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In Reply:—We read the letters to the editor written in response to our review article[1] and the accompanying editorial[2] with great interest, and we are encouraged by the enthusiasm generated for this very important discussion.

Drs. Skipper and DuPont contest our assertion that "outcomes have not appreciably changed" during the period of time covered by our review (1992–2007), and cite three papers to support their position.[3–5] Each of these papers report similar positive outcomes for physicians treated and monitored by physician health programs, but they specifically do not indicate any improvement in outcomes in the periods covered (1991–2005). These reports support our assertion that "outcomes have not appreciably changed." In interpreting these studies, it is important to appreciate that the selection process, which is generally described as individuals who *complete* a multiyear program, tends to systematically eliminate early relapsers from the data set. Nonetheless, these are peer-reviewed reports that could and perhaps should have been cited in our review. We agree that treatment and monitoring by a physician health program is essential if an anesthesiologist wishes to return to clinical practice.

Skipper and DuPont also cite the lack of evidence for patient harm reported in the 2005 study by Domino *et al.*; however, lack of evidence is not the same as lack of harm. We believe is it both self serving for the addicted practitioner as well as somewhat irrational from a neurophysiologic perspective to argue that an individual who is managing a addiction that requires diverting medication from their patients is a competent anesthesia provider. One might argue that given a stable dose of methadone, one could be an attentive and focused anesthesiologist. As pointed out by Dr. Torri, when someone is diverting drugs and charting it on a patient's record, one need not look further for harm. To suggest that harm is only measurable in morbidity and mortality is indeed to minimize the role and value of modern anesthesia practice.

Although we had a serious discussion as to whether to suggest a "one strike, you're out" policy for anesthesia practitioners, we chose to suggest an individualized approach. It should be noted that asking a trained nurse or physician to find another specialty of medicine in which to practice is hardly draconian, and we find it difficult to assert that individuals have some form of right to return to the scene of the crime. We note that "out" could easily mean out of clinical medicine entirely, but even this scenario allows for alternative careers. However, we are also acutely aware of individuals who were treated for substance abuse who have been successfully practicing anesthesiology for 20 or more years without a relapse. Unfortunately, these cases are rare. The suggestion made by Berge *et al.* is a simple solution without ambiguity, but each case of addiction and recovery has its own narrative that we believe merits consideration. We applaud the assertion made by Dr. Katz that if, as a society, we are going to adopt a "one strike, you're out" policy, it should be based on evidence. However, we add with some resignation that the lack of appropriate evidence does not diminish the imperative to make decisions when confronted with an addicted colleague.

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Looking Beyond Model Fidelity

To the Editor:—We read with interest the article by Chandra *et al.* in which the authors address the cost-effectiveness of simulation-based teaching of procedural skills.[1] The authors compared an inexpensive low-fidelity simulator to a relatively expensive high-fidelity simulator for learning a complex psychomotor skill: Fiberoptic orotracheal intubation. They found that the high-fidelity simulator had no additional educational benefit.

These findings are consistent with the results of other research that has found low-fidelity models to be as effective as high-fidelity models

The above letter was sent to the authors of the referenced article. The authors did not feel that a response was required. —James C. Eisenach, M.D., Editor-in-Chief.