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References


To the Editor:—One issue incompletely addressed by Bryson and Silverstein\(^1\) and by the accompanying editorial of Berge et al.\(^2\) is the problem of the quality of care delivered by the anesthesia care provider who is relapsing into opioid addiction.

The time between relapsing addiction and diagnosis typically extends into many months, as in a recent case presented on the first page of a Sunday Boston Globe article.\(^3\)

In this rather long time period the anesthesia care provider will be treating a few hundred patients while either under the influence of self-administered opioids or during a withdrawal syndrome. It is doubtful that his or her care would be in accordance with the principles of the American Society of Anesthesiologists. For one, vigilance would be obviously and seriously impaired either by the psychic effects of self-administered opioids or by signs and symptoms of a withdrawal syndrome. Given the suggested rate of relapse in opioid addiction from the pragmatic review of the Mayo Clinic experience (’... there has been a nearly 100% relapse [...]’\(^4\) and the high rate of individuals lost to formal follow-up in other studies, it is likely that many thousands of patients have been treated by anesthesia care providers in the course of their relapsing addiction to opioids.

I am therefore totally in accord with the proposal of Berge et al. to direct anesthesia caregivers who have become addicted to or abuse anesthetic drugs and supplements away from the practice of clinical anesthesia, once and for all and at the first diagnosis. As we struggle to improve our care and to diminish the tragic effects of medical errors, we cannot allow hundreds of future patients to predictably suffer and possibly die because of laxity and misplaced kindness in our approach to opioid addiction in anesthesia providers.

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References


To the Editor:—I read with interest the article by Bryson and Silverstein\(^1\) and the accompanying editorial by Berge et al.\(^2\) The problem of addiction among all anesthesia providers is a problem that requires continued study and attention to try and lessen the potentially devastating impact this disease continues to have among our colleagues.

While I welcomed the exposure to this issue the article brought, I am disturbed by the editorial by Berge et al. and the attention it may receive as representing current opinion regarding their recommended approach to this problem.

Coming from a background of 29 yr of private practice as an anesthesiologist and 14 yr of active recovery, I have worked with physician health programs in 2 states as well as remaining involved with well-being activities in my local hospital, my state medical association, and our state component society of the American Society of Anesthesiologists. I have been aware of and witnessed both the successes and tragedies of the disease in anesthesiology with my involvement in recovery in these capacities.

I do not agree with the proposed approach of Berge et al. of “one strike, you’re out.” I think that this is exactly opposite to the approach that should be taken to individuals who find themselves addicted to or are abusing drugs used in the work environment. I also disagree that the current default position is one of assuming a return to the workplace, a policy that I equally take issue with.

I am in agreement that there are data lacking to fully support any specific position on this issue, and also agree with Berge et al. that such data would be impossible or inappropriate to obtain using the usual scientific approach. Further, the idea that a pragmatic approach should therefore be taken is also difficult to argue with. Where these concepts diverge from what I feel needs to be done is in how to apply this to the individual physician caught up in the disease process.

Anyone who has been active in physician well-being and addiction recovery has seen that there is a great deal of ignorance about this issue by even otherwise well-educated and well-intentioned people, often in the position to either support the idea of an appropriately conducted recovery of an individual or not. My concern with “one strike, you’re out” is that you will give these individuals the easy option of dismissing every addicted anesthesia health care worker as too dangerous to return to work. That is draconian and also inappropriate. Evaluating each case individually involves a lot of work. Creating an appropriate aftercare environment of support, accountability and monitoring does also, but we as physicians need to do this for our colleagues.

Further, I believe that “one strike, you’re out” will discourage individuals who might otherwise seek help from doing so because of the