Helping the Impaired Pharmacist
A program for colleagues
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I. Introduction

Addiction to alcohol and other drugs is a common medical and social problem in the United States. Unfortunately, health care professionals are not immune to this problem, despite their knowledge and level of professional training. In fact, pharmacists appear to be at particular risk for substance abuse. Studies have shown that the prevalence of chemical dependency among pharmacists ranges between 10% and 18%. However, up to 62% of pharmacists and 46% of pharmacy students have reportedly used controlled substances without a prescription.

Addiction is defined as a behavioral pattern characterized by the compulsive use of a substance (including alcohol) in which acquiring and using the substance become the principal focus of the user’s life. The substance is used to alter feelings and to prevent withdrawal symptoms. The user is compelled to use the substance despite evidence (often compelling itself) of medical, social and economic harm. Other terms used besides “addiction” include “chemical dependency” and “impairment.”

The clinical and social impact of pharmacist impairment is enormous. The impaired pharmacist is at risk for increased morbidity, professional censure, criminal prosecution and social isolation. The families of impaired pharmacists often experience chronic stress and economic loss. Patients may suffer irreparable harm as the result of pharmacist errors. Finally, colleagues and employers may be liable for the actions of impaired pharmacists who are under their supervision.

A survey of pharmacists in recovery suggests that colleagues, employers and state pharmacy boards have been unwilling to deal with the problem of chemical dependency in the past. Of 88 recovering pharmacists, most presented with late-stage symptoms such as morning drinking, blackouts and convictions for driving while intoxicated. The mean duration of drug taking in the group was 19.5 years. Most tellingly, many of them sought help, yet were misdiagnosed by physicians.

Despite this grim picture, the prospects for recovery are often excellent, particularly with early detection. Prompt intervention can help impaired pharmacists see the consequences of their continued substance abuse. With effective treatment and follow-up, more than three-quarters of impaired pharmacists recover.

The purpose of this educational program is to teach employers and colleagues of impaired pharmacists (as well as impaired pharmacists themselves) how to recognize a substance abuse problem, and how to deal with the problem in an effective manner.
II. Goals of this program

After completing this program, participants should be able to:

1. Demonstrate knowledge of the extent of the problem and its economic and social impact.
2. Describe patterns of abuse among impaired pharmacists.
3. Identify drugs of choice among impaired practitioners.
4. List key characteristics that increase the risk for substance abuse.
5. Identify signs and symptoms of abuse among pharmacists.
6. Identify intervention measures.
7. Discuss the legal responsibilities for reporting and providing treatment.

III. Overview of impaired health professionals

The risk of substance abuse is shared by allied health professionals, including physicians and nurses. The pattern of abuse depends on the professional. In general, physicians at greatest risk for impairment include family physicians, anesthesiologists and psychiatrists. While primary care physicians tend to use a combination of opioid analgesics and benzodiazepines, anesthesiologists tended to use injectable opioids (alone or in combination with alcohol), in particular, meperidine and fentanyl. Among hospital-based nurses, injectable meperidine is by far the drug of choice, followed by benzodiazepines and other opioid analgesics.

Compared to other health care professionals, pharmacists show a distinct pattern of abuse. Pharmacists are less likely to abuse alcohol than are physicians. Compared to physicians, pharmacists are more likely to use oral codeine preparations (prescription and non-prescription) than more potent opioid analgesics as their drug of choice. In addition, pharmacists are more likely to use opioid-containing cough syrups than are other professionals. Both pharmacists and physicians tend to use benzodiazepines.

These are merely general trends. There are reports of pharmacists diverting other types of dispensed drugs, including injectable opioid analgesics.

IV. Risk factors for substance abuse among pharmacists

It is well recognized that addiction is a behavioral disorder that has both biological and psychosocial roots. There is strong evidence that genetics plays a key role in the development of addiction. A particularly strong piece of evidence is that alcoholism rates are higher among adopted boys who have an alcoholic biological parent than among boys who do not have an alcoholic biological parent.

Individuals at inherited risk of addiction probably have an enhanced ability to experience the euphoric effects of mood-altering substances such as opioid analgesics. In one study, 38% of pharmacy students reported a family history of substance abuse.

Personality factors, the result of both genetics and environment, appear to be important in the development of addiction. For instance, studies conducted with impaired
Many pharmacists possess the false belief that their detailed knowledge of pharmaceutical drugs will somehow protect them from addiction.

V. Clinical presentation

Although the pattern of chemical dependency may have recently begun, there is often an antecedent history of experimentation with psychoactive drugs. For instance, up to 62% of pharmacy students use controlled substances without a prescription. Forty-one percent of pharmacy students reportedly use controlled substances on a regular basis. In addition, between 77% and 89% of pharmacy students use alcohol, with more than 23% having more than five drinks per occasion. Marijuana use is also reportedly high in pharmacy students. The major difference between pharmacists and pharmacy students is that the students tend to use substances for recreational purposes.

Typically, impaired pharmacists experience stress at work, at home or elsewhere. This provides the stimulus to increase their drug taking. The substance is usually taken for its euphoric or pleasure-producing effects, or for its anxiolytic properties. The pleasurable effect provides the reinforcement to continue using the substance. As physical tolerance develops, a larger dosage of drug is needed to produce the pleasing effect. The impaired pharmacist begins to experience unpleasant withdrawal symptoms when the drug of choice cannot be obtained, a powerful motivator for continued drug use.

It is important to realize that most impaired pharmacists continue to function at work despite their substance abuse. Obvious indications, such as deterioration in the physical appearance of the pharmacist, are relatively late findings.

Family and social life

Usually, the earliest manifestations of substance abuse appear at home and are noticed by the family. Thus, the pharmacist's family, friends and social acquaintances may provide important clues of impairment and may help corroborate suspicions (Table 1). Family life is profoundly affected by chemical dependency. Financial problems may result from factors such as inconsistent employment, diversion of family income to pay for illicit drugs, or even compulsive gambling. The pharmacist spends increasing amounts of time acquiring and using the drugs of choice, and is increasingly preoccupied with trying to keep this behaviour a secret from the family. Consequently, the pharmacist
Usually, the earliest manifestations of substance abuse appear at home and are noticed by the family. Physical and social problems often arise during this period. Both the impaired pharmacist and the spouse may have extramarital affairs. In time, the pharmacist may exhibit extreme mood swings and explosive displays of rage.

The family functions as if under a cloud and exhibits symptoms of chronic stress. The children are often neglected or abused; their school work may suffer, or they may get into trouble with law enforcement authorities. Despite these developments, family members find themselves making excuses for inappropriate behavior by the pharmacist.

The pharmacist’s social life is also adversely affected by chemical dependency, and these factors are visible to the astute observer. The pharmacist withdraws from social activities and becomes neglectful of social commitments or, at the very least, unpredictable and unreliable. In time, a subtle erosion in ethical values may be noticed by friends and colleagues; this may be followed by the onset of legal problems. Later on, social acquaintances may observe more overt signs such as public drunkenness, physical fighting and driving while intoxicated.

Despite these developments, the family and friends often avoid dealing with the issue. It is emotionally painful to admit that a friend or family member is an addict. Instead, those close to the impaired pharmacist typically respond with rationalization and denial. They explain away the pharmacist’s inappropriate behavior, minimize its importance, or block out awareness that there is a problem.

In addition, family and friends often protect impaired pharmacists from the consequences of their behavior by, for example, inventing excuses for them. This is referred to as “enabling,” because it enables the disease process to continue. Ironically, such misguided efforts to help the impaired pharmacist actually promote the disease. A sense of loyalty to the pharmacist and a lack of information about effective action are the primary reasons that enabling occurs.

Work history and performance

Often, the employment history and application process provide telling clues to a history of chemical dependency (Tables 2 and 3).

Impaired pharmacists have a history of frequent job changes and relocations because they tend to move in order to evade detection by employers and colleagues. The impaired pharmacist seeking employment may be overqualified for the job being

<table>
<thead>
<tr>
<th>Table 1. Family and social clues to chemical dependency</th>
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<tbody>
<tr>
<td>• Children are neglected or in trouble with the law</td>
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<td>• Spouse is in psychotherapy or taking psychoactive medication</td>
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<td>• Separation or divorce</td>
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<td>• Financial problems</td>
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<tr>
<td>• Family socially isolated</td>
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<td>• Withdrawal from social activity</td>
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<tr>
<td>• Episodes of embarrassing behavior: e.g. public fights</td>
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<td>• Legal problems: e.g. drunk driving</td>
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Impaired pharmacists have a history of frequent job changes and relocations.

The pharmacist’s medical history is often telling. Impaired pharmacists often have chronic medical problems such as gastrointestinal disorders, seizures, hypoglycemia and psychiatric disorders. There may be frequent admissions to hospital. When taking a work history, look for long and unexplained absences from work.

Attempts to confirm suspicions are often frustrating. The pharmacist’s letters of reference may be vague and somewhat misleading. The spouse may refuse to be contacted. The pharmacist may refuse to undergo a pre-employment physical examination.

Long before overt signs of impairment appear, the pharmacist exhibits numerous subtle indications of chemical dependency at work. The pharmacist may be frequently absent from work or excessively late. Often, the absences follow periods of time off. Excuses for absenteeism may seem unusual or improbable. The pharmacist may take long bathroom and lunch breaks away from the work area, or may spend inordinate amounts of time at the water fountain or in the stock room.

Paradoxically, the pharmacist appears willing to work extra hours, particularly on public holidays, and is willing to be on call. The pharmacist may moonlight at other pharmacies. The pharmacist may tend to arrive long before a shift and stay long after, or may frequently show up when not scheduled to work. The impaired pharmacist wants to be in the dispensing area of the pharmacy and volunteers to check the narcotic inventories.

In time, the impairment affects the pharmacist’s relations with staff. The pharmacist exhibits mood swings and overreacts to criticism from staff. Employers may notice increasing complaints from other staff. The pharmacist may be borrowing money from other employees.

At first, there is no noticeable decline in the pharmacist’s job performance. The earliest indication may be an inconsistency in performance characterized by an alternation between high and low productivity. This may be followed by more obvious performance problems, such as difficulty recalling instructions and work details, as well as disorganization. An increase in the number of prescription errors follows, as well as an increase in customer complaints. When confronted about his or her performance, the pharmacist has difficulty recalling errors.

### Indications of pharmacy diversion

One of the most important clues that an impaired pharmacist is working in your pharmacy is the emergence of indications of possible drug diversion. A single instance

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#### Table 2. Pre-employment clues to chemical dependency

- Frequent change of employment
- Tendency to work far from home
- Vague letters of reference
- Past history of frequent hospitalizations
- Overqualified for applied position
- Spouse refuses to be contacted
- Candidate refuses physical examination
may be due to human error; multiple episodes should arouse suspicions.

Impaired pharmacists may sell drugs to drug dealers in order to support their own illicit drug habit. More commonly, they divert drugs for their own use.

A subtle indication of drug diversion is an increase in the number of controlled substance prescriptions phoned in (or faxed in) without a covering paper prescription from the physician. More overt indications include discrepancies in pill counts, as well as unexplained shortages of narcotics. Impaired pharmacists usually arrange circumstances so that they are responsible for doing narcotic inventories.

Another tip-off for diversion is an increase in the number of reported pharmacy break-ins and thefts; impaired pharmacists sometimes use such reports to conceal their own diversion. Finally, employers may notice an increase in the dispensing of prescriptions that are improperly written or even obviously fraudulent (Table 4).

**Overt signs and symptoms**

At later stages in the natural history of chemical dependence, more overt indications of impairment occur. There is a deterioration in physical appearance. Signs and symptoms of drug intoxication and withdrawal are usually present. As well, the medical complications of addiction begin to emerge.

The deterioration in the pharmacist’s appearance can be subtle or striking. Look for pallor, weight loss, as well as evidence of poor hygiene. The impaired pharmacist usually complains of insomnia and may also complain of sweating alternating with chills. Other indications include tightness of the jaw, a stern facial expression, and the grinding of teeth. A more subtle indication is the wearing of long-sleeved shirts in hot weather. You may notice a deterioration in the eating habits of the pharmacist, who either seldomly eats or has a diet restricted to foods containing sugar. Often, the pharmacist is constantly smoking cigarettes, or is constantly sucking on hard candy or mints.

The indications for drug intoxication depend on the drug used by the pharmacist. Opiate intoxication presents with pinpoint pupils, droopy eyelids, euphoria or dysphoria, apathy, inattentiveness, slurred speech, excessive itching and scratching and motor retardation. The indications for alcohol intoxication include slurred speech, ataxia, nystagmus, flushed face, irritability, euphoria and inattentiveness. The indications for benzodiazepine intoxication include sedation, inattentiveness, apathy, blackouts, memory impairment, slurred speech and muscle rigidity; these signs are magnified when a benzodiazepine is combined with alcohol or opiates.

The indications of withdrawal from

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**Table 3. Clues to chemical dependency at work**

- Frequent absences from work
- Long disappearances from work area
- Willingness to work extra hours
- Appearing at pharmacy when not on duty
- Volunteering to check the narcotic inventories
- Increase in medication errors
- Increase in customer complaints
Many pharmacists in a position to intervene fail to do so because of lack of pertinent information.

Opiates include runny nose, dilated pupils, tearing, sweating, gooseflesh, yawning, diarrhea, fever, muscle aches and rigidity in muscle movements. Signs of alcohol withdrawal include tremors, sweating, anxiety, nausea, vomiting, hallucinations and even seizures. The signs of benzodiazepine withdrawal include anxiety, tremors, itchiness or skin tingling and seizures. Subtle symptoms of withdrawal from benzodiazepines can persist for years after discontinuation.

There are numerous behavioral signs and symptoms to watch for. These include mood swings, loss of memory and blackouts. Impaired pharmacists exhibit poor impulse control. They overreact to criticism and have outbursts of anger which range from arguments to episodes of violence.

VI. Helping the impaired pharmacist

There are several reasons why it is often difficult to deal effectively with the impaired pharmacist. First, many pharmacists who are in a position to intervene fail to do so because of a lack of pertinent information or skill. In some cases, although colleagues know or suspect that a pharmacist is impaired, they are reluctant to discuss it in a way that could lead to effective action. Often, they fear that voicing their concerns might harm the impaired pharmacist or bring harm to themselves. In some cases, colleagues may do things to minimize the consequences of impairment, thus enabling the impaired pharmacist to continue using drugs and alcohol. Despite their professional training, colleagues are vulnerable to rationalization and denial, like family and friends.

The most effective way to help a pharmacist who is impaired by alcohol or drugs is to involve the state authorities in an effort to get the pharmacist into treatment. There are obvious reasons why a colleague may resist this course of action. Typically, it is perceived as an act of betrayal. This feeling is understandable, but it is based on a lack of information about the nature of addiction and the process of professional intervention by state pharmacy associations.

Colleagues should understand that the behaviour of an impaired pharmacist is out of control. If colleagues, friends or family do not intervene, the individual will likely deteriorate. Common outcomes are the loss of a professional license, personal and financial ruin, jail, illness and early death.

The best way to prevent further harm to the impaired pharmacist is to arrange an intervention by the professionals employed with a state pharmacy association. Colleagues should also understand that the majority of impaired pharmacists who enter treatment

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<th>Table 4. Clues to pharmacy drug diversion</th>
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<tr>
<td>• Increase in telephone prescriptions without covering paper prescription</td>
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<tr>
<td>• Discrepancies in pill counts</td>
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<tr>
<td>• Increase in break-in and theft reports</td>
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<tr>
<td>• Increase in fraudulent prescriptions</td>
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<td>• Prescriptions to suspected drug seekers</td>
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Each state board of pharmacy has its own set of procedures and regulations regarding the disposition of pharmacists suspected of chemical dependency. For detailed information, contact your state board or your state pharmacy association. In addition, most states have intervention and treatment programs for pharmacists, usually referred to as “pharmacist recovery networks” or “peer assistance programs.” These programs are usually staffed by professionals who are trained in intervention techniques. Some of the most effective interveners are themselves in recovery. State recovery programs usually have a 24-hour toll-free number for easy access.

Approximately two-thirds of the impaired pharmacists who enter treatment programs are identified by the state board of pharmacy, a peer, or by another professional. The professional and legal disposition of the impaired pharmacist depends on how the problem is first detected. Ideally, concerned colleagues involve the state recovery program in an intervention before the pharmacist has done significant harm to his or her career. However, if a crime has been committed, then law enforcement authorities must be notified. If the pharmacist is identified by someone not associated with the state board of pharmacy, the board need not be notified unless a pharmacy law has been broken or unless state laws require mandatory reporting (so-called snitch laws). Once notified, the state board will investigate the case and act upon the facts. Some state boards offer sanctuary from disciplinary action to the pharmacist who voluntarily withdraws from practice while entering a treatment program.

The ultimate goal is to quickly identify the impaired pharmacist so that treatment can be started as early as possible. This improves the prognosis for the pharmacist’s recovery and return to work.

Helping the impaired pharmacist involves the following steps:

**Recognition**
Recognition is a proactive system aimed at identifying the impaired pharmacist. Recognition is easier when the impaired pharmacist commits a crime such as diverting pharmacy stock, or driving while intoxicated. But these are relatively late events and it is obviously preferable to recognize the problem earlier.

Recognition means knowing the more subtle indications of chemical dependency. These include the physical symptoms and signs, as well as the typical behavioral changes. Recognition is enhanced by knowing the typical problems that occur at work. In addition, relationship problems at home and in the community may provide important clues.

**Documentation**
This is a crucial part of the process by which suspicions of impairment are verified. It is important to contact peers and other colleagues who can corroborate allegations of impairment. Friends and family members are also important sources of corroborating information.

It is important to document specific instances of suspicious behavior, including signs and symptoms of impairment. The impaired pharmacist is often in denial. Documenting specific examples makes it much more difficult for the pharmacist to effectively deny allegations of dependency. Such examples help the pharmacist to see the consequences of his or her actions.

**Intervention**
Intervention is the mechanism through which the impaired pharmacist is helped by others to see the consequences of chemical dependency. An intervention is carried out by multiple participants and is led by a
It is important to document specific instances of suspicious behavior, including signs and symptoms of impairment.

professional who specializes in intervention techniques. Some members of the group may be in recovery themselves. Friends, colleagues and family members may participate in an intervention. However, they must be educated in advance about the proper techniques. An intervention should not be carried out alone by an employer or a peer.

The purpose of an intervention is to break through the wall of denial and (if possible) have the impaired pharmacist accept a referral for treatment. Confronting the pharmacist in an antagonistic manner may only serve to firm up the pharmacist's defenses. It is imperative to approach the pharmacist in a non-judgmental manner that preserves his or her dignity. The location chosen for the intervention should be quiet and non-threatening.

The pharmacist will tend to deny direct accusations of impairment. It is much more effective to cite specific, documented examples of suspicious behavior. It is worthwhile to consider and anticipate the possible reactions of the pharmacist to the intervention. Getting the pharmacist to understand the future consequences of ongoing impairment can be effective. Threats should not be made to the pharmacist. However, an awareness that the state board of pharmacy has been informed and is awaiting the response of the pharmacist before taking action can be an effective motivator to seek treatment.

Although one of the goals of an intervention is to have the pharmacist accept treatment, this does not always occur. Sometimes, the pharmacist responds to the intervention by running away. It is not always advisable to run after a pharmacist who bolts from the intervention. Even in such instances, part of the message may have penetrated the wall of denial.

**Evaluation and treatment**

If the pharmacist agrees, then he or she is referred (and often escorted) to a treatment center for evaluation. A specific treatment plan is developed. The goal of treatment is to have the pharmacist become an active participant in the recovery process.

There are numerous types of treatment programs available. In-patient programs vary in duration from the 4 to 5 days needed to manage acute withdrawal symptoms to as long as 6 months. Because of the rising cost of inpatient care, out-patient programs are becoming increasingly popular. Out-patient programs may require that participants live at a halfway house; some programs permit participants to return home each night.

Whatever the venue, treatment programs share several aspects in common. First, the individual is detoxified. Drug therapy while in a treatment program is usually kept to a minimum. However, there is a role in some cases for antidepressant medication to treat depression associated with drug withdrawal.

In addition, disulfiram is used to discourage the use of alcohol. The opiate receptor antagonist naltrexone, which has been shown to block the euphoric effects of opiates, has been found to be a useful adjunct therapy for both opiate abuse and alcoholism.

Most treatment programs are staffed by a multidisciplinary team, with representatives from psychiatry, psychology, social work and addiction medicine. Usually, some of the team members are in recovery themselves. Although individual counseling is available, group therapy is the most common treatment modality.

Impaired women pharmacists may have different etiological factors than men. For instance, they are more likely than men to have been sexually abused. Thus, there is a growing recognition that women may do better in all-female treatment programs.

Most treatment strategies are based on the principles of the twelve-step program as developed by Alcoholics Anonymous (AA). According to AA principles, recovery does not begin until the alcoholic admits to his or her powerlessness over alcohol and drugs, and admits that substance abuse has caused
The goal of treatment is for the pharmacist to become an active participant in the process of recovery. Other principles of the program include the alcoholic taking personal responsibility for recovery, submitting to the authority of a higher power, and spreading the program’s message to others. Other groups espousing the same principles include Narcotics Anonymous (NA), Cocaine Anonymous and Substance Abuse Anonymous. Family members are encouraged to make use of support organizations such as Al-Anon.

In most treatment programs, the impaired pharmacist signs a recovery contract. This document represents the pharmacist’s signed admission of responsibility for his or her impairment as well a commitment to change. This contract usually commits the pharmacist to ongoing follow-up and monitoring, and may contain clauses regarding return to work. The contract becomes particularly important as the date for returning to work approaches.

**Aftercare**
Treatment does not end with discharge from a hospital or outpatient program. Impaired pharmacists require long-term care and follow-up. Adequate aftercare is often the most critical factor in maintaining recovery. The principles of aftercare include regular attendance at a twelve-step support group, individual counseling, random drug testing, and the support of family members and colleagues.

**VII. Returning to work**
In the past, recovering pharmacists were often terminated from their employment. However, the Americans with Disabilities Act protects individuals from termination when the cause of termination is a disease. The issue is less clear when dealing with relapse, as is described below. Aside from legal obligations, there are no reasons why most impaired pharmacists cannot return to work. Consult your state board of pharmacy for its specific regulations and guidelines.

In general, employers should treat the recovering pharmacist like any other employee. However, there are some specific mechanisms that should be in place prior to the pharmacist’s return to work. First, if the state has a recovery assistance program, the employer should insist that the pharmacist participate in it. Once this is in place, it is important that the employer and the recovering pharmacist be permitted to communicate with the assistance program as required.

Second, the employer should review the pharmacist’s recovery contract. The contract provides the employer with clear objectives and guidelines on issues such as attendance at twelve-step meetings and random urine testing. Such a contract makes it much easier for employers to take action should the pharmacist show indications of a relapse.

Alternatively, the employer and the pharmacist may sign their own return-to-work contract. This contract specifically deals with the conditions of employment. Such contracts may be drawn up and signed prior to discharge from treatment. The term of the contract can range from several months to as long as 5 years.

The first 90 days are critical to the pharmacist’s recovery. Pharmacists require a high level of support during that period of time. Thus, it is recommended that the pharmacist attend a large number of support group meetings during the first 90 days. Since the pharmacist is trying to achieve a healthy lifestyle, he or she should be assigned to a strict day schedule during that time.

If the employer operates a chain of pharmacies, the pharmacist should be assigned either to the central pharmacy or to
The first 90 days are critical to the pharmacist’s recovery. Unless it is unavoidable, the recovering pharmacist should not dispense controlled substances during the first 90 days. Otherwise, the employer should have strict inventory controls in place prior to the pharmacist’s return to work. If the pharmacist agrees, co-workers should be informed about the pharmacist’s recovery. This reduces the tendency to gossip and also provides a forum for co-workers to express their concerns.

Random urine drug screens are an important part of the return-to-work contract. These are scheduled at regular intervals ranging from once a day to once a month. The drug screens should be performed by the employer, with anonymity for the employee maintained. If the recovery assistance program or an aftercare program does the testing, the employer should have routine access to the test results.

VIII. Relapse

The prognosis for recovering pharmacists is excellent. The vast majority who enter treatment will be in recovery 1 year later. However, relapse is part of chemical dependency. It is not regarded as a failure on the part of the recovering pharmacist. There are many factors that contribute to relapse. These are often known by the acronym HALT, and consist of hunger, anger, loneliness and tiredness. Drugs and alcohol were previously used to deal with these factors, and those tendencies remain.

The consequences of relapse depend upon the return-to-work contract as well as regulations and guidelines of the state board of pharmacy. For instance, the employer may be obliged to report the pharmacist to the regulatory agency. The employer may have the option of insisting upon retreatment at the employee’s expense. In the event of theft of drugs, the employer may terminate employment and report the pharmacist to law enforcement authorities.

Table 5. Suggestions for return to work

| • Recovery assistance program involved |
| • Return-to-work contract |
| • 90 Twelve-Step meetings in first 90 days |
| • Strict day schedule |
| • Avoid narcotic dispensing in first 90 days |
| • Random urine drug screening |
| • Inform other employees if recovering pharmacist agrees |
IX. Conclusion

Chemical dependency is prevalent in our society, and pharmacists are at particular risk. Chemical dependency erodes the self-esteem of the impaired pharmacist. It disrupts relationships with colleagues and employers, and can destroy the lives of families. However, from the pain caused by impairment come the seeds of recovery. The memory of that pain provides the impetus for the pharmacist to find a new and ultimately satisfying way of life.

References


