The identification and management of the drug impaired doctor

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BACKGROUND Problem drug use occurs within the medical fraternity as it does in other parts of the population. However, doctors have traditionally been discouraged from admitting vulnerability and frequently fail to recognise or respond to early signs of problem alcohol and drug use.
OBJECTIVE This article aims to identify sequential strategies to assist the doctor to detect and intervene early when problem drug use arises in themselves or a colleague.
DISCUSSION Where treatment and monitoring is instituted early in problem drug use, outcomes are typically positive while late acknowledgment commonly results in sanctions for the impaired practitioner and greater risk to patients. Medical boards in Australia have developed supportive mechanisms for doctors to facilitate early management. Procedures are aimed at maintaining or restoring ability to work while maintaining public confidence.

The prevalence of alcohol and illicit drug use in doctors has been shown to be at least as high as that in the general population.[1,2] It is not surprising that doctors use alcohol and other drugs largely for the same reasons as other people do – to alter mood, to relax, to escape and to help cope with negative emotion.[1]

The lifetime prevalence of substance abuse disorders among doctors in Australia has been estimated to be approximately 7.7%.[3] This is not dissimilar from the US where the American Medical Association has estimated lifetime prevalence of alcoholism and drug dependence among doctors to be 6–8% and 1–2% respectively.[2]

Opinion is divided regarding the aetiology of hazardous and harmful drug use in doctors. These can be divided into extrinsic (job related) and intrinsic (personality) factors. Extrinsic factors include the long hours of work, pressure on time and resources, the demands of the job and patients, and fear of litigation. Intrinsic factors are the presence of obsessive traits, a pattern of high achievement, habitual overwork, lack of pursuits or relaxation time outside of medicine and expectations of always coping ('super coping').[2,4–6] Depression and anxiety are also associated with hazardous and harmful drug use.[4]

Professional responsibility

Hazardous and harmful drug use can interfere with a doctor's ability to work. In cases where treatment and monitoring

Table 1. Early signs of impairment in the doctor[2,9]

Personal
- Feelings of depression, anxiety or guilt
- Fatigue and physical symptoms
- Self prescribing of psychoactive drug
- Daily drug use*
- The use of the drug begins to take precedence over other activities, changes in social preferences, social withdrawal*
- Driving under the influence of drugs, accidents*
- Public intoxication*

Family/social
- Domestic disputes and breakdown, extramarital affairs, frequent absences

Work
- Ambivalence about choice of profession
- Professional isolation, single handed practice
- Stressful work conditions
- Feeling of indispensability at work, eg. being the only one who can help specific patients
- Not being able to say 'no' when this is the preferred option, eg. to demanding patients, to extra job assignments

* These generally occur later and suggest that urgent help is required.

are instituted early, outcomes are typically positive with public disclosure commonly avoided. Unfortunately, late presentation has been the rule since doctors are often capable of continuing practising undetected for many years before a crisis results in drastic action.[7,8] At this stage sudden withdrawal from work, possibly associated with deregistration, can lead to personal loss of reputation and employment.

There are a number of possible impediments to doctors seeking early assistance. First, extensive training often creates a self expectation of coping or a sense of invulnerability. The new medical graduate may experience a great sense of responsibility to live up to high expectations conferred as he or she enters the profession. Second, there may be the practitioner's fear of the public implications of self disclosure. All these may work against the open admission of the need for help, leaving the practitioner increasingly isolated and vulnerable.

Taking care and responsibility for oneself

There are a number of personal warning signs of problematic alcohol and other drug use, long before any effect at the workplace become apparent. Some of these may be apparent to close friends and colleagues. These are outlined in Table 1.[2,9]

While any single factor may have multiple causes, a cluster of these occurring together is more likely to indicate the emergence of problem alcohol or drug use.

Colleagues who are impaired by alcohol and other drug use

For a number of reasons, colleagues are often slow to act when impairment associated with alcohol and other drug use is suspected. First, doctors may have stereotypes of drug users that do not fit with that of a peer developing problem drug use. Second, most practitioners are reluctant to raise the issue because of a fear of invading privacy. Third, practitioners may deny the presence of a problem to protect the impaired colleague from the potential impact of public disclosure. This is often in the false belief that the problem drug use will resolve without intervention.

Regardless of a doctor's wish to protect a colleague, the first responsibility of a doctor is to do no harm to patients, primum non nocere. All doctors have a public duty to act on any suspicion of impairment and there are potential medicolegal consequences of not reporting concerns.[10] In some jurisdictions mandatory reporting is legislated and this is an increasing international trend.

Table 2. Late changes in the impaired doctor[2,10]

History
- Recurrent job changes, especially from one community to another
- Intervals between employment
- Acceptance of jobs which are inappropriate or for which the doctor is overqualified

Appearance
- Physical deterioration – fatigue
- Signs of intoxication or withdrawal, eg. smell of alcohol, sedation, slurring of speech, loss of coordination

Mental state
- Erratic mood and personality
- Poor memory

Behaviour
- Frequent personal medical complaints
- 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)

Staff
- Staff concerns

Patient
- Patient complaints

The most important reason for early action is the improved prognosis, ie. gaining control over the drug problem, earlier return to clinical practice and avoiding long term impairment associated with early intervention.[1,9] Protecting a colleague may lead to worse outcomes both for the impaired doctor, salient others and the public.

Signs of problem drug use do not generally appear at the workplace until late

Table 3. Tackling the impaired colleague at work[2,11]

Who
It is usually better to have more than one person present when raising the issue since this helps to reinforce the gravity of the situation and may be useful should disputes occur about what is discussed. This needs to be sensitively done as the impaired doctor is likely to feel defensive and 'ganged up' upon. It is however, 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 the issue and to help him or her
When
This should be done when the impaired doctor is not intoxicated and as soon as practicable after the event which has led to suspicion of impairment
Where
This should be done in a quiet and private place where interruption is unlikely
How
The issue should be raised nonjudgmentally and with expressions of concern
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 patient safety
Anticipate 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 a report to the Medical Board or council
Document the above

stages when severe incapacity is present. It is important to remember that apparent signs of drug use can be due to other causes and diagnoses should only be made by treating doctors. Changes at work can be summarised in Table 2.[2,10] However, colleagues can identify behaviours that suggest a problem and act to offer assistance.

Tackling drug issues and impairment in a colleague

When impairment is suspected, it is essential to document the facts clearly, focussing on work performance, eg. late attendance, episodes of intoxication, mistakes made. Documentation should be timely and limited to factual information.

Colleagues may note early warning signs of hazardous or harmful drug use as outlined in Table 1. At this stage the doctor may be unaware of any change in their behaviour and gentle confrontation by a supportive colleague may encourage him or her to seek help. If there is no evidence of drug use or impairment at the workplace, the expression of concern and support may suffice to enable the doctor to begin to address their problems.

Impairment is usually noted following a crisis at work. This can be viewed as a positive point of intervention. When impairment has been identified, colleagues must take responsibility to ensure that an assessment takes place, help is offered and patients are protected. If there is reason to suspect that patient safety may be compromised it is unacceptable to allow the doctor continue to practise. Sick leave should be taken until a full assessment and an acceptable plan for treatment, support and monitoring is implemented under the auspices of the local medical board or council. When tackling the issue of impairment at work, consider the strategies shown in Table 3.[2,11]

Support and resources

Doctors, like other people, are more likely to do well when adequately supported by family, friends and colleagues. Support should be mobilised where possible. Should problematic hazardous or harmful alcohol or other drug use in a colleague be suspected, there are a number of resources available. Organisations listed under the name 'Doctor's Health Advisory Service' in Australia facilitate independent expert advice, assessment and treatment of suspected impaired practitioners. All medical boards and councils have developed supportive procedures aimed at maintaining or restoring function. These supportive mechanisms include regular psychiatric reviews, worksite monitoring and limitations on the type of practice permitted.[12] A voluntary decision to take temporary leave (if this is deemed to be required) is preferable to involuntary suspension. In general, most states and territories have impaired doctor programs that focus on negotiated conditions, treatment and rehabilitation.[12] Deregistration and disciplinary proceedings are generally not taken lightly and usually only occur after serious offences (eg. supply of drugs to the illicit market) or after multiple unsuccessful attempts to demonstrate improvement or stability. Medical defence organisations can offer advice about the medicolegal implications of not reporting when there is evidence of impairment.

The Doctors' Health Advisory Service

Table 4. Doctors' Health Advisory Services

New South Wales	(02) 9437 6552
ACT	0407 265 414
Victoria	(03) 9349 3504
Tasmania	(03) 6235 4165
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, seven days a week with the use of answering machines and other call services.

is independent of the Medical Board. The service will not report doctors to the board nor will it threaten to do so. The 24 hour numbers for the Doctors' Health Advisory Services are listed in Table 4.

Safe practice

There are several basic tenets for the safe practice of medicine:

- every doctor and their family should have their own general practitioner[13]
- avoid self medication
- be aware of your own weaknesses
- be aware of your own consumption of alcohol and other drugs and avoid using these to relieve stress
- balance your work life with your social life
- maintain an emphasis on healthy living and learn ways to manage your own stress
- have a knowledge of the effects of alcohol and drugs and be able to spot the early warning signs of misuse (Table 1).

Conclusion

Doctors are vulnerable to problematic drug use, just like any other section of the community. The challenge is how we as a profession deal with it. Changes in the medical curriculum to address self care at an undergraduate level is a starting point.[14] However, at postgraduate level we still frequently fail to recognise or respond to early signs. As we have described, if treatment and monitoring are instituted early in problem drug use, outcomes can be positive as opposed to late recognition, which commonly results in sanctions for the impaired practitioner and a greater risk to patients.

Conflict of interest: none declared.

References

1. Wijesinghe C P, Dunne F. Impaired practitioners notified to the Medical Practitioners Board of Victoria from 1983 to 1997. Med J Aust 1999; 171:414–417.
2. Centrella M. Physician addiction and impairment. Current thinking: A review. J Addict Dis 1994; 13(1):91–105.
3. Murray R M. Psychiatric illness in male doctors and controls: An analysis of Scottish hospitals in patient data. Br J Psych 1977; 131:1–10.
4. Serry N, Ball J R B, Bloch S. Substance abuse among medical practitioners. Drug Alcohol Rev 1991; 10:331–338.
5. Vaillant G E, Sobowale N C, McArthur C. Some psychological vulnerabilities of physicians. N Engl J Med 1972; 287:372–375.
6. Wilhelm K, Diamond M, Williams A. Prevention and treatment of impairment in doctors. Adv Psychosom Res 1997; 3:267–274.
7. Cadman M, Bell J. Doctors detected self administering opioids in New South Wales, 1984–1994: characteristics and outcomes. Med J Aust 1998; 169:419–421.
8. Brooke D. Impairment in the medical and legal professions. J Psychosom Res 1997; 43(1):27–34.
9. Weir E. Substance abuse among physicians. Can Med Assoc J 2000; 162:1730–1732.
10. Dyer C. Consultant found guilty of failing to act on a colleague. Br Med J 1994; 308:809.
11. Brandon S. Persuading the sick or impaired doctor to seek treatment. Adv Psych Treatment 1997; 3:305–311.
12. Breen K, Court J M, Katsoris J. Impaired doctors: the modern approach of medical boards. Aust Fam Physician 1998; 27(11):1005–1008.
13. Pullen D, Lonie C E, Lyle D M, Cam D E, Doughty M V. Medical care of doctors. Med J Aust 1995; 162:481–448.
14. McCall L, Maher T, Piterman L. Preventive health behaviour among GPs. Aust Fam Physician 1999; 28(8):854–857.

AFP

Correction: In 'Excerpts from the RACGP independent statement on emergency contraception' (AFP October, p 914), the incorrect dosage was stated. The correct dosage of levonorgestrel given twice 12 hours apart is 750 µg not 750 mg as stated.