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CLINICAL AND HEALTH AFFAIRS

The Addicted Physician

A Rational Response to an Irrational Disease

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ABSTRACT

Physicians are as likely to experience drug and alcohol addiction as anyone in the general population. They are more likely than others, however, to abuse prescription medications. Dealing with an impaired colleague is a difficult, emotionally charged job for physician leaders and hospital administrators, who've often had little training on how to handle such a situation. In addition to describing a case of an addicted physician, this article reviews data about the incidence of addiction among physicians and the challenges associated with confronting such a problem. It also describes the legal reporting requirements and resources such as the Minnesota Health Professionals Services Program and Physicians Serving Physicians that can help physicians get into treatment programs designed specifically for health care professionals. Physicians who go through such treatment programs and subsequent monitoring have been found to have remarkable recovery rates.

The rate of addiction among practicing physicians is estimated to be between 10% and 12%, the same as or slightly higher than the rate in the general population.[1,2] Although alcohol is the primary problem in nearly half of all cases, physicians are more likely than others to abuse prescribed medications.[2] In a study of 16 state physician health programs that examined 904 physicians who had been placed under monitoring for drug abuse, more than half of the physicians were in five medical specialties: family medicine (20%), internal medicine (13.1%), anesthesiology (10.9%), emergency medicine (7.1%) and psychiatry (6.9%).2 Anesthesiologists make up 5.2 percent of physicians nationwide;[3] therefore, they are remarkably overrepresented in physician health programs. They are also much more likely to abuse highly potent opioids, in particular, fentanyl and sufentanil.[4]

The Case of Dr. P.

The text message to the chief of anesthesiology was cryptic, "Fentanyl missing, Dr. P. missing." It wasn't a complete surprise. Recovery room nurses had noted that Dr. P.'s patients seemed to be waking in excessive pain, although much more fentanyl was ordered for his cases compared with others'. There also were rumors that he had recently moved out of the family home.

The chief had heard of other anesthesia departments dealing with addiction, but now he was forced to consider the possibility that his junior colleague might be an addict. He wasn't sure how to respond. His initial thought was to fire Dr. P., but he considered the young physician's family and whether he could be sued if he did so.

The small hospital where they worked had no policy for dealing with physician impairment. The chief of anesthesiology, the hospital CEO, and the hospital's attorney reviewed the situation. They contacted the Minnesota Health Professionals Services Program (HPSP) and asked for guidance. The HPSP recommended that they urgently address three primary concerns: patient safety, their colleague's safety, and appropriate intervention. The chief quickly gathered more information from nurses and colleagues, which revealed behavioral changes, frequent unexplained absences, and charting discrepancies associated with fentanyl. Even in the absence of conclusive evidence, they acted immediately to prevent him from having any further patient contact while they arranged for a workplace intervention.

Dr. P. was escorted to a meeting where the chief of anesthesiology, the CEO, and two colleagues articulated their concerns, described their duty to report, and told Dr. P. he was required to have an evaluation for a substance-use disorder.

Dr. P. became belligerent and demanded to know what evidence they had. He said he would rather leave their hospital than put up with such accusations. He threatened a lawsuit and said he would not

seek an evaluation. They handed him a phone and advised him to discuss his stance with a staff member at the HPSP. During the phone conversation, he learned that his refusal would result in a report to the Minnesota Board of Medical Practice, with the potential for public scrutiny and reporting to the National Practitioners Data Bank. Knowing that, he agreed to the evaluation.

The HPSP recommended a physician who could do the evaluation, so the chief, along with a colleague, drove Dr. P. to the appointment. Dr. P. met with an addiction medicine physician who conducted a diagnostic evaluation. The anesthesiologist continued to deny regular or ongoing use of opioids, although the evidence suggested otherwise. A recommendation was made for further evaluation in a residential treatment setting.

Dr. P. was escorted to a residential addiction treatment facility that specializes in treating addicted physicians. (Currently, there is no such program in Minnesota, but Hazelden will provide this service starting in 2010.) He underwent further evaluation at the treatment facility, including a physical examination, psychological and psychometric testing, an assessment of family functioning, and a psychiatric evaluation. Collateral information was gathered from the anesthesiology department and from colleagues, friends, and family. Dr. P.'s urine drug screen was negative the morning after his last intravenous injection of fentanyl, and he used this information to argue that he was not an addict. However, he quickly started to exhibit classic opioid withdrawal symptoms, helping to confirm the diagnosis. Detoxification with buprenorphine was initiated to provide a safe, comfortable transition to a drug-free state.

Dr. P. was immediately welcomed by other physicians in the addiction treatment program. They described their experience in the program and their past use of drugs and alcohol. He met with his counselor and the physician director of the health care professionals program. The events leading to his admission were reviewed. He continued to deny use of fentanyl and blamed the hospital staff for his predicament. Collateral information revealed that six months prior to admission, his wife had found fentanyl and syringes in his briefcase and confronted him. At the time, she believed him when he said he had to carry it to an outpatient surgery center to administer it to a patient. However, she began to notice bizarre behavior and regular evidence of intoxication. Ultimately, she asked him to leave the home after he passed out while caring for their 4-month-old son.

The treatment facility staff informed Dr. P. of their knowledge of the collateral information and told him he appeared to be a fentanyl addict. Dr. P. was resistant and scared to begin treatment. He did not know if he would ever work as a physician again if he admitted to fentanyl use.

In group therapy, he got to know the other physicians in the program and saw how they described, in detail, their procurement and use of drugs from the workplace. He also witnessed other physicians leaving the program to return to medical practice. After 10 days of resistance, he started to talk to another anesthesiologist about what he had done. He was in group therapy one day when a physician described her divorce and the limited time she now had with her children as a result of her drug use. Thinking about his newborn son, Dr. P. broke down and honestly described his use of fentanyl. It was his turning point.

A Hidden Disease

Addiction is a disease of the brain's reward circuitry in which the dysfunction is primarily in the limbic system and the prefrontal cortex. Advances in the neurobiology of addiction have revealed the neuropathways, neurotransmitters, and receptors that drive compulsive substance use.[5] The damaged brain of a person with addiction does not recognize consequences; it only seeks the drug. Eventually, survival itself becomes secondary to ongoing use of the drug.[6] The addicted typically do not fully recognize their plight or the risks they are taking to continue drug use. Therefore, it should not be surprising that the addicted will deny substance use, bargain for situations allowing for continued use, and even give up career, family, and sometimes life itself in the pursuit of the addictive substance.

Unfortunately for the physician who is addicted, there are many reasons why peers and family members do not recognize the problem or intervene. For one thing, medical schools provide little, if any, training in how to recognize and treat addiction. Thus, the vast majority of primary care physicians are unable to recognize and appropriately treat a co-worker with alcoholism or other drug addiction.[7,8] Colleagues may be hesitant to interfere in one another's private affairs and will resist acting on a disease about which they know little.[9] There may be a conspiracy of silence in the workplace and the home, limiting involvement by friends, family members, and colleagues. If the physician is in a position of power, other employees may fear for their jobs and careers if they mention the possibility of addiction. Family members may know of the addiction before co-workers do but may

hesitate to act for fear of financial consequences. Fear of litigation can limit appropriate attention to this disease as can the misunderstanding that addiction is a choice and not an illness. Stigma and bias also come into play, as people often cannot believe a physician could have addiction or only believe addiction occurs in the lower socioeconomic classes.[10]

Assistance and Reporting Requirements

Programs such as the HPSP, a state program that provides nondisciplinary assistance to health-care professionals with an illness that may impair their ability to practice with reasonable skill and safety, can be indispensable to an administrator dealing with a physician who is suspected of abusing drugs. Such programs offer disease management, support, long-term monitoring of illness and treatment efforts, advocacy, help with fulfilling reporting requirements, and other confidential help. The expertise of their staff can reduce stress levels in everyone involved in these tremendously difficult, emotionally charged situations. Another Minnesota resource, Physicians Serving Physicians, assists employers and family members with staging interventions and preventing potential workplace complications and harm to the addicted physician and his or her patients.

All hospitals and medical clinics should have policies that guide their response to impaired personnel, as such policies limit the potential for making decisions that could have negative legal consequences. The hospital or clinic does not need evidence "beyond a reasonable doubt" to intervene, as the doctor is not being accused of a crime.[11] Instead, it can have the physician undergo a work-fitness evaluation as they seek evidence of an illness, one the physician may be the last to fully recognize.

Minnesota law requires reporting of impaired physicians and allows for discipline of physicians who do not report such situations. The report is best made in writing to the HPSP. Reporting to the HPSP is an alternative to licensing board discipline and leads to confidential help for the physician. The HPSP will subsequently report physicians to the Board of Medical Practice should they fail to comply with monitoring and their after-care plan. Minnesota law does protect those reporting and those cooperating with an investigation about a physician from civil liability or criminal prosecution.[12] The state law and the reporting process through the HPSP should minimize health care providers' reluctance to report colleagues.

Evaluating and Treating Physicians

Physicians seldom enter treatment voluntarily and at first will rarely describe their history of substance use accurately. When they are in a state of denial, they have little incentive to admit to a problem, and they are afraid and anxious about the possibility of losing their job and license.[10] They are also driven by the continued pursuit of drugs.

The diagnosis of addiction is made by history and relies on behavioral descriptions. It often requires gathering a history of substance use related to behavioral changes from multiple sources. Such collateral information is essential to the diagnostic evaluation and may be the only way to obtain a history adequate to making an accurate initial diagnosis,[11] as drug screens may not tell the whole story. It is not uncommon for screens for fentanyl and other highly potent drugs to be negative at the time of treatment admission, as those drugs are rapidly metabolized. In addition, urine drug screens can be easily manipulated.

Evaluation and treatment of physicians should be done by a multidisciplinary team that has experience working with health care professionals.[13] Addiction professionals working with this population need to understand the language of medicine, the medical workplace, the availability of prescribed medications, some of the unique stressors associated with medical practice, the potential for comorbid psychiatric illness, and the personality traits common to physicians. Psychiatric illness and cognitive impairment can complicate treatment, recovery, and successful return to work. Therefore, physicians should be screened and evaluated for these conditions as well as for drug and alcohol addiction.

In treatment programs for health care professionals, patients will participate in group and individual psychotherapy, learn about addiction, and learn skills to prevent a return to drug and alcohol use.[11] These programs emphasize fellowship and encourage physicians to learn from one another and to re-establish positive relationships that help with acceptance and healing. They require complete abstinence from alcohol and drugs, and the vast majority use a Twelve Step model based on the principles of Alcoholics Anonymous. In the study of 904 physicians who were being monitored for drug abuse, McLellan et al. found that 95 percent were treated using a Twelve Step model and 78 percent entered residential treatment for a mean of 72 days (range 30 to 90 days).[2]

Most physicians are tremendously ashamed of taking drugs from the workplace and have great difficulty admitting to this. They often think of themselves as the only physician who has ever diverted drugs for self-use. Being in group therapy with other addicted physicians often leads to admission of addictive behaviors. In these settings, physicians have the opportunity to discuss the stressors associated with medical practice and their predicament, including medical board involvement, legal concerns, and potential problems with the DEA. Participants examine their relationships, use of money, their families, decision-making, and other aspects of their lives. They are also likely to accept the fact that they have a problem, which allows for recovery to begin.

Prior to completing treatment, physicians undergo an assessment to examine their ability to return to practice. This assessment provides the opportunity to establish the risks of returning to practice, to determine a treatment plan that supports abstinence, and to decide when to return to practice.[11] Some physicians and other health care professionals can go right back to work. Others may need to have further outpatient treatment or a period of abstinence prior to returning to work. Some may have to consider a different type of practice or another specialty. A very small group of physicians will not return to medical practice.

The decision to return to work is difficult and requires the expertise of a treatment team and the HPSP staff, and the help of others in the workplace. Domino et al. described several risk factors that predicted relapse in health care professionals based on hazard ratios. They include a family history of addiction/alcoholism, which increased the risk of relapse (HR=2.29); a psychiatric illness in addition to addiction (HR=2.25); use of a major opioid and a psychiatric illness (HR=5.79); and use of a major opioid, a psychiatric illness, and a positive family history, which increased risk of relapse dramatically (HR=13.25).[14] This information is being used in treatment, monitoring, and return-to-work decisions for addicted physicians.

Special consideration must be given to anesthesiologists with addiction to major opioids, propofol, or inhalant anesthetics. These physicians have a high death rate.[15-17] If they were to return to work, they would have to handle on a daily basis the very drugs to which they were addicted. As a result, recommendations have been made to prevent their return to the operating room.[18] Currently, a group of physicians who work with addicted physicians is working on a return-to-work decision-making tool for anesthesiologists and nurse anesthetists that will help define expectations of the individual in terms of treatment, monitoring, and other activities that will help ensure abstinence.

The recovery rate for physicians is 74% to 90%, which is comparable to the rate for commercial airline pilots.4,14,19-22 Most eventually return to practice. As a result, a rehabilitation model and support for return to practice are appropriate. The HPSP contracts with recovering physicians and requires compliance with activities known to support ongoing abstinence and recovery from addiction. These activities include group therapy with other physicians, individual therapy, mutual help meetings (AA, NA, etc.), monitoring and oversight meetings with the HPSP, drug screening—both random and for cause—and workplace monitoring. Requirements also may include psychiatric care, family therapy, and restrictions on where the physician can work, work hours, and prescribing privileges.[11] Extensive, high-quality treatment, motivation to return to practice, and long-term monitoring result in remarkably positive outcomes for physicians. However, without HPSP monitoring, return to the medical workplace should not be considered.

Conclusion

Addiction is a relatively common illness, and it affects physicians at the same or a slightly higher rate as that in the general population. Addiction is a brain disease, not a moral failing or an ethical problem. Treatment in programs designed for health care professionals addresses the issues unique to physicians and other health care personnel. Physicians who get involved in appropriate treatment and monitoring programs have remarkable recovery rates. For that reason, all medical personnel with exposure to powerfully addictive medications in the workplace should have access to treatment programs for health care professionals and monitoring systems to ensure appropriate treatment and the highest likelihood of abstinence and recovery. **MM**

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