The Impaired Provider: The Best Kept Secret

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SO HOW BAD IS IT, REALLY?

OPIOIDS
IT’S BIG…

THE OPIOID EPIDEMIC BY THE NUMBERS

IN 2016:

- 116 people died every day from opioid overdose
- 42,249 people entered treatment
- 2.1 million people used prescription pain relievers
- 170,000 people misused prescription pain relievers
- 19,413 people died from prescription pain reliever overdose
- 2.1 million people used heroin
- 19,489 people died from heroin use
- 37,000 people used illegal drugs
- 584 billion dollars spent on treatment

AVERAGE NUMBER OF HEROIN USERS
IT’S BAD...
ABUSE IS AN EQUAL OPPORTUNITY EMPLOYER

IT EFFECTS ALL GEOGRAPHIC LOCATIONS
ALL ETHNIC GROUPS
Race/Ethnicity

In 2012, among persons aged 12 or older, the rate of substance dependence or abuse was lower among Asians (3.2 percent) and Native Hawaiians or Other Pacific Islanders (5.4 percent) than among other racial/ethnic groups. The rates for the other racial/ethnic groups were 8.7 percent for whites, 8.8 percent for Hispanics, 8.9 percent for blacks, 10.1 percent for persons reporting two or more races, and 21.8 percent for American Indians or Alaska Natives.

IT ISN’T CHAUVanISTIC

Drug overdose deaths (U.S.), 1999-2016
EDUCATION IS NO PROTECTION

EDUCATION AND ABUSE

AND IT’S A TEAM PLAYER...
ALCOHOL:
THE SOCIALLY ACCEPTABLE DRUG OF ABUSE
THE CLASSIC ABUSER…
SCOPE OF THE PROBLEM IN HEALTHCARE

• Approximately 10% to 12% of physicians will develop a substance use disorder during their careers, a rate similar to or exceeding that of the general population.

• Recognition of and in intervening in the disease process is often delayed, leading to an increased risk of death by inadvertent overdose or suicide.


CHEMICALS OF ABUSE

• Alcohol appears to be the primary drug of abuse in 50.3%, opioids in 35.9%, stimulants in 7.9%, and other substances in 5.9%; 50% reported abuse of multiple substances, 13.9% a history of intravenous drug use, and 17% previous treatment for addiction.

• Certain specialties, such as anesthesiology, emergency medicine, and psychiatry, appeared to be overrepresented in these programs relative to their numerical representation in the national physician pool.

Anesthesia Providers

• Only about 10% of anesthesiologists enter treatment for alcohol addiction. Instead, the vast majority of addicted anesthesiologists are addicted to potent intravenous opioids such as fentanyl and sufentanil.

• Furthermore, anesthesiologists who are addicted to anesthetic agents or anesthetic supplements (eg, opioids, propofol, volatile anesthetic agents) have a uniquely high relapse rate associated with an unacceptable risk of morbidity and mortality.


• Bell, et al (1999), was the first large-scale study that looked at the prevalence of substance abuse among nurse anesthetists. This seminal study revealed 10% of nurse anesthetists admitted to misusing powerful anesthetic medications during their career as nurse anesthetists. The 4 most common medications abused were benzodiazepines, nitrous oxide, potent opioids, and propofol.


• Bell replicated this study in 2006 (Bell, unpublished data, 2006). Unpublished reports revealed little difference, except that opioid and propofol use increased overall.

• In both studies, most of the participants who admitted to misusing these drugs had been in practice between 10 and 20 years, which is an interesting contrast from the younger age associated with anesthesiologists (1 – 5 yrs).
SO, IT'S OBVIOUSLY A PROBLEM...
BUT HOW DO WE RECOGNIZE IT?

DIVERSION
BEHAVIORS

• Consistently uses more drugs for cases than colleagues
• Frequent volunteering to administer narcotics, relieve colleagues of casework, especially on cases where opioids are administered
• Consistently arrives early, stays late, or frequently volunteers for overtime
• Frequent breaks or trips to bathroom
• Heavy wastage of drugs
• Drugs and syringes in pockets

SIGNS

• Anesthesia record does not reconcile with drug dispensed and administered to patient
• Patient has unusually significant or uncontrolled pain after anesthesia
• Higher pain score as compared to other anesthesia providers
• Times of cases do not correlate when provider dispenses drug from automated dispenser
• Inappropriate drug choices and doses for patients
• Missing medications or prescription pads
• Drugs, syringes, needles improperly stored
• Signs of medication tampering, including broken vials returned to pharmacy

PATTERNS...PATTERNS...PATTERNS...
NOT SINGLE INSTANCES !!!!
IMPAIRED

BEHAVIORS
• Severe mood swings, personality changes
• Frequent or unexplained tardiness, work absences, illness or physical complaints
• Elaborate excuses
• Underperformance
• Difficulty with authority
• Poorly explained errors, accidents or injuries
• Wearing longs sleeves when inappropriate
• Confusion, memory loss, and difficulty concentrating or recalling details and instructions
• Visibly intoxicated****
• Refuses drug testing****
• Ordinary tasks require greater effort and consume more time
• Unreliability in keeping appointments and meeting deadlines
• Relationship discord (e.g., professional, familial, marital, platonic)

SIGNS
• Physical indications (e.g., track marks, bloodshot eyes) [slurred speech, impaired coordination]****
• Signs indicative of drug diversion*
• Deterioration in personal appearance
• Significant weight loss or gain
• Discovered comatose or dead
OKAY…WE’VE IDENTIFIED A COLLEAGUE WHO MAY HAVE A PROBLEM… NOW WHAT?

• Ideally, the anesthesia professional will acknowledge his or her condition, seek help voluntarily, and not require intervention.

• However, this is often not the case due to denial of condition, stigma, fear of job loss, and other ramifications.

Colleagues play an important role in helping the impaired provider get into treatment by reporting suspicion to a supervisor or the appropriate chain of command.

REMEMBER: Anesthesia provider abusers have a much high mortality rate than other medical abusers. Reporting a colleague could save his/her life!
SO WHY DON’T WE REPORT?

- Believe someone else is addressing the issue
- Not my responsibility
- Afraid the individual will be punished excessively
- Afraid of retribution by individual/friends
- Afraid of being responsible for colleague’s loss of job or license
- Lack of knowledge of how to properly report or intervene.

THE LAW AND REPORTING

- Each state may have certain legal responsibilities in identifying and reporting providers to their supervisor or appropriate chain of command.
- States may have reporting laws which hold colleagues responsible for harm to patients if they fail to report a coworker in whom substance use disorder is suspected.
- Failure to report an impaired provider may leave the peer and/or hospital at risk for torts of negligence.

Pennsylvania Code Title 49
§ 16.61. Unprofessional and immoral conduct.

- (a) A Board-regulated practitioner who engages in unprofessional or immoral conduct is subject to disciplinary action under section 41 of the act (63 P. S. § 422.41).
- Unprofessional conduct includes, but is not limited to, the following:
  - (7) Practicing the healing arts while the ability to practice is impaired by alcohol, drugs or physical or mental disability.
  - (11) Possessing, using, prescribing for use or distributing a controlled substance or a legend drug in a way other than for an acceptable medical purpose.

• (f) Reports to the board.
• Any hospital or health care facility, peer or colleague who has substantial evidence that a professional has an active addictive disease for which the professional is not receiving treatment, is diverting a controlled substance or is mentally or physically incompetent to carry out the duties of his or her license shall make or cause to be made a report to the board.

LIABILITY PROTECTION
• Any person or facility who reports pursuant to this section in good faith and without malice shall be immune from any civil or criminal liability arising from such report.
• Failure to provide such report within a reasonable time from receipt of knowledge of impairment shall subject the person or facility to a fine not to exceed $1,000.

HOW TO REPORT
1. Chain of command—Chief CRNA/Anesthesiologist
   1. Fit for Duty Checklist
2. Hospital HR Office
3. State Board of Nursing/Medicine
   1. Nursing: (717) 783-7142 or online complaint form
   2. Medicine: (717) 783-1400 or online complaint form
   3. Osteopathic Medicine: (717) 783-4858 or online complaint form
4. Self-help
   1. AANA Peer Assistance Helpline: 800-654-5167