COMMENTARY

Alcohol Abuse in the Workplace: When You Smell It, Do You Ask?

Peter Washburn, MD

Introduction

What do you do when you smell alcohol on the breath of a coworker? For obvious—and not so obvious reasons—this question has greater significance for those in health care. The following are excerpts from my memoir of 12 years as a Navy physician. In the 70s and early 80s, I became interested in what is now called Addiction Medicine. This interest blossomed when I took a two-week course for health professionals on substance abuse at the Naval Hospital in Long Beach, CA under the leadership of Captain Joseph Pursch, MD, then Medical Director.

Fresh from this two-week course, I returned to the Naval Hospital where I was stationed, now an "expert" on the diagnosis and treatment of alcoholism. A few months after my return, I had the opportunity to put into practice something I had learned in Long Beach.

The Doctor

Before I arrived at this small hospital in the mid-1970s, I heard rumors that my new boss had a problem with alcohol, had been in treatment for alcoholism, or some variant of this theme. The details weren't clear. If he were a recovering alcoholic, it would be very interesting, rewarding, even. But if the gossip was not accurate—for example, he should have gone to treatment but hadn't—then things could be awkward. Nothing like having an active alcoholic boss to make life challenging. Since the information was so sketchy, I had to proceed as if I knew nothing of these rumors.

There was no hint that John, the Chief of Internal Medicine, had a special relationship with alcohol. I had only been at this hospital a couple months when I submitted a request to attend the substance abuse course in Long Beach. If John was in recovery, that request ought to have flushed out some comment from him. He tacitly approved it without comment. Perhaps the rumor was a little off: "Boss" is ambiguous. Perhaps the rumors were about the Commanding Officer of the hospital or the Chief of Medicine, not the Chief of Internal Medicine. I wasn't about to investigate.

The Long Beach course and vague instruction from Dr Pursch to "keep an eye on your boss," raised my awareness. Confidentiality prevented Dr Pursch from disclosing anything specific, but I was certain the rumors were about John; I wasn't certain what role I should play.

I had noticed a faint wobble of the match when lighting the cigarillos he was fond of. It was not unusual for beads of perspiration to appear on his forehead during morning rounds. Too much coffee? Nervous because he was afraid we all were getting ahead of him in medical knowledge? Too hot and humid? Not in February.

As months went by, I became more involved in the alcohol unit. John said nothing about this, neither encouraging nor hindering me. He was the perfect boss: he left me alone.

Then, one morning as we were making rounds, I detected the smell of alcohol on John's breath. It was faint but unmistakable. As we were going our separate ways, I asked one of my colleagues if he noticed anything, smelled anything. "That's *your* baby," he said, distancing himself and walking off.

John obviously wasn't drunk; he wasn't slurring his words. It would be so easy to overlook the odor of alcohol—that fruity-sour smell—on John's breath, but that went against everything I had learned in Long Beach. This small detail could be the tip of the iceberg. Captain Pursch's words kept coming back to me: "keep an eye on your boss." Did he mean I should *do* something? I was due in the clinic in a few minutes and had little time to ponder. "Deal with it directly." "Act as you would in any other medical situation," my training nagged me. I found myself following John into his office, as if to ask him something. I closed the door behind me and sat down in front of his desk.

When I met him, John was a career Navy physician, older than I, a full Commander to my more junior Lieutenant Commander. He didn't live up to the imposing figure I had imagined. The first time I saw John he was working in the Emergency Room (ER) and I

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had to precipitously revise my preconceptions. A good foot shorter than I and overweight, he had worn a set of tight, pink scrubs, which, with his dark brown hair, made him look like a bottle of Pepto-Bismol. Now, sitting behind his desk, our height differences were no longer evident; his uniform reminding me he was my boss. I leaned forward and said quietly, "John, I'm pretty sure I smell alcohol on your breath."

He stared at me blankly, as if at a loss for words. I didn't have a follow-up. A moment of silence. I groped forward. "And if I can smell it, so can the patients."

That took it out of the realm of the personal. He couldn't say, "Oh, Peter's so hung up on this alcohol thing he sees alcoholics everywhere," something I was afraid people sometimes thought.

He looked innocent. Wounded. A plaintive, *"How could you?"* was the message I was being sent. Doubt arose about what I had smelled. Had I been mistaken?

He gave a little cough, relaxed, and then smiled. He pointed to a bottle of cough syrup sitting on his desk. "Do you suppose that's what you're smelling? I've had a little cold …" He gave another cough.

I felt had. And simultaneously relieved. He has this alibi. I hadn't been wrong, or, at least not completely wrong. Just off the mark.

I sat back, confused about where to go from here. Alcohol is a good cough suppressant and is almost always the main ingredient in cough syrups.

"Well, sir … Still, I don't think it's a good idea to be rounding on patients smelling of alcohol."

He conceded with a lame, "I guess you have a point." I left his office cowed.

Out in the hallway I still felt uncomfortable. Something said I wasn't done. The new CO, the Captain, also an internist, was a likeable man although I had had almost no dealings with him up to this point. I felt he ought to know.

Without further thought, I went to his office and asked his secretary if the Captain had a free moment. Seconds later I was seated in front of John's boss who welcomingly asked, "What's up?"

I got right to the point. "I was with John just now and I can smell alcohol on his breath. He says it's the cough syrup he's taking but I think it isn't a good idea for him

Substance Abuse in the Workplace Today

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In terms of substance abuse and addiction, although many things are still the same as they were 20-30 years ago, many are different. Rumors, denial, suspicions, embarrassment, and reluctance to report are all still inherent in substance abuse situations. However, far from being a two-week training period, today there is a field of medicine, Addiction Medicine, and a specialty, Addictionology, to guide peers; and there are legal mandates that, if they existed in the 70s and 80s, are certainly stronger and more substantial.

In the Northwest, the Northwest Permanente Physician Advocate Resource (PAR) was developed 16 years ago and any physician who has concerns about another can get assistance from PAR in negotiating the process of addressing substance abuse in another physician. This can even be done anonymously. The goal is to protect patients first and foremost but also to help the physician. PAR boasts a physician self-referral rate of 84% for all categories though self-referral for substance abuse is not as high.

Whereas the armed forces have their own rules and regulations regarding substance abuse, Washington and Oregon have definitive reporting laws, specific to each state but very similar in design. Licensees are mandated—and protected—by each state's medical board to report a peer as being impaired: impairment may be caused by substance abuse or any number of other problems; eg, emotional, marital, stress, and disease. In Oregon and Washington, a substance abuse case is referred to the Oregon Health Professional Program (HPP) or the Washington Physician Health Program (WPHP), respectively, both of which have many resources to assist in investigating suspected substance abuse and a monitoring/contract system for those who seek treatment. The Washington program also provides similar services to those dealing with mental disorders resulting in impairment. Of great importance is that both provide confidentiality from public and Board of Medical Examiners purview. As long as the physician is successfully active in the program s/he is protected from public disclosure including the National Data Bank. Nurses

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to be at work with alcohol on his breath …"

The Captain raised his right hand to stop me and said, "Thank you very much. I'll take it from here," and lowered his hand. He then nodded, indicating that I was dismissed.

On my way to the clinic I wondered if I had just made a mess of things in the front office. Who knew what the ramifications might be, for me, for John. I might never get approval to attend another alcohol conference. Not if I was going to be causing trouble like this.

The next day, work was awkward. John was his usual self, although I kept my distance. I had told my nose to take a vacation; I wasn't interested any more if that smell was still there. Weeks went by. Nothing was said, by anybody. All that for nothing.

Then, suddenly, John wasn't at work. He'd be out six weeks: the length of the Navy's course of alcohol treatment at that time. Although everyone seemed to know why he was out, no one said anything about it. If he had been out because of a broken leg, there would have been bits of information floating around about how he was doing, how it happened, how to get in touch with him. But no one said a word. He was just gone. Despite the added workload on the rest of us, I was secretly elated. The right thing had happened. When John came back, he'd be in recovery and we could joke about the whole thing. Then again, he might want to take over the management of the alcohol unit; that'd be his thing. The corpsmen would be calling him up and not me.

Well, no danger of that happening. When John came back to work a couple months later nothing was different. He didn't say anything about where he'd been, no one said anything, and life went on exactly as before.

A year later he retired. He had done his 20 years in the Navy, had gotten passed over for Captain, and decided to "take the money and run." He continued to live in town but I never heard from him.

But I heard from his wife. Some months after his retirement she called to tell me John was drinking again. Was there anything I could do? I had never met her; never even talked to her. Over the phone she told me about his treatment programs. Indeed, his first treatment had been in Long Beach. The Captain had

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and CRNAs have separate protocols from physicians, monitored by a different board.

When confronted with substance abuse, denial is a frequent problem, especially with professionals—they have a lot to lose. The HPP program involves a five-year contract that includes successful completion of a treatment program followed by two years of weekly HPP-directed meetings, a determined number of Alcoholics Anonymous (AA) or Narcotics Anonymous meetings including active participation in their 12-step program, obtaining an AA sponsor and, usually, attendance at a weekly AA meeting directed at medical professionals, three to four unannounced, forensic urine analyses each month. Depending on the success of the individual, the last three years have generally similar, but reduced activities. Relapse results in increased participation and may result in greater than five years of participation. It is not unusual for physicians to voluntarily continue their participation beyond five years as part of their ongoing program of recovery. In Oregon through the auspices of HPP, 90% of physicians with Substance Abuse (SA) recover, some following further relapse. Relapse is twice the rate if there is a positive family history for SA and twice the rate with dual diagnosis. The percentage of the general public in recovery is 50%. Most states have similar programs, some more active than others. They can all be reached by (anonymously) calling the physician licensing board in each state and asking for the phone number for the monitoring program. Another valuable resource is the Web site for the Federation of State Physician Health Programs: www.fsphp.org.

The smell of alcohol on the breath or a pharmacist's suspicions may be the first sign of a problem. Although treatment, monitoring, and reporting mandates may have changed over the last 20-30 years, the personal conflict of a peer regarding whether or not to report suspected substance abuse remains the same. It is important to educate observant and caring physician leaders and peers about what happens when they report suspected substance abuse and its importance not only to patients and the system but also to the potentially abusing physician.

Today, the Joint Commission requires that medical staffs of health care organizations and private hospitals have a physician well-being committee to address confidential concerns related to physician health. The activities of these committees are protected from discovery and from disclosure, except where patient safety is an issue. Each medical center or hospital staff office should be able to provide contact information for well-being committee members. The Northwest Region's confidential Physician Advocate Resource office can easily be reached by calling 503-249-6702. ❖

gotten him into the Naval Hospital program at Bethesda for his second attempt. John's wife had gone down to Washington for the family-week part of his treatment, had gotten very involved in a support group, but was frustrated that the second treatment hadn't "taken" either. She appreciated my role in getting him into treatment the second time. Was there anything we could do now?

I was grateful that she acknowledged my having something to do with getting John into treatment, but this time, I was at a loss. With John retired the Navy couldn't make him do anything. She was already doing what she needed to: attending her support group. If he was ever willing to come to the ER, I could arrange it so that he'd be admitted, at least to detox him. But that call never came.

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Months later I heard what happened in the end. One morning their 15-year-old daughter found him on the floor in the kitchen. Dead. The official cause of death after only a limited autopsy was listed as chronic alcoholism. Later the death certificate was amended to arteriosclerotic cardiovascular disease.

I attended his funeral. A military service: taps, colleagues from the hospital in uniform, the flag that had draped the coffin folded into a triangle, presented to his wife. Afterwards, his wife hugged me. There was no need for words. The real loss had occurred long ago.

The Nurse

Several months later, it happened again. I was on duty in the ER on a Sunday afternoon. I had just finished with a patient when I noticed the commander chief nurse (CDR) standing in the hall hugging a clipboard, tension in her face. I could tell she wanted to talk to me privately. "One of the ICU nurses has alcohol on her breath," she said quietly.

"Does she seem impaired? Slurring her words?"

"Oh, no. She seems fine. She just came on shift. But, I can smell it."

John all over again. But this time it wasn't just me faced with the dilemma of the colleague with "alcohol on breath." I had the CDR to back me up. The colleague was a woman, and not my boss. I shouldn't be intimidated. Still, it wasn't going to be easy.

"Did you say anything to her?"

"No, I thought I'd talk to you first."

"How about I come with you. You can introduce me." In effect I wanted the CDR to be the one who thought something was amiss. I was just a consultant, winging it.

Jane was beautiful, early 30s, single, and blonde. She was suitably surprised when the CDR and I intercepted her coming out of a patient cubicle.

"I wanted the doctor here to see you," the CDR began. Okay, that would be my modus operandi. I recalled some alcoholism expert saying once in a lecture: if ever one was stymied about what to do with an alcoholic, translate the situation into an analogous illness—diabetes could often serve as a useful example —and then the solution about what to do would appear automatically. With that tip I proceeded as if the CDR was worried that Jane was sick, truly sick, and she wanted her to see the doctor.

"Are you okay?" I asked gently.

Jane looked up at me, alarmed, eyes wide in innocent transparency. "Why, sure. Why do you ask?"

By now the CDR had retreated out of hearing range, leaving the two of us standing in the hall.

"Well, the CDR here thought she smelled alcohol on your breath and wanted me to check it out." By now I was close enough so that I too could detect that odor of alcohol. And indeed, she seemed just fine. Just a little rattled.

"Why … why … that can't be. There must be some mistake. I haven't had anything to drink. Gee, what d'ya think, I'd come to work after belting down a few?"

Behind the little joke she was all vulnerability and authenticity. This wasn't going the way I expected. How could I do this to her, be so heartless. I persisted. This was probably not going the way she expected either: *this guy is impervious to my charms.*

Quietly, calmly, I said, "Well, why don't we go down to the ER and get a blood alcohol. If it's ok, well you … we can forget the whole thing." I knew what I was saying was inane—at least the part about "forgetting the whole thing." But the part about getting a blood alcohol felt right. If there was a question about whether a patient was jaundiced or not, one simply got a blood test and that would settle it.

"Oh, is this really necessary?" Jane protested guilelessly, backing away. The CDR was now conferring with another nurse at the desk, hopefully explaining that the Lieutenant and I were going to be off the ward a few minutes. I held firm. I hadn't been wrong about John. And this time there were two of us who smelled something.

"Come, it will only take a minute." Another lie. What was I doing? With these little lies—which seemed wholly appropriate to the situation—I was drawing on unfamiliar resources. I was making it up as I went along. I had never before had the occasion to need a

blood test on a staff member while they were on duty. It wasn't going to be anonymous; the ER staff was going to know something was going on. Maybe behind a curtain I could just draw her blood myself, take it over to the lab … I wasn't sure what I was going to do.

"Gee, I really think this is pointless," she said but abruptly stopped resisting and accompanied me down the hall as if we were talking about some patient.

Halfway down the stairs she stopped and put her hand over her mouth. "Oh my God! I *did* have a drink. I was at a party this afternoon. I forgot." Was it the privacy of the stairwell or the inevitability of the blood test that elicited this confession? She smiled as if all was forgiven. "We don't have to go through with the blood test. I *did* have a drink, just before coming to work. I didn't think it would matter." She looked at me pleadingly.

"No, I think we should go through with it."

She was rooted to the spot. She got more insistent, "All right, I had a couple. But you don't need to get a test. I admit it."

I started to falter. My inflated sense of confidence was deserting me. But I had gotten too far into this to back out now. The CDR was watching, figuratively, from the sidelines. I still would have to report back to her what I had decided to do with one of her staff. And the other nurses in the ICU knew something was up.

She must have sensed my wavering. "Look, you don't know what this means to me. I can't have this on my record." She paused. She'd said too much.

"If you have a problem with alcohol, the Navy treats this as a medical issue. You don't have to worry. Trust me." There it was, another lie. Or at least, a promise I had no authority to keep.

"No. No. You don't understand. I've already been through treatment. This isn't the first time." Defeated, she confessed. Out came the whole story of a prior treatment. She had done well for a while. Then, had started drinking again. But she was sure they were going to fire her this time.

That certainly hadn't been the case with John. I couldn't tell her anything that might identify him, but I needed his example to reassure her. "There's this physician I know who went through treatment twice and he's still on duty. If you're willing to go through treatment again, that doesn't necessarily mean the Navy would want to get rid of you. Unless, there's something else I don't know."

"No. But they treat doctors differently than they do nurses," she pleaded. *Don't they?* was the implication.

I didn't want to proceed in this direction. It would not be up to me what happened to her. Who knew what machinations went on in the upper echelons of the Nurse Corps. Doubt about the ramifications of what I was doing began to seep in.

In the ER I took her into a treatment cubicle and behind the curtain of secrecy drew a red top tube of blood. I didn't have her check into the ER; there was no paperwork. As far as the ER staff was concerned a doctor and nurse were conferring privately behind a curtain.

Once the blood was drawn I suggested she go back to work as if nothing had happened. I'd let her know what the result was.

An hour later we knew. Her blood alcohol reflected somewhat more than a couple drinks earlier that afternoon. I told the CDR to alert the ICU that they would have to cover for Jane; I had sent her home. It crossed my mind that maybe I should have put her in the hospital. She could have gone into withdrawal, maybe gotten suicidal. But I was concerned that I had hassled her enough for one day. I took a chance that these things wouldn't happen.

They didn't. She went off to another round of treatment, and weeks later she was back at work.

Although she didn't exactly thank me, she acknowledged that making an issue of her drinking had been just what she needed. She and I became almost friends. Whenever we crossed paths in the hospital we stopped and chatted, discreetly of course, about how things were going. It felt good. I even asked if she wouldn't like to come work at the alcohol unit. We were trying to get a full-time nurse and she'd be perfect.

"Oh, I don't know about that," she laughed. "I don't think I could take it. I'm doing fine just as I am."

She continued to do well. And, for the four years remaining of my duty at that hospital, I had no further occasion to confront a coworker for having alcohol on his or her breath.

Today, after a 2-year fellowship in addiction medicine and 30 years of experience, I wouldn't hesitate to address a health care professional with alcohol on their breath at work. But, wouldn't you know; now that I'm ready, it just doesn't happen. I haven't smelled that telltale odor on a doctor or nurse in years. Times have changed. Or then again, maybe they duck into the nearest bathroom when they see me coming. ❖

Editor's note

With the exception of Dr Pursch, the names have been changed to protect identity.