Curbside Consultation

Caring for the Physician Affected by Substance Use Disorder

Commentary by Ruchi M. Fitzgerald, MD, FAAFP, Rush University, Chicago, Illinois

Case Scenario

A 34-year-old physician, H.M., is an established patient in my practice. H.M. presents for a follow-up visit after finishing inpatient treatment for opioid use disorder. Your patient shares that six weeks ago they were approached by their medical director to discuss concerns from the clinic staff about H.M.'s behavior, which included late arrivals to work, unexpected absences, mood swings, and weight loss. After the meeting, H.M. agreed to an evaluation by a physician health program, and an opioid use disorder was diagnosed. Inpatient treatment was recommended, and H.M. is still on a medical leave of absence. H.M. is currently prescribed sertraline (Zoloft), 50 mg by mouth daily, and buprenorphine/naloxone (Suboxone), 8 mg/2 mg sublingually daily. H.M.'s aftercare plan includes attending community recovery meetings, focusing on self-care, and spending time with their spouse and children. H.M. reports "feeling better than I have in years" and states that they have had no cravings for opioids. The patient is attending cognitive behavior therapy sessions for treatment of depression and opioid use disorder and is enrolled in the state's physician health program.

As a family physician, what role do I play in supporting H.M.'s recovery from substance use disorder (SUD)?

Commentary

Physicians are not impervious to SUDs. Studies have suggested that the prevalence of SUDs among physicians is 10% to 15%, similar to the general population.[1] Alcohol use disorder is the most common type of SUD in physicians, and a national survey of U.S. physicians for all specialties found that female physicians reported alcohol use disorder at a higher rate than male physicians.[2] In addition, some medical specialists, such as anesthesiologists, may experience higher rates of nonalcohol SUD because of occupational exposure and access to medications in the workplace.[3] There are limited published data on this topic, and reporting bias is likely because of the sensitivity around an SUD diagnosis for practicing physicians; therefore, the true prevalence of SUD among physicians is unknown. Physicians experience several risk factors for the development of SUDs, including high levels of work-related stress; exposure to illness, trauma, and death; and untreated depression or other mental illness.[4] With evidence-based treatment and peer and professional support, physicians who have an SUD can recover their health and continue meaningful careers in medicine.

Impairment vs. Illness

Physicians are considered safety-sensitive workers. Health systems, medical licensure boards, and physician health programs may work in tandem to ensure public safety while assisting ill and impaired physicians. The primary purpose of categorizing physicians as safety-sensitive workers is to protect patients from any undue harm that might be caused by the health care professional who has not yet received help for a potentially impairing medical condition. Impairment is a functional classification; an impaired physician is one who is unable to care for patients safely and effectively. A physician with an SUD is an individual with an illness, but this alone does *not* qualify as impairment. Physicians who are impaired by an SUD should be identified and offered assistance; this process often requires the expertise of a physician health program. An SUD does not always indicate impairment, but

Case scenarios are written to express typical situations that family physicians may encounter; authors remain anonymous. Send scenarios to afpjournal@aafp.org. Materials are edited to retain confidentiality.

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without treatment it typically leads to loss of clinical competency and several personal and professional problems.[5] With intervention and treatment, such problems may be prevented or resolved. The American Society of Addiction Medicine issued a public policy statement in February 2020 about physicians affected by SUDs. The statement addresses key points such as the need to individualize treatment, appropriate management of relapse, and patients' right to privacy. It also provides helpful guidance for those in leadership positions within their health care systems.[6]

Recognizing Impairment

Impaired physicians may present late to care, often under duress. It can be difficult for colleagues to identify impaired physicians.[7] Signs and symptoms may include an accumulation of personal difficulties, including home life disruption, isolation, erratic moods, and increasing interpersonal conflicts at work. Changes in physical appearance, work hours, and unexplained absences may also indicate an impairment from an SUD. In addition, classic signs of opioid withdrawal (agitation, anxiety, sweats, complaints of abdominal pain, noticeable mood changes) or alcohol withdrawal (tremor, sweats, agitation) may be noticed at work.

Intervention

Concerned colleagues often hesitate to intervene because of uncertainty and fear of harming the individual's career or invasion of privacy. The American College of Physician's position paper on physician impairment outlines a stepwise approach to addressing an impaired physician.[8]

- If patient harm is unlikely (the physician is likely to have illness but not showing signs of impairment), a sensitive, forthright discussion with the health care professional should happen. Many physicians can be treated with early intervention and receive care from a family physician if not impaired.
- If patient harm is imminent or likely, a report should be made to a clinical supervisor, physician health program, or licensing board. This pathway is recommended when the physician will need to stop work, has professional/legal consequences, and/or is using substances at the workplace.
- If it is uncertain whether the physician is impaired from an SUD, counsel from a clinical supervisor and physician health program representative should be sought.

Physician Health Programs

Physician health programs are available in most states to assist all licensed health care professionals, including physicians and trainees, with potentially impairing SUDs and psychiatric conditions.[9] State physician health programs are confidential and offer assistance in identifying impairment and implementing a comprehensive model of support, including longitudinal monitoring and a confidential introduction to peer support communities of other recovering health care professionals. The physician health program may also assist physicians with issues related to licensure and function as an advocate for individuals returning to practice after inpatient or intensive outpatient treatment. Most physician health programs coordinate robust aftercare plans for up to five years. They work to bolster recovery by offering referrals to addiction psychiatry and behavioral health services. Many physician health programs include a three- to five-year agreement that uses the physician health program model for treating physicians; emphasizes abstinence and monitoring via a robust toxicology program, regular attendance at physician peer support (Caduceus) meetings, and community sober meetings (Self-Management and Recovery Training [SMART] or 12-step meetings); and encourages individual psychotherapy if indicated. The physician health program is designed to address addiction as a chronic disease. Return to use of substances does not necessarily result in a notification to the disciplinary authority. The program aims to support individuals who temporarily resume use (experience a lapse) in the course of recovery while working to protect patient safety. Retrospective studies have shown excellent outcomes from physician health program participation, with 70% to 80% of physicians remaining abstinent from mood-altering substances during their time in programs.[10]

Medications for Addiction Treatment

Physician health programs create individualized treatment plans that may include medications for addiction treatment.[11] Medications for evidence-based treatment of opioid use disorder (buprenorphine/naloxone, methadone, and extended-release naltrexone [Vivitrol]) reduce mortality.[12] Family physicians, particularly in areas where there is a shortage of addiction medicine clinicians, can play a critical role in supporting health care professionals in treatment for SUD by becoming familiar with the physician health program model and obtaining the Drug Addiction Treatment Act 2020 (DATA 2000) waiver to prescribe buprenorphine/naloxone for the treatment of opioid use disorder.[13,14] Medications approved by the U.S. Food and Drug Administration for treatment of alcohol use disorder include acamprosate (Campral), oral naltrexone (Revia), and extended-release naltrexone and do not require any additional training or waiver process. Medication treatments for alcohol use disorder are drastically underused in outpatient settings.[15]

When a physician who has an SUD presents to a family physician, it is important to use a shared decision-making process in creating the treatment plan. The family physician should also engage the physician health program when choosing any medication for addiction treatment and in coordinating plans for the patient's return to work. The family physician's ability to establish trust and rapport

with the patient is critical in the long-term recovery of physicians affected by SUDs.

Barriers to Treatment

Many physicians with SUD do not seek treatment due to fear of consequence and stigma. Stigma surrounding SUDs and mental health concerns is still prevalent in the medical profession. Physicians may fear loss or restriction of medical licensure as a consequence of receiving treatment for their SUD. However, lack of treatment can lead to devastating consequences, including loss of licensure, severe home life dysfunction, and physician suicide.[16] The coronavirus disease 2019 pandemic may precipitate or exacerbate mental health conditions, including SUDs, in health care professionals.[17] All physicians should be familiar with mechanisms to identify illness and impairment in colleagues and be aware of pathways to assist without disciplinary action wherever possible. Systemic efforts to help physicians include addressing physician burnout and physician well-being at the leadership level.[16,18]

Follow-up to Case Scenario

You should obtain a comprehensive history about your patient's SUD in a nonjudgmental manner and use supportive, nonstigmatizing language during the follow-up visit to establish trust and rapport. Understanding that family physicians are well-equipped to care for patients with SUD, you should educate yourself on the details of your patient's physician health program and discuss coordination with the physician health program and the return-to-work recommendations. Using a shared decision-making process, you may continue prescribing sertraline for depression and also prescribe sublingual 8-mg/2-mg buprenorphine/naloxone daily, recognizing that this is a first-line treatment for opioid use disorder.[19,20] Overdose prevention education and a prescription for intranasal naloxone should be provided to your patient, and a plan to counsel a member of H.M.'s family on overdose prevention at the next visit should be made. You should emphasize to H.M. that you support them in recovery as a fellow physician and as their treating physician. Close follow-up should continue; an appropriate interval for the next visit is two weeks.

Address correspondence to Ruchi M. Fitzgerald, MD, at Ruchi_m_fitzgerald@rush.edu. Reprints are not available from the author.

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