University of Iowa Hospitals and Clinics

POLICY ON SUBSTANCE ABUSE IDENTIFICATION AND INTERVENTION — HOUSE STAFF —

INTRODUCTION

Preamble: Definition and Contributing Factors: The UIHC operates under the Bylaws[1] which provide a mechanism to intervene on behalf of patient care and to assist the impaired clinical staff member (dentist, physician, or surgeon). Substance abuse carries significant personal risk to the individual clinical staff member[2] as well as to the staff member's patients. Chemical Dependency (Substance abuse) is a medical disease, and some clinical departments may have greater risks because of the availability of potent drugs[3].

A 7% prevalence of alcoholism among physicians implies a clear need for careful crisis intervention[4]. Within the estimated population of 15-20,000 chemically dependent American physicians, one in 100 will become addicted to narcotics, with one in ten of these committing suicide. However, abstinence "cure rates" approximate 90% for ethanol abuse and 75% for fentanyl abuse[5]. The magnitude of substance abuse in American Society makes a clear policy essential to the function of the Hospital in the University setting.

The following policy is designed to provide guidance and consistency to assessing and handling of House Staff Member work related performance problems associated with substance abuse. .

Step 1: PROGRAM DIRECTOR RECEIVES WORK RELATED PERFORMANCE PROBLEM INFORMATION FROM STAFF, STUDENTS OR PATIENTS: The Program Director may receive reports of alleged or actual House Staff member substance abuse related work performance problems (See Appendix B, "Signs, Symptoms and Considerations in Identifying Potential Chemical Dependency").

Prior to approaching the House Staff member with the substance abuse related work performance problem information, the Program Director should consult with his or her Clinical Service Head, the Medical Director of GME, the Administrative Director of GME, and UIHC legal counsel. These individuals will identify resources available to conduct an investigation, if necessary. The investigation may include pharmacy audits, consultations with the Department of Psychiatry and other relevant investigational tools.

In the event that a House Staff Member **voluntarily** identifies substance abuse related work performance problems, the Program Director should follow the procedures outlined in this policy beginning with **Step 3**.

Step 2: PROGRAM DIRECTOR DISCUSSES WORK RELATED PERFORMANCE PROBLEMS WITH HOUSE STAFF MEMBER:

The Program Director will notify the House Staff member with the allegations of potential substance abuse, framing the discussion in the context of information received related to work performance problems. The Program Director has the discretion to determine that a substance abuse problem does not exist and what, if any, further action is warranted.

If the House Staff member indicates a desire to terminate discussions of this nature with the Program Director, s/he may do so at anytime during the conversation.

Step 3: PROGRAM DIRECTOR ASSESSES THE ACCEPTANCE OR DENIAL OF THE ALLEGED SUBSTANCE ABUSE PROBLEM. Step 4 or Step 5 is then followed as appropriate:

Step 4: ACCEPTANCE – HOUSE STAFF MEMBER AGREES THAT HE/SHE HAS A SUBSTANCE ABUSE PROBLEM.	**Step 5: DENIAL** – HOUSE STAFF MEMBER DENIES THAT HE/SHE HAS A SUBSTANCE ABUSE PROBLEM.
1. The Program Director notifies the Clinical Service Head, the GME Medical Director, the GME Administrative Director, UIHC legal counsel and other entities as required, including but not limited to the UI Administration and, as appropriate, the Iowa Board of Medical Examiners. 2. The House Staff member seeks intervention and is entered into a treatment program with the expenses borne by the UIHC. The Program Director, the Clinical Service Head, the Medical Director of GME and the Administrative Director of GME must approve the treatment program. The House Staff member is encouraged to self-report the substance abuse problem to the Iowa Board of Medical Examiners if he/she has not already done so. 3. The Program Director will decide whether or not the House Staff member may re-enter the program, contingent upon considerations such as the nature of the work-related performance problem, year in training, the effect on the training program, etc. The Program Director must document that the treatment has been effective, that he/she has received reports on the House Staff member's progress while in the treatment program, that the House Staff member is in compliance with the treatment program, and that the House Staff member is willing to adhere to an aftercare program. 4. If the House Staff member is allowed to re-enter the program, the Program Director will monitor the House Staff member's compliance with the aftercare program, as set forth by the prescribed treatment program. 5. If a relapse occurs, the aftercare program is not followed or if there is a recurrence of the work-related substance abuse problem, the Program Director may:	1. The Program Director documents his/her discussion with the House Staff member, including the House Staff member's denial that a problem exists. 2. The Program Director provides copies of all relevant documentation to the Clinical Service Head, the GME Medical Director, the GME Administrative Director and UIHC legal counsel. The Program Director must also notify the Iowa Board of Medical Examiners as required. 3. The Program Director shall not require the House Staff member to submit to a drug test without first consulting with UIHC legal counsel to determine if sufficient evidence exists to satisfy a reasonable suspicion standard for drug testing. In considering whether a House Staff member should be required to submit to a drug test, the Program Director must be aware that there are many other strong indicia, other than drug testing, that can point to the existence of a substance abuse problem and that a negative test result does not conclusively indicate the absence of a substance abuse problem. If a drug test result is positive and it is the House Staff member's first offense, he/she cannot be terminated but must be offered entry into an evaluation and treatment program. If the Program Director does not have sufficient grounds to request entry into a treatment program or termination, no further action will be taken. However, the Program Director will continue to monitor the House Staff member's performance. If suspected substance abuse problems persist or if further allegations emerge, the Program Director will return to Step 2. 4. Termination from the program must result if: a. the House Staff member is required and refuses to submit to a drug test;

a. terminate the House Staff member immediately and rehabilitation is not provided at the expense of UIHC; or b. show evidence to and obtain a finding from the Graduate Medical Education Committee (or a body designated by the Graduate Medical Education Committee) that this is an isolated incident following a substantial period of compliance. In this instance, a second rehabilitation may be provided by UIHC. If a relapse occurs, the aftercare program is not followed or if there is a recurrence of the work-related substance abuse problem after this second rehabilitative attempt, the House Staff member must be terminated from the program by the Program Director and no third rehabilitation shall be provided by UIHC.	b. the House Staff member agrees to a drug test, the test result is positive and the House Staff member refuses to enter treatment; c. the House Staff member does not successfully complete a substance abuse treatment program; d. sufficient information exists regarding substance abuse related work performance problems to terminate the House Staff member; e. after an initial rehabilitative attempt, a relapse occurs, the aftercare program is not followed or a recurrence of the work-related substance abuse problem occurs and there is an isolated incident following a substantial period of compliance; or f. there is a recurrence of the work-related substance abuse problem after a second rehabilitative attempt.

Note: If the House Staff member is terminated, then all provisions of the Statement on House Staff Member Concerns will apply. The Program Director must notify the Medical Director of GME, the Administrative Director of GME and the UIHC legal counsel of the termination. The Program Director must also notify the Iowa Board of Medical Examiners and University Administration of the termination. The House Staff member will be afforded due process as outlined in Article IV, Section 7 of the University of Iowa Hospitals and Clinics Bylaws. If termination does not result, the Program Director will continue to monitor the work performance of the House Staff member and may re-visit the steps of this policy if problems persist or recur.

[1]Bylaws Rules and Regulations of the University of Iowa Hospitals and Clinics and Its Clinical Staff. Art II Section 3 Part B-2, and Art IV Section 5 part H.
[2]Crawshaw, R. et al., "An Epidemic of Suicide among Physicians on Probation," JAMA 243:1915-7, 1980.
[3]Ware, C. F. et al., "Drug Abuse among Anesthesiologists," JAMA 250:922, 1983.
[4]Krizek, Thomas K., "Substance Abuse: An Issue for Faculty and House Staff." Minutes of the Society of University Urologists pp. 34-40, Oct. 11, 1990.
[5]Krizek, Thomas K., "Substance Abuse: An Issue for Faculty and House Staff." Minutes of the Society of University Urologists pp. 34-40, Oct. 11, 1990.

Reviewed/Approved by the Graduate Medical Education Committee	*12/6/05*

APPENDIX A

RISKS OF SUBSTANCE ABUSE IN PHYSICIANS

All physicians and dentists who have access to addictive drugs are at risk for substance abuse. Several factors contribute to the development of chemical dependency:

- **Drugs are available in hospitals and operating rooms and their potential misuse is influenced by a culture of moderate to heavy drinking where alcoholic beverages are a way of life;**
- **Experimentation with mood-altering drugs is pervasive; they are available to all members of our society;**
- **Job stress is common in highly skilled and achievement oriented specialties;**
- **An "ain't got no respect" syndrome may exist where there can be a low recognition of intense work effort;**
- **A "chemical" way of life and a cultural need for instant gratification may lead to rote or mechanical ways of dealing with psychological pain, stress, fatigue, worry and physical discomfort.**

***Fraly, W.J. and Talbott, G.D., "Editorial: Anesthesiology and Addiction", Analgesia 62:465-6, 1983.**

APPENDIX B

SIGNS, SYMPTOMS AND CONSIDERATIONS IN IDENTIFYING POTENTIAL CHEMICAL DEPENDENCY*

The early clinical and behavioral characteristics of alcohol and/or substance abuse impairment may be subtle and difficult to recognize, especially when substance use is intermittent and the house staff member is not yet dependent or impaired. Clues that could raise suspicion include behavioral changes, deterioration in work performance, tardiness, irresponsibility, or anti-social conduct as well as overt manifestations such as drunkenness, hallucination, euphoria, depression, anxiety and even traffic violations related to driving while intoxicated (DWI).

Social behavior, health and work performance may be variably affected by chemical dependence. Social dysfunction may manifest itself in any of the following categories:

- **withdrawal from leisure activities, friends and family;**
- **uncharacteristic or inappropriate behavior at social gatherings, impulsive behavior. These may include:**
    - **gambling or overspending);**
    - **mood swings;**
    - **frequent illness;**
    - **prominent desire to work alone and undisturbed;**
    - **hostility; and/or**
    - **refusal to eat lunch or to take breaks**
- **domestic turmoil (e.g., separation from spouse, child abuse, sexually inappropriate behavior);**
- **change in behavior of children or spouse; and/or**
- **legal problems (e.g., DWI)**

Changes in health status may be manifest as follows:

- **deterioration in personal hygiene;**
- **striking sensitivity to temperature (may mask the desire to wear long sleeves to cover puncture sites);**
- **increased number of accidents; and/or**
- **number of health complaints and/or increased need for medical attention.**

Changes in professional relationship, particularly deterioration of work performance, include:

- **unreliability:**
    - **missed appointments;**
    - **inappropriate responses to emergencies;**
    - **absences;**
    - **poor record keeping; and/or**
    - **anesthesia mishaps**
- **complaints by patients or other staff;**
- **inappropriate drug requests:**
    - **over-prescription of medications;**
    - **excessive ordering of drugs from mail-order houses; and/or**
    - **heavy use of adjuvant drugs**
- **unstable employment history (e.g., relocation to several institutions or hospitals); and**
- **working at a level of professional responsibility below that consistent with the physician's qualifications**

Ward, C.F., et al., "Drug Abuse Among Anesthesiologists", JAMA 250:925, 1983.