

## Managing people

# Substance abuse in the OR: Why managers should not ignore it

*The first of two articles.*

**C**ecil King, RN, MS, CNOR, is a perioperative advanced practice nurse at Sinai Hospital in Baltimore. King is an outgoing, knowledgeable nurse. He's a mover and shaker in the perioperative world: active in AORN, speaking at national meetings, and writing articles for nursing journals. He's well respected by coworkers and colleagues.

He's also 6 years into his recovery from drug addiction.

King, who speaks openly about his experience, is an example of why managers should identify clinicians with substance abuse problems and help them enter treatment. We need people like King to meet society's health care needs. The good news is that 75% to 85% of nurses and physicians who enter treatment for addiction return to work.

What does an addict look like? Forget the image of the addict as a homeless person in a back alley. William Halsted, considered by many to be the "father of modern surgery," was addicted to morphine while he was making great contributions to medicine. "Dr Bob" Smith, the founder of Alcoholics Anonymous, was a surgeon.

"This disease does not know a class," says Marcia Rachel, RN, PhD, assistant dean for health systems and quality improvement at the University of Mississippi in Jackson, Mississippi. Rachel worked at the Mississippi Board of Nursing (BON) for 17 years.

Addiction doesn't discriminate by race, age, education, or profession. Health care professionals with addiction are often like King: highly motivated achievers.

Many wrongly believe health care workers have a higher incidence of substance abuse. It's estimated that 10% to 15% of health care professionals misuse drugs or alcohol during their career, similar to the percentage of the general population.

However, those who work in the OR and PACU have easier access to substances that can be abused than clinicians in other areas of the hospital. The specialty of anesthesia has a higher rate of drug abuse, again, probably due to easier access to drugs.

### Barriers to treatment

The stigma remains a barrier to getting help even though addiction is a major problem in the US, says Jackie Westhoven, RN, CEAP, of Peer Assistance Services, Inc, in Denver. The company administers all dental and pharmacy peer assistance programs in the state, as well as employee assistance programs (EAP) for many health care organizations. It also provides services for individual nurses.

Westhoven says the stigma is easing a bit because "almost every family is affected by the substance issue: it may be a husband, brother, grandchild, or grandmother. We're getting more open about it, but we have to do a better job." In surveys returned as part of the company's education programs, 75% of participants report knowing a family member with a substance abuse problem, and about that many report being aware of an employee with the problem.

Given the stigma, it's not surprising the number one reason people don't seek help is fear of exposure. Clinicians face the additional fear of losing their license—and their livelihood. It's been reported that health care professionals are harsher

towards colleagues who abuse drugs than towards those in the general population who do so, which doesn't encourage clinicians to seek help.

### **Health care professionals at risk**

Several factors put health care professionals at risk for substance abuse. Many believe their knowledge of drugs protects them from dependency. "We think we know how to use meds so we can manage it," says King.

Stress in the workplace and nurses' habit of caring more for others than themselves make nurses vulnerable. It's not unusual for clinicians with addiction to have a history of family problems, family members with chemical dependence, previous emotional or mental problems, or sexual trauma.

Addiction can take the form of alcohol, controlled substances, or street drugs such as cocaine. Categories of anesthesia drugs abused include narcotic agonist-antagonists, barbiturates, benzodiazepines, dissociative drugs, inhalation agents, opioids, and propofol. Other drugs include nitrous oxide and ketamine. Fentanyl and sufentanil may be chosen because they can be used intranasally.

Often, the pattern of abuse starts years earlier, in high school or nursing school. "Many times, addiction starts with a valid prescription; when, for example, the individual becomes addicted to the medication and begins a pattern of obtaining the substance through other means," says Nancy Brent, RN, MS, JD, an attorney in Wilmette, Illinois, who represents impaired nurses.

### **Why you can't ignore it**

Nurses have a legal and an ethical duty to report an impaired health professional.

Legal considerations include the nurse practice act and state BONs that administer and enforce the act, state laws about drug diversion and prescription fraud, and Drug Enforcement Agency (DEA) regulations. Most states require reporting the nurse to the state BON, says Brent. In some states, employer-reporting requirements are waived for nurses who voluntarily enter and successfully complete a treatment program. And all states have requirements for reporting unsafe behavior, so if the nurse's behavior may harm the patient, the obligation is there.

Physicians should be reported to the medical staff. "The person who picks up the ball is the physician administrator," says Joseph Bujak, MD, FACP, vice-president of medical affairs for Kootenai Medical Center, Coeur d'Alene, Idaho, who consults on physician issues including substance abuse. Both he and Brent agree it's best for a physician instead of a nurse to talk with the physician suspected of substance abuse. Usually, the physician who addresses the problem is the department head.

If physician leaders, including the chief medical officer, do not take action, managers should go up the chain of command.

"The board of governors has the ultimate responsibility since they extend [physician] privileges," says Dr Bujak. He acknowledges the potential problem of an administrator who "looks the other way" in the case of a surgeon who performs a high volume of cases. If all else fails, the nurse may be forced to report physicians to the state medical board.

### **An ethical duty**

Nurses have an ethical duty to their patients, their colleagues, the profession, and the community. These duties are outlined in documents such as the American Nurses Association Code of Ethics for Nurses, which emphasizes patient safety. The code also says the nurse has a responsibility to maintain safety and competence.

Legal and ethical mandates forbid "passing the buck" by simply terminating the nurse. "There has to be a mentality that this illness has to be treated," says Brent. "If the individual doesn't receive treatment, they can end up going to another facility and continuing their addictive behavior. Or, even worse, they may end up dying due to their addiction."

In addition to legal and ethical responsibilities, managers must consider financial liabilities from factors such as increased absenteeism, higher use of health care benefits, increased workplace accidents, and decreased productivity. Ignoring the situation also contributes to poor overall morale when the staff already suspects a problem.

### **Early identification**

The sooner you identify the problem, the faster the abuser can enter treatment and the better the odds of recovery. Rachel says, "It's an illness. It's predictable, progressive, and can be fatal. The worst thing a coworker or manager can do is to be blind to what's going on."

Yet managers may struggle with confronting an employee. Rachel says, "They ask themselves, 'What if I'm wrong,' but that's not the point. You want to look at how the facts relate to the standard of care."

Both Rachel and King recommend that managers focus on the work performance, not diagnosing the substance abuse problem. King adds, "Listen to your gut." If you think there is a problem, there likely is.

Signs and symptoms of addiction often don't appear in the workplace until late in the disease.

"Nurses need the job to support their substance abuse," says Rachel. "Other pieces of their lives may be crumbling, but somehow they can keep functioning at work."

Keep in mind that addiction can be subtle. "For many people, addiction sneaks up on them, and denial of any problem is strong," says Brent, "Your observational skills have to be keen." A common early finding is subtle changes in behavior, such as mood swings.

Another way to detect problems is to work closely with your pharmacy to obtain regular reports that compare medication use by person. Rachel adds that managers should spot-check documentation. "Those who falsify records are going to make a mistake as the addiction gets worse."

### **Policy in place**

A policy provides the manager with a blueprint to follow if substance abuse is suspected. Such policies should begin with a commitment to a drug- and alcohol-free workplace. It's important to outline the procedure to follow if someone is suspected of substance abuse. This usually means referral to the EAP, or, if there is an immediate problem, walking the employee to employee health services for mandatory testing. An employee who refuses EAP assistance or testing is typically subject to termination.

Many times, those who enter treatment voluntarily are granted a medical leave of absence. Another section should address procedures for returning to work, which normally include a signed contract, restrictions on handling of narcotics, and random urine testing for drugs.

Medical staff bylaws should address what to do in the case of an impaired physician. Dr Bujak suggests having physicians sign that they have reviewed the policy in this area.

All policies need to be consistent with state laws, and thorough documentation is key.

### **Treatment and beyond**

The human resources (HR) department is an excellent resource for managers. A conversation with an employee who is suspected to have an abuse problem is, to put it mildly, difficult. HR can role play the conversation with the manager, and in some cases, be present at the meeting. The good news is that clinicians are often highly motivated to succeed in treatment.

The second part of this series will discuss more about treatment, integration back into the workforce, and prevention. In the meantime, remember Westhoven's words, "It's a very treatable illness." ❖

—Cynthia Saver, RN, MS

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**Indicators of possible substance abuse**

Changes can be gradual over months or years and can be grouped into categories:

**Work patterns**

- Making rounds at unusual hours
- Signing out more narcotics than coworkers
- Choice of drug for patient is inappropriate
- Consistently late
- Inaccessible to staff
- Frequent absence from work or pattern of absenteeism on Mondays and Fridays
- Decline in job performance, such as more mistakes and poor charting without explanation (late sign)
- Frequently volunteering to work extra shifts
- Calling in sick frequently
- Frequent job changes.

**Behavioral symptoms**

- Change in behavior after health care worker “disappears” for lunch or other reasons
- Change in behavior (eg, mood swings, outbursts of anger, increased isolationism)
- Defensiveness, anxious behavior
- Changes in long-standing relationships with friends and coworkers
- Others’ perceptions
- Patient complaints of inadequate pain relief or sedation (nurse may be administering saline)
- Coworkers or colleagues complaints or concerns about behavior
- Physical signs and symptoms (often appear later)
- Weight loss or gain
- Poor physical condition or hygiene
- Fatigue
- Consistently dilated pupils
- Changes in speech patterns: slower or faster
- Frequent colds, chronically inflamed nostrils with runny nose.