

Note: PHP Perspectives is a new column bringing you news and information from the Rhode Island Medical Society's Physician Health Program (RIPHP)

When a Physician is Afflicted with Addiction

KATHLEEN BOYD, MSW, LICSW

IT MAY BE HARD TO ACCEPT that a trusted physician could suffer from the disease of addiction but it does appear that doctors are just as likely as the general public to have a substance use disorder in their lifetime. While precise estimates of the prevalence of addictive disorders among doctors



are difficult to ascertain due to probable underreporting, studies have indicated that the lifetime rate of addiction among physicians is estimated to be between 10% and 15%, which is roughly the same as or slightly higher than the rate in the general population.¹⁻³ Further, although alcohol has been identified as the primary abused substance in nearly half of all cases, physicians are seen as having more likelihood than others to abuse prescribed medications.⁴ Dealing with a physician who exhibits impairment can be a very challenging experience for colleagues, administrators, patients and family members; yet, help and recovery for these physicians often depends on the timely response or intervention of these peers, coworkers, and family members.

Many healthcare providers are reluctant to confront a colleague they suspect may be impaired. In 2010, the *Journal of the American Medical Association* (JAMA) published a survey in which 17% of nearly 1900 responding physicians

reported having had direct personal knowledge of an impaired or incompetent physician in their hospital, group or practice in the three preceding years. Of those, one-third did not report the individual. Those who kept silent said they did so because they believed someone else was taking care of

the problem (19%); they did not think reporting the problem would make a difference (15%); they feared retribution (12%); they did not see this as their responsibility to report (10%), or they worried that the physician would end up being excessively punished (9%).⁵ The American Medical Association's (AMA) code of ethics underscores the ethical and legal obligation of physicians to identify, confront, refer or report any suspected impaired colleague in order to protect patient safety (www.ama-assn.org).

The best scenario would be a physician who self-reports and seeks appropriate assessment and treatment in the absence of any harm to patients. We know that there are many barriers to seeking help: guilt, stigma, shame, denial of problem, career fears, to name a few. While it is true that there can be dire consequences for a physician who continues to practice while actively abusing substances, there are well-developed mechanisms in place to support

physicians who find themselves in need of assistance.

Formal efforts to deal with physician impairment existed as far back as 1958 when the Federation of State Medical Boards in the United States identified drug addiction and alcoholism among doctors as a disciplinary problem. Ten years later, the Federation approved a resolution calling for nationwide programs. In 1973, in the *Journal of the American Medical Association*, a landmark policy paper was published entitled: "The Sick Physician: Impairment by Psychiatric Disorders, Including Alcoholism and Drug Dependence," in which the AMA publicly acknowledged physician impairment. The outcome was to establish a therapeutic alternative to discipline for physicians. This really marked the beginning of the "physician health field." During the 1970s and early 1980s, almost every state had developed some sort of committee or program to deal with affected physicians. This was the situation in Rhode Island when, in 1978, through efforts spearheaded by Herbert Rakatansky, MD, the "Impaired Physician Committee" of the Rhode Island Medical Society (RIMS) was formed and became an official resource for the medical community. Today this program is known as the Rhode Island Medical Society's Physician Health Program (RIPHP).

RIPHP is one of 46 state physician health programs (PHPs) designed to assist in the early identification,

treatment, documentation, and monitoring of ongoing recovery of physicians with an illness that impacts or potentially impacts the care rendered to patients. Our overarching goal is to assist physicians with issues of personal health and addiction to receive proper evaluation, treatment and aftercare that will enable them to preserve their health and medical careers. Early reporting and intervention are key factors. Reporting to a PHP can be an alternative to reporting directly to a licensing board, hospital or medical practice administration, and can lead to confidential help for the physician. We try to distinguish between “illness” and “impairment” during this process. Some physicians who enter the RIPHP may be suffering from an addictive illness, but not be impaired in terms of the performance of their medical duties. While there is always the potential for impairment, many seek our services and treatment prior to crossing that line. The priority, however, will always be patient safety.

So what does the RIPHP do? A member of the RIPHP’s Physician Health Committee conducts an initial assessment of the physician with the assistance of the program director, who is a licensed mental health professional. As appropriate, we generally obtain a specialized addiction evaluation done by an outside, independent evaluator. We routinely request an updated comprehensive general medical examination. Several identifying risk factors in physicians with emerging substance use problems are: not having an identified primary care physician, not having regular recommended preventative medical care, and generally not attending to one’s own health status. We often find that a physician does not have an identified

primary care physician and has not had an updated physical in many years. After completion of the evaluations, we meet again with the physician to review the findings and recommendations. As is the case with most PHPs, if a substance use disorder is diagnosed, we request that the physician enter into a five-year monitoring contract. The elements of the contract include random urine drug screens, attendance at 12-Step meetings, counseling and medication management if indicated, and attendance at a physician recovery support group. According to a study published in 2009, physicians who undergo treatment and participate in an ongoing monitoring program have a far lower rate of relapse, with only 22% testing positive at any point during a five-year monitoring period and 71% still licensed and employed after five years.⁶

Anyone can make a referral to the RIPHP and we encourage self-referrals. We are not obligated to inform the Rhode Island Board of Medical Licensure and Discipline (BMLD) of all referrals and we strive to keep our work with physicians confidential. However, it is our established policy to inform the BMLD when there is a continuing threat to patient safety. Also, while we do receive many referrals from the BMLD, we receive no funding from the Department of Health. We are fully separate and distinct from State government and are a formal program of the Rhode Island Medical Society. If you are concerned about yourself, a colleague, or a family member, you can contact us through the Medical Society website at www.rimed.org (click on “Physician Health” link) or call 401-528-3287 for confidential assistance.

The Physician Health Committee

(PHC) is a standing committee of the Rhode Island Medical Society, comprised of approximately 25 volunteer physicians, physician assistants, dentists and podiatrists, who meet monthly to review new referrals and ongoing cases. If you have an interest in joining the PHC, please contact Herbert Rakatansky, MD, committee chairperson. ❖

References

1. Baldisseri MR. Impaired healthcare professional. *Crit Care Med*. 2007; 35(2) [suppl]:S106-S116.
2. Hughes PH, Brandenburg N, Baldwin DC Jr, et al. Prevalence of substance use among US physicians (published correction appears in *JAMA*. 1992;268(18):2518; *JAMA*. 1992; 267(17):2333-9.
3. Flaherty JH, Richman JA. Substance use and addiction among medical students, residents, and physicians: recent advances in the treatment of addictive disorders. *Psychiatr Clin N Am*. 1993; 16:189-95.
4. Merlo LJ, Gold MS. Prescription opioid abuse and dependence among physicians: hypotheses and treatment. *Harv Rev Psychiat*. 2008;16(3):181-194.
5. DesRoches CM, Rao SR, Fromson JA, et al. Physicians’ perceptions, preparedness for reporting, and experiences related to impaired and incompetent colleagues. *JAMA*. 2010; 304:187-193.
6. DuPont RL, McLellan AT, Carr G, Gendel M, Skipper BE. How are addicted physicians treated? A national survey of Physician Health Programs. *J Subst Abuse Treat*. 2009; 37:1-7.

Author

Kathleen Boyd, MSW, LICSW, is Director of the Rhode Island Medical Society’s Physician Health Program.