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\(^1\) reported a 10-yr follow-up of 255 physicians (including 35 anesthesiologists) successfully completing the California Diver- sion Program with excellent outcomes. They concluded that anesthesiologists had “equal chance of recovery and contradicts the pessimism about recovery in anesthesiologists.” Paris and Canavan\(^2\) 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.,\(^3\) 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.,\(^4\) 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 monitoring of troubled physicians.\(^5\) 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.\(^6\) found no evidence of patient harm during their 11 yr follow-up. Sivaragan et al.\(^7\) 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 that 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\(^8\) 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.** and **Robert L. DuPont, M.D.** Alabama Physician Health Program, Montgomery, Alabama. gregskipper@usa.net

**References**


(Accepted for publication January 27, 2009.)

**Anesthesiology 2009; 110:1423–4**

**To the Editor:**—Addiction remains a disconcerting disease for anesthesiologists, and we applaud Bryson and Silverstein\(^1\) for their comprehensive review. In the editorial accompanying the review, Berge et al.\(^2\) 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 anesthesiology caregivers after undergoing initial treatment, we also know that there have been many individuals who have successfully reentered the specialty of anesthesia 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 anesthesia 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.\(^3\) 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 anesthesia. 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 dark data, noting that of the 50% of anesthesia residents who continued in anesthesia after treatment, 9% died.\(^4\)

**Anesthesiology, V 110, No 6, Jun 2009**

**Reentry after Addiction Treatment: Research or Retrain?**

Copyright © 2009, the American Society of Anesthesiologists, Inc. Lippincott Williams & Wilkins, Inc.
On the other hand, research that emanates from state Physician Health Programs paints a different picture. In a retrospective case control study, Paris and Canavan compared 32 anesthesiologists with 36 physicians, and after an average follow-up of 7.5 yr, there was no difference in the relapse rates between these 2 groups. Likewise, the outcomes of residents did not differ from attending physicians. A similar report from Pelton involving 255 physicians who had participated in the California Diversion Program showed no difference in relapse rates for anesthesiologists.

It is of concern that none of the published studies describing the outcomes of addicted anesthesiologists contain specifics regarding the treatment, the follow-up care, or the factors that were used to determine whether to recommend return to anesthesia or redirection. Addiction treatment in physicians today is rich and sophisticated, with careful attention to the components of the addiction itself, peer-based support, family therapy, and continuing care protocols through Physician Health Programs in most states. Anesthesiologists or those in training who return to the specialty must now agree to specific terms of follow-up care, often including the mandatory use of naltrexone. From Domino’s work, we know that the risk of relapse in physicians is highly associated with the use of opioids, coexisting psychiatric disease, and a family history of addiction. Angres et al. have published lists of factors that they used to decide whether addicted anesthesiologists were candidates to return to the specialty immediately after treatment, should be reassessed after 2 yr, or were at high risk for relapse and not recommended for return.

Nonetheless, the science of addiction treatment remains in its infancy. An exhaustive evaluation of the addiction, psychological, psychiatric, and occupational characteristics of anesthesia providers in treatment has not been performed to date. Research that triangulates the patient characteristics, the type of treatment, and patient outcome has been hindered by the relatively low number of patients, despite the fact that disease prevalence is higher among anesthesiologists than the general population. 5 The lack of standardized reporting of treatment protocols has been put into place to decrease the likelihood and lethality of relapse. Most anesthesia personnel are carefully monitored, reengage slowly, and are at least partially protected by naltrexone, preferably administered intramuscularly. It is our belief that we need research, not a one-size-fits-all policy for our colleagues suffering from the disease of addiction.

Paul H. Earley, M.D., Arnold J. Berry, M.D., M.P.H.* Emory University School of Medicine, Atlanta, Georgia. aberry@emory.edu

References


(Submitted for publication January 27, 2009.)

To the Editor:—The article by Bryson and Silverstein and the accompanying editorial by Berge, Seppala, and Lanier together provide a comprehensive review of much of the current literature regarding the diseases of substance abuse and addiction and their devastating impact on too many anesthesia care providers.

I completely agree with the opinion expressed by Berge et al. that professional organizations must continuously reexamine their efforts to protect their patients and colleagues from the consequences of these diseases. However, their editorial does not provide sufficient justification for their “one strike, you’re out” policy towards substance abusing anesthesia care providers. They offer only anecdotal reports and fail to present any unique, peer-reviewed data or novel insights to support such a dramatic shift in policy. Their approach overlooks several important aspects of these diseases as they pertain to anesthesia care providers: 1) There are important differences between addiction to “anesthetic drugs” and “supplements,” and it is inaccurate to lump them together; 2) the circumstances under which a trainee becomes chemically dependent frequently differs from that of a seasoned practitioner, with profound implications for prognosis; 3) denying reemployment treats only a symptom and may do little to impede unresolved drug-seeking behavior (this was tragically illustrated in a recent newspaper article detailing the drug-related death of anesthesiologist); and 4) as acknowledged in the editorial, the fact remains that data are lacking to prove that relapse and death rates would be affected by redirecting recovering anesthesiologists to other specialties.

Instead of the “one size fits all” approach advocated by Berge et al., I prefer the recommendation of Bryson and Silverstein of an individualized diagnosis and treatment plan, such as is currently employed by many chemical dependency treatment centers. These programs provide distinct categories that define a patient’s risk factors and potential to return, under strict supervision, to various work environments, including the operating room. For example, those who fall into the most favorable category understand their disease, have no underlying psychiatric disorder, are committed to recovery, and have support from their families and colleagues. On the other hand, those in the least favorable category have coexisting psychiatric disease, continue to deny their addiction, and demonstrate no genuine interest in the recovery process. Individuals in the former group are excellent candidates for supervised reentry into practice, those in that latter should be directed to a different profession.

A reasoned approach such as this, coupled with strict supervision and aggressive efforts using modern technology to deter and detect drug diversion, should help us to avoid throwing out all of the babies with the bathwater.

Paul H. Earley, M.D., Arnold J. Berry, M.D., M.P.H.* Emory University School of Medicine, Atlanta, Georgia. aberry@emory.edu

References


(Submitted for publication January 27, 2009.)