Fellow Resources

- WELLNESS/RESILIENCY RESOURCES DOCUMENT
- DIVERSITY, EQUITY, AND INCLUSION RESOURCE DOCUMENT
- ACGME Competencies and UNMC Scholarly Activities
- Preventing Physician Depression and Suicide
- Physician Impairment and Substance Use Disorder

WELLNESS/RESILIENCY RESOURCES DOCUMENT

The University of Nebraska Medical Center has several resources in place to address workplace stress, burnout, depression and suicide. These resources will be useful in proactively identifying any colleagues exhibiting any signs and symptoms of burnout, depression or suicidality, referring them to the appropriate personnel and thereby improving wellbeing.

AVAILABLE RESOURCES AND ACCESSIBILITY:

On Campus

Resource	Contact
Susan Smith, RN, BS, CEAP House Officer Assistance Program (HOAP) Manager Available 24/7 by phone- unlimited access, no payment. Susan Smith works exclusively with house officers.	-402.689.1033 (Mobile) Call or text -402.559.5323 (Office)
Arbor Family Counseling- available 24/7 by phone- At UNMC or offsite- 5 free sessions	-402.330.0960/1.800.922.7379 -For Offsite: Web-Ex (HIPAA compliant) via smartphone/tablet or computer -www.arborfamilycounseling.com
UNMC Counseling in Bennet Hall- 6th floor David Carver Ph.D, 24/7/Unlimited access/No payment	-402.559.7276 -402.203.0592 (after hours)
Spiritual Care at UNMC A chaplain is available for spiritual counsel, emotional support, prayer, or a nonjudgmental presence while you work through a concern or worry.	To reach spiritual care Monday through Friday, 8 a.m. to 4:30 p.m., please call the main office at 402.552.3219. After hours, call the on-call Chaplain at 531.557.4559
Peers in Need of Support (PiNS) Colleagues are matched with one of our behavioral health responders, made up of Nebraska Medicine and UNMC psychologists, psychiatrists, social workers, marriage and family therapists, staff chaplains and other trained staff. This is not a formal evaluation or treatment, but a supportive peer to listen, offer suggestions, share resources and make referrals when needed.	Complete this confidential form or email pins@nebraskamed.com (Requests for 1:1 support should only be made by colleagues themselves, and not by their peers or supervisors)

Off Campus

Resource	Contact
Suicide & Crisis Lifeline (call or text)	988
Metro Omaha Medical Society anonymous online screening	https://omahamedical.com

UTILIZATION OF RESOURCES: Susan Smith works exclusively with the house officers. In addition to Susan Smith, other available resources are listed above. After visiting with Susan Smith or other resources, further referrals can be made to Psychiatry services if required.
CONFIDENTIALITY: All UNMC internal resources are kept confidential unless required for health reasons (impairment or imminent danger). The house officers program or department leadership will not be aware of these consultations. If further referrals are made to Psychiatry services, they are covered under HIPAA for confidentiality.
VIGILANCE: We request everyone to be vigilant to identify in self or of any peers demonstrating signs of distress/depression/burnout or suicidal thoughts and refer to the above resources. The attached Powerpoint- “Preventing Physician Depression and Suicide” will help in identifying any individuals at risk.
CRISIS RESPONSE TEAM: The Crisis Response Team (CRT) is available to prevent further tragedies. The CRT will also be activated to develop a coordinated response in the aftermath of any potential tragic events. Please see contact details of CRT personnel in the Appendix.

ADDITIONAL RESOURCES:

1. ACGME
   - ACGME Physician Well-being
   - ACGME Tools and Resources
   - ACGME After a Suicide
2. AMA (Steps Forward)
   - AMA Improving Physician Resiliency Module
   - AMA Physician Wellness: Preventing Resident and Fellow Burnout Module
   - AMA Preventing Physician Distress and Suicide Module
   - AMA Preventing Physician Burnout Module
   - AMA Creating the Organizational Foundation for Joy in Medicine
3. APA Wellness Resources
4. Agency for Healthcare Research and Quality
5. SAMHSA-HRSA Wellness Strategies
6. Physician Depression and Suicide ppt from UNMC-Psychiatry
7. Resilience Webinars
   - Resilience workshop for healthcare workers
   - Reslilience roadmap for Nebraska Medicine/UNMC colleagues
8. Other Recommended
   1. Mindfulness/Anxiety Mobile Apps
      - Headspace
      - 10 percent happier meditation (use the gift code HEALTHCARE)
      - Insight Timer (free with thousands of guided meditations)

    - PTSD Coach (Not just for PTSD; has numerous relaxation exercised in the Manage Symptoms- Tools section)
    - Mindfulness Coach
    - CBT-i Coach (cognitive behavioral therapy for insomnia)
2. Mindfulness/Anxiety Websites
    - The BHECN Serenity Project- Free Yoga (UNMC)
    - Three 2-3 minute lessons on deep breathing (Harvard Vanguard Medical Associates)
    - 3 minute body scan (UC Berkeley Greater Good Science Center)
    - 5 minute body scan (The Sleepy Aardvark)

DIVERSITY, EQUITY, AND INCLUSION RESOURCE DOCUMENT

DIVERSITY, EQUITY, AND INCLUSION (DEI) LEARNING RESOURCES AND TOOLKITS

ACGME Equity Matters: https://www.acgme.org/what-we-do/diversity-equity-and-inclusion/ACGME-Equity-Matters/
ACGME DEI Officers Forum: Email diversity@acgme.org to join
American Academy of Family Physicians Health Equity Curricular Toolkit: https://www.aafp.org/family-physician/patient-care/the-everyone-project/health-equity-tools.html
Association of American Medical Colleges (AAMC) Diversity and Inclusion Video Learning Series: https://www.aamc.org/what-we-do/equity-diversity-inclusion/learning
AAMC Unconscious Bias Resources for Health Professionals: https://www.aamc.org/about-us/equity-diversity-inclusion/unconscious-bias-training
AAMC IDEAS Learning Series: https://cloud.email.aamc.org/ideas
American Hospital Association (AHA) Health Equity Toolkit: https://www.aha.org/toolkitsmethodology/2020-12-14-health-equity-snapshot-toolkit-action
AHA Inclusion Dashboards: https://ifdhe.aha.org/system/files/media/file/2020/12/ifdhe_inclusion_dashboard.pdf
Association of Family Medicine DEI Milestones: https://meridian.allenpress.com/jgme/article-supplement/480333/pdf/jgmed21007231/
American Surgical Association DEI E-textbook: https://americansurgical.org/files/2018/Equity.pdf
American Society for Gastrointestinal Endoscopy LGBTQ+ On-Demand Webinar: https://learn.asge.org/Public/Catalog/Home.aspx?Criteria=26&Option=174&tab=2
Centers for Disease Control (CDC) Health Equity Video Series: https://www.cdc.gov/healthequity/whatis/videos/index.html
CDC Resources and Style Guides for Framing Health Equity and Avoiding Stigmatizing Language: https://www.cdc.gov/healthcommunication/Resources.html
The DEI Shift Podcast Series: https://www.thedeishift.com/
Harvard University Project Implicit: https://implicit.harvard.edu/implicit/research/
Institute for Healthcare Improvement (IHI) Triple Aim Curriculum: https://www.ihi.org/education/ihi-open-school/Pages/Curriculum.aspx
National Institutes of Health (NIH) Advancing Racial Equity: https://www.edi.nih.gov/people/resources/advancing-racial-equity
NIH Scientific Workforce Diversity Toolkit: https://diversity.nih.gov/toolkit
Nebraska Medicine Guide to Understanding Gender Pronouns:

https://onfirstup.com/nebraskamedicine/nebraskamedicine/contents/35828486
Ohio State Kirwan Institute Implicit Bias Modules: https://kirwaninstitute.osu.edu/implicit-bias-training
Stanford Unconscious Bias in Medicine CME Course: https://online.stanford.edu/courses/som-ycme0027-unconscious-bias-medicine-cme

READING COLLECTIONS, PODCASTS, PROCEEDINGS, AND BLOGS

- AAMC Diversity, Equity, and Inclusion reading collection: https://www.mededportal.org/dei
- AAMC Anti-Racism reading collection: https://www.mededportal.org/anti-racism
- AAMC Proceedings of the Diversity and Inclusion Innovation Forum: Unconscious Bias in Academic Medicine: https://store.aamc.org/proceedings-of-the-diversity-and-inclusion-innovation-forum-unconscious-bias-in-academic-medicine.html
- CDC Conversations in Equity Blog: https://blogs.cdc.gov/healthequity/
- National Institutes of Health Equity Diversity and Inclusion Blog: https://www.edi.nih.gov/blog
- UNMC podcast on unconscious bias by Dr. Jasmine Marcelin: https://podcasts.apple.com/us/podcast/jasmine-marcelin-md-facp-on-unconscious-bias-being/id1414936358?i=1000479025567

UNMC/NEBRASKA MEDICINE PEOPLE AND RESOURCES

- Shirley Delair, MD, Associate Dean of Diversity, Equity, and Inclusion, is an active member of the GMEC Committee and provides orientation on DEI topics to new house officers. Her office is devising initiatives to enhance recruitment and retention of a diverse workforce.
- Sheritta Strong, MD, Assistant Vice Chancellor of Inclusion, leads the Conversations for Inclusive Excellence virtual series for all UNMC faculty, staff, and students, at 2 PM on the second Thursday of every month. She also leads the UNMC Inclusion and Equity Council, which meets at noon on the fourth Thursday of every month.
- Nada Fadul, MD, Assistant Dean for Diversity, Equity and Inclusion Education Programs, provides faculty development sessions on DEI. She also provides consultative services for graduate medical education programs on addressing DEI in their educational programming.
- Offices of Inclusion and Equity: The UNMC Office of Inclusion focuses on educational and leadership opportunities in a safe environment, particularly in the areas of awareness/advocacy, developmental opportunities, and DEI initiatives. The UNMC Office of Equity focuses on identifying and addressing inequities in a safe environment, particularly in the areas of awareness/advocacy, collation of efforts, and data-based systems. The UNMC community can provide anonymous feedback on culture or report a bias incident at the Offices of Inclusion and Equity website: https://www.unmc.edu/diversity/
- The Office of Faculty Development partners with the Offices of Inclusion and Equity to offer trainings and workshops to UNMC faculty.
- McGoogan Library DEI collections (https://unmc.libguides.com/sb.php?subject_id=203853) on DEI in Ability, in BIPOC communities, and in LGBTQIA2S+ communities
- McGoogan Library inclusive spaces: https://www.unmc.edu/library/spaces/inclusive-spaces.html
- Nebraska Medicine Employee Resource Groups (https://www.nebraskamed.com/diversity-inclusion/employee-resource-groups)

ARTICLES OF NOTE

1. Boatright D, London M, Soriano AJ, Westervelt M, Sanchez S, Gonzalo JD, McDade W, Fancher TL.

Strategies and Best Practices to Improve Diversity, Equity, and Inclusion Among US Graduate Medical Education Programs. JAMA Network Open. 2023 Feb 1;6(2):e2255110-
https://jamanetwork.com/journals/jamanetworkopen/article-abstract/2801104
2. Gonzaga AM, Appiah-Pippim J, Onumah CM, Yialamas MA. A framework for inclusive graduate medical education recruitment strategies: meeting the ACGME standard for a diverse and inclusive workforce. Academic Medicine. 2020 May 1;95(5):710-6.
https://journals.lww.com/academicmedicine/Fulltext/2020/05000/A_Framework_for_Inclusive_Graduate_Medical.20.aspx
3. Usoro A, Hirpa M, Daniel M, Harris V, Ware A, Kernodle A, Elliott T, Piggott DA, Bienstock JL. Promoting diversity, equity, and inclusion: building community for underrepresented in medicine graduate medical education trainees. Journal of Graduate Medical Education. 2021 Feb 1;13(1):33-6. https://meridian.allenpress.com/jgme/article/13/1/33/451599/Promoting-Diversity-Equity-and-Inclusion-Building
4. Capers IV Q. How clinicians and educators can mitigate implicit bias in patient care and candidate selection in medical education. ATS Scholar. 2020 Sep;1(3):211-7.
https://www.atsjournals.org/doi/full/10.34197/ats-scholar.2020-0024PS

FOR MORE INFORMATION

An expanded version of this list with additional specialty-specific resources is available in the GMEC Teams folder. If you’re aware of a useful resource, please contact Arianne Marcoux with the UNMC Office of Graduate Medical Education (arianne.marcoux@unmc.edu) to have it added.

ACGME Competencies and UNMC Scholarly Activities

UNMC Graduate Medical Education: Meeting the ACGME Core Competencies

Competency	Definition	UNMC GME
Professionalism	CPR IV.B.1.a) : Residents/Fellows must demonstrate a commitment to professionalism and an adherence to ethical principles.	• COPIC • Annual Compliance Training (Apollo) • Excellence for Building Cultural Differences (annual compliance - Canvas) • HIPAA (annual compliance -Canvas) • Title IX (Orientation and annual compliance – Canvas) • Student Mistreatment (Orientation and annual compliance – Canvas) • Residents as Teachers (Orientation) • Program-specific initiatives and training
Patient Care & Procedural Skills	CPR IV.B.1.b) : (1) Residents/Fellows must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. (2) Residents/Fellows must be able to perform all medical, diagnostic, and surgical procedures considered essential for the area of practice.	• Annual Compliance Training (Apollo) • Zero Harm (Orientation) • Institutional Quality Goals/Patient Safety (Orientation) • Infection Control (Orientation) • Program-specific initiatives and training
Medical Knowledge	CPR IV.B.1.c) : Residents/Fellows must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social behavioral sciences, as well as the application of this knowledge to patient care.	Program initiatives and training to include • In-training examinations • Journal club • Specialty-specific curricula
Practice Based Learning & Improvement	CPR IV.B.1.d) Residents/Fellows must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and lifelong learning.	Program initiatives and training to include • Self evaluations • M&M conferences • Journal club

Interpersonal & Communication Skills	CPR IV.B.1.e) Residents/Fellows must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals.	• COPIC • Annual Compliance Training (Apollo) • Excellence for Building Cultural Differences (annual compliance - Canvas) • Zero Harm (Orientation) • Residents as Teachers (Orientation) • IHI Module – Teamwork and Communication (onboarding requirement) • Program-specific initiatives and training
Systems Based Practice	CPR IV.B.1.f) Residents/Fellows must demonstrate an awareness of and responsiveness to the larger context and system of health care, including the social determinants of health, as well as the ability to call effectively on other resources to provide optimal health care.	• COPIC • Annual Compliance Training (Apollo) • Zero Harm (Orientation) • Institutional Quality Goals/Patient Safety (Orientation) • ResQ (regular GME meeting) • IHI Modules: o Introduction to Patient Safety o Responding to Adverse Events o Root Cause Analyses and Actions o Achieving Total Systems Safety o Teamwork and Communication (onboarding requirement) • Program-specific initiatives and training

UNMC Graduate Medical Education: House Officer Scholarly Activity

The GME Office that has created multiple resources to promote scholarly activity for residents and their involved faculty mentors. The GME Office offers the following resources to promote scholarly activity for residents/fellows and their involved faculty members:

1. GME Patient Safety/Quality Improvement/Disparities Research Collaborative: This Research Collaborative promotes research in various aspects related to patient safety, quality improvement and addressing disparities in health care. The Collaborative consists of the Associate Dean, a Ph.D in statistics and two Master’s level statisticians. All of them possess significant experience in clinical research and help residents with: study design, methodology, statistical support, data acquisition, IRB approval, abstract and manuscript preparation. The Collaborative meets every Tuesday to help residents with research.
2. GME Educational Research Collaborative: This Research Collaborative promotes research in various aspects related to medical education. The Collaborative consists of the Associate Dean, and MD, Ph.D in education. Both of them possess significant experience in educational research and can help with: study design, methodology, statistical support, data acquisition, IRB approval, abstract and manuscript preparation. The Collaborative meets every Wednesday to help residents with research.
3. Annual GME Research Symposium: This campus-wide event provides the opportunity for

residents/fellows to present their research abstracts

4. Graduate Medical Education Research Journal (GMERJ): This peer-reviewed journal was started on our campus to provide an avenue for the house officers to publish their scholarly activity. Started in 2019 (with DOI), the journal has provided a good platform for residents/fellows to publish their articles.

Davis Global Center Resource for GME Programs

The Dr. Edwin G. & Dorothy Balbach Davis Global Center (Davis Global Center) is a highly advanced clinical simulation facility purposefully designed to promote simulation-based training for all health professionals and foster the practice of safe patient care in highly-functioning and effective interprofessional teams. The 192,000 sq.ft. center is spread out over five distinct floors with each floor focusing on a specific domain such as cognitive and psychomotor domains etc. This creates a safe, highly effective and innovative training environment that benefits all health professionals in training and in practice.

The Davis Global Center is one of the world's largest simulation center with some of the most advanced simulation technologies in the world that help with house officer training in all the domains ranging from cognitive, psychomotor, affective and team-based training.

Add additional information about how your program uses the space

Web site: Davis Global Center | iEXCEL | University of Nebraska Medical Center (unmc.edu)

Preventing Physician Depression and Suicide

Department of Psychiatry UNMC

- Top causes of death among residents
  - #1 Neoplastic
  - **#2 Suicide**
    - Higher rates of death early in residency (first two years)
    - Unchanged over the last 15 years

Yaghmour et al. Causes of Death of Residents in ACGME-Accredited Programs 2000 Through 2014: Implications for the Learning Environment. Acad Med. 2017 Jul;92(7):976-983

- Suicides cluster at certain times of year
  - Higher in the first (July) and third quarters (after winter holidays) of academic year

Physician Suicide Is a Multi-Faceted Problem

Individual factors

The training environment

Culture of medicine

An estimated 400 physicians die by suicide in the US per year

Center C, Davis M, Detre T, Ford DE, Hansbrough W, Hendin H, Laszlo J, Litts DA, Mann J, Mansky PA, Michels R, Miles SH, Proujansky R, Reynolds CF 3rd, Silverman M M (2003). Confronting Depression and Suicide in Physicians. JAMA, 289(23), 3161.

Risk Factors for Suicide (1/2)

- **Mental disorders (particularly depression)**
- **Alcohol and/or other substance use disorders**
- Previous suicide attempt(s)
- Family history of suicide
- Impulsive or aggressive tendencies

Easy access to lethal means (e.g., firearms)
Losses and other events (e.g., the breakup of a relationship or a death, academic failures, legal difficulties, financial difficulties, or bullying)
Isolation, a feeling of being cut off from other people
Feelings of hopelessness

US Public Health Service, The Surgeon General's Call to Action to Prevent. Suicide. Washington, DC: 1999.

Risk Factors for Suicide (2/2)

Trauma or abuse history
Chronic physical illness, including chronic pain
Exposure to the suicidal behavior of others
Cultural and religious beliefs (e.g., belief that suicide is noble resolution of a personal dilemma)
Unwillingness to seek help because of the stigma attached to mental health and substance use disorders or to suicidal thoughts
Barriers to accessing mental health treatment

US Public Health Service, The Surgeon General's Call to Action to Prevent. Suicide. Washington, DC: 1999.

Suicide Warning Signs – Talk

A person who is considering suicide may talk or write about:

- Killing themselves
- Death or dying
- Feeling hopeless, helpless or worthless
- Having no reason to live
- No sense of purpose in life
- Being a burden to others
- Feeling trapped
- Unbearable pain

Suicide Warning Signs – Behavior

Concerning behaviors, especially if related to a painful event, loss or change:

- Increased alcohol and/or drug misuse
- Searching for a way to end their lives, e.g., searching online for materials or means
- Withdrawing from activities
- Isolating from family, friends and community

- Reckless behavior or more risky activities, seemingly without thinking
- Sleeping too much or too little
- Tying up loose ends
- Visiting or calling people to say "*goodbye*"
- Giving away valued possessions to others
- Aggression
- Fatigue
- Not making plans or looking forward to future events

Suicide Warning Signs – Mood

A person who is considering suicide may display one or more of the following:

- Depression
- Anxiety
- Loss of interest
- Dramatic mood changes
- Irritability
- Humiliation
- Agitation
- Rage
- Sudden improvement in mood after he/she had appeared depressed for a while

Predictors of Depression in Physicians

- Difficult relationships with senior doctors, staff, and/or patients
- Lack of sleep
- Dealing with death
- Making mistakes
- Loneliness
- 24-hour responsibility
- Self-criticism

Bright RP, Krahn L. Depression and suicide among physicians. Current Psychiatry. 2011; 10(4):16-30.

Protective Factors Against Suicide

- Effective clinical care for mental, physical and substance use disorders
- Easy access to a variety of clinical interventions and support for help seeking
- Connectedness– Strong connections to individuals, family, community and social institutions
- Support from ongoing medical and mental health care relationships
- Skills in problem solving, conflict resolution and nonviolent ways of handling disputes

Cultural and religious beliefs that discourage suicide and support instincts for self-preservation

US Public Health Service, The Surgeon General's Call to Action to Prevent. Suicide. Washington, DC: 1999.

Barriers to Treatment

- Social and professional stigma–
  - Fear of recrimination by colleagues, facilities where they work, credentialers, or licensing boards
- Perceived lack of confidentiality–
  - Fear that his/her illness will be documented in his/her academic record
- Accessibility–
  - Difficulty finding a local provider who he/she trusts, but is not a colleague
- Reluctance to seek treatment
- Time constraints
- Affordability
- An attempt to diagnose and treat themselves
- Seeking and receiving "*VIP treatment*" from other health care providers
- Belief that treatment does not work

Bright RP, Krahn L. Depression and suicide among physicians. Current Psychiatry. 2011; 10(4):16-30.

Lack of Mental Health Treatment (1/2)

- Fears about the potential for seeking mental health care to negatively impact one's professional reputation, ability to get or maintain licensure, or malpractice insurance are largely unfounded
- **What is more likely to harm a physician's reputation, licensure and insurance, are unaddressed and worsening mental health conditions**

Gold KJ, Sen A, Schwenk TL. Details on suicide among US physicians: Data from the National Violent Death Reporting System. General Hospital Psychiatry. 2013; 35(1), 45-49.

Lack of Mental Health Treatment (2/2)

- In cases where **physicians died by suicide**, **depression** is found to be a significant risk factor leading to their death at approximately the same rate as among non-physician suicide deaths
- **Physicians who took their lives were less likely to be receiving mental health treatment** compared with non-physicians who took their lives

Gold K J, Sen A, & Schwenk T L. Details on suicide among US physicians: Data from the National Violent Death Reporting System. General Hospital Psychiatry. 2013; 35(1), 45-49.

Burnout

Emotional exhaustion–

Tired, nothing left to give, no pleasure

Depersonalization–

Cynicism, going through the motions, like a robot, automatic pilot

Decreased sense of accomplishment–

Never good enough, not worthwhile

Stress and Productivity

Approaching a Depressed Colleague

Take the lead and be gently assertive–

As a general rule, it is easier and safer for healers to be in the healing role and much harder to be in a position of vulnerabiReach out and do not wait for them to come to you

Normalize their experience–

Remind him/her of the difficult realities of medicine

Your training and your work is inherently stressful and challenging

Hence, feeling distressed or overwhelmed is natural at times

If you are comfortable, self-disclosure or sharing examples of others who have struggled can be powerfully validating

Be a good observer–

Do not tell someone how you think they may be feeling, as this could be experienced as either threatening or condescending

Rather, observe and reflect their behavior, and ask them to ascribe meaning (e.g., "*I notice you have been late to clinic/class a lot lately. How are things going for you?*")

Be reassuring–

Even though depression and other emotional problems can impact work performance at times, it does not mean you are a bad physician

It means you need to take steps to take better care of yourself

Be willing to offer flexibility and space for the person to get the help they need–

All the compassionate listening and caring for our students, trainees and colleagues will not amount to much if we do not offer opportunities for them to avail themselves of the resources they need in times of emotional distress

Furthermore, individuals probably need to hear very clearly that there will be no negative repercussions for them seeking and receiving help in times of need

Speak clearly and directly–

Once the conversation is opened, do not be afraid to use words like “*depression*” or “*suicide*”

If people are struggling with these issues, it can a relief to have an opportunity to discuss them

Know your resources–

Be ready to offer real help in the form of information about how a person in your environment can get help quickly, if necessary

Please see “Suicide Prevention” Resource Document provided by the GME office.

Physician Impairment and Substance Use Disorder

UNMC Psychiatry presentation

Physician Impairment

*“The inability to practice medicine with reasonable skill and safety to patients by reason of physical or mental illness,
including deterioration through the aging process, the loss of motor skills, or the excessive use or abuse of drugs, including alcohol.”*

AMA Code of Medical Ethics.

““…physical or mental health conditions that interfere with a physician’s ability to engage safely in professional activities...”

AMA Code of Medical Ethics.

AMA’s Code of Medical Ethics
Opinion 8.15

“It is unethical for a physician to practice medicine while under the influence of a controlled substance, alcohol, or other chemical agents which impair the ability to practice medicine.”

AMA Code of Medical Ethics.

AMA’s Code of Medical Ethics
Opinion 9.3.1 (b)

“Take appropriate action when their health or wellness is compromised, including:

(iv) seeking appropriate help as needed, including help in addressing substance misuse or substance use disorders. Physicians should not practice if their ability to do so safely is impaired by use of a controlled substance, alcohol, other chemical agent or a health condition”

AMA Code of Medical Ethics.

Alcohol Misuse

Alcohol misuse is a common **response to unmanageable stress**

Alcohol **increases impulsivity** and the **risk of a suicide attempt**

US Public Health Service, The Surgeon General's Call to Action to Prevent. Suicide. Washington, DC: 1999.

15-20% (1,2) of health care professionals will misuse substances at one point in their career

- **Alcohol** – Most commonly used
- **Opioids & stimulants** – Next most common
- **Recreational drugs (cannabis, cocaine)** use is less than the general population

Men > women likely to misuse substances

Women have higher prevalence of alcohol use and choose alcohol over other substances

Female physicians have higher alcohol misuse rates than general population

Oreskovich MR, Kaups KL, Balch CM, Hanks JB, Satele D, Sloan J, Meredith C, Buhl A, Dyrbye LN, Shanafelt TD. Prevalence of alcohol use disorders among American surgeons. Arch Surg. 2012 Feb;147(2):168-74. doi: 10.1001/archsurg.2011.1481. PMID: 22351913.

Female Impaired Physicians

More likely to report past (51.8% vs. 29.9%; OR = 2.51) or current (11.4% vs. 4.8%; OR = 2.54) **suicidal ideation**

More likely to have made a **suicide attempt** whether under the influence or not

More likely to **misuse sedative hypnotics** than men (11.4 vs. 6.4; OR = 1.87)

Less likely to have family problems, specifically in the marital realm (OR 0.50; 0.32-0.76) and with their children (OR 0.52; 0.28-0.97)

Less likely to have a mandatory referral as a presenting problem at treatment (OR 0.61; 0.39-0.95) and less likely to have had loss of staff privileges (OR 0.46; 0.26-0.83)

No gender differences in employment problems (65.3% vs. 67.5%) or legal problems

By Specialty

Most studies have reported a consistently higher rate of drug and alcohol use in emergency room physicians, psychiatrists, anesthesiologists and

physicians in solo practice

ER physicians – **Cannabis** (10.5 vs. 4.6%) and **cocaine**

Psychiatrists – **Benzodiazepines** (26 vs. 11%)

Anesthesiologists – **Major opioids** (although more have alcohol use disorders than opioid use disorders)

Pediatricians, pathologists, radiologists, and obstetricians and gynecologists have the lowest rates of substance use among physicians

Easy Access Creates Risk

Physicians have easy access to medications that can be misused:

When administering to patients

By self-prescription

Alcohol is available to physicians as it is to anyone in our society

Identifying Impairment

Family and marital problems (often occur first)

Financial issues, legal issues (DUI)

Work performance is typically not impaired until the more advanced stages (Can be 6-7 years from diagnosable SUD to treatment)

Physicians are likely to protect their work performance until the disease has neared the end stage

43% of opioid-using doctors had been using opioids for more than 2 years before detection

The physician with substance use disorder often retains the ability to protect his/her practice performance at the expense of other dimensions of life

Social, family, and emotional problems will often occur prior to practice impairment

No one sign signifies impairment

Collectively, however, they may define a pattern and provide warning that a potential problem exists

Early identification can help remediation and assure patient safety

Burden and Implications

Substance use disorder is very disabling among physicians

Addiction has been directly associated with physician suicide

Accidental death may occur while intoxicated

Patient safety

Substandard care by physicians also affects colleagues

Legal ramifications

Loss of job – Difficulty finding other jobs
Loss of medical license
Loss of DEA Registration Number

The Conspiracy of Silence Related to Stigma

The key barrier to intervention is **denial**:

By the impaired physician
By colleagues
By family
By associates

Shame –

Physician as weak, selfish, bad person

Fear of Reprisal

Loss of prestige and livelihood

The Need for Intervention

Intervention may be necessary when an individual is either unaware of her/his addiction or, because of shame, fear, or denial, is psychologically unable to recognize the seriousness of the disease or the need to seek treatment.
Physical or mental illnesses often co-occur with substance use disorders and requires intervention in their own right – Have to treat the whole person

Code of Medical Ethics
Opinion 9.3.1

When physician health or wellness is compromised, so may the safety and effectiveness of the medical care provided. To preserve the quality of their performance, physicians have a responsibility to maintain their health and wellness, broadly construed as preventing or treating acute or chronic diseases, including mental illness, disabilities, and occupational stress.

Collectively, physicians have an obligation to ensure that colleagues are able to provide safe and effective care, which includes promoting health and wellness among physicians.

State laws that require reporting of specified physician conduct to state agencies vary considerably by jurisdiction

AMA's Code of Medical Ethics
Opinion 9.3.2

Providing safe, high-quality care is fundamental to physicians' fiduciary obligation to promote patient welfare. Yet a variety of physical and mental health conditions—including physical disability, medical illness, and substance use—can undermine physicians' ability to fulfill that obligation. These conditions in turn can put patients at risk, compromise physicians' relationships with patients, as well as colleagues, and undermine public trust in the profession.

In carrying out their responsibilities to colleagues, patients, and the public, physicians should strive to employ a process that distinguishes conditions that are permanently incompatible with the safe practice of medicine from those that are not and respond accordingly.

Steps for Intervening if Physician Addiction is Suspected (*Physicians Helping Physicians*)

Contact the state physician health program (PHP) Nebraska Does Not Have a PHP – Consider LAP or EAP

Recruit others to assist you (avoid having a conversation with the physician alone – Should not be a confrontation)

Express positive regard for the physician's abilities (demonstrate respect for the individual)

Describe specific, observable problem behaviors of concern

Avoid accusation or blame; be kind and empathetic

Avoid negotiating, arguing, or bargaining (do not engage the individual in attempts to avoid the intervention)

Present a specific plan of action for assessment and treatment (consider working with the state PHP to develop a plan first)

Indicate clearly the consequences of not following through with the plan

Insist on immediate action; do not consider requests for "*one more chance*"

Provide for safe transition and transportation to the next step in the plan (typically, assist the physician in attending a professional assessment)

Activities of PHP for Physicians with Substance Use Disorders

Usually Required

- Abstinence from all substances, including alcohol
- Group therapy with other physicians with a professional facilitator
- Individual psychotherapy
- Mutual help meetings (Multiple times per week)
- Body fluid screening, random as well as for cause (Multiple times per month)

Possibly Required

- Psychiatry Care
- PCP (No self prescribing and ask advice on OTC medications)

Family Therapy
Workplace limitations (No opioids or procedures with opioids)
Prescribing limitations
Work hours limited
Neurocognitive testing
Return to work evaluation, if disability requires several months’ absence