



Canadian Society of Addiction Medicine
La Societé Medicalé Canadienne sur l'Addiction

Volume 1 Issue 4

The Bulletin

December 1996

CMSAOD SERVED US WELL..... LONG LIVE CSAM! N. el-Guebaly

On Friday October 18th the attendants at the annual meeting voted unanimously to support the Board's motion to change our society's name.

CMSAOD has served us well and will always be a part of our fond history. Formalized as a society in October 1989 at the first annual meeting in Calgary, the dates and process of its early conceptualization is the source of many reminiscences by the various "Knights at the Round Table" who participated in the creative process. In this issue we have published the reminiscences of one of the Knights, Dr. Joe Macmillan this year's Honorary member of our Society. I hope that others will follow suit so that we can build our archives. As I switch my Presidential hat from CMSAOD to CSAM, I believe that our new name positions us best to reflect the breadth and depth of Addiction Medicine into the next century.

Awaiting me upon my return from the annual meeting, was a letter from Dr. Rozecki our colleague from Richmond, British Columbia, informing us that our acronym CSAM will be the same as that of the Canadian Society of Aviation Medicine... oops! After some consultation, it became apparent that several national associations share the same acronyms, perhaps the maple leaf in ours will make a difference. This may also be an opportunity for our colleagues in Aviation Medicine to collaborate with us in addressing our common problems. We do have some overlap in interest in the field of addiction.

The Toronto meeting was stimulating and another financial success for our association. Thanks once more to Dr. Cunningham and his organizing committee as well as Wilcom Services Inc for a job well done. Please reserve in your calendar the dates of October 17-19, 1997 for the next annual meeting in Halifax.

As editor of the Bulletin I have had the fortune to receive a number of submissions which will form this edition. I also already have two articles for the next edition.

Learning as I go, my I recommend for our current format that **the maximum size of any contribution be no more than 1500 words**. This edition includes two articles promoting the need for more research activities within CSAM. As well as the draft for proposed Canadian criteria for certification in Addiction Medicine.

Wishing you the best of the season.

THANK YOU CSAM (October 19, 1996)

Dr. Joe Macmillan - Honorary Member

I first had the pleasure of speaking to you at the first meeting of the Canadian Medical Society on Alcohol and other Drugs, October 22, 1989. There are important linkages on which I need to comment, in order that you understand more fully the great accident that allowed me to find a home in this field, the great accident that allowed me to be here today so as to more clearly illuminate to you my delighted appreciation of this singular honor. It is a wonderful circumstance that the theme of this year's conference is the art of medicine.

There are 3 quotations that I need to share with you, encompassing to me what we are about in this Society.

1. Epidemiology is the medical profession's version of accounting, and as that dull profession is vital to running a modern business, so the study of diseases and how they spread and how we recover from them is actually the mother of modern medicine; in the 1830's a French physician determined that people who became ill died or recovered at the same rate whether they were treated or not. That rather awkward discovery forced the medical community to study itself, to look for things that work and things that do not, and along the way changed medicine forever from a trade to a scientific art.

2. Tennyson said "men may rise on the stepping stones of their dead selves to higher things" and

3. Alfred North Whitehead said "Fundamental progress has to do with the reinterpretation of basic ideas".

In 1977, Dr. William Henderson, Deputy Registrar of the College of Physicians and Surgeons of Ontario saw that we were clearly behind the USA in identifying and trying to adequately treat a problem that had been given the dubious sobriquet of the IMPAIRED Physician. The American Medical Society of Alcoholism (AMSA) had taken the forefront with this issue.

He decided to convene a meeting with himself, Dr. Douglas MacDonald, my boss, and CEO of the Donwood Institute, and Dr. James Rankin, then Head of the Clinical Institute of the Addiction Research Foundation. By their second meeting they had decided they needed input from a Treatment Physician and I was asked to join the unofficial group. Project DOC was born, and the Doctor's Group, first in Canada and second in North America began in July 1977.

In a short time Dr. Fred Glazer, ARF, and Dr. Jack Saunders OMA were added, followed by Dr. Jan Dowsling and Dr. Connie Townsend. Dr. Rankin left to go home to Australia, returned in time to take over as Chairman when Dr. Henderson retired. Dr. MacDonald moved away, Dr. Joan Brewster brought a scientist's view to the committee and later Drs. Ron Pound and Maris Anderson came aboard.

In 1986, after 10 years, education had been directed first at the collegial and licensing boards for physicians, the OMA and CPSO, followed by similar efforts directed toward the same associations of the other 4 Health Professional bodies. A linkage of the acute care facilities of the Clinical Institute of the Addiction Research Foundation to the Residential and Out-Patient treatment services of the Donwood Institute, making use of their standard Follow-up was bolstered by the development of The Doctor's Group and the formation of the Physician Advocates of Ontario; the committee saw clearly the need to expand to the next level of work; a secretariat, adequate housing, a permanent director and adequate funding.

A formal request was made to the funding bodies to accomplish this. This was not possible.

The project DOC committee met for a study weekend in March 1987 to deliberate it's next move. The first order of Business was to declare itself an independent body of interested physicians in CD and sever it's connection with the funding body.

Wide ranging discussion resulted first in the idea of creating an Ontario Society on Alcoholism which would umbrella other Provincial Societies on Addiction until the several would be strong enough to become a National Organization.

By the end of the day it was clear that our course must take the direction and the risk of beginning a national organization! It was envisioned to be a Repository and Clearing House of Information, friendly to Research, and the accumulation of Data, and a place that would be warmly supportive to dialogue between colleagues of many divergent views.

Present that weekend were Drs. Jim Rankin, David Korn, Jan Dowsling, Joan Brewster, Ron Pond, Maris Anderson and me! I would like to offer a photograph of those men and women for inclusion in the Archives of the Society.

And by October, 22, 1989, this brave new Society opened it's doors for business, it's eyes to the world and survived! And here we are tonight. I need to make these remarks to you in honor of those who were so instrumental in our birth and in honor and deep affection to those colleagues who have died and cannot join us tonight in our mutual celebration of health, life and friendship.

I am particularly proud to have had a hand in the conception and birth of our society., in which we are able, in a safe, friendly and collegial venue, to examine our knowledge and our biases and as a result, become more valuable to our prime responsibilities, our patients.

The fact that you would choose to gift me in this fashion is an immense honor and it is very important to me that I acknowledge this to you. With dignity to the profession and to the presentation and with the deepest of pleasure I accept this as the most meaningful tribute I can imagine, coming from my professional compatriots whom I respect, admire and know well.

In accepting this gift, I acknowledge the spirit of those who have gone before us, I mark to you all Health Professionals in Recovery from Chemical Dependency and I signal to you the spirit of Recovery of our patients from this vicious and insidious enemy that we are sworn to defeat.

From my heart, to each and all of you in the Society, both absent and here tonight,
THANK YOU!!!

Editors note:

Is there role for research and researchers in CSAM? I have received this month, two contributions for our Bulletin which are complementary in their concerns. One from our Secretary, Dr. Campbell and the other from our most dedicated associate member, Dr. Brewster. They both provide food for thought regarding the development of a most important dimension for CSAM. Your feedback will be welcomed.

GUIDELINES AND THE NEED FOR MORE CLINICAL RESEARCH IN ADDICTION MEDICINE

W. Campbell, MD

When Robert M Persig, (author of *Zen and the Art of Motorcycle Maintenance*) in his philosophical novel "Lila", states that the "metaphysics of quality is: good is a noun", he is attempting to bridge the gap between the physical world and that of the psyche. This duality has existed since man developed consciousness, but even as more knowledge of the mind becomes available, the mind/body split remains wide and at present shows little evidence of being brought together. In fact, more knowledge of the mind suggests that the Cartesian duality of the separation of the mind and spirit is still as ignomitic today as it was when Descartes wrote "Cogito ergo sum" (I think, therefore I am) in the 1600's.

Today we are still not close to measuring or qualitating the conscious thoughts of an individual and even more unable to measure what we call spirituality, which must be a result of conscious thoughts. The problem of body/mind separation is particularly significant in the field of addiction medicine where historically, the concept of recovery has developed through spirituality, not from what has been considered to be traditional medical therapies. Although scientific knowledge and the understanding in the field of addiction medicine has increased since the beginning of Alcoholics Anonymous in 1934, the problem of how the mind or spirit effect recovery has not been investigated to any great extent, most probably because, with the knowledge base available in scientific medicine, the study of the spirit appears to be impossible and results uninterpretable.

Despite the fact that 80% of conventional medicine is unproved, the need for clinical research in addiction medicine is paramount to provide both scientific validity to the area and answer questions of treatment and outcome. Much of what has been presented as scientific knowledge in addiction medicine in the past has not been scientifically validated and could be called what philosophers consider "folklore". For addiction medicine to be recognized as a valid field, it must be based on research of such nature that it is accepted by the medical community and science at large. If this does not occur, addiction medicine will remain a hodgepodge from different disciplines such as psychiatry, neuro-physiology, or internal medicine rather than a whole that transcends the sum of it's parts.

While empirical paradigms have been developed and integrated into the field, addiction medicine still must grapple with the premise that something unseen, unknown, and unmeasurable can cause an addicted person to change behavior and improve function. This is the basis of Alcoholics Anonymous. While few in the field of addiction medicine will argue that the concepts of Alcoholics Anonymous are, and will remain central to the recovery of some addicted individuals, no-one seems to be able to adequately integrate the concept into mainstream scientific thought or medicine. The mind/body split remains untouched. Perhaps to understand the phenomenology of consciousness or spirituality in the context of the proofs required by mainstream medicine is impossible with the tools we have available today, logic and scientific principles. As the research of consciousness expands (and resultant spirituality) more understanding of both physical and metaphysical aspects of recovery should result.

The importance of observation and research cannot be overstated. Charles Darwin urged a skeptical approach to unconfirmed observations; he believed that accepting flimsy

evidence is much more dangerous than adopting incorrect theories. "False facts are highly injurious to the progress of science for they often long endure, but false view if supported by some evidence, do little harm as everyone takes a salutary pleasure in proving these falseness". Addiction medicine has many "facts" that have not been proven yet are taken at face value because of their folklore aspect (codependency, adult children of alcoholics, Alcoholics Anonymous "works", recovery through twelve steps, etc.) Large multicentre studies are being done regarding outcome including optimal matching, with little results so far. At the clinical level there is a dearth of research attempting to explain even simple concepts of recovery. Until this basic clinical research is carried out, the Field of Addiction Medicine will remain dependent on the work of other specialties rather than assuming the identity of a specialty independent of others.

Interestingly the observations of alcoholics in the Big Book of Alcoholics Anonymous written in 1939 exemplify the validity of acute and meticulous observation. In the chapter titled "There is a Solution" (pp 20-24) a description of the various types of drinkers labels the addicted as one who has lost control of the ability to control / drink alcohol. More than 50 years later science / medicine is able to confirm this observation and differentiate problems of tolerance / withdrawal from those of preoccupation and loss of control and separate dependence from addiction. Perhaps part of the success of Alcoholics Anonymous was not the transcendent / spiritual aspect of recovery but the lessons learned from careful observation and the pragmatic empirical method used to develop a recovery process, eventually couched in the pseudo-religious language of the Oxford Group.

Alcoholics Anonymous shows that even individuals that have lost control of alcohol consumption and are constantly preoccupied with alcohol have the potential to recover. Yet, despite 50 years of experience of recovery, little scientific work has occurred in the field to explain why and how a person changes. Purpose in life, awareness, spirituality, and the effect of God, community etc. are a major part of this field. They do not seem to be studied for many reasons, most stated previously, but having said that, they could be, by the clinicians in the field. The studies need not be large and difficult, but would need to be scientifically valid. The questions need not be complex, but until done, addiction medicine will still function as an art, not a science. It's validity in the medical community will be suspect.

The concepts on which western medicine is based upon can be thought of as coming from the Greek philosophers. Simply put they suggest that:

- 1) Genuine human knowledge can be acquired only through a rigorous employment of human reason and empirical observation.
- 2) The ground of both must be sought in the present world of human experience, not in an undemonstrable other worldly reality. The only truth that is humanly accessible and useful is imminent rather than transcendent.

3) The causes of natural phenomena are impersonal and physical and should be sought within the realm of observable nature. All mythological and supernatural elements should be excluded from causal explanations as anthropomorphic projections.

4) Any claims to comprehensive theoretical understanding must be measured against the empirical reality of concrete particulars in all their diversity, mutability and individuality.

5) No search for truth is final, and the search for truth must be both critical and self critical. Human knowledge is fallible and must be constantly revised in the light of further evidence and analysis.

I suggest that each person in addiction medicine has the obligation to do clinical research based on these five points. The field is filled with unanswered questions. It leads to areas of the mind that defy understanding at present, but if addiction medicine is to become a valid and recognized part of the medical system, we will need our own body of clinical based research that starts with the clinician on the front line. Theories are theories and paradigms are paradigms, that's all. What addiction medicine needs are facts based upon observations, hypothesis, measurement and analysis at clinical level. No practice is too small to research and no question too unimportant to be studied rationally and scientifically. I hope the next conference provides more scientific papers, that the discussions are long and maybe even heated and that the result is a better understanding of the process of recovery and addiction as well as the phenomena of what is occurring at the conscious / spiritual level. Only if individual members of this organization do this basic work can addiction medicine claim to be a valid entity. I would ask every member to consider posing a question, making a hypothesis, gather the data, do the analysis and present their results in Halifax in 1997 or Victoria in 1998.

CSAM - A SCIENTIST'S VIEW

Joan M. Brewster, Ph.D.

At the 1996 CSAM annual meeting in Toronto, there was discussion of the need for an expanded scientific thrust in CSAM, as well as discussion of the role of "Associate Members" in the organization. Below are the thoughts of a long-time Associate Member on these issues.

History

CMSAOD was originally envisioned as a National organization of physicians and researchers interested in problems with alcohol and drugs. While the organization was to have a medical focus, it was not solely a practitioners' group. CSAM has functioned well as a vehicle for networking and education among physicians who work with alcohol and drug problems, and has had some role in encouraging medical education on this topic, but the research potential of CSAM has not been met. Indeed, most of the non-physician

scientists who joined the organization at the beginning have dropped out. If CSAM is to move into a leadership role in the field, science cannot be ignored.

A major scientific initiative of CMSAOD, begun in 1989, was the study of Drug Use Among Canadian Professionals, which included physicians, pharmacists and lawyers. This study was initiated by Dr. Jean-M. Ruel of the Bureau of Dangerous Drugs of Health Canada, which financed the study. The Bureau wanted to work with a National organization, and contracted with CMSAOD, which sub-contracted the survey to me at the Addiction Research Foundation of Ontario. The survey resulted in a major report to Health Canada in 1993, several conference presentations, and publications that are still in preparation. The survey is well regarded and widely cited. Unfortunately, this model of scientific activity by CMSAOD has not been repeated.

Why has CSAM not lived up to its promise scientifically? To some extent, the dominance of the AA-based "medical model" has not been welcoming to science. The organization's efforts have concentrated on "spreading the word" about Addiction Medicine, without pursuing a role in the development of the knowledge base. The loss of scientific members has been partly in reaction to CSAM's directions; the effect of this loss has been to further exacerbate the problem. However, it is now clear that furthering the legitimacy of Addiction Medicine requires activity on several fronts: practice supports and networking, education and contribution to knowledge.

A Changing Climate

At the October 1996 annual meeting, there was frequent mention of the need for openness to alternate models of problems with alcohol and other drugs, and the necessity of collaboration with scientists who study the problems with alcohol and other drugs. Several speakers mentioned the need to put to rest the "dichotomy" between disease and behavioral approaches to treatment of problems, noting that effective practice makes use of a range of interventions. Implicit in this openness is the need for research on the effectiveness and appropriate use of various methods. In his Banquet address, Dr. David Smith emphasized the need to move beyond the medical model and develop collaborations with those working from other backgrounds.

Consistent with this collaborative approach, ASAM gave its Annual Award this year to a Research Psychologist, Dr. Jack Henningfield, for "expanding the frontiers of Addiction Medicine and broadcasting our understanding of the addictive process through research and innovation". Dr. Henningfield's research is in the area of nicotine dependence, Dr. Carlton Erikson, is not a physician.

CSAM - A New Name - New Initiatives

Furthering the legitimacy of Addiction Medicine, and the leadership role of CSAM in this area, requires that CSAM support scientific initiatives in addition to its current networking and educational functions. Scientific activities may include data-gathering

and program evaluations, but are primarily theory-driven scientific work that expands basic knowledge of the field.

Research initiatives by CSAM will require commitment over a period of years, but the time is right to begin. Not only is there recognition within CSAM that scientific activity is needed, but cuts to government-supported organizations such as the Canadian Center of Substance Abuse and the Addiction Research Foundation have left a leadership gap. There is no Canadian National Scientific conference devoted to substance abuse problems. Scientists present results at an array of discipline specific and substance-specific local and international conferences. Also, there is no Canadian Journal devoted to interdisciplinary findings on substance abuse problems. CSAM could begin the process of carving out a leadership role by expanding the scientific program at the annual meetings. A modest beginning would be the announcement that the CSAM annual meeting will be a National scientific conference, accompanied by invitations to key members of the various disciplines to present papers. The call for papers should be expanded beyond current CSAM members, with a special invitation letter announcing an expanded scientific program.

The current Canadian Addiction Medicine Bulletin newsletter could grow into a scientific journal, but it might better develop a separate journal; major organizations such as CMA currently produce both a journal for wide distribution and a members' newsletter for internal news and business. Also, a name such as Canadian Journal of Substance Abuse, or Canadian Journal of Addiction would encourage contributions by scientists of various disciplines.

A renewed CSAM Research Committee might take the lead on the development of a scientific conference and journal, but ultimately a journal requires more time than a volunteer committee can give. Future opportunities for carrying out research through CSAM, on the model of the survey of Professionals' Drug Use, might be developed, although this could prove difficult in today's funding climate. Physician Health is an obvious area of expertise within CSAM, and the Canadian Physician Health Program Database is an embryonic project that falls into this category. The scientific side of this project could be developed by a renewed Research Committee, in collaboration with CSAM's obvious strength in the area of physician health, the organization should support a wide range of scientific activity and not become tied to this one issue.

Another area in which CSAM need to expand its activities is in collaboration with other organizations. For example, the CMA has taken some initiative in hosting International Conferences on Physician Health (the 1994 CMSAOD meeting was held in proximity with this conference in Ottawa). The American Medical Association has also recently supported a US initiative on research in physician health. Links should be made with substance abuse research groups in other disciplines, such as Epidemiology, Psychology, and Neuroscience. Ties could also be made with policy researchers.

Membership Categories:

The issue of "Associate Members" has been entwined with discussions about the role of the organization, and some CSAM members are concerned about being outnumbered by addiction counselors, nurses, psychologists and other practitioners. There is legitimate concern that giving voting rights to Associate Members will dilute the medical focus of CSAM. One possible approach to the problem of membership categories would be to have three categories (aside from student, retired, etc.): Member, Associate Member (non-physician practitioners), and Scientific Member (physicians and non-physicians whose primary activity is research rather than practice.)

REMINDER: MEMBERSHIP DUES

We are gratified by the fact that sixty per cent of our membership have renewed so far their annual dues 1996-1997. This is a reminder to the other forty per cent to expedite this matter.

Our national medical society is making strides at a time where the national, and provincial organizations involved in our field are struggling financially. A strong representation with CMA, the Federal Government and the Colleges becomes even more important.

Please forward dues as well contributions to the Bulletin to:

CSAM

c/o Addiction Center

Foothills Hospital

1403, 29 Street, NW

Calgary, Alberta T2N 2T9

Note: contributions to the Bulletin are to be within 1500 words

Editor's Note

The last page are the proposed Canadian criteria for certification. A consensus is emerging through several drafts.

Please respond to Dr. Cunningham and express your news on this important matter.

BEST OF THE HOLIDAYS!

PROPOSED CANADIAN CRITERIA FOR CERTIFICATION IN ADDICTION MEDICINE

DRAFT #3 - October 1996

1. Graduation from Medical School in Canada or the United States approved by the Committee of Accreditation of Canadian Medical Schools (CACMS) or equivalent.
2. In good standing with a provincial or territorial licensing authority.

A) Training

- Completion of residency program approved by a) Professional Corporation of Physicians of Quebec, b) College of Family Physicians of Canada, c) Royal College of Physicians & Surgeons of Canada and successful completion of the examination.
- Evidence of one (1) year full time involvement in the field of Addiction Medicine.

OR

B) Practice Eligible

- Membership in the College of Family Practice for two years.
- Membership in Canadian Society of Addiction Medicine for two years.
- Successful completion of practice review of clinical addiction practice conducted by an Ad Hoc Practice review Team of Canadian Society of Addiction Medicine.
- Sit the ASAM examination within two years of the practice review.
- Attend the Canadian Society of Addiction Medicine Annual Meeting or equivalent for two years prior to certification.

Fifty (50) hours of Main-Pro credits for family physicians and/or approval of diary entries in the Maintenance of Competence Program (MOCOMP) of the Royal College of Physicians and Surgeons of Canada obtained in the two (2) years prior to presentation for credentialling.

Please send feed back by January 31, 1997 to:

Dr. G. Cunningham
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Homewood Addiction Division

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