PERSPECTIVES OF THE PRIVATE SECTOR LEADERS

Conference Chair Addison D. Davis IV.

We are going to begin the conference with a panel presentation that will give us a preview of some of the issues we will be discussing. We have three distinguished panelists: Dr. Bertha Madras, Dr. Sheldon Miller and Dr. Mark Kraus. We have asked each of them to provide their own perspective on the issues we are facing and to offer their insights as to possible solutions. They will look at undergraduate medical education, graduate medical education, and continuing medical education. We'll follow that with a general discussion, so that each of you has an opportunity to contribute.

Our first speaker is Bertha K. Madras, Ph.D. Dr. Madras is a professor of psychobiology in the Department of Psychiatry at the Harvard Medical School, and chairs the Division of Neurochemistry at the New England Primate Research Center. At the medical school, she is the Associate Director for Medical Education in the Division on Addictions, chairs the Faculty Affairs Committee, and is a member of the subcommittee of professors.

Dr. Madras will be followed by Sheldon I. Miller, M.D., who is the Lizzy Gilman Professor of Psychiatry at the Feinburg School of Medicine at Northwestern University in Chicago. Until two years ago, Dr. Miller also was chair of that university's Department of Psychiatry and Behavioral Sciences. He is currently a member of the board of directors of the Accreditation Council for Graduate Medical Education and a member of the board of directors of the American Board of Emergency Medicine and of the executive committee of that board. His other current positions include the board of directors of the American Academy of Addiction Psychiatry and the editorship of the American Journal on Addictions.

Our third panelist is Mark L. Kraus, M.D., FASAM. Dr. Kraus is a general internist in private practice at Westside Medical Group in Waterbury, Connecticut, and Medical Director of Addiction Medicine at Waterbury Hospital. He also is Assistant Clinical Professor of Medicine at Yale University School of Medicine, and a Fellow of the American Society of Addiction Medicine.

Undergraduate Medical Education

Bertha K. Madras, Ph.D., Harvard Medical School.

This is a unique gathering. In my view, the institutions and individuals who are represented here can mount a significant response and play a pivotal role in reducing the medical and social problems contributing to and associated with drug abuse.

I'd like to share my experiences in developing and presenting an elective course on substance abuse to the fourth year Harvard Medical School students. The background of this course is very simple. Dean Tosdan, then the Dean of Harvard Medical School, was approached by two CEOs who had family members with substance abuse problems. Both came to him with very profound complaints that the physicians who cared for their family members did not help their family members deal with the substance abuse problems. What they felt is that physicians in general are not being properly educated about substance use disorders.

In response to this, the Dean developed a small committee and then a larger committee. Out of that came a number of initiatives, one of which was to develop a course on substance abuse. I was appointed to develop the course and to direct it, and to develop a public education program that involved a museum exhibit at the Museum of Science in Boston, as well as a CD-ROM for the public. There were other initiatives as well.

The course is given in a one-month block during the last month of year four of medical training. It falls under the rubric of the advanced biomedical sciences curriculum. The idea is to reinforce the scientific basis of medicine for graduating medical school students. My charge is to present the basic biological principles and translate the information into medical practice.

Although I had anticipated that most of the students interested in this course would be future psychiatrists or future

addiction medical specialists, in fact, such students represented a tiny fraction of the people who signed up for the course. The vast majority were interested in internal medicine, OB-Gyn, surgery, emergency medicine, or just people who came to me and said, "I'm taking this course because I recognize the high prevalence of substance abuse problems in medical practice. I am insecure about how to diagnose substance abuse problems and how to manage patients with substance abuse problems. And I'm insecure about my understanding of the underlying biology and how to begin to explain it to my patients."

Initially, we developed what I would consider a very conventional course, a core curriculum taught by a cohort of at least fourteen of my colleagues and myself. I teach all the basic neurobiology. My colleagues teach screening, diagnosis, detoxification, and treatment of adolescents and adult populations with substance abuse problems. I present the didactic information about the history, legal issues, and neurobiology of substances.

The course includes roundtable discussions, where the faculty discuss the overlap between pain control and opiate abuse, the risks of drug abuse to the developing fetus and child, gambling as an addictive behavior, research paradigms for investigating drugs, long-term effects of substances with regard to neuropsychological sequelae, as well as brain biology and cell and molecular biology. And we cover every single drug that we are aware of at the present time.

The course has non-traditional features as well, which I would divide into two areas: student perspectives and learning perspectives. The most important challenge that I found in presenting the course was how to reduce the stigma of even considering this as an appropriate body of knowledge for physicians.

We begin by asking the students to complete a questionnaire containing about 20 questions probing their attitudes towards substance abuse. This is done privately, to learn how they really feel. At the end of the course, they're asked to bring their responses back to the class to see whether their attitudes have changed. Most of the students say they feel the course has helped them develop an understanding of addiction as a true medical problem and that in fact their attitudes have changed.

We also deal with the students' attitudes towards politically charged issues such as needle exchange, medical marijuana, and drug legalization. To do so, we use a debate format because it is important to have the students arrive at conclusions based on their understanding of the evidence. To the debate, the students bring their personal convictions about drugs, ranging from permissive to prohibitive. They debate the issues one by one. What is fascinating is that by the end of the debates, many students develop relatively conservative attitudes toward these issues.

Finally, we focus on science and evidence-based medicine. We bring the discipline of addiction into mainstream medicine by looking at cellular and molecular biology, by looking at brain imaging approaches to understanding the influence of drugs.

We offer unique perspectives by bringing students to a detoxification center and allowing them to interview patients who are undergoing the process of detoxification. Their stories occasionally have brought the entire class — as well as two instructors — to tears.

The students also interview patients. In one case, we asked a surgeon to bring in a patient as well as a psychiatrist who's a specialist in addiction medicine. The students heard the surgeon conduct a standard patient interview, juxtaposed with how a specialist in addiction medicine would interview the same individual. Then the students are given an opportunity to interview patients.

We also bring in the former associate medical examiner of Massachusetts to present a dramatic set of slides on the pathology of substance abuse. Students who are not convinced that drugs have any malevolent effect on the body leave that class with their minds changed.

Another core feature of the course is a discussion of the medical license, which is presented as a privilege. We emphasize that personal impairment jeopardizes the license. The Executive Director of the Physicians Health Service, which cares for impaired physicians, comes in to describe the program, the types of facilities that are available to help those who have personal problems or suspect a problem in a colleague.

We bring in the Chairman of the Board of Registration in Medicine and discuss licensing and physician conduct. We also bring in a representative of the Drug Enforcement Administration to instruct students on the DEA vantage in terms of prescribing practices as well as how to stay off DEA's radar screen.

The course has been very successful. The evaluations have been very good, and I really enjoy the fresh perspectives the students have brought to it over the more than 10 years it has been offered.

The most common feedback we receive from students is that all the members of their class should have taken the course. We have been discussing this with the Dean of Education at the Harvard Medical School. Part of the debate is whether it should be given in one solid block in the last year, of whether it should be divided across the four years to reinforce the message. I will leave you with that as an issue to discuss.

Graduate Medical Education

Sheldon I. Miller, M.D., Northwestern University Medical School.

From the standpoint of the future education of physicians about addiction issues, I see graduate medical education as a very important area for us to address. But first, because the people here are from very different backgrounds, I'm going to risk boring a few people by describing the structure of graduate medical education. Two organizations are involved with the production of specialists in American medicine: one is the Accreditation Council for Graduate Medical Education (ACGME), which has under its aegis 24 residency review committees. Those committees oversee more than 10,000 residencies and more than 100,000 residents in the U.S. The ACGME reviews and accredits the programs where physicians train.

The other important organization is the American Board of Medical Specialties, which brings together the boards that govern specialty practice. These boards set the standards for their specialties.

It is fair to say that the structure of every single medical specialty in the U.S. is determined by the boards and the residency review committees. It is critical to understand this if we hope to move forward with physician training about the addictions at the level of graduate medical education.

While there have been multiple efforts in this direction in the past, which have not met with total success, I do want to remind you that there have been some very positive outcomes. These provide an example and, perhaps, a "road map" of how we might navigate the complex, politically interdependent process required to achieve change in graduate medical education. I may be a little chauvinistic here, but I want to focus on the specialty of psychiatry, which has managed to make a great difference.

If you have looked at some of the background material for this conference, you'll notice that different medical specialties have widely differing levels of addiction content. The specialty that stands out by virtue of the fact that 95 percent of its training programs have significant addiction content is psychiatry. That's not a result of anybody being particularly insightful, but of a lot of effort that actually achieved success. I raise it as an example for other specialties.

Approximately 10 years ago, a process began in the same way this conference started: a group of interested individuals wanted to create a subspecialty of addiction psychiatry. Their reason was not to create a lot of specialists to treat all patients with addictive disorders, although they did want to develop experts to care for the really difficult cases. But their principal reason for wanting a subspecialty was to train educators and researchers, because medicine is a field that listens to its own subspecialists. This is true of every specialty: If there is a subspecialty group within the organization, it has an important voice, which simply doesn't exist in organizations that do not have such subspecialties. So those of us who were involved felt it was very critical to create such a body.

A lot of effort went on within the professional organization — in this case, the American Psychiatric Association. There also were very intense meetings with the American Board of Psychiatry and Neurology, which was the only avenue through which a subspecialty could be created. That went on for several years. We met…We talked…We researched…We talked…We met…We were disappointed…We were encouraged…All of it happened. And then, finally, it became clear that with just the support of the American Psychiatric Association — not enthusiastic support, but just some support rather than hostility — the American Board of Psychiatry and Neurology would be willing to create a subspecialty of addiction psychiatry.

The moment that happened, the Residency Review Committee for psychiatry — which is the other side of this equation — became energized, because suddenly a whole new series of requirements had to be written. It quickly became clear that such requirements could not be written unless the issue was also addressed in the core requirements for the specialty. So the creation of the subspecialty not only led to what we were seeking, which was teachers and researchers, it also created an impetus for the field to recognize that there cannot be a subspecialty in the addictions in the absence of a core body of knowledge in the primary specialty. As a result, psychiatry developed requirements for the addiction content of core curricula, as well as a requirement for the amount of time spent in clinical experience for every single graduating psychiatrist.

There still aren't enough addiction psychiatrists that every program has one, but many medical schools around the country do have such subspecialists. Nevertheless, curricula have been developed. And even in those programs that do not have a subspecialist in addiction psychiatry, there is a body of educational material to support the program requirements.

One of the advantages of having these requirements adopted by the board and the residency review committee is that if a training institution fails to satisfy the requirements, it may lose its residency program. So meeting the requirements no longer is optional; it is mandatory for every graduating resident. That would be the ideal for all medical specialties.

I offer this as a model and as a challenge to other specialties, so that their boards, their residency review committees, their

professional organizations, might come together and hopefully do some of the same things. Obviously, the exact content is going to differ for each specialty, but there is a core body of knowledge that won't be different and thus should be available to every graduate physician as they go through their specialty training.

Let me be clear: what we achieved in psychiatry required considerable time and effort, but it is very doable. The group of people at this conference have the expertise and authority to achieve similar progress in other specialties. In many ways, it is easier now, because the whole field has moved forward. The stigma is still there, but it isn't quite as bad as it used to be. We've seen tremendous strides in understanding the science underlying the addiction process. As a result, we ought to be able to make significant progress in graduate medical education.

Continuing Medical Education

Mark L. Kraus, M.D., FASAM, Yale University School of Medicine.

We've heard from an expert in undergraduate medical education, and we've heard from a leader in graduate medical education. One of the lessons I took from both is that the teaching of the addictions in medical schools and residency programs can be strengthened, and that progress is possible. Meanwhile, the majority of our attending physicians — the population I represent — have not received any formal training in screening and brief intervention for substance use disorders. Many have prejudices towards this population, not believing at all that substance use disorders are brain diseases, but just willful misconduct.

Moreover, today's private practitioners are putting in very long hours, because medical economics dictate the reality of "volume medicine" in order to cover the overhead costs and soaring medical malpractice premiums. There is precious little time to attend continuing education programs at their hospitals, as they used to do, and even less time to travel to conferences because of the obvious costs and loss of income that entails.

As a result, computer-based CME programs have gained popularity. But after a long day, or night, sitting in front of a computer to take a clinical course on addiction medicine may be the last thing such a physician would want to do.

Given these realities, how can we persuade these private practitioners to achieve the core competencies we're advocating: do we use the "carrot" of compensation or the "stick" of mandates?

Whatever training we offer as training in the core competencies for this group of physicians must be efficient: time-efficient, cost-effective, and clinically practical.

We have tremendous leaders at this meeting. We have people who have done serious work on this problem. We even have scientific evidence that supports what we're saying. Yet, despite all of these things and all the wonderful work that's come before us, the change we're seeking hasn't occurred. It just hasn't happened. We must ask ourselves and our organizations and our associations and agencies, why not? And how can it be righted now? How can we actually achieve progress? It's our responsibility…our responsibility.

When we leave this room, it's our responsibility to make sure change happens. I hope that each and every one of you leaves this room today not thinking that it can't happen, but saying that it will happen. Dr. Miller said it well: If it isn't going to happen here, it's never going to happen at all.

GENERAL DISCUSSION

David C. Lewis, M.D., Chair, Physicians and Lawyers for National Drug Policy.

Dr. Kraus is right: there has been a kind of repeat performance every decade since the 1970s. The first occurred at the Rockefeller University in the early 1970s. I happened to be there as a youngster, accompanying the chair of the Department of Medicine at Harvard, who brought me to listen. That conference decided that medicine — mainstream medicine — should play a larger role in treating the addiction.

The next effort, in the 1980s, was at an AMERSA conference at the Annenberg Center, where competencies were defined for each of the specialties to guide curriculum development. In the 1990s, there was the Macy Conference, which I chaired, and which addressed the knowledge needs of primary care physicians.

So, with all this effort, you ask: Why didn't something happen? Well, the culture wasn't right. So solutions have to involve changing the culture, and finding approaches that are attuned to the culture.

Each of past the conferences, as this one will, devised very specific approaches to changing the educational system. We can talk about carrots and sticks, but I think unless such changes are presented at the highest levels of the public health system in a forceful and continuous way — in the same way that we developed a real understanding of depression and mental health as disorders that could be treated in the mainstream of medicine — we're not going to get there.

No matter what we do here, I think we also have to make recommendations to the greater society — the greater culture — as to what we can do as health professionals to educate the public. And that must involve the government officials here as well as the health officials.

Beverly Watts Davis, Director, Center for Substance Abuse Treatment.

Dr. Lewis, I think you've made a great case for why prevention has to play a very primary role in what we do. It's what you describe as a strategy, a universal strategy, in communities that are trying to change norms and attitudes and behaviors. Physicians have an incredible ability to make that happen. In prevention, we're hoping that medical students receive better training in substance abuse prevention, which should be easy because it fits within their norms.

We can continue to treat people for alcohol and drug problems, but unless we begin to change the culture in which people live, we will always be left to treat these disorders rather than preventing them. Our hope is that we will be able to weave prevention into our recommendations for medical education — there are curricula that actually have begun to do that in medical schools. I hope you will take a look at prevention as an essential part of medical education.

Lawrence S. Brown, Jr., M.D., M.P.H., FASAM, President, American Society of Addiction Medicine.

Sometimes it seems to me that we avoid the most difficult factors that influence medical education. One of those is the influence of professional peers and teachers who say that this is or is not a good thing — that we have too many competing priorities to address alcohol and drug problems.

So I think we need to look at what influences the content of undergraduate, graduate and postgraduate medical education and medical practice. Because if we don't do that, we're going to continue to miss an opportunity to influence change.

Winston Price, M.D., President, National Medical Association.

Attitudes are influenced tremendously by the individuals who sit at the table. While it is encouraging to see a mix of individuals here to address the issue, we all know that the individuals who sit around the table to develop curricula or to decide what becomes mandatory for the educational process do not reflect all of America's populations. And so they lack some important perspectives about how substance abuse impacts the everyday life of various communities.

Even if you accept the fact that there are no socioeconomic or ethnic boundaries with respect to substance abuse, I think that medical students and residents are influenced by the social mix of individuals that they see on the floors. And when the majority of individuals that they see affected by substance abuse are not the individuals who are their peers in medical school or residency training, they're going to have a different view of what's important.

I can assure you that in municipal hospitals throughout the United States, and particularly in the African American and Latino communities, there is an inadequate mix of individuals taking care of the neediest patients, many of whom need substance abuse prevention or treatment. Until we address that social issue — until medical schools, residency programs, and faculty represent the true mix of America — we'll continue to sit around tables with very learned individuals trying to come up with solutions. So I hope that is factored into the mix as well in order to come up with realistic solutions.

Richard Suchinsky, M.D., Associate Director, Department of Veterans Affairs.

I'd like to go back to Dr. Madras' program at Harvard, which is remarkable achievement. What impressed me most is that it gives medical students an opportunity to interview patients in depth and to obtain a detailed history. That's something that usually does not happen. The opportunity for a physician, particularly a primary care physician, to be able to spend enough time with a patient to get a detailed history is beyond the life I know. Dr. Kraus alluded to that as far as post-graduate education is concerned. But in the actual practice of medicine, unless you are a psychiatrist who is actively involved in doing intensive psychotherapy, the chances of your being involved in a practice situation that allows you to do anything in-depth with a patient as far as addiction problems simply doesn't exist.

In fact, in most public institutions, even the role of the psychiatrist is seen as writing prescriptions. Any time he or she spends talking to the patient is considered wasted time. Tremendous forces are impinging on the profession right now, and they work against being able to intervene effectively with substance use disorders.

William O. Vilensky, D.O., R.Ph., J.D., Representing the American Osteopathic Association.

I have a rather unique perspective on this discussion. Twenty-three years ago, the New Jersey State Medical Board retained me as a consultant in a case involving two physicians who were overprescribing amphetamines. Both received harsh penalties, including license suspensions and fines in the range of $25,000 to $50,000. That's tantamount to the loss of their practices.

Andrea G. Barthwell, M.D., FASAM, former Deputy Director for Demand Reduction, Office of National Drug Control Policy.

Earlier this year, I was at a conference and heard Dr. Sheila Blume remark that we use "addict" or "alcoholic" as a descriptor, not a diagnosis. When we say someone is a 43-year-old alcoholic, we're using that label to describe who he or she is. Then we don't feel obligated legally, morally or ethically in the same way we would if we described the patient as a 43-year-old diabetic.

We will not have a significant shift in the way in which we approach education at all levels of training, or even in the provision of care, until we have shifted these terms from being descriptors to diagnoses. That really is the nature of our task here. People reject the call to leadership all the time, but even when it's rejected, the responsibility doesn't go away. As physicians, we have to assume that responsibility to lead.

We know that budgets are tight. There's no new money on the table for this. No one is clamoring for this content in medical education. Few doctors accept this role. The drug addiction treatment enterprise — not addiction medicine but the drug addiction treatment enterprise — is not welcoming. And even when physicians do care about this issue, we're generally characterized as indifferent to it.

But we physicians are constantly being required to adapt and adjust to new conditions, new paradigms, new settings. We can do this. What's needed is to find a way for physicians to contribute that's consistent with our skills, interests, abilities, and settings. We've got to start early and we've got to provide information at all levels of training and practice. And we've got to work to create a new standard of care, or the situation is not going to change. We've got to stay engaged for the long haul. For example, we have to find individuals who are willing to cultivate long-term relationships with legislators and other individuals. And we have to use our combined authorities to advocate for funds, to educate for change, and to communicate the need to do this.

But we're in a very unique situation here, because this is a White House sponsored event. We have attention at the top. We have concerned members of Congress who are represented here. While it is true that we've had similar meetings before, we've never before had all these conditions present at the same time. We've hit the jackpot this time.

So we need to leave here with a strategic plan or a blueprint for our work, and we need to work with our Federal partners to excite them about the potential for change. If we do that, whenever they can find a way to support our initiatives, they will do so. We have to be very clear in articulating what initiatives we want supported — what will get us to the place we need to be. And we have to be sure that when we go back to our organizations, we work together in ways that we've never worked together before. That's my vision for this meeting.

Afterward, I was asked what I thought of the outcome. I replied that I thought it was too harsh. And I said they should take a course on the proper prescribing of controlled substances, because doctors don't get this kind of training as part of the core curricula of osteopathic or allopathic medical schools. As a result, they're sitting ducks for the scammers and others who abuse or divert drugs. Plus, they don't know enough about medical recordkeeping to understand how to properly document what they're doing.

The New Jersey Board of Medicine and the Deputy Attorney General asked me to set up such a course in New Jersey. The Federation of State Medical Boards heard about the course and invited me to address one of their annual meetings.

The course has been successful. How do I measure success? Among the 650 physicians who have taken the course, there's been almost no recurrence of problems. I've since retired, and the course is no longer offered, but about a year ago we put it on DVD, and that has been successful too. So there are models of successful continuing education programs ***[also see the description of the model continuing education program in the Resources section of this report].***