CSAM NEWS

Newsletter of the California Society of Addiction Medicine Fall 1997 Vol. 24, No. 2

Prescribing Methadone

A federal initiative to allow physicians to prescribe methadone and LAAM for maintenance treatment of opioid dependence is under discussion by FDA, Substance Abuse and Mental Health Services Administration (SAMHSA), and General Barry McCaffrey's White House Office of National Drug Control Policy (ONDCP). At a NIDA-sponsored conference on heroin use and addiction, General McCaffrey said doctors should be allowed to prescribe methadone and stated that his office will try to convince the policy makers accordingly, according to a report in the October 6 issue of *Alcoholism & Drug Abuse Weekly*.

Registrants at the CSAM State of the Art Course in November will get details about this initiative from the Center for Substance Abuse Treatment (CSAT). Buprenorphine will also be reviewed as a promising alternative for methadone by Walter Ling, MD. ○

Pain Patient's Bill of Rights

Within the medical community there is both concern about undertreatment of pain and apprehension about possible investigation by regulatory agencies of physicians who manage difficult cases of chronic pain. Passage of California's SB 402 addressed that concern and apprehension by establishing the "Pain Patient's Bill of Rights."

Two new sections of the Health and Safety Code contain legislative findings and declarations related to the treatment of severe, chronic intractable pain. Among the declarations are these:

- Inadequate treatment of acute and chronic pain is a significant health problem.
- A physician treating a patient who suffers from severe chronic intractable pain may prescribe a dosage deemed medically necessary to relieve severe chronic intractable pain as long as the

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No More Treatment for Infectious Diseases in Narcotic Treatment Programs

BY JOHN J. MCCARTHY, MD

On July 1, 1997 major changes were made in the way methadone services are reimbursed under the Medi-Cal system in the State of California. In the past, programs contracted with counties for what amounted to a set fee per capita. Within that rate, the program could provide the methadone treatment services, plus acute medical care, as needed. Programs could take the public health approach of treating some acute medical conditions on site. Not all programs provided the same levels of service; there were annual reimbursement adjustments for differences in services and differences in costs. Now, programs are reimbursed *only* for the methadone-specific elements such as intake physical exams, the required laboratory assessments, and ordering and dispensing methadone. Reimbursement does not cover the treatment of infectious diseases or any other acute medical condition. The state has declared that these are to be billed through the fee-for-service Medi-Cal system. Theoretically if a narcotic treatment program treats an abscess, for example, or high blood pressure, in a fee-for-service Medi-Cal patient, the program can be reimbursed by Medi-Cal. However, the fee-for-service Medi-Cal system is disappearing and being replaced with managed care. We must now refer the patient to a managed care company.

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The Rights and Responsibilities of Physicians in the Use of Opioids for the Treatment of Pain

Background

Physicians' concerns regarding possible legal, regulatory, licensing or other third party sanctions related to the prescription of opioids contribute significantly to the undertreatment of pain.

Physicians are obligated to relieve pain and suffering in their patients. Though many types of pain are best addressed by non-opioid interventions, opioids are often required as a component of effective pain treatment. In patients complaining of pain, which is a subjective phenomenon, it is often a difficult medical judgment as to whether opioid therapy is indicated.

This may be a particularly difficult judgment in patients with concurrent addictive disorders for whom exposure to potentially intoxicating substances may present special risks. It is, nonetheless, a medical judgment which must be made by a physician in the context of the doctor-patient relationship based on knowledge of the patient, awareness of the patient's medical and psychiatric conditions and on observation of the patient's response to treatment. The selection of a particular opioid medication(s), and the determination of opioid dose and therapeutic schedule, similarly must be based on full clinical understanding of a particular situation and cannot be judged appropriate or inappropriate independent of such knowledge.

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The California Society is a specialty society of physicians founded in 1973. Since 1989, it has been a State Chapter of the American Society of Addiction Medicine.

Despite appropriate medical practice, physicians who prescribe opioids for pain may occasionally be misled by skillful patients who wish to obtain medications for purposes other than pain treatment, such as diversion for profit, recreational abuse or maintenance of an addicted state. The physician who is never duped by such patients may be denying appropriate relief to patients with significant pain all too often. It must be recognized that physicians who are willing to provide compassionate, ongoing medical care to challenging, psychosocially stressed patients may more often be faced with deception than physicians who decline to treat this difficult population.

Addiction to opioids may occur in the course of opioid therapy of pain in susceptible individuals under some conditions. Persistent failure to recognize and provide appropriate medical treatment for the disease of addiction is poor medical practice and may become grounds for practice concern. Similarly, persistent failure to use opioids effectively when they are indicated for the treatment of pain is poor medical practice and may also become grounds for practice concern. It is important to distinguish, however, between physicians who profit from diversion or other illegal prescribing activities and physicians who may inappropriately prescribe opioids due to misunderstandings regarding addiction or pain.

Physicians traditionally have received little or no education on addiction or clinical pain treatment in the course of medical training. This omission is likely a basis for inadequate detection and management of addiction and inadequate assessment and treatment of pain.

Recommendations

1. Physicians who prescribe opioids for the treatment of pain should use reasonable medical judgment to establish that a pain state exists and to determine whether opioids are an indicated component of treatment. Opioids should be prescribed in a legal and clinically sound manner, and patients should be followed at reasonable intervals for ongoing medical management and to confirm as nearly as is reasonable that the medications are used as prescribed. Such management should be appropriately documented.

2. Physicians who are practicing medicine in good faith and who use reasonable medical judgment regarding the prescription of opioids for the treatment of pain should not be held responsible for the willful and deceptive behavior of patients who successfully obtain opioids for non-medical purposes. It is the appropriate role of the DEA, pharmacy boards and other regulatory agencies to inform physicians of the behavior of such patients when it is detected.

3. Physicians who consistently fail to recognize addictive disorders in their patients should be offered education, not sanction, as a first intervention.

4. Physicians who consistently fail to appropriately evaluate and treat pain in their patients should be offered education as a first-line intervention.

5. For the purpose of performing regulatory, legal, quality assurance and other clinical case reviews, it should be recognized that judgment regarding a) the medical appropriateness of the prescription of opioids for pain in a specific context, b) the selection of a particular opioid drug or drugs, and c) the determination of indicated opioid dosage and interval of medication administration, can only be made properly with full and detailed understanding of a particular clinical case.

6. Regulatory, legal, quality assurance and other reviews of clinical cases involving the use of opioids for the treatment of pain should be performed, when they are indicated, by reviewers with a requisite level of understanding of pain medicine and addiction medicine.

7. Appropriate education in addiction medicine and pain medicine should be provided as part of the core curriculum at all medical schools.

8. Legal and/or licensing actions against physicians who are proven to profit from diversion of scheduled drugs or from other illegal prescribing activities are appropriate.

Adopted by the ASAM Board of Directors, April 1997

Pain Patients Bill of Rights

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prescribing is in conformance with the provisions of the California Intractable Pain Treatment Act (Section 2241.5 of the California Business and Professions Code.)

- The patient's physician may refuse to prescribe opiate medication for a patient who requests the treatment for severe chronic intractable pain. However, that physician shall inform the patient that there are physicians who specialize in the treatment of severe chronic intractable pain with methods that include the use of opiates.

In a related action, ASAM adopted a statement on the rights and responsibilities of physicians who presribe opioids for treatment of pain. The full text appears in this issue.

Copies of the Pain Patient's Bill of Rights and the Intractable Pain Treatment Act are available from the CSAM office. o

Treatment of Infectous Diseases in Narcotic Treatment Programs

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Methadone programs now find themselves in a situation where they see patients with acute infections such as cellulitis or abscesses and they are prohibited from being reimbursed for treatment of these acute infectious diseases. Instead, they are told to send the patient to the managed care company. This new system is an attempt to separate the billable components of methadone treatment from other medical services, which are presumed to be available elsewhere. However, the fact is that many heroin addicts do not seek or cannot access treatment elsewhere – even if they *are* enrolled in a managed care company. Methadone treatment program personnel are now faced with the frustrating dilemma of having patients with acute infectious diseases whom they must refer out, in spite of the fact that they know these referrals will be failures most of the time.

the dilemma of having patients with acute infectious diseases whom we must refer out, even though we know these referrals will be failures most of the time

Infectious diseases are now the dominant treatment issue in most methadone treatment programs. We see HIV, hepatitis C, necrotizing fasciitis, cellulitis and abscesses with increasing frequency. At the very least, the State should have included the acute management of such infectious diseases within the core treatment services of a narcotic treatment program. However, this is a complicated issue, and hard, bureaucratically, to accomplish. State regulators and decision makers are still grappling with the problem.

The California Society of Addiction Medicine Committee on the Treatment of Opioid Dependence intends to follow this issue. Information and comments from physicians in narcotic treatment programs should be sent to the Committee in care of the chairman, Walter, Ling, MD. How are infectious diseases and other acute medical conditions being treated? What is the outcome? o

Perspectives on CSAM – Is it Worth it?

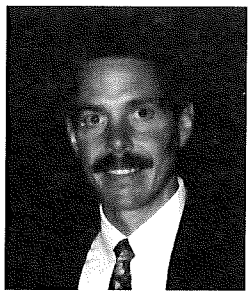
As CSAM begins its 25th year, medical practice is changing substantially. Demands on our time are increasing. Income is shifting. CSAM has announced a dues increase. Is it worth it? Several members of the Executive Council offered their perspectives.

Gail N. Shultz, MD
Incoming President of CSAM

Two years ago when I was elected to the Executive Council, we were faced with a mounting deficit, and there was no clear direction for solving the problems. I wondered, "Is this a dying organization?" There wasn't much energy, we were struggling with basic questions. Today, that is no longer true. We are still faced with major problems, but the Executive Council members and I are excited and eager to take them on. We have a clear idea of how to solve them.

My primary goal as CSAM president during the next two years will be to involve more of our members in CSAM activities. We are hoping that this year's State of the Art Course in San Francisco will provide more interaction and involvement for all of us.

When I joined CSAM in 1985 it was because I was told "Join them - that's where the action is." I believe that is true. I've heard the question "What does CSAM do for me?" I can't directly answer that question for you, but I know what it took for me -- becoming involved in the organization.



Steven J. Eickelberg, MD, FASAM

I've been active in CSAM since becoming a member in 1990. My activity is motivated primarily by the following three factors: 1) a strong desire to contribute to providing the highest quality physician education in addiction medicine available; 2) service to the organization which provides knowledgeable and responsible leadership and advocacy for physicians' impaired by substance use disorders; and, 3) camaraderie. I currently serve on the Education Committee and Executive Council. Previously I have been active on various sub-committees, ad hoc-committees and the Committee on Physician Impairment. I am continually impressed by the physician leadership within CSAM which rises-up to meet and address the onslaught of tumultuous challenges and issues which have faced us in addiction medicine over the last decade.

One of the greatest pleasures in my professional life has been to work side-by-side with the CSAM physicians who answer the bell, fight, and provide leadership and advocacy for appropriate and high standards of patient care, quality physician education, public policy issues which affect patient care and the practice of addiction medicine, advocacy for the Physicians' Diversion Program, etc. I am proud to be apart of an organization which meets "the demands du jour" and the organizational priorities identified and defined by its members.

My friends and colleagues in CSAM are the most dedicated, devoted, wise and committed physicians that I know. I value these kinships more than any within my profession life. A wonderful bonus and additional pleasure to serving CSAM has been the opportunity to work with our tireless, devoted, and loving Executive Director, Ms. Gail Jara. Certainly the organizational quality that we've all grown to know and expect is a reflection of her commitment to excellence in general, and to CSAM specifically.

Gary Jaeger, MD

In the mid 1980s Humboldt County residents had no access to medical model detoxification or recovery services. The nearest services were in Redding, three and one-half hours to the east; Santa Rosa, five hours to the south or Grants Pass, Oregon, about five hours to the north. One of the two local hospitals asked if I would be willing to establish a program within their facility. While willing, I did not have sufficient experience to establish such a program without assistance. Joe Zuska and Max Schneider in Orange County allowed me to spend time in their facility and shared freely their policies, procedures and philosophies. Before I left Orange County, Max handed me an AMSAODD new member application and told me to fill it out and submit it. He really didn't present this as a choice, simply as something I needed to do if I was serious about providing care to addicted individuals. This proved to be the single most valuable piece of advice Max gave me.

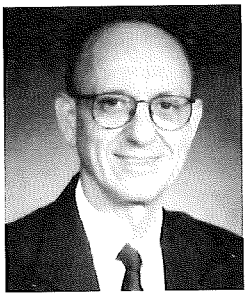
Over the next several years I had many occasions to remember the value of Max's "advice." While I was more knowledgeable about addiction issues than my colleagues in Humboldt County, examples of my limitations occurred far

more frequently than I liked to admit. Gail Jara was always available at the California Society office to direct me to the right resource. Michael Parr in Sacramento supplied expertise in managing pregnant addicts. Other society members around the state graciously tutored me when my own knowledge was lacking. The members of the society became my peer group in addiction medicine. The Review Courses and State of the Art programs kept me challenged and aware of the deficiencies in my education that called for further focused study. The CSAM Newsletter provided additional, often in-depth, information on issues of basic importance to my practice.

The work of the California Society with the Medical Board of California and the California Medical Association formed the foundation upon which we in Humboldt County built the system of Physician Well-being Committees that still serve Humboldt and Del-Norte Counties. Again, Gail Jara and several individual members of the society provided invaluable assistance in the formation of this consortium of well-being committees.

I owe much to the California Society of Addiction Medicine. Now, as the leadership is being passed from the founding members to another generation, I feel a debt of gratitude that can only be repaid by sharing my time and knowledge in the same way. The challenges we face are no larger or smaller than those faced by our founding members. They are just different. A healthy California Society of Addiction Medicine is an essential ingredient if we are to have a voice in shaping the future of Addiction Medicine.

CSAM has provided me with special knowledge and skills in addiction medicine which have allowed me to become certified in addiction medicine, making me more available to my addicted patients and to other doctor's addicted patients.



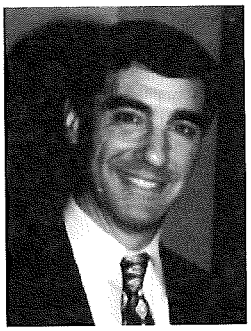
Joseph Galletta, MD

Margaret B. Yates, MD

Why is CSAM important to me? I sometimes find myself asking, why *do* I belong to CSAM? Why do I need one more society to pay dues to? Just to establish my professional legitimacy? After all, I've never been a joiner, always thought of myself as a loner, enjoyed my own company. Why is CSAM important to me other than as a "district branch" of ASAM? Pride of primogeniture? Partly. The Review Course and State of the Art Courses? Absolutely. They are outstanding and focused much closer to my own clinical interests than the excellent but basic science-oriented ASAM courses. The opportunity as a group to have our voice be heard on issues of public policy such as managed care, opioid prescribing and marijuana use. Of course CSAM keeps my brain alive, gives me authority with my patients, many of whom have another diagnosis in addition to addiction and are reluctant to take medications when they need them.

But none of these is where my heart lies. My real reason is the people. People I've known for many years, but rarely see; new people working in areas that didn't exist 20 years ago; non-medical people; young people; serious people I can laugh with. And because many of these people are in 12-Step recovery programs, the degree of honesty and openness in CSAM meetings is in refreshing contrast to other scientific meetings I attend.

CSAM is treatment for the isolation of solo practice, an opportunity to share ideas, plans, fears, failures, successes. CSAM gives me hope for the future of Addiction Medicine.



William S. Brostoff, MD, FASAM

I joined the California Society in 1983, not long after I became Medical Director of Chemical Dependency Services at Ross Hospital. The California Society was at that time an exciting organization: the leading physicians in addiction medicine were leaders or members, and there were projects involving a certifying exam, the possibility of board status for addictionists, and educational courses featuring state-of-the-art topics. It's a cliche to say that "collegiality" is an important component of membership, but it is accurate to say that I found a sense of fellowship and non-competitive acceptance that was unequaled in any other medical organization or society. And there was an extraordinary sensitivity and compassion toward the recovering alcoholic and addict, including some of us!

I still believe the California Society is exciting. New projects and ideas emerge – for example, the Opiate Committee and the Medical Marijuana Task Force. The tradition of commitment to top quality educational programs goes on. We seem to be determined to be ourselves while we continue as a key component of ASAM. Through my membership I have had the privilege to be closely associated with some of the finest physicians in the country, and that is something of which I am very proud.

An Open Letter to the CSAM Task Force on Medical Marijuana

I would like to have these comments entered into the Committee's record.

1. If there is a medication available that will help sick people, it should be used for the appropriate persons, for the appropriate reasons, in the appropriate amounts, and for the appropriate lengths of time. It is inhuman to withhold such medication on a political basis if it has been shown medically to be efficacious.
2. I believe the California Society must take the stand that there is enough evidence to suggest medical benefits for certain patients for marijuana by smoke where it is not efficacious in the form of the currently prescribed tablet. Therefore, it behooves the governments of the states and the United States to do all possible to promote proper scientific research regarding such a drug – especially marijuana. The results of these studies should remain public and should be free of political influence.
3. It is the California Society's responsibility to do all possible to promote objective scientific studies and let the political aspects of those studies fall where they may. We are a scientific organization, not a political one.
4. On the other hand, I believe that we have the mandate to use our political influence over collateral agencies and contacts within the various legislative levels to push forward this agenda. We should advocate for science for science's sake with no vested interest on our part except for the exposure of facts and truth.
5. Passions are running high on both sides of the issue. As a scientific society we must become passionate only for truth. We must become passionate for the benefit of our patients – again, tempered by truth and fact not anecdotal reports per se.

I hope you understand the tremendous importance of this Committee's work. I applaud you for it.

Max A. Schneider, MD, FASAM

News About Members

Charles Dorsey has been promoted to Chief Physician and Surgeon for Napa State Hospital from his position in charge of Addiction Medicine Services. He continues to be active in the addiction medicine program.

Don Wesson has resigned as medical director at MPI Treatment Services, Summit Medical Center in Oakland effective when the new medical director assumes responsibilities. He will continue at Summit Medical Center as the Scientific Director in Chemical Dependency.

Max Schneider has been appointed as the chemical dependency expert for the Diversion Program for podiatrists.

Nick Rosenlicht has returned to California from New Jersey; he is now at the San Francisco VA.

New Members

As ASAM notifies us of new members, we ask each one for information to put in the newsletter.

John W. Wong, MD, (Psychiatry) is the Medical Director of Ventura County Behavioral Medicine Department and the Behavioral Medical Center in San Gabriel.

George Danial, DO, (Family Medicine) is Medical Director of the Golden State Care Center in Chatsworth.

Vache Chakmakian, MD, (Family Medicine) is Chief Medical Officer in the San Bernardino County Sheriff's Department; more than 50% of his time is working with drug and alcohol addicted patients.

Status Report from the CSAM Task Force on Medical Marijuana

The CSAM Task Force on Medical Marijuana is considering whether to develop a White Paper focusing on what is known about the potential for addiction and other psychological/developmental harm caused by cannabis use, especially in children, adolescents and young adults.

The Task Force is also considering a statement calling for any system of distribution created for medical marijuana to adhere to principles which currently govern the distribution system through pharmacies. o

CONTINUING MEDICAL EDUCATION

ASAM MRO Courses

The Basics of Being a Medical Review Officer – Friday, 8:00 am to 11:45 am

The Latest on the Science, Rules and Art of Drug Testing and Assessment – Friday, 1 pm to Sunday, noon

November 14-16, 1997, in Seattle, WA
Sponsored by the American Society of Addiction Medicine
Credit: Up to 19 hours of Category 1 credit
Fees: For "The Basics," $75 for ASAM members, $100 for nonmembers.
For "The Latest," $500 for ASAM members, $550 for nonmembers.
For information, contact ASAM. Phone 301/656-3920; Fax 301/656-3815.
MRO Certification: The Medical Review Officer Certification Council (MROCC) will offer the MROCC Certification Examination immediately following the ASAM course. A separate application must be requested from MROCC, 55 West Seegers Road, Arlington Heights, IL 60005. Phone 708/228-7476.

21st Annual AMERSA National Conference

November 13-15, 1997
Holiday Inn, Old Town, Alexandria, VA
Sponsored by the Association for Medical Education and Research in Substance Abuse
For information, contact AMERSA, Brown University Center for Alcohol and Addiction Studies, Box G, Providence, RI 02912. Phone 401/863-2960

AAAP 8th Annual Meeting and Symposium

December 4-7, 1997
San Antonio Convention Center
Sponsored by the American Academy of Addiction Psychiatry
Fees: $425 for members; $550 for non-members
Symposium topics include: Early Risk Factors and Prevention Techniques; Marijuana: An Update; Cross Cultural Issues in Substance Use Disorders; Attention-Deficit Hyperactivity Disorder and Substance Abuse
For information: AAAP, 7301Mission Road, Suite 252, Prairie Village, KS 66208. Phone 913/262-6161 Fax 913/262-4311

CSAM Events

- ***Los Angeles Regional Meeting***
  Medical Marijuana: What's All the Fuss About?
  J. Thomas Ungerleider, MD
  October 23, 1997, 7:00 p.m.
  At the home of Margaret Yates, MD

- **Addiction Medicine:**
  State of the Art 1997
  November 5-8, 1997
  Radisson Miyako Hotel, San Francisco

- ***San Francisco Bay Area Regional Meeting***
  An Addiction Medicine Perspective on Medical Marijuana
  Timmen L. Cermak, MD
  January 29, 1998 7:00 p.m.
  His Lorship's Restaurant, Berkeley Marina

- **CSAM Gala**
  February 28, 1998
  Center Club
  650 Town Center Drive, Costa Mesa
  adjacent to the Orange County
  Performing Arts Center

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