Substance abuse by anaesthesiologists, shouldn't we do more?

Patrice Forget, M.D. Ph.D.[1]

Alexander Baldacchino, M.D. Ph.D.[2]

[1] Institute of Applied Health Sciences, Epidemiology Group, School of Medicine, Medical Sciences and Nutrition, University of Aberdeen; NHS Grampian; Aberdeen, United Kingdom.

[2] Population and Behavioural Science Division, School of Medicine, University of St Andrews, Fife, United Kingdom; President of the International Society of Addiction Medicine (ISAM)

Corresponding author, address and email to : Patrice Forget, University of Aberdeen; Foresterhill, AB25 2ZD; Aberdeen, United Kingdom. Phone: +447852678499. Email to: forgetpatrice@yahoo.fr

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Too many of us have known of a colleague who is presenting with substance use disorder with resultant severe consequences to the person or to others. Substance Use Disorder (SUD) is not specific to our specialty, but doctors are at the top of the occupational risk ranking, and the anaesthesiologist is at the top of these as witnessed by the pattern of reports and complaints to the General Medical Council in the United Kingdom [1].

Use is not misuse, and misuse is not addiction. But, in this issue, da Silva Rodrigues and co-workers show that there is high to moderate certainty that there are more than twice as many deaths from substance use among anaesthesia providers, compared to other health professionals [2]. They also show that while alcohol is one of the most frequently used psychoactive substances, opioids are the most commonly used anaesthetics. Interestingly, no association was found between mood disorders or all-cause mortality associated with drug abuse.

This is consistent with previous reports, indicating that the problem can affect any of us [3]. We work in a stressful environment and with access to highly addictive substances. According to Bryson, the problem is far from solved and could even get worse [4]. Bryson reported that while the incidence of SUD among anaesthesia providers decreased during the 1990s, it has increased since 2000. Moreover, as the incidence of SUD among anaesthesia providers may follow the incidence in the general population, a more recent increase can be expected, at least in countries where the problem is on the increase overall.

Da Silva Rodrigues and his colleagues did not specifically study evolution over time. In addition, they mainly analysed data from America and Asia, and unfortunately little data published in

Europe. This should be a warning to us that the problem is global and must be addressed worldwide.

If not for ourselves, we need to put in place strategies to support our colleagues and be proactive in educating all of our employees. Mayall clearly outlined why and how every anaesthesia department in hospital settings should develop and maintain a set of proactive and preventive measures, integrated into a dedicated strategy with dedicated and competent individuals [3]. When problems are identified, actions should to be conducted with the greatest respect to the individual in a non-judgemental and destigmatising fashion but equally balanced with clarity around the governance process to minimise harm to oneself or others [5,6]. So, while it's likely that we haven't overlooked the issue, we should provide evidence of what we are doing and share best practices, without stigma or reactive decisions such as , reducing access to the drugs we need in our practice. No preventive strategy can be declared effective without an established monitoring and audit process. This should lead to high-quality, forward-looking research that is not only able to better quantify the problem, but also to highlight successful solutions and suggest implementation elsewhere. If the strategies may be different from one country to another, the context being sometimes very different (for example, self-prescription, common in some countries is prohibited in others), the solution could be, at least partially, similar, in that recognising it is the common denominator.

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