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Special Article

Physician Attitudes Toward Distressed Colleagues

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Attitudes and behaviors of physicians toward their impaired colleagues often affect whether the latter seek treatment. Negative responses include (1) silence, usually based on anxiety, ignorance and pessimism; (2) tentative responses based on stereotyped assumptions or distraction by organic problems; (3) judgmental responses that may result in mutual avoidance, and (4) permissive responses that encourage continued use of alcohol or other drugs. Positive responses include (1) confrontation in a concerned, constructive manner as early as possible; (2) assistance to the impaired colleague in obtaining treatment, and (3) education and information sharing to increase awareness of potential and real problems.

Educational programs can help physicians develop more positive attitudes toward both impaired colleagues and impaired patients. The emphasis is on active participation. The goals of these programs should include optimism about therapy, using structured treatment approaches that include paraprofessionals and formerly impaired physicians on the treatment team, and the development of confrontational skills on the part of each physician.

THE PROBLEM OF PHYSICIAN IMPAIRMENT is as old as the profession of medicine, but has received little mention in its history. It is only within the past decade that the problem has begun to receive systematic attention from organized medicine. The first national conference on the subject of impaired physicians, sponsored by the American Medical Association (AMA), was held in 1975. Since that time there has been increased activity in the areas of detection, discipline and treatment.

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In the last decade the AMA has reported a sixfold increase in state disciplinary actions against physicians.[1] From 1971 to 1977 four disciplinary actions were tallied: censure, denial of license reciprocity, suspension of narcotics permits and license revocation. In 1971 there were 199 such actions arising out of 1,275 initiated. In 1977 there were 685 actions out of 3,662 initiated. These figures reflect an increase in the number and rate of disciplinary actions. Fortunately, treatment and educational options have been added to the range of disciplinary measures. The AMA model legislation prepared in 1976 adds required continuing medical education (CME),

supervision of practice, and counseling or treatment to the actions a board can take. This represents a shift toward a more positive attitude on the part of organized medicine.

Punitive discipline is usually unpleasant, and this fact contributes to avoidance of the subject of physician impairment by other physicians. It is not enough, however, to account for the variety of negative attitudes encountered among physicians. These attitudes are complex combinations of belief, emotion, knowledge and past experience. An attitude can be viewed as a learned, generalized, enduring mental readiness or predisposition to act in response to different stimuli, such as patients, family or friends.[2]

This paper reviews the literature of the relationship between attitudes and behavior of medical students and physicians and discusses early findings on physician behavior and attitudes toward their impaired colleagues. The paper concludes with some suggestions about medical education for attitudinal change.

Review of the Literature

The relationship between expressed attitudes and behavior is not clear. Research in attitudinal change shows an imprecise relationship between self-reported attitudes and behavior.[3] One of the few studies to relate attitudes to physician behavior was done by Dressler and co-workers.[4] They followed 20 residents in psychiatry who saw 248 patients admitted to the emergency room of one of Yale's teaching hospitals after attempting suicide. The residents rated each patient on a mood adjective checklist.[4] The patients whom the residents rated with warmth and understanding, indicating a positive attitude, tended to be seen for over 30 minutes and were referred as voluntary patients to private psychiatric or mental health facilities. The patients rated with disinterest and annoyance, reflecting a negative attitude, tended to be seen for less than 30 minutes and to be referred as involuntary patients to the state hospital. Clearly, other factors such as situational pressures have a major influence on behavior, and these need to be taken into account.

There is some evidence that attitudes are relatively stable over time and are not easily changed. Kiesler and colleagues have noted that "Most attitude studies show some net positive gain, but observation shows people to remain remarkably fixed in their beliefs and habitually resistant to persuasion."[3] Reynolds and Bice[5] reached a similar pessimistic conclusion after five months of vigorous efforts to alter interns' attitudes toward long-term patients whom they often labeled as "crocks."

The attitudes reflected in the negative behavior of physicians toward their impaired colleagues, as described in this paper, begin early. Rezler, in a review of attitude changes during medical school, blamed the production of "such strong feelings of inferiority in medical students that they defend themselves by becoming cynical."[6] Fisher and his colleagues documented increasingly negative attitudes toward alcoholic patients from the first year of medical school through residency training.[7]

There are some positive notes in this otherwise gloomy picture. Morse and co-workers,[8] in a survey of 665 Midwest physicians, found that the majority claimed to be comfortable with alcoholic patients, willing to make the diagnosis of alcoholism, interested in remaining medically involved during treatment, and valuing nonmedical resources such as Alcoholics Anonymous (AA). However, most also felt pessimistic about the overall outcome and recognized both the need for more education about alcoholism in medical school and their own current need for further understanding of the disease.

Educational strategies have been developed to change attitudes and to promote positive effects on physician behavior. Zimbardo and co-workers state that "all the techniques which are known to increase or decrease learning should be applicable to producing change in attitudes."[2] Jerome Frank,[9] in examining the techniques that were important in producing attitudinal change in physicians, emphasized participation, improvisation rather than rote learning, and repetition. Mogar and his colleagues[10] at Mendocino's award-winning alcoholism program (Mendocino State Hospital, Talmage, CA), have confirmed Frank's view. They believe the most powerful determinant of physician attitudes is experience working with alcoholic patients in a treatment setting which is humanistic and strongly optimistic and which tries to match the help that a patient is seeking with the kind of help the staff can provide.[10]

Physician Behavior and Attitudes

The following behavioral descriptions are based on interviews with formerly impaired physicians who have been able to resume responsible medical practice. The material summarizes the attitudes and actions of colleagues as perceived by physi-

cians who were struggling with disabling alcohol and drug abuse. (Videotapes of excerpts of these interviews are available from the author for medical educational purposes.)

Negative Behaviors

Silence is the most commonly encountered response. It is characterized by the statement, "I didn't tell and they never asked." The mutual nature of this silence on the part of the impaired physician and his or her colleagues has sometimes been referred to as collusion or conspiracy. However, there is no evidence that the silence is consciously determined. Anxiety, ignorance and pessimism all contribute to this reaction.

Anxiety may be the most common determinant. None of us want to make an unrequested diagnosis of a colleague's condition, especially when it has negative connotations and is one about which we cannot be 100 percent sure. There is also a shared anxiety about underlying anger. We fear an angry reaction and possible litigation, even though the real risk may be negligible. Our impaired colleagues fear accusations, condemnation and even "crucifixion."

Ignorance contributes in at least two ways. We are always ignorant of the full extent of the problem as experienced by a distressed colleague and, therefore, are unwilling to risk raising the issue. More important, we may be ignorant of the nature of alcohol and drug dependence, or other aspects of mental illness. Few of us received much training in these areas during our medical school, residency or continuing education experiences. Our diagnostic criteria may be stereotypic, based on skid row extremes or our own patterns of alcohol use.

Pessimism can have a powerful negative influence. Our pessimism about treatment outcome, often based on a sample of the worst cases treated in teaching hospitals, facilitates avoidance and denial. Frequently, it reflects a lack of belief both in the efficacy and outcome of treatment and in the power of peer influence or interpersonal relationships. Even greater pessimism may be felt by an impaired colleague if he believes that his condition is untreatable and that his case is hopeless.

Tentative responses are those that are partial or incomplete. These occur when we raise the issue incompletely and then let it drop. Both parties feel discomfort during the confrontation and, often, relief when the matter can be dropped. Three examples of this type of response are as follows: First, a confronting physician's stereotyped assumptions may result in the use of yes-no questions, which he or she believes will serve as a useful screening purpose. "Are you drinking a quart a week?" is a question which is easily and concretely denied by a physician who is drinking a quart a day.

Second, a confronting physician may raise the issue and then deny it himself. "You're too young to be an alcoholic," reflects an older physician's disbelief that a medical student or resident could have a problem which the physician believes occurs at an older age. This mistaken belief results in missing opportunities for early diagnosis and intervention in medical school or residency training where these problems often begin.

Distraction by other medical issues is a third example. In one case, the presence of hypertension made it possible for a resident's colleagues to ignore the young physician's alcoholism. Discomfort with emotional and behavioral problems results in avoidance behavior by attending physicians who then treat the physical effects of alcohol and drug abuse as though they were the cause. This sadly myopic pursuit of organic red herrings results in missing opportunities to obtain treatment for the underlying problem.

Judgmental responses deal with physician impairment as a moral problem rather than a medical one. The underlying tone is one of anger and condemnation. The self-righteousness implicit in this response immediately establishes a hierarchy with the impaired physician in the inferior position. "You ought to be ashamed of yourself," also has a personal quality which evokes images of childhood transgressions.

Judgmental responses are the ones most expected and feared by impaired physicians. The possibility of being blamed or condemned by an angry colleague may be used to justify not seeking help. The result is mutual avoidance between an impaired physician and his colleagues, with greatly diminished possibilities of treatment.

Permissive responses encourage others to take alcohol or drugs without regard for their potential to impair health or create dependency on their use. One physician, when applying to medical school, was interviewed in a hotel room. The young man, who was unaware of any problem at the time, informed the interviewer that he took his whiskey straight. The response was, "By God, that's the way you're supposed to drink Old Grandad!" The

ubiquitous presence of alcohol at social functions both during and after medical school, may present a persistent pressure to conform. It may also be interpreted by an insecure physician as a test of social and personal acceptability.

Less common, but more dangerous is the suggestion that alcohol or other drugs be used for the relief of tension or other symptoms. This response encourages self-prescription, which is always hazardous in that it avoids more constructive alternatives, risks increasing dependence and continues to postpone getting professional help.

Positive Behaviors

Confrontation should occur early and in a concerned, friendly, constructive way. Anger has no place in the confrontation unless the physicians involved are good friends and intend to continue their relationship. The purpose of the confrontation is to raise the issue of real or potential impairment, based on factual observation, in such a way that the physician at risk experiences support, collegial concern and optimism for treatment, if the latter is needed. It is inappropriate to attempt confrontation casually, or in passing. This response facilitates both denial and avoidance and makes the needed follow-up more difficult.

Assistance with practical issues can be very useful. Many impaired physicians who successfully get into treatment programs have received help from colleagues in making arrangements for appointments, help at home and coverage for their practice.

Education and information sharing help promote awareness of the potential for impairment in each of us and the effective help that is available. We all share the occupational hazards of our profession. It can be mutually beneficial to share our concerns and ideas with each other. Physicians should be well informed and optimistic about treatment for the causes of impairment. One such example is the Georgia Disabled Doctors Program, which has had considerable success in returning impaired physicians to successful medical practice.[11] This program emphasizes early intervention, confidentiality and voluntary participation.

Little is known about physician attitudes underlying the above behavior. Niven gave a questionnaire to 734 physicians attending CME programs at the Mayo Clinic and reported his findings at the AMA Conference on the Impaired Physician held in Minneapolis in 1977. Copies of the data can be obtained from Dr. R. G. Niven, Department of Psychiatry, Mayo Clinic, Rochester, MN 55901. The top five behaviors, rated by physicians responding to the questionnaire, as indicative of impairment problems are shown in Table 1. All of these deal with intoxication, drinking or self-prescription. Two of the five behaviors about which there was least concern included personality changes when drinking and regularly having a little too much to drink at social gatherings.

Less enthusiasm was shown on the Niven questionnaire for intervening in cases of physician impairment, as can be seen in Table 2. The notable exception was in willingness to help a physician's family and to cover his or her practice. It is this kind of assistance that greatly facilitates a physician's return to practice after treatment. Only 16 percent indicated a willingness to discuss their concern with their colleague's spouse.

We were interested in having Nevada physicians take the Niven survey for comparison purposes.

TABLE 1.—*Five Physician Behaviors Most Indicative of Problems**

Behavior	*Percent Rating Behavior as Significant (N=734)*
Is intoxicated while on call for emergency room coverage	96
Is seeing patients in his or her office after having three drinks at lunch	93
Begins to regularly use self-prescribed hypnotics, stimulants or minor tranquilizers	93
Drinks in a way that leads spouse to express serious concern that he or she has a drinking problem	93
Has slurred speech on rounds leading to nurses' concern that something is wrong	92

*The top five behaviors as rated by 734 physicians responding to a questionnaire given by Dr. R. G. Niven of the Mayo Clinic to be indicative of impairment problems.

TABLE 2.—*Physician Interventions*

Intervention	*Percent Indicating Agreement (N=734)*
I would be willing to help my colleague's family and to help cover his practice should he need to be admitted to hospital for a problem of psychiatric or chemical dependency	92
I would be uncomfortable but willing to discuss my concern with him	66
I would discuss my concern with other colleagues first	64
I would be willing to participate with a medical society committee in evaluating and advising my colleague even though he or she may be angry and resist the offer of help	61

His sample, while large, is heavily weighted for family practitioners, most of whom probably practice in the Midwest. The Washoe County Medical Society Committee on Major Health Issues, which has responsibility for physician well-being, approved the survey if it was shortened. The board of directors of the society turned the shortened survey down and refused to recommend it to the Nevada State Medical Association. Two major objections were raised in the discussion. The first objection was that if the press got hold of the results it would be damaging to the public image of physicians. This decision was made in a county where four physicians had committed suicide within the previous two years.

In our own work with physicians some interesting patterns have been observed. A Standardized Test of Attitudes and Knowledge (STAK) was developed by the Career Teachers in Alcohol and Drug Abuse.* Validation and reliability studies are being completed. (Copies of the test can be obtained from the author.) The STAK has been given to over 600 clinicians, including 274 physicians attending CME courses on alcohol and drug abuse at various locations across the United States. These physicians volunteered because of their interest in substance abuse and their willingness to complete the attitude survey.

The results concur with Niven's finding that physicians are nonpunitive toward their impaired colleagues. Eighty-five percent disagreed with the statement, "A physician who has been addicted to narcotics should not be allowed to practice medicine again." No age or specialty bias was evident in responses to the above statement. Analysis of variance showed a significant ($P<0.001$) relationship between this nonjudgmental response and high scores on the attitudinal factors of treatment optimism and treatment intervention of the STAK.

The relationship between one's personal experience with chemical dependence and attitudes toward early diagnosis and intervention has not been clear. Table 3 compares the STAK responses of 132 physicians who completed an optional section in which they rated their own dependence on tobacco and alcohol. The data suggest that among physicians who admit to tobacco and alcohol dependence, when compared with physicians who do not, there is greater agreement regarding the importance of early diagnosis and treatment intervention. Both of the items in Table 3 are contained in the treatment intervention factor. This finding may be related to the demonstrated value of peer support in the treatment of alcohol and drug dependence. Many programs for impaired physicians recommend that formerly impaired physicians be included on the confrontation and intervention teams. The attitudinal differences shown in Table 3 may account in part for the greater effectiveness of these physicians in motivating their distressed colleagues to accept help.

Discussion

The above findings suggest that as physicians we are in conflict on the subject of physician impairment. Early in training we begin to develop negative attitudes toward those with alcohol and drug dependency and those with some forms of mental illness. One part of the negative attitude is pessimism about treatment. At the same time, however, we do not wish to punish our impaired colleagues or see them removed from medical practice if they can be treated.

One solution to this dilemma is to consciously

*Tracy L. Veach and Michael Herring assisted with the development of STAK and the analysis of data.

TABLE 3.—*Differences in Attitudes and Chemical Dependence (N=132)**

Attitudinal Statement	*Tobacco-Dependent Physicians (N=36)*	*Alcohol-Dependent Physicians (N=15)*
Physicians who diagnose alcoholism early improve their chance of treatment success.	More Agreement (P 0.05)†	More Agreement (P 0.007)
A person who is dependent on alcohol or drugs cannot be helped until he or she has hit rock bottom.	More Disagreement (P 0.001)	More Disagreement (P 0.05)

*Of 132 physicians who completed the optional section of the STAK, 36 rated themselves as dependent on tobacco and 15 as dependent on alcohol.

†Significance levels determined by x^2 test.

address the problem of attitude change in undergraduate, postgraduate and continuing medical education. Using the principles of participation and experience outlined earlier in this paper, we have been able to show that after a one-week course positive changes occurred in medical students' attitudes toward patients with chemical or alcohol dependency and treatment outcomes.[12] Similar changes in physician attitudes are described by Pursch as a result of a two-week course on alcoholism.[13] On the basis of his experience with 475 physicians he believes that 75 percent of all physicians are unable to deal effectively with alcoholism, either in making an accurate diagnosis or in instituting effective management of the illness. He concludes that "Our trainees have touched many alcoholic livers—but almost no alcoholic lives."

If positive attitudes and behavior toward physician impairment and its treatment are to be developed in all practicing physicians, then intensive educational efforts will be needed. To be effective these programs must have clear goals based on principles that in the past have shown some effectiveness in altering attitudes.

We would suggest a set of educational goals based on those described by Pursch.[13] As a result of educational experiences designed to influence attitudes, medical students and physicians will learn the following:

- Alcohol and drug dependence are treatable illnesses. Treatment of impaired physicians has a high probability of success.[11]
- Effective treatment of impaired physicians needs a structured approach, preferably with a multidisciplinary team.
- Paraprofessionals and formerly impaired physicians are key members of the treatment team.
- Physicians can confront impaired physicians effectively.

These goals can be achieved by involving medical students and physicians in educational experiences characterized by active participation in clinical problems in the classroom and in treatment settings for impaired physicians.

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