



## PFSP Perspectives: Alberta Doctors' Digest

### Hail physician: Dare to care

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#### Part I

As physicians we cannot separate ourselves from the greater culture of substance use and abuse around us. But our professional responsibility calls on us to be aware of our personal use of substances, risks for substance use disorders and responsibility to provide patient care as safely as we can. We also need to assist our colleagues in times of need.

In a time of self-reflection, perhaps ask yourself the following questions.

- ◆ Have you ever felt:
  - You should Cut down on your drinking?
  - People Annoy you by criticizing your drinking?
  - Bad or Guilty about your drinking?
  - A need for a drink first thing in the morning to steady your nerves or to get rid of a hangover (Eye opener)?

A score of two or greater is considered clinically significant for alcohol problems.<sup>1</sup>

If you scored less than two positives, consider these questions regarding risk:

- ◆ Are you drinking:
  - More often than you did five years ago?
  - More than you did five years ago?<sup>2</sup>
- ◆ Do you drink:
  - Five drinks or more on any one occasion during the month?
  - More than 14 drinks per week if a male or more than nine drinks per week if a female?

A physician in recovery, whom I respect very much, states risk simply, "No alcoholics worth their salt can stop at two."

How can physicians be at risk for substance use disorders? We are at risk biologically if our family or personal history includes disorders of mood, anxiety or substance use disorder.

Perhaps our risk follows our self-selection in medical school and into a culture of personal and professional perfectionism. This is a seductive peril. Work addiction can follow and, not uncommonly, substance use disorders can be a cross-addiction. We work to the exclusion of our families and friends and to those parts of ourselves that are truly interesting.

Perhaps the binge drinking included in medical school social events never stopped. For some of us, perhaps escalating substance use began as a way of dealing with fatigue and multiple stresses of training and practise. For others, repeated vicarious occupational traumas were triggers for initial substance abuse.

There is specialty-associated risk. Anesthetists, for example, are over-represented in most physician treatment programs.<sup>3</sup>

Themes of shame are prevalent in personal experiences of individuals with substance use disorders. Feeling bad about oneself adds to the risk.<sup>4</sup> "Our training makes us vulnerable to shame because of our perfectionism, the use of shaming as punishment for shortcomings as students and trainees (especially when there is judgment of a lack of dedication), a sense of hard work and a proper reverence for role obligations probably contributes further to the extreme sensitivity of doctors to shaming."<sup>5</sup>

It has been noted that "shame slows and prevents improvement."<sup>5</sup> Perhaps it delays seeking treatment.

Physicians experience social conditions unique to the profession, which potentially increase risks for substance use disorders.<sup>6</sup> Risks are also increased with access to the "candy store" including operating rooms, procedure suites, emergency departments where opiates like fentanyl and sufentanil are available, the sample cupboard and prescription pads (our own or through a collegial corridor consultation).

A physician's spouse permits me to share her observations during social events at medical meetings internationally. "The specialists of a certain age are all talking about the different benzodiazepines and hypnotics they take . . . and trust me, these medications are not prescribed by their personal physicians."

Through the Physician and Family Support Program (PFSP) experience, we know that some physicians chose to self-prescribe and abuse medications appropriate, perhaps, during their decade of graduation but not in the last 20 years.

I don't recall a section in training about self-pharmacology for the physician. Do you? An anesthetist told me, "I know these drugs inside out. I thought I was in control. I was not and I forgot that there was no one to rescue me with a ventilator."

Given the scrutiny to which we are subjected in our professional lives and fiduciary responsibilities regarding patient safety, it is sometimes perplexing why our struggles with substance use disorders are not identified and, in fact, are "missed" by our colleagues.

There are possibly two important factors:

1. Work is the last to go.<sup>7</sup> Unfortunately, by the time substance abuse is displayed in the workplace, the disease is well entrenched and the physician may have already lost family, friends and financial security.
2. A conspiracy of silence<sup>6</sup> has been maintained by colleagues and/or the interdisciplinary team.

For colleagues, it does not matter why it happened or what the specific percentages are of physicians who may suffer with substance use disorders during our lifetimes. It is important to be aware that once these illnesses are identified and intervened upon, the course of the illness is positively altered, particularly for physicians as compared to the general population.

Many colleagues are stunned when one of their own “suddenly” goes for substance use disorder treatment. Other colleagues may self-righteously say, “I knew something. . . .” But if colleagues did nothing, their professionalism is in question.

What might you look for in a colleague struggling from a substance use disorder? Check Part 2 in the November/December Alberta Doctors' Digest for advice from Dr. Lynn Hankes, former director of the Washington State Physician Health program. As well, the column will illustrate the vital support PFSP can provide for colleagues at risk. The program's goal is to enhance recovery.

Colleagues need to dare to care.

References available upon request.