

Editorial

The impaired anaesthetist - *is this a problem in South Africa?*

The dictionary definition of “impaired” states the following: damaged or weakened.

In the South African context, and with the guidance of the HPCSA, the definition of *impairment* for the purposes of the Health Professions Act No. 56 of 1974 suggests:¹

“Whenever it appears to the Council that a person registered under this Act:

- Has become mentally or physically disabled to such an extent that it would be contrary to the public interest to allow him to continue to practice
- Has become unfit to purchase, acquire, keep, use, administer, prescribe, order, supply or possess any scheduled substance
- Has used, possessed, prescribed, administered or supplied any substance referred to above regularly for other than medicinal purposes
- Has become addicted to the use of any substance referred to above

The Council shall cause the matter to be investigated

In addition, the Workgroup on Impairment states: “Specifically impairment has been defined as having significant difficulty in carrying out the requisite tasks of a job at a level objectively approaching competence. It is important to understand that, though subjective distress is often the prelude or concomitant of impairment, it is not the same thing.”²

In the United Kingdom, impairment is defined as “the exhibition of conduct or professional performance posing a danger to patients”.

When one mentions impairment it is immediately assumed that the reference is to substance abuse, but, as can be seen from the HPCSA definitions, impairment includes physical and mental disability. When this disability occurs in a colleague, it is often difficult to ascertain whether it is significant enough to result in impairment. Under these circumstances we are advised by the HPCSA: “It is every doctor’s duty to inform an appropriate person or body when doubt arises about a colleague’s fitness to practice safely and effectively.” In anaesthesia in South Africa, should this “body” be our Society, and does SASA need to revise the previously recommended guidelines for the identification and management of “The Impaired Anaesthetist”?

If one looks specifically at the issue of **substance abuse** among anaesthetists, our colleagues in Australia, New Zealand and the United Kingdom are streets ahead of us in defining the magnitude of the problem, as well as in having national guidelines on how to manage the individual anaesthetists involved.

In a survey conducted by Fry in 2003, a questionnaire investigating substance abuse was sent to 128 anaesthetic departments in Australia and New Zealand.³ One hundred replied (78%), and reported 44 cases of substance abuse. Abusers were more likely to be male, aged between 25 and 35 years, and to have abused opioids. Other agents included induction agents and benzodiazepines, followed by alcohol. Nineteen per cent of abusers made a long-term recovery within the specialty, although 75% initially returned to work. In 24% of the cases the eventual outcome was death. Of interest is that only 19 of the 100 departments that replied stated that they had a formal intervention policy in place within their institution. I wonder how many of our departments in South Africa have a policy? The reasons given for anaesthetists turning to substance abuse are stress and burnout, both of which are on the increase and need to be managed by training departments and “SASA equivalents”. In a survey conducted in Canada in 1994 the “areas of major personal concern” during a career in anaesthesia changed from financial in medical school and residency to aging and physical problems during anaesthetic practice.⁴

In 1999, the Council of the Association of Anaesthetists of Great Britain and Ireland (AAGBI) formed a working party to look at alcohol and drug abuse among anaesthetists.⁵ Of importance is that the safety and wellbeing of the patients need to be considered, as well as that of the individual concerned. In 1998, the British Medical Association suggested that one in fifteen (7%) doctors in the UK may suffer from some form of dependence on alcohol or drugs in their lifetime. Interestingly, anaesthetists are not the highest risk group amongst doctors, as was previously thought. The AAGBI working party sent a questionnaire to 304 departments of anaesthesia in the UK and Ireland and received a 71.7% response. The findings were similar to those from New Zealand in that they showed that many departments had no policies in place to deal with the problem and, if there were policies, many were not aware of them. A total of 81% of substance abusers were male, in the 30–39 year age group, and opioids and benzodiazepines were the most commonly abused substances.

(Alcohol was abused more frequently in the >40 year group.) Interestingly, 47% of abusers returned to work as anaesthetists,⁵ which appears to be higher than the figures from Fry's study.³

Roberta Hines⁶ and Karen Domino⁷ have emphasised some pointers in the diagnosis and management of the substance-abusing anaesthetists. Characteristics may include the following: signing out increased quantities of opioids or sedatives; inconsistencies in recording missing drugs; long duties, with the individual seeking extra out-of-hours duties; wearing long sleeves to conceal arms; spots of blood on clothing; changes in behaviour (wide mood swings) and movement patterns at work; altered/illegible records; refusing lunch relief or breaks; desire to work alone; frequently relieves others; frequent bathroom breaks; disproportionate numbers of patients in pain in the recovery room; observed tremors or pin-point pupils, or other physical signs such as weight loss. Hines also emphasises the difference between abuse and addiction, and that the step leading from the one to the other has to do with compulsion.⁶ She cautions us that detected addicts are often found comatose, and untreated addicts may be found dead!

The most frequently abused agents among young anaesthetists in surveys conducted in the USA, Canada, UK, Australia and New Zealand are opioids – predominantly fentanyl and sufentanil. Alcohol abuse is more common in the older anaesthetist. Other agents include cocaine, benzodiazepines (midazolam) and propofol, with the abuse of volatiles, particularly sevoflurane, on the increase. The time until detection varies, with sufentanil being the shortest at one to six months, fentanyl at six to 12 months, and other injected drugs longer than a year. The reporting may be from many sources, but is often from our nursing colleagues.

The treatment of substance-abusing anaesthetists can be remarkably effective, but must be initiated immediately and voluntarily. This may well be problematic, as the abuser's initial response when confronted is denial. In addition, it is vital to have family support throughout the protracted period of treatment, which must be undertaken in a recognised programme. During this period, the anaesthetist is usually suspended from practicing anaesthesia by the HPCSA ("securing patient safety through the imposing of restrictions on impaired persons"), which mandates the Health Committee to monitor the practitioner's progress regularly. It is a costly exercise, as the anaesthetist is required to pay for the treatment and rehabilitation. Baird and Morgan raise the issue of whether an anaesthetist who has been dependent on opioids should be allowed to again practice anaesthesia.⁸ The risk of relapse after opioid addiction is greater in the first five years, and is quoted to be as high

as 70% in the case of fentanyl addiction. If there is a relapse, it often results in death due to accidental overdose. Domino demonstrated that anaesthesiologists have nearly three times the rate of drug-related deaths than general internal medicine physicians, which is a very sobering fact.⁷

The Talbott Recovery Programme in Atlanta, Georgia has developed a re-entry classification, according to which they grade substance-abusing anaesthetists on the basis of criteria such as understanding of the disease and their own rehabilitation, strong family support, balanced lifestyle, commitment to (and investment in) anaesthesia, bonding with the treatment programme and commitment to a recovery contract. Anaesthetists are categorised into three different groups: group one will most certainly return to anaesthesia; group two may possibly return; while group three is redirected to another specialty. Successful re-entry of group one (and possibly group two) requires strict criteria, similar to some of the requirements of the Health Committee of the HPCSA. These include an ongoing treatment programme, random urine/blood screens, no night/weekend calls initially and a re-entry agreement with a three to five-year monitoring period. It would appear from the literature that approximately 40% return to anaesthesia successfully, with a further 40% changing to another specialty successfully.

The international literature on the impaired anaesthetist, and in particular the substance-abusing anaesthetist, is unanimous in its criticism of the lack of education of anaesthetic trainees and anaesthetists and anaesthesiologists on the issue. In addition, it is felt that it is a chronic disorder, similar to diabetes and hypertension, and should be treated as such, with guidelines on the identification and management of the condition, at every institution where anaesthesia is practised.

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Christina Lundgren

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