

# Identifying and Assisting the Impaired Physician

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# Course Objectives

- Do professionals become addicted?
- What are the signs and symptoms of the disease?
- How can we motivate a professional to seek help?
- What does an evaluation include?
- How do we treat a professional who is addicted?
- How do we monitor the recovery of a professional after treatment?
- Can they return to safe practice?
- What is the outcome of treatment?

Why would well-educated healthcare professionals, who are so familiar with the cause and results of substance abuse, alcoholism, sexual harassment and/or abuse, ever be susceptible to impairment ?

# RISK FACTORS FOR PROFESSIONALS

- Professional demands
- Role strain
- Responsibility for patients/clients
- Need to accumulate knowledge and skills
- Peer competition
- Idealism of the professions
- Public image eroding
- Other

# RISK FACTORS: ROLE STRAIN

- Professional demands/personal needs conflict
- Career/family conflicts
- Lack of role models
- Depression, suicide and marital distress

# RISK FACTORS: OTHER

- Access to controlled substances
- Social isolation
- Independent nature of work with little supervision or support
- Personality characteristics
- Long hours, sleep deprivation, fatigue
- Perpetually changing work conditions
- Accumulating financial debt for education and practice
- Self treatment and self prescribing

# Serious consequences of errors

Genetic predisposition

Dysfunctional family of origin  
(baggage we take through life  
and medical education)

We are taught to take care of the needs of others first, and our own needs second (if at all).

We are taught to tolerate distress and dissatisfaction.

We are taught to focus on problems and facts, rather than strengths and feelings.

# Burnout

Chronic overstress

Emotional exhaustion

Depersonalization (withdrawal  
from others)

Reduced sense of personal accomplishment

# 5 Warning Signs

- Increase in problems with relationships
- Increase in physical problems
- Increase in negative thoughts
- Significant increase in bad habits
- Emotional/physical exhaustion

# Biologic Factors

- Poor sleeping, eating and exercise habits
- Family history of psychiatric illness
- Overuse of alcohol and drugs
- Anxiety, affective and eating disorders

# Psychological Factors

- Overly conscientious
- People pleasing
- Sense of responsibility and guilt
- Unrelenting perfectionism
- Need to control others
- Chronic self doubt
- Uncomfortable with love and approval
- Ability to delay gratification

All this can add up to unrelenting pressure that may cause a medical professional to inappropriately seek relief through alcohol, drugs or other activities.

In some cases, stress can trigger depression, anxiety, or other underlying psychological or psychiatric problems.

# Impairment

(the loss of the ability to carry out professional and personal responsibilities),  
has traditionally been  
associated with substance abuse  
(dependence on drugs or alcohol).

# Ten categories of problem behavior constituting impairment (Georgia Board of Medical Examiners)

1. Substance-related disorder
2. Substance-related disorder associated with partial relapse
3. Inappropriate prescribing practices
4. Mental disorders
5. Misinformed, after a period away from medical practice
6. Physical disability
7. Behaviorally disruptive
8. Sexually exploitative
9. Unethical behavior
10. Cognitive problems/senility

# Three major types of impairment affect healthcare professionals

1. Substance abuse (92%)
2. Psychiatric illnesses and behavioral problems (6%)
3. Senility (2%)

# Dysfunction can also result from:

Behavioral addictions  
compulsive gambling  
sexual disorders

Medical conditions  
Alzheimer's disease, head injury, stroke,  
psychiatric disorders,  
or dementia due to aging

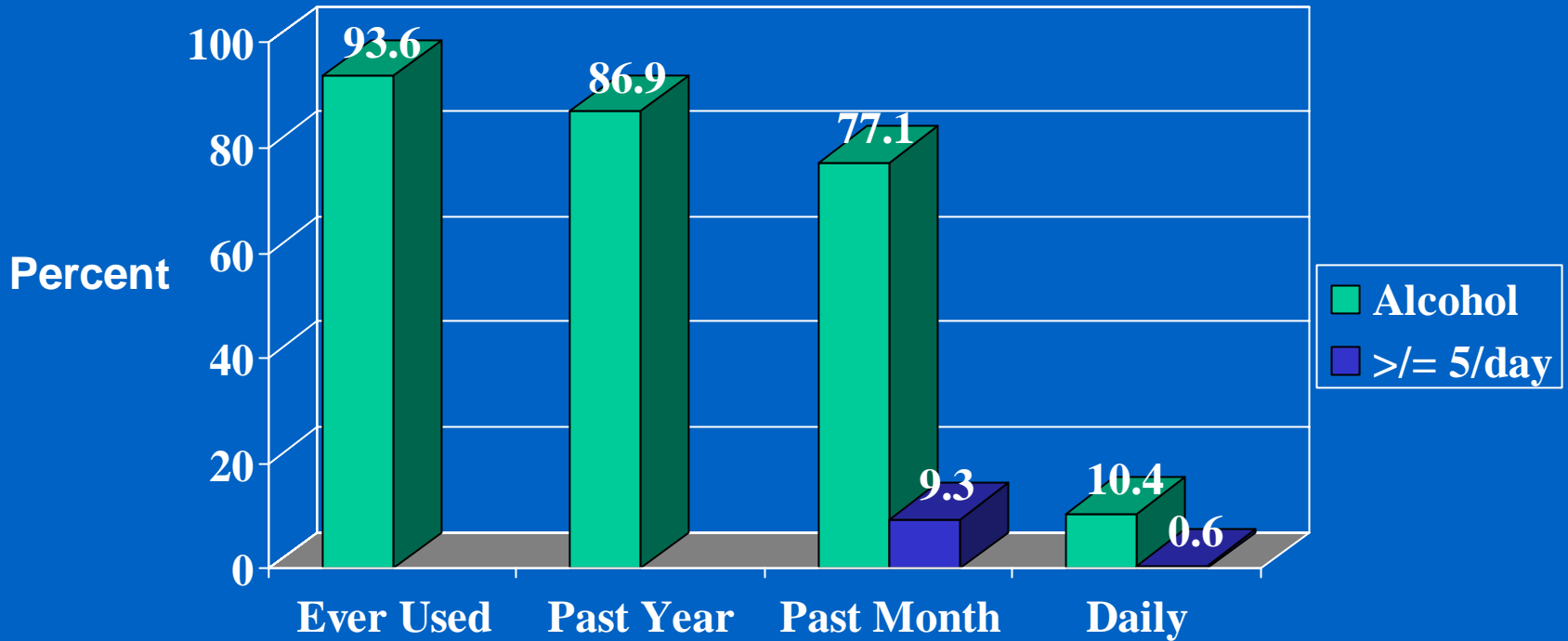
Substance abuse  
is by far the most common cause  
for impairment among healthcare  
professionals.

<b>DRUG</b>	<b>EVER USED</b>	<b>PAST YEAR</b>	<b>PAST MONTH</b>	<b>DAILY</b>
ALCOHOL	93.6	86.9	77.1	10.4
>/= 5			9.3	0.6
TOBACCO	51.1	13.7	10.6	6.3
>HALF PK			4.8	3.9
MINOR OPIATES	39.9	17.6	4.5	0.2
BENZ.	24.0	11.4	5.3	0.5
MAJOR OPIATES	7.5	1.1	0.3	
COCAINE	10.3	1.1	0.3	
SEDATIVE	9.2	2.7	1.0	0.1

PREVALENCE OF DRUG USE  
US PHYSICIANS

From: Hughes JAMA 1992

# Alcohol



PREVALENCE OF  
SUBSTANCE USE  
US PHYSICIANS

# SELF REPORTED PREVALENCE ABUSE & DEPENDENCE US PHYSICIANS

<b>TOTAL ALCOHOL AND/OR DRUGS</b>	<b>EVER %</b>	<b>PAST YEAR %</b>
TREATED	4.9	0.6
NOT TREATED	3.0	1.5
TOTAL	7.9	2.1

# DEFINITION

Impairment occurs when a healthcare professional becomes addicted to alcohol or drugs, or shows mental, behavioral, ethical or age-related problems that interfere with good patient care.

The percentage of healthcare professionals who become impaired on the job is no different than that in other professions.

About 10-15% of healthcare professionals are affected at some point in their careers.

**One in seven**

The less cheerful news is that many impaired professionals do not get help early enough because they are protected by colleagues and/or family members who enable them to continue working without relief or intervention.

The stakes are high--  
a career can be derailed when  
drug/alcohol abuse or sexual  
abuse of a patient is revealed.

# JCAHO

## Medical Staff Chapter

### Physician Health

- Revision to Comprehensive Accreditation Manual for Hospitals, Medical Staff Standards.
- Effective January 1, 2001.
- MS.2.6 “The medical staff implements a process to identify and manage matters of individual physician health that is separate from the medical staff disciplinary function.”

# Intent of MS.2.6

- “An organization has an obligation to protect patients from harm. In this regard, the medical staff and organization leaders design a process that provides education about physician health, addresses prevention of physical, psychiatric, or emotional illness, and facilitates confidential diagnosis, treatment, and rehabilitation of physicians who suffer from a potentially impairing condition.”

# Intent of MS.2.6 (continued)

- “The purpose of the process is assistance and rehabilitation, rather than discipline, to aid a physician in retaining or regaining optimal professional functioning, consistent with protection of patients. “

“If at any time during the diagnosis, treatment, or rehabilitation phase of the process it is determined that a physician is unable to safely perform the privileges he or she had been granted, the matter is forwarded to medical staff leadership for appropriate corrective action that includes strict adherence to any state or federally mandated reporting requirements.”

# MS.2.6 Process Design Should Include Mechanisms for the Following:

- Education about illness and impairment recognition issues specific to physicians
- Self-referral by a physician and referral by other organization staff
- Referral of the affected physician to the appropriate professional internal or external resources for diagnosis and treatment of the condition or concern
- Maintenance of the confidentiality of the physician seeking referral or referred for assistance, except as limited by law, ethical obligation, or when the safety of a patient is threatened

## MS.2.6 Process Design Mechanisms (continued)

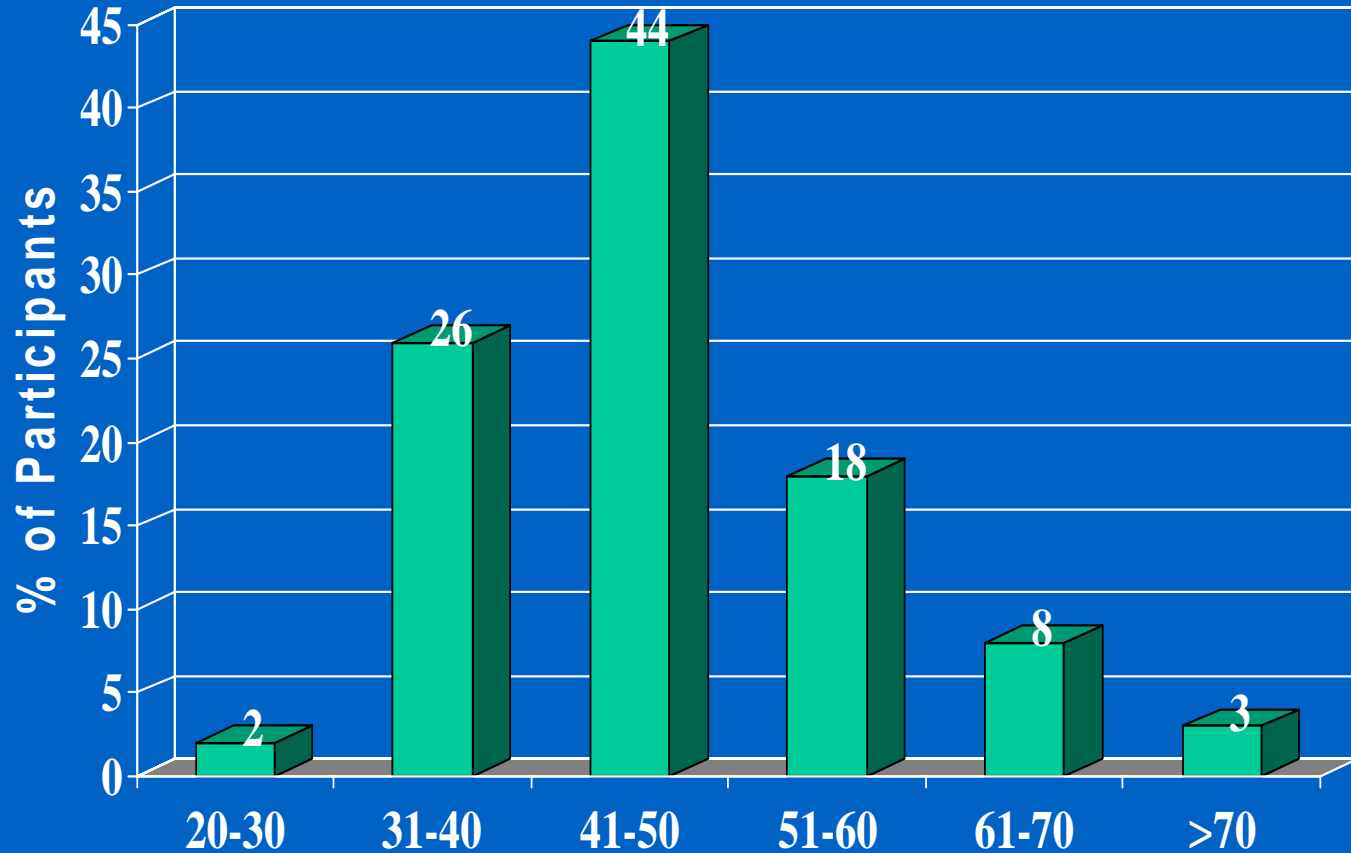
- Evaluation of the credibility of a complaint, allegation or concern
- Monitoring of the affected physician and the safety of patients until the rehabilitation or any disciplinary process is complete
- Reporting to the medical staff leadership instances in which a physician is providing unsafe treatment

Research suggests physicians are less likely than the general public to be ensnared by alcohol and drugs.

Physicians as a group tend to  
drink more alcohol  
than other professionals  
of their age and gender  
in the general population.

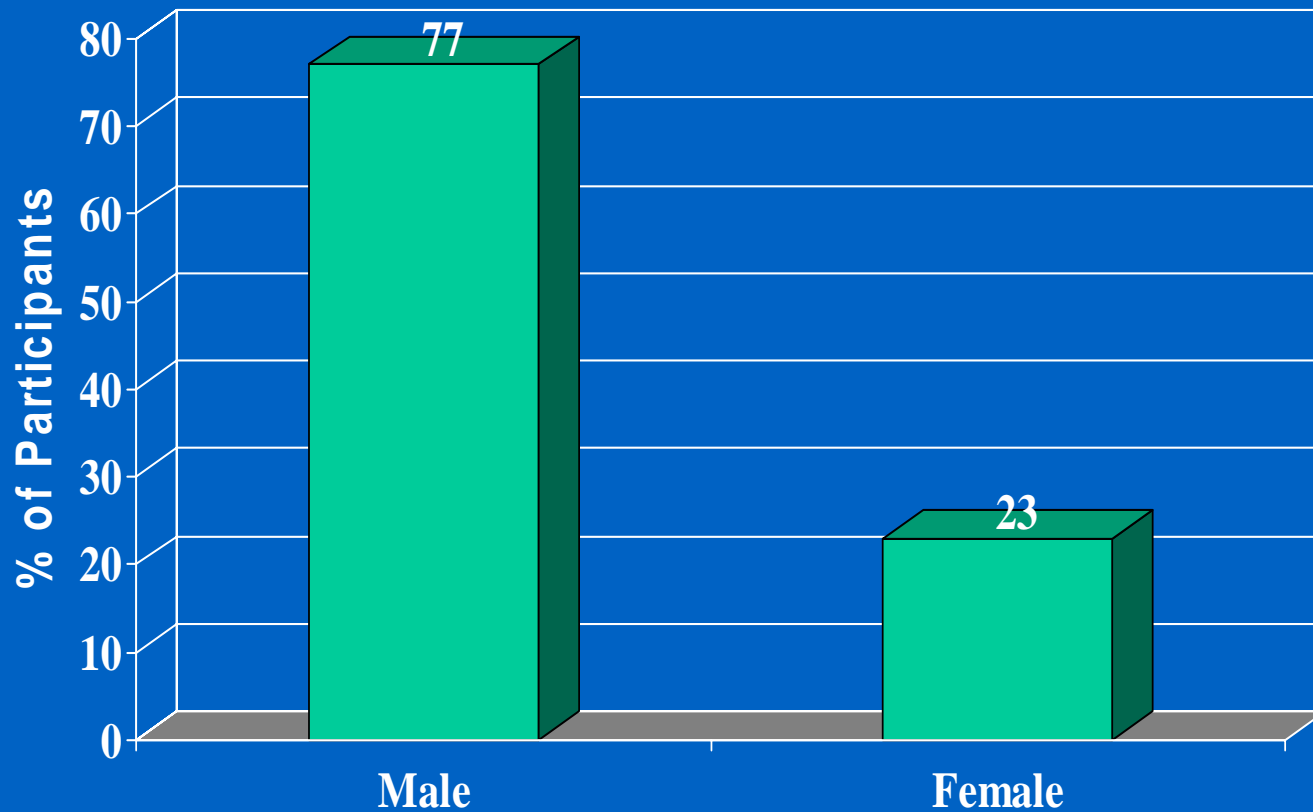
# “Who gets sick?”

## Age

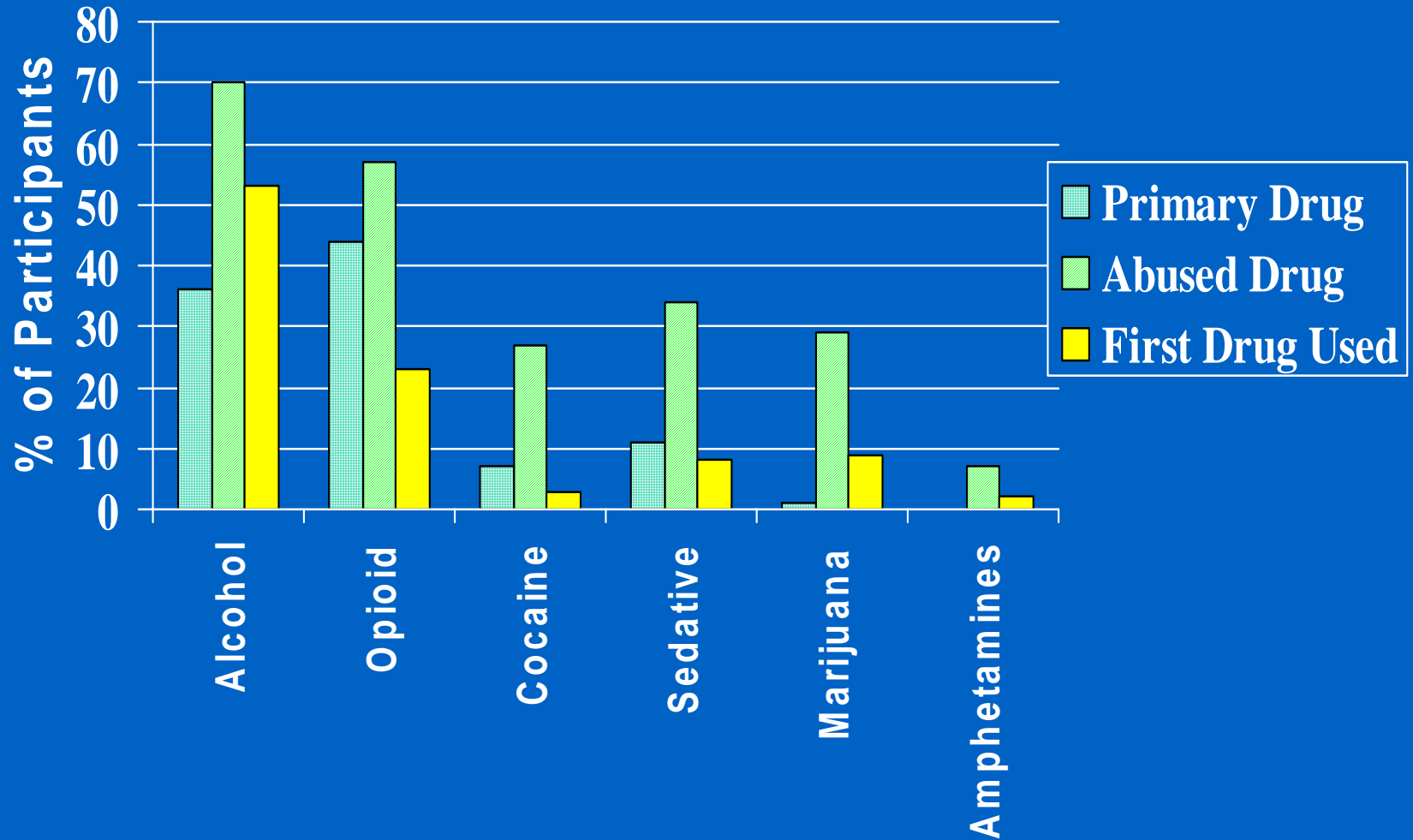


# “Who gets sick?”

## Sex

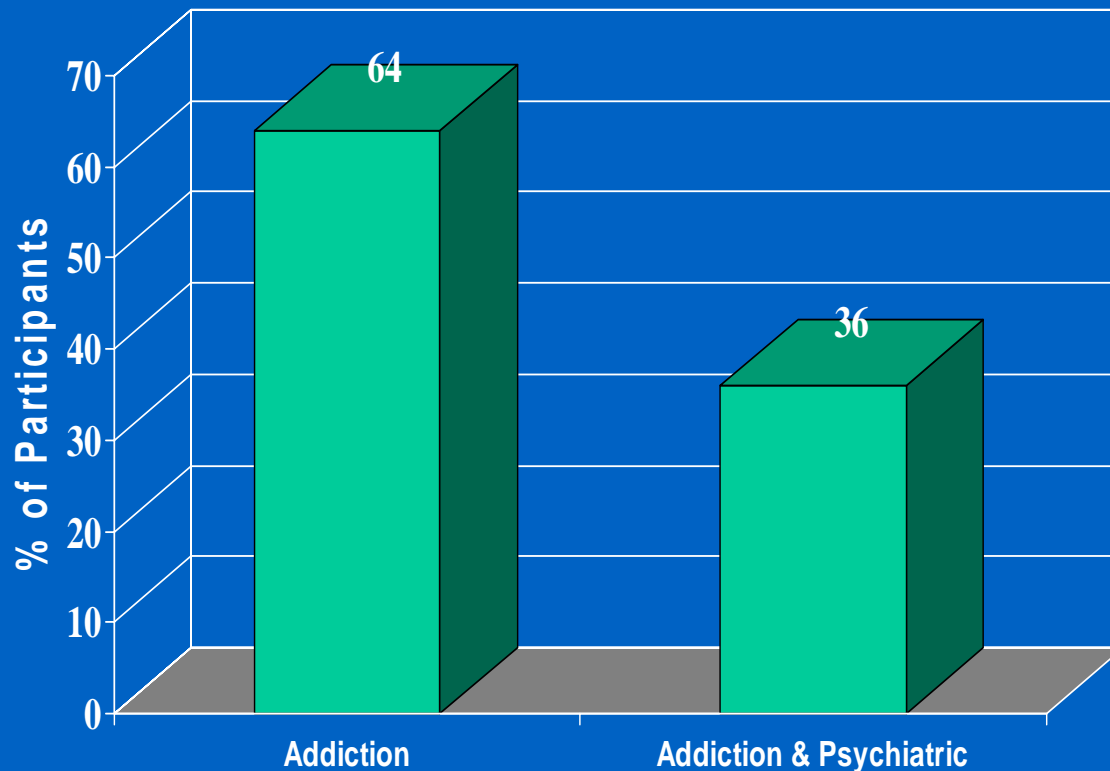


# “What do they use?”



# “What do they get?”

## Concurrent Psychiatric Diagnoses



Alcoholism in women physicians is a  
special problem;

cross-addiction is common  
(only 40% used alcohol alone)

Doctors are less likely to use tobacco or illicit drugs (cocaine or marijuana) than nonphysicians of the same age and gender.

Physicians use more prescription drugs and opiates than the general population.

11% had used benzodiazepines in the last year without another doctor's supervision

17% had treated themselves with minor opiates in the last year

This ranks as a five-fold increase  
in prescription drug usage,  
compared with the general  
population.

Healthcare professionals  
must cope with the ready  
availability of drugs.

Physicians and nurses who have greater physical access to drugs tend to self-treat more often than those who have less access to drugs.

Those who prescribe controlled substances more often also tend to take them more often.

# The Disease of Addiction

- Disease of the brain
- Symptoms include: loss of control, tolerance, withdrawal, craving, use in spite of harmful consequences or in hazardous situations.
- Typical response of the individual to the symptoms is Denial

# The Disease of Addiction

- Typical response of the family and significant others to the symptoms is Enabling
- Typical response of society to the symptoms is Judgment
- Evidence is that the disease is treatable with excellent outcomes

# The Disease of Addiction

## Progression

Experimentation: Learning mood swings (reward)

Early Stage: Seeking mood swings (reward)

Middle Stage: Harmful dependence and loss of control

Late Stage: Using to feel normal (withdrawal) and medical complications

# EARLY STAGE SIGNS FAMILY/SOCIAL SYSTEM

- Gradual social withdrawal
- Changes in family interaction
- Behavior changes
- Occasional intoxication
- Frequent mood swings
- Unpredictability
- Poor stress tolerance
- New set of drinking/using companions

# EARLY STAGE SIGNS ALL PROFESSIONS

- Suspicion of intoxication
- Unpredictability
- Isolated incidents of questionable judgment/practice
- Episodes of “forgetfulness”
- Changes in office or institutional practice
- Withdrawal from professional committees or organizations
- Defensiveness if questioned
- Irritability
- Adequate performance but unavailable for “extras”
- Less creativity

# MIDDLE STAGE FAMILY/SOCIAL SYSTEMS

- Lack of financial responsibility
- Impulsive spending
- Erratic behavior
- Emotional withdrawal
- Poor communication
- DUI arrests/charges
- Sexual dysfunction
- Blackouts (memory impairment under the influence)
- Verbal, physical or sexual abuse of spouse, children, friends or employees
- Broken promises

# MIDDLE STAGE FAMILY/SOCIAL SYSTEMS (CONTINUED)

- Decline in health status: trauma, medical problems
- Unkempt appearance at times
- Episodes of public intoxication
- Argumentativeness
- Explosive outbursts of temper
- Defensiveness or suspiciousness
- Children often in trouble
- Spouse less involved in activities outside the home

# MIDDLE STAGE

## ALL PROFESSIONS

- Conflicts with colleagues or staff
- Verbal abuse of office or institutional staff
- Inappropriate behavior
- Alcohol on breath and attempts to cover with mints, mouthwash
- Observed occurrences of intoxication, drowsiness, hypersensitivity during work hours
- Deadlines barely met or missed altogether

# MIDDLE STAGE

## ALL PROFESSIONS

- Erratic behavior
- Observed poor judgment
- Decline in quality of work
- Client, patient or other complaints
- Office or institutional staff complaints
- Changes in practice observed by colleagues
- Frequent disruption of office or  
institutional schedule
- Absences with elaborate explanations offered
- Personal or professional behavior changes observed  
by office staff

# MIDDLE STAGE HEALTH PROFESSIONALS

- Increased ordering of office or institutional stock of abusable drugs
- Questionable pharmacy practices
- Inappropriate prescribing for patients or family members

# LATE STAGE FAMILY/SOCIAL SYSTEMS

- Marked alienation from friends
- Neglect of or giving up social life, hobbies or sports
- Alienation from religious and community groups
- Family deterioration including divorce or separation
- Abuse of spouse or children
- Sexual dysfunction
- (impotence, frigidity, loss of desire)
- Financial crisis
- DUI or other legal action
- Suicide attempts, often masked as accidents

# LATE STAGE ALL PROFESSIONALS

- Obvious intoxication
- Poor technical skills, tremors, blackouts, inability to concentrate
- Staggering gait, disorientation, nodding off
- Inappropriate behaviors
- Unpredictable office, hospital, church or court schedule
- Client or patient complaints
- Clerical staff asked to make excuses or cover up for absences, uncompleted work

# LATE STAGE MEDICAL SYMPTOMS ALL PROFESSIONALS

- Observable decline in physical health
- Weight changes
- Pupils dilated/constricted; face flushed/bloated
- Serious medical complications
- Emergency room treatment: overdose, skin infections, GI symptoms, heart problems, burns, accidents, claims of muggings with no witnesses

# LATE STAGE HEALTHCARE PROFESSIONAL

- Gross malpractice
- Errors in medication prescriptions
- Unavailability when on call
- Poor documentation of patient records
- Questionable documentation on pharmacy records
- Increased controlled substance orders
- Drug diversion from hospital, pharmacy or office
- Subject of medical staff review and possible disciplinary action

# RISK BY SPECIALTY

Anesthesia-opioids and benzodiazepines

Internal Medicine-opioids and  
benzodiazepines

Psychiatry-benzodiazepines

Emergency Medicine-cocaine

Family Practice-opioids and  
benzodiazepines

Pediatrics-alcohol

Surgeons-opioids and benzodiazepines

Regardless of specialty,  
physicians face the greatest risk  
from self-medication with  
controlled substances, especially  
narcotics.

Physicians may think they are invulnerable to dependence since their prior training leads them to believe they know the effects of drugs and will be able to stop when dependence begins.

***Denial is another hazard.***

# The Disease Begins Early

Substance abuse disorders are noted early in adult life.

Most alcoholics have at least one other alcoholic family member.

# **At a Midwestern medical school, studies showed the following:**

- 11% of the class met the criteria for excessive drinking for at least one 6-month period
- 18% met criteria for alcohol abuse at least sometime during the first two years

# Residency training is no better.

Among 215 residents surveyed,

- 14% showed pathologic use of alcohol

- 3% showed social or occupational impairment

- 3% showed both

# Recognizing the signs of impairment

Impairment isn't easy to recognize, especially when caused by chemicals other than alcohol.

Medical professionals can be very clever about hiding any outward signs that might give away drug or alcohol abuse.

An added problem is that the serious consequences of reporting a colleague's impairment may make other healthcare professionals hesitate to report abuse, or lead them to cover for a co-worker.

The impaired professional faces loss  
of license and  
derailment of career.

Friends of the impaired physician  
fear loss of friendship, or that the  
impaired doctor will be permanently  
suspended from practice or commit  
suicide.

Family members, colleagues,  
or close friends may also enable the  
professional to continue drinking or  
abusing drugs  
by protecting him/her  
at all costs.

The cost is also high  
to these “enablers”.

## Family/Friends Enable by:

Making excuses for the professional's inappropriate behavior

Making excuses for the tardiness, absenteeism or  
low quality work

Rationalizing and minimizing the professional's use of alcohol or drugs

Attempting to control the professional's use

Assuming responsibility for the professional's tasks

Rarely following through with ultimatums

Blaming circumstances or others for the professional's symptoms of  
impairment

## Colleagues Enable by:

Believing that addiction or mental illness can't happen to a professional

Making excuses for an impaired colleague's behavior or performance

Minimizing the obvious effects of alcohol/other drug use in a friend or colleague

Rationalizing changes in a colleague's performance, behavior or appearance

Covering up for a colleague's errors or omissions

Not using the peer assistance network available to them

Diagnosing or treating

## **Institutions Enable by:**

Promoting “secrets” about professionals to avoid, to save face, and to avoid litigation

Denying the need for educational programs about impairment

Not having adequate employee insurance and other benefits to cover treatment for addiction or mental illness

Failing to develop written policies

Failing to develop peer assistance committees

Although healthcare professionals can be extremely clever and ingenious about hiding substance abuse, enough evidence eventually accumulates or enough incidents occur that it becomes impossible to ignore.

# Signs of Impairment

## High Risk Conditions for Addiction

Family history of addiction in first-degree relatives

Access to mood-altering medications, especially opioids (particularly in anesthesiology)

Domestic breakdown

Unusual stresses at work

# Signs of Impairment

## Suspicious Behaviors

Use of large quantities of alcohol; frequent bouts of drunkenness

Frequent nonspecific medical complaints (fatigue, insomnia, indigestion, “depression”)

Self-prescribing sedative-hypnotic, opioid medications

Neglect of responsibilities (late to rounds, missing appointments)

# Signs of Impairment

## Suspicious Behaviors, cont.

Frequent outbursts of anger

Growing staff concerns about a colleague's behavior

Sexual promiscuity

Citations for driving under the influence (DUI)

# Signs of Impairment

## Suspicious Signs of Addiction

Smell of alcohol on breath

Wobbly gait

Slurred speech

Unexplained tremor

Disheveled appearance

Sleepiness

Unexplained weight changes

Depressed mood

# Clues to Substance Abuse in a Physician's Life

## Community

Isolation and withdrawal from community or leisure activities, including hobbies, church, friends and peers

Embarrassing behavior at clubs or parties

Arrests for driving while intoxicated, legal problems

Unreliability and unpredictability in community and social activities

Unpredictable behavior -for example, inappropriate spending, excessive involvement in political activities

# Clues to Substance Abuse in a Physician's Life

## Family

Withdrawal from family activities, unexplained absences from home

Fights, child abuse

Development in spouse of “spousaholism”

Sexual impotence, extramarital affairs, contra-cultural sexual behavior

Assumption of surrogate role by spouse and children

Geographic separation or divorce proceedings by spouse

# Clues to Substance Abuse in a Physician's Life

## Employment

Numerous job changes in the last five years

Frequent geographic relocations for unexplained reasons

Frequent hospitalizations

A complicated and elaborate medical history

Unexplained intervals between jobs

# Clues to Substance Abuse in a Physician's Life

## Employment, cont.

Indefinite or inappropriate references

Working in a job that is inappropriate for qualifications

Reluctance of job applicant to let spouse and children be interviewed

Reluctance to undergo pre-employment physical examination

# Clues to Substance Abuse in a Physician's Life

## Physical Status

Deteriorating personal hygiene

Deterioration in clothing and dressing habits

Multiple physical signs and complaints

Numerous prescriptions and drugs

Accidents

Emotional crises

# Clues to Substance Abuse in a Physician's Life

## Office

Disruption of appointment schedule

Hostile, withdrawn, unreasonable behavior to staff and patients

“Locked door syndrome”

Excessive ordering of supplies of drugs from local pharmacy or by mail

Complaints by patients to staff about Dr's behavior

Unexplained absences from the office (“illness”)

# Clues to Substance Abuse in a Physician's Life

## Hospital

Making rounds late or inappropriately; abnormal behavior during rounds

Decreasing quality of performance, such as in staff presentations or chart notes

Inappropriate orders or over-prescription of medications

“Hospital gossip”

Involvement in malpractice suits and legal sanctions against the hospital

Reports from ER staff of being frequently unavailable

The concrete, immediate goal is to move the person towards an evaluation (not necessarily into treatment).

Those who act in the intervention must separate their roles from that of a treater.

The interveners must stay within boundaries with an immediate goal of evaluation, not treatment.

Present their facts and concerns and ask the meaning of their facts and concerns.

The immediate goal is to proceed to assessment.

# The Intervention Team

A coordinator

Personally significant individuals with firsthand information

Professionally significant individuals with firsthand information

Another recovering professional

# Predictable Responses

Defiance

Threats

Denial

Excuses

Promises

Bargaining

Depression

Acceptance of evaluation

Denial is a major obstacle to  
successful treatment

The goal is not to punish the professional,  
but to prevent destruction of physical,  
emotional, professional and family life.

Intervention is advocacy for the physician,  
nurse or other professional before his/her  
license to practice their  
profession is jeopardized.

# The diversion program is not disciplinary.

It is a protection against punishment and is designed to encourage early identification, intervention and self-referral to treatment, and avoids the threat of loss of licensure.

# COMMITTEES OR PROGRAMS COMMON FEATURES

- Confidential assistance
- Clear understanding of reporting requirements
- Education/prevention programs
- Confidential reporting process
- Intervention teams
- Referrals for assessment and treatment
- Aftercare agreements for monitoring and follow-up
- Advocacy for return to practice after successful treatment
- May provide financial assistance for treatment and/or aftercare

# Multidisciplinary Assessment

Alcohol and drug assessment

Physical examination

Laboratory testing

Psychiatric evaluation

Psychological evaluation including testing

Collateral interviews

# Expectations of Treatment Programs

Multidisciplinary assessment

Solid basic program of addiction treatment

Treatment of medical and psychiatric comorbidities

Continuing care weekly for 2 years with addiction counselor in group with other professionals

Quarterly visits with treating physician for 5 years

Collection site for random toxicology

# The Support System

Medical Director/Case Manager

Addiction Medicine Physician

Primary Care Physician

Addiction Counselor led support group

12-step groups & sponsor

Toxicology coordinator

Work place monitor/PAC/EAP

# The 12-Step Program of Alcoholics Anonymous

1. We admitted we were powerless over alcohol--that our lives had become unmanageable.
2. Came to believe that a power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to God *as we understood Him*.
4. Made a searching and fearless moral inventory of ourselves.

5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humbly asked Him to remove our shortcomings.
8. Made a list of all persons we had harmed, and became willing to make amends to them all.
9. Made direct amends to such people whenever possible, except when to do so would injure them or others.

10. Continued to take personal inventory and when we were wrong promptly admitted it.

11. Sought through prayer and meditation to improve our conscious contact with God *as we understood Him*, praying only for knowledge of His will for us and the power to carry that out.

12. Having had a spiritual awakening as a result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs.

# Recommended Implementation

- Physician Wellness Committee
- Membership carefully selected
- Responsible for education, acceptance of self-referral, and referrals from others.
- Referral for evaluation and treatment
- Maintenance of confidentiality
- Evaluation of complaints, allegations, concerns
- Monitoring reentry
- Reporting unsafe practice

# Elements of Written Aftercare Agreement for the Addicted Professional

Treating physician: specialist in addiction medicine

Primary care physician: specialist in primary care

Other specialists, therapists as appropriate to problems

Weekly support group led by addiction counselor or physician

Random urine toxicology

12-step meetings – attendance confirmed in writing

Sponsor

Case manager contact monthly for first year

Annual meeting with Case manager & Medical Director

# A contract for care

- type and degree of monitoring
- what to do in case of a “slip”
- leave of absence from work ?
- under what conditions can the physician return to caring for patients ?

# Usually the agreement calls for:

- successful completion of a primary treatment program (inpatient or outpatient)
- continued regular meetings in a recovery program (documented)
- periodic drug screening for no less than two years

# PROFESSIONAL ASSISTANCE

## PREVENTION OF RELAPSE

- Maintain an informal support group: family, friends, teachers, etc.
- Attempt to maximize balance in life: hobbies, exercise, good nutrition, family and spiritual support
- More formalized support
- Teach non-chemical coping skills
- Education on addiction and cross-addiction issues
- Humanize work conditions

# Time Management

- Time = energy
- Choose energy creating vs. energy depleting activities
- Organize
- Delegate
- Schedule - don't over commit
- Set priorities - include yourself and your family in the list of priorities
- Anticipate and prepare for situations
- Consider and use options - learn to look for them
- Learn to say "No" - open mouth, say no, close mouth
- Stop trying to please everyone

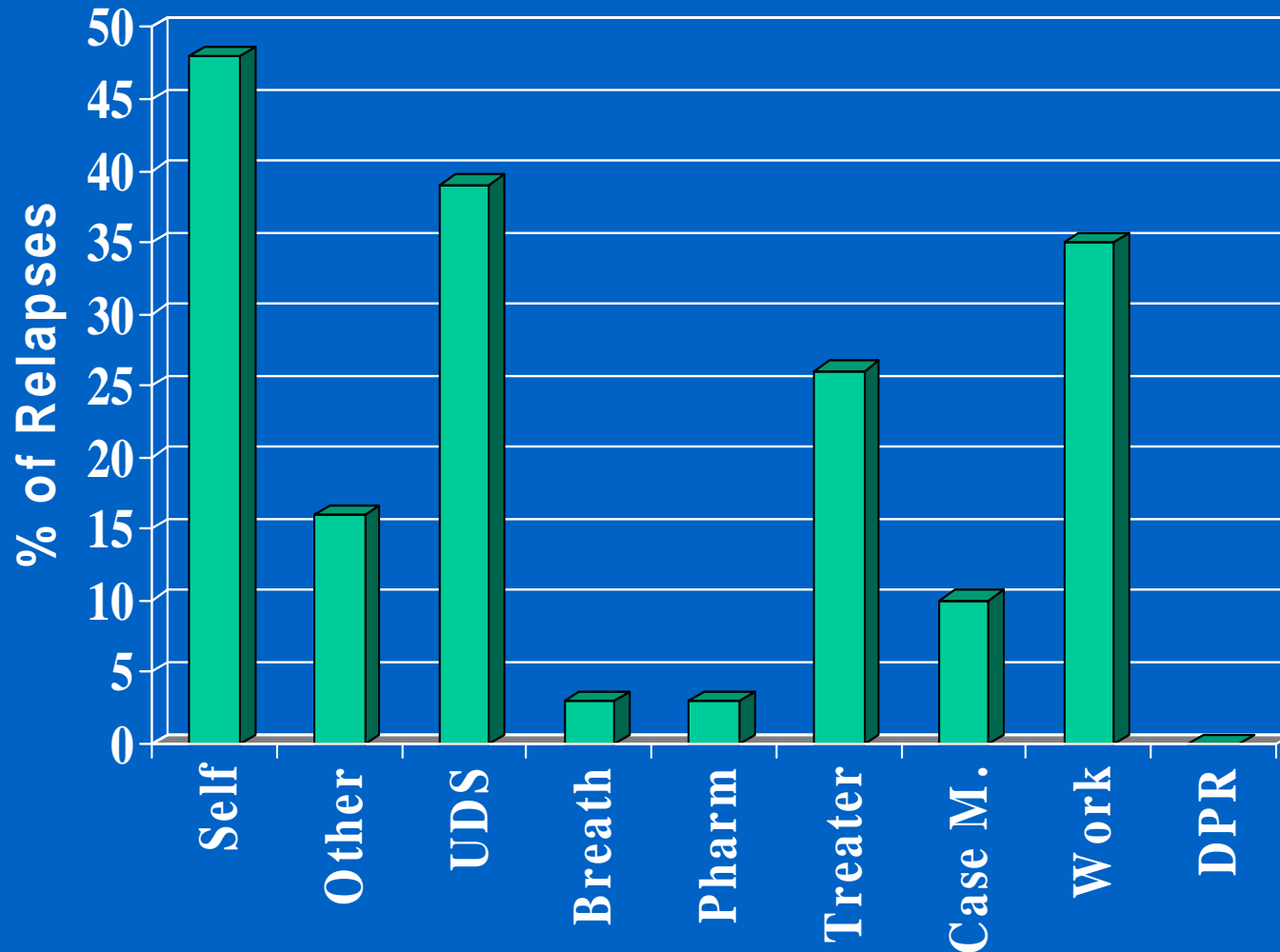
# Other Suggestions

- Add fun to work
- Slow down – remember, you're dead a very long time
- Don't take work home - if you do set limits on when and where it is done, give family a choice on limits
- Take regular time off - don't end holiday until the next is planned
- Use support system - 1 or more good friends, people breaks at work, a pet
- Share your stories - transform shame/secret to share/support
- Laugh more often
- Let go of guilt - acknowledge it, let go of it

# Relaxation Techniques

- Many methods to choose from
- Spiritual relaxation, meditation
- Rehearse for the performance - don't expect it to work unless you have practiced it daily

# Detecting Relapse



# Factors That Contribute to Relapse

Failing to understand and accept the disease concept

Continued denial

Dishonesty-reality distortion and emotional concealment

A dysfunctional family

Lack of a spiritual program

Inability to cope with stress

Unresolved anger about a person or situation

Isolation and failure to become an active member of recovery programs (A.A., N.A., for example)

# Factors That Contribute to Relapse, cont.

Untreated secondary addictions (food, work, sex)

Cross-addiction to more than one chemical

Holiday syndrome (increased chance of relapse over holidays)

Severe withdrawal

Overconfidence

A return to drinking or using friends and old habits

Guilt over the past

Shame from early childhood experiences and feeling unworthy

Medical problems

# Factors That Contribute to Relapse, cont.

Multiple relapses, and not successfully completing treatment

Poor continuing monitoring

Failure to treat co morbid psychiatric illnesses

Not focusing on total abstinence

Over dependence on an intellectual understanding of illness,  
rather than commitment to the twelve steps of recovery

Use of intravenous narcotics

Poor relationship skills

Occupational or legal difficulties

# CONDENSATION:

Failing to understand and accept the  
disease concept

Continued denial

Dishonesty-reality distortion and  
emotional concealment

Denial is a major obstacle to  
successful treatment

75-85% of physicians who enter treatment programs successfully return to their professional positions

When you see yourself as  
perfect and expect yourself to be  
perfect, and find out  
you are not,  
it can be  
quite a shock

Many doctors feel that being a physician hinders their recovery, because they felt that they were too intelligent and knew too much about the disease of alcoholism to become alcoholic.

The most significant part of recovery was acknowledging that they had to get past their shame and humiliation, and accept the fact that they were alcoholic.

# Physician Readings from Alcoholics Anonymous, 4<sup>th</sup> Edition

- “Doctor Bob’s Nightmare”, pgs. 171-181.
- “Physician, Heal Thyself”, pgs. 301-308.
- ‘Acceptance Was The Answer”, pgs. 407-420.

# Pearls of Pathology

- Do professionals become addicted?
- What are the signs and symptoms of the disease?
- How can we motivate a professional to seek help?
- What does an evaluation include?
- How do we treat a professional who is addicted?
- How do we monitor the recovery of a professional after treatment?
- Can they return to safe practice?
- What is the outcome of treatment?

# Illinois Professionals Health Program 847-795-2810

- Sponsored by:
  - The Illinois State Medical Society
  - Illinois State Medical Insurance Exchange
  - Other Health Professional Organizations
  - Illinois Department of Professional Regulation
- Providing services to:
  - Physicians
  - Nurses
  - Dentists
  - Podiatrists
  - Pharmacists
  - Veterinarians
  - Other allied health professionals

# Illinois Professionals Health Program Services

- Consultation for hospitals, group practices, EAPs (Employee Assistance Programs), colleagues and family members
- Coordinate intervention services
- Referrals to approved treatment providers for assessment and treatment
- Written aftercare agreements
- Case Managers who coordinate care of multiple providers over 5 years
- Random toxicology program
- Advocacy
- Research

# Illinois Professionals Health Program

## How We Will Help

- Education on physician and allied health professional impairment
- Consultation for hospitals, practices, colleagues and family members
- Coordinate intervention services
- Referrals to approved treatment providers for assessment and treatment
- Written monitoring agreements
- Case manager to facilitate and monitor compliance with agreements who will report to your committee
- Random toxicology program
- Advocacy for return to practice
- Research

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