

The Physician's Role in Treating Addiction as a Diagnosable and Treatable Illness

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Like millions of others, I watched with intense interest the pre-election news coverage, including the accusations regarding ACORN. I was particularly struck by the implications that ACORN had hired "homeless people, convicted felons, recovering alcoholics, and drug addicts—people who will do anything for money," at least according to CNN, CBS, NBC, ABC, and FOX news. Imagine the scandal if ACORN had stooped so low as to hire people with diabetes or asthma. It was quite sobering to realize how much education there is left to do for the general public regarding addictive diseases. Unfortunately, that same ignorance exists in the medical profession as well.

Alcoholism and Drug Addiction are Primary Illnesses

About 10-12% of the United States adult population has an addiction. This means that if you, as a physician, treat 1,000 patients, at least 100 are addicted. Do you know who they are? Probably not. Not knowing who they are means they are undiagnosed and untreated. The alcoholic or drug addict's self-assessment can make the diagnosis difficult. Alcoholics and addicts operate under a delusion that they are not addicted. This delusion is different from a lie. Alcoholics and addicts can describe their drinking or drug use in a way not even remotely resembling reality, and yet they can pass a lie-detector test. As a physician it is important that we are able to screen for addiction with every patient. It really is not that time-consuming. *How many days in the past month have you consumed an alcoholic beverage? How many ounces of alcohol do you consume per drinking episode? Have you ever blacked out? And there are the CAGE questions^a as well. Have you ever felt you should cut down on your drinking? Have people annoyed you by criticizing your drinking? Have you ever felt bad or guilty about your drinking? Have you ever had a drink first thing in the morning to steady your nerves or*

get rid of a hangover? It is also a good idea to ask the spouse or significant other about the patient's alcohol use. Your efforts in treating other medical conditions will likely lead to great frustration and poor outcome if the addiction is undiagnosed. Patients with hypertension that is harder to control in the morning could be experiencing alcoholic withdrawal. Patients with chronic complaints of awakening in the early morning hours could be experiencing alcohol withdrawal. Psychiatric patients who complain of chronic anxiety during the day,

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punctuated with panic in the morning, could be experiencing alcohol withdrawal. Alcoholic patients present to their physicians complaining of depression, anxiety, and sleep disturbance. Unfortunately, these symptoms do not respond to traditional treatment if the drinking continues.

At Fellowship Hall,^b I monitor patients' depressive symptoms by using Beck Depression Inventories. About 95% of patients have scores greater than 30 at admission, indicating severe depression. By day 21, only about 4% continue to have elevation

a The CAGE is a very brief screening tool that asks four direct questions. Any positive answer warrants investigation. The more answers endorsed the more likely that the patient is having problems with alcohol.

b Fellowship Hall, founded in 1971, is a 60-bed private nonprofit alcoholism and drug treatment facility providing medical detoxification and 12-step based treatment to adult men and women.

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in their Beck Depression Inventory scores. This is what is known as substance-induced mood disorder. The DSM-IV (*Diagnostic and Statistical Manual of Mental Disorders-IV*) clearly states for each diagnosis that the diagnosis should not be made if the symptoms can better be explained by a medical disorder or a substance use disorder. For example, cocaine-induced mania followed by alcohol-induced depression does not constitute bipolar disorder. More importantly, neither antidepressants nor mood stabilizers change the use patterns of alcoholics or addicts. There are some patients that are alcoholics who have comorbid psychiatric disorders. Unfortunately, the substance use must stop before symptoms of the psychiatric disorder will remit, even if the psychiatric intervention is appropriate. Regardless of which came first, the substance use must be in remission before the psychiatric symptoms can effectively be addressed. The same is true for conditions such as diabetes, hypertension, and hypothyroidism. Make addiction your first “rule out” in every patient.

Alcoholism is a primary illness, not the result of an underlying condition. There are structural differences in the brain in people with addictions prior to introduction of the addictive chemical, and certainly after repeated exposure. In addition, some people have a predisposition to addiction. Naïve drinkers with a family history of alcoholism experience greater euphoria when exposed to alcohol as compared to those without a family history. This partly explains why non-alcoholics cannot understand the drinking patterns of alcoholics. It is these brain differences that drive the compulsion to use the chemical despite negative consequences. This is the hallmark of addiction: continued use despite negative consequences. A person who is addicted may have, for example, multiple citations for driving while intoxicated (DWIs) or repeated elevated liver enzymes despite warnings from his physician about the adverse health consequences. Drinkers who can stop will stop when confronted with negative consequences. Alcoholics continue to drink despite these consequences and develop sophisticated rationalizations to continue.

Alcoholism and Drug Addiction are Diagnosable and Treatable Illnesses

The way physicians are trained to recognize and treat this population is fraught with problems. As medical students and residents, our exposure to alcoholics and addicts is generally in the emergency department (ED) with the patient being highly intoxicated and often belligerent. If you assess this patient appropriately, which rarely happens, and make an appropriate disposition, which also rarely happens, and the patient is compliant with that disposition, which, again, rarely happens, you will never see that patient in the ED again. Alcoholics are less likely than people with diabetes or asthma to re-present to the ED after appropriate treatment. If any of the three “ifs” fails, the patient will re-present. This may lead to the care provider developing the belief that alcoholics and addicts never get better. The reality, however, is alcoholics

and addicts respond to appropriate treatment with greater success than most (other chronic illnesses).

Addiction is a chronic and often relapsing illness. Care providers see a relapse as a treatment failure. Imagine a diabetic patient who for six years closely follows his diabetic treatment plan of appropriate diet, exercise, and insulin. For six years his blood glucose is normal. Then for some reason the patient stops taking insulin and winds up in a diabetic ketoacidosis (DKA). The physician will attempt to convince the patient to be compliant with the insulin and may use the six-year success period as evidence that insulin is effective. The opposite is true with alcoholism. The alcoholic faithfully follows her 12-step recovery program for six years and then stops. Soon after, her Alcoholics Anonymous (AA) meeting attendance stops, and the alcoholic begins drinking again. Care providers use this as a demonstration that treatment doesn’t work. In both instances, treatment worked as long as the patient was compliant.

Suppose tomorrow you see a patient in your practice with mildly elevated liver enzymes, and you talk to the patient about his drinking. Frequently, alcoholics are told to “cut down on your drinking, and I’ll see you in three months,” without being told how to address their excessive use of alcohol. Suppose you see a patient with a blood sugar of 400, and as their physician you tell them to lower their blood sugar and you’ll see them in three months. Generally physicians will prescribe appropriate anti-hyperglycemic medications and refer the patient to a specialist and a nutritionist for added support.

Very few physicians understand addiction and even less know how to treat it. A few years back, during grand rounds for a family medicine department, an attending physician made this statement: “I know what the symptoms of alcoholism are, what the abnormal lab values are, and can diagnose alcohol dependence. But I never do, because I don’t know what to do about it.” Imagine if I said, “I know the abnormal EKG finding for an acute myocardial infarction (MI) and the patient’s symptoms, but I never diagnose acute MI, because I don’t know what to do about it.” To do nothing is the worst thing you can do.

For the alcoholic, the key to recovery is abstinence. I will generally contract a patient into an abstinence-based plan that includes AA, outpatient therapy, inpatient treatment, or other appropriate services. If the patient drinks again, I recommend a more intensive level of care—generally inpatient treatment. It is important that the family be informed of this agreement and be willing to follow through with the noncompliance contingency plan that was developed at the initial contract session. The patient’s inability to abstain is seen not as failure but merely as data that their disease is too far progressed to treat at an outpatient level of care. The exception is a patient who cannot safely stop drinking. Delirium tremens has a 30% mortality rate. For many patients, detox is not a do-it-at-home project. I have seen countless patients who have been given a benzodiazepine to self-detox and present now addicted to both

the benzodiazepine and alcohol. As we know, a combination of alcohol and benzodiazepine has the potential to be a lethal combination. The American Society of Addiction Medicine (ASAM) has delineated levels of care from detox to outpatient. Each patient is assessed on a multidimensional model and placed in the appropriate level of care. Patients can move up or down these levels of care depending on progress or lack thereof. Treatment is seen as a process rather than an event. ASAM's four levels of care for alcohol and other drug (AOD) abuse treatment are described in *Patient Placement Criteria for the Treatment of Psychoactive Substance Use Disorders*.¹ They are presented in Table 1, with brief descriptions of settings and services.

Recently I admitted a patient who had been prescribed acamprosate. He was taking this medication as prescribed: one 333mg tablet each morning with the plan to titrate

the medication up to recommended dose. Acamprosate is prescribed at 666mg three times each day. There is no titration up or down. This was not the glaring error, however. The error was that the patient had been prescribed the medication as the sole intervention into his alcoholism. There are three medications that have been shown to be efficacious in the treatment of alcoholism. Naltrexone, acamprosate, and disulfiram. None, however, have ever been shown to have any efficacy unless part of a comprehensive treatment program.

Everyday in your practice you will encounter alcoholism and drug addiction. Don't be fooled by the presentation of the consequences of the illness; if you only treat the consequence you will miss the cause. Alcoholism and drug addiction are diagnosable and treatable illnesses that warrant our attention and intervention. Perhaps the only wrong intervention is to do nothing. **NCMJ**

Table 1.
American Society of Addiction Medicine Adult Placement Criteria for the Treatment of Psychoactive Substance Abuse

Level I Outpatient treatment	An organized nonresidential treatment service or an office practice with designated addiction professionals and clinicians providing professionally directed AOD treatment. This treatment occurs in regularly scheduled sessions usually totaling fewer than nine contact hours per week. Examples include weekly or twice-weekly individual therapy, weekly group therapy, or a combination of the two in association with participation in self-help groups.
Level II Intensive outpatient treatment (including partial hospitalization)	A planned and organized service in which addiction professionals and clinicians provide several AOD treatment service components to clients. Treatment consists of regularly scheduled sessions within a structured program, with a minimum of nine treatment hours per week. Examples include day or evening programs in which patients attend a full spectrum of treatment programming but live at home or in special residences.
Level III Medically monitored intensive inpatient treatment	An organized service conducted by addiction professionals and clinicians who provide a planned regimen of around-the-clock professionally directed evaluation, care, and treatment in an inpatient setting. This level of care includes 24-hour observation, monitoring, and treatment. A multidisciplinary staff functions under medical supervision. An example is a program with 24-hour nursing care under the direction of physicians.
Level IV Medically managed intensive inpatient treatment	An organized service in which addiction professionals and clinicians provide a planned regimen of 24-hour medically directed evaluation, care, and treatment in an acute care inpatient setting. Patients generally have severe withdrawal or medical, emotional, or behavioral problems that require primary medical and nursing services.

REFERENCE

- 1 Hoffman NG, Mee-Lee D, Halikas JA. *Patient Placement Criteria for the Treatment of Psychoactive Substance Use Disorders*. Chevy Chase, MD: American Society of Addiction Medicine; 1991.