

# A 35-Year-Old Physician With Opioid Dependence

John R. Knight, MD, Discussant

**DR REYNOLDS:** Dr L is a specialist physician in practice for several years who became addicted to hydrocodone. Dr L lives with his wife, who is also a physician, and his 2 young children.

Dr L was well until several years ago, when he was grieving after a stressful life event. He began taking antidepressant medication from the sample closet in his office. He stopped taking the medications after several months because he had no relief from his symptoms. Gradually, most of his grief symptoms resolved.

Some time later, Dr L became ill with an upper respiratory tract infection. Again, he self-treated his symptoms, this time with a cough syrup containing hydrocodone that he obtained from his office sample closet. The hydrocodone improved not only his cough but also his mood, and he began to take it regularly to get through the day, even after his cough resolved. It allowed him to function at a level he perceived as higher than his normal baseline: he was productive, attentive, happy, and energized. He began requiring more and more of the hydrocodone to achieve these effects.

Dr L continued to use hydrocodone from his sample closet, going through numerous bottles weekly. He wrote prescriptions for the medication in tablet and liquid form so that he would have a back-up supply when the sample closet became empty. At one point, while he was out of town and away from his medication, he told his unsuspecting wife about his addiction, and he stopped using. When he had not taken hydrocodone for more than 36 hours, he experienced significant withdrawal symptoms that included anxiety, fatigue, and depression. To diminish them, he began taking hydrocodone again (without his wife's knowledge) within a week of returning to work. At that point, he realized that he had a problem with addiction but did not seek help. Ultimately, he was taking about 200 mg per day of hydrocodone. During this entire 18-month course, Dr L did not seek medical care.

Approximately 6 months later, and after about 2 months of suspicions related to observed mood changes and categorical denials that anything was wrong, his employer confronted him about his drug use. He was referred to the state physician health

program by a supportive chief of staff and division head at the hospital where he had been admitting his patients. There were no issues about the quality of his care for patients during his time using hydrocodone; if anything, he reported that he had been more productive than previously.

The state physician health program determined that Dr L had a substance dependence problem and the state licensing board required that he seek inpatient addiction treatment, which is where we interviewed him. If he fulfills all the goals of treatment, and the required aftercare, his license will not be suspended (it is still active), and this episode will not enter his file.

Dr L is currently midway through a planned 3-month stay at an inpatient addictions center. His medical insurance will not pay for his treatment, so he is paying approximately \$30 000 out-of-pocket for care. He has not been diagnosed with any co-occurring psychiatric illness, such as depression.

Dr L reports no history of previous addictions of any sort. He reports not misusing alcohol during college or medical school and not smoking cigarettes regularly. He has never been treated for any psychiatric illness and has no family history of addiction.

At the time of his admission to the inpatient unit, Dr L had been off opioids for a number of days. He had a completely normal physical examination. Laboratory tests revealed normal blood cell counts, chemistries, and thyroid studies. His urine test was positive for tetrahydrocannabinol (THC) (91 ng/dL), but negative for all other substances.

## DR L: HIS VIEW

I was using hydrocodone, mostly in cough syrup form, beginning roughly a year and a half ago. The effects of the hydrocodone were essentially to energize me and also, obviously, to make me feel better. The depressive symptoms that I think I had originally went away very quickly when I would take that, within a matter of 10 to 15 minutes. Originally, a

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couple of teaspoons would last 4 or 5 hours. That quickly didn't last nearly as long as time went on. But the effect, even at the end, was still the same—it really increased the amount of energy, the amount of stamina—my ability to focus was actually greater on the medication than off.

The negative effects I felt would be those that I would get if I didn't take it. By the end, if I didn't have any for about 36 hours, I would start to feel anxious and, more than anything, extraordinarily tired, depressed, unable to move, and unable to function.

There were no performance questions, and I know that for a fact, because I've spoken to the board of medicine here. Nor was there any evidence of that from my staff or from my colleagues. It clearly was a matter of missing samples and my colleagues just sort of catching on that I was the one who was taking the samples.

I never thought that this would happen to me. I can't imagine that anyone thinks it's ever going to happen to them. That's certainly one of the first things that we are taught, and I believe. You have to admit that you're powerless over your addiction and, because of that, you need to learn to ask for help. And we as physicians are very poor at asking for help.

I knew very little about addiction before coming here, obviously. I didn't learn much [about it] during medical school or residency. Even though we saw plenty of patients with addiction, we always thought of it as sort of a moral argument rather than a disease.

I do think that physicians are susceptible to addiction in a number of ways. We could talk about the genetics of it, which clearly plays a role, but stress plays a huge role in creating addiction. It raises the threshold for your pleasure centers. In other words, if you don't experience pleasure, then you need something to create that pleasure. And it is very easy for physicians to have access to chemicals that will do that.

Is there going to be any push for, not just research, but also education for primary care physicians, residents in internal medicine, pediatrics, family practice, to learn about addiction as a disease? It is something I had never really learned about until it happened to me—and until I got to this point—and I think that's sad. It's clearly one of the most common diseases in the United States now, and we're taught very little. Also, is there going to be any change in the way we treat these patients when they come through our doors?

### **AT THE CROSSROADS: QUESTIONS FOR DR KNIGHT**

What is an impaired physician? Are all physicians with substance use disorders impaired? How many physicians with substance use disorders are currently practicing in the United States? Are physicians at higher risk for substance use disorders than professionals in other fields? What substances do physicians typically abuse? What should a physician do if he or she may be developing a problem with substance use? What should a colleague do if he or she suspects another physician of having a problem with substance use? When one is the pri-

mary care physician for a physician, what additional history should be obtained in an effort to screen for substance use disorders? What treatment can be offered to affected physicians, and how successful is it? When can the physician return to practice and with what restrictions? What are the job prospects for Dr L? What do you recommend for him?

**DR KNIGHT:** The term “impaired physician” refers to any physician who is unable to practice medicine with reasonable skill and safety because of mental illness, a physical illness or condition, or the misuse of alcohol or other drugs.<sup>1</sup> Originally, the term was used to describe physicians with substance use disorders, such as alcohol or drug abuse and dependence. Some have extended the use of this term to include physicians with special health issues, such as human immunodeficiency virus (HIV) infection or AIDS.<sup>2</sup> Although it may pose infectious risks during invasive procedures, HIV infection does not negatively impact cognitive function until its latest stages. During recent years, physicians with disruptive and inappropriate behaviors have been increasingly identified and referred to treatment and monitoring programs for physicians with health problems.<sup>3</sup> However, this report will focus primarily on physician misuse of prescription psychoactive substances.

According to the American Psychiatric Association, substance use disorders are defined by “a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues use of a substance despite significant substance-related problems.”<sup>4</sup> These symptoms may or may not be present in the workplace. Therefore, physicians who misuse alcohol and other drugs may deny impairment in their ability to practice medicine, just as in this case with Dr L.<sup>5</sup> Physicians may go to great lengths to prevent their drug use from presenting at work.<sup>6</sup> However, if physiological tolerance and withdrawal develop, the physician may become a daily user. Dr L reports that for him progression to daily use occurred over the course of a year.

In alcohol or drug dependence, impairment in the ability to practice medicine can result from either acute intoxication or from symptoms of withdrawal, including alcohol “hangovers.” Dr L reports that use of hydrocodone initially improved his productivity. In my experience, this report is not uncommon among physicians who misuse prescription medications, including opioids, stimulants, and benzodiazepines. Use of prescription medications may in part reflect efforts at self-treatment for undiagnosed co-occurring disorders.<sup>7</sup> Dr L dates the onset of his problems to a stressful life event and resulting feelings of depression. His first attempt at treating himself involved the use of antidepressant medication, which he reportedly found ineffective. However, he later found incidentally that hydrocodone relieved his depressive symptoms. Despite these claims of initial benefit, however, most physicians I have worked with report that their use of drugs progressed, leading to abuse and dependence and a decline in both personal and professional performance over time.

## Epidemiology

Rates of substance use disorders among US physicians are similar to those in the general population, with the lifetime prevalence of substance dependence reported to be between 8% and 15%.<sup>8-12</sup> The 1992 Physician Substance Use Survey (PSUS), which included 9600 physicians, found that 8% of responding physicians reported lifetime occurrence of a substance use disorder, and 2% occurrence within the past year.<sup>13</sup> In Massachusetts, all medical specialties are represented in the monitoring programs for physician health.<sup>14</sup> The PSUS found that specialties with greater access to injectable drugs (eg, anesthesiology, emergency medicine) may be at higher risk for development of substance use disorders.<sup>15</sup> Self-reported substance use disorders were highest among psychiatrists and emergency physicians, and lowest among surgeons.<sup>15</sup> Emergency medicine physicians reported using more illicit drugs (adjusted odds ratio [OR] for marijuana, 2.23; 95% confidence interval [CI], 1.13-4.41), while psychiatrists used more benzodiazepines (OR, 3.16; 95% CI, 2.07-4.82).<sup>16</sup> Pediatricians and surgeons tended to report overall lower rates of substance use, while anesthesiologists tended to report higher rates of use for major opioids (OR, 2.0; 95% CI, 0.7-3.3).<sup>16</sup>

The PSUS compared physicians' rates of alcohol and drug use with pooled data from the 1988 and 1990 National Household Survey on Drug Abuse and found that physicians appeared to be more likely to use alcohol than their age and gender counterparts in the general population.<sup>13</sup> For example, the prevalence of alcohol use among 35- to 44-year-old men was 87.6% for PSUS physicians compared with 79.4% for the general population; for women, the rates were 84.6% vs 70.0%, respectively. Physicians were less likely than the general population to use illicit drugs, such as marijuana, cocaine, and heroin. However, they were more likely to report use of prescription analgesics (12.6% vs 2.6%) and tranquilizers (9.3% vs 1.8%), often citing "self-treatment" as the reason.<sup>13</sup> This pattern is common, and I recommend that physicians refrain from self-treatment. Dr L reported previously treating himself with antidepressants, and his first use of hydrocodone was for self-treatment of a cold. He obtained the medications for these self-treatments by taking samples from the closet in his office; in the Massachusetts Physician Health Services program, this behavior is also commonly reported by physicians. While Dr L's history did not include use of illicit drugs, he did have a positive test for THC, indicating that he had used marijuana within several days or weeks of being admitted for treatment.

Little is known about the relationship between the specific drug of abuse and the level of physician impairment. Dr L reports few adverse effects on his functional abilities. This may be true, but physicians also may minimize the effects that drugs have had on their ability to practice. Factors influencing the level of impairment include the pattern of use (eg, morning use vs evening/weekend use), amount of substance taken, and the individual's tolerance to the drug in question.<sup>4</sup> Ironically, some drug-dependent individuals may show fewer signs of impairment when a drug is present in their se-

rum than when the level falls and they experience the negative physiological and cognitive concomitants of acute withdrawal.<sup>4</sup> Dr L reported that withdrawal symptoms after 36 hours included increased anxiety and fatigue, both of which would likely have had serious negative effects on his performance. His drug of choice, hydrocodone, has an intermediate onset and moderate duration of action. Drugs that have steeper pharmacokinetic curves (eg, injectable opioids, inhalants) are likely to produce greater and more obvious degrees of impairment in a shorter period of time. Drugs with longer onset and duration of action (eg, benzodiazepines) may produce more subtle impairment, and their use may therefore go undetected for longer periods of time. Long-acting drugs may also produce protracted periods of symptomatic withdrawal, requiring close medical monitoring and management during the early stages of treatment.<sup>17</sup>

## Where to Get Help

Any physician who is concerned about a possible problem with alcohol or drugs should seek help immediately. Because of potential implications to licensing and professional standing, confidentiality of assessment and treatment should be protected to the greatest extent possible. Many hospitals and other health care organizations have confidential physician health or wellness committees, which provide confidential information, assistance, treatment referral, and supervised aftercare for physicians with any kind of medical or psychiatric impairment. Alternatively, physicians may choose to seek help from a trusted professional colleague, such as their primary care physician, an addiction specialist, or a psychiatrist. Each state in the United States has a program designed to assist physicians with substance use disorders and a directory of these programs is available through the Federation of State Physician Health Programs Web site.<sup>18</sup>

## When a Colleague Needs Help

Anyone who is concerned that a physician colleague may have a problem with alcohol or drugs should immediately arrange for the colleague to receive help. One report indicates that among physicians the mean duration of substance-related problems before receiving treatment is 6 to 7 years.<sup>19</sup> Most physicians participating in state monitoring programs are not self-referred,<sup>20</sup> and a properly prepared intervention meeting can result in timely acceptance of referral to treatment, as seen with Dr L.<sup>5</sup> There is little empirical evidence on effective techniques for intervening with health professionals.

The principles of directive interventions that we use in the Massachusetts Physician Health Services program are summarized in the BOX.<sup>21</sup> They can be easily remembered by the mnemonic acronym FRAMER, the letters of which represent how one should carefully "frame" the statement of concerns during an intervention. First gather all of the *facts*, including any written complaints or notes documenting oral reports of concern about a physician's appearance or performance. Notes should record specific observations (eg, "Nurse

**Box. Principles of Directive Interventions**

- F Gather all of the FACTS.
- R Determine your RESPONSIBILITY for reporting; consult confidentially with medical and legal experts.
- A Bring in ANOTHER PERSON.
- M Begin the meeting with a MONOLOGUE, in which you present the facts and summarize your responsibility.
- E Insist on a comprehensive EVALUATION. Refrain from giving a diagnosis.
- R Insist on a REPORT BACK, and signed releases allowing all parties to freely communicate.

Adapted with permission from Physician Health Services.<sup>21</sup>

N. reported that the doctor's gait seemed unsteady") and avoid conclusions that cannot be proven (eg, "The doctor was intoxicated"). Determine your *responsibility* for reporting a colleague to licensing authorities. State laws often require hospitals and/or individual health care providers to report any physician whom they believe may be impaired unless the physician accepts referral to an approved treatment and monitoring program.<sup>22</sup> Arrange for an intervention meeting to be held in a private place, such as your office. I recommend that you ask *another person* to attend the meeting with you, such as a professional from the state physician health program. Begin the meeting with a short *monologue*, in which you first list the specific reports and observations that have led to your concern. Insist on a referral for a comprehensive *evaluation* to determine the nature of the underlying problem and need for treatment. For physicians who acknowledge the problem, direct referral to treatment is appropriate. For those who deny or minimize the problem, referral for an evaluation may be more acceptable. Before concluding the meeting, insist on a *report back* from the evaluator and signed releases that authorize open communication among all those involved. Set a deadline for completion of the evaluation or entry into treatment. You may need to excuse the physician from practice immediately and insist that he or she not return to work until the entire process has been completed.

**The Role of the Primary Care Physician**

Having a physician for a patient may present challenges not otherwise encountered in primary care practice.<sup>23</sup> Physicians treating physicians should refrain from giving "informal consultations" or from writing prescriptions in the absence of a medical evaluation, which may be requested as a "personal favor." Treating physicians also should never recommend that physician-patients write prescriptions for themselves, and they should discourage any kind of self-treatment. Primary care physicians should include questions on tobacco, alcohol, and drug use as part of their usual health history during routine well-care visits with colleagues (as with all patients).<sup>24,25</sup>

If asked to see a colleague who may be impaired, the physician should perform a complete medical and psychosocial

history, physical examination, and appropriate diagnostic testing. The history should include questions about negative changes in performance at work or at home; use of substances in situations where it is hazardous (eg, driving after drinking); substance-related legal, social, and interpersonal problems; loss of control over use of substances (eg, drinking more than planned); tolerance and/or withdrawal symptoms; cravings and quit attempts; and other substance-related physical or psychological problems.<sup>4</sup> Diagnosis and treatment of co-occurring medical problems and psychiatric disorders are also critical to treatment success.<sup>26,27</sup> Addicted physicians (addicted patients in general) may have chronic pain, anxiety, and depression, or other disorders requiring pharmacotherapy and/or behavioral treatments.<sup>28-32</sup>

If a physician is suspected of using alcohol or drugs at work, but denies using, I recommend immediately requesting a urine and/or blood specimen for laboratory testing. This testing presents a unique opportunity to refute concerns. However, I recommend consultation with a toxicologist before collecting the specimen. Laboratory testing is technically complex and only one opportunity exists to obtain the correct specimen and appropriate test. All specimens should be collected and handled using procedures that guarantee validity and chain of custody.<sup>33</sup> All positive screening test results must be confirmed with gas chromatography and/or mass spectrometry.<sup>34</sup>

**Treatment Options**

There is very little published evidence on the optimal type or length of physician treatment. One study of 120 Oklahoma physicians found that 3 to 4 months of residential treatment was associated with more favorable outcomes, defined as either complete abstinence or brief relapse, compared with 4 to 6 weeks of treatment (85% vs 37%).<sup>35</sup> Residential treatment programs, like the one that Dr L is completing, typically last several months.<sup>5</sup> These programs usually begin with a 2- to 3-day period of close medical monitoring and treatment for any symptoms of acute drug withdrawal. Once medically stable, the physician moves into a period of intensive residential rehabilitation, which includes individual and group therapy, educational sessions, and attendance at 12-step support meetings (eg, Alcoholics Anonymous). During the rehabilitation process, physicians may need to undergo neuropsychological testing and/or psychopharmacological evaluation and treatment. Many residential programs include a family component and, toward the end of treatment, encourage brief visits home. Some physicians may benefit from less intensive interventions, such as outpatient programs that include individual counseling, group therapy, and psychoeducational interventions.

I believe that most physicians can return to practice soon after completing initial treatment, as long as they are being closely monitored. Dr L reports that he is hoping to return to medical practice after a month or 2 of "focusing on recovery," which is appropriate. He also reports his intention to join the local physician health program and obtain



clearance from his state licensing board. Physician health programs typically last for several years and include documentation of compliance with counseling and/or pharmacotherapy, monitoring by physician colleagues, random urine drug testing, and attendance at support meetings.<sup>18</sup> Recovering physicians rate support meetings as very important to recovery.<sup>36,37</sup>

While completing treatment, physicians may be absent from their practices for an extended period. For those who will return to the same practice, patients and coworkers should be told that the physician is away on personal or family medical leave. It is usually unnecessary, and potentially harmful, to provide more detailed information in advance of the physician's return.

Published studies have reported varying but generally high rates of success for physicians in treatment and monitoring programs (TABLE).<sup>35,38-45</sup> However, there are no comparative trials and virtually all reports are based on studies in relatively small, nonrepresentative samples drawn from a single state treatment or monitoring program. In addition,

follow-up intervals and definitions of success and methods of assessing it have also varied widely. Nonetheless, the great majority of physicians in monitoring programs are able to continue or resume medical practice.<sup>39,42,45</sup>

#### Future Job Prospects for Dr L

I believe that the job prospects for Dr L are excellent. It is unfortunate but understandable that his previous employer will not accept him back. At his earliest opportunity, Dr L should arrange to meet with his former employer to discuss providing a reference for him to prospective employers. I recommend that Dr L begin this meeting with an apology for any improper or dishonest behavior and an offer to make restitution if appropriate. He should then state his intention to find other employment and to notify prospective employers himself about his history of drug use and recovery, relying on the state physician health program to provide documentation of ongoing recovery. He should ask if his former employer would at least be willing to attest to his clinical abilities and reliability prior to using drugs.

**Table.** Outcomes of Physician Treatment and Monitoring Programs

Source	Intervention	Sample Size	Outcome Measure (Definition of Success)	Method	Follow-up Interval	% Success
Gualtieri et al, <sup>39</sup> 1983	Individualized treatment program and multiple-level monitoring system	117 Participants in California diversion program	Able to continue practice	Not specified	Not specified	93
Morse et al, <sup>40</sup> 1984	3-6 wk inpatient hospital program	53 Physicians who completed treatment	Abstinence or 1 brief relapse	Self-report	1-5 y	83
Crowley, <sup>41</sup> 1986	Individualized treatment and laboratory testing	15	No drug use	Self-report, collateral report, laboratory testing	5-41 mo	47
Shore, <sup>45</sup> 1987	Comprehensive initial evaluation and required adherence with individualized treatment plan	63 Physicians on probation with Oregon Board	Engaged in medical practice, stable professional and interpersonal relationships	Systematic record review	0-96 mo	75
Geyser, <sup>42</sup> 1988	At least 4 wk inpatient treatment followed by individual therapy, attendance at Alcoholics Anonymous/Narcotics Anonymous meetings, and random testing	49 Participants in Arizona state program	"Successfully rehabilitated"	Not specified	2-3 y	88
Smith and Smith, <sup>35</sup> 1991	Group I: inpatient treatment for 2-3 mo; group II: inpatient treatment for 4-6 wk; group III: other	Group I: 47; group II: 65; group III: 21	Abstinence from alcohol/drug use	Record review	Not specified	Group I: 83; group II: 31; group III: 19
Gallegos et al, <sup>43</sup> 1992	Completion of initial treatment followed by individualized treatment plan, attendance at Alcoholics Anonymous/Narcotics Anonymous meetings, and random testing	100 Participants in Georgia Impaired Physicians Program	Complete abstinence from alcohol/drug use	"Reports from many sources," random laboratory testing	20 mo	77
Reading, <sup>44</sup> 1992	Individualized treatment plan	80	No use of alcohol/drugs by self-report, collateral report, laboratory testing	Survey	24 mo; 9 y	84; 74

Dr L will need to disclose his history of drug use to prospective employers, but he should carefully choose the appropriate time and setting. Early interviews are sometimes no more than opportunities to see if the potential employment is desirable. If this is the case, and Dr L does not wish to pursue the opportunity further, disclosure of personal information may be unnecessary. However, if Dr L decides that the employment opportunity is something he wishes to pursue, he should make the disclosure to his potential new employers at the earliest opportunity. The disclosure should be made in person to the chief of service or equivalent at the new practice or hospital. In preparation, he should write a personal statement (which he will of course not read at the employment interview); preparing it in advance will help him decide what information is appropriate to disclose. Once he has a first draft, I recommend that he rehearse his disclosure “speech” with his therapist, attorney, or other trusted person. The statement should include a very brief statement of his past drug problem, a detailed description of his treatment and monitoring program, and end with a statement of his future plans for recovery and career. He should also mention any positive outgrowths of his experience, such as becoming a stronger and more compassionate physician.

### Recommendations for Dr L

I would first offer my congratulations to Dr L on his willingness to receive treatment. It is exceedingly difficult for a physician to admit that he needs help, but without such an admission recovery is seldom possible. My suggestion to Dr L is that he should complete treatment and then enter into an agreement with the state health program as quickly as possible. He should attend as many support meetings as possible, where he will hear stories of experience, strength, and hope from recovering colleagues. He should continue in therapy and any other recommended treatments. He might find it beneficial to become involved in working the 12 steps of recovery.<sup>46</sup> If Dr L follows through, he is likely to find life better than he can now imagine.

### QUESTIONS AND DISCUSSION

**A PHYSICIAN:** Briefly, what are the legal implications for physicians who have broken the law around narcotics, and do they need a lawyer to help them in certain circumstances?

**DR KNIGHT:** I always urge physicians whose substance use disorder has involved the use of prescription drugs to consult an attorney. In terms of clinical management or prognosis, I see little difference between alcohol use disorders and prescription drug use disorders. But a different legal issue arises: you actually have to break the law to obtain prescription drugs. Diverting samples is technically a violation, although I don’t know of anyone who has been prosecuted for that. What typically happens is that physicians write prescriptions under false names, which is clearly a violation. They do need to obtain legal counsel on disclosing any illegal behavior to the licensing board.

**A PHYSICIAN:** At what point are we obligated to report a physician to the board?

**DR KNIGHT:** If you have a reasonable basis to believe that the physician is abusing alcohol or drugs, you have an obligation to report him/her to the board. However, many states allow for a confidential referral to a physician health program in place of a board report. This is commonly referred to as a “diversion program.” Our hope in referring to the state program, frankly, is that none of us ever has to make a licensing board report. However, if the person refuses help, then you must report him/her to the board.

**A PHYSICIAN:** When prescribing a simple narcotic agent, such as acetaminophen with codeine, do I need to counsel physicians that they shouldn’t work while taking it?

**DR KNIGHT:** It depends on the dose and what effect you believe that it may have. There are ordinary doses of opioid analgesics that are generally not impairing. However, you should individualize the decision the same way that you would if your patient were an airline pilot or a heavy equipment operator. For physicians participating in the state monitoring program, if they require opioid analgesia for an injury, we require them to stay out of work until they complete the course of medication. The reason is that we are testing them, and we don’t want them to have positive tests while working—even if it’s legitimately prescribed.

**A PHYSICIAN:** For many people, Alcoholics Anonymous is not the right choice. What do you suggest for people who don’t necessarily fit into the category of those who will readily join a 12-step program?

**DR KNIGHT:** There are alternatives. There’s a program known as Smart Recovery that takes a more cognitive-behavioral approach to self-management. Their strategies are based on known cognitive behavioral therapy techniques and motivational enhancement.<sup>47</sup> In Massachusetts, for example, the Physician Health Service Program has support groups for physicians; some function on a 12-step model and some don’t.

**A PHYSICIAN:** The residential treatment program that you mentioned is physician-specific. Doesn’t that contradict the tenet that addiction is the same for everyone no matter who you are? Doesn’t that complicate treatment by keeping physicians separated as a unique group?

**DR KNIGHT:** There are no data indicating either a plus or a minus to having physician-only treatment. Many programs, rather than being exclusively for physicians, may be for health professionals, including psychologists, pharmacists, and nurses. Some might include people from other professional backgrounds. It’s a sad but true fact of life that these programs are costly. Some run more than \$20 000, and insurance seldom covers the entire cost. Another issue is that they tend to be longer and more intense than community-based programs, so it requires quite a commitment to go. I believe that unique issues afflict health professionals concerning ready access to certain chemicals, the stresses involved with practice, and licensing. These programs are especially designed to help with those aspects.

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