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The Organizational Impact of Impaired Health Care Executives or Physicians: A Review and Recommendations

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The negative impact of an impaired health care executive or physician on an organization can be significant. This article reviews the literature on impaired health care executives and physicians. Case studies are provided, and recommendations are made for boards of directors, senior management, executive coaches, and employee assistance professionals to consider when faced with impaired leaders or professionals.

KEYWORDS *health care executives, impaired physicians, leadership, organizational psychology*

Health care executives and physicians are as vulnerable as anyone in the general population to having an impairment of some kind (Berge, Seppala, & Schipper, 2009; Mines, Anderson, & Von Stroh, 1991; Merlo & Gold 2008; Panagopoulou, Montgomery, & Benos, 2006; Potter, 2006; Rosen et al., 2009; Rosenstein & Mudge-Riley, 2010; Seppala, & Berge, 2010; Voltmer, Kieschke, Schwappach, Wirsching, & Spahn, 2008; Walker, 2004; Wunsch, Knisely, Cropsey, Campbell, & Schnoll, 2007; Yancey & McKinnon, 2010). The implications for a health care organization having an impaired executive or physician are significant. The costs to the health care organization when a

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physician or health care executive is impaired may include malpractice claims paid and the cost of employment contract buyouts or payoffs. Other expenses may also include lost productivity on the part of staff as they compensate for the impaired physician or health care executive, "work arounds" such as spending a half-million dollars for a small office for an interpersonally toxic physician, lost profitability due to substance-abusing executives making poor business decisions, and increased costs due to sexual harassment or other toxic work environment driven complaints or litigation (R. A. Mines, personal communication, 2010).

WHAT IS IMPAIRMENT?

Although *impairment* is most often thought of in terms of drugs and alcohol, the problem is much broader. In its "sick doctor statute," the American Medical Association (AMA) defined *impairment* as "the inability to practice medicine with reasonable skill and safety due to physical or mental disabilities, including deterioration through the aging process, loss of motor skill, or abuse of drugs or alcohol" (American Medical Association Council on Mental Health, 1973, p. 684). In a similar vein, Lalrotis and Grayson (1985) elaborated that impairment might be an interference in the professional functioning that could be due to a number of factors including chemical dependency, mental illness, or personal conflict. Kutz (1986) indicated that there is a "diminishment from a previously higher functioning" (p. 220). Jacobson and Kominoth (2009) used a comprehensive definition of *impairment* that included the historic categories of alcoholism, substance abuse, and mental illness plus any inability to perform one's job duties due to cognitive, emotional, or physical problems that can be due to, but not limited to, gambling, stress, Internet abuse, burnout, sexual disorders, debilitating medical conditions, overwork, and interpersonal conflict. For the purpose of this article, broad views encompassing all aspects of the impairment definition are used (Jacobson & Kominoth).

IMPAIRMENT LITERATURE

There is a significant body of literature related to physician impairment. This literature may also be applied to health care executives with a few exceptions.

Susceptibilities and Prevalence

There are some substances that physicians are more likely to abuse than the general population (Yancey & McKinnon, 2010). Addiction diseases impair

more physicians than any other disease (Merlo & Gold, 2008). Alcohol is the most commonly abused drug in America and is used and abused more frequently by medical professionals than the rest of the population. Narcotics are also more frequently abused by physicians. Perhaps this is because physicians have easy access to prescriptions through their colleagues or self-prescribing. Street drugs on the other hand are less likely to be abused by physicians than the rest of the general population (Yancey & McKinnon, 2010).

Differences in drug choice tend to vary in terms of physician specialty. For instance, emergency room physicians tend to use and abuse illegal street drugs whereas anesthesiologists tend to use narcotics, and finally psychiatrists tend to abuse mood-altering substances (Yancey & McKinnon, 2010). There are also gender differences in the substances used by physicians contributing to their addictions. According to research, women are less likely than men to develop substance abuse and dependence unless there is access to psychoactive substances; in such circumstances men and women will progress to abuse and addiction at similar rates. Female physicians are more likely than male physicians to abuse sedative hypnotic drugs and prescription opioids. Women physicians are also the most likely to use and abuse multiple substances at once and encounter addictions at an earlier age. Male physicians were more likely to abuse alcohol (Wunsch et al., 2007).

The rates of prescription drug abuse are 5 times higher among physicians compared to the general population. The prescription drug of choice tends to be opioids and benzodiazepines. More recently, sublingual and intravenous analgesics have become more prevalent among physicians (Merlo & Gold, 2008).

Psychopathology and Mental Health

Successful completion of suicide is much higher among physicians than non-physicians (Merlo & Gold, 2008). Studies evaluating discharge data in men and women show differences in mental health concerns between men and women physicians. Men and women physicians were equally as likely to face a comorbid Axis I or II diagnosis. Female physicians are the most likely to have had a history of suicide attempts and affective disorders. Female physicians are also more likely to have depression and bulimia (Wunsch et al., 2007).

Burnout

Although not a psychological diagnosis, physicians experience burnout much like other caregivers in the health care field (Potter, 2006). Burnout is of great concern in the health care setting because many believe that it reduces the quality of care that medical providers provide patients (Rosen et al., 2009).

Impact of Physician Impairment

Physician impairment is a significant issue that has severe public health implications (Merlo & Gold, 2008). In one survey of 1,627 physician executives, nearly 95.7% of hospital executives reported that they encountered disruptive behavior from a physician. Of that 95.7%, 70.3% stated that the disruptive behavior comes from the same physician. Nearly 80% of those surveyed stated that they were hesitant to report the behavior because they feared retaliation (Mustard, 2009).

When physicians are impaired they typically exhibit problematic and disruptive behaviors within the workplace. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) outlined examples of disruptive behaviors. The behaviors include impatience with colleagues and patients, condescending tones, threats, refusals to answer questions, pages, and phone calls, and lack of cooperation during routine activities. JCAHO connected the previously listed disruptive behaviors to poor patient satisfaction, medical errors, adverse outcomes, and increased costs due to turnover (Mustard, 2009).

Legally, there are many aspects to consider when dealing with an impaired physician or executive. Of course, the first is the ethical and legal obligation to protect the patients within the health care organization after an impaired physician has been discovered. Another legal compliance concern is adhering to the Americans with Disabilities Act (ADA), which in most cases protects employees that are attending chemical dependency programs and those who are in recovery from retaliatory or discriminatory action. Overall, the ADA requires reasonable accommodations for the alcoholic and/or drug addict. In addition, Family Medical Leave Act (FMLA) regulations may apply as well. Upon the employees' return from treatment, they must follow the strict guidelines set forth by the hospital including consequences for relapse (Berge et al., 2009).

Intervention and Treatment

The majority of physicians improve when they receive treatment for substance abuse, as reported in a 5-year study that 78.7% of physicians who went through physician health programs were licensed and working (McLellan, Skipper, Campbell, & DuPont, 2008). One study noted that in a sample of 100 physicians in Canada, who were followed in a substance dependence monitoring program, 85% successfully completed the program. Of these, 71% had no known relapse and another 14% eventually successfully completed. They were monitored over 5 years. It is expected that for mental health and other conditions that success rates would be similar to those expected in the general population. It is crucial for those responsible

for overseeing physicians and health care executives that they have confidence that individuals who demonstrate impairment at work can be successfully intervened with for the most part and returned to work (Brewster, Kaufmann, Hutchison, & MacWilliam, 2008).

RECOMMENDATIONS

To manage impaired executives and physicians, boards of directors, senior leadership, executive coaches, and employee assistance professionals need to be able to recognize the signs and symptoms of impairment, have a set of actionable steps to take, and be aware of their personal psychological bias and vulnerabilities that may interfere with their ability to act decisively.

Diffusion of Responsibility

In situations where role, authority, and accountability are ill defined or unclear, the board or senior management may be waiting for someone else to initiate action regarding the work performance and its impact. The social psychology research is replete with evidence regarding bystander effects. Essentially, this line of research stated that when no one is in charge or has authority, a group of people will not take action and assume someone else will (Kenrick, Neuberg, & Cialdini, 2002).

We Owe Them

The board or senior management often holds the assumption that because of past contributions to the organization, the organization owes the individual and therefore cannot take action. An example of this is the case of a Board of Directors (BoD) who had an impaired CEO for more than 2 years and did not take action because the CEO was associated with an increase in top line revenue of 300% in the prior 5 years.

Personal Relationships

In some cases, the board members and/or senior management do not take action because they have a friendship with the person. They feel it would be disloyal, or worse, they also have performance or impairment issues and are colluding with the person to perpetuate the behavior or culture. An example of this was a senior management team that did not intervene with a vice president of marketing who would publically berate physicians in a specific specialty for not supporting his new marketing initiatives regarding new procedures being promoted by select vendors with whom he had

"special" relationships. The physicians were intimidated and did not think they could go to the board, senior management, or their intervention or support.

Denial

This presents as the individuals with authority to act do not think the problem is as big as it is. A senior management team of a large practice had one managing physician who they all thought drank too much, yet they did not think she had a problem until they attended a senior management retreat and she proceeded to order bottle after bottle of expensive wine. She became visibly impaired and started insulting and yelling at the resort staff when they suggested the group had enough to drink. The practice was prohibited from returning to the resort and paid extra to the staff and resort for the situation to mitigate further legal action.

Coalesced Authority, Power, and Influence

Adizes (1999) noted that when authority, power, and influence get consolidated/coalesced in one or a few individuals they have a disproportionate impact on decisions about a number of matters including intervention with impaired professionals. In one case, a physician/board member had taken on a number of stressful tasks over the years and even though there were six other board members, she was able to protect an impaired CEO for over two years because the other board members, with the real authority of a majority, did not challenge the perceived authority of this active and involved board member (Adizes, 1999).

Conflict Avoidance

Sometimes conflict is difficult for board members to contend with, and they wait to address it hoping it is a temporary problem.

SIGNS AND SYMPTOMS

Senior leadership and/or the BoD may not have the clinical expertise to diagnosis a colleague nor would they want the ethical problem of acting in dual roles. However, it is important to be able to identify the behavior and understand what their options are in terms of resources in their health care systems. The following list of indicators of declining job performance give senior management and/or a BoD a full, yet not exhaustive, overview (Mines and Associates, *Supervisor Training Manual*, 2011).

The question for senior management or the BoD then becomes what to do about the colleague when there is a clear pattern of decline in performance over time?

STEPS

There are some clear steps to take and questions to consider as senior leadership or the BoD proceeds.

Step 1—Recognition

What are the signs and symptoms of the employee with a problem? (See Table 1.)

Step 2—Documentation

Which forms of documentation highlight patterns that are clues? (In situations where illegal or unethical behaviors exist, a formal and well-documented investigation is most often required.)

Step 3—Action

Can This Professional Be Rehabilitated?

As part of the decision process, the employer team needs to determine whether he person can be rehabilitated and if so, can that person be rehabilitated in a timely manner so as to not put the organization under undue duress. This may need to be done in conjunction with consultation from a mental health/substance abuse professional regarding prognosis.

Do the Liabilities of His or Her Retention Make Continued Action Impossible?

In some cases, the prognosis for change is low or the acuity is so high that the liability of continuing or returning the individual to work is not worth the behavioral risk to the organization. An example of this (see Case Study B in the following section) would be an impaired CEO with an untreated sexual addiction who had more than 20 sexual harassment complaints filed with human resources. In this case, the BoD determined that even if the CEO received treatment and could return, the message to the 20-plus females in the organization was such that they did not want to restress them by having the CEO in the work environment.

TABLE 1 Signs and Symptoms of Impairment

Work performance	Absenteeism	Reliability	Attitudes and habits	Physical appearance	Safety
Lowered productivity.	Repeated absences, especially following weekends or holidays.	Procrastination.	Unreasonable sensitivity to normal criticism from peers or supervisors.	Obvious changes in personal grooming, dress, or demeanor.	Increase in personal injuries due to accidents on and off job.
Frequently changing work pace with extreme highs and lows.	Returning late from lunch or breaks.	Increased time needed to complete tasks.	Avoidance of fellow workers.	Observable physical changes.	Carelessness in use of equipment.
Limited attention span or impaired ability to concentrate.	Early departures or unexplained disappearances.	Neglect of details and/or required documentation.	Unreasonable intolerance or suspicion.		Lack of concern for safety of others.
Disregard of regulatory requirements or constraints.	Increase in tardiness.	Missed deadlines.	Inconsistent demonstration of clinical objectivity.		
Errors in judgment.	Absences without good reason or with increasingly improbable excuses.	Poor quality of work.	Sudden shifts in mood.		
Excessive waste.			Long lunch hours, long coffee breaks, frequent trips to the water fountain or restroom.		
Unreasonable fatigue.			Inappropriate communication with patients, peers, or team members.		

Which Methods of Approaching an Employee Are Most Effective?

It is usually best to have the person's direct supervisor/manager (e.g., chair of the board, chief medical officer, and chief of the department) and human resources meet privately with the individual. This prevents a "he said, she said" situation if the situation ends up in court. It also allows the physician or executive to retain his or her privacy as well as dignity. The two-person team needs to have their documentation completed. This is not a situation for debate or discussion. This is a situation where the employer's plan of action is presented.

Step 4—Referral

How Can You Maximize the Chances That Your Employee Will Seek Help?

The first consideration is what resources the organization has available to it. Most organizations have human resources, health insurance, and physician health programs; whereas many have Employee Assistance Programs, and legal consultation regarding employment law; and some use executive coaches for upper-level executives. Some professional associations may have resources available as well. All of these resources in various combinations may be brought into consideration depending on the specifics of the individual situation. For example, the Employee Assistance Program may be utilized to monitor an executive's compliance with drug testing or the physician health program will work with the medical licensing board regarding specific stipulations related to the physician's practice.

Step 5—Follow-Up

It is crucial that senior leadership and/or the board be clear about the organizational channels, protocols, human resources, and legal resources. All resources become important as these situations present, evolve, and/or deteriorate. For example, the Employee Assistance Program and its staff can monitor compliance with treatment for a year after the individual returns to work.

Organizational Consequences of Failure to Act

Some organizational consequences from failure to intervene when a health care executive or physician is impaired include lost revenue; sexual harassment and hostile work environment lawsuits; executive-level team performance failure (and subsequent firings); lost productivity on part of staff; lost profitability; lost contracts; employee turnover and subsequent lost

intellectual capital; lost reputation; increase in the number of team members with emotional distress with anxiety, hopelessness, and depression symptoms; and malpractice suits and settlements. The following case studies illustrate these consequences.

CASE STUDIES

The case studies are composites designed to maintain the confidentiality of the individual and the organization.

Case Study A: The Substance-Abusing Health Care Executive

A health care executive who headed up a large division of a hospital system was observed to have increased her use of alcohol at organizational functions, was progressively, over 3 years, noted to come in late, no longer was accessible to staff without an appointment, started smelling of alcohol during the day, started missing work, and as her job was to oversee the finance function in her division, started missing mission-critical financial deadlines due to procrastinating on financial reviews, ignoring contract negotiations, and similar high-level strategic decisions.

The health care executive was eventually confronted with her behavior, went into treatment, failed treatment, and was given a large severance package for reasons too complex to detail here. The cost to the organization was significant in terms of lost productivity, lost collections and billing, payouts, legal and consulting costs, as well as lost intellectual capital and time.

Case Study B: Top Leadership Sexually Harassing Staff and Patients

The chief physician of a large group practice was alleged to have harassed more than 20 staff members by making offensive comments of a sexual nature, inappropriately touching staff, and making inappropriate comments to patients while exhibiting little or no insight into his behavior. Upon investigation, the individual stated he was in recovery from a sexual addiction and sexual abuse. The board was divided as to sending the person to treatment and retaining or terminating the person. The decision was to terminate him. The cost to the organization was significant in terms of legal (litigation was avoided) time, consultants, and severance. Fortunately, there were no sexual harassment suits as the staff felt that the board had acted in their best interests and in a timely manner. There were other complex legal and licensing matters in the case that are beyond the scope of this article.

Case Study C: Physician Malpractice

A surgeon in a large surgery practice was found guilty of numerous crimes related to deaths that occurred during or shortly after his surgeries. Upon investigation, it was found that there were mixed opinions regarding the basis for this. One group thought it was because he took high-risk cases that no one else would take and therefore had a higher death rate. Another group thought that he was cavalier, narcissistic, and operated with disregard for procedure, safety, and patient welfare. In addition, he operated at a number of hospitals, and there was no central clearinghouse that would have picked up on his practice patterns and death rates. Eventually he was convicted and lost his license to practice. The practice group and the hospitals incurred millions of dollars in malpractice claims. The consultants assisted in revamping the QA procedures, training the medical chief, and assistant medical chiefs in better management skills and techniques designed to monitor and reinforce the standards of care and to intervene sooner than later with their colleagues.

CONCLUSIONS

Based on the epidemiology research related to mental health, substance abuse, and other related behavioral problems, 30% to 40% of health care executives and physicians could be working with some type of impairment. The degree of impairment and the impact on the organization can have a wide and varied negative effect.

The senior management team and the BoD need to be able to recognize a decline in work performance that occurs over a defined period of time that is not due to skills or systems issues. Once this pattern has been identified, a plan needs to be followed in which the individual is assessed, an intervention is made, and preidentified resources are brought in to assist in making the determination to retain or terminate employment and identify collateral risks to the organization.

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