

## Chemically Dependent Health Professionals

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***No one drinks to become alcoholic, any more than one eats medium rare hamburgers for the purpose of having a myocardial infarction or seeks unsafe sex to acquire syphilis.***

DAVID C LEWIS

### INTRODUCTION

***Early on, I was able to control and/or curb the use of alcohol periodically.... [Later] I started each day remorseful and promising myself I wouldn't drink, but almost invariably concluded the day drinking.... The last days of drinking were horrible. Nothing was functional in my life except the anger and resentment I directed at those who were trying to help. Until the final stages of my drinking, to my knowledge, no one ever suggested to me that there may have been a problem, and I certainly couldn't recognize the problem in myself.***

ANONYMOUS<sup>1</sup>

***An unused 5-cc syringe lay among the rubble of my failed efforts. As I picked up the syringe, a thought flickered across my mind: What would it feel like?... Months later, I was profoundly aware of the deception that had taken over my life—it was almost like having another personality.... One time I overdosed and put my head on the operating table next to the bypass patient. I had nodded off and was fast asleep. The surgeons and others made light of it, and I excused my aberrant behavior by saying I was overworked and exhausted.***

IGOR ROSIEN<sup>2</sup>

Fortunately, these physicians ultimately received treatment, established recovery, and lived to tell their story. Not all are as fortunate. Untreated addiction to alcohol or drugs is a devastating, chronic, and often fatal disease. The hallmark of addiction is the compulsion to continue to use a substance even after having adverse reactions to it. Addicts are neither morally weak nor lacking in ethical character or willpower. They develop guilt and shame as their behavior violates their own value system.

In physicians, the disease of addiction is almost always in an advanced state before signs and symptoms become obvious in the workplace. Although the actual prevalence remains unknown,<sup>3</sup> 8% to 12% of health professionals are estimated to develop a substance-related disorder at some point in their life. Risk factors that may increase the likelihood of addiction in health professionals are shown in the box below.<sup>4</sup>

Early symptoms of chemical dependency are frequently nonspecific. Chemical dependency has been called the “great imposter and masquerader” and likened to syphilis in its ability to mimic multiple conditions.<sup>5</sup> The table lists symptoms frequently seen as addiction develops.

Risk factors for addiction in Health professionals
<ul style="list-style-type: none"> <li>• Family history of chemical dependence</li> </ul>
<ul style="list-style-type: none"> <li>• Access to pharmaceuticals</li> </ul>
<ul style="list-style-type: none"> <li>• Emotional problems</li> </ul>
<ul style="list-style-type: none"> <li>• High levels of stress</li> </ul>
<ul style="list-style-type: none"> <li>• Thrill seeking</li> </ul>
<ul style="list-style-type: none"> <li>• Self-treatment of pain</li> </ul>
<ul style="list-style-type: none"> <li>• Chronic fatigue</li> </ul>

## **BARRIERS TO IDENTIFICATION: CONSPIRACY OF SILENCE**

Physicians frequently fail to confront addiction in colleagues, even when its presence is undeniable.<sup>6</sup> Colleagues may delay reporting in an effort to protect a possibly impaired practitioner from adverse consequences such as shame, social stigmatization, income loss, and licensure actions.<sup>7</sup> We are afraid of being wrong and may fear retaliation.

Yet, failing to identify addiction because of possible consequences is like failing to diagnose a cancer because it will cause pain. Addiction is probably the only condition in which we avoid diagnostic procedures until the patient is in critical condition. Out of loyalty and respect, we think we owe our colleagues a chance to deal with their substance use on their own. We think that they will be able to stop if they know they are in trouble and that they can get it under control themselves.

Addicted persons develop denial, which convinces them that the disease is not present. Denial is an unconscious psychological defense mechanism that develops over time through repeated rationalization. Denial differs from lying in that it is not a conscious intent to deceive. It allows addicts to justify their behavior and to avoid painful knowledge about their actions.

Even without denial, the guilt and shame associated with this diagnosis will cause the professional to avoid detection and resist treatment. Associates, colleagues, and spouses are also susceptible to the use of denial.<sup>8</sup> Significant others who would never think of ignoring symptoms of diabetes in their loved one tolerate signs of addiction or turn away in frustration. The deteriorating behavior, poor performance, absenteeism, and isolation of the addicted professional are frequently attributed to stress from the relationship or financial and business difficulties that the person encounters, rather than the addiction that underlies them all. Addiction is a diagnosis we are loath to make except by exclusion of all other possibilities. Fear of damaging the professional standing of a colleague—particularly if not absolutely

certain the condition exists — causes colleagues to rationalize behavior, minimize difficulties, and avoid confronting the addicted person.

## Summary Points

- Health professionals are not immune to alcohol and drug addiction
- Chemical dependency occurs in intelligent, ethical, conscientious providers, but it will alter these traits as it progresses
- Chemical dependency does not have to destroy a professional's career, personal life, or professional standing
- Timely identification, diagnosis, and intervention—with coercion, when needed—may save a career and a life
- Untreated addiction leads to disability and/or death; treatment leads to recovery and renewal of life

## PROFESSIONAL RESPONSIBILITY

Many states have requirements for institutes and licensed professionals to report to the licensing board a physician who they think may be impaired. The requirement does not include proving impairment because that is the purview of the licensing authority. The overriding concern behind these regulations is the protection of the public. However, the threat of disciplinary action can serve as a powerful deterrent to physicians seeking treatment and to colleagues reporting suspected impairment.

To try to meet the need for public protection and to provide an avenue for confidential rehabilitation for the practitioner, most states have developed organized physician health programs (PHPs) (see resources box). Reporting to these entities may satisfy the requirement to report while avoiding formal investigation and disciplinary action.<sup>9,10</sup>

A comprehensive report on the philosophy, components, and structure of effective PHPs is available from the Federation of State Medical Boards.<sup>11</sup>

Disciplinary action does little to intervene in chemical dependency and is frequently counterproductive to recovery and professional reintegration. Physician health programs offer confidential consultation and assistance with interventions. They will facilitate selection of an evaluation or treatment center, assist with workplace reintegration, and provide a comprehensive program of aftercare and monitoring. Monitoring by PHPs is designed to detect relapse, which often characterizes chemical dependency. If a relapse is suspected, an evaluation occurs promptly to determine the severity and arrange appropriate treatment. Relapse severity may range from a self-disclosure of drinking while on vacation to returning to active drug use in the workplace. When indicated, a practitioner must discontinue clinical practice.

It makes no more sense to refuse services to a relapsed physician than it does to refuse hospitalization to a person with diabetes after the first episode of ketoacidosis. All PHPs will report a practitioner for disciplinary action if treatment is refused or the practitioner insists on continuing to practice against recommendations. Although they are dedicated to rehabilitating practitioners, public safety comes first. For health professionals entering intensive treatment followed by comprehensive long-term aftercare and monitoring, success rates for long-term sobriety are reported in the range of 70% to 90%.<sup>12,13,14</sup>

*Alcohol addiction spreads its effects into the home and work place*

## Symptoms of addictive disease

Behavioral Indicators	Compulsion	Personal and Social Destruction	Family Problems	Emotional Instability	Work Difficulties	Health Problems
Inappropriate behavior or comments	Irresponsible, illogical, and irrational use	Violation of one's own value system	Marital or sexual problems	Poor sleep, lethargy	Decreased quality and efficiency	Frequent common infections
Defensiveness	Lying, stealing, hiding use, "stockpiling"	Decreased involvement	Extramarital affairs	Depression	Tardiness, absences	Self-prescribing
Workaholism	Using before a social event	Unreliability and neglecting commitments	Frequent (sometimes violent) arguments	Unexplained grief	Loss of satisfaction and interest in work activities	Medicinal for sleep, anxiety, and the like
Poor reliability	Using alone	Socialization with users	Unexplained absences	Argumentative, edgy, explosive outbursts	Mistakes and accidents	Frequent, vague or complex illnesses
Failure to accept personal responsibility	Structuring life around use	Unpredictable behavior	Problems with children	Anxiety, hyper activity	Conflicts with authority	Gastrointestinal complaints
Decreased tolerance for others	Self-medicating with samples	Embarrassing behavior	Separations, divorce	Poor memory and concentration	Overprescribing or underprescribing	Hypertensive headaches
Public intoxication	Rationalization of use	Leaving church affiliation	Withdrawal from family	Isolation or withdrawal	Rounds at unusual times, frequent bathroom breaks	Withdrawal symptoms
Legal problems; cited for driving under the influence	Inability to stop or control use once started	Isolation	Loss of friends	Financial problems	Blaming, accusing, paranoia, feeling victimized	Patient complaints

## ASSESSMENT AND INTERVENTION

Given that the workplace is normally the last arena for symptoms of addiction to emerge, a greater than 90% probability exists that when suspicions arise, they prove to be true. It is important not to ignore a sentinel incident. Take immediate action whenever possible. If current intoxication is suspected, getting a urine or blood specimen provides the most definitive answer. If this is not possible, clearly document the incident, your observations, and your concerns for future reference—otherwise, you may become convinced that you were imagining things. Many hospitals have policies and procedures for evaluating suspected intoxication in the workplace. It is preferable to intervene before such a workplace crisis arises. Early on, however, situations are rarely clear-cut.

When addiction is first suspected, it is prudent to discreetly discuss concerns with others who may have additional information or observations. Never try to intervene alone. Get professional advice. Some hospitals have physician wellness committees for assistance. Physician health programs are excellent resources. Confidential reports may be made to the PHP, or you may call with questions; anonymous calls are welcome. A professional will help clarify the severity of a concern and discuss options on how to best approach your particular situation. This will depend on a number of questions. Is the possibly impaired practitioner your boss, employee, friend, competitor, or spouse? Are they intimidating or litigious? Can you be objective? Is there a specific concern, such as the physician personally picking up

prescriptions for patients or prescription fraud? Who else may have information? Is there an administrative problem, a patient complaint? Who is available for support? Is the person suicidal? It is difficult to make global recommendations because each situation is unique.

Following the receipt of a report, a PHP will make a discreet inquiry to determine the validity of the report and if there is an imminent threat to the public. If a preliminary assessment indicates reasonable cause for concern, an intervention will be arranged. The ultimate goal of an intervention is for the practitioner to go forward with a comprehensive evaluation or treatment. The impaired colleague's acceptance of the problem at this juncture, while helpful, is not critical. A good intervention is supportive and respectful and may lay the groundwork for a positive treatment experience (see case history). Interventions must be tailored for the particular situation, whether it is a peer-, administrative-, or family-generated intervention.<sup>6</sup>

Some principles of intervention apply to all situations.<sup>15</sup> Each intervention should include several participants. It needs to occur as close to the precipitating incident as possible and at a time when the physician is sober. The location should be quiet, non-threatening, and private. Specific reports of behaviors or incidents of concern should be reviewed. Intervention leaders should be well prepared, and professional clout should be used when needed. Only participants able to be non-judgmental should be included.

Reinforce the personal and professional value, dignity, and worth of the physician. Remember that he or she is likely to feel intense guilt, shame, and hopelessness. Anticipate possible reactions and prepare contingency plans for addressing barriers to compliance with requests. Identify the bottom line in advance, but allow the physician to select from several options to meet the goal, if possible, eg, choosing the evaluation or treatment facility. It is advisable to evaluate suicide potential and have a contingency plan for immediate hospitalization, if required.<sup>16</sup> Offer hope, support, and respect.

## **Case Study**

Hal, a 45-year-old pediatrician and chief of staff at the hospital, is married with children. Lately his partners and staff have noticed that he keeps to himself. He seems more cynical, critical of medicine, and less tolerant of patients.

Hal's wife, also a physician, has received comments from colleagues and hospital staff that he seemed tired, grumpy, and on edge. But his partners and staff are surprised when his wife discloses her concern about his escalating use of Vicodin [hydrocodone bitartrate with acetaminophen] and Ultram [tramadol hydrochloride] and asks for help with an intervention. No one suspected that drugs or alcohol were involved in his behavior change. True, a lot of opiate samples are being received, but they hadn't thought that the doctor himself might be using the drugs. They hesitantly agree to confront him about his behavior.

Hal has a strong family history of alcoholism and depression. Following minor surgery, he used some Vicodin and experienced increased energy and a feeling of being on top of things, so he kept taking it. His wife became concerned, and Hal said he would stop. Instead, he concealed his use. During the ensuing months, she would find carelessly discarded medication boxes. He would deny use, always giving a reason for the boxes.

After attending a lecture on physician wellness, Hal's wife discussed the issue with the speaker, who gave her information about the state's diversion program. After many conversations with these professionals,

she felt confident enough to facilitate an intervention. But would she alienate her husband forever? She knew she would certainly lose him if she did nothing. But even if she lost him, it was the only way that he would be helped.

She spent a week of planning, which she hid from Hal, and then the state's intervention team had a final meeting with Hal's colleagues and office staff.

Early one morning, an airplane ticket and a suitcase were packed and waiting. Hal's partners were prepared to step in and resolve all the barriers that he suggests are preventing his immediate departure for treatment. Everyone was in place, waiting for Hal to arrive at the office. He walked in, saw them, and turned to leave. He was reminded that he was among friends who love him and that he is a good doctor. He clings to his wife, saying "I just didn't know what to do."

Hal returns 60 days later. The office has been cleared of all narcotics. When he first meets with colleagues and staff, there are a few awkward moments, but he is welcomed and supported once it is clear he is grateful and happier. A few months later, business is returning to normal. He keeps his practice lighter. Giving urine specimens is a pain, but life is good. A few years later, meetings are a joy. People seek him out as an expert in addiction issues ("I have this patient..."). His practice and family are thriving.

## **RECOVERY**

Today's environment necessitates monitoring and documentation of recovery for health professionals. Yet, maintaining the maximum level of confidentiality remains vital. Confidentiality of alcohol and drug treatment records is intended to ensure that a person seeking and receiving treatment for a substance-related disorder is not made more vulnerable than a person with an alcohol or drug problem who does not seek treatment.<sup>17</sup> Participants in a PHP receive advocacy based on evidence of recovery from chemical dependency. When in remission, chemical dependency does not adversely affect a physician's ability to practice medicine.

Areas in which advocacy may be helpful include workplace reintegration; obtaining or retaining professional credentials, malpractice coverage, or other professional privileges; and using and maintaining insurance benefits. With proper treatment and follow-up, chemically dependent licensees can continue their practice, often with minimal interruption. Physicians typically recoup any professional and financial losses within 2 years. Life gets better. Many are eventually able to acknowledge that the intervention saved their life. Intense primary treatment followed by comprehensive long-term monitoring and aftercare is thought to be largely responsible for the high rates of long-term recovery seen in physicians.<sup>7</sup>

## **State diversion programs**

Most state diversion programs offer protection from disciplinary action to participants under a formal agreement with their state licensing authority. Programs may be operated by a private not-for-profit corporation, a state medical society, or as an independent confidential program of the licensing authority. Although each state's program may vary somewhat in specifics, their overall mission, philosophy, and requirements are similar.

The Federation of Physician State Health Programs is a national organization currently representing 39 state physician health programs. The Federation provides programs a forum for education and exchange of information. Their long-term goal is to increase program uniformity and develop national guidelines.

## CONCLUSIONS

Chemical dependency does not have to be a condition that destroys a professional's life. Timely identification, diagnosis, and intervention, with coercion when needed, may be career and life-saving. Intervention in the cycle of chemical use allows the addicted professional an opportunity for recovery.

*A changed outlook and a measure of humility have resulted in more tolerance and less judgment of others. Relationships have been restored, with stronger foundations and firmer bonds than I have ever known. Most important, the recovery program...has allowed engagement in a process that has led to the discovery of a higher power and a quality of life that I never knew was available to me. Five years ago, I would never have believed that my life would be like it is today.'*

Recovery is a process of personal growth and frequently includes a spiritual awakening. It enhances the life experience. The worst thing you can do for an addicted person, or yourself, is to ignore the problem. Waiting for spontaneous insight from an addicted person is futile.

### Author:

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## **South Austin Medical Center . . . . Briefs on Impaired or Dysfunctional Practitioner!**

SAMC Medical staff have established bylaw provisions to address medical staff and/or allied health practitioner who may have a behavioral, physical or mental impairment that may contribute directly or indirectly to patient harm. The process covers identification, intervention & treatment.

This brochure provides mostly chemical dependent impairment information but be aware that physical or mental or age related disabilities can also pose a risks to our patients.

Some of the signs of addictive disease can be from physical or mental causes and we cannot always assume it's from chemical dependency.

With this in mind & without prejudice, reporting is very important to assist the impaired practitioner to get assistance and/or treatment.

### **Reporting:**

**If any individual working in the hospital has a reasonable suspicion that a practitioner is impaired, please follow these steps:**

- A. Notify your immediate Supervisor or Administrator on-call as soon as possible especially if patient's safety is at risk.**
- B. The Supervisor or Administrator on-call will notify the CEO or Chief of Medical Staff or CNO who will initiate the investigation and intervention depending who is the impaired practitioner.**
- C. Any impaired healthcare practitioner posing risk to patients, peers or other employees must be removed and escorted to a private area for further intervention.**

**Confidentiality must be maintained at all times in dealing with any impaired staff. Support & respect during challenging times will help them to a faster recovery.**