Chemical Dependency Issues In Emergency Medicine Residency Programs

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Section 1. Introduction

A. Chemical dependency as a disease

It is important that those involved with physician impairment recognize alcoholism and other drug addiction as a disease. This focus is essential to successful treatment. Addiction as a disease is characterized by signs and symptoms in a susceptible host interacting with a causative agent in a permissive environment. Certain individuals are prone to addiction and if there is exposure to the right combination of substances and external conditions these individuals develop this chronic and progressive disease.

The amount of drug exposure and the frequency of use necessary to develop addictive disease is unpredictable. The main issue regarding chemical dependency is the effects of drug use on the person's life. Chemical dependency is characterized by loss of control over drug use and continued use in spite of adverse consequences.

B. Physician impairment

Physician impairment, narrowly defined, refers to an inability to skillfully and safely care for patients. This can be from many causes but chemical dependence is the leading cause. To restrict the definition of impairment to patient care issues is a disservice to the physician, his or her family and community. Physical illness, criminal and unethical behavior due to substance use fall outside of this narrow definition but certainly are reasons to initiate treatment for this disease.

The exact incidence of chemical dependence among physicians is unknown but it is assumed to be similar to that of the general population which is about ten percent. For afflicted physicians, the most encouraging aspect of this disease is the favorable outcome for those who complete long-term treatment. Success rates of over 80% are reported by various state impaired physician programs.

C. The EM experience

The rate of chemical dependency in practicing emergency physicians is unknown. However, in past studies of physicians treated for chemical dependency, emergency physicians were over represented. Recent data regarding EM residents is available and indicates the need for attention to this issue. Important points for program directors include the following:

1. The rate of suspected or presumed alcoholism by CAGE scoring among EM residents was 12.5%. This is very similar to residents of other specialties.
2. EM program directors underestimated the number of their residents abusing alcohol.

3. Use of other illicit substances by EM residents is low but does exist.
4. Currently, just over one-third of EM residents report receiving education regarding physician impairment.
5. The rate of chemical dependency among EM faculty is unknown.

D. ACGME and RRC issues

1. The General Requirements state that a residency program is responsible for "monitoring resident stress, including mental or emotional conditions inhibiting performance or learning, and drug or alcohol related dysfunction. Program directors and teaching staff should be sensitive to the need for timely provision of confidential counseling and psychological support services to residents." Additionally, institutions sponsoring graduate medical education are required to have a written policy and an education program regarding physician impairment. (ACGME Bulletin; October, 1993)
2. The Special Requirements for Residency Training in Emergency medicine includes the following statement: "Emergency medicine training programs should provide access to education on the problem of the impaired physician. Programs should identify impaired physicians, and intervene appropriately."

Section 2. Identification of the chemically-dependent physician

A. General issues

1. The obvious signs of dependency or abuse are often attributed to stress and overwork.
2. Self-denial and lack of insight prevent early self-referral by the dependent physician.
3. Financial, emotional and co-dependency issues make it difficult for the family to seek help.
4. Lack of knowledge and personal discomfort with this issue prevent physicians from aiding their colleagues.

Any suspicion of chemical dependency must be addressed. The risks of ignoring this are significant to patients, the hospital, the reputation of the department and, perhaps highest, to the impaired physician. While under-identification of impairment is well documented, the possibility of misidentification is also present. Return to work without prejudice and expunging all references to the allegations of impairment are standard procedures if misidentification occurs. (see section 5.C)

B. Who's at risk?

Chemical dependency can affect anyone but those at higher risk include: males, single persons and those with a family history of alcoholism.

C. Signs of impairment

Most impaired physicians develop their problem long before they become residents. Many of the individual signs of impairment listed below are not specific to chemical impairment; as they can occur from other causes. However, familiarity with the fact that these signs do occur with impairment is essential to early detection. Generally, it is not one sign alone but a constellation of such that prompt serious consideration of an impairment problem. The disease is usually first manifested in family life, then in the social arena. Signs of impairment at the hospital are generally the last in the sequence. Deterioration in physical status is an important sign, but occurs late in the disease.

1. Family life:

marital problems - affairs, separation, divorce
financial problems
domestic violence
withdrawal from family activities
problem behavior in children
unexplained absences from home
sexual problems - impotence, odd behavior

2. Social life:

embarrassing behavior including overt intoxication
unreliable or unpredictable in social activities
isolation from friends, peers, church
legal problems, especially driving under the influence arrests

3. Physical and mental changes:

personality/behavior changes
deterioration in personal hygiene, dressing habits
abnormal eating habits
excessive tiredness
multiple illnesses, symptoms
frequent injuries or accidents
frequent medical care - hospitalizations, prescriptions, medical and dental visits
emotional crises
wearing long sleeves in warm weather

4. Hospital life:

absenteeism, tardiness
deteriorating quality of work, including documentation
preferring to work alone, avoiding peers
refusing work relief
inadequate or inappropriate responses to pages/calls

frequent bathroom usage
“wastage” of drugs
topic of complaints or gossip

5. Recruitment issues - red flags on the application:

frequent hospitalizations
complicated medical history, especially traumatic
unexplained gaps in training
history of absences, irresponsibility
marital/personal problems

Section 3. Managing residents with chemical dependency

A. Data gathering and documentation

The suspicion of chemical impairment mandates a full investigation. The careful, confidential collection of facts is critical to a smooth handling of this problem. The program director or a designated resource person should handle this sensitive matter. The program must have an expectation that pertinent observations be communicated (see section 5.C). Members of the program must be aware of the dangers and potential liability for not reporting witnessed behaviors (see section 4.C).

The most revealing information is likely to come from those who may be the most reluctant to report it, the resident’s family. They should be approached with concern for the potentially impaired individual as the foremost factor.

B. Intervention

When a reasonable suspicion of chemical impairment exists, plans must be made for confronting the resident in a process called intervention. Delaying this step until patient management errors are documented or explicit evidence of impairment such as workplace intoxication occurs is fraught with danger. Key points regarding intervention include:

1. Intervention should be conducted with the assistance of someone trained in the technique. The state medical society impaired physician’s program or the hospital committee on impairment are useful resources (see section 5.A).
2. The desired outcome of intervention must be established in advance. Generally the goal is to have the resident evaluated by a psychiatrist experienced in physician impairment and to comply with any recommendations made by the consultant. Having a number of options for assessment and treatment is useful to invoke a cooperative spirit. However, it is inappropriate for the impaired physician to design his or her own course of action.

3. There should be some means to bring pressure to bear on the individual to accept evaluation and treatment. This can include referral of the situation to the state licensing board.
4. There should be at least two interveners. They should include individuals aware of the circumstances leading to intervention who can be rational, sympathetic and non-judgmental.
5. Timing is important. Intervention should occur as early as possible, especially if a crisis has occurred. It should not be undertaken when the physician is intoxicated.
6. The setting should be quiet, private and non-threatening.
7. The atmosphere should be one of caring and genuine concern for the impaired physician.
8. It is important to provide hope to the impaired physician. It should be dear that the purpose of the intervention is to save the physician and his or her medical career. The expectation is a return to medical practice after evaluation and treatment.
9. Depending on the circumstances, the spouse or family may play a critical role in the intervention. This decision for inclusion is best left up to those experienced in physician impairment and intervention.

C. Initial treatment

The treatment plan for an impaired resident will be recommended by the consulted professional. Program directors should be aware of the following general points:

1. Initial inpatient treatment is generally recommended as it offers many benefits including: intense treatment to overcome denial, a better chance to discover possible coexistent illness such as psychiatric illness, and smoother transition of the physician into the role of care recipient
2. The usual length 9f time for the initial inpatient treatment is one month.
3. The inpatient treatment is often followed by several months of a transitional residence arrangement within the system of the treatment program.
4. The resident may be expected to attend various meetings including support groups, Alcoholics Anonymous, Narcotics Anonymous and private psychotherapy.
5. It should be noted that, in many areas, there are programs that specialize in the treatment of the impaired healthcare professional.
6. Other components of monitoring include making sure that the resident regularly attends group and individual therapy. Generally, a recovered physician will serve as a sponsor for the resident and assist in this monitoring.

D. Re-entry and monitoring

The legal aspects of this disability (see section 4) make it very likely that the impaired resident who is successfully treated will return to the residency program. It is appropriate for the program director to have honest discussions with the resident about the advisability for continued training in the specialty of emergency medicine with its known stresses. Such discussions should be well

documented particularly if it is mutually agreed that the resident will not continue in the program.

1. A written re-entry contract should be signed by the resident. Essential components of this agreement are outlined in Section 5.D.
2. The recommended monitoring period is usually several years.
3. It is appropriate to recommend repetition of previous training if believed necessary
4. Random drug screening is a standard part of monitoring the recovering physician. Anyone supervising this should insist that urine samples be collected under direct observation.

E. Relapse

Although the success rate of treatment is high, the program director and members of the program must constantly watch for warning signs of relapse. An eight-year follow-up study of chemically impaired physicians found that approximately one-half will have a relapse, with 22 months the average time to relapse. The following warning signs would prompt investigation for possible relapse:

1. Any noncompliance with the treatment plan. This includes missing appointments, meetings and failing to show for requested drug screening.
2. Resurfacing of denial-based thinking or behavior. The physician may minimize the problem or blame others or circumstances for the previous events.
3. Evidence of other substitute addictive behaviors.
4. Reappearance of the signs of impairment (see section 2).

Section 4. Legal and practical issues

The information contained in this section should not be considered legal advice. Consultation with a qualified attorney should be sought when considering these issues.

A. Chemical dependency as a disability

The Americans with Disabilities Act (ADA) which went into effect on July 26, 1992 defines a disabled person as one "with a physical or mental impairment seriously limiting one or more major life activities". A person with a history of impairment, or one who is perceived by others as having an impairment is also covered under the ADA. This broad definition includes physicians suffering from chemical dependency.

A person who is an alcoholic is an "individual with a disability" under the ADA. An alcoholic in recovery therefore is protected from discrimination. However, an alcoholic whose current use of alcohol impairs job performance or conduct may be disciplined, discharged or denied employment to the extent that this person is not a "qualified individual with a disability." An

individual who is currently engaging in the illegal use of drugs is not an “individual with a disability” under the ADA. Persons dependent on drugs, but who are no longer using drugs illegally and are receiving treatment for drug dependence or who have been rehabilitated successfully, are protected by the ADA from discrimination on the basis of past drug addiction.

State and federal handicap laws (ADA) mandate that every employer, including hospitals, ensure each recovering chemically impaired individual who applies for employment or reinstatement be afforded the same protection received by anyone with a handicap. Section 504 of the Vocational Rehabilitation Act of 1973 prohibits discrimination against otherwise qualified handicapped individuals. Violation of this act results in loss of federal funds to any institution discriminating against the disabled.

B. Drug screening

The Drug-Free Workplace Act of 1988 does not mandate drug testing, but encourages drug screening through a requirement that recipients of federal monies provide drug-free workplaces. The Drug-Free Schools and Communities Act Amendments of 1989 extends this act to all educational institutions receiving federal funds.

1. Urine testing does not violate one’s constitutional right to privacy or represent unreasonable search according to the Supreme Court, as these constitutional rights refer to governmental authority, not other nonfederal independent entities. The timing of drug screening should be clearly defined by the hospital or university policy. Possible timing of drug screening includes:

a. Pre-employment drug testing
b. For-cause: a suspicious behavior or complaint may trigger testing
c. Post-accident testing
d. Random testing: may be a specific component of a return to work agreement for individuals in recovery. Random testing without cause as part of an overall program for all individuals would be highly unusual.

2. Limitations of drug screening - The laboratory used must be extremely reliable. Urine screens are the most common modality employed. Each result must be confirmed by two separate methods as unconfirmed tests can results in false positives.

3. Common pitfalls include:

a. Improper labeling of specimens.
b. Specimen alteration by substitution or dilution. Viewing collection of the voided specimen is the preferred method. Trusting the suspected or recovering impaired physician to provide a true sample is inappropriate given the nature of this disease. Comparing specific gravity to expected norms can alert to problems.
c. Improper or no alternative procedure for confirmation of a positive test.

d. Failure to test for the right drugs. The sensitivity and specificity of the test must be understood. The drug in questions may not be part of the panel or the test's sensitivity may be inadequate for a drug present in only small amounts, such as Fentanyl.
e. Breaks in the "chain of evidence" may allow deception or mixing of specimens.
f. Inappropriate timing of drug screening. Random samples are best. Short notification of less than 12-24 hours is preferred. While monitoring recovery, testing on a fixed schedule less than twice a week is a set-up for deception.

4. A positive test means that the reported drug is present in the specimen. It does not establish that a dependency on that drug exists, nor does it by itself prove the drug was the cause of an impaired performance.

C. Reporting laws and liability

All fifty states have reporting laws of some variety. Some require that suspected impairment be reported to medical licensure/disciplinary boards, while others allow for referral to a medical society's impaired physician's committee which contract with the involved physician to participate in a recovery/rehabilitative program. As long as the physician continues to participate, the committee can refrain from involving the licensure board.

Some states have "whistleblower" laws that encourage reporting of impaired colleagues. Both civil liability and potential inclusion as a contributor in a malpractice case against the impaired physician may occur if one has knowledge and fails to report the suspected impairment. It is advisable to review the exact reporting laws in your state.

D. Resident contract and benefits

Residents should clearly be informed of the institution's substance abuse policies, as well as its procedures for dealing with impairment.

1. General contractual concerns:

a. A statement should be included addressing dismissal for cause: e.g., if treatment will not be accepted, or criminal conduct occurs.
b. The institution or program should consider the inclusion of a statement covering the use of drug screening and the implications of failure to submit to such screening.

2. Contractual concerns for the recovery period:

a. The hospital is not likely to prevail in rejecting the recovering physician for reinstatement if it cannot demonstrate objective evidence that a reasonable probability of harm will occur to either the applicant or patients.
b. Important items that should be covered in the r-entry policy are discussed in section 5.

3. Benefits:

a. Adequate leave time should be provided to address inpatient treatment if indicated. This should be established by contract.
b. Health insurance should cover inpatient and outpatient detoxification and psychiatric services; as many chemically dependent physicians are dually diagnosed with psychiatric illnesses. Coverage should be high enough to address the potential costs of inpatient services.
c. Disability insurance should be provided and should also address psychiatric disability.
d. Salary continuation during a leave of absence for treatment must be addressed. Disability insurance may not be activated for a substantial time period and the impaired physician is often in a precarious financial situation. Leave without pay may create major difficulties.

Section 5. Resources for residents with chemical dependency

A. State medical societies (In some areas this may apply to county medical societies)

1. State agencies protect the public by enforcing professional standards. They regulate the practice of medicine and are not necessarily established to assist the impaired physician.
2. Every state medical society has a stated policy and a committee to deal with physician impairment.
3. The state committees on the impaired physicians concentrate on problems with chemical dependence. However, these committees also handle major psychiatric disorders and ethical issues.
4. The impaired physician committee can help the resident deal with legal issues; i.e., serve as an arbitrator in the legal arena between licensure board and resident.
5. The state committee may be able to investigate and intervene if the hospital does not have a committee that serves this function. The state committee also supplements services offered by the hospital's impaired physician's program.

B. Role of the hospital committee

1. All medical facilities should have clear policies and programs to assist in reducing the use of alcohol and drugs by members of the medical staff and to enable staff with substance abuse problems to obtain appropriate counseling and treatment. The hospital administration should consider aid to impaired residents as a hospital responsibility. This approach is best implemented by an impaired physician committee which is also able to deal with residents' problems.
2. This committee can be incorporated by the medical staff bylaws or be an ad hoc committee.
3. Membership may be restricted, for confidentiality reasons, to attending physicians. Other potential members include administrators, hospital staff, housestaff, medical students, and family members. Legal counsel and psychiatrist should be included.

4. A member should be identified as a contact person for the residency program, preferably a psychiatrist who could also be involved in prevention oriented programs. This member might also serve as a liaison with the county and state impaired physician programs.
5. Each department should have its own resident wellness committee to assist in prevention as well as early identification of problems.

C. Model chemical dependency policy (See Appendix A)

Every hospital should have a written physician impairment policy including the following points:

1. A statement which recognizes chemical dependency as a medical disease.
2. A statement which indicates clinical practice is not compatible with active impairment.
3. A confidential resource person for both departmental and hospital committees with name and telephone number listed.
4. A statement indicating that it is the duty of all members of the department to report concerns about themselves and others to the resource person.
5. A clearly defined policy which describes the process for referral or self-referral of residents with chemical dependency or severe emotional problems.
6. A description of how the suspected impairment will be investigated. This should include evaluation by someone specializing in physician impairment on either the hospital committee or the state medical society committee.
7. The procedure to be followed if the resident is thought to be impaired. This should include a leave of absence and preferred treatment, usually inpatient with outpatient continuing care.
8. The appropriate services that are covered by the resident's health insurance or are financed by the hospital. This should be clearly stated in the policy as well as in the resident's contract.
9. The procedure to be followed if suspected impairment is not confirmed. This generally includes removing all references to the allegations from the record and return to work without prejudice.
10. A statement regarding return to work. This may be the re-entry policy or just refer to this policy.
11. A statement that the departmental policy is subservient to institutional policy and criminal statutes.

The residency program can use this list to create its own policy if the hospital policy is inadequate or has not been developed.

D. Model re-entry guidelines

Following successful treatment it is important that the residency program have a firm set of guidelines for the resident's re-entry into the program. This is accomplished by having the resident sign a re-entry agreement. Most state programs will provide you with a re-entry contract. In general the resident will agree to the following:

1. That the treating physician will document that the resident has received adequate treatment and that returning to residency is appropriate at this time.
2. That the recovery period will be supervised by a professional qualified in managing physician impairment.
3. To provide documentation of continued compliance with all aspects of the treatment and recovery program.
4. To abstain from all psychoactive substances including alcohol.
5. To review all prescription and over-the-counter drug therapy with the physician supervising recovery.
6. To submit samples for drug screening up on request. Random sampling with a short notification period (less than 12 to 24 hours) is best.
7. To regularly attend counseling sessions as recommended by the treating physician.
8. To meet with the residency director or assigned mentor on a regular basis to review progress.

It should be stipulated in the re-entry agreement that if any of these conditions are broken, the resident's employment will be terminated immediately without recourse to a grievance procedure. A statement should also be included as to who will bear the cost for monitoring.

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Appendix A: Model Chemical Dependency Policy

The following policy pertains to all resident and faculty physicians in the Department of Emergency Medicine.

1. Chemical dependence is a medical disease.
2. The safe clinical practice of emergency medicine is not possible by a person with untreated or relapsing chemical dependence. The care of patients while under the influence of alcohol, illegal drugs or while impaired due to improper self-medication is prohibited.
3. The Program Director of Emergency medicine or his/her designee shall be the confidential resource person on matters related to chemical dependence.
4. It is the duty of all members of the Department of Emergency medicine to report concerns doubt themselves or other members of the Department to the designated resource person.
5. The designated resource person will investigate any concerns regarding chemical dependency. This investigation may include blood or urine drug screening of the physician. All members of the Department must cooperate with this investigation and must accept a decision by the resource person for formal evaluation of chemical dependency or face immediate termination from the department.
6. Formal evaluation for chemical dependency will be initiated by the resource person by contacting the state impaired physician's program (or hospital impairment committee) which will then conduct the evaluation. All physicians undergoing formal evaluation will immediately be placed on a medical leave of absence.
7. If formal evaluation confirms chemical dependence, the physician will agree to all recommendations of the evaluating professionals. Immediate inpatient treatment will usually be necessary.
8. While under treatment the physician will remain on medical leave of absence until judged fit for work by the treating impairment professionals. Return to work shall be governed by the Chemical Dependence Re-Entry Policy.
9. Medical insurance coverage provided by the institution covers physicians for ____days of inpatient treatment and ____ days of outpatient/continuing care related to chemical dependence. The physician's salary will (will not) be paid during the medical leave of absence for a period of up to _____ days. Disability benefits will begin ____days after initiation of the medical leave of absence. All expenses connected with treatment of impairment beyond those covered are the responsibility of the physician.
10. If the investigation finds no evidence of chemical dependence, all references to this will be expunged from the physician's record and there will be immediate return to work without prejudice.
11. Departmental policy is subservient to institutional policy and criminal statutes.
12. The designated departmental resource person is: _________ and can be reached at:____________.