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The Impaired Anesthesiologist: More Than Just Drugs and Alcohol

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Stem Case and Key Questions Content

Over the last year "Bill", one of your colleagues in an academic anesthesiology department has been moody, aloof, irritable, and withdrawn. While never outgoing and gregarious, he had been jovial and friendly with members of the department. He has called in sick three times in the last month, which is rare for him-he hadn't called in sick three times in the previous five years. Moreover, he rarely talks about his favorite activity, coaching his son's soccer team. His rapport with surgeons has never been good over the years, and now he is in frequent arguments with surgeons both in and out of the operating room.

1. What could be wrong with him?

2. What symptoms would be indicative of substance abuse?

3. What symptoms would be indicative of an affective disorder?

4. Should the Department consider this to be a problem, or is simply a personal concern?

5. What should the department do about this situation, if anything? The chairman has asked you to look into the problem. There have been no discrepancies with controlled substances in any case he has performed or supervised. The other department members have also noticed that Bill seems much sadder than usual. Someone saw him looking at a website about depression the other day. He was also seen reading about suicide methods online. You take what you think is a bold step and call his wife during the workday. She informs you that Bill has been seeing a therapist for depression ever since she gave him an ultimatum-to seek help or else. His depression has been difficult on her and the children. He comes home from work and goes to bed. Bill is also taking an antidepressant for which one of his colleagues wrote as a favor. She doesn't think he is getting better, but Bill thinks he is. You decide to finally confront Bill and discuss this problem with him. You plan on meeting with him tomorrow.

6. What is the rate of depression in the general population?

7. What is the rate of depression among anesthesiologists?

8. What preparations will you make?

9. Should you meet with Bill alone, or with others present? Who? Bill tells you that he has been depressed for a couple of years now. There has been no specific life stressor, but he feels he is tired of being 'bullied' by surgeons. He admits he was looking at suicide methods, but he is not serious about suicide. He volunteers to take any drug screening test you want. He really feels that he is improving and does not want to go to a psychiatrist. He is worried now that everyone will think he is weak, crazy, and that if word of this gets out he will have a hard time with licensure and credentialing. He begs you to keep all of this secret.

9. Is Bill at risk for suicide?

10. What is the suicide rate for anesthesiologists?

11. How does the rate compare to the general population, or other physicians?

12. How do we know whether Bill is functionally impaired? What would be the indicators?

13. Can Bill's problem become a patient safety issue?

14. Should Bill be worried about credentialing now?

15. Does the department have any weight in forcing Bill to seek more adequate treatment?

Model Discussion Content

Depression is a common disability in the world and it affects millions. The rate of depression in the general population is around 12-13%, while the rate in physicians may be higher. But what separates physicians from the rest of the population is the increased incidence of suicide, especially in anesthesiology[1, 2, 3, 4]. The exact rate of suicide among physicians varies from study to study, but is at least is 1.4 times that of the general population, and in some studies is 3 times that of the general population. The study by Alexander et al. in *Anesthesiology* in 2000 showed a rate of suicide in anesthesiologists of 1.45 that of an internist control group[5]. Depression in resident physicians and medical students has been shown to be even higher. While our specialty has done tremendous work to focus attention on recognition and treatment of substance abuse, we have done little to educate ourselves and others about the symptoms, treatment, and problems associated with depression and other affective disorders. In 2003 the *Journal of the American Medical Association* published a consensus statement from the American Foundation for Suicide Prevention concerning depression and suicide in physicians[6]. Many physicians are hesitant to seek treatment for depression due to the stigma associated with the condition because of concerns over difficulty with licensing, credentialing, hospital privileges, and professional advancement. The authors of the statement recommended changing professional attitudes and institutional policies to encourage physicians to seek treatment. Licensing and privileges should be based on the level of impairment, not the presence of the disease. It is believed that depression has a genetic component that will

manifest itself due to environmental stresses. Much has been learned about the biochemistry of depression and the balance of neurotransmitters in the brain. Pharmacologic therapy is focused on increasing the concentration of some neurotransmitters e.g. serotonin. Specifics in regard to the biochemistry and pharmacology of depression, however, are beyond the scope of this discussion. Symptoms of depression can vary widely, but commonly include:

Persistently sad, anxious, or empty mood
Hopelessness
Quietness
Aloofness
Restlessness, irritability
Decreased energy, fatigue
Feelings of guilt, worthlessness, helplessness, and failure
Loss of interest in hobbies and activities
Disinterest in work-related activities
Difficulty concentrating, remembering, making decisions
Overeating or appetite loss
Sleep problems
Difficulty with intrapersonal and/or professional relationships
Substance abuse
Thoughts of death or suicide; suicide attempts
Medical errors, acts of commission or omission

The physical consequences of depression are well known[7]. Suicide is of course one consequence of depression[8, 9,10]. Cardiovascular disease is more common in those with depression, and the risk of myocardial infarction in depressed males is 4-5 times that of nondepressed men[11,12,13]. Elevated cortisol levels are also seen[14]. Osteoporosis is more common[15]. The risk of cancer may be increased, and those depressed individuals with cancer have a lower survival rate[16,17]. A recent study by Farenkoph, et al. demonstrated that the rate of medication errors made by depressed pediatric residents in 3 major US teaching hospitals was 6 times higher than their nondepressed colleagues at the same institutions[18]. The prevalence of depression in these residents was 20%, which the authors noted was almost twice that of the general population. Nearly half of the depressed residents were unaware of their depression. It is important to note that the data was collected before implementation of the 80-hour work week limits. A subsequent study done after implementation of the 80-hour work week by the same group yielded similar rates of depression. A 2011 study in *Archives of Surgery* of 8,000 surgeons showed that 30% of respondents exhibited symptoms consistent with depression, and 6% of respondents had contemplated suicide[19, 20]. While no study on anesthesiologists and medical errors due to depression have been undertaken, it seems that depression would surely lead to more errors in our specialty as well. The nature of anesthesiology means that errors can lead to catastrophic results; those practitioners with depression may very well have decreased vigilance[21]. Disruptive medical behavior observed in someone who had not previously behaved in such a manner needs to be investigated by colleagues as it can be a sign of not only

depression, but other affective disorders and also substance abuse. In addition, depressed clinicians may be more susceptible to the adverse effects of medical bullying[22, 23, 24, 25]. Depression is one of many human factors that can affect patient safety as well as the efficiency of an operating room. Because of the concern for patient safety, the department, as well as the hospital administration is required to make a determination as to whether or not the practitioner (Bill) can practice safely. The basis of the determination rests in the documented behavior of the practitioner and not in a diagnosis. Thus, a practitioner who carries a diagnosis of depression, but in whom there has been no reason to question their care of patients, should not be burdened in any way. In fact, the Americans with Disabilities Act protects those with established illness who are otherwise capable of safe practice. If there is reason to believe that a person's practice is unsafe for any reason, then it is necessary to intervene. This intervention can be at the departmental level, but in fact is usually at the level of the medical director of the hospital or the executive committee. Legal requirements vary from state to state, but appropriate counsel rior to intervention is very important. As a specialty, we need to tackle this health problem much the same way that we have dealt with substance abuse in the past. We can decrease the stigma involved with depression in regards to licensing, credentialing, etc. by focusing on the level of impairment and not the presence of the disease. We need to be able to identify depression in our colleagues by knowing the signs and symptoms. Our specialty has done a wonderful job in bringing attention to the dangers of substance abuse, especially in training programs. The American Foundation for Suicide Prevention has a wealth of information on its website, www.afsp.org, and its companion site, www.doctorswithdepression.org. Their documentary, *Struggling in Silence: Physician Depression and Suicide* is available on DVD from the site. Much like residency programs across the nation have shown the *Wearing Masks* series for several years, we should also make *Struggling in Silence* a part of our curriculum. A simple depression screening test based on only two questions can identify up to 90% of those with depression[26]:

During the Past Month,
1. Have you often been bothered by feeling down, depressed, or hopeless?
Yes/No

2. Have you often been bothered by little interest or pleasure in doing things?
Yes/No

Depression is a disease and needs to be treated as one, just like diabetes or hypertension. Other specialties are addressing the issue of depression in its clinicians. It is our responsibility to ourselves, our families, our colleagues, and our patients to bring to light the negative effect that depression and other affective disorders can bring, and to also show that recognition and treatment of these disorders can be successful.

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