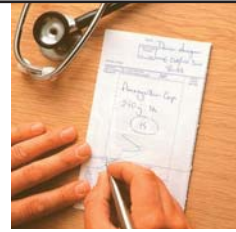


Management of the impaired doctor



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This is the sixth article in a series of case files from general practice that explore treatment issues around substance use and commonly encountered general practice presentations.

BACKGROUND

The lifetime prevalence of substance abuse disorders among doctors in Australia has been estimated to be approximately 8%. These disorders can interfere with a doctor's ability to function and pose a risk to patient welfare and safety.¹

OBJECTIVE

This article identifies key indicators to the development of problem alcohol and drug use in a general practitioner, associated possible psychiatric morbidity, work deficits, and the need for colleagues to recognise and respond in a timely manner to resolve these events.

DISCUSSION

Where intervention, treatment and monitoring are initiated early in problem drug use, outcomes for the GP are typically positive. Outcomes are better where there is adequate support by friends and colleagues, and where there is a clearly defined management strategy.

Case history – Tom

It is Monday morning and your first day working as a general practitioner in a busy rural general practice. There are two other GPs, Tom and Judith, who are practice partners. Tom, the senior partner, started the practice 29 years ago and is highly respected by the community; he is one of the main GPs on the emergency department roster at the local regional hospital.

One of the practice staff tells you that Tom and his wife have recently separated and that she has moved with their children to the city. Since the separation, Tom has focussed on work and has increased his already extremely heavy workload, and now sees patients on weekends and public holidays – days he previously reserved for the family.

Early signs of stress

The practice is busy for you, but you notice that Tom's workload seems particularly excessive. Over the following weeks you become concerned about Tom and his ability to adequately manage his caseload. He is now undertaking home visits before and after surgery hours, and after his all night emergency department (ED) hospital work.

However, as you haven't known him long, you feel it would be inappropriate to talk to him about this. You do, however, discuss your concerns with Judith, who also shares concerns about Tom's workload, but reassures you that he is a capable general practitioner used to the level of work needed in rural areas. Judith also believes work is helping Tom cope with his personal distress.

During your first 2 months at the practice you notice that Tom arrives at work late on several occasions. You assist by seeing his booked patients. Initially you assume that Tom's lateness is due to his heavy workload at the hospital, but one day after seeing a hospital patient before coming to work you realise that he has come in late from home. As some of his patients have complex problems you ask Tom if you can meet to catch up to discuss a few cases, and he suggests dropping around to his house to share a few drinks. You notice that although Tom consumes several glasses of wine over a 45 minute period, he does not appear to be affected. Nevertheless, you are glad to see that Tom is taking time to relax.

As part of her annual leave, Judith has negotiated 3 weeks holiday to coincide with her children's school vacation. Because the practice has been unable to attract a locum, both you and Tom are providing cover.

Signs of an impaired doctor

Over the following weeks Tom becomes increasingly late for work, at times arriving 2 hours late. His self care also deteriorates, and he is increasingly unkempt with dishevelled clothes and red eyes. You regularly smell alcohol on his breath upon his arrival for work. In covering his patients, you observe that his case notes are becoming more and more disorganised. You also discover that he has, in instances, prescribed opioids and other drugs without any record being kept.

One evening at a social function, you talk to a nurse who works with Tom at the local hospital. While she is initially guarded in her comments, she eventually relaxes and confides that she has witnessed a dramatic decline in Tom's appearance and competency over the past 4 months and that she has concerns about his ability to effectively manage patients. When pressed she indicates that he has started making mistakes in writing out medication charts and another doctor recently had to rewrite a warfarin regimen which was clearly wrong. While he used to be 'easy going' he has

Establishing dialogue

Judith starts the meeting by asking Tom how he is. He responds by saying that he is 'coping okay'. Judith then says: 'I should probably have asked you this before because when I look back the signs were there, but I was hoping it wasn't the case. Tom, are you drinking too much?' Tom does not answer. Judith then openly asks about drinking alcohol at work, at which stage Tom becomes visibly upset, saying that he will deal with his own problems and storms out of the room. Judith and you wait for a few minutes and then go to Tom's room where you find him distressed and teary. Tom admits he has been using alcohol, initially red wine and then whisky, to help cope with his separation, but over the months, alcohol use has become more and more regular and is now a daily event. Although he would not think of coming to work intoxicated, he indicates that he feels the need for a little alcohol in the morning just to steady his nerves.

Judith asks how the hospital work is going, and Tom concedes it's all becoming too much. She then asks him if he has attempted to self medicate for his alcohol withdrawal, and he admits that he has been using benzodiazepines. To avoid drawing attention to himself he has been taking these from the hospital, but has nearly been caught on a number of occasions. He had tried using the benzodiazepines in the morning before surgery to reduce his feelings of anxiety, but felt he was unable to focus at work and was concerned that he was likely to make clinical mistakes. Accordingly, he recently stopped using the benzodiazepines (Table 1).

become irritable and impolite to both staff and patients, and there have been complaints from patients over the past few months regarding his abruptness and attitude.

A week later a senior member of the nursing staff confides in you that she saw Tom taking diazepam from the medical trolley without recording it. More recently, she understands that one of the junior doctors saw him take a bottle of diazepam from the drug cabinet and put it in his pocket. When she asked if there was some problem, Tom had replied that it would sort itself out, and walked out of the ward.

A need for collegial involvement

The next morning as you drive into the work car park you see Tom drinking out of a small bottle before leaving his car and entering the surgery. When you enter the surgery and talk to him, alcohol is clearly evident on his breath. You are now convinced that Tom

is not capable of functioning optimally as a GP, and that his compromised state is likely to pose an unacceptable risk to patient welfare and safety. Regardless of your desire to protect Tom – and your discomfort in intervening – your first responsibility as a doctor is now to protect the welfare and safety of patients; '*primum non nocere*' or 'first do no harm'. There are now potential medicolegal consequences for Tom, you and the practice, should you not take action.² Importantly, in situations such as with Tom, the earlier an intervention takes place the better the likely outcome. These include reduced risk to patients, maintenance of the doctor's status and reputation, successful resolution of problem substance use and eventual return to optimal work functioning without involvement of the Medical Board.^{3,4}

Accordingly, you telephone Judith at home and tell her of your concerns, the information provided by the ED nurse, and

Table 1. Establishing dialogue⁴⁵**Who**

It is usually better to have more than one person present when raising the issue of problem substance use. This helps to reinforce the gravity of the situation, allowing colleagues to show they are united in their wish to tackle the issue and help the impaired practitioner, and may be useful should disputes occur about what was discussed

How

The impaired doctor is likely to feel defensive and 'ganged up' on. Accordingly, concerns should be raised with sensitivity and in a nonjudgmental manner with expressions of concern

Why

It is better for the impaired doctor to know that the issue is in the open with colleagues, and that they are united in their wish to tackle it and to help him/her

When

The issue should be raised when the impaired doctor is not intoxicated and as soon as practicable after the event that has led to suspicion of impairment

Where

This should be done in a quiet and private place where interruption is unlikely

What

State the facts focussing on work performance (eg. what happened, when it happened, who was involved)

Do not assume anything about the cause. Drug use may be one possible cause, but the primary issue is work performance

Express concern about the doctor as well as for patient safety

Anticipate anger, denial, alternative explanations and the expression of competence

Listen to explanations, look at options, but do not waiver from a need to ensure patient safety

Result

Achieve agreement on temporary cessation of work if patient safety cannot be ensured

Agree on immediate assessment by a psychiatrist or other relevant health professional

Agree on involvement of the Doctors' Health Advisory Service, disclosure of treatment plans, and treatment information necessary for colleagues to assess the doctor's status and ensure patient safety

Involve the Medical Board if the issue cannot be resolved and patient safety is a concern

Document the above

Table 2. Doctors' Health Advisory Service

New South Wales	02 9437 6552
ACT	02 6270 5410
Victorian Doctors Health Program	03 9495 6011
Tasmania	03 6223 2047
Queensland	07 3833 4352
South Australia	08 8273 4111
Northern Territory	08 8927 7004
Western Australia	08 9321 3098

Note: Some of these numbers are available 24 hours, 7 days a week with the use of answering machines and other call services

Judith arrives about 15 minutes later and asks both you and Tom to her room for a meeting.

Taking action

After an open discussion, it is agreed that Tom should take leave from both the practice and hospital appointment, and should contact the Doctors' Health Advisory Service to seek assistance (*Table 2*). The Doctors Health Advisory Service' facilitates an assessment and treatment plan for Tom, which in his case includes an admission to a private hospital in the city to withdraw from alcohol, individual counselling, and a monitoring program starting with withdrawal and continuing through his return to work. Tom is also commenced on a selective serotonin reuptake inhibitor (SSRI) for the management of depression. At the end of a 2 month period, Tom returns to the general practice, working initially on a part time basis and 2 months later, moving back to a full time workload.

In retrospect, Judith conceded that signs of Tom's problematic alcohol and drug use were evident long before any impact became apparent at the practice (*Table 3*).

that you have just observed Tom drinking at work. After making a telephone call to another ED doctor she knows, Judith rings back indicating that she will come to the

surgery immediately, and asks you to have the receptionist let patients know there may be a delay in seeing a doctor. She then asks you to transfer the call to Tom's office.

Table 3. Late changes in the impaired medical practitioner⁶

<p>History</p> <ul style="list-style-type: none"> • Recurrent job changes, especially from one community to another • Intervals between employment • Acceptance of jobs that are inappropriate or for which he/she is overqualified <p>Appearance</p> <ul style="list-style-type: none"> • Physical deterioration, fatigue • Signs of intoxication or withdrawal, eg. smell of alcohol, sedation, slurring of speech, loss of coordination <p>Mental state</p> <ul style="list-style-type: none"> • Erratic mood and personality • Poor memory <p>Behaviour</p> <ul style="list-style-type: none"> • Frequent personal medical complaints 	<ul style="list-style-type: none"> • Persistent overwork • Absences from work • Loss of reliability, lateness • Indecision and errors • Accidents • Inappropriate prescribing and over prescribing • Seen to be taking pills or alcohol at work • 'Locked bathroom' syndrome • Increasing isolation professionally and socially <p>Staff</p> <ul style="list-style-type: none"> • Staff concerns <p>Patient</p> <ul style="list-style-type: none"> • Patient complaints
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She reflects that confronting Tom with his alcohol and drug use would have been difficult, and for that reason she avoided it – in effect colluding to protect Tom from having to deal with his substance abuse. By doing this, Judith may have denied Tom the opportunity of earlier intervention. Judith was not alone in this failing, as hospital staff had also chosen not to confront Tom about his use of benzodiazepines and other concerning behaviour. Judith tells you, that for the sake of all concerned; Tom, the practice, and the patients, she is grateful to you for having impelled her to confront Tom so that he could deal with his behaviour.

Conclusion

Problem drug use occurs within the medical fraternity, as it does in other sectors of the population. Aetiological factors include habit-

ual overwork, lack of recreational time outside of medicine, demands of the job and patients' expectations, depression, anxiety and obsessive traits. Drug use can interfere with a doctor's ability to work and may ultimately compromise the welfare and safety of patients. However, the prognosis is generally good, especially if early intervention can be offered within a supportive and open framework. A fundamental resource is the Doctors' Health Advisory Service or similar local support service who can be contacted anonymously by the impaired doctor or concerned colleague, and who can provide and facilitate the provision of independent expert advice, assessment and treatment.

Conflict of interest: none declared.

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The 5 domains of general practice



1. Communication skills and the patient-doctor relationship



2. Applied professional knowledge and skills



3. Population health and the context of general practice



4. Professional and ethical role



5. Organisational and legal dimensions