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Is there a Doctor in the House?

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This is an unusual question when the condition being treated is identifiable by causes and effects (symptoms) that clearly indicate a diseased organ. But why are doctors often on the periphery-or absent-when the disease is addiction?

"Why should they be?" someone asks. "Who needs a doctor anyway? They just push drugs and make you switch addictions. I got clean without a doctor."

I have heard these questions and statements from those actively addicted, but sadly, just as often, I've heard them from stalwart pillars of recovery groups and from those entrusted with the treatment of individuals that are still suffering.

What is this illness, really? If it is a disease, doctors are needed, but their role is undefined. It is safe to say that too often doctors do not have a role.

This is not a treatise on why we call addiction a disease. That has been done many times and very convincingly. Today we can describe the disease of addiction with great chemistry and pathos and detail. We study it, read about it, spend billions on it, yet in the opinion of many, we do not always do a very good job of treating this chronic and fatal disease. If the standards and measures of positive outcomes that we use for treating other diseases, such as diabetes or heart disease, are applied to the disease of addiction, we fall woefully short. Is this because addiction is so much harder to treat?

The answer to this question could only be accurately given if the same resources, money, and expertise were currently being applied for addiction as they are for other chronic illnesses. Herein lies the problem. The industry that is currently available to provide quality care has become one of "boutique programs with screenings and assessments made by salespeople," as described in a comment about an article in the 2 July 2013 *Addiction Professional* magazine.

An important distinction should be made here. There are many fine programs providing high-quality care for this disease. I am not addressing these, and we know which ones they are. Unfortunately, the number of patients for whom these programs are able to provide high-quality care pales when placed beside the numbers being treated at hundreds, if not thousands, of other treatment centers that market and apply unproven or outdated care. We have an addiction treatment industry populated by places selling the "easier, softer way" with absolutely zero evidence-based practices, yet they are too often considered acceptable and mainstream. A perusal of the Internet easily reveals thousands of centers with claims of amazing success rates, leaving one wondering why addiction even continues to be a problem!

Anne M. Fletcher, in her book *Inside Rehab*, describes the reality of this situation. Some centers do better than others, but a large number fall short of what must be achieved. Thomas McLellan states, in the book's introduction, that "seriously addicted people *are* getting very limited care at exhaustive costs and with uncertain results." He further states that "my research on addiction treatment programs suggests that this discouraging picture underestimates the problems in the treatment system." Consider the real success rates of any of the centers or methods described in her book. "Success" in this setting can be defined as an arrest of the progression of the disease manifestations that lasts. Apply these success rates for a loved one with cancer or heart disease. Is this good enough? You would of course choose a center anyway if that were all that was available to you, or if they convinced you that they offered you the best chance. What if you later discovered, after a recurrence of the disease manifestations (relapse), that the most modern, up-to-date knowledge and applications of treatment of the disease were not used for your loved one? There is no question that a huge deficit exists in what has proven successful in the treatment of addiction and what is found in many programs.

There are many reasons for this disparity, or "gap," as the National Center of Addiction and Substance Abuse (CASA) at Columbia University called it last year. The 573-page report on "the gap between science and practice" of addiction medicine reports that only one in ten people of the millions that need treatment for addiction actually receive it, and of those that do, "most do not receive anything that approximates evidence-based care." The CASA findings were reported in this publication a few months ago. That paper (and this discussion) is absolutely not an accusation against thousands of competent and diligent therapists in this field, as was received, by some, as noted in the comments section of that article. Rather it is an incrimination of the medical field (doctors) for allowing a disease—that killed more people last year than died at the peak of the AIDS epidemic—to remain "largely disconnected from mainstream medical practice," as stated in the report.

Our medical system makes sure that someone going home, after being admitted to a hospital in a coma and found to have diabetes, has appropriate aftercare. This means arrangements are made for follow-up with the appropriate medical specialists. Home visits, to educate and evaluate, with frequent reports to the doctor, are routine. The patient is given appropriate medications and instructed in continued self-care. Logs are kept, the content is reported to the doctor, and adjustments in treatment are made based on the information obtained. This kind of care is more intensive initially, then as needed, and it continues for the life of the patient as long as the patient remains engaged. If they do not remain engaged, phone calls and even social service visits are made to re-engage the patient. Someone at the doctor's office, usually a nurse, is responsible for coordinating all of this aftercare and ensuring its best possible success. Overall, a multidisciplinary, multi component patient-centered approach to healthcare delivery is enacted.

I have just described and defined chronic-disease management as it exists today for diseases such as diabetes, congestive heart failure,

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asthma, stroke, dementia, and many others. This is considered the standard of care for these diseases, yet the chronic disease of addiction is absent from any discussion of chronic-disease management in today's medical community. We check blood glucose levels four times a day in diabetics, and address the results each time with great success. Addiction programs such as those required for impaired physicians have random daily call-ins to check for alcohol or drugs and have documented success rates often greater than ninety percent. Now we need the non-impaired physicians to do the same for non-physicians with addiction!

What can we do?

Just as diabetics must approach their disease by doing tests and adjusting lifestyles one day at a time, addicts must approach their disease one day at a time. We must treat one patient at a time in the manner in which they deserve. This can mean arranging follow-up with an ASAM/ABAM-certified physician—or one with experience in addiction, if possible.

We can begin the process of formulating and implementing a chronic-disease management plan upon initial encounter with an addict/alcoholic as a client. Make sure the client becomes a patient too. Know that a Suboxone-certified doctor is educated only about Suboxone, not the intricacies involved with the treatment of addiction. The apparatus available for chronic-disease management must begin to be deployed for addiction, and doctors at every level must become involved extensively in this process. Such a grassroots effort can eventually lead to insurance, policy, medical education, and financial changes that are needed on a much grander scale to make a real difference. We can start making a real difference today with one patient.

A disease of the pancreas called diabetes can lead to abnormal glucose levels, and subsequently alterations in vision, renal function, and every system associated with small vessels. All of this must be treated with a multidisciplinary approach. A brain disease called addiction leads to abnormal dopamine levels and a cascade of subsequent chemical alterations resulting in abnormal behaviors and a change in fundamental drives. This, too, requires a multidisciplinary approach to treat the resulting sickness of mind, body, and spirit.

Capable therapists and psychologists most ably treat the mind. The medical community must up their game in the body portion of treatment. The entire industry must evolve with insistence on making available the evidence-based treatments on offer today in less than thirty percent of treatment centers and actually provided in a fragment of that (CASA 2012). Only if these things are done can the third, and in my opinion, the most important portion of this disease be addressed—the spiritual portion.

Chemical processes in the brain lead to consciousness and behavior. They also result in things like intuition, fairness, love, and ultimately peace. Chemistry contributes to spirituality. We must recognize that this continuum from cellular chemistry through spirituality is a two-way street. Changing one's spirituality leads to chemistry changes. Medication can change neurochemistry temporarily. Meditation changes dopamine. Acceptance changes serotonin. Doctors, therapists, and self-help groups are all imperative components of the treatment of this complex disease, addiction.

Therapists are usually "in the house." Where are the doctors?