The Elephant in the Exam Room: Health Care Providers and Risky Substance Use

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Humans have a complicated relationship with alcohol. We drink when we're happy, and we drink when we're sad. We drink with others, and we drink in isolation. In fact, we have a complicated relationship with most psychoactive substances. We eat, drink, swallow, snort, inhale and inject them. We advertise them, compare our favorite brands, and use them in family traditions and religious ceremonies. Some of our substances are legal, some are legal and regulated, and others are illegal, yet still commonly used.

We are proud of some uses and are embarrassed about others. Yet, we seldom discuss when using becomes a problem, in part because alcohol and drug use can lead to disconnection with our affinity groups — groups in which a person normally has things in common. Unhealthy substance use by one member of the group could cause other members to question their established norms in all sorts of substance use-related behaviors. Questioning can lead to change. And change is hard.

SUBSTANCE USE AMONG HEALTH CARE PROFESSIONALS

Like other members of the U.S. workforce, health care workers struggle with alcohol and drug use. While there are certainly bad outcomes from substances driving the opioid overdose epidemic, these do not drive the major impact of substance use disorders on the health care workforce. The vast majority of illness and death among health care professionals is due to legal substances — chiefly alcohol. Rates of tobacco and nicotine use among health care professionals have plummeted in recent decades, and cannabis use has not significantly gained popularity due to its own combination of inconsistent legalization and human resource policies regarding impairment.

Alcohol permeates health professional culture, and the most studied profession regarding alcohol use is medicine. In the course of a physician's education, simply attending college elevates the risk of both alcohol use and binge drinking. According to the National Survey on Drug Use and Health, 53% of college students reported drinking alcohol in the last month compared to 44% of a similarly aged cohort.[1] Likewise, 33% of full-time college students report binge drinking in the last month compared to 28% of the same-age noncollege cohort.[2] In a large survey of medical students, 32% met diagnostic criteria for alcohol use disorder. These students were also more likely to report being burned out and depressed.[3] Among those who completed their training, 13% of male physicians and 21% of female physicians met diagnostic criteria for alcohol use disorder. These percentages are a few points higher than the general population. In the same survey, misuse of prescription drugs and use of illicit drugs were rare. Alcohol use disorder was associated with burnout, depression, suicidal ideation, lower quality of life, lower career satisfaction and recent medical errors.[4]

WHY PHYSICIANS ENGAGE IN RISKY USE OF SUBSTANCES

The high prevalence of substance use disorders has been explored in medical literature, and the causes are still being investigated. Contributors to this prevalence include the personalities of those drawn to a career in medicine, their family histories of substance use, the training culture or environment, and the systems of care in which physicians practice, including ease of access to prescription opioids and occupational exposure to anesthetic and analgesic agents.[5]

People drawn to medical careers have or admire qualities of independence, self-confidence and perseverance.[6] They also possess qualities of self-sufficiency and invulnerability.[7,8] They are uncomfortable making errors or performing poorly, and are especially uncomfortable managing outcomes that are beyond their control.

Medical education is seeking to provide a healthier, more diverse and more sustained workforce. But this has not always been a priority. Undergraduate medical education has typically been characterized by expectations of massive knowledge acquisition and flawless, yet rapid, perfection of clinical behaviors, reflected in the axiom "see one, do one, teach one." And, while younger students, resident physicians and practicing physicians are being trained in more humane and realistic models — including models with decades of evidence of effectiveness from other professions — their instructors were trained in the archaic model and often resist education to modernize their teaching methods and performance expectations.

The brokenness of the U.S. health care system has been highlighted by the public health emergency brought on by COVID-19. This brokenness includes lack of access to effective and welcoming care, uncontrolled prices and cost providing a poor return on investment, deficient quality of care and pervasive inequities and disparities in health care delivery.[9] Researchers admit that the data are just emerging on the correlation of COVID-19 and professional burnout.[10] Still, it is intuitive to project that professionals working in systems in which they experience poor professional outcomes beyond their control will experience frustration, despair and regular challenges to their mental health.

RESOURCES FOR TREATMENT FOR SUBSTANCE USE DISORDERS

Of course, clinicians seeking treatment to reduce or abstain from substance use can call the appropriate number for help listed on the back of their insurance cards. However, stigma makes many individuals uncomfortable with receiving care for substance use and other behavioral health problems in their own system. Nontraditional routes to find information for care for substance use disorders include the following:

- **Addiction Medicine Fellowship Programs:** These are training programs for the medical specialty of addiction medicine. These programs are aware of the best, local evidence-based treatment programs. There are currently more than 90 fellowships in the U.S., and a map of these can be found on the American College of Academic Addiction Medicine's website at https://acaam.memberclicks.net/finding-and-applying-to-fellowships.
- **Your State Department of Mental Health:** These state departments are the venue for dispersing opioid funds from the federal government. They typically maintain lists of treatment programs.
- **The Substance Abuse and Mental Health Services Administration's National Helpline:** This free, confidential hotline — available at 1-800-662-HELP (4357) — is a 24/7, 365-day-a-year treatment referral and information service for anyone facing mental and/or substance use disorders.

TREATMENTS FOR SUBSTANCE USE DISORDERS

Treatments for substance use disorders exist, and most of them have existed for years. In the past decades, physicians and other health care professionals have typically been told to stop drinking and go to a 12-step program. Such 12-step programs, including Alcoholics Anonymous and other mutual support programs, have helped many, but have not always been — and some continue not to be — supportive of other treatment

methods, such as medications.

FDA-approved medications for alcohol use disorder have existed for decades. The three medications include naltrexone, acamprosate and disulfiram. All work differently and have their own risks and benefits. Each works best for patients with different biological and life situations. They can be used together with behavioral therapies and mutual support groups, and treatment plans can be tailored to the preferences and goals of the individual.

There are also FDA-approved medications for nicotine use disorders, including various nicotine replacement therapies, varenicline and bupropion. FDA-approved medications for opioid use disorders include buprenorphine products, methadone and naltrexone.

These treatments can be initiated in an ambulatory care setting. (The exception is methadone, which, for opioid use disorder treatment, must be administered through a brick-and-mortar opioid treatment program — or methadone clinic — under federal rules and regulations.)

WHY MORE HEALTH CARE PROFESSIONALS DON'T SEEK HELP

Seeking help before risky use of substances becomes problematic is the best course of action for health care professionals, but there are powerful individual, professional and cultural barriers that discourage help-seeking behaviors.

Barriers to accessing care for the individual include lack of recognition of a problem, denial of the severity of a problem, fear of stigma, co-occurring behavioral health conditions, and predictable social, family, professional and economic consequences of the diagnosis. Most physicians practicing today were trained in systems with inadequate education about substance use disorders and typically do not engage in continuing education about them.[11] Many health professionals are unaware of how to recognize and appropriately treat addiction.[12]

And even when an individual is ready to engage in treatment, treatment itself can be problematic. Sadly, since many health professionals don't admit issues until they are reported for problematic behavior, they can be caught up in a system of professional reporting and proscriptive programming that can jeopardize their livelihood, license and ability to practice in their chosen field.

Physician health programs are offered in most states and are designed to help physicians with substance use disorders and mental health issues.[13] However, there is controversy surrounding the effectiveness of these programs. While some studies suggest that they are essential for protecting public health and changing the culture of medicine,[14] others suggest that they may do more harm than good.[15]

STOP STIGMA OF SUBSTANCE USE DISORDERS, STARTING WITH THE JOB APPLICATION

The National Institute of Mental Health defines a substance use disorder as "a treatable mental disorder that affects a person's brain and behavior, leading to their inability to control their use of substances like legal or illegal drugs, alcohol, or medications."[1] However, despite this being recognized as a medical disorder, health care providers must answer questions about substance use and behavioral health on license applications and renewals, job applications, forms for hospital privileges, credentialing materials and other professional forms.

This is an outdated, stigmatizing practice — and it comes perilously close to violating the Americans with Disabilities Act, which protects those in recovery or who have recovered from a substance use disorder. These applications already contain questions about the applicant's ability to perform one's job. That is adequate.

In Catholic health care, we believe that people have the ability to grow and change, therefore we can lead the field in removing these questions from our job applications and truly welcoming new employees to the team.

NOTE

1. National Institute of Mental Health, "Substance Use and Co-Occurring Mental Disorders," March 2023, https://www.nimh.nih.gov/health/topics/substance-use-and-mental-health.

As we emerge from the COVID-19 pandemic, we have the opportunity to act in meaningful ways on lessons we have learned. And one of those lessons is the absolute need to promote a healthy, resilient and stable health care workforce.

Some criticisms of physician health programs are:

- Physicians who voluntarily disclose they have mental health or drug problems can be forced into treatment without recourse, face expensive contracts for treatment services, and are frequently sent out of their home state to receive the prescribed therapy.[16]
- There is no meaningful oversight and regulation of these programs.[17]
- Physicians are sometimes falsely accused of having addiction, or other psychological problems, and end up getting help they don't need, which drains their savings, endangers their licenses and even leads to some young doctors taking their own lives.[18]
- The physician is basically at the mercy of the physician health program, and as one critic states, "There is no one outside the program looking at them, monitoring their practices and making sure that they're really acting in a benevolent way."[19, 20]

CARING FOR THOSE WHO CARE FOR US

As we emerge from the COVID-19 pandemic, we have the opportunity to act in meaningful ways on lessons we have learned. And one of those lessons is the absolute need to promote a healthy, resilient and stable health care workforce.

We are not going to program our way out of the current situation. Creating an activity designed to promote resiliency can be tempting, but this can be just one more activity for workers to fit into their already crowded schedules. Instead, leaders should listen, respond to frontline workers and consider evaluating other options for support. How can individuals be supported in the workplace? How can employers promote help-seeking behaviors? How can systems not only decrease stigma in our language, incentives and expectations, but, when needed, how can systems also make treatment attractive? How can conversations about behavioral health be normalized along with other chronic conditions? How can work environments be more humane for workers? What can health care learn from other industries and professions that have focused on meaningful worker health and well-being?[21]

While supporting our current workforce, we must support innovation and pilot programs for our future employees to create the workforce we need. Some older workers must stop eye-rolling and criticizing our students and trainees and instead believe them when they tell us what they need. Accommodation of future workers needs to be as generous as our ministry's willingness to embrace new technology, new communication devices and new treatments and cures.

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QUESTIONS FOR DISCUSSION

The author, Dr. Fred Rottnek, directs multiple efforts related to education and treatment for substance use disorders. While health care providers often aim to model healthy behaviors, Rottnek notes that "alcohol permeates health professional culture." Prescription and illegal medications also can lead to harm and even death when abused.

1. In Catholic health care, we are called to whole-person caring. Does your workplace support healthy mental, physical and spiritual choices for those who work there? Who is responsible for ensuring that decisions and environments don't contribute to staff burnout? Is there a way for care providers to voice when they are struggling or need a break?

2. What more could your workplace do to reduce the stigma around substance use disorders? Is there ever any discussion about ways to seek help if someone wants or needs it? What about protecting their privacy?

3. Is there education to explore generational differences in how people understand and communicate about how best to handle tough days on the job? What do you think your workplace could most do to reduce stress, anxiety and the potential for moral anguish and improve the overall environment?

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