CORRESPONDENCE

Jonathan D. Katz, M.D., Yale University School of Medicine, New Haven, Connecticut. Jonathan.Katz@Yale.edu

References


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To the Editor:—One issue incompletely addressed by Bryson and Silverstein1 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 […]”)2 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.

Andrea Torri, M.D., Massachusetts General Hospital, Boston, Massachusetts. atorri@partners.org

References


To the Editor:—I read with interest the article by Bryson and Silverstein1 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

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The Quality of Care by Opioid- and Anesthetic-abusing Personnel


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One Strike, You’re Out: One Size Fits None

One Strike, You’re Out: One Size Fits None


(Accepted for publication January 27, 2009.)
In Reply—We thank the authors of the six letters to the editor, as well as the many other concerned readers of Anesthesiology who have contacted us personally, in response to our editorial on the abuse of narcotics and other anesthesia-associated drugs by anesthesiologists and related professionals (e.g., Certified Registered Nurse Anesthetists [CRNAs], Student Nurse Anesthetists, and Anesthesia Assistants), hereafter collectively referred to as anesthesia care providers (ACPs). The goal of our editorial was to promote scholarly discussion about the strengths and limitations of the anesthesiology community’s current approach to dealing with drug-abusing ACPs. All who have commented seem to agree that the anesthesiology community is faced with a serious problem, but the question remains, “What should we do about it?” Underlying the messages of all who have spoken is a concern about striking a balance between preserving the personal and professional rights of ACPs found abusing these drugs versus protecting the health and safety of both the drug abusers and the vulnerable patients in their care. Clearly it is difficult to make optimally informed decisions given the lack of information on the scope of the problem, deficiencies in the current approach, and the outcomes of all drug abusers (including drug-abusing ACPs involved in ideal treatment programs vs. those receiving suboptimal monitoring and care).

Despite these limitations, the Federation of State Physician Health Programs (dealing with physician programs) and the National Organization of Alternative Programs (dealing with nursing programs) have labored to provide uniform standards for Health Professionals Programs (HPPs; i.e., the individual state’s programs primarily responsible for monitoring and caring for drug-abusing physicians and nurses). Those who have embraced these standards and designed optimal treatment and aftercare programs, and the ACPs who have diligently participated in those programs and returned to meaningful employment, are to be commended for their efforts. Although not all 50 states have such well-functioning HPPs, and although the exemplary programs are not universally successful in treating drug-abusing ACPs and returning them to the workplace, the exemplary programs nonetheless represent an ideal worth striving for. Successful HPPs should be celebrated, replicated, and required for addicted ACPs who seek to return to healthcare employment.

Consistent with this view, authors of four of the six letters commenting on our article (i.e., Cohen, Earley, Skipper, and Specht) shared with readers the results reported by several studies conducted by state HPPs showing narcotic and related-drug abuse relapse rates for anesthesiologists no higher than with physicians in other specialties addicted to other drugs (most commonly alcohol). Of note, the authors of the 4 letters reported no deaths among the drug abusers. Skipper et al. refer to a subset of 102 addicted anesthesiologists with “slightly better outcomes and no deaths” in a recently published review of United States HPPs, although there are no published data in the reference that would allow us to confirm this conclusion. Thus, we must take this claim at face value, without the ability to critique and criticize the underlying evidence.

Despite the optimistic picture provided by many of the letter authors, anesthesiologists continue to relapse and die, as documented by the literature.4,5 That no deaths were captured in the data sets provided by the letter authors, and considering the small sample sizes involved in the various letter-writers’ comments, we must reflect on a point made by one of the corresponding authors, Dr. Berry, in an 2000 editorial where he and a coauthor introduced an article that had studied cause-specific mortality risk in 40,000 anesthesiologists. According to Berry and Fleisher, even with this large sample, the finding of a 34% excess risk of death of accidental poisoning (i.e., fatal overdose) in male anesthesiologists when compared with the risk of the general population did not reach statistical significance. Berry and Fleisher suggested that an even larger sample or a longer period of follow-up would be necessary to detect small yet statistically significant increases in risk.7 It is difficult to square this statement based on data from 40,000 anesthesiologists with the willingness of the current letter authors to rely on data sets that consist of 32,8 35,9 33,10 and 102 presumably highly selected anesthesiologists to assert the relative safety of returning addicted anesthesiologists to the practice of clinical anesthesia. Skipper acknowledges the weakness of these data in a recent 2008 paper he coauthored concerning the effectiveness of HPPs, stating, “It is not possible from the evidence here to prove whether this form of support and monitoring for physicians with substance use disorders is appropriate, too harsh, or too permissive. Any episode of substance use in the context of patient care has the potential for considerable harm.” That an ACP who has suffered a relapse will almost certainly be caring for many patients between relapse and intervention is emphasized by Torri.