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 [...]”) 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


2. Berge KH, Seppala MD, Lanier WL. The anesthesiology community’s approach to opioid- and anesthetic-abusing personnel: Time to change course. ANESTHESIOLOGY 2008; 109:762-4


(Accepted for publication January 27, 2009.)

Anesthesiology 2009; 110:1425-6

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concern that this action will end their career. Rather than disclose the need for help, even after years of successful practice, the individual will choose to remain out there rather than suffer the inevitable consequence of career loss. This has a strong potential for keeping the individual isolated, disease progressing, until he injures a patient or himself and then is discovered. For some individuals career redirection needs to happen and is the right approach, but it shouldn’t be applied to everyone any more than the idea that everyone should get a chance to return to the same work environment in the same capacity.

I am also disappointed in the editorial policy of Anesthesiology that allowed this editorial to be published without so much as a counterpoint view. For the uneducated and inexperienced in this area this editorial may well be adopted as the standard approach by some departments and treatment centers dealing with these personnel, simply because it appeared as it did in this journal. That would be very unfortunate and a tragedy for some in its own right.

I think this editorial, unlike the article by Bryson and Silverstein, have helped foster the idea that we need a ‘one size fits all’ approach where what we should be doing is to evaluate each case individually, applying data where they it exist (like family history, personal history, length of time using, comorbidities, family and hospital/department support, and environment, among others) and individually making a decision to return to the same work or not, employing appropriate monitoring, aftercare and safeguards for the individual and to protect his or her patients.

I agree that it is time we revisit the issue of addiction among our anesthesia caregiver peers. We should continually revisit the handling of this problem, given the potentially tragic consequences to our peers and their patients. I would propose continuing to develop an individualized care plan, based on the best data and judgment available, for each of them much as we do for all our other patients.

Thomas C. Specht, M.D., Tahoe Forest Hospital, Truckee, California. tcspecht@usamedia.tv

References


(Received for publication January 27, 2009.)