Addiction and anaesthetists

Despite efforts to raise awareness and improve education on the subject, talk of addiction still makes for an awkward topic of conversation.

Amongst doctors in general, there is a probable lifetime prevalence of substance abuse of 10–12%.1 Studies specific to anaesthetists suggest an incidence of addiction of between 1–2% over the various survey periods.2–4 Anaesthetists are over-represented in treatment centres which deal solely with addicted doctors in the USA.5 This is due to the significantly higher numbers of anaesthetists abusing intravenous opiates than other specialties,2,5 and the rapid downhill course and profound dependence necessitating in-patient management. Sadly, the risk of drug-related death remains higher in anaesthetists than in all other specialties, peaking in the first five years after medical school graduation.5

Worse than one realises

Bryson found that 62% of American programme directors had experience with at least one substance abusing trainee.6 In 64%, the drug of choice was fentanyl, 16.3% for alcohol, 12.6% midazolam, 10.4% opioid tablets, and propofol in 8.1%. Wischmeyer found a five-fold increase in propofol abuse in anaesthetic trainees over a ten-year period, peaking at a level of 18% with a mortality of 28%.7 Similar mortality (26%) was reported in inhalation agent abusers.8 These figures would be unacceptable as outcomes in any other treatable disease.

This year, the American Society of Addiction Medicine has redefined addiction emphasising that it is a primary brain disorder and not a behavioural problem.9 Substance abuse can be described as the continued use of a drug despite negative consequences; addiction or dependence occurs when cessation of intake causes physical withdrawal symptoms.

Background

That some individuals are more prone to developing addiction is generally agreed. There is no single determining factor, but usually a combination of biological, psychosocial and environmental factors – a mixture of nature and nurture.

Alcohol is the most common substance of abuse in all doctors. Drinking will surprisingly continue despite negative consequences such as job difficulties, relationship breakdowns, financial problems, loss of driving licence; the alcoholic is driven by an irrational compulsion to continue, and frequently results in despair to the point of suicide. Fortunately, the depression associated with active alcoholism often abates when sober.

Access and familiarity with a substance play a significant part, exemplified in that anaesthetists are more likely to abuse drugs than alcohol, to abuse narcotics, and to abuse drugs intravenously.5,10 Fentanyl can lead to physical addiction in as little as six weeks of use, but more commonly comes to light after at least six months. Consequently, the sequelae of opiate addiction are seen in a much younger age group than alcohol abuse. Anaesthetists have a lower overall incidence of addiction than psychiatrists and emergency physicians,10 but it is the aggressive nature of fentanyl addiction and the high mortality that bring attention to our speciality.

Behavioural changes are probably the most common indicators of substance abuse. Addicts become very adept at hiding and covering up both diversion of drugs from theatre and problems outside work. When signs of illness become noticeable at work, for instance weight loss, the process is very
advanced. Consequently, even small changes in a doctor’s behaviour, if persistent, may be the tip of an iceberg, and should be taken very seriously.

**Intervention**

All of this can lead to a difficult situation, especially if dealing with a close colleague, and is one for which there is very little in the way of training. With behavioural changes or repeated absences due to hangovers, it may not be easy to appear sympathetic. A badly conducted intervention can produce an adverse result, and there is a real risk of self-harm following such an occasion. Sometimes, the doctor is actually relieved to have been called to task, typically being someone who is aware that they have a problem and is struggling with the relentless monotony of daily drug use. An angry or defensive response is much more difficult to deal with. These meetings should not be conducted on a one to one basis.

Patient safety is obviously the primary concern. It is suggested that clinical directors, College tutors and others, go to the meeting armed with names and phone numbers of appropriate institutions and contacts (see below), and should have already been in touch with occupational health and/or an addiction psychiatrist prior to the meeting.

If patient harm has occurred, the GMC should be contacted. Otherwise it is a decision for the team looking after the doctor concerned. Opiate abuse is a frequent reason for reporting but, in fact, reporting is not mandatory. The GMC is aware that addicted doctors go under their detection ‘radar’. Where all the conditions that may have been imposed on registration (for instance, attendance at various help groups and meetings – see below) are being addressed, the GMC will often suggest managing the problem at local level. Knee jerk suspension is not the rule, although it is usually the consequence of non-alcohol addiction problems.

Reporting a colleague to the police for theft (for instance, using drugs obtained from work) leads to houses being searched, court appearances, and much additional stress. A criminal record can cause problems with visa and mortgage applications. An addict is only usually dishonest in the context of their active addiction and, once well again, will not exhibit an ongoing probity issue. Any doctor who has appeared in court for any offence is automatically reported to the GMC.

There is a very real suicide risk after intervention, and suspected addicts should not be ‘home alone’ afterwards. A call to the British Doctors and Dentists Group (BDDG) can provide a colleague to talk to, and one who knows how the addict feels.

**Recovery**

It is important to appreciate that just putting the drink or drugs down doesn’t instantly result in a cure. Being left with many of the feelings and problems that caused drinking in the first place will lead to a relapse if not addressed. Centres that produce good results are usually based on the ‘twelve step model of recovery’, which starts during time spent as an in-patient, and involves attending AA or Narcotics Anonymous (NA). NA is not exclusively for narcotic users, but acts for any drug problem. For those who don’t ‘take to’ AA or NA, there are other groups such as SMART recovery (www.smartrecovery.org.uk). The value of being supervised by a complete ‘programme’ or practitioners health programme (PHP), as opposed to a spell in a treatment centre, is in the continuous monitoring of the process. This is so important. Many addicts strangely quite welcome hair testing as an extra safeguard (perhaps the one positive of being under GMC review!). Also important are regular ‘aftercare’ groups, psychiatric, psychological, and even financial help and advice. It is important to allow time on the rota where possible for these appointments – the GMC often requests evidence of attendance.

**Return to work**

Continuing training in anaesthesia remains a controversial topic. Of programme directors surveyed, 43% believed that trainees should be allowed to continue in post, and 30% were against.6 Some studies have shown that relapse rates for anaesthetists are not significantly different from those of other physicians, and no relapse-related patient harm occurred in two long-term follow up studies.4,11

Data are lacking about what happens to trainees who leave anaesthesia for another speciality, and whether this reduces the risk of relapse. Early reports of poor outcomes have tended to colour the picture – Menk reported that only 34% of trainees returned to anaesthesia, with a 16% mortality as a result of suicide or relapse.3 Better results come from doctors managed by a PHP, where recent results have been more encouraging – 76% of anaesthetists remaining abstinent and in anaesthetic practice over a five-year follow up.4
Probably the best indicators of relapse risk came from an 11-year follow up by Domino, of 292 addicted doctors. The three outstanding factors were:

1. intravenous opiate use
2. family history of addiction
3. co-morbid psychiatric diagnosis.

Results suggest that anaesthetists using major opioids, but with no other risk factors and no history of previous relapse, are probably good candidates for return to their specialty. Having two of these factors should raise the question of changing specialty.

Several directors of treatment centres with a particular interest in anaesthetists have designed the Medical Professionals Addiction Recovery Inventory (MPARI). This looks at many work and life aspects, and is being developed as a tool to aid in risk stratification for anaesthetists (in addition to Domino’s criteria).

Results from Atlanta (Paul Earley personal communication) and use of the MPARI tool are encouraging, suggesting that, with aggressive follow up and monitoring, we might eventually expect the recovery rates for opiate-addicted anaesthetists to be similar to those of other specialties.

**Summary**

There is no place for a ‘one rule fits all’ and each case must be managed on an individual basis. It is hoped that the very encouraging results from the first two years of the UK’s Practitioner Health Programme (Dr C Gerada personal communication) continue, and that similar centres will be funded outside London.

Unfortunately, despite greater regulation and an increase in education on chemical dependency, the incidence of opiate abuse has not decreased. Publications such as those from the American Society of Anesthesiologists would be a welcome inclusion in our anaesthesia training curriculum, and the College should openly recognise the problem with a view to further activity on what is an important part of both education and patient safety.

**Useful contacts**

**The Practitioner Health Programme (PHP)**

http://www.php.nhs.uk

0203 049 4505

This confidential service has been available to doctors with addiction and other health problems in the London area since 2008. Following in-depth assessment, if in-patient de-toxification is thought necessary, this takes place at a centre outside London, but is funded by the NHS. Follow up and monitoring are multidisciplinary and rigorous. Plans for expansion outside London will hopefully be successful, because feedback and results so far have been extremely good.

**The British Doctors and Dentists Group (BDDG)**

www.bddg.org

London: 07825107970
Outside London: 07976717211

This is a network of doctors and dentists who have themselves recovered from addiction, and are still well again. They meet on a monthly basis at one of 18 groups covering the UK. Following initial contact, callers may be put in touch with someone near their home who can introduce them to their local group. Problems can be discussed at these meetings that may not be appropriate to discuss at Alcoholic Anonymous (AA), for instance, the GMC and work issues. Most find the meetings very helpful.

Those close to addicted doctors suffer too, and the BDDG has a families’ group who can be contacted on 07714331725.

**Sick Doctors Trust (SDT)**

www.sick-doctors-trust.co.uk

0370 444 5163*

The SDT is an independent addiction-specific charity established in 1995, which provides a 24-hour confidential helpline manned by doctors experienced in addiction, mostly recovering addicts and alcoholics themselves. It provides help and support to doctors who think they may have a problem with substance abuse. Callers may remain anonymous if they wish. Help offered includes referral for assessment, advice about treatment centres when appropriate, and an introduction to long-term befriending and support services. The helpline also accepts calls from family members or friends as well as concerned colleagues.

*Note change of number since publication of the AAGBI Welfare resource ‘glossy’.

**GMC**

0161 923 6402

The GMC can be contacted to discuss performance issues, or to seek advice on how to proceed when raising concerns about a doctor’s health.

**BMA Doctors for Doctors**

08459 200 169

Although this is not an addiction-specific service, it may provide help with employment issues which may arise.

**References**


13 Berry AJ, Polk SL. Chemical Dependence in Anesthesiologists: What you need to know and when you need to know it. ASA 2002; Committee on Occupational Health of Operating Room Personnel Taskforce on Chemical Dependence (http://anestit.unipa.it/mirror/asaa/ProfInfo/chemical.html accessed 24.7.11).