RES 7
C-4/16

SUBJECT: American College of Osteopathic Family Physicians (ACOFP) Policy Position on Cognitively Impaired Physicians

SUBMITTED BY: ACOFP Board of Governors

REFERRED TO: 2016 American College of Osteopathic Family Physicians (ACOFP) Congress of Delegates

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RESOLUTION NO. 7

1 RESOLVED, that the Congress of Delegates of the American College of Osteopathic Family
2 Physicians (ACOFP) ADOPTS and APPROVES the proposed ACOFP Policy Position on
3 Cognitively Impaired Physicians, as submitted by the ACOFP Board of Governors.
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ACTION ________________

1 ACOFP WHITE PAPER **DRAFT as of February 6, 2016**

2 COGNITIVELY IMPAIRED PHYSICIANS

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4 The ACOFP basic tenets are advocacy, education and leadership. This includes Advocacy for our
5 members to practice osteopathic family medicine without prejudice or unwarranted restriction. It also
6 includes Advocacy for our patients and patient safety.

7 The transformation of the healthcare system in the United States affords all patients an expectation of
8 high quality patient-centered care. This care should be delivered by competent physicians who are free
9 from physical, psychiatric and emotional illness or injury that inhibits their ability to deliver quality
10 healthcare. As part of its commitment to the safe and effective delivery of patient care, the ACOFP also
11 advocates for proactive educational opportunities for practicing physicians concerning mental and
12 physical health and physician impairment issues. The goal of these sessions is to address prevention,
13 treatment and rehabilitation of illness or potentially impairing conditions. These goals also should
14 include the evaluation of the ability of the physician to acquire new or changing medical knowledge.

15 The term "cognitively impaired physician" may include a variety of conditions and populations.
16 Cognitive impairment refers to the inability of the physician to adequately gather, evaluate, and process
17 medical information and to apply appropriate medical knowledge and skills. This may also include the
18 impaired ability to learn new information. A cognitively impaired physician may include but is not
19 limited to:

20 1. Physicians with specific medical conditions that despite the use of assistive devices and
21 technology, are unable to use their senses to evaluate and treat patients.
22 2. Physicians suffering from uncontrolled with drug and alcohol related illnesses.
23 3. Physicians with neurodegenerative disorders with impaired working memory or the ability
24 to process and store information. This includes physicians with dementia.
25 4. Physicians with medical conditions that require medications that impair their cognitive
26 process or memory.
27 5. Physicians suffering from uncontrolled mental illness which impaired their thought process
28 or memory.

It is the policy of ACOFP that physicians should be allowed to remain in practice as long as patient safety, quality medical practice and patient well-being are not compromised. Self-regulation is an important aspect of professionalism, but there are instances where physicians may not be aware of the significance of their own cognitive impairment. It may be the observations of colleagues, medical staff members, nurses, or employees that first notice a physician's cognitive impairment. Physician monitoring may include the following:

1. Physicians who are members of an active medical staff at a hospital or other medical institution should be monitored by colleagues and peers on that staff. Irregularities or signs of cognitive impairment should be brought to the attention of the chief of staff, chief medical officer or their designee for further evaluation. Guidelines and standards should be an essential part of the medical staff bylaws. Routine physical examinations as required by the bylaws should include cognitive evaluation.
2. Physicians who practice in a private group should be monitored by their colleagues in that practice. Appropriate guidelines instituted by that practice should address cognitive impairment.
3. Physicians in large corporate practices should be governed by the guidelines of that organization. Policies concerning cognitive impairment should be well delineated as well a method of reporting any concerns to the chief executive officer (or designee).
4. Physicians employed in academic institutions should be monitored by colleagues, deans and department chairs. Appropriate guidelines should be a part of the institution's standards.
5. Physicians who are board certified may undergo routine evaluation through the re-certification and maintenance of certification processes. Face-to-face evaluation, such as the American Osteopathic Board of Family Physicians neuromuscular medicine testing, provides another valid avenue to assess a physician's cognitive abilities.
6. Physicians in solo practice who are not active members of a medical staff or who are not actively pursuing re-certification or maintenance of certification have a limited opportunity for monitoring by others. These physicians should empower their own staff to carry out appropriate monitoring.
7. Monitoring may include psychometric evaluation to determine the clinician's ability to safely engage in active clinical practice.

59 It is the duty of physicians to continually assess and evaluate their own physical and mental abilities. It is
60 also the duty of physicians to report any significant cognitive impairment of a colleague to the
61 appropriate hospital, or clinic authorities. Of particular concern are physicians with limited exposure to
62 peers, who are not on active medical staff or practicing with other physicians. It is vital that these
63 physicians have access to resources to help them in self-monitoring. These resources should be available
64 through state and national professional societies.

65 It is the goal of The ACOFP to assist physicians in their care of patients. This includes proactive
66 involvement in maintaining competency in cognitive abilities. The ACOFP shall be proactive in assisting
67 in the development of tools for assessing cognitive skills for physicians, as well as providing guidelines
68 for self-reporting both by the individual physician and for colleagues of any cognitively impaired
69 physician.

70 The ACOFP supports the adoption and implementation of the following standards by hospitals, health
71 plans, academic institutions, and state licensing boards:

72 1. The practice environment should be one that allows for confidential reporting and self-reporting
73 of illness or other potentially impairing conditions.
74 2. The identity of the person(s) reporting concerns regarding the possible cognitive impairment of
75 a physician should be in writing and should be kept confidential. If in the opinion of the
76 appropriate officer/administrator the allegations are credible, an investigation should be
77 undertaken. The physician in question shall be directly contacted and made aware of the
78 allegations. The physician shall be given the opportunity to respond to the allegations.
79 3. If the concern is deemed substantial, the physician should undergo a complete medical exam
80 that is related to the performance and scope of practice, including psychometric evaluation.
81 4. A drug test should be obtained to determine if the physician is using drugs illegally or abusing
82 legal drugs.
83 5. A physician deemed impaired should have access to professional resources such as counseling,
84 medical treatment or rehabilitation services for the purpose of diagnosis and treatment of the
85 conditions of concern.
86 6. If the impairment is a disability, reasonable accommodation should be made to enable the
87 physician to competently perform clinical duties.
88 7. If the impairment constitutes a direct threat to the health and safety of patients, the physician,
89 or other co-workers, immediate action should be taken. Every attempt will be made to reach a

90 voluntary agreement for adjustment of the physician's duties and privileges. If a voluntary
91 agreement cannot be reached, the physician could be subject to the appropriate corrective
92 action with strict adherence to any applicable medical staff by-laws, facility work rules, and state
93 and federal reporting requirements.

94 8. If an adjustment in a physician's duties and privileges has occurred, a process for rehabilitation
95 and reinstatement should exist.

96 A. A physician suffering from a physical, psychiatric or emotional illness or injury shall be
97 given the opportunity to demonstrate improvement in their condition. The facility may
98 request reasonable proof of completion of treatment and clearance to return to practice.
99 Upon receipt of appropriate documentation the physician should be granted
100 reinstatement of clinical privileges. The physician may be required to obtain periodic
101 reports from the treating physician, attesting to the physician's continued ability to safely
102 provide medical care.

103 B. Physicians suffering from drug or alcohol related impairment shall be given the
104 opportunity to demonstrate resolution of their condition. Upon receipt of appropriate
105 documentation the physician should be granted reinstatement of clinical privileges. The
106 patient's treating physician shall attest to the physician's condition and continued
107 treatment as appropriate. If indicated, the physician shall provide periodic reports from
108 the physician regarding the ability of the physician to safely provide medical care. If
109 applicable, the physician shall provide documentation of compliance with other
110 requirements of a physician's health/recovery committee (State or local/employer).

111 Related Readings

112 1. Lee L, Weston W. The aging Physician. *Canadian Family Physician.* January 2012:58:17-18.

113 2. Eva K. W. The aging Physician: Changes in Cognitive Processing and Their Impact on Medical
114 Practice. *Acad. Med* October 2002:77(10): S1-S6.

115 3. Eva K. W. Stemming the tide: Cognitive aging theories and their implications for continuing
116 education of the health professions. *J Contin. Educ* Health Prof. 2003; 23:133-140.

117 4. Smart DR. Physician Characteristics and Distribution in the US American Medical Association
118 2015 Ed.