

Physician substance abuse and addiction:

recognition, intervention, and recovery

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The OMA Physician Health Program (PHP) was founded in 1995, with an initial mandate to provide assistance to physicians who experience problems with drug and alcohol abuse and addiction.

Since its inception, the program has assisted hundreds of physicians troubled by substance use disorders, and much has been learned about the problem.

Definitions

The salient features of a diagnosis of substance dependence or addiction usually include the inability to control one's use of these substances, preoccupation about using drugs or drinking, continuing to do so despite adverse life consequences, and physiological tolerance and withdrawal symptoms.

It is important to view drug or alcohol dependence as a primary disorder that is often progressive, and possibly fatal, if left untreated.

Substance abuse is characterized by the repeated, inappropriate use of a mood-altering substance which, in some way, interferes with health and/or quality of life. This diagnosis can be made if substance dependence diagnostic criteria are not met. Substance abuse may progress to dependence if unaddressed.

Callers to the Physician Health Program who suffer from drug or alcohol problems fall into both categories. Expert assessment is sometimes re-

quired to differentiate between substance abuse and dependence.

Prevalence

The prevalence of drug and alcohol problems within the medical profession has been the subject of speculation and misconception. Research indicates that such problems are not likely to be more common among physicians than the general population.

In a 1986 review of the issue, published in the *Journal of the American Medical Association*, Brewster said, "Extreme statements regarding the prevalence of problems with alcohol and other drugs have often been made without empirical support."¹

In 1992, Hughes et. al. reported that in a survey of more than 9,000 physicians in all specialties, almost eight per cent reported substance abuse or dependence problems at some time in their lives.²

Regardless, if a physician is impaired due to a substance use disorder, patient care can be affected, and the physician risks serious personal morbidity, or even death.

Commonly abused substances

It is prudent to regard substance dependence as a single entity, rather

than a collection of addictions. The majority of physicians treated for addiction acknowledge abusing many drugs and alcohol. Still, alcohol is most often identified as the drug of choice.

PHP data reveal that 47 per cent of doctors monitored by the program list alcohol as their drug of choice. Of these, half have a history of abusing a range of other drugs as well. Thirty-five per cent of the PHP participants were dependent upon opioids as their drug of choice, seven per cent used cocaine, five per cent sedative and hypnotic drugs, and the remaining six per cent include a variety of other drugs, such as cannabis, solvents and anesthetic agents.

Risk factors

Although data tend to suggest that substance dependence affects doctors in ways similar to the general population, there are some considerations pertinent to medical professionals that merit discussion.

In 1972, Vaillant reported on the psychological vulnerability of physicians. According to his prospective study, doctors were more likely to experience problems with drugs and

Table 1
Signs of Addiction in Physicians

- Personality change
- Loss of efficiency and reliability
- Increased sick time and other time away from work
- Patient and staff complaints about physician's changing attitude/behaviour
- Indecision
- Increasing personal and professional isolation
- Physical changes
- Unpredictable work habits and patterns
- Moodiness, anxiety, depression, suicidal thoughts or gestures
- Memory loss
- Uncharacteristic deterioration of handwriting and charting
- Unexpected presence in hospital when off-duty
- Heavy "wastage" of drugs
- Inappropriate prescription of large narcotic doses
- Insistence on personal administration of parenteral narcotics to patients
- Long sleeves when inappropriate
- Frequent bathroom use
- Alcohol on the breath
- Wide mood swings

alcohol, require psychotherapy, and have marital problems, than were other matched non-health professional controls.³

Vaillant believed that physician vulnerability was related to unmet personal needs; some doctors choose a medical career to help themselves by helping others.

While many dispute the existence of a "medical personality," PHP staff have observed personality traits common among physicians seeking assistance.

These doctors are usually compassionate people, dedicated in the extreme to the well-being of their patients — to their own detriment and often that of their families. They tend to be perfectionistic, obsessive and rigidly self-controlled. Stressed and lacking healthy coping strategies, some find ease and comfort in drugs or alcohol. Thus, the seeds of abuse and dependence are sown, especially when there is a family history of substance use disorders.

Access to mood-altering drugs is another consideration, although not

the most important. Self-treatment with prescription drugs is always ill-advised. But self-administration of mood-altering drugs is a dangerous and risky proposition.

Anesthetists who self-administer potent opioids, such as fentanyl, are a special case illustrating this point, as these drugs are particularly dependency prone.

Many doctors experiencing problems with drugs and alcohol are reluctant to request help. They may deny the magnitude of the problem in their lives, just as others around them might deny what they are observing due to their own discomfort, lack of knowledge about how to help, or other factors.

The suffering doctor may also be fearful that to reach out might result in a report to regulatory authorities, and represent the end of his or her career. This is seldom the case.

But, together, these factors and others mean that doctors experiencing drug and alcohol problems seldom receive assistance early in the course of the disorder.

Recognition

There is rarely a single observation that will clearly identify an addicted colleague.

As with other illnesses, an accurate diagnosis is made by a physician familiar with the signs and symptoms of chemical dependence.

Still, there are clues readily apparent in doctors affected by drug or alcohol abuse that can be appreciated by any caring observer, especially if they are familiar with the doctor's baseline behaviour prior to the substance abuse becoming problematic.

Many of these observations have been previously described in the *Ontario Medical Review*.⁴

Generally, the affected physician will appear moody, withdrawn and more irritable than expected. Previously decisive, reliable and predictable, he or she may have difficulty making decisions, fail to meet professional commitments, and change routines, perhaps arriving at the hospital to do rounds at odd hours.

Excessive use of alcohol at social and CME events, and alcohol on the breath at work, are worrisome signs. Any doctor who insists on administering parenteral narcotics to patients personally, and who has heavy "wastage" of drugs, must be viewed with concern.

Addicted doctors often become depressed and, in advanced cases, may make suicidal gestures. Some will be successful.

These clues and others are listed in Table 1 (above), originally prepared by Dr. Graeme Cunningham, director of alcohol and drug services at the Homewood Health Centre in Guelph.⁵

It is important to recognize that the suffering doctor is very sensitive to the shame and stigma that accompanies a drug or alcohol problem. Such physicians will go to great lengths to conceal their disorder from colleagues, even when they are no longer able to disguise their problems at home.

For this reason, observations made in the workplace might well represent illness that is fairly advanced, and demanding of immediate attention.

Help

It is not unusual for physicians in a community to be aware that one of their colleagues is struggling personally in some way. In the earlier stages, the nature of a problem might not be clear. Caring individuals will offer help.

One or two friendly colleagues can approach the doctor and share their observations and concerns.

If especially concerned, a clinical resource, such as a psychiatrist or therapist, might be made available in advance of approaching the troubled doctor.

An offer to facilitate an appointment with that resource is an affirmative, helpful action. And, it is necessary to follow-up with the doctor to verify that positive action has been taken, and to affirm support.

Unfortunately, in the case of the addicted doctor, denial is often present. This often results in deliberate, conscious deception of others, as well as less conscious self-deceit and minimization of the severity of the problem.

Dependent physicians also likely feel guilt and shame about what they have done and how they see themselves as a result of their illness.

When these psychological forces are at play, the doctor confronted in an informal manner, no matter how well-intentioned and thorough, may not respond favourably.

Two myths must be confronted when considering addicted doctors. The first is that they must "want help" before intervention is successful. The second is that they must "hit bottom" before they will be receptive to assistance.

These myths are represent serious misconceptions. Confronting an impaired colleague, while difficult, must be done swiftly and competently. It can be a life-saving action.

The process of helpful confrontation is called intervention. It has been well described by Vernon Johnson and others,⁶ and an outline of the intervention process has been published in the *Ontario Medical Review*.⁷

Intervention should be carried out as early as possible when impairment due to substance abuse is suspected.

The intervention, which must be properly planned and rehearsed, is conducted by at least two individuals in a position of importance in the affected physician's life, such as a partner, department head, or chief of staff. Sometimes, family members are also involved.

The dependent physician is presented with objective, documented evidence of his or her behaviour of concern in a caring but firm manner.

The minimum goal of the intervention is to motivate the physician to follow through with an expert clinical assessment, arranged in advance.

Sometimes, in more advanced cases, the preferred outcome is to discontinue clinical practice immediately following the intervention, and enter treatment directly.

An expertly conducted and highly motivational intervention will likely yield the preferred result. Still, many impaired physicians thus confronted will resist assessment and treatment, preferring to handle the problem

themselves in their own way. Such measures usually fail.

The Physician Health Program believes that it is essential for intervenors to be prepared to notify regulatory authorities in some way if the dependent physician refuses to comply with the intervention.

Outlining a clear consequence for lack of compliance usually results in the desired outcome.

Some suggest that such an intervention, especially if there is a "threat" to notify authorities, places the suffering doctor at risk of suicide. This risk is minimized by arranging helping resources in advance, and making sure that the time from intervention to assessment or treatment is short. Sometimes, this is achieved by escorting the doctor to treatment directly from the intervention.

At the least, intervenors and other caring individuals should remain in close contact with the doctor until it is assured that he or she is safe. To do less is not acceptable.

Physicians have a moral and ethical obligation to do their best to help dependent colleagues, even if the

Table 2
Components of a Recovery Program

- Outpatient aftercare: group and individual therapy
- Caduceus peer support group
- Mutual help group: Alcoholics Anonymous (AA), Narcotics Anonymous International Doctors in AA (IDAA), Women for Sobriety
- Pharmacotherapy (e.g., disulfiram, naltrexone)
- Proper nutrition
- Regular exercise
- Healthy spiritual life
- Healthy balance between work, rest and leisure activities
- Assessment, treatment of concurrent problems (e.g., psychiatric, marital)
- Family treatment and support
- Rigorous monitoring, including random body fluid analyses

actions taken on a colleague's behalf are personally difficult.

The Physician Health Program is available to offer advice about intervention, or to participate directly when required.

Treatment: substance abuse and addiction

Physicians who have been diagnosed with substance abuse (but not dependence) benefit from education about the benefits of abstinence, or low-risk use of mood-altering substances. An addiction medicine physician, knowledgeable family physician, or other substance abuse professional can provide this information.

Once a substance dependence/addiction diagnosis is confirmed, treatment programs designed specifically for the physician/patient are available.

Inpatient treatment is not always required, but is the norm when a period of detoxification, or a respite from medical practice, personal circumstances and stress, is required.

It is often difficult for physicians to assume the role of patient, and inpatient programs designed specifically for physicians and other health professionals can facilitate this transition.

Most inpatient facilities do not segregate physicians in treatment, but rather offer therapy groups for health professionals in parallel to those offered for the entire patient

population. These groups give recovering doctors an opportunity to address special issues arising from their professional lives.

Inpatient treatment is followed by formal aftercare that lasts several months to several years.

Recovering doctors are usually encouraged to make use of community-based mutual help programs such as Alcoholics Anonymous, or other 12-step or similar programs.

Most also attend peer support groups (often called Caduceus groups), where they join other health professionals in recovery.

These and other elements of a comprehensive recovery program are listed in Table 2 (above).

Special mention should be made of the addicted physician's family. Addiction affects the entire family, and programs exist that provide education, counselling and support for spouses and other family members. An untreated and unsupported family suffers needlessly, and can predispose a relapse into addictive behaviour by the physician.

Monitoring

In Ontario and many other North American jurisdictions, there are formal monitoring programs that recovering doctors may use to enhance their recovery program.

Monitoring includes regular in-

terviews to ascertain the health status of the recovering individual, as well as to encourage full compliance with all prescribed recovery activities. Progress reports are received from treating clinicians, and random urine toxicology screens are performed.

The Physician Health Program conducts such a comprehensive monitoring program, which also provides case management services and advocacy for the doctor in recovery. These programs usually continue for five years or longer.

Outcomes

The prevalence and expression of substance use disorders in physicians is much like that in the general population. But outcomes, especially among those doctors enrolled in monitoring programs, are better.

The PHP experience to date reveals that of the first 100 doctors monitored in recovery, more than 70 per cent have enjoyed sustained remission of their substance dependence, never experiencing a relapse. There are similar reports from many other jurisdictions.

Substance dependence is, nevertheless, a disease of relapse. Relapse, when it occurs, should be treated seriously and promptly. Breaks in abstinence can be minor or life-threatening. Once again, careful monitoring goes a long way toward prevention and early detection of relapse events.

The experience of relapse can be helpful to the recovery process, pointing out untreated problems, or revealing components of the recovery program that need strengthening.

The majority of doctors who experience relapse make the appropriate adjustments and continue to enjoy good health.

In fact, it has been the experience of the PHP that more than 90 per cent of the physicians monitored return to excellent health and productivity.

Conclusion

Substance use disorders affect physicians just as they affect members of the general population — medical

training does not confer immunity, nor does it result in excessive risk.

Denial (by physician, family and colleagues) is a major symptom and a significant obstacle to timely diagnosis and treatment. Thoughtful intervention does work, and effective treatment is available.

Once the addictive disorder is in remission, sustained abstinence, productivity and healthy lifestyles are the expected norm. There are also treatment and support programs for families of recovering doctors.

Recovery from chemical dependence means improved physical, psychological and emotional health.

Social lives are improved, and families are rebuilt. Even matters of the spirit flourish. This is the beauty of recovery.

So it falls to each of us as physicians to care about the well-being of our colleagues, to be watchful for signs of drug or alcohol problems, and to be prepared to respond.

With respect to this problem, we really are our brothers' and sisters' keepers. **OMR**

References

1. Brewster JM. Prevalence of alcohol and other drug problems among physicians. *JAMA* 1986; 255(14):1913-20.
2. Hughes PH, Brandenburg N, Baldwin DC, et al. Prevalence of substance use among U.S. physicians. *JAMA* 1992;267(17):2333-9.
3. Vaillant G, et al. Some psychological vulnerabilities of physicians. *NEJM* 1972;287:372-375.
4. Kaufmann M. Recognizing the signs and symptoms of distress. *Ont Med Rev* 1999;66(5):46-47. This article is also posted online at: www.phpoma.org/pdf/May99.pdf.
5. Cunningham GM. Paying attention to substance abuse in physicians. *Canadian Journal of Diagnosis* 1993;10(4):76-88.
6. Johnson VE. *I'll Quit Tomorrow*. Harper and Row, New York, NY, 1980.

7. Kaufmann M. After the call: the Physician Health Program referral and intervention process. *Ont Med Rev* 1999;66(3):54-56. This article is also posted online at: www.phpoma.org/pdf/Mar99.pdf.

Suggested reading

1. Talbott GD, Gallegos KV, Angres DH. Impairment and Recovery in Physicians and Other Health Professionals. In: *Principles of Addiction Medicine*. American Society of Addiction Medicine, Chevy Chase, Maryland, 1998, Chapter 3.
2. All Physician Health and related columns published in the *Ontario Medical Review* are posted on the Physician Health Program Web site (www.phpoma.org/articles.html).

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