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Restoring professionalism: the physician fitness-for-duty evaluation ☆

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ABSTRACT

Objectives: We compare findings from 10 years of experience evaluating physicians referred for fitness-to-practice assessment to determine whether those referred for disruptive behavior are more or less likely to be declared fit for duty than those referred for mental health, substance abuse or sexual misconduct.
Method: Deidentified data from 381 physicians evaluated by the Vanderbilt Comprehensive Assessment Program (2001–2012) were analyzed and compared to general physician population data and also to previous reports of physician psychiatric diagnosis found by MEDLINE search.
Results: Compared to the physicians referred for disruptive behavior (37.5% of evaluations), each of the other groups was statistically significantly less likely to be assessed as fit for practice [substance use, %: odds ratio (OR)=0.22, 95% confidence interval (CI)=0.10–0.47, $P<.001$; mental health, %: OR=0.14, 95% CI=0.06–0.31, $P<.001$; sexual boundaries, %: OR=0.27, 95% CI=0.13–0.58, $P=.001$].
Conclusions: The number of referrals to evaluate physicians presenting with behavior alleged to be disruptive to clinical care increased following the 2008 Joint Commission guidelines that extended responsibility for professional conduct outside the profession itself to the institutions wherein physicians work. Better strategies to identify and manage disruptive physician behavior may allow those physicians to return to practice safely in the workplace.

1. Introduction

> "Professionalism is based on the principles of primacy of patient welfare, patient autonomy, and social justice. It involves the following professional responsibilities: competence, honesty, patient confidentiality, appropriate relations with patients, improving quality of care, improving access to care, just distribution of finite resources, commitment to scientific knowledge, maintaining trust by managing conflicts of interest, commitment to professional responsibilities."
> American Board of Internal Medicine Foundation, American College of Physicians, European Foundation of Internal Medicine. Medical professionalism in the new millennium: a physician charter. *Ann Intern Med* 2002;136:243–246

Ethical guidance [1] for physician conduct [2] has evolved over millennia and reflects cultural mores. To our knowledge, this report is the first to describe findings and remedial recommendations for physician subjects referred for fitness-for-duty (FFD) evaluation following the 2005 American Psychiatric Association guidelines [3]. Interested readers are referred to other sources [4–9] describing the standards and practices for evaluation of physicians, but little data on the comprehensive FFD evaluation of physicians have been published. In this article, we describe the results of preliminary analysis of data accumulated conducting physician FFD evaluations using a standardized comprehensive assessment methodology at our center over 10 years. Comparison of these findings with the general physician population [10] might help to elucidate certain environmental, cultural, legal and economic characteristics that result in such FFD referrals and may serve to influence policymakers who strive to enhance the quality of healthcare in this country and beyond.

2. Design and methods

The Vanderbilt Comprehensive Assessment Program (V-CAP) has conducted FFD evaluations since 2001 for licensed clinicians who practice outside Vanderbilt's Health Affiliated Network. V-CAP is a multidisciplinary team of specialists in psychiatry, addiction, internal medicine, psychology, neuropsychology, sex therapy, social work and nursing. Psychiatric examination includes focused assessment of

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Table 1
Elements of the V-CAP FFD evaluation

Detailed collateral information	Assessment procedures	Optional consults
Preevaluation	Psychiatry	Neuropsychological evaluation[b]
Referral reason	Internal medicine	
Pertinent records	Laboratory	Subspecialty
	Hearing & vision	(e.g., neurology)
With authorized releases	EKG, stress test	
Practice performance	Spirometry	Polygraph Examination
Workplace environment		
Family & social life	Psychological testing	
	MMPI-2, PAI, EQi	
	MoCA or MMSE	
	(Other specific tests) [a]	
	Self-report screening tools	

EKG, electrocardiogram; MMPI-2, Minnesota Multiphasic Personality Inventory [11]; PAI, Personality Assessment Inventory [12]; EQi, Emotional Quotient Inventory [13]; MoCA, Montreal Cognitive Assessment [14]; MMSE, Mini Mental Status Examination [15].
[a] Additional specific testing of memory and cognitive function, e.g., Wechsler Adult Intelligence Scale [16].
[b] Halstead–Reitan Neuropsychological Battery and other standardized tests of neuropsychology [17].

substance use along with other psychiatric disorders plus appropriately targeted psychological testing (Table 1).

The reasons for referral, the questions being posed and the degree of confidentiality are all clarified before the evaluation is scheduled. Typically, 2 full days, at minimum, are required for the assessment team to elicit necessary information from the subject.

After obtaining consent, extensive collateral information is gathered systematically from relevant third-party informants that may include spouse, therapist, physicians, treatment program, colleagues, administrative staff and others in the doctor's work (clinical) environment.

A comprehensive report is generated describing the multiaxial diagnosis, based upon the Diagnostic and Statistical Manual of the American Psychiatric Association [18], in language that is clear and sufficiently free of mental health jargon to ensure comprehension by an average physician. FFD status is designated as (a) fit or (b) unfit for practice, and remedial recommendations are included when appropriate. Deidentified data are digitally recorded, with approval of the Vanderbilt University Medical Center Institutional Review Board, utilizing Research Electronic Data Capture.

2.1. Statistical analysis

Descriptive statistics were used to summarize the demographic, diagnosis and referral variables. Years of age were described using means and standard deviations. We attempted to assess for consistency of our findings by seeking possible differences in the characteristics of the physicians (arbitrarily 50% of total) referred for FFD evaluations during the early years (2001–2007) in comparison with more recent years (2008–2012). χ^2 tests of independence were used for all of the nominal and ordinal data, and independent *t* test was used for years of age at referral. Associations of the reasons for referral with the presence of an Axis I and Axis II diagnosis made during the evaluation and the FFD recommendation were conducted using multiple logistic regression analysis. A *P* value of .05 was used for reaching a conclusion of statistical significance for all tests conducted.

3. Results

3.1. Characteristics of V-CAP FFD + referrals

Three hundred eighty-one physicians (M.D. or D.O.) had been referred for evaluation at V-CAP between 2001 and March 2012. The demographic characteristics (age, sex, marital status, location by state or province, and practice specialty) of the physician subjects are displayed in Table 2.

Table 2
Demographic characteristics and primary specialties of physicians referred to V-CAP

	2009 population estimate[a]	Total (*N*=381)
		Mean (S.D.)
Age (years)		48.9 (9.5)
	%	*N* (%)
Age interval		
<35 years	15.0	22 (5.8)
35–44 years	22.0	103 (27.0)
45–54 years	22.7	147 (38.6)
55–64 years	19.6	92 (24.1)
≥65 years	20.7	17 (4.5)
Male	70.4	341 (89.5)
White	71.0	318 (83.5)
Married		259 (68.0)
Trained in the USA	74.1	307 (83.4)
Anesthesiology	4.7	23 (6.0)
Emergency medicine	3.7	10 (2.6)
Family medicine	10.9	62 (16.3)
Internal medicine	41.4	105 (27.6)
Pediatrics	8.7	15 (3.9)
Psychiatry	5.3	19 (5.0)
Obstetrics gynecology	4.7	35 (9.2)
Radiology oncology	6.9	23 (6.0)
Surgery	13.7	78 (20.5)
Resident trainee		9 (2.4)
Other		2 (0.5)

[a] Information published by the AMA.

When compared to general physician demographic characteristics published for 2009 by the American Medical Association (AMA) [10], the V-CAP referrals were more likely to be middle-aged (63% were 45–64 years old vs. 42% 2009 AMA, $P<.001$), to be male (90% vs. 70%, $P<.001$), to be white (84% vs. 71%, $P<.001$) and to have been trained in the United States (83% vs. 74%, $P=.002$).

In comparison with published distributions of specialties in the 2009 AMA tables, family medicine (16% vs. AMA 11%) and surgery (21% vs. AMA 14%) tended to be overrepresented in the V-CAP referrals, while internal medicine (28%) tended to be underrepresentative of the general US physician population in 2009 (41%) ($P<.001$) (Table 2).

3.2. Referral sources

Overall, the most common source of referral was the state Physician Health Programs (approximately 40%, Table 3). No statistically

Table 3
Sources and characteristics of physicians referred to V-CAP

	Total (*N*=381)
	N (%)
Self-referral	29 (7.6)
Hospital referred	72 (18.9)
Practice referred	31 (8.1)
State physician health	153 (40.2)
State medical board	36 (9.4)
Personal attorney	35 (9.2)
Therapist referred	4 (1.0)
Other	21 (5.5)
Disruptive behavior	143 (37.5)
Sexual boundary issues	86 (22.6)
Substance use issues	77 (20.2)
Mental health issues	57 (4.7)
Other	18 (4.7)
Medical board involvement	108 (28.5)
History of licensure sanctions	103 (27.9)
Suspension of privileges	175 (51.0)
Monitoring agreement	144 (38.8)