REPORT OF SCIENTIFIC MEETING

David E. Longnecker, M.D., Editor

National Conference on the Impaired Physician

The 1973, the Council on Scientific Affairs of the AMA issued an article, published in JAMA, concerning the sick physician.[1] From this began a series of conferences initially concerned only with physicians, but, more recently, with the entire spectrum of health care professionals, the most recent of which was held in Chicago, Illinois, on October 8–11, 1987, immediately prior to the Annual Meeting of the American Society of Anesthesiologists. The ASA Committee concerned with this subject selected two members to attend and represent the ASA at this meeting. The following is their report.

It is worth noting at the outset that this conference attracts a far smaller and more diverse group of participants than does a typical anesthesia conference. Nurses, podiatrists, dentists, veterinarians, and physicians, along with psychologists and medical social workers, all attend, drawn to conference by a common interest in functional impairment in their peers. The majority of the major treatment centers for chemical dependency are represented, as are the various official licensing authorities for the various professions. This entire area of interest is so new (this is only the eighth such conference) that the meeting takes on the guise of a trading mart for new ideas and experiences. For example, each director of a state medical society program for physicians is forced, by the fact of different state laws, to approach his or her relationship with the State Board slightly differently. For those seeking a global answer to problems at a national level, this is a nightmare. For others, interested in examining numerous approaches to a multifaceted problem, this is an ideal situation. One has an opportunity to compare absolute confidentiality in reporting impairment to mandatory disclosure, using only the most straightforward index to define success: ease of case finding and number of individuals able to return to work. The trend of the last three conferences has been a maturation of experience with greater follow-up. From the follow-up information, it seems clear that chemical dependency is a relapsing disease. The majority of closely followed patients with this diagnosis will "slip," generally within the first 2 yr following initial therapy. As was pointed out, however, relapses come in all gradations, from brief, self-reported, isolated drug use to complete reversion to a pre-treatment lifestyle, with a return of massive denial and hostile withdrawal. The former, correctly dealt with, has little to do with eventual outlook, while the latter clearly has ominous implications. A conclusion from this information is that follow-up is the heart of any treatment process, not only to report the disease history, but because each individual physician or nurse *needs* follow-up to maintain recovery. There was nearly universal agreement that the minimum essentials for success were: 1) aftercare contracts; 2) urine, and/or breatholyzer, screening, and 3) regular attendance at AA or other similar 12-step programs.

Among the specialties of medicine, only anesthesiology is generally mentioned. Other specialties are part of nearly random background noise, while ours represents a recurrent tone. Most of the large treatment programs reported that about 15% of the physician admissions were from our specialty. Partly, this is due, as was noted in a recent article, to the fact that anesthesia looks for problems and, therefore, anesthesia finds problems. It is also due to the fact that anesthesiologists are much more likely to be addicted to potent opiates and, therefore, much more likely to receive inpatient hospitalization as initial therapy. The average age for anesthesiologists in treatment seems younger each year, with residency and post-residency years heavily represented. Return to work certainly is practicable, and naltrexone is frequently used, but a recommendation for specialty change for a junior resident with a narcotic addiction is not uncommon. Disturbingly, the average age of onset of drug use among these young physicians was about 14 yr inferring that attempting to start drug education in medical school is a bit late. One suggestion mentioned was to look at prevention as the "cure" to this disease. A recent literature theme, restated in the meeting, is that chemically familiar students are much more likely to be in the top quarter of their class than the bottom, akin to the fact that only star athletes seem to use drugs while playing. Fentanyl remains the drug of choice among anesthesiologists and, to date, there still remains no reliable affordable urine screen for the drug —although work is certainly in progress. One different theme of this conference was the fairly new emphasis on non-chemical impairment due primarily to psychiatric disease. This was in conjunction with discussion of the AMA-APA study on physician suicide, reported in summer of 1987.[2] While there is an enormous amount that is not known about this subject, there was encouraging information about physicians who experienced mental disturbance, received therapy, and were able to return to the active practice of medicine. In fact, for the majority of such doctors, the loss of practice time was quite minimal.

In summary, anesthesiology remains significantly over-represented among all specialists, as reported by major centers dealing with chemical dependency. Fentanyl is the drug most frequently abused, and it remains largely undetectable in urine screening. The average age of the impaired anesthesiologist is slightly over 30 yr, possibly distorted by the fact that 70% or so of most physicians in treatment are from University

settings. Obviously, this raises questions about nonuniversity situations that cannot be easily dealt with. Drug use, for recreational purposes, starts early in life. Except for the use of synthetic narcotics among anesthesia personnel, the apparent wave of the future among impaired physicians is cocaine, and, in this respect, physicians are becoming more like the "mainstream" of Americans.

C. F. WARD, M.D.
Department of Anesthesiology
University of California San Diego Medical Center
San Diego, California

L. MICHAEL NEWMAN, PH.D., M.D.
Department of Anesthesiology
Rush-Presbyterian-St. Lukes Medical Center
Chicago, Illinois

REFERENCES

1. AMA Council on Mental Health: The sick physician: Impairment by psychiatric disorders, including alcoholism and drug dependence. JAMA 223:684–687, 1973
2. AMA Council on Scientific Affairs: Results and implications of the AMA-APA physician mortality project. Stage II. JAMA 257:2949–2953, 1987