

dilator has been shown to have a favorable cardiovascular safety profile⁴ and beneficial outcomes in both uncontrolled asthma despite standard treatment and mild asthma with an endotype of type 2 low inflammation.^{5,6} In patients with asthma as well as hypertension and other coexisting conditions, physicians should consider anticholinergic bronchodilators within the context of precision medicine.

Chen-Hsing Lin, M.D.

Houston Methodist Hospital
Houston, TX
clin3@houstonmethodist.org

No potential conflict of interest relevant to this letter was reported.

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THE AUTHORS REPLY: Our article reviews the potential mechanisms that link the disease expression of both hypertension and asthma as well as relevant pharmacologic and lifestyle approaches for the management of hypertension. We referenced the review article by Israel and Reddel¹ advocating a trial of a long-acting anticholinergic agent for patients with uncontrolled asthma despite the use of inhaled glucocorticoids and long-acting bronchodilators that enhance bronchodilation and delay the first severe exacerbation with tiotropium.²

Lin alludes to the potential advantages of anticholinergic agents, with the implication that within precision medicine they should be incorporated for patients with asthma and hypertension. However, questions remain. Lin cites a review article by Fanta³ that underscores the fact that anticholinergic agents are not generally recommended for patients with acute symptoms of asthma because of the delay in onset of relief. In one trial involving patients with mild asthma and a low eosinophilic phenotype, in the majority of patients there was no significant difference in the response to either tiotropium controller therapy or mometasone as compared with placebo.⁴ Although anticholinergic agents have been deemed by investigators to be reasonably safe, they have been reported to result in autonomic imbalance, with implications for cardiovascular health.⁵ We agree with Lin regarding anticholinergic pharmacotherapy; outcome studies are required, however, to guide clinicians with respect to their preferential use in patients with asthma and hypertension.

Sandra C. Christiansen, M.D.

Bruce L. Zuraw, M.D.

University of California, San Diego
La Jolla, CA
scchristiansen@ucsd.edu

Since publication of their article, the authors report no further potential conflict of interest.

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Opioid Use Disorder in Physicians

TO THE EDITOR: In the Perspective article by Beletsky and colleagues (Aug. 29 issue),¹ the authors overlook the fact that physicians with opioid use disorder who were receiving care in physician

health programs (PHPs) had the same remarkably positive long-term outcomes as their peers with other types of substance use disorders.² Only one physician received methadone, which

was used to treat chronic pain. None received opioid agonists to treat their opioid use disorder. All were randomly tested for alcohol, opioid, and other drug use during the 5 years of their care. Only 22% had any positive test over that long period, and two thirds did not have a second positive test.

A case can be made for some PHPs to include opioid-agonist treatment, but to ignore the evidence of PHP success without the use of opioid agonists is a mistake. If opioid-agonist treatment is integrated into PHP care, it is vital for outcomes to be studied and reported. I urge those in the field of addiction medicine to reflect on how fundamentally different PHP care is from most treatments for substance use disorder and to find practical ways to integrate elements of the PHP experience into programs so that, like PHPs, they can make long-term recovery the expected outcome of treatment.

Robert L. DuPont, M.D.

Institute for Behavior and Health
Rockville, MD
bobdupont@aol.com

No potential conflict of interest relevant to this letter was reported.

1. Beletsky L, Wakeman SE, Fiscella K. Practicing what we preach — ending physician health program bans on opioid-agonist therapy. *N Engl J Med* 2019;381:796-8.
2. Merlo LJ, Campbell MD, Skipper GE, Shea CL, DuPont RL. Outcomes for physicians with opioid dependence treated without agonist pharmacotherapy in physician health programs. *J Subst Abuse Treat* 2016;64:47-54.
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TO THE EDITOR: Beletsky et al. note that the neurocognitive effects of opioid-agonist therapy as it relates to potential impairment of physician job performance is “far from settled science.” In the face of this uncertainty, the authors promote a permissive stance toward treatment with opioids for PHP participants.

PHPs undertake a responsibility to protect the safety of patients in addition to promoting the health of physicians. In the absence of high-quality evidence to guide them, PHPs must decide where their default position should lie when it comes to the question of whether prescribed treatment opioids could impair the ability of physicians to practice their profession safely. There is justification for concern.

Calibrated pharmacotherapy that carefully mitigates undesired cognitive effects of treat-

ment opioids is not a certainty in many volume-stressed practice settings. The neurocognitive effects of opioid-agonist therapy as provided in real-world settings can impair executive function^{1,2}; by extension, the effect on patient safety is uncertain. Considering lessons^{3,4} from widespread underestimation of the risk posed by prescribed opioids, I advocate further study and a continued cautious approach.

Jon Lepley, D.O.

Corizon Health
Philadelphia, PA
jon.lepley@corizonhealth.com

Dr. Lepley reports being a member of the Pennsylvania Physicians' Health Program Advisory Committee but states that the content of this letter represents his viewpoint as an individual. No other potential conflict of interest relevant to this letter was reported.

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TO THE EDITOR: The article “Practicing What We Preach” underscores the risks of allowing well-intentioned advocacy to substitute for meaningful scientific inquiry. The “systematic ban” on opioid-assisted therapy is a false narrative that is predicated on a mistaken idea that abstinence-based recovery precludes appropriate use of prescribed medications. PHPs universally support medication-assisted treatment and were among its earliest adopters. Prudent use of prescribed medications, including opioid-assisted therapy, is completely consistent with the abstinence-based PHP recovery model. The evidence of the unparalleled success of PHPs in producing high rates of sustained recovery among health professionals is well established.

The authors state that PHPs' (nonexistent) bans on opioid-assisted therapy codify antiquated attitudes and stigma and that denying such therapy to physicians is “bad medicine, bad policy, and discriminatory.” This misinformed rhetoric about PHPs is harmful when it contributes to outcomes such as that in the tragic vi-

gnette described in the companion article, “A Lethal Hidden Curriculum.”¹ Physicians should not be discouraged from seeking PHP assistance because of such misinformation.

Chris Bundy, M.D., M.P.H.

Federation of State Physician Health Programs
Seattle, WA

No potential conflict of interest relevant to this letter was reported.

1. Lucey CR, Jones L, Eastburn A. A lethal hidden curriculum — death of a medical student from opioid use disorder. *N Engl J Med* 2019;381:793-5.

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THE AUTHORS REPLY: Our Perspective article urged the removal of de facto bans on opioid-agonist treatment, making it an option for all PHP participants. Although deeply flawed, assessments by PHP proponents suggest that one in four participants are not adequately served under the current framework.¹ For these and many other health care practitioners who are affected by opioid use disorder, opioid-agonist therapy represents an effective, cost-effective, and lifesaving treatment option.

DuPont’s call to revisit evidence of PHP exceptionalism bolsters our appeal for greater transparency and robust evaluation of PHPs. We strongly disagree that the evidence supporting PHP abstinence-based models is of high quality. Existing studies suffer from selection biases, lack of appropriate controls, and other major flaws. In contrast, the effectiveness of opioid-agonist therapy is beyond doubt.^{2,3} We urge research funders and publication forums to provide incentives for better-quality evaluations.

We share Lepley’s view that opioid-agonist pharmacotherapy in clinicians warrants “further study and a . . . cautious approach.” But there is little reason to imply, as Lepley appears to do, that such an approach supports de facto bans. Using potential practitioner impairment to rationalize a blanket ban, while no analogous bans exist for other potentially impairing substances and health conditions, lays bare a pernicious double standard. With this, we take issue.

Conversely, Bundy claims that our indictment of PHP bans is false and misinformed. On the basis of publicly available information,⁴ there is little question that opioid-agonist therapy is generally inaccessible to practicing health care pro-

viders. Some jurisdictions do provide access,⁵ but in the absence of data transparency, it is impossible to document the reach of exceptions. We have called on Bundy and members of the Federation of State Physician Health Programs (which he heads) to disseminate information on PHP access to opioid-agonist therapy according to state. So far, we have not received a data-driven rebuttal. In its absence, it strains credulity to claim that our article, rather than PHP policies and practices, chills help-seeking among health care providers.

Leo Beletsky, J.D., M.P.H.

Northeastern University
Boston, MA

Sarah E. Wakeman, M.D.

Massachusetts General Hospital
Boston, MA

Kevin Fiscella, M.D., M.P.H.

University of Rochester School of Medicine and Dentistry
Rochester, NY

Since publication of their article, the authors report no further potential conflict of interest.

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