# Drug Diversion in the Anesthesia Profession: How Can Anesthesia Patient Safety Foundation Help Everyone Be Safe? Report of a Meeting Sponsored by the Anesthesia Patient Safety Foundation

Diversion in the workplace can adversely impact the safety of health care professionals and patients. The Anesthesia Patient Safety Foundation (APSF) believes that substance use disorder, diversion in the workplace, and their potential adverse effects on patient safety need to be addressed through open discussion, education, research, policy, and possible other interventions. To make progress in this area, the APSF convened a conference entitled "Drug Diversion in the Anesthesia Profession: How Can APSF Help Everyone Be Safe?" in Phoenix, Arizona, on September 7, 2017 (Supplemental Digital Content, Document, http://links.lww.com/AA/C616). It was comoderated by the authors. APSF President Mark A. Warner, MD, welcomed >50 participants who represented large anesthesia group practices and practice management companies. The attendees participated in a half-day conference to discuss relevant anesthesia patient safety issues related to the opioid epidemic and, specifically, drug diversion in the health care workplace.

The workshop was introduced by a multidisciplinary panel of experts who provided information on patient and health care worker (HCW) safety implications associated with drug diversion. The goal of the workshop was to develop (broad) recommendations to reduce the associated risks to providers and patients from drug diversion. The conference started with a series of informational presentations by diverse stakeholders with associated audience response polls followed by panel discussions and small-group breakout sessions.

## DISCUSSION

Despite an extensive awareness of the prevalence of substance use disorder in health care professionals and data demonstrating that substance misuse is an occupational hazard for HCWs and those in training, little progress has been made improving the prevalence, education, and outcomes. Substance use disorder is a problem that continues to impact society. It is estimated that 10%–15% of HCWs, including anesthesia professionals, will misuse drugs or alcohol at some time during their career.[1] It has been suggested that substance use disorder is the most frequent disabling illness in HCWs. There clearly is a need for multidisciplinary coordination of efforts to reduce drug diversion within the health care workplace as highlighted in the presentations at the workshop.

Supplemental digital content is available for this article. Direct URL citations appear in the printed text and are provided in the HTML and PDF versions of this article on the journal's website (www.anesthesia-analgesia.org).

DOI: 10.1213/ANE.0000000000003878

### Drug Diversion

"Drug Diversion from the Health Care Workplace: A Multi-Victim Crime," Keith H. Berge, MD (Mayo Clinic, Rochester, MN), noted that not only do addicted HCWs divert drugs from their employers to support their addiction but they also divert drugs from their patients. This poses a major patient safety risk and exposes patients to blood-borne pathogens as evidenced by the outbreaks of infections associated with diversion.[2] Dr Berge supported the notion that it is a multivictim crime that places patients, addicted HCWs, their coworkers, their employers, and society at risk and emphasized that vigilance is mandatory. Moreover, he advocated for policies and procedures within health care institutions for dealing with investigations and managing possible outcomes of confirmed diversions.[3]

### Securing Narcotics

"Securing Narcotics: Standard of Care Evolves in Wake of Hepatitis C Outbreaks," Brian Thomas, JD (Preferred Physicians Medical, Overland Park, KS), provided a medicolegal perspective on drug diversion and tampering by highlighting 3 high-profile cases in which hospital employees infected patients with blood-borne pathogens. The hospital employees stole the anesthesia providers' narcotics that were left unsecured, injected themselves, refilled the syringes with saline, and returned them to be administered to patients. These incidents resulted in dozens of patients being infected with life-threatening Hepatitis C, multiple lawsuits, medical and nursing board investigations, and widespread negative publicity for the involved health care providers and facilities.[4] He discussed that in medical negligence litigation, the standard of care is defined by expert opinion and testimony. In light of recent highly publicized cases, the consensus among anesthesiology experts is all schedule 3 and 4 narcotic medications should be kept in locked enclosed areas when not under the direct control of anesthesia professionals. He also offered risk management strategies that included: carefully reviewing and adhering to all hospital/facility drug storage and security policies, never leaving controlled substances or medications likely to be diverted unsecured and unsupervised, carefully considering whether to keep controlled substances or medications likely to be diverted on your person once dispensed, reporting any suspicious behavior or activity if you suspect drug diversion, and implementing workplace drug testing policies.

### Why and How Drug Diversion Occurs

"The Silent Epidemic Drug Diversion in the Health Care Setting," Tricia Meyer, PharmD (Scott & White Temple Medical Center, Temple, TX), pointed out how common theft/diversion of controlled substances is in the health care workplace and that it may be attributed to the high-risk settings and easy access to drugs in these areas.[1,5] There are several other potential reasons, including self-medicating for personal health problems, cultural acceptance of pharmacological agents to cure ills, decrease pain, overwork, sleep deprivation, availability and access, advanced parenteral

administration skills, believe immunity to drug abuse, and exposure to death and dying.[6,7]

The Joint Commission sets expectations of medication security in their Medication Management Standards to ensure that hospitals secure medications in protected areas and locked when necessary, in accordance with law and regulation, to prevent diversion.[8] Each organization is then responsible for developing a controlled substance diversion prevention program that complies with federal and state laws and regulations. In addition, a hospital should use technology and ongoing surveillance to consistently review procedure compliance and effectiveness, strengthen controls, and seek to proactively stop diversion.[7]

However, many health care systems have inconsistencies in their oversight of controlled substances, poor accountability, inconsistent compliance with regulatory requirements, processes favoring convenience over control, inconsistent and delayed consequences, lax processes, and a culture of reluctance to speak up that can enable diversion.

In her presentation, Dr Meyer noted that the goal is to reduce the number of employee diversions, the lag time between employees beginning diversion and discovery, and reduction of the number of vials/tablets/syringes diverted by addicted employees. There are opportunities for diversion at almost every step of any medication use process. Diversion can occur at procurement, preparation/dispensing, prescribing, administration, and waste/removal of controlled substances. Each of these represents a theft risk point, and safe guards must be in place at each step.

### The Impaired Provider

"Catch Me, (If You Can)," Rigo Garcia, CRNA (Parkdale Center for Professionals, Chesterton, IN), shared his personal journey with substance use disorder and experience as the co-founder and executive program director of a center that specializes in diagnosis, treatment, monitoring, and advocating for the addicted professional and their families. In his presentation, Mr Garcia described the inconsistencies and noncompliance in organizational regulatory requirements that enable addicted HCWs access to misuse controlled substances. He advocated that because HCWs remain at higher risk of substance use disorder due to easy access to medications, expert knowledge in how to use them, and increasingly stressful jobs, proper treatment followed by an accountability monitoring program are essential for sustained sobriety. Mr Garcia stressed that a punitive-only approach to managing the impaired provider has been proven to be ineffective over the past 50 years and is detrimental to those who are desire to seek help voluntarily.

### The Opioid Sommelier

"Are Opioids Necessary for Surgical Patients?" Ronald S. Litman, DO, ML (The Children's Hospital of Philadelphia, Philadelphia, PA, and the Institute for Safe Medication Practices, Horsham, PA), shared his perspective that any attempt to prevent diversion of opioids in the perioperative environment may ultimately be unsuccessful if it relies on education, surveillance, or vigilance because these all are historically unreliable in producing changes in behavior. Dr Litman made the provocative recommendation that the only reliable way to prevent diversion by anesthesia professionals is to remove their ability to access and administer opioids. Although opioids are traditionally used as part of a balanced anesthetic technique, their intraoperative use has not been definitively associated with improved outcomes. In fact, the blinded substitution of β-blockers for opioids has resulted in less postoperative opioid use.[9,10]

Therefore, Dr Litman introduced the concept of the "opioid sommelier," a health care professional who is designated to administer opioids in the perioperative environment. This method would be designed to eliminate opioid diversion by anesthesia and other operating room personnel. It would potentially decrease first-time opioid use by HCWs if the drugs are not available to individual personnel. Several obstacles would need to be overcome due to the current standard of care that requires each anesthesia professional to administer their own opioids. These include identifying specific opioid sommeliers, defining their credentials and responsibilities, determining how these people would prioritize opioid administration, and attaining buy-in from all perioperative personnel.

## RECOMMENDATIONS

Audience polling throughout the meeting revealed attitudes and priorities about substance use disorder in anesthesia providers and drug diversion in the perioperative environment (Table 1). The most agreed upon action item (92% agreement) was for anesthesia practice groups to develop and implement drug testing policies. However, as previously discussed in this Journal, the practicalities of implementing such a system

**Table 1. Attitudes About Substance Use Disorder and Drug Diversion**

| Statement to Which Audience Members[a] Responded | Agreement (n = 51), % |
|---|---|
| Addiction is a choice and not so much an actual disease. | 7 |
| Drug diverters display patterns and behaviors that make them relatively easy to identify. | 6 |
| Drug diversion from the health care workplace is a rare event. | 18 |
| The impaired anesthesia professional who is found to be diverting medication should be confronted by human resources, facility security, and their direct supervisor. They should be escorted to their locker to clean it out immediately and immediately sent home pending further investigation. | 37 |
| Operating rooms are "secure areas." | 9 |
| Anesthesia professionals should keep prepared syringes on their person. | 50 |
| The theft of 1 oxycodone is a crime that MUST be reported to the Drug Enforcement Agency (United States) within the business day. | 84 |
| Anesthesia practice groups should develop and implement drug testing policies. | 92 |
| Most health care workers who divert drugs are caught by self-reporting. | 0 |
| Surgical procedures can be done without opioids. | 77 |

The attendees represented clinical operations of health care facility, administrative operations of health care facility, and research operations of health care facility, corporate, or other business environment. More detailed demographics of the participants were not available.

[a]The 51 attendees consisted of 66% anesthesiologists, 15% nurse anesthetists, 4% nurses, 4% nonclinical health care professionals, and 11% corporate/industry professionals.

**Table 2. Recommendations and Associated Potential Interventions for Health Care Facilities or Health Systems**

| Recommendations | Potential Interventions |
|---|---|
| Develop a prevention focus related to substance use disorder and diversion within health care organizations. | Develop a Clinician Wellness Committee within the procedural practice. |
| Provide a comprehensive educational program related to substance use disorder to reduce the stigma associated with it and to promote a culture of safety. | Develop educational modules and build a culture of safety that addresses the factors that increase the risk for substance use disorder. |
| Develop clear policies related to drug diversion and substance misuse. | Convene a multidisciplinary group to review best practices and develop policies for the prevention and detection of drug diversion and substance misuse in procedural practices; this should include a drug diversion team that investigates missing drug events. |
| Health care organizations should identify and provide appropriate recommendations related to "process of reporting" and treatment options for all anesthesia professionals. | Develop an information tool kit and designate a resource person within each anesthesia group and health care organization. |
| Develop a comprehensive approach to managing the key areas of focus related to substance use disorder. | Annual competencies modules related to wellness, substance use disorder, diversion, and treatment options should be available and widely communicated within health care organizations. |
| Develop a comprehensive requirement for new employee reference checks (including clarity on any gaps in employment). | Standardize a comprehensive reference checking process. |
| Develop consistency across all health care institutions as it relates to oversight of controlled substances. | Create and uphold a well-defined policy for institutional oversight of controlled substances. |
| Prioritize compliance and accountability. | Standardize drug testing policies. |
| Intensify research and learn from all health care disciplines. | Multidisciplinary collaborations to facilitate research, education, and policy development |

are not always straightforward.[11,12] As a result of the presentations, and further discussions during small breakout sessions, our diverse group of stakeholders put forward a broad portfolio of recommendations (Table 2).

In summary, substance use disorder is an addiction and, as with any addiction, it is a disease. Its diagnosis, management, and treatment will vary depending on the severity of the disease. Effective means of treatment must focus on recognition that substance use disorder is not curable and requires lifelong surveillance. Equal emphasis must be placed on prevention. Substance use disorder and diversion of medications in the workplace can adversely impact the safety of health care professionals and patients. Health care organizations have an opportunity to implement positive change by implementing a culture of safety and accountability.

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