FEATURE

A UBC, Vancouver Coastal Health and St. Paul's Hospital Strategy for Education in Addiction Medicine

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Past research has described the substantial proportion of the global burden of disease attributable to the use of alcohol, tobacco and illicit drugs[1] and, in Canada, it has been estimated that the costs attributable to substance use approach $40 billion annually.[2] However, despite these substantial health and social costs, there has been a well described discordance between scientific evidence and policy in this area[3] with most resources going to criminal justice activities that have not been well evaluated.[4,5]

When the Office of the Auditor General last reviewed Canada's drug strategy in 2001, its report estimated that, of the $454 million spent annually on illicit drug control efforts in Canada, $426 million (93.8%) was devoted to law enforcement.[6] The report further concluded that "Of particular concern is the almost complete absence of basic management information on spending of resources, on expectations, and on results of an activity that accounts for almost $500 million each year."[6] Since this time, the federal government has redoubled its focus on treating drug addiction as a criminal justice issue enacting mandatory minimum sentences for even minor drug law offences.

Despite this allocation of resources, a growing range of innovative tools have been developed that enable physicians and allied health practitioners to identify, prevent, and treat addictive disorders. Unfortunately, while the science of addiction medicine continues to progress in leaps and bounds, the medical community has done a poor job of translating research into improved care of these patients.

For instance, the new extended release formulation of a drug called naltrexone is a perfect example of how British Columbia is playing catch-up in the world of addiction treatment. The drug, which has been marketed in the US under the trade name Vivitrol, takes advantage of modern advancements in pharmaceutical development enabling an extended-release preparation that allows the drug to be slowly released over the course of a month after a single intramuscular injection. As an opioid antagonist, Vivitrol reduces the rewarding effects of alcohol and completely blocks the effects of opioids like heroin for up to 30 days. In the first large randomized trial published in the Journal of the American Medical Association, Vivitrol reduced heavy drinking in alcoholics by 25%.[7] In a subsequent study published in the British Medical Journal The Lancet, 90% of heroin addicted individuals prescribed Vivitrol became abstinent compared to 35% of patients injected with a placebo.[8] In a study published earlier this year, which considered the most down-and-out population of addicts using both methamphetamine and heroin and published in the American Journal of Psychiatry, the drug more than doubled the rate at which patients became drug free.

Aside from its substantial benefits in alcohol treatment, the drug has significant healthcare cost savings and public health implications in Canada where untreated heroin addiction and addiction to prescription opioid drugs like oxycodone and morphine remain serious public health concerns. Unfortunately, highlighting the need to improve strategies for patient care locally, extended-release naltrexone (Vivitrol) is not presently available in Canada.

Furthermore, while there are a number of available medications to treat opioid and other forms of substance abuse, many physicians are unaware of how to use these tools. For instance, a recent audit of healthcare among U.S. adults found that quality varied substantially according to medical condition and that, in the case of alcohol addiction, the percentage of recommended care received was approximately 10%, and interventions for smoking cessation were similarly low.[9]

With the majority of resources aimed at addressing the addiction problem going to criminal justice-based strategies and effective medical treatments either not available or under-utilized, the medical community must ask itself—why? The failure to adequately train physicians in addiction medicine certainly helps to answer that question.

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For instance, where virtually all other medical disciplines graduate an annual wave of well-polished, new specialist physicians from residency and fellowship programs based within Vancouver's university-affiliated hospitals, there has been no fellowship training program in addiction medicine in the province until recently. As a result, despite the fact that advances in addiction research have helped identify effective new treatments, there are few skilled physicians to prescribe them. Dedicated and caring as they usually are, most Canadian physicians who consider themselves addiction medicine specialists had to assemble their knowledge about addiction treatment after graduating from their medical training.

From a patient's perspective, imagine being rushed to the hospital emergency room clutching your chest in the throes of a heart attack and being seen by an extremely well-meaning physician who has had to learn about cardiology without the existence of a local standardized curriculum.

Outside of British Columbia, a recent report from the U.S. National Center on Substance Abuse entitled "Addiction Medicine: Closing the Gap between Science and Practice" highlighted the fact that most people with addiction in the U.S. do not get treatment from a physician at all.[10] Rather, much as in Canada, U.S. addictions care is often provided by "unskilled laypersons."[10] The report's harshest criticism is saved for the medical community, stating that "most medical professionals who should be providing addiction treatment are not sufficiently trained to diagnose or treat it."[10] Research by this same group has also found that 94% of U.S. physicians "failed to include substance abuse among the diagnoses they offered when presented with symptoms of alcohol abuse."[10] Calling the lack of training of physicians a "monumental lost opportunity,"[10] the report describes a "failure of the medical profession at every level—in medical school, residency training, continuing education and in practice—to confront the nation's number one disease."[10]

Closer to home, while for over 15 years UBC has led other medical schools in the country in the amount of addiction medicine taught to undergraduate students and to Family Medicine Residents, overall training opportunities in addiction medicine have been very limited. Change is coming rapidly, however, in British Columbia. Specifically, a ground-shifting initiative has recently emerged at St. Paul's Hospital and UBC through a $3,000,000 donation from Goldcorp Inc., which has enabled the establishment of the St. Paul's Hospital Goldcorp Fellowship in Addiction Medicine. The fellowship is interdisciplinary and seeks to provide a one-year specialty training for physicians from family practice, internal medicine and psychiatry. It is envisioned that fellows will pursue this training upon graduation. However, with recognition of the importance of increasing the pool of physicians with expertise in addiction medicine, UBC Postgraduate Medical Education has also allowed for psychiatry and internal medicine residents to pursue elements of the fellowship curriculum through approved electives. Fellows will get clinical experience in key areas of the field including inpatient and outpatient detoxification protocols and procedures, inpatient addiction medicine consultation service, youth addiction and mental health, residential treatment focused on women, chronic pain management, and longitudinal community based addiction treatment. In addition, they will obtain academic training in the science of addiction medicine through academic half days, journal clubs, and conference attendance. The fellows will explore ways to impact public policy, conduct patient advocacy and take a leadership role in research projects. The fellowship has now received accreditation from the American Board of Addiction Medicine and full details regarding the fellowship and how to apply are available through the fellowship website at: www.addictionmedicinefellowship.org.

Using the infrastructure provided by this new fellowship, UBC has also expanded addiction medicine training opportunities for medical students through the creation of an addiction medicine elective as well as elective rotations within the family practice, internal medicine and psychiatry residencies (Figure 1). There is also a mechanism for physicians in practice to get an additional 3 to 6 months of training in addiction medicine through the UBC Enhanced Skills Program.

Ultimately, through the greater incorporation of addiction medicine training into medical school and residency programs at UBC, as well as the creation of continuing medical education and intensive fellowship training opportunities, British Columbians will be better served by the greater incorporation of addiction science into evidence-based medical practice.

The development of a broader group of academic and leadership-minded addiction medicine physicians also has the potential to begin the slow process of public education required to treat those who are alcohol or drug-addicted with compassion and care, rather than continuing to over rely on a moralistic criminal justice approach that has not served the interests of patients, public health, or the taxpayer.

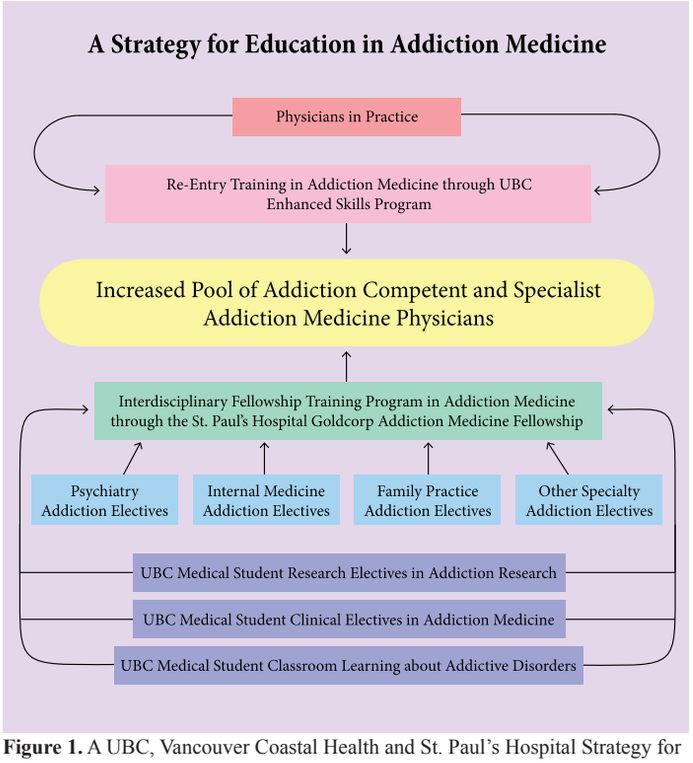

Figure 1. A UBC, Vancouver Coastal Health and St. Paul's Hospital Strategy for Education in Addiction Medicine

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The Human Face of Addiction, Recovery, and Advocacy

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MY STORY

I was recently invited to be a guest speaker for the small break-out groups at a lecture and tutorial titled "The Human Face of Addiction" for the UBC Faculty of Medicine's Doctor, Patient, and Society course. I shared some of my personal story with the students in a small group, and we discussed why I believe so strongly in Twelve Step programs, such as Alcoholics Anonymous (AA).

Like many addicts and alcoholics, I have a background. Environmental stressors and my personal history, combined with genetic factors, have made me especially susceptible to addiction. The American Society of Addiction Medicine states that two key factors leading to addiction are "exposure to trauma or stressors that overwhelm an individual's coping abilities", and that the result of exposure to these trauma and stressors is "disruption of healthy social supports and problems in interpersonal relationships which impact the development or impact of resiliencies".[1] In other words, due to a lack of healthy coping mechanisms, addicts turn to substances or addictive behaviours to help them deal with the ups and downs of their lives—or not deal with them at all by numbing everything out.

The students I interacted with were interested in my history and how it related to my alcoholism. My exposure to trauma and stressors began when my parents divorced when I was very young. After being separated from my birth father from the age of three, we finally reunited when I was 21 years old. I didn't understand it at the time but the sense of loss deeply affected me. My older brother was in a serious car accident when we were both in high school and was in a coma for several days. It took him years to recover. In my early 20s, I lost my brother to the disease of addiction and his death has profoundly affected our family.

After my brother's death, I remember drinking for the effect for the first time: to numb the pain. Drinking became more and more a priority in my life. I was a weekend binge drinker who, for a long time, believed I was simply having fun. It was easy for me to look at my life and think that I had everything under control. It was my sister who finally persuaded me to go to my first AA meeting.

I entered the meeting skeptical, embarrassed, and full of fear. In the meeting, I heard people share their experiences and stories of strength and hope. I was able to look at the similarities of my situation and not dwell on any of the differences. I identified with how people said they felt when they were still actively drinking, waking up in

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