The Impaired Health Care Professional

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DR STEVEN MISZKIEWICZ *(Chief Resident, Waukesha Family Practice Residency Program, Medical College of Wisconsin)*: Today the Department of Family Practice Grand Rounds, Medical College of Wisconsin, is a discussion of the impaired health care professional. The case report is that of a nurse who was admitted to our teaching service for care for chemical dependency. The subsequent discussion at morning report regarding the medical, psychological, and legal ramifications of her case revealed considerable confusion and division of opinion regarding care of the impaired professional. Our discussion of this case will attempt to clarify many of these issues and increase overall awareness in recognizing and approaching one of the most underdiagnosed diseases in medicine: chemical dependency.

CASE PRESENTATION

DR ELIZABETH ZIETLOW *(Second-Year Family Practice Resident)*: Mrs K., a 35-year-old licensed practical nurse, was admitted to the chemical dependency treatment unit following an intervention by her physician employer. She was working as the head nurse in a three-physician office, where she had been for several years; she supervised all of the other office staff there.

On the weekend before admission, Mrs K. called in a prescription for herself to a local pharmacy, saying on the telephone that she was Dr S. The pharmacist was suspicious of the voice, and contacted Dr S., who confirmed that no prescription had been ordered by her. Dr S. recognized Mrs K.'s name as that of the head nurse of another area physician, whom she contacted with the information. The employing physician then called the physician assistant, who also worked within the clinic, as well as a chemical dependency counselor from outside the clinic. They arranged an intervention with Mrs K. on the following Monday when she arrived at work. Following the intervention, Mrs K. agreed to enter a chemical dependency treatment unit rather than lose her job.

Initially, Mrs K. admitted to using one or two oxycodone and four butalbital compounds per day for the past year for tension headaches. She denied other drug use as well as any alcohol use. There were no prior identified problems with substance abuse. The remainder of her medical history revealed multiple somatic complaints, including headaches and abdominal pain, but was otherwise unremarkable. She also described feelings of depression with loss of appetite, insomnia, easy fatiguability, decreased libido, and feelings of worthlessness, but she denied suicidal ideation. Mrs K. identified many stressors in her life, including difficulty in her marriage, feeling inadequate on the job, a recent death in the family, and problems dealing with her three children. She admitted to no prior problems with depression, and had never received counseling or psychiatric help.

Physical examination at the time of admission was unremarkable. Laboratory data were significant only for a positive urine drug screening test for benzodiazepines.

Mrs K. entered intensive inpatient treatment for chemical dependency. At first she minimized her problems with drug use and focused on her abdominal pain. More facts came to light during a meeting of the employees at her office, however, which was held to help them work through what had happened to Mrs K. In retrospect, each one of them now recognized situations involving Mrs K. that had been ignored or downplayed. These included uncharacteristic poor driving, slurred speech, canceling or forgetting engagements, and frequent complaints of pain and problems at home. On occasion Mrs K. would bring two prescriptions to a physician for signature, one made out for a patient and the second blank, saying that Mrs K. would fill it in later. Medications were noted to be missing from the locked cabinet, or if they had been signed out, the person whose initials were on the sign-out denied knowledge of having done so. The employing physician also called some of the area pharmacists, who gave her a list of several psychoactive medications that had been "prescribed" for Mrs K.

All of this information was conveyed back to the chemi-

Submitted July 21, 1989.

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cal dependency unit physician, who confronted Mrs K. with the new facts. She then revealed more about her substance use, admitting to taking 8 to 12 pills per day of narcotics, pain relievers, and antidepressants for at least 3 years. She became able to express shame about her chemical dependency, stating that she "should have known better." She also felt guilty about involving her co-workers. By the time of discharge the counseling team felt she was progressing well in treatment and that she would be successful in outpatient follow-up. After discharge, however, she failed to comply with the treatment plan and was dismissed from her employment. She was then lost to follow-up for several months.

CHEMICAL DEPENDENCY ISSUES

DR DAVID BENZER *(Addictionologist and Director, McBride Center for the Impaired Professional, Milwaukee Psychiatric Hospital)*: The patient presented here, Mrs K., illustrates classically many of the issues involved in working with substance abuse and health care professionals. From the prolonged delay in diagnosis, to the intervention finally performed, to her entry into treatment, Mrs K.'s case is typical. Her eventual outcome, however, falls into that of the minority of professionals whose treatment initially is unsuccessful.

Prevalence

The American Nursing Association has estimated that 6% to 8% of nurses are affected by chemical dependency,[1] although the number may actually be much higher. Nurses appear to be at high risk for many reasons. Professionally, the stresses and demands of the nursing profession are great, including role strain in the changing nursing profession, disruptive life style from working different shifts, difficulty setting limits on the demands that others make of them, and suppression of their feelings toward patients and toward other professionals. Easy access to addictive medications, coupled with a false sense that the nurse is somehow in control of his or her reactions to addictive drugs, leads to an increased risk of using such drugs routinely. Family characteristics of nurses may also place them at risk; a family history of alcoholism exists in up to 80% of nurses.[2] In addition, female nurses have higher rates of marriage to alcoholics than most other groups of women do. Ultimately, the overwhelmed coping skills in a nurse who may be genetically at higher risk to begin with, and who has easy access to mood-altering chemicals, may set the stage for the progression of chemical dependency.

Recognition of Chemical Dependency

Chemical dependency in health care professionals presents insidiously. Professional life is often the last area of their lives in which the consequences of substance abuse become manifest. The usual progression is for the effects to be felt first within the family, then in the larger social circles of the community, and lastly in the workplace. By the time the problems have become apparent at work, the individual is already in the late stages of substance abuse, and the abuse has typically been occurring for many years. For nurses, it is estimated that 5 to 10 years of substance abuse have passed before manifestations are evident on the job. For physicians, this period is often even longer. Chemically dependent health care professionals still have a deep commitment to their work and feel strong ethical pressures to perform well on the job. In addition, the workplace is often the source of access to medications, and in the later stages of the disease they will work to protect this source.

Early signs of impairment in nurses that become manifest at work include tardiness and absenteeism, changes in behavior, irritability with co-workers and complaints of "personality conflicts," and manipulation of co-workers to cover errors and time off. Later, the nurse may be noted to be eager to give medications to patients and to control the keys to the narcotics cabinet. Medication errors and discrepancies in counts become more frequent. The appearance of the person may deteriorate, and behavior problems become more pronounced. The end stages of impairment, if not identified and dealt with, include frequent moves by the nurse to different floors, hospitals, or even cities to avoid confrontation. Termination of employment by the employer for absenteeism or for other reasons, without the abuse problem being mentioned, is not uncommon.[3] This pattern of geographic escapes may progress until the chemical dependency results in a gross act of negligence. In Mrs K.'s case, the manifestations of substance abuse were rife; particularly notable was the manipulation not only of other nurses in the office, but also of her physician employers.

Denial plays a prominent role in the response of fellow workers to the substance-using professional, as was also strikingly evident here. Common features are the enabling actions, including ignoring such obvious signs of impairment as poor driving, slurred speech, and disheveled appearance. Also, camouflaging the impaired professional's behavior on the job by covering up absences and overlooking poor documentation of the signout of narcotics enables the problem to continue. The result of these behaviors on the part of fellow workers is that a "conspiracy of silence" develops, which, unfortunately, allows the disease to progress.

The first step in helping the professional who is chemically dependent is, obviously, the identification of the prob-

lem. The steps taken after that are approaching the individual through an intervention, having the individual undergo evaluation for chemical dependency, and helping him or her enter a treatment program, eventually planning for a return to professional life. Long-term monitoring of the recovery is essential, both to help prevent relapse and to facilitate reentry to the profession.

The Intervention

Once the problem of substance abuse has been identified or suspected, handling it with both the impaired employee and other employees involved must be done expediently and sensitively. The specific approach to the impaired professional is called *intervention*, and has been defined as "a structured method of penetrating the delusional system of chemically dependent persons to help them become aware of reality and to become willing to accept help." [1] The level of denial in the health care professional who is chemically dependent may be extreme, in that the threat of loss of both the caregiver function and professional status is profound. Thus, an approach that has been thoroughly prepared is necessary.

The three elements of preparation for an intervention are documentation of work performance, selection of the intervention team, and research into the specific treatment options to be presented.[4] Performance documentation needs to be thorough and specific, with as much detail and substantiation as possible. Sensitivity to confidentiality while obtaining this documentation, however, must also be a priority. The team should be carefully selected, and will often include the immediate supervisor, a trusted coworker who manifests insight into this individual's problem of chemical dependency and who has observed and can corroborate the facts being presented, and possibly a professional from a treatment program, if such help is available. This group should meet before the intervention to discuss how it will be handled. The options for treatment, including some knowledge about insurance coverage and the logistics of getting the person into a program, as well as the outcome should the individual refuse treatment, should be decided ahead of time. In many cases of interventions with health care workers, it is the threat of job loss that ultimately motivates them to seek help.

The intervention should initially be scheduled with the professional as simply a meeting with the supervisor, rather than announcing that an intervention is going to take place. At the meeting, those present share their concerns about the person's clinical practice, citing documented behaviors. Critical to this approach is being nonjudgmental and caring of the welfare of the person being confronted, placing concern about that person's long-term health and career before all other concerns.[5] Understanding of the anticipated denial is also important. At the conclusion of the meeting, the professional is asked to submit to an evaluation for chemical dependency. The impaired professional should be reassured that his or her job is secure if treatment recommendations are accepted.

Follow-up

Following the intervention, the professional may be at increased risk for suicide until entry into the treatment program can be accomplished. Thus, if entry cannot be immediately effected, a close friend or family member should remain with the person at all times until entry into treatment.

Resolution following the intervention should include closure for the team members who participated in the intervention by providing an opportunity to express their feelings. In addition, state agencies may need to be notified about the professional. Requirements about notification, as well as actions taken by an agency as a result of the notification, are quite variable from state to state and among different professional organizations.

For supervisors or co-workers in situations in which interventions are difficult, other options for helping the impaired professional would include notifying the employee assistance program, if one exists at the employee's workplace; involving a peer-assistance program of the state professional association, again, if one exists; or contacting for assistance professionals working in the area of addiction in local treatment programs.

In this particular case, the intervention was done by the physician employer, together with the physician assistant who worked closely with the head nurse (the patient), and a substance abuse counselor. Substantiation of the impairment, such as was known at the time, was detailed to the patient, and an ultimatum was presented to her to receive help for substance abuse or to lose her job. Mrs K. responded by agreeing to enter a chemical dependency treatment program.

Many features of treatment of health care professionals are different from that of the general public, and have led to specialized treatment programs involving only professionals. In common are the need for specific chemical dependency programs that utilize a 12-step approach such as found in Alcoholics Anonymous, and the need for total abstinence from all mood-altering drugs. Treatment programs specializing in treating professionals, however, circumvent some problems this group may experience. Health care personnel often have difficulty in accepting the patient role, and may tend to focus on helping other patients instead of dealing with their own illness. A prime example is physicians who set up "walk-in clinics" in their rooms in the treatment center for nonprofessional patients

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who are willing to accept the free advice that is happily dispensed by the "doctor-patient." Treatment programs geared toward the professional patient help to eliminate this evasive tactic. Also, health care professionals tend to intellectualize their problems, creating additional barriers to treatment. The denial inherent in such behaviors may be difficult for nonprofessional peers to see through. Even deeper may be the guilt and shame experienced by health professionals, with difficulty recognizing or admitting either potential or real harm that may have come to patients in their care, as well as fear of rejection by their peers. These needs appear to be better addressed in a treatment center that specializes in treating professionals. Mrs K. went through many stages of working through denial, shame, and guilt while in treatment, but may have been hampered by not being in a professionals' program.

Follow-up for the professional must continue over several years. Usually an intensive schedule of meetings and support groups is arranged for the first 6 to 12 months, followed by additional support sessions to complete a minimum of 2 years of monitoring and aftercare. Integral parts of this follow-up may include the use of random urine drug screening on a frequent basis, and regular visits with the addiction specialist managing the case. This highly structured aftercare approach maximizes the recovery of the professional and facilitates reentry by objectively documenting recovery through regular therapy visits as well as the urine drug screenings.

In returning the health care professional to work, some important initial considerations are to specify clear job expectations, provide a stable work shift, minimize access to controlled substances, and prepare other employees for the individual's return. Regular performance monitoring and reviews should be carried out through the individual's supervisor.

Success rates for treatment of professionals through this type of program have been good, with 75% to 80% recovery at 3 years.[6,7] Unfortunately, Mrs K. does not yet appear to be one of these success stories.

FAMILY MEDICINE ISSUES

DR JUDITH PAUWELS *(Assistant Professor, Department of Family Practice)*: I participated in the initial morning rounds presentation of this patient, where many issues were raised for which no entirely satisfactory answers could be found. Why was this patient not recognized sooner? If suspicions had been raised sooner, how should an office employee be approached? What special issues arise in working with a health care professional who is chemically dependent? Dr Benzer has given us some excellent insights into these questions.

The issues here are especially pertinent for us as family physicians, fulfilling multiple roles in our professional lives. The health care professionals around us are not only our co-workers, but are often our patients coming to us for care; they may also be social acquaintances or even our friends outside the work environment. If, as multiple studies have indicated, we poorly identify substance abuse among our patients as a whole,[8] how much more difficult is it for us to detect it in those with whom we share more intimate relationships?

As Dr Benzer indicates, much of the need in appropriately identifying a health care professional who is impaired is knowing the warning signs and having the sensitivity in our observations of those around us to identify them. Tools that may help, particularly in our roles as professional managers in our offices, would include periodic reviews with our employees in which warning signs of impairment are specifically addressed. Clear policies and procedures regarding job performance and disciplinary actions should be written in an employment manual given to all employees. Drug control procedures in our offices should be reviewed regularly. Perhaps most important, education about chemical dependency should be provided for all of those working in health care fields, including those in outpatient settings.

LEGAL ISSUES

I would like to ask Dr Benzer to clarify some legal questions. If we were to identify a health care professional, be it a nurse or another physician, as possibly chemically dependent, are there legal obligations for us to report the potential problem to state medical associations or other bodies? Are there any penalties for not reporting suspected impairment? Would we violate confidentiality in reporting an impaired professional if knowledge of the chemical dependency arose in the context of a physician-patient relationship?

DR BENZER: No legal obligation exists in the state where this patient is licensed to report substance abuse to a state association or other regulatory agency. Reporting requirements for chemically dependent professionals do vary from state to state and among professions, as noted previously. There are state associations that take an active role in helping impaired professionals get evaluation and treatment, even when mandatory reporting to regulatory agencies is not required. In Wisconsin, for example, the state medical society offers a voluntary and anonymous reporting, intervention, treatment, and monitoring service for physicians, which has been very successful over the past decade in getting help for physicians suffering from chemical dependency as well as from other causes of impairment.

When no legal obligation to report exists, there are no penalties for failing to report.

The issue of confidentiality becomes complex when the involved health care worker has admitted substance abuse in the context of the physician-patient relationship. The confidentiality implicit in that relationship must be counterbalanced with the reporting regulations in place on a state-by-state basis in deciding how to proceed.

DR PAUWELS: Physicians will need to contact the applicable professional association in their state for assistance when making decisions about reporting an impaired professional with whom they have contact. The primary ethical obligation remains action based on caring for the professional's career as well as for the well-being of patients and other professionals with whom the person works.

PHYSICIAN IN AUDIENCE: Dr Benzer, is it known whether the care provided by an impaired health care professional is substandard? Have major errors been identified in the care provided by most of these individuals by the time they are entered into treatment programs?

DR BENZER: Usually the workplace is the last area of their lives in which impairment manifests itself, as mentioned. Most professionals continue to pride themselves in their work, and work hard to protect this area. Substandard care, if it occurs at all, is a late event in the progression of the disease in almost all cases. Although the issue has not been thoroughly studied, it appears that most of these individuals do not commit major errors in their work during the time prior to entering treatment.

DR MISZKIEWICZ: Thank you all for attending this Grand Rounds. I hope that this discussion will help to increase our level of sensitivity to the potential for chemical dependency among those who are often working side-by-side with us in our hospitals and in our offices.

Acknowledgment

Additional support was provided by Waukesha Memorial Hospital, Waukesha, Wisconsin.

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