



Helping the Impaired Physician

A program for colleagues

(3 hours CME credit)

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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. Their risk of addiction is at least as high as that of the general population. According to one estimate, up to 17,000 physicians have substance abuse problems at any one time (Centrella, 1994). Anesthesiologists and family physicians appear to be at particular risk. Residents in emergency medicine, psychiatry and anesthesiology may also have higher rates of substance abuse.

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. "Addiction," "chemical dependence" and "impairment" are commonly used terms for what is defined in DSM IV as substance dependence. It must be distinguished from substance abuse, which involves harmful consequences from the use of a drug but not the compulsive use that is central to substance dependence.

The clinical and social impact of physician impairment is enormous. The impaired physician is at risk of increased morbidity, professional censure, criminal prosecution, and social isolation. Each year, approximately 100 physicians die in the U.S. as a direct result of chemical dependency (Centrella, 1994). The families of impaired physicians often experience chronic stress and economic loss. Patients may suffer irreparable harm as the result of physician errors. Finally, colleagues and employers may be liable for the actions of impaired physicians who are under their supervision.

Despite this grim picture, the prospects for recovery are often excellent, particularly with early detection. Prompt intervention can help impaired physicians see the consequences of their continued substance abuse. When long-term monitoring is put in place, physicians have better treatment outcomes than those of the general population. With effective treatment and follow-up, more than 80% of impaired physicians can recover (Reading, 1992).

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

The impaired physician is at risk of increased morbidity, professional censure, criminal prosecution and social isolation.

Alcohol is by far the most common drug used by impaired physicians.

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 physicians.
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 physicians.
6. Identify intervention measures.
7. Discuss legal responsibilities for reporting and providing treatment.

III. Overview of impaired health professionals

It was once thought that health professionals were 30 to 100 times more likely to have substance abuse problems than the general population. However, recent data suggests that the prevalence of substance abuse among health professionals is probably comparable to the prevalence in the general population (Centrella, 1994).

Alcohol is by far the most common drug used by impaired physicians. Seventy-one percent of physicians who entered treatment with the Impaired Physicians Program of the Medical Association of Georgia reported alcohol as a drug of abuse (Gallegos et al., 1992) (see Table 1). However, nationwide patterns of drug abuse cannot be inferred from data taken from a single state. The local or regional pattern of drug abuse is determined by the availability of drugs, state drug schedules, and customary practice.

Patterns of abuse also depend on the specific profession. In general, physicians at greatest risk of impairment include family physicians, anesthesiologists, surgeons (including obstetricians), emergency physicians and psychiatrists.

While primary care physicians tend to use a combination of opioid analgesics and benzodiazepines, anesthesiologists tend to use injectable opioids (alone or in combination

with alcohol), in particular, meperidine and fentanyl (Pelton & Ikeda, 1991). Among hospital-based nurses, injectable meperidine is by far the drug of choice, followed by benzodiazepines and other opioid analgesics.

Residents have distinct patterns of substance abuse when compared with physicians in practice. Psychiatric residents are more likely to have tried a variety of substances, and tend to be active users of alcohol, cannabis and benzodiazepines. Emergency residents are more likely than other residents to use cocaine. In one study, medical students tended to abuse cannabis and cocaine (Centrella, 1994).

Physicians are more likely than pharmacists to abuse alcohol. Compared to doctors, 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 physicians and pharmacists tend to use benzodiazepines.

Recently, there have been reports of physicians developing abuse problems with butorphanol, a mixed opioid agonist-antagonist. Butorphanol was formulated as a nasal spray several years ago, and was

originally approved by the Food and Drug Administration as an unscheduled drug (now scheduled) for the short-term relief of migraine headaches.

It should be emphasized that these are merely trends. As Table 1 demonstrates, there are reports of physicians abusing the full gamut of abusable substances.

IV. Risk factors for addiction among physicians

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 (Huebert, 1994).

Individuals at inherited risk of addiction probably have an enhanced ability to experience the euphoric effects of mood-altering substances such as opioid analgesics. Thus, a positive family history of substance abuse is a significant risk factor. In one study, 38% of pharmacy students reported a family history of substance abuse (McAuliffe, 1987).

Personality factors, the result of both genetics and environment, appear to be important in the development of addiction. For instance, impaired physicians tend to have narcissistic personality traits and react to stressful situations with anxiety or anger. Early parental deprivation has been noted in up to 77% of impaired physicians under age 40 (Centrella, 1994). Conversely, a psychologically sound childhood probably affords considerable protection from substance abuse. The earlier an addiction develops, the more likely it is to be associated with a significant psychiatric disorder, chiefly depression.

Typically, physicians who develop alcohol and drug problems are overachievers; they often rank in the upper third of their class. Most are men, although this may change as

It is well recognized that addiction is a behavioral disorder that has both biological and psychosocial roots.

Table 1. Pattern of substance abuse among physicians

Drugs most frequently reported abused	percent
Alcohol	71
Cocaine	21
Meperidine	19
Diazepam	18
Marijuana	17
Oxycodone	12
Fentanyl	11
Codeine	9
Amphetamine	7

Source: Gallegos K.V. Lubin B.H. Bowers C., et al. (1992, April). Relapse and Recovery: five to ten year follow-up study of chemically dependent physicians – the Georgia experience. MMJ, pp. 315-319.

Many impaired physicians hold the false belief that their detailed knowledge of pharmaceutical drugs will somehow protect them from addiction.

more women enter medicine. Impaired physicians tend to be young; in one study, the mean age of physicians entering a recovery program was 39 years. Impaired physicians may be single, divorced, separated or widowed.

Finally, many impaired physicians hold the false belief that their detailed knowledge of pharmaceutical drugs will somehow protect them from addiction.

There are several environmental factors that place physicians at risk, including stress at home or at work, chronic conditions causing pain (examples include chronic back pain or migraine headaches) and fatigue. Psychiatric illnesses that predispose physicians to substance abuse include anxiety, depression and insomnia.

Working conditions tend to predispose high-risk physicians to chemical dependency.

For instance, many physicians work long hours on call without appropriate breaks. Drugs may be used to stay awake or feel energetic. Some physicians with low self-esteem develop a pattern of professional or academic success that can only be maintained by habitual overwork. Failure to maintain unrealistic standards of practice results in feelings of guilt and shame.

Self-medication with psychoactive drugs is probably underreported. Luckily, self-medication is not usually a repeated behavior. However, it can easily become habitual. Physicians at risk use mood altering drugs to cope with the demands of their work and their families, to treat symptoms of mental illness, for recreational purposes or as a substitute for alcohol when alcohol abuse has already begun.

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 (McAuliffe, 1987). Forty-one percent of pharmacy students reportedly use controlled substances on a regular basis. Many medical students and residents also experiment with controlled drugs or use them regularly. Six percent of those referred to the Impaired Physician's Committee of the Kentucky Medical Association were medical students or residents (Blonde, 1992).

Typically, impaired physicians 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 physician 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 physicians continue to function at work despite their substance abuse. Obvious indications, such as deterioration in the physical appearance of the physician, 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 physician's family, friends and social acquaintances may provide important clues of impairment and may help corroborate suspicions (Table 2).

Family life is profoundly affected by chemical dependency. Financial problems may result from factors such as inconsistent



Usually, the earliest manifestations of substance abuse appear at home.

employment, the diversion of family income to pay for illicit drugs, and even compulsive gambling. The doctor 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 doctor usually withdraws from the family and from social activities. Sexual problems often arise during this period. Both the impaired physician as well as the spouse may have extramarital affairs. In time, the physician 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 spouse is often taking psychoactive medication or is in psychotherapy. The children are often neglected or abused; their school work may suffer, or they may get into trouble with law enforcement authorities.

The physician's social life is also adversely affected by chemical dependency, and these factors are visible to the astute observer. The physician typically withdraws from community activities and loses friends. In time, a subtle decrease 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 physician typically respond with rationalization and denial. They explain away the physician's inappropriate behaviour, minimize its importance, or block out awareness that there is a problem.

In addition, family and friends often protect impaired physicians 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 physician can actually promote the disease. A sense of loyalty to the impaired doctor 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 3 and 4).

Impaired physicians have a history of frequent job changes and relocations because they tend to move in order to evade detection by employers and colleagues. The

Table 2. Family and social clues to chemical dependency

- Children are neglected or in trouble with the law
- Spouse in psychotherapy or taking psychoactive medication
- Separation or divorce
- Financial problems
- Family socially isolated
- Withdrawal from social activities
- Episodes of embarrassing behavior: e.g. public fights
- Legal problems: e.g. drunk driving

physician seeking employment may be overqualified for the job being applied for, or the doctor's qualifications may seem inappropriate. Look for unusually long intervals of time between jobs.

The physician's medical history is often telling. Impaired physicians often have chronic medical problems such as gastrointestinal disorders, seizures, hypoglycemia and psychiatric disorders. Another indication of medical problems is a long list of prescribed medications. There may be frequent hospital admissions. A work history may include long and unexplained absences from work.

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

Job performance is one of the last areas affected by chemical dependency. Some impaired physicians show mild deterioration in their clinical practice, or none at all. The physician 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 physician may take long bathroom and lunch breaks away from the work area, or may spend inordinate amounts of time

in his office with the door locked.

Paradoxically, the physician may be willing to work extra hours, particularly on public holidays, and is willing to be on call. The physician may moonlight at other clinics or hospitals. He or she may arrive long before a shift and stay long after, and may show up when not scheduled to work. The impaired physician working in a hospital may insist upon administering opioid analgesics himself and may spend time at the medication cupboard.

In time, the impairment affects the physician's relations with staff. Emergency room staff are most likely to catch physicians displaying abnormal behaviors such as mood swings, slurred speech, or overreacting to criticism from staff. Employers may notice increasing complaints from patients and other staff. The physician may be borrowing money from other employees. Hospital duties are often affected. Look for a deterioration in the physician's handwriting, inappropriate orders, unavailability when on call, and inappropriate responses to calls from referring physicians and nursing staff. The physician may prescribe controlled substances inappropriately, and often appears to believe that he or she is the only one capable of helping a patient. Clinical errors and malpractice suits may also be an indication of impairment.

Impaired physicians have a history of frequent job changes and relocations.

Table 3. 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

At later stages in the natural history of chemical dependence, the physician's health is directly affected.

Indications of drug diversion

One possible clue that an impaired physician is working at your hospital or clinic is evidence of drug diversion. A single instance may be due to human error; multiple episodes should arouse suspicions.

Some impaired physicians sell prescriptions to drug dealers in order to support an illicit drug habit. As a result, there may be an increase in the number of known drug addicts or drug seekers receiving narcotic prescriptions.

More commonly, impaired physicians divert drugs for their own use. Look for reports of missing drugs from the narcotic cupboard, as well as an increase in the frequency of restocking of non-controlled psychoactive drugs. A more subtle indication of diversion is an increase in the number of patients dissatisfied with their pain management despite receiving opioids. In some cases, impaired physicians or nurses administer sterile saline or water to the patient, keeping the opioid for themselves.

In addition, impaired physicians often show a lack of clinical judgement in their prescribing of controlled substances to their patients.

Overt signs and symptoms

At later stages in the natural history of chemical dependence, 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 physician's appearance can be subtle or striking. Look for pallor, weight loss, as well as evidence of poor hygiene. The impaired physician 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 physician, who either seldom eats or has a diet restricted to foods containing sugar. Often, the physician is constantly smoking cigarettes or is constantly sucking on hard candy or mints.

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

Table 4. Clues to chemical dependency at work

- Frequent absences from work
- Long disappearances from work area
- Willingness to work extra hours
- Appearing at hospital or clinic when not on duty
- Volunteering to administer parenteral opioids
- Increase in patient or colleague complaints



Colleagues should understand that the majority of impaired doctors who enter treatment later return to their careers successfully.

The indications of withdrawal from 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 physicians 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 physician

There are several reasons why it is often difficult to deal effectively with the impaired physician. First, many physicians 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 physician 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 physician or bring harm to themselves. In some cases, colleagues may do things to minimize the consequences of impairment, thus enabling the impaired physician 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 physician who is impaired by alcohol or drugs is to involve the state authorities in an effort to get the impaired doctor 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 medical associations.

Colleagues should understand that the behaviour of an impaired physician 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 physician's career is to arrange an intervention by the professionals employed with a state medical association. Colleagues should also understand that the majority of impaired doctors who enter treatment later return to their careers successfully (Reading, 1992).

Each state board of medical examiners has its own set of procedures and regulations regarding the disposition of physicians suspected of chemical dependency. For detailed information, contact your state board or your state medical association. In addition, most states have intervention and treatment programs for physicians, referred to as "physician's health programs" or "physician's recovery programs." These 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.

The professional and legal disposition of the impaired physician depends on how the problem is first detected. Ideally, concerned colleagues involve the state recovery program in an intervention before the physician has

done significant harm to his or her career. If the physician is identified by someone not associated with the state board of medicine, the board need not be notified unless state laws have been broken or 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 physician who voluntarily withdraws from practice while entering a treatment program.

The ultimate goal is to quickly identify the impaired physician so that treatment can be started without delay. Prompt treatment improves the prognosis for the physician's recovery and return to work.

Helping the impaired physician involves the following steps:

Recognition

Recognition is a proactive system aimed at identifying the impaired physician. Recognition is easier when the impaired physician commits a crime such as driving while intoxicated. But these are often 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 physician is often in denial. Documenting specific examples makes it much more difficult for the physician to effectively deny allegations of dependency. Such examples help the physician see the consequences of his or her actions.

Intervention

Intervention is the mechanism through which the impaired physician is helped by others to see the consequences of chemical dependency. An intervention is carried out by multiple participants, mainly individuals who play an important role in the person's private and professional life. It is led by a 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 techniques used. An enabling spouse can undermine the goals of the intervention. 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 physician accept a referral for treatment. Confronting the physician in an antagonistic manner may only serve to firm up his or her defenses. It is imperative to approach the physician in a non-judgmental manner that preserves the individual's dignity. The location chosen for the intervention should be quiet and non-threatening. The intervention should occur as soon as possible following a precipitant crisis, but should occur at the time when the physician is sober.

The physician is presented with documentation of specific behaviors. Since denial is common, it is much more effective

It is important to document specific instances of suspicious behavior, including signs and symptoms of impairment.

to cite specific, documented examples of suspicious behavior. It is worthwhile to consider and anticipate the possible reactions of the physician to the intervention. Getting the physician to understand the future consequences of ongoing impairment can be effective. Threats should not be made to the physician. However, an awareness that the state board of medical examiners has been informed and is awaiting the response of the physician before taking action can provide the impetus to seek treatment.

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

Evaluation and treatment

If the physician agrees to treatment, 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 physician become an active participant in the process of recovery.

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. Although physicians have been traditionally treated in 4 to 6 week long inpatient programs, the rising cost of inpatient care has meant that outpatient programs have become increasingly popular. Out-patient programs may require that participants live at a halfway house; some programs permit participants to return home each night. Long-term inpatient programs are often recommended to minimize relapses.

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, some rapid detoxification programs now use ultra short-acting general anesthetics along with opioid agonist-antagonists such as naltrexone and buprenorphine. There is also a role in some cases for antidepressant medication to treat depression associated with drug withdrawal. Disulfiram is used to discourage the use of alcohol. Recently, an oral form of naltrexone, which has been shown to block the euphoric effects of opiates, has been found to be a useful adjunct 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 physicians 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 being powerless over alcohol and drugs, and admits that substance abuse has caused the alcoholic's inability to manage his or her life. Other principles of the program include the alcoholic taking personal responsibility for his or her 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.

There are a number of treatment centers that exclusively treat physicians. One of the key features of physician-only programs is the concept of mirror image therapy. Following a period of time in treatment, the physician observes newer patients as a mirror image to his or her own impairment (Centrella, 1994).

In most treatment programs, the impaired physician signs a recovery or continuing-care contract. This document represents the physician's signed admission of responsibility for his impairment as well as his commitment to change. This contract usually commits the physician 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.

For example, the continuing care contract at Georgia's Impaired Physician's Program requires that recovering physicians participate in aftercare for a period of 20 months. It requires that attendees undergo frequent random urine drug screens, have a primary care physician, and a monitoring

physician who acts as a recovery mentor. The Georgia contract requires recovering physicians to attend a minimum of 5 AA or NA meetings per week, and 1 Caduceus Club (a twelve-step recovery group for health professionals) meeting. Other components of the contract include individualized fitness and spirituality programs, as well as psychotherapy and marital therapy where indicated (Gallegos et al., 1992).

Aftercare

Treatment does not end with discharge from a hospital or outpatient program. Impaired physicians 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. Follow-up appears to be a more important determinant of successful recovery than the method of treatment. Follow-up of at least 2 years correlates positively with successful outcomes.

Impaired physicians
require long-term
care and follow-up.

VII. Returning to work

In the past, recovering physicians 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 physicians cannot return to work, although they may be advised not to return to their original specialty or to work outside of medicine for a period of time. Consult your state board of medical examiners for its specific regulations and guidelines.

In general, employers should treat the

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

Second, the employer should review the physician's recovery contract. The contract provides the employer with clear objectives and guidelines on issues such as attendance

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at twelve-step meetings and random urine testing. Such a contract makes it much easier for employers to take action should the physician show indications of a relapse.

Alternatively, the employer and the physician 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 California Physicians Diversion Program requires that recovering physicians with hospital privileges inform the hospital's Well-Being Committee that they are in the program. Physicians who do not have hospital privileges are required to inform an equivalent monitor at the physician's place of work (Pelton & Ikeda, 1991).

The first 90 days are critical to the physician's recovery. Physicians require a high level of support during that period of time. Thus, it is recommended that the physicians attend a large number of support group meetings during the first 90 days. Since a healthy lifestyle is an important part of recovery, the physician doing shift work should be assigned to a strict day schedule during that time.

Random urine drug screens are an important part of the return-to-work contract. These are unscheduled and take

place at intervals ranging from once a day to once a month. The drug screens are usually performed by the physician's recovery program or by the therapist or physician supervising treatment. However, urine testing may be performed by the physician's employer, with anonymity for the employee maintained. If the recovery assistance program or aftercare program does the testing, the employer should have routine access to the test results.

A somewhat controversial part of some recovery programs is known as contingency contracting. In a written contract, the recovering physician directs his or her therapist to mail a letter voluntarily surrendering the physician's license to practice in the event of a positive urine test. Although some studies have not documented any benefits to negative reinforcing measures, one study of contingency contracting demonstrated a 100-fold reduction in drug-use days by this method. It should be emphasized that contingency contracting is not used by itself, but is intended to help provide a useful period of monitoring in order to make lasting changes (Centrella, 1994).

A contingency contract has enabled some physicians to obtain probationary privileges that they would not otherwise have been able to obtain.

Table 5. **Suggestions for return to work**

- Recovery assistance program involved
- Return-to-work contract
- Frequent Twelve-Step meetings in first 90 days
- Strict day schedule
- Random urine drug screening
- Contingency contracting
- Inform other employees if physician agrees



The consequences of relapse depend upon the return-to-work contract as well as regulations and guidelines of the state board of medicine.

VIII. Relapse

Physicians in treatment programs have better outcomes than the general population. Two-year follow-up data from the Physician's Health Program of the Medical Society of New Jersey demonstrated a recovery rate of 83.8% with no relapses and 13.8% with one relapse (Reading, 1992). A longer follow up study of recovering physicians in Georgia showed a 77% rate of documentable abstinence (Gallegos et al., 1992). These results greatly exceed recovery rates for the general population, even though non-physicians who enter treatment are exposed to similar treatment modalities. The better outcome for physicians may be the result of better motivation, close monitoring, clear consequences for treatment failure, and better aftercare.

Nevertheless, relapse is part of chemical dependency. It is not regarded as a failure on the part of the recovering physician. 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. Family and emotional issues frequently trigger relapse. Some physicians refuse to believe that drug abuse is a lifelong disease.

The consequences of relapse depend upon the return-to-work contract as well as regulations and guidelines of the state board of medicine. For instance, the employer may be obliged to report the physician to the regulatory agency. If a contingency contract is in place, the therapist may be obliged to send the physician's letter of resignation to the state medical board. An 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 physician to law enforcement authorities.

IX. Conclusion

Chemical dependency is prevalent in our society, and physicians are at particular risk. Chemical dependency erodes the self-esteem of the impaired physician. 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 recovering physician to find a new and ultimately satisfying way of life.

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