SUBSTANCE USE DISORDERS IN HEALTHCARE PROFESSIONALS

BY: WILLIAM R. CARPENTER, D.O.

DISCLOSURES

- NONE

OBJECTIVES:

- RECOGNIZE THE PREVALENCE OF AND MOST COMMON SUBSTANCE USE DISORDERS IN HEALTHCARE PROFESSIONALS
- KNOW PREDISPOSING CHARACTERISTICS AND/OR COMMON COMORBIDITIES
- BE ABLE TO RECOGNIZE SIGNS AND SYMPTOMS OF SUBSTANCE USE DISORDERS IN THE WORKFORCE
- KNOW HOW TO PERSONALLY GET HELP AND/OR HOW TO HELP A COLLEAGUE
- BE FAMILIAR WITH THE ROLE OF A PHYSICIAN HEALTH PROGRAM

SUD PREVALENCE IN PHYSICIAN POPULATION

- **10%–15% PERCENT OF HCPS WILL MISUSE SUBSTANCES DURING THEIR LIFETIME** (MERLO ET AL, AM J ON ADDICTIONS 2013)
  - SIMILAR TO GENERAL POPULATION
- **A 2015 STUDY OF 7206 AMERICAN PHYSICIANS OF VARIOUS SPECIALTIES** (ORESKOVICH ET AL, AM J ADDICT. 2015)
  - **RATES OF ALCOHOL USE DISORDERS AMONG FEMALE PHYSICIANS WAS 21.4% COMPARED TO 12.9% IN MALE PHYSICIANS**
    - BASED ON SCREENING WITH THE AUDIT-C AND WORLD HEALTH ORGANIZATION ALCOHOL, SMOKING, AND SUBSTANCE INVOLVEMENT SCREENING TEST MEASURES

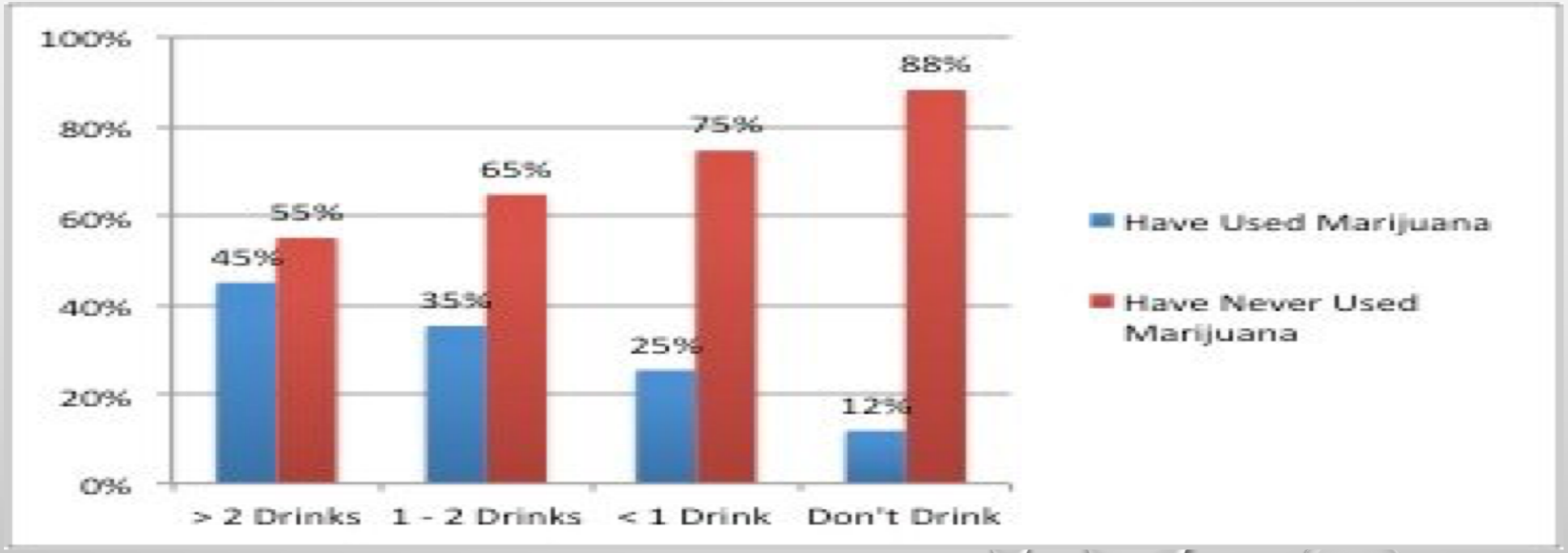
MOST COMMON SUBSTANCES OF ABUSE

- **5 YR LONGITUDINAL COHORT OF 904 PHYSICIANS (87% MALE) ENROLLED IN 16 STATE PHP'S (MCLELLAN ET AL BMJ 2008)**
  - **ALCOHOL WAS PRIMARY DRUG OF ABUSE IN 50.3%**
  - **OPIOIDS IN 35.9%**
  - **STIMULANTS IN 7.9%**
  - **OTHER SUBSTANCES IN 5.9% (BENZODIAZEPINES, COCAINE, MARIJUANA, ETC)**
  - **50% REPORTED ABUSE OF MULTIPLE SUBSTANCES**
- ***RATES OF PRESCRIPTION DRUG ABUSE ARE UP TO 5 TIMES HIGHER AMONG PHYSICIANS*** THAN IN THE GENERAL POPULATION, WITH ***ESPECIALLY HIGH RATES OF BENZODIAZEPINE AND OPIOID ABUSE***
  - (MERLO ET AL, AM J ON ADDICTIONS 2013) (MERLO ET AL, HARVARD REVIEW OF PSYCHIATRY 2008)

Marijuana Use in Physicians

Medscape 2015 online survey (19,916 us physicians across 25 specialties)- **just under a quarter of physicians reported ever having tried marijuana**. **Three percent said they had used marijuana in the past year**, also a lower percentage than that found in the Gallup poll for the general population

Medscape 2015 Report shows correlation between higher levels of daily alcohol consumption and a greater tendency to have used marijuana



SUD- PREDISPOSING RISK FACTORS

- GENETIC PREDISPOSITION
  - **40-60% OF RISK IS GENETIC** (HART AND KRANZLER 2015)
- STARTING ALCOHOL, NICOTINE OR OTHER DRUG USE AT AN EARLY AGE
- PSYCHOLOGICAL FACTORS
  - STRESS, **PERSONALITY TRAITS LIKE HIGH IMPULSIVITY OR SENSATION SEEKING, PSYCHIATRIC DISORDERS (DEPRESSION, ANXIETY**, EATING DISORDERS, PERSONALITY AND OTHER)
- ENVIRONMENTAL FACTORS
  - **EXPOSURE TO ABUSE OR TRAUMA**, SUBSTANCE USE OR ADDICTION IN THE FAMILY OR AMONG PEERS, ACCESS TO AN ADDICTIVE SUBSTANCE; MEDIA EXPOSURE THAT ENCOURAGES SUBSTANCE USE, ETC

SUD- RISK FACTORS (PHYSICIAN SPECIFIC)

- **MEDICAL TRAINING**
  - **PROMOTES AND CONDITIONS ATTRIBUTES THAT CAN INTERFERE WITH WELLNESS**
  - EARLY ASSUMPTION OF RESPONSIBILITY, INDEPENDENCE, PERSEVERANCE, AND SELF-RELIANCE
  - THE ABILITY TO PERFORM UNDER STRESS AND DESPITE PERSONAL DIFFICULTIES IS A HALLMARK OF THE PROFESSION
  - IN AN ANONYMOUS SURVEY OF 280 ATTENDING PHYSICIANS AND 256 ADVANCED PRACTICE CLINICIANS AT A MAJOR CHILDREN'S HOSPITAL, *MORE THAN 80 PERCENT CAME TO WORK EVEN WHEN PHYSICALLY ILL IN THE LAST YEAR DUE TO A SENSE OF OBLIGATION TO PATIENTS AND COLLEAGUES, AS WELL AS FEAR OF OSTRACISM* (SZYMCZAK ET AL, JAMA PEDIAT 2015)

SUD- RISK FACTORS (PHYSICIAN SPECIFIC)

- **GREATER ACCESS TO PRESCRIPTION DRUGS**
  - **87% OF PHYSICIANS HAVE PRESCRIBED THEMSELVES MEDICATIONS, AND IN THE PAST, OVER HALF (55.3%) OF HCPS WHO HAVE A PRESCRIPTION FOR PAINKILLERS WROTE THE PRESCRIPTION THEMSELVES** (MERLO ET AL, HARVARD REVIEW OF PSYCHIATRY 2008)
  - **CONFIDENCE IN UNDERSTANDING MEDICATIONS MAY CONTRIBUTE TO SELF-MEDICATION AND UNDERESTIMATING CONSEQUENCES OF UNSUPERVISED OR NONMEDICAL USE OF PRESCRIPTION DRUGS** (MERLO ET AL, J AM PHARM ASSOC 2003)

PREDISPOSING SPECIALTIES

- **ADDICTION APPEARS TO OCCUR AT A HIGHER RATE AMONG PHYSICIANS IN ANESTHESIOLOGY, EMERGENCY MEDICINE, AND PSYCHIATRY** (MCLELLAN ET AL, BMJ 2008)
- CONTRIBUTING FACTORS MIGHT INCLUDE:
  - **STRESSES OF THE WORK**
  - **READY ACCESS TO NARCOTICS AND OTHER PSYCHOTROPIC DRUGS IN THE WORKPLACE**
  - **PERHAPS A SELECTION BIAS IN THE TYPE OF PHYSICIANS WHO SEEK THESE SPECIALTIES** (GALLEGOS ET AL 1988)
- ***ANESTHESIOLOGISTS HAVE BEEN FOUND TO BE MORE LIKELY THAN OTHER PHYSICIANS TO USE DRUGS INTRAVENOUSLY, AND TO ABUSE OPIOIDS AND PROPOFOL*** (WISCHMEYER ET AL 2007)
- **MULTIPLE STUDIES SUGGEST PEDIATRICIANS HAVE THE LOWEST RATE OF ADDICTION**

SIGNS OF SUD IN THE WORKPLACE

- **CHANGES IN MOOD/AFFECT –**MOOD SWINGS, DEPRESSION, BLUNTED AFFECT, IRRITABILITY, APPEARING OVERWHELMED
- **DECREASED PRODUCTIVITY –**TARDINESS, ABSENTEEISM, FREQUENT BREAKS, MISSED APPOINTMENTS
- **INCREASED MISTAKES –**MEDICAL ERRORS, CHARTING ERRORS, FORGETFULNESS
- **INCONSISTENT HOURS –**ROUNDING AT VARIABLE TIMES, UNEXPLAINED DISAPPEARANCES,
- **COMPLAINTS FROM PATIENTS, COLLEAGUES, SUPERVISORS, OR LAWSUITS**
- **EVIDENCE OF DIVERSION –**MISSING/BROKEN VIALS, FAILURE TO DOCUMENT APPROPRIATELY, EXTRA ATTENTION TO PATIENTS RECEIVING ABUSABLE MEDICATIONS, INAPPROPRIATE PRESCRIBING
- **DETERIORATION IN APPEARANCE –**DISHEVELED, POOR HYGIENE
- **DETERIORATION IN PHYSICAL HEALTH –**FLULIKE SYMPTOMS, APPEARANCE OF OVERSEDATION, BLOODSHOT/WATERY EYES, WEIGHT LOSS/GAIN, LACK OF COORDINATION OR TREMORS
- **CHANGES IN SOCIAL INTERACTION –**SOCIAL WITHDRAWAL, INCREASED CONFLICTS, EXCESSIVE DRINKING AT EVENTS, INAPPROPRIATE BEHAVIOR

TABLE 1. **Signs and Symptoms of Addiction That Might Appear in the Workplace**

Possible signs suggestive of alcohol dependence

- Alcohol on breath
- Slurred speech
- Ataxia
- Erratic performance or decrement in performance
- Tremulousness
- "Out-of-control" behavior at social events
- Problems with law enforcement (eg, domestic abuse, driving while intoxicated)
- Hidden bottles
- Poor personal hygiene
- Failure to remember events, conversations, or commitments ("blackouts")
- Tardiness
- Frequent hangovers
- Poor early morning performance
- Unexplained absences
- Unusual traumatic injuries
- Mood swings
- Irritability
- Sweating
- Domestic/marital problems
- Isolation
- Leaving the workplace early on a regular basis

Berge et al, Mayo Clin Proc 2009

Opioid Use Disorder- Clinical Manifestations in the Workforce

Possible signs suggestive of opiate dependence

- Periods of agitation (withdrawal) alternating with calm (drug was jus taken)
- Dilated pupils (opiate withdrawal)
- Pinpoint pupils (side effect of opiate)
- Excessive sweating
- Addition of long sleeves (to hide needle tracks)
- Frequent bathroom breaks (to take another dose)
- Frequent unexplained absences during workday
- Spending more hours at work than necessary (access source of drug)
- Volunteering for extra call
- Volunteering to provide extra breaks or refusing breaks
- Volunteering to clean operating rooms
- Volunteering to return waste drugs to pharmacy
- Rummaging through sharps containers
- Sloppy record keeping or discrepancies between charted dose and actual dose administered
- Excessive narcotic use charted for patients
- Assay of waste drug returned showing evidence of dilution
- Never returning any waste at the end of a case
- Patients arriving in postsurgical recovery room with pain out of proportion to charted narcotic dose

Berge et al, Mayo Clin Proc 2009

SUBSTANCE USE DISORDER- DSM 5

A PROBLEMATIC PATTERN OF SUBSTANCE USE LEADING TO CLINICALLY SIGNIFICANT IMPAIRMENT OR DISTRESS, AS MANIFESTED BY **AT LEAST TWO OF THE FOLLOWING, OCCURRING WITHIN A 12-MONTH PERIOD**:

- **MORE USE THAN INTENDED**
- **CRAVING FOR THE SUBSTANCE**
- **UNSUCCESSFUL EFFORTS TO CUT DOWN**
- **SPENDS EXCESSIVE TIME IN ACQUISITION**
- **ACTIVITIES GIVEN UP BECAUSE OF USE**
- **USES DESPITE NEGATIVE EFFECTS**
- **FAILURE TO FULFILL MAJOR ROLE OBLIGATIONS**
- **RECURRENT USE IN HAZARDOUS SITUATIONS**
- **CONTINUED USE DESPITE CONSISTENT SOCIAL OR INTERPERSONAL PROBLEMS**
- **TOLERANCE**
- **WITHDRAWAL**

SUD COMORBIDITIES IN PHYSICIANS

- A STUDY OF 157 PHYSICIANS REFERRED TO THE VIRGINIA PHP FOUND: WIJESINGHE ET AL 2001
  - **39 PERCENT WERE REFERRED FOR AN UNCOMPLICATED SUD**
  - **39 PERCENT FOR A MENTAL DISORDER WITHOUT AN SUD**
  - **21 PERCENT HAD A DUAL DIAGNOSIS OF A SUD WITH A CO-OCCURRING A MENTAL DISORDER**
    - THE MOST PREVALENT COMORBID DISORDERS AMONG THE PHYSICIANS WITH AN SUD WERE:
      - **BIPOLAR DISORDER – 33 PERCENT**
      - **DEPRESSION – 24 PERCENT**
      - **ANTISOCIAL PERSONALITY DISORDER – 9 PERCENT**
      - **GENERALIZED ANXIETY DISORDER – 9 PERCENT**

OTHER POTENTIAL CONSEQUENCES OF SUD

- INCREASED SUICIDE RISK- AN AVERAGE OF 400 US DOCTORS COMMIT SUICIDE EVERY YEAR
  - **SUICIDE RATES** AMONG PHYSICIANS ARE HIGHER THAN RATES IN GENERAL POPULATION, 1.41 TIMES HIGHER FOR MEN, AND 2.27 TIMES HIGHER FOR WOMEN (SCHERNHAMMER ET AL AMERICAN JOURNAL OF PSYCHIATRY 2004)
- A 2014 REPORT BY THE GENERAL MEDICAL COUNCIL IN THE UNITED KINGDOM SUGGESTS THAT PHYSICIANS MAY BE AT INCREASED RISK FOR SUICIDE WHILE UNDERGOING INVESTIGATION OF THEIR FITNESS-TO-PRACTICE MEDICINE (HORSFALL 2014)

BARRIERS TO TREATMENT

- *HESITANCY OF HCPS, AS WELL AS THEIR COLLEAGUES AND FAMILY MEMBERS, TO REPORT ANY PROBLEMS WITH SUBSTANCE ABUSE OR ADDICTION*
  - DUE TO FEAR OF POTENTIALLY NEGATIVE SOCIAL, PROFESSIONAL, LEGAL, OR FINANCIAL CONSEQUENCES.
- A 2010 STUDY PUBLISHED IN THE JOURNAL OF THE AMA SURVEYED MORE THAN 1800 PHYSICIANS TO LEARN ABOUT THEIR EXPERIENCES WITH IMPAIRED COLLEAGUES:
  - 17% PERSONALLY KNEW OF AN IMPAIRED PHYSICIAN WITHIN THEIR CIRCLE IN THE LAST 3 YEARS
    - ONLY 67% OF THIS GROUP REPORTED THEIR INCOMPETENT COLLEAGUE TO A RELEVANT AUTHORITY
    - AMONG THE 17% THAT KNEW OF AN IMPAIRED PHYSICIAN, ONLY 44% OF THOSE IN A SOLO OR TWO-PERSON PRACTICE FILED A REPORT, COMPARED TO 77% OF THOSE WORKING AT UNIVERSITIES OR MEDICAL SCHOOLS

RESPONSIBILITIES OF COLLEAGUES

- **COLLEAGUES PLAY A PRIMARY ROLE IN IDENTIFICATION OF PHYSICIANS WITH AN ACTIVE SUD**
  - THOSE INVOLVED (COLLEAGUES, ADMINISTRATORS, AND FAMILY MEMBERS) SHOULD RECORD DETAILS OF ABERRANT BEHAVIORS, PERFORMANCE DEFICIENCIES, AND PSYCHOSOCIAL PROBLEMS
- **A STEPWISE APPROACH SHOULD BE TAKEN, STARTING WITH:**
  - **A SENSITIVE BUT FORTHRIGHT DISCUSSION WITH THE PERSON *IF PATIENT HARM IS UNLIKELY***
  - **A REPORT TO LICENSING BOARDS OR CLINICAL SUPERVISORS *IF PATIENT HARM IS IMMINENT OR SUSPECTED.***
    - NEARLY ALL STATES IN THE UNITED STATES HAVE LEGAL REQUIREMENTS THAT PHYSICIANS REPORT IMPAIRED COLLEAGUES TO STATE MEDICAL BOARDS OR PHPS
    - MANY STATES ALLOW FOR ANONYMOUS REPORTING

RESPONSIBILITIES OF COLLEAGUES (CONT)

- **SPECIFIC POTENTIAL RAMIFICATIONS OF NOT INTERVENING INCLUDE:** (BERGE ET AL, MAYO CLIN PROC 2009)
  - **PUTTING THE PHYSICIAN'S PATIENTS AT RISK OF HARM**
  - **SUBJECTING THEMSELVES TO POTENTIAL PROFESSIONAL OR LEGAL SANCTIONS**
  - **DENYING THE PHYSICIAN AN OPPORTUNITY FOR TREATMENT**
  - **THE LONG-TERM IMPACT OF THE SUD ON THE PHYSICIAN'S FAMILY, CAREER, LIFE, ETC**
- *IN UNCERTAIN CASES, PHYSICIANS SHOULD SEEK COUNSEL FROM DESIGNATED OFFICIALS OR SUPERVISORS*

OTHER BARRIERS TO TREATMENT

- **PHYSICIANS OFTEN HAVE SOPHISTICATED DENIAL WITH ELABORATE JUSTIFICATION AND RATIONALIZATION, MAKING INTERVENTION MORE DIFFICULT.**
  - MANY PHYSICIANS HAVE DIFFICULTY ADMITTING THAT THE CLINICAL CARE THEY PROVIDE HAS BEEN IMPAIRED.
  - PROFESSIONAL ARROGANCE CAN LEAD TO DIFFICULTY TAKING DIRECTIONS OR INPUT FROM OTHERS
- **GENDER MAY BE AN ISSUE; RESEARCH STUDIES SUGGEST THAT FEMALE PHYSICIANS WITH A SUBSTANCE ABUSE DISORDER (SUD) ARE NOT REFERRED FOR TREATMENT AS FREQUENTLY AS MALE PHYSICIANS** (WUNSCH ET AL 2007).
  - *BECAUSE OF THIS, FEMALE PHYSICIANS MAY HAVE MORE SEVERE SUD AND/OR MORE SEVERE PSYCHIATRIC COMORBIDITY AT THE TIME OF REFERRAL*.

ASSESSMENT

- PHYSICIANS WITH AN ACTIVE SUD TYPICALLY ENTER TREATMENT IN A COUPLE DIFFERENT WAYS:
  - ON THEIR OWN INITIATIVE:
    - SOMETIMES AFTER RECEIVING FEEDBACK FROM A FAMILY MEMBER OR COLLEAGUE, OR AFTER AN INTERVENTION
  - AFTER BEING REFERRED BY A MEDICAL BOARD OR JOB
    - FOR DISCIPLINARY ACTION AGAINST THEIR LICENSE OR THREAT OF LOSING THEIR JOB

ROLE OF PHYSICIAN HEALTH PROGRAMS

- **INCLUDES:**
  - **CONTACT WITH COLLEAGUES OF THE PHYSICIAN WHO HAVE RECOGNIZED THAT HE/SHE MAY HAVE A SUBSTANCE USE DISORDER (SUD)**
  - **REFERRAL OF THE PHYSICIAN TO QUALIFIED ADDICTION SPECIALISTS FOR ASSESSMENT AND TREATMENT**
  - **DURING TREATMENT- REGULAR CONTACT WITH TREATING CLINICIANS AND REVIEW OF THEIR WRITTEN REPORTS.**
  - **ACTING AS AN INTERMEDIARY BETWEEN THE PHYSICIAN AND THE STATE MEDICAL BOARD**
  - **WORKING WITH THE PHYSICIAN'S EMPLOYER, COLLEAGUES, AND/OR STAFF TO FACILITATE THE PHYSICIAN'S RETURN TO WORK.**

PHYSICIAN HEALTH PROGRAM CONTRACTS

- PHP CONTINGENCY **CONTRACTS** FOR PHYSICIANS WITH MODERATE TO SEVERE SUD ARE **TYPICALLY FIVE OR MORE YEARS IN DURATION.**
- THEY IMPOSE CONDITIONS UPON THE PHYSICIAN'S BEHAVIOR IN RETURN FOR A PATHWAY TO RECOVERY AND RETURN TO MEDICAL PRACTICE.

PHP CONTRACTS

- **CONDITIONS OF SUCH A CONTRACT TYPICALLY INCLUDE:**
  - WITHDRAWAL FROM CLINICAL PRACTICE UNTIL HE OR SHE IS DETERMINED TO BE ABLE TO RETURN TO PRACTICE SAFELY.
  - AVOIDANCE OF ALL ADDICTING SUBSTANCES (INCLUDING OVER-THE-COUNTER MEDICATIONS SUCH AS SLEEP AIDS AND ANTIHISTAMINES) AND BEHAVIORS (EG, GAMBLING) THAT PATHOLOGICALLY STIMULATE THE REWARD AREAS OF THE BRAIN.
  - PARTICIPATION IN ADEQUATE AND APPROPRIATE SUD TREATMENT, AS DETERMINED BY THE PHYSICIAN'S ADDICTION SPECIALISTS AND THE PHP, AS WELL AS OTHER MENTAL HEALTH CARE AS INDICATED.
  - PARTICIPATION IN WEEKLY OR MONTHLY GROUP SESSIONS WITH OTHER PHP-CONTRACTED PHYSICIANS, LED BY AN ADDICTIONS COUNSELOR WHO REPORTS BACK TO THE PHP.
  - RANDOM DRUG TESTING
  - REGULAR CONTACT WITH THE PHP TO MONITOR THE PHYSICIAN'S BEHAVIOR.

TREATMENT

- **HCP-SPECIFIC TREATMENT PROGRAMS ARE CRITICAL, AS STATE MEDICAL BOARDS REQUIRE HIGHER LEVELS OF TREATMENT INTERVENTION IN THE INTEREST OF PATIENT SAFETY** (BENNETT ET AL, CURRENT OPINION PSYCHIATRY 2001)
  - **SPECIALIZED PROGRAMS FOR HCPS NOT ONLY PROVIDE MORE INTENSIVE TREATMENT AND CONTINUING CARE PLANS BUT ALSO *WORK WITH PATIENTS IN MATTERS SPECIFIC TO*:**
    - **PROFESSIONAL LICENSING**
    - **PRIVATE PRACTICE**
    - **MEDICAL REPUTATIONS**
    - **OTHER UNIQUE AREAS OF INTEREST**
- TO AVOID ANY RISK OF BIAS DURING TREATMENT, IT IS **STRONGLY RECOMMENDED THAT HCPS ARE TREATED OUTSIDE OF THEIR MEDICAL COMMUNITY BY COUNSELORS AND DOCTORS WITH WHOM THEY ARE RELATIVELY UNFAMILIAR**

AT A GLANCE: THE SIX DIMENSIONS OF MULTIDIMENSIONAL ASSESSMENT

ASAM's criteria uses six dimensions to create a holistic, biopsychosocial assessment of an individual to be used for service planning and treatment across all services and levels of care. The six dimensions are:

1	DIMENSION 1	**Acute Intoxication and/or Withdrawal Potential** Exploring an individual's past and current experiences of substance use and withdrawal
2	DIMENSION 2	**Biomedical Conditions and Complications** Exploring an individual's health history and current physical condition
3	DIMENSION 3	**Emotional, Behavioral, or Cognitive Conditions and Complications** Exploring an individual's thoughts, emotions, and mental health issues
4	DIMENSION 4	**Readiness to Change** Exploring an individual's readiness and interest in changing
5	DIMENSION 5	**Relapse, Continued Use, or Continued Problem Potential** Exploring an individual's unique relationship with relapse or continued use or problems
6	DIMENSION 6	**Recovery/Living Environment** Exploring an individual's recovery or living situation, and the surrounding people, places, and things

TREATMENT

- **NEUROPSYCHOLOGICAL TESTING** IS HELPFUL IN THE ASSESSMENT OF PHYSICIANS WITH SUDS, PARTICULARLY WHEN THERE ARE CONCERNS ABOUT COGNITIVE IMPAIRMENT.
  - **DEPENDING ON THE SPECIALTY, EVEN "MINOR" DEFICITS IN PROCESSING SPEED AND FINE MOTOR COORDINATION MAY ADVERSELY IMPACT THE PHYSICIAN'S ABILITY TO PRACTICE WITH REASONABLE SKILL AND SAFETY**
  - RESULTS CAN ALSO BE USED IN CONFRONTING DENIAL AND DETERMINING FITNESS FOR RETURN TO PRACTICE.
- **COMPREHENSIVE DRUG TESTING** IS AN IMPORTANT PART OF ASSESSMENT WHEN USED TO VALIDATE A PATIENT'S HISTORY OF DRUG USE AND TO CONFRONT DENIAL.
  - THIS TYPICALLY INCLUDES URINE TESTS AND MAY INCLUDE HAIR AND/OR NAIL TESTING

ACUTE TREATMENT LENGTH

- A STUDY OF 802 PHYSICIANS WITH AN SUD PARTICIPATING IN ONE OF 16 PHPS FOUND THAT A MAJORITY OF PHYSICIANS RECEIVED **RESIDENTIAL TREATMENT**, WITH A **MEDIAN LENGTH OF STAY OF 12 WEEKS** (MCLELLAN ET AL, BMJ 2008)
  - **THE OVERALL PERIOD OF ACUTE TREATMENT FOR PHYSICIANS IS TYPICALLY 3 TO 6 MONTHS**
- **FACTORS FAVORING MORE INTENSIVE LEVELS OF CARE AMONG PHYSICIANS INCLUDE:**
  - **HIGH LEVELS OF PHYSICIAN DENIAL OF A PROBLEM WITH SUBSTANCES**
  - **RISKS TO PATIENT SAFETY FROM PHYSICIAN IMPAIRMENT**
  - **NEED TO REMOVE THE PHYSICIAN FROM HIS/HER MEDICAL COMMUNITY TO ENSURE OBJECTIVE AND/OR CONFIDENTIAL TREATMENT**

TREATMENT

- **SOME PHYSICIANS WITH A MILD SUD MAY *NOT* NEED INTENSIVE TREATMENT**. SUCH CASES GENERALLY HAVE LEVELS OF SUBSTANCE USE THAT:
  - **DO NOT MEET CRITERIA FOR A MODERATE TO SEVERE SUD**
  - **ARE NOT ACCOMPANIED BY HIGH DENIAL**
  - **DO NOT DIRECTLY THREATEN THE PHYSICIAN'S CLINICAL JUDGMENT OR PATIENT CARE**
- **AN EXAMPLE IS A PHYSICIAN WITH AN ISOLATED INCIDENCE OF DRIVING UNDER THE INFLUENCE AFTER A WEEKEND PARTY AND WITHOUT OTHER RISK FACTORS.**
  - APPROPRIATE TREATMENT COULD BE OUTPATIENT MOTIVATIONAL ENHANCEMENT AND BRIEF INTERVENTION, WITH A **SUSTAINED PERIOD OF MONITORING VIA RANDOM DRUG TEST TO ENSURE THE PROBLEM IS NOT MORE SEVERE THAN INITIALLY BELIEVED**.

RETURN TO WORK

- **RETURN TO PRACTICE IS GENERALLY BASED ON AN ASSESSMENT OF A PHYSICIANS:**
  - ACCEPTANCE OF THE SUD DIAGNOSIS
  - UNDERSTANDING OF ADDICTION AS A CHRONIC DISEASE REQUIRING LIFELONG ATTENTION
  - COMPLETION OF SUD TREATMENT, WITH SUPPORT OF TREATMENT TEAM TO RESUME WORK
  - DOCUMENTATION OF SUSTAINED ABSTINENCE (TYPICALLY THROUGH RANDOM URINE DRUG TESTING)
  - TREATMENT AND STATUS OF CO-OCCURRING MENTAL DISORDERS
  - JUDGMENT AND COGNITION (INCLUDING RESULTS OF NEUROPSYCHOLOGICAL TESTING)
  - THE PHYSICIAN'S ABILITY TO MANAGE STRESSES AND TRIGGERS
  - SUPPORT NETWORK INCLUDING FAMILY SUPPORT
  - ESTIMATED RISK OF RELAPSE
  - MOTIVATION TO FOLLOW AN ESTABLISHED CONTINUING CARE PLAN

RETURN TO WORK

- **OCCUPATIONAL FACTORS CONSIDERED IN ASSESSING THE PHYSICIAN'S READINESS TO RETURN TO WORK GENERALLY INCLUDE:**
  - **LEGAL/LICENSURE REQUIREMENTS HAVE BEEN SATISFIED**
  - **WORKPLACE MONITOR/SUPERVISOR HAS BEEN IDENTIFIED AND ACCEPTS RESPONSIBILITIES**
  - **NECESSARY WORKPLACE MODIFICATIONS OR PRACTICE RESTRICTIONS HAVE BEEN AGREED TO**

TABLE 3. **Activities Required or Suggested by Physician Health Programs for Addicted Physicians**

Usually required by state physician health programs

- Abstinence from all drugs of abuse
- Group therapy with other physicians provided by a professional facilitator (weekly)
- Individual psychotherapy (weekly)
- Mutual help meetings, usually a 12-step program (multiple times per week)
- Monitoring meeting with state program (monthly)
- Drug screening, random and for cause (multiple per month)
- Workplace monitor to supervise return-to-work activities

Possible further requirements

- Psychiatric care
- Primary care physician (no self-prescribing or prescribing for family members, not even antibiotics)
- Family therapy
- Workplace limitations (eg, no access to opioids or procedures with opioids)
- Prescribing limitations (eg, no prescribing of controlled substances)
- Work hours limited
- Neurocognitive testing
- Return to work evaluation, if disability requires several months' absence

Merge et al, Mayo Clinic Proc 2009

TREATMENT OUTCOMES

- **PHYSICIAN'S DEMONSTRATE SOME OF THE HIGHEST SUCCESS RATES IN ANY SPECIALIZED POPULATION**.
  - RETROSPECTIVE STUDIES OF PHPS IN THE UNITED STATES HAVE FOUND THAT **BETWEEN 75 AND 90 PERCENT OF PHYSICIANS AND OTHER HEALTHCARE PROFESSIONALS COMPLETED SUD TREATMENT, RETURNED TO WORK, AND REMAINED WORKING AT FIVE YEARS FOLLOW UP**

    (MCLELLAN ET AL, BMJ, 2008) (BOHIGIAN ET AL, J ADDICT DIS. 2005)
- HOWEVER, RESULTS FROM PHP STUDIES MAY UNDERESTIMATE THE RELAPSE RATE OF PHYSICIANS BY OMITTING PATIENTS LOST TO FOLLOW UP AND DEPENDING ON DRUG SCREENS AS MEASURES OF ABSTINENCE.

TREATMENT OUTCOMES

- THE WASHINGTON STATE PHP OVER A 10-YEAR PERIOD FOUND THAT **25% HAD AT LEAST 1 RELAPSE** (DOMINO ET AL, JAMA 2005)
- **RELAPSE RISK WAS INCREASED BY:**
  - **A FAMILY HISTORY OF A SUBSTANCE USE DISORDER**
  - **A COEXISTING PSYCHIATRIC ILLNESS (DOMINO ET AL, JAMA 2005)**
  - **INDEED, IN THE SETTING OF OPIOID ADDICTION, A COEXISTING PSYCHIATRIC ILLNESS OR A POSITIVE FAMILY HISTORY OF ADDICTION RESULTED IN A SIGNIFICANTLY INCREASED RISK OF RELAPSE.**
  - **THE 3 FACTORS, WHEN COMBINED IN A SINGLE INDIVIDUAL, RESULTED IN A 13-FOLD INCREASE IN RISK OF RELAPSE**

FUTURE PREVENTION/EARLY INTERVENTION IDEAS

- **ROUTINE SCREENING FOR DRUG USE —RANDOM DRUG TESTING OF PHYSICIANS MAY BE AN EFFECTIVE COMPONENT OF BOTH PREVENTION AND EARLY INTERVENTION**
  - **CONTROVERSIAL AND RESISTED BY MANY ORGANIZATIONS REPRESENTING PHYSICIANS**
  - **MANDATORY TESTING IS PERFORMED IN OTHER PROFESSIONS WHERE PUBLIC SAFETY IS AN ISSUE, SUCH AS TRANSPORTATION**
  - **SOME EXPERTS SUGGEST RANDOM DRUG TESTING OF PHYSICIANS, WITH INITIAL APPLICATION IN THE HIGH RISK FIELDS OF ANESTHESIOLOGY, SURGERY, AND EMERGENCY MEDICINE.**
  - **FOR CAUSE TESTING FOLLOWING AN ADVERSE EVENT HAS BEEN CONSIDERED BUT DISCOURAGED**

MAOPS- PHYSICIAN AND HEALTH PROFESSIONAL WELLNESS PROGRAM (PHP)

- SUPPORT MEDICAL STUDENTS, RESIDENTS, PHYSICIANS, AND OTHER ALLIED HEALTH PROFESSIONALS STRUGGLING WITH ADDICTION OR WITH PHYSICAL OR MENTAL HEALTH CHALLENGES
- ANNUAL PHYSICIAN WELLNESS RETREAT- SEE MAOPS WEBSITE FOR MORE DETAILS
- MEMBER ASSISTANCE PROGRAM (MAP)

MAOPS- PHYSICIAN AND HEALTH PROFESSIONAL WELLNESS PROGRAM (PHP)

CONTACT 573-632-5562

- JIM WIEBERG, M.ED., LPC
  - DIRECTOR
  - JWIEBERG@CRMC.ORG
- HEATHER JOHNS, LCSW
  - ASSOCIATE DIRECTOR
  - HJOHNS1@CRMC.ORG
- WILLIAM R. CARPENTER, D.O.
  - MEDICAL DIRECTOR
  - WCARPENTER@CRMC.ORG

QUESTIONS?

Thanks