

New Research Changes the Landscape for Cannabis

By TIMMEN CERMAK, MD, EDITOR, CSAM PRESIDENT-ELECT



After years of reporting that there are no data supporting the idea that marijuana damages neural tissue, two recent reports make this assertion no longer valid. The landscape regarding the safety of cannabis has dramatically changed.

Monica Rais et al. reported in the *American Journal of Psychiatry* (165:4, April 2008, pp. 490-496) that "First-episode schizophrenia patients who use cannabis show a more pronounced brain volume reduction over a 5-year follow-up than patients with schizophrenia who do not use cannabis."

In their MRI study of 51 recent-onset schizophrenics, they discovered only slight decreased gray matter volumes in both those schizophrenics who smoked marijuana and those who didn't compared to matched controls. MRIs five years later confirmed the same degree of gray matter loss in the schizophrenics who did not smoke marijuana that had been reported by previous studies.

The schizophrenics who used marijuana over the five years since their first break were found to have lost significantly more gray matter than abstaining schizophrenics. "The patients who continued to use cannabis showed a less pronounced improvement in positive and negative symptoms compared to nonusing patients. Although further studies

need to be conducted to confirm whether the brain volume loss is a direct or an indirect effect of cannabis in schizophrenia, this study suggests that some of the detrimental effects of cannabis on the course of illness may be explained by its effect on the progression of brain changes in schizophrenia."

The following month, Yücel et al. in the *Archive of General Psychiatry* (Vol 65, No. 6, June 2008, pp. 694-701) reported regional brain abnormalities associated with long-term heavy cannabis use.

Fifteen subjects chosen for an absence of polydrug use and neurological/mental disorders and positive for smoking >5 joints daily for >10 years were matched with controls. High resolution MRIs revealed reduced hippocampal volumes (12.1% on the left and 11.9% on the right) and reduced amygdala volumes (6.0% left and 8.2% right). While the histology involved in this reduced volume is unknown, previous animal studies found neuronal loss, glial loss, reduced cell size and a reduction in synaptic density in homologous regions in rodents up to 7 months following heavy exposure to THC.

In addition, measures of subthreshold psychotic symptoms and verbal learning ability found increased positive psy-



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Physician Health Takes Center Stage

MSNBC ran a story several months ago that was later in large part replicated on CNN's *Anderson Cooper 360*. Both media accounts, designed to shock the public, told of "troubling cases in which doctors have been accused of botching operations while undergoing treatment for drugs or alcohol have led to criticism of rehab programs that allow thousands of U.S. physicians to keep their addictions hidden from their patients." In the reports, the stories claimed "the medical community is using confidential treatment programs to protect dangerous physicians." These stories began appearing, not only on television, but also in newspapers after the Medical Board of California (MBC) moved to end its 28-year-old program. They did so despite the strong voice of the medical community urging the state to run the program efficiently and warning that having

no such program would put public safety at greater risk.

The move to eliminate the California Physician Diversion Program was led by Julie deAngelo Fellmeth of the University of San Diego's Center for Public Interest Law. Fellmeth, a long time critic of diversion, bid for and received a state-funded contract to become the Enforcement Monitor (i.e., external auditor) of the program and subsequently released reports identifying numerous deficiencies in the way the program was being run. Her report charged lax enforcement of random drug screening, poor completion of paperwork, and staffing shortages, among other shortcomings.

The need for a well-run program was reiterated by addiction specialists at numerous hearings, but fell on deaf ears. The

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Physician Health Takes Center Stage

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Medical Board succumbed to the public outrage generated by the Fellmeth report and her orchestrating of press conferences of patients who claim they have been harmed by an addicted doctor.

This has led us to where we are today — California's program ended June 30. Indications are that if no alternative program is formed to fill this void, the Medical Board could invoke a "zero-tolerance policy" similar to what was in place

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before 1980, when doctors who were found by the Medical Board to have drug or alcohol problems had their license immediately revoked.

Some believe that physicians who have an addictive disease should simply lose their license and thereby their livelihood. They argue that diversion is a failed concept and the public has the right to know the medical history of a physician.

Prior to the MBC's Diversion Program, physicians were forced to hide this addiction in fear of automatically losing their license. With the advent of physician diversion, a

path was provided that allowed for strict monitoring with random drug testing and worksite supervision. While there were noted lapses within the program, there is no evidence that a physician in the program ever harmed a patient. It is vital for the public interest to ensure there is a safe route that encourages physicians to be proactive in addressing their problems before a patient is injured.

The MBC admits that they are generally unaware of physicians who are suffering from addiction until some event is made public such as a patient being victim of malpractice. Without a physician health program the MBC will not have the ability to act in a proactive manner to lead potentially impaired physicians into recovery and therefore has placed patients in a more vulnerable position due to its move to eliminate a successful program.

Over the past year, CSAM has been working with other stakeholders including the California Medical Association, California Psychiatric Association, and Kaiser to reconstruct a physician health program that will protect the public and allow physicians to address their diseases. CSAM supports protects the public by encouraging physicians to come forward and address the disease of alcohol and drug addiction before a patient is harmed.

The following article by Michael Wilkes, MD, Professor of Medicine at UC Davis, expresses much of CSAM's perspective on Diversion. It was originally published in the Sacramento Bee on Sunday, April 6, 2008. He has kindly given us permission to reprint it in our newsletter. ■

The Battle Over Diversion Continues

BY MICHAEL S. WILKES, M.D., PH.D. UC DAVIS, VICE DEAN, MEDICAL EDUCATION, OFFICE OF THE VICE CHANCELLOR, HUMAN HEALTH SCIENCES AND DEAN



I recently wrote a column dealing with how ill-prepared doctors of all specialties are in dealing with patients who have addictions and substance abuse problems. I received a large pile of mail, much of it from physicians outraged at the way the Medical Board of California (the organization that licenses doctors in California) is pre-

paring to deal with physicians who have substance abuse problems.

For years, the Board had a diversion program that required treatment, random testing, and close monitoring of problem doctors. But last summer, the Board voted unanimously to abolish the drug and alcohol-diversion program beginning in June.

The Board cited several poorly conducted state audits that uncovered deficiencies in the program, including instances in which the program did not perform random drug tests.

"Uncovered" is hardly a descriptive term, given that we have known about this sloppy testing for several years. Despite the program's sloppiness, there is no example of a patient being harmed as a result of a missed random drug screening.

I also have spoken confidentially with many physicians who have been rehabilitated and are now fully functioning doctors — some of them leaders in their fields. The diversion program isn't perfect, but eliminating it is a remarkably backward approach to a small but serious problem.

When inspectors found a problem with the way the military treated some returning wounded soldiers, the government didn't close down the Veterans Administration system. When there were problems with health care in prisons, we didn't close the prisons. Yet the medical board can find no solution to physicians with addiction problems other than closing the diversion program?

We should fix it so it works properly and the public can have confidence that the issue is being addressed in a

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CSAM Announces New Legislation: AB 214

Public Protection and Physician Health Program Act of 2008

BILL NUMBER: AB 214

INTRODUCED BY: Assembly Member Felipe Fuentes as of June, 26, 2008

The Medical Practice Act provides for the licensure and regulation of physicians and surgeons by the Medical Board of California. Until July 1, 2008, existing law requires the board to oversee diversion programs for physicians and surgeons with alcohol and drug abuse problems.

This bill would enact the Public Protection and Physician Health Program Act of 2008, which would establish within the State Department of Public Health the Public Protection and Physician Health Committee (consisting of 12 members appointed by specific entities,) and would require the committee to recommend to the department a physician health program and would authorize the department to contract with the physician health program for purposes of care and rehabilitation of physicians and surgeons with alcohol or drug abuse problems or mental disorders, as specified. The bill would impose requirements on the physician health program relating to, among other things, monitoring the status and compliance of physicians and surgeons who enter treatment for a qualifying illness, as define, pursuant to written, voluntary agreements, and would require the department and committee to monitor compliance with these requirements. The bill would provide that a voluntary agreement to receive treatment would not be subject to public disclosure or disclosure to the Medical Board of California, except as specified, and would not be subject to disclosure in any civil action or proceeding, as specified. The bill would authorize the board, upon recommendation of the committee, to increase physician and surgeon licensure and renewal fees for purposes of the act, and, would require the board to collect and transfer those funds to the department, thereby making an appropriation. The bill would require the committee to make specified reports to the department, and would require the Bureau of State Audits to biannually conduct a performance audit of the committee and the physician health program, as specified. Vote: majority . Appropriation: yes . Fiscal committee: yes. State-mandated local program: no.

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. The Legislature hereby finds and declares that:
(a) The protection of the public from harm by physicians and surgeons who may be impaired by alcohol or substance abuse or mental disorder is paramount.
(b) It is essential for the public interest and the public health, safety, and welfare to focus on early intervention, assessment, monitoring, and treatment of physicians and

surgeons with significant health impairments that may impact their ability to practice.

(c) It is necessary to create a program in California that will permit physicians and surgeons to obtain treatment and monitoring of alcohol or substance abuse or mental disorder recovery so that they do not continue to treat patients while impaired.

SECTION. 2. Article 14 (commencing with Section 2340) is added to Chapter 5 of Division 2 of the Business and Professions Code, to read:

Article 14. Physician and Surgeon Diversion Program

2340. This article shall be known and may be cited as the Public Protection and Physician Health Program Act of 2008.

2341. For purposes of this article, the following terms have the following meanings:

- (a) "Board" means the Medical Board of California.
- (b) "Committee" means the Public Protection and Physician Health Committee established pursuant to Section 2342.
- (c) "Department" means the State Department of Public Health.
- (d) "Impaired" or "impairment" means the inability to practice medicine with reasonable skill and safety to patients by reason of alcohol abuse, substance abuse, alcohol dependency, any other substance dependency, or mental disorder.
- (e) "Physician health program" means the program for the prevention, detection, intervention, monitoring, and referral to treatment of impaired physicians and surgeons contracted with by the department pursuant to this article.
- (f) "Physician and surgeon" means a holder of a physician's and surgeon's certificate, and, for purposes of this article only, shall also include a resident or intern.
- (g) "Qualifying illness" means "alcohol or substance abuse," "alcohol or chemical dependency," or a "mental disorder" as those terms are used in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) or subsequent editions.
- (h) "Treatment program" means a plan of care and rehabilitation services that is provided by an organization or persons authorized to provide those services, as approved by the department, for impaired physicians and surgeons who enter into an agreement with the physician health program pursuant to this article.

2342. (a) There is hereby established within the Department of Public Health the Public Protection and Physician Health Committee. The committee shall be comprised of 12 members.

(A) Four members appointed by the director of the department, including the following:

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(i) Two members who are licensed mental health professionals with knowledge and expertise in the identification and treatment of substance abuse and mental disorders.

(ii) Two members who are physicians and surgeons with knowledge and expertise in the identification and treatment of alcohol dependence and substance abuse, including one member who shall be a designated representative from a panel recommended by a nonprofit professional association representing physicians and surgeons licensed in this state with at least 25,000 members in all modes of practice and specialties.

(B) Four members appointed by the Governor, including the following:

(i) Two members who are physicians and surgeons.

(ii) Two members of the public.

(C) One member of the public appointed by the Speaker of the Assembly.

(D) One member of the public appointed by the Senate Committee on Rules.

(E) Two members of the board designated by the board.

(2) For the purpose of this subdivision, a member of the public shall not be a physician and surgeon licensed in any United States jurisdiction.

(c) The committee shall prepare recommended rules and regulations necessary or advisable for the purpose of implementing this article. The rules and regulations shall include appropriate minimum standards and requirements for treatment, referral, and monitoring of participants in the physician health program. The department shall adopt regulations for the implementation of this article, taking into consideration the regulations recommended by the committee.

2343. (a) The committee shall recommend a physician health program to the department, and the department may contract with that physician health program. The physician health program shall be a nonprofit corporation organized under Section 501(c)(3) of Title 26 of the United States Code. The chief executive officer shall have expertise in the areas of alcohol abuse, substance abuse, alcohol dependency, other substance dependencies, and mental disorders. The board of directors shall include representation from the following statewide organizations:

(1) The California Medical Association.

(2) The California Society of Addiction Medicine.

(3) The California Psychiatric Association.

(4) The California Hospital Association.

(b) Subject to requirements adopted by the department pursuant to this article, the physician health program shall do all of the following:

(1) Develop standards, criteria, and guidelines for the acceptance, denial, referral to treatment, and monitoring of physicians and surgeons in the physician health program.

(2) Agree to make its services available to all licensed physicians and surgeons with a qualifying illness of an alcohol or substance abuse disorder or mental health disorder.

(3) Promote, facilitate, or provide information that can be used for the education of physicians and surgeons with respect to the recognition and treatment of alcohol dependency, chemical dependency, or mental disorders, and the availability of the physician health program for qualifying illnesses.

(4) Offer assistance to any person in referring a physician and surgeon for purposes of assessment or treatment, or both, for a qualifying illness.

(5) Monitor the status of a physician and surgeon during treatment who enters treatment for a qualifying illness pursuant to a written, voluntary agreement.

(6) Monitor the compliance of a physician and surgeon who enters into a written, voluntary agreement for a qualifying illness with the physician health program setting forth a course of recovery.

(7) Agree to accept referrals from the board to provide monitoring services pursuant to a board order.

(c) The physician health program shall also do all of the following:

(1) Set or collect reasonable fees, grants, and donations for administrative purposes or for services provided.

(2) Work collaboratively with the committee to develop model compliance agreements.

(3) Work collaboratively with the committee to identify qualified providers of services as may be needed by the individuals participating in the physician health program.

(4) Report annually to the committee statistics, including the number of individuals served, the number of compliant individuals, the number of individuals who have successfully completed their agreement period, and the number of individuals reported to the board for suspected noncompliance; provided, however, that in making that report, the physician health program shall not disclose any personally identifiable information relating to any physician and surgeon participating in a voluntary agreement as provided herein.

(d) The department, in conjunction with the committee, shall monitor compliance of the physician health program with the requirements of this act and its implementing regulations.

2344. The department has the sole discretion to designate the physician health program for licensees of the board and no provision of this article may be construed to entitle any physician and surgeon to the creation or designation of a physician health program for any individual qualifying illness or group of qualifying illnesses.

2345. (a) In order to encourage voluntary participation in monitored alcohol or chemical dependency or mental disorder treatment programs, and in recognition of the fact

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that mental disorder, alcohol dependency, and chemical dependency are illnesses, a physician and surgeon, certified or otherwise lawfully practicing in this state or applying for a license to practice in this state, may enter into a voluntary agreement with the physician health program. The agreement between the physician and surgeon and the physician health program shall include a jointly agreed upon treatment program and mandatory conditions and procedures to monitor compliance with the treatment program, including, but not limited to, an agreement to cease practice.

(b) Any voluntary agreement entered into pursuant to this section shall not be considered a disciplinary action or order by the board, shall not be disclosed to the board, and shall not be public information if all of the following are true:

(1) The voluntary agreement is the result of the physician and surgeon self-enrolling or voluntarily participating in the physician health program.

(2) The board has not received or filed any written complaints regarding that physician and surgeon relating to an alcohol or chemical dependency or mental disorder affecting the care and treatment of patients.

(3) The physician and surgeon is in compliance with the treatment program and the conditions and procedures to monitor compliance.

(c) (1) If a physician and surgeon enters into a voluntary agreement with the physician health program pursuant to this article, the physician health program shall do both of the following:

(A) Report to the committee the name and results of any contact or investigation involving a physician and surgeon who is suspected of being, or is, impaired and who is reasonably believed to constitute an imminent danger to himself or herself or to the public.

(B) Report to the committee if the physician and surgeon fails to cooperate with the physician health program, fails to cease practice when required, fails to submit to evaluation or treatment, whose impairment is not substantially alleviated through treatment, or who, in the opinion of the physician health program, is unable to practice medicine with reasonable skill and safety.

(2) Upon receiving a report pursuant to paragraph (1), the committee shall refer the matter to the board consistent with rules and regulations adopted by the committee.

(d) If the board has not instituted any disciplinary proceeding as provided in this article, any information received, maintained, or developed by the board pursuant to this article relating to the alcohol related, substance-related, or mental disorder impairment of any physician and surgeon, and any voluntary agreement made pursuant to this section, shall be confidential and shall not be available for, or subject to, public information, discovery, or civil court subpoena, or for introduction into evidence in any medical professional liability action or other civil action for damages arising out of the provision of, or failure to, provide health care services.

2345.5. The application for a physician and surgeon's license and certificate shall not require disclosure of a voluntary agreement entered into pursuant to Section 2345.

2346. The committee shall report to the department statistics received from the physician health program pursuant to Section 2343, and the department shall, thereafter, report to the Legislature the number of individuals served, the number of compliant individuals, the number of individuals who have successfully completed their agreement period, and the number of individuals reported to the board for suspected noncompliance; provided, however, that in making that report the department shall not disclose any personally identifiable information relating to any physician and surgeon participating in a voluntary agreement as provided herein.

2347. (a) A physician and surgeon participating in a voluntary agreement shall be responsible for all expenses relating to chemical testing, treatment, and recovery as provided in the written agreement between the physician and surgeon and the physician health program.

(b) In addition to the fees charged for the initial issuance or biennial renewal of a physician and surgeon's certificate pursuant to Section 2435, and at the time those fees are charged, upon recommendation of the committee, the board shall charge each applicant or renewing licensee an additional fee for the purposes of this article.

(c) The board shall transfer all funds collected pursuant to this section, on a monthly basis, to the department. All costs of the committee and program established pursuant to this article shall be paid out of the funds collected pursuant to this section.

2348. The department shall contract with the Bureau of State Audits to conduct a biannual performance audit of the committee and the physician health program or programs contracted with pursuant to this article. The bureau shall maintain the confidentiality of all records reviewed and information obtained in the course of conducting the audit, and shall not disclose any information that is identifiable to any program participant. A copy of the performance audit shall be submitted to the department, and to the Assembly and Senate Committees on Business and Professions. The Bureau of State Audits may contract with a third party to conduct the performance audit, except that the audit shall not be conducted by any person or entity that regularly testifies before the board. This section is not intended to reduce the number of audits the Bureau of State Audits may otherwise be able to conduct.

2349. Nothing in this article shall be construed to provide immunity from civil liability for any physician and surgeon who is a participant in the program for any acts or omissions within the course and scope of his or her practice. ■

Letter to the Editor — Response to Tribute

BY DON WESSON, MD, FORMER EDITOR, CSAM NEWS



I was pleased and touched by Peter Washburn's "Tribute" in the winter 2008 issue of *CSAM News*. Peter and I have lunch occasionally to discuss theater, dance, and movies. When we had lunch last October, he asked if he could "interview me" for something he was writing. From that brief interview and his review of *CSAM News* archive, he distilled considerable information about my tenure as *CSAM News* editor.

When I began editing *CSAM News*, the format of a "lead article" followed by shorter "newsy" pieces had already been established. My efforts usually went into getting someone to write the lead article. If I couldn't stir up something by the often already overdue deadline, I wrote a lead article. Much more commonly, I worked with CSAM members to develop their ideas into a lead article. For some, little work on my part was required; for others, it approached co-authorship. I wanted to provide members an opportunity for publication and to make each article easy to read. I hoped that CSAM members would see *CSAM News* as a forum where they could try out their ideas and later develop them into a manuscript for submission to a "real" journal.

Peter's "Tribute" was courageous. At the time Peter wrote it, I was quite controversial among many CSAM members because of my day time job (now retired). I much admire and appreciate Peter's courageousness and vision. ■

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New Hepatitis C University On-Line Course and Mentoring

CSAM member Diana Sylvestre, MD has developed an innovative free on-line CME course called "Hepatitis C University". www.hcvu.org is a site that provides mentoring, on-line video lectures, PowerPoint slides, testing, and CME certificates upon completion of the tests. It is easy to take the course and earn CME by following these easy instructions:

STEP 1: Go to: <http://www.hcvu.org>

STEP 2: Sign in/register to create your profile

STEP 3: Begin the core curriculum/module



Get Ready for Proposition 5 Coming in November

CSAM supporting major initiative to expand drug treatment in California



It's official! 760,000 voters signed petitions to qualify the Nonviolent Offender Rehabilitation Act (NORA), the most ambitious sentencing and prison reform in US history, for the California ballot in November. On June 2nd, the Secretary of State announced that

enough signatures had been collected (and verified) and that NORA had officially qualified as Proposition 5.

CSAM was one of the first medical organizations to endorse NORA which is being called the largest drug treatment expansion in US history. NORA will more than double the funding available for drug treatment in California and create—for the first time—a system of care for teenagers

“NORA gives us the opportunity to stop letting addiction drive incarceration in California.”

with drug problems. By rationalizing our prison and parole policies and making sure that nonviolent offenders have access to treatment and rehabilitation, NORA will significantly reduce the size of the prison population. And that's how NORA will pay for drug treatment expansion in the community.

When NORA goes before voters in November, Californians will have the opportunity to take reform into their own hands and implement common-sense solutions to prison overcrowding. NORA will protect public safety and save taxpayers billions of dollars by safely shrinking the size of the nonviolent prison population by tens of thousands within just a few years.

NORA gives us the opportunity to stop letting addiction drive incarceration in California. NORA would give tens of thousands of nonviolent offenders access to treatment-instead-of-incarceration and rehabilitation programs—a change that would dramatically improve people's lives, reduce the number of people locked up unnecessarily and decrease the likelihood of recidivism.

NORA would make treatment accessible to young people for the first time in the state. And the measure would make low-level marijuana possession an infraction—like a traffic ticket—rather than a misdemeanor, a sentencing change that could affect 40,000 people a year and conserve millions of dollars in court resources for other, more serious cases.

As the state's budget deficit continues to rise, NORA gives voters the opportunity to stop letting the prison

system soak up our ever-increasing portion of spending. Instead, NORA presents the state with an option for more effective—and less costly—policies to protect public safety and make sure there are sufficient resources to go around. The nonpartisan legislative analyst projects that NORA will save at least \$2.5 billion in prison construction savings because new facilities will not need to be built. ■



CSAM MEMBERS FROM ACROSS THE STATE MET FOR A BRIEFING IN SACRAMENTO ON MAY 20 TO MAKE PREPARATIONS TO SPEAK OUT IN SUPPORT OF THE BALLOT INITIATIVE IN ORDER TO ENSURE ITS PASSAGE IN NOVEMBER.



DAVE FRATELLO, COMMUNICATIONS DIRECTOR FOR THE CAMPAIGN FOR NEW DRUG POLICIES AND CSAM PAST PRESIDENT DONALD KURTH, MD, DISCUSSED THE NORA BALLOT INITIATIVE AT THE MAY 20 MEETING IN SACRAMENTO. KURTH, WHO ALSO HOLDS THE POST OF MAYOR OF RANCHO CUCAMONGA, WAS PART OF A DELEGATION OF CSAM MEMBERS TRAVELLED TO SACRAMENTO FOR MEETINGS WITH 35 LEGISLATORS TO DISCUSS DRUG TREATMENT LEGISLATION.

Changes the Landscape for Cannabis

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chotic symptoms and decreased verbal learning ability. The increase in subthreshold positive psychotic symptoms was inversely associated with changes in the left hippocampus.

“Previous functional imaging studies have found reduced left hippocampal activation during cognitive performance in cannabis users, and there is evidence to suggest that hippocampal abnormalities in psychiatric disorders such as schizophrenia are more prominent in the left hemisphere. These findings converge to suggest that the left hippocampus may be particularly vulnerable to the effects of cannabis exposure and may be more closely related to the emergence of psychotic symptoms.

“These findings challenge the widespread perception of cannabis as having limited or no neuroanatomical sequelae.”

I think I have earned a reputation as being a balanced observer, and not an alarmist, about marijuana. The reports outlined above, however, give reason to pause. Perhaps marijuana is like alcohol in the sense that moderate amounts can be tolerated without damage by most people, but excessive amounts are neurotoxic to almost everyone.

On the other hand, maybe we are merely on the threshold of discovering that even moderate amounts can produce moderate, subclinical damage.

It would be prudent to conclude that the jury is still out on this question. Future data, gathered with increasingly precise instruments, will be needed to answer the questions that these two reports open. Until then, it is only fair to state that the landscape is certainly shifting for cannabis. ■

Effective Strategies for Treating Pain and Addiction

Wednesday, October 22, 2008

9:00 am - 5:00 pm

Newport Beach Marriott

at CSAM's Review Course on Addiction Medicine

To register: www.csam-asam.org

Battle Over Diversion Continues

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rigorous manner.

Some may ask, ‘Why not just take away the abusing doctor’s licenses?’ — after all, they made this lifestyle choice. That would be wrong, because adopting such a policy fails to recognize substance abuse as a treatable disease.

Ironically, removing a doctor’s license without offering a chance for rehabilitation would actually increase the number of impaired doctors caring for the public. Doctors with substance-abuse problems, lacking options for treatment that would allow them to continue to practice, would be more likely to hide.

Doctors often work under great pressure and are only human. As such, it is not surprising that a few doctors succumb to addictive behaviors. If the intent of the Medical Board is to protect the public, this is best achieved by early identification, effective treatment and close monitoring (with authority to revoke a license if necessary).

A perfectly designed system would encourage doctors and nurses to confidentially report a physician they believe

is impaired. This is the system used by nearly every other state in the country with great success. Doctors and nurses are encouraged to report colleagues, with the understanding that the abuser will be medically treated and closely monitored, after the Board conducts an investigation.

If doctors and nurses believe that reporting a colleague will result in the loss of license and livelihood, far fewer would report an impaired colleague.

It seems the Medical Board is more interested in flexing its muscles to show the public that it is tough than in dealing with a complex problem. It is time that the Medical Board of California demonstrates some medical insight into the problem of substance abuse and base its policy on scientific evidence.

Doctors should be treated with the same dignity, compassion and confidentiality that we provide our patients. The public’s health is of paramount importance. But throwing the baby out with the bath water serves no one’s best interest. Reach Dr. Wilkes at: drwilkes@sacbee.com.

CSAM IS WORKING TO:

Protect the Public. If physicians do not have a clear path to come forward and address their disease they will remain unknown and undetected until it is too late, resulting in patient harm.

Preserve Physician Health. Physicians, just like any other person, may fall victim to an addiction and they deserve the right to rehabilitation in a secure environment that protects patients. ■

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CONFERENCE HIGHLIGHTS



Future of Genomic Medicine in the Addiction Field

Charles O'Brien, MD, PhD, Vice Chair, Department of Psychiatry and Director, Center for the Study of Addictions at the University of Pennsylvania School of Medicine



Neurobiology of Addiction: Springboard to New Treatments

George Koob, PhD, Professor and Chair, Committee on the Neurobiology of Addictive Disorders, The Scripps Research Institute



Trends in Prescription Drug Use and Misuse

H. Westley Clark, MD, JD, MPH, Director, Center for Substance Abuse Treatment

Substance Abuse Treatment: What is it? What is it supposed to do?

Richard Rawson, PhD, Associate Director of the UCLA Integrated Substance Abuse Programs; Associate Director, UCLA Department of Psychiatry

Club Drugs

Karen Miotto, MD, Associate Professor, Department of Psychiatry and Behavioral Science, UCLA School of Medicine

Substance Abuse, Pregnancy, and Fetal Development

M. Lynn Yonekura, MD, Professor, Department of Obstetrics/Maternal Fetal Medicine, Harbor-UCLA Medical Center

CONFERENCE WORKSHOPS

- **Effective Strategies for Treating Pain and Addiction**
- **Methadone Maintenance Treatment in 2008**
- **Physician Impairment in a Changing Environment: Guidance for Physicians and Well-Being Committees**
- **Coding to Optimize Reimbursement for Substance Abuse Treatment**



SPECIAL EVENTS

Olympic Drug Testing: A Postcard from Beijing

Donald Catlin, MD, Professor Emeritus, UCLA; Founder UCLA Olympic Laboratory; CEO, Anti-Doping Research

Friday Evening Poolside BBQ

(included in conference registration, guests welcome with additional fee)

Unwind southern California-style, at a pool-side BBQ in the hotel's spectacular veranda overlooking Newport Harbor. This will be a fun event, full of surprises, that you won't want to miss.

PREPARING FOR THE ASAM CERTIFICATION EXAM?

The Review Course presents an overview of the core elements of addiction medicine, presented by top experts in the field. Participants receive a course syllabus with copies of all lecture handouts and other materials that can serve as a study guide and help prepare for the exam.

For those who wish to have additional focused exam preparation, we are offering a Special Certification Exam Preparation Track. During the conference plenary, participants in the certification track will sit at a table with other exam takers and a facilitator who will help identify the key material for the exam and answer questions. In all, this option provides 6 hours devoted to test-taking strategies, sample questions, high-yield exam content, and tips on how to prepare for the exam. Participants in the exam preparation track will receive an additional CD-ROM with study materials and resources that will complement the Review Course material.



The conference hotel is the **Newport Beach Marriott Resort and Spa**. A limited number of rooms are available at the conference rate of **\$189 per night** for single or double rooms **until October 1**. After this date,

the hotel may offer any remaining rooms at the prevailing rate. To make reservations, phone **800/228-9290** or **949/640-4000**. The Newport Beach Marriott is located at 900 Newport Center Drive, Newport Beach, CA 92660. Identify yourself as a CSAM registrant to receive the conference rate.

CSAM Hosts Dual Diagnosis Conference at UCSF

Addiction medicine and mental health care often treat the same population. 44% of alcohol abusers and 64.4% of other substance abusers admitted for treatment have at least one other psychiatric diagnosis. Conversely, 29-34% of all mentally ill people also have substance abuse problems. Addiction medicine without psychiatry and psychiatry without addiction medicine fail to adequately treat the 7-13 million people with co-occurring disorders.

CSAM took an important step into the arena of co-occurring disorders and demonstrated its ability to contribute to awareness and treatment for this large population when it devoted an entire day to the discussion of treating patients with Dual Diagnosis Disorders. "No Wrong Door: Current Thinking in Dual Diagnosis Disorders" was held at the Laurel Heights Conference Center at UCSF in San Francisco on May 30th. Course planners were Monika Koch, MD, Mason Turner, MD, and Dykes Young, MD. Co-sponsored by The Permanente Medical Group, over 120 physicians and clinicians from throughout California attended the conference. Distinguished faculty from the San Francisco VA Medical Center, Kaiser Permanente, UCLA, UCSF and private practitioners covered topics including mood disorders, PTSD and substance abuse, ADD as a precursor to addiction, treating tobacco dependence in smokers with co-occurring mental illness, treatment approaches to depression and anxiety in early recovery and medication and drug use.

Thanks to our faculty: **Mason Turner, MD, John Tsuang, MD, Martha Schmitz, PhD, Steve Batki, MD, Tim Cermak, MD, Judith Prochaska, PhD, MPH, Dykes Young, MD, Christy Waters, MD, and Darryl Inaba, PharmD.**

The long-standing schism between the mental health and the addiction worlds was beautifully bridged for a day. By taking more of a lead in speaking across disciplines, CSAM has the potential to bring a more complete vision of caring for those patients who have all too often had their care split between two turf-protecting treatment systems. If addiction is a brain disease, then it is one variety of mental disorder among all the others. It may finally be possible to re-integrate addiction treatment into the mental health world without losing our identity or jeopardizing the powerful tools of recovery developed over the last half

century and more. In fact, it may even be time that the mental health world adopts a recovery model for many of the conditions it has traditionally treated.

To order a syllabus from this conference, contact the CSAM office at 415.764.4855. ■



TWO OF THE FACULTY AT THE MAY 30 CSAM DUAL DIAGNOSIS COURSE "NO WRONG DOOR" WERE MARTHA SCHMITZ, PhD, CLINICAL PSYCHOLOGIST AT SAN FRANCISCO VA MEDICAL CENTER AND MASON TURNER, MD, CHIEF OF PSYCHIATRY, KAISER PERMANENTE, SAN FRANCISCO.



JOHN TSUANG, MD, DIRECTOR OF DUAL DIAGNOSIS TREATMENT PROGRAM AT UCLA MEDICAL CENTER SPOKE AT THE MAY 30 CSAM COURSE.

Doctors in Distress — CMA Confidential Help Available

Concerned that a colleague, a family member, or you, may have an alcohol, chemical dependence, mental/behavioral problem? The CA Medical Association offers the Confidential Assistance Line, a 24-hour, voluntary phone service for physicians, dentists, medical students, residents, their families and colleagues. This service is completely confidential and using it will not result in any form of disciplinary action or referral to any disciplinary body. Physicians and dentists who volunteer their services on the line are experienced in treating professionals, including physicians with impairment problems. The goal is treatment not discipline. **In Northern California, please contact 650/756-7787. In Southern California, please contact 213/383-2691.**

Zito Asked to Support CSAM-Initiated Bill to Remove Barrier to Screening and Brief Intervention



RENEE ZITO, DIRECTOR, CA DEPT OF ALCOHOL AND DRUG PROGRAMS

With the support of Assemblymember Paul Krekorian (D-Glendale), CSAM continues to work to secure the repeal of the Uniform Accident and Sickness Policy Provision Law (UPPL) and has introduced AB 1461. The outdated UPPL law has had the unintended consequences of impeding public health by discouraging alcohol screening and treatment, increasing alcohol-related health care costs, and impeding law enforcement efforts by allowing drunk drivers to escape detection. The old law allows insurance companies to refuse payment of insurance claims if the injury happened in an accident that was caused by alcohol or other drug use, thus creating a disincentive to screen for such use. Removing this barrier to screening will substantially facilitate the implementation of Screening, Brief Intervention and Referral to Treatment (SBIRT) programs throughout emergency departments and trauma centers in California.

Dr. Tim Cermak, CSAM President-Elect and co-chair of



the SBIRT subcommittee of the Governor's Prevention Advocacy Council (GPAC) ushered a resolution calling for the repeal of UPPL through GPAC. On the basis of this resolution, a letter was sent to the Director of the Department of Alcohol and Drug Programs, Renee Zito, seeking her support of this repeal effort and help in urging the Governor to sign the bill when it reaches his desk. ■

Coding to Optimize Reimbursement for Substance Abuse Treatment

Saturday, October 25, 2008 • 1:30 pm - 3:30pm • Newport Beach Marriott

This course is designed to assist providers and their office personnel seeking to maximize reimbursement for substance abuse services and increase access to care for their patients. It will include a review of the types of services provided and the coding and documentation requirements for these services. Medical necessity for the reimbursement of these services is provided by the use of ICD-9 diagnosis codes. The importance of ICD-9 specificity, linking of the ICD-9 to the service and sequencing of the ICD-9 will be discussed. Medicare proposed fee schedule changes for 2009 will be covered, as well as a preview of any new ICD-9 codes that become effective for use October 1, 2008. Finally we will discuss the importance of understanding Modifiers and their use in getting your services reimbursed.

Lynn Handy, President and CEO, The Coding Source

Register at: www.csam-asam.org

NEW
WORKSHOP!

SAVE THE DATE!

Addiction Medicine Review Course 2008

October 22-25, 2008

Newport Beach Marriott Resort and Spa • *Newport Beach, CA*



Four-day overview of the principles of addiction medicine. An excellent review for those preparing to take the ASAM certification exam. Conference will feature a special "Certification Exam Review Track" with extra sessions to prepare those taking the exam.

Conference Chair: *Jean Marsters, MD*

CSAM

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