Impaired physicians: They are not the only ones at risk

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Only in recent years has the medical profession been confronted by a problem that had gone unnoticed and unresolved in the past — the significant number of doctors whose skills have been impaired because of alcoholism and other types of chemical dependency.

As our denial that the problem existed was eroded by emerging disclosures — it has been said to affect anywhere from 5% to 17% of North American doctors — our lack of awareness and knowledge became more and more apparent. The disease's consequences include deterioration of personal health and relationships, dysfunctional marriages and families, and impairment of professional competence and conduct. The initial focus of concerned physicians was doctors whose illness was affecting their professional lives.

Across Canada, professional associations and provincial licensing bodies reacted in one of three ways. In some provinces college registrars assumed responsibility for detection, validation, confrontation and diversion into treatment programs as an alternative to discipline and censure.

In others, provincial medical associations developed "at-risk" committees which assumed an advocacy role, relying on self-disclosure and private referral to hot lines to discover doctors in trouble, with peer pressure being the primary coercive method of intervention. With this approach, recovered physicians began to surface and became useful resources because of their experience and understanding of the illness's dynamics. Such programs made more doctors aware that addictive illness existed within the profession.

Finally, some provinces chose to compromise and blend the two approaches by creating an intermediary body between the provincial colleges and professional associations.

Regardless of mechanisms used, doctors suffering from alcohol and drug addiction began to be recognized with increasing frequency and were being referred into treatment programs. They were able to re-enter into more functional and healthier personal and professional lives.

Unfortunately, some of the doctors who had simply been confronted returned to practice carrying a considerable load of guilt and shame and remained somewhat isolated from colleagues. Conversely, others were welcomed back by peers and were actively supported in overcoming some of the shame that always accompanies this illness.

As great as the variation in methods and mechanisms of intervention was, the variation in follow-up approaches was not much different. Some believed that maintenance of sobriety required body-fluid monitoring and supervision. Others insisted that long-term remission could only be maintained with group aftercare and attendance at mutual-help programs — Alcoholics Anonymous and Narcotics Anonymous.

Once again, the two basic approaches were a supervisory, paternalistic one, which had some success from a coercive perspective but did little to develop personal responsibility, integrity and self-esteem, and an open, self-reporting, self-responsible system that served mature individuals who were in healthy remission. However, the latter approach did little for those who still denied they had a problem.

In different components of all provincial programs, the debate between the disciplinary "big-brother" approach versus the "honesty-is-the-best-policy" one continues, with the evolution of several compromises. Both approaches work in selected cases, but these different philosophies could impede the development of adequate "at-risk" and "well-being" programs for doctors. A partial solution in three provinces is the appointment of a salaried, part-time coordinator who can accommodate specific individual needs and ensure proper program development.

The coordinator's role has evolved as specific needs emerged in different provinces.

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What appears common to all is continuing education about addictive disorders and other stress-related occupational hazards, continued development of intervention skills and strategies, provision of direct access to support and treatment programs, and some form of follow-up and aftercare.

Moreover, the team approach between coordinators and dedicated committee members is instrumental in recognizing emerging needs. Is a coordinator needed? The answer hinges on the choice between confronting the problem in an ongoing manner, or dealing with it only when a crisis develops.

Upon close examination, a clearer perception of the natural evolution of the physician-impairment problem emerges. It becomes clear, for instance, that a substance-abuse problem often affects an individual's personal and family life for at least 5 years before it becomes visible in professional life. When the problem does become visible there, the shame, guilt and anger is shared by family members, close friends and colleagues. Before it becomes clear that treatment and aftercare are necessary, the inner community of family and friends has unconsciously become a "therapeutic-and-support" community without recognizing that a progressive illness is present.

This only becomes apparent as this ad-hoc therapeutic community becomes alienated because of the afflicted individual's behaviour. It is at this stage that "significant others" may seek advice and assistance or refer the physician to a therapeutic program, but not to a disciplinary one. The consequence is that healthier physicians with fewer social and professional problems are now entering recovery programs.

The patterns of addictive illness are as different as physicians' personalities. At one end of the spectrum are the younger, flamboyant, multiple-substance abusers who often socialize in underground drug subcultures with other professionals — nurses, lawyers and the like. At the other end is the respectable pillar of the community or medical faculty who quietly drinks himself to sleep every evening after a 16-hour day, never appears intoxicated, slips into a depression and commits suicide.

Hence, all provincial programs face a challenge. They must continue developing professional awareness, selecting appropriate methods of recognition, referral, intervention, treatment and aftercare, especially in light of the extreme diversity of these problems.

As the addictive disorders are successfully intercepted, and treatment and rehabilitation strategies evolve, a new reality begins to emerge. Although it is tempting to restrict the term "impaired physician" to addicts and alcoholics, other problems affecting the well-being of doctors and their families are surfacing. They must be addressed. Conditions affecting our roles as physicians are gaining most of the attention, but programs for aging physicians with and without cognitive impairment are needed, as are strategies for supporting doctors with psychiatric disorders.

However, there are even more ubiquitous problems below this surface awareness that affect physician well-being without necessarily impacting on professional life — eating disorders, compulsive caregiving with consequent exhaustion and depression, materialism, and addiction to stress and prestige.

As the medical profession continues on a path of recovery from obvious illnesses, perhaps the next phase will involve healthy pursuit of personal well-being and a balance between professional, family and community life. This evolution can only occur through programs that focus on physician health and cannot logically evolve through agencies concerned only with professional conduct and discipline.

Finally, there may be an obligation to some victims who remain unattended and ignored when physicians maintain an "at-risk" lifestyle — doctors' spouses and families and physicians in training at the undergraduate and postgraduate levels. Perhaps some of the lessons learned during this journey towards recovery can influence the choosing of a healthier path for those who follow.■

A helping hand is available in several provinces

If you think you, a colleague or a family member might need help in dealing with possible drug or alcohol abuse, confidential assistance is available from at-risk committees run by CMA divisions in several provinces:

British Columbia:
1-800-663-6729
Alberta: 1-800-232-7294
Manitoba: (204) 237-8320
Ontario: 1-800-268-7215
New Brunswick:
(506) 635-8410
Nova Scotia:
(902) 453-1844
Prince Edward Island:
(902) 892-7527