

## Chemical Dependence in Anesthesiologists: What you need to know when you need to know it.

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Chemical dependence is a devastating disease that must be recognized before it can be treated. In most cases, the addict is the last to acknowledge its presence. Thus, it is imperative that we, the friends, colleagues and relatives, gain a clear understanding of the disease before we are confronted with it. This booklet is a short summary of the information you will need to begin the process of helping someone who is unable to ask for that help, and to assist with return to work following treatment. We ask that you read it with an open mind. You never know when your understanding may save the life of a loved one, colleague or friend.

### INTRODUCTION

Early identification of addiction, before professional impairment occurs, is paramount. However, identification is often difficult because the multiple signs and symptoms are subtle and none of them is diagnostic when taken alone. Individual family members and colleagues typically see only a part of the constellation of clues, making it easier for the addicted individual to hide the disease. For these reasons, it is imperative that educational efforts, such as this booklet, be directed at appropriate family members as well as the professional community if we are to increase the opportunity for early recognition and treatment.

This publication provides the background that will help you find answers to the following questions:

1. What should I do if I suspect drug or alcohol abuse in a colleague or my spouse?
2. What should I do if I know of drug or alcohol abuse in a colleague or my spouse?
3. Should I hire an anesthesiologist with a history of drug or alcohol abuse?
4. Could this happen to me?

Impairments in physicians present risks to the public, the physician, the family, the hospital, and to professional colleagues of the physician. Impairment may result from psychiatric illnesses such as depression, from advancing age, from physical disabilities and from dependence upon drugs. While all of these may have serious consequences, this booklet will be limited to drug addiction because the majority of those afflicted develop the disease during the most productive portions of their professional careers.

Chemical dependence is a chronic, relapsing disease that affects individuals in all social strata and in all walks of life. It occurs no more frequently among physicians than it does in the general public, although it is particularly noticeable when it occurs in professionals. For an addiction to develop, there must be a drug that is readily available and an urge to use that drug. The urge is genetic and behavioral in origin; availability is situational. To become an addict, the physician must have an inherent susceptibility to the disease and must be able to obtain drugs. Drug type and availability are usually dictated by the physician's medical specialty.

Although there are no precise data regarding the prevalence of dependence on alcohol and other drugs in anesthesiologists, recent survey data\* indicate that in anesthesia training programs in the United States, the disease appears at a rate of about 0.5 percent per year of all personnel in those programs. As yet, there are no similar data for anesthesiologists in private practice. Both the survey data and reports from treatment centers have clearly shown that the potent opioids, fentanyl and sufentanil, are the drugs abused most frequently by

anesthesiologists, comprising about 70 percent of cases. In the survey, alcohol and cocaine each accounted for about 10 percent of the cases, while the remainder were divided nearly evenly among several other drugs, including benzodiazepines, potent inhalation agents, nitrous oxide, sodium thiopental, lidocaine and propofol.

The disease is progressive, with a rapidity of onset that depends upon the "drug of choice." While addiction to alcohol may take decades to become apparent, addiction to the potent opioids frequently becomes apparent within weeks. Unless the disease is recognized and treated appropriately, it will result in social, psychological and physical harm to the abuser, and may end in death.

Early detection is usually difficult, since the signs and symptoms of dependency are frequently quite subtle until the later stages of addiction have developed. Identification is also hampered by the overwhelming denial of the disease, not only by the addict but also by colleagues and family members. Self-reporting is unusual, in large part because of the denial and also because of the fear of losing one's job, one's license to practice medicine and the respect of others.

It is therefore imperative that physicians, their families and other health professionals be well-educated about chemical dependence. Education of hospital administrators is equally important. Hospital and departmental policy manuals should contain procedures for managing addicted physicians. Only then will we as physicians be in a position to aid chemically dependent colleagues.

The goal of these educational efforts and substance abuse policies is to assure 1) timely identification of these individuals, 2) intervention to facilitate rapid entry into treatment programs, 3) adequate time for appropriate treatment, and 4) subsequent follow-up care, which is imperative for successful return to the workplace. This sequence can lead to an excellent prognosis for long-term recovery.

### ADDICTION

Addiction is the overwhelming compulsion to use drugs in spite of adverse consequences. It is a chronic, progressive disease that results in loss of control of one's life. Unless it is recognized and treated skillfully, addiction will result in disability and will often end with death. Physical dependence frequently develops but is not present in all drug addictions.

Abuse involves the inappropriate use of drugs (including alcohol) but is not accompanied by the uncontrolled compulsion seen with addictions. The person who is arrested for driving under the influence of alcohol, who realizes the transgression and is able to avoid further incidents, has abused the drug. In contrast, the person who irrationally blames the arrest on outside influences such as the officer's career goals and who continues drinking uncontrollably, is addicted.

### Disease

The American Medical Association recognized addiction as a disease in the early 1970s. There is conclusive documentation of the inheritance of alcoholism, and there is strong support for biochemical etiologies of addiction to both alcohol and to other drugs. Addiction presents as a characteristic constellation of pathological signs and symptoms that occur through the interaction of a susceptible host, a causative agent (drug) and an environment in which the drug is available. When exposed to a critical combination of drugs and external conditions, vulnerable individuals will become addicts, and some will die from their disease. The ASA survey documented the deaths of several anesthesiologists during each year that it was conducted.

The disease appears to be far more common in men than in women. While about 25 percent of individuals in anesthesia training programs in the United States are women, the ASA survey showed that only 10 percent of addictions in that cohort involved women. Data from treatment programs support this observation. This variation, however, may be due to case selection and reporting, rather than demonstrating a true difference in incidence by gender.

**Table 1**  
**What to Look for Outside the Hospital<sup>1</sup>**

1. Addiction is a disease of loneliness and isolation. Addicts quickly withdraw from family, friends and leisure activities.
2. Addicts have unusual changes in behavior, including wide mood swings, periods of depression, anger and irritability alternating with periods of euphoria.
3. Unexplained overspending, legal problems (such as DWIs), gambling, extramarital affairs and increased problems at work are commonly seen in addicts.
4. An obvious physical sign of alcoholism is the frequent smell of alcohol on the breath.
5. Domestic strife, fights and arguments may increase in number and intensity.
6. Sexual drive may decrease significantly.
7. Children of the addict may develop behavioral problems.
8. Some addicts frequently change jobs over a period of several years in an attempt to find a "geographic cure" for their disease or to hide it from co-workers.
9. Addicts need to be near their drug source. For a health care professional, this means long hours at the hospital, even when off duty. For alcoholics, it means calling in sick to work. Alcoholics may disappear without explanation to bars or hiding places to drink secretly.
10. Addicts may suddenly develop the habit of locking themselves in the bathroom or other rooms while they are using drugs.

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11. Addicts frequently hide pills, syringes or alcohol bottles around the house.
12. Persons who inject drugs may leave bloody swabs and syringes containing blood-tinged liquid in conspicuous places.
13. Addicts may display evidence of withdrawal, especially diaphoresis (sweating) and tremors.
14. Narcotic addicts often have pinpoint pupils.
15. Weight loss and pale skin are also common signs of addiction.
16. Addicts may be seen injecting drugs.
17. Tragically, some addicts are found comatose or dead before any of these signs have been recognized by others.

**Table 2**  
**What to Look for Inside the Hospital<sup>▲</sup>**

1. Addicts sign out ever-increasing quantities of narcotics.
2. Addicts frequently have unusual changes in behavior such as wide mood swings, periods of depression, anger and irritability alternating with periods of euphoria.
3. Charting becomes increasingly sloppy and unreadable.
4. Addicts often sign out narcotics in inappropriately high doses for the operation being performed.
5. They refuse lunch and coffee relief.
6. Addicts like to work alone in order to use anesthetic techniques without narcotics, falsify records and divert drugs for personal use.
7. They volunteer for extra cases, often where large amounts of narcotics are available (e.g., cardiac cases).
8. They frequently relieve others.
9. They are often at the hospital when off duty, staying close to their drug supply to prevent withdrawal.
10. They volunteer frequently for extra call.
11. They are often difficult to find between cases, taking short naps after using.
12. Addicted anesthesia personnel may insist on personally administering narcotics in the recovery room.
13. Addicts make frequent requests for bathroom relief. This is usually where they use drugs.
14. Addicts may wear long-sleeved gowns to hide needle tracks and also to combat the subjective feeling of cold they experience when using narcotics.
15. Narcotic addicts often have pinpoint pupils.
16. An addict's patients may come into the recovery room complaining of pain out of proportion to the amount of narcotic charted on the anesthesia record.
17. Weight loss and pale skin are also common signs of addiction.
18. Addicts may be seen injecting drugs.
19. Untreated addicts are found comatose.
20. Undetected addicts are found dead.

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### Signs and Symptoms

The signs and symptoms of the disease usually develop in a characteristic progressive fashion, beginning with changes in 1) community activities, 2) family life, 3) employment, and 4) day-to-day work habits. Most of them are subtle and difficult to recognize.

The rapidity of onset of the disease appears to be directly related to the potency of the drug of choice. Thus, addiction to alcohol may take decades before becoming apparent. In contrast, addiction to fentanyl characteristically takes less than a year and sufentanil less than a month, respectively, before the disease is perceptible to others.

Many of the manifestations of addiction that appear in Table 1 (page 8) are seen outside of the hospital. This is especially true with addictions to alcohol and most orally administered drugs, both of which develop slowly. Thus, the physician's spouse, partner or friends may be the first to recognize the early warning signs of the disease. Since addictions to the potent opioids, fentanyl and sufentanil, develop rather rapidly, most of the signs and symptoms of addiction to these drugs, which are included in Table 2 (page 9), will be apparent in the hospital setting.

Unfortunately, the most common response of persons when faced with the possibility of addiction in a colleague or friend is to categorically deny that it is present. Denial involves the development of rationalizations for irrational behavior patterns. For example, the addict with a closet full of stolen syringes may be able to convince himself and those around him that he is keeping them in the event that his diabetic father runs out of his own supply.\* Denial is a pathologic alternative to facing the prospect that the signs and symptoms point to addiction. Unfortunately, with the exception of witnessed self-administration, none of the signs and symptoms seen at home or at work is diagnostic. Thus, in order to recognize the disease, the myriad of indicators must be viewed as a whole. For example, a collection of syringes, long hours at work even when not on call, loss of interest in sports, forgetting a child's birthday party, mood swings and other signs each taken in isolation do not bring to mind the possibility that they result from addiction. When examined collectively, however, they may.

### Tolerance

During the relatively short course of addiction normally seen with fentanyl or sufentanil, the addict develops an incredible tolerance to the drugs, resulting in the use of progressively larger doses. Over a six- to 12-month period, a fentanyl addict may attain a habit of 80 to 100 ml of fentanyl per day. Within weeks of the onset of addiction to sufentanil, daily use may be as much as 10 to 20 ml. A tenth of these doses would kill a person who is drug-naive.

Many recovering anesthesiologists have said that the first time they "used," the feeling was indescribably good. They have also reported that they were never able to attain the same sensation again, in spite of using progressively escalating doses of drug. In fact, as their addictions progressed, they had to "use" almost continuously to avoid the symptoms of withdrawal that accompany abstinence in those who have developed a physical dependence.

Physicians who choose potent opioids are usually identified more rapidly than those who become addicted to other drugs. The latter group may successfully conceal the effects of chemical abuse on their professional activities for years. The rapid deterioration that results from the abuse of potent opioids leads to the perception among both the medical and nonmedical communities that anesthesiologists are more prone to addiction than practitioners of any other specialty. They are not. However, when they become addicted, the disease tends to become apparent more quickly than in others because fentanyl and sufentanil are the drugs most commonly used by anesthesiologists.

### Gathering Information and Reporting the Findings

The presence of behavioral changes suggestive of chemical dependence raises a suspicion but should never be construed as conclusive proof of drug abuse. However, when the disease is suspected, it is important that the possibility be investigated in an expeditious but caring and confidential manner.

Suspicion of a drug problem should be reported, but it is crucial that it be reported to the proper person or committee. Depending on the particular institution, this may be the physician well-being committee of the state medical society, a peer assistance committee, the department's chair, a direct supervisor or other relevant individual. It should be the responsibility of this person to investigate confidentially the available information and to seek corroborating documentation. The investigation may involve interviews with associates, colleagues, family members, friends and others acquainted with the person in question, as well as reviews of anesthetic and pharmacy records.

For the protection of the suspected addict, it is important not to go directly to police or other authority whose prime charge is to prosecute. Anyone who has diverted controlled drugs for personal use has, by law, committed a felony and is subject to prosecution. This individual is, at the same time, however, acutely ill and urgently in need of treatment. Prosecution may be in the individual's future, but treatment should be the primary intent of the initial investigation.

### Potential Legal Issues

Laws regarding chemical dependence in physicians vary from state to state. Some require that all cases of chemical dependence in physicians be reported; some mandate reporting abuse of all drugs except alcohol; and others have no statutory requirement to report impaired physicians at all. Laws that demand reporting directly to regulatory boards, rather than to committees whose goal is to assist the ill physician, may tend to cripple the activities of these advocacy committees. As a result, unless the aim of the board is advocacy, few physicians in these states will receive the needed medical care. Impairment is not primarily a legal issue, but it is imperative for those concerned to contact the medical society in the state of record should questions arise regarding specific methods of management.

Hospitals, medical staffs and individual physicians have occasionally been found negligent for failure to monitor or restrict the privileges of an impaired physician. Therefore, to be aware of and yet to ignore chemical dependence may result in legal liability. That is the basis of the "snitch law" which is enforced in some states. If reasonable care is taken to see that an impaired physician is identified and treated in accordance with accepted medical practice, liability -- other than possible imputed liability for any malpractice engaged in by the impaired physician -- is generally reduced or eliminated.

In most states, legislation provides immunity from liability to members of a professional society or medical staff committee whose purpose is to review the quality of medical services. Persons who give information to such committees are also usually granted immunity, providing they believe the information is true, they are not reporting it with malice, and they discuss it only with the committee.

### Intervention#

Intervention is the process of proving to an addict that he or she is ill and is in need of immediate evaluation and treatment. Its primary purpose is to overcome the denial that is inevitability present. Rather than being punitive, an intervention is advocacy, or in the words of recovering addicts, a demonstration of "tough love." Only when substantial evidence confirming the presence of addiction has been collected should intervention be attempted.

Interventions should be undertaken by a group of people who are genuinely concerned about the individual. They should be led by an individual who has both training and experience in the process. Interventions should never be conducted by a single person, no matter how experienced. The participants, ideally numbering from three to about eight, may include friends, colleagues and family of the addicted physician. They should be selected carefully.

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The intervention should be scrupulously planned and not be limited by time. Each participant should prepare a detailed list of his or her observations that demonstrate the individual's addictive behavior. This information should be presented during the intervention. If possible, at least one member of the group should be a physician who is recovering from the disease. Most addicts feel remorseful, isolated and unique, sure that their plight has never happened to anyone else. To have one of the participants say, "I know where you are coming from; I've been there myself" may be an extremely important component in a successful intervention.

Plans must be made in advance for immediate referral of the individual to a facility skilled in conducting a comprehensive medical and psychological evaluation of addicts. Arrangements should be made for transportation of the person to the facility, and someone should be selected to accompany the addict. Should long-term treatment be indicated, it is best carried out in a program experienced in managing addicted physicians.

The conduct of the intervention depends on the specific circumstances of the case, but should always stress advocacy for the individual. That person will probably not realize that addiction is a disease that if left untreated will lead to irreparable damage to his or her health, personal and professional life, and that it may end in death. Conversely, the individual probably does not realize that if the disease is treated, the likely result is long-term recovery.

A well-planned and -managed intervention will usually result in the physician agreeing to enter a substance abuse treatment program. However, the intervenors must be prepared for a refusal and should use all available coercive measures if necessary. The possibility of returning to medical practice is a powerful motivation for recovery. Thus, the threat of being reported to a state medical board, which will likely result in loss of one's medical license and professional career, is usually the best of these measures.

Not all interventions are successful. Every effort should be made to minimize the chance of the physician "bolting" following a failed intervention. The potential for self-harm under these circumstances is real.

### Treatment

Successful treatment of an impaired physician is a multidisciplinary effort. Detoxification, intensive education and behavior modification in early recovery are usually best achieved during inpatient treatment. However, the current climate of cost cutting in medical care may reduce this option from several weeks to only a few days. The majority of time now spent in treatment is usually on an outpatient basis but with the same goals in mind.

Many feel that it is vital that physicians be treated at a facility whose personnel are skilled in managing addicted physicians. Although this may not always be possible, it is important that a physician in early treatment see that there are peers who share the same disease. In addition, the veneer of the medical degree should be stripped away as soon as possible. Unless there are other physicians in treatment, it is likely that the isolated physician will be placed on a pinnacle, both by those in treatment and by those who are providing the therapy.

During the initial phase of treatment, the impaired physician should undergo intense medical evaluation. Physicians skilled in internal medicine, psychiatry, neurology and addiction medicine should all be involved. Other specialists should be consulted as needed. Detoxification, if needed, should be carried out simultaneously.

Long-term treatment may require several months. Many programs have their patients reside in "halfway houses," where they can begin to learn how to interact with one another. The key elements of the therapy during this phase are complete abstinence from all mood-altering drugs, facilitated group psychotherapy with other recovering addicts, and regular participation in self-help fellowships such as Alcoholics Anonymous (AA) or Narcotics Anonymous (NA).

The use of specific blocking drugs such as disulfiram (Antabuse®) for alcohol, and naltrexone (Trexan®) for both alcohol and opiates is recommended by many therapists. Most believe the use of these drugs is an important adjunct to long-term recovery. Frequently, this therapy begins during treatment and is continued for up to a year following discharge.

Family members are also adversely affected by the disease. Usually, they develop their own denial patterns, anger and inability to deal with feelings about addiction and its adverse consequences. Accordingly, treatment should not be limited to the recovering physician but should also involve the family. Many programs offer weekend sessions specifically designed to provide vital information about the disease of addiction to spouses and children. Often included in these meetings is an introduction to AlAnon and other self-help groups that are targeted at the family.

### Aftercare

Aftercare should begin the moment the recovering physician is discharged from formal treatment. It is a life-long process of maintaining a healthy, drug-free life. Many treatment programs insist that their patients sign an aftercare contract prior to discharge. Stipulations in these documents usually include some or all of the following:

1. Regular attendance at 12-step meetings; usually daily for at least 90 days following treatment. Some may require at least three to five meetings per week for years. Failure to adhere to this stipulation is almost a certain sign of relapse.
2. Attendance at regular self-help meetings for physicians (like the "Caduceus Club" that was established by G. Douglas Talbot, M.D., in Atlanta, Georgia).
3. Obtaining a primary care physician who will be responsible for prescribing all drugs needed by the recovering physician, including those that are available over-the-counter.
4. Recommendations concerning returning to work should be made in writing by the treating facility, state medical society and/or other organization with expertise in managing aftercare in anesthesiologists. Contracts may address details such as whether or not the

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person should return to the practice of anesthesiology, the administration of controlled drugs, rate of resumption of responsibilities, hours worked and others.

5. Regular monitoring of recovery by a physician who has been trained to perform this task.
6. Mandatory collection of random urine or blood screens for a period of five years or more are mandated by most programs. Collection of specimens should be witnessed to avoid the possibility of deception. Fentanyl, sufentanil and their metabolites are challenging but not impossible to detect. If indicated by the drug of choice, these relatively expensive assays should be specifically requested.
7. Many recovery programs include weekly facilitated meetings of recovering physicians. The rationale for these meetings include: a) the fact that recovering physicians are usually more sensitive than monitors at detecting subtle signs of impending relapse, and b) that urine screens detect relapse only after it has occurred, while the group may identify it before the fact.
8. Many feel that physicians recovering from addiction to opioids should take naltrexone for at least six months following the termination of treatment. The drug and its metabolites are relatively easy to detect.
9. Management in the event of relapse should be addressed in the contract. It usually will include re-evaluation by experts and return to treatment if indicated by the evaluation.

### Return Home

Return to living at home may be a difficult process for both the recovering addict and the family. It will be facilitated during treatment if family members attend educational sessions specifically designed for them.

### Work

Whether a recovering anesthesiologist should return to the practice of anesthesiology is a hotly debated topic for which there are no firm answers. The attitudes of departmental colleagues, surgeons, other members of the medical staff and the administrators of the hospital play a major role. If these individuals are unwilling to accept the recovering physician and the stipulations outlined in the aftercare contract, then the likelihood of successful return will be slim. On the other hand, if they have a basic understanding of the disease of addiction and are amenable to gradual return to work in keeping with the contract, then the outcome in most cases will be positive.

Should a health care entity decide not to permit the recovering anesthesiologist to return to practice solely on the basis of his or her history of addiction, it may be vulnerable to legal action by the anesthesiologist. The Americans With Disabilities Act (ADA), a federal law that protects disabled workers, defines addiction as a disability. It states that a recovering individual may not be refused employment solely on the basis of that disability. One key for the entity is whether or not it has a real or imputed employer-employee relationship with the anesthesiologist. If this relationship does not exist, then the law would not be applicable. In addition, the ADA does not offer protection to addicts who are currently engaging in the illegal use of drugs.

The potential for successful return to work may be in part related to the drug of abuse. Preliminary analysis of data obtained in the ASA survey of anesthesia training programs, indicated that only about 50 percent of physicians with a history of fentanyl abuse returned to the specialty following treatment. Of those who returned, nearly half were terminated either voluntarily or involuntarily. In that group, the apparent relapse rate was nearly 20 percent per year over a maximum period of 18 months. In contrast, for those who abused nonopioid drugs, the relapse rate was about 4 percent per year. These figures must be regarded with caution since they do not take into account the length and type of treatment, the willingness of the department to accept the individual and other factors that are felt to be important to long-term recovery.

### For Help

Every state medical society has a program for the identification and management of chemically dependent physicians. Most of these will provide assistance with confidential investigation, intervention, treatment referral and aftercare monitoring, and will advocate for the recovering physician in matters of interest to the state board of medicine. A telephone call to the medical society in your state will begin this important process.

The telephone number for the **ASA's Hotline on Chemical Dependence** is **(847) 825-5586**. It is printed at the bottom of the inside cover of every edition of the ASA NEWSLETTER. With attention to strict confidentiality, personnel will provide callers with the appropriate telephone numbers for their locality and, if possible, will offer the name of a confidential consultant who can provide additional information and resources.

\* Survey of Chemical Dependence in Anesthesiology Training Programs in the United States: 1986-1995. [Analysis of data and preparation of report are in progress.]

^ Tables 1 and 2 are adapted from Farley WJ, Arnold WP. VIDEOTAPE: Unmasking Addiction: Chemical Dependency in Anesthesiology. Produced by Davids Productions, Parsippany, NJ, funded by Janssen Pharmaceutica, Piscataway, NJ, 1991.

+ Johnson VE. Intervention: How to Help Someone Who Doesn't Want Help. Johnson Institute Books, Minneapolis, 1986.

We have used the masculine pronoun because addiction is much more common in men.

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