EXECUTIVE SUMMARY

In December 2004, the Office of National Drug Control Policy (ONDCP) in the Executive Office of the President hosted an important Leadership Conference on Medical Education in Substance Abuse. The conference brought together leaders of private sector organizations, Federal agencies, organized medicine, and licensure and certification bodies to discuss ways to enhance the training of physicians in the prevention, diagnosis, and management of alcohol and drug use disorders, including prescription drug abuse. Participants were charged with identifying strategies and action steps to improve physician knowledge and skills through enhanced undergraduate, graduate, and continuing medical education.

The conference was co-sponsored by the Center for Substance Abuse Treatment of the Substance Abuse and Mental Health Services Administration, as well as the National Institute on Alcohol Abuse and Alcoholism and the National Institute on Drug Abuse of the National Institutes of Health, with the assistance of the Robert Wood Johnson Foundation.

Conference Goals.

Conference participants were charged with identifying competencies, objectives, and action steps to help all physicians master core competencies in preventing, identifying, and managing substance use disorders (SUDs). As the Surgeon General of the United States, Richard H. Carmona, M.D., M.P.H., observed in his address to the conferees, the medical community — particularly primary care physicians — has a pivotal role to play in helping to identify patients who may have substance use disorders and guiding them to appropriate treatment. For this to occur, he said, medical students, residents, and practicing physicians need more and better training about the disease of addiction and the impact it can have on many other medical and psychiatric disorders.

ONDCP Director John P. Walters pledged that his office and other Federal agencies will continue to support scientific research and clinical education that help to reduce the illness and deaths associated with substance use disorders. He also promised support for research that helps bring the medical community better tools to identify, prevent, and treat those who are at risk for or experiencing such disorders, including problems with prescription drugs.

Director Walters added that the current conference represented a unique opportunity to achieve those objectives because it had created an unprecedented gathering of leaders at the highest levels of multiple government agencies and private sector organizations.

Conference Organization.

In planning the Leadership Conference, ONDCP drew on several past efforts to identify essential physician competencies related to substance use disorders. These competencies have been defined with growing specificity over the past 25 years. For example, the "AMA Guidelines for Physician Involvement in the Care of Substance-Abusing Patients," adopted as the policy of the American Medical Association (AMA) in 1979, articulates the principle that every physician must assume clinical responsibility for the diagnosis and referral of patients with SUDs, and broadly defines the competencies required to meet that responsibility.

The Macy Conference on Training About Alcohol and Substance Abuse for All Primary Care Physicians, held in 1994, moved the conversation forward by elaborating on the competencies articulated in the AMA policy statement. The report of the conference also contained a number of thoughtful essays on the subject by conference chair David Lewis, M.D., and other leaders in medical education (Lewis, 1994).

Project Mainstream, conducted by the Association for Medical Education and Research in Substance Abuse (AMERSA), with assistance from the Health Resources and Services Administration and the Center for Substance Abuse Treatment, represents a multi-year effort to describe in detail the areas of knowledge and skills required by practitioners of many health professions (AMERSA, 2002). The competencies and recommendations offered in the Project Mainstream report have been endorsed by many health professions organizations, including AMA, the American Osteopathic Academy of Addiction Medicine, and the Society of Teachers of Family Medicine.

Taken together, these efforts and the broad areas of consensus they achieved provided a solid foundation for the work of the Leadership Conference.

Perspectives on the Problem and Possible Solutions.

Distinguished speakers at the Leadership Conference suggested a number of approaches to address the challenge.

ONDCP Director John P. Walters described a public health approach built on the concept of SUDs as a contagious disease. Director Walters pointed out that, while SUDs are not spread by bacteria or other biological agents of infection, they are spread by behavior. As an example, he pointed out that when young people begin to use alcohol, tobacco, or other drugs, they expose their peers to that behavior and thus encourage them to begin using. Because peer relationships are an important part of adolescent development, this kind of "infectious behavior" forces young people to choose between emulating drug-using behavior or losing their friends. As in dealing with other infectious disorders, Director Walters said that preparing physicians to intervene effectively requires a comprehensive approach.

NIDA Director Nora D. Volkow, M.D., adopted a similar paradigm when she suggested that physicians may more readily accept their role in preventing, identifying, and managing patients with SUDs if training programs and curricula emphasize analogies to conditions that are widely understood in the medical community, such as cardiovascular disease and diabetes. For example, Dr. Volkow pointed out that, although the victim of a heart attack or stroke could be said to have brought the disease on himself or herself through diet and other lifestyle choices, physicians nevertheless feel an obligation to screen for, diagnose, and treat cardiac disorders. In this more productive concept, she noted, it makes little difference whether a disease is brought on by excessive exposure to fat or to abused drugs; one changes the functioning of the arteries and the heart, the other changes the functioning of the brain. Both require medical intervention.

NIAAA Director Ting-Kai Li, M.D., told the conferees that current efforts to overcome the barriers to physician learning and participation are "necessary but not sufficient." Specifically, Dr. Li recommended that current research and education initiatives be augmented by a collaborative program for the development of core faculty in schools of health professions education. Such programs would have both a career teacher and a scholar — investigator component, he said, describing such an initiative as a way to develop faculty who are knowledgeable about SUDs and who are able to invest in both teaching and research. Dr. Li said that such career clinical scholars and investigators would be key members of the faculty, responsible "for education, for conducting research on education and health services research, and for mentoring the next generation of clinical scholars and investigators."

Dr. Li announced that NIAAA is willing to use its KO7 grant mechanism to support both the career development of young clinical investigators and the mentoring component of such a program. NIAAA is willing to invest in this over the next nine years in a collaborative manner, he said, but the success of such an initiative will depend on the degree of buy-in from the schools of medicine and other health professions. Accordingly, he noted that "this proposal to further invest in the goal of high-quality alcohol prevention treatment and care can be done best in collaboration with the professional schools and with other Federal agencies and private sector organizations."

The National Highway Traffic Safety Administration (NHTSA) Administrator, Jeffrey Runge, M.D., who trained as a trauma surgeon, pointed out that one of the keys to case-finding is development of a screening approach that will not require extra time in the emergency department and other high-volume locations. For example, because emergency physicians often see 15 patients in an hour, they do not have time to go through lengthy screening questionnaires with every patient. In addition, to help physicians feel comfortable in screening patients, Dr. Runge noted that we also have to help them believe that they can successfully refer patients for formal assessment and treatment.

The insurance laws build in a disincentive for physicians to screen patients in emergency settings, he said, because state laws allow insurers to deny payment for care related to alcohol or drug use. To remedy the situation, he urged the conferees to look to the model legislation prepared by the National Association of Insurance Legislators, which bans such discriminatory practices.

Dr. Runge also suggested that accreditation can be used as a motivator. As an example, he noted that that the Committee on Trauma of the American College of Surgeons is considering including screening intervention protocols in the requirements for trauma center designation. He added that the Joint Commission on Accreditation of Healthcare Organizations might want to consider incorporating a similar requirement in its accreditation standards.

Vice Admiral Richard H. Carmona, M.D., M.P.H., told the conferees that patients and the public also have a role, saying: "To prevent substance abuse and save millions of lives, we must focus on closing the gap between what health professionals know about substance abuse and what the rest of America understands. I think most of you will agree that in our country, we have a largely 'health illiterate' society. Health literacy is the ability of an individual to access, understand, and use health-related information and services to make appropriate health decisions. So how does the average person deal with all of the great scientific information that we are trying to give them to change their behavior to keep them healthy, to make their lives better? They simply don't understand. The literature's pretty strongly supportive of the fact that half of patients don't understand the appointment slip

and when they're supposed to come back, and a quarter of the people don't understand their prescriptions and what's on them. This health literacy block is very, very significant in everything we do."

Dr. Carmona concluded that, "there is a gap between those of us who have the knowledge and those who need the knowledge," adding that "Improving health literacy involves giving people information about the safe use of prescription drugs, about staying away from illegal drugs, and about drinking only in moderation, if at all. We also must train ourselves and the next generation of medical professionals to watch for signs of abuse or addiction in our patients."

All the speakers acknowledged past efforts to teach physicians the competencies they need to care for patients with SUDs. While many of these efforts have been effective in demonstrating the medical basis of SUDs and creating a clinical paradigm similar to that for other chronic diseases, the speakers also agreed that the depth of the initiatives varies by clinical discipline and academic institution. They called for public-private sector collaborations to support efforts to more fully integrate effective curricula on SUDs into the mainstream of medical education at all levels — undergraduate, graduate, and CME — and across all disciplines.

Conference Outcomes.

ONDCP Director John P. Walters pointed out that all the data reviewed in the conference underscored the fact that medical students, residents, and practicing physicians need more and better training about the disease of addiction and the impact it can have on many other disorders, including cancer, cardiovascular disease, stroke, infectious diseases, mental illnesses, and even obesity. Accordingly, he asked the participants to develop action plans to improve physician knowledge and skills through enhanced training in undergraduate, graduate, and continuing medical education.

In response to Director Walters' call to action, the conferees agreed that the critical core competencies for physicians encompass a thorough understanding of the basic biomedical sciences (e.g., molecular biology, genetics, anatomy, physiology, pharmacology, and pathology), as well as knowledge and skills in the following areas:

1. *Screening, Prevention, and Brief Intervention.* All physicians should know how and when to screen patients for SUDs. Such screening may involve (1) direct questioning by a physician or other health care professional; (2) self-administered questionnaires; or (3) laboratory tests.

   Physicians also should be able to provide preventive counseling to patients at risk for SUDs, as well as brief interventions to those who screen positive for such disorders. (Brief interventions are time-limited, patient-centered counseling strategies that focus on changing behavior and increasing medication compliance.)

   Training programs should devote specific attention to building physicians' knowledge and skills in these areas. For example, a required curriculum in screening, preventive counseling, and brief treatment interventions should be integrated into the standard curricula of all medical schools and residency training programs. Such a curriculum should outline the components of screening and brief intervention. Training programs should emphasize the effectiveness of office-based screening and interventions in primary care settings.

2. *Co-Occurring Medical and Psychiatric Disorders.* Physicians should understand the medical and psychiatric comorbidities and complications of substance use disorders. They also should be able to evaluate patients with such co-occurring disorders and complications and refer patients to specialized treatment services that match the patients' individual treatment needs.

   Co-occurring disorders can be difficult to detect because substances of abuse can cause symptoms that are time-limited but indistinguishable from those seen in many other medical and psychiatric disorders; for example, substance withdrawal or acute intoxication can mimic almost any psychiatric disorder. On the other hand, treating such co-occurring disorders can markedly improve the outcome of treatment for SUDs.

   To assure that physicians achieve competence in this area, a curriculum addressing the medical and psychiatric comorbidities of SUDs should be integrated into the standard curricula of all medical schools and residency training programs. Similarly, curricula on the diagnosis and management of conditions that frequently coexist with SUDs — such as liver disorders, HIV/AIDS, and eating disorders — should incorporate information on the ways in which the symptoms, progression, and management of those disorders may be affected by an undiagnosed SUD.

   Increased training on co-occurring disorders also should be available through continuing medical education programs. Such training should focus on the recognition, treatment or referral of comorbid medical and psychiatric conditions in patients with SUDs.

3. *Prescribing Drugs with Abuse Potential.* Physicians should have a thorough understanding of the clinical, legal, and ethical considerations involved in prescribing medications with abuse potential. Such knowledge encompasses drug selection, communicating the treatment program to the appropriate individuals (patient, family, and other health professionals), correctly executing the prescription order,

and monitoring the treatment program to determine whether changes are needed to achieve optimum effectiveness and safety of drug therapy. It also involves avoiding undermedication (underprescribing), overmedication (overprescribing), and drug misuse or abuse (AMA, 1981).

This knowledge should be reinforced through undergraduate, graduate, and continuing medical education programs in all specialties. Physicians who complete such training should be able to demonstrate that they are able to prescribe medications in a therapeutic manner to all patients, including those at risk for, presenting with, or with a history of SUDs, so as to minimize the risk of inducing or perpetuating prescription drug misuse or abuse.

Each of the foregoing competencies is relevant to all disciplines and specialties. In addition, physician education can and should be tailored to specific practice situations and patient populations. For example, pediatricians have a special need for knowledge about SUDs as developmental disorders and the skills to perform screening, intervention, and referral. Pediatricians also need to consider the issues raised by children and adolescents whose parents or other caregivers have SUDs and to acquire the skills needed to address such situations. Similarly, specialists in obstetrics/gynecology need the knowledge and skills to address substance-related problems in pregnant and parenting women. Finally, because primary care physicians serve diverse populations of patients in terms of gender, socioeconomic status, and culture, they also must be culturally competent in communicating with patients and their families.

Action Steps.

Next, the conferees agreed on a series of specific recommendations and action steps. They pointed to nutrition and geriatrics as good examples of how cross-cutting ideas have been incorporated into medical education and practice, and suggested that they be used as models. Their recommendations included strategies specific to undergraduate, graduate, and continuing medical education, as well as the following general recommendations:

1. Ask the Surgeon General to convene a working group of medical organizations to draft a strong ethics policy stating that physicians may not ignore the signs or symptoms of alcohol and drug problems, on the grounds that substance use disorders are medical illnesses and may not be ignored or left untreated.
2. Work with medical student organizations to help students and residents advocate for better education in the identification and management of substance use disorders, which afflict one in 10 patients in primary medical practice.
3. Develop collaborative projects to design useful clinical models and tools. Involve multiple government agencies and private-sector organizations.
4. Work with the Federal health agencies to develop and fund a program (similar to the Career Teacher program of the 1980s) that would support the recruitment and training of medical school faculty to become experts on SUDs. Experience shows that such faculty members go on to become "champions" for adding addiction-related content to the curriculum in undergraduate and graduate medical education.
5. Establish an expert panel to assist the National Board of Medical Examiners and the National Board of Osteopathic Medical Examiners in developing test questions on substance use disorders for licensure and certification exams.
6. Teach about prescribing and prescription drug abuse in the same way other areas of clinical knowledge and skills are taught. Employ multiple focused interventions, which research shows are more effective at changing behaviors than single exposures.
7. Amend medical licensure and certification/recertification standards to require competency in prescribing controlled drugs. For example, DEA could require that, at the time of re-registration, physicians present evidence of CME credits and/or focused self-assessment to achieve competence in this vital area.
8. Address patients' health literacy needs by working through public-private partnerships to evaluate and/or develop educational materials that physicians can give to patients for whom they prescribe drugs with abuse potential.

The conferees also recommended that ONDCP schedule a follow-up meeting in a year to revisit the objectives, strategies, and action steps and to measure progress in implementing them. In the interim, they pledged to continue the dialogue.

This report of the Leadership Conference outlines the rationale for greater physician involvement in recognizing and treating patients with SUDs, describes current barriers to education in this field, and evaluates the impact of prior initiatives to improve physician education about SUDs. In addition, it proposes core clinical competencies for all physicians, based on important work that has been done by a number of organizations over the past 30 years (AMA, 1979; Lewis, 1994; AMERSA, 2002a, 2002b). Finally, it summarizes the recommendations of the leaders in organized medicine, medical education, licensure and accreditation, and Federal health agencies who gathered for the Leadership Conference.