

**DRUG AND ALCOHOL ABUSE AMONGST ANAESTHETISTS:  
GUIDANCE ON IDENTIFICATION AND MANAGEMENT**

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## SUMMARY

- An anaesthetist whose life and work are affected by alcohol or drugs is a risk to patients, colleagues and them self.
- Early identification and treatment of anaesthetists with alcohol or drug related problems would facilitate return to better health and to work.
- Trusts should have protocols for the management of alcohol and drug abuse that should be accessible and followed.
- Reports of alcohol or drug abuse in anaesthetists must be taken seriously and action taken.
- Those making reports must be aware that they are acting in the best interests of the anaesthetist concerned.
- All reports should be made, in confidence, to the clinical director or head of department. If evidence exists that patient safety could be at risk, the clinical director must report the case to the medical director.
- The first meeting with an anaesthetist who is abusing alcohol or drugs should never be on a one to one basis. Specialist advice should be sought early.
- Arrangements should be made for the anaesthetist concerned to be relieved of their duties pending further investigation and/or treatment. Some may need immediate access to specialist treatment following this intervention.

In 1999, Council of the Association of Anaesthetists of Great Britain and Ireland (AAGBI) formed a working party to consider alcohol and drug abuse amongst anaesthetists. This document provides a framework to help anaesthetists recognise a colleague whose life and work are affected by such abuse and recommends appropriate action. The safety and well being of patients and the individual are a priority. The importance and efficacy of treatment are emphasised. The use of tobacco products is not considered.

#### **Footnote**

The term substance is used to cover alcohol, illicit drugs and prescription medications taken inappropriately.

The distinction between substance abuse and dependence (addiction) is important (Appendix 1).

In this document the term **substance abuse** is used broadly to describe the following:

- use of a substance that leads to impairment in physical and psychological health and social dysfunction;
- inappropriate use of prescription drugs;
- illegal drug use that will probably lead to harmful consequences either by virtue of quantity used or method of use (e.g. injecting).

## **INTRODUCTION**

There is considerable evidence from Australia, New Zealand, Canada and the USA suggesting that there are risks to patients, anaesthetists and other staff when drug and alcohol abuse are not identified and managed appropriately [1,2,3]. A survey from Australia and New Zealand suggested that 1.3 % of all registrars in anaesthesia suffer from a drug abuse related problem requiring intervention during their training [4]. Personal experiences and anecdote suggest that alcohol and drug related problems exist amongst anaesthetists in the UK and Ireland but, until recently, no attempt has been made to quantify these problems.

### **Prevalence in the general population**

Since the 1960s increased availability of drugs and alcohol has led to an escalation in use, abuse and dependency. Within the general population 60% use alcohol, 25% are drinking above the recommended safe limits of two units per day for women and three units per day for men and 5% are addicted to it [5]. In the adult population 15% use cannabis, 5% use amphetamines and 2.2% are dependent on drugs [6].

### **Prevalence in the medical profession**

A recent report from the British Medical Association (BMA) suggested that one in fifteen (7%) doctors in the UK may suffer from some form of dependence on alcohol or drugs in their lifetime [7]. Some evidence exists that the prevalence is greater in the medical profession than in the general population [7,8,9,10] but other studies suggest that alcohol use amongst doctors may have declined [11]. The General Medical Council (GMC) has recently published information on reported cases which indicates that anaesthetists are not the highest risk group amongst doctors [12] and this is also supported by recent work from the USA [13].

## **ASSOCIATION OF ANAESTHETISTS STUDY OF SUBSTANCE ABUSE AMONGST ANAESTHETISTS**

On the recommendation of the working party, Council of the AAGBI commissioned a study by the Alcohol and Drug Research Centre, Edinburgh to assess the extent of alcohol and drug abuse problems amongst anaesthetists in the UK and Ireland. Between September and December 1999, clinical directors (or their equivalents) of the 304 departments of anaesthesia in the UK and Ireland received a brief, standardised questionnaire on two occasions. These were accompanied by a letter from the President of the AAGBI and the Chairman of the working party that stressed the

importance of participating in the study and indicated that all data were anonymised. Clinical directors were asked to report and describe any cases of drug or alcohol abuse, where action was taken, in their department over the preceding ten-year period.

Data were collected on the age, gender and grade of individuals. Details were also recorded on how the problem was first noticed, whether alcohol or drugs had been the cause and what action had been taken. Respondents were asked to note what policies exist in their own hospitals and how confident they felt in dealing with such problems.

A total of 304 departments received the questionnaire and 218 (71.7%) were returned. This high response rate gives the results great strength and indicates the perceived seriousness of the subject. Though a report of the study will be published (in press), a summary of the survey findings is outlined below:

- 130 cases were reported over the ten year period;
- only 58.8% of respondents were aware of policies to deal with alcohol problems in their trust; 49.7% were aware of policies to deal with drug related problems;
- almost 60% of respondents felt '*not very confident*' or '*not at all confident*' in managing a case of alcohol or drug abuse in an anaesthetist , only 2% felt '*completely confident*';
- cases were most commonly reported in the 30-39 years age group;
- 81% of cases identified were males;
- 43.2% were trainees, 34.6% of cases were consultants, 11.5% were locums and 10% were non-consultant career grades;
- alcohol problems feature more commonly in the over 40 years age group while drugs alone (most commonly opioids and/or benzodiazepines) occurred in anaesthetists under 40 years;
- most cases (over 90%) were initially recognised through the observations of others;
- professional responses were varied and included 'doing nothing', an informal talk with senior colleagues (47.2%), referral for treatment, employment under supervision, formal disciplinary procedures, early retirement or dismissal;
- 46.9% of those with identified alcohol or drug abuse problems returned to work as anaesthetists;
- in the most extreme cases, drug or alcohol related death (or suicide) was the point at which substance abuse was first recognised.

This section outlines some general and special risk factors which apply to anaesthetists:

**Availability** - anaesthetists have easy access to a wide range of potent psychoactive drugs. Opioids promote rapid tolerance and dependence, particularly the highly lipid soluble agents (e.g. fentanyl). Anaesthetists who are addicted to drugs used in anaesthetic practice stay at work in order to maintain their supply.

**Stress** - anaesthetists often work in isolation in a stressful environment over which they have little control. Long tense hours of work, together with protracted and arduous training and a competitive career structure, may create difficulties at work and home. Mistakes made by anaesthetists may have major medicolegal consequences.

**Psychological** - anxiety, depression, personality problems and severe mental illness (e.g. psychosis) may precipitate or be associated with substance abuse.

**Social** – alcohol and drug use are perceived differently in various social, cultural and ethnic groups. Peer pressure may play a role in initiation and experimentation. For example, until only recently it was considered socially acceptable for doctors to smoke and drink during working hours.

**Genetic** - there is some evidence to support a genetic component for alcoholism [14].

## **IDENTIFICATION**

Individuals with alcohol and drug related problems present a broad range of symptoms and signs. Changes in appearance and alterations in patterns of behaviour and activities may become evident. These changes may be subtle and occur over a few days or even years depending on the nature of the substance(s) being abused. The more common signs and symptoms are detailed in Appendix 2.

An anaesthetist with alcohol or drug related problems is often difficult to recognise. An individual may maintain a professional demeanour that belies serious illness. These cases are often not recognised until a professional mishap is reported (e.g. drink-driving offence or prescribing irregularities) or a drug related event occurs (e.g. overdose or suicide).

**The need for early identification cannot be over emphasised.** Early intervention will lead to early assessment and treatment, thus avoiding harm to patients and further harm to the anaesthetist concerned.

## **REPORTING AND INVESTIGATION**

Reporting of cases of alcohol and/or drug abuse may come from several sources:

- the individual;
- colleagues or other staff (e.g.. ODPs, nurses);
- patients;
- family or friends.

### **General policy**

All anaesthetists have a duty of care to both patients and colleagues. Established mechanisms and protocols for reporting incidents must be well publicised at departmental and hospital level. Early recognition should facilitate access to a predetermined arrangement locally. A national policy for dealing with drug and alcohol problems would enhance the capacity to deal effectively with these problems.

**The identification and reporting of suspected cases of alcohol and/or drug abuse should not be seen as a punitive act but as the first step towards treatment and recovery. The value of treatment and successful outcome must be emphasised.**

It is essential that members of staff should feel able to raise genuine concerns without fear of victimisation. It is equally important that confidentiality of all parties is strictly maintained.

### **Self - referral**

Individuals who self-refer are likely to seek help via agencies remote from the workplace. Treatment may even have started without those at work being aware of the problem.

### **Family, friends or patients**

Information from these sources may arrive via the chief executive, medical director, occupational health physicians or through informal discussions with colleagues or friends. All reports of this kind must be taken seriously and action taken as outlined below.

### **Route of reporting**

Reporting by colleagues should normally be directly to the clinical director who should keep confidential notes of all reports and action taken. Some reporters will be reluctant to give written evidence but should be encouraged to do so. Trainees may be more inclined to discuss sensitive issues with the college tutor or their mentor who should discuss matters with the clinical director. Line managers for non-medical staff (e.g. ODPs, nurses, ancillary and other supporting staff) who receive reports from their staff should be aware of their duty to report such cases to the clinical director.

Clinical directors, heads of departments or lead consultants have a duty of care to refer cases to the medical director in line with the agreed trust or hospital policies on alcohol and drug abuse. Clinical and medical directors must be familiar with these policies in their own hospitals (example in Appendix 3). Cases involving trainees should be reported to the regional advisor who will discuss the problems with the postgraduate dean where appropriate.

### **Obtaining evidence**

Obtaining evidence to confirm or refute a suspicion or report is an essential but difficult and sensitive exercise. Confidentiality must be maintained. This will be difficult if reports are based only on changes in physical, psychological or behavioural demeanour. Reports of isolated events (e.g. theft of drugs, witnessed consumption of drugs or alcohol in the workplace) must be treated with great care if only one witness exists. The possibility that an uncorroborated report of alleged substance abuse is malicious should always be considered. Equally, however, that possibility must never be used as an excuse for failure to take appropriate action. Careful examination of prescribing records will be necessary to substantiate inappropriate use of drugs. This seemingly simple task will be difficult to achieve without arousing suspicion unless random checks are commonplace in the workplace. Written records of all interviews and related events should be kept secure.

Obtaining evidence about trainees who are rotating to several hospitals for short periods may be particularly difficult. This is also true for locums. Further information may be available from regional advisors or directors of schools of anaesthesia.

## **Independent practice**

There is a need for a system of reporting and supporting those anaesthetists working in independent practice where a defined management structure may be unclear. Anaesthetists working in independent practice often work at several different hospitals and it may be difficult to observe inappropriate patterns of activity. Any information should be reported confidentially to the relevant medical committee.

## **Republic of Ireland**

The consultants' common contract in the Republic of Ireland is significantly different from contracts held by NHS consultants and the roles of clinical and medical directors, where such posts exist at all, are less clearly defined than in the UK. Anaesthetists who may become involved in dealing with colleagues who are alleged to have substance abuse problems should seek expert advice on the contractual issues which apply, prior to taking any action.

## **In summary:**

- all reports or observations of alcohol or drug abuse in anaesthetists should be taken seriously, investigated without delay and recorded;
- patient safety may be at risk;
- a single reported episode of working under the influence of alcohol or drugs may be a marker of significant underlying problems and should be considered very seriously with due investigation to ensure it was an isolated event;
- initial reporting should normally be to the clinical director (or equivalent);
- clinical directors should request (but not insist on) written evidence;
- clinical directors must keep written and confidential records of all relevant meetings and discussions;
- if there is a suspicion that patients have been put at risk, the medical director should be informed immediately and action initiated in accordance with guidance given below and hospital policies (example in Appendix 3);
- systematic analysis of previous employment records, sick leave records, prescribing records and professional demeanour may give valuable clues to suggest the presence or absence of substance abuse.

## MANAGEMENT

If there is substantial evidence to suggest that an individual has been abusing alcohol or drugs and particularly if there is evidence of potential or real harm to patients, a process of intervention must be initiated. The working party does not support the concept of an informal meeting with the individual concerned and this is reinforced with advice from overseas [15, 16]. The process of formal intervention may not be required if the anaesthetist has self-referred but this will not remove the need for the professional responses outlined below.

### Intervention

The term intervention is used here to describe the process of demonstrating to a substance-abusing anaesthetist that he or she has a problem that requires urgent attention. Intervention must only take place when there is substantial evidence to confirm the presence of abuse or addiction. One purpose of this intervention is to confront the strong denial that is very commonly present and so motivate the individual to seek treatment.

### **A one-to-one confrontation must be avoided.**

The following points can be used as a guide to those planning a meeting of this kind:

- Intervention must be undertaken by a group of at least three people who may include a senior member of the department, a person representing the doctor's personal interests (e.g. the doctor's general practitioner, a family member, a representative of a professional organisation such as the BMA or medical defence organisation) and a practitioner with specialist experience in this area, usually a psychiatrist. Some advocate the presence of a physician who is already in treatment.
- It would be normal procedure to inform the individual concerned that a meeting was planned to discuss concerns about their practice but this decision should be weighed against the risk of self-harm.
- Those with knowledge of the case who are present at the intervention must be prepared to present the observations and evidence regarding alcohol or drug abuse in the individual.
- Plans must be made in advance to facilitate treatment. This may involve referral to a previously identified national specialist treatment centre and/or more specialised local facilities if available. The psychiatrist will normally advise appropriate action

- Immediate admission to a specialist unit may be advised in order to minimise the risk of self-harm. There is a real possibility of self-harm following intervention.

Following intervention, immediate action will fall into several categories;

**1. Where harm to a patient has occurred as a result of substance abuse.**

Suspension should be undertaken formally with a clear statement as to the reasons for the suspension and an indication of further action. The GMC must be notified and this has to be backed up through the normal disciplinary procedures of the hospital by written confirmation of the action taken. Advice as to the opportunities for the doctor to receive support from the BMA or a defence organisation should be made clear. The individual should be strongly advised to accept the plans to initiate treatment.

**2. Where there is clear evidence of abuse but no harm to a patient has occurred.**

The doctor should be offered treatment and support, usually through a mechanism of sick leave. Continuing contact with patients should cease and consideration given as to the action to be taken as regards continuing GMC registration (see below).

a. *If the individual accepts the problem* and the situation remains largely confidential, then help may be sought through the Association's Sick Doctor Scheme. If the situation is common knowledge throughout the hospital, help may be sought locally.

b. *If the individual refuses to accept the problem*, the situation is more difficult to handle. Until the situation is clarified, then there may have to be local restrictions on practice with alterations in sessions and an agreement to random testing of breath, blood, urine or hair for the substance(s) in question.

### **The involvement of the GMC**

Where there is any possibility of danger to patients from anaesthetists who are abusing alcohol or drugs, it is essential to involve the GMC and its Health Committee at an early stage. It is the aim of the Health Committee both to protect the public and also to offer the doctor full support in overcoming the problem. It may be difficult for doctors to accept this position. It is, however, in the interests of the doctor and his or her advisers to ensure that the best possible medical advice and

support is made available so that the best chances of a return to a satisfactory medical career can be ensured.

## **Treatment**

It is not the remit of this document to describe details of the complex treatment of substance abuse but some information is outlined below. *It must be emphasised that treatment is effective and will lead to a significant improvement in physical, psychological and social well-being for most who are willing to engage in a treatment programme* [17]. Treatment for serious cases of alcohol and drug misuse may take several months and long periods of leave may be necessary.

The goal of a substance dependent anaesthetist is abstinence for life.

Referrals for treatment and rehabilitation should normally be organised through the psychiatrist, the individual's GP or through the trust's department of occupational health. Treatment of medical practitioners with problems relating to alcohol or drug abuse is a multidisciplinary process involving highly qualified experts. Specific treatment will be directed to individual needs depending on the type and severity of the substance abuse and the nature of associated problems.

Some substance abusers will need detoxification and rehabilitation at a specialist in-patient addiction unit. This involves input from psychiatrists and/or physicians with a specialist interest and expertise in addiction.

The objective of treatment and rehabilitation focuses on education and behavioural modification to achieve abstinence from all mood-altering drugs. This may involve both pharmacological and psychological interventions. Units specialising in the treatment of medical practitioners are favoured in the USA. Treatment will usually last for several months or even years and could involve a supportive network of family members and close friends. Individuals in treatment will feel isolated and need intense support. Many support facilities exist to enable individuals with alcohol and drug related illness to return to a healthy life at home and work.

Longer term treatment and monitoring may include:

- Attendance at self-help groups (see Appendix 4) where recovering individuals are encouraged to attend daily after initial treatment. Many attend regular meetings indefinitely.

Self-help groups attending to the special needs of health care professionals exist

- Re.g.ular monitoring by a specialist therapist (e.g. psychiatrist). Signs and triggers of impending relapse can be identified.
- Mandatory substance testing (breath, hair, urine, blood). This can be random and re.g.ular. Specific tests for most drugs now exist. Hair testing will show the presence of drugs taken several weeks before testing. If traces of drug are found, individuals will need to re-enter treatment. Those who have returned to work will find that their jobs are in jeopardy if they are not abstinent.

### **Return to work**

Resuming a normal pattern of personal and professional life will be the objective of most of those in recovery. This may, however, be difficult.

The General Medical Council will determine fitness to practise in referred cases. At a local level, the decision to return to work should be made by a group including the patient, GP, specialists involved with their care and clinical and/or medical director.

The medical director may seek advice from the department of occupational health to advise on fitness to practise. Consultant specialists in occupational health may be able to offer valuable support to anaesthetists who are ill, especially if the doctor concerned is not registered with a GP as is often the case. However, their dual role as adviser to the employer and advocate to the employee may be perceived as a conflict of interests, with hospital doctors being reluctant to use occupational health services. It is clear that occupational health services operate at different levels of expertise in different regions and those involved with cases of this nature will have to be guided by local experience and protocol.

For some, the stress of the workplace may have been a major contributing factor. These individuals will need counselling about the advantages and disadvantages of returning to the same type and place of work. Career advice and retraining in a different medical speciality or alternative employment may be indicated. The difficulties involved, especially for a senior member of staff, should be recognised and need to be considered when employment options are discussed.

If the operating theatre was the source of the abuser's drugs, there is a perception that the risk of continued employment in that environment is too high. In the USA, however, many anaesthetists have returned to their previous positions. The cost of monitoring such an exercise is high. The risk

of relapse over the first 18 months is about 20% in treated fentanyl addicts who return to anaesthesia [6].

### **Legal and Professional Issues**

Medical practitioners are lawfully allowed to possess controlled drugs during the course of their professional activities. The source of drugs must be accountable. The theft and illegal trade of controlled drugs is a criminal offence. Diversion of drugs away from their designated use in hospital can be considered as theft (e.g. drugs prescribed for a patient which are not administered and subsequently used by the prescribing practitioner for his or her own use).

There is no requirement in law to report a suspected crime to the police. Reporting is at the discretion of the hospital as dictated by their policy for alcohol and drug related cases involving staff. Once the police have been notified, it is their duty to investigate. Issues relating to medical practitioners may be reported to the GMC by the police.

### **Education and Awareness**

Alcohol and drug abuse is common in the general population, as are related psychological and social problems. Colleagues and friends can help to identify individuals whose consumption of alcohol or drugs is interfering with their work. Continuing education of all members of the department of anaesthesia can improve the chance of early detection and prevention. This will result in early treatment which is likely to enhance its effectiveness. It is now commonplace for all members of departments of anaesthesia in the USA, Canada and Australia to have regular lectures on this topic.

### **CONCLUSION**

All staff should be made aware of the mechanisms and policies which exist to help colleagues who are abusing alcohol or drugs. Staff need to know who to approach, that their discussions will be in confidence and that their role is supportive, not punitive. Policies for the management of alcohol and drug related problems involving staff must be available within each trust and accessible to all clinical directors and heads of department.

*'Someone should have said something'* should not be a phrase used in retrospect.

## APPENDIX 1

### **Dependence Syndrome [18]**

This syndrome description comprises specific criteria by which a diagnosis of dependence (addiction) can be made. Three or more of the following criteria are required to make a diagnosis:

- 1 Strong desire or sense of compulsion to take the substance.
- 2 Impaired capacity to control substance use in terms of onset, termination or levels of use.
- 3 A physiological withdrawal state when the substance is reduced or stopped and relief when consumption is resumed.
- 4 Evidence of increased tolerance i.e. increased use for the same effect.
- 5 Preoccupation with substance use i.e. alternative interests or activities are substituted in spending time obtaining substances.
- 6 Persistent use of substances despite evidence of harmful consequences.

## APPENDIX 2

### Signs and symptoms of substance abuse.

#### A. General

##### *Behavioural problems:*

*Ne.g.lect and deterioration in appearance*

*Fatigue and lethargy*

*Mood swings (e.g. depression, elation, anger, irritability, anxiety)*

*Drowsiness or agitation*

*Anger and aggression*

*Violence*

*Suspicious and paranoid*

*Suicidal thoughts or intent*

##### *Work related problems:*

*Poor time keeping*

*Unreliable*

*Poor administration and poor record keeping*

*Difficult relationships with colleagues*

*Frequent job moves*

*Absenteeism or paradoxically at work more than is necessary*

##### *Social problems:*

*Difficult relationships*

*Concern expressed by family and friends*

*Domestic instability*

*Social withdrawal*

*Children may develop behavioural problems*

*Frequent house moves*

*Financial problems, fraud, debt*

*Signs and symptoms more likely to be alcohol related:*

*Smell of alcohol*

*Absenteeism (e.g. at the beginning of the week after a weekend of binge drinking)*

*Bottles around house or office, or inappropriate places (e.g. car)*

*Poor memory, difficulty in concentration, impaired judgement*

*Confusion*

**B. Intoxication and withdrawal syndromes [18]**

*Signs and symptoms of alcohol intoxication:*

*Slurred speech*

*Flushed face*

*Impaired attention*

*Disinhibition*

*Unsteady gait and posture*

*Conjunctival injection*

*Impaired judgement*

*Lability of mood*

*Argumentative and/or aggressive*

*Nystagmus*

*Decreased level of consciousness*

*Signs and symptoms of alcohol withdrawal:*

*Tremor: tongue, eyelids, outstretched hands*

*Agitation, insomnia*

*Transient visual, auditory, tactile hallucinations or illusions*

*Nausea, retching, vomiting, sweating*

*Delirium tremens – confusion, disorientation, hallucinations, agitation, pyrexia*

*Grand mal convulsions*

***Signs and symptoms related to other drugs - general observations:***

*Disproportionate numbers of patients in pain in recovery or complaints of pain by patients out of proportion to drugs they have ostensibly been given*

*Inconsistencies in recording and unaccountable missing drugs*

*Signing out of inappropriately high doses of narcotics and other drugs*

*Isolation at work so as to falsify records and/or use drugs*

*Long hours at the hospital to obtain drugs, volunteer for long cases or extra on-call work*

*Personal wish to administer drugs to patients*

*Refuse coffee and lunch breaks, difficult to find between cases (taking naps or injecting)*

*Frequent requests to use the toilet*

*Carrying syringes and ampoules in clothing; pills and syringes around house or office*

*Bloody swabs and syringes containing drugs in conspicuous places*

*Injection marks on arms: note long sleeved clothes in warm weather*

*Flu-like symptoms (opioids)*

*Pin point pupils when using and dilated pupils when withdrawing (opioids)*

***Signs and symptoms of stimulant intoxication:***

*Euphoria and increased energy*

*Agitation*

*Pupillary dilatation*

*Argumentative, abusive, aggressive*

*Evidence of weight loss, nausea, vomiting*

*Sweating or chills*

*Hypertension, tachycardia, chest pain*

*Grandiose beliefs, paranoid thoughts*

*Auditory visual or tactile hallucinations*

***Signs and symptoms of stimulant withdrawal:***

*Increased appetite*

*Insomnia or hypersomnia*

*Dysphoric mood*

*Craving for drugs*

*Lethargy and fatigue, depression, suicidal thoughts*

***Signs and symptoms of opioid intoxication:***

*Slurred speech*

*Apathy and sedation*

*Disinhibition*

*Drowsiness*

*Impaired judgement*

*Lability of mood*

*Pupillary constriction*

*Psychomotor retardation*

*Decreased level of consciousness*

***Signs and symptoms of opioid withdrawal:***

*Craving*

*Restless sleep*

*Sneezing, eyes watering, yawning*

*Piloerection and recurrent chills*

*Pupillary dilatation*

*Abdominal and muscle aches and pains*

*Nausea, vomiting and diarrhoea*

## APPENDIX 3

### EXAMPLE PROTOCOL

#### A POLICY TO MANAGE DOCTORS WITH ALCOHOL AND/OR DRUG PROBLEMS

##### Introduction

The trust is committed to providing safe and effective care for patients and must ensure that medical staff have a mechanism that enables them to report concerns about the conduct, performance or health of medical colleagues (Chief Medical Officer, December 1996).

##### Aims and Objectives

The GMC publication 'Duties of Doctors' states that all doctors must *act quickly to prevent patients from risk if you have good reason to believe that you or your colleague may not be fit to practise*. The procedure is applicable to all doctors within the trust, senior or trainee, substantive or locum.

##### Procedure

Any doctor concerned that a colleague may not be fit to practise should discuss the matter with their consultant, the clinical director or medical director.

In general, concerns about trainee doctors should first be considered by the relevant consultant (e.g. college tutor). Concerns about substantive staff and locums must be discussed with the clinical director.

If a trainee is involved, the postgraduate dean should be consulted.

Such matters should always be brought to the attention of the medical director who should make a formal note of the report.

If a report is received about a locum, the agency must be informed.

Concerns about the clinical performance of medical directors should be raised with the chief executive by the clinical director.

## **Investigation**

The medical director, or in the case of medical directors the chief executive, will institute an inquiry by appointing an appropriate investigating officer. Support should be provided by a senior member of the human resources department and the clinical risk manager. This may be a preliminary inquiry and outside the trust's formal disciplinary mechanisms. It should be led by the medical director.

Every care will be taken to ensure confidentiality of parties while any **allegation** is being investigated.

## **Suspension**

If there are any concerns about the safety of patients, the doctor should be given leave or suspended while an investigation is pursued. In certain circumstances it may be more appropriate to consider restriction of clinical work or re-allocation of duties. If disciplinary action is contemplated, suspension may be required. It is emphasised that suspension is used to enable investigation while ensuring the safety of patients. It does not imply guilt and is not punitive.

## **Reporting / Decision**

Upon the receipt of the report, it is for the medical director to decide how to pursue the matter. This decision should be promptly reported to the chief executive of the trust. This should occur within one month of receiving the complaint.

The medical director should also report the matter to the GMC. The stage at which this should be done will depend upon the nature of the concerns expressed and formal guidelines issued by the GMC.

The doctor under investigation should be kept informed of progress at all stages.

## **APPENDIX 4**

### **HELPFUL ORGANISATIONS**

Association of Anaesthetists' Sick Doctor Scheme Tel: 020 7631 1650

Alcoholics Anonymous Tel: 01904 644126

British Doctors and Dentists Group Helpline, Tel: 020 7487 4445

BMA 24 hr Stress Counselling Service for Doctors Tel: 0645 200169

GMC Fitness to Practise Directorate Tel: 020 7580 7642

General practitioners

Local specialist substance misuse services

Narcotics Anonymous Tel: 020 7730 0009

National Counselling Service for Sick Doctors Tel: 01455 255171

Occupational health services

Royal College of Psychiatry Faculty of Substance Misuse Executive Tel: 020 7235 2351

Support for re-training (GMC) Tel: 020 7915 3642

The Sick Doctors Trust (Addicted Physicians Programme) Tel: 01252 345163

## References

1. Talbott GD, Galle.g.os KV, Wilson PO, Porter TL. The Medical Association of Georgia's Impaired Physicians Program. *Journal of the American Medical Association* 1987; **257**: 2927-2930.
2. Lutsky I, Hopwood M, Abram SE, Jacobson GR, Haddox JD, Kampine JP. Psychoactive substance use among American anesthesiologists: a 30-year retrospective study. *Canadian Journal of Anesthesia* 1993; **40**: 915-921.
3. Adler G, Potts F, Kirby R, Lopalo S, Hilyard G. Narcotics control in anesthesia training. *Journal of the American Medical Association* 1985; **253**: 3133-3136.
4. Weeks AM, Buckland MR, Morgan EB, Myles PS. Chemical dependence in anaesthetic re.g.istrars in Australia and New Zealand. *Anaesthesia and Intensive Care* 1993; **21**: 151-155.
5. Jenkins R, Bebbington P, Brugha TS, Farrell M, Lewis G, Meltzer H. British psychiatric morbidity study. *British Journal of Psychiatry* 1998; **173**: 4-7.
6. Drugs, Dilemmas and Choices. Royal Colle.g.e of Psychiatrists and Royal Colle.g.e of Physician; Gaskall, London. 2000
7. Working group on the misuse of alcohol and drugs by doctors. London: British Medical Association, 1998.
8. Richards C. The health of doctors. Kings Fund paper no 78. London: King Edward's Hospital Fund, 1998.
9. Kelly S, Charlton J, Jenkins R. Suicide deaths in England and Wales 1982-92: the contribution of occupation and geography. *Population Trends* 1995; **80**: 16-25.
10. Pilowski I, Sullivan G. Mental illness in doctors. *British Medical Journal* 1989; **298**: 269-70.

11. Plant ML, Plant MA. Trading places? Doctors, nurses and alcohol. *Social Pharmacology* 1988; **2**: 327-342.
12. Morgan M, White C, Fenwick N, Smith I. An evaluation of the General Medical Council's health procedures. London: General Medical Council, 1999.
13. Hughes PH, Storr CL, Brandenburg NA, Baldwin DC, Anthony JC, Sheehan DV. Physician substance abuse by medical speciality. *Journal of Addictive Diseases* 1999; **18**: 23-37.
14. Raistrick D, Hodgson R, Ritson R, eds. Tackling alcohol together. London: Free Association Books, 1999.
15. American Society of Anesthesiologists. Chemical dependence in anesthesiologists: what you need to know when you need to know it. Park Ridge, IL, USA, 1998.
16. Australia and New Zealand College of Anaesthetists. Welfare of anaesthetists special interest groups: Auckland substance abuse protocols. Auckland, New Zealand, 1999.
17. Personal communication. Arnold WP. University of Virginia, USA, 1999.
18. The ICD-10 classification of mental and behavioural disorders : clinical descriptions and diagnostic guidelines. Geneva: World Health Organisation, 1992