College of Intensive Care Medicine
of Australia and New Zealand
ABN: 16 134 292 103

CICM WELFARE

SUBSTANCE ABUSE IN INTENSIVE CARE

What is Substance Use Disorder?

Substance use disorder (SUD) is defined by the DSM-V for 10 separate classes of drugs, covering 11 potential problems associated with their use. The World Health Organisation describes substance abuse as the harmful or hazardous use of psychoactive substances, including alcohol and illicit drugs. These can lead to a dependence syndrome characterised by (for example) a strong desire to take the substance, problems controlling its use, persisting despite harmful consequences, prioritisation of use above other obligations, increased tolerance and a physical withdrawal state.[1]

In both Australia and New Zealand, in line with other Western Countries, alcohol consumption is not only socially acceptable, but a normal part of adult leisure time.[2] Substance use can be problematic without meeting the DSM Criteria.[3] The point where alcohol use transitions from 'low risk' to 'harmful' is defined by the screening test used: One of the best screening tools for alcohol misuse is the Alcohol Use Disorders Identification Test- Consumption (AUDIT-C). AUDIT-C is a three-item screening test which has been shown to be effective at detecting a full spectrum of potentially risky alcohol use, even in respondents who report drinking within daily or weekly 'safe' limits.[4]

Other substance use, whilst less 'socially acceptable' than the use of alcohol, is still a problem which affects medical professionals across specialties. Access to and familiarity with these drugs puts certain groups at higher risk [5], such as those working in Anaesthesia and Intensive Care Medicine.

How can I Recognise SUD?

The ANZCA Welfare of Anaesthetists Group (WOAG) Guideline is a recommended resource in identifying the potential warning signs in the operating environment; some of which are transferrable to the ICU setting. In addition to performance, record keeping and atypical behaviour (e.g. 'going missing', volunteering to obtain and administer narcotics within the ICU) there may be more subtle mood and behavioural signs both at home and at work[6]. The evolution of SUD is complex - the use may be grounded in the treatment of physical pain, psychiatric illness, and/or as a manifestation of risk taking behaviour. In anaesthesia; an area with potential overlap with ICU practice, the first manifestation of SUD may be in either the accidental or deliberate overdose

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resulting in death.[6] This is clearly devastating for family, colleagues and departments.

What should I do if I suspect SUD in a colleague?

The regulatory authorities on both sides of the Tasman provide information on a practitioners responsibilities to the health and safety of the public if there are grounds to believe a doctor is working whilst under the influence of drugs or alcohol. In Australia it is mandatory to notify [the] Australian Health Practitioner Regulation Agency (AHPRA) if you suspect someone has practiced under the influence of drugs or alcohol[7]. In New Zealand it is similarly mandatory to notify the Medical Council of New Zealand (MCNZ) if you suspect that someone has practiced under the influence of drugs or alcohol. The relevant websites provide details of the specific requirements regarding mandatory reporting.

The Medical Council of New Zealand has published information on supporting doctors' health[8]. They acknowledge that there are many barriers to doctors seeking help: fear of confidentiality breaches, embarrassment, or fear of disciplinary action[5]. Some doctors recognise they have a problem and seek help, whilst others lack insight or are prevented by the fears outlined above.

If you suspect a colleague is working whilst intoxicated it is essential to collate evidence in a confidential and sensitive manner, whilst maintaining the safety of the patients, by removing them from clinical contact. A doctor in this position is at a very high risk of self-harm, so ensuring access to a supervised detoxification facility and/support people are essential. A more detailed description of how this can work in practice are available in the ANZCA resource[6].

Is that the end?

Experiencing a problem with SUD is not necessarily the end of a career in Intensive Care Medicine.

The most important step is to seek help. Efforts will be focussed on addressing the specific issues and determining whether, and when, the doctor is able to return to work. There may be the need for close supervision from both the department and the regulatory authority. It is possible that screening and monitoring will be put in place for an extended period, potentially for the duration of practice.

Summary

The underlying message is that SUD is a real problem throughout society, and doctors are not immune. The dangers of SUD in ICU and anaesthesia are magnified as a result of the nature of the job and the access to drugs. The safety of patients and staff are paramount. A well-developed process is required locally to investigate and manage SUD, in conjunction with the appropriate regulatory authority. It is not necessarily the end of a career, but will seldom get better without intervention.

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