Public Health

Substance abuse among physicians

Epidemiology

The general perception that rates of substance abuse are higher among physicians than among the general public appears to be based more on folklore than on fact.[1] Prevalence data concerning substance abuse among physicians are generally lacking, and most of the published data are based on descriptive studies that use convenience samples unsuitable for comparison with other populations. The prevalence of alcoholism and illicit drug use among physicians is likely similar to that in the general population,[2] at about 9%.[3] However, physicians may be at increased risk for prescription drug abuse, particularly abuse involving opiates and benzodiazepines.[1]

Although physicians probably face no special risk of developing addiction problems, they do confront special problems when they try to enrol in effective treatment programs. Like other professionals such as airline pilots and dentists, addicted doctors pose a risk to the safety of the general public. The medicolegal implications are profound, because the primary mandate of provincial licensing bodies is to protect the public from unqualified or impaired physicians. Admitting to an addiction places a physician's reputation, accreditation and employment in jeopardy. Consequently, addicted physicians find it difficult to seek help.[4] They suffer a disease of isolation and denial that is often fostered and enabled by silent colleagues; skilful intervention can save lives. Appearance of a problem in the workplace often signifies advanced disease. Too often the diagnosis of an addiction does not emerge until the impaired physician is incapacitated, necessitating urgent removal from work. Physicians should be alert to conditions and behaviours that may signal a substance abuse disorder in a colleague (Table 1).

Most provincial medical associations and addiction treatment facilities provide confidential phone lines that offer guidance to impaired physicians or their colleagues. The Ontario Medical Association receives about 130 of these calls annually; over 30% are from concerned colleagues and about 20% are from the families of impaired physicians.

Table 1: Identification of the impaired physician

High-risk conditions	Family history of addictions
	Domestic breakdown
	Unusual stresses at work
Behaviours	Changes in behaviour from baseline
	Loss of reliability
	Frequent medical complaints
	Self-prescribing of mood-altering medications
	Mood changes
	Staff concerns
	Citations for impaired driving
Signs	Smell of alcohol
	Ataxic gait
	Slurred speech
	Tremor
	Dishevelled appearance
	Somnolence

Clinical management

A comprehensive treatment program for physicians involves: immediate intervention; evaluation and triage at an appropriate facility; uninterrupted therapy, usually in a residential setting; family involvement; and appropriate re-entry into practice with comprehensive case management, monitoring, advocacy and a relapse contingency plan.

The conventional treatment program includes inpatient detoxification, medical and psychiatric evaluation, and rehabilitation with group therapy and attendance at meetings of mutual support groups such as Alcoholics Anonymous, Narcotics Anonymous and Caduceus (a support group for impaired medical personnel). After full assessment and treatment, the recovering physician is transferred to continuing care, with weekly outpatient sessions continuing for 2 to 3 years. Ideally, a recovery contract is written between the recovering physician and a treating clinician, institution, provincial assistance program or the college.

Relapse prevention

The requirement for close follow-up is believed responsible for the high recovery rates of more than 80%. Factors that can contribute to relapse include unresolved anger, guilt or shame, isolation, failure to focus on abstinence and occupational or legal difficulties.

In general, physicians with substance abuse problems or questions can receive confidential help from addiction resource centres or physician assistance programs operated by provincial medical associations. — *Erica Weir*, CMAJ

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References

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