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MINDFULNESS AND COMPASSION AS ANTIDOTES TO PHYSICIAN ADDICTION

Patricia Lynn Dobkin, Editor-in-Chief
Department of Medicine & Programs in Whole Person Care, Faculty of Medicine, McGill University, Montreal, Quebec, Canada
patricia.dobkin@mcgill.ca

ABSTRACT

Addiction, broadly defined, is common in healthcare settings. A person can be addicted to substances, junk food, work, power, money, using mobile devices, and so on. The problem is generally ignored until dire consequences occur (e.g. a critical mistake is made, or the clinician acts in an unprofessional manner). Once identified, addicted physicians are usually referred to Physician Health Programs i.e. sent elsewhere to deal with their presumed personal issues. A Buddhist view of addiction differs from Western psychology and psychiatry in that it examines compulsive behaviours in the light of 'common humanity.' Craving is seen to be the cause of (all) suffering. Obsessions (about the desired object) occur in the mind; this then triggers compulsive acts. And thus, treatment includes examining how the mind works, how it influences behaviours, and how it can be used to heal suffering.

KEYWORDS: Addiction, Physician health, Buddhist psychology

Typically, physician impairment has been associated with substance abuse. More recently, burnout and depression have been considered important manifestations of impairment [1]. The 3rd International Congress on Whole Person Care taking place in Montreal in October 2019 will address: Compassion, Addiction and Culture Change. The themes of the congress intrigued me enough to submit an abstract and write this essay examining physician addiction from a novel angle. In the context of the Clinician's Art, I will not be comprehensive; rather, my intention is to invite readers and those working

in healthcare systems to offer compassion as an antidote to people/colleagues who suffer deeply due to this problem. As is evident in the narrative written by Dr. Grinspoon [2] "Back from the Abyss: A Recovered Doctor's View of the Opioid Epidemic," medicating stress and emotional pain with opiates not only failed to bring him genuine relief, but it also cost him dearly. Relevant herein, the way the judicial system and medical board treated him rendered his road to recovery longer and harder following rehabilitation.

'Addicted to what?' one may ask. Opioids, benzodiazepines, stimulants and alcohol have been viewed as the main culprits. Nonetheless, other than substances, one can be addicted to work, gambling, sex, e-mailing, surfing social media sites, and so on [3]. Reliable prevalence data are lacking for alcohol and substance abuse in doctors. In 2000, Weir [4] suggested that the rate was "likely similar" to that of the general population – 9%, whereas in a more recent study of American doctors [5] 12.9% of men and 21.4% of women (albeit, with a response rate of only 26.7% of the 27,276 MDs surveyed) met criteria for alcohol abuse or dependence. Reportedly, abuse of prescription or illicit drugs was rare. Given the stigma attached to addiction, underreporting makes it impossible to know the true extent of the problem.

According to the Centre for Addiction and Mental Health in Ontario, Canada [6] a simple way of describing addiction is the presence of 4 **C**s:

1. **C**raving
2. Loss of **C**ontrol of amount or frequency of use
3. **C**ompulsion to use
4. Use despite **C**onsequences

The 4th **C**, consequences, refers to various aspects of a person's life: physical and mental health, family relationships, social networks and work performance. All are important to whole person care. How is addiction related to burnout and distress? The etiology of addiction is multifactorial (e.g. genetic predisposition, environmental, childhood abuse). Co-morbidity is high (e.g. depression, personality disorders). Abuse of substances can start as a form of self-medication, as described by Dr. Grinspoon. This is where overlap with burnout may occur. Physicians feel emotionally exhausted, no longer think they are doing a good enough job; subsequently, they may become cynical and withdrawn from the person-part of medical care.

There are many reasons why impaired physicians hide their problems; some of these are related to the culture of medicine itself. It is normative for doctors to work while ill, as they are concerned that they will burden their colleagues should they take time off to recover. At times, inter-collegial conflicts contribute to distress. Evaluations are constant and can be tough during training (and beyond) rendering it hard for a physician to admit 'not knowing' or being stuck in a problem, including a personal one. Moreover, a sense of being made of the 'right stuff', a kind of machoism whereby illness reflects weakness may exist. There is

shame attached to any form of mental illness, especially addiction. An unspoken rule, 'Don't ask, don't tell.' pervades. Institutions vary regarding the duty to act when one suspects a colleague is impaired. One may hesitate for fear the person in question may lose their license to practice – a dreaded consequence. Wistrand [7] points out that role confusion i.e. transitioning from doctor to patient (with addiction, as well as other illnesses) is especially challenging.

To date, the solution has been to refer them to Physician Health Programs (PHPs). These agencies, in turn, refer the 'doctor-patient' to a specialist and/or treatment centre, monitor progress, and may negotiate return to work. In fact, Dr. Grinspoon mentioned that this step helped him the most by providing long-term follow-up. But as noted in the Canadian Medical Association report, barriers to seeking treatment (in general) were: (1) believing the situation was not severe enough, (2) ashamed to seek help, (3) not aware of the range of services available. In fact, a report from the UK [8] regarding healthcare professionals (about half were MDs) referred for inpatient treatment showed that self-referral was unlikely (9% of their sample). Referrals were mostly due to absenteeism or an incident in which the person was intoxicated at work.

A Buddhist view of addiction differs from Western psychology and psychiatry [9] in that it examines these behaviours in light of 'common humanity' (see Houlihan and Brewer [10] for the science of mindfulness as a treatment for addiction). The four noble truths and their application in medicine are summarized in Table 1.

1. The truth of suffering (*Dukkha*)
2. The truth of the origin of suffering (*Samudāya*)
3. The truth of the cessation of suffering (*Nirodha*)
4. The truth of the path to the cessation of suffering (*Magga*)

The Buddha is often compared to a physician. In the first two Noble Truths he diagnosed the problem (suffering) and identified its cause. The third Noble Truth is the realisation that there is a cure.

The fourth Noble Truth, in which the Buddha set out the Eightfold Path, is the prescription, the way to achieve a release from suffering.

Table 1 The Four Noble Truths in Buddhism

In general, the first **C**, craving, is seen to be the cause of (all) suffering (the Second Noble Truth). This can be craving for alcohol, power, sex, status, or for the end of unpleasant conditions, such as withdrawal symptoms. The third **C**, compulsion results from obsessions. And thus, treatment includes examining how the mind works, how it influences behaviours, and how it can be used to heal suffering.

One rehabilitation center (https://www.hope-rehab-center-thailand.com/blog/personal-development/buddhism-and-addiction/) applies the Buddhist Eightfold path to recovery from addiction. For example, in their program:

- Right understanding – learn about the nature of addiction
- Right intention – commit to sober living; be kind with yourself and others
- Right mindfulness – use mindfulness so you are less caught up in thoughts and emotions; notice automatic reactivity and break its cycle
- Right concentration – practices like mindfulness improve focus leading to clearer thinking
- Right effort – make sobriety your number one priority in life
- Right view – with the help of therapy you begin to let go of beliefs and opinions that have been holding you back in life (e.g. low self-esteem)
- Right livelihood – if the way you make your living is triggering your addictive behaviour (e.g. prescribe and dispense medications), you may need to make career changes
- Right action – commit to regularly doing the things you need to do to maintain sobriety

Levine [11] published a book in 2014 entitled, Refuge Recovery: A Buddhist Path to Addiction Recovery. He echoes and expands upon the above by integrating selected elements of the 12-step programs (e.g. Alcoholics Anonymous). The path to sobriety includes commitment to abstinence, daily meditation practices, written exercises to gain insight into the causes and conditions of addiction, as well as finding community support. Helping others on the path of recovery (like AA sponsors) is encouraged. Levine acknowledges the ethical and emphasizes the spiritual aspects of overcoming addictions without using language based in theology (i.e. God, Higher Power).

Most approaches to the treatment of addiction place the burden on the individual. Yet, addiction does not occur in a vacuum. There are cultural and environmental factors (e.g. ease of availability) that contribute to the problem. Rather than blame the person, can compassion (another **C**) be brought to the situation? First, self-compassion is needed because shame and guilt are so dominant across addictions. Learning to work with the ‘inner critic’ and the reinforcement of negative mental patterns with mindfulness practices can gradually ‘make space’ for healing emotions such as love and gratitude. Importantly, affiliating with others who do not criticize and marginalize the person in question is essential. Some rehabilitation programs offer groups for doctors, dentists or other healthcare professionals so they can feel less isolated and address their special needs.

Staff at the Physician Health Program in Ontario, Canada note:

"*These doctors are usually compassionate people, dedicated in the extreme to the well-being of their patients — to their own detriment and often that of their families. They tend to be perfectionistic, obsessive and rigidly self-controlled. Stressed and lacking healthy coping strategies, some find ease and comfort in drugs or alcohol. Thus, the seeds of abuse and dependence are sown, especially when there is a family history of substance use disorders*." [12]

Self-awareness (that emerges with regular meditation practice) and self-compassion need to be nurtured in the context of social relationships. Wistrand [7] describes how one addicted doctor received support from his manager and associates. For example, following recovery, colleagues helped him to 'catch up' professionally upon return to work. It may be beneficial to have representatives from the PHPs share their expertise with physicians and medical boards who judge 'offenders'; emphasizing that addiction is a chronic illness. An attitude change may ensue, reducing stigma. Marshall [13] stresses the need for education about addiction, in general, and specifically about risk factors for doctors, beginning in medical school. As an addiction psychiatrist, she recommends providing more support for doctors early in their carriers and ensuring they have their own GPs to avoid self-medication. Given current rates of burnout in residents, her call for action over a decade ago remains pertinent. At the organizational and policy-making levels, examination of what changes could be made to address contributors to distress, burnout, and addiction is called for.

Addiction is widespread in the general population. Clearly the 'war on drugs' and punishment tactics have failed. When heroin addiction plagued Portugal's population a radical approach was tested. In 2001, possession and consumption of *all drugs* were decriminalized. Rather than be arrested, those caught with a personal supply were warned, paid a small fine, and/or were told to appear before a local commission – with a doctor, lawyer and social worker who informed them about harm reduction, treatment, and offered support services. Outcomes are promising (e.g. dramatic decreases in HIV infections), although not all aspects of the problem have been tackled. A slow culture shift enabled this to occur. Is it not time to have one in the medical system? Imagine what that might look like and reflect on what you can do personally to impact your work environment so that physicians with addiction can be treated with respect and compassion.■

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