficult, deprived or abusive childhoods.

Personality disorders are difficult to manage when the registrant disagrees significantly with the Board about the nature and attribution of the main concerns. As in anorexia nervosa, the Board focuses on public protection and the functional consequences for patients, while considering comorbidities, such as substance misuse and depression (Dr B Kotze, Psychiatrist, presentation to the NSW Medical Board, 2003).

Psychotic disorders

Schizophrenia has onset in the late teens to 30s. Although the prognosis is improved with assertive early intervention,¹⁴ the disruption to cognitive processing and interpersonal relationships may prevent some of those affected from completing their medical studies. Psychotic episodes in bipolar disorder or major depression are likely to recur and increase the possibility that ongoing involvement in the program will be needed.

The Board must consider whether students with ongoing psychotic illness or significant residual impairment can manage as doctors. It proactively encourages and facilitates alternative careers, and considers

comorbidities, such as substance misuse. Impaired registrants usually require long-term, close monitoring, which they find frustrating.

The future

The program will continue to evolve and respond to changing information about impairments that affect doctors’ health and work practices. We are also undertaking formal assessment of the outcomes of the program, both qualitative (eg, exit interviews with participants) and quantitative (eg, rates and risk factors for relapse). The development of decision parameters that are transparent and can be applied consistently will greatly assist in further development of the program.

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