

the REPORTER

CME: THE MANY FACES OF PHYSICIAN IMPAIRMENT

CLOSED CLAIM STUDY: FAILURE TO TREAT
PREGNANCY-INDUCED HYPERTENSION

CLOSED CLAIM STUDY: FAILURE TO DIAGNOSE
IMPENDING MYOCARDIAL INFARCTION



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CONTINUING
MEDICAL
EDUCATION

CME: THE MANY FACES OF PHYSICIAN IMPAIRMENT

by Brian S. Sayers, MD



OBJECTIVES

Upon completion of this educational activity, the learner should be able to:

1. identify common causes of physician impairment;
2. review statutory requirements for reporting impaired practitioners; and
3. discuss risk management considerations when observing a potentially impaired physician colleague.

COURSE AUTHOR

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DISCLOSURE

Brian S. Sayers has no relevant financial relationship(s) with ineligible companies to disclose. TMLT staff, planners, and reviewers have no relevant financial relationship(s) with ineligible companies to disclose.

TARGET AUDIENCE

This 1-hour activity is intended for physicians of all specialties who are interested in learning more about physician impairment, including how to recognize signs of physician impairment and how to appropriately help a potentially affected colleague.

CME CREDIT STATEMENT

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This course has been designated by TMLT for 1 credit in medical ethics and/or professional responsibility.

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RELEASE/REVIEW DATE

This activity is released on March 1, 2026 and will expire on March 1, 2029. Please note that this CME activity does not meet LSA's discount criteria. Physicians completing this CME activity will not receive a premium discount.

INTRODUCTION

Our work as physicians to deliver effective care for patients depends on many factors — knowledge, experience, compassion, kindness, and fidelity are merely a few. But just as importantly, our effectiveness also depends on our own physical and mental health. “Physician impairment” occurs when a physician has a condition that interferes with their ability to safely practice medicine and effectively care for patients.

Causes of physician impairment include physical or mental health illness, cognitive problems, or substance use disorder (SUD). Unfortunately, reliable data on the frequency of physician impairment is lacking, but likely significantly higher than seen in published estimates.

These studies are subject to predictable limitations. They may rely on self-reporting, limited sample size, specific regional or specialty sampling, or they may be derived from disability insurance carriers that rely on historical claims data from a select population of covered individuals. Most of all, impaired physicians often go to great lengths to conceal their impairment.¹

We, as physicians, are uniquely at risk of impairment. Our work is stressful, often involves long hours, and can be isolating. By nature and by training, we are perfectionists and may exhibit obsessive-compulsive tendencies. We may also be less likely to admit difficulties or seek help. As physicians, we also have unique access to substances that can cause impairment, trigger addictive behaviors, and damage our health.

Impaired physicians often fail to acknowledge or seek help for impairment for fear of damage to their reputation, or of dire consequences from the organizations they work within or are licensed and credentialed by.

In this article, we will discuss the most common causes of impairment: substance use disorders, physical impairment, cognitive impairment, and mental health issues. We will also review statutory requirements for reporting impaired practitioners, as well as cover some risk management considerations when observing a potentially impaired physician colleague.

WHAT IS PHYSICIAN IMPAIRMENT?

The American Medical Association (AMA) defines an impaired physician as someone “unable to practice medicine with reasonable skill and safety to patients because of physical or mental illness, including deterioration through the aging process or loss of motor skill, or excessive use or abuse of drugs including alcohol.” This definition, based on the landmark 1973 article, “The Sick Physician,” emphasizes a range of causes of impairment as well as the ultimate goal: to ensure that patients are cared for by physicians with reasonable skill and safety.²

The Texas Occupations Code, section 160.003, defines an impaired physician as one who “poses a continuing threat to the public welfare through the practice of medicine.” It is important to carefully consider the wording of this definition. It does not state that physical, mental, behavioral, or substance use disorders, per se, constitute physician impairment as defined here.³

This distinction can be particularly nuanced as certain conditions that are either well controlled or irrelevant to a practitioner’s specialty may not constitute impairment. For example, a physician with a significant tremor might not be able to safely perform surgery or other procedures but may safely perform in a specialty that is primarily cognitive and not procedure based. Or a physician with SUD who is currently being closely monitored or who has demonstrated a long history of successful recovery (sobriety) is able to safely practice medicine.

THE ROLE OF STATE AND COUNTY MEDICAL BOARDS, SOCIETIES, AND PROGRAMS

State medical boards are charged with protecting the public’s safety, in part by identifying and responding to medical practitioners who may pose a continuing threat to the public. Their role is primarily investigative and disciplinary. State medical boards also screen those applying for licensing or pursuing important educational

and rehabilitative goals. More recently, these boards have also directed their attention and resources to issues related to physician wellness and burnout.

Physician health programs (PHPs) were established in the 1970s to address physician impairment at its earliest stages; to preserve or restore an affected practitioner's ability to practice medicine safely; and to protect the public.

The Federation of State Medical Boards notes that, "The purpose of a physician health program is to guide the rehabilitation of potentially impaired and impaired physicians, other licensed healthcare professionals, or those in training suffering from substance use disorders, psychiatric, medical, behavioral or other impairing conditions, including burnout, consistent with the needs of public safety. This involves the early identification, evaluation, treatment, monitoring, documentation of adherence, and advocacy, when appropriate, of licensees with potential impairing illness(es), ideally prior to functional impairment."⁴

While PHPs function to primarily protect public safety, they do so by empowering physicians to help themselves to restore their own ability to practice medicine safely; protect their medical license and livelihood; and provide a monitoring framework that is effective in achieving these goals. Through a PCP structure, physicians reach these goals while maintaining their dignity, confidentiality, and legal rights.

For example, the PHP in Texas operates under the jurisdiction of the Texas Medical Board (TMB). In most circumstances, physicians with impairments who comply with their PHP contract and monitoring program are protected from TMB disciplinary actions.

Practitioners may be referred to a PHP for required monitoring by a state medical board, or may self-refer, in which case the impairment is generally not reported to the medical board as long as the physician remains in compliance with their PHP contract. Colleagues, health care organizations, or the public may also report concerns to a PHP through a simple reporting process generally available on PHP websites.

In most states, including Texas, reporting a physician to a PHP is confidential, with the identities of the reported physician and the reporter being protected. Texas law protects this information, and it is not subject to public disclosure under the Texas Public Information Act. However, this information may be disclosed under certain legal circumstances or actions, such as in a disciplinary hearing.^{5, 6}

While a PHP facilitates and monitors physician recovery, they do not provide the actual care nor do they prescribe medications. PHP contracts consist of a multifaceted, proven, peer-based program to support success in long-term recovery, protect the physician's ability to practice, and ensure public safety.

In many larger counties, **county medical societies** may offer **Physician Health and Rehabilitation Committees** that support their local colleagues facing impairment challenges, most of whom are under contract with a PHP. These committees typically focus on meeting and developing ongoing supportive relationships with colleagues under PHP contract; provide advocacy and real-time support to complement their colleagues' work with the PHP; and offer important information to the PHP on their colleagues' ongoing recovery efforts. These committees also serve as an accessible local resource for reporting or self-reporting potential impairments to a PHP or, less commonly, to a state medical board.

COMMON PHYSICIAN IMPAIRMENTS

Substance use disorder (SUD) is the most common form of reported physician impairment. SUD includes issues with alcohol and illicit and prescription drugs, including medications generally limited to use in hospitals or other medical care facilities. SUD often occurs in combination with other mental health conditions, complicating diagnosis and treatment.

The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), published by the American Psychiatric Association, defines SUD as a problematic pattern of substance use leading to clinically significant impairment or distress. It is diagnosed when at least two of 11 specific criteria are met within a 12-month period.

These criteria are grouped into the four main categories, with severity rated at three levels depending on how many criteria are present:

1. impaired control:
 - taking the substance for long periods or in larger amounts than intended;
 - being unable to cut down or stop substance use despite a desire to do so;
 - spending excessive time to obtain, use, and recover from the substance;
 - experiencing intense cravings, desires, or urges for the substance;
2. social impairment:
 - failing to fulfill major obligations at work, school, or home;
 - continuing to use the substance despite it causing social or interpersonal problems;
 - reducing or abandoning social, occupational, or recreational activities because of substance use;
3. risky use:
 - using the substance in physically hazardous situations;
 - continuing substance use even when aware it is likely causing or worsening a physical or psychological problem;
4. pharmacological criteria:
 - developing a tolerance to the substance, so that taking more of the substance is necessary to achieve the same desired effect; and
 - experiencing withdrawal symptoms when substance use stops.^{7, 8}

Conservative estimates hold that 8 to 12 percent of physicians will have significant issues with SUD at some point in their career. Certain medical specialists are more likely to be reported for SUD, including anesthesiologists, emergency medicine physicians, and psychiatrists.

Alcohol is the most abused substance among physicians, usually reported to be similar to the general population. Physicians have higher rates of prescription drug abuse, particularly benzodiazepines and opioids, compared with the general population. This is because of the common practice of self-treatment and the ease of access to many drugs.^{9, 10, 11}

Several factors have been identified as putting physicians at risk for development of SUD.

- **Family history** — almost three-fourths of physicians with SUD report a family history of addiction.
- **Comorbid psychiatric disorders** — must be seriously considered when assessing risk of suicide and tailoring a treatment program.
- **Work-related factors** that can include burnout, stress, long hours, or recent clinical errors.

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- **Non-work-related factors**, such as relationship difficulties, financial problems, social isolation, or a history of trauma.¹¹

Female physicians with SUD appear to have higher rates of comorbidities; however, they appear to show less impairment on medical and legal functioning than their male counterparts. According to a Mayo Clinic study, 87 percent of physician subjects enrolled in a PHP were male. Male physicians are also more likely to be referred for treatment or disciplinary action.^{11, 12}

RECOVERY SUCCESS RATES

Some good news is that physicians with SUD who undergo treatment by a PHP are more likely than the general population to reach and sustain recovery. One study of physicians who completed a typical five-year, PHP-styled program showed that 78 percent of participants maintained their licenses and were working. Only 11 percent of these physicians had their licenses revoked.¹³

Successful recovery at five years in PHP programs has been cited in the 75-95 percent range.¹⁴ A five-year PHP contract typically includes the following components:

- assessment of the presence of SUD and comorbid conditions;
- inpatient or, less commonly, intensive outpatient programs for initial treatment;
- “frequent, random, robust, and prolonged urine testing,” or other monitoring;
- ongoing care from a physician with expertise in addiction medicine;
- ongoing counseling and/or psychiatric care when indicated;
- worksite monitor, or a designated colleague who is willing and able to report their observations of the physician to the PHP; and
- participation in a peer-supported recovery program. Alcoholics Anonymous is a longstanding evidence-based program most often used, but other established options such as SMART, Recovery Dharma, or Women for Sobriety are popular and well regarded.

COGNITIVE IMPAIRMENT

Recognizing and overseeing cognitive impairment in physicians — especially aging physicians — is concerning and highly controversial. Numerous high-profile, non-medical professions have mandatory retirement ages, such as airline pilots, air traffic controllers, certain state and federal judges, and federal law enforcement officers, including the FBI.

Some countries have mandatory retirement ages for physicians, most typically surgeons. This may not entirely be based on cognitive concerns. Instead, mandatory retirement ages may exist to manage the health care workforce and promote career advancement for younger physicians and new graduates.

No large scale, federally mandated retirement age or age-based cognitive testing for U.S. physicians currently exists. However, as our general and physician populations age, the issue of cognitive health in physicians is gaining increased attention.

The Age Discrimination Employment Act (ADEA) protects most physicians from a mandatory retirement age, while the Americans with Disabilities Act (ADA) may provide some statutory roadblocks to routine age-related cognitive testing. In 2018, based on a complaint from a physician, the Equal Employment Opportunity Commission charged Yale New Haven Hospital with a violation in requiring medical staff members over age 70 to complete cognitive testing to maintain privileges.

Rather than mandated requirements that face legal hurdles, it seems more likely that organizations will adopt a policy of voluntary, recommended assessments. The American College of Surgeons has issued guidance recommending a “comprehensive, lifelong assessment program inclusive of all physicians” to “create a culture of safety, equity, and transparency in monitoring potential declines that could affect surgeon competency.”¹⁵

Physicians are not immune to age-related cognitive decline. Yet, within our realm of highly specialized training, experience, and deeply embedded knowledge, it may be more difficult to identify without formal testing. One study looking at cognitive testing in six hospitals showed that cognitive impairment was observed in 14.4 percent of practicing physicians over age 70.¹⁶

A separate study showed “a decline in cognitive functioning of older physicians detectable at about 60 years, which is 10 years later than in the general population. This is likely due to physicians’ higher educational level and intellectually demanding occupation, factors that increase and maintain cognitive reserve.”¹⁷

Further complicating the issue of physician cognitive impairment is the obvious recognition that there are numerous non-age-related causes of cognitive compromise, such as physical health, lifestyle factors (poor diet, lack of exercise), environment, social, and mental health conditions, like depression or anxiety.

DISRUPTIVE BEHAVIOR

As defined by the AMA, disruptive physician behavior is speaking or acting “in ways that may negatively affect patient care, including conduct that interferes with the individual’s ability to work with other members of the health care team, or for others to work with the physician.”¹⁸ It is a pattern of behavior that can manifest as passive-aggressive, aggressive, intimidating, or bullying behavior that can disrupt effective patient care by affecting the cohesive functioning of the health care team; the individual performance of those on the receiving end of the behavior; or the effectiveness of the offending physician.

Disruptive behavior is often driven by impulsive and maladaptive expressions of underlying personality traits or disorders. The most encountered personality disorder traits among physicians are narcissism, obsessive-compulsiveness, and antisocial personality disorder.¹⁹ But these individuals may actually represent a minority of those exhibiting disruptive behaviors, a fact that must be carefully considered by health care organizations, state medical boards, or PHPs when making care decisions regarding these individuals.

A study from the Professional Assessment Program at Abbott Northwestern Hospital found disruptive behaviors were caused by personality disorders or traits in 27 percent of physician subjects; 78 percent had a primary psychiatric disorder, most often depression (40 percent) or SUD (27 percent). Other researchers noted a significant number of subjects having one or more psychiatric disorders (20 percent) or both psychiatric and personality disorders (50 percent).^{20, 21, 22}

Disruptive physician behavior has been increasingly recognized as a threat in recent years. Particularly in the hospital setting. Nurses, physician colleagues and other members of the health care team have become empowered to report disruptive behaviors based on clear policies emphasized by hospital systems and efforts to nurture a culture of intolerance toward such behavior.

Numerous programs have been developed to evaluate and treat physicians exhibiting disruptive behavior in both inpatient and intensive outpatient settings. These physicians, especially those with co-morbid conditions, may be referred to a PHP or state medical board for rehabilitative monitoring similar to physicians with SUD.

PHYSICAL IMPAIRMENT

Like their patients, physicians are also prone to medical conditions that can cause physical limitations or disability during their professional lifetime. Most of these illnesses or conditions do not significantly impair a physician's ability to practice safely and effectively. Relatively benign conditions may affect one physician's work significantly, while severe disability in another physician may not preclude continued safe practice in their specialty.

Insurance industry data suggests that one in four physicians will file a disability claim at some point before retirement. It is difficult to translate this data across the board to uninsured physicians where under-reporting may make accurate estimates impossible.

Employed physicians are afforded the same protections under the ADA as any other employee in terms of non-discrimination and reasonable accommodations. Yet, there may be tension between these protections and ensuring that the physician is not impaired in a way that reasonable accommodations cannot address.

IMPAIRMENT FROM MENTAL HEALTH CONDITIONS

While certain mental health conditions are reported to be more prevalent in the physician population, reporting bias brings this conclusion into question. While physicians are susceptible to the same spectrum of mental health illnesses as the general population; physicians experience them with higher frequency beginning early in their training. Physicians also have significantly higher rates of suicide.

In spite of these high numbers, physicians are reluctant to seek help for a variety of reasons. One study shows that 40 percent of physicians state that they would be unwilling to seek help for psychiatric illness due to concerns about licensing issues.²³

There are many reasons why this stigma persists for physicians. Fortunately, in recent years with the physician wellness movement, there has been improvement on many fronts. State licensing boards and hospital medical staff credentialing processes have almost universally done away with intrusive, personal, and largely irrelevant questions used in the past. Questioning is now similar to what is found on Texas Medical Board applications (registration and renewal).

"Are you currently suffering from any condition for which you are not being appropriately treated that impairs your judgment, or that would otherwise adversely affect your ability to practice medicine in a competent, ethical, and professional manner?"²⁴

Recognizing the importance of easily accessible and confidential mental health services, many state and county medical societies have created free or low cost, confidential counseling programs for physicians. Along with most hospital systems and large medical practices, they have also emphasized establishing an open dialogue about receiving help for mental health conditions as a normal part of maintaining health and professional effectiveness.

REPORTING REQUIREMENTS

While the issue of reporting impaired physicians is complicated, the actual reporting is not. Physicians have both an ethical obligation and, in Texas, a legal requirement, to report colleagues who are impaired. Requirements may vary by state. Ethical obligations are found in Opinion 9.031 of the AMA Code of Medical Ethics' Opinions on Physicians' Health and Conduct. It states:

“Physicians have an ethical obligation to report impaired, incompetent, and/or unethical colleagues in accordance with the legal requirements in each state and assisted by the following guidelines:

Impairment. Physicians' responsibilities to colleagues who are impaired by a condition that interferes with their ability to engage safely in professional activities include timely intervention to ensure that these colleagues cease practicing and receive appropriate assistance from a physician health program. Ethically and legally, it may be necessary to report an impaired physician who continues to practice despite reasonable offers of assistance and referral to a hospital or state physician health program. The duty to report under such circumstances, which stems from physicians' obligation to protect patients against harm, may entail reporting to the licensing authority.”²⁵



Chapter 60 of the Texas Occupations Code delineates statutory reporting requirements. “A person or committee subject to this section shall report relevant information to the board relating to the acts of a physician in this state if, in the opinion of the person or committee, that physician poses a continuing threat to the public welfare through the practice of medicine.” When reporting a colleague to the TMB or PHP, the identity of the reporter is kept confidential.²⁶

Beyond ethical and legal reporting obligations, physicians or medical organizations in which they practice may face civil liability if they fail to recognize obvious impairments or fail to report or act on this knowledge.

To report a colleague showing signs of impairment, you may choose to seek advice or assistance from your county medical society, Physician Rehabilitation Committee, or your medical practice or hospital leadership. In some scenarios, physicians or medical practices should consult an attorney for additional guidance.

RISK MANAGEMENT CONSIDERATIONS

Recognize signs and symptoms of physician impairment

It is important for health care professionals to be able to identify signs and symptoms of physician impairment to help prevent injury to patients.

Signs and symptoms of SUD that may be seen in physicians include:

- inaccessibility to patients and staff;
- completing rounds at odd hours;
- decreased chart performance and documentation errors;
- ordering large quantities of drugs;
- issuing inappropriate orders or prescriptions;
- forgetting oral orders;
- slurred speech during off-hour phone calls;
- heavy drinking at hospital or office functions;
- multiple prescriptions for family members;
- arriving late to work or for appointments;
- leaving work early;
- increased absences, sick leave, and unexplained disappearances during work hours;
- increased patient complaints;
- increased secrecy;
- decreased productivity;
- decreased quality of care;
- increased conflicts with colleagues;
- vague letters of reference; and
- erratic job history that includes new jobs in different locations and unexplained time off between jobs.¹⁹

Prioritize the safety of patients and colleagues

If there is an immediate threat to patients and staff members, you may be required to refuse to allow the impaired physician to see patients, notify practice or organization leadership or administrator, or even call security if the situation is an emergency.

Documentation

If you see behaviors that are concerning, document them clearly and objectively. Keep detailed, factual records of specific events, including dates, times, behaviors observed, patient names, and your concerns for the safety of the patient and the physician or colleague.

Do not speculate in the record about the underlying cause of the individual's behavior. Avoid using non-medical terms, such as "alcoholic" or "acting crazy." Instead, use terms such as "had slurred speech" or "exhibited signs of excessive anger/confusion/anxiety."

Communication

In many situations, it may be best to avoid a one-on-one confrontation with a colleague you suspect is impaired. Even if you are comfortable having this conversation, out of concern and to encourage seeking help or self-reporting, this is a job for administrators or intervention specialists. Collegial support can be crucial but is best given with PHP supervision. Your role is to observe and report, not diagnose and treat.

Ensure that you report your concerns to the appropriate authority, according to your institution's protocols and your state's rules. This may include your department director, practice leadership, hospital administrator, medical chief of staff, or state PHP. Again, PHPs are designed to provide confidential help to impaired physicians while protecting patients and public safety.

It is also important to only discuss your concerns with appropriate individuals and institutions. Avoid talking to uninvolved colleagues, friends, or family members, as this may inadvertently expose your colleague to reputational harm — and expose you to potential legal action.

Again, if you are uncertain about how to proceed or to act, consult your county medical society, your practice or hospital leadership or an attorney.

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CLOSED
CLAIM
STUDY

FAILURE TO TREAT PREGNANCY- INDUCED HYPERTENSION

by Laura Hale Brockway, ELS, Vice President, Marketing

This closed claim study is based on an actual malpractice claim from Texas Medical Liability Trust. This case illustrates how action or inaction on the part of the physicians led to allegations of professional liability, and how risk management techniques may have either prevented the outcome or increased the physician's defensibility. This study has been modified to protect the privacy of the physicians and the patient.

PRESENTATION

A 41-year-old woman came to Ob-Gyn A for care during her second pregnancy. The patient was at 13 weeks of gestation at this visit.

The patient's history included chronic hypertension, obesity, and lupus anticoagulant syndrome. Seven years earlier, Ob-Gyn A performed a premature cesarean delivery on the patient due to pregnancy-induced hypertension (PIH).

PHYSICIAN ACTION

Ob-Gyn A noted that the patient's blood pressure was being managed by her primary care physician. The patient had been taking hydrochlorothiazide, but it was changed to labetalol and nifedipine due to her pregnancy. Ob-Gyn A also noted that the patient was on heparin and aspirin for lupus anticoagulant. At this visit, the patient's blood pressure was 142/94 mm Hg.

Ob-Gyn A referred the patient to a Maternal-Fetal Medicine (MFM) physician due to chronic hypertension and advanced maternal age. The patient's blood pressure continued to be elevated during her visits with the MFM physician, ranging from 126/86 mm Hg at 17 weeks to 142/94 mm Hg at 29 weeks.

An ultrasound at 29 weeks showed the fetus was in the breech position. The patient's blood pressure was slightly elevated at visits from 30 to 35 weeks. At 36 weeks, it was 150/96 mm Hg.

On the morning of June 3, at 36 weeks and four days, the patient was admitted for a cesarean delivery due to PIH. Ob-Gyn B, who was on call for Ob-Gyn A during admission, evaluated the patient for high blood pressure. The patient had been given 20 mg IV labetalol and Ob-Gyn B ordered an additional 40 mg and repeat BP in 10 minutes. The patient reported a stress headache, but denied blurry vision, shortness of breath, or right upper quadrant pain. Ob-Gyn B documented that pre-eclampsia labs were pending.

Ob-Gyn A performed a cesarean delivery the same day. There were no complications reported. The newborn's APGAR scores were 8 and 9.

In the first 24 hours after the cesarean delivery, the patient's blood pressure ranged from 80/93 to 172/100 mm Hg. She was seen by Ob-Gyn C, who restarted labetalol 200 mg/twice a day that had not been restarted after delivery.

During the second postoperative day, Ob-Gyn C's plan was routine care with discharge planning that included increasing labetalol to 300 mg and restarting enoxaparin. In response to the patient's increasing blood pressure, Ob-Gyn C started the patient on nifedipine. Her blood pressure range was 176/88, 172/100, and 171/88.

The patient was discharged on June 6 (postoperative day 3). Ob-Gyn C documented that the patient was in good condition and was instructed to follow up in two weeks for an incision check. Her discharge medications included nifedipine XL 90 mg two tablets by mouth for 30 days with two refills; labetalol 200 mg; and enoxaparin 40 mg daily for six weeks. The patient's blood pressure at discharge was 139/83 mm Hg.

The patient saw Ob-Gyn A on June 23 for a two-week postpartum check. The patient's blood pressure was not documented, and Ob-Gyn A said she tried to enter the BP values into the EMR system but was unable to.

At her six-week postpartum check on July 18, the patient saw Ob-Gyn C. The physical exam found no issues with her heart and lungs; no edema in extremities; and no tenderness or pain on abdominal or genital exam. The patient was told to return in one year for a well-woman exam. Her blood pressure was 128/78 mm Hg. There was no documentation that the patient was instructed to follow up with her primary care physician for management of her blood pressure and there was no mention of her blood pressure medication or that it was refilled recently.

Two weeks later, the patient was found unresponsive at home. EMS transported her to the emergency department of a large metropolitan hospital. Resuscitative efforts were unsuccessful and the patient died. The cause of death was listed as dilated cardiomyopathy associated with hypertensive cardiovascular disease.

ALLEGATIONS

A lawsuit was filed against Ob-Gyns A, B, and C. The allegations were failure to diagnose and manage the patient as a high-risk pregnancy due to chronic hypertension and pre-eclampsia and failure to treat the patient's hypertension in the prenatal and postnatal periods.

LEGAL IMPLICATIONS

The plaintiff's ob-gyn expert criticized the defendants for failure to diagnose and classify the patient as a high-risk pregnancy with chronic hypertension and severe superimposed pre-eclampsia. This expert claimed the patient should have been given magnesium sulfate before delivery and for a minimum of 24 hours after the delivery. Further, a cardiology consult should have been ordered and an echocardiogram obtained to determine the patient's cardiac function. The expert stated that failure to do so was a violation of the standard of care and led to cardiovascular decompensation resulting in cardiac arrest and death.

Defense experts who reviewed this case stated that the patient's death was the result of a sudden cardiac event that could not have been predicted. There was no evidence to suggest that the defendants failed to meet the standard of care. Ob-Gyn A promptly referred the patient to MFM and monitored her closely to ensure she was taking her blood pressure medications. The patient was treated appropriately in the hospital with blood pressure medications and delivery was timely and appropriate. The patient did not exhibit signs or report symptoms of pre-eclampsia and there was no reason to give magnesium sulfate or request a cardiology consult and echocardiogram. Further, the patient did not report any symptoms during the postpartum period that were consistent with cardiomyopathy or heart failure post cesarean delivery.

The defense of this case was challenged by documentation issues. Ob-Gyn A's notes contained numerous mistakes relating to the patient's medical history, including misidentifying the patient's anticoagulation condition and misstating the number of pregnancies. There was no documentation of the type of chronic hypertension the patient had. Ob-Gyn A also did not write an order after the delivery to restart the patient's blood pressure medications.

The hospital records did not indicate that the patient had a primary care physician, though Ob-Gyn A assumed the physician who had prescribed the patient's medications before her pregnancy was her PCP. There was no correspondence between this physician and Ob-Gyn A. There was no documentation that the patient was told to return to this physician after the delivery for management of her blood pressure medications.

Ob-Gyn A's clinic was using two separate EMR systems when the patient was seen for this pregnancy. This made it difficult to retrieve all the patient's records during the investigation of this case.

DISPOSITION

This case was settled on behalf of Ob-Gyn A. The case against Ob-Gyns B and C was dismissed.

RISK MANAGEMENT CONSIDERATIONS

The continuity of care in this case between Ob-gyns A, B, and C was severely impeded by poor documentation. If a case proceeds to trial, a jury might be unable to determine if physicians are in good communication if that communication is not properly documented, including recommendations, decisionmaking, and rationale.

The defense of this case may have been helped if the defendant physicians had followed the following documentation best practices:

- fully document all patient-provider and provider-provider communications, including prescription orders, test results, information shared, and decisions made;
- fully document informed consent discussions with the patient or the patient's guardian (was this patient informed and fully aware of the consequences of chronic hypertension during pregnancy and the importance of her medications and following up with her PCP?);
- maintain detailed records of all provider-to-provider consultations; the records in this case did not include the name or any consultation notes with the patient's PCP; and
- avoid using multiple EMR systems; if you are using more than one system (such as during a transition from one EMR to another), regularly audit and ensure that EMR records are synced and contain up-to-date and contemporaneous information. This may necessitate consulting with your EHR/EMR vendor or IT professional.

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CLOSED
CLAIM
STUDY

FAILURE TO DIAGNOSE IMPENDING MYOCARDIAL INFARCTION

by Wayne Wenske, Senior Marketing Strategist

This closed claim study is based on an actual malpractice claim from Texas Medical Liability Trust. This case illustrates how action or inaction on the part of the physicians led to allegations of professional liability, and how risk management techniques may have either prevented the outcome or increased the physician's defensibility. This study has been modified to protect the privacy of the physicians and the patient.

PRESENTATION

On Friday, September 2, a 57-year-old man came to his internal medicine physician's office on a walk-in basis. He reported waxing and waning chest pain for one week, with his last episode occurring that day at work. The patient denied being in pain at this visit. He was scheduled as the last patient of the day.

The patient's history included hypertension, hyperlipidemia, and uncontrolled diabetes. His father's history included a coronary artery bypass graft at age 43.

The patient — who had a 3-year history with the practice — had a mixed record of medical compliance. He often did not return for follow-up appointments and did not follow treatment recommendations to properly control his diabetes. He had previously been hospitalized for chest pain.

PHYSICIAN ACTION

The patient reported chest burning, squeezing, and tightness with diaphoresis and dyspnea to the clinic's physician assistant (PA). The patient said his symptoms were aggravated with exertion and relieved with rest. The duration of episodes had increased over the past week, lasting up to 15 minutes per episode.

The PA obtained an electrocardiogram (EKG) that showed the patient had a normal sinus rhythm with non-specific ST-T wave changes. The patient denied radiation of pain, palpitations, numbness, tingling, or any neurological deficits. He also denied a history of anxiety or acid reflux and stated that he had never experienced this pain before.

The PA recommended the patient go to the ED, but the patient declined because he wanted to go home to have dinner with his family. The PA ordered a chest X-ray and provided a referral to a cardiologist for a stress test. The patient was instructed to go immediately to the ED if he had another episode.

The next morning, the patient collapsed at home and his wife called 911. He was transported by EMS with CPR in progress to a local hospital. The patient died shortly after arriving at hospital.

The patient's internal medicine physician was asked to sign the death certificate. She signed and reported the patient's immediate cause of death as "diabetes mellitus with underlying causes of hypertension and hyperlipidemia."

The PA added the patient's September 2 visit notes and refusal to go to the ED to the patient's medical record on Monday, September 5.

ALLEGATIONS

A lawsuit was filed against the PA and the internal medicine physician. Allegations included failure to diagnose and treat an impending myocardial infarction (MI).

LEGAL IMPLICATIONS

Two internal medicine consultants who reviewed this case for the defense believed the patient came to the PA with symptoms suggestive of coronary ischemia. These symptoms, in addition to multiple cardiac risk factors,

should have led the PA to immediately refer the patient to the ED. Had the patient gone to the ED, he would likely have been admitted for a thorough cardiology evaluation; serial EKGs and cardiac enzyme testing; stress testing; and, if required, catheterization.

Consultants for the plaintiff were critical, expressing that this patient should have been immediately taken to the ED for evaluation. One consultant stated that the PA should have more forcefully informed the patient of the risks of noncompliance and insisted on emergent transfer to the nearest ED.

The PA testified that the patient was not experiencing chest pain during the visit, and the EKG was normal without any concerning ST changes to indicate either acute MI or unstable angina. However, this testimony was not supported by contemporaneous documentation.

The PA also testified that while the internal medicine physician was not at the office during the patient's visit, the physician was readily available and could have been easily reached if the PA had a question or concern about the patient.

The internal medicine physician testified that she was informed of the patient's death after the fact. Before signing the death certificate, she reviewed the patient's medical record and found it to be incomplete. The record was missing the visit notes from the Friday, September 2, office visit.

DISPOSITION

This case was settled on behalf of the PA. The case against the internal medicine physician was dismissed.

RISK MANAGEMENT CONSIDERATIONS

The defense of this case was compromised by the PA's failure to document the patient's visit on September 2. The PA's testimony, along with some expert opinions, suggested that the PA treated this patient appropriately and met the standard of care. Yet the PA failed to document the care provided when it occurred, which might have caused a jury to speculate on whether the defense was credible.

Had the patient's visit been fully, accurately, and contemporaneously documented, there would have been a clear record of what transpired between the patient and provider. In this case, the medical record was updated after the patient's death, which could lead those reviewing the record to question its validity.

In addition to the visit notes, it would have helped the defense if the PA had documented the patient's informed refusal or noncompliance with recommendations to go to the ED. As with informed consent, it is important to document when a patient refuses to follow a provider's professional recommendations or instructions.

When documenting informed refusal, include test results; treatment discussed or offered; reasoning behind treatment offered; conversations with the patient, including risks of noncompliance; conversations with other providers and specialists; the patient's refusal of care and reasoning; and the patient's mental status and decision-making capacity. Request the patient sign the note or statement of informed refusal.

Depending on the circumstance, consider using an informed refusal form for your practice. If a patient's refusal could lead to severe or permanent injury or death, use of this form may help you clearly document the refusal.

Also, asking a patient or guardian to complete or sign the form may reinforce the seriousness of the situation to an indecisive patient or guardian and help them to reconsider.¹

SOURCE

1. Wenske W. Avoiding common documentation errors. *the Reporter*. Quarter 1, 2024. Texas Medical Liability Trust. Available at <https://www.tmlt.org/resource/cme-avoiding-common-documentation-errors>. Accessed February 3, 2026.

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