To the Editor:—The recent editorial by Berge and colleagues1 sends an extremely important message to the anesthesia community, and I agree with many of its thoughtful and incisive points. However, I must take issue with the authors’ proposed new default position of “one strike, you’re out.” I believe that the question of return to work is far too complex to be approached in a monolithic fashion that lumps all anesthesiologists who have manifested drug dependence into a single group that “should be directed toward lower-risk occupational environments, either within medicine or in a different field entirely.”

A uniform prognosis cannot be assigned to every drug-dependent anesthesiologist. For example, Domino et al.2 suggest that dual diagnosis and family history are among the major factors that must be taken into account when predicting the risk of relapse in opioid-addicted physicians. My own experience supports an additional and extremely important variable that must be considered when deciding whether or not a drug-dependent anesthesiologist should return to his or her profession: The availability of long-term supervision, support, and monitoring. The Medical Society of the District of Columbia’s Physician Health Committee (PHC) intervenes on physicians whose colleagues (and sometimes themselves) believe them to be suffering from the disease of drug dependence. The PHC refers this physician to a specialist in addiction medicine and, if recommended, facilitates admission to treatment (usually residential). Immediately after discharge the physician, now in early recovery, enters into a five-year contract with the PHC. This contract mandates random drug testing (a daily phone call determines whether or not an observed urine sample must be furnished within the next 12 h), monitoring by a member of the PHC, participation in 12-step programs, and continuing aftercare under the supervision of an addictionologist. Some of our clients also submit hair samples for drug testing every two to three months. Our recommendation for a graduated return to work is made only after we receive a recommendation from the treating specialist that this would be appropriate.

Aftercare of opioid-addicted anesthesiologists in recovery may include the use of depot naltrexone. At least one supervisory member of the department is made aware of the individual’s history at the time of return and is informed that the PHC will be responsible for monitoring.

Approximately 90% of physicians (including anesthesiologists) enrolled in the Washington, DC Medical Society’s Physician Health Program have successfully completed their 5-yr contracts.3 The PHC has monitored sufficient numbers of anesthesiologists in recovery whose return to work has been recommended to support my stance that “one strike” need not preclude reentry into anesthesiology. At the present time, although some of our clients do indeed voluntarily leave anesthesiology for another medical specialty, those who have returned to the practice of anesthesiology have been successful in their recovery. While the group of anesthesiologists with whom we have experience is small in comparison with the entire national cohort, our observations support my view that individual consideration, long-term close surveillance, and aftercare by specialists in addiction medicine may provide an alternative to the editorial’s default position.

In contrast, the editorial4 appears to base at least some of its argument on a “pragmatic review of our personal experience with our Mayo Clinic nurse anesthetists,” leading to the observation that “there has been nearly a 100% relapse rate” (relapse is not defined and could represent anything from a single “slip” to a full-fledged resumption of frequent drug use). It is significant that the authors do not provide evidence of long-term monitoring of these nurse anesthetists. Indeed, they state that “it is difficult to exactly quantify the relapse rate, because far too often affected individuals are simply lost to formal follow-up.”

Finally, the editorial refers to Gastfriend’s statement that addiction is “a brain disease that subverts self-preservation”4 to support its contention that “decision-making is damaged by addiction so that abstinence is not simply a choice.” However, Gastfriend also clearly emphasizes—quoting reports from several other Physician Health Programs—that “the vast majority of physicians who have substance use disorders seem to do surprisingly well in recovery.” While I certainly do not disregard the unmistakable threat that addiction poses to anesthesiologists and patients, my own personal experience, and that of other PHC chairs, suggests that the editorial’s pessimism is not justified. Documented sobriety is possible within the operating room environment. When complemented with vigilance,5 including supportive and careful long-term monitoring, return to work can be successful for both the physician and society.

Peter J. Cohen, M.D., J.D., Physician Health Committee of the Medical Society of the District of Columbia and Georgetown University Law Center, Washington, DC. ccohenp@aol.com

References


(Received for publication January 27, 2009.)

Anesthesiologists Returning to Work after Substance Abuse Treatment

To the Editor.—We read with interest the review article Addiction and Substance Abuse in Anesthesiology by Bryson and Silverstein1 and the companion editorial by Berge et al.2 While the former is an excellent overview, the authors inaccurately state that “outcomes have not appreciably changed” for anesthesiologists treated for substance abuse and the emergent role of state Physician Health Programs (PHPs), and their documented achievements in this regard are not adequately emphasized. The subsequent editorial then mentions patient harm, ignoring literature to the contrary, and jumps to the unwarranted policy recommendation of “one strike, you’re out.”