Short title: Administrative management of substance use disorder

1. Purpose

Work conditions and ready access to drugs of addiction pose a unique risk to anaesthesia and pain medicine practitioners. The purpose of this document is two-fold:

1.1 To provide a guideline for the approach to workplace management of the practitioner with possible or proven anaesthesia medication related substance use disorder (AMR SUD).

1.2 To provide specific and practical advice to guide anaesthetists, clinical leaders and hospital management in the coordination and administration of tasks necessary to manage such practitioners responsibly and fairly.

2. Scope

This document is intended to apply to all specialist anaesthetists, anaesthesia practitioners, specialist pain medicine practitioners, specialist international medical graduates (SIMGs) and anaesthesia and pain medicine trainees.

It is not intended to apply to non-anaesthetist sedationists, nurses and technicians although it is recognised that the principles may be applicable.

This guideline focuses on AMR SUD based on exposure to medications used in the operating theatre (including, but not limited to, opioids, propofol, ketamine, benzodiazepines and inhalational agents), and the procedural environment, recognising that concurrent misuse and addiction to other substances including alcohol may apply. The principles may apply to all SUDs such as alcohol abuse.

It is not a guideline for the clinical/therapeutic management of affected practitioners.

Whilst it is not a definitive guideline for facility administrative processes it is recognised that the principles may apply.

The term head of department is used for the position of facility professional clinical lead, who may otherwise be known as clinical director or craft group leader.

3. Background

This professional document proposes a holistic, individualised, departmental and management approach with a focus that is inclusive with a view to practitioner, patient and staff safety and welfare.

The aims of the guideline are to:

3.1 Encourage a safe, holistic, compassionate, evidence-based, timely approach to recognition, intervention, referral to appropriate care, rehabilitation and return to work of the practitioner with suspected or diagnosed AMR SUD.

3.2 Focus on providing a safe and inclusive work environment for the practitioner with AMR SUD whilst recognising the serious nature of the condition that requires lifelong commitment by the practitioner and long-term support from the work environment.

3.3 Provide guidance and shared understanding to all practitioners and managers including heads of department, colleagues, medical administrators, treating practitioners as well as the regulatory authorities and employers, of:

- The condition.
- The unique context of anaesthesia.
- The high fatality rate.
- The complexities and expected processes of managing a safe return to work, whilst meeting many competing requirements.

3.4 Provide guidance on how to manage relapse such that the public, the practitioner, and colleagues in the work environment feel and remain safe.

4. Substance use disorder (SUD)

SUD is a chronic disease of the brain mediated via the reward centres with distinct biochemical changes leading to compulsive substance use and loss of self-control. It requires diagnosis by a specialist and may be classified as mild, moderate or severe (Appendix 1).

It is important to acknowledge that SUD is a serious illness. Loss of self-control and denial are features of the disease and should not be regarded as moral failure.

Practitioners with AMR SUD form a subset of SUD with a particularly high mortality. Attention should be focused on prevention and early diagnosis.

Every case is unique. Practitioners may present on a spectrum of behaviours which can broadly lie within the following **five patterns** including:

1. As a colleague in distress due to a variety of triggers without evidence or signs of substance misuse.
2. As a colleague with substance misuse of non-anaesthesia prescription or recreational drugs including alcohol.
3. As a colleague with out-of-work criminal charges related to illicit substance possession or misuse.
4. As a colleague with more subtle or increasing signs of distress and mounting evidence of anaesthesia substance misuse.
5. As an intoxicated or impaired colleague with direct evidence of using anaesthesia or non-anaesthesia drugs in the workplace.

4.1 Risk factors for substance misuse, abuse and SUD

4.1.1 Anaesthetists and pain medicine practitioners often work in stressful environments and may be part of poorly functioning teams or lack adequate support at work or home.

4.1.2 Pre-existing health conditions, such as pain, insomnia, or mental health disorders may be exacerbated by their work.

4.1.3 Personal characteristics that can contribute include stressful life events, perfectionist tendencies, maladaptive coping strategies, and competition for employment and career advancement.

4.1.4 Social and emotional trauma, experiences of racism, discrimination and harassment can contribute to risk.

In all these contexts, the easy access to potent sedative and opioid agents presents a significant risk.

For a list of risk factors see appendix 2.

4.2 Warning signs of SUD

There are extensive non-specific warning signs which may include changes in behaviour, prescribing and patient outcomes. It is a summation of all observed features.

For a list of warning signs see appendix 3.

5. Substantiation (in the case of increasing concerning reports)

There is a need to balance natural justice with patient safety and practitioner wellbeing as well as the urgency of the presentation.

5.1 In cases where substance misuse is suspected, reports of potentially impaired anaesthetists should be supported by credible evidence and investigated in a timely manner with confidentiality to protect the practitioner's rights whilst recognising the responsibility to safe patient care. Graded interventions are required (see appendix 4).

5.2 Concerns may also arise from patient outcomes, such as higher report rates of inadequate pain relief or critical incidents. Additionally, a decline in clinical performance, including documentation errors or inconsistent care may be noted.

5.3 Behavioural changes, such as increasing isolation, erratic behaviour, frequently leaving the operating theatre, absenteeism, or mood swings, may also be indicative of impairment.

5.4 Physical or cognitive signs of impairment, such as slurred speech or frequent fatigue, are further examples.

Identifying substance misuse/SUD patterns is essential for ensuring both patient safety and the wellbeing of the practitioner.

Substantiation of concerns should be confirmed confidentially as soon as possible by the head of department and/or a few trusted medical or nursing colleagues. Gathering information should be prompt as undue delay may result in a tragic outcome. The head of department should make records of all information. Early involvement of the facility director of medical services, or equivalent, is advised.

6. Interventions

The approach to intervention is unique to each case and can be considered in five basic patterns of behaviours associated with escalating concerns/issues in the practitioner, ranging from a troubled colleague with no substance use through to suspected substance use disorder.

6.1 A troubled colleague

6.1.1 A colleague may be in distress without signs of substance misuse. The possible causes include issues with personal physical or mental health, family issues, or stressors including racism, financial, examinations, fatigue, a critical incident, negative staff interactions or a complaint.

6.1.2 Recreational or non-anaesthesia substance use/abuse may be an issue.

6.1.3 In the absence of risk to patients and staff, and if the practitioner is not perceived to be in crisis, this can be managed at a local level with appropriate referral to other skilled practitioners, including optimisation of the practitioner's cultural safety.

6.1.4 The colleague should be offered time off or reduced workload if required and ongoing liaison and support should occur till the problem approaches resolution.

6.1.5 Early intervention aims to minimise the risk of deterioration of circumstance which may be more detrimental to the practitioner including substance misuse or SUD.

6.2 A colleague with substance misuse/SUD of non-anaesthesia prescription or recreational drugs

As per 6.1. Drug use may impact on practitioner health, performance and patient safety and action might need to be more targeted. Graded intervention with facilitated referral to GP or addiction specialist is required.

6.3 A colleague with out-of-work criminal charges related to illicit substance possession or misuse

This is a matter for resolution by the director of medical services in consultation with the practitioner, their legal representative and the regulator.

Support and assistance should be offered.

6.4 A colleague with or without signs of distress, but mounting evidence of anaesthesia substance misuse

Every case will be different, and the approach will need to be tailored accordingly.

6.4.1 As an initial response, colleagues should report their concerns to the head of department. It is then up to the head of department to respond accordingly.

6.4.2 Support and assist the practitioner.

6.4.3 The level of response should be tailored according to the urgency and magnitude of events. A carefully planned intervention interview with the practitioner should be conducted sensitively with adequate support for the practitioner, who is vulnerable and may be very distressed when confronted.

6.4.4 It may be necessary to intervene even though evidence may be ambiguous.

6.4.5 As a matter of patient and practitioner safety, the doctor should be willing to provide a urine test and /or hair sample to their employer/facility (see item 6.5.4).

6.4.6 The head of department needs to ensure support for colleagues who may have been involved in reporting. They also have a duty to prevent and/or control gossip. The practitioner has a serious illness and deserves respect and confidentiality. Nevertheless, there is often significant moral injury which requires careful navigation and leadership.

6.4.7 If the doctor has little insight, or is in denial, resolution is much more difficult. If the substantiating reports are considerable, it is more likely that the practitioner will admit there is a problem. Continue to support and advise using a graded response. If appropriate, consider making a voluntary notification to the regulator. Ensure that the medical executive is involved in the process.

6.5 An intoxicated or impaired colleague with direct evidence of using anaesthesia substances in the workplace. This is a crisis requiring immediate action

6.5.1 Immediately ensure any relevant patient is safe and that the practitioner is medically safe. Arrangements should be made for cover for the practitioner's patients/list.

6.5.2 An intervention interview needs to be urgently convened (as per appendix 4).

6.5.3 Mandatory notification to the regulator is required.

6.5.4 Facilities should consider having a drug and alcohol policy which allows for drug screening on request preferably with an independent pathology facility A practitioner should then expect to provide a contemporaneous urine sample and/or hair sample for drug screening if requested, with attention to direct supervision and chain of custody requirements. Such a policy does not include screening for monitoring.

6.5.5 It should be recognised that the practitioner will be under significant distress. Facilitated involvement of their partner or other suitable support person, GP, Addiction Services or other available support services can be lifesaving.

6.5.6 As the risk of self-harm in this period is particularly high the practitioner should not leave the facility alone and should be supported.

Appendix 4 contains a summary table and detail on the graded approach to each presentation based on the Vanderbilt model.

7. Specific roles and responsibilities

7.1 Head of department

7.1.1 Case management

7.1.1.1 The head of department, or a delegate, as a clinical professional leader must lead any intervention as well as the return-to-work process, supported by medical administration.

7.1.1.2 Needs to ensure support for colleagues who may have been involved in reporting.

7.1.1.3 Must uphold the principles of natural justice as well as control and prevent gossip. The practitioner has a serious illness and deserves respect and confidentiality.

7.1.2 Department preparedness

7.1.2.1 There is a need to educate all practitioners and proactively establish a system approach to the administrative management of SUD.

7.1.2.2 Must ensure the hospital systems for the control of medications including storage, dispensing and disposal of anaesthesia drugs (including inhalational agents) are reviewed, promulgated and audited.

7.1.2.3 Should establish a wellbeing advocate and/or committee that should consider issues of work-life balance including rostering, work hours and department culture.

7.1.2.4 Should, if possible, convene a substance use committee to develop a plan including identifying potential SUD support services in advance of issues arising. These may include transfer of care for an affected practitioner to an urban centre if in a rural facility there are concerns about practitioner confidentiality or that the environment cannot provide best practice care. Liaison with local GPs or a GP with special interest in addiction who can see them urgently or other support services is recommended. Doctors' Health Advisory Services are invaluable in providing immediate, confidential advice and referral. The plan should be readily available in the department/practice.

7.2 Medical administrators

7.2.1 Need to protect patients, the public and staff, ensure the practitioner remains safe and reduce reputational risk.

7.2.2 Decisions and arrangements need to be made with the practitioner, head of department and other relevant clinical directors, for leave, credentialing and any legal obligations[1].

7.2.3 Need to advise the practitioner to report the issue to other facilities at which they work and to inform their Medical Defence Organisation.

7.2.4 There may be employment and industrial relations requirements that will be guided by the relevant Human Resource (HR) department.

7.2.5 Disciplinary proceedings may be initiated by the facility if drugs have been perceived to have been diverted or stolen; where possible, consideration should be given to delaying any disciplinary proceedings until the practitioner is well, taking into account other considerations relating to timing. Any decision to institute disciplinary proceedings relating to conduct is based on the local legislative environment, policies and by-laws and should be based on sound evidence.

7.2.6 Management of AMR SUD within the setting of private practice or the practitioner practicing at multiple locations is challenging. Decisions in the private sector will be contingent on the bylaws of the organisation, and it may be that contracts can be terminated, credentialing withdrawn possibly with no obligation to support the practitioner. With ongoing commitment by the recovering anaesthetist, the support of private hospital administration, colleagues and good communication with treating practitioners, a supervised return to work within the private sector may be possible. The reintegration of anaesthetists with SUD into a structured public anaesthetic department with a higher level of supervision and resources may be a desirable option. The achievability of this is dependent on the cooperation of a range of stakeholders, state Health authorities and department heads and needs to be negotiated.

7.3 Regulatory bodies

7.3.1 Mandatory obligations apply once there is reasonable belief that concerns about SUD are valid

7.3.1.1 Mandatory notification to the regulator, although the responsibility of all associated practitioners, will generally be performed by the most senior person, and where appropriate should be done in conjunction with the hospital director of medical services.

7.3.1.2 The practitioner can be helped to self-notify, or it can be undertaken by the medical administrator. If a self-notification, it is important to ensure that this is done satisfactorily.

7.3.1.3 For a regulator self-notification may demonstrate a degree of insight and perhaps indicates a willingness to embark on treatment and rehabilitation.

7.3.2 After a mandatory notification the regulator will typically call an urgent process to assess risk to the public.

7.3.2.1 Usually, conditions are imposed and coordination between the regulator and treating practitioners will determine when the return to work is likely to occur. When supervised by the regulator regular reports will be submitted to determine lifting of conditions.

7.3.2.2 The regulator is responsible for protecting the public, not supporting the impaired practitioner or their colleagues. Regulatory response is legalistic and takes time for due process.

7.3.2.3 It may be a significant period of months to years before a practitioner is allowed to resume practice, depending on progress in their rehabilitation process, as reported by treating doctors.

7.4 Treating practitioners

7.4.1 Confidential access to quality multidisciplinary treatment and ongoing care by a General practitioner (GP) and specialists is required.

7.4.2 Coexisting substance use and mental health diagnoses is common and needs to be managed concurrently. Complete abstention is required before return to practice.

7.4.3 The possibility of relapse needs to be considered, and a contingency plan made readily available with the practitioner and treating practitioners. This should include the possibility of not returning to work in their specialty and consideration of other work options.

7.4.3.1 Toxicology tests to monitor for relapse are usually part of monitoring by the regulator and include both hair and urine/blood at specified laboratories.

7.4.3.2 The head of department and the medical administrator should know, as part of the return to work agreement, contact details for a support person as well as treating practitioners in the event of an impending or actual relapse.

7.4.4 Active and open engagement with the process by the practitioner is related to long term success.

7.4.5 The support of a colleague who is a mentor and support person is linked to recovery.

7.4.6 Self-help groups such as Doctors in Recovery are recognised as invaluable[2].

7.5 Practitioner with SUD

7.5.1 In the acute phase, attention needs to focus on keeping patients safe and ensuring the practitioner obtains treatment and rehabilitation.

7.5.2 It is imperative that ultimately the practitioner realises and accepts that they have a lifelong illness and they need commitment to becoming and staying well. As with other illnesses, they need to comply with and work within the restrictions that may be imposed.

7.5.3 There needs to be insight into the breach of the social contract with society that underpins medical professionalism that has occurred. This includes the breach of trust of colleagues.

Practitioners have an obligation to respect and uphold Good Medical Practice[3,4], and ANZCA's Supporting Professionalism and Performance[5], as well as meet the very high societal expectations of professional behaviour in return for their privileged position.

7.5.4 Active and open engagement with the process by the practitioner is related to long term success.

8. Return to work (RTW)

Returning to work after treatment is a complex process that requires careful coordination and alignment with therapeutic goals. It may be months to some years before the practitioner is judged by treating specialists to be rehabilitated enough that this can occur. It should be noted that for some practitioners serious consideration should be given to alternative work.

8.1 RTW is usually determined by the treating specialist(s) in conjunction with the regulator (if involved).

8.2 Similar to other injuries, before an RTW input from the treating practitioners must be sought regarding the scope of practice, the number of hours that can be safely worked and any necessary safety measures. It is common for the practitioner to experience stress, anxiety and tiredness.

8.3 The progressive RTW program must be designed in cooperation with the treating specialist(s). The practitioner can consent to such discussions, with the treating practitioners only disclosing information necessary for this part of the process. Such consent to correspond with treating doctors should be regarded as a necessary, non-optional precondition for RTW.

8.4 RTW will involve considerations such as identifying a suitable setting, organising medical and administrative arrangements, scope of practice, supervision, work hours and on-call restrictions, mentoring, drug testing, and meeting regulatory requirements. The RTW program should set progress goals for increasing autonomy and ongoing support.

8.5 It may be beneficial to have multiple supervisors in the RTW plan.

8.6 Despite every effort not everyone is able to return to work in their specialty.

9. Relapse

9.1 A clear relapse management plan should be established from the outset

9.1.1 There should be recognition that relapse may occur.

9.1.2 The RTW plan should include contact details for support persons and treating practitioners.

9.1.3 Relapse will result in immediate notification of the regulatory body.

9.2 Vocational advice should be sought if returning to anaesthesia is no longer feasible. Given the high risk of death associated with substances like propofol and inhalational agents, particularly in cases of relapse, this step is critical to ensuring practitioner safety[6].

9.3 The RTW plan should function as a signed collaborative agreement, ensuring transparency and accountability.

9.4 The head of department should manage how information about the practitioner is shared within the department, ensuring confidentiality while fostering a supportive environment. Some practitioners have found sharing information about their condition with colleagues on their return to work helpful, providing they feel safe, and there is a commitment to minimising corridor gossip and destigmatising the disease. This is an individual decision.

It is acknowledged that RTW is usually challenging. There are both patient and practitioner safety issues to consider including the capacity of a facility to facilitate supervision and oversight.

10. Education on SUD

10.1 Education of all practitioners about SUD is essential and should be ongoing.

10.2 Education should include contemporary information about risk factors, the scale of the problem, the SUD disease process, signs and symptoms of substance abuse at home and the workplace, the process to follow if concerned about a colleague, process and issues of treatment and re-entry and include agencies available if need to seek help.

10.3 Discussion of these issues should occur in dedicated education sessions, allowing discussion of issues and concerns.

10.4 Anaesthetists should be encouraged to discuss these issues with family and friends as signs and symptoms often appear at home prior to the workplace.

10.5 Every doctor should have their own GP (PG49(G) Practitioner health).

11. Drug testing in the workplace

Many high-risk industries have drug testing in the workplace. There is no legal requirement or impediment in Australia or New Zealand to having such drug testing. Ideally a comprehensive workplace drug and alcohol policy should be in place, outlining the objectives, limits and consequences of a program to prevent and control the impact of drug use in the workplace. All facilities are encouraged to develop such a policy to be agreed to as a condition of employment.

12. Summary

12.1 SUD is a serious lifelong disease that requires skilled intervention and a lifelong commitment by the practitioner to get well and stay well. When involving drugs used in the anaesthesia and pain medicine environment it is particularly challenging due to the significant risks and the unique work environment. In cases where irrefutable use in the workplace is detected, an urgent intervention is

necessary. However, for most situations, a carefully planned approach, supported by corroborating evidence, is recommended.

12.2 Each case is unique, requiring a thoughtful and sensitive response with a clear plan for the next steps. It is essential that the practitioner feels supported and understands that the process is primarily concerned with the welfare of the practitioner and the public. At the early stages, disciplinary actions should not be discussed, as the priority is to temporarily remove the practitioner from the clinical environment to protect patient safety and ensure the practitioner receives timely medical and psychological care.

12.3 The RTW plan should be developed collaboratively by an interdisciplinary team and executed with care to support the practitioner's recovery and reintegration. It is essential for the practitioner to demonstrate insight, acceptance, honesty and full cooperation to obtain an optimal outcome, although this is not always achieved. The development of these factors should be progressively assessed during recovery and rehabilitation. Plans for management of relapse are an integral part of any RTW plan.

12.4 Not all practitioners can return to work in anaesthesia or pain medicine practice and support and vocational guidance are necessary to divert them to other meaningful work.

12.5 The principles of this document should apply in all settings.

See further below for appendices. This document is accompanied by a background paper (PG48BP) which provides more detailed information regarding the rationale and interpretation of the Guideline.

References

1. NSW Health. Managing Complaints and Concerns about Clinicians [Internet]. Available from: https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2018_032.pdf.
2. Australia and New Zealand College of Anaesthetists. Wellbeing: Networks & support [Internet]. 2025. Available from: https://libguides.anzca.edu.au/wellbeing/networks
3. Medical Board of Australia. Good medical practice: A code of conduct for doctors in Australia. Australia 2020.
4. Medical Council New Zealand Te Kaunihera Rata o Aotearoa. Good medical practice. New Zealand 2021.
5. Australia and New Zealand College of Anaesthetists. ANZCA Supporting professionalism and performance – A guide for anaesthetists and pain medicine physicians [Internet]. 2024. Available from: https://www.anzca.edu.au/getContentAsset/9017d13b-7288-4cd0-8e34-f5e0476ba574/80feb437-d24d-46b8-a858-4a2a28b9b970/ANZCA-Professionalism-Performance-Guide_2024.pdf?language=en
6. Fry RA, Fry LE, Castanelli DJ. A retrospective survey of substance abuse in anaesthetists in Australia and New Zealand from 2004 to 2013. Anaesth Intensive Care. 2015; 43(1):111-7.

Relevant documents

PG49(G) Guideline on the health of specialists, specialist international medical graduates and trainees

PG43(A) Guideline on fatigue risk management in anaesthesia practice

PG13(PM) Guideline on return to pain medicine practice for specialist pain medicine physicians

PG50(A) Guideline on return to anaesthesia practice for anaesthetists

PG51(A) Guideline for the safe management and use of medications in anaesthesia

PS57(A) Position statement on duties of specialist anaesthetists

ANZCA Handbook for training

FPM Training Handbook

Standards for Anaesthesia

Supporting Professionalism and performance- A guide for anaesthetists and pain medicine physicians

Promoting good practice and managing poor performance in anaesthesia and pain medicine

Advisory statement on the storage of propofol in clinical settings (endorsed document)

Professional documents of the Australian and New Zealand College of Anaesthetists (ANZCA) are intended to apply wherever anaesthesia is administered and perioperative medicine practised within Australia and New Zealand. It is the responsibility of each practitioner to have express regard to the particular circumstances of each case, and the application of these ANZCA documents in each case. It is recognised that there may be exceptional situations (for example, some emergencies) in which the interests of patients override the requirement for compliance with some or all of these ANZCA documents. Each document is prepared in the context of the entire body of the College's professional documents, and should be interpreted in this way.

ANZCA professional documents are reviewed from time to time, and it is the responsibility of each practitioner to ensure that he or she has obtained the current version which is available from the College website (www.anzca.edu.au). The professional documents have been prepared having regard to the information available at the time of their preparation, and practitioners should therefore take into account any information that may have been published or has become available subsequently.

Whilst ANZCA endeavours to ensure that its professional documents are as current as possible at the time of their preparation, it takes no responsibility for matters arising from changed circumstances or information or material which may have become available subsequently.

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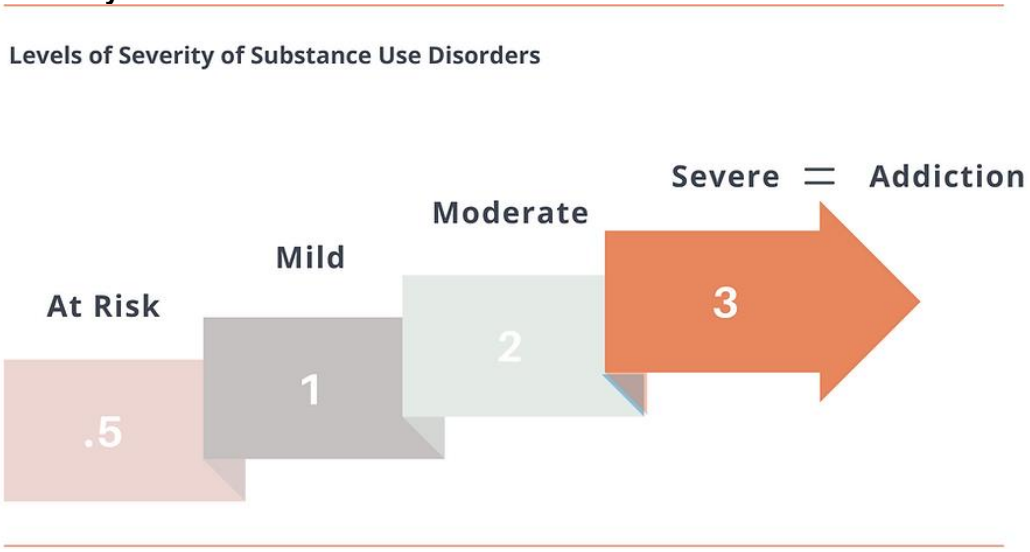
Appendix 1 – DSM 5 criteria for diagnosis of substance use disorder (SUD)

Warning signs are different from diagnostic criteria. The grading of SUD is made by the treating psychiatrist/addiction specialist according to the DSM criteria for the diagnosis of substance use disorder. 'Use' does not necessarily equate to SUD.

Categories of substance use disorder symptoms

1. Taking more of the substance or using it for longer than intended.
2. Trying unsuccessfully to cut back or quit.
3. Spending lots of time either getting or using substances or recovering from their effects.
4. Experiencing craving, or the strong urge to use substances.
5. Failing to fulfill obligations at work, school, or home as a result of substance use.
6. Continuing to use substances despite the consequences that occur.
7. Cutting back on or giving up activities or social engagements to use substances.
8. Ending up in dangerous situations as a result of substance use.
9. Using the substance despite it making existing conditions worse, or causing new ones.
10. Developing tolerance, i.e. the need to take more to achieve the desired effect.
11. Experience symptoms of withdrawal after not using the substance for some time.

Grading of severity of substance use disorder



Appendix 2- Risk factors for substance misuse, abuse and SUD

Risk factors for developing substance dependence

- Parental history of alcohol or drug abuse (even when adopted at birth)
- Childhood abuse—physical, emotional, or sexual
- Dysfunctional family/lack warmth and support
- Racial discrimination
- Sexual harassment
- Gender discrimination
- Having another mental health disorder
- Being male
- Experimenting with drugs/alcohol at young age
- Peers who use drugs
- Tendency for doctors to self-medicate
- Sense of professional immunity from addiction

Additional risk factors specific to anaesthetists

- Direct contact with drugs (anaesthetists are generally the only doctors to give drugs directly, rather than by proxy via a prescription)
- Daily exposure to highly potent and addictive opiates and sedatives—drugs most other doctors do not encounter
- Drugs are immediately available
- Only small volumes are required, so easy to remove (divert)
- Drug abuse as a student may encourage trainees to enter the speciality hoping for easy drug access

Appendix 3- Warning signs for SUD

Some of the changes typically observed in the affected practitioner include, but are not limited to, the following:

- Withdrawal from family, friends, and leisure activities
- Mood swings, with periods of depression alternating with periods of euphoria
- Increased episodes of anger, irritability, and hostility
- Spending more time at the hospital, even when off duty
- Volunteering for extra call
- Working primarily after hours
- Refusing relief for lunch or coffee breaks
- Wearing long sleeves
- Requesting frequent bathroom breaks
- Signing out increasing amounts of narcotics or quantities inappropriate for the given case
- Discrepancies in drug records
- Frequent request to access controlled drugs
- Weight loss and pale skin
- Frequent episodes of patients with unusually inadequate analgesia in the immediate postoperative period despite the anaesthesia record showing appropriate doses of opioids

Appendix 4 – Summary table and suggested responsibilities for the management of affected practitioners

Summary table for the management of distressed colleagues:

Type 1 As a colleague in distress due to a variety of triggers without evidence or signs of substance misuse

Type 2 As a colleague with recreational or non-anaesthesia prescription drugs substance misuse

Type 3 As a colleague with out-of-work criminal charges related to illicit substance possession or misuse

Type 4 As a colleague with more subtle signs of distress but mounting evidence of substance misuse

Type 5 As an intoxicated or impaired colleague with direct evidence of using anaesthesia substances in the workplace (crisis)

Types	*Head of department	Medical administrator	Mentor	Regulator Notification	MDO	Evidence gathering
Type 1	Y Initial RUOK empathic probing confidential conversation encouraging self-care	N Unless a patient safety risk then Y	Y	N	N unless a critical incident or significant complaint	N
Type 2	Y Initial RUOK empathic probing confidential conversation encouraging self-care. May need to escalate to insistence on seeking help or face being stood down	N Unless a significant critical event or complaint	Y	N Unless treating practitioner decides there is public risk Intoxication at work would meet criteria for mandatory notification	Probably N	N
Type 3	Y Ensure adequate support and referral has occurred. Guidance from medical administrator	Y	Y	Y Practitioner notification	Y	N
Type 4	Y Must act on expressions of concern Commence information gathering Notify medical administrator of impending need for an intervention interview	Y	Y	N (till interview) Mandatory Encourage practitioner to notify but must ensure it is done satisfactorily	N (after interview) Medical advisers can be helpful to practitioner	Y confidential timely

Type 5	Y Ensure practitioner and their patients are safe Need to notify medical administrator and arrange an urgent intervention interview Practitioner must cease work immediately and alternative cover organised for their patients Arrange a support person for the practitioner to attend the hospital and care for them Try and contact suitable clinical/therapeutic support for immediate care if practitioner consents If a trainee, the SOT needs to be notified, and they notify ANZCA in due course	Y Suspend practitioner or ask them to voluntarily step down/relinquish credentialing Outline next steps: Professional therapeutic help Regulator notification HR notification Leave & remuneration arrangements Other medical tasks may apply such as working within managing misconduct policies	Y	Y Mandatory If practitioner is able, encourage to self-notify with guidance/supervision to ensure it is done satisfactorily	Y (after interview)	N

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*Head of department or craft group representative or senior colleague(s) or supervisor of training

1. A potential graded intervention and management of practitioners

Every case will be different and the approach will need to be tailored accordingly.

1.1 Colleagues who are concerned should report their concerns to the head of department. That individual should lead and coordinate any process and respond according to the needs of the situation.

1.2 Suggestions for early interventions include one or more general ‘RUOK’ conversations

1.3 Gather information and corroborate any concerns regarding issues such as patient incidents, staff interactions, prescribing practices and anaesthesia records.

1.4 Continue to support the practitioner and ensure the practitioner is medically safe.

1.5 The level of response should be tailored according to the urgency and magnitude of events. As information is gathered, an intervention interview with the practitioner should be planned carefully and sensitively with adequate support for the practitioner, who is vulnerable and may be very distressed when confronted.

1.6 The intervention interview should be conducted by 2 or 3 senior individuals such as the head of department (or delegate)/craft group representative, a department welfare officer if available, and a medical administrator, which may reasonably be varied according to the skills and resources available in each situation. Cultural safety should be optimised.

1.6.1 A professional colleague should be available to act solely as the support person for the practitioner.

1.6.2 The interview should be held in a quiet confidential space, concern for the practitioner expressed and evidence presented.

1.6.3 The practitioner should be given time to respond.

1.6.4 The initial focus needs to be on getting the practitioner to express that they have a problem, whilst offering empathy, help and support.

1.7 Clear processes need to be mapped for the practitioner that may include:

1.7.1 Immediate cessation of duties at the workplace with discussion of type of leave and remuneration if appropriate.

1.7.2 If not present, identification of a suitable support person/s at the workplace and/or at home

1.7.3 Contacting any external support person to come to the hospital, explain the situation and take the practitioner to their GP and then home.

1.7 4 Notification to the regulator.

1.7.5 Report to other facilities at which they work.

1.7.6 The practitioner should not be allowed to leave the hospital alone.

During the interview, available treatment options, such as seeing an addiction physician or addiction psychiatrist, as well as the importance of seeing their GP, should be highlighted. If the doctor agrees, expedited referrals to these clinicians may be helpful. It is also important to emphasise that regulators and hospital administrators will be more reassured about their safe return to work if there is documented evidence of structured treatment, such as detoxification in an inpatient facility if necessary, and support letters documenting their participation in the treatment from suitably qualified clinicians, including the doctor's GP and the treating specialist.

When intoxication or direct evidence of use of substances in the workplace is evident urgent assessment post interview by Alcohol, Tobacco and other services (ATODS), addiction medicine or liaison psychiatry should ideally occur to assess the need for detoxification. However, given the pressure on mental health services this may not be feasible. It is then essential that the practitioner sees their GP urgently or attend the emergency department if required.

1.8 As a matter of patient and practitioner safety, the doctor should be willing to provide a contemporaneous urine test and/or hair sample to their employer/facility. Facilities should consider developing policies that mandate drug testing and ensure attention to direct supervision and chain of custody of samples.

1.9 The head of department needs to ensure support for colleagues who may have been involved in reporting concerns. The head of department has a duty to prevent and to control gossip. The practitioner has a serious illness and deserves respect and confidentiality. Nevertheless, there is often a significant moral injury to others which requires careful navigation and leadership.

1.10 If the doctor has little insight, or is in denial, resolution is much more difficult. If the evidence is considerable, it is more likely that they will admit there is a problem.

2. Return to work

Returning to work after treatment is a complex process that requires careful coordination and alignment with therapeutic goals. It may be months to years before the practitioner is judged by their treating specialist to be rehabilitated enough to ensure this can occur.

2.1 Return to work is usually recommended by the treating specialist(s) in conjunction with the regulator if involved.

2.2 Similar to other significant injuries or illnesses before a return to work, input from the treating practitioners must be sought regarding the number of hours and duties that can be safely worked and any necessary safety measures. Stress, anxiety and tiredness are common.

2.3 The progressive return to work program should be designed in cooperation with the treating specialist(s). The practitioner can consent to such discussions, with the treating practitioner only disclosing information necessary for this part of the process.

It should be required for the practitioner to consent to the involvement of their treating doctor (best to be a specialist experienced with addiction medicine) as a necessary pre-condition to embark on a return-to-work program.

2.4 It will involve considerations such as identifying a suitable setting, organising medical and administrative arrangements, graduated scope of practice, supervision, work hour restrictions, mentoring, drug testing, and meeting regulatory requirements. Care is often fragmented, with limited communication between the practitioner, their treating physicians, the hospital and department and the regulator, resulting in a lack of shared knowledge and oversight.

2.4.1 An agreed set of goals and corresponding actions must be established, with all parties—practitioner, clinical director/Head of Department, and medical administrator — clearly understanding their roles.

2.4.2 If the treating practitioner does not agree to be involved, another suitably trained specialist should be engaged to do so. Need an expert opinion, ongoing, independent of the workplace, but well informed about the work.

2.4.3 This agreement should outline expectations, as well as provide contact details for support persons and treating practitioners, allowing for any concerns about the practitioner to be addressed in a timely manner while respecting confidentiality and principles of fairness.

2.4.4 The return to work plan should be carefully detailed, including supervision requirements, limits on working hours, how duties should be escalated, and ongoing liaison with the treatment teams.

2.4.5 Monitoring through drug testing (urine drug screens and hair analysis) by an independent pathology centre should be part of this plan if the regulator is not involved. In this scenario, advice should be sought from suitably qualified clinicians regarding the nature and the duration of the monitoring.

Note that the USA programs recommend drug testing at diminishing frequency and oversight **for at least 5 years.

Appendix 5

Return to Work supervision arrangements and expectations

This is a guide indicative of the detail that may be required in a return to work plan. It should be modified to suit each individual circumstance..

Supervision requirements can only be updated when the whole supervisor group meets consensus.

- There needs to consensus between Ahpra accredited supervisors, and agreement with hospital administration.
- There will be approximately 6 calendar months of 1:1 supervision. Stepdown to 2:1 or other arrangement will be guided by Ahpra and work performance.
- Work will be 2 days per week with direct 1:1 supervision by Ahpra approved supervisors at a single facility only. Work cannot take place if a supervisor is not available on a given day. A supervisor must be present at all times.
- Facility card access to be limited by Security to 07.45-18:00 to specified locations (eg. anaesthetic department, main theatres but excluding medication room).
- Weekdays only and work limited to the Main Operating Theatre complex (No off-floor sites)
- Personal clothing to be worn to work and change into Hospital issue scrubs at work in the main change rooms. Personal clothing to be worn home after work completion.
- No bags to be taken into theatre
- No Pyxis/medication storage access
- No initial drawing up of schedule 8 drugs except for spinal/epidural administration under sterile conditions.
- Administration of Schedule 8 drugs will be verified pre and post administration by supervisor similar to requirements for RNs
- Elective lists and straightforward trauma lists only. Not to work in acute emergency theatre or conduct acute emergency cases in an elective theatre unless they are Cat C or D without time pressures.
- Opioids left over from Spinal anaesthetics will be discarded by the Supervisor as soon as the spinal dose has been drawn up.
- Tea breaks will be taken at the same time as the Supervisor and relief will be requested from another suitably senior anaesthetic registrar or consultant. There should be an effort to remain generally visible to other staff where possible.
- Toilet breaks will be taken in the main theatre complex toilets not stand-alone cubicles
- There will be no handling of drugs in Recovery areas and supervisors will accompany the practitioner to recovery
- Registrars will not initially be rostered in the same theatre.

References for Appendices

Appendix 1a

Hawaii Island Recovery. Substance use disorder, causes, signs and symptoms, treatment. Section: Is Substance Use Disorder in the DSM? [Internet]. Available from: https://hawaiianrecovery.com/rehab-blog/substance-use-disorder-signs-symptoms-treatment. Accessed 2 Jun 2025.

Appendix 1b

Addiction Policy Forum. DSM-5 criteria for addiction simplified [Internet]. 2020. Available from: https://www.addictionpolicy.org/post/dsm-5-facts-and-figures. Accessed 2 Jun 2025.

Appendix 2

Berry A, Arnold W. Chemical dependence in anesthesiologists: What you need to know when you need to know it. Park Ridge, Illinois, American Society of Anesthesiologists Task Force on Chemical Dependence of the Committee on Occupational Health of Operating Room Personnel. 1998.

Appendix 3

Mayall R. Substance abuse in anaesthetists. BJA Education. 2015; 16(7):236-41.

Appendix 4

Created by G Goulding FANZCA & M Mulligan FANZCA. Based on Vanderbilt Centre for Patient & Professional Advocacy: Promoting professionalism Pyramid tiered intervention approach.

Appendix 5

A deidentified actual return to work supervision plan.