

Physician Substance Use – Selected Articles

Berge, K. H., Seppala, M. D., & Schipper, A. M. (2009). Chemical dependency and the physician. *Mayo Clinic proceedings*, 84(7), 625–631. [https://doi.org/10.1016/S0025-6196\(11\)60751-9](https://doi.org/10.1016/S0025-6196(11)60751-9)

Although the nature and scope of addictive disease are commonly reported in the lay press, the problem of physician addiction has largely escaped the public's attention. This is not due to physician immunity from the problem, because physicians have been shown to have addiction at a rate similar to or higher than that of the general population. Additionally, physicians' addictive disease (when compared with the general public) is typically advanced before identification and intervention. This delay in diagnosis relates to physicians' tendency to protect their workplace performance and image well beyond the time when their life outside of work has deteriorated and become chaotic. We provide an overview of the scope and risks of physician addiction, the challenges of recognition and intervention, the treatment of the addicted physician, the ethical and legal implications of an addicted physician returning to the workplace, and their monitored aftercare. It is critical that written policies for dealing with workplace addiction are in place at every employment venue and that they are followed to minimize risk of an adverse medical or legal outcome and to provide appropriate care to the addicted physician.

Berge KH, Fitzsimons MG; Substance Use Disorder (SUD) Prevention. *ASA Monitor* 2015;79(2):44-46.

Efforts to prevent substance use disorders (SUDs) among physician anesthesiologists have traditionally focused on education, heightened awareness, substance control and diversion prevention measures. Very few studies have evaluated the breadth, scope and effectiveness of these preventative efforts.

The Accreditation Council for Graduate Medical Education Program Requirements for Anesthesiology require that residents demonstrate an understanding and acceptance of their role in the recognition of impairment, including illness and fatigue in themselves and in their peers.¹ The ASA Task Force on Chemical Dependency created the Model Curriculum on Drug Abuse and Addiction for Residents in Anesthesiology. This comprehensive document was created more than a decade ago to encourage safety in the workplace.² However, the education provided to residents in anesthesiology programs is variable. Lutsky reported in 1993 that fewer than 15 percent of physician anesthesiologists could recall any education at all.³ Booth reported an improvement in that all residents noted at least one hour of training in substance abuse during their residency programs by 2002, yet the incidence of SUD did not decrease.⁴ No recent survey has examined the scope of current prevention efforts and correlation with SUDs. Many programs utilize the “Wearing Masks” video educational series produced by the American Association of Nurse Anesthetists.

Boyd JW. (2015), Deciding Whether To Refer a Colleague to a Physician Health Program. *AMA J Ethics*;888-893. doi: 10.1001/journalofethics.2015.17.10.spec1-1510

Although there are currently no national standards for or routine audits of state PHPs, implementing such standards and regularly inspecting programs for compliance would go a long way to ensure the fair and ethical treatment of physicians suspected of substance abuse. Great thoughtfulness and care must be exercised when dealing with a colleague who might have a substance use disorder. Falsely accuse a physician, and the damage to your colleague's career, family, and patients can be extreme. Allow an impaired colleague to continue to work out of fear of taking action, and the danger to the physician and to patients can be extreme. Thus, it is imperative for health care personnel to properly navigate a course that carefully considers competing ethical principles and steers between the rocky shoals on either side. Moreover, given PHPs' power and the potential costs to physicians—much less the inability in many

states to effectively protest PHP recommendations—caution should be exercised when considering referring a colleague to a PHP.

DuPont RL, McLellan AT, Carr G, Gendel M, Skipper GE (2009). How are addicted physicians treated? A national survey of physician health programs, *Journal of Substance Abuse Treatment*, Volume 37, Issue 1, 2009, Pages 1-7, ISSN 0740-5472. <https://doi.org/10.1016/j.jsat.2009.03.010>

Introduction: Physicians with substance use disorders receive care that is qualitatively different from and reputedly more effective than that offered to the general population, yet there has been no national study of this distinctive approach. To learn more about the national system of Physician Health Programs (PHPs) that manage the care of addicted physicians, we surveyed all 49 state PHP medical directors (86% responded) to characterize their treatment, support, and monitoring regimens. Results: PHPs do not provide substance abuse treatment. Under authority from state licensing boards, state laws, and contractual agreements, they promote early detection, assessment, evaluation, and referral to abstinence-oriented (usually) residential treatment for 60 to 90 days. This is followed by 12-step-oriented outpatient treatment. Physicians then receive randomly scheduled urine monitoring, with status reports issued to employers, insurers, and state licensing boards for (usually) 5 or more years. Outcomes are very positive, with only 22% of physicians testing positive at any time during the 5 years and 71% still licensed and employed at the 5-year point. Conclusion: Addicted physicians receive an intensity, duration, and quality of care that is rarely available in most standard addiction treatments: (a) intensive and prolonged residential and outpatient treatment, (b) 5 years of extended support and monitoring with significant consequences, and (c) involvement of family, colleagues, and employers in support and monitoring. Although not available to the general public now, several aspects of this continuing care model could be adapted and used for the general population.

Kenna, G. A., & Lewis, D. C. (2008). Risk factors for alcohol and other drug use by healthcare professionals. *Substance abuse treatment, prevention, and policy*, 3, 3. <https://doi.org/10.1186/1747-597X-3-3>

Background: Given the increasingly stressful environment due to manpower shortages in the healthcare system in general, substance induced impairment among some healthcare professions is anticipated to grow. Though recent studies suggest that the prevalence of substance abuse is no higher in healthcare professionals (HPs) than the general population, given the responsibility to the public, any impairment could place the public at increased risk for errors. Few studies have ever reported predictors or risk factors for alcohol and other drug use (AOD) across a sample of HPs. Methods: The study used a cross-sectional, descriptive self-report survey in a small northeastern state. A 7-page survey was mailed to a stratified random sample of 697 dentists, nurses, pharmacists and physicians registered in a northeastern state. The main outcome measures were demographic characteristics, lifetime, past year and past month prevalence of AOD use, the frequency of use, drug related dysfunctions, drug misuse and abuse potential. Six contacts during the summer of 2002 resulted in a 68.7% response rate (479/697). Results: Risk factors contributing to any reported past year AOD use, as well as significant (defined as the amount of AOD use by the top 25% of respondents) past year AOD use by HPs were examined using logistic regression. Risk factors of any self-reported past year AOD use included moderate or more frequency of alcohol use, being in situations when offered AODs, feeling immune to the addictive effects of drugs (pharmaceutical invincibility) and socializing with substance abusers. Risk factors of significant past year AOD use were HPs with younger licensees, a moderate pattern of alcohol use and not socializing with substance abusers. Conclusion: National and state organizations need to develop policies that focus on prevention, treatment, and rehabilitation of alcohol and other drug-using healthcare professionals. The results of this study may help to delineate the characteristics of HPs abusing drugs, leading to the development of more

effective policies designed to protect the public, and move toward more tailored and effective intervention strategies for HPs

Oreskovich, M.R., Shanafelt, T., Dyrbye, L.N., Tan, L., Sotile, W., Satele, D., West, C.P., Sloan, J. and Boone, S. (2015), The prevalence of substance use disorders in American physicians. *Am J Addict*, 24: 30-38. doi:10.1111/ajad.12173.

Background: There have been few studies on the prevalence of substance use disorders (SUDS) in the physician population at large nor have any studies compared the prevalence of SUDS in American physicians by specialty. Methods: We conducted a national study of SUDS in a large sample of U.S. physicians from all specialty disciplines using the AMA Physician Masterfile. Substance Use Disorders (SUDS) were measured using validated instruments. Results: Of the 27,276 physicians who received an invitation to participate, 7,288 (26.7%) completed surveys. 12.9% of male physicians and 21.4% of female physicians met diagnostic criteria for alcohol abuse or dependence. Abuse of prescription drugs and use of illicit drugs was rare. Factors independently associated with alcohol abuse or dependence were age (OR 1.985; $p < .0001$), hours worked (OR 1.994; $p = .0094$), male gender (OR 1.597; $p < .0001$), being married (OR 1.296; $p = .0424$) or partnered (OR 1.989; $p = .0003$), having children (OR .745; $p = .0049$), and being in any specialty other than internal medicine (OR 1.757; $p = .0060$). Specialty choice was strongly associated with alcohol abuse or dependence ($p = .0011$). Alcohol abuse or dependence was associated with burnout ($p < .0001$), depression ($p < .0001$), suicidal ideation ($p = .0004$), lower quality of life ($p < .0001$), lower career satisfaction ($p = .0036$), and recent medical errors ($p = .0011$). Conclusion: Alcohol abuse or dependence is a significant problem among American physicians. Since prognosis for recovery of physicians from chemical dependency is exceptionally high organizational approaches for the early identification of problematic alcohol consumption in physicians followed by intervention and treatment where indicated should be strongly supported.