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| St. Joseph’s / Candler Health System | **Medical Staff Policy**  **Title: Physician Health Issues**  **Section: Medical Staff Services** | **Policy Number:**  **MS 012****0**  **Key Function:**  **Effective Date:**  **07/09/01**  **00/00/0000**  **Page 1 of 9** |

**Policy Statement**

St. Joseph’s/Candler Health System, Inc. is committed to providing patients with quality, safe care and to provide a safe working environment for all Medical Staff and coworkers of the Health System. The delivery of quality, safe care can be compromised if a member of the Medical Staff is suffering from impairment. Impairment may result from a physical or mental condition.

It is the policy of St. Joseph’s/Candler Health System, Inc. through the respective Medical Staffs to provide a process to identify and manage matters of individual health for members of the Medical Staff which is separate from actions taken for disciplinary purposes. The purpose of the process is to facilitate the rehabilitation, rather than discipline, by assisting a practitioner to retain and to regain optimal professional functioning that is consistent with protection from harm of patients, medical staff members, and other persons present in the hospital. Issues of impairment relating to members of the Medical Staff will be referred to the Medical Staff Leadership and Medical Staff Advisory Committee as appropriate. The Medical Staff Advisory Committee will handle health/impairment issues in a confidential manner to the extent possible. Reports shall be made to The President/CEO of the Hospital, Co-Chairs of the Joint Credentials Committee, Chairs of the Medical Executive Committee and Department Chairs, as appropriate.

**Entities to who this Policy Applies**

St. Joseph’s/Candler Health System, Inc. Medical Staff

# Objectives

To educate members of the Medical Staffs and co-workers about licensed independent practitioner health; and address prevention of physical, psychiatric, or emotional illness.

To facilitate confidential diagnosis, treatment, and rehabilitation of licensed independent practitioners who suffer from a potentially impairing condition.

To facilitate the rehabilitation, rather than discipline, by assisting a practitioner in retaining or regaining optimal professional functioning, consistent with protection of patients.

To provide a mechanism for confidential reporting or self-reporting of health/impairment issues of sufficient magnitude as to affect a physician’s competence.

To define a process for investigation, interventions for directing affected physicians to appropriate treatment and evaluation, and the terms and conditions for return to work following successful treatment.

**Definition of Terms**

Impaired: For purposes of this policy “impaired” means excessive use or abuse of any narcotic, drug or chemical, including alcohol, or the inability to practice medicine with reasonable skill and safety to patients because of physical or mental illness, including loss of motor skills or deterioration through aging.

Medical Staff Leadership: Presidents(s) of SJ and CH Medical Staff, Co-Chair(s) of Joint Credentials Committee, Department Chairperson as appropriate

**Procedure**

**Report and Referral**

1. Members of the Medical Staff and other health care providers are educated about illness and impairment recognition issues specific to physicians (at-risk criteria).

2. Any individual with a concern that a member of the Medical Staff may be unable to safely perform the privileges he/she has been granted in any way (physical, psychiatric, or emotional condition) shall immediately submit a written report to the Department Chair. If the Department Chair is unavailable, the report shall be submitted to the Vice President of Medical Affairs (VPMA), Co-Chairs of the Joint Credentials Committee (JCC), Chairs of the Medical Executive Committee (MEC), or any member of the Medical Staff Advisory Committee. If a report is made by an individual other than a Medical Staff member, the report is directed to the Vice President of Medical Affairs and/or President/CEO of the Hospital. Self-referral by a physician is acceptable. The report must include a description of the incident(s) that led to the concern and must be factual in nature.

Sufficient cause for concern and subsequent reporting includes, but is not limited to:

* Evidence of substance abuse-e.g. prescription or non-prescription drugs or alcohol
* Impaired performance on duty
* Disruptive or abusive behavior
* Negligent or declining performance
* Evidence of major debilitating illnesses, depression, dementia, or other psychopathology.

1. 3. Upon receiving a report and description of the incident(s), the Department Chair or designee, President (s) of Medical Staff and/or Co-chairs of Joint Credentials Committee in collaboration with VPMA, will investigate the relevant facts, including a discussion of the incident with the individual who files the report and other involved persons and personal observation in a meeting with the medical staff member.

4. If, upon completion of the interviews, the medical staff member is felt to be impaired, a clinical examination and/or testing may be conducted if appropriate. The clinical exam/testing will be performed with concern for the individual’s dignity, and to the extent possible, with respect for his/her confidentiality. Results of clinical evaluations will be maintained in the practitioner’s confidential quality/healthcare portion of his/her credential file.

a. Specimens must be collected using “chain of custody” within two hours of request by a laboratory designated by the investigating persons.

b. The testing will cover the spectrum of tests covered in the then current Healthcare Professional Panel. The practitioner may receive a list of the tests in the current Healthcare Professional Panel upon request.

c. The practitioner will sign a release of information form for clinical examination and testing. The release must allow and instruct the results to be sent to the Vice President of Medical Affairs (VPMA) for St. Joseph’s/Candler.

d. Practitioners who refuse to sign the release of information form for the clinical examination and testing are subject to immediate disciplinary action, up to and including suspension or termination.

e. Testing will be at the medical staff member’s expense.

5. The facts of the investigation are reported to the Co-Chairs of the Joint Credentials Committee and the Chairs of the Medical Executive Committee (Presidents of the Medical Staffs).

6. If, after discussing the report with the individual concerned, the Co-Chairs of the Joint Credentials Committee or Chair(s) of the Medical Executive Committee in collaboration with the VPMA believes there is enough information to warrant intervention, a plan is developed along with the individual practitioner. The matter may be referred to the Medical Staff Advisory Committee as appropriate.

7. If the Medical Staff leadership, in collaboration with the VPMA, feels outside intervention is needed and if the concern is related to substance abuse, the physician will be referred to the Georgia Professional Health Program (Georgia PHP) for assessment.

8. The Medical Staff leaders have the authority to refer the physician to appropriate professional internal or external resources for evaluation, diagnosis, and treatment of the condition or concern, and have the results of the evaluation provided to the leaders. Consent for release of information to the Medical Staff leadership must be signed by the physician.

9. Depending upon the nature and severity of the impairment, the Medical Staff leadership has the following options:

* Recommend a voluntary leave of absence, during which time he/she would participate in rehabilitation or treatment program to address and resolve the impairment;
* Recommend that appropriate conditions or limitations be placed on the physician’s practice;
* Recommend that the physician voluntarily agree to refrain from exercising some or all privileges in the hospital until rehabilitation or treatment has been completed or an accommodation has been made to ensure that the physician is able to practice safely and competently;
* Recommend that some or all of the physician’s privileges be suspended if the physician does not voluntarily agree to refrain from practicing in the hospital.

10. Hospital counsel shall be consulted to determine whether law enforcement or other state or federal regulatory agencies must be notified and any further action that needs to be taken.

11. If the physician agrees to abide by the recommendations, a confidential report will be made to the President/CEO of the Hospital, the Joint Credentials Committee, Medical Executive Committee and the Medical Advisory Committee.

12. In the event that there is a concern by the President/CEO of the Hospital, President(s) of the Medical Staff, or Co-Chairs of the Joint Credentials Committee that the action of the Medical Staff leadership is not sufficient to protect patients, the matter will be referred back to the Medical Staff leadership with specific recommendations on how to revise the action or it will be referred to the Joint Credentials Committee for an investigation and recommendation for action.

13. If the Medical Staff leadership recommends that the physician participate in a rehabilitation or treatment program, it shall assist the physician in locating a suitable program.

14. Not all impairments require the same treatment. Treatment should be individualized considering severity, longevity, and recommendations from professional assessments.

15. Copies of the original report, actions taken by the Medical Staff Advisory Committee, President(s) of the Medical Staff and/or Joint Credentials Committee will be maintained in a confidential physician file. If the investigation reveals that there is insufficient evidence to warrant immediate action, a copy of the report will be maintained in the confidential physician’s file and the physician’s activities and practice will be monitored for safety and quality purposes.

16. In the event that there is an apparent or actual conflict between this policy and the bylaws, rules and regulations, or other hospital or Medical Staff policies, including the due process sections of the bylaws and policies, the provisions of this policy shall supersede such bylaws, policies, rules or regulations.

# Rehabilitation

1. When sufficient proof that a physician who has been suffering from impairment has successfully completed a rehabilitation or treatment program, the physician shall be referred to the Medical Staff Advisory Committee for monitoring and follow-up. The Medical Staff Advisory Committee may recommend that the physician’s clinical privileges be reinstated (See below). In making this recommendation, the Medical Staff Advisory Committee must consider patient care interests as paramount.
2. Prior to recommending reinstatement, the Medical Staff Advisory Committee and the Joint Credentials Committee must obtain a letter from the physician overseeing the rehabilitation or treatment program. The physician will need to sign the appropriate release of information. The letter must include the following:

* The nature of the physician’s condition;
* Medical treatment (including all medications) physician is undergoing;
* Whether the physician is participating in a rehabilitation or treatment program and a description of the program;
* Whether the physician is in compliance with all of the terms of the program;
* To what extent the physician’s behavior and conduct need to be monitored;
* Whether the physician is rehabilitated;
* Whether an after-care program has been recommended to the physician and if so, a description of the after-care program; and
* Whether the physician is capable of resuming medical practice and providing continuous, safe and competent care to patients.

3. After the Medical Staff Advisory Committee makes their recommendation to the Joint Credentials Committee, the JCC may accept as recommended or may modify the recommendation prior to recommending to MEC and Board for approval.

4. Should a physician fail to complete the required rehabilitation program, the Medical Staff Advisory Committee has the right to recommend to the JCC, MEC and the Board suspension of privileges until such time as the physician complies. Should suspension be for thirty (30) days or greater, it becomes reportable to the National Practitioner Data Bank.

**Reinstatement**

1. At its discretion, the JCC may require any or all of the following agreements or undertakings by an impaired staff member before recommending reinstatement of the staff member’s privileges:

* Active participation in an ongoing after-care program in which the Hospital and Medical Staff have confidence and which will provide ongoing support to the impaired staff member. The staff member must agree to continue in the program and abide by the terms of the program. The program must remain in place for at least 24 months, and be reviewed by the Joint Credentials Committee at six -month intervals.
* A letter to the Co-Chairs of the Joint Credentials Committee from the treatment center providing care to the impaired staff member which covers a description of the impairment, current status, description of the treatment and long term prognosis.
* A letter from the impaired staff member’s primary care physician to the Co-Chairs of the Joint Credentials Committee covering the same points listed above and his/her opinion of whether the impairment has been corrected.
* The impaired staff member’s agreement to:
* Comply with the recommendations of any drug enforcement licensing agency, addressed to the Co-Chairs of the Joint Credentials Committee
* Offer and obtain supervised urine/blood samples for drugs screens at the discretion of the Medical Staff Advisory Committee’s recommendation
* Abstain from any mood changing chemical, except as prescribed by his/her primary care physician.
* Regularly attend a self-help group and provide the Medical Staff Advisory Committee with the name, location, time of meetings, and contact person.
* Agree to any special terms concerning his/her disease as outlined by the Medical Staff Advisory Committee.

1. Assuming that all of the information received indicates that the physician is capable of resuming care of patients and is no danger to self and others, the following additional precautions should be taken before the physician’s clinical privileges are reinstated:

* The physician must identify at least one practitioner who is willing to assume responsibility for the care of his or her patients in the event of the physician’s inability or unavailability; and
* The physician shall be required to provide periodic reports to the Medical Staff Advisory Committee from his/her attending physician, for a period of time as specified by the Committee, stating that the physician is continuing rehabilitation or treatment, as appropriate, and that his/her ability to treat and care for patients in the hospital is not impaired. Additional conditions may also be recommended for the physician’s reinstatement.

1. The final decision to reinstate a physician’s clinical privileges must be approved by the President /CEO of the Hospital in consultation with the President(s) of the Medical Staff and Co-Chairs of the Joint Credentials Committee. No action will be implemented until approved by the Hospital Board of Trustees.
2. The physician’s exercise of clinical privileges in the hospital shall be monitored by the Department Chair(s) or by a physician appointed by the Department Chair(s). The nature of that monitoring shall be recommended by the Medical Staff Advisory Committee in consultation with the President(s) of the Medical Staff and the Co-Chairs of the Joint Credentials Committee.
3. If the physician is suffering from an impairment related to substance abuse, the physician must, as a condition of reinstatement, agree to submit to random alcohol or drug screening tests at the request of the President/CEO of the Hospital, the President(s) of the Medical Staff, the Co-Chair (s) of the Joint Credentials Committee, or any member of the Medical Staff Advisory Committee or their designee.
4. The physician will remain under the monitoring the Medical Staff Advisory Committee until such time as the Medical Staff Advisory Committee feels the physician is rehabilitated, competent and safe to return to practice without monitoring and oversight and the JCC, MEC and Board are in agreement.

# Commencement of an Investigation

1. The hospital and the Medical Staff believe that issues of impairment can best be dealt with by the Medical Staff leadership and Medical Staff Advisory Committee to the extent possible. If, however, the Medical Staff leadership and/or Medical Staff Advisory Committee makes a recommendation, including a recommendation for an evaluation or restriction or limitation of privileges, and the physician refuses to abide by the recommendation, the matter shall be referred to the JCC for an investigation to be conducted pursuant to Article III, Part E., Section 8 of the Joint Credentialing Manual.

## Documentation and Confidentiality

1. The original report and a description of any recommendations made by the Medical Staff leadership and/or Medical Staff Advisory Committee should be maintained in a confidential physician file, separate from the credentials file. If, however, the review reveals that there was no merit to the report, documentation to support this decision is attached to the report and filed in the physician’s confidential QA file. If the review reveals that there may be some merit to the report, but not enough to warrant immediate action, the report shall be included in the physician’s confidential QA file and the physician’s activities and practice shall be monitored until it can be established whether there is an impairment that might affect the physician’s practice. The physician shall have an opportunity to provide a written response to the concern about the potential impairment and this shall also be included in his/her confidential file.
2. The President/CEO of the Hospital or President of the Medical Staff or their designee shall inform the individual who filed the report that follow-up action was taken.
3. Throughout this process, all parties should avoid speculation, conclusions, gossip, and any discussions of this matter with anyone other than those described in this policy.
4. If at any time it becomes apparent that the matter cannot be handled internally, or jeopardizes the safety of the physician or others, the President/CEO of the Hospital, President(s) of the Medical Staff and the Co-Chair(s) of the JCC may contact law enforcement authorities or other governmental agencies.
5. All minutes, reports, recommendations, communications, and actions made or taken are deemed to be covered by the provisions of GA. Code Ann. Section 31-7-130 to 31-7-133 and Section 31-7-140 to 31-7-143 and the corresponding provisions of any subsequent federal or state statute providing protection to peer review or related activities. The committees and/or panels charged with making reports, findings, recommendations or investigations pursuant to this policy shall be considered to be acting on behalf of the Hospitals and their Boards when engaged in such professional review activities and thus shall be deemed to be “professional review bodies” as that term is defined in the Health Care Quality Improvement Act of 1986.
6. All requests for information concerning the impaired physician shall be forwarded to Legal Services for response.

References:

1. Joint Commission 2013 standard MS.11.01.01
2. St. Joseph’s /Candler Health System Joint Credentials Manual, Medical Staff Bylaws, Rules and Regulations.
3. Horty, Springer and Associates. Medical Staff Leader Handbook, 2000 Edition.

**Approval**:

Recommended by the Joint Credentials Committee: April 1, 2013

Revised and Recommended by the Joint Credentials Committee: March 7, 2016

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Chair, Joint Credentials Committee Chair, Joint Credentials Committee

St. Joseph’s Hospital Candler Hospital

Recommended by the Medical Executive Committee: April 8, 2013

Revised and Recommended by the Medical Executive Committee: March 14, 2016

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Chair, Medical Executive Chair, Medical Executive Committee

Candler Hospital St. Joseph’s Hospital

Approved by the Board: March 15, 2016

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Chairman, Board of Trustees Date

Candler Hospital

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Chairman, Board of Trustees Date

St. Joseph’s Hospital

Original Implementation Date: 7/9/2001

Effective System Date: 7/9/2001

Next Review Date: 7/9/2002

Originating Department/Committee: Medical Staff Services

Reviewed: 4/12/2002, 02/2013, 03/07/2016

Joint Credentials Committee: 03/04/2013 suggestions for change made (back to JCC in April)

Joint Credentials Committee: 04/01/2013, 03/07/2016

Joint Medical Executive Committee: 04/08/2013, 03/14/2016

Revised: 5/31/2002, 02/2013, 04/2013, 03/2016

Rescinded:

Former Policy Number(s):