

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 physician controls, and after an average follow-up of 7.5 yr, there was no difference in the relapse rates between these 2 groups.⁵ Likewise, the outcomes of residents did not differ from attending physicians. A similar report from Pelton⁶ 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.⁷ 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.⁸

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 is critical but nonexistent. Addiction is a complex disorder with varying severity, course treatment sensitivity, and outcome. Berge *et al.*² by suggesting that we apply a "retrain everyone" policy, ignore this complexity.

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Throw out the Bathwater; Keep the Baby

To the Editor:—The article by Bryson and Silverstein¹ and the accompanying editorial by Berge, Seppala, and Lanier² 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.² 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 an anesthesiologist);* and 4) as acknowledged in the editorial, the fact remains that data are lacking to prove that relapse and death rates

One of the authors (PHE) directs a program that in the past 9 yr has evaluated or treated 128 addicted anesthesiologists, as well as hundreds of anesthetists. Many of them do return to anesthesia with a carefully staged reentry process. Additional assessment and management protocols have 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.

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would be affected by redirecting recovering anesthesiologists to other specialties.

Instead of the "one size fits all" approach advocated by Berge *et al.*,² I prefer the recommendation of Bryson and Silverstein¹ of an individualized diagnosis and treatment plan, such as is currently employed by many chemical dependency treatment centers.³ 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.

* http://www.boston.com/news/local/massachusetts/articles/2008/11/09/something_anything_to_stop_the_pain/?page=full. Accessed January 25, 2009.

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

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.

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

To the Editor:—I read with interest the article by Bryson and Silverstein¹ and the accompanying editorial by Berge, Seppala, and Lanier.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