Abstract

In 1973, the American Medical Association’s Council on Mental Health defined impairment in physicians as “the inability to practice medicine with reasonable skill and safety to patients by reasons of physical or mental illness, including alcoholism or drug dependence.”

Identification of the impaired physician is essential because patient safety may be at stake, and untreated substance dependence may lead to loss of license, serious health problems, and even death.

Keywords

Prevalence of use
Characteristics
Impaired woman physician
PHP
Intervention
Confrontation
Treatment
Aftercare
Recovery

Key Chapter Points

- In 1973, the American Medical Association’s Council on Mental Health defined impairment in physicians as “the inability to practice medicine with reasonable skill and safety to patients by reasons of physical or mental illness, including alcoholism or drug dependence.”
- Most physicians who abuse substances continue to function fairly well until the problem is far advanced.
- There are six areas in physicians’ lives where clues to their chemical dependence can be found: (1) community involvement, (2) family life, (3) employment patterns, (4) physical status, (5) office conduct, and (6) hospital duties.
- Although nearly one-third of physicians are female, nearly 90% of physicians referred for substance use disorder treatment are male.
- Nearly all state medical societies and state licensing boards have a Physician Health Program (PHP) for dealing with impaired physicians.
The Federation of State Physician Health Programs (FSPHP) is a nonprofit organization that serves as a forum for information exchange among the various state programs. The AMA’s Code of Medical Ethics states that “physicians have an ethical obligation to report impaired, incompetent and unethical colleagues” and lists several guidelines to follow. Typically, the substance-dependent physician is more dysfunctional (physiologically, psychologically, socially, spiritually) than nonphysicians. Treatment often is divided into three phases: (1) inpatient, (2) halfway house, and (3) mirror imaging. When a structured aftercare program is undertaken, the success rate increases to approximately 90%. In 1973, the American Medical Association’s Council on Mental Health defined impairment in physicians as “the inability to practice medicine with reasonable skill and safety to patients by reasons of physical or mental illness, including alcoholism or drug dependence.”

Identification of the impaired physician is essential because patient safety may be at stake, and untreated substance dependence may lead to loss of license, serious health problems, and even death. Physicians frequently begin using alcohol or other drugs to self-medicate their own stress. They may have compulsive personality traits, marked by a triad of self-doubt, guilt over perceived deficiencies, and an excessive sense of responsibility. These traits are often combined with a low intrinsic sense of self-worth because physicians typically identify their self-worth with what they do rather than who they are [1].

Most of the risk factors for physician substance abuse are similar to those of the general public. However, among the strongest physician-specific predispositions to developing substance abuse are (1) self-treatment with prescription medications, (2) high stress or long hours of practice, and (3) easy or constant access to controlled substances [2].

### 1. Prevalence of Use

The prevalence of substance dependence among physicians is difficult to ascertain and probably will remain that way since many impaired physicians are not identified and treated and some have entered treatment voluntarily and confidentially, never coming to the attention of the licensure board. Conservative estimates are that 8–eight 12% of physicians will develop a substance abuse problem at some point in their careers. At any given time, as many as 7% of practicing physicians may have a substance use disorder [2].

Alcohol is the most commonly abused substance among physicians. Compared with the general population, physicians have higher rates of prescription drug abuse, particularly benzodiazepines and opioids. This is because of the common practice of self-treatment and the ease of access to many drugs [3]. Minor differences exist in the incidence of abuse in certain medical subspecialties, with emergency medicine, psychiatry, and anesthesiology, having slightly higher rates of abuse than other specialties [2].

### 2. Characteristics of the Impaired Physician
Most physicians possess a strong drive for achievement, they tend to be very conscious, and they have an ability to deny personal problems. Although these attributes are advantageous for success in medicine, they may predispose to impairment.

Most physicians who abuse substances continue to function fairly well until the problem is far advanced. Alcoholics, for instance, can often remain sober during working hours for many years, even though they drink large amounts of alcohol at night and on weekends. Intravenous opioid or cocaine abusers, on the other hand, may go from use to dependence in a matter of weeks to months [2].

Identifying impaired physicians is difficult, primarily because of two factors: (1) the conspiracy of silence among professionals and other people in physicians’ lives and (2) self-deception in impaired physicians. Talbott and Benson presented six areas in physicians’ lives where clues to their chemical dependence can be found: (1) community involvement, (2) family life, (3) employment patterns, (4) physical status, (5) office conduct, and (6) hospital duties. The areas become involved sequentially, although two or three may seem to be involved simultaneously. The last area affected is the medical setting—hospitals, staff rounds, emergency departments, and medical society meeting [4].

2.1. Community Involvement

Isolation and withdrawal from the community and its activities often signal the onset of chemical dependence in physicians. Talbott and Benson described the “target syndrome” in which successive rings of involvement (community activities, leisure activities, church, friends, peers, distant family, nuclear family) are peeled away until only the center of the target, the physician, remains. The community and friends gradually lose respect for the physician and lose confidence in his emotional stability.

The impaired physician becomes isolated and withdrawal from community activities, leisure activities and hobbies, church, friends, and peers. He displays embarrassing behavior at clubs or parties, and may have arrests for driving while intoxicated and other legal problems. He is unreliable and unpredictable in community and social activities. His behavior is unpredictable. He may develop inappropriate spending habits and excessive involvement in political activities [4].

2.2. Family Life

As part of the target syndrome, impaired physicians withdraw from family activities, relationships, and communication. They have unexplained absences from home. They may get into fights and may be guilty of child abuse. The children may become involved in abnormal, antisocial, and illegal behavior. Family fights may occur. The best way to identify impaired physicians is not to ask who drinks alcohol or uses other drugs addictively but instead to look at those physicians who are separated from their families or whose children have serious emotional, legal, or scholastic problems.

The spouse and children may have to assume surrogate roles due to the “absence” of the impaired physician.

Sexual problems—impotence, extramarital affairs, and contracultural sexual behavior—may occur. The spouse may physically leave him, and divorce proceedings may take place [1].

2.3. Employment Patterns
The impaired physician may have a history of making numerous job changes in the past 5 years. He may also make frequent geographic relocations for unexplained reasons (geographic cure). Unexplained intervals between jobs can also be a significant clue. Inappropriate jobs for a person’s level of training may be another clue. He may have hospitalizations for drug-related problems. His medical history may be complicated and elaborated. In job applications, he may give indefinite or inappropriate references, and he may be reluctant to let his spouse and children be interviewed. He also may be reluctant to undergo an immediate preemployment physical examination for fear that his liver enzymes will be found to be elevated or other signs of drug dependence will be discovered [4].

2.4. Physical Status

Next, physical signs and symptoms of the disease become evident. Poor personal hygiene and unkempt appearance in a previously well-dressed physician are strong clues. Deterioration in his clothing and dressing habits may develop.

Numerous and constant physical complaints, frequent visits to fellow physicians, multiple medications (often self-prescribed), and frequent hospitalizations may provide additional clues.

Repeated automobile accidents or accidents while on vacation or involved in hobbies or leisure activities may also provide evidence of chemical dependence, as may wide mood swings and emotional crises [4].

2.5. Office Conduct

Impaired physicians may arrive late or have unexplained and lengthy absences from their offices. They may have frequent “illnesses.” They may have disrupted appointment schedules.

They may become angry, hostile, and inconsistent, prompting complaints from patients and, later, office staff. Physicians may give inappropriate orders, and frequently lock themselves in their offices or bathrooms to use drugs. Talbott and Benson call this the “locked-door” syndrome.

They may order medications for themselves from local druggists or by mail or email. Patients may complain to the staff about the doctor’s behavior [4].

2.6. Hospital Duties

The last place impaired physicians’ problems become apparent is in the hospital. Making rounds at midnight, writing inappropriate orders, going into the wrong rooms, reading the wrong charts, writing more illegibly than usual, or writing inappropriate orders for medications can all be signs of substance dependence.

The impaired physician’s behavior frequently changes, and he may be slow in responding to emergency room calls or not answer them at all. Hospital staff may notice slow, slurred speech, and may report smelling alcohol on his breath. Impaired physicians may become involved in malpractice suits and legal sanctions against hospitals. Reports of behavioral changes from hospital personnel (“hospital gossip”) may begin [4].

Artecona also compiled a list of characteristics that may help identify the impaired physician (Table 23.1 [5]).

Table 23.1 Characteristics of the impaired physician: (Based on Artecona [5])
<table>
<thead>
<tr>
<th>Alteredcations with staff, peers, and patients</th>
<th>Inappropriate orders</th>
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<tbody>
<tr>
<td>Avoids departmental meetings, CME events,</td>
<td>Indefinite references</td>
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<tr>
<td>medical social events</td>
<td>Irresponsibility</td>
</tr>
<tr>
<td>Black-outs</td>
<td>Irritability, mood swings</td>
</tr>
<tr>
<td>Bruises</td>
<td>Negative attitude, argumentative</td>
</tr>
<tr>
<td>Decreased performance</td>
<td>Odd hours for rounds, volunteers for graveyard shift, absent from doctor’s lounge, eats alone</td>
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<tr>
<td>Deviation from standard procedures</td>
<td>Overreaction to criticism</td>
</tr>
<tr>
<td>Dilated or constricted pupils</td>
<td>Personality change</td>
</tr>
<tr>
<td>Disheveled appearance</td>
<td>Prolonged lunch break</td>
</tr>
<tr>
<td>Drug procedures (use of excessive amounts,</td>
<td>Red, yellow, or black and blue eyes</td>
</tr>
<tr>
<td>unwitnessed wasting, insufficient patient</td>
<td>Slurred speech on phone</td>
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<tr>
<td>analgesia, excessive spillage/breakage)</td>
<td>Staff, patient, or peer complaints</td>
</tr>
<tr>
<td>Frequent forgetfulness</td>
<td>Subject of hospital gossip (marital problems, DUI, financial problems, party reputation)</td>
</tr>
<tr>
<td>Frequent illness</td>
<td>Tremors</td>
</tr>
<tr>
<td>Frequent malpractice actions</td>
<td>Unavailable when on call</td>
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<tr>
<td>Frequent tardiness, frequent absences</td>
<td>Unexplained intervals between jobs, frequent job changes, frequent relocations</td>
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<tr>
<td>Frequent trips to bathroom</td>
<td>Unusual medical history</td>
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<td>Hasty rounds</td>
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<td>Heavy drinking at staff or social functions</td>
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<td>Inaccessibility</td>
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<td>Inappropriate anger</td>
<td></td>
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<td>Inappropriate charting</td>
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</tbody>
</table>

Impaired physicians don’t seek help due to shame and guilt, and they are conditioned to maintain emotional control. Time demands of work make it hard to get care. They fear stigma and career impact, and they see themselves as healers—not among those who need healing.

Physicians who are abusing alcohol or other drugs work hard to keep their probable invisible. They become loners, avoiding colleagues and friends who might notice the effects of substance abuse. Suggestions that the physician’s behavior or performance has changed are first met with explanations and later with avoidance or anger. The drug-abusing physician will often leave a job rather than being identified as impaired [2].

Differentiating substance abuse from clinical depression can also be difficult. A depressed colleague may not be outwardly depressed. As with the substance abuser, there may be irritability, apathy, or interpersonal strife. The physician’s quality of work may decline because of sleep problems, fatigue, or poor concentration, and he may fall behind on record keeping and other administrative duties. Attempts to compensate for low productivity may result in working excessive hours or rounding at unusual times. The depressed physician may withdraw from participation in once enjoyable social activities and may exhibit an increased use of alcohol and
drugs. Clearly, there is a considerable overlap between impairment by substances and depression [6].

3. The Impaired Woman Physician

Although nearly one-third of physicians are female, nearly 90% of physicians referred for substance use disorder treatment are male. Female physicians are more likely to suffer major depression and less likely to have a personality disorder or to have criminal consequences of their substance use problem. They are more likely to undergo treatment and more likely to have suffered permanent physical damage from their substance use than their male counterpart.

Female physicians also are—more likely to have begun their substance use after a traumatic life event, and to have a shorter course between the onset of drug use and the initiation of treatment. They are less likely to use illicit substances. They are more likely to take prescribed opioids and tranquilizers than their male counterparts [1].

Several studies have examined substance-dependent women in medicine. Bissell and Skorina examined the patterns of diagnosis, referral, and help-seeking behaviors of 95 alcoholic women in AA who had at least a year of sobriety. Addiction to drugs other than alcohol was common, with only 40% reporting addiction to alcohol alone. Nearly 77% reported serious suicide ideation prior to sobriety, 27.4% reported suicide ideation after stopping drinking, and 40% had actually made suicide attempts—15.8% of them more than once. Treatment experiences ranged from AA only (21%) to long-term resident treatment of 15 weeks or more (23%). Most had reached treatment by means other than referral by therapists or by impaired physician committees [7].

Martin and Talbott studied 37 female physicians who had been in treatment in the Georgia Impaired Physicians Program. This represented only 4.6% of all physicians in the program, despite the fact that nationally, at that time, women made up 13.4% of all physicians. The physicians tended to be high academic achievers, and many had mates who expected them to fit into traditional social and family roles. Many identified with self-effacing and nonassertive roles rather than with more powerful postures male physicians often identify with [8, 9].

Many of the issues of female physicians in treatment are the same as those of nonphysician women discussed in Chap. 15.

4. Physician Health Programs

4.1. Early Efforts

The American Medical Association (AMA) provided early leadership in the area of physician impairment. In 1972, the AMA House of Delegates adopted a policy statement declaring that any physician who became aware of an apparent problem in a colleague had the ethical responsibility to take affirmative action—that is, to seek treatment or rehabilitation for that physician [10].

In 1974 the AMA drafted model legislation that state legislatures could use in modifying individual medical practice acts to provide for the treatment and rehabilitation of impaired physicians. The response of state medical societies to those initiatives was dramatic [11, 12].

4.2. The Programs
Nearly all state medical societies and state licensing boards have a Physician Health Program (PHP) for dealing with impaired physicians. State medical society programs typically offer impaired physicians confidential and nonpunitive assistance. If they refuse to cooperate in their own rehabilitation, some state medical associations report them to the state board of medical examiners. Some PHPs are run by independent nonprofit corporations and others by state medical societies; still others are under the aegis of state medical licensing boards. Some are well funded; others are not.

All shared information is treated confidentially and can be given without fear of retaliation. The PHP can serve as an advocate for the physician before the medical board. After the initial contact is made with the PHP, the organization will arrange for a comprehensive assessment of the physician to help identify a substance abuse problem or psychiatric illness.

If the PHP determines that an intervention is needed, a small group consisting of representatives from the PHP or local physician wellness committee, and sometimes colleagues, will meet with the physician and recommend a formal evaluation be done to determine if any treatment is necessary [11, 13].

Medical societies usually have mechanisms for confidential reporting of impairment. Reports may come from colleagues, hospital administrators, nurses, patients, or physicians’ families. Once the information is verified, it is given to a committee member, or members, who is responsible for confronting physicians with evidence of their impairment and persuading them to enter treatment [14].

At the end of treatment, physicians enter into a contract with the PHP, which typically lasts for 5 years for substance dependence. Random urine drug screens are required with declining frequency. Members are required to attend 12-step support group meetings (AA, NA, CA) three to four times per week in the first 3 years and two to three times per week in the last 2 years. They also are required to attend a Caduceus meeting once a week. Group and/or individual therapy or treatment may be required for a minimum of 2 years. Workplace/practice monitoring is required.

Dupont et al. looked at 904 physician participants enrolled in the 16 PHPs. The physicians were predominantly male (86%). The average participant was 44 years old and married (63%). Family medicine represented 20%, internal medicine 13%, anesthesiology 11%, emergency medicine 7%, and psychiatry 7%. The primary drugs of choice reported by these physicians were alcohol (50%), opioids (33%), stimulants (8%), and other substance (9%).

Fifty percent reported abusing more than one substance, and 14% reported a history of intravenous drug use. Seventeen percent had been arrested for an alcohol or other drug-related offense, and 9% had been convicted on those charges. Thirty-nine percent had a prior experience in addiction treatment, and 14% had experienced disciplinary action by their licensing agency prior to this episode of care [15].

4.3. Federation of State Physician Health Programs

The Federation of State Physician Health Programs (FSPHP) is a nonprofit organization that serves as a forum for information exchange among the various state programs.

The Federation of State Physician Health Programs evolved from the initiatives taken by the American Medical Association (AMA) and individual state physician health programs. It focuses on rehabilitation and monitoring of physicians with psychoactive substance use disorders as well as mental and physical illness [16].
5. Intervention by Confrontation

Directly questioning a physician about his substance abuse is rarely successful, and will often lead to counter accusations, such as “You’re out to get me” and “You are trying to ruin my practice.”

The AMA’s Code of Medical Ethics states that “physicians have an ethical obligation to report impaired, incompetent and unethical colleagues” and lists several guidelines to follow. Before reporting impaired physicians to the state licensing board, the guidelines state that doctors should try to get an impaired colleague into a treatment program or contact their hospital’s chief of staff [17].

However, in a survey by Terry, only 65% of physicians stated that they would report the impaired physician to the appropriate authorities. Thirty-one percent said they would talk to the physician privately, but take no other action. Five percent said that they would ignore the situation [18].

A process that culminates in confrontation, intervention, is often necessary to get impaired physicians to go to treatment because they have difficulty reaching out for help. It involves convincing them of the seriousness of their drug problem and helping them enter treatment, while protecting their dignity, preserving their anonymity, and sparing them embarrassment. It is not an easy or pleasant task, but it is a necessary one. The two main types of intervention are professional and nonprofessional. Nonprofessional intervention is done most often by family members and/or close friends [4, 11], and was discussed in Chap. 17. Professional intervention is discussed below.

5.1. The Intervention Team

The intervention team should consist of at least two persons. The team concept allows the confronters to give each other emotional support. At least one member of the team should be someone in the same specialty, of the same sex, and, if possible, recovering from substance dependence. Members of the team should have nonjudgmental and supportive attitudes and should have experience or training in intervention strategies [11].

Members of the intervention team must have no professional or social association with the impaired physician. Because of the impaired physician’s denial, he would use such a relationship to destroy the effectiveness of the intervention [19].

5.2. Preparing for the Confrontation

Training of the intervention team begins by examining their attitudes and instilling desirable ones in them. These attitudes include: understanding, appreciating, and accepting that substance dependence is a biopsychosocial disease, not a bad habit, moral or ethical fault, or psychological disorder. Substance dependence is a disease involving the family, which needs to be included and helped.

Response to the intervention team may be anger, threats, hostility, or massive denial; the team must be prepared for this.

The intervention team should have clearly defined goals and objectives for the confrontation. Regardless of its outcome, the team should have a plan of action when they leave the confrontation. Members should anticipate and be prepared to deal with denial, hostility, and
other defenses. They should have documentation on paper of the impaired physician’s destructive behavior and actions resulting from substance dependence, and they should mobilize support systems, including the spouse and older children and the physician’s partners, peers, nurses, or hospital administrator. The team may have to meet two or three times before actually confronting the impaired physician [19].

5.3. The Confrontation

When the members of the team feel they are adequately prepared, they contact the impaired physician by telephone, telling him that the caller represents the state medical society and that they need to see him or her immediately on professional business, which is too personal to discuss on the phone. The physician is given a choice of meeting with the team in his office, his home, or in the state medical society office. A date, time, and place for the meeting are then arranged.

At the time of the confrontation, the following procedure is followed [19]:

1. The leader of the intervention team introduces himself or herself as well as the other members of the team and explains why they are there.
2. The leader explains the medical society’s program for impaired physicians and its advocacy role. The physician is told that the team is there to help, not hurt.
3. The team member who is a recovering physician discusses his disease and recovery, pointing out that substance dependence is a treatable disease and that the behavior, actions, emotions, and consequences are secondary to the illness. Members emphasize that the impaired physician is suffering from a disease and is not bad, evil, weak, or crazy.
4. Members present the specifics of the physician’s drug-abusing behavior in a factual, nonjudgmental manner.
5. Members anticipate the physician’s responses, such as denial, anger, or rationalization. They should never argue with the physician or get angry or defensive, even in the face of personal or professional attack.
6. The team should not let the physician sidetrack the discussion.
7. The intervention team shares its assessment of the seriousness of the physician’s problem.
8. Members explain what will happen if the physician does not enter treatment.
9. The impaired physician is given specific treatment plans and programs, both local and out of state, but is not allowed to arrange for a friend to treat him. Members advise him that the treatment plans and programs presented are the only ones acceptable to the state medical society [19, 20].

Once a mutually acceptable treatment source is agreed on, arrangements are made for the physician to enter treatment. He is presented a contract that states he will not practice again until cleared according to the advocacy position of the state medical society as it relates to licensure, medical staff positions, and medical standing in the community.

If the team is unsuccessful, it returns in a day or two. If this intervention fails, the physician is told that the intervention committee will abandon its advocacy role and make a report to the impaired physician committee, which in turn may file a report with the state medical association, which can then notify the state examining and licensure board of the physician’s problem [19].

6. Treatment
Typically, the substance-dependent physician is more dysfunctional (physiologically, psychologically, socially, spiritually) than nonphysicians. They often have been so absorbed in their practices that they have become isolated from other people. Because elaborate denial and defense mechanisms are part of the disease of substance dependence, they go to great lengths to deny that they have a problem and to prove that their lives are under complete control. Another problem with treating physicians is that they adamantly reject the role of patient.

The treatment of physicians with substance dependence problems is different from the treatment of the general public. Short-term outpatient therapy relapse rates are greater than 60%, which is unfavorable, considering physicians will be returning to a workplace where judgment must not be compromised. Extended treatment that lasts three to 4 months has better success rates [11].

Treatment of physicians is more successful if it takes place in a center that has a significant number of other physician patients. Unless there are a number of physician patients in the program, the physician in treatment often gets special treatment from other patients and staff, negating some of the benefits of treatment [2]. The sarcastic title “Mdiety” sometimes is given to physicians in this circumstance.

Although there is a relatively low incidence of primary psychiatric disorders among substance-dependent physicians, secondary depression is common. This usually clears in a few days to weeks after detoxification. Physicians tend to minimize their drug use. Whereas street addicts tend to congregate in a drug culture, physicians tend to use drugs privately for fear that their drug abuse will be discovered [11].

Because of most physicians’ high level of denial, inpatient treatment is almost always indicated. Treatment programs vary considerably throughout the country. The format for the Medical Association of Georgia’s Impaired Physician Program has become a model for many. Treatment is divided into three phases: (1) inpatient, (2) halfway house, and (3) mirror imaging [21].

**Phase I. Inpatient**

The first phase is inpatient treatment, which lasts 28 days or more, and obeys the same principles outlined in Chap. 15. In addition, problems specific to physicians, such as practice and licensure issues, are discussed in groups for impaired health professionals.

**Phase II. Halfway House**

During the second phase, physicians live in halfway houses with other impaired health professionals. During the day, they attend a partial hospitalization (day program). Several evenings a week, they attend AA or NA meetings, and once or twice a week, they attend a Caduceus meeting, which is a support group for health professionals. This phase is about a month long.

**Phase III. Mirror Imaging**

In phase three, physicians participate in a process called mirror imaging. As part of treatment, they may work in treatment centers as associate counselors, but not as physicians. Mirror imaging is a method of allowing patients to see other patients whose disease is more
advanced than theirs and to realize that “there, but for the grace of God, go I.” They continue to live in half-way houses, to attend evening AA or NA meetings, and to attend some evening group sessions. They also continue to attend Caduceus meetings. This phase may last 1 year to 2 months or more.

There are several prognostic indicators as to whether a physician will do well in treatment and recovery and be able to return to medical practice. These indicators include the following: (1) an acceptance by the physician accepts that he has the disease of substance dependence and has a high motivation for recovery; (2) he has supportive family members, significant others, and close friends; and (3) there are minimal legal complications and problems with license, hospital privileges, or employment.

7. Aftercare

At the time of discharge from treatment, physicians sign aftercare contracts that may require them to attend three to four AA or NA meetings a week, as well as weekly meetings of local Caduceus clubs. Random drug screens are an integral part of aftercare, which usually lasts for 5 years. During this period, and afterwards, Caduceus clubs serve as physician advocates in issues such as licensure and DEA registration [22–24].

8. Recovery

After treatment, most physicians can return to their prior specialties. For all physicians with substance use impairment, work hours may need to be restricted to allow a gradual return to work that coincides with establishing a steady recovery program.

Recovery for physicians progresses through the same stages as for nonphysicians—pretreatment, stabilization, early recovery, middle recovery, and late recovery. Recovering physicians also may be caught up in partial recovery, and many of the factors contributing to their relapse are the same as for other addicts (Chap. 17).

Many physicians face a temptation nonphysicians do not have to deal with—such as returning to a profession in which mood-altering and addicting drugs are abundant. The anesthesiologist whose drug of choice was fentanyl, for example, must return to the operating room after treatment and actually administer the drug to patients. When relapse does occur, physicians should follow the procedures outlined in Chap. 16.

A factor that may be important to a successful return to practice is the possibility that relapse will entail financial, personal, and professional losses. Modifiable factors that contribute to relapse include failure to understand and accept that substance dependence is an illness, continued denial, a dysfunctional family, poor mechanisms to cope with stress, overconfidence, poor relationship skills, and shame and guilt [25].

For married physicians, spouses usually play major roles in detection, intervention, treatment, and recovery. Families can be physicians’ most important resources in recovery. Al-Anon, Alateen, and Nar-Anon can be exceptional sources of information and support for spouses and other family members [26–28].

Success rate for treated substance-abusing physicians is about 70%. However, when a structured aftercare program is undertaken, the success rate increases to approximately 90%. The majority of relapses occur in the first 2 years after treatment. After 5 years of recovery, physicians are less likely to suffer a relapse [2].
9. Summary

Conservative estimates are that eight to 12% of physicians will develop a substance abuse problem at some point in their careers. In 1973, the American Medical Association’s Council on Mental Health defined impairment in physicians as “the inability to practice medicine with reasonable skill and safety to patients by reasons of physical or mental illness, including alcoholism or drug dependence.” Most physicians who abuse substances continue to function fairly well until the problem is far advanced.

There are six areas in physicians’ lives where clues to their chemical dependence can be found: (1) community involvement, (2) family life, (3) employment patterns, (4) physical status, (5) office conduct, and (6) hospital duties. Directly questioning a physician about his substance abuse is rarely successful, and will often lead to counter accusations, such as “You’re out to get me” and “You are trying to ruin my practice.” Although nearly one-third of physicians are female, nearly 90% of physicians referred for substance use disorder treatment are male.

Nearly all state medical societies and state licensing boards have a Physician Health Program (PHP) for dealing with impaired physicians.

The Federation of State Physician Health Programs (FSPHP) is a nonprofit organization that serves as a forum for information exchange among the various state programs. The AMA’s Code of Medical Ethics states that “physicians have an ethical obligation to report impaired, incompetent, and unethical colleagues” and lists several guidelines to follow.

Typically, the substance-dependent physician is more dysfunctional (physiologically, psychologically, socially, spiritually) than nonphysicians. Treatment often is divided into three phases: (1) inpatient, (2) halfway house, and (3) mirror imaging. When a structured aftercare program is undertaken, the success rate increases to approximately 90%.

References


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