



## Is your doctor addicted?

Random drug screening urged for health care workers

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Had she been a pilot, or a train engineer, or even a bus driver, chances are someone would have discovered, before it was too late, the demons Kristen Parker was battling. Unfortunately for the people whose lives she would forever alter, Parker was merely a hospital worker.

The 26-year-old surgical technician was hired by Rose Medical Center, in suburban Denver, in the fall of 2008. While she was required to jump through plenty of pre-employment hoops, including a drug test, there was no random drug testing once she landed the job. Which was tragic, because if hospital officials had periodically screened Parker for drug use the way the transportation industry screens millions of its employees every year, they no doubt would have found out the truth sooner.

Despite somehow managing to pass that initial test, Kristen Parker had a drug problem. A very serious drug problem. Her addiction was so severe, in fact, that within a few days of starting her job, she began treating the drugs available in the medical center's operating rooms as her own personal stash.

When doctors and nurses in the OR weren't looking, Parker would quietly steal syringes filled with the narcotic Fentanyl, which is up to 100 times as powerful as morphine, and replace them with syringes filled with saline. At first those replacement needles were new and sterilized. But as Parker's addiction worsened, she became sloppier and more brazen. Soon she was swapping the Fentanyl syringes for dirty needles she'd used to inject herself.

Horrifying? Absolutely, especially given this fact: The previous summer, while living in New Jersey, Parker thinks she contracted hepatitis C from using dirty needles to shoot herself up with heroin.

Parker's behavior eventually aroused suspicions, and she was fired after failing a drug test. But it wouldn't be until June 2009, after Parker had begun working at yet another Colorado medical facility, that Rose officials, along with the state health department, began piecing together the damage she had wrought. Ultimately, they calculated, she had exposed nearly 6,000 patients to hepatitis C.

### Unknowning victims

Among those victims is Jake, a 21-year-old Marine who checked into Rose Medical Center in February 2009 to have a suspicious growth in his throat removed. The growth turned out to be benign, but the care he received from Parker was anything but.

Today Jake is in the middle of interferon treatments for his hepatitis C. Twice a day he's required to swallow a handful of pills; once a day he has to inject himself in the stomach. Every day he has a low-grade fever and suffers body aches. And he knows his long journey has just begun.

"The doctors have told me there's no such thing as a cure for hepatitis C," says Jake. "The best-case scenario is that they control it enough that I'm not contagious anymore."

Maybe the scariest part of Jake's story is that in many ways, it isn't so unusual. Scan news accounts from the past few years and you'll find case after case of drug-addled health care workers endangering innocent and completely unknowing patients:

- In 2006, a St. Louis surgeon hooked on pain pills poked a hole in the colon of a patient he was operating on, causing so much damage that about 12 inches of the man's colon would later have to be removed.
- In 2007, a Pennsylvania dermatologist who was addicted to the powerful pain reliever hydrocodone was arrested by police. Her staff told investigators the doctor was sometimes so zonked out that she had trouble finishing surgery, and that on one occasion a patient was left with part of her nose hanging free because the doctor had missed a stitch.
- In 2008, a Massachusetts nurse was sentenced to 4 1/2 years in jail after she had siphoned pain medication from bottles and replaced it with saline. Numerous patients just out of surgery were given the watered-down, completely ineffective drugs.

How could such nightmares occur — particularly in a health system that more than 300 million Americans assume is safe and secure? The short answer: The system isn't nearly as safe and secure as we might like

to think.

### **Protecting patients**

That's because doctors and nurses, unlike airline pilots, truck drivers, some big-city firefighters, and other professionals whose performance impacts public safety in the United States, are not required by law or regulation to be randomly screened for drug use. As a result, you have zero guarantee that the surgeon fixing your ACL, or the nurse administering your medication, or even the dentist performing your root canal isn't quietly hooked on something that could inhibit — or completely annihilate — his or her ability to treat you safely and effectively.

"The American public has accepted the idea that a physician works in the patient's best interest. And most physicians do," says Lucian Leape, M.D., a professor of public health policy at Harvard's school of public health and a leading advocate for patient safety. "But in the past 20 years, there's more and more evidence that we have some definite problems."

There's so much evidence, in fact, that Dr. Leape now believes it's time to flip the current arrangement on its head — to move from a system in which patients must blindly trust that the people treating them are drug- and alcohol-free to a system in which health care workers are required to prove, through random and periodic drug testing, that they're drug- and alcohol-free. "I'm very much in favor of random testing," Dr. Leape says. "We have a responsibility to identify problem doctors and bring them into treatment." And to protect patients in the process.

But not everyone agrees. In fact, many of the most influential voices in the medical profession are not even paying much attention to the problem. The American Medical Association, for example, has no policy at all on the drug testing of physicians despite numerous examples of patients harmed by substance-abusing doctors. The AMA declined our request to have a medical expert speak on the subject. Meanwhile, although some hospitals have instituted pre-employment drug screening, only a few around the country have implemented a random screening program. Instead, most facilities just blithely assume their workers are drug-free.

All of which is disquieting to victims of drug-induced hospital horror stories, like Jake's. "I was always under the impression that an operating room was one of the safest places," he says. He pauses, no doubt contemplating the terror inflicted on him and 6,000 others by Kristen Parker. "I guess I was wrong about that."

### **Drug testing for doctors?**

Certainly no one looks forward to the prospect of peeing into a plastic container to prove he or she is fit to do a job. Yet all clinical members of the anesthesia department at Massachusetts General Hospital, one of the country's oldest and most prestigious medical facilities, are required to do exactly that. If their tests come back clean, the residents are free to keep on practicing. If not, a second sample is sent to another certified lab for confirmation. If the second sample is positive, the doctor is steered into treatment for drug use.

This program, along with a similar one that's in effect at the Cleveland Clinic, began in 2004 after a rash of publicity emerged about high addiction rates among anesthesiologists. (A 2005 survey by the Cleveland Clinic Foundation found that 80 percent of anesthesiology residency programs had problems with drug-impaired residents.) "Some view it as an invasion of privacy. But others feel we have the safety of the public in our hands, just like bus drivers and pilots do," says Michael Fitzsimons, M.D., the Massachusetts General anesthesiologist who is the driving force behind the testing program. "And because of that, we not only have to be drug-free, but also have to prove we're drug-free."

The results of the program should give confidence to patients — at least those patients who have dealings with Mass General anesthesiology trainees. According to a study in the journal *Anesthesia & Analgesia*, four cases of substance abuse among Mass General anesthesiology residents were reported in the 6 years prior to the program's launch; in the 4 years after the launch, the number of cases fell to zero. None. The very prospect of being tested, it seemed, had changed doctors' behavior.

That's one reason Dr. Fitzsimons would like to see the program expanded to all doctors. While anesthesiologists have received most of the attention when it comes to addiction, the truth is that substance abuse is a problem throughout the medical profession. Not only are doctors five times more likely than the rest of us to abuse prescription drugs, but studies also have found that up to 15 percent of health care professionals will battle a substance abuse problem during their careers.

Of course, from the public's point of view, the real problem isn't the number of doctors and nurses who become addicted; it's that without testing to flag drug or alcohol use, it's far too easy for those addicted doctors and nurses to keep on practicing medicine.

Take Mike, for example, a beefy dentist from a small community in the South. For much of the past decade, patients have shown up at his office completely unaware that on some mornings he was still drunk from the night before. "I've practiced hung over and didn't do right by my patients," he says one morning in a group session at the Florida Recovery Center, a facility specializing in addiction treatment and rehab for professionals, including health care workers. "I have that guilt and that shame."

Or consider David, a pediatrician from the Washington, D.C., area. After his wife complained about his heavy drinking, he did what to him seemed only logical: He brought his booze to the office. At first he wouldn't have a drink until the end of the day, after he'd finished seeing patients. "But the clock slowly starts to get pushed back a little bit," he says. "First you're not going to drink before 5:30, then it's 4:30, then it's 2:30, then it's, 'Why not just be a little high all the time?'" He finally decided to seek help when one afternoon, with kids outside in his waiting room, he was so drunk he couldn't stand up from his desk.

Ironically, David, who's now retired, spent his career working for the U.S. government, which drug-tests more people than any employer on earth. But as a physician with the National Institutes of Health, he was never screened in more than 30 years of practice. Would it have made a difference? He gives an answer common among addicted health care professionals: "Absolutely. It would have forced me into treatment earlier."

### Doctors' status

The notion of workplace drug screening as a way to protect the public first gained momentum in the 1980s; it was a Reagan-era response to the rise of casual drug use. President Ronald Reagan himself signed an executive order in 1986 mandating drug screening of all federal employees. Over the next several years, the private sector followed suit, with workplace testing at companies spiking more than tenfold between 1987 and 1993. The practice wasn't without controversy — some employees and civil libertarians said it violated privacy rights — but the courts have generally ruled in favor of drug screening for people who hold jobs that may pose a threat to public safety, and the public seems to have accepted the idea of giving up some rights in exchange for greater safety and security.

So given the tenor of the times, not to mention the life-and-death nature of what health care workers do, how have most of them managed to have the specimen cup pass them by? In part, the reason may be the lack of a high-profile disaster drawing attention to the cause — as was the case with the transportation industry. It was in 1987, after a fatal Conrail accident in which the brakeman and engineer were both found with traces of marijuana in their urine and blood, that transportation secretary Elizabeth Dole proposed a regulation for mandatory random testing for everyone in safety-sensitive positions, including airline pilots and transit drivers.

"When we board an airplane, train, or bus, or drive our cars on the highway, we literally put our lives in the hands of others," Dole said at the time. "The abuse of drugs and alcohol by transportation workers... is a life-threatening violation of that trust."

The irony is that while the following year 6 percent of rail workers tested positive for drugs, a Harvard survey 2 years earlier had found that about 10 percent of doctors regularly used drugs once a month or more.

Which points to another reason doctors have avoided testing: status. The government and the public seem to have little problem telling a blue-collar subway engineer to offer up his urine, but we've been far more hesitant to put the same demands on a Harvard-trained oncologist or a Johns Hopkins cardiologist. Indeed, in 1990, officials at Hopkins announced a plan to randomly test all their physicians for drugs — only to drop the plan several months later after the doctors objected to it.

"There's a long history of professionalism when it comes to medicine," says Harvard's Dr. Leape, "and the public has generally accepted the idea that physicians are self-regulating."

To its credit, the medical profession hasn't completely ignored addiction among its members. Since the 1970s, most states have had Physicians' Health Programs, or PHPs. These government-supervised plans allow doctors with addiction problems to receive treatment, confidentially and without disciplinary action, provided they come forward voluntarily. On one level, PHPs have been remarkably successful: A study published last year in the *Journal of Substance Abuse Treatment* found that 5 years after treatment, 78 percent of physicians who had participated in PHPs remained clean and sober — a rate four times higher than that of most rehab patients.

That said, there's clear evidence that PHPs alone simply don't do enough to protect the public, starting with lax oversight of the 22 percent of doctors who relapse. After two external audits in a 2 1/2-year period revealed serious problems, including inadequate monitoring of participating physicians, the California Medical Board decided to disband the state's PHP in 2007. "The purpose of the program was

supposed to be protection of the public, not physicians," says Julianne D'Angelo Fellmeth, administrative director of the Center of Public Interest Law at the University of San Diego, who conducted one of the audits. "There are some doctors who don't want to recover. They want to maintain their licenses and their addictions."

What's more, unlike random drug screening programs, PHPs come into play only after the fact — after a doctor acknowledges that he or she has an addiction problem. For many patients, that's too late.

### Thinking twice

In one case, between the fall of 2002 and the summer of 2004, a Pennsylvania man named Terry Golden, who was having urinary problems, went to see Milan Smolko, M.D. Several times Dr. Smolko examined Golden, ran tests, and, finding nothing amiss, sent him home. What Golden didn't know was that Dr. Smolko was addicted to the narcotic oxycodone (sold as OxyContin). In time, the doctor's addiction became so severe that he began obtaining prescriptions from another physician for a different narcotic. As a result, he missed what any doctor in his right mind would have seen: Terry Golden had bladder cancer. He died in early 2008, at the age of 60.

And Dr. Smolko? His license was eventually suspended. The jury that found him guilty of malpractice for failing to diagnose Golden's cancer awarded his widow \$1.88 million. (The decision is currently under appeal.)

In addition to privacy concerns, people who oppose drug testing of doctors typically cite a variety of practical problems, including the unreliability of drug tests and the high cost of screening everyone. "It's an incredibly expensive proposition," says Martin Donohoe, M.D., an Oregon-based physician who has spoken out against random screening. Dr. Donohoe notes that the federal government spends between \$35,000 and \$75,000 for every drug user it finds among its employees. And since most people who test positive are moderate drug users and not abusers, says Dr. Donohoe, the cost of weeding out a single addict who might pose a real threat to the public could range from \$700,000 to \$1.5 million.

But Dr. Donohoe's argument ignores two points: First, addicted doctors who make mistakes are themselves incredibly expensive, not only in terms of the mistakes and malpractice judgments but in lost human life. Second, the point of random screening isn't merely to weed out drug users; it's to make people think twice about using drugs in the first place.

And there's evidence that testing does that. Screening of transportation workers has drastically reduced the number of substance abuse cases in that industry. And in the case of doctors themselves, addiction researcher Mark Gold, M.D., says that the main reason PHPs have four times the success rate of average rehab plans is because active supervision and random urine testing keeps the consequences in the physician's mind.

For a doctor, who faces the loss of money, patients, and status, "that's powerful behavioral intervention," says Dr. Gold. "It keeps you on alert."

One person who'd gladly offer up his urine is Jake, the Marine now afflicted with hepatitis C. Between treatments, he has been studying to become an EMT. When he learned that, like nearly every other health care worker in America, he would never be subjected to random drug screening, he had a simple reaction.

"That," he says, "is ridiculous."

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