

Ethics in health care: “Physician, heal thyself”

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Keywords: physician, heal, impairment, doctors

Abstract

Doctors have an obligation, derived from duty to protect patients from harm, to take positive action if a colleague is impaired. In this article, the Health Professions Council of South Africa ethical guidelines concerning the duty of a doctor to report impaired practitioners is reviewed, followed by an overview of the regulations relating to the impairment of students and practitioners. Problems that doctors face, which may contribute to their impairment, will be discussed. Finally, while supporting the ethical duty to report impairment, a suggestion is made that during medication education, more emphasis should be placed on doctors recognising that they are human and fallible.

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S Afr Fam Pract 2014;56(1)(Suppl 1):S14-S16

Introduction

In 1522, William Tyndale published the first English translation of the *New Testament* from existing Greek, Latin and Ancient Hebrew sources. In his translation, Tyndale used the English word “physician” to capture the English meaning of the original Latin word, *medice*, used in the passage from the *Gospel of Luke*, 4:23: “Physician, heal thyself” (*Vicision heale thy selfe*).¹ This parable relays how Jesus returns to Nazareth anticipating criticism from his Jewish community, helping others in faraway places, but forgetting those in one’s own community. The moral of the story is that we should ensure that we are without fault before attempting to correct the faults of others.

Discussion

Doctors have an obligation, derived from an obligation to protect patients from harm, to take positive action if a colleague is impaired. The Health Professions Council of South Africa (HPCSA) is the professional body that is responsible for protecting the public’s health. It is “committed to the prevention, early identification, treatment and rehabilitation of impaired students and healthcare practitioners”.² The HPCSA ethical guidelines concerning the duty of a doctor to report impaired practitioners is examined in this article.³ This is followed by an overview of the regulations that relate to the impairment of students and practitioners.⁴ Then problems that doctors face, which may contribute to their impairment, will also be discussed. Finally, while supporting the ethical duty to report impairment, a suggestion is made that during medication education,

more emphasis should be placed on doctors recognising that they are human and fallible. This, and other systemic approaches, may assist doctors in distress.

What is impairment?

According to the HPCSA, “impairment” refers to “a mental or physical condition, or the abuse of, or dependence on, chemical substances which adversely affected a student’s or practitioner’s competence, attitude, judgment and performance”.⁴ Zabow suggests that the concepts of impairment, incompetence and unethical behaviour are each approached differently by different authorities, as well as by the HPCSA: “The impaired physician is unable to practise medicine with reasonable skill and safety because of physical or mental illness, or substance abuse, for example”.⁵ Without the requisite medical skills and effectual safe practice, there is a likelihood that an impaired practitioner will cause harm to patients, which would damage the patient, the particular practitioner and the medical profession.

The HPCSA’s ethical and professional rules concerning the reporting of impairment are clear. Rule 25 states:⁶

“(1) A student, intern or practitioner shall:

- (a) Report impairment in another student, intern or practitioner to the board if he or she is convinced that such student, intern or practitioner is impaired.
- (b) Report his or her own impairment or suspected impairment to the board concerned if he or she is aware of his or her own impairment, or has been publically

informed, or has been seriously advised by a colleague to act appropriately to obtain help in view of an alleged or established impairment.

- (c) Report any unprofessional, illegal or unethical conduct on the part of another student intern or practitioner".

There are occasions when impairment is blatantly obvious. It may reasonably be concluded that there is impairment if, for example, an anaesthetist consistently has pinpoint pupils, wears long sleeves to cover his arms, has been noticeably observed to suffer wide mood swings, has increasingly altered or illegible handwriting on medical records, signs out a progressive number of opiates and sedatives, and has observable tremors.⁷ However, if you work with a doctor who intimidates and bullies staff, uses abusive language and constantly makes derogatory statements about others while in professional practice, he or she is clearly troubled. Questions need to be asked: 'Is he or she currently experiencing difficult circumstances', a "moody individual" or an impaired practitioner? Zabow reminds us that subjective (as perceived by a given person) distress and impairment are two different things.⁵

One of the difficulties in reaching a definitive conclusion with regard to psychological impairment in a colleague is that those who may be suffering from it "often have difficulty acknowledging they are susceptible, while addiction and depression are as common in healthcare providers as they are in the general population."⁸ Even raising the question may be difficult. A report in the *Journal of the American Medical Association* states that "the stigma against physicians with depression is a strong disincentive for obtaining treatment".⁸ It is common for doctors to be portrayed as almost superhuman in their stamina, dedication and resolve. It is also emphasised in medicine practice that doctors should place the needs of their patients above all other concerns. While this is admirable, it also results in doctors denying that they or their colleagues may be in need of care. Moreover, suspecting that a colleague might be impaired, investigating it and concluding that it exists, acting to assist that colleague, and finally reporting a colleague's impairment to the HPCSA's Health Committee is a difficult and often uncomfortable task.⁹

The results of a 2010 study on perceptions, preparedness for, and experiences about, the reporting of impaired or incompetent colleagues, found that "64% (n = 1 120) of surveyed physicians agreed with the professional commitment of reporting physicians who are significantly impaired or otherwise incompetent to practise. Nonetheless, only 69% (n = 1 208) of physicians reported being prepared to effectively deal with impaired colleagues in their medical practice, and 64% (n = 1 126) reported being prepared to deal with incompetent colleagues. Seventeen per cent (n = 309) of the physicians had direct personal knowledge of

a physician colleague who was incompetent to practise medicine in their hospital, group or practice. Of those with this knowledge, 67% (n = 204) reported this colleague to the relevant authority ... and physicians working in hospitals or medical schools were most likely to report. The most frequently cited reason for taking no action was the belief that someone else was taking care of the problem [19% (n = 58)], followed by the belief that nothing would happen as a result of the report [15% (n = 46)] and fear of retribution [12% (n = 36)].¹⁰

An Australian postal survey on 2 564 practitioners reported that 26% of the responding doctors acknowledged having a condition that they felt needed medical treatment, but were reluctant to consult a medical practitioner.¹¹ There has been a tendency in the history of medicine for doctors to deny their own health issues.¹² Certain working conditions may act as triggers, highlighting health problems in practitioners. It is easy to understand that doctors may experience a great amount of frustration, particularly in hospitals that lack senior-level guidance and are under-resourced are underserved, as well as being deficient in functioning equipment and prone to staff dispiritedness. This is because they are unable to treat patients effectively and "to live up to their highest ideals".¹³ Working in such a system may give rise to feelings of abandonment, incompetence and frustration in doctors.¹⁴ This sense of helplessness can easily result in "compassion fatigue".

In a report by Daniels,¹⁵ Bushkin, a psychologist, distinguishes between the terms "compassion fatigue", "post-traumatic stress" and "burn out". "Compassion fatigue" is a new-age term for having experienced a traumatic incident and being unable to process that incident emotionally. 'Post-traumatic stress' has a diagnosis and involves, among others, vivid imagery and thinking about the event constantly. 'Burn out' is when someone is working 19 hours a day, does not eat well is not getting enough exercise. (The condition) does not have to have emotions involved".

Pfifferling and Gilley considered "compassion fatigue" as a form of burn out that expresses itself as a combination of physical, emotional and spiritual collapse, a definition that considered to adequately capture its meaning in family medicine practice.¹⁶ The problem is that compassion fatigue, if not identified and treated, may escalate and result in symptoms of severe mental strain such as poor concentration, increasing mistakes, apathy, guilt and depression.¹⁷ At the far end of this spectrum, doctors may turn to anti-social behaviour or drug and substance abuse to relieve their disillusionment. Doctors should not reject their own humanity. They are also susceptible to health problems. Moreover, the same ethical principles that guide the doctor-patient relationship, such as respect, confidentiality, informed consent and compassion, are applicable to the doctor as a patient.

The HPCSA reported 314 cases of impaired practitioners in South Africa as at 13 June 2013. Doctors accounted for 238 (75.8%) of the total.¹⁸ This figure represents an increase over the previous number of reported cases, and may be owing to greater awareness of the problem. If unaddressed, the "top seven stressors" as reported by the HPCSA, could contribute to impairment in South African medical students, interns and practitioners.

These stressors are:¹⁹

- Wealth expectations from society and family.
- Dysfunctional marriages and relationships.
- Work-related fear of failure and low self-esteem owing to inadequate training.
- Having an expensive lifestyle on a "relatively poor" salary.
- Pre-existing or new medical and mental problems.
- Long working hours in toxic conditions with inadequate resources.
- Increasing debt as a result of loans to finance lifestyle.

It is a formidable task to tackle problems such as they are sourced in personal lifestyle choices, societal perceptions of roles, institutional or system failures, current economics and individual financial management. Perhaps one of the first steps is greater recognition by doctors that professional competence and commitment allows for compassion not only for patients, but also for other professionals and themselves. Having greater empathy and recognising and taking action there is evidence of distress in colleagues may be first steps towards erosion of the myth that doctors are infallible.²⁰

Conclusion

More emphasis should be placed in medical education on doctors recognising that they are human and fallible. Ethical practice norms should include the transformation of professional attitudes, awareness by doctors of their situation and challenges pertaining to their humanness, as well as changes in institutional policy that encourage doctors to seek help. In such ways, the medical profession can seek to ensure that its members are optimally competent before they attempt to cure others.

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