A pioneering experience in Brazil: the creation of a support network for alcohol and drug dependent physicians. A preliminary report

Uma experiência pioneira no Brasil: a criação de uma rede de apoio aos médicos dependentes de álcool e drogas. Um relatório preliminar

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Abstract

Objective: The objectives of this study are to present the creation and operation of a support network to help physicians in Brazil, describe the socio-demographic profile, and investigate the prevalence of mental disorders and chemical dependence among physicians seeking treatment. Method: Semi-structured interviews using ICD-10 criteria were conducted to obtain data regarding alcohol/drug dependence, and psychiatric comorbidity. Socio-demographic and occupational characteristics were obtained. Results: 247 patients made contact and 192 attended the first evaluation visit. Of those, 158 were male, and most (55%) were married. The mean age was 42.4 ± 11.1 years. The reasons for seeking treatment were: comorbidity between mental disorders and chemical dependence (67.7%); chemical dependence (20.8%); mental disorders (7.8%); and burnout (4.2%). The mean interval between the detection of the problem and seeking treatment was 7.5 years. Factors associated with the severity of the problem included unemployment (21.6%), difficulties of practicing professional activities (63.5%), problems with the Regional Council of Medicine (13%), psychiatric hospital admission (31.2%), and self-medication (71.8%). In our sample, 9.3% of the physicians had changed their area of specialization. Conclusions: A high prevalence of psychiatric disorders was found in this sample as well as psychosocial and professional problems. Treatment networks focusing on the physicians' mental health could catalyze cultural changes in treatment-seeking behavior, thereby improving early detection and treatment.

Descriptors: Physicians; Mental health services; Substance-related disorders; Burnout, professional; Mental health disorders

Resumo

Objetivo: Pretendemos apresentar a criação e o funcionamento de serviço específico para médicos no Brasil, descrever o perfil sociodemográfico, prevalência de transtornos mentais e dependência química entre médicos que buscaram o serviço. Método: Foram realizadas entrevistas clínicas semi-estruturadas baseadas no CID-10 para diagnóstico de dependência de álcool/drogas e comorbidade psiquiátrica. Um perfil sociodemográfico e ocupacional foi obtido. Resultados: 247 contatos foram feitos e 192 pacientes compareceram ao primeiro atendimento. Destes, 158 eram homens, a maioria casados (55%), idade média de 42,4 ± 11,1 anos. As causas de procura por atendimento foram: comorbidade entre transtorno mental e dependência química (67,7%), dependência química (20,8%), transtornos mentais (7,8%), burnout *(4,2%). O intervalo médio entre a identificação do problema e a busca de tratamento foi de 7,5 anos. Desemprego (21,6%), problemas no exercício profissional (63,5%), problemas no Conselho Regional de Medicina (13%), internação psiquiátrica pregressa (31,2%) e auto-medicação (71,8%) associaram-se à gravidade dos problemas. Mudança de especialidade ocorreu em 9,3% da amostra. Conclusões: Observamos uma prevalência alta de transtornos psiquiátricos bem como problemas psicossociais e profissionais nesta amostra. Serviços específicos de atenção à saúde mental dos médicos podem ter efeito catalisador nas mudanças culturais quanto à procura de ajuda, favorecendo a detecção precoce e tratamento.*

Descritores: Médicos; Serviços de saúde mental; Transtornos relacionados ao uso de substâncias; Síndrome do esgotamento profissional; Transtornos mentais

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Introduction

The issue of physicians' mental health and the availability of psychiatric support for physicians[1] and residents[2] are relevant topics in the scientific literature. Issues related to occupational health[3] and the stressful nature of medical work[4] have been widely discussed. In addition, it is known that physicians tend to work in an independent manner, with a controlling attitude, giving the false impression that they "can take care of themselves" and "know what they are doing". In general, the medical culture values characteristics such as independence, self-efficacy and competitiveness. Those who have a mental disease are stigmatized and lose the respect of their peers and patients. Denial of mental suffering results in a delay in seeking help and treatment. Chemical dependence or mental disorders, combined with the medical culture of self-negligence and procrastination, can lead to problems in professional relationships or in the care of patients.

This issue deserves further discussion, and the sooner this debate takes place, the better, because it is possible to detect a significant incidence of alcohol- and drug-related problems as well as psychiatric disorders among medical students.[5]

Physicians present higher incidence of psychiatric disorders than other professionals in similar occupations.[6] The main cause of early retirement among physicians is psychiatric disorders, especially those related to anxiety, depression, or alcohol dependence.[7] In a 25-year follow-up study involving 114 surgeons, it was found that alcoholism occurred in 7.3% and was the principal cause of early retirement.[8]

The combination of the above-mentioned factors indicates the importance of implementing specific services for the care of physicians. In fact, these services follow a worldwide trend and have been growing in size and scope in countries such as the United States, the United Kingdom, Australia, Canada, and Spain. In this context, a consensus reached in Barcelona in 2001, convening European networks for physicians, set the following essential missions for these services:[9] ensure the same access to treatment that is offered to the general population; maintain confidentiality; create a sufficient number of treatment programs to meet the demands of ailing physicians; maintain contact with agencies that regulate professional practice (whose role is to finance and manage these services); maintain the quality of the treatment provided; have a preventive purpose, providing favorable conditions for the early detection of mental disorders. In addition to the above, the service also has to develop research projects evaluating physician work conditions and risk factors for mental disorders, as well as promote health awareness campaigns.

Access to reliable epidemiological data in the medical population is difficult due to factors such as fear of stigma and concerns regarding confidentiality. Such studies can be carried out in one of three principal modes:[10] population survey, analysis of physicians submitted to disciplinary processes, or analysis of clientele treated at facilities designed specifically for physicians. Since this is a hard to reach clientele, there is a great need for studies that use convenience samples such as the one we present. Specifically in Brazil, there is little reliable data to serve as basis for adequate treatment policies.[11]

Physician support network

1. Network description

The objectives of this network, resulting from an agreement reached in May 2002 between the Conselho Regional de Medicina do Estado de São Paulo (CREMESP, State of São Paulo Regional Medical Council) and the Universidade Federal de São Paulo (UNIFESP, Universidade Federal de São Paulo) Study Centre of the Department of Psychiatry, are as follows: to reduce the disabilities arising from various mental disorders and chemical dependence; ensure prompt access to treatment; perform early diagnosis, thus protecting both the physician and the patients. The network is headquartered at the Unidade de Pesquisa em Álcool e Drogas (Alcohol and Drug Research Unit).

The network consists of a psychiatric clinical support service, which can be initially accessed by e-mail or by telephone. In this first contact, a trained secretary records identification data for further follow-up by telephone and schedules an interview with a psychiatrist within the following 24 to 72 hours. The erratic nature of physician-patient motivation requires that medical care be provided as soon as possible.

After a one-month initial period, the patient is referred to a network of 25 psychiatrists practicing in the state of São Paulo in order to proceed with the treatment. On a regular basis, physician-patients receive telephone calls to evaluate the evolution of the case.

This network receives financial and strategic support from CREMESP, as well as legal counseling in cases that need guidance related to ethical and legal issues. This is not, however, a service requiring expert examination and the confidentiality of the medical care is guaranteed. Accordingly, CREMESP is not notified regarding any of the cases.

Data deriving from interviews are used in a confidential research project, assuming that the participant gives written informed consent. This study was approved by the UNIFESP Ethics in Research Committee pursuant to Resolution 196/96 of the National Health Council (n. 1230/03).

Method

Two trained interviewers carried out a semi-structured assessment, which lasted for about 90 minutes, and registered socio-demographic occupational data, patterns of psychoactive substance use, as well as data related to alcohol/drug dependence and the presence of other mental disorders. The psychiatric diagnoses were made using a symptom checklist based on the ICD-10 criteria. Correlated variables, such as unemployment, marital problems, motor vehicle accidents, psychiatric hospital admissions, change of area of specialization, problems at work, and problems with CREMESP, were assessed dichotomically according to their occurrence (yes/no).

All physicians who participated in the first interview were included in the study sample.

Results

From May 2002 to May 2006, 247 physicians contacted the network, and 192 attended the first interview. Of those 192, 158 (82.3%) were male, 107 (55%) were married or had a steady partner, 53 (28%) were single, 21 (11%) were separated or divorced, and 11 (6%) were widowed. Most patients (164 cases, 85.4%) came from the state of São Paulo.

Spontaneous search for treatment occurred in 99 cases (52%); 59 (32%) were referred by family members, and 29 (16%) were referred either by their peers or by CREMESP.

The mean age was 42.4 ± 11.1 years old at the time of treatment. Since the mean age was 32.5 ± 9.73 years old at the onset of the problem and 40 ± 11.2 years old when treatment was sought, there was a mean delay of 7.5 years in seeking treatment.

The main diagnoses were as follows: alcohol/drug dependence concomitant with a mental disorder (130 patients, 67.7%);

only alcohol/drug dependence (40 patients, 20.8%); mental disorders (15 patients, 7.8%); and "burnout" (8 patients, 4.2%).

The main psychiatric diagnoses and those related to the use of psychoactive substances are shown in Table 1.

Marital problems arising from psychiatric disorders or chemical dependence occurred in 98 (53%) of the cases.

As to work-related problems, 41 physician-patients (21.6%) reported being unemployed at some point, 122 (63.5%) reported problems in the practice of their professional activities, 26 (13%) had experienced problems with CREMESP, and 35 (18.2%) had other legal issues. There were 60 physician-patients (31.2%) who had previously been admitted to a psychiatric hospital. Self-medication was common (138 cases, 71.8%). Motor vehicle accidents attributable to substance use occurred in 50 cases (26%).

Due to mental disorders or chemical dependence, 18 physicians (9.3%) changed their areas of specialization.

A significant portion (55 of the 247 telephone contacts) received no treatment of any kind. Given the difficulty to begin the treatment process, the study of obstacles to the treatment[12] and the telephone follow-up evaluation of those cases that made initial contact by telephone or e-mail may be essential for the clinical approach of this clientele

Discussion

Since this study is a description of the only network designed specifically for physicians practicing in Brazil, it gives the only description of a convenience sample of physicians under treatment, which is a way of assessing the epidemiological picture of physicians. The fact that all interviews were conducted by the same two interviewers increases the data reliabilit. However, the findings cannot be extrapolated to all physicians currently presenting problems resulting from mental disorders, which we believe still represent a considerable amount of cases not being treated.

Our experience showed that the profile of physicians contacting the network has been gradually changing, with a steady increase in the spontaneous search for treatment. In a previous study of substance dependent physicians,[11] we observed spontaneous search for treatment in 30.3% of the sample. This increase (52% in this sample) is a relevant finding, since it is associated with a higher rate of adherence to treatment among health professionals.[13]

Recognizing mental disorders, drug dependence, and suicidal behavior among physicians is very important. Unfortunately, these reports are often neglected, which consists in a serious obstacle to face the problem.[14] Preventive attitudes must be adopted, since there is epidemiological evidence showing that drug and alcohol problems are increasing among Brazilian college students, including medical students.[15]

We believe that better instruction in medical schools can improve early detection, as well as increase treatment seeking behavior and reduce self-medication. In our view, the support of agencies that regulate professional practice improves the visibility of the network. No resistance of the population served by this network was found during the study.

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Table 1 - Main mental disorders in the population of 192 physician-patients*

Diagnosis of disorders caused by psychoactive substances (ICD-10)			
Drug	Total	Harmful use	Dependence
	n (%)	n (%)	n (%)
Alcohol	104 (54.1)	21 (10.9)	83 (43.2)
Benzodiazepines	65 (33.8)	3 (1.5)	62 (32.3)
Opioids	54 (28.1)	4 (2.1)	50 (26.0)
Cocaine and crack	40 (20.8)	7 (3.6)	33 (17.2)
Marijuana	28 (14.5)	10 (5.2)	18 (9.3)
Amphetamines	13 (6.8)	4 (2.1)	9 (4.7)
Inhalants	2 (1.0)	1 (0.5)	1 (0.5)
Diagnosis of mental disorders (ICD-10)			
	n		%
Depression (F32 and F33)	65		33.9
Anxiety disorders (F41)	22		11.5
Bipolar disorders (F31)	14		7.3
OCD (F42)	5		2.6
Schizophrenia (F20)	5		2.6
Phobic disorders (F40)	3		1.5
Attention deficit disorders and hyperactivity (F90)	3		1.5
Pathological gambling (F63)	3		1.5
Anorexia (F50)	1		0.5
Personality disorders (F60)	31		16.1
"Burnout" (Z73.0)	8		4.2

**This number may exceed 192, since various cases present multiple diagnoses*

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