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Anesthesiologists Returning to Work after Substance Abuse Treatment

To the Editor:—We read with interest the review article *Addiction and Substance Abuse in Anesthesiology* by Bryson and Silverstein¹ and the companion editorial by Berge *et al.*² While the former is an excellent

overview, the authors inaccurately state that “outcomes have not appreciably changed” for anesthesiologists treated for substance abuse and the emergent role of state Physician Health Programs (PHPs), and their documented achievements in this regard are not adequately emphasized. The subsequent editorial then mentions patient harm, ignoring literature to the contrary, and jumps to the unwarranted policy recommendation of “one strike, you’re out.”

* See Web site of the Federation of State Medical Boards at http://www.fsmb.org/pdf/1995_grpol_Physician_Impairment.pdf. Accessed April 8, 2009.

Three articles strikingly absent in the review and our own recent work document excellent outcomes for all physicians, including anesthesiologists, treated and monitored by PHPs. To summarize each, Pelton and Ikeda³ reported a 10-yr follow-up of 255 physicians (including 35 anesthesiologists) successfully completing the California Diversion Program with excellent outcomes. They concluded that anesthesiologists had “equal chance of recovery and contradicts the pessimism about recovery in anesthesiologists.” Paris and Canavan⁴ reported a case control study comparing relapse and recovery rates between addicted anesthesiologists and other physicians. Thirty-two anesthesiologists were compared with 36 randomized physician controls. After an average of 7.5 yr, the relapse rates between groups were not significantly different. They concluded, “with aggressive follow-up and monitoring, clinicians can expect similar relapse and recovery rates for anesthesiologists as others.” The authors cite Domino *et al.*,⁵ but they didn’t mention that the study reported excellent outcomes over an 11-yr follow-up among 262 physicians, of whom 33 were anesthesiologists, and there was no statistical difference in relapse rates for anesthesiologists as compared with other physicians. In addition, there was not a single anesthesiologist overdose death. Finally, McLellan *et al.*,⁶ recently published by our group, looked at outcomes of 904 physicians from 16 PHPs followed for 5 or more years. Of this group, 102 were anesthesiologists who we found received more intensive monitoring and had slightly better outcomes with no deaths. Overall, outcomes were remarkably positive for all physicians.

Furthermore, the brief mention of “Impaired Physician Programs” in this review fails to adequately describe modern PHPs that have taken the lead nationally, represented by the Federation of State Physician Health Programs, and are now supported and acknowledged by the Federation of State Medical Boards as preeminent clinical mediators of early detection, treatment, and long-term monitoring of troubled physicians.* These programs use innovative technologies for monitoring (for example, regularly testing hair or fingernails for fentanyl and internet-based notification and monitoring) and treatment (such as depo-naltrexone), to mention a few, that identify relapse early and likely account for improved outcomes.

Berge *et al.*, in their subsequent editorial, highlighted concerns about patient safety without mentioning data to the contrary. For example, Domino *et al.* found no evidence of patient harm during their 11 yr follow-up. Sivaragan *et al.*⁷ examined data from the American Society of Anesthesiology malpractice database, seeking evidence of patient harm from substance abuse. Of the 2,715 closed anesthesia claims, in only 7 was substance abuse noted in the claim summary. Two of the 7 cases involved substance-abusing nurse anesthetists inadequately supervised by anesthesiologists. Three of the remaining 5

claims involved serious patient harm (brain damage or death) as a result of lack of vigilance or judgment during anesthesia. Two involved anesthesiologists who were alcoholics, and the third involved an anesthesiologist who left the care of the patient to smoke a cigarette. The two alcoholic anesthesiologists had been unavailable to provide care, one because of alcohol intoxication and the other who left to attend rehabilitation without providing backup care for a chronic pain patient. In summary, of 2,715 malpractice claims against anesthesiologists 5 involved substance abusing anesthesiologists, 4 of whom were alcoholics and the other a smoker. None involved drug-addicted anesthesiologists. The special stigma directed toward opiate-addicted anesthesiologists does not appear to be warranted.

The recommendation, therefore, by Berge *et al.* to change the default policy to “one strike, you’re out” is misguided. Before discarding anesthesiologists that fall prey to the scourge of substance abuse, let us first establish early detection programs, such as workplace drug testing, that have only just begun to be used⁸ to identify problems early, before overt impairment or overdose; and second, immediately refer those affected to PHPs so they can be properly managed and monitored to assure good outcomes.

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