Model Health Professionals Training Act

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Policy Statement

Prevalency of People with Untreated Alcohol and Other Drug Problems in the Health Care System.

> "The problem of alcoholism and drug addiction is a most serious health problem in the United States; [it is] the fourth major illness; and [it] has the third highest major disease fatality rate."[1]

Since death certificates may reflect any of a variety of addiction related or aggravated medical conditions, these numbers may well be underestimates. In any case, if alcohol and other drug related accidents and injuries are factored in, then alcohol and other drug abuse and alcohol and other drug addictions become the leading killers of Americans.[2]

Awareness of the alcohol/drug involvement in many illnesses, injuries and accidents causes some to conclude that it is the "No. 1 cause of morbidity and mortality in America."[3]

Research and surveys find that individuals with untreated alcohol and other drug problems appear frequently in the health care delivery system for a wide array of addiction related illnesses and injuries.

Some of these illnesses, medical complications and disease sequelae are: hypertension, stroke, diabetes, cirrhosis, cancers of the liver, larynx, esophagus, stomach, colon, and breast, heart attack, damage to the brain, pancreas and kidneys, ulcers, colitis, fetal alcohol and drug effects and syndrome, other birth defects, infections, damage to the immune system, AIDS, respiratory illnesses and edema.

The prevalency of untreated addicted individuals within the health care delivery system is quite high:

- Up to 50% of all general hospital admissions are alcohol and drug related.[4]
- 15% of all visits to doctors may be alcohol-related.[5]
- 30%-40% of inpatient hospital admissions are alcohol-related.[6]
- At least 15% of ambulatory patients are alcohol and other drug related.[7]
- 50%-60% of emergency room admissions are alcohol-related.[8]
- "On the average, untreated alcoholics usually incur general health care costs that are at least 100% higher than those of nonalcoholics over pretreatment levels... In the last 12 months before treatment, the alcoholic's costs are close to 300% higher than costs of comparable nonalcoholics."[9]

- Families of untreated alcoholics and addicts also use health care two to three times higher than the general public.[10]

Diagnosis and treatment of addictive diseases is clearly critical to proper patient care and to an effective health care cost containment strategy.

Despite these repeat contacts with the health care system, the alcohol and other drug abuse problem is diagnosed less than 5% of the time.[11]

Again, according to Dr. Otis Bowen, then Secretary of the U.S. Department of Health and Human Services:

> Up to 50% of all general hospital admissions are related to alcohol and other drugs, but many of these patients leave the hospital with their problem undiagnosed.[12]

Despite repeated contacts with health and medical services, the primary illness at work is rarely identified.

> Two of the country's leading doctors - Otis Bowen, Secretary of Health and Human Services and James Sammons, Executive Vice President of the American Medical Association - recently joined in a report saying 15 percent of all visits to doctors may be alcohol-related but only 2 to 3 percent are usually so diagnosed. Drug abuse, less familiar to most doctors, is probably diagnosed even less often.[13]

In sum, this is an illness that is greatly over-represented in people who appear in the health care system; that causes repeated use of health care; that may be the leading cause of morbidity and mortality in this country, and yet: it is diagnosed less than 5% of the time.[14]

With preparation and proper education in addiction, the health care system can learn to provide intervention early in the disease progression before permanent and costly health impairment has occurred. Those interventions are humane, medically appropriate and will also lead to reduced spending on alcohol and drug related accidents, injuries and illnesses.

History of Medical Education in Alcohol and Other Drug Abuse and Addiction.

Despite the high prevalence of people with untreated alcohol and other drug addictions in the general health care system, medical education and training in addictions continue to be sparse and in need of development.

Prior to the 1970s, medical education "virtually ignored alcohol and other drug abuse as a major concern."[15]

Partially in response to the drug abuse of the 1960s and growing focus on health care cost containment, interest in medical education in alcohol and other drugs increased in the early '70s. Meetings, conferences and federal support (National Institute on Drug Abuse (NIDA) and National Institute on Alcohol Abuse and Alcoholism (NIAAA)) led to the development of the Career Teacher Training Program in the Addictions.

Results of the Career Teacher Program continue to be promising but evaluations ten years after it started found: "...the percentage of required teaching hours on alcoholism and drug abuse remained well under 1%, a level far out of proportion to the extent of the public health problem"(emphasis added).[16]

Fortunately, the effort did not end here. In 1976, the Career Teacher network founded the Association of Medical Education and Research in Substance Abuse (AMERSA). From here substance abuse programs were instituted in several medical schools. In addition, medical schools, the federal government and foundations teamed up to develop model medical curriculum, guidelines and resources for undergraduate, resident and post graduate school programs.

In 1985, at AMERSA's 9th annual conference, conferees agreed that primary care doctors including general internists, pediatricians, psychiatrists and family physicians should have proficiency in alcohol and other drug abuse in each of these areas at a minimum:

(1) Epidemiology, including knowledge of the natural history of substance abuse and risk factors;

(2) Physiology and biochemistry of dependency and addictions;

(3) Pharmacology, including knowledge of the effects of commonly abused drugs and drug-drug interactions;

(4) Diagnosis, intervention and referral;

(5) Case management, including short and long-term consequences of abuse and dependency; and

(6) Prevention through health promotion, early identification and patient education.

The conferees went on to add "primary care physicians should identify and assess their own personal and professional attitudes toward alcohol and drug abuse."[17]

Since the early 1970s, NIDA and NIAAA have also provided financial support and awards to a number of medical speciality organizations such as the American College of Emergency Physicians, the Society for Teachers of Family Medicine and the American College of Obstetricians and Gynecologists.

Despite these developments in medical school education in alcohol and other drug abuse, Lewis et al note:

> A common response to pressure to include substance abuse training in medical school or postgraduate education has been to provide one or more elective courses or a limited exposure as part of preclinical training. But this limited exposure ... virtually ensures that physicians will not be exposed to the range of problems and opportunities for successful intervention that substance abuse entails[18]

Can Physician Intervention and Attitudes Make a Difference?

A poll completed in 1982 by the American Medical Association found that 71% of physicians "felt either incompetent or ambivalent about treating alcoholism."[19] Nonetheless, 90% of patients surveyed indicated that "they would like their physician to recognize and participate in the treatment of their alcohol and drug problems."[20]

Other research suggests that even minimum physician intervention appears to make a difference in whether or not an alcohol and other drug addicted individual seeks treatment for this health problem.[21]

Despite this high potential for successful intervention, Dr. John Chappel, in an article entitled "Physician Attitudes and the Treatment of Alcohol and Drug Dependent Patients", cautions that physician attitude may stand in the way of diagnosis, intervention and treatment of alcohol and other drug problems:

> Studies of diagnostic practice indicate that the pervasive attitude among physicians is that 'It is better to suspect illness than not - better safe than sorry.' Yet, in the case of chemically-dependent persons, that traditionally positive physician attitude is often reversed. It seems safest NOT to diagnose alcoholism or drug dependence...[22]

In addition to this, "... many physicians have a stereotype of the alcohol-dependent patient as a derelict ... The result is delay (in diagnosis) until the condition has reached an advanced stage."[23]

The delay then leads to diagnosis only when late stage physical pathology is in evidence. This, in turn, reinforces physician stereotypes about addicted people, blocks intervention earlier in the disease progression, discourages referral to treatment and encourages physician and patient pessimism about the prospects for recovery.

Surveys of members of Alcoholics Anonymous confirm this tendency and find physicians last on the list of referral sources to this critical part of recovery, as noted in the following chart:

Factors Responsible for Coming to Alcoholics Anonymous.[24]

Factor	1977	1980	1983
A.A. member	44%	42%	37%
"On my own"	33%	27%	27%
Family	22%	21%	20%
Couns. & rehab	19%	26%	31%
Doctor	10%	9%	7%

Considering the attitudes blocking diagnosis and intervention, Chappel recommends the regular use of questionnaires for all patients at risk and notes that one such effort "increased the detection rate of alcoholism by nine times in one year."[25]

Summary

Training in alcohol and other drug abuse and addiction for physicians and other health care practitioners will enhance early identification and referral and has high potential to reduce health care expenditures as well as human misery.

State statutes requiring routine medical school education on alcohol and other drug abuse are critical components of proper patient care and any effective health care cost containment strategy. Such statutes will result in better, more humane care of untreated addicted people and their families.

ENDNOTES

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2. *Id.* at 1, 13.
3. *Recognizing and Treating the Alcoholic,* BEHAVIORAL MEDICINE 14 (January 1980).
4. Bowen, O., former Secretary of the U.S. Department of Health and Human Services, ALCOHOLISM AND DRUG ABUSE WEEKLY 6 (January 25, 1989).
5. Bowen, O., and Sammons, J., *Why Doctors Miss the Warning Signs,* The Washington Post, December 27, 1988.
6. THE ALMACAN 40 (December 1988); THE EMPLOYEE ASSISTANCE PROGRAM DIGEST 16 (May/June 1989).
7. Brown University Digest of Addiction Theory and Application, Video/Conference Material (December 7, 1988).
8. Supra note 6.
9. Langenbucher, J.W., McCrady, B.S., Brick, J., Esterly, R., *Addictions Treatment in General Clinical Population, Chapter 4,* in SOCIOECONOMIC EVALUATIONS OF ADDICTIONS TREATMENT 11 (Center of Alcohol Studies, Rutgers University, 1993); Holder, H.B. and Hallen, J.B., MEDICAL CARE AND ALCOHOLISM COSTS AND UTILIZATION: A FIVE YEAR ANALYSIS OF THE CALIFORNIA PILOT PROJECT (National Institute on Alcohol Abuse and Alcoholism, December 1981).
10. *Id.* at 19.
11. THE ALMACAN, *supra* note 6; Bowen, O., and Sammons, J., *supra* note 5.
12. Bowen, O., *supra* note 4.
13. Bowen, O., and Sammons, J., *supra* note 5.
14. THE EMPLOYEE ASSISTANCE PROGRAM DIGEST, *supra* note 6.
15. Lewis, D.C., Niven, R.G., Czechowicz, D., and Trumble, J.G., *A Review of Medical Education in Alcohol and Other Drug Abuse,* 257(21) J.A.M.A. 2945 (June 5, 1987).
16. *Id.* at 2946.
17. *Id.* at 2947.
18. *Id.* at 2948.
19. *Id.* at 2945.
20. *Id.*
21. 261 J.A.M.A. 407 (January 20, 1989).
22. Chappel, J., *Physician Attitudes and the Treatment of Alcohol and Drug Dependent Patients,* 10(1) JOURNAL OF PSYCHEDELIC DRUGS 27 (January-March 1978).
23. *Id.*
24. A.A. SURVEYS ITS MEMBERSHIP: A DEMOGRAPHIC REPORT (Box 459, Grand Central Station, New York, N.Y. 10163, Fall 1984).
25. Chappel, J., *supra* note 22.

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Accreditation and curriculum statutes for medical schools, nursing schools, paramedic schools, and schools training other health professionals shall be amended to add the following language:

Curriculum requirements under this section shall mandate a minimum of 30 hours of study of alcohol and other drug abuse and addiction. The program for the study of alcohol and other drug abuse and addiction shall be approved by the [single state authority on alcohol and other drugs] in consultation with the American Society of Addiction Medicine and the state medical society and shall include, but not be limited to, diagnosis of addictive diseases, early warning signs of alcohol and other drug abuse, identification and referral skills, treatment approaches and appropriate use of support groups for affected individuals and for the families of affected individuals.

Further, the practice act in this state shall require that all practitioners who apply for periodic relicensure shall present evidence of completion of a minimum of ten hours of continuing education of alcohol and other drug abuse and addiction. Such courses shall include, but not be limited to the subjects listed above.

COMMENT

Experts report that addictive diseases constitute the single most neglected public health problem in the United States. Although physicians and other health professionals are able to address secondary organ damage with considerable energy and expertise, many are remiss in recognizing the patient's primary health care problem - substance abuse and addiction.[1]

Presently, responsibility for addressing educational needs in this area has fallen largely to professional associations and speciality societies on a voluntary basis.

Many health professional associations and specialty societies have identified core bodies of knowledge for their members. For example, the American Medical Association has developed "Guidelines for Physician Involvement in the Care of Substance-Abusing Patients." Similar guidelines have been developed by the American Nurses Association, the American Psychological Association and a number of speciality groups.

More broadly, a federally convened Physicians' Consortium on Substance Abuse Education worked for three years developing consensus statements (1991) on the needs of practitioners at all levels of training.

What has been lacking to this point, is a method of translating these voluntary efforts into reality for medical practitioners. The [Model Health Professionals Training Act] will provide the impetus through the established mechanism of professional training.

[1] Valiant, G.E., *Alcoholism and Drug Dependence,* in THE HARVARD GUIDE TO MODERN PSYCHIATRY (Nicholi, Jr., A.M. ed. 1978); Bowen O., and Sammons, J., *Why Doctors Miss The Warning Signs,* The Washington Post, December 27, 1988; Lewis, D.C., Niven, R., Czechowicz, D., and Trumble, J.G., *A Review of Medical Education in Alcohol and Other Drug Abuse,* 257(21) J.A.M.A. 2945-2948 (1987).

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