

Confrontational Approach Has No Role in Addressing Physician Addiction

To the Editor: The article by Berge et al¹ entitled “Chemical Dependency and the Physician” contained little new information and several inaccuracies. First, contrary to the views of the authors who state “the problem of physician addiction has largely escaped the public’s attention,” the public is fascinated with this subject. CNN recently reported on the closing of the California Diversion Program, *US News and World Report* published a survey regarding “Would you want to know if your doctor is addicted?” and during the past 20 years there have been repeated news upheavals and hysteria regarding this issue. The fascination by the public likely represents the incongruity of the mainstream view of addiction as a moral failure that affects lower class individuals and the image of the physician.

Second, the section on intervention is misinformed. The authors suggest using a “confrontational approach, [wherein] the addict is faced by a roomful of family members, coworkers, supervisors, etc, who offer specific evidence of the addictive behavior....” In 28 years of working in the arena of physician health, I have performed thousands of interventions, and this type of “Johnson model” intervention is ill-advised, risky, more difficult to arrange, and less effective. In contrast, the most common model of intervention performed by Physician Health Programs (PHPs) is a nonconfrontational “professional intervention” model, in which evaluation is “strongly advised because concerns have arisen” without pressing the issue of whether or not there is a bona fide problem. Immediate discontinuation of work is recommended to avoid liability issues. If the physician considers refusing, he or she is gently advised that the alternative to the clinical (and usually confidential) approach of the PHPs is to refer the matter to the regulatory board. Prompt entry into the “safe harbor” of evaluation can be

accomplished in the vast majority of cases without confrontation, thus avoiding the stress and attendant risk associated with confrontation. **We frequently handle such interventions by telephone.** In our series of 328 such interventions by telephone, there have been no differences in successful entry into evaluation and no deaths, compared with in-person intervention.

Finally, the authors refer to the oft-repeated and likely faulty data published almost 2 decades ago by Menk et al,² before advances gained by PHPs, in which 16% of relapses were associated with death. Articles that document highly successful treatment and long-term care of anesthesiologists were not mentioned.³⁻⁵

The article by Berge et al is well written but contains substantial misinformation. Involving a medical director of a PHP, an ultraspecialized area of medicine, who is on the front line of intervention and management of addicted physicians for future reviews would be optimal.

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