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Safety and risk in practice

Health workers and street drugs

In view of the extent of use of "street drugs", particularly among young urban residents, one must expect to encounter the phenomenon among employees in hospitals and the health services generally. In the US, attempts to ensure a "drug-free workplace" had by 1996 reached the point where more then eighty percent of corporations employed some form of drug-testing programme on their workers [1]. Drug testing in the health care sector, by contrast, has been slow to develop, and where an institution does perform testing on its employees it often excludes physicians from the programme. There is no great technical obstacle to introducing such programmes, which generally concentrate on the collection of urine samples and the detection of traces of marihuana, cocaine, amphetamines and barbiturates; the tests may be carried out as part of recruitment routines, routinely on all staff, on a random or periodic basis, or simply where evidence comes to the fore that drugs may have been used and confirmation is sought. How intensive the programme is will essentially depend on the supposed extent of the problem. Some have argued that "...casual drug use among health professionals in such as way as to expose them to the risk of drug abuse and addiction may be higher..." than in the working piopulation as a whole [2]. Insofar as physicians are concerned, the American Medical Association has stated that "...when physicians or other individuals who are employed to protect the health and safety of the public abuse drugs, the consequences are potentially life-threatening" [3]. An important variant is also cultural: in parts of the Middle East where the daily use of Khat is normal in all segments of society, including the medical profession [4], it will not be regarded as a risk; the same is likely, rightly or wrongly, to apply as regards marihuana in some parts of Europe.

An aspect of current interest, and which is coming emphatically to the fore in the United States, is whether a hospital or other institution could be held liable for failure to maintain a drug-testing programme among its staff [5]. The view that such a programme constitutes invasion of privacy should be taken seriously, though it is likely to be outweighed by the possibility that drug use may endanger patients. In cases of alleged patient injury, institutions have in the past been held liable for failure to examine a doctor's competence, but it is not clear how far the duty goes to examine his fitness to practice. A court in Georgia concluded in 1990 that "While it may be negligent to hire or retain a physician whose performance is compromised by illegal drug use, it is not negligent to hire or retain a physician who is only rumoured to use illegal drugs" but this judgement relates primarily to the degree of suspicion which must exist to justify testing; it seems to imply that if the suspicion is sufficiently strong there will be a duty to investigate it. In other countries, drug-dependent physicians have been held incompetent to practice, though these cases have related to potent narcotics or alcohol and again the question arises whether use of a drug such as marihuana will be considered a bar to competent practice. The current situation would appear to be that every hospital and health institution should have a drug testing programme for its employees, including physicians; how intensive it is will depend very much on the extent and nature of supposed drug use and of risks to the patient.

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The doctor as a vector of disease

The fact that physicians were themselves transmitting the causative agent of puerperal fever was discovered independently in Austria and America more than 150 years ago. While that appalling risk was eliminated by the simple use of hypochlorite disinfectant, doctors remain significant vectors of a range of diseases; they include influenza, tuberculosis, streptococcal pharyngitis, chickenpox and herpes simplex type 1 infection [1]. A very significant step intended to remedy this situation was taken in Canada in May of this year with the official publication of recommendations seeking to prevent the transmission of blood-borne diseases from physicians and other health care workers to patients. Based on the work of a consensus conference held earlier in the year, they call among other things for mandatory screening for hepatitis B infection and (for those health workers who test positive for HBeAg) a suspension of the right to perform “exposure-prone” surgical procedures [2]. They deserve to be read in full.

There has been a somewhat hostile reaction from some in the Canadian medical profession to the introduction of mandatory measures and prohibitions, and it is being argued that voluntary measures have had a fair degree of success. The fact is cited, for example, that whereas in 1990 a Florida dentist transmitted HIV infection to six of his patients there have been no further cases of this type in the USA since the dental profession voluntarily adopted a prevention programme [3]. It is also argued that the heavy emphasis placed in the Canadian proposals on hepatitis B represents a costly imbalance; in the view of the critics the risks to patients resulting from the transmission by physicians of the influenza virus or of antibiotic-resistant micro-organisms represent problems of sufficient magnitude to the community to deserve relatively more attention. However well intentioned the Canadian proposals are, the medical profession seems unlikely to endorse them until these issues have been addressed.

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