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.”²

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 anesthesia. 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 editorial¹ 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, 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

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To the Editor.—We read with interest the review article Addiction and Substance Abuse in Anesthesiology by Bryson and Silverstein⁵ and the companion editorial by Berge et al.⁶ 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.”

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Vigilance and the Drug-dependent Anesthesiologist

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Three articles strikingly absent in the review and our own recent work document excellent outcomes for all physicians, including anesthesiologists, treated and monitored by PHPs. To summarize each, Pelton and Ikeda reported a 10-yr follow-up of 255 physicians (including 35 anesthesiologists) successfully completing the California Diversification Program with excellent outcomes. They concluded that anesthesiologists had “equal chance of recovery and contradicts the pessimism about recovery in anesthesiologists.” Paris and Canavan reported a case control study comparing relapse and recovery rates between addicted anesthesiologists and other physicians. Thirty-two anesthesiologists were compared with 36 randomized physician controls. After an average of 7.5 yr, the relapse rates between groups were not significantly different. They concluded, “with aggressive follow-up and monitoring, clinicians can expect similar relapse and recovery rates for anesthesiologists as others.” The authors cite Domino et al., but they didn’t mention that the study reported excellent outcomes over an 11-yr follow-up among 262 physicians, of whom 35 were anesthesiologists, and there was no statistical difference in relapse rates for anesthesiologists as compared with other physicians. In addition, there was not a single anesthesiologist overdose death. Finally, McLellan et al., recently published by our group, looked at outcomes of 904 physicians from 16 PHPs followed for 5 or more years. Of this group, 102 were anesthesiologists who we found received more intensive monitoring and had slightly better outcomes with no deaths. Overall, outcomes were remarkably positive for all physicians.

Furthermore, the brief mention of “Impaired Physician Programs” in this review fails to adequately describe modern PHPs that have taken the lead nationally, represented by the Federation of State Physician Health Programs, and are now supported and acknowledged by the Federation of State Medical Boards as preeminent clinical mediators of early detection, treatment, and long-term management of troubled physicians. These programs use innovative technologies for monitoring (for example, regularly testing hair or fingernails for fentanyl and internet-based notification and monitoring) and treatment (such as depot-naltrexone), to mention a few, that identify relapse early and likely account for improved outcomes.

Berge et al., in their subsequent editorial, highlighted concerns about patient safety without mentioning data to the contrary. For example, Domino et al. found no evidence of patient harm during their 11 yr follow-up. Sivaragan et al. examined data from the American Society of Anesthesiology malpractice database, seeking evidence of patient harm from substance abuse. Of the 2,715 closed anesthesia claims, in only 7 was substance abuse noted in the claim summary. Two of the 7 cases involved substance-abusing nurse anesthetists inadequately supervised by anesthesiologists. Three of the remaining 5 claims involved serious patient harm (brain damage or death) as a result of lack of vigilance or judgment during anesthesia. Two involved anesthesiologists who were alcoholics, and the third involved an anesthesiologist who left the care of the patient to smoke a cigarette. The two alcoholic anesthesiologists had been unavailable to provide care, one because of alcohol intoxication and the other who left to attend rehabilitation without providing backup care for a chronic pain patient. In summary, of 2,715 malpractice claims against anesthesiologists 5 involved substance abusing anesthesiologists, 4 of whom were alcoholics and the other a smoker. None involved drug-addicted anesthesiologists. The special stigma directed toward opiate-addicted anesthesiologists does not appear to be warranted.

The recommendation, therefore, by Berge et al. to change the default policy to “one strike, you’re out” is misguided. Before discarding anesthesiologists who fall prey to the scourge of substance abuse, let us first establish early detection programs, such as workplace drug testing, that have only just begun to be used to identify problems early, before overt impairment or overdose; and second, immediately refer those affected to PHPs so they can be properly managed and monitored to assure good outcomes.

Gregory E. Skipper, M.D.,* Robert L. DuPont, M.D. *Alabama Physician Health Program, Montgomery, Alabama. gregskipper@usa.net

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Reentry after Addiction Treatment: Research or Retrain?

To the Editor—Addiction remains a disconcerting disease for anesthesiologists, and we applaud Bryson and Silverstein for their comprehensive review. In the editorial accompanying the review, Berge et al. have taken an extreme position by recommending that “anesthesia caregivers who have become addicted to or abuse anesthetic drugs and supplements should be directed toward lower-risk occupational environments, either within medicine or in a different field entirely.” Although this suggestion may be appropriate for some addicted anesthesia caregivers after undergoing initial treatment, we also know that there have been many individuals who have successfully reentered the specialty of anesthesiology to become productive clinicians and academic leaders. The critical question is whether we can differentiate the treated addict who will relapse from the one who can, under the right circumstances, be integrated back into the practice of anesthesiology without adverse consequences. Is there data to support Berge et al.’s recommendation?

The cry for redirecting recovering anesthesia personnel to other specialties began with the Menk et al 1990 publication describing the experience of anesthesia training program directors. Data were collected on 180 residents abusing opioids or other addicting drugs. The relapse rate was 66% for the 79 opioid-dependent residents who returned to anesthesiology. It was especially disturbing that there were 14 deaths among this group. Since the relapse rate was much lower (30%) in returning residents who had abused alcohol or nonopioids, the authors recommended redirection into another medical specialty for residents who had been addicted to parenteral opioids. Collins presented similarly stark data, noting that of the 50% of anesthesia residents who continued in anesthesiology after treatment, 9% died.

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