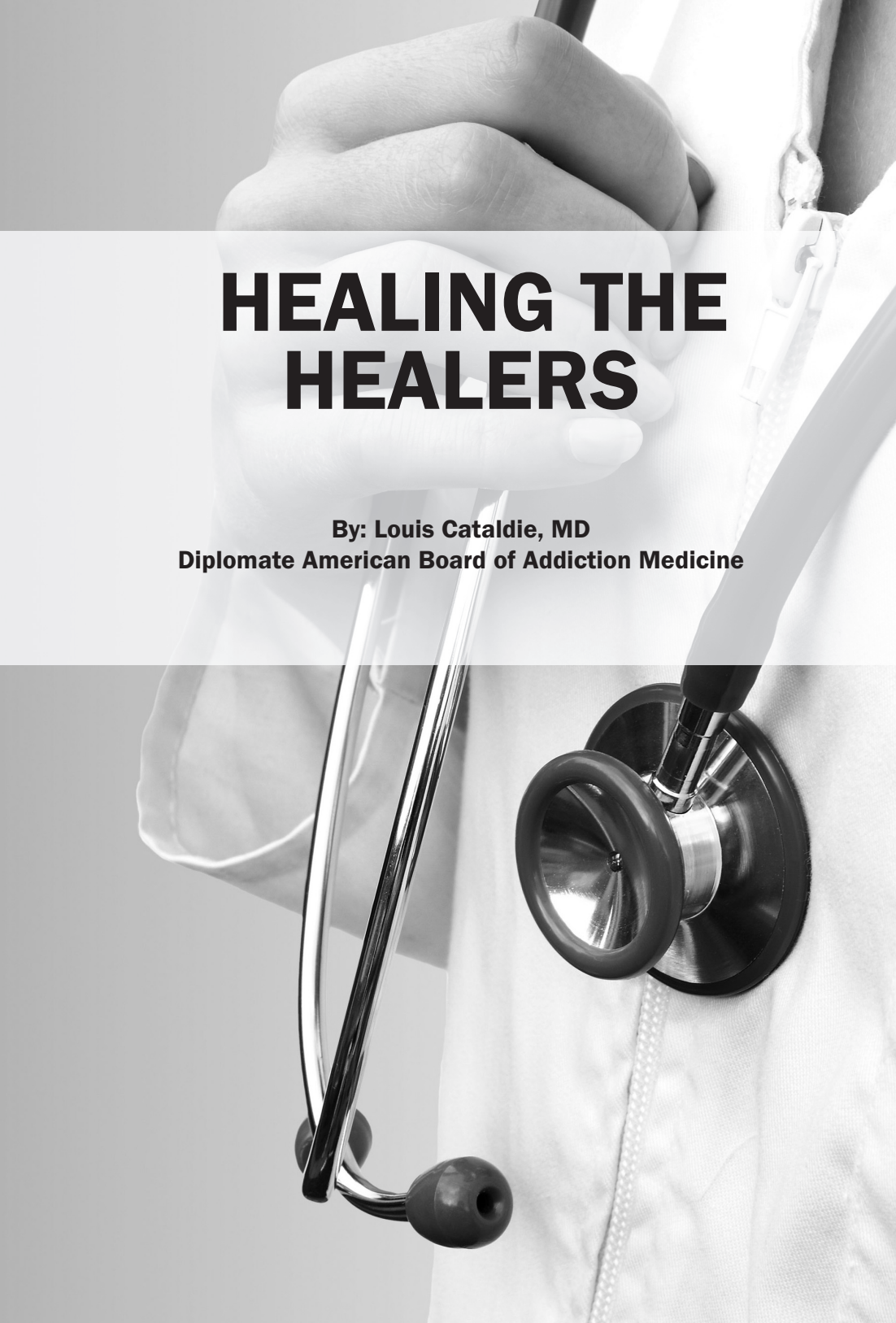

HEALING THE HEALERS

By: Louis Cataldie, MD
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Florence Nightingale School for Nurses

Healthcare Cultures: Healers hold a very special place in society. Of course we are not called "healers" anymore and nurses are not called "nightingales" anymore. Current society labels us as Health Care Providers (HCPs). We embrace and practice the art and science of helping people who have diseases and/or injuries. Registered Nurses are held in high esteem. They are also part of a healthcare culture that has been around since there were nurses.

Welcome to the Club: Years ago, when I was in medical school, I had the good fortune to train under the tutelage of a well-respected and very wise staff physician. During that time, he imparted several "pearls of wisdom" that have served me well over the years. One of those concerned the relationships that develop between members of the healthcare provider world.

> *"Son,"* He said sipping his pre-rounds coffee at 5 AM, *"You may have the ultimate responsibility for patient care but never think you run the hospital. Nurses run the hospital. And let me tell you something else. They can be your best friends or your worst enemies. They can make your life tolerable or they can make your life a living hell. And, if they say something is wrong with a patient, you better listen. Medicine is like an extended family. We may disagree and get angry but at the end of the day we are all about patient care."*

That was sound advice. From my years in various hospital settings, including being the Vice-President of Medical Affairs for a major multiple hospital system, I can attest to that truism. Indeed, I have passed it on to others. Physicians, nurses (including Nurse Practitioners and Certified Registered Nurses Anesthetists), physician assistants, and anyone else who provides life and death care to patients develop a special culture. We have our own esoteric language. We can communicate volumes to each other by a mere glance. We share common ethics and values. We work under the same stressful conditions. We hold ourselves to high performance standards. We worked hard to get where we are and we take pride in our professions and our achievements. We have purpose and we make a difference.

Nurses are the backbone of patient care and they do run the hospitals. Doctors know it, at least the savvy ones do. Administrators know it. Nurses know it. And most patients, and their family members, figure it out pretty quickly.

Healthcare providers function within an ever changing, stressful, and often unforgiving environment in which 99% is considered a failing grade. You almost have to be in the healthcare field to understand some of those pressures. The price of failure is guilt and shame. Nurses develop a unique culture that bonds them together with other nurses and other providers.

Carol C., RN, Pediatric ICU. *"It is like you have to read each others' minds and anticipate the other person's next move. The stakes are high. As a matter of fact they are the highest in the world. We are talking about life or death decisions for a child. We better be able to trust each other and be a team."*

That culture extends beyond patient care. We tend to develop a sense of camaraderie and we tend to take care of each other. While this is a good thing, it can also be a bad thing.

Why nurses become nurses: There are multiple factors that make nursing an attractive profession. These include social prestige, financial security, expanding opportunities, and the satisfaction that comes with helping others. It takes a special type of person to become a nurse. When I ask nurses why they became nurses, the answers vary but the overwhelming majority rate patient care as number one. This is reflected in the level of care they give and the pride they take in their profession. Many of them were inspired by their own personal experiences with other nurses.

“I was impressed with the way the nurses cared for my mother.”

“When I was sick in the hospital, the nurses made me feel safe.”

“I wanted to make a difference in peoples’ lives.”

“My mother was a nurse and I wanted to be like her. It runs in the family.”

Nursing is rewarding, but it is also tough profession. And, like everyone else in the world, nurses get into problems with alcohol and drug dependency. Nurses have unique stressors and while they share some commonalities with other alcoholics and addicts, they have unique differences. This booklet is about those issues.

Colleen W., RN, Med-Surg: Some nurses, like Colleen, get into trouble with mood altering substances before becoming nurses. Here is her story: “I never was much of a drinker or a drugger for that matter. I had pretty good grades in high school as a matter of fact I was in the top 10% of my class and I really did not have to study that much. I figured it would be just as easy in nursing school. Boy, was I wrong. I made a low “C” on my first test and went into panic mode. I was lucky enough to get in with a pretty good study group and that is when I got introduced to Adderall. Everybody was taking it. The told me about this Nurse Practitioner who was handing it out like Halloween candy. I went to her and answered a few questions that I have been prepared for by my friends. I walked out of there with a prescription and I would just go back whenever I needed more. She also gave e some Ambien for sleep. If I got too amped up on the Adderall and was out of the Ambien, I learned to take a drink or two to come down and sleep. I also found out that I could drink alcohol and not get too drunk if I took an Adderall before I went out. I guess that sort of led me into trying other stuff. Adderall really did help me study. It also helped me work extra shifts to pay off my student loans. I got to where I relied on the Adderall to work and the Ambien to sleep.”

The Board of Nursing referred Colleen to treatment due to the fact that she had diverted Ambien at work. She had been a Registered Nurse for six months at the time. Her supervisor confronted her due to medication discrepancies and when they insisted on a drug test, she confessed.

Colleen is certainly responsible for her behavior but she is also a casualty of "academic doping". According to numerous studies, use of Adderall in this type of situation increases risk for other drug use. Up to 96% of persons who use Adderall for non-medical purposes (academic doping is a non-medical purpose) use other illicit drugs.

Colleen also exemplifies some basic tenets of drug abuse. She was made **aware** of Adderall academic doping by her peer group. There was definitely an atmosphere of **acceptance** among the student nurses in her study group. Her **assessment of the risk** from using was very low. Her peers were using it and all they reported were positive results. And, the drug was readily **available.** Once she used a controlled drug for non-medical purposes, she became a drug abuser. This also set the stage for her to continue the using behavior and to rationalize drug diversion (theft). After all, she used Adderall and Ambien before and got away with it, which means she could obviously handle it and those warnings were meant for people less knowledgeable than her. Why not divert that PRN Ambien that Mrs. Jones decided not to take?

The transition from non-medical use to diversion is often a subtle one. In Colleen's case, it started with her first dose of "academic dope".

Drug Dependency is almost an occupational hazard in nursing. The easy access and the fund on knowledge about the effects of medications can make nurses more susceptible to thinking they can "control it." Some areas of nursing are more high risk that others. Anesthesia is one of those areas.

Gerald D., CRNA: *"I went into nursing with the goal of becoming a CRNA and I made it. I love everything about it and now I may have thrown it all away behind my drug addiction. I should say my opiate addiction. I only use opiates. I rarely drink because I just do not like the feeling. But I loved that damn Fentanyl. I guess I loved all of it. When I was in high school, I fractured my femur and was given a prescription for hydrocodone. I really like it. Opioids energize me. It is like I can go forever. But, once the bone healed I got off the stuff and that was that. I am a good CRNA. Which means I am in demand. I took on another job at another hospital and I was burning the candle at both ends. I remembered how the opioids energized me. So I shot up a small amount of Fentanyl at work and I was off to the races. I could work 24 hours without any problems. At least that it was I thought. Then I started relying on it. I knew I was going to have to detox myself because when I got off I had withdrawal symptoms. I had it planned out but I got called out to work and I had to go in. So I hit up a little to get me by. But it was not enough and I started detoxing at the hospital. I decided to hit up between cases and they found me passed out in the bathroom. They gave me Narcan and that of course put me into acute withdrawal and now I am here in treatment. People at work were really surprised to find out I was a drug addict. I hid it well."*

Gerald may have hidden his addiction well. Nurse addicts are loners and nurses are smart. He became quiet adept at deflecting questions from his peers.

"I admit I came in looking pretty rough a few times but I just told everyone I was working too many shifts back to back. That was something we all understood. One time I was having some detox signs and I played it off like I had the flu."

Gerald probably had some help hiding out. Nurses tend to cover for each other and they tend to discount obvious signs of addiction in their peers. They may not be comfortable confronting their suspicions. They may have a misplaced sense of loyalty. They may minimize any signs of impairment.

One of his co-workers later indicated that she was concerned about this behavior but thought he was just going through a bad time. She had covered up a couple of drug errors she caught and made it her duty to watch out for any "mishaps". She did not want to report him because she knew he was the sole support of his family and his aging mother. In short, she was enabling him through her silence.

Gerald also presents with another facet of addiction that may seem strange to some people. The opioid drugs energize him. They make him

feel good and give him the energy to work long hours. The majority of people who take opiates medically for acute pain often report the opiates knock them out. People who get energized by opioids are obviously at high risk for opioid addiction.

Nurse anesthetists are not the only nurses getting into opioids. Where there are opioids, there is opportunity. If opioids are on the unit, the danger of diversion exists. But, you do not have to be a hospital nurse to be around opioids. Home hospice nurses and home care nurses are exposed to prescription opioids on a regular basis.

Plus, there is the ubiquitous “hallway consult” in which a physician quickly scribbles out a prescription on requires from a nurse. If that does not suffice, the nurse can always try to forge a prescription. That behavior often turns out badly.

While nurses have excess to various addictive drugs, they also have access to alcohol just like everyone else.

Rita S, RN, Obstetrics: *"I am here (in treatment) because my supervisor smelled alcohol on my breath. I had been drinking the night before and I did not stop soon enough. I knew I should not have gone in but I already had several absences and I know they were getting suspicious. I have gone in with a hangover and the shakes before. I take a 0.5 Xanax for the shakes and I can function pretty well. I just screwed up this time. I know I need to stop drinking but I cannot afford to be out of work. I am the breadwinner in my family. I am not like these other nurses. I do not divert drugs I do not take drugs except as prescribed. So I do not need inpatient treatment. All I need is outpatient or just monitoring. I tried to stop before but this time I have learned my lesson. You do not have to worry about ever seeing me here again."*

Rita has a long list of work problems. She comes in late or she calls in at the last minute. She has mood swings and has "snapped out" at patients. She is employed in a hospital that is short staffed and has difficulty getting nurses so there is the possibility that there has been some professional enabling by her supervisor. She is obviously fearful for her license but still wants to bargain her way out of inpatient treatment even though two facilities have recommended it. She does not see herself as an impaired nurse. The Board of Nursing disagrees with her.

Rita's life is chaotic. Her 17-year-old daughter wants to drop out of school and she is using marijuana. Her 13 year-old-son stays away from the house as much as possible. She admits feeling guilty about passing out on the couch instead of interacting with the children. Rita and her husband argue about almost everything including money. He drinks but not as much as her. She gets very angry when he tells her to tone the drinking down. Her husband has been laid off and the family is in financial trouble. Without

Rita's income, the family would be broke. Her relationship with her mother is turbulent. Rita's mother says Rita does not remember phone calls that she makes late at night. Her mother thinks she is depressed and needs to see a psychiatrist.

Rita fulfills all the criteria for a simple alcohol dependency screening too called the **CAGE**:

- **C** – People around her at expressing concern about her drinking.
- **A** – She get angry when confronted about her drinking.
- **G** – She has guilt about her drinking behavior.
- **E** – She needs an "eye opener" at times to ward off alcohol withdrawal. In her case, she takes a Xanax.

Rita's life has been falling apart for a couple of years. By the time a nurse displays alcohol or other drug induced dysfunction at work, the addiction has progressed to a significant level of severity. She needs treatment.

Signs of Addiction in the Workplace: There are many clues that a peer may be suffering from the brain disease of addiction. Unfortunately, co-workers often do not put all these clues together" until after some sort of crisis brings the nurse's addiction to the forefront. Here are some signs of addiction:

- Absence from the unit for extended periods of time
- Frequent trips to the bathroom
- Arrive late & leave early
- Excessive mistakes
- Medication errors
- Narcotic discrepancies
- Large amounts of narcotic wastage
- Frequent reports of inadequate pain relief by nurse's patients
- Offers to medicate co-worker's pain patients
- Altered verbal or phone medication orders
- Changes in appearance
- Diminished alertness
- Memory problems
- Abnormal pupils size
- Unexplained or unusual bruising
- Hand tremor
- Irritability
- Inappropriate verbal or emotional responses
- Isolation from peers
- Works at multiple facilities
- Jumps from one facility to another

Treatment Issues in Nurse Recovery: The number one barrier a nurse faces when confronted with the need for treatment is the fear of "loss of license." This is a real fear but it is not based upon sound fact. Many State Nursing Boards have alternative programs. An alternative program refers to the fact that the Board would rather the nurse get help and be monitored than go through a disciplinary process. This is not a free pass. Alternative programs are in place to help the nurse as well as the public because these programs combat the conspiracy of silence phenomenon.

For example, the Louisiana State Board of Nursing has an alternative process that results in a 90% recovery rate for participants in its Recovering Nurse Program. If a nurse comes forward as a self-report, she/he may qualify for a confidential agreement. This generally calls for an evaluation, possibly treatment, and a monitoring process for several years. It is a win-win situation. The nurse gets help and the Board safeguards the public.

Special Treatment Needs: The addictive behaviors of nurses are generally not like those of non-medical addicts. As stated earlier, nurse addicts are loners. They are not in the "drug culture." They hide their addictions and they use in secret. Rationalization and intellectualization are generally prominent defense mechanisms. They also present with a great amount of guilt and shame, including "professional shame".
One, criticism I have heard from uninformed people, including some therapists, it that special treatment program tend to make healthcare professionals feel they are better than other addicts. In reality, the opposite is true.

I think this nurse's statements deflate that criticism.

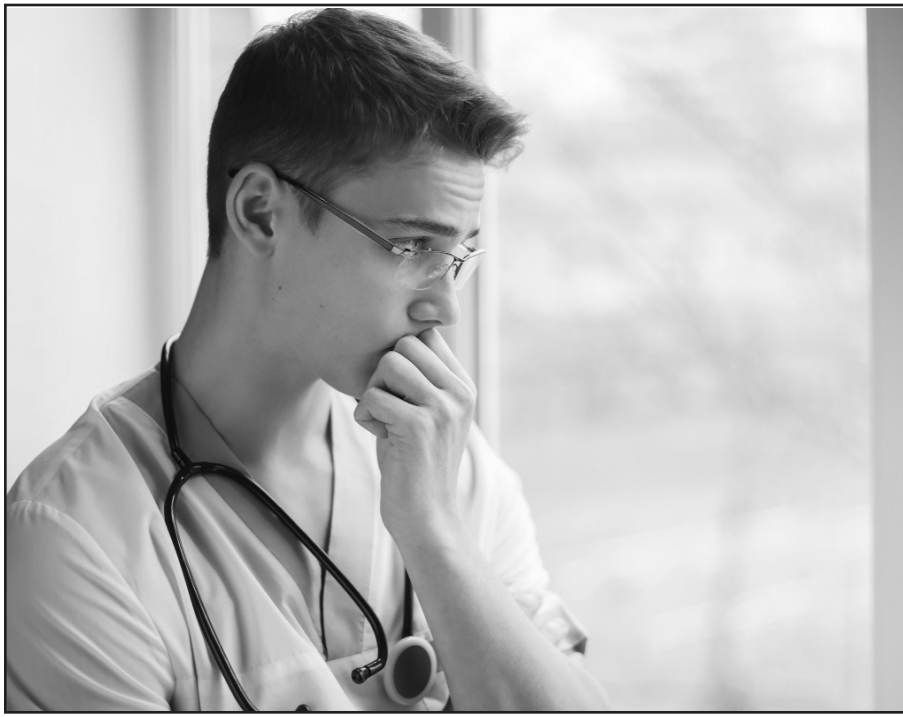
Jason H., trauma nurse: *"It's not that I think I am better than other addicts, it's that I think I am worse. I knew I was doing wrong. I was in way over my head. But, I was afraid to reach out for help. I tried so hard to control it myself. I betrayed everything I stood for. I felt like was betraying my patients because that is what I was doing. I was lying to my co-workers and my family. I was always afraid of getting caught so I kept others away. I kept telling myself that I am smarter and better than this. I am not."*

Jason is a good nurse and he is experiencing "ego deflation at great depth." He has violated a sacred code of ethics. He has violated the Nurse Practice Act and he has diverted narcotics, which is a felony.
He, like many other nurses, has also practiced under extraordinarily stressful situations.

Shirley P., RN, Emergency Department: *"I remember my first CODE. We all do. I remember most of them prior to Ambien. If we were successful, a positive attitude permeated the unit. But, if we were unsuccessful, the team just sort of drifted away. Some of us would get together later at the local pub to decompress but we often avoided really talking about it. You know? It was not supposed to really get to us. You know? There was not room for self-doubt on our team. Or at least that was the unspoken rule. We would avoid the pain with alcohol and bravado. That did not work out well for many of us. Some of us ended up in treatment and some were not so fortunate.*

I would go home and I could not sleep, especially with shift work. That is when the Ambien started. I became a zombie with that stuff. One of my biggest fears is that I hurt someone while I was numbed out on that crap. There is so much I simply do not remember."

Self-Medication: Nurses who try to self-medicate negative emotional states, such as job related grief, are at high risk for addiction. Part of treatment is learning to deal with that pain and learning healthy ways to cope. That is best accomplished in healthcare specific groups in which others can relate to such unique stressors.



The list of unique stressors can seem overwhelming:

- **Shift work** –Inefficient sleep takes a heavy toll on many nurses. There are acute and chronic adverse effects to disrupting normal circadian rhythms, not the least of which is depression.
- **Burnout –** Nurses can suffer from all sorts of "Battle Fatigue" such as decision fatigue, compassion fatigue, and alarm fatigue.
- **Patient Load -** Between a nursing shortage and financial constraints, patient loads appear to be increasing.
- **Perfectionism –** Nurses are expected to give one hundred percent 24/7. It is an unrealistic expectation but a lot of nurses buy into it.
- **People Pleasing –** Being caretakers, some nurses fall into the trap of trying to please everyone. Since this is impossible, especially with disruptive patients' relatives, the nurse may feel inadequate. The need to "people please" may be related to family of origin issues such a being raised in an alcoholic family.
- **Administration –** There seems to be constant friction between the "bean counters" and the caregivers. Nurses often cast themselves in the roles of defending patients against the perceived "evils" of the administrators.

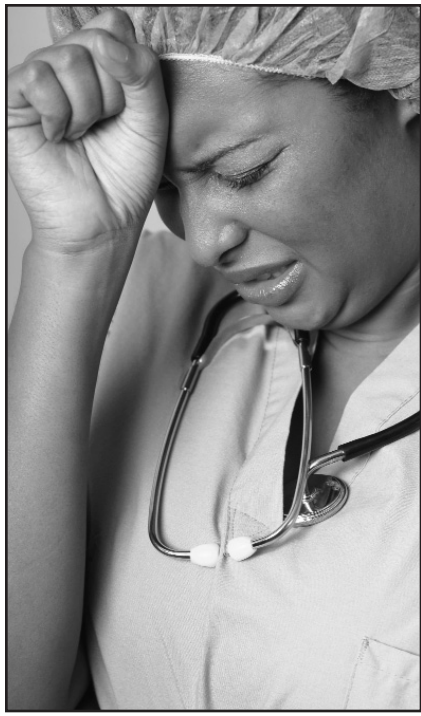
- **Disruptive Physicians –** Feeling powerless to deal with abusive physicians creates a hostile work environment. These doctors should be reported but they may also be protected by administration, especially if they are major admitters to the hospital.
- **Technological Advances –** The implementation of advances, including Electronic Health Records has proven to be very stressful for many healthcare providers.
- **Pain -** According to the American Nurses Association, 52% of all nurses suffer from back pain. Many of these nurses are prescribed narcotic analgesics. Some of them become dependent and some become addicted.

Sara Jeanne A., RN, Physical Rehab: *"I injured my back a couple of times but I did not let that stop me from working. The first time I was trying to transfer this big guy from his bed to a wheelchair on my own. The aides were tired up, because we are chronically short staffed. I knew better and I paid for it. I felt my back pop when he almost fell. I started taking NASAID like I was eating M&Ms. Then I did it again on a very large woman. The orthopedist recommended surgery but I was afraid of that. He put me on some Norco and flexeril. . I could not sleep on the Norco so he added some Xanax at night. Then I was tired from shift work so my PCP put me on Nuvigil. I would take all that and go to work. I admit that on rare occasions I would have to take an extra Norco or a Tramadol that I got from my PCP, for the pain. I thought my work was fine but I feel asleep a work and they said an needed an evaluation for addiction. I am not an addict. I just did what I had to do to keep working. I am a single mom with three kids. You can do the math. I do not have time for surgery and rehab for myself."*

Assets and Liabilities in Treatment: Nurses are smart people. They have the ability to grasp concepts quickly. That can be a definite asset in treatment for addiction. It can also be a liability that presents in the form of intellectualization and "analysis paralysis". It is much easier to be objective rather than subjective early in the treatment process.

Cathy M, Telemetry (two months into treatment) addressing **Theresa B., NICU** (newcomer) in nurses' group: *"I did the same thing you are doing Terry. I would pick this brain disease concept apart and look for why I was not an addict. I would also over-analyze everything told to me in group. And I would want to debate it. We are comfortable living in our heads. Applying treatment to ourselves can be another matter. For me it was all part of my denial."*

Compassion and Rescuing: Nurses are trained to step in and rescue people. When someone is in distress, they try to make things better. That is a definite asset in the world of medicine but it can be a liability in a recovery group setting. There are times when other group members need to recall life events and behaviors that cause emotional pain. This is part of a process that allows the person to resolve painful issues that if not addressed act as triggers to relapse. Interfering with that process by trying to recue the person from pain is non-therapeutic. In "mixed groups" (composed of non-healthcare professional patients), other group member may cast the nurse into the role of "co-therapist. It is "natural" for the nurse to accept this role. Subsequently, the nurse does not get the benefit of the group process.



Secrets Kill: Nurses are trained in confidentiality and they know how to keep things to themselves. They also are reluctant to share certain professional issues in "mixed groups". Indeed, there are things that should not be shared in mixed groups. Issues related to violations of patient care will be understood among peers. One of the prices of societal prestige is higher societal expectations and harsher society response of failure to fulfill those expectations. Nurses entering recovery are generally filled with fear and shame. They are very unforgiving of self at times and they do not need to be pelted with more negative judgmentalism. They also need to be in treatment with other nurses who are progressing though the stages of recovery. This not only promotes bonding into the group but also instills hope.

Understanding of Disease: Nurses have the foundation to understand pathology. They can understand the brain disease of addiction. Like any other addict giving up their love object (alcohol or other drugs), nurse go through a grief process. But they grasp disease concepts and understand treatment plans. Addiction is a primary, progressive, destructive, and chronic illness. Once they apply these concepts to their own addictions and approach addiction in the context of chronic disease management, they achieve sobriety. About 90% of nurses do this and enjoy a life free of addiction.

If you are a nurse and have concerns that you may have a problem with alcohol and or other drugs I strongly encourage you to reach out for help. Addiction is a progressive illness and the consequences tend to worsen over time. Alternative nursing board programs exist to allow you to get help before experiencing some professional crisis.

If you are concerned about a nurse who needs help, I encourage you to educate yourself about addictions and to explore ways to help that nurse get help.

Check out the Recovery Nurse Program (RNP) on the Louisiana State Board of Nursing (LSBN) Website:

http://www.lsbn.state.la.us

Addiction Assessments
Ambulatory Detoxification
Medication Management
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Lane
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A Substance Abuse Treatment Program at Lane Regional Medical Center

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