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Addicted Health Care Professionals: Missing the Wood for the Trees?

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Addicted Health Care Professionals: Missing the Wood for the Trees?

Alain Braillon, University Hospital, Amiens

Banja (2014) is rightly concerned with addicted health care professionals, a security issue too rarely raised as even the magnitude of this problem remains poorly investigated, but his title is unduly provocative and he may have missed the most damaging addiction.

First, is testing of school bus drivers a bad idea? Testing is efficient and clearly lays down the rule. Federal law mandates implementing and maintaining a drug and alcohol testing program compliant with the Department of Transportation regulations (49 Code of Federal Regulations [CFR], Part 382 and Part 40). This has not only concerned targeted pilots since 1991 but also includes many jobs, even pipeline controllers. Transportation is the gold standard for security, and the Office of the Secretary of Transportation clearly states that a “drug and alcohol testing program is a critical element of the Department of Transportation’s safety” (http://www.dot.gov/odapc/why_this_program_is_important). For a long time, identifying best practice through benchmarking has been essential for improvement in quality and security (Braillon et al. 2007). In contrast, focusing on rare and tragic events, such as a Stevens Johnson syndrome or a case settled for \$15.5 million (Banja 2014), may not be the best method to improve quality of care (West, Weeks, and Bagian 2008). For too long, health care professional organizations and the Surgeon General have failed to raise the bar. Happily, Levinson and Broadhurst (2014) recently claimed, “Hospitals should be required to perform random drug tests on all health care workers with access to drugs.”

Second, an effective policy against addiction, like any other policies, must (a) use methods based upon scientific evidence, (b) be subject to regular evaluation, and (c) stand on several pillars such as prevention, treatment, and public safety. There is no magic bullet and speaking up is only a piece of a comprehensive framework. Moreover, even in the United States, where there is a long history of promoting speaking up and protecting those who do so (the Lloyd–La Follette Act was issued in 1912), retaliation (bullying, gagging, criminal prosecution, etc.) against whistleblowers remains too frequent in health care

organizations (Lowes 2010). It is no accident that Philipsen and Soeken (2011) provided a “survival guide” for nurses who want to blow the whistle. In Canada, protection for whistleblowers is notoriously poor (<http://canadians4accountability.org/accountability-and-whistleblowing>). In Europe, except the United Kingdom, it is even worse, and speaking up is even an offense in France (Braillon 2010).

Third, tobacco is the most frequent and damaging drug. It kills one out of two who use it. Approximately 480,000 people die prematurely from smoking or exposure to secondhand smoke each year in the United States, which is far more than the 292,000 U.S. soldiers who died during World War II. Smoking by health care professionals is also damaging to the quality of care. In fact, it is a major barrier to tobacco interventions with patients. When compared with physicians who smoke, nonsmoking physicians are more likely to identify the smoking status of their patients, provide advice on quitting and intensive cessation counseling, and initiate cessation interventions (Huang et al. 2013). Last, the role model cannot be ignored. Nonetheless, among the 800,000 U.S. licensed practical nurses the prevalence of smoking is 21% (Sarna et al. 2014). This is far more than in the general population (16%). Accordingly, pediatric nurses perform poorly in identifying and counseling parents who smoke about the risks of secondhand smoke when their children are treated in hospitals (Braillon and Croghan 2014). Among U.S. physicians, the prevalence is 11%, which remains too high. In Italy, the prevalence of smoking among health care professionals is 44%—more than twice of the general population: 48% for nurses, 34% for doctors (Ficarra et al. 2011). Smoking in health care professionals questions their training and consistency. Are they aware of the outcomes (life expectancy for smokers is at least 10 years shorter than for nonsmokers) and that efficient treatments are available? Personally, I would not rely more on a health care professional who smokes than on a hygienist with grubby fingernails.

Impaired professionals can receive the help they need to return to safe practice, as recovering professional

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programs are effective. However, support and treatment should not be dissociated from the business of protecting victims: detection, conviction, and punishment. When recruiting, employers should be entitled to ask a job applicant for a certificate of fitness for the position, including drug tests, delivered by specially trained and authorized physicians. This is the case in many countries and it is even mandatory for specific jobs. For health care professionals, revalidation or recertification could also be an opportunity.

All things considered, who can claim we do enough to avoid hazardous professionals in the health care system? ■

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Unintended Effects on Morale of Mandatory Postincident Testing

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Physician morale is at an all time low. A recent survey of American Medical Association (AMA) Physicians, capturing approximately 14,000 doctors across the United States, found that more than three-quarters of physicians (77.4%) are somewhat pessimistic or very pessimistic about the future of the medical profession; more than 84% of physicians agree that the medical profession is in decline; the majority of physicians (57.9%) would not recommend medicine as a career to their children or other young people; more than one-third of physicians would not choose medicine if they had their careers to do over; and more than 60% of physicians would retire today if they had the means. Physicians identified the single greatest contributor to this decreased morale as “liability and/or defensive medicine pressures” (Goodman et al. 2012).

Professor Banja (2014) has eloquently articulated that it is not clear that any demonstrable harm can be attributed to impaired physicians:

The evidence that currently exists demonstrates a lack of causal or even correlational evidence among the clinical performance of health professionals who abuse alcohol or drugs, their putative commission of error, and the extent to which such errors actually result in serious harm. (27)

It is similarly not clear to even supporters of the idea of alcohol and drug (A&D) testing that either impaired physicians or impaired nurses are sources of error-causing harm. The recent *New York Times* op-ed supporting physician drug testing cited two examples of patients being

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