

## Helping addicted colleagues

Stephen M Jurd

*Addiction is a treatable disease and patients can enjoy rather than endure recovery (MJA 2004; 181: 400-402)*

My work is regarded in various ways by my colleagues. Some see me as a quixotic figure ranting futilely against the impregnable world of alcohol and other drugs, as in the cartoon. Others see me as a sort of medical Mother Teresa on Sydney's North Shore, devoted to a life of cleaning others' mess. I think most simply shake their heads, believing that I am delusional and beyond help. This article seeks to define and refine this "delusion": that addiction is a disease, that it is treatable, and that patients enjoy rather than endure recovery.

### Do addicted doctors need special treatment?

I sometimes feel that all the hard work and inconvenience of gaining a medical qualification is worth it for one short sentence: "Doctor is busy." As doctors, we have a wealth of privileges not afforded other members of the community. Not only are we excused for lateness, we also have access to a wide range of medicines (many of them dangerous, even in prescribed doses), and are permitted, even expected, to examine people's bodies and to ask intrusive questions.

With these privileges come ethical dilemmas that are not new to the profession — abortion, euthanasia, inappropriate relationships with patients, confidentiality, and commitment to training the next generation of practitioners. All rate a mention in the Hippocratic Oath. However, Hippocrates did not have a protocol for addicted colleagues.

The saying that addicts and alcoholics are just like other people except more so is attributed to Sylvester Minogue, a psychiatrist influential in the introduction of Alcoholics Anonymous to Australia. I believe that alcoholic and addict doctors are just like other alcoholics and addicts, except more so. The issues of shame and guilt, of inability to believe that an intelligent person could perform such irrational and obviously unintelligent actions, still abound. Furthermore, colleagues who are patients know and have opinions about many interventions, reducing any chance of a placebo effect and virtually eradicating the impact of medical advice. They're in the club, and they look carefully for any hint of superficiality in explanations and advice.

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### Are addicts simply adults behaving very badly?

Understandably, the moral stance has been the traditional first response by families, communities and medical boards when learning of a doctor's addiction. Attempts to keep the community safe from addicted doctors have traditionally involved the law and lawyers, in a process that selected out, then deregistered, the "bad apples". The problem is that addiction also occurs in undeniably "good" colleagues, whose work and track record make it both unacceptable and unhelpful to deal with them punitively (Anecdote 1 and Anecdote 2).

### Addiction is not "like" a disease — it is one

This is the heart of my fortifying "delusion" and a debate in which I participated in the Journal in 1992.<sup>1,2</sup> Then, as now, I believed that addiction is a disease because it has definable clinical features, a substantial genetic influence, a reasonably predictable natural history, effective treatments, and even potential biological markers.

More recently, others have compared addiction with medical conditions like asthma, diabetes and hypertension.<sup>3</sup> These comparisons have yielded remarkable similarities in genetic heritability, pathophysiology, role of

personal responsibility, and treatment response. The effectiveness of drugs such as naltrexone<sup>4</sup> and acamprosate<sup>5</sup> in the short- and medium-term course of alcohol dependence, and methadone in opiate dependence,<sup>6</sup> also argues strongly for medical involvement.

### The issue of hopelessness

Even more important than whether addiction is a disease is the fact that prognoses are not nearly as hopeless as most medical colleagues believe. The natural history of alcohol addiction can include remission, mostly through long-term abstinence, and often associated with attendance at Alcoholics Anonymous (Anecdote 3).<sup>7</sup> However, the fact that psychosocial interventions work (as they do for many medical conditions) does not render addiction a "non-medical" problem, as some have argued.

Sustained abstinence is not an end in itself. If prolonged abstinence merely resulted in a desert of joylessness, as so many people in active addiction fear, then my job would indeed be difficult. In fact, real recovery takes off once abstinence becomes comfortable. New relationships are formed or old ones improved. Central issues, such as what constitutes meaning in life, are addressed. That common core belief of self-inadequacy begins to wither.

If addiction is a disease and resetting one's neural "reward" pathway from the ventral tegmental area to the nucleus accumbens of the brain is a key feature,<sup>8</sup> then the treatment is only complete when ego-syntonic activities are fully rewarding — that is, previ-



ously enjoyed experiences, such as the joy of relationships, work and recreation, are fully enjoyed once more. Patients of mine in longer-term recovery do not continue to mourn for the moments of pleasure experienced at the end of a needle or a drinking binge. Instead, they are grateful for each sober day. Often, they gladly provide me with assistance with newer patients.

### Rehabilitation: a more enlightened attitude

The progress made in treating doctors' addiction is obvious over my 20 years of practice. Medical or licensing boards worldwide have come to recognise that the safety of the community is enhanced by having a rehabilitative attitude to alcohol and drug dependence.<sup>9</sup> Unidentified doctors still drinking or using drugs pose a greater danger to the community than those who have been identified, are seeking treatment, and are supervised by a stringent medical board program.

Medical boards have also come to recognise that monitoring impaired doctors in a process independent of the treatment process is likely to be more beneficial for both doctors and the community. Both treatment and monitoring are important and neither should interfere with the other. The NSW Medical Board was at the vanguard of this movement in developing the Impaired Registrants Program (IRP). Under this program, doctors identified as having breached laws or regulations (such as the NSW *Poisons and Therapeutic Goods Act 1966* through self-prescribing of drugs of addiction) make certain voluntary undertakings, such as to attend for assessment by a Board-appointed psychiatrist (whose only role is to provide detailed feedback for the Board's use).<sup>10</sup> One of the conditions imposed by the IRP is for the practitioner to concurrently undergo treatment.

Soon after the establishment of the IRP, I decided that I would be a treating psychiatrist and never a Board-appointed one.

I have become much more disposed to referring my medical colleague patients to the IRP, as I have found that assessments by independent psychiatric colleagues can augment and monitor my own assessments and treatment. My other (non-medical) patients do not have the back-up of an independent assessment every 6 or 12 months. My involvement in this process also means I receive regular reports from the Medical Board about my patients and any changes to their conditions. My own frisson of anxiety at receiving an unexpected piece of mail from the Board reminds me of just how trying this process is for my patients.

### Issues of concern for doctors on monitoring programs

Many problems can loom larger than usual for doctors in medical board monitoring programs. For instance, confidentiality is absolutely paramount (Anecdote 4), a drug test result that has gone astray may be misconstrued as a deliberately missed test, and false-positive test results can be especially trying for someone in recovery and working hard to comply with every condition of the IRP (Anecdote 5).

All NSW doctors in the IRP are identified as such on their medical registration cards, which bear the word "conditional". This can be a great source of agitation, and, as some suspect, of prolonged unemployment.

Lest I be seen as advocating greater freedoms for doctors on the IRP, let me also say that some doctors may show enough change to satisfy their supervisors, but seem to gain little real insight into their problems. The NSW program is unable, in its present form, to deal with this issue of reluctant compliance.

#### Anecdote 1

Dr A was a trainee physician who had been practising in another jurisdiction. He returned to Sydney, unregistered, and was referred by a senior specialist. A had developed an addiction to pethidine in the context of major social upheaval while working, and had been found diverting some from the hospital. His registration was suspended for 9 months, but no treatment was offered.

On his return to Sydney and referral to my care, he was only able to gain the benefit of the NSW Impaired Registrants Program (IRP) after his suspension elsewhere ended. He responded to a regimen including counselling, urine testing and regular review by the IRP. Initially, he worked in unfashionable posts, but later returned to his previous level, passed his specialist exams, married and had children.

#### Anecdote 2

Dr B was an influential specialist who referred himself, saying that his principal problem was migraines, but he had begun to self-medicate with a variety of opiates, including pethidine. Representatives of the Pharmaceutical Services Section of the Department of Health (which monitors the dispensing of Schedule 8 drugs in New South Wales) had visited him and informed him that it would be best if he voluntarily surrendered his right to prescribe S8 drugs.

On taking a history, I discovered that, some 20 years before, he had been identified as having misused opiates, been reprimanded by the Medical Board, and been sent for treatment, which was unconventional, unmonitored, and, as his current presentation showed, ineffective.

#### Anecdote 3

A 22-year-old medical student's drinking habits and poor exam results were a source of concern to his supervisors. He was called before the warden of the clinical school and reprimanded. He resentfully disregarded this advice, but soon after was serendipitously placed as a medical student at a drug and alcohol treatment facility, where he identified himself as an alcoholic. He became a member of Alcoholics Anonymous and has remained sober and happy for many years without treatment.

I know of his story because he sometimes helps me in supporting my medical patients.

#### Anecdote 4

Dr C, a Resident Medical Officer from another hospital, rang to say that he desperately needed inpatient treatment under my care. I agreed, not learning until later that he was due to commence a term at Royal North Shore Hospital in the 12 months after his discharge.

Subsequently, a colleague and rival of C was found to have enquired about gaining access to C's inpatient medical records. C's initial distress was well managed, he became a dedicated Narcotics Anonymous member, and has now graduated from the Impaired Registrants Program and been drug-free for more than 5 years.

#### Anecdote 5

A colleague referred his patient, Dr D, who had been self-injecting benzodiazepines and lying about his alcohol use. After a brief negotiation, D informed the Impaired Registrants Program. He began urine testing, attending the Doctors Recovery Group and Alcoholics Anonymous. D became distressed when, despite a month of abstinence, his urine was still testing positive for benzodiazepines.

He sought detailed quantitative analysis of his urine benzodiazepine levels allowing for the urine concentration, which subsequently showed an exponential decline consistent with abstinence. After only a year, his work, marriage, parenting, physical health and leisure pursuits have all improved dramatically.

### The future

Trends in the United States are for programs that manage identified addict and alcoholic doctors to be handled by systems outside medical boards. These newer programs (including one in Victoria) are called “Doctors Health Programs” (DHP). Most of these are funded in much the same way as medical boards, by medical registration fees, but these programs are independently involved in monitoring, often at four levels (individual, group, workplace and pathology), leaving the medical board to perform disciplinary functions. These programs are probably more intrusive than the ones run by the medical boards, but, while disciplinary procedures may still be imminent if compliance with the DHP is found wanting, many find it an advantage that the term “conditional” is not emblazoned across the registration papers of a doctor in early recovery.

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