CSAM news
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THE VOICE FOR TREATMENT
QUARTERLY NEWSLETTER OF THE CALIFORNIA SOCIETY OF ADDICTION MEDICINE

2003 LEGISLATION ROUNDUP

CSAM Continues To Be a Strong Voice in the State Capitol

Substance abuse parity legislation (SB101) which was introduced by Senator Chesbro in January is awaiting a study by UCLA on the bill's financial impact (required of all health insurance mandates). CSAM 2003 President **Dr. Gary Jaeger** met with the California Chamber of Commerce which strongly opposed parity legislation in previous years, labeling it a "job killer bill." Thanks to CSAM's efforts it is likely that the Chamber will not oppose the bill this year, and Dr. Jaeger has been invited to give presentations to several Chamber Committees.

Two important bills that were supported by CSAM became law. SB295 provided funding to the California Marijuana Research Program to study the safety and efficacy of medical marijuana. SB 151 eliminated triplicate requirements for Schedule II Controlled Substances beginning July 1, 2004. A bill, opposed by CSAM, that would have exempted people accused of non-violent possession of GHB, rohypnol and ketamine from participation in Proposition 36 treatment (instead of jail) programs did not survive in committee.

CSAM strongly supported two bills that passed the legislature but were vetoed by the outgoing governor. AB 1308 would have required local correctional facilities to provide evidence-

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Addiction Medicine in China

by David E. Smith, MD

In September 2002, I went to China as part of an international delegation to the World Health Organization/Beijing University conference on substance abuse held at the Beijing Institute of Mental Health. I had the privilege of meeting the leading mental health and addiction doctors in China, including Professor Shen Yucun and to be part of a historic public health moment that introduced the concepts of twelve-step recovery to one quarter of the world's people.

Beijing University and the Beijing Institute of Mental Health are the primary institutions for the delivery of mental health services in China. The mental health hospital was founded in 1951. Professor Wu Zhengya, a psychiatrist famous throughout China, established a department of psychiatry for teaching and research. Professor Shen Yucun assumed a leadership role and was influential in bringing about modern addiction treatment and the fellowship of Alcoholics Anonymous to China. The conference was organized by Dr. David Powell, Director of the Asia Institute. He has long worked with China in the area of substance abuse and AIDS prevention.

DAVID SMITH (ASAM), ANTHONY EDMANSON, AND BOB MACFARLANE (NARCOTICS WORLD SERVICES) AND WAYNE MORAN (INTERNATIONAL SOCIETY AND BEIJING UNIVERSITY) AND FACULTY OF BEIJING UNIVERSITY WHO ORGANIZED THE FIRST NARCOTICS ANONYMOUS MEETING IN CHINA.

I was privileged to be part of a faculty that included experts from around the world, including Dr. George Valliant, who has made such a contribution to the addiction medicine field with his research on the national history of alcoholism, including the crucial role of AA and long term recovery from alcoholism, and as leadership from Narcotics Anonymous International, and Dr. Wayne Moran, a leading addiction medicine expert in Hong Kong and fellow International Doctors in AA and International Society of Addiction Medicine member. Our delegation also included representatives of Narcotics Anonymous General Services Administration and Alcoholics

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Let your voice be heard!

SECOND ANNUAL

CSAM Legislative Day

January 28, 2004

Sacramento, CA

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Anonymous General Services Administration.

Dr. Moran indicated that while non-Chinese expatriates living in China had AA meetings, until two years ago, AA meetings for Chinese Nationals was illegal. Despite an escalating heroin problem in China, there were no Narcotics Anonymous meetings, and because of frequent needle sharing there is a dramatic escalation of HIV/AIDS.

In August 2001, Dr. Valliant and two members of AA General Services Administration were invited to the People's Republic of China to talk about alcoholism and AA. It was the first time members of the AA fellowship were able to share their experience, strength, and hope with the medical establishment in China and with the Pioneers of AA in China. The Pioneers of AA in China, who held the first meeting less than a year and a half prior to this meeting, met with the delegation from the United States to strengthen the acceptance of AA in China by explaining the 12-step process of recovery from an Addiction Medicine perspective.

My presentation focused on addiction as a brain disease and various techniques for detoxification and treatment of dependence on opiates, stimulants including amphetamine, cocaine, and alcohol, using techniques developed at the Haight Ashbury Free Clinics and principles of addiction treatment established by the American Society of Addiction Medicine.

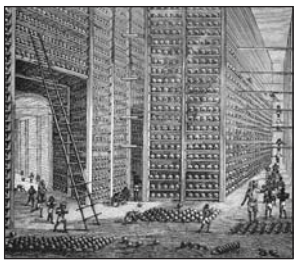
Opium and Heroin in China

Opium and heroin have a long history in China. Many Chinese have bitter recollections of the opium wars of the 19th Century, when British traders backed by English government gunboats forced opium grown in British India into China and thereby virtually ruining the Chinese economy.

The First Opium War started when the Chinese government tried to stop British merchants from illegally importing opium. Britain responded by sending an expedition of warships to the city of Guangzhou. The British won a quick victory, and the conflict was ended by treaties under which China was forced to pay a large indemnity, open five ports to British trade and residence including the establishment of British Hong Kong as a lucrative port for the importation of heroin. The British also won the Second Opium War, fought for much the same reasons. The resulting treaty opened additional trading ports and allowed even greater privileges to Western countries. Dr. Moran described the creation of Hong Kong in the 1890s as "a drug deal gone bad" for China.

Opium smoking, forced onto China by Britain in the 19th Century undermined Chinese society.

Scenes in the Patna opium factory, from the London weekly magazine, The Graphic, 24 June 1882.



Today, Hong Kong still serves as the major drug smuggling port, not only into China, but worldwide.

In 1949, when China's communist government took power, there were 70 million opium addicts. The communists shut down the opium dens and declared the nation drug free, claiming that heroin addiction was a consequence of the capitalist system. Because of draconian measures and capital punishment of drug abusers, heroin addiction rates decreased dramatically. In 1988 it was estimated that there were less than 70,000 heroin addicts in all of China.

As a result of China's policy of rapid industrialization, with its opening of borders to free trade, there has been a dramatic increase in heroin addiction. Official estimates presented at our conference estimated the current number of heroin addicts in China at 900,000. Non-government epidemiological experts indicate that the actual number is much higher ranging from four million to ten million. This underestimation of the extent of addiction is largely due to the government's draconian approach. In China, drug traffickers are often executed and addicts are sent to labor camps – a similar approach to the US criminal justice system of boot camps and incarceration.

In his presentation, Dr. Moran painted a graphic picture of the victims of the potent heroin available, including needle abscesses and overdose deaths. Many overdose deaths occur after addicts are released from the labor camps and had lost their tolerance for heroin. They readministered the drug, overdosed and died. The success rate for heroin addicts when released from the labor/political rehabilitation camps was less than five percent according to the government, similar to the Lexington incarceration experience of the United States in the 1950s where only about 5% of the addicts stayed off heroin after their discharge.

As a result of the Chinese government's failure to control addiction, experts in our delegation were invited to present contemporary addiction treatment standards based on ASAM patient placement criteria ranging from antagonist therapy with naltrexone to agonist therapy with methadone as well as drug-free therapies including therapeutic communities. The Chinese government opposed agonist therapy such as methadone maintenance, but was more oriented toward antagonist therapy such as naltrexone. Based on the trainings given by Walter Ling, they were open to partial agonist therapy such as buprenorphine. US drug policy with its emphasis on supply side reduction, incarceration and just say "no" prevention message was presented by Charles Curie director of SAMHSA and Barbara Rogers of the Office of National Drug Control Policy.

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Alcohol in China

Alcohol, first introduced 4,000 to 5,000 years ago, has a much longer history in China than opium and heroin. Chinese nobility consumed alcoholic beverages in the form of rice wine at social events and national ceremonies. Alcohol was romanticized and Chinese literature considered appropriate drinking a virtue to beautify, dignify, and philosophize. Despite this romanticization early Chinese medical literature recognized the potential for alcohol problems.

Chinese experts presented medical literature on alcohol problems including mentions of fetal alcohol syndrome symptoms in ancient medical textbooks. They used the following quote, "Intercourse after drinking will make your offspring inferior."

However, Chinese medical textbooks emphasize the health benefits of alcohol but contain very little on alcoholism. Since the 1980's, China has rapidly moved from a rural agricultural society to an industrialized, urban one. The attendant disruption of family has greatly increased the problem of alcoholism, particularly among males.

I had the privilege of attending a Chinese AA meeting and participating in medical grand rounds with Dr. Moran. Members of our delegation interviewed patients on the alcohol ward at the psychiatric facility and discussed cases with residents. Most of the alcoholic patients that entered the psychiatric facility came in because of alcoholic hallucinations and DT's. So their alcoholism had to be very far advanced with severe medical and psychiatric symptomatology before they were initiated into treatment.

Alcoholics Anonymous had gained a foothold of very little to what we would call post-hospitalization aftercare in China. Although the meeting was run in a fashion very similar to the US meetings, it was interesting that the psychiatrist that translated indicated that in China they do not believe in God and therefore use higher power in the third step. There are several different definitions for higher power and it appears that the spirituality of AA is much more applicable to current Chinese philosophy and society than a Western-style religion would be. The focus of AA and its traditions allowed AA to gain a foothold and help suffering alcoholics in China. A more traditional religious approach would have been rejected.

Tobacco and Other Drugs

Tobacco addiction was an enormous problem in China and had a long history. It was first introduced during the Qing dynasty in the middle part of the 19th Century. As previously discussed, this was a period of increasing Western influence and trade, which led to the Opium War and the Boxer Rebellion (1898-1900). The Qing dynasty, China's last, was overthrown by nationalist revolutionaries. Initially, tobacco use was strictly prohibited by the emperor, but it became the number one recreational drug until the introduction of opium. It was estimated that 35% of the population smoked. Today tobacco is a leading cause of medical death and disability.

There was also the recent introduction amongst the youth of a variety of drugs that have been long seen in the United States. In China, ice (d-methamphetamine) is beginning to make its appearance in clubs, especially in prosperous coastal cities, such as Shanghai, just as it did in the US during in the 1990's. Methamphetamine, manufactured mainly in illicit laboratories, has been increasing dramatically both in China and other areas of Asia such as Thailand. (Walter Ling has been organizing modern drug treatment at the request of the Thai Government.) Parallel to the increase in methamphetamine has been a dramatic increase in violence.

The Chinese call the drug ecstasy "Yaotouwan" or "headshaking pills." The concept of the rave club was first described in China in 2000, indicating that drugs, sex, and rock and roll have started to permeate China in the new millennium, particularly in more Westernized cities such as Shanghai, which interestingly enough was where Mao Tse Tung organized the first Chinese Communist Party meetings in the 1920's.

In the US, psychedelic rock concerts during the 1967 summer of love in San Francisco popularized the sound of Jerry Garcia, Grateful Dead, Janis Joplin, Big Brother and the Holding Company, Grace Slick and the Jefferson Airplane. All eventually did benefits for the Haight Ashbury Free Clinics. The Chinese government frowns upon these rave clubs and individuals that are caught using ecstasy. Even though they would not have what we would describe as an addiction problem, they are sent to the labor rehabilitation camps. Clearly, there is no concept of Rock Medicine in China.

Parallel to the rise in addiction and new sexual freedom there is a dramatic increase in sexually transmitted diseases. Over a million people are infected by HIV in China. Seventy percent of the new cases are IV drug users using contaminated needles. However, the Chinese government is ambivalent about both the rising HIV and drug epidemic. The medical community in Beijing wants to initiate Western-style addiction treatment and public health AIDS approaches. Dr. David Powell who organized our substance abuse delegation also met with the leading HIV public health experts in China to improve their approaches to HIV prevention and treatment.

However, on August 24, two weeks prior to our arrival, a public health expert in Beijing, Wan Ayanhai, was arrested and detained by the government for attempting to protest government AIDS policy using methods similar to Act-Up, a public advocacy citizen group that demonstrated in favor of improved HIV/AIDS care as in the United States. It became clear that while some public health approaches could be accepted, Western-style protest will not be.

I was reminded of the traditions of Alcoholics Anonymous of maintaining focus on our purpose, which was to help the suffering alcoholics and addicts in China. I was privileged to be part of this historic delegation and

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Legislative Day 2004

Make the Voice of Addiction Treatment Heard in Sacramento!

January 28, 2004

2004 PROMISES to be a decisive year for addiction treatment in California. On the negative side, the budget crisis threatens drastic cutbacks in treatment. At the same time, there is also a good chance that substance abuse insurance parity legislation will make it to the floor of the legislature, to the governor's desk, or even be signed into law. It is imperative that the voice of addiction medicine professionals is heard by our elected officials and that our scientific expertise and clinical experience inform the debate.

On January 28, 2004, CSAM will sponsor its Second Legislative Day in Sacramento. Addiction medicine physicians and other treatment professionals from across California will meet for a day of education and discussion of addiction treatment issues with our elected representatives.

The March 2003 Report by the State's Little Hoover Commission highlights the staggering costs of untreated substance abuse in the State: "Eight in 10 felons who are sent to prison abuse drugs or alcohol. But the costs are not limited to the criminal justice system. Some $11 billion is spent from the state General Fund responding to problems created by abuse and addiction. The expenditures and losses to individuals, corporations and public agencies that result from abuse and addiction in California bare estimated to top $32 billion."

As addiction medicine physicians we know that, managed correctly, alcohol and drug treatment works and is a cost-effective response to these expensive maladies – saving $7 for every dollar spent.

Legislative Day will focus on these issues:

- Insurance Parity for Substance Abuse Treatment
- AIDS/Hepatitis C Prevention/Needle Exchange/Syringe Policy
- Expanding Access to Effective Treatment of Opioid Addiction
- Treatment vs. Incarceration (Proposition 36)

CSAM Legislative Day is free to CSAM members and their guests. Please RSVP before January 22 by calling the CSAM office at 415-927-5730 or sending an e-mail to csam@compuserve.com.

2003 LEGISLATION ROUNDUP

CSAM Continues To Be a Strong Voice in the State Capitol

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based drug treatment and a sliding scale methadone maintenance for indigent addicts. AB 1308 was based on ASAM's recent public policy statement on treatment of the incarcerated. The other vetoed bill would have allowed for pharmacy sales of syringes. Both bills will be reintroduced in the next legislature with Governor Schwarzenegger in office.

Addiction Medicine in China

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found the Chinese people to be informed and very friendly hosts. Surprisingly, they were also very computer literate. I found at the University they had accessed our Haight Ashbury Clinic website as well as our online medical service, AlcoholMD.com, and were quite familiar with our work at the Haight Ashbury Free Clinics, including our book *Clinicians Guide to Substance Abuse* and Dr. Daryl Inaba's book, *Uppers Downers and All Arounders*.

In this age of the internet, I was able to find a computer and communicate with my family, friends, and colleges in the United States on a daily basis, but I couldn't figure out the phone system or how to get around Beijing on a bike without having a frightening experience in the unbelievable traffic. It was easier for me to communicate with the United States using e-mail than it was to talk on the phone to someone down the block. Despite these personal limitations and dependence on technology we were able to contribute to our mission and pass along our passion for science including epidemiology, detoxification and treatment, including changes in neurochemistry in association with addiction while maintaining a compassion for people including recovery and spirituality associated with AA and NA. Given the globalization of information the advances in China have been dramatic. The communication link between Haight Ashbury Free Clinics and Beijing University reminds me of the Grateful Dead line, "What a long strange trip it has been."

DAVID SMITH (ASAM), WAYNE NEWTON (ISAM) AND THE DIRECTOR OF THE BEIJING PSYCHIATRIC INSTITUTE AT AA MEETING FOR CHINESE NATIONS IN FRONT OF A POSTER OF THE 12 STEPS IN CHINESE. THE POSTER THEY ARE HOLDING SHOWS THE 12 STEPS AND 12 TRADITIONS IN ENGLISH.

UCLA REPORT ON PROP. 36

New Law Places More than 30,000 in Treatment During First Year

In 2000 over 60 percent of California voters approved Substance Abuse and Crime Prevention Act (SACPA), known as Proposition 36. SACPA represents a major shift in criminal justice policy. Adults convicted of nonviolent drug-related offenses and otherwise eligible for SACPA can now be sentenced to probation with drug treatment instead of either probation without treatment or incarceration. Offenders on probation or parole who commit nonviolent drug-related offenses or who violate drug-related conditions of their release may also receive treatment.

UCLA Integrated Substance Abuse Programs (ISAP) was chosen by the Department of Alcohol and Drug Programs to conduct the independent evaluation of the program over five and one-half years ending June 30, 2006.

In the first release of findings from their evaluation UCLA researchers report that the law placed more than 30,000 drug offenders in treatment during its first year – more than half for the first time. The independent evaluation offers the first profile of the flow of offenders through the SACPA pipeline across all 58 California counties during the 12 months ending June 30, 2002.

About half of SACPA offenders in treatment identified methamphetamine as their primary drug problem, and researchers reported overall treatment retention rates comparable to non-SACPA treatment clients. The evaluation identified about half of SACPA clients as whites, 31 percent as Hispanic and 14 percent as African American. Seventy-two percent were men.

"The program introduced thousands of new clients into local drug treatment systems during its first year. It's critical to note that SACPA participation is voluntary; it reflects an affirmative decision by eligible offenders," said Douglas Longshore, a behavioral scientists at ISAP and the study's principal investigator.

"The level of participation in year one is notable when considering the high level of collaboration required among local agencies involved in planning and administration; coordination of assessment, treatment and supervision of offenders; staff training; and problem solving," Longshore said. "Despite the challenges and ongoing concerns over funding, most county representatives offered favorable reports on local implementation."

Among the findings:

- The court found 53,697 drug offenders eligible for SACPA during the law's first year, and 82 percent (44,043) chose to participate in SACPA.
- Of those, 85 percent (37,495) completed assessment, and 81 percent (30,469) of assessed offenders entered treatment. Overall, 69 percent of offenders who opted for SACPA in court entered treatment – a "show" rate that compares favorably with rates in other studies of drug users referred to treatment by criminal justice or other sources.
- About 50 percent of SACPA offenders in treatment reported methamphetamine as their primary drug problem, followed by cocaine/crack (15 percent), marijuana (12 percent) and heroin (11 percent), according to the report. On average, SACPA clients had longer drug use histories than non-SACPA clients referred to treatment by criminal justice.
- Most SACPA clients (86 percent) were placed in outpatient drug-free programs, and 10 percent were placed in long-term residential programs.
- SACPA clients remained in treatment at rates similar to those among non-SACPA clients.
- Three strategies were associated with higher "show" rates at assessment: 1) placing probation and assessment staff at the same location, 2) allowing "walk-in" assessment, and 3) requiring only one visit to complete assessment. Handling SACPA offenders in drug court was strongly related to higher "show" rates at treatment.

The full report is available on the CSAM website at http://www.csam-asam.org/SACPA2003report.pdf

CSAM Celebrates Its 30th Anniversary

The California Society of Addiction Medicine celebrated its 30th Anniversary in 2003 with a gala dinner and celebration during its State of the Art Conference in San Francisco. Some of the Society's earliest members and leaders – Arthur Bolter, MD; David Smith, MD; Max Schneider, MD; Gail Jara and others spoke about the founding of the Society, what it has accomplished over the years and the challenges ahead.

The following notes – drawn from a longer article by Steve Heilig, published in CSAM News *on CSAM's 20th Anniversary – recount some of the early years of the organization.*

CSAM grew out of the need to get the treatment of addiction into the medical mainstream and to remove legal restrictions that prevented physicians from treating addicts. "State law at that time was still a holdover from the early 1900s … At the time we were getting organized, doctors treating opioid addicts were technically in violation in the law – its language stated that no doctor could treat addicts outside of a state or county hospital or jail," CSAM's founder, the late Jess Bromley recalled in *CSAM News*.

When two doctors in Riverside County were charged for secretly admitting heroin addicts to a community hospital to manage their withdrawal, Bromley called David Smith, founder of the then newly founded Haight-Ashbury Free Medical Clinics. "I was sitting in the detox clinic when Jess Bromley called and told me two doctors had just been arrested for doing what I do every day. That really got my attention," Smith remembered.

With the help of the CMA, Bromley and others authored a bill in 1971 to change the restrictive state drug laws. "We got about 20 people together and drove back and forth to Sacramento to lobby for change. Senator George Moscone became an ally and the CMA was on our side. We took the issue to one of the early Haight-Ashbury Free Medical Clinic Conferences and got grass roots support. We got the law changed at last," Bromley recalled.

CSAM's efforts to move the treatment of addiction into mainstream medicine involved both getting recognition within the CMA and also getting support for the new organization within academic medicine.

The connection with CMA was strengthened by Gail Jara who had joined the CMA staff in 1972 after the successful lobbying partnership. "We carried the resolution to the CMA to form a specialty society, and we were very well received," Bromley recalled. "There were many visionary people there at the time who saw this as an important field needing more medical involvement."

In the academic arena, people like Charles Becker of UCSF, George Lundberg of USC, Joe Takamine and Tom Ungerleider of UCLA and Joe Zuska of the Navy all played important roles. "Here was someone who brought the imprimatur of the university to add to the recognition that we weren't just a bunch of quacks. Chuck Becker did that for us. We had our first meeting at his house in Tiburon," recalled Jack Gordon.

"I recognized that there was no teaching about chemical dependency in the medical school, while that was the root of so many of the problems we saw in the clinics," Chuck Becker recalled. "I was lucky there was this very good group of practicing physicians getting organized. But I have to say that the guru was Gail Jara, who helped us to formulate regular protocols and was an administrator of great skill and compassion. She brought practice, research and treatment all together."

Not everyone was initially enthusiastic about mainstreaming addiction medicine. "I had initially been alienated from the mainstream," recalls David Smith. "Jess Bromley and Gail Jara convinced me that we had to work for change from within organized medicine – if only to keep from getting arrested."

There were other organizations in existence at that time – the American Medical Society on Alcoholism (AMSA) founded in 1954 by Ruth Fox and the National Council on Alcoholism founded in 1944 by Marty Mann – but CSAM stood apart from then, because it focused on the role of the physicians who treated all drug dependence. It did not endorse the separation between alcohol and other drugs.

"As an internist you had to keep very busy and see a lot of patients in those days," Jack Gordon recalls. "Getting together with these great folks was almost like a form of recreation, for it was fun and they were on to something very worthwhile. The biggest debates I recall in the beginning were over what to name the new group. It was born as the California Society for the Treatment of Alcoholism and Other Drug Dependencies, and everyone called it the California Society."

The first formal meeting of the Society was held on April 23, 1973 at the San Francisco Hilton. At the next meeting the first slate of officers was proposed. Charles Becker was chosen as the first president of the new organization. The first annual meeting was held on March 3, 1974 in conjunction with the CMA's Annual Scientific Assembly. The first issue of the newsletter, edited by David Smith was distributed at that meeting.

The rest, as they say, is history.

From CSAM News 1984

The hard-working Executive Council

Pictured here during a break in the June, 1984 meeting of the Executive Council are, from left to right, Richard Merrick, Gail Jara, Anthony Radcliffe, Joseph Frawley, Josette Mondanaro, Jerome Fishgold, Katrin Fletter, David Smith, Leon Marder, John Milner, Walter Ling, Jess Bromley, Max Schneider. Executive Council members not present for this photo: Raymond Anderson, Amer Rayyes, Donald Wesson.

PRESIDENT'S COLUMN

CSAM: On Track for a Bright Future

by Donald J. Kurth, MD, FASAM
President, California Society of Addiction Medicine

The following remarks were delivered by Dr. Kurth on October 10, 2003 at the CSAM Inauguration Gala:

I want to first thank all of you for your support and encouragement. I want to thank our Executive Council, all of our membership, and especially, all of our CSAM staff who have helped to make us the great organization we are today. I have learned much from all of you and I hope we can all continue to learn together from one another. But let me take just a few moments to share with all of you my vision for CSAM as an organization as we move on into the future. And a bright future it will be for all of us and for our patients.

DONALD J. KURTH, MD, FASAM

We have many strong traditions at CSAM and I plan to support those traditions as others have done before me. I want to build on our strengths and capitalize on our successes. Education, strong standards for our specialty, a strong relationship between CSAM and ASAM, a strong CSAM membership with an emphasis on new members, and finally, a strong role in shaping the public policy of our state, and thereby our nation.

Education has long been the core of our strength and will continue to be our number one focus in the future. We have recently received the Samuel Sherman Award from the California Medical Association for our excellence in programming and I plan to build on this excellence in the future. Education will continue to be a major focus of our organization, building on our accomplishments with innovative, high quality programming to meet the needs of our membership. The State of the Art Course, the CSAM Review Course, Buprenorphine, Well Being and Intervention Courses, Primary Care Courses, and of course Pain and Addiction Courses will all continue. And we will also continue with the high quality and very informative CSAM Newsletter to help tie us all together with up to date communication between conferences and meetings. MERF has been the conduit for many new addiction professionals to learn about our specialty and will continue to be a valued component of our constellation of educational programs in the future.

We value our high professional standards. As addictionists, we have developed and supported the very highest standards for our professional community and we will continue to uphold those standards in the future. We will continue to support our patient placement criteria, a strong credentialing process, and the application of our standards to public policy wherever applicable.

We will continue to build and strengthen our relationship with our national organization, the American Society of Addiction Medicine. Historically, CSAM has had a strong bond with ASAM and we will continue to strengthen that bond in the future. We in California also have a track record of striving to set the pace of progress of addiction medicine for our nation and we will work to continue to fulfill that role.

We are a premier professional organization, and we strive to set the standards for our profession. But, we are no stronger than our membership. The recent ASAM Membership Survey has shown that our membership is very happy with the benefits of membership, but we may be facing tough economic times in California in the near future and we must not lose our focus. New members will continue to be our life's blood and recruiting and maintaining our membership will always be an important focus of our organization.

Finally, public policy will continue to be a major thrust of our organization. The recent Membership Survey found that the three highest ranked benefits of membership are education, high professional standards, and a strong, active and visible stand on public policy issues. Public policy is a critical co-partner with education. We need the knowledge, yes, but we also need the ability to apply that knowledge to helping our patients. And, it is sound public policy that allows us to accomplish that goal.

We at CSAM have a strong track record in public policy. In fact, we stand at the cutting edge across the nation. We will continue to fulfill our potential as leaders in this arena. The Membership Survey showed that almost two thirds of our membership wanted to see the development of a political action committee. We have heard you and we will be moving forward with ideas on how to accomplish that goal in the near future.

The marriage of education and public policy allows us to bring all of our resources to bear on the problems of addiction for the individual, as well as for society. And we will be there, on the front lines, fighting for our patients and for our specialty. CSAM will be there.

We have a bright future just ahead of us. As an organization, our leadership style has become one of openness and we encourage our members to step forward and take part in your organization. If you have been standing in the back thinking about getting involved, now is the time to take that step. Please feel free to contact me personally, or the CSAM office to ask how you can contribute. We stand at the very edge of dramatic change in addiction medicine. We at CSAM are the leaders of that change. By working together, we can make a better world for all those who suffer from this terrible disease and at the same time create a bright future for us all.

2003 State of the Art Conference

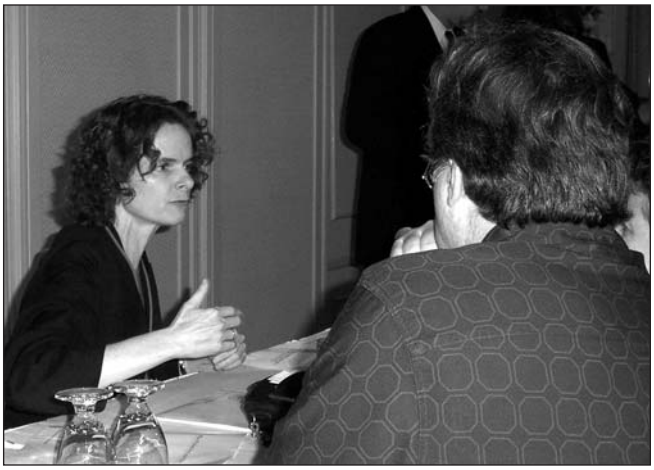
A huge success!

CSAM's biennial State of the Art Conference took place October 8-11, 2003 at the Radisson Miyako Hotel in San Francisco. The conference – one of the best attended State of the Art Conferences ever – drew over 320 registrants and 400 participants counting faculty and exhibitors. Twenty-nine residents and nine residency training program faculty attended the conference on scholarships from the Medical Education and Research Foundation.

Conference highlights included keynote addresses by Andrea Barthwell, MD, Deputy Director of the Office of National Drug Control Policy, and Nora Volkow, MD, Director of the National Institute on Drug Abuse. The Vernelle Fox Award was presented to Joan Zweben, PhD and the Community Service Award was presented to Danny and Helen Leahy. CSAM celebrated its 30th Anniversary with a Gala Banquet (see page six for details).

Immediate Past President **Peter Banys, MD** (left) receives an award for his service to CSAM from outgoing CSAM President **Gary Jaeger, MD**.

Barry Rosen, MD speaks to KRON reporter Henry Tannenbaum at the State of the Art Conference. News of Rush Limbaugh's addiction to pain medication drew reporters to the conference and gave CSAM an opportunity to speak on the importance of chemical dependency treatment.



NIDA's new Director, **Nora Volkow, MD** speaks with conference attendees after delivering a keynote address.

2003 State of the Art Conference Planning Committee: **Lori Karan, MD**; **Daniel Glatt, MD, MPH**; **Denise Greene, MD**; **Dykes Young, MD**; **Romana Markvitsa, MD**; **David Pating, MD**; **Barry Rosen, MD**; **Sean Koon, MD**.

CSAM President **Donald Kurth, MD** and Education Committee Chair and President-elect **David Pating, MD** display the 2003 Samuel Sherman Award, presented by the California Medical Association in recognition of CSAM's outstanding achievements in continuing medical education.

Joan Zweben, PhD, recipient of the 2004 Vernelle Fox Award with **David Smith, MD** and **Romana Markvitsa, MD**.

Donald Kurth, MD; **Lyman Boynton, MD** and **Gary Jaeger, MD** present the 2004 Community Service Award to **Helen and Daniel Leahy**.

Bioethics and Addiction Medicine

by Michael J. Meyers, MD, FASAM

Editor's Note: We will attempt to periodically include some discussion of bioethics (as it relates to the practice of addiction medicine) in this "Forensics" column of the newsletter. The field of bioethics is generally considered to be of great forensic interest and relevance, as it involves the application of social and legal values to problematic clinical situations. The following article is by Michael Meyers, MD, a practicing addictionist and bioethicist at Kaiser in Los Angeles. It presents a succinct overview of the common issues and conflicts that emerge in bioethics consultations regarding addicted patients.
— Douglas Tucker, MD, Column Editor

Prior to the mid 1970's, patients and their families rarely challenged the authority of physicians. Whatever moral or ethical concerns that were implicit in the practice and decision making of medicine were strictly in the realm of the practitioner. Certainly no one could have predicted the rapidity and extent to which much of medicine would become open to public debate, and how the emergence of so-called modern bioethics would offer a sharp critique of our previously insular world. The political and social climate of the late 1960's, with the emergence of the struggle for equality and civil rights, had set the stage. It was the tragic failures within research medicine to respect basic human rights, however, most notably by the revelations about the Tuskegee syphilis study and what was going on in New York State's Willowbrook Hospital, which propelled the dialogue to look at even more fundamental questions about the character of medical authority within all reaches of clinical medicine, not just in the area of research. The outcome has seen the emergence of the primacy of informed consent across all disciplines of care, including clinical practice and research.

Modern bioethics can thus be characterized as a new, patient-centered ethic, with advocacy of the patient as a genuine participant in their care, rather than simply as an object of diagnosis and treatment. No longer would the medical profession be the sole and final arbiter – the "holders of professional dominance" – as to what constitutes disease, and it would even be called into question who should determine who gets access to treatment, and what that treatment should entail.

As a discipline, the historical realm of ethics was not that of the practicing physician, but of the philosopher and theologian, with formal concepts and structured methodology, expressed via a specialized terminology, which allowed for the application of ethical reasoning to situations in which there might be inherent moral considerations. Being only passing observers of medicine (unless and until they or a family member became a patient!), their knowledge was mainly of an academic nature.

From the time of Hippocrates, physicians were expected to act in an ethical and moral manner (per our "Oath") in order to bring about successful healing. The operative paradigm that "the doctor knows best" served all involved parties well, as public health medicine and technology made great strides in alleviating much of human suffering, and greatly improved the quality (and longevity) of life. There simply did not appear to be a need for much dialogue, or shared decision-making. As this paternalistic model became challenged, physicians were simply ill prepared to employ or embrace the concepts and methods of the academicians, with their tradition of thoughtful contemplation, as it was applied to the practice of medicine. The medical profession as a whole has been struggling mightily to respond to this paradigm shift, and the field of addiction medicine has been especially slow in acknowledging and responding to this challenge.

Modern bioethics is a dynamic process that engages society at many levels: within the media and popular culture (e.g., the TV series "E.R."), in political debate, in the anxious discussions of patients, doctors and families regarding issues of treatment and care, in institutional review boards, in the boardrooms of biotech companies, and in many other venues. This is not the work of academia, but of the real world. It involves gray areas of uncertainty, such as physician-assisted suicide, genetic manipulation/cloning, and the like. It occurs daily, in the dialogue and discussions among concerned individuals who attempt to deal with the ethical dilemmas which arise in the conflicting rights, duties, expectations, and, values of the various shareholders, all of which may be good in their own right, but not all of which can be wholly satisfied in any particular situation

Bioethics, as a practice, serves as a means to facilitate decision making, by identifying and clarifying potential dilemmas that arise from a perceived conflict in values between sincere parties. Clinical bioethics provides consultation when anyone involved with the patient, e.g., individual members of the treatment team, the attending physician, or the family or surrogate, identify areas of conflict that have ethical components. The consultative team then helps to identify and clarify the potential dilemmas, analyze any contentious issues, weigh the moral consequences of various alternatives, and then suggest possible solutions. At times, these consultations are informal "curbsides," wherein staff simply needs information and reassurance that what they are doing in their treatment plan is ethically sound. Other circumstances may require convening a formal case consultation in order to satisfy hospital policy or procedures, such as might be involved with a guardianship or competency issue.

Historically, there has been a general consensus surrounding four ethical principles that describe duties for practitioners within health care. These ethical principles are (1) the respect for personal decision making about one's own body and health (*autonomy*, wherein the ration-

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al individual should be permitted to be self-determining), (2) the obligation to act in ways that do not harm or injure others (*nonmaleficence*) (3) while promoting the welfare of others (*beneficence*), all of which are inherent in the doctor/patient relationship. (4) *Justice*, referring to the equitable distribution of resources and burdens in the context of health care, is much more complex and problematic, and is more germane to organizational and even societal levels of discussion. These are cornerstones for our professional conduct as physicians, and are practical and useful as moral action guides. They are not rules, however, that should be applied automatically, but are desirable duties in health care that can be used as a lens through which to view the notion of what constitutes ethical behavior in particular circumstances.

These principles may sometimes lead to conflicting duties, and there is no formula for deciding which should take priority. There are significant limitations to a strict principle approach in health care ethics, the most obvious being oversimplification, wherein the ethical principles are reduced to a set of 'rules.' Another would be the overplaying of the principle of autonomy as the ultimate 'trump' card, thereby closing off other considerations. With multiple principles in play at any one time, for example, bringing 'benefit' to the patient, while 'doing no harm,' the moral agent (the treating physician) must balance the costs and benefits regarding the recommendation for a specific course of treatment. A classic example is the 'principle of double effect,' wherein an action intended to be beneficial can have adverse consequences that are unintended but foreseeable. For example, the use of high-dose narcotics to relieve pain in a terminal patient, may then have the unintended consequence of hastening death secondary to respiratory depression.

When conflicts of values occur between patients and/or their family members and physicians, there must be a system in place that provides an open forum to discuss these differing opinions in a non-judgmental way. This often occurs, for example, when a family member insists that the treatment team do 'everything possible' for a loved one in the face of overwhelming medical futility. The consultative process moves the deliberations out of the strictly medical arena and into the realm of process, value and decision-making. Ethics consultation attempts to identify the relevant values, the conflicts around these values, and the options available to the patient, the patient's family, and the health care professional (and by extension, the health care delivery system or organization). An ethics committee does not sit in judgment, and does not make decisions for physicians, patients, or families, but attempts to mediate a consensus which will permit resolution of the conflict. This is accomplished by a discussion, which proceeds in a formal series of steps:

1. Presentation of information about the case by the involved parties
2. Identification of the ethical issues and formulation of alternative courses of action
3. Evaluation of the benefits and burdens of the various possible actions
4. Coming to a consensus by evaluating and ranking the ethical values underlying each possible action.

Bioethics and Addictive Disease

The ethics of addiction medicine involves consideration of the core dynamics of addictive disease, along with "the distortions of cognition, feelings, perception and behaviors, and the erosion of relationships, societal role and sense of self." Treatment of addictive disorders, like the treatment of other mental illnesses, affects "these most basic of human qualities," and, like psychiatrists, addiction medicine physicians "enter their patients' lives in ways that are distinctly personal and distinctly powerful." Our care of individuals with addictive disease raises many issues that pose extremely complex and difficult questions and concerns, especially regarding autonomy and "the principled use of power in clinical care." (Roberts 2002)

Many of the ethical issues that arise in our field are a direct consequence of the unique factors of addictive disease. First and foremost is the profound and complex role of denial in addictive disease. Denial is here being conceptualized in the broad sense of refusal to fully recognize and accept the presence of addictive disease, its consequences to the self and others, or both. This definition includes minimization, rationalization, projection, and other defense mechanisms, which may be demonstrated not only by the addicted individual, but also by significant others, family, friends, peers, colleagues, and caregivers. Important individuals in the addicted individual's life often demonstrate "enabling" behavior, which prevents the addicted patient from experiencing the negative consequences of his or her behavior (also known as "codependency").

The potential exists for conflict between the principle of autonomy and the12 step-based treatment philosophy in this context. Inherent in the autonomy principle is respect for informed consent, and the right to refuse treatment, either wholly or in part. In many instances, such as acute intoxication and organic brain syndromes, we give treatment without consent to a person who is truly incapable of making treatment decisions on his/her own, and whose untreated condition constitutes an imminent threat for significant harm to self or others. Such circumstances notwithstanding, the notion of informed consent becomes more problematic for the person with addictive disease. When most people speak of capacity to make healthcare decisions, they often think primarily of cognitive functioning – the ability to understand information. Most people with addictive disease don't lack information; it's just that addicts and alcoholics often make bad decisions which involve faulty logic and justifications (denial, rationalization, etc.), usually in order to continue using and/or drinking. The disease itself

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Bioethics and Addiction Medicine

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affects decision making; these individuals are often highly intelligent and are not incapable of receiving facts and information, but by the very nature of the disorder itself, the 'bad choices' they make are based on distorted thinking. The question appears to be whether this makes them incapable of participating with informed consent. We should generally not treat patients without consent, but then how can we effectively treat addicted patients who don't want to be treated?

This is one of the core tensions in medical ethics and addiction treatment (and certainly for psychiatry as well) – beneficence vs. autonomy: How to reconcile the all-too-frequent occurrence of formulating a treatment plan that you believe has the best chance for success, and then respecting the individual's choice when they flatly reject the prescription? We simply can't say that everything should be in favor of autonomy, or in favor of beneficence.

The "new bioethics" recognizes the paradigm shift in the doctor / patient relationship, from one of compliance to concordance. Compliance is defined here as the degree to which the patient follows the doctor's management plan, and essentially involves one person, the doctor, making the treatment decisions. Concordance, on the other hand, defines an agreement between the patient and the physician, which takes into account the patient's perspective.

Within the context of true informed consent, we in addiction medicine must be intellectually honest with our patients and ourselves about what AA is and what it is not. The 12 steps of AA evolved and were presented by the founders of the program as a suggested path of personal spiritual transformation. Bill W. and Dr. Bob might be shocked to see how they have 'morphed' into a compulsory top down treatment protocol in most treatment centers. Today, almost every hospital, treatment center, court and prison, mandate AA participation for everyone in treatment - some, if not many, of whom are neither alcoholics nor addicts, but happened to get caught with a positive urine test. We have an ethical obligation to acknowledge this creation of what some have referred to as 'POW members' of AA, who may possibly outnumber the 'real alcoholics' at any given AA meeting.

This is not meant as an indictment of AA. Intuitively, and experientially, we know that it can be effective in establishing a program of comfortable living, without drinking or using, for a good number of individuals. However, until more scientific studies of its effectiveness in promoting recovery occur (which may prove difficult or impossible by the very nature of an anonymous program), treatment recommendations from our profession for AA participation must be carefully placed in context.

This brings up another important ethical consideration in the field of addiction medicine, that of autonomy vs. coercion. Autonomy compromise in addiction medicine occurs when a person with special knowledge or control dominates the patient's power of choice. This places a special burden on how those with 'power'– real or perceived – structure their interventions. It may be argued that the phenomenon of denial, by its very nature, constitutes 'impairment of judgment' to the degree that the individual lacks competence to autonomously accept, reject, or modify the treatment options offered. This can easily lead to an 'ends justify the means' situation on a potentially very slippery slope.

Coercion, which might be more gently called 'leverage,' is not itself treatment, though it may be an important step in getting someone to treatment. When coercion is present within the context of addiction treatment, it often conflicts with the patient's right to self-determination, and it is within the many layers of nuance and context here that discussion, analysis, and clinical judgment becomes critical. How much coercion is appropriate and justified, and how much is "too much," must be arrived at on a case-by-case basis. In most forensic or criminal justice contexts, some degree of coercion is a given, though clinicians are often uncomfortable with it. The imposition of external control is clearly both appropriate and necessary when the public safety may be at jeopardy, in order to protect the rights of potential victims. In non-forensic contexts, however, setting limits with such statements as "if you leave AMA one more time, and don't go to residential treatment, you may not get another opportunity to do so," or "your step work is unacceptable – shape up or ship out" may not be ethically justifiable.

Realistically, autonomy for the chemically dependent individual is a qualified right at almost every level of treatment. Treatment may well be mandated or offered as an alternative to sanctions of some kind (e.g., divorce, job loss, reporting to the police, etc.). Similarly, there may be circumstances, such as acute intoxication, which result in severely impaired judgment – along with the potential for self-destructive behavior – where the individual may be unable to make a rational decision, and requires treatment on an involuntary basis. Nor does an individual have the right to engage in behaviors that disrupt the orderly administration of treatment to others. In general, minors (meaning below 18 or 21) are regarded as incompetent to make independent judgments regarding treatment, and the institution and treatment professional have an expanded duty to exercise reasonable supervision and control. Likewise, impaired professionals (physicians, attorneys, commercial pilots, etc.) are in a position to directly injure others as a result of their addictive illness, and may thus be forced into treatment as a prerequisite for retaining (or regaining) their professional licensure. In such circumstances, the right to autonomy is clearly outweighed by legitimate societal values and goals.

An additional area of conflict regarding coercion is that of disclosure and confidentiality. Addiction treatment services, like all other medical services, are dispensed in the context of a contractual arrangement

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between patient and the physician (who may be acting as a health plan representative in the private or public sector), which is binding on both parties. Full disclosure, for example, requires representing to the patient and/or families the exact nature, length, and cost of recommended treatment, as well as the potential power that may be exercised if the patient is non-compliant with the recommendation of the treatment team. This might, in some instances, involve severe consequences such as jail time, job loss, or revocation of a professional license.

Circumstances where a patient may be coerced or leveraged into treatment by external agencies, be it under the threat of legal, social, or professional sanctions, can lead to limitations of patient confidentiality, such as the right of the individual to limit the content, purpose, and duration of consent for disclosure of any or all information. In general, assuming that the addicted individual is not grossly impaired, it is the "reasonableness" of any coercive element for release of information that deserves consideration and discussion by the patient and physician.

Finally, if patient autonomy has been at the forefront of discussion over the past decade, today physician autonomy seems to be becoming a critical issue. The oft-used example is that of the low-back pain patient pressuring the physician for an MRI, which the physician does not feel is clinically indicated. The patient (or patient's family) may charge that the physician is reacting out of a financial incentive not to order the test. The notion that forces external to the doctor-patient interaction have interceded in the character of that relationship is not new, but the quality of trust has certainly been increasingly affected, as patients worry that the doctor has lost the authority to provide appropriate care.

In all areas of medicine, but especially in addiction medicine, contractual arrangements for treatment (such as managed care authorizations for different levels of care) are fraught with potential conflict. One need only look to the multitude of lawsuits filed by consumers against managed care organizations, and the disparities between ASAM placement criteria and actual managed care practices.

This review will hopefully serve as a springboard for ongoing dialogue regarding ethical features and conflicting values that confront us every day in the practice of addiction medicine. We need to anticipate and responsibly work through higher-risk ethical situations, and gather information and insights from the multidisciplinary field of bioethics to address morally important aspects of everyday care for our patients with addictive disease. As Dr. Roberts says: "The ethical dimensions of patient care are inseparable from other aspects of clinical excellence." (Roberts 2002)

REFERENCE

Roberts, L.W., "Ethics as Endeavor in Psychiatry: Principles, Skills and Evidence," *Psychiatric Times*, Dec. 2002, Vol. XIX, Issue 12.

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CSAM news

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BOOK REVIEW

Hooked: Five Addicts Challenge Our Misguided Drug Rehab System

By Lonny Shavelson
The New Press, New York, 2001
Paperback. $19.95
Reviewed by Peter Washburn

"How can it be, that even when you make sense you don't make no sense?"

These are the exasperated words of Darlene, a hallucinating methamphetamine addict, who is trying vainly to see her putative case manager, "the Wizard" as she dubs this elusive individual. She has just spoken to a Kafkaesque intermediary who has told her that she has to come back in a week or two.

This scene of frustration playing out in the waiting room of a San Francisco mental health agency vividly depicts one of the many hurdles faced by the patients described in *Hooked: Five Addicts Challenge Our Misguided Drug Rehab System*. Vivid, because the author, Lonny Shavelson, an ER physician and photojournalist, is standing by with camera and tape recorder, getting it all down.

The project started in 1997 when Dr. Shavelson, intrigued by an announcement in San Francisco that "treatment on demand" was now available, wanted to see "if treatment really does keep addicts off drugs." He obtained permission from San Francisco's Department of Health to visit a number of their affiliated public sector drug and mental health programs. Sitting in on groups he met a number of patients, five of whom, with their complete consent, let the author follow them on their journeys in and out of various programs. Not only do we see rehab from the patient's point of view, but we also see what happens out of sight of the treatment providers. Lonny, doffing the trappings of doctor-hood, follows them to their homes or homeless encampments, hangs out with them in public places, or watches them shoot up. Via photographic portraits and verbatim dialogue, the reader gets to experience these individuals and their environment from the safety of the armchair.

Interwoven into the strands of these stories are brief summaries and background information on the types of treatment the patients encountered: harm reduction, case management, relapse prevention, and drug courts. Anyone unfamiliar with the turbulent history of Synanon will get a review of that California phenomenon in the discussion of therapeutic communities.

Going from the general to the specific, the reader is then introduced to how these treatment concepts are put into practice by various programs in San Francisco, an added bonus for anyone working in the mental health field in this city. Names you may have encountered, but weren't familiar with, are attached to real institutions. Walden House and Synanon get the longest treatment. Target Cities, Westside Mental Health Clinic, Haight Ashbury Clinic, Iris, and Friendship House make appearances, some as walk-ons, some with dialogue and accompanying photographs.

Generalizing from the stories of our five heroes and heroines, the third theme of the book, the weakest, in my estimation, is Shavelson's editorialization on how policy and concepts come face to face with the patient in the waiting room as he has witnessed it in San Francisco in the late 90's.

Shavelson makes a number of valid criticisms about the treatment programs he has observed. However, for some, I wanted to quibble. For example, his point about psychological counseling: "All rehab counselors must be trained to recognize and treat the multitude of addicts who also have psychological disorders, and refer them to appropriately intensive additional care when needed." Hard to argue with that. Yet, for all the patients with character disorders that one would encounter in this population, therapy is, in my opinion, overvalued. Another point: "Each and every rehab program must be required to have a formal, structured association with a drug detox center where it can send relapsed clients." Hard to argue with that either. Yet, for a residential program to immediately refer a relapsed client to detox, may be inappropriate. Referral to a methadone program might have been more efficacious for Mike, the heroin addict evicted from Walden House. In my experience, when a patient relapses in the absence of some coercive element, they are frequently not available or willing to increase the intensity of treatment.

There are some omissions. The success of one patient, who achieves his recovery largely by attending AA, is downplayed. If the tape recorder and camera prevented the author from following this patient to any of his AA meetings, then he and we are deprived of a description of an important component of recovery. There is no discussion of methadone programs. For a balanced view of available treatment options, this should have been included.

Some of the statistics are not accurately cited. Shavelson equates illicit drug use with addiction, and tries to make some point noting a 45% decline in illicit drug use between the late 70's and the late 90's and comes up with an erroneous 45% reduction in the number of addicts during this period. This is hardly the case in face of a crack cocaine epidemic and a resurgence of heroin. And an attorney is quoted as saying that in San Francisco, "we make seven to eight thousand narcotics arrests every week." Did he mean every year?

Finally – WARNING: skip the following if you don't want the book's ending given away – if the programs are so

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MBC Guidelines for Prescribing for Pain

THE MEDICAL BOARD OF CALIFORNIA revised its guidelines for prescribing controlled substances for pain and published them in Action Report of October 2003. The Action Report with the full text of the Guidelines is available from the Medical Board's website www.medbd.ca.gov. Click on Action Report.

During the period of public comment, CSAM asked the Medical Board for clarification of the sections that refer to treating patients with the dual diagnosis of chronic pain and addiction. In a letter to the MBC, CSAM said that all patients being treated for both conditions, and all physicians treating them, should receive the protections of California's Intractable Pain Treatment Act (CIPTA), and pointed to the need for widely accepted guidelines for treatment of patients with the dual diagnosis of pain and addiction. The CSAM Task Force on Pain and Addiction will consider developing such guidelines as it begins activities early in 2004.

CSAM Task Force on Pain and Addiction

IN PREPARATION for activating CSAM's new Task Force on Pain and Addiction, there was an open meeting for all interested physicians during the annual meeting in October in San Francisco to gather information and opinions about the needs of physicians who provide treatment for pain in California. Approximately 25 physicians participated in a discussion to suggest the direction for the new Task Force.

Asked if they had experienced restrictions on their ability to provide clinically appropriate treatment for pain to certain patients, they said yes and gave these examples:

- 6 said lack of information; I don't know what to do for this patient.
- 14 said lack of consultants and referral resources
- 5 said fear that my treatment might trigger the attention of law enforcement and/or Medical Board investigators
- 1 said the patient's insurance company refused to authorize treatment
- 1 said his partners are very reluctant to prescribe for pain patients.

All of these issues are seen as appropriate referrals to the new CSAM Task Force. The roster for the new group will be drawn from the CSAM Committees on Public Policy, Education, and Treatment of Opioid Dependence. In addition, there will be at least one member in common with the ASAM Committee on Pain and Addictive Disease co-chaired by Seddon Savage, MD and Howard Heit, MD, and liaison membership designed to develop communication and unity with pain management groups, such as the American Academy of Pain Medicine.

Suggestions for what the new Task Force should do included drafting clinical guidelines; developing position CSAM statements; advocating for physicians and patients; and proposing research questions. Examples of projects in these areas are:

Policy Statements:

- There should be a position statement that addiction is not a contraindication to the treatment of pain.

Guidelines and Standards:

- We should develop coherent guidelines for quality of patient care.
- We should develop standards for curriculum for pain treatment specialists about addiction and curriculum for addiction medicine specialists about pain.
- We should describe what qualifies as adequate pain/addiction assessment.
- We should describe what qualifies as adequate monitoring of a patient being treated with opioids for pain and/or addiction.
- We agree on criteria for when a pain specialist should refer to an addiction medicine specialist and when an addiction medicine specialist should refer to a pain specialist.
- We should define what constitutes adequate addiction treatment in the pain patient.

Research Questions:

- We need studies to identify the rate of substance abuse in adequately treated pain patients: e.g., a pharmaco-economic study: does adequate pain treatment reduce costs to society in other areas? CSAM should make recommendations for studies to the VA and to large group practices such as Kaiser.

Interested members can submit suggestions to the Task Force by writing to the CSAM office.

BOOK REVIEW

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flawed, how come the outcome by the end of the book for these five patients is so surprisingly good. These are, after all, the most difficult patients to treat: dually diagnosed, homeless (several of them), and without health insurance.

But never mind all that. The book is a good read: vivid, funny, and suspenseful. I challenge any reader to read the first two pages and not get "Hooked."

CONTINUING MEDICAL EDUCATION

January 13, 2004
Opiate Maintenance Pharmacotherapy: A Course for Clinicians
Crowne Plaza Union Square, San Francisco, CA
Sponsored by American Association for the Treatment of Opioid Dependence
For information call AATOD at 856-423-7222

February 4-7, 2004
International Conference on Pain and Chemical Dependency
New York Marriott at the Brooklyn Bridge, Brooklyn, New York
CREDIT: 25 hours of Category 1 CME
Register online at www.painandchemicaldependency.org
or call 404-233-6446 for more information

February 21, 2004
Intervention and Assessment of Impaired Physicians: A Best Practices Workshop
Sheraton Hotel, Los Angeles Airport
Sponsored by California Society of Addiction Medicine
CREDIT: 6 hours of Category 1 CME
For more information contact CSAM at 415-927-5730

February 27-29, 2004
ASAM MRO Course and Forensic Issues in Addiction Medicine
Marriott Marina del Rey, Marina del Rey, CA
Sponsored by American Society of Addiction Medicine
CREDIT: 18 hours of Category 1 CME
For information go to www.asam.org
or call ASAM at 301-656-2920

April 1, 2004
Buprenorphine in Office Based Treatment of Opiate Dependence
Hyatt Regency Embarcadero, San Francisco, CA
Sponsored by California Society of Addiction Medicine and American Society of Addiction Medicine at California Academy of Family Physicians Annual Scientific Assembly
CREDIT: 8 hours of Category 1 CME –
Fulfills buprenorphine training requirement
under Substance Abuse Treatment Act
Register online at www.familydocs.org
(click on "scientific assembly")

April 22-25, 2004
Ruth Fox Course for Physicians
Pain and Addiction: Common Threads IV
35th Annual ASAM Medical Scientific Conference
Marriott Wardman Park Hotel, Washington, DC
Sponsored by American Society of Addiction Medicine
For information go to www.asam.org
or call ASAM at 301-656-2920

SAVE THE DATE!

ADDICTION MEDICINE REVIEW COURSE 2004
October 6-9, 2004
La Jolla Marriott Hotel, La Jolla (San Diego), CA

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