

## Addressing Impairment in a Colleague

NORMAN A. CLEMENS, MD  
MARC HORWITZ, MD  
JANET SHARP, MA, LPCC-S

**It is an anguishing experience for a professional community to deal with a colleague's impairment. This column is the outgrowth of a recent workshop in a multidisciplinary psychoanalytic center focused on the ethical, technical, and humane dimensions of that situation. A hypothetical case history was used to stimulate discussion of issues related to clinical evidence of impairment, protection of patients/clients, the role of aging in observers as well as the observed, denial and wishful thinking that may delay intervention, how to intervene, and duties imposed by the various health professional licensing boards. The discussion also focused on the effects of impairment and intervention on confidential psychotherapeutic relationships and process as well as on personal friendships, monitoring colleagues dealing with impairments, and the resources for response within the professional community such as assistance and ethics committees.** (*Journal of Psychiatric Practice* 2011;17:53–56)

**KEY WORDS:** therapist impairment, aging, denial, licensing boards, ethics, assistance programs, confidentiality, psychoanalysis, psychotherapy

Few things cause more consternation and reluctance to act in a professional community than emerging evidence of impairment in a colleague. Often it becomes evident through observations by other professionals or their support staff, but sometimes it appears when a distressed patient reluctantly comes forward to report concerns. Unfortunately the first confrontation may be a complaint about an alleged ethical violation or a complaint to a state licensing board.

One response from the health care professional associations has been to create assistance committees that can deal with problems at an earlier stage, both to reduce the harm to patients and to avoid disastrous complications for the impaired professional. But interventions may be painful and difficult. They call for discretion and concern for the rights and wel-

fare of all of the parties concerned. Ethical issues arise about the interventions themselves—and about the failure to intervene.

Health care professionals, particularly those who work with mental health problems, need to be forewarned and forearmed to deal with the subtleties of detecting and dealing with impairment. Since no one is immune from impairment, professionals also need to be attuned to the signs of personal difficulty and how to get help in dealing with it. In order to meet this need, the Ethics Committee and the Patient and Colleague Assistance Committee (PCAC) of the Cleveland Psychoanalytic Center have organized workshops for its members and students, with visitors from other centers, entitled “Real-Life Worries in Clinical Practice: Ethical Challenges for the Psychotherapist.” In November, 2010, the workshop dealt with addressing impairment in a colleague. The proceedings seemed worthy of sharing with other colleagues. The format was to present a detailed, strictly hypothetical case study and then open the floor for discussion by the assembled psychoanalysts and psychotherapists. Over the course of the discussion, the myriad complexities of the situation came to light. An account of the discussion and some comments by the authors follow the case study.\*

---

\*Dr. Horwitz was the author of the case study. Ms. Sharp was the scribe for the discussion, with her notes being projected on a screen as she wrote them. She summarized the discussion for this paper. As chair of the Ethics Committee, Dr. Clemens was the moderator for the discussion, with the participation of Murray Goldstone, M.D., chair of the Patient and Colleague Assistance Committee.

Dr. Clemens is a Clinical Professor, Dr. Horwitz is an Assistant Clinical Professor, and Ms. Sharp is a Clinical Instructor in the Department of Psychiatry of the Case Western Reserve University School of Medicine. All are on the faculty of the Cleveland Psychoanalytic Center, Cleveland, Ohio.

The authors wish to acknowledge the other members of the Ethics Committee and the Patient and Colleague Assistance Committee of the Cleveland Psychoanalytic Center for their extensive contributions to the planning and implementation of this workshop.

DOI: 10.1097/01.pra.0000393845.56217.69

# Psychotherapy

## Case Study

Dr. Noble was concerned about his friend and psychoanalytic colleague of over 35 years, Dr. Elder. Several months earlier, Dr. Elder had become light-headed while driving home from his office. He barely managed to pull over to the curb. After 3 days in the hospital, his doctors determined that he had suffered a transient ischemic attack (TIA). This condition often progresses to a stroke. Fortunately Dr. Elder's symptoms cleared. He was prescribed a blood thinner and, to Dr. Noble's knowledge, there were no further episodes.

Dr. Elder's wife had recently confided to Dr. Noble's wife that Dr. Elder had become more irritable, especially if he forgot someone's name, or couldn't find his keys, which was happening more frequently. Dr. Elder was having trouble sleeping, adding a glass of wine at bedtime to his usual before-dinner martini. On several occasions, he had awakened in the middle of the night to check the house for intruders. He told his wife that, if he heard noises again, he was going to call the police to patrol his house. His wife, who heard nothing on those occasions, became alarmed.

Dr. Noble reflected that Dr. Elder seemed to age after his TIA. Did Dr. Elder have trouble finding his words sometimes, or was Dr. Noble looking too hard for changes in his friend? Dr. Elder had told him that he was thinking of not accepting new referrals for analysis, and might even cut down his office practice to 3 or 4 days a week because he was "tired all the time." Dr. Noble had to admit that he too was more fatigued at the end of the day and had been aware of having less energy for the past few years. He chuckled, with some relief, that Dr. Elder seemed as sharp and shrewd as ever at their poker game every other week.

However, 2 days earlier, Dr. Noble's relief vanished. His phone rang at 7:15 Saturday morning. It was Dr. Elder "Have you left yet? I'm at the Q [pro basketball arena] waiting for you. I can't figure it out—no one's here. The box office isn't even open yet. Did they cancel the game?" Dr. Noble stifled his apprehension. "It's still morning," he said. "The game's tonight. I'll see you then. Go on back home." "You're kidding," responded Dr. Elder "God, what was I thinking? Sorry—did I wake you up? I must be having a senior moment," he said sheepishly. After hanging up, Dr. Noble reluctantly decided to call Dr.

Wise, current chair of their Psychoanalytic Center's PCAC, to discuss his concerns about his longtime friend.

Dr. Wise was not surprised at Dr. Noble's call, and they agreed to meet later that week. Dr. Wise had also noticed Dr. Elder's aging. Through his administrative responsibilities, Dr. Wise had learned that Dr. Elder had not paid his dues to the Psychoanalytic Center for over a year, despite gentle reminders, and was the only member in arrears. Two incidents had particularly concerned Dr. Wise. About a year ago, he had received a call from one of Dr. Elder's analysands [analytic patients], who had been referred by the Center staff when she called about her concerns about her analyst. The analysand complained that Dr. Elder had been falling asleep during her sessions—she could hear his rhythmic breathing and occasional snoring during part of their sessions at least two or three times per week. She was angry and frustrated and wondered if she should be referred to another analyst. She did not wish to file a formal complaint, nor did she wish to meet directly with Dr. Wise to discuss her situation in more detail, preferring to preserve her privacy. Not wishing to further complicate what could be already complicated transference/counter transference issues, Dr. Wise discussed hypothetical possibilities for the patient and told her it would be up to her entirely as to how much of their conversation, if any, she should share with Dr. Elder. Dr. Wise said he would be available if she wished to contact him again, but he had not heard from her since.

A second incident had occurred 2 weeks earlier. The Center secretary, who was also the acting librarian, had told Dr. Wise that she had reminded Dr. Elder of several overdue books, when he had dropped in at the Center's office. A candidate [analyst in training] had been asking for one book in particular so would Dr. Elder mind returning it as soon as he could? Dr. Elder, whose manner was ordinarily courteous, even charming, surprised her by bristling resentfully. He told her he did not appreciate being "blindsided" by her insinuation, that he was very scrupulous about borrowing and returning books, and that she should double check her records. He was sure the books would turn up on the shelves. Two days later when their paths crossed again, she told him she had double checked her records, and the shelves, and detailed the books that were checked out in his name: two for over 6 months and

two for over a year. She was sure Dr. Elder looked puzzled for an instant when she told him she had double checked her records. He quickly recovered, smiled at her warmly, said, "Hmm... thank you." Then he walked away.

Dr. Wise thought ahead to the upcoming meeting with Dr. Noble, about their likely troubled colleague, Dr. Elder.

## Discussion

The hypothetical case of Drs. Elder, Noble, and Wise is one that will strike a familiar chord for many readers, as it did for participants in the Cleveland workshop. There are many reasons for which a psychotherapist's professional functioning may be compromised, such as illness in the therapist, mourning, and other personal pre-occupations, but the deleterious effects of aging in oneself and one's colleagues are facts of which the entire professional community must be aware.

If polled, how many therapists and their patients could answer affirmatively that they have perceived or suspected cognitive decline in their colleagues, their own therapists, or themselves? How many have side-stepped their own concerns to avoid the anxiety, scrutiny, and social, organizational, and political disturbances that could ensue from voicing their observations?

Perhaps more than physicians in other specialties, psychiatrists, as well as psychotherapists from the behavioral sciences, practice in relative isolation, within the confines of the consulting room. This circumstance creates a special burden for the practitioner to self-monitor for impairment of all degrees, and for the professional community to maintain a frank yet compassionate milieu in which impairment can be recognized and addressed, preventing or at least minimizing harm.

How successfully did the doctors in our case study bear their respective responsibilities to each other, to the larger professional community, to the patient who complained, and potentially to other current and future patients who may or may not possess the courage to speak up? How noble, and how wise, were the so-named doctors? What dilemmas and pitfalls befell them, and how might we benefit from their experiences?

An informal analysis of perspectives voiced at the ethics/PCAC workshop showed that mistakes were

made in two spheres: objectivity about signs of Dr. Elder's impairment and the choice of actions in response. First, both Dr. Noble and Dr. Wise observed evidence of mental decline in their colleague that both were reluctant to admit. Dr. Noble seemed to have a watchful eye trained on his long-time friend after the TIA but relaxed his vigilance when Dr. Elder's health stabilized. When, a few months later, Dr. Elder's wife confided ongoing concerns to Dr. Noble's spouse, Dr. Noble was confronted with new cause for concern. This time, Dr. Noble doubted his interpretation of events and rationalized that fatigue was normal for their age, and that his friend's mental fog was an exception to his clarity in other situations.

How severe do warning signs need to be to warrant alarm, he may have asked himself, and how might "reporting" Dr. Elder affect their relationship? Isn't every mature adult forgetful and tired at times? Dr. Noble recognized these phenomena within himself. He avoided speaking with the PCAC chair, Dr. Wise, until evidence of Dr. Elder's dementia was irrefutable.

The participants were left to speculate whether Dr. Noble had contemplated first approaching his friend carefully and directly. Might he have learned that Dr. Elder was aware of his impairment and amenable to the understanding and counsel of a dear colleague and friend? How might any of us react to growing awareness of cognitive decline, and how much impairment is too much to maintain a psychiatric or psychotherapy practice? How does one's relationship with the probably impaired colleague influence the course of action or inaction? What degree of certainty is needed to initiate a conversation with a colleague or an assistance committee such as the one chaired by Dr. Wise?

The consensus in Cleveland was that Dr. Wise unwisely postponed taking steps to protect the public from harm. Dr. Wise wasn't surprised by Dr. Noble's call because he was aware that signs of possible impairment in their colleague had been mounting. The first and most critical red flag was a call about a year earlier from a patient who was seeing Dr. Elder several times a week. Frustrated and angered by Dr. Elder's frequent sleeping during her sessions, she inquired about changing analysts, but Dr. Wise, "not wishing to further complicate...transference/counter transference issues," in essence conveyed that she would be on her own to work things

# Psychotherapy

out with her analyst. We infer from the case report that he had additional rationales, or rationalizations, for doing nothing: The patient declined to file a formal complaint, and to protect her privacy she didn't want to meet face-to-face with Dr. Wise. Although he invited her to call again, if she so wished, is it any wonder that he never heard from her again?

Many in the Cleveland group thought that Dr. Wise's response constituted, at best, a lost opportunity and a failure to grasp the essential nature of the committee that he chaired. A PCAC (of the type that the American Psychoanalytic Association encourages in its member institutes) is designed to assist patients and their therapists before alleged infractions reach the level of a complaint to an ethics committee or a state licensing board. No formal complaint is required to initiate a confidential and often excruciatingly sensitive discussion within the PCAC about problems that are alleged. In this case, Dr. Wise deprived himself, the committee, and the patient of the benefit of the committee's collaboration. Instead, he decided in isolation that the best approach was not to get involved in the patient's misery.

The potential for the patient to feel that she had been rebuffed and that her suffering had been discounted was high. Because Dr. Elder's drowsiness was symptomatic of an increasingly incapacitating dementia, there was little reason to suspect that the patient was simply acting out issues from the transference, and little hope that the problem could be worked through with her analyst. We can only surmise what became of the patient's analysis, as well as the treatment of Dr. Elder's other patients, as he slipped further into decline. These sad scenarios, although fictional, probably mirror actual occurrences more often than we would like to believe.

Had Dr. Wise been wiser, he might have thanked the patient for expressing her concerns and informed her that the PCAC existed for the purpose of considering problems such as the one she reported. He might have told her that he would like—or perhaps

that it was his duty—to consider the situation with them without disclosing her identity. With her permission, he would follow-up by phone in a few weeks, but, if she wished, she could contact him again in the interim. It is within the purview of an assistance committee to contemplate and propose solutions to difficult situations. It is in no one's interest that such committees dismiss patient complaints as the result of transference enactments. Both committee chairs and members are on shaky ground if they infer the degree of a colleague's impairment, if any, without considering the evidence. The pooled wisdom of individuals charged with providing assistance can be an invaluable resource.

The true-to-life, fabricated case of Drs. Elder, Noble, and Wise perhaps raises more questions than it answers, but the exercise of identifying those questions and proposing solutions was felt to be a worthwhile endeavor for workshop participants. Early in the discussion, the irony of the surnames Noble and Wise surfaced. Was Dr. Noble truly noble, or did he merely strive to think clearly and act responsibly in a personally painful situation? And how wise was the doctor by that name? The collective wisdom was that his well-intentioned decision not to take Dr. Elder's patient's complaint to the PCAC was an error that may have proved costly to the patient and presumably others who were unable to complain.

The varied pathways to supporting impaired colleagues and protecting their analysands, psychotherapy patients, patients' families, supervisees, and students from harm are paved with potential pitfalls having to do with the imperfect lens through which we view ourselves and our peers. Awareness-raising exercises, such as the Cleveland Psychoanalytic Center regularly conducts, highlight some of the knottier issues associated with impairment, illustrate the respective functions of assistance and ethics committees, and cultivate a milieu in which real-life concerns can be sensitively addressed as they arise.