

WRITING BOARD

For the Physician, By the Physician: The Management of Addiction in Medicine

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Huddled in a small auditorium with a group of 40 first-year medical students, I led the professionalism and ethics discussion, an orientation week staple. The clinical vignette we were given involved a medical student who consumed excessive amounts of alcohol in social settings, behaved abrasively when inebriated, arrived late to class, and repeatedly missed deadlines. The vignette elaborated that the student, when confronted regarding his alcohol consumption, justified his behavior by citing the success of his family members (fellow physicians) who drank similar amounts. The first question on the handout was how we as peers would respond or react. Some students said that they would attempt to enlist confidential student services to avoid jeopardizing the student's career. Others mentioned working with friends to support the student in question. While the responses were well thought out, I strayed from the given script and asked, "What would you do if the student seemed to be just fine despite drinking excessively? What if the difference between the work of this student and an unaffected student was imperceptible?" After some pause, I admitted that I was not sure whether I would be inclined to speak up. Other students started nodding, acknowledging the now-apparent gulf between our theory and practice. In doing so, we stumbled on an unconsciously held belief, that a physician is defined by the care they deliver, even if this comes at the cost of the care they may need. It then begged the question: What happens when a physician fails?

As the first-year students soon found out, medical school makes great efforts to inculcate the importance of empathy in patient care. Instead of blaming patients for being noncompliant, we are taught to listen and understand their perspectives as legitimate. Viewing the patient beyond their diagnoses is of utmost importance in curricula across the country. Yet the treatment of medical students by their own institutions reveals a similar difference between theory and practice. In a 2018 study of medical students in Florida, researchers found that a significant number of students reported unsupportive learning environments, citing "general antipathy" from educators and administrators towards students.¹ While the COVID-19 pandemic exacerbated this,² medical students already exhibited higher rates of generalized anxiety disorder, depression, and burnout compared with the general population, attributing

the demanding academic workload as one of the most significant stressors. Situated in this paradoxical milieu, many students turn towards other means of coping. A recent study showed that about a third of medical students reported consuming 5 or more drinks in one sitting within the past 2 weeks.³ Researchers hypothesized that this was a conservative estimate due to study design parameters. Furthermore, medical students often avoid disclosing mental health disorders to their institutions due to a fear of negative consequences and perceived lack of confidentiality.⁴ Given this context, the discussion I led would have been better served if we asked how medicine responds, reacts, and even contributes to substance use disorder (SUD) in physicians.

While data on SUD among medical students is sparse, it is abundant when it pertains to physicians. A 2015 national survey examining alcohol abuse among physicians across all specialties found that 15.3% of respondents met the criteria for alcohol abuse or dependence (female physicians exhibited higher rates), while 1.3% of physicians reported abuse of opioids.⁵ In a more recent study examining the consequences of SUD among anesthesiologists, 23% of physicians with SUD followed up for 30 years had died of an SUD-related cause.⁶ Additionally, 32% of physicians relapsed at least once. The study also found that opioids were the most common substance of abuse among anesthesiology residents.⁶ These issues only compound with high rates of physician burnout, which is characterized as “high emotional exhaustion, high depersonalization, and a low sense of personal accomplishment from work.”⁷ In a 2019 report by the National Academy of Medicine, an alarming 54% of US physicians were estimated to experience varying degrees of burnout symptoms.⁷ Not surprisingly, physician burnout has been shown to increase the likelihood of addiction, particularly among surgeons.⁸ One would think that these findings would inspire a greater sense of empathy in medicine for individuals with SUD. The reality suggests a more complicated landscape.

Stigmatizing attitudes influence not only how we talk about addiction, but also how we treat it as physicians. This is particularly evident when examining treatment practices and policies for opioid use disorder (OUD). Data from a 2019 national survey of US primary care physicians found that despite most respondents classifying OUD as a chronic condition, less than 30% were comfortable with having an individual with OUD as a neighbor, partner, or family member, even if the individual was seeking treatment.⁹ These findings correlated with a decreased likelihood of physicians prescribing opioid analogs, such as buprenorphine or methadone, that are used in evidence-based medically assisted treatment of OUD. Regina LaBelle, director of the Addiction and Public Policy Initiative at the O’Neill Institute at Georgetown University Law Center, and former acting director of the Office of National Drug Control Policy under the Biden-Harris administration, described physicians prescribing buprenorphine when indicated as a “one-off” occurrence. She also highlighted discriminatory policies related to methadone

use. “The hoops someone must go through to get methadone treatment is not something we would tolerate if it were treatments for any other condition. People stand outside in line just to get methadone treatment,” she said. She elaborated, “West Virginia, which has been in the top 5 states for overdose deaths, currently has a moratorium on methadone.” LaBelle suggested that part of the difficulty of obtaining methadone is related to “racial undertones,” with methadone more commonly prevalent in racial and ethnic minority group communities compared with buprenorphine, which can be delivered in a private physician’s office setting.

The stigma towards prescribing and accessing treatment options for OUD is only worsened by the dearth of qualified physicians and overall lack of adequate training. Currently, physicians must undergo 8 hours of training, while physician assistants and nurse practitioners need 24 hours of training to obtain an X-waiver, which allows health care workers to prescribe buprenorphine for OUD in an outpatient setting to more than 30 patients. Physicians, however, do not feel qualified with only 8 hours of training for OUD treatment.¹⁰ Moreover, only 4% of licensed physicians are approved to prescribe buprenorphine, while 47% of US counties lack a buprenorphine-waivered physician.¹¹ Education for use disorders of other substances—such as alcohol, tobacco, and other drugs besides opioids—mirror trends seen with OUD training as early as medical school education. LaBelle, who championed harm reduction policies and instituted a practice guideline change that no longer required an X-waiver for treating fewer than 30 patients with buprenorphine, pointed out, “The broader issue is that we rely on that singular training targeted for treating OUD as training for treating all SUD, despite alcohol use disorder being the most common.” She also described inadequate medical education as a major contributor to lack of care for patients with SUD. In fact, a 2018 *New York Times* article found that only 15 of the 180 US medical school curricula that teach addiction include substances besides opioids as part of addiction education.¹² With poor education, limited access to treatment, and notable rates of SUD, physicians face an almost impossible task of providing care to their patients let alone each other.

Despite significant barriers facing physicians treating SUD, state physician health programs (PHP) uniquely provide physicians with treatment for medically debilitating disorders, such as SUD, while maintaining patient confidentiality to avoid disciplinary, punitive consequences. A recent study that examined participants over 5 years following treatment completion at a PHP found that two-thirds of physicians rated their treatment as “extremely helpful,” with another 17% rating it as “moderately helpful.”¹³ Additionally, 89% of physicians reported no recurrence during the 5-year monitoring period, while 97% of physicians identified as “in recovery” following treatment. Of note, PHPs provide more concerted and comprehensive care for physicians compared with the members of the general population receiving standard of care and demonstrate better outcomes.^{14,15} In this way, the PHP structures

provide a successful path to recovery for physicians, but also a path for all members of society who experience SUD. While they do exhibit successful outcomes for many physicians, the promise of PHPs is tempered by the program's stringency and absoluteness that, in some cases, hinder treatment.

Certain facets of PHP policies suggest that they may do more harm than good. For example, if PHPs deem a physician to be "noncompliant," they are reported to their state medical board, which has the power to revoke their license. If a physician were to miss an Alcoholics Anonymous meeting, fail to show up for a drug test, or disagree with their diagnostic assessment, they would be characterized as "noncompliant" and reported to their state medical board.¹⁶ In a 2014 audit of the North Carolina PHP, investigators noted a lack of "objective, impartial due process" for physicians who dispute their evaluations or directives.¹⁷ A commentary published in the *BMJ* by Cavenar,¹⁸ a psychiatrist and advocate for PHP reform, shared anonymous anecdotes of physicians coerced into PHP treatment out of fear of losing their medical licenses, despite not meeting the diagnostic criteria for their supposed disorder. Wible¹⁹ echoed a call for reform of PHPs in her commentary published in *Medscape*, attributing the death of a physician to the inflexibility of PHPs and subsequent threat of license revocation. Taken together, PHPs seem to be a step in the right direction for treatment of SUD in physicians and even the general population. Yet the anecdotes shared, lack of objectivity in the PHP evaluation process, and punitive measures used for noncompliance insinuate that even the care of physicians perpetuates stigmatizing attitudes towards addiction.

As medical students, we are asked to not judge the patient before us, to listen in earnest, to heal, and do no harm. When we take histories from standardized patients, we practice acknowledging the humanity of others—expressing joy for their successes and sorrow for their losses—while ascertaining their unique constellation of symptoms. We are asked to be as empathic as we are analytical when caring for our future patients. And we assume these roles indefinitely from the moment we put on our white coats, untouched by the fluids and feelings of others, and recite the Hippocratic oath. Yet the treatment of addiction for and by physicians indicates a lack of reciprocity of empathy that is fundamentally rooted in fear. A fear that builds as early as medical school when a student is afraid of asking their peers for help. A fear that contributes to the discomfort of a new physician encountering the impaired physician. A fear that limits the number of physicians who are willing and able to treat patients with OUD. Although this fear permeates the field of medicine, it must pale in comparison to the fear experienced inwardly by those battling their addictions. Indeed, what happens when the physician, who is defined by the care they deliver at the cost of the care they need, fails? To answer this question, perhaps we must admit that in fearing mental health, we have already failed our own.

REFERENCES

1. Hill MR, Goicochea S, Merlo LJ. In their own words: stressors facing medical students in the millennial generation. *Med Educ Online*. 2018;23(1):1530558. [doi:10.1080/10872981.2018.1530558](https://doi.org/10.1080/10872981.2018.1530558)
2. Halperin SJ, Henderson MN, Prenner S, Grauer J. Prevalence of Anxiety and Depression Among Medical Students During the Covid-19 Pandemic: A Cross-Sectional Study. *Journal of Medical Education and Curricular Development*. 2021;8. [doi:10.1177/238212052199115](https://doi.org/10.1177/238212052199115)
3. Ayala EE, Roseman D, Winseman JS, Mason HRC. Prevalence, perceptions, and consequences of substance use in medical students. *Med Educ Online*. 2017;22(1):1392824. [doi:10.1080/10872981.2017.1392824](https://doi.org/10.1080/10872981.2017.1392824)
4. Mehta SS, Edwards ML. Suffering in Silence: Mental Health Stigma and Physicians' Licensing Fears. *American Journal of Psychiatry Residents' Journal*. 2018;13(11):2-4. [doi:10.1176/appi.ajp-rj.2018.131101](https://doi.org/10.1176/appi.ajp-rj.2018.131101)
5. Oreskovich MR, Shanafelt T, Dyrbye LN, et al. The prevalence of substance use disorders in American physicians. *Am J Addict*. 2015;24(1):30-38. [doi:10.1111/ajad.12173](https://doi.org/10.1111/ajad.12173)
6. Warner DO, Berge K, Sun H, Harman A, Wang T. Substance Use Disorder in Physicians after Completion of Training in Anesthesiology in the United States from 1977 to 2013. *Anesthesiology*. 2020;133(2):342-349. [doi:10.1097/aln.0000000000003310](https://doi.org/10.1097/aln.0000000000003310)
7. Committee on Systems Approaches to Improve Patient Care by Supporting Clinician Well-Being, National Academy of Medicine, National Academies of Sciences, Engineering, and Medicine. *Taking Action Against Clinician Burnout*. Vol 2019. National Academies Press; 2019. [doi:10.17226/25521](https://doi.org/10.17226/25521)
8. Patel RS, Bachu R, Adikey A, Malik M, Shah M. Factors Related to Physician Burnout and Its Consequences: A Review. *Behav Sci (Basel)*. 2018;8(11):98. [doi:10.3390/bs8110098](https://doi.org/10.3390/bs8110098)
9. Stone EM, Kennedy-Hendricks A, Barry CL, Bachhuber MA, McGinty EE. The role of stigma in U.S. primary care physicians' treatment of opioid use disorder. *Drug and Alcohol Dependence*. 2021;221:108627. [doi:10.1016/j.drugalcdep.2021.108627](https://doi.org/10.1016/j.drugalcdep.2021.108627)
10. Bottner R, Bratberg J, Martin M, Weimer MB, Jordan A, Tierney M. Don't "Waive" Goodbye to Education for Opioid Use Disorder. *NAM Perspect*. 2021;11(10). [doi:10.31478/202110b](https://doi.org/10.31478/202110b)
11. Haffajee RL, Bohnert ASB, Lagisetty PA. Policy Pathways to Address Provider Workforce Barriers to Buprenorphine Treatment. *Am J Prev Med*. 2018;54(6 Suppl 3):S230-S242. [doi:10.1016/j.amepre.2017.12.022](https://doi.org/10.1016/j.amepre.2017.12.022)
12. Hoffman J. Most Doctors Are Ill-Equipped to Deal With the Opioid Epidemic. Few Medical Schools Teach Addiction. *The New York Times*. <https://www.nytimes.com/2018/09/10/health/addiction-medical-schools-treatment.html>. Published September 10, 2018. Accessed December 4, 2022.
13. Merlo LJ, Campbell MD, Shea C, et al. Essential components of physician health program monitoring for substance use disorder: A survey of participants 5 years post successful program completion. *Am J Addict*. 2022;31(2):115-122. [doi:10.1111/ajad.13257](https://doi.org/10.1111/ajad.13257)
14. Polles A, Bundy C, Jacobs W, Merlo LJ. Adaptations to substance use disorder monitoring by physician health programs in response to COVID-19. *J Subst Abuse Treat*. 2021;125:108281. [doi:10.1016/j.jsat.2021.108281](https://doi.org/10.1016/j.jsat.2021.108281)
15. Goldenberg M, Miotto K, Skipper GE, Sanford J. Outcomes of Physicians with Substance Use Disorders in State Physician Health Programs: A Narrative Review. *Journal of Psychoactive Drugs*. 2020;52(3):195-202. [doi:10.1080/02791072.2020.1734696](https://doi.org/10.1080/02791072.2020.1734696)

16. Lenzer J. Physician health programs under fire. *BMJ*. 2016;353:i3568. doi:10.1136/bmj.i3568
17. Wood BA. North Carolina Physicians Health Program. *Published online April*. 2014:22.
18. Cavenar JO. Re: Physician health programs under fire. *BMJ (Clinical research ed)*. Published online July 5, 2016. Accessed December 4, 2022. <https://www.bmj.com/content/353/bmj.i3568/rr/926458>
19. Do Physician Health Programs Increase Physician Suicides? Published 2015. Accessed December 4, 2022. <https://www.medscape.com/viewarticle/850023>