# Treating Doctors as Patients

**Anger** *from page 1*

diology the most common subspecialty in the sample.

Anesthesia was the most common specialty, comprising 13 cases, followed by ob.gyn., with 12 cases. Four of the cases involved emergency medicine physicians, 3 involved neurologists, and 2 involved psychiatrists.

Displays of anger proved to be the most common reason for referrals. In 36 cases, doctors were referred because they had lashed out physically or verbally, or because they had spooked their colleagues with behaviors such as wearing a gun in the operating room.

An additional 19 cases involved performance and compliance issues, and 11 cases involved sexual misconduct by the doctors. Other problems included sexual harassment, suspicion of substance abuse, communication problems with staff or peers, theft, and antisocial behavior.

Dr. Schouten noted that in California, the state medical board investigates about 10,000 complaints about disruptive physicians per year. Typically, nearly 80% of these are closed after an initial inquiry, but 20% are investigated further.

In this review, which looked at 584 physicians who had been disciplined by a state medical board over a 30-month period, 75 or 12.8% were psychiatrists—although psychiatrists make up only 7.2% of the percentage of physicians in California, he said. (See chart.)

Diagnosing disruptive doctors involves a caveat, Dr. Schouten said. When physician referral programs send doctors for a psychiatric evaluation, they often are unable to keep physicians in a behavior improvement program without a diagnosis of an Axis I or II disorder.

"There is a bias in favor of finding something to write on the form," Dr. Schouten said. As a result of that bias, the most common diagnosis in his sample was "personality disorder not otherwise specified," for 37 doctors, followed by 15 cases of major depression. There were also 10 cases of substance abuse, 9 diagnoses involving personality traits, 7 cases of adjustment disorder, and 6 cases each of bipolar disorder and sleep disorder. Other non–Axis I and II diagnoses included two cases of anxiety disorder, two cases of attention-deficit hyperactivity disorder, and one case of obsessive-compulsive disorder.

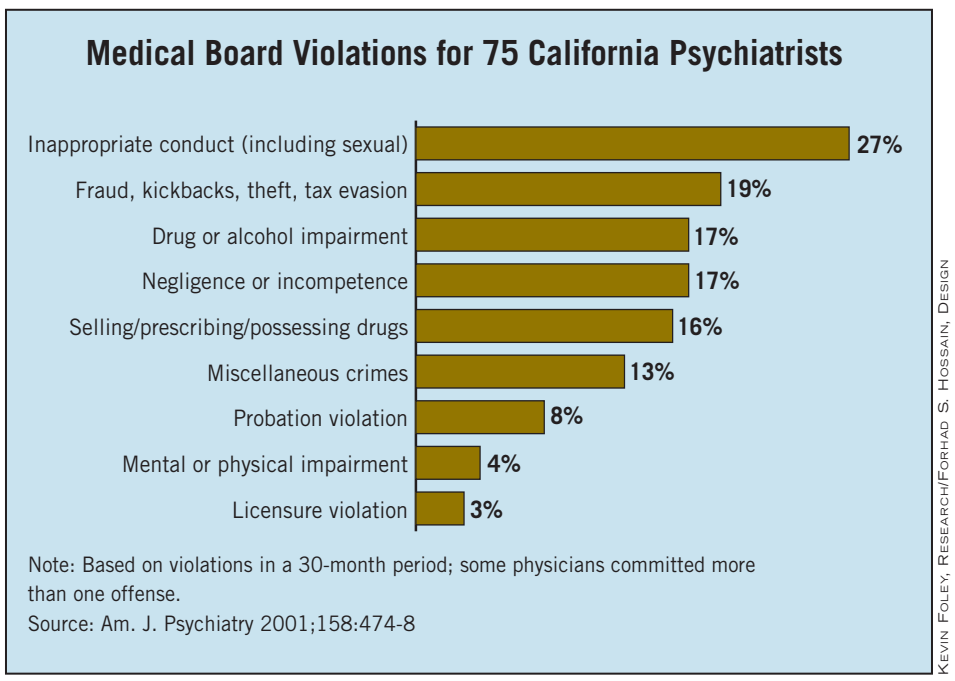
Complete medical screening is an important part of a fitness for work evaluation. Hypertension, found in six cases, was the most common medical problem in the group, followed by hypothyroidism in five cases, and sleep apnea in four.

Among the postevaluation recommendations for these physicians were initiation or continuation of psychiatric treatment, including psychotherapy with a focus on gaining insight into the reasons for the bad behavior; anger management; cognitive-behavioral therapy; and random urine screens in cases of substance abuse. Dr. Schouten strongly recommended that physicians receive follow-up treatment from someone of the same cultural background who is not a colleague, if possible.

The data on outcomes for doctors who have psychiatric referrals are soft, he admitted, but about 80% of physicians whom he has evaluated returned to work. About 9% went out on disability.

Many physicians who are referred for a psychiatric consultation resent any suggestion that they be held accountable for their actions, but the term "anger management" meets with less resistance than does "psychotherapy" because it lacks the stigma associated with a mental health problem, he noted.

"Physicians are amazingly lacking in insight into their own behavior," Dr. Schouten said. "One of the things treatment programs struggle with is how to teach insight to these very bright, well-trained people." ■




KEVIN FOLEY, RESEARCH/FORHAD S. HOSSAIN, DESIGN

## What to Ask: How to Evaluate a Doctor Who Is Referred for Disruptive Behavior

When evaluating a doctor who has been referred for disruptive behavior, consider the nature and culture of the community, the hospital, and the staff, advised Julia Reade, M.D., director of the forensic psychiatry fellowship at Massachusetts General Hospital in Boston.

Stereotypes and misunderstandings often jeopardize doctors' relationships with their colleagues, she said.

In some cases, a referral visit opens a Pandora's box of other mental and emotional issues for the doctor. In others, a doctor's immediate coworkers may have recognized a problem and kept it a secret from the hospital administration to preserve the doctor's reputation.

A psychiatric evaluation must take the context of the problem behavior into account. Dr. Reade mentioned one case in which a surgeon's colleagues were frightened when they discovered that he was bringing a handgun to the operating room every day.

As it turns out, the doctor had grown up around guns and had been assaulted in the past. The reason he took the gun with him to the operating room was because he thought it was dangerous to leave it in his locker at the hospital.

Doctors might also behave badly because of stress at home or at work, or because they feel that their medical decision-making is being compromised by managed care.

The presence of a concurrent illness can be a problem as well.

"One of our most common recommendations to doctors is to get themselves internists," Dr. Reade said.

Doctors tend not to pay attention to their own medical treatment and should not be prescribing their own medicines, she added.

When evaluating disruptive doctors:

► Clarify the questions being addressed. Can the doctor return to work, but with a different supervisor, or different nurses? Should the doctor take a leave of absence?

► Identify who will receive the results of the evaluation (hospital administrators, licensing board).

► Identify the source of the complaint. Does the doctor treat nurses well but lash out at colleagues? Have patients complained about the doctor's behavior?

► Identify the context of the complaint. How big is the hospital? How big is the community? What are the demographics of the area?

► Identify the cast of characters. Does the doctor have a lawyer? Will the licensing board be involved?

► Consider unspoken agendas. Are there mixed messages from the hospital? Are they looking for an excuse to unload a troublesome doctor or desperate to keep a skilled clinician despite persistent personality problems?

► Understand the timing of the referral. Why is this doctor being referred at this time? Have there been organizational changes or financial changes at the hospital? Has there been a very recent change in the doctor's behavior?

The evaluation of a fellow physician places unique demands on psychiatrists. "There is pressure for a diagnosis, and you are frequently asked unanswerable questions, such as 'Is this doctor a pervert?' or 'Will he or she burn down the hospital?' " Dr. Reade said. The psychiatrist must gauge how much information to put in a formal report, knowing that results of psychiatric evaluations do not always remain confidential.

# Fitness-for-Duty Evaluations Should Focus on Key Facts

ARLINGTON, VA. — Every company is strongly invested in its employees' ability to do their jobs, Ronald Schouten, M.D., said at the annual meeting of the Academy of Organizational and Occupational Psychiatry.

Companies with concerns about an employee's mental health will often call in a psychiatrist for a fitness-for-duty evaluation. An independent evaluation differs from a clinical evaluation in several ways, said Dr. Schouten, director of the law and psychiatry service at Massachusetts General Hospital in Boston.

In a clinical evaluation, the psychiatrist focuses on the diagnosis and relief of symptoms and acts as a patient advocate. An independent fitness-for-duty evaluation, however, is an objective, functional assessment conducted by a third party for the benefit of the employer, to determine whether the patient is capable of doing his or her job.

Everything a psychiatrist writes in a fitness-for-duty evaluation can be made available if the case involves a lawsuit, Dr. Schouten said. However, most employers simply want to know whether or not the person is fit for work, and what, if any, special accommodations he or she needs. A postevaluation report can generally be brief, as long as it includes the following elements:

► Identification of the person.

► An explanation of why the person was referred.

► Consent forms and limits of confidentiality.

► Job description and the job functions.

► Medical and psychological history that is deemed relevant.

► Observations related to fitness for duty.

► Recommendations for treatment and/or return to work.

In addition, a detailed report typically includes results from a mental status exam and other tests that were administered.

**—Heidi Splete**