Short title: Administrative management of substance use disorder BP

1. Introduction

It is recognised that substance use is common in societies around the world. Some substances are legal, others illegal. Cannabis and alcohol remain the most common substances abused in our general population and in 5%, the level of use interferes with daily functioning and impacts on health, family relationships and wellbeing.

PG48 pertains mainly to substance abuse of drugs used in anaesthesia practice, an occupational hazard for anaesthetists given the unique work environment, and exposure to potent, highly addictive substances. In addition, pain medicine practitioners may also be at risk, especially if involved with procedural interventions involving addictive substances. Despite controls being in place, diversion is relatively easy. Tolerance and dependence may develop rapidly. Death may occur due to inadvertent overdose, airway obstruction, or more rarely, suicide. Death may be the initial presentation.

Based on data from USA 1.6% of anaesthetists will develop a problem over a 30-year career[1]. The relapse rate was 40% and the mortality rate due to SUD was 19%. The mortality rate for anaesthetists with substance use disorder (SUD) in Australia & NZ is 18% with a successful return to work rate of 32%[2]. The outcomes for inhalational agent abuse (US data) are worse with a mortality of 26% and a successful return to work rate of 22%[3].

2. Background

In view of emerging trends in the knowledge and treatment of substance use disorder, plus encouraging data on improved outcomes for affected anaesthesia practitioners from doctors' health programs in North America, the need for a new Professional Document with collaborative advice by experts including psychiatrists, addiction medicine specialists, medical administrators and anaesthetists was commissioned.

This work builds on the ongoing work of the Wellbeing Special Interest Group, who first published on this in 1996 with a subsequent revision in 2016.

There are several models used in relation to SUD, with the biopsychosocial model incorporating the Biomedical and the Psychosocial models. These view SUD as a disease of the brain with genetic or biochemical causes leading to biochemical changes within the brain, while also subject to a complex interplay of psychological and social factors. Note that not all substance use leads to SUD.

Early data showed a relatively poor successful return to work (RTW) for anaesthetists. Recent data from the USA is more encouraging, with a successful return to work at 5 years of 75%[3]. However, this is in the context of well-conducted doctors' health programs with surveillance for 5 years, and that data will not necessarily be replicated in Australia & New Zealand, where such programs do not exist. This contrasts with the most recent data for Australia & New Zealand which shows a lower successful return to work rate of only 32%.

SUD is a DSM-5 condition with eleven diagnostic criteria. Current research shows that it is a serious chronic disease of the brain mediated via the reward centres, marked by compulsive drug use despite negative outcomes. It induces functional biochemical changes relating to reward, stress and self-control.

These changes may persist after cessation of the drug(s) perpetuating the addictive cycle.

There is significant likelihood of relapse, which for propofol carries a mortality risk of 45%[2]. However, there is now effective evidence-based treatment that can, with ongoing practitioner commitment and appropriate support, lead to lifelong remission.

It is hoped that this document will help provide safe and inclusive workplace environments for affected practitioners, which will reduce stigma, promote recovery and assist in reintegration back into their specialty.

3. Review of issues

Methods

Search topic: Substance Use Disorder

Database search included Medline (medical), Embase (medical) Psychinfo mental health, psychology, psychiatry) and grey literature (theses/reports/websites) since 2000 and limited to English language.

After consideration by the document development group (DDG), the DDG Lead reviewed titles and abstracts and distilled those relevant to this area.

Medline 5, Embase 3, Psychinfo 1, grey literature 2.

The group achieved consensus on expert professional opinion and included specialist representatives from RACMA, RACP Chapter of Addiction Medicine, RANZCP Faculty of Addiction Psychiatry, Ahpra, Faculty of Pain Medicine, ANZCA and anaesthetists with lived experience.

3.1 Occupational Hazard

3.1.1 Occupational hazard encompasses many types of hazards, including, but not limited to, biological, physical and psychosocial hazards.

3.1.2 Unique to anaesthesia is the easy access to potent sedative & opioid drugs and it is not possible to eliminate this risk.

3.1.3 Administrative controls include compliance with the medication legislation including storage, witnesses, signing and discarding.

3.1.4 Regular training needs to occur to educate and reinforce previous learning for practitioners around medication safety and compliance.

3.1.5 Psychosocial hazards may exist for staff because of the behaviours of the SUD practitioner. These need to be recognised and managed.

3.2 Interventions

Interventions that are suggested are unique to each case and can be classified according to presentation into five distinct groups with escalating concerns/issues.

It may be beneficial to have multiple supervisors in the RTW plan as they need to support each other and provides increased opportunity for the affected practitioner to work. One supervisor should have a coordinating role. All supervisors should have equal say in the RTW plan. Appendix 4 contains a summary table and more detail on the potential approach to each presentation.

3.3 Trainees

Inappropriate use of alcohol or recreational and/or non-prescribed drugs, and/or treatment with prescribed drugs that risks compromising the safe practice of anaesthesia or pain medicine fall within the scope of ANZCA Regulation 37, namely that when ANZCA becomes aware, that:

3.3.1 When conditions have been placed, or undertakings agreed on to limit a trainee's practice, the trainee will be placed in interrupted training from the date the conditions are imposed.

3.3.2 At the earliest opportunity a trainee performance review will occur.

This process will occur separately from the regulatory processes.

FPM By-law 4 has similar provisions.

Decisions will be based on regulations of the college, and restrictions on training will be based on the regulator-imposed restrictions on practice. Employment decisions, which may impact training, are made by the relevant employer/s.

It should be noted that the risk of relapse and death either by overdose or suicide is higher in trainees than in specialists. Evidence strongly suggests that for their own safety, trainees should receive vocational advice to consider retraining in another specialty[4,5].

3.4 Private practice

Work patterns vary widely from sole public practice, mixed public/private, sole private practice and locum work. Some work in departments or private practices, others work independently and use a billing service. Many anaesthetists work at multiple settings.

Public appointments can have multiple employment conditions including permanent employee, permanent contractor (VMO) or short-term contract such as locum.

Returning to work safely and well supported can therefore be very challenging to organise.

It should be noted that the document development group debated at length the difficulty of maintaining stable employment following anaesthesia medication related substance use disorder (AMR SUD), particularly for those anaesthetists who work exclusively in the private sector. It is not possible for ANZCA to mandate that public hospital departments be obligated to employ an anaesthetist with a substance use disorder for their return to work.

3.5 Support

3.5.1 Australia and New Zealand do not have formal, well organised independent Doctors' Health programs as they exist in the USA and Canada.

3.5.2 The best outcome data for doctors with AMR SUD come from North American programs which have initial mandatory 6-week residential rehabilitation and undertake job placement, drug screening and ongoing support, including through relapse. The practitioner signs a 5-year contract with the program.

3.5.3 There are some private drug and alcohol units in Australia and New Zealand which have the required experience and facilities but by and large are not involved in the ongoing support in the workplace.

3.5.4 Overseas research supports practitioners remaining under review for at least 5 years, depending on progress of recovery and rehabilitation[3].

3.5.5 Best outcomes occur when the practitioner is well motivated, honest and with minimal denial, working within their individual recovery program.

3.5.6 Access to and information about the ANZCA doctors support program is available via the ANZCA website.

4. Regulatory bodies

In Australia and New Zealand regulatory bodies are best placed to provide independent oversight, including drug screening protocols and requirements.

5. Relapse

5.1 The relapse rate in Australia and New Zealand is unknown.

5.2 Every case is unique and needs to be considered on its own merits.

5.3 Whilst important to treat the relapsed practitioner with compassion, it is also important to recognise that AMR SUD is a serious medical condition. It may be safer and more appropriate for the practitioner to work in another field if a high risk of relapse persists.

6. Prevention strategies

6.1 Ongoing review of anaesthesia drug handling processes.

6.2 Ongoing education.

6.3 Departmental or practice wellbeing advocate.

6.4 Departmental or practice wellness programs including encouraging everyone having their own GP, adequate leave approval, and fatigue management policies.

6.5 If feasible, a substance misuse committee to proactively consider local issues and available resources including establishing a readily accessible resource folder identifying local resources. Relationships with local care providers should be established in advance of a crisis.

6.6 Facilities are encouraged to develop a strategy for Anaesthesia and Pain specialist practitioner drug testing for practitioners suspected of AMR SUD consistent with other high-risk industries such as aviation and mining.

7. Summary

In proposing the recommendations in the accompanying guideline, it is understood that each case of suspected or proven AMR SUD in a practitioner is unique and requires a tailored approach.

Active engagement of subject experts including medical administration, specialist experts in drug and alcohol addiction, psychologists and GPs will facilitate the management of each case. Identifying individuals and establishing these relationships at the local facility in advance of a crisis may be desirable.

Some of the recommendations may present a challenge, however they are designed to assist in managing the SUD. Adoption of processes outlined in the guideline should facilitate practitioner health and patient safety.

Related ANZCA documents

PG06 Guideline on the Anaesthesia record

PG43 Guideline of fatigue risk management in anaesthesia practice

PG49 Guideline on the health of specialists, specialist international medical graduate and trainees

PG50 Guideline on return to anaesthesia practice for anaesthetists

PG51 Guideline for the safe management and use of medications in anaesthesia

PS57 Position statement if duties of specialist anaesthetists

PG65 Guideline for the performance assessment of a peer

ANZCA Critical incident debriefing toolkit: 3: Supporting a trainee/colleague in distress

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References

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ANZCA website: www.anzca.edu.au