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6 Training & Exams

Intro

- At start of training -
 - formalise a career plan with family, SOT, colleagues, mentor
 - consider joining NZSA
- get involved with ANZCA Training Committee
- attend a part zero course

Exams

- 1st attempt is best attempt
- don't attempt exam prematurely
- attend courses, tuts & practise vivas
- joining a study group
- if you fail - objectively investigate why and make a plan to succeed next time
- see a psychologist if over anxious

Life Balance

- in the long term: person & family needs take precedence of professional demands
- recognise hard work in maintaining in relationships as well as passing exams
- factor personal & recreational time into study time
- consider part time training or deferment (although extended leave may ⇒ degradation of skills)

Personal Health

- exercise and eat well
- rest & sleep
- mentoring relationship is valuable (apparently)
- be aware of risks to your well being & close relationships during training/examination
- substance abuse & suicide are real risks in anaesthetic trainees
- get a GP - and pay them regularly for a visit (good to spread the money around)

7 Sexual Misconduct

- Australian/NZ Law: You must notify someone if you believe (presume Australian Med Council or NZMC) if:
 - another registered health practitioner is:
 - practising while on alcohol or drugs
 - engaged in sexual misconduct with patients connected to his profession:
 - current patients
 - past patients - may be mitigating factor depending on longevity of patient and time lapse from end of professional relationship
 - risked public harm because of an 'impairment'
 - risked public harm due to deviation from accepted professional standards
 - student has an impairment which may place public at substantial risk of harm
- sexual misconduct:
 - can apply between colleagues if power or age differential
 - accessing porn etc in workplace
- discretion in application of this is up to the courts

- reasons for rules regarding sexual misconduct between pt & doctor:
 - professional relationship relies on absolute trust & confidence in Dr
 - Dr in unique position regarding physical & emotional proximity
 - Dr:Pt relationship is not equal. Pt is vulnerable. Dr is authority
 - Community expectation of Dr's is of utmost integrity
 - Improper behaviour by a Dr damages credibility of medical profession as a whole
 - Unacceptable to blame pt for a sexual relationship developing
 - Personal involvement will lead to clouding of clinical judgement
- Overall principle is no exploitation of pt or abuse of Dr's power

8 Mentoring & Peer Support

- mentoring = alliance of 2 people that creates a space for dialogue resulting in reflection, action, & learning for both
- mentor = wise or trusted advisor or guide

Mentor Role

- give advice on personal & professional support, clinical matters, colleague relationships, critical incidents, career options
- act as listener, role model, teacher, resource facilitator, coach
- should not make decisions for mentee but promote reflection to facilitate decisions
- should not replace peers, family, friends, other professionals
- must be excluded from assessment or performance system
- SOTs should not be a mentor

Systems

- mentoring
 - ▶ = voluntary between senior and junior
 - ▶ one way flow of support
- peer support =
 - ▶ groups of colleagues eg study group, or special interest group
- buddy system
 - ▶ = between colleagues of similar age/experience
 - ▶ mutual flow of support

Principles

- informal can be fine
- formal system:
 - ▶ must not replace professional procedures
 - ▶ must be voluntary & confidential
 - ▶ mentees should select their own mentors or be matched by experienced supervisor
 - ▶ popular mentors should not be overloaded
 - ▶ confidentiality & trust vital
 - ▶ system to
 - allowed termination of unproductive/damaging relationships = trial of 3 months
 - deal with inappropriate advice
 - ▶ initial meeting = 1hr:
 - establish confidentiality
 - get to know each other
 - wishes for relationship
 - ▶ scheduled regular meetings +/- ad hoc meetings

Process To Establish Formal System

- establish local need by consensus within department
- encourage discussion about need for mentors
- appoint coordinator
- advertise program
- identify senior staff willing to be a mentor
- limit number of mentees/mentor
- training for participants
- regular encouragement for program within department eg case presentations
- evaluation of program to justify continued support
- financial resources to support program must be considered for training & monitoring

9 Your Own GP

- Drs strongly recommended to have own GP
- Recommendation imp't despite acknowledged potential loss of confidentiality if consulting about a condition which may be significantly affecting their performance

Excuses

- there are 21 !??:
 - ▶ late presenter - it's not serious
 - ▶ unhappy with submissive pt role
 - ▶ accept other Dr opinion
 - ▶ I can manage myself - GP's are useless
 - ▶ embarrassed to discuss problems with other Drs
 - ▶ Cant accept different style of Dr
 - ▶ Lack of trust in other Drs
 - ▶ A GP would be intimidated having to attend to me (Anaesthetists and their ego's)
 - ▶ Will GP respect my confidentiality
 - ▶ Unable to see them - office hours
 - ▶ Do i sit in waiting room
 - ▶ How do i pay

10 Breaking Bad News

Summary

- situations:
 - ▶ ICU
 - ▶ after adverse event
- Dr's should be trained in how to do it
- SPIKES:
 - ▶ S etting ⇒ privacy
 - ▶ P atient Perception ⇒ check persons understanding
 - ▶ I nvite information ⇒ check situation
 - ▶ K nowledge transmission ⇒ provide simple clear info
 - ▶ E motions & empathy ⇒ acknowledge emotions. Elicit & address concerns
 - ▶ S ummary & Strategise ⇒ document & plan further action

Important Points

- plan & rehearse strategy
- it is very important. Doing it well means:
 - ▶ ↓litigation
 - ▶ ↓long term distress & ↑acceptance of news
 - ▶ ↑consent to organ donation
 - ▶ ↓Dr stress & burnout
- If you do it badly perception can be that you dont care
- If adverse outcome:
 - ▶ approach relevant dept (eg legal services/pt liaison officer) prior to discussion
 - ▶ BUT timely deliverance of news is important
 - ▶ open disclosure of facts:
 - truthfully & sensitively delivered
 - in keeping with local policy
 - ▶ apologise for events
 - ▶ do not admit fault
 - ▶ Should write down fact based document as soon as possible after event in conjunction with medical defence organisations

Key Practical Steps

- private room - no interruptions
- support persons:
 - ▶ for you
 - ▶ for relative/patient
- bring junior Dr along to learn skills
- Check identity of person you're talking about

- everybody sitting at same level
- check team members have a consistent story
- warning shot: 'Im afraid i have difficult news....'. Pause allow time
- deliver information in small pieces with no jargon
- Tailor info & speed of delivery to audience
- allow pauses at all times
- express sympathy without accepting blame:
 - ▶ ' I wish the news were better'
 - ▶ 'I wish we had better treatments for this'
 - ▶ 'i am sad this has happened to you'
- apologise but don't admit fault:
 - ▶ ' I am so sorry this has happened'
 - ▶ NOT "i am so sorry i did this to you'
- acknowledge & verbalise emotional responses:
 - ▶ 'I can see this is very upsetting for you'
 - ▶ 'I understand you are very angry about this'
- check understanding:
 - ▶ 'would you like me to repeat that?'
 - ▶ 'would you like me to tell you more'
- elicit & address concerns:
 - ▶ 'have i covered all your concerns'
- offer assistance to tell others eg family, priest, support workers at hospital (palliative care, counselling)
- offer further contact - eg at another time
- Document: record the interview in the pt notes incl those present & agreed decisions

11 After a Major Anaesthetic Mishap

- Major mishap = “an incident which may have (a “Near Miss”), or has, potential to produce harm to a patient”.
- Leads to 4 areas for aftermath consideration
 - Patient/relative (see RD 10)
 - Anaesthetic Practise / Environment
 - Staff members involved (see RD 5)
 - Root cause analysis (RCA)
- Then...
 - ♣ Equipment involved should be isolated for examination
 - ♣ Primary Team informed, Hospital admin informed, if medico-legal process implied then management, insurers, legal advisor informed.
 - ♣ FACTS, not opinions should be documented – for records, medio-legal defence, coroner’s exam.
 - ♣ NEVER alter existing notes
- Patient/relative: interviewed by surgeon/anaesthetist
- Staff members involved: support system should be in place, it’s responsibility of all involved; debrief, counselling, ‘open door’ policy for professional support eg
 - GP, local welfare officer, mentor, friend, SOT; keep close watch of those involved during this time
 - Other examples: Doctors Health Advisory Service (DHAS) ANZ, Mental Health Team, ANZCA Welfare rep, Lifeline etc...
- Root cause analysis: by reviewing body; identify ways to improve future care

12 The Isolated Anaesthetist

- Refers to Anaesthetists working in rural areas / solo practice ie less immediate support;
- Relevant issues included:
 - Harder to find cover for leave: so beware of this and endeavor to arrange regular leave for whatever reasons to achieve work/life balance; buy a locum to cover you
 - ♣ It’s valuable to maintain a roster, if number of local anaesthetists permits; non-specialist anaesthetists can be trained up to meet rostering requirement
 - Of if you decide to work as locum, make sure contract is in place, beware of unfamiliar workplace, equipment, personnel etc.
 - Link with regional referral centre is important
 - Intensive care may be required – link with nearest intensivist for advice, referral etc.
 - CPD: attend local/regional/national meetings – help with network building + knowledge. Valuable to have a CME meeting facilitator/coordinator locally.
 - Peer support group is useful – in person or correspondence; or mentoring programme.
 - Affiliation with professional organisations eg. ASA or NZSA, or rural SIG.
 - Privacy is harder to maintain in small town; set personal/professional limit clearly; avoid informal consultation
- IMGs may face further challenge – cultural, communication issues etc; Overseas Trained Specialist Anaesthesia Network (OTSAN) is helpful.
- Other sources of support: GP, Hospital Employee Assistance Program (EAP), local/regional/national Welfare Officer/SIG group

13 Impairment in a colleague

- Standards for Anaesthetist practice covers multi-facet: manner, ethics, codes of conduct on different tiers – local/ANZCA/MCNZ, legal requirements, safety/quality of practice/care to patients as well as colleagues.
 - Codes of conduct = values/behaviours developed and accepted by medical profession; in general include *honesty, patience, integrity, diligence, respectfulness, professionalism (including confidentiality), compassion, cooperation, tolerance and humility, commitment to 4 principles of biomedical ethics (autonomy, justice, beneficence, non-maleficence)* and other desirable virtues
 - Apply in all interpersonal interactions – in person, in print, in social media.
- Impairment = when above is consistently missed; wordy version = '**consistently** departed from the expected behavior set out in CoD above, which **impacts** on performance.'
 - Can be acute, chronic, temp, permanent
 - If patient safety is potentially jeopardized, we have legal obligation to report impairment to relevant authority (ie mandatory reporting, doc 24) ie employer, college, council.
 - ♣ Mandatory Reporting is outlined in:
 - Health Practitioners Competence Assurance Act 2003 New Zealand
 - Health Practitioner Regulation National Law Act 2009 Australia
 - ↳ = criminal act not to report in Oz (NZ voluntary)
 - MCNZ, Medical Board of Australia have 'Impaired Registrant' panels – who supervise and supports rehab of impaired colleagues.
 - Categories of reporting to MCNZ:
 - Conduct
 - Competence
 - Health
 - Can report employees, students, educational authorities
 - A practitioner may be unwell, stressed, or distressed, without being impaired
 - Must not practice if cannot perform functions of medicine:
 - Judgement
 - Skill
 - Use of knowledge
 - Appropriate behaviour
 - Not risking patient infection
 - Confidentiality must be maintained, unless otherwise by legal requirement esp where patient safety is jeopardized
 - Intervention may be difficult, but we must avoid condoning poor behaviours, and always engage in other professional help. NEVER provide clinical advice to impaired colleague or take on 'duty of care' for colleague.
 - Ways to recognize impairment include:
 - Nursing/technician report of concerns/uncomfortable incidents/safety issue
 - Personal observation
 - QA, peer review
 - Family members report
 - If suspected, further investigate the issue to confirm or negate suspicion. Consider the following:
 - Privacy
 - Discussion with another trusted colleague
 - Consult local Doctor's Health Advisory Service (DHAS)
 - ?potential medico-legal issue – consult defence organization

- ?criminal activities – report to Justice League/Authority
- Documentation
- Confrontation needs extreme care as often is a difficult conversation
- Support established for impaired colleague once impairment is confirmed / raised
- NB. Substance Abuse is elaborated in another doc – RD 20.
- Recommendations to prevent impairment:
 - Buddy, mentor, GP, seek professional help and avoid self-diagnose or medicate or informal corridor consultation.

14 Medico-legal issues

- Ways to minimise medico-legal issues:
 - Keep good documentation, timely, accurate, detailed; lack of it weakens a defence greatly; good record = good defence.
 - Maintain professional manner
 - ♣ Timely, continued contact, bedside manner, empathy towards patients/relatives, even if they complain after adverse events
 - Focus on sharing goal of better outcomes
 - ♣ Maintain good collegial relationship; do not publicly criticise colleagues
 - Be mindful with delegation of responsibility esp to junior/locums, as you can still be held responsible
 - Medical defence insurance
 - Informed consent, which helps to
 - ♣ Identify expectation
 - ♣ Explain ‘material risk’
 - ♣ Give ‘reality check’
 - Apology – allowed by ANZ legislation
 - ♣ As acknowledgement of outcome and regret, whether or not you have been negligent.
 - ♣ It’s appropriate to ‘express sympathy without accepting blame.’
 - ♣ Legally, it’s not equivalent to admission of guilt
 - ♣ Consider local policy on ‘open disclosure’.
- If claim happens:
 - Call your lawyer aka Consult medical defence organisation; provide factual information; never alter existing records
 - Consult local institutional policy; director of service
 - Take care of yourself – talk to friend, family, colleague, GP; stress level likely significant and over long period of time.
- NB: Notifiable conduct requires mandatory reports; these include:
 - Practice while intoxicated, sexual misconduct, impairment (see separate RD) leading to harm.

15 Training and family responsibilities

- Anaesthetic practice demands flexibility on domestic arrangements to cope with last minute problems
- Family is over work; however getting balance right is not easy; discuss role with family members during busy time can be helpful, and be prepared for ongoing re-evaluation of role.

- Consider taking turns in professional priorities with partner; be fair with partner's career plan.
- Looking after children while working/training is not easy. Be ready to take sick leave for sick family member, get any domestic help/child care that's available to you.
- Talk to friends, colleagues who have been through similar phases for advice. Planning for career directions in 5-10 years time is important and consider the balance of work and life in long term.

16 Welfare Issues in Anaes Dept and Private Groups

- Orientation
 - of new staff, to department (physical facilities, personnel, equip etc)
 - Inform new staff of expectations, ascertain goals and objectives
- Trainees
 - Review selection criteria and appointment process
 - Promote educational activities and support exam sitters
 - Enable/encourage study groups
 - Provide career advice
 - Support SOT(s)
- In-training assessment
 - Ensure process followed closely
- Mentors and Buddies
 - Consider mentor system for trainees, buddy system for specialists
- Welfare Strategies and Education in Doctors' Health
 - Appoint resource person for dept welfare issues (ensure dept know who this is)
 - Alert staff to welfare issues, and how to access Welfare SIG and Resource Docs
 - Regular education sessions on welfare issues for dept
 - Substance abuse recognition important (see RD 20)
- Resources
 - Maintain list of local welfare resource personnel and helping organisations
 - Consider establishing formal link with "liaison" psychiatrist
 - Be aware of EAP (employee assistance program)
- Fatigue
 - Consider prospective measures to minimize fatigue for all staff
 - Ensure time off after night call
 - Option of ceasing night-call for older members
- Crises
 - Critical Incident Support process should be in place and promulgated
 - DA should provide help for staff involved with unexpected bad patient outcomes
 - Anaesthetist directly involved should be relieved of duties at least for day of event; support and follow-up must be arranged
 - Ensure debriefing session offered
- Department and Group Meetings
 - Ensure regular discussion of welfare and organisational issues
 - Don't forget social activities and a recreation area with good coffee

RD 17 – Infectious Diseases

- Intro:
 - Exposure prone procedures (EPPs): involve contact between healthcare worker and patients
 - Procedures constitute risk to patient and proceduralist

- Routes of transmission: hollow bore needle-stick injuries; droplet or mucosal contacts during intubation, airway or other procedures; contamination via instruments
- **Blood borne viruses**
 - HIV 0.3% risk to healthcare worker after occupational exposure
 - HBV -HbsAg 1-6%
 - HbeAg 22-31%
 - HCV 10% (1.9% if virus PCR –ve)
- HepB
 - Most infectious blood borne disease
 - Vaccination available – give immed to those with significant exposures who are not vaccinated
 - Some are non-responder to vaccines – not protected
 - Anti-HBs titres measured to differentiate responders from non-responders
 - ♣ Initial responder not offered booster, even if titre drop, unless immunocompromised
- HepC
 - No immunization or post-exposure prophylaxis proven to be effective
 - Rx of acute HepC with interferon 2a prevent chronic infection
 - Previous exposure doesn't result in immunity, re-infection can still occur
- HIV
 - Risk from occupational exposure low
 - Commence post-exposure prophylaxis (PEP) with 1-2 hr after significant exposures, still effective until 72hr post exposure
 - PEP difficult to tolerate due to s.e
 - HIV seroconversion generally documented within 4 weeks from exposure
- Immediate post-exposure management:
 - Wash exposure site, rinse eyes/mouth with water
 - Risk assessment
 - Fill in incident report
 - Patient consent for baseline tests
 - Consult ID specialist
 - PEP for high-risk exposures
 - Organise F/U
 - Maintain confidentiality
- **Airborne diseases**
 - N. meningitides, measles, M. tuberculosis, SARS
 - Spread by aerosols; pathogens disperse by air current, inhaled by individual in area with shared air circulation;
 - ♣ protection provided by tightly fitted N-95 mask.
 - Influenza and most resp viruses spread by droplets
 - ♣ Droplets expelled from infectious person and fall within 1m radius; standard mask and contact precautions within 2m radius sufficient

- ♣ E.g. pneumococcal pneumonia, streptococcal pharyngitis, pertussis, parvovirus B19
- BCG vaccine available – 50% protective efficacy
- Flu vaccines – 70-90% efficacious

- **Recommendations:**

- Anaesthetists participate in vaccination program (incl HepB, Influenza, Pertussis, MMR, Varicella, HepA; BCG if in high-risk TB area)
 - ♣ Onus on individual to undertake
- Hospt may request evidence of infectious status and immunisations
- Anaesthetists who perform EPPs have responsibility to know infectious status, and should undergo regular checks (every 1-2 years)
 - ♣ Re-check status after significant exposures
- If HIV Ab+/HBeAg+/HBV DNA+/HCV PCR+ should inform employer
 - ♣ Should not perform EPPS (controversial)
- Standard precautions for all patient contact
- Transmission-based precautions for airborne diseases
- Consult expert after significant exposures
- Check whether income protection policies cover occupationally-acquired infections.

18 Latex Allergy

- Intro:
 - Natural rubber latex= sap from rubber tree, Hevea brasiliensis
 - Protein portion responsible for type I hypersensitivity (urticaria which can - >anaphylaxis
 - Chemicals give latex its elasticity – can cause type 4 contact dermatitis
- Assoc RF for latex allergy:
 - Atopy
 - Exposure to latex
 - Assoc. food allergies (banana, avocado chestnut, kiwifruit, tomatoes, potatoes, stone fruits)
- Why latex gloves a problem?
 - Latex aeroallergens – latex allergens absorbed into cornstarch powder, become source airborne allergen ->
 - ♣ sensitise individuals working in environ. more effectively than wearing gloves
- Anaesthetist with latex allergy:
 - Seek occupational advice in view of high risk work environment
 - No RX available – latex avoidance only mx (incl avoid inhalation powder from latex gloves)
 - Early diagnosis
 - Determine severity of reaction to latex
 - ♣ Severe – may not be able to work in acute health care environ
 - Avoid areas where powdered gloves used
 - Use neoprene/nitrile gloves if risk blood contamination

- Other staff in area should use non-powdered latex or synthetic gloves
- Care to avoid latex outside work environ (latex balloons and condoms)
- Guidelines for reduction of sensitization to latex
 - Ongoing education
 - Identification and advice to individuals with atopy/rashes
 - Accurate dx (see 'allergist')
 - Provide appropriate gloves

19 Ergonomics

Anaesthetists should be aware of Occ health and safety check lists for their workplace.

Ways to help your back and neck:

- Lifting
 - Know own strength
 - Lift and carry close to body
 - Bend knees (make legs do work)
 - Don't twist back (turn with feet)
- Sitting
 - Upright chair with back support; get up an stretch q20-30min
 - Computer screen at height at which don't have to flex/extend neck
 - Use appropriate glasses
- Standing
 - Have working surface at comfortable height
- Driving
 - Adjust seat from time to time, take breaks
 - Try folded towel or other lumbar support in small of back
- Activity
 - 20-30min walking/cycling/swimming 3x/week. Gradually increase physical activity
- Relax
 - Learn to reduce stress; use relaxation techniques.

20 Suspected or Proven Substance Abuse (Misuse)

Introduction:

- Anaesthetists over-represented in rehab centres for substance abuse/misuse (most use IV – opiates, propofol (now 45% drug of choice with 45% mortality), midazolam; alcohol).
- Substance use disorder = 2-3 criteria out of 11
- Many depts have experienced trauma of discovering a member has addiction
- First indication may be manifest by death (deliberate or accidental)
- Suicide in anaesthetists freq. assoc. with substance abuse, and mental illness (cause of death 6-10% of anaesthetists)
- Drug/alcohol misuse may occur sec. to:
 - Underlying psychiatric disorders

- Mental/physical pain
- Risk-taking personalities
- Substance misuse must be recognised and death prevented
- Important to identify individuals as soon as possible and instigate intervention (promotes health of anaesthetist, avoids potential harm to patients)
- Increasing awareness of problem means individuals more frequently identified and treated
- Some may commence return to work programs, others may benefit from career change

Substance Abuse Policy

- Policy should be evidence based:
 - Safety for staff and patients
 - Definitions
 - Prevention & education
 - Privacy & confidentiality
 - Treatment/Intervention plan
- Team of interested people with full redundancy
- External support of other agencies eg CADS ⇒ inpatient services

Recommendations:

1. Raising awareness and being prepared

- Proactive program in department – education
- Substance misuse interest group
- Guideline for detection and treatment of substance misuse
- Identify local treatment resources
- Focus on therapeutic strategies, not employment/disciplinary/criminal processes

2. Suspicion and recognition of drug abuse

- Direct evidence of substance abuse – IV needle/cannula insitu, observing substance misuse
 - ♣ Critical situation, requires immediate action:
 - Call MET if necessary – safety to staff member
 - Don't leave doctor alone
 - Relieve of clinical duties – **must** ensure safety of patient & continue anaesthetic service
 - Notify HOD
 - Notify duty psychiatrist – immed. escorted admission to inpatient detox centre
 - Notify regulatory authority
- Major signs of drug abuse (1 signs sufficient to justify report of suspected drug abuse; if sign observed, mandatory to immediately report to senior colleague):
 - ♣ Injection marks
 - ♣ Drugs or equipment in non-workspace environment
 - ♣ Observation of diversion, self-administration, misuse, falsification of records
 - ♣ Signing out of increasing quantities of drug
 - ♣ Inconsistencies in recording drug use for patients
 - ♣ Increasingly illegible, inaccurate, altered record-keeping

- ♣ Consistent pattern of complaints regarding excessive pain by recovery/ward staff in patients of particular anaesthetist
- ♣ Major change in attitudes or behaviours
- ♣ Tremors or other withdrawal symptoms
- ♣ Intoxication or bizarre behavior
- Circumstantial evidence (sufficient to arouse suspicion or justify report):
 - ♣ At work:
 - Long-sleeved gowns or warmer clothes than necessary (conceal arms, keep warm (sensitive to temp))
 - Spots of blood on clothing
 - Increased sick leave and/or absenteeism
 - Unavailability, irregular hours, decrease in reliability, poor punctuality
 - Working alone, refusing breaks, willing to relieve others
 - Volunteering for more cases/on call
 - Leaving patients unattended in OT
 - Being found in unusual places
 - Carrying syringes or ampoules in clothing
 - Being in hospital out of hours when not on duty/call
 - Personally administering medication normally others responsibility
 - Increasing time in toilet/bathroom
 - Intoxicated behaviour, pin point pupils, weight loss, pallor
 - Increase in accidents or mistakes
 - Unsatisfactory work records
 - Frequent moving or changing jobs
 - Unexplained absences while at work or on duty
 - Elaborate rationalisations of bizarre or irrational conduct
 - ♣ At home:
 - Significant changes in behaviour, presentation, personality or emotions
 - Wide mood swings, periods of depression, euphoria, caginess or irritability
 - Social withdrawal, increased isolation or elusiveness
 - Deterioration of personal relationships, development of domestic turmoil, decrease in sexual drive
 - Overspending
 - Elaborate rationalisations of bizarre or irrational conduct
 - Obtaining an unusual medical diagnosis for bizarre conduct or symptoms (which are in fact arising from drug usage)
 - Deterioration in personal hygiene
 - Numerous health complaints, impulsive behaviour.
 - Health concerns expressed by partner or family
 - Other inappropriate conduct.

3. Collection of evidence

- Assure reporter observations will be taken seriously and confidentially
 - ♣ Discretion required from reporter pending investigation
- Preparation and response:
 - ♣ Written evidence collated, oral evidence documented

- ♣ Internal investigation to confirm report

- Protect suspect and patients

4. Verification of abuse

- Consider retrospective and/or prospective audit of suspects clinical drug usage
- Careful observation for signs and symptoms of misuse
- If definite evidence – must inform relevant medical board/council

5. Intervention

- Never attempt on insufficient evidence
- Consider more rapid intervention if major signs of illness observed
- Intervention planning
 - ♣ Intervention team
 - ♣ Inform medical board/council of intervention plan
 - ♣ Plan intervention in advance
- Intervention meeting
 - ♣ Early on normal operating day when anaesthetist on duty
 - ♣ Inform anaesthetist of intervention on arrival to work
 - Give opportunity to appoint an advocate
 - Thereafter accompany anaesthetist at all times
 - ♣ Chosen advocate or appointed mentor should be present
 - ♣ Ensure emotional and safety needs of person are met
 - ♣ Conduct intervention firmly and sensitively
 - ♣ Introduce team members and explain reason for meeting
 - ♣ State evidence and allow a response
 - ♣ Outline options available
 - ♣ Reassure of doctor of continued support
 - ♣ Meeting should end with anaesthetist being accompanied to detox unit
 - ♣ Early psychiatric risk assessment recommended
 - Suicide risk high
 - ♣ Record results of intervention meeting and subsequent treatment

6. Treatment options

- To be decided by professional treating team (not intervention group or department or college)
 - ♣ Voluntary treatment
 - Immediate psychiatric assessment might be recommended
 - Outpatient treatment rare
 - Transfer to detox facility
 - Assessment and treatment of associated psychiatric disorders
 - Participation in group therapy (AA, NA etc)
 - ♣ Involuntary treatment, may include:
 - Mandatory reporting to medical board/council
 - Committal under Mental Health Act, or Alcohol & Drugs Act
 - Police report (not mandatory, may be inappropriate)

7. Return to work

- Required assessment by appropriate bodies
- Cooperation of department in development of monitoring program
- Contract with board/medical council may include limitations on practice, workplace monitoring/supervision, prohibition on self-prescribing, substance use monitoring
- Alternate retraining (within or outside of medicine) or change of employment may be necessary

Alcohol Abuse

- Safe limits (National Institute on Alcohol Abuse and Alcoholism):
 - Men – 2 drinks/day
 - Women – 1 drink/day
- Intervention:
 - Same lines as for substance abuse, treatment may be easier and conducted in outpatient setting
 - Denial, belligerence and aggression frequently encountered when attempting to discuss abuse with doctor
- Signs and symptoms (non-specific):
 - Inappropriate (time/place) for the smell of alcohol on breath
 - Impaired performance and personality changes
 - Interpersonal difficulties with family, friends, or co-workers
 - Drinking excessive amounts of alcohol frequently
 - Drinking when it is dangerous to do so (such as during or before driving)
 - Binge drinking - frequent excessive drinking
 - Legal problems related to drinking
 - Craving and loss of control
- Physical dependence:
 - Withdrawal symptoms eg nausea, sweating, shakiness, anxiety after stopping drinking
- Tolerance – may develop, intoxication not always evident
- Treatment
 - Usually detox unit, +/- AA attendance