

# Research Sought on Physicians' Addiction Recovery

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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 treat-

ment 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. Dr. Galanter advised 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.

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).

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.

"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." ■

## 66% of patients on lipid-lowering therapy have at least 1 lipid outside current recommendations<sup>1</sup>

That is nearly 2 out of every 3 patients who are currently taking lipid-lowering therapies. In fact, this same analysis found that over 25% of patients had 2 or more lipid abnormalities (LDL-C, HDL-C, or TG) outside current NCEP ATP III guidelines.<sup>3,1</sup>

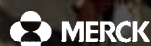
<sup>3</sup> NCEP ATP III=Third Report of the National Cholesterol Education Program Adult Treatment Panel.

## Evidence has shown that each of the 3 major lipids contributes to CV risk<sup>2-4</sup>

High LDL-C has been extensively and conclusively linked to increased CV risk.<sup>2</sup> Evidence also suggests that low HDL-C increases CV risk, regardless of LDL-C level.<sup>2</sup> Elevated TGs may also compound CV risk, independent of LDL-C and HDL-C levels.<sup>3,4</sup>

References: 1. IMS Health. *Anonymized Patient-Level Data Custom Analysis*. July 2004–June 2006. 2. Kannel WB. Status of risk factors and their consideration in antihypertensive therapy. *Am J Cardiol*. 1987;59:80A–90A. 3. Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults. Executive summary of the third report of the National Cholesterol Education Program (NCEP). Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults (Adult Treatment Panel III). *JAMA*. 2001;285:2486–2497. 4. Nordestgaard BG, Benn M, Schnohr P, Tybjaerg-Hansen A. Nonfasting triglycerides and risk of myocardial infarction, ischemic heart disease, and death in men and women. *JAMA*. 2007;298:299–308.

To learn more about how each of the 3 major lipids affects CV risk, visit [www.TotalLipids.com](http://www.TotalLipids.com).



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