Physicians with Substance Use Disorder

Help Is Available

Support is available for physicians with substance use disorder, allowing them to return to health and their profession.

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The prevalence of mental illness, burnout, and substance use disorder (SUD) in physicians is high and similar to rates reported in the general population or other occupational groups.[1,2] Although SUD is problematic in any profession, SUD in physicians is particularly dangerous because of the risk to patient safety.[3] Many resources are available to help physicians with SUD, including a physician health program (PHP).[4] PHPs offer peer-to-peer support as they guide physicians to treatment and recovery while observing strict confidentiality, and since their introduction, they have been proven effective.[5] Their stated purpose is "*to prioritize public safety and sustainability of the career and well-being of…health professionals*."[5]

This article details the landscape of SUD in physicians and offers an overview of the PHP rehabilitation and recovery process. Our goal is to disseminate knowledge with the hope of reducing the stigma that often accompanies SUD and to provide information to help individuals experiencing SUD or their colleagues who know help is needed but do not know where to find it. With support, physicians with SUD can return to health and maintain their practices. The Figure provides an overview of options for what to do if you suspect a colleague may be impaired at work with SUD or if you are concerned about your own issues with substance use/abuse. This article is not comprehensive and should be regarded as a primer. We draw upon a recent webinar presented by some of the authors at the New York County Medical Society Grand Rounds CME Program.[3]

What Is SUD?

SUD is a complex neuropsychiatric disorder. It is not a failure of character, morals, or willpower.[6,7] SUD is defined as the recurrent use of a drug or alcohol that causes significant functional impairment, including the inability to fulfill responsibilities at work.[8] Physician impairment specifically refers to the "*inability to practice medicine with reasonable skill and safety due to a health condition*."[5] Having an illness does not constitute impairment, but impairment always implies the presence of an illness.[5]

Within the context of impairment attributable to substance use, substance use must be distinguished from SUD. Substance use is defined as a behavioral or lifestyle action made by an individual who does not have the more debilitating SUD.[6] Sometimes such individuals may take substances in excess; however, they do not have the morbidity or mortality associated with SUD.[6] The action of drinking alcohol or taking a drug in itself does not point to SUD. In 2020, for example, more than 2.3 billion people worldwide consumed alcohol.[6] The same year, an estimated 59.3 million people (12 years or older) in the United States used an illicit substance.[6] Of these, a minority of people will develop SUD.[6]

SUD in Physicians: Prevalence and Use Characteristics

Among physicians, the lifetime prevalence of SUD is 8% to 15%, with a point prevalence of 2% to 3.8%.[7] As with the general population, physicians may become addicted to a wide range of chemical substances, with alcohol the most abused, especially in some medical specialties, such as dermatology and orthopedic surgery.[9] The overall rate of abuse of illicit substances in physicians was reported to be rare, according to survey results published in *The American Journal on Addictions*,[9] but the rate of abuse of prescription drugs, such as benzodiazepines and some opiates, is higher than in the general population.[1] Figures on substance use prevalence derived from surveys, however, are problematic, because many are outdated and most rely on self-report. More instructive is a long-term retrospective survey of official records.[10] According to an analysis from that survey, the overall incidence of SUD in anesthesiologists was low (0.75%), but the pattern of abuse was somewhat different compared with that found in other medical specialties: opioids, including fentanyl and sufentanil, were most abused (55%), followed by alcohol (40%) and anesthetics/hypnotics (20%). A review of PHP enrollments reveals a disproportionately large participation by physicians in specific specialties, especially anesthesiologiy, emergency medicine, and psychiatry.[12]

Risk Factors for SUD: Considerations for Physicians

Contributing factors to SUD development include stress, genetic vulnerability, and comorbid psychiatric disorders (eg, depression, anxiety, bipolar disorder).[6] Most physicians work under a high stress level, which worsened during the COVID-19 pandemic.[13] Although, as previously noted, reported rates of mental illness in physicians are similar to those found in other populations, the suicide rate among physicians is more than twice that of the general population.[13] Alarmingly, the suicide rate for Black male physicians is 4 times that of the general population.[13]

Another risk factor, unique to health care professionals, is proximity and ready access to psychoactive or other drugs.[14] Some physicians may have a sense of invincibility and think they can safely self-treat pain, depression, or anxiety without becoming addicted to medications or drugs.[14] Several factors contribute to this false narrative: the psychological defense mechanism of denial, a culture of self-care, and the stigma of being treated for a mental disorder.[15-17] In some instances, impaired judgment may lead physicians to believe that they can treat and/or manage their SUD on their own without seeking care from specialists in this field.

Stress

The effects of stress on physiologic well-being are well-reported in the literature. Research results have provided a deeper understanding of distress and its role in human behavior (ie, the conscious appraisal of aversive conditions and motivation to avoid or escape that stressor), including SUD.[18] Physicians under stress or in distress may use drugs as a coping mechanism. The unique interface of occupational stress and ready access to drugs found in medicine was recognized by the Cleveland Clinic's Anesthesiology Institute, which initiated a mandatory educational component on the risks of drug addiction for all departmental personnel.[19] Effective strategies to mitigate effects of environmental stress include organizational procedures (eg, identification of individuals at risk), exercise, improved social relations, meditation, coaching, psychotherapy, 12-step programs, and medical management.[12,20] Without stress management strategies, the risk of physicians self-medicating with psychoactive drugs or alcohol increases. Over time, this coping mechanism may become habitual and lead to the development of SUD.

Impediments to Physicians with SUD Seeking Care

Physicians with SUD avoid seeking care for a variety of reasons, according to a 2019 review of scientific articles published in Drug Alcohol Dependency.[21] Physicians may be unfamiliar with addiction and recovery. They may underestimate the severity of their addictions or think that addiction only happens to other people. They may fear losing their jobs, income, or reputation among family, friends, and society. The elevated socioprofessional status of physicians cannot be underestimated; according to a recent Pew Research Center survey, nearly 74% of Americans reported a positive view of physicians.[22] Regarding mental health problems and drug addiction, many physicians with SUD self-stigmatize.[23] They may feel shame, worry about their careers and ability to access mental health care, and harbor doubts about professional confidentiality. This is in marked contrast to the opinions of their colleagues. Although physicians hold a more negative attitude in general toward individuals with SUD than with other diagnoses, the overwhelming majority of physicians are accepting of the occurrence of SUD in their colleagues.[24]

Concerns About Sanctions and Liability

Physicians with SUD may fear legal consequences and wonder whether a patient learning about the disorder could sue for malpractice. Physicians may anticipate losing their medical licenses and being unable to practice medicine. Professional misconduct is defined as practicing while impaired by alcohol, drugs, or physical or mental disability.[25] An impaired physician may put patients' lives at risk (eg, in surgery, prescribing medication, advising treat-

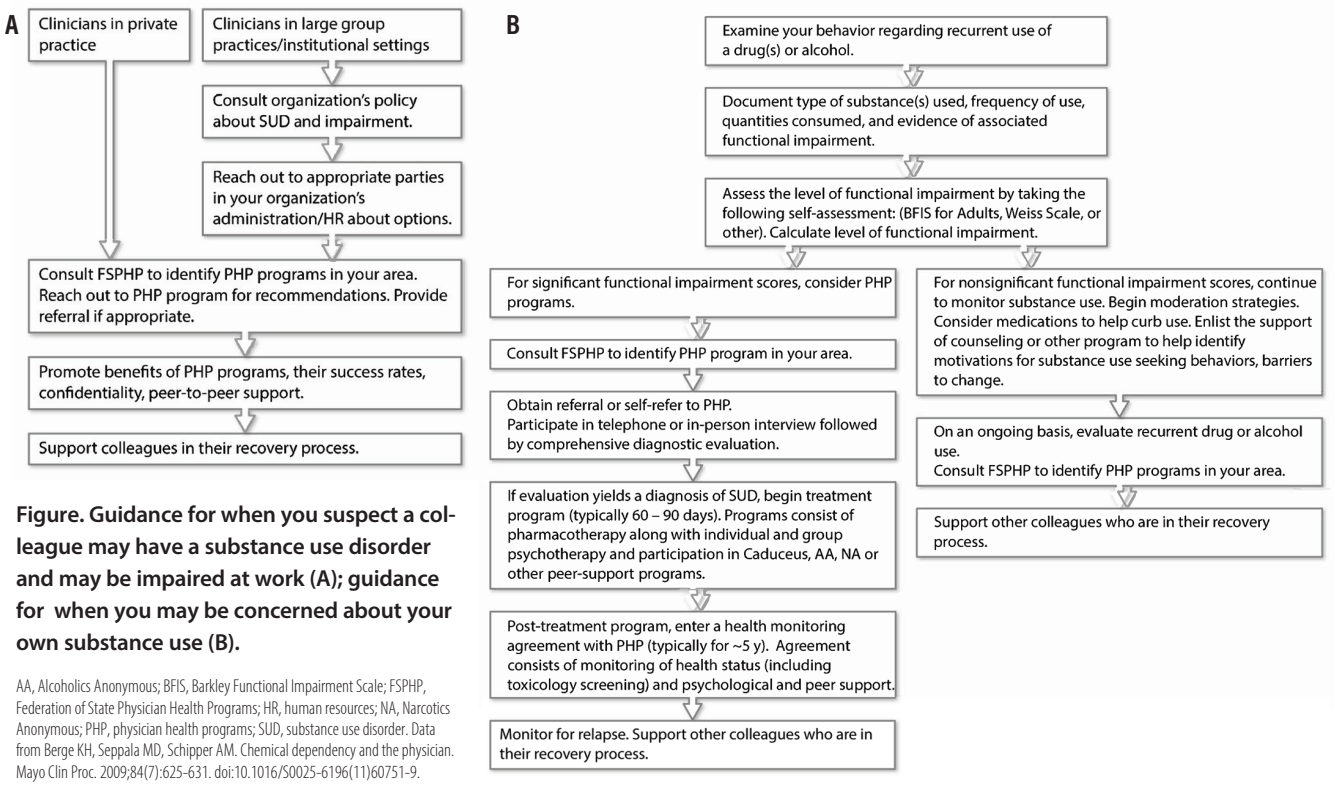

Figure. Guidance for when you suspect a colleague may have a substance use disorder and may be impaired at work (A); guidance for when you may be concerned about your own substance use (B).

AA, Alcoholics Anonymous; BFIS, Barkley Functional Impairment Scale; FSPHP, Federation of State Physician Health Programs; HR, human resources; NA, Narcotics Anonymous; PHP, physician health programs; SUD, substance use disorder. Data from Berge KH, Seppala MD, Schipper AM. Chemical dependency and the physician. Mayo Clin Proc. 2009;84(7):625-631. doi:10.1016/S0025-6196(11)60751-9.

ment, or responding to an emergency).[26] The identification of impaired physicians could contribute to the erosion of public trust in health care professionals.[27] These concerns are valid. However, such outcomes can be minimized or avoided by engaging the help of PHPs.[28]

An Effective Path to Recovery

Punitive approaches to SUD, including legal sanctions or disciplinary action, delay treatment.[28] A more enlightened view was expressed in the landmark 1973 article, "The Sick Physician: Impairment by Psychiatric Disorders, Including Alcoholism and Drug Dependence,"[29] in which SUD was conceptualized as an illness deserving diagnosis and treatment rather than punishment. State medical boards subsequently adopted more therapeutic mechanisms to address SUD in physicians.[4,28] By the early 1980s, PHPs could be found in most states.[4]

Although many physicians try to resolve problems on their own or seek care from mental health providers or addiction specialists, PHPs may be more effective for those with SUD. Early studies including toxicology screens showed significantly higher abstinence 5 years after PHP completion (78%) compared with 6 months standard treatment (40% to 60% abstinence) as well as a high retention of licenses (72%).[30] PHPs, as the backbone of support for physicians with severe SUD or psychiatric or behavioral disorders,[4] are so effective in confronting SUD that recovery is the presumed outcome of treatment.[4,31]

PHPs are authorized by state law or under contract with state medical boards. PHPs exist in most states and Washington, DC, with the Federation of State Physician Health Programs (FSPHP) serving as an umbrella organization.[4] FSPHP has a robust membership, including PHPs from 47 states and 22 international PHPs, and relationships with the American Medical Association, the American Psychological Association, and other medical associations.[4]

PHPs may differ from state to state in terms of structure, mandate, or operations, but their mission remains the same: helping physicians recover from SUD or behavioral or mental disorders. Protecting patient health and safety, preserving a physician's practice, and upholding medical principles further shape the PHP's purpose. PHPs typically employ mental health clinicians to provide case management that is overseen by a physician medical director or medical consultant with mental health or addiction medicine training. PHPs may draw upon program alumni and volunteers to provide a community of recovery support for program participants.[4]

PHPs assess the circumstances surrounding the referral to the program, recommend additional evaluation and treatment options, monitor ongoing care, and document the physician's progress. The entire process is confidential. The identity of the referring party is protected, as is the

physician's, to safeguard reputations, careers, and personal or professional relationships, and to help everyone feel safe contacting a PHP.[4]

The PHP Process

In the first step of the PHP process, a referral is made. This includes self-referrals as well as referrals by clinical colleagues, state licensing boards, hospital staff, treatment providers, medical schools, law enforcement, family members, attorneys, or others.[31] The next step is an in-person or telephone interview between the referred physician and the PHP intake staff.[31] If there is concern for SUD, the PHP will most often refer the physician for a comprehensive SUD diagnostic evaluation at a PHP-approved evaluation center that has demonstrated experience and expertise in the assessment of safety-sensitive health care workers. The comprehensive diagnostic evaluation is a multiday, multidisciplinary assessment that includes a complete medical history and physical examination, laboratory tests, toxicology testing, psychologic evaluation, psychiatric assessment, neuropsychologic screening, and interviews of collateral historians such as colleagues or family members (with authorized consent).[4,31]

If the evaluation yields a diagnosis of SUD, the evaluator will provide the physician with treatment recommendations to be completed at PHP-approved treatment programs. Most often, treatment is recommended at the residential or partial hospital level of care and typically lasts from 60 to 90 days.[4,31] The individual is introduced to Caduceus or other peer-support meetings and psychosocial support groups (eg, 12-step programs, such as Alcoholics Anonymous, Narcotics Anonymous, SMART Recovery, or Refuge Recovery).[4,31] Pharmacotherapy for addiction, as well as any co-occurring mental health conditions, and individual and group therapy using evidence-based treatments are provided.

The PHP stays abreast of the physician's progress in treatment through communication with professionals at the facility.[4,31] After treatment, the physician enters a health monitoring agreement with the PHP. The agreement provides support for the physician's recovery, a system of accountability, and verification of health status and safety to practice that may be useful or necessary for the physician to resume work. Most agreements require abstention from alcohol and mood-altering substances, random toxicology testing, and participation in Caduceus or other support or monitoring groups. Each agreement is individualized. Many also include psychiatric care, counseling, and medication management. Most SUD agreements have a 5-year duration.

The Blueprint study, which was the first national study of state PHPs, reported that 78% of monitored physicians completed their 5-year PHP contract without relapse.[4,31] Subsequent studies reported similar or higher rates of success.[4] The PHP model's success rate greatly surpasses that of treatment programs for the general population and is matched only by programs geared to the treatment of commercial airline pilots with SUD. Moreover, post-PHP malpractice risk is significantly lower than that before PHP treatment, with post-PHP malpractice risk 20% lower than for a matched cohort of physicians never involved with the PHP.[4]

Return to use may be part of the recovery process. PHPs categorize return to use into 3 levels: level 1, prodromal behavior without alcohol or drug use (eg, not adhering to elements of the monitoring agreement or recovery continuing care plan); level 2, use of unauthorized substances outside of the physician's medical practice; and level 3, use of unauthorized substances within the practice context.[4] PHPs respond with increased monitoring and oversight to level 1 and, if possible, level 2 events. Level 3 events trigger removal from practice referral for recovery evaluation, and notification of the medical board in case of patient harm.[4]

The success of PHPs should inspire physicians with SUD, their colleagues, and their families to trust that rehabilitation is possible. At the same time, no one should assume that recovery is easy. People with mental health disorders or SUD, including physicians, may face discrimination and bias by the health care system. In addition, physicians are expected to shoulder a disproportionate cost burden in obtaining specialized evaluation and treatment required by the safety-sensitive nature of their profession. Addressing barriers to recovery should be a shared responsibility.[32]

Alternatives to PHPs

Although PHPs are effective for most physicians with SUD, some individuals may achieve abstinence outside of the purview of a PHP. Treatment by other clinicians, rather than self-management, is crucial for physicians with SUD to achieve abstinence and return to clinical medical practice.

Spiritual Wellness

Various professional organizations and societies, including the World Health Organization, the World Psychiatric Association, and the Spirituality Interest Group of the International Association of Addiction Medicine, consider spiritual health an important dimension of quality of life and worthy of consideration in the care of individuals with SUD.[33-35] Spirituality is defined as "*a dynamic and intrinsic aspect of humanity through which persons seek ultimate meaning, purpose, and transcendence, and experience relationship to self, family, others, community, society, nature, and the significant or sacred*."[36] Numerous studies show an association between spiritual wellness and improvement in pain, depression, and anxiety levels; overall well-being; and other health factors.[37-39] Guidelines for addressing spiritual health include diagnosing spiritual or existential distress.[36,40]

Physicians with SUD may experience spiritual or exis-

tential distress and a spirituality-oriented program may help them rediscover meaning and purpose. Twelve-step programs often describe themselves as spiritual rather than religious fellowships; the programs encourage participants to accept a power—any power—greater than themselves.[35] Physicians concerned about confidentiality can attend physician-only 12-step programs or Caduceus meetings, many of which have virtual meeting options.

Recommendations for treating patients, including physicians, with SUD include an assessment of their spiritual health. Guidelines for performing a spiritual assessment and developing a treatment plan, including referral to resources such as meaning-oriented therapy, meditation or mindfulness classes, or a spiritual counselor, if appropriate, have been integrated into an evidence-informed education curriculum.[40]

Illustrative Case Examples

Case 1 illustrates treatment of an anesthesiologist with SUD through a PHP. (In New York State, the PHP is called Committee for Physician Health.)[41] Case 2 depicts an emergency physician who attained abstinence outside of the purview of a PHP. Case 3 describes a primary care physician who recognized impending SUD, which resolved with treatment for stress and existential distress.

Case 1

AE, a 35-year-old anesthesiologist with longstanding alcohol use and access to opioids, began diversion for personal use while on overnight calls from the operating room. Colleagues suspected substance misuse. AE was asked to go on leave by the chair of the department and reported to the Committee for Physician Health.[41] AE attended inpatient rehabilitation, followed by outpatient rehabilitation, and returned to work on long-acting injectable naltrexone 6 months later. AE is doing well and abstinent from opioids and alcohol. AE continues with intensive 12-step program meetings, weekly therapy, naltrexone, and urine screens and receives job monitoring in conjunction with the Committee for Physician Health.

Case 2

During the COVID-19 pandemic, GM, a 45-year-old emergency physician with major depressive disorder, began consuming large amounts of alcohol and smoking marijuana after work in the setting of multiple stressors, including a challenging work situation. Friends encouraged GM to seek help for the depressive symptoms and escalating substance use. GM delayed seeking help until contemplating using marijuana gummies during the work day. GM began to see a psychiatrist and therapist and experienced improvement of mood with medications and cognitive-behavioral therapy. GM never received formal addiction care, but the self-medication with alcohol and marijuana ended when the depressive symptoms resolved.

Case 3

TK, a 40-year-old primary care physician, was overwhelmed with an increased workload after the COVID-19 pandemic as well as the loss of a colleague who had recently died by suicide. TK began drinking increasing amounts of alcohol. After performing a full assessment, TK's physician referred TK to counseling and a 12-step program (Alcoholics Anonymous). After 2 months, TK stopped drinking alcohol, continued in Alcoholics Anonymous, and engaged in wellness activities at the workplace, leading to an improvement in coping skills and stress management.

Conclusion

Most physicians with SUD need support in addressing their disordered use of alcohol or drugs. For many, this can come from the confidential help and advocacy available from PHPs.[4] The rehabilitation success rate of physicians involved with PHPs is very high. By speaking with honesty and encouragement to those with addiction, being prepared with sources of assistance, such as PHPs, advocating for reforms to reduce barriers to help-seeking and PHP use, and addressing spiritual health as part of the whole-person care of physicians with SUD, the medical community can reduce stigma, help physicians who are ill, and promote a safety culture in medicine that engenders the trust and wellbeing of patients. ■

Resources

Contact information for all state PHPs can be found on the FSPHP website at https://www.fsphp.org/state-programs.

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