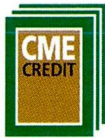

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New hope for impaired physicians: Helping the physician while protecting patients

PHYSICIANS CAN find themselves trapped in a downward spiral of dependence on drugs or alcohol, much like anyone else. Yet paradoxically, the power and status that physicians enjoy can worsen the problem, by increasing the stress on the physician and decreasing the incentives of friends, family, and colleagues to confront the problem.

The medical profession is addressing the problem of substance abuse in its ranks by setting up programs to confront impaired physicians about their substance abuse problem, ensure their entry into treatment, and monitor their recovery.

Everybody wins with such an approach: the physician gets help and gets back to work (although under therapeutic supervision), and the public is protected. Specific treatment is widely available, and the outcomes are good in the majority of cases.

ABSTRACT

The medical profession has developed a greater awareness of the problem of substance abuse among physicians, and has responded by setting programs to confront impaired physicians about their problem so that they can overcome their resistance to treatment. Nonetheless, the most effective strategy is prevention: instilling physicians-in-training with a more cautious attitude towards drug and alcohol use.

KEY POINTS

Chemically dependent physicians are difficult to identify and treat, as they are expert at hiding their problem and tend to have a well-entrenched denial system.

Marital problems are generally the first indication of drug or alcohol abuse.

Approximately 50% of dependent physicians do well after 2 to 4 weeks of intensive inpatient treatment; for the rest, we recommend continued residential treatment.

Certain groups of specialists have a higher prevalence of chemical dependence, notably anesthesiologists and family physicians in solo practice.

A HIDDEN PROBLEM RECOGNIZED

In recent years, the public and the medical profession have become much more aware and concerned about drug and alcohol abuse among physicians, a problem that in the past often remained hidden. Patients worry about placing their lives in the hands of practitioners who are unable to perform at their best; hospitals are concerned about potential liability due to negligence and malpractice; and government bodies are concerned about allowing impaired practitioners to retain their licenses.

The medical profession finds itself in a dilemma in dealing with an impaired physician, facing both an obligation to help physician-col-

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leagues while protecting patients from suboptimal practice. Maintaining the delicate balance between the interests of the physician's livelihood and public safety is not easy, but to its credit, the medical profession is responding. Spearheaded largely by the International Doctors in Alcoholics Anonymous, the American Medical Association, and the American Society of Addiction Medicine, a "peer physician assistance movement" has developed into an extensive network of physician-effectiveness committees in state medical societies. Borrowing principles from the employee assistance movement, these committees are confronting the problem directly: while serving as advocates for impaired physicians, they can require that the physician enter treatment and maintain fitness to practice or risk losing hospital privileges or even his or her medical license.

SUBSTANCE ABUSE BEGINS EARLY, BUT HOW COMMON IS IT?

The exact incidence of chemical dependency among physicians is not known,[1] but substance abuse accounts for most cases of physician impairment. In one study, drug abuse was the most common referring complaint (38%), followed by alcohol abuse (29%), both alcohol and drug abuse (17%), and mental illness and substance abuse (8%). Mental illness alone was noted in only 6% of cases.[2]

Dependent physicians tend to have a well-entrenched denial system

Impaired physicians often say that their medical school days provided the right mixture of stress, insufficient social life, and lack of support to foster destructive, dysfunctional coping behavior, which eventually led to chemical impairment.[3] In one study,[4] 11% of medical students met clinical research criteria for drug or alcohol abuse (habituation, tolerance, withdrawal symptoms, or drug-related arrests). Of interest, excessive drinking had no measurable impact on academic performance in the first 2 years of medical school; in fact, students who abused alcohol got better grades and higher scores on the National Board of Medical Examiners Part I Test than those who did not. Alcohol abuse also had no discernible impact on clerkship performance in the third and fourth years. This demonstrated competence and success may lead hard-drinking students and physicians to discount warnings about the hazards of alcohol abuse.

A larger, national study[5] found that, in general, medical students use mood-altering substances much less frequently than comparable groups of young people, with the exception of alcohol and tranquilizers. This study also indicated that use of such substances usually begins well before medical school, frequently as early as grade school or high school. Only 1.6% of medical students felt they needed help for substance abuse; indeed, only 9 students out of 2,023 admitted to being currently dependent on any substance other than tobacco.

Another national study[6] found that most young physicians who use drugs started in high school or college, and that medical school and residency were not particular breeding grounds for substance abuse. However, more medical students used tranquilizers or opiates than did persons in a national age-matched cohort. Among residents, there were three major patterns of drug use:

- Recreational (alcohol, marijuana, cocaine, psychedelics).
- To improve performance and maintain alertness (tobacco, amphetamines).
- For self-treatment or treatment under another physician's supervision (tranquilizers, opiates, barbiturates).

Only one fourth of the respondents knew if their institutions had a clear policy or educational program about alcohol or drug abuse, but 20% indicated they had colleagues they considered impaired by alcohol or drugs. The researchers concluded that postgraduate institutions should develop policies on drug abuse and try to prevent the problem through education programs.[6]

THE IMPAIRED PHYSICIAN: A CHARACTERISTIC PATTERN

In our experience, it is difficult to diagnose chemical dependency in physicians, because dependent physicians tend to have a well-entrenched denial system. They are sophisticated (from training and experience) at avoiding detection, and they find plausible rationalizations for their use of drugs. Nonetheless, there are usually some signs.

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Marital problems

Marital problems are generally the first indicator of drug abuse. As the spouse becomes aware that the physician is "eating the mail" (ingesting samples), self-prescribing, or using family members' ailments to obtain drugs for self-use, concern gives way to arguments and fights over the drug use. Eventually, mistrust, anger, and alienation become deeper and may lead to separation or divorce.

Behavioral changes

Personality changes and deterioration of ethics may be the next step, with gross changes of behavior and attitude, especially seen in outbursts of anger, irritability, paranoia, or inappropriate sexual or financial behavior.

Legal problems

For physicians the most frequent legal problems caused by substance abuse are charges of irregularities in prescription-writing. Frequent or repeated malpractice suits can also be an indicator. Other legal problems that impaired physicians share with members of the general population who abuse drugs and alcohol are driving while intoxicated, domestic violence, tax evasion, or personal bankruptcy.

Physical signs of physician impairment

Oddly, physical deterioration often becomes evident before occupational impairment does. Alcoholic physicians may have the classic physical stigmata of alcoholism with reddened face, bulbous nose, hand tremors, jaundice, intestinal bleeding, pancreatitis, neuropathies, or seizures. Those who abuse injectable drugs long-term may have injection "tracks," necrotic skin lesions, and hardened, boardlike fibrotic changes of muscle tissue. Any loss of consciousness in a physician may indicate a drug problem.

Job performance deterioration

Finally, job performance begins to deteriorate. The impaired physician develops a pattern of chronic lateness or long unexplained absences from work. Patients and staff note alcohol on the breath, slurred speech, and other evidence of intoxication, including inappropriate remarks and behavior toward patients and staff, being asleep or not arousable on call, unanswered and unreturned phone calls, deterioration of record-keeping, practice errors, and often, cover-ups by office staff and family.

Self-prescribing: "I need it to function"

When physicians misuse drugs through self-prescribing, they often begin with a legitimate reason, such as depression, kidney stones, irritable bowel syndrome, chronic headache, or neck or back spasms. Finding that the medication works well to relieve physical and psychological discomfort, they continue to use it, gradually taking over the responsibility for diagnosing and treating their own ailments and prescribing drugs for themselves, often with the excuse that self-treatment is more convenient and takes less time away from practice and patients. They continue self-prescribing with the rationale that "I need it to function in spite of my ailment." Finally, the addicted physician comes to feel that the ailment is unbearable without constant and chronic self-medicating.

Suicide is more common among impaired physicians

Impaired physicians often meet their end in suicide. (Also common are accidental deaths due to overdose.[7]) A survey conducted jointly by the American Medical Association and the American Psychiatric Association found that physicians who committed suicide were more likely to have made previous suicide attempts, talked about suicide, prescribed themselves psychoactive drugs, and suffered financial losses than were physicians who died of other causes.[8] However, the greatest difference lay in their use of drugs and alcohol: more than one third of the physicians who committed suicide were believed to have had a drug problem at some time in their lives, vs one seventh for the control group. More than half of those who committed suicide had prescribed a psychoactive drug for themselves, vs only one fifth of those in the control group.[8]

Office staff and family often help cover up the problem

Risk factors for chemical dependency

Availability of drugs may be a particular problem among anesthesiologists and general practitioners in small practices. In one study,[2] physicians in solo private practice of family medicine were the group most frequently referred because of impairment.

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Ignorance about addiction. Although physicians may have experience in treating addiction, they tend to see the sickest, most hopeless members of the chemically dependent population and therefore may not recognize the less-extreme signs in themselves. This limited sample may produce a skewed and unnecessarily negative view of addiction and of the prospects for recovery.

A feeling of uniqueness may be a problem for physicians, since their education and selection process fosters it. Many physicians harbor an amazing sense of invulnerability, as reflected in a high rate of accidents in private aviation among physician-pilots.

Occupational stress and overwork can be used as a refuge from other kinds of emotional pain. Also, medical marriages often do not seem especially durable or supportive.[7]

Anesthesiologists are at special risk

Anesthesiologists appear to be at more risk for chemical dependency than most other physicians. In one survey of anesthesia training programs, a total of 334 confirmed cases of substance dependency was found over a 10-year period, including a substantial number of cases in instructors, and 30 deaths due to overdose. Meperidine and fentanyl were the most frequently abused drugs in this study. The researchers concluded that chemical impairment among anesthesiologists was more common than usually thought, perhaps because of drug availability.[9]

In another study,[10] nearly 12% of the 1,025 physicians seen by the Medical Association of Georgia Impaired Physician Program over a 14-year period were anesthesiologists; in a study in California,[1] 14% of physicians referred were anesthesiologists. Since only 4% of US physicians are anesthesiologists,[11] anesthesiologists appear to be overrepresented among chemically dependent physicians.

The Georgia study cited several factors as contributing to the higher rate of impairment among anesthesiologists: they have ready access to narcotics; if they abuse drugs they tend to abuse potent ones that produce addiction very quickly; they handle drugs more than other physicians do; many of the drugs they use require only small amounts for their full therapeutic effect; and it is easy to divert small amounts of drugs without getting caught. The researchers also noted that it is difficult to test for highly potent drugs of the fentanyl class and such testing is not routinely done, even during routine blood and urine screening.[10]

Dependent physicians can be intimidating when confronted

ADDICTED PHYSICIANS ARE DIFFICULT PATIENTS

In our experience, drug-involved physicians are difficult patients. Their emotional make-up, training, and experience reinforce denial and the myth of invulnerability. The impairment may be well hidden behind a facade of success and competence. They are products of a training regimen that reinforces self-reliance and self-discipline; often they have difficulty giving up work and practice responsibilities to assume the role of a patient. Their experience as authority figures makes it difficult for them to listen, accept the diagnosis, and comply with treatment. In the early stages of addiction there is little accountability to others. The family, often dependent on the physician's income or prestige, may be reluctant to "blow the whistle."

Sometimes, a whole community may conspire to "kill the physician with kindness" by reacting in protective (enabling) ways rather than coercive ones, owing to the lofty status of physicians in general and the particular physician's history of good service to the community. The physician may be afraid of a breach of confidentiality, fearing that "everybody will know; my patients will go to other physicians; no other doctors will refer me patients in the future." These fears are seldom valid in our experience; generally the community and peer physicians are delighted that the physician is taking measures to get help.

Unfortunately, dependent physicians have difficulty acknowledging their illness or seeking treatment without encouragement.[12] Usually it is not until progressive behavioral deterioration becomes obvious to family or colleagues that the individual seeks assistance. Even then, because their judgment is clouded by drugs or alcohol, many physicians continue to use these substances. Often, they leave or curtail practice rather than seek help.

Like executives and other "VIP" patients, physicians can be intimidating when con-

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fronted. They often rely on status to try to blunt the constructive coercion process by intimidation or threats of retaliation. Finally, they may "flee into health" with firmly stated resolutions and promises to be "good." All of these responses indicate continued inability to accept the need for help and monitoring, and are far less desirable than an attitude of doing whatever is recommended to get well and regain credibility.

CONFRONTING THE IMPAIRED PHYSICIAN

Because it may be difficult to confront the impaired physician, this job calls for someone with "clout," such as the hospital chief of staff or president, the state medical society, or, at some hospitals, the hospital physician health committee. Whatever their provenance, these bodies have the authority to give the impaired physician an ultimatum: get treatment (and remove yourself from practice until fit for duty), or risk losing your privileges, license, and livelihood.

When suspicious circumstances arise, these medical authorities must confront the problem, requiring the physician to obtain a professional, comprehensive evaluation, and requiring compliance with any and all treatment recommendations. The physician may be offered extensive help in doing so, including paid time off, relief from clinical duties, and insured treatment.

The Physician Health Committee at the Cleveland Clinic

At the Cleveland Clinic, a Physician Health Committee has been appointed as a subcommittee of the Office of Professional Staff Affairs. This committee includes members from the departments of anesthesia, employee assistance, the office of general counsel, medicine, surgery, education, psychiatry, and chemical dependency rehabilitation. Three subcommittees provide physician advocacy, administrative and legal oversight, and treatment.

All cases of possible physician impairment at the staff or resident level are referred to the Physician Health Committee for review, oversight, and monitoring, and this committee decides whether the physician needs mandatory treatment, when and if the physician can gradually return to clinical duties, or if he or she should be terminated. It also reports to the State Medical or Pharmacy Board when necessary. Although the committee takes into account the opinion of the physician's department chairman, its judgment usually prevails.

INPATIENT TREATMENT FAVORED

To work best, treatment programs must be comprehensive and long-term. Most often, inpatient treatment is recommended for physicians, for a variety of reasons. Usually, intensive, supportive psychotherapy is needed to overcome the strong initial resistance that physicians present. This resistance stems from a variety of causes, including the stigma of needing help, a sense of powerlessness, a fear of surrender, and the need to comply fully with therapy. Because physicians have a great deal to lose with a relapse, it is best to try hard at the outset to "do it right the first time." Concerns about liability, professional reputation, and credibility also favor inpatient treatment, as the physician or hospital may be under pressure to demonstrate that everything possible is being done to correct the situation and prevent a recurrence. Because the patient and family often have a well-entrenched denial system, a "total immersion" approach involving an inpatient stay with intensive therapy is frequently essential.

Generally, the community is delighted when physicians get help

Generally, a 2- to 4-week intensive stay is adequate for about 50% of physicians. For the remaining 50%, a transitional phase of residential treatment gives the newly sober physician more time to practice recovery skills, change his or her attitudes, get involved in Alcoholics Anonymous, and live drug-free, with group support and freedom from family and job pressures.

"Twelve-step" self-help meetings are a major source of support at all phases of the treatment program and are strongly encouraged as a lifetime commitment. Such self-help groups include Alcoholics Anonymous, Narcotics Anonymous, International Doctors in Alcoholics Anonymous, specialized hospital-sponsored groups,[13] and Caduceus Clubs. These clubs, now scattered across the United States, are transitional support groups for

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drug-involved physicians and are based on the 12-step program of Alcoholics Anonymous.

Pharmacologic adjuncts are frequently used. Disulfiram (Antabuse) has been found to produce a modest increase in rates of sobriety. Naltrexone (ReVia), a long-acting opiate receptor blocker, is often required for narcotic-dependent physicians, and is also used to curb craving for alcohol and prevent relapses. Enrollment in peer assistance programs is strongly recommended, and most programs rely heavily on random urine testing.

OUTCOMES

Most studies have found that outcomes of treatment are better for impaired physicians than for unselected patients. In fact, drug-abusing physicians can generally look forward to resuming their careers and maintaining an alcohol- and drug-free lifestyle.[14] Reasons for favorable outcomes include mandatory treatment under a probationary reporting system overseen by others, frequent urine checking, and involvement in peer assistance programs. Structured monitoring is therapeutic in itself and seems to force longer periods of abstinence from drugs and alcohol.[15]

Frequent urine testing helps assure compliance

A BETTER PREVENTIVE STRATEGY NEEDED

While the medical profession has done much to respond to the needs of drug-involved physicians once identified, the best remedy is to prevent impairment. A much more vigorous effort at prevention needs to be undertaken to instill a more cautious attitude among physicians toward drug use by themselves and their family members. This new attitude should recognize that:

- Mood-altering drugs are inherently dangerous, and that they should be used with caution and their places of storage kept secure.
- Peer pressure to use alcohol, recreational drugs, or medications operates on everyone; abstention and drug-free socialization and recreation by physicians should be encouraged and reinforced.
- A life that is drastically out of balance because of chronic overwork or stress is unhealthy and risky and does not justify the use of substances for coping.
- Physicians need to accept responsibility for much of the "stress" that they perceive. Our own achievement orientation, our drive to excel, and our exaggerated sense of responsibility and self-importance may lead us to think that we are helpless victims of awesome and uncontrollable stresses, the only solution for which is the comfort and refuge of alcohol or drugs. We as physicians need to begin to cultivate a life that is not only "dedicated" but also balanced and healthy in mind, body, and spirit.

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