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ORIGINAL ARTICLE

Prescription Drug Dependence, Smoking Relapse, and Professional Burnout among Medical Professionals: The Role of Emergency Physicians in Early Intervention

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ABSTRACT

Background: Substance use disorders (SUDs) and professional burnout are increasingly prevalent among healthcare professionals, yet they remain under diagnosed due to stigma and fear of professional consequences. This article explores the interplay between prescription drug dependence, smoking relapse, and occupational stress, particularly in cases where financial distress triggers substance use. The role of emergency physicians (EPs) in early identification, intervention, and rehabilitation is discussed.

Methods: A case based approach was used to analyze the risk factors, clinical manifestations, and treatment strategies for addiction and burnout among medical professionals. The latest evidence based guidelines from the American Society of Addiction Medicine (ASAM) and the National Institute on Drug Abuse (NIDA) were reviewed.

Results: Emergency physicians are often the first responders to impaired healthcare professionals. A structured intervention, including pharmacological management, nicotine cessation support, cognitive-behavioral therapy (CBT), and workplace modifications, was found to improve patient outcomes and professional reintegration.

Conclusion: Early detection and a non-punitive, structured intervention model can facilitate long-term recovery among medical professionals struggling with substance dependence, financial stress, and burnout. Emergency physicians play a pivotal role in initiating treatment pathways and advocating for a stigma-free recovery environment.

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KEYWORDS

• Prescription drug dependence • Physician burnout • Substance use disorder emergency physicians • Psychiatrist role • Rehabilitation center • Nicotine relapse • Financial stress • Cognitive-behavioral therapy • Addiction intervention • Workplace rehabilitation • Early intervention • Regular exercise

INTRODUCTION

The Growing Crisis of Addiction Among Medical Professionals

Physicians are at higher risk of substance use disorders (SUDs) due to workplace stress, emotional exhaustion, and easy access to prescription drugs.[1] However, addiction in doctors is often under reported due to professional stigma and fear of disciplinary action.[2]

Among medical professionals, the most commonly misused substances include:

Sedatives/Hypnotics (Zolpidem, Benzodiazepines) – Used for stress-induced insomnia but frequently misused, leading to cognitive impairment.[1]

Opioids & Pregabalin – Initially prescribed for pain but misused for anxiolytic and euphoric effects.[3]

Nicotine & Alcohol – Commonly used as coping mechanisms in high-stress environments.[4]

Emergency physicians (EPs) frequently encounter healthcare professionals with undiagnosed SUDs, making them key players in early intervention and structured recovery programs.[5]

Case Analysis: A Medical Professional Struggling with Addiction and Burnout

Clinical Presentation

A 36-year-old male doctor presented with:

Prescription Drug Dependence – Chronic daytime Zolpidem & Pregabalin use, escalating from occasional use to dependence.[1]

Cognitive Impairment at Work – Symptoms of slurred speech, confusion, and reduced efficiency, leading to patient safety concerns.[2]

Nicotine Relapse – Resumed smoking after six years of abstinence, triggered by financial stress and professional burnout.[4]

Work-Life Imbalance & Burnout – Long working hours, social withdrawal, and financial stress contributed to worsening psychological distress.[6]

Trigger: Financial Stress and High-Risk Trading

The physician suffered intraday trading losses of ₹ 45 lakhs, leading to:

The need to work two jobs to recover financially.

Increased stress and substance use as a coping mechanism.

Emotional dysregulation and risk-taking behaviors, worsening workplace performance.

Financial instability is a major but under recognized driver of substance use disorders (SUDs) and compulsive behaviors in physicians.[7,8] Despite multiple concerns raised by colleagues, his symptoms were dismissed as personal irresponsibility rather than a treatable medical condition.[3]

The Role of the Emergency Physician in Early Intervention

1. Early Identification of Substance Use Disorder (SUD) in Physicians

Emergency physicians were the first to recognize red flags, including:

Frequent ED visits for unexplained anxiety, insomnia, and mood disturbances.

Workplace performance issues, including absenteeism and near-miss medical errors.[9]

Recurrent nicotine/alcohol relapses, indicating worsening stress and loss of control.[4]

2. Pharmacological & Addiction Intervention

A structured medical approach included:

Zolpidem withdrawal – Gradual tapering with Diazepam substitution to prevent withdrawal-related rebound insomnia.[10]

Pregabalin discontinuation – Slow dose reduction to avoid withdrawal symptoms.[11]

Sertraline (100mg) & Buspirone (10mg) – Addressed underlying anxiety and depression.[12]

Quetiapine (100 mg) – Assisted in mood stabilization and sleep regulation.[13]

3. Nicotine Cessation & Financial Stress Management

Nicotine patches & CBT – Helped regain smoking abstinence.[4]

Impulse control therapy – Prevented further high-risk financial behaviors.[7]

Financial counseling & rehabilitation – Addressed gambling like trading behaviors and prevented future economic distress.[8]

4. Workplace & Psychological Rehabilitation

Work modifications – Shorter shift durations and supervised schedules facilitated recovery.[6]

CBT & DBT - based coping strategies – Addressed maladaptive stress responses and financial risk-taking.[14]

Non-punitive recovery program – Ensured professional reintegration without stigma.[5]

Outcome & Recovery

- Successful cessation of Zolpidem & Pregabalin dependence.
- Smoking cessation achieved through nicotine replacement therapy & CBT.
- Improved professional performance following work schedule modifications.
- Financial stability improved through behavioral interventions.

Discussion: Key Lessons from the Case

1. Addiction in physicians is a medical disorder, not a personal failure.
2. Financial stress is a critical but overlooked risk factor for SUD and burnout.
3. Emergency physicians play a pivotal role in early detection & intervention.
4. Hospitals must integrate financial counseling and mental health screening for at-risk professionals.

CONCLUSION

This article highlights the critical role of emergency physicians in identifying, managing, and supporting medical professionals struggling with prescription drug dependence, nicotine relapse, and financial stress-induced burnout. A non-judgmental, structured intervention model can lead to full recovery and professional reintegration. Hospitals and medical institutions must shift toward a rehabilitation-based approach rather than punitive measures to ensure physician well-being and optimal patient care.

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