Re-Entry of Illegal Substance Abusing Faculty (Trainees) into the Department
Pro-Con Debate

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Risks for Anesthesiologists

- High stress job (Emerg Med and Psych)
- Ready direct access to controlled substances
- Prescribing and administering agent
- IV drugs over oral (compared to med. special.)
- More potent drugs (narcotics vs. alcohol)
- Highly addictive drugs (fentanyl class)
- Rapid dose escalation due to habituation
- Sensitization in the OR environment
- Because of the risk of job loss, reduced rate of self reporting; until it is too late

Incidence/Prevalence

- Data from treatment programs show that anesthesiologists are over represented (13-15%) compared to other physician specialties
  - Talbot et al. JAMA 257:2927-2930, 1987
  - Paris and Cananvan J Addict Dis 18:1-7, 1999
  - Pelton and Ikeda J Psychoactive Drugs 23:427-431, 1991
- Specialized Centers, narcotic addiction
- Higher reporting, aware of risk, high vigilance

Incidence/Prevalence

- Survey 2002 - Incidence of drug abuse is 1 % for faculty and 1.6% for residents in anesthesiology
  - Booth et al. Anesth Analg 95:1024-1030, 2002
  - Death or near death often identifier of the physician substance abuser
  - Ibid
- Agrees with estimates between 1970 and 1980
  - Ward et al. JAMA 250:922-925, 1983
- Caveat – survey data to PDs and Chairs

Shocking Statistic
High Death Rates (1º Residents)

- Menk et al. 1990 - 16% relapse rate among parenteral narcotic users after re-entry to residency (all 13 relapses heralded by death)
  - criticized due to low number per program
- Booth et al. 2002 1-1.6% detection rate and 18% were detected by death or near death
- Collins et al. 9% relapse related deaths in a cohort of 199 residents

If we support re-entry Rehab Potential

- Survey 167 cases surviving initial diagnosis
  - Opioids ~ 34% success rate of training re-entry
  - Etoh et al. 70% success rate of re-entry
    - Menk 1990
- Survey 10 yrs 1991-2001
  - 46% successfully completed anesth residency
    - Collins 2005
- Studies largely comprised of residents
- Most rehab 6 weeks or less (likely too little)

Success in Rehab requires help Physician Health Programs

- State run programs
- Varying degree of support
- Related to funding available
- Not all states have them (~ 40)

What are PHPs doing?

- Education, early detection, evaluation and referral to abstinence-oriented treatment
- Inpatient abstinence programs (60-90 days)
- Psychiatrists, addictionologists, counselors
- Naltrexone therapy
- 12 step program (AA or NA)
- Urine and hair sampling (random)
- Coping with stress and gradual re-entry

State PHPs Success in Rehabilitation

- MDs followed by state physician health progs.
  - 75-90% success rates 5 years of more
  - Oregon experience 75% success with urine testing
    - Shore JAMA 257:2931-2934, 1987
  - California experience 90% successful grads
    - Of 266 MDs, 35 anesthesiologists (6 residents)
    - No difference in success/failure in anesth specialty
      - Pelton J Psychoactive Drugs 25:159-164, 1993
  - Despite high risk, equivalent recovery is possible

Physician Health Programs

- Recent study of 5 year follow up 1995-2001
  - Skipper et al. Anesth Analg 109:891-896, 2009
- 16 state PHPs included
- 26 programs declined; resources or regs prohibit
- 904 physicians from 16 PHPs; 42 residents excluded younger and small number
- 96 anesthesiologists; 13 lost to follow up
- 83 anesthesiologists compared to 697 non-Anesth
- 86% male, average age in 40s, IV drugs preferred

Results Skipper et al. 2009

- At least one positive test
  - Anesth 11% vs. non-Anesth 23%
- Reported to the state board for non-compliance
  - Anesth and non-Anesth ~ 20%
- End of 5 yr contract
  - Anesth 71% vs non-Anesth 67% released
- Extended program beyond 5 years
  - Anesth 18% vs. non-Anesth 16%
- Failure to complete program
  - Anesth 9% vs. non-Anesth 20%

Results of Skipper et al. 2009

No difference in % Anesth vs non-Anesth

Licensed	76	73
not clinical	1	6
Revoked	7	11
Retired	5	4
Died	6	3

Implication rehabilitation can be successful

Propofol – The New Story

- Wischmeyer et al. 2007 queried narcotics, sedatives and propofol; all care providers 1995-2005
  - 18% abused propofol
  - 5 fold increase over the 10 years
  - 28% of cases of propofol abuse detected by death

Perhaps Good News on the Horizon

Random Screening in Residency

Fitzsimons et al. Anesth Analg 107:630-635, 2008

- Pretesting phase 1% positive urine screens overall and 2.2% in CA-1s (403 resident-years)
- Began random urine testing July 2005
- CA-1 residents two random tests per year and an added 20% of class had a third test
- CA-2 and CA-3 residents one test per year and an added 30% of class had a second test
- Did not include propofol nor sufentanil
- No events in 330 resident-years since testing began; P = 0.13 Fischer's exact test

Can we improve the chances of successful recovery

Risk Factors for Relapse

- Family history of substance use disorder
- Use of a major opioid
- Co-existing psychiatric disorder

Relapse Prevention

- Gradual increase in workload
- Frequent monitoring through drug testing
- Attendance for group support and medical f/u
- Control/limit of direct access to drugs
- Monitoring diversion; record review and PYXIS
- Observation by peers

Signs of Opiate Dependence

- Agitation alternating with periods of calm
- Pupillary changes
- Sweating
- Wearing long sleeve shirts
- Frequent breaks or work absences
- Excessive narcotic charting, never returning waste
- Patients arriving in PACU in pain
- Volunteering to work nights, alone. extra shifts, to clean the OR, poor charting

Summary

- While incidence may not be greater in Anesth
- Drug use is a serious problem
- High risk environment; risk takers
- Death rate is high (residents at greater risk)
- Little margin for error in rehabilitation
- Rehabilitation can be successful
- Requires elaborate programs of support

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The Pro Side of the Discussion

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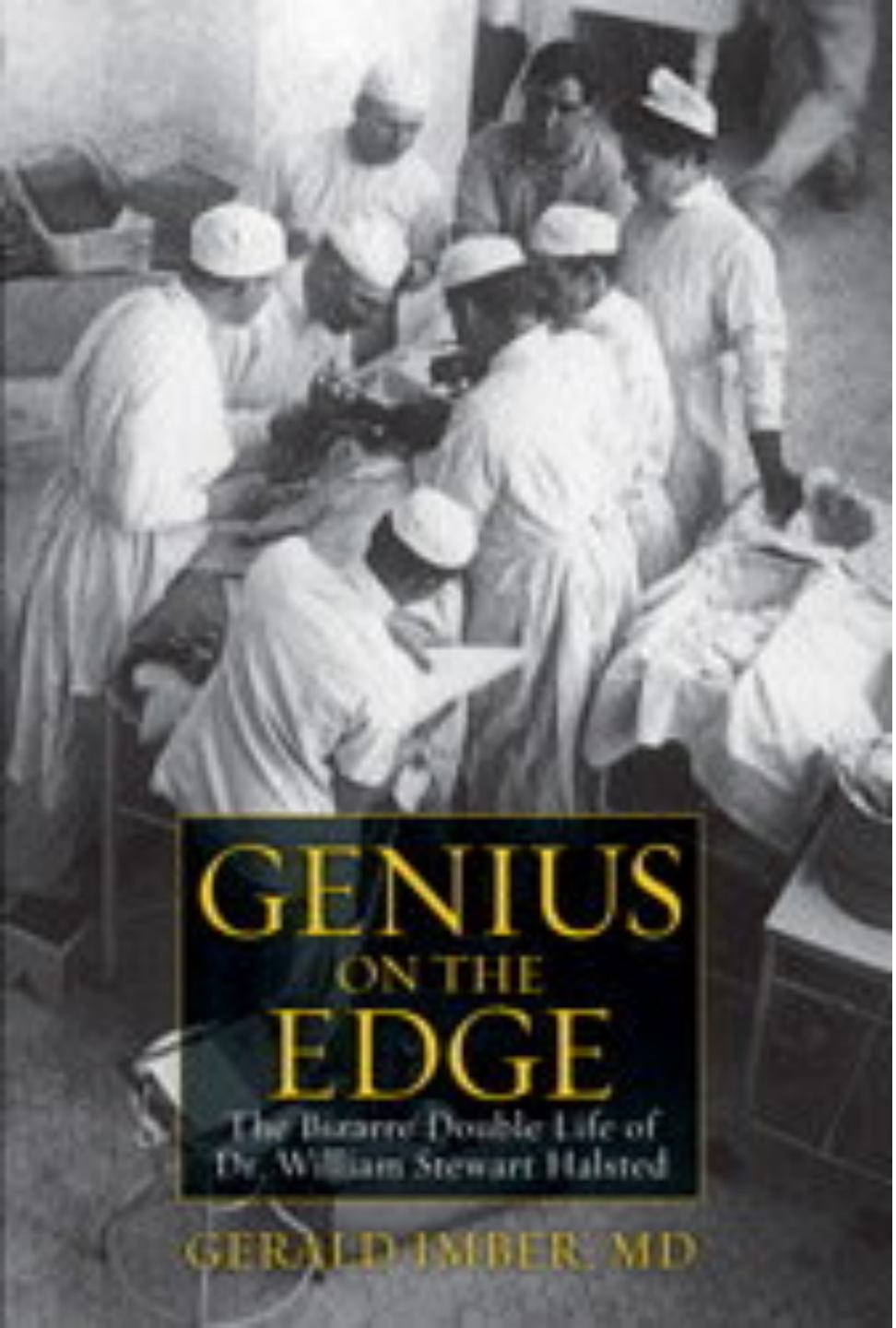

Genius on the Edge

The bizarre double life of Dr William S. Halsted

Halsted was a cocaine and then morphine addict all of his life

Arguments for Re-entry

- Addiction is a disease and when treated patients should be allowed to practice their trade
- There are recognized and successful treatment programs with rigorous requirements and include Psychological evaluation and chemical deterrents, warning signs and screening tests for recurrence

Arguments for Re-entry

- Society has invested a great deal to train physicians, especially consultants
- Despite the risks and down side, recovered physicians can still add value and are worth the re-investment
- The Halsted Equation

Arguments for Re-entry

- Benefit of a early warning, collegial workforce
- The high risk environment can be tempered
  - Gradual increase of workload
  - Intensive monitoring of drug management
  - Academic buffer using residents and CRNAs for PYXIS access

High Death Rates for Relapse

- Highest for Residents
- Requiring a different approach or standard
- What is the death rate for those not allowed to return to the practice?
- Shore in examining the Oregon experience found high suicide rates associated with a punitive approach in contrast to the high recovery rates associated with a good monitoring program.
    - Shore JAMA 257:2931-4, 1987

Are We Allowing Harm to Patients

Closed Claims Analysis

- 2715 closed anesthesia claims
- 7 cases involved substance abuse or dependence
  - 2 of 7 involved CRNA under supervision, MDA not present during the incident
  - 3 of 5 involved substance using MDA involved death or anoxic brain injury
  - 2 of these involved alcoholism; 1 tobacco
  - Remaining 2 of 5 unable to provide care
    - 1 did not respond to emergency, Etoh intoxication
    - 1 did not arrange coverage while away in detox (pain patient)

Proposal for Re-Entry

- Advocate against “one strike and out”
- Evaluate each case individually for risk
- Look for psychiatric and medical co-morbidity, family risks or lack of support structures, other stressors (medical, financial, professional)
- Enforce strict systems for compliance with testing and professional support inside the department, hospital, and state
- Look harder at the risk to residents, re-direction

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Addiction Usually Involves Diversion

- Diversion is stealing
- Diversion is illegal
- Diverting is immoral and unethical
- It should be a plain and simple decision
- Do we disclose the problem to patients

Outcome Studies

- Are flawed
- Only a subset – under represent the full story
- Good results tend to be reported
- Data are often protected and not open for review
- The risk of relapse is death
- Anesthesiologist are risk takers; always at risk
- There are safer areas to practice in medicine

Cost to Society is Too Great

- Rehabilitation is not cheap
- Recovering addicts will not get the needed support of their colleagues
- Errors do occur in practice leading to harm
- There is increased liability to the practice
- Societal trust can never be regained

A Great Debate Ensued