Almost Everything You Want to Know about the AANA’s Peer Assistance Advisors Committee

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Since its inception as an AANA ad hoc committee more than 27 years ago, the primary purpose of the Peer Assistance Advisors Committee (PAAC) has been to reduce the loss and suffering that our professional community experiences as a result of chemical dependency, a devastating occupational hazard for anesthesia professionals and their patients. The PAAC is currently an ongoing, fully recognized, AANA committee. For an in-depth historical review of the committee’s history see The AANA Journal Imagining in Time column by former PAAC Chair Diana Quinlan, CRNA, MA.1

Despite the growing awareness of the risks of chemical dependency and concerted efforts to reach out to the anesthesia community over the past 27 years, the data concerning the epidemiology of chemical dependency among anesthesia professionals are particularly alarming. Donald Bell’s study in 1999 found that nearly 10 percent of CRNAs were misusing controlled drugs.2 This does not include alcohol, nicotine, and prescription medications. The implications for patient safety and provider health are staggering. The recent emergence of propofol as a drug of abuse and addiction has raised the stakes substantially.

The one take-home message from the PAAC that we would like to stress is that our goal, first and foremost, is to save lives, and second is to help resurrect anesthesia careers, but only when and where appropriate. Reentry into clinical anesthesia practice can be an incredibly high-risk proposition, and not every clinician is going to be able to reenter safely. The issues and processes relating to reentry into clinical practice will be reviewed in a future article.

Signs and Symptoms of an Impaired Colleague

The Peer Assistance Advisors respond to the hotline (800) 654-5167 calls 24/7; all calls are confidential. The most common call fielded revolves around choosing the appropriate course of action when it is suspected that a colleague is impaired. The more common behaviors associated with impairment that should raise the index of suspicion occur when an individual:

• Comes to work during scheduled time off and loiters around the department drug supply.
• Isolates him or herself and withdraws from peers.
• Takes frequent bathroom breaks or disappears while on duty.
• Expresses a desire to take extra call.
• Displays a gradual decline in work performance.
• Consistently signs out more narcotics than peers.
• Displays patterns of inappropriate drug choices and dosages.
• Exhibits increasing mood liability with frequent, unexplained anger and overreaction to criticism.
• Experiences increasing difficulty with authority.
• Becomes forgetful, unpredictable, confused, and lacks concentration.
• Suffers from frequent illnesses or physical complaints.
• Exhibits dishonesty, often over trivial or unimportant matters.
• Makes elaborate excuses.
• Suffers from tremors or “Monday morning shakes”.
• Reveals evidence of alcohol or drug use, such as odor of alcohol on breath, heavy perfume or mouthwash.
• Wears long sleeves.
• Appears intoxicated at social functions.
• Is discovered comatose or dead.

When it is confirmed that a colleague is impaired and an intervention is indicated, it should be appreciated that an intervention represents an opportunity to do tremendous good or serious, potentially lethal, harm. The single most critical component is that an adequate preintervention assessment be conducted and that all appropriate psychological resources are in place prior to any attempt to intervene. The first phase of the process is information gathering and documentation. This includes:

• A review of work behaviors and performance evaluations.
• Analysis of controlled substance utilization, clinical records, and observations of specific behaviors by colleagues and supervisors with particular attention to attitude, appearance, affect, and attendance.

This needs to be documented in a linear timeline format with specific dates and occurrences in sequential order. Once this data is available, consultation with your state or national Peer Assistance Advisors is in order. Do not attempt an intervention alone; the AANA online directory of every state’s resources is easily accessible at www.AANAPeerAssistance.com. Follow the links for “Peer Assistance in Your State” or “Getting Help for Yourself and Others” at http://webapps.aana.com/Peer/directory.asp. PAAC members are also available for consultation; their contact information is listed online, or call the hotline at 800/654-5167.

The critical components involved in an effective intervention process need to be in place prior to the intervention. This means coordinating a large number of variables.

Advisors is in order. Do not attempt an intervention alone; the
• Is the documentation compelling, sequential and well supported?
• Is the family, particularly the significant other, informed and supportive?
• Has an interventionalist been contacted and available to coordinate the process?
• Has the intervention team been briefed? This should include: Clinical supervisor, administrative supervisor, where available a recovering CRNA with experience in the intervention process, a member of the human resource department, and member of the security department.
• Has an admission been arranged with a comprehensive chemical dependency treatment facility that has a healthcare professionals program, an addictionologist, and an addictions psychiatrist for inpatient evaluation?
• Have arrangements been made for a medical leave of absence?
• Has the team reviewed the nurse practice act to determine their responsibilities in reporting or having the CRNA self report to the state’s alternative program or state board of nursing?
• Have arrangements been made to put the student nurse anesthetist/CRNA in touch with Anesthetists In Recovery (215/635-0183)?

Once these questions have been addressed, the intervention team is ready to proceed with the intervention process with the goal being an immediate admission to an inpatient, comprehensive chemical dependency program with experience in the evaluation and treatment of anesthesia providers. Please remember that the PAAC members are available for assistance with this process at any time. It is absolutely imperative that all members of the intervention team are aware of the chronic, progressive, and often fatal nature of chemical dependency, particularly when intravenous drug use is involved.

Following a successful intervention there are often questions regarding the reentry process. The simple answer is that not every student nurse anesthetist/CRNA will be able to safely reenter clinical anesthesia practice. The following basic guidelines, which are also listed online at www.AANAPeerAssistance.com, should be the minimum standards that are utilized:

• Comprehensive evaluation and treatment recommendations by an American Society of Addiction Medicine (ASAM) board certified addictionologist, ideally one experienced in evaluating and treating anesthesia professionals. This often requires evaluation at an inpatient facility with a healthcare professional program.
• Evaluation by an American Academy of Addiction Psychiatry (AAAP) board certified addiction psychiatrist where appropriate.
• For individuals with an intravenous drug addiction or major opioid misuse history, we recommended a minimum of one year out of clinical anesthesia practice and a comprehensive evaluation prior to resuming clinical anesthesia practice.
• Requirement of participation in a monitoring program, preferably of five years duration, with the potential for voluntary monitoring for the duration of clinical practice. This should include regular random toxicology screening, regular attendance at recovery-based meetings, and continuous follow up and aftercare with an addictionologist.
• Recognition that CRNAs and student nurse anesthetists have special occupational risks and concerns for recovery making it paramount that we get it right the first time, every time.
• Recognition that propofol is a widely abused anesthetic agent with a high risk of mortality, particularly when the CRNA or student nurse anesthetist has been undertreated.
• We only support abstinence based recovery and strict avoidance of opioid replacement therapy (ORT) in CRNAs and student nurse anesthetists in clinical practice.
• We fully support the utilization of naltrexone where the addictionologist has deemed it appropriate.

The PAAC looks forward to continuing its mission of decreasing the impact of chemical dependency upon our community and invites you to share your observations, concerns and questions with us at any time.

Resources

AANA Peer Assistance
Contact Information
The AANA peer assistance homepage can be found at http://www.AANAPeerAssistance.com
The AANA Peer Assistance Hotline number is (800) 654-5167. The Anesthetists In Recovery (AIR) homepage can be found at http://www.aana.com/Resources.aspx?id=1224. AIR can be reached at (215) 635-0183 or at a.to.z@comcast.net.