characterization of the recovery status and medication adherence with buprenorphine therapy. Buprenorphine alone or in combination with naloxone is reinforcing.[3] It is unclear whether replacement therapy eliminates the use of other drugs of abuse in naturalistic (nonresearch) settings. Patients taking buprenorphine are known to stockpile their medications, either out of concern for running short or at times to ensure an adequate supply for detoxification after a lapse.[4] Buprenorphine abuse also occurs[5-7] and is difficult to detect with simple screening of body fluids,[8] and continued abuse in a safety-sensitive worker is especially problematic. Buprenorphine and methadone have a street value that alone sets them apart from other medications used in addiction care.

Second, nearly every HCP who has developed opioid dependence is removed from the work setting while in the initial stages of treatment. Health care practitioners are commonly held out of work for a specified period by professional health programs and licensing bodies in the interest of public safety. This delay provides ample opportunity to complete the process of primary and secondary opioid withdrawal. Although maintenance therapy creates a smooth transition from short-acting, highly reinforcing opioid drugs to long-acting opioid drugs, maintenance therapy is often difficult and painful at the termination of the drug therapy, despite the best efforts of skilled practitioners. This occurrence suggests that the best counseling for the addicted patient (unless one plans lifelong treatment) would be to assist the patient in making a choice about *when* one will undergo the process of opioid withdrawal not *if* they will. In the case of HCP patients who are often away from work for a specified period, the best time to complete painful detoxification is the present.

Third, substantive literature indicates that the long-term prognosis for opioid-addicted HCPs (especially physicians) is excellent with current abstinence-based protocols.[9-11] In any medical field, before experts can academically espouse the helpfulness of a new protocol, it must be weighed against the current effective and well-studied paradigm. Therefore, clinicians who are promoting buprenorphine maintenance for HCPs can only assert scientific value of buprenorphine maintenance after they have compared it to the current standard in the same cohort. Today's standard for HCPs is abstinence-based treatment and documented support group meetings, combined with behavioral and drug screen monitoring. With the current effectiveness of treatment in this group, why would anyone want to throw an unevaluated protocol into the mix? One should be even more wary of untested protocols in safety-sensitive workers.

Fourth, unjust or not, safety-sensitive workers are held to a different standard than other individuals. This has led the Federal Aviation Administration, for example, to restrict the use of any medication or substance that has the potential to impair reasoning or judgment (recently, a limited number of selective serotonin reuptake inhibitor medications have been approved for commercial pilots under the arduous "special issuance" procedure). Medical professionals likely have little concern about the cognitive effects of a pilot who has been stabilized with an antidepressant, such as bupropion or a selective serotonin reuptake inhibitor. However, one airline crash that involves a pilot who is taking such a medication could damage public opinion; the accuracy of this concern does little to alter its intensity. Similarly, one lawsuit against a physician who is taking a compound that has even a hint of potential to impair thinking or judgment could damage public faith in a hospital, health care system, or medicine in general. Whether we like it or not, politics have a say in our medical decisions. Living in the modern world, one cannot espouse any protocol without taking into account the impressions of the public and legal system, lest the effects of one unfortunate outcome prevent subsequent individuals from obtaining life-saving treatment.

For these reasons, I applaud Hamza and Bryson for their strong note of caution. My guess is it may not be popular, but their call to await further well-designed studies before opioid substitution therapy is implemented is a sound call and good medical judgment.

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Buprenorphine Maintenance Therapy in Opioid-Addicted Health Care Professionals

To the Editor: In their article entitled "Buprenorphine Maintenance Therapy in Opioid-Addicted Health Care Professionals,"[1] Hamza and Bryson draw a distinction between a "harm reduction and damage control model" of opioid-addiction management and treatment for which abstinence (including, very specifically, abstinence from prescribed agonists) defines both the treat-

ment process and its therapeutic objective. The authors' notion that there is an inherent contradiction between continued prescribing of medication and a patient's "recovery" and the suggestion that reducing harm and controlling damage are not part and parcel of any practice of medicine are extraordinary. The authors accept a role for medications such as buprenorphine and methadone when "used to help retain people in the detoxification phase of treatment" but postulate that "maintenance is another matter and indicates severe difficulty with maintaining recovery." In fact, the primary challenge faced by health care professionals and recipients of addiction treatment of all kinds is precisely this "difficulty." In other words, the problem is not the achievement of abstinence but how to maintain it.[2]

No empirical evidence is presented to support the recommended exclusion from practice, across the board, of health care professionals who are being prescribed buprenorphine. None of the studies cited relied on employment data, malpractice experience, or other measures or proxies of practice competence, and several reported results of buprenorphine administration (some by intravenous injection) among nontolerant individuals. Furthermore, to the extent that there is a basis for concern over individuals receiving *maintenance* treatment with opioid agonists, it would presumably be vastly greater for those receiving opioids for pain management (acute or chronic) and probably extend to those taking benzodiazepines for insomnia, antidepressants, and a wide variety of other medications.

The efficacy of maintenance treatment of addiction has been confirmed consistently in reports from throughout the world for almost half a century. This treatment has been strongly endorsed by the highest governmental, academic, and clinical authorities in the United States and internationally. It is ironic that health care professionals, of all people, should argue that it should be rejected when it comes to colleagues who want and need the help that it can provide.

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Buprenorphine Maintenance Therapy in Opioid-Addicted Health Care Professionals Returning to Clinical Practice: A Hidden Controversy

To the Editor: The article by Hamza and Bryson[1] cites several studies to support their opinion that health care professionals should not be returned to practice if their treatment includes opioid agonist therapy. The quality of the evidence cited is poor. Three of the studies[2-4] evaluate the effects of buprenorphine in "healthy volunteers" rather than in patients after careful dose titration. Other studies are small and poorly controlled for the duration of therapy and other drug use. The most relevant study[5] compares patients taking buprenorphine with those taking naltrexone. The findings were not striking; although the buprenorphine patients differed significantly from the controls on several measures, they did not differ from the naltrexone group. In fact, the authors of this study state, "Furthermore, the nondiffering percentage of abnormal cases between the two patient groups led us to infer that treatment with either BPM [buprenorphine] or FHAN [naltrexone] is not accompanied by qualitative differences in the cognitive profiles of these patients."

The poor response rate of the physician health programs they surveyed may have more to do with the skill of the authors in engaging their study participants than with secretive practices by these programs. The survey protocol is vague, and there is no statement of institutional review board approval for the study. Furthermore, the methods in the survey may have resulted in invalid findings. For example, we find the comment describing the New York program as "no policy, left to treating psychiatrist" extremely misleading. In fact, treatment decisions are made in collaboration with the physician health program and subject to its approval. Although it is not uncommon for a participant to require agonist therapy initially, continued use is carefully reevaluated, including the use of neuropsychiatric evaluation and clinical skills assessment before return to work if indicated. The same approach is used for participants prescribed other psychoactive medications with potential cognitive untoward effects.

Much in this article is informed by bias rather than science. The authors characterize opioid-addicted health care professionals as "masters of drug diversion." This view perpetuates stigma by stereotyping health care professionals with substance use disorders. Although the authors note that physicians in physician health programs tend to do better in treatment than other patients with substance use disorders, without good evidence they promote naltrexone because "it undeniably strengthens the safety net." The pervasive bias is further reflected in value judgments about "the improved quality of life for the professional" with the use of the abstinence model and by citing an oral communication describing opioid agonist therapy as "psychotoxic" and "a potential predictor of increased risk for relapse." Hamza and Bryson are correct in their conclusion that more study would contribute to a fuller understanding of the role of opioid agonist therapy in the treatment of health care professionals. It is unfortunate that their review and survey results are so unilluminating.

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