

A Departmental Policy Addressing Chemical Substance Abuse

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Substance abuse is a major socioeconomic problem. However, the ready availability of potent narcotic and sedative drugs probably constitutes a unique risk for anesthesiologists. Until recently, few anesthesia departments were prepared to recognize or safely manage afflicted colleagues. Because we felt it important to educate our staff and residents and to have a response mechanism established *prior* to the advent of a substance abuse problem, a departmental committee was formed to develop a Substance Abuse Policy. The policy has served to increase our general awareness and to direct our actions effectively when dealing with physician impairment. It is presented here in the belief that other departments might find it useful in tailoring their approach to this problem.

CHEMICAL SUBSTANCE ABUSE is a major socioeconomic problem. The loss of productivity and the consequences to the individual, family, and society are enormous. The prevalence of chemical substance abuse among *all* physicians appears to be close to 10%, and anesthesiologists seem to be consistently overrepresented among physicians in treatment for addiction.^{1,2} Anesthesiologists make up 3.6% of U. S. physicians, yet they represent 10-13% of physicians in treatment programs.^{3,4} There is realistic concern, therefore, that anesthesiologists are at increased risk of addictive disease. This may be due in part to their role as administrators of potent narcotics and sedatives. Anesthesiology is one of the few medical specialties in which a physician commonly administers these drugs personally. Few anesthesia departments or training programs have escaped the tragedy of an addicted colleague.⁵

Many departments or institutions are not sufficiently prepared to identify or safely manage afflicted colleagues. Our department recognized this after the development of addiction in three departmental members over a period of 5 years. This prompted the Department of Anesthesia

at the University of Pennsylvania to form a Substance Control Committee comprised of concerned members of the staff. Our earlier experience had suggested that inconsistent or poorly thought-out intervention, management, and treatment hindered short-term care and may have compromised long-term prognosis. Therefore, the charge of the committee was to educate our staff and residents, to establish a response mechanism *prior* to the advent of a substance abuse problem, and to develop a Substance Abuse Policy. Our policy is presented here in the belief that other departments might find it useful in tailoring their approach to this problem.

The purpose of the policy was two-fold: first, to clarify the department's position on substance abuse in the interest of resident and staff education; and second, to have a structured mechanism *in place* should a problem arise. Such a mechanism would ensure that afflicted individuals could be confronted effectively and safely brought to inpatient evaluation, so that appropriate therapy and long-term follow-up would occur.

University of Pennsylvania Department of Anesthesia Substance Abuse Policy

Although the Department feels that abuse of alcohol or controlled substances is incompatible with the practice of medicine and constitutes grounds for termination of employment, we recognize that addiction is an illness and approach this issue with several principles:

1. The safety of both the abuser and of our patients is of prime importance.
2. The privacy and dignity of affected individuals are to be maintained if at all possible.
3. No differentiation shall be made or assumed between staff and residents in control and management programs.
4. The Substance Control Committee will manage the substance abuse programs and, where intervention appears necessary, will do so only after conferring with the chairman.

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5. Of necessity, some recommendations are quite specific. Others are more general, leaving room for judgment to be exercised.

6. Recommendations will be modified by the Committee as appropriate.

7. Education is an integral part of our program. There will be a lecture in the summer introductory program and at least one seminar during the year to increase resident and staff awareness.

8. No clinically practical system for drug accountability can completely prevent abuse of controlled substances by determined individuals. However, changes in the handling of controlled substances will be effected as appropriate to encourage personal accountability and to limit the quantities of controlled substances readily available to individuals.

9. Cocaine will no longer be dispensed, as its efficacy as a topical analgesic or in preventing epistaxis during nasal intubation does not appear to be greater than placebo,⁶ and its potential for misappropriation is great.

I. PHILOSOPHY

The members of the Department consider it vital to identify and to help any colleagues who are abusing sedative, narcotic, or stimulant drugs. While this policy is formulated for the Department of Anesthesia, concern about a member of another department who is apparently involved with illicit drug use will be directed to the chairman of that individual's department.

The Department believes that individuals abusing such drugs are running significant risks to their own physical, emotional, and social well being. The incidence of fatal drug overdose (accidental or intentional) in physicians abusing drugs is substantial.⁷ Hence, no one is doing such physicians "a favor" by "protecting" them—especially in view of the long-standing nonpunitive policy of this department toward identified drug abusers who are willing to participate in an approved treatment program.

Of equal importance, the dangers posed to patients by a drug-abusing anesthesiologist are self-evident. Therefore, responsibility for our patients precludes allowing them to be cared for by a colleague whose performance is known (or strongly suspected) to be affected by drugs.

II. WHAT TO DO IF DRUG ABUSE IS SUSPECTED

It is our strong desire to encourage colleagues of individuals suspected of drug abuse to take those steps most likely to rescue the individual so suspected. These include asking a member of the Substance Abuse Committee, the

department chairman, or some other *informed and experienced* colleague for help or advice about what to do.

Persons expressing concerns about a colleague should be reassured that the department will do everything possible to protect the job and reputation (as well as the life and health) of the suspected substance abusers. Similarly, requested anonymity by any individual reporting suspected abuse will be respected, but with the understanding that no *official* action will ever be taken by the department solely on the basis of anonymous information.

An individual may be identified as performing professional duties under the influence of illegally obtained stimulant or sedative drugs or under the influence of alcohol by one of two processes: 1) voluntary acknowledgement, either before or after confrontation; 2) through gathering and submission of evidence by concerned colleagues. The individual so identified will be relieved of patient care responsibilities until the chairman and designated members of the department (based on the information received from the treating physician or program) approve the return of that individual to patient care responsibility.

A list of appropriate resources to contact if members of the department want help, either for themselves or for a colleague, follows:

1. Any member of the Substance Control Committee.
2. The department chairman.
3. A designated staff psychiatrist with whom the department has made *previous arrangements* for immediate evaluation and inpatient management of addicted persons.
4. A local impaired-physicians program (usually affiliated with a county or state medical society).

III. AFTER THE DECISION TO CONFRONT HAS BEEN MADE

Drug abuse is a progressive, debilitating, chronic disease. The aim of the department is to aid, not to prosecute, the affected individual. Because an addict can be expected to say whatever is needed to maximize access to drugs, it is necessary to conduct the confrontation in an unyielding fashion. Thus, the course of action the addict must take in order to continue to have the department's support must be decided *in advance* of the confrontation.

The department insists that any of its members found to be addicted to mood-altering chemicals be given only two options:

§ Confrontation is the formal process of interview and data presentation described in detail in "Section IV."

Option 1. Agree to enroll in a long-term treatment program approved by the department and its consultants. While awaiting admission to the appropriate program, they must agree to admission to a local inpatient unit. (Mechanisms are currently *in place* to facilitate immediate admission to a local unit so that the quite real risks of unsupervised withdrawal are avoided).

Option 2. Resign from the department.

Confrontation of a newly discovered addict will be arranged as rapidly as possible. A casual, poorly planned confrontation by an inexperienced individual is potentially harmful to the affected individual and is to be avoided.

Admission arrangements to a local unit prior to confrontation are mandatory to protect addicted persons who may seek access to drugs following confrontation if permitted to do so. Because of the acute emotional stress, the likelihood of overdosage is greatly increased. It is unreasonable and cruel to expect confronted individuals to control their own behavior in such a highly stressful situation. No confrontation, then, will take place in the absence of an immediately available inpatient bed.

During the course of the confrontation, the addict's financial responsibilities for treatment will be explained. The cost of an appropriate program can be as much as \$10,000 for the first month. Much of the treatment cost may *not* be covered by medical insurance. All uninsured costs of therapy will be the responsibility of the individual being treated. Whenever necessary, however, the department will provide some or all of the necessary funds in the form of a loan (Appendix 1).

IV. THE CONFRONTATION

Participants. At least two staff members should confront the addicted person. One will have authority to enforce the department's policy. The second should be primarily in a supportive role. Neither will allow any deviation from the prior decision.

The evidence for drug use should be presented with names and dates, whenever possible. It is to be expected that an addicted individual will deny use and "explain away" large bodies of circumstantial evidence. Because the individual is being asked to allow treatment of a disease, *not* to be punished for a crime, the confronters need not feel they should have to produce proof to the level of "beyond a reasonable doubt." The evidence need only be clear and convincing to the Committee.

Next, the options of treatment or resignation should be presented. If treatment is chosen, the costs should be presented and financial aid offered, if it is essential.

Throughout the confrontation, impaired individuals should be allowed to express themselves. The confrontation should be structured to allow as much emotional

support as possible. If the addict accepts treatment, the preselected therapist will be notified immediately and the individual will be escorted to an inpatient unit. No deviation from immediate inpatient treatment will be allowed.

V. FOLLOWING TREATMENT

Recovering addicts will be interviewed by a subcommittee of the Substance Control Committee after the period of treatment (the length of which is determined by their therapist or the treatment program). The subcommittee will explore with the recovering physician the option of retraining in another medical specialty because of the ready availability of drugs in the daily practice of anesthesia. Such a specialty change is easier to accomplish if the recovering physician has little time invested in anesthesia (*e.g.*, a first-year resident). In the case of a more senior anesthesiologist or if the recovering addict insists on returning to anesthesia training, the subcommittee may support this on a conditional basis if the individual's therapist also supports the decision. The conditions include continued outpatient therapy, an appropriate monitoring program, total abstinence from *all* mood-altering chemicals (as recommended by every expert we have consulted), and adherence to tight standards of behavior. If opioids were among the drugs abused, naltrexone maintenance will be required for resumption of employment. Recovered addicts should be made to understand that they will be judged by their *actions* and not their *words*. The recovered addict will be asked to agree to a list of unpermissible behavior patterns, such as cessation of follow-up therapy, drug or alcohol use, and inappropriate behavior. The committee will assist in the construction of the list. Deviation from acceptable behavior will be cause for immediate action.

When there is a relapse, the recovering addict will be immediately evaluated by the therapist or the designated staff psychiatrist. Following this evaluation, the recovering addict will again have the options of intensified outpatient or inpatient therapy, as recommended by the therapist, or resignation. Despite early "slips" (usually occurring in the first year) the prognosis for long-term recovery is good, given a well-structured reentry and monitoring program.¹

The Substance Control Committee has unanimously approved these recommendations, and they have been implemented. Their effectiveness is being monitored, and alterations to this program will be implemented as indicated.

APPENDIX 1

In the case of an addicted resident, the loan will bear a favorable interest rate, and payment of interest only would be

required for the duration of medical training (not necessarily in anesthesia). The principal will be amortized over a 5-year period or less after completion of training.

A departmental staff member will pay prime rate on the loan with the principal being due in 2 years. During treatment, the individual will continue to receive salary for up to 4 months. Continuation of salary after this interval will be at the Chairman's discretion, based in part on career decision, but will not exceed 6 months.

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