

## **IMPAIRED PROFESSIONALS: WHO ARE THEY AND WHERE DO THEY FIT?**

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### ***IMPAIRED PROFESSIONALS: WHO ARE THEY AND WHERE DO THEY FIT?*** ***INTRODUCTION***

The purpose of this paper is to explore two basic questions that arise in connection with the term "impaired professionals"--a term that has been receiving frequent use in the alcohol and drug treatment field. The first question, "who are they?", gives rise to two sub-questions--"what does it mean to be impaired?" and "who is a professional?". Similarly, the second question, "where do they fit?", gives rise to two sub-questions--"where do they fit in treatment and recovery?" and "where do they fit in the work place?".

There were two major sources of information for this paper--(1) articles about impaired professionals that have been published in drug and alcohol, employee assistance and medical journals and (2) interviews, primarily by telephone, with the following professionals who deliver services to impaired professionals:

Mary Sue Bullock--Intake Coordinator, Caduceus Outpatient Addiction Center (COPAC), Jackson, Mississippi;  
Tom Casselton--Program Director, Virginia State Bar Association's Lawyers Helping Lawyers Program;  
Carol Bowers--Program Director, Impaired Nurses Program, Talbott Recovery System, Anchor Hospital, Atlanta, Georgia;  
Renee Brouckhouse--Program Coordinator, Impaired Professionals Program, Heritage Addiction Treatment Center, Melbourne, Florida;  
William Farley--Medical Director, Perspectives Health Program, Peninsula General Hospital, Hampton, Virginia;  
Candace Jenkins--Program Coordinator, Perspectives Health Program;  
Dottie Moffitt--Program Manager for Chemical Dependency Services, White Pines Hospital, Wheat Ridge, Colorado  
Susan Neveu--Coordinator, Impaired Professionals Program, Ridgeview Institute, Smyrna, Georgia;  
John Petraitis--Director, Employee Assistance, Reynolds Metals Company, Richmond, Virginia;  
Dr. John Rosecrans--Professor of Pharmacology, Virginia Commonwealth University; facilitator of a weekly after care group of impaired professionals in connection with the Perspectives Health Program;  
Dr. Thomas Schauland--Medical Director, Chemical Dependency Unit, Peninsula General Hospital, Hampton, Virginia; and  
Mike Wade, Police Department, Henrico County, Virginia.

## ***BACKGROUND***

Before exploring the questions set forth above, it is helpful, if not essential, to trace the history of treatment programs for impaired professionals. As early as 1973, a report issued by the American Medical Association's Council on Mental Health recognized drug and alcohol abuse among physicians as a problem and referred to "impaired physicians". As more and more physicians went into treatment for chemical dependency, addiction treatment specialists began to observe that they were experiencing a very high relapse rate--a rate noticeably higher than the relapse rate for the general population. For example, Dr. G. Douglas Talbott, the founder of the Georgia Impaired Professional Program and the generally acknowledged father of impaired professionals programs, is said to have claimed that of the first 100 impaired physicians he treated, 80% relapsed.

Accordingly, specialized programs for chemically dependent physicians were developed. The first was in 1975, when the Medical Association of Georgia (MAG) implemented a statewide Impaired Physicians Program. This was the first program in the nation for any type of impaired professional. Major elements of the program include the identification, intervention, assessment, treatment and rehabilitation of physicians impaired by chemical dependence, psychiatric illness and other emotional disorders. This program has achieved national recognition, and thousands of physicians from all over the country have been referred to it for evaluation or treatment. As a result of its success, state and local medical societies in virtually every state have established impaired physician committees and programs to help deal with incidents of obvious or suspected physician impairment.

Programs similar to the Georgia program were subsequently implemented for other types of health care professionals--i.e., nurses, dentists, psychologists, veterinarians and pharmacists. For example, the American Nurses Association (ANA) issued a document in the early 1980's recognizing addiction as a disease. Up to that time, nurses caught diverting controlled substances typically were arrested, sent into the criminal justice system, and often went to jail or prison. Believing that it was more important to keep nurses working as nurses than to send them to jail, the ANA requested states to set up programs to deal with addicted nurses. Each state has handled this in its own way.

For example, various states have established programs whereby a nurse who is caught diverting can, in lieu of being prosecuted through the criminal justice system, accept a probation or consent order which prescribes a comprehensive treatment and after care plan which the nurse must strictly comply with or face loss of license and/or criminal prosecution. The order might also prohibit the nurse from signing out or administering certain drugs for several years and require regular monitoring--including random urine screens--for four or five, sometimes even seven, years.

Health care professionals with drug or alcohol problems face serious consequences with their state licensing boards (such as the suspension, revocation or placing on probation of their licenses) and/or state or local professional organizations. In fact, these consequences are the sole reason why many health care professionals go into treatment. Accordingly, advocacy with state licensing boards and state professional societies has been a key component of impaired professionals programs from their earliest days. For example, if a physician satisfactorily follows the prescribed treatment and after care program, the impaired professional program acts as his advocate before

the state licensing board or state medical society .

As time went on, programs for impaired health care professionals began to take in non-health care professionals. There were two primary reasons for this. First, because of the expertise they had developed in providing treatment and advocacy for health care professionals, it was logical and natural to take in non-health care professionals--such as commercial pilots, attorneys and clergymen--with drug or alcohol problems who also needed advocacy. Second, there are a number of characteristics (which are discussed further below in the section on where impaired professionals fit in treatment and recovery) which professionals (whether health care or non-health care) commonly tend to share and which tend to play a major role in their becoming addicted and in their relapsing. Accordingly, impaired professional programs now include both health care and non-health care professionals.

### ***WHO ARE IMPAIRED PROFESSIONALS?***

#### ***WHAT DOES IT MEAN FOR A PROFESSIONAL TO BE IMPAIRED?***

There are numerous definitions of "professional impairment" in the literature. They all require that there be some problem which makes a person's job performance unsatisfactory or unacceptable. Thus, an individual with a problem which does not make his job performance unsatisfactory or unacceptable would not be deemed to be professionally impaired.

Most definitions of professional impairment are broad enough to include any personal or behavioral problem (such as alcoholism, drug addiction, mental or emotional distress, financial adversity, legal difficulties, senility, physical limitations, and marital or family concerns) which makes a person's job performance unacceptable. However, when most people--especially people working in the chemical dependency field--refer to impaired professionals, they typically mean people who are impaired due to alcohol or drug use.

There are a variety of possible reasons for this. First, alcohol or drug problems are the most common cause of professional impairment; probably more professionals are impaired due to alcohol or drug use than from all other possible causes combined. Second, each of the other possible causes of impairment accounts for a very small percentage of the total cases of professional impairment. For example, in impaired physician programs which deal with impairments caused by both chemical dependency and psychiatric illnesses and other emotional disturbances, only a very small percentage of the physicians are treated solely for psychiatric illnesses or emotional disorders. Third, each of the other possible causes of impairment typically has its own unique means of treatment, if treatment is even feasible, and, except for psychiatric illnesses and other emotional disturbances, programs have not been set up for professionals with other types of impairments--i.e., the only impaired professionals programs in existence are those dealing with chemical dependency and psychiatric illnesses and other emotional disturbances. Fourth, impairment caused by other factors can often be more difficult to recognize or identify than impairment resulting from drug or alcohol use, and, normally, the person must be grossly impaired before someone steps in. Fifth, even if someone is eventually recognized or identified as suffering from an impairment caused by something other than alcohol or drug use, it is often difficult to do anything about it, since it becomes a matter of proving professional incompetency to

a licensing board. Finally, most other types of impairments, such as those resulting from the person being an ACOA or co-dependent, tend not to have the same potential for creating harm or danger to clients or the public as do drug or alcohol addictions. Accordingly, this paper is limited in scope to professionals whose impairment results from alcohol or drug use.

The people interviewed in connection with this paper were in general agreement that health care professionals can run into serious difficulties with state professional societies and/or licensing boards as a result of alcohol or drug use even if such use does not clearly result in unsatisfactory work performance. They can run into serious problems if (a) they are chemically dependent, (b) they are caught diverting drugs, (c) they are caught using drugs or having alcohol on their breath at work or (d) their alcohol or drug use adversely affects their judgment at work or their job performance. In order to avoid the criminal justice system and/or to save their licenses, such individuals generally end up in an impaired professionals program. Thus, even though the definitions of professional impairment in the literature typically require that the impairing condition prevent the individual from performing his work satisfactorily, it appears that health care professionals with drug or alcohol problems of the types identified above are generally considered to be impaired, regardless of whether it can be shown that their drug or alcohol use makes their job performance unsatisfactory.

### ***WHO ARE PROFESSIONALS?***

A "professional" is generally thought of as a person who has training from a professional school, is licensed to practice by a state governing authority and/or by a state professional association, and is subject to ethical codes and standards of conduct regarding the offering of services to clients and the public. Lawyers, physicians, psychologists, dentists, pharmacists, veterinarians and registered nurses are but some of those who would be considered "professional".

However, in the context of impaired professionals programs, the universe of "professionals" is much larger. Impaired professionals programs typically take in commercial pilots, clergymen, senior business executives, college professors, teachers, law enforcement personnel and even professional athletes.

In addition, some impaired professional programs, because of the expertise they have gained providing advocacy for health care and other professionals to licensing boards and professional organizations, take individuals from virtually any occupation that requires some form of licensure or certification. For example, the coordinator of one impaired professionals program who was interviewed in connection with this paper indicated that they have taken cosmetologists into their program!

The program directors/coordinators of impaired professionals programs who were interviewed in connection with this paper generally are in agreement that there is no "bright line" test for deciding whether a particular individual who is not a "professional" in the traditional sense should be placed in an impaired professionals program. There simply is no cut-and-dried checklist for making this decision. Such decisions are typically made on an ad hoc basis, with the program staff making a collective, subjective determination as to whether the individual would be best served by placement in the impaired professionals program.

In making this determination, the staff looks at how closely the individual's intelligence, education, training and occupation give rise to those characteristics (discussed in the following section dealing with where impaired professionals fit in treatment and recovery) which tend to be commonly shared by health care professionals and which tend to play a major role in their becoming addicted and in their relapsing. The more of these characteristics an individual displays, the more likely it is that he will be placed in the impaired professionals program.

The factors that are looked at include:

- The person's need for advocacy before a licensing or regulatory board;
- The person's education level;
- The person's intelligence level;
- How much does the person operate out of his head, rather than from his feelings;
- How much power the person is used to having and how much the person is used to being in control;
- How much shame the person has about his addiction;
- Whether the person has devoted a major portion of his life to training or preparing for his occupation;
- Whether the person's ability to earn a livelihood is totally or almost totally tied to the particular job or license that is in jeopardy;
- How much of the person's identity is tied up in his job and his work life--i.e., is his job a major portion or virtually all of his personal identity--and what amount of his time does he devote to his job; and
- How well would the person fit in the program.

For example, depending on where they come out after an assessment of all of these factors, some impaired law enforcement officials and professional athletes might be deemed appropriate for placement in a particular impaired professionals program, while others would not.

Some addiction treatment professionals, however, feel that not all impaired professional programs operate in such a high-minded manner. For example, several people interviewed in connection with this paper believe that some facilities have established impaired professionals programs because such programs are now the "in thing" to have and that they use them to (i) attract people in need of treatment who want to be able to say or feel that they were in an elite, exclusive program and (ii) make more money, since impaired professionals programs tend to run longer than regular treatment programs.

### ***WHERE DO THEY FIT?***

### ***WHERE DO THEY FIT IN TREATMENT AND IN RECOVERY?***

As noted above, as more and more addicted physicians and other health care professionals began to enter treatment programs, some addiction treatment specialists began to observe that they experienced a high relapse rate--a rate noticeably higher than the relapse rate for the general population. An inordinately large number of health care professionals would relapse not long after getting out of treatment.

The addiction treatment specialists interviewed in connection with this paper believe that, due to their education, higher intelligence, specialized training and work experiences, health care professionals tend to commonly share certain characteristics which tend to put them at risk of becoming addicted and of relapsing after treatment. These characteristics include:

- Their denial:
- They tend to more strongly and more frequently deny or fail to recognize that they have a problem;
- They are much more sophisticated and subtle in their denial;
- They use their intellects to the maximum in their denial;
- They tend to see themselves as different or better than the average person--i.e., they feel that they are too smart for it to happen to them; and
- Their families tend to be in stronger denial than typical families of addicts;
- Their training and their profession tend to reinforce their belief that they are all powerful and can successfully treat the problem alone, without anyone's help;
- They have much stronger shame than the average addict. Since (i) they know so much about the human body and what can happen to it from alcohol and drugs, (ii) they tend to see themselves as being smarter than others and (iii) they often have the need to be perfect all the time, they often shame themselves badly. They feel they should have known better;
- Their higher intelligence often helps make them think they can get through treatment and recovery simply on the basis of their superior intelligence, which they can't. It also tends to keep them in their heads, rather than in their feelings, which makes treatment more difficult;
- They tend to work in positions where they are very powerful and exercise a lot of control. As a result, they tend to be in conflict around being trained to be and seeming to be so powerful, yet being powerless over drugs or alcohol. Also, many think they can go back to work after treatment and control their addiction just like they control everything else;
- It is more difficult for them to ask others for help, since (i) they are used to others asking them for help, (ii) they often feel they are invincible and should be able to deal with every situation, so that asking someone else for help would be a sign of personal weakness and failure, (iii) they are taught to control the world around them and not require any help and (iv) asking for help would mean disclosing that they have a problem, which could lead to notoriety, loss of status and loss of job;
- They've spent a great deal, if not most, of their lives training or preparing for their profession, and most, if not all, of their personal identity is tied up in or dependent on it;
- They tend to work in high stress jobs and work environments and have very poor skills for coping with stress; and
- They often face the easy availability or close proximity of drugs in their work place. Accordingly, impaired professionals programs are typically designed to address those characteristics commonly shared by health care professionals which tend to put them at risk of addiction or relapse. On the other hand, however, the general philosophy has been not to limit admission to these programs to professionals. Typically, some non-professionals are included in these programs, and they receive the same treatment as the professionals and do virtually everything the professionals do-- except that there typically is a weekly Caduceus or Caduceus-type meeting for the health care professionals

and, in some programs, there are weekly self-help group meetings for particular professions, such as nurses and physicians, which enable them to discuss issues common to their profession. Caduceus meetings are peer-led, self-help groups in which health care professionals are able to talk about such things as board hearings and licensing issues and to be in close, continuing contact with other health care professionals who have achieved a stable recovery.

The rationale behind keeping impaired professionals in close contact with "real people" is to avoid or cut down on their feelings of exclusivity and elitism and to keep them in touch with, or bring them back to, reality. It is very important that, when a very intelligent and highly educated physician is pontificating and intellectualizing as part of his denial during group therapy, he be told by the ship worker with a below average IQ who is sitting next to him, "Doc, I can't understand a word you're saying, but I do know that you're totally full of crap", and then have everyone in the room nod their heads in agreement.

Most impaired professionals programs utilize "mirror imaging therapy". Patients have the opportunity to do this after they reach a certain stage in their treatment program. In mirror imaging therapy, they assist other people with similar problems through a placement in an approved chemical dependency treatment facility for several days a week, under the supervision of a licensed professional. The other days of the week are spent in continuing treatment in the program. Mirror imaging therapy is designed and intended to give the professional patient a sense of identity as a recovering addict, rather than as the professional with the initials behind his name. This therapy, plus things like not allowing them to have beepers or to call their office, are meant to help them see themselves as a recovering addict--not as some elite professional.

Some impaired professional programs include treatment which is exclusively for the professionals in the program. For example, they might have one or more weekly group therapy sessions which are limited to professionals. These therapy groups would focus on the various issues professionals tend to have in common--such as going back to work, licensing issues and having greater shame. They may also have educational programs designed specifically for professionals and covering their special issues, such as what about their training or job will make recovery harder.

Some programs also have "Ropes Courses" or "Wilderness Adventure Programs", which can be of particular benefit to professionals by teaching them how to take, rather than give, directions, how to act as part of a team rather than as an individual and how to communicate non-verbally.

It should be noted that far more health care professionals enter into impaired professionals programs than other types of professionals. This is primarily because a great number of the health care professionals who enter these programs must do so in order to avoid or mitigate licensing or board problems, whereas other types of professionals often do not have licensing issues in connection with their chemical dependency. It should also be noted that health care professionals tend to stay in treatment for a longer period of time than other professionals. The reason is not that the people running these programs think that they should stay in treatment longer than other people. They generally would like everyone in these programs to stay as long as the health care professionals stay, since statistics clearly show that relapse rates go down as the length of time in treatment goes up. However, they typically have leverage only over the health care professionals in the program, who must stay because of their licensing issues. Most of the other professionals can leave whenever

they choose, since they are not there because of licensing issues.

It should also be noted that, following treatment, continuing care tends to be different for health care professionals and any other professionals with licensing or board issues.

Because of their licensing or board issues, they typically must agree--often in a written contract--to follow a prescribed after care program, which may require participation in one or more weekly therapy groups and/or self-help support groups for a stated period, which could be a number of years.

Professionals with licensing or board issues typically are subject to monitoring by their impaired professionals program. They generally are required to provide urine samples on demand for a specified number of years. Also, the impaired professionals program will provide advocacy in connection with their licensing and board issues so long as they satisfactorily complete the treatment program and follow the continuing care plan.

### ***WHERE DO THEY FIT IN THE WORK PLACE?***

The very structure of their practice tends to make early detection and intervention more difficult for professionals, since professionals often are insulated from appraisals of their work or close supervision. Consequently, when their performance becomes impaired, there are few who may intervene before their impairment becomes flagrant and potential harm to clients or the public becomes major. This is quite different from the work situation for most non-professionals, where, at the first inkling of a problem, the supervisor may give the employee two choices--referral to an Employee Assistance Program or disciplinary procedures. For the professional, unless his ability to practice is grossly compromised or he is caught diverting drugs or using drugs on the job, coercion is limited. Impairment in practice must be clearly documented before it goes to the licensing board. Thus, for the potentially impaired professional who is still practicing adequately though not at maximal efficiency or skill, there is no clear coercive incentive to seek treatment.

Another work place issue in connection with impaired professionals relates to whether the standards dealing with when and whether an impaired professional must stop working in his regular job and when a recovering impaired professional may resume his regular job should be any different than those applicable to non-professionals. Although there is not much discussion of this issue in the literature, an article on the California diversion program for impaired physicians indicates that a California physician undergoing treatment will be allowed to continue to work when it is safe and possible for him to do so. However, if the public would be at risk, the physician is required to give up his practice until the diversion committee thinks he can again work productively and safely. This standard is consistent with the views of the people who were interviewed in connection with this paper.

Safety issues are often more pronounced with professionals, especially health care professionals and commercial pilots, since their impairment would generally raise public and client safety issues far more serious than those which would generally arise in connection with the average person with drug or alcohol problems.

The literature discloses some special problems in the work place for impaired and recovering drug and alcohol counselors. In many states, they are held to a different standard than other professionals. For example, for licensure in some states, they must certify to a period of

continuous sobriety--often one or two years. Thus, a recovering counselor who slips with one drink is subject to losing his job and certification, whereas one who is not in recovery could get drunk on more than one occasion and have no repercussions with his job or license.

## ***RECOMMENDATIONS***

Although the literature indicates that a person will not be deemed to be professionally impaired unless his drug or alcohol use makes his work performance unacceptable, I would recommend that if any aspect of the person's life is adversely affected by alcohol or drug use, the person should be deemed to be impaired and required to obtain evaluation and, if appropriate, treatment. A prime example would be the person who comes home from work every night and has three stiff drinks and then either passes out or stays awake and abuses his family, but is seemingly okay the next morning when he returns to work. The literature is quite consistent in stating that a person's work performance is the last thing to go as his disease progresses. Hence, it is quite likely that his work eventually will be seriously affected. I believe that it would be better for all concerned if such a person were required or encouraged to go into treatment sooner, rather than later.

Moreover, there may professional impairment in this situation, even if it is not overt. New research on perceptual impairment shows that at even small doses, alcohol and other mood-altering drugs can cause significant changes in reaction time and perception. Furthermore, prolonged use of addictive substances appears to have even greater cognitive and perceptual effects on an individual than previously thought.

Similarly, I would also recommend that a professional be deemed to be impaired if, due to drug or alcohol use, he is not operating optimally or as well as before, even if his work performance is still adequate. Eventually, the disease is likely to progress to a point where his work is no longer acceptable. Thus, it is in everyone's best interest that he be promptly required to obtain evaluation and, if appropriate, treatment.

I would also recommend that impaired professionals be allowed to stay in their jobs while being treated for chemical dependency, so long as they can perform their work satisfactorily and pose no safety threat to their clients or the public. If it becomes necessary for them to cease working, they should be allowed to return to their jobs once they no longer pose a safety threat.

I would also recommend that peer assistance programs be established by all professional societies and organizations to enable their members to go for evaluation and treatment without fear of disciplinary actions or licensure problems. Without peer assistance programs which are not run by and do not report to or notify licensing boards, impaired professionals often do not get treatment due to their fear of licensing boards.

I would also recommend that for professional groups which have greater access to drugs, such as anesthesiologists and those health care professionals who regularly handle or dispense pain killers or other narcotics, an improved mechanism be developed for monitoring the presence of substance abuse.

I would also recommend that drug and alcohol counselors in recovery not be discriminated against

if they slip. A determination of a person's "return to work" status should be based on the individual case, not solely on the basis of a person's prior disability.

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