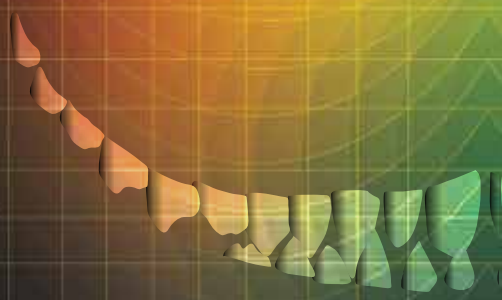
IN A WONDERLAND THEY LIE



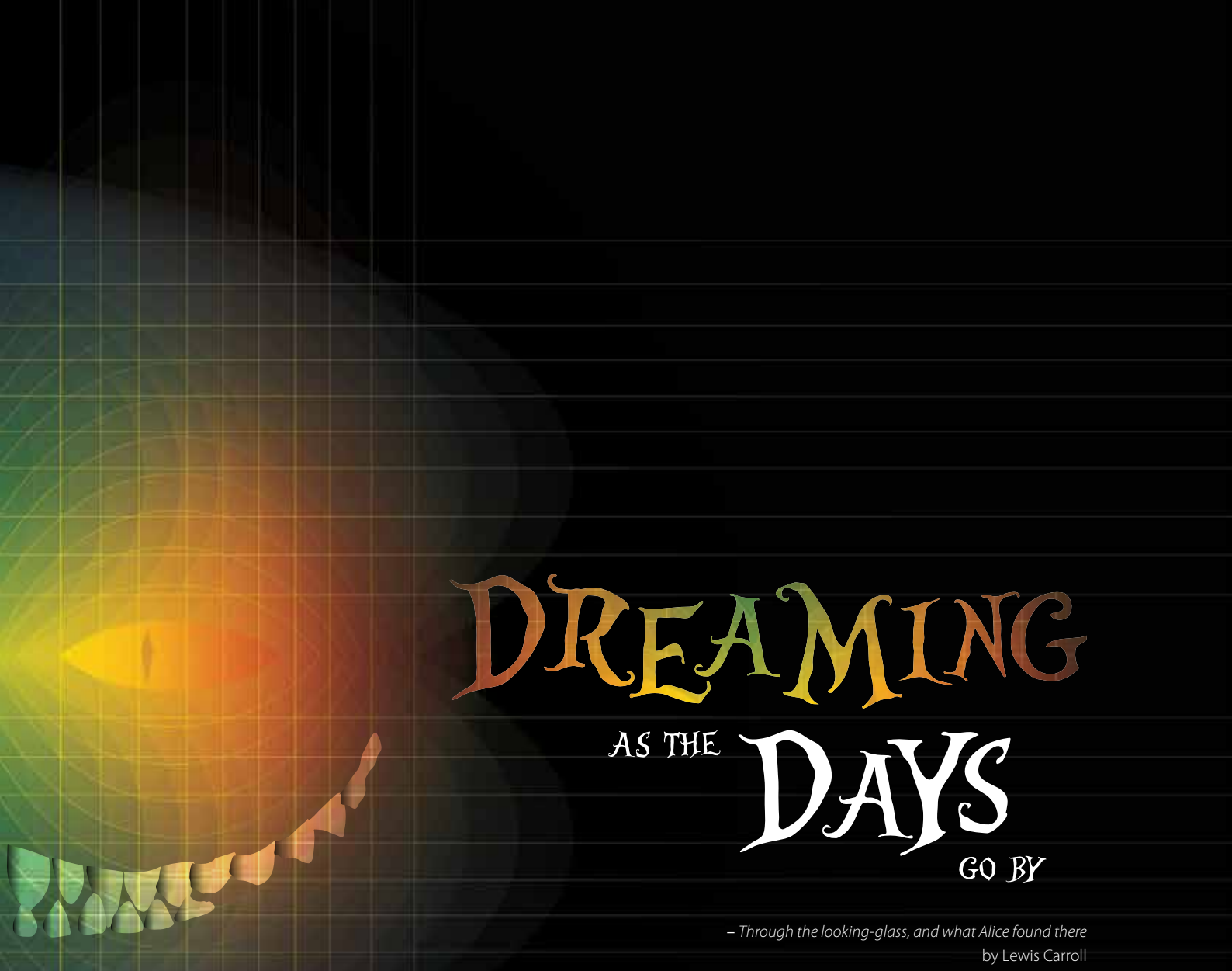
In the February 2014 issue of *Australian Pharmacist*, Peter Waterman explored the sensitive topic of substance abuse among pharmacists and other healthcare professionals *(If you drink from a bottle marked poison, page 33)*.

This month he follows up with an alarming report on what the consequences can be for those who drink from a bottle marked poison.

Healthcare professionals with substance abuse problems present many challenges for experts trying to help them. Not the least is that healthcare professionals make notoriously bad patients.

Added to this is the fact that healthcare professionals may be in a higher level of

Peter Waterman is the Director of Public Affairs at PSA National Office and a regular contributor to *Australian Pharmacist*.



DREAMING AS THE DAYS GO BY

– Through the looking-glass, and what Alice found there
by Lewis Carroll

denial and their education and training may also give them a higher level of credibility in their denial. Some may not be in treatment voluntarily and may have only entered a program to try to protect their ability to continue to practise.

A study published in the *Substance Abuse: Research and Treatment Journal* says many health professionals in treatment also face losing their licence, and 'thus admission to treatment may not be completely voluntary'.

The report, *A Two Year Longitudinal Outcome Study of Addicted Health Care Professionals: An Investigation of the Role of Personality Variables* (Angres, *et al.*) says, 'Treating healthcare professionals with substance abuse disorders is not only challenging, but requires a multidisciplinary team with experience working with addiction in this population, as the degree of resistance to treatment may be great.

'Further, the intellect and education level inherent to this population has been associated with exceptional rationalisation and denial, which can further perpetuate treatment difficulties.'

Patterns of behaviour

The Canadian Council on Drug Abuse (CODA) states that with healthcare professionals the process of addiction, along with the patterns of behaviour a substance-using health professional might show, is different from that of a typical substance abuser.

'Health professionals are quite good at hiding the problem, and function well until the problem is seriously advanced and the end stage of substance abuse is reached. They work hard to keep the problem invisible.

'Usually, the initial symptoms include a change in their personal relationships and a decrease in community involvement. Although a drug user would usually tend to experience a decrease in work performance, or might be frequently absent, healthcare professionals who are abusing drugs tend to not show impairment related to job performance until they have already developed a significant substance abuse problem.

'This is because the workplace is generally the source of their addiction and is where they obtain their drug supply. In contrast, if the drug is obtained away from the workplace, they would frequently be absent, arrive late or leave early.'

'If a healthcare professional is a substance abuser and obtaining their drug supply at work, they might do this by diverting the drug.

'Indicators that a health-care professional is potentially diverting drugs from the work-place for recreational purposes might be signing out more controlled substances than co-workers, reporting more medication spills or wastes, excessively administering PRN (take as needed) pain medications to patients, waiting until alone to open narcotics, evidence that someone has tampered with the medication containers, and being defensive when questioned about medication errors, to name a few.'

Kay Dunkley, Program Coordinator of the Pharmacists' Support Service (PSS), said health professionals such as pharmacists are different from others with drug or substance problems as they are generally well educated and can hide their problems better.

'They also tend to be in greater denial than the rest of the population and this all adds up to them being more challenging to treat,' she said.

'Most of the calls we get are because people have got themselves into a difficult situation one way or another.

'One thing about health professionals is that it is very hard for them to become a patient and to admit they have a problem because they are very used to being in control of a situation.

'Having to put themselves into a patient mode is a very difficult step for them to take.

'They want to be able to make their own decisions so this is a reason that health professionals need a different approach to other people in the population who have similar problems.

'And of course once they are back in the workplace they have access to the drugs again and that is of course problematic.'

Dr Kym Jenkins, Medical Director of the Victoria Doctors Health Program which provides doctors with assistance, said health professionals presented different

Typical cases which may present to PSS

Marion*, a middle-aged pharmacist, is finding work very stressful and is anxious about the viability of her pharmacy in the current economic climate. She is prescribed some oxazepam by her GP. Her use escalates and she starts to self-medicate with stock from the pharmacy. Now she cannot face work without taking oxazepam several times a day. She realises that she has a problem.

Ryan*, a hospital pharmacist working in the ICU, is caught by a pharmacist colleague falsifying drug of addiction records to support his dependence on oxycodone. When dispensing for patients he has been supplying smaller than prescribed quantities and keeping the rest for himself. His misuse of drugs started with using party drugs when he was still a student. The stress of his role in ICU leads him to the use of drugs to help him relax and sleep at night.

challenges as patients because of their training.

'They know about medications and health conditions and so have more knowledge than most patients,' she said.

'They therefore need to be seen by other health professionals who have the additional skills to cope with these situations.

Mandatory reporting

Many who deal with this problem feel that mandatory reporting may be discouraging impaired health professionals from seeking help.

Writing in *Pharmacy Times*, clinical pharmacy writer Yvette C. Terrie, said that although the issue of substance abuse among pharmacists was seldom discussed, it was an issue of fundamental significance which could negatively impact the pharmacy profession.

'Approximately two thirds of impaired pharmacists in recovery treatment programs were discovered by their local state board of pharmacy, a peer, or another health care professional,' she wrote.

> "Having to put themselves into a patient mode is a very difficult step for them to take."

'Studies suggest that certain factors may predispose pharmacists to the development of a substance abuse problem; for example, stress associated with working conditions or the demands of working long shifts, personal issues, or the belief that their knowledge of medicines will somehow prevent them from becoming addicted.'

She concluded that for pharmacists facing the challenge of overcoming an addiction, recovery was a realistic goal when the affected pharmacist made a commitment to therapy.

'Recognising the signs and symptoms of a substance abuse problem and acknowledging that the problem exists are the most crucial steps on the road to recovery,' she said.

'Through proper intervention and treatment, it is possible for impaired pharmacists to once again achieve a better quality of life that is productive and free of substance abuse and function once again as a responsible health care professional.

'Early recognition of a substance abuse problem can prevent impaired pharmacists from compromising patient care and avert serious consequences that may involve medication errors.'

Tom*, a pharmacist in his mid-20s, has a motor bike accident which leaves him with chronic pain. He is treated with *Oxycontin* legitimately by his surgeon. His GP notices escalating use and refuses to prescribe higher doses or larger quantities. Tom starts to help himself to stock returned by patients, taking whatever he can find. One morning he does not arrive at work and is not answering his phone. When the police break into his flat he is found comatose on the lounge room floor with an empty bottle of spirits and empty packets of *Oxycontin* and *MS Contin*.

Jim* has been working in his rural pharmacy six days a week for the past 30 years. He doesn't take meal breaks and works from 9am to 9pm five days a week and 9am to 4pm on Saturday. He is also on call for the local hospital after hours. He lives alone as his wife moved to the city when the children left for university, expressing the view that he was married to his work and not to her. The pharmacy is across the road from the local bottle shop and Jim always has a bottle of scotch on hand to help him through the day. The local GP drops in with some owing scripts and notices that Jim is unsteady on his feet and smells of alcohol.

Julie* was prescribed *Ritalin* as an adolescent for ADHD. She found it very useful during her years of study to gain her PhD. Now she is working for a pharmaceutical company which has high expectations and she finds she needs to use stimulants to work the long hours expected of her. Through her work she has some medical contacts who prescribe *Ritalin* for her as a favour, however as her use increases she turns to illegal street drugs to meet her needs. Unable to sleep she then needs temazepam to bring her down. Her behaviour is becoming erratic and one of her medical colleagues expresses concern.

**Name fictitious*

Stephen Marty recalls

'I remember an intensive care specialist who wrote some brilliant protocols for ICU, did in-house training at the hospital where he worked but he developed a habit and was suspended for diverting and stealing ampoules of midazolam. When he died he was on his knees, with a sandwich in his hand. And he just obviously succumbed and rolled over sideways. So he was still in this kneeling position, on his side, sandwich in his hand – deceased.

'And I think of a nurse who stole what she though was the remains of a pethidine ampule but it was succinyl choline and she was bolt upright, dead, in the female toilets near the operating theatre. That would have been horrific as she would have been fully conscious but she was paralysed in her breathing. She would have known what was happening but unable to do anything about it.

'Some years ago we had a pharmacist who had a cocaine problem and he was suspended and then came back to work under imposed conditions but as soon as those conditions were lifted he started using again. The message out of that is that you don't solve these problems in the short term and the consensus among medical consultants is that after three years of non-use you can generally start to feel confident they won't re-use. I asked him what happened and he said that he was doing well but when those conditions were lifted it was a case of: 'Wow here I am, in the candy store.'

Electronic medical records

The advent of electronic medical records (EMRs) has seen a correlating rise in impairment among some health professionals, according to a US expert.

Philip Hemphill, Director of the Professional Enhancement Program at Mississippi's Pine Grove Behavioral Health and Addiction Services, told *Australian Pharmacist* that the introduction of electronic medical records (EMRs) have caused an increase in healthcare professionals experiencing burnout and even suicidal tendencies.

'EMRs bring significant stressors during preparation, implementation, and monitoring that are necessary,' Dr Hemphill said.

'Fear seems to be the main response because of the 'unknown' factor and some respond destructively. The learning curve can bring confidence and empowerment once mastered.'

Dr Hemphill has also said EMRs essentially removed 'the art, the creative part of healthcare, which allows a story to be told. EMRs make the work much more restricted than it was in the past'.

How pharmacists divert drugs

The Chair of the Pharmacy Board of Australia (PBA), Stephen Marty, says an attitudinal change in the pharmacy profession has facilitated the diversion of drugs by people who are impaired

'In the past 10 years or so there has been an attitudinal change and I look around Australia at the number of incidents involving Schedule 8 drugs,' he said.

'One of the big issues is poor control and as more Schedule 8s are held in stock the pharmacy runs out of room so they may fail to keep them in the safe, which is a statutory criminal offence.

'Those who want to access these drugs exploit weaknesses in the system.

'I think of a hospital pharmacist who was diverting for his own use from medicines returned from wards so there were poor controls in place.

'There have been instances of pharmacists who have used from returns from nursing homes or deceased estates.

'If they think no one is going to know they are kidding themselves because they are all headed in the one direction and that's downwards,' Mr Marty said.

Lack of accountability provides opportunities for drug diversion which can be almost impossible to trace, Kay Dunkley, says.

'Returned medicines being diverted by pharmacists who have a problem is not uncommon. They are not accounted for before being disposed of in RUM (Return of Unused Medicines) bins so a pharmacist with a problem can divert. There is no accountability for how many are returned,' she said.

'Obviously for drugs that are kept locked up in a safe the pharmacist has to keep records of how many come in, how many go out and so on and that makes it a bit trickier. Of course there are ways and a pharmacist may place orders and not record them in the drugs

of addiction register and instead keep them for personal use.

'There are ways around it but usually they get caught but the system is not fool proof.'

Preventing diversion

Pharmacy Products and Purchasing magazine recently reported that healthcare workers' close proximity to highly addictive medications required the development and implementation of effective anti-diversion policies.

'Although some healthcare workers divert medications for personal use, others divert to sell drugs to others, supply a significant other or friend, or to ensure a party supply,' the magazine said.

'The common denominator in all cases of drug diversion is proximity and access to controlled substances. Restricting access to medications… as well as instituting robust tracking technology, are vital to ensuring medication security.

'Implementing systems that improve control over access to desirable drugs, as well as developing and reinforcing a culture that supports robust diversion management policies and procedures, will best prevent diversion incidence.'

The magazine also pointed to the fact that familiarity can be a factor.

'Oftentimes, when staff members have worked together for many years, the resulting familiarity may lead to a lackadaisical approach to diversion prevention; this can give rise to a culture that suggests diversion is not a major concern,' it said.

'In addition, remember that healthcare workers at all levels in the organisational structure are at risk; do not assume that individuals in positions of power are immune from the lure of diversion.

'And the fact that diversion has not occurred previously is not indicative of the future potential for diversion; approximately 10% to 15% of healthcare providers will misuse drugs and/or alcohol at some point in their careers. Moreover, it is probable that diversion has occurred but has simply gone undetected.'

WHAT DO YOU THINK?

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