

HOSPITAL PHYSICIAN®

PSYCHIATRY BOARD REVIEW MANUAL

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The *Hospital Physician Psychiatry Board Review Manual* is a study guide for residents and practicing physicians preparing for board examinations in psychiatry. Each manual reviews a topic essential to the current practice of psychiatry.

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The Impaired Physician

Editor:

Jerald Kay, MD

Professor and Chair, Department of Psychiatry, Wright State University School of Medicine, Dayton, OH

Contributor:

Sarah Izenour, MD

Psychiatry Resident, Department of Psychiatry, Wright State University School of Medicine, Dayton, OH

Table of Contents

Introduction	2
Substance Use in Physicians	2
Mental Health in the Physician	5
Physical Disability	8
Reporting	8
Conclusion	9
References	9

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The Impaired Physician

Sarah Izenour, MD

INTRODUCTION

Physicians are not immune to ailments found in the general population. A physician may be susceptible to chemical dependency, mental illness, behavioral problems, and physical disabilities, all of which may impair a physician's ability to practice safe medicine. The American Medical Association (AMA) defines physician impairment as "any physical, mental, or behavioral disorder that interferes with the ability to engage safely in professional activities."¹ The term "impairment" is frequently differentiated from incompetence and unethical conduct (**Table 1**)²⁻⁴; however, a physician who is impaired may often display incompetence and unethical conduct.

Physician impairment was brought to attention by the AMA Council on Mental Health's report of "The Sick Physician" in 1973.⁵ The AMA addressed the ethical responsibility that organized medicine has in protecting patients from the impaired physician and also addressed the need to provide treatment and rehabilitation of the physician, restoring him/her to a useful life. Since then, all U.S. states have responded by developing services for physicians in need, which are operated under state regulation and legislation.⁶

SUBSTANCE USE IN PHYSICIANS

PREVALENCE

The prevalence of substance use disorders among physicians is largely unknown because data are lacking.⁷ However, it is thought that physicians have the same prevalence rates for alcohol and drug disorders as the general population.⁸ There is a 13.5% lifetime prevalence of alcohol disorders and 6.1% lifetime prevalence of drug abuse and dependence in the general population.⁹

SUBSTANCE USE PATTERNS

Although the prevalence of substance use disorders among physicians appears to be similar to the general population, the type and reason for substance use dif-

fers. A study by Hughes et al¹⁰ found that over the course of a lifetime, physicians were as likely to have experimented with illicit substances as the general population but were far less likely to be current users. Physicians were more likely to use alcohol and prescription substances (minor opiates and benzodiazepines) than their age- and gender-matched peers. Hughes et al¹⁰ attributed the higher rate of alcohol use among physicians to socioeconomic class. The higher use of prescription substances is particularly concerning, as the primary reason for use was self-treatment. Hughes et al¹⁰ also found that approximately 9 out of 10 physicians had tried alcohol and about half of all physicians had tried tobacco. The most common illicit substance tried by physicians throughout their lives was marijuana, followed by (in order of descending prevalence) cocaine, psychedelics, inhalants, and heroin. The prescription substances most commonly used were (in order of descending prevalence) minor opiates (eg, codeine, propoxyphene hydrochloride), benzodiazepines, amphetamines, barbiturates, major opiates (eg, meperidine hydrochloride, fentanyl citrate), and steroids.

The pattern of substance use among residents and medical students has also been studied. Hughes et al¹¹ compared substance use among third-year resident physicians to peers of similar age in the general population. The majority (80%) of residents began using substances prior to starting medical school. Residents' substance use was significantly lower than that of their peers in the general population; however, both male and female residents used alcohol and benzodiazepines more often as compared with peers of similar age. A sizeable portion of residents initiated benzodiazepine use (31.4%) and prescription opiates (23.1%) during residency training, with the reason for use being self-treatment.

Baldwin et al¹² compared substance use of senior medical students with an age-related comparison group and discovered that medical students reported less use of marijuana, tobacco, cocaine, amphetamines, lysergic acid diethylamide (LSD), opiates, and barbiturates but were more likely to use alcohol, tranquilizers, and psychedelics other than LSD. The only difference in timing of the onset of substance use was with medical students'