

CSAM's Forum for Dialogues in Addiction Medicine

The Medical Board's Physician Diversion Program Eliminated

BY TIMMEN CERMAK, MD, EDITOR

Welcome to the third installment in our FORUM series. Each newsletter, I am choosing an issue that would benefit from being elevated to the surface, where open discussion of different perspectives can advance our understanding of the issue, and of each other. Views are presented not in a pro-con, point-counterpoint framework, but rather as examples of differing perspectives. Dialogue is the most important goal for each FORUM. This issue focuses on "The Medical Board's Physician Diversion Program." Previous issues have focused on "Medication-Assisted Therapy and Sobriety" and "Prometa Protocols." These can be found archived at: www.csam-asam.org.



ALTERNATIVE MONITORING PROGRAM MUST BE SECURED

On July 26, the Medical Board of California (MBC) decided it was not capable of effectively running the Physician Diversion Program, which for the past 27 years has been monitoring and providing guidance to physicians with substance abuse problems. The MBC voted unanimously at its quarterly meeting in South San Francisco to eliminate the program, pointing to operating flaws identified in recent audits.

The Medical Board's decision to close the program was made despite concerns voiced by CSAM, California Medical Association (CMA) and others in the medical community that closing the program would seriously impact patient safety. CSAM strongly believes that the program is vital to not only protect public safety but also to preserve the rights of medically disabled physicians.

Diversion has been the target of criticism periodically over the years due, in large part, to widely held public prejudice and misunderstanding about the disease of addiction, especially when it occurs in high-risk professionals.

CSAM and CMA urged the medical board not to abandon its responsibilities, but rather to take the necessary steps to strengthen and properly oversee this important program, however, the MBC voted unanimously against continuing the program beyond its June 30, 2008 sunset date.

CSAM has been asked by the medical board to participate in a summit with other stakeholders to identify a viable alternative to a medical-board-run diversion program and members of CSAM are in the midst of preparing recommendations for this summit. CSAM will work with the MBC to ensure the availability of a high-quality diversion program in California. It was reckless for the current program to be abandoned before acceptable options were explored, however, that is the position we now find ourselves in and we will work with the MBC to identify a viable alternative monitoring program that can be implemented with a smooth transition.

PROBLEMS CREATED BY ELIMINATING THE DIVERSION PROGRAM

The Diversion Program is a critical public safety program, designed to monitor physicians identified as impaired with addiction or mental illness to assure that they do not practice unless or until they can do so safely. It monitors more than 300 physicians in any given year, half of whom voluntarily participate based on assurance of confidentiality. Without this program more impaired physicians will go undetected and unmonitored, posing an unnecessary risk to patients. The MBC will bear the responsibility for this increased risk.

The Diversion Program protects patients by having, and using, the authority to immediately pull a participating physician from medical practice. This "immediate action" ability was a primary reason for the establishment of the program more than 20 years ago. By contrast, the enforcement arm of the MBC routinely takes more than one year to prosecute physicians who pose risk to patients for any reason.

Public safety may not be adequately served by the Medical Board handing the Diversion Program over, as some suggest, to an outside vendor that has neither undergone scrutiny of state auditors nor demonstrated a track record for monitoring physician populations. If an alternative for the Medical Board-run Diversion Program is considered, it must be done after a careful review of program needs, quality benchmarks, and an appropriate planning and implementation process is developed to ensure a smooth transition of current participating physicians. It is literally impossible for the Medical Board of California to wash its hands of overseeing Diversion. MBC will



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remain responsible for the actions of whatever outside vendor is chosen, but will have less direct access to overseeing diversion than it presently has with its board-run program.

The Legislature had no intention of terminating the Diversion Program on the basis of the audit report alone. It was only after the Medical Board indicated a lack of resolve to fix the management problems identified in the audit that the option of terminating Diversion arose. If the Legislature now sunsets (discontinues) the program, the Medical Board will bear the responsibility for failing its obligation to protect the patients of California.

The MBC recently created a clinical Diversion Advisory Council (DAC). That council met for the first time only in

early July and is at work developing recommendations for a new monitoring program. CSAM members **David Pating, MD** and **Stephanie Shaner, MD** have been appointed to the DAC.

Addiction and mental illness are diseases. Neither is a crime. If the Medical Board of California chooses to view these medical conditions solely from an enforcement perspective and chooses to respond to them solely with the tools of enforcement, they will be guilty of a profoundly regressive stance which opens the MBC to issues of discrimination and its attendant liabilities.



Reform of the Diversion Program is Necessary

BY DAVID BREITAAPT, MD

The concept of diversion is not in dispute, but the current system needs fundamental reform. The California Medical Board's Physician Diversion Program has been a failure on two fronts. It does not adequately identify the impaired. And the methods of rehabilitation are deeply flawed.

The Medical Practice Act states that the Board will seek ways and means to identify and rehabilitate physicians and surgeons with impairment due to abuse of dangerous drugs or alcohol, or due to mental illness or physical illness, affecting competency so that physicians and surgeons so afflicted may be treated and returned to the practice of medicine in a manner which will not endanger the public health and safety. Approximately 350 physicians are enrolled in The Diversion Program today. This is 3% of the estimated 12,000 California physicians who will suffer from substance dependence at some point in their lives (based on a 10% lifetime prevalence for 120,000 physicians). Failure.

California is one of only five states that the licensure body still runs the treatment and rehabilitation aspects of diversion. This hybrid system – part medical care, part criminal justice – unnecessarily imports uncertainty and anxiety into the recovery process. Added to this are budget restrictions, poor records, difficulty assessing quality of care, and use of case managers overseeing care rather than trained addictionologists.

The California Physician Diversion Program would be improved by the following:

1. Privatization
2. Medicalization – Physician supervised treatment
3. Community-based treatment
4. More active identification of impaired physicians

A majority of the other states have organized very successful diversion programs (at patient expense) that depend

on total, private-sector management of the illness. Several of these states (MA, WA, MD, AZ) have published remarkable data. Acceptance by patients was exceptional. Relapse rates are better than standard treatment results from acknowledged centers. Recovery dysphoria, endured by mandated clients, so common in California, is rare. The Medical Board of California does not seem to separate their approach to the “sick” doctor from the legal/punitive methods deemed necessary with the lazy-the ignorant-the fraudulent-or the criminal physician.

Medicalization means the transfer of clinical responsibility for all patient care to a primary addictionologist (or addiction psychiatrist in the case of dual diagnosis) in the patient's local community. The value of MD directed treatment teams will be improved family interventions and treatments, improvement of urine and other tests, pharmacotherapies for specific patients like the dually diagnosed and finally, the obvious blending of science and spiritually-based systems.

Out-of-state facilities have often enjoyed most-favored status for detoxification and stabilization treatment. There is no shortage of splendid addictive disorder and psychiatric specialists throughout this state. CSAM and County Medical Societies should provide geographic lists of “preferred”, willing and skilled clinicians who can accept partnering with the Medical Board on a fee for service basis.

Finally, a more effective system needs to be developed for identifying impaired physicians and getting them into needed treatment. When Diversion is connected to a system that is also responsible for enforcement, this process is more difficult. I believe that placing the treatment of impaired physicians into the hands of respected addiction and mental health experts in their local community will automatically increase participation in Diversion.

Diversion needs a more authentic and valid healing image, rather than the cop image that is currently projected. ■

IMPORTANT DISCLAIMER: CSAM takes absolutely no responsibility for the opinions expressed by FORUM participants. Readers must evaluate each contribution for accuracy, bias, and integrity of scientific analysis. Inclusion of a perspective in the FORUM implies no endorsement of the author's opinion by CSAM.

President's Column

Alternative Monitoring Program Must be Secured

By DAVID PATING, MD, CSAM PRESIDENT



One “truism” about drug addiction and its treatment — everyone has an opinion. Like religion and politics, beliefs about drug addicts divide the public into two competing camps, right and left, -- pitting Public Safety against Public Health. When it comes to addicts, someone always wants to “lock ‘em up” while others argue for “rehabilitation.”

CSAM is committed to fight for a Public Health approach to drug dependence. Recently, the legislature approved \$7B for two new California Prisons, while simultaneously proposing cuts for Prop 36 diversion to drug treatment. The proponents of enforcement continue to ignore the “inconvenient truth” that up 50% of county arrests are for drug-related crimes and treatment costs merely 1/10th of the \$35,000 needed for incarceration. Inflaming the fear of drug addicts blinds public sentiment and the legislature, leading to calls for “flash incarceration” for relapsing addicts. This perspective punishes addicts through reprehensible acts of stigma.

Meanwhile, on the “enlightened” side of Sacramento, the Medical Board of California elected to disband the Diversion Program for physicians in July 2008. This model program imploded after two critical audits by an avowed opponent of Diversion (hired by the Medical Board) revealed program deficiencies in documentation and monitoring. The regressive closure of the Diversion program is ominous. It harkens back to the 1970’s when physicians lost their license for substance abuse or mental illness. When asked what tolerance the Board has for risk to public safety, the answer was “zero”. When asked what will be the fate of physicians who voluntarily seek rehabilitation, the answer was silence.

I am worried. The difference between enforcement and treatment perspectives is becoming increasingly polarized, and physicians are being handled like criminals. CSAM — an organization which promotes access to evidence-based quality treatment — is thoroughly devoted to protecting the public’s health. But we believe that, when the forces of incarceration are permitted to determine the role of treatment, the winds of policy begin carrying the smell of blood. ■

What is UPPL and Why Does it Matter to Insurance Parity for Substance Abuse?

By TIMMEN CERMAK, MD, EDITOR



In 2001 the National Association of Insurance Commissioners (NAIC) unanimously voted to change the model **Uniform Accident and Sickness Policy Provision Law (UPPL)** by adding the language that limitations on insurers’ liability for losses sustained as a consequence of intoxication “may not be used with respect to a medical expense policy.” Hospital, medical and surgical expenses resulting from injuries and illness that involve alcohol or other drug use should, in effect, no longer be discriminated against by refusals to provide the same medical insurance coverage provided for non-alcohol involved injuries and illness.

Rationale for repealing UPPL for medical insurance appears to stem largely from perceived unintended consequences of the law. UPPL is now generally seen as threatening public health by discouraging alcohol and other drug screening, and therefore treatment. By discouraging early intervention, UPPL has ultimately increased costs for alcohol and other drug related health care. And UPPL has impeded law enforcement by enabling drunk drivers to escape detection in the ER and inhibiting detection of people with substance abuse problems before they drive under the influence.

Support for repeal of the old UPPL model law comes not only from NAIC, but also from the American Medical Association (AMA) (2003), Mothers Against Drunk Driving (MADD), the American College of Emergency Physicians, American Public Health Association, American Bar Association, Council of State Governments, American College of Surgeons, and the American Society of Addiction Medicine (ASAM).

There is, however, an even more basic rationale for repealing UPPL’s discriminatory impact on health care - one based on the California Society of Addiction Medicine’s (CSAM) Blueprint for Treating Drug and Alcohol Addiction in California. CSAM begins with the assertion that Addiction is a Brain Disease. While early experimentation with alcohol and other drugs involves willful behavior, medical opinion now recognizes that once changes in the brain have been produced by a combination of individual risk factors and sufficient exposure to a substance a disease state exists. Addiction is a chronic brain disease that benefits from medical management.

In order for medicine to manage the disease of addiction, there must be full access to treatment. Any barrier to this full access inhibits early diagnosis and intervention, which are the hallmark of successful approaches to good public health. Sufficient data exists to justify a major commitment to screening for alcohol and other drug involvement in emergency departments, trauma centers, hospitals and clinics. Those who screen positive should then be provided brief interventions and referrals to treat-

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Purdue Pharma Found Guilty

Purdue Pharma and three of the company's executives, including Dr. Paul Goldenheim, its former medical director, pled guilty in federal court to criminal charges of misleading doctors and patients by claiming that Oxycontin was less likely to be abused than traditional narcotics.

The crime is technically called "misbranding," a broad statute that makes it a crime to put false or misleading information about a drug on its labels or ads (or to promote it for unapproved use).

Oxycontin is a time release preparation of oxycodone, designed to provide up to 12 hours of analgesia. Pharma heavily promoted its use with general practitioners. But drug users soon discovered that chewing the tablet, or crushing and snorting or injecting it, produced a powerful high.

The results were soaring rates of opiate addiction, related crime and fatal overdoses. Its use in Appalachia was so widespread that it became known as "hillbilly heroin."

Internal Pharma Purdue documents show that the company recognized, even before marketing began, that physicians trained in addiction would be concerned about Oxycontin's potential abuse. Despite this warning, between 1995 and 2001, the drug was touted as being less likely to cause addiction because of its time-release formula.

Purdue Pharma realized \$2.8 billion in revenue from Oxycontin during that period. ■

Source: *NY Times*, May 11, 2007, "Narcotic Maker Guilty of Deceit Over Marketing," Barry Meier

Welcome New Members!

Mirella Bazan - *Torrance*

Daniel Brockett, MD - *Costa Mesa*

Michael Dillon, MD - *June Lake*

Jonathan Fellers, MD - *Fresno*

Molly James - *Davis*

Maralee Joseph, MD - *Sonoma*

Scott Lauze, MD - *San Francisco*

Paula Lum, MD, MPH - *Palo Alto*

Sudha Madabhushi, MD - *Hemet*

Shahla Modir, MD - *Manhattan Beach*

Don Paxton, MD - *Toluca Lake*

Layne Rasmussen, MD - *San Diego*

Monisha Vasa, MD - *Studio City*

Susan Weinstock, MD - *Del Mar*

New Hepatitis C University On-Line Course and Mentoring

CSAM member Diana Sylvestre, MD has recently developed an innovative free on-line CME course called "Hepatitis C University": www.hcvu.org is a site that provides mentoring on-line video lectures, power-point slides, testing, and CME certificates upon completion of the tests.

It is easy to take the course and earn CME by following these easy instructions:

STEP 1:

Go to: <http://www.hcvu.org>

STEP 2:

Sign in/register to create your profile

STEP 3:

Begin the core curriculum/module



CSAM Introduces New On-Line Blog

Give us your opinion at www.CSAM-ASAM.org

CSAM offers an on-line BLOG to allow exchange of ideas beyond the newsletter. In each newsletter, we have a topic/issue that would benefit from being elevated to the surface, where open discussion of different perspectives can advance our understanding of the issue, and of each other. In this issue, the topic of our FORUM is the Medical Board's Diversion Program.

Post your own comments to the On-Line Blog discussion of this previous topic and our latest topic discussed in this issue. **Go to: www.csam-asam.org and click on "CSAM BLOGS".**



From Addict to Physician—A Determined Life

Donald Kurth beat his heroin addiction to become a doctor and now is also Rancho Cucamonga's mayor

(REPRINTED WITH PERMISSION. LOS ANGELES TIMES CALIFORNIA SECTION, APRIL 23, 2007 BY JONATHAN ABRAMS, TIMES STAFF WRITER)

Donald Kurth beat his heroin addiction to become a doctor and now is also Rancho Cucamonga's mayor. But in 1969, he stood in a New Jersey courtroom at the mercy of the judge.

A heroin addict, Kurth had been arrested for petty larceny and drug possession. His oversized jeans sagged at the waist. His belt had been stolen that week by a corner drug-seller in Harlem.

Perhaps seeing a speck of promise in the 20-year-old, the judge offered him drug rehab instead of jail.

Kurth balked. If he did the time, he'd be back on the street sooner.

Consider it a gift and take it, his attorney told him.

Nearly 40 years later, Dr. Donald Kurth still reaches back to that memory for inspiration. The judge's gift ultimately led to college and then Southern California, where he is chief of addiction medicine at Loma Linda University Behavioral Medical Center — and mayor of Rancho Cucamonga.

"It's like the story of the comeback kid," said Kurth, now 57. "I knew my life was spiraling out of control, but luckily, I was able to pull it out."

Kurth grew up in the New Jersey suburbs and was a fan of Timothy Leary, the former Harvard lecturer who promoted the benefits of LSD.

He sipped his first alcohol at 12, toked his first marijuana at 15.

"It wasn't like anyone came to the schoolyard and asked me if I wanted drugs," Kurth said. "I was the one out looking for them."

Though Kurth was once a gifted student, his top marks soon plummeted.

After narrowly graduating from high school, he flunked out of two small colleges.

"Everyone said he had the highest IQ of his class," said Kristine Kiley, Kurth's younger sister. "But he couldn't attend his own graduation because he was getting into so much trouble."

Kurth's father scolded him but was unsure of how to cope with his rebellious son.

So Kurth drifted, ending up in New York. Sometimes he had no place to sleep. Often he huddled in condemned buildings.

He chose cocaine over marijuana, then heroin over cocaine.

"Drugs were brand new then and represented a mutiny against our parents," Kurth said. "We all believed we could change the world, and we all thought getting high was going to do it."

There is little in Kurth's life today that hints of those days on the street.



NEWLY ELECTED MAYOR OF RANCHO CUCAMONGA DONALD KURTH, MD (LEFT) WITH ASSEMBLY MEMBER PAUL KREKORIAN IN SACRAMENTO AT CSAM LEGISLATIVE DAY IN FEBRUARY 2007

He has a soft face and a graying mustache and speaks with sincere emotion. Diplomas decorate his office at Loma Linda University Behavioral Medical Center.

Three years ago he married Dee Matreyek, who runs the nonprofit Restorative Justice Center, which helps criminals fit into society upon release. The wedding followed nearly two decades of courtship.

"Of course, I was skeptical at first; that's why we dated on and off for 18 years," said Matreyek, laughing.

Kurth, who learned policymaking as chairman of various physician organizations, was appointed to an open City Council seat in Rancho Cucamonga in 2002. For someone who had problems making decisions in his youth, the responsibility of being a councilman had great appeal. It showed how far he had come.

In November, he squeaked past incumbent Bill Alexander to become mayor. Kurth got 49.5% of the vote; Alexander, 45.8%.

Some opponents denounced his past at council meetings and handed out fliers detailing his drug history.

During one City Council session, a woman called Kurth a heroin addict.

The next week she apologized and said she misspoke — that Kurth was actually a cocaine abuser.

"He certainly doesn't go out and paint a tag that says 'Look at me,' but people who try to use his background against him don't succeed," said Councilwoman Diane Williams.

The attacks were nothing compared with those he survived as a young addict living on the streets.

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From Addict to Physician—A Determined Life

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Once, two men approached Kurth in a rough Harlem neighborhood shortly after he'd bought some drugs.

They frisked him for the heroin, not knowing he clutched it in his hand.

One grabbed Kurth from behind while the other jabbed a knife into his belly.

Blood splotted through his black-and-blue sweater.

He stumbled two blocks to a drug dealer's apartment, where the two stitched his wounds. A hospital visit was out of the question because a warrant was out for his arrest.

The arrest eventually came, and in 1969 Kurth went before the judge on a brisk winter day.

Challenged by himself and loved ones, he chose drug rehabilitation over jail and enlisted at Daytop, a New York therapeutic center.

Those who relapsed there wore shirts reading "I'm Sorry I Acted Like a Baby."

The shirt was among Kurth's most frequently worn accessories.

"I kept telling him, 'You've got it here in the head, Donald,'" recalled Msgr. William O'Brien, Daytop's founder. "He was erratic and he was a scatterbrain, but he had the determination to change his lifestyle."

Kurth gained respect for his doggedness, and after more than two years of recovery, his hunger for drugs had been replaced with a hunger to learn.

"I was pretty high on being clean, and I felt grateful for my life," Kurth said. "I wanted to do something with it."

After his release, he worked at odd jobs, looking for a way to jump-start a stalled education.

After one particularly grueling day working in construction, Kurth walked into Fairleigh Dickinson, the largest private university in New Jersey, and asked to speak with an admissions counselor.

"She did everything but laugh in my face, and asked me why would they want to accept me?" Kurth said. "So I asked to speak with the dean."

Kurth pleaded with the dean and caught another break. He could take a night course and, if he performed well, would be granted full admission.

He took English 101, and aced the class. It was the first of many successes he had at Fairleigh Dickinson.

A mentor noticed Kurth's enthusiasm and suggested he apply to top-tier schools. Ivy League schools.

The types of universities skeptical over applicants with a couple of Bs, let alone those with arrest records.

With other schools denying him based on his past, Columbia University took a chance, and he enrolled at the Manhattan college.

"It was pretty awesome and remarkable," said Kiley, his sister. "I just kept thinking, if these people knew what he had been through, they would be really amazed."

After graduating with honors, Kurth enrolled at Columbia's medical school — one of the best in the nation. He

completed an internship at Johns Hopkins University, then ventured west to begin a residency program at UCLA.

But at the same time, he began undergoing treatment for life-threatening colon cancer. Drinking alcohol increases the risk of cancers of the mouth, esophagus, pharynx, larynx and liver in men, and of breast cancer in women, according to the National Cancer Institute.

Kurth's problems with alcohol had continued beyond the time he quit using drugs, but he hasn't used it since 1993.

"I suffered through the agony of addiction-related cancer, but I wasn't going to make mine a tale of woe," he said.

He was determined not to let the disease be his downfall.

Surgery and a year of chemotherapy sent the illness into remission, and Kurth started working at his current job, the chief of addiction medicine at the Loma Linda Behavioral Medical Center.

His principal responsibility is managing the medicine of patients trying to rid themselves of dependence on drugs — patients who mirror his past.

"They can relate to me because I can talk to them about my own past," said Kurth, who champions the benefits of rehabilitation over jail sentences for drug offenders. "It's very rewarding because you can make a dramatic difference in people's lives."

Kurth now heads a city that is rapidly turning into a destination for middle-class African Americans, Latinos and Asian Americans.

Since 1995, the city's population has increased nearly 50%, from 114,000 residents to more than 170,000.

He plans to focus on cutting the city's crime rate and carefully managing the city's development and growth, all while maintaining his post at the hospital, aiding those who were once in his shoes.

"I like to stay busy," Kurth said. "I've been fortunate in my life with my recoveries. I've been given a new life, so every day is exciting." ■

[Editor's Note: Dr. Donald Kurth is one of six pioneers who has used innovative techniques to help conquer alcohol and other drug addiction and support recovery who will be honored at the fourth annual America Honors Recovery Luncheon sponsored by the Johnson Institute on Thursday, September 27, 2007 in the Ballroom of the National Press Club, Washington, DC. He is passionate about public policy and social justice aspects of addiction and recovery. Dr. Kurth is a past president of CSAM and serves on the Board of Directors of the American Society of Addiction Medicine (ASAM). He is ASAM-certified and practices as the medical director at Loma Linda University's Behavioral Medicine Clinic. He advocated on behalf of Proposition 36 and has been instrumental in the forming of the ASAM Legislative Advocacy Committee. Dr. Kurth's most recent accomplishment further allows him to spread the message of addiction and recovery.]

Doctors in Distress

CMA Confidential Help Available

Concerned that a colleague, a family member, or you, may have an alcohol, chemical dependence, mental/behavioral problem? The CA Medical Association offers the Confidential Assistance Line, a 24-hour, voluntary phone service for physicians, dentists, medical students, residents, their families and colleagues. This service is completely confidential and using it will not result in any form of disciplinary action or referral to any disciplinary body. Physicians and dentists who volunteer their services on the line are experienced in treating professionals, including physicians, with impairment problems. The goal is treatment not discipline.

In Northern California, please contact 650/756-7787.

In Southern California, please contact 213/383-2691.

Information: Kathleen de Fabrique, 415/882-5107,

kdefabrique@cmanet.org

In Memoriam

ASAM Past President, **Joseph J. Zuska, MD** (President: 1977-1979) passed away on Friday, May 18. Among his many accomplishments, Dr. Zuska (Captain USN Medical Corps Ret.) founded the Navy's first pilot program for the treatment of alcoholism at the Naval Station at Long Beach, California in 1965. He was 93 years old.

John P. McGovern, MD died in Galveston Texas Thursday May 31, 2007. He made his name in medicine, and left his name on institutions. Dr. John P. "Jack" McGovern, was a noted allergist, scholar and philanthropist. McGovern died of pneumonia at John Sealy Hospital at the University of Texas Medical Branch at Galveston about noon, almost a week after he fell at home. He was 85 years old. Houston venues that bear his name include the John P. McGovern Hall of the Americas in the Museum of Natural Science, the John P. McGovern Building, which houses the Museum of Health and Medical Science and its McGovern Theater, the John P. McGovern Historical Collections and Research Center at the Texas Medical Center Library and the John P. McGovern Children's Zoo.

Tod H. Mikuriya, MD, a California psychiatrist who was widely regarded as the grandfather of the medical marijuana movement in the U.S., died on May 20, 2007 at his home in Berkeley. He was 73. The cause was complications of cancer.

CSAM-Sponsored CME

September 14

7:00 pm to 9:00 pm

CSAM Regional Dinner Meeting

"Dextromethorphan Abuse in Adolescence: A Rising Trend"

Speaker: Ilene Anderson, PharmD

Location: *Frantoio Ristorante, Mill Valley*

September 28

9:00 am to 4:30 pm

"Conducting and Reporting Substance Abuse Evaluations of Licensed Professionals"

Location: *Camino Medical Group*

701 E. El Camino Real, Mountain View

September 29

9:00 am to 4:30 pm

"Third Annual South Bay Conference on Physicians Well-Being"

CSAM has endorsed the Santa Clara County Medical Association's Third Annual South Bay Conference on Physicians Well-Being (CME to be provided by CMA)

Location: *Camino Medical Group*

701 E. El Camino Real, Mountain View

November 2

7:00 am to 9:00 pm

CSAM Regional Dinner Meeting

"Documenting Disabilities"

Speaker: Barry Zevin, MD

Location: *Kaiser, Sacramento*

November 6

7:00 am to 9:00 pm

CSAM Regional Dinner Meeting

"Review of Mindfulness in Treatment of Attention Deficit Hyperactivity Disorder and Implications for Substance Abuse Treatment"

Location: *The Victorian, Santa Monica*

October 17 - 20

CSAM Addiction Medicine State of the Art Conference 2007

Sheraton Universal Hotel, Universal City (Los Angeles)

Up to 25 hours of Category 1 CME.



December 5-8, in New Orleans, Louisiana
2007 INTERNATIONAL DRUG POLICY REFORM CONFERENCE
Astor Crowne Plaza/French Quarter
Hosted by the Drug Policy Alliance

Please visit <http://conference.drugpolicy.org> or call (866) 219-4582 for more information.

2008 Election Notice to CSAM Members

CSAM Executive Council - Slate Proposed by Nominating Committee

Following is the slate of candidates proposed by the Nominating Committee, Chaired by Don Kurth, MD, for election to the CSAM Executive Council in 2008.

OFFICERS

Judith Martin, MD - *President*

David Pating, MD - *Immediate Past President*

Tim Cermak, MD - *President-Elect*

Jeffery Wilkins, MD - *Treasurer*

COMMITTEE CHAIRS

(serving on the Executive Council)

Denise Greene, MD - *Public Policy*

Karen Miotto, MD - *Opioid Dependence*

Stephanie Sharer, MD - *Well-Being*

Monika Koch, MD - *Education*

AT-LARGE CANDIDATES

There are two "at-large" positions open. One is a 4-year term and the other is a 2-year term. The candidate receiving the most votes will serve the 4-year term:

Tom Brady, MD

Murtuza Ghadali, MD

Barry Rosen, MD

Mason Turner, MD

REPRESENTATIVES

Peter Banys, MD - *ASAM Representative*

Steve Eickelberg, MD - *MERF Representative*

FROM THE CSAM BYLAWS

The President shall appoint, with the approval of the Executive Council, a Nominating Committee that shall consist of at least one Active member not serving on the Council. The Committee chair shall be the Immediate Past President.

The Committee shall call for nominations from the membership at least 90 days prior to the Annual Membership Meeting. The Committee shall nominate a candidate for each position of elected office for the ensuing term and shall notify in writing the membership of its choice not less than 30 days before the annual meeting. Any person so nominated shall have given his or her prior consent to the nomination.

The Executive Director shall mail a proposed slate showing those committee-nominated and self-nominated candidates approved by the Nominating Committee and those nominated by petition of members. The Committee shall conduct an election by mail ballot in accordance with the California Nonprofit Corporation Law in which each Active member shall have one vote to cast for each officer position and each director-at-large position being filled by election.

Within 30 days after the Committee's written notice to the membership of its nominees, the members, by a petition of two percent (2%) of the voting membership, may nominate an eligible member for an elective office. In the event a petition is put forth, a vote for the contested position will take place at the Annual Membership Meeting.

The results of the election shall be announced no later than the Annual Membership Meeting to be held on **Friday, October 19, from 1:00 pm to 1:30 pm at the Sheraton Universal Hotel in Universal City (Los Angeles)** during the CSAM State of the Art Conference. ■

Preconference Workshops at State of the Art 2007

Wednesday, October 17, 2007

Sheraton Universal Hotel, Los Angeles, CA



A. USING DEVELOPMENTAL SKILLS TRAINING IN ADDICTION TREATMENT

Laurel Mellin, MA, RD & David Ingebritsen, PhD, LCPC

B. PHARMACOLOGICAL INDUCTION OF THE SPIRITUAL EXPERIENCE

Timmen Cermak, MD & Robert Jesse

C. HEPATITIS C UNIVERSITY: MUST-KNOWS FOR THE ADDICTION SPECIALIST

Anthony Albanese, MD, Diana Sylvestre, MD, & Dennis Bleakley, MD

D. ACCESS TO TREATMENT: OBTAINING INSURANCE BENEFIT AUTHORIZATION FOR OUR PATIENTS

Thomas J. Brady, MD, MBA, John P. Femino, MD, & David Mee-Lee, MD

E. GLOBALIZATION OF ADDICTION

*Peter Banys, MD * Walter Ling, MD, Richard Rawson, PhD, & David Smith, MD*

F. MINDFULNESS IN ADDICTION TREATMENT

Alan Marlatt, PhD & Elizabeth Suti, MA, MFT

G. PAIN AND ADDICTION: ADDRESSING THE TOUGH CASES

Barry Rosen, MD, Karen Miotto, MD, Jodie Trafton, PhD, Neal Slatkin, MD, Mel Pohl, MD, & Jim Tracy, DDS, CADC

Guidelines for Communicating our Messages about Addiction



Dear CSAM Members,

Education is central to CSAM's mission – both education of professionals and the general public. As the Society takes more prominent public policy stances, each of us is more likely to have opportunities to speak to journalists and reporters. It is important to be clear when you speak on behalf of CSAM, representing an agreed upon public policy position, and when you speak solely on your own behalf.

Members are encouraged to answer questions that come your way from the media. Be prepared to give simple statements of one or two important points. You should be sure to restate these points more than once during an interview. It is also very likely that the person questioning you has misinformation that he or she assumes to be true. Pay close attention to their questions. You will need to briefly and politely correct any misinformation and then again give a clear message of one important point. Media interviews at NOT Grand Rounds. Do not give interviewers the benefit of all your knowledge or all the exceptions to the rule – just one clear statement in a friendly fashion. Each of us can do this.

--**Timmen Cermak, MD**, *Editor and Chair, CSAM Communications Committee*

What is UPPL and Why Does it Matter

continued from page 3

ment when appropriate. Benefits from integrating a system of SBIR (Screening, Brief Intervention and Referral) into medical care would be nearly immediate and truly enormous. Medical costs would be reduced. ER's would be less burdened and run more efficiently. The cost to society from drunk driving and criminal activity would be reduced. And individual suffering would be lessened.

The single most powerful enemy of implementing such a beneficial tool as SBIR is stigma - the result of ignorance, prejudice and discrimination. Addiction remains steadfastly within the framework of morality for many Americans, and those who suffer from addictive disease continue to be stigmatized. Society wages war against drug and alcohol users and permits institutionalized discrimination against them. By seeing addiction through the lens of morality, we see addicts as doing bad, and therefore being bad. The modern, appropriate, manner of wagging fingers at miscreants is to accuse them of failing to recognize their "individual responsibility" for behaving better. From the perspective of morality, addiction is to be punished, not treated (read "coddled"). "Tough love" means making addicts pay the full cost of their medical care rather than be able to access benefits from the medical insurance they have already purchased. That should teach them to behave better. And if it doesn't teach them, they'll have to pay for it again, and again, and again. For the one thing we know is that untreated addiction often lurches from one disaster to the next, from one illness or injury to the next.

Admittedly, the logic of UPPL makes sense, on the surface. If my medical insurance is not going to apply to any injury incurred when I am intoxicated, then I'll take care to be sure I never have anything to drink before I get in the car. But this logic only works with someone who is

not an alcoholic. An alcoholic's logic goes "If I have enough to drink that my judgment is impaired, then I won't drive." But, once their brain is intoxicated enough to impair judgment, then their judgment is impaired enough to no longer be influenced by UPPL's logic. The only one UPPL helps is the insurer's bottom line, except that this benefit is largely negated by physicians' reluctance to document alcohol and other drug use. So the insurer ends up paying anyway.

Individual responsibility is part of the solution - but individual responsibility for cooperating with treatment, not for the disease itself. The medical framework has profoundly different implications than the moral framework. Instead of stigma, we have disease. Instead of shame and punishment, we have nonjudgmental treatment. Instead of stigma, we have compassion. Instead of discrimination, we have parity.

The UPPL issue is essentially the same issue as denial of parity. Both are based on old science and stigma. Both designate specific illnesses to be excluded from coverage by medical insurance, despite the fact that modern science understands the pathologic processes underlying the illnesses and medicine today provides useful treatment. And both base their arguments on faulty economic data - substituting a perception of short term gain for ignored long term loss. Both actually work against the financial interests of their proponents. But such is the power of stigma, prejudice and denial.

Repeal of UPPL will cost as little as instituting parity. And both will eventually reduce health care costs and benefit both individuals and the general public health. ■

NOTE: CSAM will continue to fight in Sacramento for repeal of UPPL.

Join us in Los Angeles for CSAM's State of the Art Conference, October 17-20

Sheraton Universal Hotel • Universal City (Los Angeles)

For more information: www.csam-asam.org

BY LORI D. KARAN, MD, CONFERENCE CHAIR



The 2007 State of the Art Conference will emphasize advanced topics vital to furthering the clinical practice of addiction medicine. Keynote speeches by both **Timothy Condon, PhD**, Deputy Director of NIDA, and **H. Westley Clark, MD, JD, MPH**, Director of CSAT, will provide a national perspective emphasizing innovations in addiction research, intervention, and treatment.

Pre-conference workshops on Wednesday present an in-depth approach to topics with greater opportunity for interaction with renowned faculty. Topics include Hepatitis C for the Addiction Specialist, Maximizing Reimbursement for Services, Pharmacologic Induction of the Spiritual Experience, Globalization of Addiction, Developmental Skills Training, Mindfulness Practices, and Pain and Addiction.

On Thursday, plenary sessions will explore the process for medication development and post-marketing surveillance and reflect on the ways that pharmaceutical company interests may influence patient care. The levels of evidence needed to adopt pharmacotherapies will be contrasted with those needed for behavioral therapies. Investigating research parameters which describe addictive behavior and assess treatment outcome will lead to a discussion of the meaning of recovery and the extent to which experimental findings can be generalized to clinical practice.

Friday morning's presentations on pain and addiction range from investigating opiate responsive neurocircuits to novel approaches for medication development. The impact of disordered sleep on pain and addiction, and a model program for the non-opioid management of chronic pain in addicted patients will be described.

The line-up for Friday afternoon's session on steroids is extraordinary. Authors **Lance Williams** and **Mark Fainaru-Wada** will discuss the role of anabolic steroids in sports followed by Don Caitlin, MD's tales of drug testing for the Olympics. Ruth Wood, PhD, will discuss mechanisms for the psychoactive effects of steroids, while Harrison G. Pope, Jr., MD, will discuss the clinical ramifications of these findings.

On Saturday, we will address the needs of special populations including Hispanics, adolescents, the lesbian and gay communities, and one model of prevention for families. In addition, throughout the conference, exercises in mindfulness and movement are designed to enhance learning and participation.

Exciting breakfast and evening events are scheduled. A breakfast discussion with ASAM President Michael Miller,

MD and Treasurer Stuart Gitlow, MD on Friday morning will highlight ASAM's plan to achieve conjoint specialty status and discuss the potential for parity and other policy initiatives. On Wednesday evening, "The Comic Shrink," Dr. Howard Richmond, will pack in laughs. During Thursday night's dessert reception, Judge James Gray will discuss his experiences enforcing drug statutes with provocative perspective entitled, "Why Our Drug Laws Have Failed." Finally, on Friday night Mark Fainaru-Wada and Lance Williams, will discuss the investigative reporting and aftermath of *Game of Shadows: Barry Bonds, BALCO, and the Steroids Scandal that Rocked Professional Sports* at a dinner and book signing.

Need we say more? Whether you want to advance your understanding of addiction medicine, improve your clinical practice, or relax and network with incredible peers, CSAM's 2007 State of the Art Conference is not to be missed! Register On-line at: www.csam-asam.org. Questions? Call 415-927-5730.

PLANNING COMMITTEE

Lori D. Karan, MD, Conference Chair, Drug Dependence Research Laboratory, Clinical Psychopharmacologic Research, University of California, San Francisco

Stephanie Shaner, MD, Conference Vice-Chair, Department of Addiction Medicine, Kaiser Permanente, Los Angeles Medical Center

James Barger, MD, Department of Mental Health, Los Angeles County Alternatives, Glendale Memorial Hospital

Murtuza Ghadiali, MD, Department of Internal Medicine at Kaiser Hospital, South San Francisco

Robert Martin, MD, Associate Clinical Professor of Psychiatry, USC

Jean Marsters, MD, Assistant Clinical Professor of Psychiatry, UCSF

Karen Miotto, MD, Associate Professor, Department of Psychiatry and Behavioral Science, UCLA School of Medicine, Los Angeles, CA

Garrett O'Connor, MD, Chief of Psychiatry, Betty Ford Center, Rancho Mirage, CA

Barry M. Rosen, MD, Medical Director, The Sequoia Center, Redwood City, CA

California Society of Addiction Medicine's Summary *Blueprint for Treating Drug and Alcohol Addiction in California*

BY DAVID PATING, MD

1. ADDICTION IS A BRAIN DISEASE

Research shows that addiction begins in the brain's disordered response to drugs, leading to craving, loss of control, and resultant family and social disruption.

2. TREATMENT SAVES LIVES

Addictions are chronic, relapsing disorders, with treatments that are as effective as those for other chronic medical diseases. Even methamphetamine addiction is as responsive to treatment as diabetes and hypertension.

3. FULL ACCESS TO TREATMENT

Large-scale studies have demonstrated that parity for chemical dependency treatments does not significantly increase premiums. CSAM believes that limiting full access to treatment is unfair to consumers and discriminates against those suffering from addiction.

4. TREATMENT, NOT PRISON

Our courts and prisons are overburdened by nonviolent drug-related offenders. CSAM believes that the social disruptions caused by disease are best ameliorated by medical treatment.

5. EARLY DIAGNOSIS AND INTERVENTION

Emergency rooms are heavily burdened by addicts needing treatment. Withholding insurance reimbursement following positive drug screening is counterproductive.

6. INTEGRATED TREATMENT FOR CO-OCCURRING DISORDERS

CSAM supports access to integrated treatment for patients with co-occurring medical, psychiatric and substance use disorders. There should be "No Wrong Door" into treatment.

7. SPECIAL POPULATIONS REQUIRE OUTREACH

CSAM supports a full range of comprehensive and individualized programs to meet the special needs of adolescents, women, the homeless, and the incarcerated.

8. METHADONE WORKS

CSAM supports methadone and buprenorphine treatment as the Gold Standard for opiate addiction in all settings, including prison and probation programs.

9. GOOD TREATMENT REQUIRES GOOD SCIENCE

Addiction treatment should be subject to the same level of outcome studies required by other medical diseases. "Magic bullet" cures, however highly touted initially by testimonials, are generally not effective, and should not be supported until positive results are scientifically proven.

10. RECOVERY TAKES COMMUNITY

Stigma creates an invisible barrier that hinders patients and families from seeking addiction treatment. Communities must work to overcome the public stigma of addiction. Hope is realistic. Treatment works and can restore the health of patients, families and their communities. ■

The logo for the California Society of Addiction Medicine (CSAM) is displayed in a large, white, serif font. The letters are bold and slightly shadowed, giving them a three-dimensional appearance as if they are floating above the page.

CSAM State of the Art Course in Addiction Medicine

October 17-20, 2007
Sheraton Universal Studios, Los Angeles

Conference Chair: *Lori Karan, MD*
Vice Chair: *Stephanie Shaner, MD*

To find out about newly scheduled regional meetings and other courses offered by CSAM,
visit: www.csam-asam.org where registration is available on-line.



CSAM

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