Reentry and Recidivism for Certified Registered Nurse Anesthetists

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Prevalence of the Problem and Scarcity of CRNA-Specific Studies
The self-reported prevalence of drug diversion for self-administration among CRNAs is estimated to be 9.8% (Bell, 2006; Bell, McDonough, Ellison, & Fitzhugh, 1999). Therefore, of the more than 40,000 practicing CRNAs in the United States, that would imply that approximately 4,000 CRNAs are diverting and using medications. Though cases of trafficking or diverting to others exist, they are rare, and Bells data specifically examine the far more common practice of CRNA self-medication.

An extensive review of the literature reveals that much of the focus on drug diversion has involved physicians and nurses. The overwhelming majority of nursing publications that examine diversion of drugs by specialty fail to include CRNAs. The sparse literature that exists on CRNAs focuses on the incidence and demographic characteristics of those who divert drugs based on self-report (Bell, 2006; Bell et al., 1999).

About one-third of critical-care nurses report easy access to controlled substances, and the combination of having easy access and working in a critical-care specialty has been associated with the greatest likelihood of illicit drug use (Trinkoff & Storr, 1994). These high-risk factors certainly apply to CRNAs, who work in a critical-care specialty and have easy access to controlled drugs.

Components of Safe Reentry into Practice
Several recommendations have been made for reentry programs for CRNAs, but none has been empirically tested. Generally, these recommendations call for detoxification, treatment, and then gradual reentry into practice when it is deemed safe. Whether or not a recovering CRNA (or anesthesiologist) can safely return to anesthesia practice without relapsing, despite follow-up care and monitoring, remains controversial (Bryson & Silverstein, 2008; Collins, McAllister, Jensen, & Gooden, 2005). One major risk associated with returning to the practice environment is the presence of cues previously paired with drug use, such as handling anesthetic drugs and associated paraphernalia (Heinze, Wolling, & Grusser, 2007).

Reentry to clinical practice of recovering health-care professionals (HCPs) is an important issue for department, hospital, and system administrators, profession leaders, and the public. The American Association of Nurse Anesthetists (AANA) has traditionally advocated for public safety through the removal and safe return of CRNAs suffering from addiction, yet the AANA recognizes the precarious nature of this undertaking and maintains high standards for reentry.

Two classic textbooks cover the standard components of a safe, reasonable reentry of the anesthesia practitioner (Angres, Talbott, & Bettinardi-Angres, 1998, and Higgins Roche, 2007). These components, which appear frequently in the pro-reentry literature (Monroe, 2009), include, but are not restricted to, the following:

- A solid foundation in a 12-step program
- Participation in the state’s monitoring program (if applicable)
- Attendance at Caduceus (HCP support group) meetings
- A work-site monitor
- Random drug screens
- A back-to-work contract
- Naltrexone use
- No overtime.

Bryson & Silverstein (2008) recommend 1 year away from anesthesia practice before reentry. They believe the recovering addict must focus on recovery and sobriety versus career. Reentry contracts commonly forbid overtime, so the recovering addict has time for 12-step meetings, aftercare, and Caduceus meetings and can maintain a balanced, healthy life. (Angres et al., 1998; Bryson & Silverstein, 2008; Higgins Roche, 2007).

The literature on reentry for HCPs does not support opioid replacement therapies such as the mu agonists, buprenorphine and methadone, which are commonly used in other opiate-abusing populations. Instead, the literature advocates in favor of the mu antagonist, naltrexone (Bryson & Silverstein, 2008; Higgins Roche, 2007; Oreskovich & Caldeiro, 2009).

The alternative-to-discipline programs of many state boards of nursing (BONs) and state medical boards require participation in 12-step programs, such as AA or Narcotics Anonymous (Baldissere, 2007, DuPont, McLellan, Carr, Gendel, & Skipper, 2009; Hughes, Smith, & Howard, 1998). Attending 12-step meetings is a common stipulation in reentry or back-to-work contracts (Angres et al., 1998; Bryson & Silverstein, 2008; Higgins Roche, 2007).

Despite the common recommendation regarding 12-step programs, research on their effectiveness is limited. Galanter, Talbott, Gallegos, & Rubenstone (1990) surveyed 100 physicians in the Georgia Impaired Physicians Program. The 160-question, multiple-choice or numerical-response survey asked the degree to which certain recommendations contributed to recovery. Respondents indicated that AA was the most potent component in their recovery and that group
Measuring Success
CRNA reentry to practice is rarely addressed in nursing publications (Saver, 2008a, 2008b) and even less often in physician anesthesiology publications (Berge et al., 2008). The rate of successful reentry into practice can only be inferred from reviewing this literature—primarily from rates of relapse and recovery from alternative-to-discipline programs.

Monroe and colleagues (2008) found that alternative-to-discipline and disciplinary programs reported success rates for reentry into practice between 68% and 90%. Thus, both types of programs have consistently helped a majority of nurses recovering from addictive disorders to reenter the workforce. However, alternative-to-discipline programs remove impaired clinicians from practice in days to weeks compared to months or years with disciplinary programs. Thus, the public is protected sooner, and the nurse receives treatment faster.

The success of a program may also be measured in terms of the rate of recovery or retention (Monroe et al., 2008). The authors found recovery rates of 47% to 95% and retention rates for nurses in the profession of 61% to 85%. The authors found little empirical evidence in the literature about reentry and monitoring programs. They further caution that success rates may tell us very little about the progress being made nationwide in addressing substance use disorders among HCPs (Monroe et al., 2008).

Reentry of Nurses
Data supporting successful reentry of nurses to practice are encouraging. Hughes, Smith, & Howard (1998) evaluated Florida’s Intervention Project for Nurses, the first alternative-to-discipline program in the United States, and found that over 80% of impaired nurses reentered nursing, with less than 25% having relapsed (Hughes et al., 1998).

Yocum and Haack (1996) found that alternative-to-discipline programs removed impaired nurses from the workplace more quickly and had reported a recovery rate nearly double that of the punitive programs. Baldissiri (2007) reported that up to 75% of HCPs remain sober for more than 10 years after treatment, with 15% to 20% relapsing within 1 to 2 years of initial treatment.

Reentry of CRNAs
Only one study specifically addresses the reentry needs of the CRNA. A retrospective study by Sibert and Dennen (1996) reported the results of a four-question survey completed by 60 recovering CRNAs and evaluated important factors for maintaining sobriety to facilitate reentry. Respondents identified these factors as participating in a 12-step program (64.4%), attending support groups (61%), having random drug screening (39%), and serving as a mentor or sponsor for another addicted CRNA (27.1%). The four most challenging obstacles to successful reentry were receiving disciplinary actions from the state BON (69.8%), finding employment (56.6%), working with managers uninformed about chemical dependency (39.6%), and a lack of employers willing to monitor the employee adequately (28.3%).

Discussion
Reentry of the recovering HCP remains a controversial and a precarious undertaking. The standard recommendations appear consistently in the literature; however, most of them are based on collective expert opinion, not empirical data. The reported successes of the alternative-to-discipline programs do not clearly explain their significant contributions. Studies are largely retrospective analyses and self-reporting, which raises questions. How would one undertake a genuine evidence-based study to assess reentry? Would subjecting participants to reentry methods not yet discussed in the peer-reviewed literature be ethical?

The use of pharmacotherapeutics for treatment of HCPs in recovery, including CRNAs, needs to be further investigated. Cognitive and psychomotor functions have been tested in other drug-abusing populations while taking these maintenance drugs, yet no studies have been done in recovering HCPs. An assessment of these therapies in critical situations that require split-second decision making and precise hand-eye coordination could be undertaken in a simulation laboratory.

The AANA is careful about its reentry recommendations and understands that not every CRNA is an appropriate candidate. Even when people follow guidelines, some relapse, and frequently the least suspected person is diverting medications.

The role of appropriate inpatient and intensive outpatient treatment, aftercare, follow-up treatment, back-to-work contracts, random drug testing, and a solid support system cannot be overemphasized. Addiction must be treated as any other life-threatening illness, and reentry into the workplace must be undertaken with every appropriate safeguard available.

[A thoroughly planned recovery, including a well thought out and structured reentry contract are essential for a successful return to clinical practice.] Each episode of relapse makes subsequent reentry attempts more difficult. We must strive to establish evidence-based, safe, effective standards for reentry that will protect the HCP, the profession, and most importantly, our patients.

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References


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