Study Charts Program for Physicians in Recovery

BY DOUG BRUNK
San Diego Bureau

CORONADO, CALIF. — Of 104 physicians in New York state who were admitted to substance abuse treatment programs between 2003 and 2004 and were monitored for a mean of 41 months by the state's Committee for Physicians' Health, only 9 (9%) were discharged because of noncompliance with program expectations.

That might spell success at first glance, but at the annual meeting of the American Academy of Addiction Psychiatry, Dr. Marc Galanter emphasized the need for more research to optimize treatment outcomes for physicians in recovery.

"There are still a number of issues to be considered," said Dr. Galanter, professor of psychiatry and director of the division of alcoholism and drug abuse in the department of psychiatry at New York University, New York. "One is the need for prospective study—following the treatment contemporaneously—which we have yet to see," he said. "Another is to better understand the role of medication."

Buprenorphine inevitably will be used more widely; however, the question of whether physicians should be allowed to practice while taking opioid maintenance therapy is likely to become a political issue at the state level, he said.

He also recommended that a more active role for cognitive-behavioral therapy "be studied because this is a modality that is currently regarded as essential to effective treatment."

Dr. Galanter based his remarks on results from a study he led that sought to provide an independent evaluation of the oversight and rehabilitation of 104 substance-abusing physicians who had completed their monitoring period by the New York State Committee for Physicians' Health (CPH). About 30% of physicians who enroll in the CPH program receive at least 28 days of inpatient treatment. Components of ambulatory management include workplace monitoring, 12-step program attendance, and random urine toxicologies.

Predictors of relapse included past use of cocaine, unemployment at time of program admission, and a greater mean number of urines tested.

The researchers, who were not affiliated with CPH, selected the 104 records at random (Am. J. Addict. 2007;16:117-23). The mean age of the study participants was 42 years, most (96) were male, about half (51) were married, and 66 were employed as physicians at the time of admission.

More than half (59) had a history of substance abuse treatment, and 38 had attended 12-step meetings before program admission. In addition, 33 were in psychotherapy of some sort prior to admission, and 27 were taking psychiatric medications, primarily antidepressants.

"This underlines the importance of psychiatric input and oversight in these programs," said Dr. Galanter, who is also the editor of the journal Substance Abuse.

The most common primary substance of abuse was alcohol (38), followed by prescription opiates (35).

The top five medical specialties represented were anesthesia (22 physicians), internal medicine (11), family medicine (10), obstetrics and gynecology (9), and pediatrics (8). "Anesthesia is overrepresented among impaired physicians because of access to addictive agents, and because in some cases people go into anesthesia attracted to the idea of handling and having access to opioids," Dr. Galanter said.

On average, the overall period of treatment and monitoring was 41 months, and 30 participants required inpatient hospitalization at study entry.

Fifteen physicians did not want to attend 12-step meetings but were pressed by counselors to do so. Of those, nine later went. "The outcome of those pressed to go was not significantly different from that of the other patients," he said. "So apparently the coercive nature of the treatment in that regard was not compromising to the outcome."

Of the 104 patients, 38 relapsed as confirmed by urine toxicology or by confirmation from an informed source. Even under good circumstances, some relapse is inevitable before the patient is stabilized, Dr. Galanter said. However, one complication is that physician impairment programs are responsible for serving large numbers of physicians.

"The pressure of the needs of public health that they experience puts them in a difficult position," Dr. Galanter said. "My impression is that it's remarkable how effective they are in balancing the physician needs against the demands of the general public."

Predictors of relapse included past use of cocaine, unemployment at the time of program admission, a greater mean number of urines tested, and a longer length of program involvement.

Nine patients were discharged for noncompliance with program expectations. "They essentially lost the option of practicing medicine," he said. "Relatively speaking, this gives you an idea of a very good outcome, considering that full compliance is essential to success in this program."

Dr. Galanter said he considers the 12-step component of the CPH program essential to overall success. Given the need for full abstinence before returning to practice, he pointed out, these spiritually oriented 12-step programs are uniquely valuable in ensuring an optimal outcome.

"It's really remarkable what transformation many of these physicians experienced over the course of rehabilitation," he said. "What we don't know is how we can compare recovery of this kind to recovery based on opioid replacement or on the variety of medications that we're going to be using.

"It's an issue of tremendous importance in terms of our investigation of future psychosocial modalities." ■

Some Medical Students Admit Club Drug Use

BY DOUG BRUNK
San Diego Bureau

CORONADO, CALIF. — One out of six medical students at a private Midwestern medical school reported prior use of at least one club drug, results from a survey found.

"Therefore, physicians should be cognizant, when treating medical students, physicians, or other health care workers, that we are not excluded from substance abuse," Dr. Alex Horowitz said in an interview after presenting the study during a poster session at the annual meeting of the American Academy of Addiction Psychiatry. "The same principles should be applied when assessing health care workers for substance use as when assessing the rest of the population."

In what he said is the first study of its kind, Dr. Horowitz and his associates asked 340 students at a private Midwestern medical school to complete an anonymous survey about their use of and attitudes about club drugs. Generation I club drugs were defined as cocaine and LSD; generation II club drugs included methylenedioxymethamphetamine (also known as Ecstasy), methamphetamine, gamma hydroxybutyrate (GHB), Rohypnol, ketamine, and dextromethorphan.

Nearly half (46%) of the respondents were first-year medical students, 34% were second-year students, and 20% were third-year students. The overall prevalence of lifetime club drug use was 17%, with Ecstasy and cocaine as the most popular agents of choice (12% and 6%, respectively), reported Dr. Horowitz, psychiatric unit chief of the methadone treatment program at Bellevue Hospital Center, New York.

He noted that the prevalence of medical students' lifetime Ecstasy use was similar to that of their peers in the general population, as reported in the National Institute on Drug Abuse's 2004 "Monitoring the Future" survey. However, the use of generation I club drugs by medical students was lower than that of their peers in the general population, an association that remains unclear.

Compared with students aged 21-25 years, those aged 26 and older were more likely to have used the generation I drugs (cocaine, 16% vs. 4%, respectively; LSD, 14% vs. 2%). However, no relationship was found between age and use of generation II club drugs in general.

Students who reported never using club drugs perceived regular cocaine use as posing the greatest risk to health (89%), followed by Ecstasy (72%).

For students who reported lifetime use of at least one club drug, the perceived risk of using cocaine and Ecstasy regularly was significantly lower (75% and 58%, respectively). The use of club drugs did not differ between men and women, but women found them to be generally more harmful than men did.

"There appears to be a correlation between knowledge/perceived harmfulness of each drug and drug use," said Dr. Horowitz, of the department of psychiatry at New York University, also in New York. "Therefore, increasing formal medical student education on club drugs would help them be aware of dangers of club drug use, and also would help them know how to then assess and treat their patients who use club drugs."

A greater number of students thought it would be necessary to revoke the license of physicians who were currently using generation I club drugs than those who were using generation II club drugs (27% vs. 20%, respectively). Women were more likely than men to endorse license revocation for physicians currently using generation I club drugs (33% vs. 22%, respectively) and for those currently using generation II club drugs (26% vs. 15%, respectively).

Dr. Horowitz acknowledged that the self-reported nature of the study is a limitation. "Some medical students may underreport their drug use for fear of having anyone find out, despite the anonymity of the survey," he said.

Another limitation is that the data were collected in a classroom setting, which means that participants were limited to students more likely to attend class. However, the survey was administered in a class that was considered mandatory. ■

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