

EDITORIAL

Substance use disorder (SUD) among anesthesiologists



During the past decades, organizations that regulate training and practice in anesthesiology worldwide have approached a series of risks associated with occupational activity. The guidelines issued by these organizations are universally acknowledged for making anesthesia safer for patients, and for anesthesiologists.

The literature however has shown epidemiological data that reaffirm previous information published that substance dependence and suicide among anesthesiologists are problems widely not solved. Thus, the currently defined substance use disorder (SUD), which includes opioid abuse, is prevalent among anesthesiologists within the general medical category. The data has been revealed by epidemiological research published by authors associated with the American Society of Anesthesiologists (ASA), among other institutions.

The time has come for all of us to play a leadership role in medical occupation well-being issues, by objectively and actively defining concrete actions to correct the causes of substance abuse, proposing support to those affected by substance abuse disorder. A poignant question emerges: if not now, when?

The use of substances that modify consciousness has pervaded the evolution of mankind.¹ It has always been so, and so will probably continue. A contemporary example is the “recreational opioid use crisis” that is occurring in several regions in the world, particularly in the US, and that has not reached Brazil yet.^{2,3}

In the opioid use crisis, besides illicit substances for recreational purposes, many medically prescribed opioid analgesics have been used in the SUD scenario.³ However, other legal substances, such as tobacco and alcohol, in addition to benzodiazepines, also are among the substances playing a significant role in SUD, including in Brazil.

SUD is characterized by the occurrence of negative consequences related to substance use, such as consequences to user’s health and social life, and to economic problems. Frequently, individuals with SUD are also involved in criminal activities.

If the general population is exposed to the risks represented by SUD, physicians and other health professionals are particularly susceptible to SUD. In this case, not only the health of professionals is at risk, but also their reputation and, potentially, the safety of the patients under their care,⁴ given that anesthesiologists with SUD expose patients to the risk of dying.⁵

Although SUD rates among health professionals have not been totally elucidated, they may be similar to those in the general population, but recently have grown.⁵ Unlike the general population, health professionals handle medications, such as benzodiazepines and opioids, more frequently,^{4,6} and easier access to these drugs can play an important role in this specific feature.

Anesthesiologists are considered health professionals at a high risk of developing SUD, and the estimated occurrence rate is 1.6%, excluding alcohol dependence.⁴ Just as in the general population, men are more affected, as are individuals with other psychiatric comorbidities.^{5,7} According to Sousa et al in an innovative Brazilian study published in the present edition of BJAN, 23% of anesthesiologists included in the sample admitted having used psychoactive substances at some point in time, a much higher percentage than the one found in the US. Surprisingly, in the Brazilian study, 82% of anesthesiologists knew a colleague that already abused of a psychoactive substance.⁸

Among the substances used by Brazilian anesthesiologists with SUD, alcohol excluded, opioids stand out, and are used by 67% of professionals.⁸ In the US, opioids are also the most used recreational substances among anesthesiologists, although 26% of professionals abuse of more than one substance concomitantly. The most frequent opioids among US anesthesiologists are injectables, chiefly fentanyl and sufentanil.⁴

In the overall Brazilian population, the age-adjusted estimated prevalence of individuals with opioid use disorder is 30 to 40 cases per 100 thousand inhabitants – rather lower than the US prevalence, which is 1,050 to 1,300 cases per

100 thousand inhabitants.⁹ The mortality rate by various causes among recreational opioid users is extremely high. The occurrence of overdose in this population is estimated at 19.8%.¹⁰

The mortality rate of Brazilian anesthesiologists with SUD is not known, but in the United States, a study found a mortality rate of 19% among 601 anesthesiologists who developed SUD between 1977 and 2013.⁴

The present BJAN issue has another interesting Brazilian study on the subject. Authored by Serebrenic et al, the article is a case series describing deaths of Brazilian anesthesiologists in which a ‘‘psychological autopsy’’ was performed.¹¹ The study, in addition to Sousa et al, sheds some light on this scarcely understood and investigated conundrum in Brazil, and in other countries.

Some intriguing data were revealed by the study of Serebrenic et al. Of the 18 cases identified of Brazilian anesthesiologists who died from intentional or accidental drug overdose, most were men. In the study only eight cases included an in-depth analysis, and for four of them, opioid was implicated in death. Among the included deaths the most frequent personality trait was introspection, and these individuals usually performed their professional activities satisfactorily. Some of them, however, stayed longer periods at the workplace and neglected some of their tasks.¹¹

As little is known about SUD among anesthesiologists, developing preventive and therapeutic measures for these professionals is challenging. However, substance abuse, stress in the workplace, burnout, depression and anxiety are known to be closely related to the occurrence of medical errors, with potential risks to patients.⁵

We should all be aware of the problem, which is close to every one of us. By being pro-active in the identification of colleagues with SUD, showing empathy and fighting prejudice, we avoid losing lives of colleagues. Individuals with SUD are ill and deserve adequate treatment, and in the same way that we do not abandon our anesthetized patients, we should never turn our back on our colleagues.



Conflicts of interest

GAMB is a researcher and lecturer for Laboratorio Cristalia. GFDN declares no conflicts of interest.

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