3.1.3 Physicians and Substance Abuse

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Educational Objectives

1. To understand a physician's legal and ethical responsibilities when another physician is impaired due to substance abuse (alcohol and/or drugs).
2. To understand how these responsibilities can change depending on situational details.

Case

For over six years, Dr. Smith and Dr. Jones have been colleagues in the general medicine department of the town's main hospital. Although Dr. Jones doesn't count Dr. Smith as a close friend, she does consider him to be competent and committed. Generally they work the same schedule, attend many of the same meetings and have chatted informally at departmental and hospital social events. Over the past few months, however, Dr. Jones has heard various staff members remark how stressed and disorganized Dr. Smith seems to be, and how often his patient appointments are rescheduled at the last minute.

Today, Dr. Jones is in early and opens up the department's office area. Passing Dr. Smith's office she sees him asleep at his desk, an almost empty liquor bottle beside him. She wakes him up. He is disoriented and looks awful. "What are you doing here?" he asks her. Dr. Jones tells him it's 7 am, to which he replies, "Oh boy, I gotta get home ... get a shower and some coffee." Clumsily standing up and reaching for his suit jacket, he continues, "Tell Marge [the receptionist] I'll be back at 9, okay?" Seeing Dr. Jones' concerned expression, Dr. Smith says, "Hey, there's nothing to worry about."

Questions

1. What is so worrisome about substance abuse?
2. Must Dr. Jones confront Dr. Smith?
3. What steps should Dr. Jones take?
4. What should Dr. Jones do if she decides to talk with Dr. Smith, but he does not acknowledge any problem?
5. (a) What if Dr. Jones is a third-year resident and Dr. Smith is her preceptor?
   (b) Or if Dr. Smith is a well-known fundraiser or researcher?
   (c) Or if Dr. Smith himself is worried about his alcohol use?
6. What should Dr. Jones do if Dr. Smith is going to drive home?

Discussion

Q1. What is so worrisome about substance abuse?

When physicians abuse alcohol and/or drugs, serious harms are likely. Patient health, recovery and safety are at risk. Colleagues' own work and relationships with the physician are compromised. Physicians' family and personal responsibilities are damaged. Their employment and career are threatened. Furthermore, morbidity and mortality risks for physicians increase significantly, especially if opioids are being abused. They are at greater risk of physical problems, suicide or death by overdose.

As with the general public, approximately 8–10% of physicians have substance problems, of which alcohol abuse is the most common. However, higher rates have been noted in fields such as emergency medicine, psychiatry and individual practice due to increased stress, easier access to certain drugs and/or more isolation. Acknowledging the problem or seeking help can be more difficult for physicians because they are presumed to be more informed about the deleterious effects of alcohol and drugs, or because the signs and symptoms are tolerated as erroneously caused by the seriousness, complexity and fast pace of physicians' work.

Q2. Must Dr. Jones confront Dr. Smith?
Physicians will often compromise their personal lives in an attempt to delay substance abuse from impacting on their clinical responsibilities and work lives. Consequently, when signs of possible alcohol/drug abuse begin to be noticed at work, the person's problem is probably long-standing. However, many physicians do not confront or report impaired colleagues because they worry about the consequences they will face, such as lost privacy, a tarnished reputation, and a revoked licence.

Although some US states have legislation requiring physicians to report impaired colleagues to government agencies or boards, no comparable federal or provincial legislation exists in Canada. The Canadian Medical Association (CMA)'s Code of Ethics, however, stipulates that physicians practice unimpaired, seek help for personal problems and report unprofessional conduct. The Canadian Psychiatric Association holds that if a diagnosing or treating psychiatrist believes a physician is impaired, the psychiatrist must ensure the physician discontinues his/her practice until after recovery. Provincial regulatory colleges may also have information to help guide a physician's response to and interactions with an impaired colleague.

Q3. What steps should Dr. Jones take?

Dr. Jones should carefully review the information she presently has. Is it reliable and adequate enough to conclude that Dr. Smith is likely practicing while impaired? What is she obligated, permitted or prohibited from doing? If she is unsure how to answer these questions, various groups can help. Her hospital may have a process for identifying and confronting impaired colleagues. Other resources include provincial regulatory offices, provincial offices of the Physicians Health Network or her College and, if she is a member, the Canadian Medical Protective Association (CMPA).

In any conversation with another party, Dr. Jones must be diligent in treating details about Dr. Smith as confidential, particularly because she is at this point in the information-gathering phase. Once the missing information is gathered, she should carefully determine the sequence of appropriate next steps and who is responsible for what. "Appropriateness" will be determined by who has administrative and professional responsibilities for Dr. Smith's clinical practice, behaviour and well-being and his patients' safety.

Q4. What should Dr. Jones do if she decides to talk with Dr. Smith, but he does not acknowledge any problem?

Before talking with Dr. Smith herself, Dr. Jones should consider his likely reactions to being confronted by her. She has no professional obligation to place herself at risk in an effort to help a colleague. However, if she decides to talk with him and nothing he says alleviates her concerns, she should move to the next step in the sequence described in Question 3.

Q5a. What if Dr. Jones is a third-year resident and Dr. Smith is her preceptor?

Many medical schools establish offices expressly to support and counsel students and residents who encounter academic and personal difficulties during their training. These offices are created in recognition of the authority and power differentials between students/residents and their preceptors, senior physicians and other hospital staff. Provincial regulatory colleges and their resident associations may also be able to advise Dr. Jones how best to deal with Dr. Smith.

Q5b. Or if Dr. Smith is a well-known fundraiser or researcher?

It is important to remember that other people are probably aware that Dr. Smith's behaviour is unprofessional and poses risks to others. Therefore, it is in the hospital's long-term interests to assist Dr. Smith with accessing treatment so that he can competently resume his practice as well as his fundraising or research activities. However, there may be public reputation and/or money at stake, and confronting Dr. Smith might result in Dr. Jones being criticized or sanctioned in some way. Therefore, it would be advisable for Dr. Jones to review her evidence and options with an independent organization such as the Physicians' Health Network, provincial regulatory association or CMPA while still protecting the confidentiality of Dr. Smith's situation.

Q5c. Or if Dr. Smith himself is worried about his alcohol use?
Physicians have ethically and legally sanctioned fiduciary duties to help and not harm their patients. Therefore, once Dr. Smith acknowledges he may have a substance problem, he must seek out therapists or programs to help him recover and monitor his ongoing progress, given that occasional relapses are probable. Moreover, he must consider transferring his patients to another skilled physician until he can practice competently and safely once again.

Q6. What should Dr. Jones do if Dr. Smith is going to drive home?

Provincial legislation differs as to whether a healthcare professional must report a patient who is suspected of driving while impaired. In Ontario, for instance, a physician who believes his/her patient has a condition that makes that patient an unsafe driver is required to contact the Ministry of Transport. Dr. Jones should learn the legal reporting requirements for the province in which she practices (this applies to all her patients).

Because Dr. Smith is not Dr. Jones' patient, however, legislation may not be applicable. If she has no legal obligation to report him, the ethical concepts of beneficence and non-maleficence still support her suggesting that he be driven home by a friend or taxi, just as she might do for anyone she has good reason to believe is too impaired to drive safely.

Conclusion

The good news is that, with treatment, physician recovery rates range from 30% to 90%, which are higher than those for the general public.\textsuperscript{1,2,4} Physician recovery rates with treatment are high because of physicians' personal commitment combined with support from health care facilities, the Physicians' Health Network, the CMA, provincial regulatory colleges and/or provincial RCPSC offices. While there is no legal obligation in Canada for a physician to report an impaired colleague, there may be institutional requirements. Moreover, there are ethical reasons to address signs that a physician may have a substance-use problem and to carefully determine an effective and respectful way to help an impaired colleague. Every physician has legal and ethical duties to practice unimpaired. If a physician develops a substance-use problem, he/she must seek out and participate in therapy and subsequent monitoring so as to resume high-quality and safe treatment of his/her patients.

References


Further Reading and Resources