This article is based on one person's extensive experience as the person responsible for managing doctors in training who present with drug or alcohol problems. The approach differs in some details from that recommended in the new AAGBI guidance (The guidance suggests that 'a one to one confrontation should be avoided and efforts should be made to collect objective evidence'). This is not surprising - the guidance is new, and has not been written with respect to trainees in particular. Although the article deals specifically with trainees in difficulty, all grades of doctor (and others) may develop these problems.

Anaesthesia News would welcome your views about any issues raised in this article or the guidance.

Managing a crisis – the trainee with a drug or alcohol problem

The theatre nurse finds a trainee breathing entonox. Or a registrar comes for a private word and says 'I was arrested for drink driving last night'. These are situations that we probably all dread. The way we handle early interactions with a doctor in serious difficulty may make a big difference to the outcome; so it is worth thinking about what to do if we find ourselves in these circumstances.

This article describes how I have managed doctors in training (in several different specialties) who have had drug and/or alcohol problems. This article draws on my experiences of managing situations when I have been approached by individual trainees, or when they have been 'caught in the act'. Managing others' concerns, when the individual him or herself has not shared their health difficulties can be more complex.

In the 16 years I worked in the Northern Deanery as Associate Dean and then Specialty Dean Director, I have seen over 200 trainees who have become ill during training. Of these, two thirds had a psychiatric or stress-related problem. Many had been ill for some time, and either not recognised that they were ill or decided against reporting this. A small number used drugs or alcohol.

There are several things to consider. Immediate patient safety must come first; a person currently under the influence of drugs or alcohol must be removed from the clinical situation. Once this is done, and assuming the person is sober enough to talk, it's important to find somewhere appropriate to hold a confidential conversation. As I'm doing this, I run through a mental check-list: what would it be like to be this doctor, who is the best person to have this conversation, what skills must I demonstrate, and what practicalities need sorting out?

What it would be like to be the doctor in difficulty?

In most circumstances, doctors who abuse drugs or alcohol have begun the habit as a coping strategy because of stress or illness. Doctors who are ill, particularly those with psychological or stress-related illness are concerned about being stigmatised. They describe a feeling of shame, of letting themselves down by not meeting their own high personal standards, worries about confidentiality and loss of control and fears about damage to their livelihood because of disciplinary action or referral to the General Medical Council (GMC). Particular concerns for those in training grades are that they may lose the respect of others, and that disclosing a mental illness, especially alcohol or drug use, may threaten their career and job prospects.

So the person is being very brave in talking at all. He or she will have mentally rehearsed this situation many times and reached the conclusion that it's safer to say nothing about his or her problem. Even if the person wanted to talk, deciding who to tell is difficult.

Who is best to have this conversation?

It is important that the doctor speaks to someone he or she respects and trusts to keep the matter as confidential as possible. So I ask 'You will need to talk to someone about this. Should this be me or is there someone else you would prefer to talk to?' I offer the trainee the option of bringing someone with them. Sometimes, but in my experience rarely, they will want to.

What skills must I demonstrate?

The conversation will only be useful if the trainee feels that the conversation is confidential and he or she is being treated with respect, empathy and genuineness. I need to make sure I demonstrate these qualities, not just feel them. I start with a comment such as 'We need to talk about what's happened, and how you are. The most important thing we need to do is explore and understand what's going on from your perspective.'

The first thing I do is to listen. It might seem a rather weak response when you have a hundred questions going round in your head. But just listening actively to everything the person says, summarising and being sure to notice the trainee's feelings and reflect them back accurately, is likely to achieve most. You're not the person's doctor – you don't need to know what substances, how often, where or when.

Caught in the act, most people acknowledge events. Those who refute what is described or deny their involvement are almost always using a coping strategy of putting blame on others or on circumstances; they know they've got a problem but don't feel safe to talk about it. If this happens, I start by explaining what I saw or has been reported to me as having occurred, outline what happens to doctors with drug and alcohol problems and what we are required to do to meet governance and GMC requirements. I also make clear that they are not alone, and that many colleagues who have found

themselves in this sort of difficulty return to work and/or to training. There are a number of services for doctors with health difficulties and for doctors with drug and alcohol problems* and I make sure the trainee is made aware of these.

What practicalities need sorting?

Three aspects need to be managed; the doctor's health and treatment, governance, and informing those who need to know that a trainee has a drug or alcohol problem.

Health and treatment

The outcome I aim for is that the trainee gets to the right services to treat and support them, but in a way that preserves his or her dignity and keeps the details of his or her situation as confidential as possible. Treatment of their underlying problem might be achieved through their GP, via the consultant occupational physician or through direct contact with the local drug and alcohol service. As many such people have an underlying illness which also needs treatment, a consultation with the GP can be helpful. However there are a group of doctors for whom the GP is a family friend, or part of a social, ethnic or religious community, when the problem of disclosure and potential stigma can be a significant barrier. If there is a good Occupational Physician in the Trust or available via the Deanery, it is very useful for the trainee to see this person. It is the responsibility of the Occupational Physician to advise the trainee, Trust and Deanery as to whether the doctor is well enough to continue working and if so, what adjustments are needed to their duties or working pattern. In practical terms this usually means the doctor is 'given permission to be ill', and to take time away from work to address the underlying causes of their problem as well as their drug or alcohol usage. If the doctor is well enough to remain at work in some capacity, the Occupational Physician acts as the doctor's advocate in making sure the duties and/or training requirements expected of a trainee are realistic in the context of their health difficulties. The Occupational Physician may also refer them on to the appropriate clinician (often a psychiatrist) and to the drug and alcohol service, as they will know which doctors are used to treating fellow professionals.

Governance

The GMC requires every doctor to

- Act without delay if you have good reason to believe that you or a colleague may be putting patients at risk
- Consult a suitably qualified colleague if your judgement or performance could be affected by a condition or its treatment and ask for and follow their advice about investigations, treatment and changes to your practice that they consider necessary.

In practice, this means that every doctor has a responsibility to remove a colleague from the immediate clinical situation if the doctor is under the influence of drugs or alcohol. The doctor him or herself must not put patients at risk, and must consult and follow the advice of the Occupational Physician, their GP and the consultant who treats them as a patient.

For doctors in training, the 'Gold Guide' 2010 stipulates that

- When identified, matters relating to ill-health or to substance misuse should be dealt with through employers' occupational health processes and outside disciplinary procedures where possible.

Thus, the Trust in which a trainee works and the Deanery in whose programme he or she is training both have a responsibility to provide the trainee with the wherewithal to get treated and to address their tendency to use drugs or alcohol as a coping strategy. In the medium term, the Trust and Deanery

should support the trainee in returning to work, and returning to training, once they are well enough. Many such situations fall under the disability discrimination act, which places a duty on employers to make 'adjustments' , such as to working hours, place of work or by modifying procedures for assessment. Again this is something for which the advice of a consultant Occupational Physician is important.

Who else will need to know?

The Postgraduate Dean, Trust Medical Director and Clinical Director will need to know of the trainee's drug or alcohol problem because of their accountability for patient safety, and the GMC must be informed because of its fitness to practice responsibilities.

I find this part of the discussion quite tricky to phrase well and introduce at the right time. If the earlier conversation has gone well, and I have managed to demonstrate respect, concern and empathy with the trainee, trust should be starting to develop between us. But this is often tenuous and can be easily broken. By introducing the need to inform those responsible for patient safety and fitness to practice too early in the conversation, I might add to their feelings of embarrassment and disgrace. Sometimes this is too much of a challenge and the trainee resists. The worry for me is that, quite often, the underlying reason for the drug or alcohol use is depression, and further disempowerment could have dire consequences. Doctors with psychiatric conditions and particularly those who use drugs or alcohol describe feelings of shame at not meeting their own high standards and humiliation at being found out, and unfortunately, faced with discovery, there is the possibility of self-harm or suicide.

On the other hand, if the trainee can be brave enough to seek the help they need and to inform someone senior in the Trust and the Deanery, then this is likely to set them on a better footing. They can then be seen as someone who has taken ownership of their problem, and is doing something about it. If the trainee is known to be seeking and complying with treatment, and using appropriate support, this will also stand them in better stead with the GMC.

When discussing the trainee's health with third parties, I myself, the Clinical Director, Medical Director, Postgraduate Dean and GMC must each provide the same standard of confidentiality as is afforded to patients. The trainee must not become the subject of corridor gossip or the matter discussed where you can be overheard.

The GMC guidance on confidentiality makes clear that expressed consent must be sought if details about the trainee's health are disclosed to third parties, unless the disclosure is required by law or can be justified in the public interest. Such disclosures should be kept to a minimum. The trainee must have access to or copies of information exchanged about them and be informed about how information will be used. In practical terms this means that informing the Clinical Director and Medical Director that the trainee has a health issue, is possibly not well enough to work and has told you that he or she has been using drugs or alcohol, is in the public interest, but saying that the doctor is depressed and binge drinking is not, unless the trainee has consented to revealing this information. The situation is slightly different if the trainee has been arrested for drunk driving or has been obtaining drugs fraudulently by self-prescribing. Both of these are illegal activities which should be disclosed to those in authority.

The GMC will need to be informed at an appropriate point if the doctor has a drug or alcohol problem. The psychiatrist from the drug and alcohol service is often best placed to do this, as they have a better understanding of the clinical picture. Information about health can be disclosed to the GMC without the trainee's consent, but the trainee must be informed as to what the GMC is told, even though their consent is not required. When a doctor is arrested or cautioned on a drink driving charge, or has been caught self-prescribing opiates or benzodiazepines by a pharmacist, the police automatically inform the GMC.

So how do I pick my way through this minefield? I explain that the Medical Director, Clinical Director and GMC will need to know that the trainee has a health

Summary

What to say

Listen first, then summarise. Offer own/others' observations when trainee is ready to hear

When to say it

Timely approach – as soon as something needs discussion

How to say it

Demonstrate respect empathy and genuineness

How to respond if the trainee disagrees

Summarise both sides and explain the duties outlined in 'Good Medical Practice - Duties of a doctor' and paragraphs 58, 77 & 79

Where to say it

Confidential conversation, neutral safe environment

Who should say it?

Someone the trainee trusts and respects