



## Physician Wellness and Substance Use-a Brief Review

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### Editorial

#### The issue

In recent years there has been an increased discussion of topics related to physician “burnout” and the interplay between this and the rising rates of suicide and substance use among physicians. According to recent surveys, the endorsed rates of burnout symptomatology range from 25% to 69% depending on specialty and these have increased from 2011 to 2015 [1,2]. When it comes to occupational related stress, up to 88% of physicians feel they are under moderate-severe stress [3]. The majority do not foresee our field changing for the better to allow for a work life balance and 6 out of 10 physicians would not recommend a career in medicine to their children [4].

#### Where does it stem from?

The main reasons behind burnout at an occupational level include loss of autonomy, increased paperwork requirements, lack of a work life balance, high number of hours required, declining reimbursement and increased debt. In addition, compassion fatigue, feeling that patients are prevented from getting best care, pressure from patient satisfaction and performance scores and the sense of hopelessness when it comes to alternative work options are all significant factors.

#### Consequences

Burnout can have a pervasive negative impact on all aspects of physicians’ lives. Professionally, it correlates with a decrease in quality of care, patient satisfaction, and productivity. It leads to an increase in error rates, malpractice, as well as increase in physician and staff turnover [5-8]. On a personal level it leads to dissipation of relationships and increase in depression, substance use and suicides [9,10].

#### Suicide

A Medscape poll from May 2018 revealed that 65% of physicians and 38% of medical students know or have known a physician who has attempted or died by suicide. Every year 1 million patients lose their physician to suicide with close to 400 physicians committing and this could be higher due to under reporting. Compared to the general population, both male and female physicians have higher rates of suicide and due to greater knowledge and better access to lethal means they have higher completion rate. Female physicians actually succeed at the same rate as their male counterpart whereas in the general population the rate of completed suicide is one fourth lower for females [11]. Importantly, the risk for suicide increases when mental

health conditions are unaddressed. A poll of resident physicians revealed 1 in 4 residents experience a major depressive episode during training compared to 7%-8% among similarly aged individuals. A similar number endorsed having had suicidal thoughts at some point during their training. Interestingly, among those who completed four sessions of web based cognitive behavioural therapy sessions, suicide ideations decreased to 50% indicating there are options for those that seek help. Most physicians however do not seek help but rather resort to lethal means or self-medication as a way to address stress, anxiety and mood symptoms.

#### Substance use

Physicians report rates of substance and alcohol abuse ranging between 10%-15% compared to 9% in the general population [12,13]. This increases the risk of inadvertent overdose or suicide by means of the substance. Alcohol is the most commonly abused however compared to the general population physicians have a higher rate of prescription drug abuse (opioids and benzodiazepines) [14,15]. Physicians in different specialties tend to use different classes of drugs -although alcohol is most popular throughout, only 10% of anaesthesiologists entered rehabilitation programs for it, with most of them having struggled with intravenous fentanyl, sufentanyl diverted from workplace or their patients [16]. A 2013 study in the Journal of Addiction medicine reported 69% of physicians abused prescriptions to “relieve stress and physical or emotional pain” [17]. A closer look at rates of substance abuse separated by medical specialty reveals that the highest incidence is found among emergency medicine, anaesthesiology and generally the same specialties that have endorsed high rates of burnout and stress in other surveys [13,15,18]. Interestingly, physicians that get help for substance use tend to excel in rehab with successful abstinence rates at 5 years of up to 80% compared to 20% in the general population [19]. This is largely attributed to the state Physician Health Programs (PHPs) available to licensed professionals that provide resources, support and monitor distressed individuals while cooperating with medical boards in advocating for the right to practice while under their care. A coexisting ongoing mental health condition does increase the risk for relapse and even overdose in the setting of opioids [20].

#### Early recognition

Recognizing signs of depression or substance use in a fellow physician is challenging and confronting or reporting suspicion can make for a difficult conversation. An addicted physician may continue to function at a high level with no behavioural changes [18].

In recent years, increased paperwork requirement and pressure to see more patients back to back compounded by the dissipation of the physician lounge and physician-only events have resulted in physicians being estranged from their colleagues and loss of close personal relationships between colleagues. Any subtle signs or changes in behaviour from baseline may not be easily recognized. Also, colleagues may not be inclined to report what they perceive as unusual behaviour to their supervisor or the board because of fear that their co-worker may be punished in the face of inconclusive evidence. Some may also not know who to report within a corporation or what steps need to be taken. Sometimes co-workers or family may even participate in what Berge et al. calls a “conspiracy of silence” in effort to protect the family or co-worker from economic and professional ruin [18].

### Barriers to seeking help

One challenge in regard to substance abuse among physicians is that by the time it is diagnosed it is already advanced to a “use disorder” and the opportunity for early identification and intervention has been missed [18]. The same is true for mental health hence accounting for the high suicide rates. There are several reasons behind this help avoidance phenomenon aside from the fact that physicians tend to endure emotional pain much longer than physical pain. The culture of medical practice does not historically place an emphasis on personal wellbeing and most physicians fear the stigma and consequences attached to revealing such issues-for example discrimination in medical licensing, revocation of hospital privileges and prejudice against professional advancement and overall reputation. There is also a component of time and money as most physicians that seek help, must do so far from their communities and prefer to fund treatment out of pocket rather than through insurance. The majority of disability coverage limit claims for substance use or mental health to up to 24 months.

### PHPs and more challenges to seeking help

As previously mentioned, PHPs can potentially be of benefit to licensed physicians. They are led by fellow physicians and provide resources and an extra layer of advocacy to the board. It involves self-accountability which translates to a higher abstinence rate and continued ability to practice medicine while in remission. Physicians in distress can voluntarily reach out to their state PHP before their condition becomes advanced and seek treatment and resources. Random urine screens and compliance with activity and group requirements provide assurance to PHPs. Unfortunately, there is no assurance that agreeing to voluntary treatment and monitoring will prevent punishment and discrimination from the medical licensing boards. Physicians fear that their current oversight system is defaulted to punitive measures against the individual reaching out for help rather than the same compassion and care they provide to patients dealing with substance use disorders. Some boards, instead of working with the PHPs to ensure physicians are able to practice under careful monitoring, resort to license revocation and suspension. Punitive models tend to be associated with increased physician suicides [21]. With the society view shifting from addiction as being a moral failure that deserves punishment to a disease that can be treated it is expected that addicted physicians be regarded in the same light.

### What can be done

Current literature points to the loss of autonomy experienced by physicians working in large health systems to be the main driver of

physician burnout in these settings [22]. Health care organizations should adopt a “distributive leadership model” allowing physicians to actively participate in health care governance. Sharing administrative and policy leadership positions with non-physician administrators provides physicians with more control over their practices and hence leads to less stress, frustration, and sense of helplessness [22]. Organizations should also provide physicians with sufficient administration time, resources, training, and administrative support.

There are a couple of things we could do in light of the rising rates of substance use and suicide that go undetected in the physician population. First step would be to work on erasing the stigma associated with endorsement of high level of occupational stress and burnout. A team approach needs to be undertaken to discuss the topic and strategies to increase physician wellness when concerns are initially expressed. This can occur in team meetings, retreats, social gatherings etc. We should also make it easier for physicians who start experiencing mood distress and problematic substance use to seek help in a confidential and nonpunitive way. Reporting guidelines need to be reconsidered and a consensus among medical boards needs to be created. At a medical community level, we need to create stronger social supports by fostering a sense of community among physicians. We should encourage each other to seek help when distressed and foster relations between colleagues in order to identify when someone is struggling. Larger hospital systems should also have internal policies and guidelines to identify and address the issues early on (before medical boards get involved and patient care is impacted) and connect with PHPs prior to becoming a fully developed problem.

### References:

1. Gazelle G, Liebschutz JM, Riess H (2015) Physician burnout: coaching a way out. *J Gen Intern Med* 30: 508-513.
2. Peckham C (2015). *Medscape Physician Lifestyle Report 2015*. Medscape.
3. VITAL WorkLife & Cejka Search (2015) *Physician Stress and Burnout Survey*.
4. *physician outlook and practice trends* (2013).
5. Shanafelt TD, West C, Zhao X, Novotny P, Kolars J, et al. (2005) Relationship between increased personal well-being and enhanced empathy among. *J Gen Intern Med* 20: 559-564.
6. Firth-Cozens J, Greenhalgh J (1997) Doctors' perceptions of the links between stress and lowered clinical care. *Social science & medicine* 44: 1017-1022.
7. Shanafelt TD, Bradley KA, Wipf JE, Back AL (2002) Burnout and self-reported patient care in an internal medicine residency program. *Ann Intern Med* 136: 358-367.
8. Williams ES, Skinner AC (2003) Outcomes of physician job satisfaction: a narrative review, implications, and directions for future research. *Health care management review* 28: 119-139.
9. Schernhammer E (2005) Taking their own lives-the high rate of physician suicide. *N Engl J Med* 352: 2473-2476.
10. Drummond D (2015) Physician burnout: its origin, symptoms, and five main causes. *Fam Pract Manag* 22: 42-47.
11. *Highest Suicide Rate by Profession*. New Health Guide.
12. Hughes PH, Brandenburg N, Baldwin DC, Storr CL, Williams KM, et al. (1992) Prevalence of substance use among US physicians. *Jama* 267: 2333-2339.
13. McLellan AT, Skipper GS, Campbell M, DuPont RL (2008) Five year outcomes in a cohort study of physicians treated for substance use disorders in the United States. *Brmj* 337: a2038.
14. Merlo LJ, Gold MS (2008) Prescription opioid abuse and dependence among physicians: hypotheses and treatment. *Harv Rev Psychiatry* 16: 181-194.

15. Gourlay DL, Heit HA (2008) Pain and addiction: managing risk through comprehensive care. *J Addict Dis* 27: 23-30.
16. Talbott GD, Gallegos M, Wilson PO (1987) Impaired Physicians Program. *JAMA* 257: 2927-2930.
17. Cottler LB, Ajinkya S, Merlo LJ, Nixon SJ, Abdallah AB, et al. (2013) Lifetime Psychiatric and Substance Use Disorders Among Impaired Physicians in a Physicians Health Program: Comparison to a General Treatment Population. *J Addict Med* 7: 108.
18. Berge KH, Seppala MD, Schipper AM, editors (2009) *Chemical dependency and the physician*. Mayo Clin Proc: Elsevier.
19. Kliner DJ, Spicer J, Barnett P (1980) Treatment outcome of alcoholic physicians. *J Stud Alcohol* 41: 1217-1220.
20. Domino KB, Hornbein TF, Polissar NL, Renner G, Johnson J, et al. (2005) Risk factors for relapse in health care professionals with substance use disorders. *JAMA* 293: 1453-1460.
21. Shore JH (1987) The Oregon experience with impaired physicians on probation: an eight-year follow-up. *JAMA* 257: 2931-2934.
22. Southwick FS, Southwick SM (2018) The loss of a sense of control as a major contributor to physician burnout - A neuropsychiatric pathway to prevention and recovery. *JAMA Psychiatry* 75: 665-666.