Addiction in Anaesthesiology: Sometimes Sh*t Happens

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ABSTRACT

Anaesthesiology demands a vigilant and controlled cautious person with a good-tempered manner and professional character. Those virtues and values were built through thousands of trials, errors, failures, chances, and breakdowns. When some individuals could resist and thrive, others may fall and surrender. Anaesthesiologists are responsible for patients and the utmost importance should be placed on the patient’s physical safety and survival. The aim to become a good anaesthesiologist who focuses on the patient’s safety and wellbeing can sometimes take its toll by sacrificing the well-being of the anaesthesiologists themselves.

Anaesthesiologists have their own timeframe in life and it cannot be described by a regular person. An anaesthesiologists work demands timeless working hours, constantly strained workloads as well as personal and family detachment which consumes many daily routines and good logical senses. The average person would struggle to comprehend problems this causes in daily human life. Of course, every normal person has limits, including anaesthesiologists, when they are dealing with failures and mistakes involving humans not only at work but also in their relationships. While some of them would recover, others would fall into depression and become addicts, especially when they have access to narcotics and painkillers.¹²

The writers have to admit that while collecting references and data related to addiction among anaesthesiologists, we found very limited, covered, inaccessible, and minimal tracks of related situations. While it can be deemed as unprofessional or against working ethics, addicts could be involved in severe criminal punishment in several countries. This would definitely affect recovered anaesthesiologists, relapses, survivors and even coworkers discussing these incidences it in a decent manner.

Addiction has become the third most related occupational hazard in anaesthesia and predominantly involves the service provider, the man behind the gun, the anaesthesiologists. Strange enough, the first and the second place occupational hazards are not too far away from causing the third hazard. Researchers have found strong connections between coping mechanisms and addiction with respect to burnout risks. This means that coping mechanisms that require good emotional intelligence could be a sensible answer to deal with occupational hazards. Emotional intelligence is a skill that can be learned and taught, it can also progress in accordance with life experiences and would accompany maturity and chivalry. There is no special course or lesson for emotional intelligence that could even make it easier, like a ‘101-system’ or another systematic lesson. A subtle but loud statement has proven that in order to get a professional anaesthesiologist to minimize his or her risk of addiction, he or she should have a good emotional intelligence in any possible way.¹²

In 2002, several experts were conducting interviews and sessions with several anaesthesiologists ranging from juniors to seniors about their view of tension and job responsibility and how they overcome failures and critical situations at work. Their answers are not shocking, but rather ironically displeased. Years of mental training have built vigilance and toughness in their characters but perhaps they lack emotional intelligence and psychological stability.³

Other experts had been moving forward by doing studies on post-traumatic stress disorder in physicians from an underserviced area suggesting a high prevalence of mental illness in physicians. They mailed a PTSD Checklist-Civilian Version (PCL-C) to 331 physicians in Northwestern Ontario Canada with some additional comments and demographic information requested. From 159 completed questionnaires received, the prevalence of probable PTSD was 4.4%. No differences between demographic groups were observed for probable PTSD, but possible PTSD was more frequent in males than females. Respondents identified overwork, insufficient resources and relationships with colleague and patients as common stressors.⁴

Researchers at Northwestern University in Chicago also conduct a survey of anaesthesiology residents throughout the country and received 1508 responses in 2013. They responded to questions regarding frequency of burnout and depression, in order to assess whether they were at a higher risk for medical errors. They found that 41% of the residents were considered at risk for exhaustion,
22% had possible depression, and 17% were at risk for both. These results were based on high scores in the areas of emotional exhaustion, depersonalization, and low scores of personal accomplishment. Researchers also found that exhaustion and depression were more likely in female residents, residents who worked more than 70 hours per week, and residents who drank more than five alcoholic beverages per week. Residents who smoked also had a higher risk for depression. Also when compared to people in the same age group, the residents were almost twice as likely to screen positive for depression and even suicidal thoughts. Unfortunately, there are no sufficient data regarding similar problems in practicing anaesthesiologists.5

In order to understand this serious problem in a much-defined way, we should take a look at other psychological and mental problems that can become burdens nationwide especially when they are related to military personnel. Military combatants are known for high-impact and vigilant training in urgent risk-taking situations. They are also trained to follow standards, rules, and orders in a leadership form to take down every specific problem. Patronized leadership and seniority-based communication are also strongly internalized. Those situations are in fact quite similar when we are dealing with day-night time working anaesthesiologists as a trainee and even in real practice.6

Veterans of war have mental trauma caused by incidents at war which can lead to Posttraumatic Stress Disorder (PTSD) and has become a field of interest for many psychosocial and behavior experts. Researchers in 2010 found the point prevalence of combat-related PTSD across studies of US combat veterans ranges from about 2-17%. This is quite a number that causes a significant burden and post-war additional expenses. Some researchers have linked the size of the rostral anterior cingulate in the frontal cortex with the risk of having PTSD in military veterans. These findings would also elaborate ideas of incorporating the sizes of rostral anterior cingulate from a PET Scan into the first private recruitments in order to prevent risks of larger costs of treating them after they have become mental patients.6

Psychiatrists and psychosocial experts have agreed that treating victims of PTSD would require similar regiments to patients who battle with addictions, alcoholism, and other mental illnesses. Prescribed medications, continuous support, and long-term commitment to cognitive behavioral therapy could reduce and minimize risks of suicide and mortalities. Combinations of multimodal therapy includes various experts and costly treatment.6-7

Considering anaesthesiologists who are prone to depression and addiction, those probabilities previously explained would become reality. Prevention of addiction is much better than treating relapses in adults with many capabilities, such as anaesthesiologists. Consecutive boards and lecturers should have taken this matter into special consideration. Prejudice and nonchalance only make things worse and do not solve the problems.

One of the hallmarks of anaesthesia is making rapid decisions in critical situations and swiftly and safely carrying through necessary actions. When the anaesthesiologists make a patient unconscious for an operation, he or she takes on a great responsibility. Even if most anaesthesiologists follow the expected routine, deviations do occur, and they must bring the situation back on track. In anaesthesia, most activity takes place during induction and emergence. During the operation, there is often a period of maintaining and supervising patient’s physiological wellbeing. However, more than half of reported adverse events occur during this period and sustained vigilance is necessary.3

Although safety should always come first, anaesthesiologists are also affected by productivity demands. The lack of time could make them stressed and may tempt them to cut corners by not adhering to prescribed security standards. However, the public demands safe care and mistakes are not tolerated.3

Interestingly, in an interview study on stress and wellbeing at work, trainee and specialist were asked about the drawbacks in work and gave answers about feelings of insufficiency and loneliness.8

Traditionally, research on stress has mostly focused on how the negative effects of stress can be avoided or, at least, attenuated. The point in this perspective is to see that coping with stress as a way of generating the positive effect. Some anaesthesiologists manage to create eagerness and curiosity in the most stressful work situations.9

Lazarus and Folkman as stress researchers had quoted that “Stress is an inevitable aspect of the anaesthetist’s condition. It is coping that makes the big differences in outcome.” The first step in the appraisal process is defining whether it is potentially stressful. If so, the next step is to define it as a threat or a challenge. Seeing the situation as a threat means that there is a risk of an unfavorable outcome that may harm the anaesthesiologists. Negative emotions such as fear and anxiety may arise and a flight reaction can be provoked. On the other hand, if the anaesthesiologist sees the situation as a challenge, mobilization of coping efforts will follow and positive emotions such as eagerness and curiosity are more likely to arise. The distinction between a threat and a challenge is important because of the difference in the resulting stress response.
depends not only on the situation as it is objectively but also on how the situation is construed and how it is appraised. The stress-reducing effect of coping can be registered as an attenuation of the metabolic stress response. After a primary appraisal of a difficult situation, the next step for the anaesthesiologist (second appraisal in coping theory) is to decide what should be done and reflect on whether he or she will succeed in performing the necessary action.⁴

Sometimes expert anaesthesiologists will encounter difficult clinical situations that they cannot deal with satisfactorily. They could reduce stress effect by thinking of it in a new way and by redefining it through reappraisal. Using this cognitive process, they may change the meaning of the situation, even if the situation has not been changed objectively.⁵

Anaesthesiologists could work on three main categories of difficulties consisting of medically difficult situations, moments of work overload, and difficult ethical decisions. Their strategies for handling a medically complex situation consists firstly, of simplifying and starting with the obvious, secondly, asking for advice without prestige, and thirdly, getting support from colleagues. Moments of work overload are handled by prioritizing between work tasks, delegating work to nurses or other doctors, and getting help even in unconventional ways, for instance, by calling colleagues that are not on call but rather, in their home.⁶

Ethical problems differ from acute medical problems, in that they do not have a well-defined best solution. Dealing with ethical problems can be trained, and physicians can learn to make an ethical decision both quickly and adequately. Clinical ethics committees have been widely used and ethical rounds where nurses and doctors reflect on experiences of difficult ethical situations have been shown to increase the understanding of the role of ethical principles and how to use them in clinical decision-making.⁷

An experienced anaesthesiologist talked not only about problem-solving but also about coping reappraisal. Developing few thought lines such as seeing difficulties as inherent in the specialty, accepting limits of your own competence, accepting limitations of what health care can do, and see moments of high demands as part of work. By reframing the situation, anaesthesiologists could reduce its stress content even if the problem at hand could not be successfully solved.⁸

Anaesthesiologists work to give safe anaesthesia to patients and this could do both harm and good to the anaesthesiologists themselves. Even though it is stressful, the effects on physical health and mental wellbeing can be buffered by effective coping strategies. Inexperienced trainees may be tempted to avoid difficult situations. Avoidance is an inadequate coping strategy and is linked to worse outcomes in terms of mental health. Therefore support must be given to those who need it in order to stay and do their best in demanding situations.

Programs for anaesthesia training should be aimed to not only make professional anaesthesiologists but also facilitate the learning of successful coping strategies in supervisions sessions where both seniors and juniors together to reflect on recently demanding situations.⁹

The truth about horrible situations involving colleagues who undoubtedly are involved in addictions should be accepted with humble and open-minded thoughts. Normal persons make normal mistakes. Anaesthesiologists are not beyond normal beings and can make mistakes as well. Prejudice, cowardliness and irresponsible acts would only lead us -who claimed to be the best in teamwork- into separation and never-ending disputes. Punishment should be taken as the last choice and decided after several considerations. Professional boards and special committees that undertake these important decisions should also consider the victims welfare and mental health.

We have to admit that anaesthesiologists are merely humans with flaws and need to be reminded of everyday self-correction and evaluation. Failures may happen thousand times in millions of trials, but the commitment and persistence to rise up and try to live again, try to give the best effort to ensure optimum work is done would be the sign of thriving anaesthesiologists. They are not only struggling with work and personal life but also drawing good values and strong moral ethics that would follow them until the end of life. Career life may put them up and down respectively, personal life might be deranged, social life may be inconsistent, but as long as anaesthesiologists could bring their heads up, to become the navigator, ‘to view from the head of the table’ not only in the operating theater but also in their own private life, they would not easily risk their life and put others they care most in danger and troublesome situations.

Values and a good act of social human being need to be underlined not only to anaesthesiologists in troubles but also to us as coworkers and teammates. Sharing support and expertise would be the most valuable items that we could give and take from each one of us. The personal experience of one person could be a good lesson for another and a reminder for the rest of all. After all, teamwork is a good key to understanding and without teamwork there would be no sane anaesthesiologists.
REFERENCES


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