Drug and Alcohol Abuse amongst Anaesthetists
Guidance on Identification and Management

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This guideline has been seen and approved by the Council of the AAGBI.

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The vast majority of anaesthetists will be unaffected by substance abuse, but for those few that are affected the consequences can be devastating both for them and for their patients.

Drug and alcohol abuse is a problem for some anaesthetists, as it is in the general population. Drug abuse is more common than alcohol abuse in trainees.

The most immediate risk is of harm to patients.

A report of drug or alcohol abuse in an anaesthetist should be taken seriously and investigated without delay. Physical or behavioural symptoms at work indicate advanced addiction.

Anaesthetists are more likely than other doctors to abuse narcotics as a drug of choice, to abuse drugs intravenously and to be addicted to more than one drug.

Concerns should be reported to the clinical director in the first instance. A one-to-one confrontation should be avoided and efforts should be made to obtain objective evidence.

Clinical managers should be aware of policies and sources of assistance for managing these doctors.

Many addicted doctors find it difficult to seek help and tend to become isolated.

There is a danger of self-harm following intervention. Plans must be made in advance to facilitate treatment and for admission to a specialist unit if necessary.

The ultimate objective should always be to try and resume a normal pattern of personal and professional life; this may be difficult particularly for anaesthetists.

Anaesthetists willing to engage in treatment often experience a significant improvement in physical, psychological and social wellbeing. Support is required on a long-term basis.

2. Introduction

The vast majority of anaesthetists will be unaffected by substance abuse, but for those few that are affected the consequences can be devastating both for them and for their patients.

Illicit drug and alcohol use is relatively common in the general population and continues to increase in prevalence in many western societies. The lifetime risk of dependence has been estimated as 7% -15% in doctors [1, 2, 3].

Over 90% of the adult population in the UK drink alcohol, with 31% of men and 20% of women exceeding the recommended daily intake [4]. Studies suggest that the incidence in doctors of disorders of alcohol use over a lifetime is 13-14%, similar to that in the general population [2, 5]. Evidence suggests that alcohol dependence is more common in older anaesthetists [6, 7], but is less common than in other specialities [8].

Nationally, 10.5% of the population use illicit drugs, particularly in younger age groups. Drug dependence has been assessed as affecting 2.2% of the adult population [9]. Doctors are less likely to use illicit drugs than the general population but more likely to use benzodiazepines and minor opioids as a result of privileged access [2]. In anaesthetists illicit drug use is more common under the age of 40 years, and 80% of cases are male [7]. Studies from the US and Australia have reported a 0.4 - 2% prevalence of drug dependence in anaesthetic trainees [6, 10-12]. Anaesthetists are at a greatly increased risk of suicide and drug-related death compared to matched controls in the general population, and the time of highest risk is in the first five years following graduation [13].

Data from the US indicate that anaesthetists, psychiatrists and emergency medicine physicians are up to three times more likely to access specialist treatment facilities for substance abuse disorders than other speciality groups [6, 8, 14, 15]. Anaesthetists are more likely to abuse opioids as a drug of choice, to abuse drugs intravenously and to be addicted to more than one drug [6, 16]. Some of those in treatment actually cited drug availability or access as a reason for choosing anaesthesia as a career [14]. In 2007, 66% of the General Medical Council (GMC) annual caseload involved health problems – 43% involved alcohol abuse, 20% abuse of other substances and 26% involved affective disorders [17].

Opioid abuse
The incidence of non-alcohol substance abuse in all grades of anaesthetist has remained consistent at 1-1.6%, over the last three decades. Rapidly acting drugs are most commonly used, particularly fentanyl [11, 16, 18]. Rapid tolerance and dependence occur, and tolerance to doses of fentanyl of over 100 $ml.day^{-1}$ (5 $mg.day^{-1}$) may develop over a six month period [19].

Propofol abuse
This has been reported since the mid-1990s, with many fatalities. These were predominantly in anaesthetic trainees, but also in operating department practitioners and intensive care unit staff. One American survey showed a 5-fold increase in propofol abuse in anaesthetic trainees over a 10 year period, with 18% of departments having reported at least one case of propofol abuse in that decade (incidence 1:1000 anaesthetists per decade). Of those reported to be abusing propofol the mortality was 28% [20]. Users may erroneously feel that propofol is safe to use as the quick recovery after sub-anaesthetic doses prevents overt signs of abuse such as drowsiness. Death is often the only sign of drug abuse.

Ketamine abuse
Ketamine is known to be a drug of abuse in the general population, with a prevalence rate of 1.9% [9]. Ketamine abuse has been reported in anaesthetists [21]. Its short duration of action and predominant use outside the workplace may account for the paucity of recent literature. Like propofol, ketamine abuse is best detected by hair sampling.

Cocaine abuse
It is known that cocaine use has escalated recently, with a 6.6% increase in the general population in the UK in the last year [9]. Anecdotally, cocaine use has also increased in the medical profession. Cocaine and cannabis are amongst the five drugs most frequently used by doctors, particularly those in training [11, 22].

Inhalation agents
In a recent national survey, 22% of anaesthetic departments reported one or more cases of abuse of inhalational agents, with a mortality rate of 26%. These agents are often used in conjunction with other substances, often to ease withdrawal from opioids [23].

Recent review articles that describe the incidence and outcomes of addicted physicians in general [24-26], and with specific reference to anaesthetists [27-30] are listed.

3. Factors influencing substance abuse

Many factors influencing drug and alcohol abuse are not exclusive to either doctors or anaesthetists, but some may be particularly relevant to those undertaking an anaesthetic career.

Environmental factors
The use of alcohol and/or drugs is more acceptable in different social and age groups. This influences the initial exposure to the substance and ongoing opportunities for their use. Home or social circumstances are also important – in one study, 60% of addicted physicians reported physical or emotional abuse at some stage in their life [31].

Genetic/biochemical factors
There is evidence to suggest that some individuals may have an underlying susceptibility to addiction; there is a significantly higher risk of dependence where a parent or other family member is a substance abuser [22, 32]. In addition, dopamine D2 receptor (DRD2) gene dysfunction and GABA receptor variants are associated with the risk of addiction [33, 34].

Stress
Anaesthetists often work long hours in an isolated and stressful environment over which they have little control. Long and unsociable hours of work, high levels of responsibility, a demanding training and a competitive career structure may create difficulties for individuals both at work and at home. There is also the potential in anaesthetic practice for serious medical errors.

Some individuals under stress will use drugs or alcohol as an inappropriate coping strategy. In an AAGBI study of 1000 anaesthetists in 1997, 92% of respondents reported consuming alcohol with a median weekly consumption of 15 units; some anaesthetists reported consumption of up to 70 units per week [7].

Psychological factors
Approximately one third of all individuals will at some time in their lives suffer from significant psychological disturbance, usually in the form of anxiety and/or depression, occasionally progressing to severe mental illness.

In some, this may lead to abuse of several drugs and/or alcohol. Of those with a mental health disorder, 29% also have an addictive disorder [5].

Availability
The fact that anaesthetists have easy access to a wide range of psychoactive drugs may well influence the likelihood of trying them.

Having become dependent, staying at work helps the addicted doctor to maintain his/her supply of drugs.

4. The substance abusing anaesthetist

Risks

The most immediate risk is of harm to patients.

If the doctor concerned is working while under the influence of drugs or alcohol there is a risk of harm to patients, and this must be the over-riding concern. Both decision-making powers and clinical competencies may be affected with resulting slowed or impaired reactions to urgent situations. End-stage addicted anaesthetists are so distracted by their addiction that they are also more likely to take risks.

The second and longer term risk is to the anaesthetist him/herself including his/her mental and physical health, family and personal relationships and, of course, career.

Warning signs of alcohol abuse [35]

The first clues that a doctor may have a drug and/or alcohol problem are often non-specific and not obvious except to the most hawkish of eyes. Particular attention should be paid to locum doctors, particularly to long-term locums who have been moving around the country. Doctors with mental health problems may be at particular risk as some will turn to alcohol or drugs as a coping strategy. A drink-driving charge should be reported to the Trust and should be taken seriously

- Subtle change in personality – 'something not quite right'
- Mood swings and/or anxiety – at times flushed and full of bonhomie, at other times irascible and irritable
- Gets drunk rather easily at departmental events and behaves bizarrely and out of character
- Dishevelled appearance, forgetful, disorganised
- Unexplained minor injuries, e.g. facial bruising
- Staff members report the smell of alcohol
- Drug errors, illegible handwriting
- Secretive, socially isolated, regularly turns up late for work, or misses meetings
- Frequent changes of address
- Marital/relationship problems, call for help from family members, including children

Warning signs of drug abuse [6, 27]

- Behavioural changes
- Needle marks on the arm, long sleeves
- Unexplained regular facial bruising (propofol abuse)
- Physical signs of withdrawal
- Regular absences from theatre
- Volunteering to draw up drugs for others
- Patients in excessive amounts of pain
- Insisting on personally administering opioids in the recovery room
- Excessive or unnecessary prescribing of opioids
- False recording of drug administration
- Improper recording on the anaesthetic record
- Failure to discard wastage
- Over-anxious to give breaks
- Presence in hospital out-of-hours
- Enthusiasm for long, difficult or complicated cases
- Volunteering to work extra shifts or to do extra or late cases on a list
- Offering to stay late, or working overtime especially if likely to be working alone

Raising concerns

Self-referral

Individuals who self-refer have recognised their need for treatment. They are likely to seek help from outside agencies and treatment may even have started without those at work being aware of the problem. Stigmatisation and the potential loss of livelihood are barriers to self-referral even where an individual has insight into his/her problem.

Family and friends

While family and friends may not wish to feel that they are betraying the affected individual they should be made aware that such action is in the best interests of both patients and the doctor.

Patients

Patients may complain that the doctor smells of alcohol or is acting strangely.

Colleagues and other staff

Altered behaviour is a common sign. Paradoxically, it may be more evident to those who know them less well, while closer colleagues may rationalise odd behaviour. An alteration in behaviour on return to theatre after a break should also raise concern.

Locums and trainees
It may be more difficult to obtain evidence about trainees or locums who rotate to several hospitals for short periods and it is important to work with regional advisers and schools of anaesthesia.

Doctors in independent practice
They may work at several different hospitals and therefore it may be more difficult to spot inappropriate patterns of activity. Unless an individual hospital has a specific protocol, any suspicions should be reported confidentially to the chairman of the medical staff committee of that hospital.

Taking action is not difficult where the evidence of drug or alcohol abuse is plain to see. Unfortunately, more often, the changes are subtle and we may be less alert to them or tend to make excuses for them, and avoid addressing the possibility of substance abuse. As a result we delay helping for too long.

Where we have such concerns, we have a duty of care, in the interests of both patients and of the affected doctor, to raise these sooner rather than later.

Likewise, it is the duty of all anaesthetists, who suspect that they themselves have, or are developing, substance abuse problems, to refer themselves for treatment.

Actions that should be taken

What should you do if you suspect an anaesthetic colleague of substance abuse?
Concerns about an anaesthetist should normally be reported to the clinical director in the first instance. All those involved including clinical directors should keep written and confidential records of all relevant interviews and events, meetings and discussions.

Junior doctors may find it easier to raise the subject with their educational supervisor or mentor. Non-medical staff may report to their line manager. It is important that all staff are aware of their duty to relay this information to the clinical director while maintaining confidentiality.

Hospitals should have a formal policy concerning drug and/or alcohol abuse; a typical policy is demonstrated in Appendix 3. Clinical directors have a duty of care to inform the medical director of each case in line with the local Trust or hospital policy.

Where the individual is a trainee, there are specific Trust and deanery reporting systems. In the case of rotating trainees, information will need to be passed on when they rotate. This is the responsibility of the college tutor.

Confirming suspicions

Efforts should be made to obtain objective evidence. A single reported episode of working under the influence of alcohol or drugs may be a marker of a significant underlying problem and should be considered very seriously with due investigation.

Evidence must be sought to confirm or refute any report of substance abuse. Full confidentiality must be maintained during these investigations as there is always a possibility of malicious reporting. Isolated events reported by a single witness should be treated with great care, (e.g. drug theft, or drug/alcohol consumption in the workplace). Prescribing and nursing records must be examined carefully in order to substantiate the inappropriate use of drugs.

5. Initial interventions

In deciding when or if to intervene, it must be remembered that our first duty of care is to the patient. A one-to-one confrontation should be avoided.

The term 'intervention' is used here to describe the process of enabling the substance abusing doctor to admit that he/she has a problem that needs urgent attention. Many abusing doctors are in denial and can only begin meaningful treatment when they can admit there is a problem.

If there is substantial evidence to suggest that an individual has been abusing alcohol or drugs and particularly if there is evidence of potential or real harm to patients, urgent intervention is required. Those with knowledge of the situation must be prepared to present the evidence regarding the drug or alcohol abuse. The aim of intervention is to resolve concerns at an early stage.

Where there are significant allegations, the doctor should be interviewed by the medical director and the clinical director. Plans must be made in advance of the interview to facilitate support and treatment, including identification of specialist treatment centres and other specialised facilities if available. Many specialist units will provide free assessment. The GMC will discuss a case and give advice on an anonymous basis ahead of an intervention. The doctor concerned may find it valuable to be accompanied by a colleague or other individual representing his/her interests or to be represented by the British Medical Association (BMA) or similar organisation. Clinical directors should be familiar with these avenues of help and explore the possibilities before an intervention (see Appendix 2).

The doctor should be informed of the concerns being raised (without necessarily divulging the source of information) and any plans for further investigation or intervention. In this difficult situation the doctor should be offered the opportunity to undergo an assessment, rather than insisting he/she has an addiction problem and needs treatment. The process should also involve occupational health and a psychiatrist with special experience in the field – this may come via the treatment centre.

It is important to remember that addiction is recognised as a disease [36], and a substance abusing colleague should be offered treatment as for any other chronic illness. It is appreciated that a sympathetic attitude may be difficult if there has been a history of repeated absences, covering for the suspected doctor and other problems.

There is a real possibility of self-harm following intervention. Immediate referral to a specialist unit may minimise this risk. The doctor concerned should not be left unsupported following this initial interview. Contact with a member of the local British Doctors and Dentists Group (BDDG) may be helpful in this role (see Appendix 2).

Actions to protect patients

Where harm has occurred to a patient as a result of substance abuse
The doctor should be formally excluded from work with a clear statement as to the reasons for this and what further actions are to be taken. The GMC should be informed. These actions must be backed up via written confirmation through the normal disciplinary procedures in the hospital.

The doctor should be offered treatment and support. He/she should be advised concerning opportunities for support from the BMA and his/her medical defence organisation, and should also be strongly advised to accept the plans to initiate treatment.

Where there is clear evidence of abuse but no harm to a patient has occurred
The doctor should be offered treatment and support, usually through a mechanism of sick leave. All continuing contact with patients should cease. The doctor should then be offered an appropriate management plan as detailed below.

- **The doctor accepts that there is a problem.** If the situation is largely confidential then the doctor could be offered psychiatric help outside his/her own region. If the situation is common knowledge and the doctor is comfortable with local treatment, this could be provided.

- **The doctor refuses to accept that there is a problem.** If there is corroborating evidence to the contrary, the situation is more complex. The doctor should be asked to consent to random testing of breath, blood, urine or hair samples as appropriate, under the supervision of occupational health. No patient contact should be allowed while further investigation takes place. Referral to an agency in Appendix 2 is advised for a full independent assessment to take place.

6. The GMC and substance abusing doctors

Advice from the GMC must be sought at an early stage where there is any danger to patients from doctors who are abusing alcohol or drugs. This will usually be by the medical director who should be in possession of all available evidence. The GMC has a statutory primary obligation to protect the public but at the same time aims as far as possible to support doctors in overcoming their addiction problems through medical supervision.

GMC medical assessment

The GMC will arrange for medical assessment of the doctor to take place, which will involve two examinations by experts in substance abuse. Following this a decision will be made as to whether or not the doctor should have restrictions placed upon his/her registration. The majority of cases are resolved without the need to appear at Fitness to Practise Panel. In those cases where restrictions are felt necessary, the GMC will arrange for ongoing supervision (see Appendix 1). This will be done through an appropriate supervisor who will report back to the GMC – the supervisor will often have been one of the experts conducting the original assessments.

The addicted doctor will remain under supervision until the GMC is satisfied that his/her impairment has been resolved – usually a period of several years for substance abusing doctors.

Any doctor who appears in court for any reason is automatically referred to the GMC. This also applies to drink-driving offences. Whether a doctor is using, abusing, or actually addicted, possession of recreational drugs is illegal. The GMC does recognise that some kinds of criminal behaviour, e.g. buying controlled drugs on the street or stealing from employing organisations, are often driven by addiction, and will arrange for medical assessment as part of their investigation.

It is in the interests of both the doctor and his/her advisors to ensure that the best possible medical advice and support is provided in order to optimise the chances of a return to a satisfactory medical career.

7. Treatment, support and monitoring

Treatment

Addiction is a disease that has biological, behavioural, and social components and any effective treatment must address these issues [19]. Addiction should be managed through professional colleagues and support agencies listed in Appendix 2.

Treatment may involve admission to hospital or an addiction facility for detoxification, further physical and psychological assessment, family work, and introduction to self-help organisations such as Alcoholics Anonymous or the British Doctors and Dentists Group (BDDG). For doctors, the goal is typically abstinence, as return to work is not otherwise feasible. Treating psychiatrists and other professionals usually work with occupational health physicians in setting up a back-to-work programme, which will involve a network of professionals including the general practitioner (GP), a designated workplace supervisor, a mentor (see below), and if the GMC is involved, a medical supervisor.

Inpatient detoxification and rehabilitation at a specialist unit may be required. The overall treatment may last for months or years and long periods of leave may be required.

It must be emphasised that treatment outcomes for doctors have consistently been shown to be effective and lead to a significant improvement in physical, psychological and social wellbeing for those doctors willing to engage in a treatment programme.

The goal of a substance dependent doctor is life-long abstinence from all mood altering substances.

Signs and symptoms of opioid withdrawal

- Craving
- Restless sleep
- Sneezing, eyes watering, yawning
- Piloerection and recurrent chills
- Pupillary dilatation
- Abdominal and muscle aches and pains
- Nausea, vomiting and diarrhoea

Signs and symptoms of stimulant withdrawal

- Increased appetite
- Insomnia or hypersomnia
- Dysphoric mood
- Craving for drugs
- Lethargy and fatigue, depression, suicidal thoughts

Signs and symptoms of alcohol withdrawal

- Tremor: tongue, eyelids, outstretched hands
- Agitation, insomnia
- Transient visual, auditory, tactile hallucinations or illusions
- Nausea, retching, vomiting, sweating
- Delirium tremens – confusion, disorientation, hallucinations, agitation, pyrexia
- Grand mal convulsions

Support

Addicted doctors feel isolated and need intense and long term support. This can come from a network of family and close friends. In addition there are many other agencies that can support the doctor in his/her return to a healthy life at home and at work (see Appendix 2).

Support is likely to include attendance at self-help groups. This may need to continue indefinitely as there is a continuing risk of relapse. It is recognised by Alcoholics Anonymous that those who stop attending regular meetings or lose contact with peer support group members are more likely to relapse. It has also been observed that doctors who present for treatment generally do very well and are less likely to relapse if they regularly attend meetings of the BDDG in addition to Alcoholics Anonymous or Narcotics Anonymous.

Mentoring

Many doctors find it very valuable to have support and advice from a colleague outside his/her line management structure.

Monitoring

Mandatory biochemical monitoring

This is important especially in the first two years post-treatment when relapse is most likely to occur. Mandatory testing of breath, hair, urine and blood, both regularly and at random, should be used to ensure that the individual remains drug or alcohol abstinent. Hair testing can show the presence of drugs taken several weeks earlier.

Clinical monitoring by a specialist

Specialist clinical monitoring, such as by a psychiatrist, will enable early identification of signs or triggers of impending relapse.

Relapse

Relapse may occur with the return to substance abuse in a diagnosed addict following discharge from a recognised treatment centre or after a period of abstinence following attendance at Alcoholics or Narcotics Anonymous. The substance used is not necessarily the initial drug of choice. The belief by primary opioid abusers that alcohol is an acceptable alternative has led to many relapses.

Relapse occurs most commonly in the first two years of recovery – the major risk factors are primary opioid addiction, a co-morbid psychiatric illness and a family history of substance abuse disorder [32]. Other contributory factors include previous relapse, failure to focus on abstinence and failure to attend help groups plus workplace or legal difficulties. If evidence of further abuse is found the individuals will need to re-enter treatment and their jobs are likely to be at risk.

8. Return to work

The ultimate objective should always be to try and resume a normal pattern of personal and professional life; this may be difficult, particularly for anaesthetists (see below).

Where the doctor has been referred to the GMC, the GMC will determine fitness to practise – whether and when a doctor can return to work.

At a local level the decision to return to work will be a joint decision involving the doctor, his/her GP, the treating psychiatrist, the medical director and/or clinical director. Occupational health may also be involved.

There are a number of important considerations that need to be addressed before a doctor can resume work.

1. Stress in the workplace

If stress in the workplace has been a major contributing factor then it may be unrealistic for the affected individual to return to the same stresses unless there has been a fundamental change in the dynamics of the job. The advantages and disadvantages of return to the same type and place of work must be discussed in depth with the doctor. If he/she is early in his/her career then retraining in a different specialty should be considered. This may be difficult for more senior staff but at the very least, his/her job plan should be modified realistically. This could include undertaking part time work or undertaking more administrative or teaching commitments. Return should be gradual, with allowance made for attending treatment and monitoring appointments.

2. Drug abuse and anaesthesia

Return to work and continuing in anaesthesia is a subject of much current debate [26, 30, 37]. Where the operating theatre was the source of drugs abused, there is some evidence that the risk of relapse in those continuing employment in the operating theatre is very high [12]. This is usually in those with the major risk factors for relapse noted above, and those who did not adhere to recommended treatment and recovery guidelines [15]. The prospects for those without major risk factors and who were compliant with treatment and other recommendations are more favourable [32].

Despite earlier reports of poor outcomes in opioid addicted anaesthetists [12], there are more encouraging recent reports [8, 16]. A significant proportion of anaesthetists do not relapse and it would therefore be wrong

to label all anaesthetists with opioid addiction as being unable to return to full normal activity. Addiction impairs more doctors than any other disease [38] but there is evidence that, given the appropriate treatment, follow-up and support, a large number of addicted anaesthetists do as well as other specialities in recovery, and remain in anaesthesia [8, 16, 32].

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Appendix 1: Definitions

The recognition of substance dependence as a disease and its definitions, some of which are detailed below can be obtained from the World Health Organization (ICD criteria), the American Psychiatric Association (Diagnostic and Statistical Manual [DSM] classification) and American Society of Addiction Medicine websites.

Impairment
An impaired doctor is one who is unable to practice medicine with reasonable skill and safety to patients because of physical or mental illness, including deterioration through the ageing process, characterological or psychiatric difficulties or excessive use of alcohol or other drugs.

Substance abuse (DSM IV-TR criteria) [39]
- Recurrent substance use resulting in a failure to fulfil major role obligations at work, school or home
- Recurrent substance abuse in situations in which it is physically hazardous
- Recurrent substance-related legal problems
- Continued substance use despite having persistent or recurrent social or interpersonal problem caused or exacerbated by the effects of the substance

The equivalent to substance abuse in the International Classification of Disease (ICD) is termed 'harmful use', and is defined as "A pattern of psychoactive substance use that is causing damage to health. The damage may be physical (as in cases of hepatitis from the self-administration of injected drugs) or mental, (e.g. episodes of depressive disorder secondary to heavy consumption of alcohol)." [40]

The term 'substance' is used to cover alcohol, illicit drugs and prescription medications taken inappropriately. It is used to describe:
- The use of a substance that leads to impairment in physical and psychological health and in social dysfunction
- The inappropriate use of prescription drugs
- Use of illegal drug use that will probably lead to harmful health consequences either by virtue of the quantity of drug or method of use (e.g. injecting)

There is an important difference between substance abuse and dependence (addiction).

Dependence syndrome (addiction)

The dependence syndrome is "A cluster of physiological, behavioural, and cognitive phenomena in which the use of a substance or a class of substances takes on a much higher priority for a given individual than other behaviours that once had greater value." [40]

A definite diagnosis should only be made if three or more of the following criteria have been experienced or exhibited at some time during the previous year.

a. A strong desire or sense of compulsion to take the substance;
b. Difficulties in controlling substance-taking behaviour in terms of its onset, termination, or levels of use;
c. A physiological withdrawal state when substance use has ceased or have been reduced, as evidenced by: the characteristic withdrawal syndrome for the substance, or use of the same (or closely related) substance with the intention of relieving or avoiding withdrawal symptoms;
d. Evidence of tolerance, such that increased doses of the psychoactive substance are required in order to achieve effects originally produced by lower doses (clear examples of this are found in alcohol – and opioid – dependent individuals who may take daily doses sufficient to incapacitate or kill non-tolerant users);
e. Progressive neglect of alternative pleasures or interests because of psychoactive substance use, increased amount of time necessary to obtain or take the substance or to recover from its effects;
f. Persisting with substance use despite clear evidence of overtly harmful consequences, such as harm to the liver through excessive drinking, depressive mood states consequent to periods of heavy substance use, or drug-related impairment of cognitive functioning; efforts should be made to determine that the user was actually, or could be expected to be, aware of the nature and extent of the harm. [40]

GMC definitions

1. Your (day-to-day work/surgery etc) must be directly supervised by a registered medical practitioner of consultant/GP Principal grade. (See Glossary for full definition)

2. Your (day-to-day work/surgery etc) must be closely supervised by a registered medical practitioner of consultant/GP Principal grade. (See Glossary for full definition)

3. Your (day-to-day work/surgery etc) must be supervised by a registered medical practitioner of consultant/GP Principal grade. (See Glossary for full definition)

Glossary

Directly supervised
The doctor's work must be directly supervised at all times by a supervising consultant based in the same place of work. The level of supervision required is equivalent to that of an FY1 trainee.

Closely supervised
The doctor's day-to-day work must be supervised by a consultant, who must be on site and available at all times. The doctor's work must be reviewed at least twice per week with the supervising consultant. The level of supervision required is equivalent to that of a novice anaesthetist.

Supervised
The doctor's day to day work must be supervised by a consultant, who may be off site but available on-call. The doctor's work must be reviewed at least once a fortnight with the supervising consultant. The level of supervision required is equivalent to that of a middle grade trainee.

Royal College of Anaesthetists definitions (for comparison):

Direct supervision
Immediately available – in the theatre or available in the theatre suite and without other responsibilities.

Indirect supervision
Local – on the same geographical site and able to attend within 10 minutes.

Distant supervision
On a different geographical site or unable to attend within 10 minutes.

Appendix 2: Sources of support

More details and relevant documents may be found on the AAGBI website, www.aagbi.org/memberswellbeing.htm

Alcoholics Anonymous (AA)
www.alcoholics-anonymous.org.uk **0845 769 7555**
Do you think you may have a problem? Check lists: http://www.alcoholics-anonymous.org.uk/newcomers/?pageID=77

The British Doctors and Dentists Group (BDDG)
www.bddg.org **07792 819 966 (national secretary)**
This is a countrywide network of doctors and dentists at various stages in recovery from addiction, who meet on a monthly basis at one of 18 groups covering the UK. Following initial contact, callers may be put in touch with a doctor (in some cases another anaesthetist) nearer to their home who may then introduce a new doctor to the group at the local meetings.

Problems can be discussed at these meetings that may not be appropriate to discuss at Alcoholics or Narcotics Anonymous meetings; for example, GMC proceedings and issues surrounding return to work, etc.

There is also an associated families group, where direct relatives of addicted doctors and dentists can obtain help and support. Each BDDG meeting usually has a families group. Support for family members of addicted doctors can be obtained via the Families Group of the BDDG – www.bddgfamilies.org.uk

Doctors' Support Line (DSL)
0844 395 3010
A confidential and anonymous peer support helpline for doctors who need to talk to someone whatever their concerns. Doctors in the group have themselves been troubled at some stage in their lives, and help is offered to those who are beginning the process of re-establishing themselves after a breakdown or other mental crisis.

Doctors' Support Network (DSN)
www.dsn.org.uk **0871 245 8376**
A group with regular meetings throughout the country for help with stress, burnout, anxiety, depression, psychoses and eating disorders. This may be helpful for addicted doctors with dual diagnoses.

GMC Investigation Team
0161 923 6402 practise@gmc-uk.org

Healthcare Professionals Recovery Group (HPRG)
01327 262 823
These monthly meetings are attended by doctors, dentists, nurses, pharmacists and other healthcare professionals who have addiction problems. They too are confidential and offer similar help and support to that of the BDDG.

Narcotics Anonymous (NA)
www.ukna.org **0300 999 1212**
Narcotics Anonymous is for recovering addicts who meet regularly to help each other stay clean. It is not restricted to those with opioid abuse problems as the name may suggest, but any drug including tranquillisers, recreational drugs and alcohol. The website contains some questions and information for those who think they may have a problem.

Do you think you may have a problem? – checklists may be found at: http://www.na.org/admin/include/spaw2/uploads/pdf/litfiles/us_english/IP/EN3107.pdf

The majority of AA or NA meetings are 'closed' and are only for recovering addicts/alcoholics and those who think they may have a drug problem. A meeting described as 'open' may be attended by anyone, e.g. professionals working with addicts or family members, friends etc. Meetings lists are on the AA or NA websites with details of open meetings at each venue.

Practitioner Health Programme (PHP)
www.php.nhs.uk **020 3049 4505**
This is an NHS funded but entirely confidential service open to doctors and dentists living or working in the London area. Care is multidisciplinary in nature and provides appropriate specialist care and support for any doctor with addiction, mental or physical health concerns. Where inpatient therapy is thought necessary, this will be organised and funded by the PHP/NHS. Follow-up, monitoring and help with returning to work are also part of the services offered. Unfortunately this is currently only available to London-based doctors, but plans for expansion to cover other areas of the country are in place. Advice can be obtained by phone even if outside the M25 area.

Royal Medical Benevolent Fund (RMBF)
www.rmbf.org **0208 540 9194**
The RMBF offers financial support and is also developing a helpline. It was set up by doctors to help colleagues and their dependants in need.

Sick Doctors Trust (SDT)
www.sick-doctors-trust.co.uk **0370 444 5163***
The SDT is an independent charity established over 14 years ago, which provides a 24-hour helpline manned exclusively by experienced doctors who are either in recovery from addiction themselves, or trained counsellors. It provides help and support to doctors who think they may have a problem with their use of alcohol or other drugs, whether prescribed or not. Calls are treated with strict confidentiality, and callers may remain anonymous if they wish.

Help offered includes assessment, advice, referral for treatment when appropriate and introduction to long term befriending and support services. The helpline also accepts calls from family members or friends, concerned colleagues and others.
*** please note change of number since publication of the AAGBI Welfare Resource Pack.**

Other resources

Addaction	**020 7251 5860** www.addaction.org.uk
Adfam (for families affected by drugs and alcohol)	**020 7553 7640** www.adfam.org.uk
Al Anon (for families/friends of problem drinkers)	**020 7403 0888** (24 hours) www.al-anonuk.org.uk
Alcohol Concern	**020 7264 0510** www.alcoholconcern.org.uk
Drinkline	**0800 917 8282**
National Drugs Helpline	**0800 77 66 00** www.talktofrank.com

Appendix 3: Example of a Trust alcohol and substance abuse policy

1. Introduction

The Trust recognises that the prevalence of substance abuse and alcohol related problems within the general population means that there will inevitably be members of staff with such problems. Drugs and alcohol have an impact on cognitive performance and are associated with cognitive failures at work. This may have implications for the care of patients and the health and safety of an employee and his/her colleagues.

1.1 Alcohol and substance abuse related problems at work are defined as:

- any drinking of alcohol
- any use of illicit non-prescribed drugs
- any misuse of prescribed drugs
- any use of any other substance of abuse, e.g. solvents

that has the potential to interfere with an employee's functioning and performance in any aspect of his/her job. This definition covers usage outside the workplace but where the effects have or may have an impact on an employee's functioning at work.

Throughout the remainder of this document the term substance will be used for alcohol, prescribed and non- prescribed drugs and any other substances used in the circumstances described above.

2. Policy aims

The principal aims of this policy are:

2.1 To ensure that the Trust meets its obligations to safeguard the health, safety and welfare of its employees and patients using its services.

2.2 To prevent and reduce the incidence of substance related problems in the workplace.

2.3 To recognise that substance dependency is a health issue and to ensure that employees experiencing these difficulties have access to appropriate help.

2.4 To foster a climate that will encourage individuals experiencing these problems to come forward for help in the knowledge that they will receive support and fair treatment.

2.5 To facilitate the rehabilitation of employees who develop substance abuse problems.

2.6 To give managers a clear framework within which to deal with substance abuse problems constructively.

3. General provisions

3.1 No-one will report for duty under the influence of any substance that affects his/her ability to carry out his/her duties.

3.2 No-one will consume alcohol or use substances of abuse whilst at work, including breaks.

3.3 Any individual found drunk or under the influence of any substance on duty will be subject to the Trust's Disciplinary and Capability Policy and Procedure. Managers should ensure that the employee leaves the workplace and arrange to interview him/her after a suitable interval.

3.4 The supplying of drugs of abuse to other people is a criminal offence. Any employee found or suspected of undertaking this activity will be reported to the police.

4. Roles and responsibilities

4.1 The Director of Human Resources is responsible for the implementation of this policy and ensuring regular review is undertaken.

4.2 Line managers are responsible for ensuring employees are aware of this policy and for investigating and referring to the Occupational Health Service (OHS) when an employee is suspected of having a substance abuse related problem.

4.3 Managers may recognise a problem by a changing attitude to work by employees which may be evidenced through poor punctuality, poor attendance, declining performance, the smell of alcohol on the breath or behaviour suggestive of intoxication, changes in mood

and levels of co-operation with colleagues and declining personal standards of dress and hygiene.

4.4 The OHS is responsible for advising on an affected employee's fitness for work and ensuring that the employee who accepts help is referred on to an appropriate agency. The OHS operates within strict rules of medical confidentiality and any medical information obtained within the context of clinical activities will not be released without the consent of the individual concerned other than in exceptional circumstances as laid down by the General Medical Council, Nursing and Midwifery Council etc.

4.5 Employees have a responsibility to ensure that they are fit to undertake their duties in a safe and appropriate manner at all times.

4.6 Employees are responsible for seeking help if they have a substance abuse problem that is likely to have an impact on their performance at work.

4.7 Employees are required to encourage colleagues whom they suspect have a problem to seek help via the OHS or by discussion with their line manager. If the colleague refuses to seek help, employees have a duty to bring their concerns to the attention of their line manager, otherwise they may be vulnerable in the event of a health and safety issue.

5. Employees with substance related problems

5.1 It is recognised that substance abuse problems are primarily matters of health and social concern with which sufferers need help.

5.2 Employees who suspect or are aware that they have a substance abuse related problem are encouraged to seek medical help through the OHS (including the staff support and counselling service), their GP, or directly with an appropriate agency. (See list at Appendix 2).

5.3 Any employee who has been identified as possibly having an alcohol or substance abuse problem affecting his/her conduct and/or performance at work will be asked to discuss the matter with his/her line manager.

5.4 The employee will be offered the opportunity to seek assessment from

the OHS who will refer for treatment from an appropriate agency if necessary. With the employee's consent the OHS will keep the employee's GP informed of progress.

5.5 Whilst the OHS make every effort to arrange an urgent appointment for employees following a request, in the event of a delay and where there is concern that an employee may not be fit in the meantime, the manager, in conjunction with the Divisional Human Resources Manager, will make a decision as to the appropriate interim action. This may include special paid leave, suspension on full pay or sick leave.

5.6 In any discussion of an alcohol or drug related problem (whether at the initiative of the individual or manager) the same rules of confidentiality would apply with respect to these conditions as to any other health complaint. However, behaviour associated with misuse may have to be disclosed where there is evidence of criminal activity, abuse of a professional position or potential harm to patients or colleagues.

5.7 Leave to undergo treatment will be dealt with under the normal sick pay provisions.

5.8 The OHS will advise on fitness to return to work and any job modification, temporary or permanent redeployment necessary as a result of the individual's substance abuse problems.

5.9 An employee identified as having a potential problem who declines help and whose behaviour or performance at work continues to be a source of concern will be subject to normal disciplinary procedures. This may result in termination of employment, which can be on health grounds in appropriate circumstances.

5.10 It is recognised that relapses do occur. Therefore an employee with an identified problem who receives help but whose performance subsequently relapses due to a recurrence of the substance abuse problem will have the new situation considered on its merits. If appropriate, a further opportunity to seek/accept help will be offered.

6. Testing for alcohol and substances of abuse in the workplace

6.1 This Trust does not operate a systematic screening programme for the use of drugs or alcohol.

6.2 However, as being under the influence of alcohol or substances of abuse in the workplace may represent a risk to the safety of the employee, his/her colleagues or patients, individuals suspected of abuse may be tested for such substances or markers of misuse as part of the occupational health assessment.

6.3 Testing will be part of a clinical occupational health assessment and informed consent will be obtained at the time of testing. The OHS will monitor employees using blood and/or breath tests for alcohol and urine testing for drugs and would generally expect to see a return to normal blood tests and consistently negative urine tests before a return to work would be considered. On a return to work the employee will remain under review by the OHS and a system of unannounced testing will usually be agreed for a period, typically six months. Each employee is assessed on an individual basis.

6.4 Results of testing are medically confidential and as such are defined as sensitive personal data under the Data Protection Act. These results will not be released to the employer or any other third parties without the consent of the employee. They will assist the occupational health practitioner in assessing fitness for work and formulating an appropriate occupational health management plan.

6.5 Refusal to undergo testing or repeated non-attendance will result in the OHS making recommendations regarding the employee's fitness to work on the information available and without the benefit of the test results.

Appendix 4: Identifying unsafe drinking habits

Over recent years a number of screening questionnaires have been developed with the objective of identifying hazardous, harmful and dependent drinking. The 10-item Alcohol Use Disorders Identification Test (AUDIT) is the gold standard, but shorter versions of this questionnaire are also available (e.g. AUDIT-C). The AUDIT questionnaires are useful in detecting problem drinking, but are not diagnostic and should not be used in isolation. They are freely available on the internet. Readers are referred to the Department of Health sponsored Alcohol Learning Centre website.

The 10-item AUDIT can be administered as a structured or self-report interview and takes about 2-3 minutes to complete.

Older screening questionnaires include the CAGE and the Michigan Alcoholism Screening Test (MAST). These questionnaires tend only to identify severe or dependent drinking.

AUDIT questionnaire: screen for alcohol misuse [41]

1. How often do you have a drink containing alcohol?

- Never (0)
- Monthly or less (1)
- 2-4 times a month (2)
- 2-3 times a week (3)
- 4 or more times a week (4)

2. How many standard drinks containing alcohol do you have on a typical day when drinking?

- 1 or 2 (0)
- 3 or 4 (1)
- 5 or 6 (2)
- 7 to 9 (3)
- 10 or more (4)

3. How often do you have six or more drinks on one occasion?

- Never (0)
- Less than monthly (1)
- Monthly (2)
- Weekly (3)
- Daily or almost daily (4)

4. During the past year, how often have you found that you were not able to stop drinking once you had started?

- Never (0)
- Less than monthly (1)
- Monthly (2)
- Weekly (3)
- Daily or almost daily (4)

5. During the past year, how often have you failed to do what was normally expected of you because of drinking?

- Never (0)
- Less than monthly (1)
- Monthly (2)
- Weekly (3)
- Daily or almost daily (4)

6. During the past year, how often have you needed a drink in the morning to get yourself going after a heavy drinking session?

- Never (0)
- Less than monthly (1)
- Monthly (2)
- Weekly (3)
- Daily or almost daily (4)

7. During the past year, how often have you had a feeling of guilt or remorse after drinking?

- Never (0)
- Less than monthly (1)
- Monthly (2)
- Weekly (3)
- Daily or almost daily (4)

8. During the past year, have you been unable to remember what happened the night before because you had been drinking?

- Never (0)
- Less than monthly (1)
- Monthly (2)
- Weekly (3)
- Daily or almost daily (4)

9. Have you or someone else been injured as a result of your drinking?

- No (0)
- Yes, but not in the past year (2)
- Yes, during the past year (4)

10. Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested you cut down?

- No (0)
- Yes, but not in the past year (2)
- Yes, during the past year (4)

Scoring the audit

Scores for each question range from 0 to 4; thus the maximum score is 40. A score of 8 or more is associated with harmful or hazardous drinking; a score of 13 or more in women, and 15 or more in men, is likely to indicate alcohol dependence.

The AUDIT-C comprises the first three questionnaires of the AUDIT. Anyone scoring 5 or over on the AUDIT-C is AUDIT-C positive and should go on to complete the 10-item AUDIT.

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