Doctors Square Off on Employee Drug Testing

The President's drug adviser says federal programs work, but JAMA editor calls them "chemical McCarthyism"

AMID much controversy but with the enthusiastic support of the Reagan Administration, programs to test employees for drug abuse are being rapidly implemented in both the public and private sectors. In the federal government, programs have so far been inaugurated in the departments of the Treasury, Justice, and Transportation as well as the Department of Defense. In August, the Department of Health and Human Services issued technical and scientific guidelines for testing as well as standards for certification of laboratories doing work for federal agencies. The government is primarily interested in five drugs: marijuana, cocaine, amphetamines, opiates, and PCP.

Preemployment screening and "for cause" drug tests—and, to a lesser extent, random drug checks—are also spreading rapidly in private industries, particularly in transportation and public utilities.

At the annual meeting the Institute of Medicine* there was a brisk exchange between a journal editor and the government's top drug spokesman that brought the debate over the ethical and technical aspects of drug testing into sharp focus.

Donald Ian MacDonald, who is director of the White House Drug Abuse Policy Office (and of the Alcohol, Drug Abuse and Mental Health Administration), favors testing. George D. Lundberg, editor of the *Journal of the American Medical Association*, had nothing good to say about it.

Lundberg, a pathologist who labels drug testing programs "chemical McCarthyism," took the cautious scientific point of view, while MacDonald contended that the programs have been demonstrated to be effective in reducing drug-related accidents. "It's our belief that it's worth the cost and somewhat intrusive nature of testing," he said.

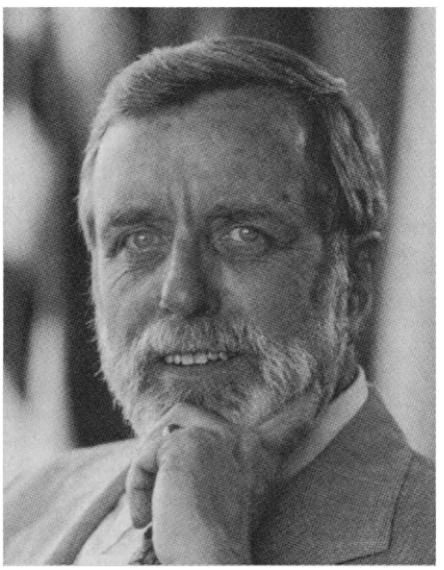
MacDonald, in defense of the federal offensive, argued that one in six members of the federal work force uses illicit drugs on a regular basis, and 44% of all new employees had used drugs such as marijuana and cocaine within the prior year. He said there are 23 million monthly users of illicit drugs in the country. Although cocaine use has leveled off since 1985, he said drug use is becoming more prevalent. For example, he said pre-employment screening of applicants to the New York Transit Authority revealed one-third of the group to have drugs in their urine. As evidence of the effectiveness of screening programs he cited a spot check of Navy personnel in San Diego and Portsmouth in 1983 which revealed that 48% smoked marijuana. Since the widespread adoption of screening programs for military personnel, he said that proportion has gone down to 2%.

MacDonald acknowledged that the problem of individual rights is a tough one, but suggested that, contrary to some assertions, illicit drug use "is not a victimless crime." He said users say there is nothing wrong with doing it on their own time, but this claim is undermined by a recent study that showed that the performance of airplane pilots is impaired a day after smoking one joint of marijuana.

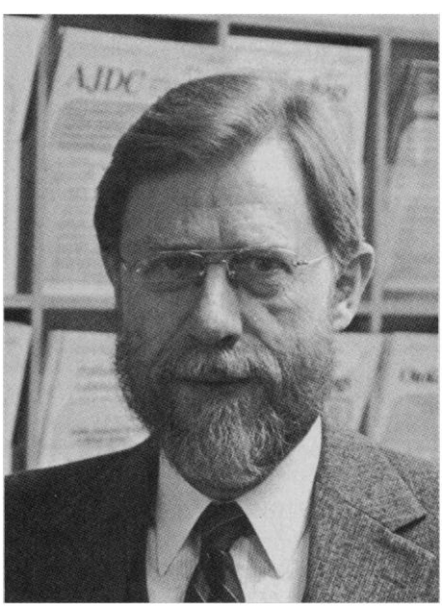
Although MacDonald at one point asserted that he and Lundberg were basically in agreement, they seemed to differ on just about every aspect of the drug testing enterprise, including privacy, accuracy of tests, and costs, as well as basic goals. MacDonald reiterated the Administration call for a "drug-free America," while Lundberg said "there will always be drug use and drug abusers."

Lundberg said "to my knowledge there is no study anywhere to support the notion that the benefits of this approach will exceed the costs." He said tests should be good, fast, and cheap, but that at present no program can combine more than two of those factors. He said that despite improvements in laboratory procedures, there is still a substantial number of false positives, and the lower the rate of drug abuse in a given population, the higher the percentage of false positives. For example, where there is 0.1% prevalence of drug abuse, the predictive value of a positive result is only 1.9%. This goes up to 95% (assuming tests are 95% reliable) where the prevalence is 50%.

Lundberg insisted that so long as procedures do not call for direct observation of urination, there is bound to be cheating. The only way the government's program will work, he said, is with the participation of large numbers of trained "micturition observers." He added, "you are going to need a constitutional amendment to do this." He also pointed out, as did Kurt M. Dubowski of the University of Oklahoma Health Sciences Center, that urine testing has serious shortcomings because it does not indicate whether a drug is present in the blood, nor does it reveal the time or quantity of drug intake.



Ian MacDonald *believes the results justify the intrusive nature of testing.*



George Lundberg *says no program will be reliable without "trained micturition observers."*

*The testing debate was part of a day-long meeting on "Alcohol and Drug Problems: Biology, Behavior, and Public Health," held on 21 October at the National Academy of Sciences.

Lundberg also quibbled with the government's contention that costs of collecting and processing urine specimens can be held to $15 to $25 per specimen. He said it would cost more like $75 to $100 to "do it right"—including measures to minimize risks of contamination and misidentification of specimens. "The lab people love this," he said, predicting that nationwide adoption of urine testing programs can grow to a $10-billion-per-year business.

Lundberg proposed that in lieu of the current approach, representatives from science, government and industry should get together and put together a "lexicon" of jobs and rate them for whether psychoactive drug screening should be included in the job description.

Dubowski was sympathetic with Lundberg's analysis. He later told *Science* that the costs of doing proper testing could approach $300 a specimen. He also said private sector programs will be useless unless they conform with the guidelines for federal programs. [Representative Glenn English (D-OK) has introduced a bill that would require this.]

Dubowski reiterated that, despite anecdotal evidence of the effectiveness of drug testing programs, there is no published research that relates them to enhanced workplace safety. He said such programs will have a temporary deterrent effect, but that urine testing may be no more effective than hanging antidrug posters in the workplace.

One of the main criticisms of the Administration program is that it is confined to a few illicit drugs and does not cover barbiturates, alcohol, or any of the thousands of "designer drugs" that have come into use. According to Michael Walsh of the National Institute on Drug Abuse, who heads the Interagency Coordinating Group on employee drug testing, health organizations have lobbied strenuously to get the government to stick to testing for illicit drugs so as to avoid the risk of stigmatizing those on therapeutic drugs. As for alcohol, MacDonald said that was a "red herring" and the government could not very well take sanctions against every sailor coming back tipsy from shore leave. Dubowski adds that there are practical impediments to alcohol testing since urine tests are inappropriate and Breathalyzer tests would involve major additional costs. (Breathalyzer tests are required in some private sector programs.)

Jack D. Barchas of the Stanford University School of Medicine, who organized the symposium, later suggested that the way to get around the problem—as well as avoid the moralistic aspects of drug testing—is to design minimal performance tests to see if people are capable of doing their jobs adequately. Dubowski agreed that this is something worth looking into. However, he pointed out that many other factors, such as fatigue, illness, and emotional upset can contribute to a bad performance, and strong motivation to perform well may overcome the effects of drugs among some employees. He also said that in view of the large differences among individuals, employers would have to establish a baseline performance standard for each employee.

For all their inherent flaws, occupational drug screening programs are becoming a major trend. One of the benefits of the government's program, says Walsh, is that its guidelines will contribute to the overall quality of laboratory testing whether or not the HHS guidelines are ultimately extended to the private sector.

Despite a multitude of lawsuits from labor unions and the American Civil Liberties Union, programs that are properly designed—including advance notification of employees and confirmatory testing—are being sustained in court challenges, says Walsh. The most recent government case was a suit against the Department of Transportation in which federal district court judge Gerhard Gesell ruled that the program was legal. ■ CONSTANCE HOLDEN

Yale Takes Action Against Psychiatrists for Financial Improprieties

A misguided attempt to help the daughter of a Yale University School of Medicine psychiatrist has resulted in the demotion of two psychiatric administrators and the firing of two others following a state audit of the Yale-affiliated Connecticut Mental Health Center.

Gary L. Tischler, chairman of the Department of Psychiatry and chief of psychiatry at the Yale–New Haven Hospital, and Boris M. Astrachan, director of the mental health center, resigned their administrative posts on 15 September following a university finding of "possible improprieties" in the use of state funds to pay for some nonexistent consulting work for Yale by Tischler's daughter Laurie. In addition, the administrator of the center, Henry H. Harvey, and associate administrator Anthony E. DiSalvo were dismissed and were suspended from their appointments as lecturers in the medical school. Tischler and Astrachan are staying on as professors of psychiatry.

The problems arose in the course of a routine state audit last June of the mental health center, which is run by contract with the university. Auditors could find no record of consulting on mental health program development allegedly done by Laurie Tischler, for which the state Department of Mental Health was billed $27,602.50 over the past 2 years.

None of the principals could be reached for comment. Medical school dean Leon Rosenberg, who directed the university's investigation, calls the situation a "tragedy" resulting from excessive warm-heartedness and poor judgment on the part of those involved. As he tells it, Laurie Tischler, 26, was physically and emotionally debilitated after a series of operations over a period of 4 years. After unsuccessful attempts by Tischler to find employment for his daughter in the Yale community, Harvey, a longtime friend of the Tischler family, "decided to find a job for her."

A position was found at a private psychiatric facility unaffiliated with Yale, but the facility could not afford to give her a salary. So Harvey and DiSalvo "for reasons that are absolutely impossible to imagine," says Rosenberg, worked out an arrangement whereby she would receive compensation from Yale. The consulting contract was signed with her name by someone else, he says (there were no plans for her to do any consulting), and he does not know if she was aware of the deception. Tischler and Astrachan were not involved in making the arrangements but were aware of them (Tischler became chairman of the psychiatry department 6 months later). "It simply didn't register [in Tischler's mind] that it was seriously wrong," says Rosenberg.

Rosenberg agrees that officials' readiness to engage in the deception "makes you wonder" about the extent to which this sort of thing is being done elsewhere. Ironically, he adds, Laurie Tischler has done so well at her new job that she was put on salary and the Yale arrangement was terminated last December.

Gary Tischler has reimbursed Yale and Yale has reimbursed the state for the money. However, the audit report has been sent to the state's attorney for possible prosecution.

The university has appointed Benjamin S. Bunney as acting chairman of the psychiatry department and acting psychiatry chief at the hospital, and Ezra E. H. Griffith as acting director of the mental health center. ■ CONSTANCE HOLDEN