M.C. is an evening shift nurse on a busy medical surgical oncology nursing unit in a large metropolitan hospital. She is one of seven nurses on the unit with less than two years of nursing experience. Her peer group has developed close relationships, and the group often meets after work for cocktails.

Many of her coworkers notice that M.C. drinks several cocktails per outing and is considered to be the life of the party when she appears intoxicated. Although some of her colleagues note that M.C. is getting close to the edge of what might be considered a problem behavior, no one ever mentions or discusses her drinking with her or considers a planned intervention, even if her drinking behavior could compromise her personal safety (i.e., impaired driving). M.C. is considered fun to be around, is perceived as an excellent nurse, and is a hard worker on the unit and volunteers for extra shifts. She even agrees to do day and evening double shifts when her colleagues are short staffed and the unit would otherwise have to rely on per diem nurses.

One Saturday morning, M.C. comes to work for an additional day shift, is irritable, has slurred speech and an unkempt appearance, and is clearly impaired from the past evening’s drinking. R.H., the only other nurse on the unit for the weekend, has to make the decision of whether or not to confront M.C.

M.C. becomes adamant that she does not have a problem and denies intoxication. R.H. contacts the covering supervisor who visits the unit, excuses M.C. from her shift, and initiates the help M.C. desperately needs (i.e., counseling or admittance to a rehabilitation program for nurses). In a debriefing session with her nurse manager, R.H. states that she felt she did not have the skills or expertise to deal with the situation. She was very uncomfortable with the impromptu confrontation that took place on the unit.

In this example, the unit nurses enabled M.C. and indirectly perpetuated her behavior (Markey, 1995; Tubbs, 1998) by not speaking directly with M.C. about her drinking. Nurses in situations like this one often feel guilty for tattling on their coworker and do not wish to get a nurse colleague in trouble (Markey, 1995; “Nurses and Alcohol,” 1992). Nurses, in an unconscious manner, may deny the work unit’s “family secret” of housing an alcoholic nurse (Gorman & MacDougall, 1998). Some nurses may not want to confront a colleague; therefore, they adhere to an informal nursing code of silence because they do not want to be the one who turned a nurse in and caused him or her to lose a job or nursing license (Casedone, 1994; Markey, 1995). Denial by both the impaired nurse and his or her coworkers can serve as an effective temporary coping mechanism and often is emotionally easier to deal with during a crisis situation than directly confronting another individual (Scott, 2010). Although M.C. received help in the end, her colleagues and nurse manager may have intervened sooner if they had the support, skills, tools, and training to do so.

Incidence Rate

Eighteen million Americans struggle with alcohol abuse, and more than half of all adults have a family history of alcoholism or problem drinking (Scott, 2010). Because exactly how many nurses abuse alcohol is unknown, providing an exact incidence rate is challenging (Jefferson & Ensor, 1982; O’Dowd, 2006). Prevalence of alcohol abuse in the profession of nursing has been reported at 6%–10% (Scott, 2010; “The Do’s and Don’ts of Helping the Impaired Nurse,” 2008); this mirrors a prevalence of 10% in the general U.S. population. Using these rates, the estimated amount of alcoholic nurses in the United States would be around 40,000 (Dunn, 2005; Lachman, 1986). Allsop (1987) and Grace and Rees (1994) rank nursing as one of the top 10 professions that suffer from alcohol abuse. More than...
one-third of nurses drink more than is considered safe (O’Dowd, 2006), with one estimate suggesting that 10%–15% of nurses will have alcohol or drug abuse issues at some point during their professional career (Crosby & Offer, 1988). Alcoholic nurses may not fit a predicted stereotypical “skid row” image; one study of 100 alcoholic nurses discovered that most had graduated in the top third of their class, held advanced degrees, held responsible and demanding jobs, were respected for their excellent work, and were ambitious and achievement oriented (Bissell, 1979).

An anonymous mail survey found that oncology nurses were twice as likely as other nurses to engage in binge drinking (Trinkoff & Storr, 1998). One theory suggests that oncology nurses use alcohol to mask the emotional pain and to distance themselves from patients with cancer. Others feel that alcohol provides an escape or serves as a stress release (Castledine, 1995; Naegle, 1988). Contributing factors to nurses’ alcoholic tendencies include stress in the work environment, isolation at work, short staffing, and either too much or too little activity in the work environment (Booth, 1987).

Because alcohol consumption is socially accepted by some members of society, nurses may be uncertain or even ignore specific criteria that define alcoholism and the behavioral clues that indicate a call or need for help (Allsop, 1987; Cannon & Brown, 1988). Presenting signs and symptoms of an alcoholic nurse are outlined in Figure 1.

**Personal Screening**

Nurses also need to come to terms with their own personal alcohol consumption and drinking behaviors. Even a few alcoholic beverages can make a difference in a nurse’s professional judgment. The rate of alcohol metabolism is the same regardless of a person’s gender, height, weight, or race. The body can take from 1–10 hours to metabolize alcohol (regardless of whether it is hard liquor or wine or beer) with the blood alcohol concentration continuing to increase after the last drink is consumed (Hanson, 2010).

A paradigm shift in the view of alcohol abuse is necessary for nursing teams to talk, confront, and intervene with colleagues like M.C. Before behaviors change, attitudes must change toward perceiving alcoholism as a chronic and progressive illness. When alcohol abuse is perceived as a chronic illness as opposed to a personal lack of control or a moral issue, more colleagues may actually be able to have conversations with a nurse who they think is in trouble and, more importantly, those suffering from alcoholism may seek the help they need.

Conversations about alcoholism may be outside of a nurse’s comfort zone when talking to a peer. Some nurses may find that discussing personal drinking behaviors are easier when assessing and caring for patients or total strangers as opposed to peers. Existing literature outlines strategies for starting difficult conversations with friends or colleagues, an excellent resource for such a difficult topic (Patterson & Grenny, 2002). A precipitating event, such as the one outlined in the earlier case study, often initiates an intervention. Many nursing articles suggest that interventions are challenging and a group consisting of an intervention specialist, a team of nurses, and a representative from an employee assistance department should confront a colleague with a suspected alcohol abuse problem together in a planned intervention (Alexander & O’Quinn-Larson, 1990; Allsop, 1987; Crosby, 1990). However, other authors suggest that speaking one-on-one to a nurse who may be in trouble is okay and exemplifies a caring, supportive, and compassionate colleague who wants to do the right thing (Gorman & MacDougall, 1998). Although the case study in this article painted a different scenario, a survey of Oregon nurses revealed that 75% stated that they would be willing to confront an impaired peer (Cannon & Brown, 1988). The only wrong thing to do about a fellow nurse who is impaired is to do nothing (Jefferson & Ensor, 1982).

Nursing colleagues on the unit or staff must support the nurse and refrain from judging. One study showed that supervisors were more inclined to express attitudes toward disciplinary action, whereas staff nurses were more inclined to perceive alcoholic nurses as having a treatable disease (Hendrix, Sabritt, McDaniel, & Field, 1987). When the stigma has been removed, it may be easier to know how to recognize alcohol impairment so that the necessary conversations followed by the necessary steps for assistance can occur. Numerous organizations provide treatment and support for nurses who struggle with alcohol addiction (Cannon & Brown, 1988; Casedone, 1994; LaGodna & Hendrix, 1989; Tirrell, 1994; Weir, 2010) (see Figure 2). Family members of alcoholic nurses should not be forgotten or neglected in the process. Services and support should also be extended to the families of impaired nurses (Markey, 1995).

**Symptoms Related to Professionalism**
- Frequent change of jobs or voluntary resignation or termination from a job within the past year
- Change in behavior or exhibits inappropriate behavior
- Move to a less busy unit or to an off-shift with less supervision
- Isolation from the rest of the staff
- Volunteers for numerous extra shifts
- Shuns job assignments or seeks job shrinkage
- Complains about personal problems

**Symptoms Related to Performance**
- Tardiness
- Two or more days absent from work in one month
- Failure to meet deadlines
- Increased number of work-related errors and poor performance
- Increase in patient or family member complaints, angry outbursts, or arguments with nurses, physicians, and staff

**Symptoms Related to Hygiene or Physical Attributes**
- Decline or change in personal appearance, such as unkempt hair
- Fatigue, irritableness, and poor coordination
- Headaches
- Slurred speech
- Aggression, depression, or lehargy
- Inability to concentrate
- Sluggish responses
- Alcohol odor on breath
- Strong odor of mouthwash or breath mints
- Diaphoresis
- Dozing off on duty
- Tremors or restlessness

**Figure 1. Signs and Symptoms of Nursing Alcohol Abuse**

Note: Based on information from Bissell & Haberman, 1984; Bissell & Jones, 1981; Castledine, 2002; Crosby, 1990; Dunn, 2005; Jefferson & Ensor, 1982; Lachman, 1986.
Cost

The total cost of the impaired nurse can range from $54,000–$95,300 for the employer, the nurse, and the professional board of nursing (LaGodna & Hendrix, 1989), with costs stemming from counseling, treatment, investigation, legal fees, and loss of income. Although cost is one factor in the entire trajectory, it does need to be considered when addressing impairment. A nurse recovery program in Tampa, FL, showed that retaining a nurse’s job while he or she is in recovery was less costly to the healthcare institution compared to replacing the impaired nurse (Naegle, 1988).

Solutions

A need for education to increase awareness for early detection of alcoholism in nurses clearly exists. Impaired nurses are hazardous to patients and can lead to adverse patient outcomes (Castledine, 1995). Alcoholism should be viewed as an acute, chronic, complex, progressive primary disease or illness that follows a predictable course (Booth, 1987; Heise, 2003; Markey, 1995). Clear policy and strategies for early recognition and intervention must be in place—Castledine (2002) suggested random urine testing of employed nurses as a deterrent to alcohol abuse—and all team members should be kept abreast through clear communication. Nursing staff and administration must have the skill set, support, and tools required to execute existing policies and procedures to actively engage and intervene with a nurse who is in trouble. A supportive and empathetic attitude by fellow staff members, rather than a judgmental one, can be more beneficial toward the impaired nurse. Assessment of the work environment and plans to address contributing factors also should be considered (LaGodna & Hendrix, 1989). When nurses keep themselves safe, they are in a better position to keep their patients safe.

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