Week 8 (Edited) - Youth, Elderly & Ethics

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00:05

All right, now that our recording has started, I'm going to say that again, welcome. And good morning, everyone. We are on week eight of our office hours. And this week we are featuring or talking about treatment for different ages. So youth and elderly, and then ethics and ethics is a large topic. So we have quite a few practice questions to go through. As a reminder, if you are able to and comfortable with it, please turn your cameras on, it just makes for a more engaging session. You're also all able to unmute yourself. So if at any point you have any follow up questions or comments or anything like that, feel free to unmute yourselves and chime in. Or you can always type it into the chat. And I'll be monitoring that.

00:43

For those of you who are new. I think I recognize most names. I'm Giulia DeMello, and I work here at ASAM, and then this week, we are featuring Dr. Michael Fingerhood. So I will turn it over to him to get us started.

00:55

So thanks, Giulia, so I'm Michael Fingerhood, you can see who I am. I've been involved with ASAM for a long time. For many years, I led the annual meeting, and I now lead the state of the art conference, I head Medical Education Council. So I'm an internist who does addiction medicine within the setting of primary care. So the angle that I know best, even as we go through questions is again, as a primary care internist who does addiction medicine, I also do Addiction Medicine consults in the hospital. So we're... and then provide also, buprenorphine treatment in unusual settings, including at a church.

01:38

So that's a little bit about me. And just to warn you, I'm from Brooklyn, New York, and my Brooklyn accent inevitably comes out on occasion. So I did not write any of these questions. So we'll blame Giulia if we don't like any of them. So So again, as Giulia said, you can interrupt, you can ask-

discussion- you know, discuss something, you can say, "There's no way that that answer's right," if you want. It's meant to be open.

02:13

And you heard that it's gonna be discussing younger, younger adults and adolescents, older adults, the other end of the spectrum, and then some background and ethics. Ethics was lumped in here. I've done workshops on ethical issues within Addiction Medicine at conferences for ASAM so we're going to open up so I'm going to read each question and then a pause for you to think about it. You can decide if you want to ask questions or comments as well. Some of them are more straightforward, some are more trivial. But they're meant to spur think- thought and there are clear right answers, most of them. For those of you taking the board exam, the- this- doing these sessions will help you with the board exam as well. I found even when I did the board exam, just going through lots of questions was useful.

03:11

Now having said all that, which is a risk factor for substance use disorder in an adolescent. I'm going to ask people to think about the answer. And a couple of people have put answers already in the chat. So a lot of you have said, "mood disorder", just the other things that aren't on the list for you to think about is, in analysis, some, often knowing more about the home environment is useful to know, family history. And then also, early use also, of the substance as respect for that later developing a use disorder. And as everyone's said, almost I think everybody who put an answer in the chat A is correct.

04:01

Dr. Fingerhood, if you don't mind. Could you just reread the question with the answer choices for the folks that are audio only?

04:07

Oh, you bet. I'm sorry. No, no, go back. Sorry. So which is a risk factor for substance use disorder in an adolescent? Choices are mood disorder, engagements with extracurricular activities, early age of puberty, and social status, and we heard that the answer is mood- mood disorder. And the- certainly things like extracurricular activities would probably decrease.

04:32

This is a little bit off topic, but there were studies looking for instance at college students, though, develop substance disorder that some extracurricular activities increase the risk, for instance, involvement in a fraternity actually increases the risk. So I mean, maybe that's why that choice was thrown in.

04:50

04:30

I will read all the choices going forward. Of course, the next one has lots of words, and that's why Giulia wanted me to have to read all the answers. Which of the following statements about effective approaches to adolescent substance use is true? I'm just going to take a background is, if you think addiction, providing addiction treatment is challenging. Working with adolescents, I think is the most challenging thing I've done. I participated in adolescents training program back a while ago. And you definitely have to be creative and have careful conversation when working with adolescents.

05:30

So here are the choices. When a youth says they're not ready to quit- asking to quit, asking further questions can damage the therapeutic relationship. B is the clinician should avoid recommending against any substance use since that is likely to work against future engagements and prevent honest reporting by the adolescent. C- clinicians should review the pros and cons of substance use with a patient and attempt to highlight discrepancies between the youth's stated personal goals and substance related behaviors that may be barriers to achievement of those goals. And D although marijuana may be harmful for some adolescents, there's evidence that it has an appropriate medicinal role in alleviating symptoms of anxiety and depression for some.

06:17

I'm looking in the chat and all chat responses were C. We'll go the next slide and I'll say it again. So the answer that people chose was "clinicians should review the pros and cons of substance use with a patient and attempt to highlight discrepancies between the youth's personal goals and substance related behaviors that are barriers achievement of those goals.

06:36

And I think this is the right answer for anybody with a substance use disorder, not just adolescents. And I sometimes bring it to the forefront, right? People like to use the substance they're using because when they started using it, they liked the way it made them feel. And then we have to go over then through conversation understands despite the fact that you like the way you feel, what are the what are the things that have happened as a consequence. So I think that is clearly the right answer. And the message should be one that's- you know the therapeutic relationship is inherent, obviously in any conversation and warnings... pure warnings don't work.

07:27

An 11 year old girl is brought to the emergency room- department- I'm sorry- by her mother because she's agitated and frightened after smoking a marijuana cigarette. The girl says that God is punishing her for using marijuana and fears she will die. She has no history of prior drug use or psychiatric problems. Patient's mother says that her father and one of her brothers has schiz- schizophrenia. Physical examination shows no abnormalities except for injection of the conjunctiva. Blood pressure's 100 over 60, pulse of 120, respiration's 25. So elevated heart rate and respiratory rate. Complete blood count, urine analysis and blood chemistry are normal.

08:14

Which of the following is the most likely explanation for this patient's behavior? The choices are A- guilt, acute guilt reaction, B- marijuana-induced panic episode, C- presence of formaldehyde in the- or other adulterants that could be in a marijuana cigarette. Presence of phencyclidine in the marijuana cigarette.

08:38

So the answers are B but- which is marijuana induced panic episode. And people in the chat said that correctly. So a paradoxical response is to to marijuana can actually happen in any age group. I've seen it happen to older adults. In fact, recently an older adult who thought it might help with a medical problem. It can include- in this instance it was panic- include paranoia as well. And older adults, you can see paranoia as well as in younger people such as this. So B is the most likely answer but I just want to touch on the fact that's in the in some areas that you can actually see phencyclidine on smoked things that people buy. So typically, the way PCP is used is actually usually with a regular cigarette in which it is actually dipped in a solution that has PCP and then smoked, but that wouldn't be the most likely and it really depends on the geographic setting to even know if there's PCP in that community.

09:53

A 17 year old boy is seeking confidential care for a substance use problem. He reports that he's driven a car while intoxicated several times and wants to avoid further high risk substance use. The boy's parents have shown religious convictions against substance use, and he asks that they not be notified. When is it ethically justifiable to break the confidentiality of an adolescent patient who's engaging in risky behavior? And these are the choices that... I just want to point out that sometimes we do think about an age that we would think, for instance, a 17 year old, different than an 11 year old, for instance, that we heard about in the previous... the 17 year old is kind of on the borderline right in terms of being an adult. And that's those are sort of our thought process, as we're thinking about this.

10:50

So the choices are A- never, confidentiality cannot be breached under any circumstances, B- only when it is legally required for public health reporting. C- in specific circumstances when it is necessary to protect the teen or third parties from harm, and D- when it would be in the patient's best interest or the best interests of other relevant parties. I'm looking at people, so there were some C, some C's, and someone else just put in a D. And the answer that was - there's they're slightly overlapped. So that's why perhaps the person who said D. So the answer that was desired was "in specific circumstances, when it is necessary to protect the teen or third parties from harm."

11:42

So so so harm is a bit more specific than interests, right, so that the specific interest has to be "harm". And interests are bit vague to know what that means. And that's really what the situation is

here. And I think that's the situation when we think about confidentiality of substance use in older individuals as well, so not just the 17 year old, for instance. Perhaps somewhat analogous situation would be I remember, I admitted someone a few years ago for alcohol withdrawal, who was a school bus driver who was continuing to drive while they were drinking. Right. So that would be a situation where you want to protect third parties from clear risk of harm. So really, the important piece is the word is protection related to harm.

12:45

12 year old middle school boy comes in to see for a Well Child exam. Here's someone younger now. His parents do not report substantial health concerns. However, they noted slightly worse grades at school in the past semester and several head bumps recently. During your one on one interview, the child admits drinking with friends on average once per month in the past year. When drinking he usually drinks one to two drinks, but recently had three drinks at a party. His parents are not aware of his drinking and he asks you not to disclose it to his parents. What is the best course of action?

13:22

Again, this is a little bit similar to the previous... A- maintain the child's confidentiality as substance use related information is highly sensitive, and confidential in minors and the patient did not agree to disclose it to the parents. Again, notice this a 12 year old so this is someone not late in adolescence, but someone who's you would regard as being younger for sure at 12. Maintain the child's conf- confidentiality because disclosing it to the parents against the child's wishes may undermine the patient-clinician relationship and child's trust in you, C- break the patient's confidentiality and discuss it with the parents because all parents should know about their child's drinking. So that's a statement again, it doesn't mention age, and then D- break the patient's confidentiality and discuss it with the parents because the child's drinking places them in high risk category and at 12 years old, he's not considered to be at an age of consent.

14:21

And people have chosen D. And that is correct again, considering his age, especially as a 12 year old, not a 17 year old. And certainly we worry about the risk. So everybody got that correct.

14:42

And now we're shifting to over age 60, a 68 year old gentleman with a history of type two diabetes mellitus and neuropathic pain related to diabetic neuropathy presents to your office complaining of increased depression associated with insomnia and anhedonia. He denies suicidal ideation and says his family is supportive. Taking into account the risks and benefits of medications including side effects, adverse events and efficacy of medications, which of the following would be included as first line treatment for co-occurring depression and neuropathic pain in this patient?

15:21

A- sertraline and amitriptyline. It doesn't mean that you're prescribing both, but it's that you could

A- sertraline and amitriptyline. It doesn't mean that you're prescribing both, but it's that you could consid- consider them. Duloxetine or venlafaxine. So, nortriptyline or amitriptyline. And citalopram and amitriptyline. So most people put B so it's duloxetine which is an SSNRI- the only one in that class while the sertraline and citalopram are SSRIs. Actually duloxetine has a uni- a unique indication for pain, especially back pain. And the other point here as we shift to the answer, which is that is that in older adults, there's something called beers criteria, which is a list of medications to be considered carefully for use in older adults and tri-cyclic antidepressants, amitriptyline and nortriptyline are both on that list. And generally, we tend to avoid them in older adults, if we could think about using medication that's safer, such as duloxetine or venlafaxine.

16:43

The question is what is the relation to addiction? So... not necessary... not necessarily.... there is one I could say that if this patient had some other addiction, the choice would still be the same. So I understand your comments. But it's just meant to to understand older adults as well and the treatment of pain in older adults. And in older adults with a pain syndrome I think duloxetine is a useful consideration.

17:21

A 66 year old widow presents to you for the first time requesting refillable alprazolam 0.5 milligrams four times per day. I'll just say that typically, this is not unusual to inherit someone from another provider unfortunately, and she may have been receiving this for 20 or 30 years, unfortunately. She says the alprazolam helps with worry, poor sleep and ulcer pains and that she only buys one day supply of medication at a time because each night, young men in the neighborhood break into her mobile home to vandalize and steal small items. We don't know if she'd been prescribed in the past, the situation, but that's how the specialists wrote it. Exam reveals a pulse of 100, blood pressure is slightly elevated 138 over 94. She appears tremulous. She's just anxious, and she has noted impaired short term memory.

18:16

The best course of action would be admit her to the hospital, A, B- obtain serum electrolytes, C obtain a brain magnetic magnetic resonance imaging scan or MRI. Administer small dose of anti psychotics like haloperidol.

18:33

It looks like anybody who put a comment in chat shows A- admit to hospital. Obviously hope that she agrees to that. But it clearly looks sounds like she's having benzodiazepine withdrawal. And I think, I would encourage her, if she was willing to be treated, especially since she already is in withdrawal and tremulous in order to get up to treat her withdrawal as well as come up with a good plan to help her symptoms.

19:04

Not part of this question.... Someone said yes, I doubt hospitals would agree to admission. I think you do your best to because in this woman there'd be a risk, for instance, you'd have to convince the risk of seizures as a complication in withdrawal. I think it's important to realize.

19:26

The other aspect of of taking care, if I was taking care of her would be I would make sure she realized that the any benefits she sees is outweighed by the risk and realize that as we think of other medications to treat her poor sleep and worry that she won't get the same effect from alprazolam that perhaps she was getting from what she was buying. And the other point to realize is that street alprazolam in 2023 has a lot of risks, as there's much evidence of tainting of pressed pills of alprazolam for instance, with fentanyl. So increased risk there as well. And if you want to, you can actually easily search online for an alprazolam pill press and you come up with lots of places where you can make your own alprazolam with whatever you want, and people buy it without any realization that it is counterfeit.

20:30

You're approached by a colleague who wants to discuss a difficult case with you. He tells you that one of his patients, a 78 year old woman who's dying from stage four breast cancer, and in obvious and severe pain has declined opioid analgesics for pain. Patient's daughter, however, is urging your colleague to prescribe an opioid analgesic, without his patient's knowledge to relieve her pain. You explained to her colleague, to your colleague, I'm sorry, that if you were to prescribe an opioid without his patients knowledge, even with the intention of relieving her suffering to do so would violate which two core ethical principles?

21:10

And the choices are A- autonomy and beneficence, B- autonomy and justice, C- autonomy and non-maleficence, or D justice and non-maleficence. And everybody has said C, and that is the correct answer. But just to go over. Autonomy clearly has to be honored here. Right? So, if a patient expresses a wish, and you don't, that is reasonable, you clearly have to agree to their wish. Non-maleficence- So there would be, it comes from not honoring somebody's wishes, right? So. So that where is where that answer comes from. Beneficence means we should always be doing things to benefit our patients. But this is in this instance, it's a negative, right? So we're saying that you shouldn't... non-maleficence to to not do what our patient wants. So it might mean that you educate or have a discussion about it, maybe it's an open discussion that further down the line and the individual would be open to opioids. But certainly we should honor the patient's wishes at this point.

22:39

This question is about usually about procedures or could be involved in research, which of the following are the three basic components of informed consent? And the choices are A- knowledge, capacity, and voluntary acceptance, B- knowledge, competency and capacity, C- knowledge, beneficence, and voluntary acceptance, and D- knowledge, competency and voluntary consent? So

obviously, knowledge is what has to be part of it, right? It's in all the answers. And then what are the other aspects of... and I see mostly A's. I'm gonna give you the answer and then we're going to discuss more.

23:21

So the answer is A. So all of you got it right. And I always like to... voluntary acceptance is really important and places where we worry about voluntary acceptance is especially as we study ethics and research is for example, with carceral settings. And remember, capacity is a term that we have to understand because sometimes patients can have capacity to understand informed consent but may not have capacity to do other things. So the capacity is specific to the decision in a specific informed consent. So I always like to point that out.

24:08

Which of the following is the definition of beneficence: A is acts of mercy kindness and charity, B- one ought not to inflict evil or harm, C- being free from controlling authority and D- to each person equal share.

24:38

Oh that's just a comment from Giulia, sorry, so so I'm going to... it's acts of mercy, kindness, or charity. Beneficence means we... right... we want to provide benefits and how do we provide benefit and we do it's through what we do in terms of being kind, charitable, and merciful. Not to inflict evil or harm is non-malficence. Being free from showing authority- I'm not sure what that means, and to each person equal share isn't always necessarily true. And there's difference between equity and equality I like to point out as well.

25:28

An Addiction Medicine physician is a co-investigator in a pharmaceutical study investigating a new pharmacotherapy to help people reduce THC or cannabis marijuana withdrawal symptoms, if people want to quit using marijuana. This physician likes giving talks about this new pharmacotherapy and makes an honorarium that helps him pay his med school debt. What basic principle of ethics might this violates? A- his autonomous- this is a little different, right? Because it's you have to put it in the context of patient care: A- autonomy, B- beneficence, C- non maleficence, and D- justice.

26:29

A couple answers so- sorry. So the answer here... So, I think this, some people had a different answer. And I think this is kind of a tricky question to think about. Some people, yes, some people said non, non-maleficence. But, so, the reason here is right, so, so that whatever you do is directly supposed to be of benefit to your patients. And surely beneficence means that it's purely a kindness without any stipulation, right? So here the person is encouraging the treatment in order for him to have benefit rather than the patient's benefit. Non-maleficence would mean that, is there going to be some harm?

It's not clear that there's going to be harm but it's a bit it's still a violation of beneficence in that you're not truly doing which would be of benefit to your to your patients. So that so it's a nuanced answer to this question.

27:50

Patient is in dire need of substance use disorder treatment, and she has no insurance. She comes to you with an insurance card belonging to her adult daughter and asks you to file a Medicaid claim in her daughter's name. If you knowingly collaborate with your patient, this action would be A- an act of kindness and acceptable, B- collusion and fraudulence. C- permissible under Medicaid regulations, because it is her daughter's card, or D- an act of beneficence and therefore ethical.

28:27

Waiting for someone to answer in the chat. I just have to tell you that I had a funny situation about a year ago where a patient asked me to write a prescription for an antibiotic for their dog or their pets. So that was even beyond asking to write for their child. And I've actually had someone ask even for a spouse whether I would write an order for them in their name because their insurance copay would be less. Clearly that I mean, the easy answer is that this would be fraudulent, right? So you can't do something that's fraudulent and that outweighs anything that you think would be helpful or you're just trying to be kind is that you can't do something that's fraudulent especially because writing that would be break- breaking, potentially a federal law and writing it because Medicaid is a federal program that's assigned to states. So please don't do anything that would be fraudulent.

29:38

Non medical criteria such as ability to pay, social worth, perceived obstacles to treatment, patient contribution to illness or past use of resources should not be considered when determining the care patient receives. And this is in the AMA code of ethics. The ethical principle that most guide the previous statement in the AMA's code of ethics is which one of the following... I'll just say that the AMA's code of ethics. So, in the ASAM Handbook of Addiction Medicine, I clearly delineate the AMA code of ethics. So this is within the realm of Addiction Medicine. And the choices are: A- justice, B- fidelity, C- beneficence or D- autonomy. I'm looking to see if anybody answers. I won't put anybody on the spot. Okay, we got some answers. And people are right, so indeed it is A that's just straight, we should think about how we treat patients based on situation not all those other qualifiers.

31:03

So this is a long one, with a question on the next page. So JW is a 42 year old internal medicine physician who works in a large multi-specialty clinic in a small town. His wife works in the clinic as a part time nurse for another physician. He describes himself as a dedicated physician who spends more time with his patients than is the norm. He feels stretched by the conflicts between keeping the practice financially viable and good patient care. The staff of the clinic report that he's always had difficulties keeping up with his paperwork. In the past year, however, he has adopted the habit of working late to catch up with paperwork. In the past several months, his staff noticed that his mood has become more erratic, alternating between isolation and periods of gregarious talkativeness.

Although it seems like that's kind of repetitive. Late one afternoon the practice administrator receives a call from a local pharmacy. The pharmacist is concerned about the number of prescriptions JW is writing for controlled substances. Apparently the sub- prescriptions were written for his elderly mother.

32:17

What is the best course of action to investigate concerns about JW's prescribing? The choices are: A- call the Drug Enforcement Administration or DEA B- discuss the sit- the situation with JW's wife, C- go directly to JW and ask him to explain the situation, or D- call the state physician health program and ask for more advice. It looks like all the people who volunteer their answer have chosen D. And that's correct. So, so and I've been involved and assisted the board of physicians on multiple occasions in terms of physicians who... there are questions about their use of substances. And it's actually in, in at the state level, I think in virtually every state I've... most experienced here in Maryland, it has done very well and compassionately.

33:19

A is definitely I would definitely not call the DEA and there's no reason to discuss it with his wife. Probably if I was a clinician in the practice with JW, I would not want to know more about his problems keeping up then this specific situation and calling the state physician health program is always safe because they'll give you advice. They won't initially ask you the name of the position you just explain the situation as it was stated in the question and receive advice on what to do next.

33:59

And this is a continuation. The practice administrator speaks confidential- confidentially to JW and discovers that he suffers from a substance use disorder. He refers JW for further evaluation and treatment. In needing to ensure coverage for JW's patients, what should the practice administrator tell his physician colleagues about JW's diagnosis and prognosis?

34:26

A- that there's nothing to worry about and that JW will be able to resume his practice immediately upon completion of treatment for mental illness. B- that JW's prognosis is good but the practice should immediately tell all staff about his problems they can observe him after returning from treatment. C- that JW is on medical leave. That his prognosis with appropriate treatment is good and his medical condition and diagnosis is a private matter, or D that JW's prognosis is good as long as he complies with all aspects of continued monitoring for substance use disorder. Everybody in the chat has put C and clearly that's correct. And that that'd be the correct answer no matter what the problem was right? That it's the... medical diagnosis should always be confidential. And this is always the right answer, no matter what the process, no matter what the reason is for medical leave.

35:28

There's a lot of questions here on potentially impaired health care providers. You walk into the

There's a lot of questions here on potentially impaired health care providers. You walk into the surgical dressing room, and you smell alcohol on the breath of a surgeon. You know that he is scheduled to do a major abdominal procedure the next day. Your best immediate course of action is to: A- say nothing and watch for further evidence of substance use, B- report the incident to the hospital's impaired physician committee, C- call the physician's wife to ask if he has a drinking problem, or D- report the incident to the chief of psychiatry.

36:03

And all the people in the chat who put it at answer, B. I should say that, in general, hospitals all have a committee. If you're not sure where to speak to somebody, I would speak to a hospital administrator without revealing much just to find out who to speak to, and then certainly take action from there. And these committees are are meant to certainly be compassionate toward the physician, but also obviously to protect patients at the same time. Again, the answer is report the incident to the hospital's impaired physician committee.

36:47

And Dr. Fingerhood. There was a question about the previous one. Dr. Jenner was asking, "Why is it appropriate to share the prognosis-" of not this one, the one before it? So JW's case?

37:02

I'm sorry. Anyway, I think you're right. I, I agree with you. I would say that's perhaps the answer should be that JW is on medical leave. And that his mental condition and diagnosis is a private matter. So I think you're right, we didn't need that little phrase. I wouldn't use that middle phrase, perhaps even unless the person said it was okay. So I agree with you. That's that seems to be the best answer. But perhaps the better answer would be C without that middle phrase. So thank you for saying that.

37:51

So that's great that you paid attention to that. A physician learns that a pharmacist has been stealing medications from work. He is employed at a regional US retail pharmacy chain. Pharmacist has taken two pills from every alprazolam prescription filled over the past two months, and has sold them for recreational use. Which of the following is the most appropriate initial step by the physician?

38:19

And the choices are A- confront the pharmacist with the allegation, just scrolling down the chat, sorry. B- contact a lawyer about risk liability, C- report the pharmacist to the head office of the pharmacy chain or D- report the pharmacist to law- law enforcement authorities. And in the chat people have all voted for D and that is the correct answer here. Right. This is now a legal issue related to the

pharmacist so it's up to legal- federal law enforcement authorities to decide what they want to do or how they want to address it. But we're worried about a legal issue here. I wouldn't directly confront the pharmacist in this type of situation since it's a legal issue.

39:17

We're doing okay for time. The primary set of federal regulations that places all substances, which are in some manner regulated under existing federal law into one of five schedules were set in which law? I'm going to go through the answers but I'm going to qualify them. A- the Pure Food and Drug Act, B- the Harrison Narcotics Act. C-the Marijuana Tax Act or D- the Controlled Substance Act. So there's a little bit of trickery here. So people voted for D. The answer actually there is the Harrison Narcotic Act which said that medications would be restricted. And this is over 100 years old- that specifically looked at restrictions of opioids, right? We didn't have- 100 years ago, there were no benzodiazepines, or barbiturates. And it was really meant to limit opioids at that point.

40:15

And until the Harrison Narcotic Act of 1914, that, that, for instance, if an individual walked into your office and said, "I'm in opiate withdrawal," you could actually prescribe them morphine and say here, we're going to help you with your opioid use disorder, although that wouldn't be the term you're- help you with withdrawal. And you're going to use this tincture opium.

40:39

There is no- the other acts that are listed there. They don't exist. So just be aware that even though it seems like there would be a Controlled Substance Act, there is no Controlled Substances Act. So so it's, perhaps the thought is, is that there's, there's, and we'll talk more about this, the scheduling of drugs, sched- and we'll talk in a second, but schedule one drugs that are that are thought not to have therapeutic use. And there's argument now as to whether they're truly schedule one or not. And then risk potential puts them in two, three and four, or five. So there's a predecessor to the DEA but those- scheduling didn't even come out to come to be until the 1960s. But that was through the predecessor to the DEA and then the DEA. But that's where it actually comes from the original Narrison Narcotics Act.

41:43

And this is going to get into the different scheduling. A 32... So, there is- someone commented again, there is there was no specific Controlled Substances Act that was created. So, so the the reason that they were scheduled in the first place, though, was actually through the act - of the for the common for us - through the Harrison narcotics act.

42:14

A 32 year old woman presents to the clinic for her monthly visit and medication refill. She has been adherent with her medication has had appropriate random urine drug screens, and there have never been any concerns regarding pill shopping, or diversion, according to the PDMP, or prescription drug

been any concerns regarding pill shopping, or diversion, according to the PDMP, or prescription drug monitoring program. At the end of her visit, the clinician provides you with a triplicate prescription, under which schedule does this medication most likely fall. Just realize that for most of us, we're doing electronics prescriptions. So this might be a little bit of an antiquated question, but there are settings where there are still triplicate prescriptions on the schedule... The answers are A- schedule one, B- schedule two, C- schedule three. And D- schedule four. Schedule one again is, for instance, heroin, cannabis. Schedule two are things that are generally opioids of highest risk. phenol, oxycodone, morphine. Hydrocodone was moved to schedule two. Schedule three, again, are medications lower risk than the opioids I mentioned and schedule four are things like cough medicine with codeine. And look at the answer. So everybody says schedule two, right. So so it's it means that it's scheduled drugs that have the highest risk of misuse. And they're the ones that I- I just mentioned.

43:56

What is expected to be the most significant effect of the Affordable Care Act on the treatment of substance use disorders. A- increase in the number of patients with addiction eligible for specialty care, B- increase in block grants, funding for specialty care program, C- expansion of insurance benefits to cover prevention, early intervention for medically harmful substance use, and D- increase in the number of providers who prescribe buprenorphine/naloxone?

44:41

And people put in the chat put C- expansion of insurance benefits of covered prevention, early intervention in medically harmful substance use and indeed it attempted to- there are certainly more people who even could have insurance through Medicaid, expansion as well, and provided the first time inclusion in a better way of prevention.

45:06

On the previous question I didn't write there are some questions still. So I'm gonna ask Giulia, because I didn't write the previous question, to find out from the person who wrote it related to the scheduling of drugs.

45:19

Ah, is it the scheduling or is it the Harrison Narcotics Act?

45:22

Yes. So my understanding is that the Harrison Narcotics Act as the one that initially stated that there had to be, you know, that that clari- that stated that's only certain medications could be prescribed, but I'm going to ask the question, who wrote that question? Giulia.

45:42
So I actually have the reference pulled up in the answer. So I can clarify that a little bit.

45:48
That's what I thought. So would you put the reference?

45:51
So Oh, no, I didn't share it in the chat. But I can share it in- that I think that the key is that the question was just asking, essentially, how did we identify the substances to be scheduled in the future? So the question...

46:04
Yeah, so I understand what people are saying. So perhaps the question should be worded better?

46:09
Yes, the question should be worded better. It's worded confusingly. But y'all were correct. So the Harrison Narcotics Act essentially created the legal versus illegal substances, and then the Controlled Substances Act- Act of 1970 actually put them into schedules. So-

46:25
It's wrapped in a way but the question should be better.

46:28
Yes. The question is just worded confusingly. Hopefully, though, feedback that we have from the ABPM and the AOA is that none of the questions on the actual exam will be meant to confuse you, so they should be a little bit clearer. But I think that one was created by our faculty more just to go through each of the different actions. Yeah. Okay. So to help. But yes, so the Harrison Narcotics Act first created this sort of idea of legal versus illegal substances and made it more contained, and then the Controlled Substances Act of 1970, then actually put them into schedule. Yeah. So I'll put those links in there as well.

47:05
And thank you for your comments from the...

47:13

Regulations concerning the privacy of medical records 42 Code of Federal Regulations, Part Two, people refer to CFR, are to govern the management and disclosure of any information related to screening, identification, treatment, or referral to treatment of patients with an alcohol or drug use disorder. Which of the following circumstances allows disclosure of information covered by 42 CFR Part Two, without the patient's written authorization? I'll just put the background to this question. There's a lot of question of whether 42 CFR perpetuates stigma of patients with substance use disorders. And there's always been calls to find ways to amend 42 CFR.

47:55

But here are the answers. A- the information is requested by the patient's immediate next of kin. B- the patient is a minor unable to provide consent, C- a request from a police officer investigating a motor vehicle collision, or D- use for chart audits for quality improvement activities within the same facility. So in this instance, on this question, yes, people put the answer, and it's more knowing what's not right. Than knowing, I think that perhaps what is right, because that's how I would view this question, knowing that what you can't do and then you're left kind of with which one you could do. And people all said D, yeah, so obviously, confidentiality. So it's easy to know that regardless of what the medical problem is, A can't be correct. And B doesn't seem right. And even so all these perhaps would be incorrect, no matter what that situation would be. And so in this instance, right, it'd be for something that is does not in any way, cause patient harm or breach confidentiality. And I assume that the chart audit would then eventually use de-identified data.

49:24

And this comes up actually a fair amount in my circumstance, which of the following meets the definition of a program, according to 42 CFR Part Two? A- a paramedic called to the scene of a non fatal drug overdose who administers Naloxone, B- the physician to whom a non fatal overdose victim is brought during the course of a typical emergency department episode of care. C- a psychiatrist performing consultation services in a hospital ICU, or D- a physician who primarily works in substance disorder diagnosis and treatment center within a general medical facility. And looks like everybody chose D. And that's correct.

50:11

So the situation that's sometimes up, for instance, I'd mentioned at the beginning that I take care of patients in primary care who have substance disorder, and that's different, right? So I'm providing overall health care. But I don't have a special- specialized program that I'm providing primary care to my patients who have alcohol use disorder, or opioid use disorder. And I'm addressing that as I'm addressing their other health problems. So we actually as the unique setting where I take care of patients, we actually are able to, indeed have a legal review to say that we did not meet the definition of under 42 CFR Part Two as a program, because we're providing clinical care.

51:00

And this is a very specific answer. So I was I asked Giulia about this, this question, I'll read it to you.

What 1976 court case established, that correctional authorities are expected to reasonably assess and treat the medical needs of people whom they incarcerate and the answers are A- Gideon v. Wainwright, B- Shorley v. Sidelis? C. Collar v. Kansas. And D. Estelle v. Gamble, looks like everybody knew the answer. So Giulia has told me that there are three court cases that are that people are expected to know. And maybe Giulia, you can set you can let people know the other two, if you can. And the answer is D, Estelle v. Gamble. And it is really important to realize. And this has come about as for instance, here in Maryland, we had a law passed that all correctional facilities must offer medications for opioid use disorder. And that a substance use disorder meets the definition under this court case of medical needs of people. Because unfortunately, in many settings, substance use disorder has been separated out from other medical needs, and that is incorrect.

52:33

I think, like, I finished a few minutes early, and so if there are other comments or other things that you want to tell us... from people or Giulia, are you able to somehow add in the other cases at some point?

52:50

Yeah, I'm actually looking for them right now. Off the top of my head, I know, the Gideon case was one to cite. So for reference, we don't get access to the actual questions to the exam. But we do get comments from folks that have taken the exam and other faculty members that have worked on these things. And so I just know, pretty much anytime anybody shares any insight, I know that and try to bring it into these office hours in the course in some way. So I know the Gideon case is one that's good to know, I know Tarasoff is really good to know. But I will find the rest of the cases. And I'll make sure to add it either into our next office hour. Or send it as an email to everyone. But I'm trying to pull them up right now. In the meantime...

53:32

I'll just add, as somebody who has taken the exam that just that's just the past, in that you can pass the exam easily without knowing trivia. So if you can just know how to take care of patients, you'll do fine. Because I remember there were I think it was one court case. And then this is not my topic today. But genetics, I think there were like three things to memorize about genetic alleles that that predispose or have a role in addiction, and I memorize those three and there's one question that asked about, but again, I'm gonna emphasize that if you're taking the board exam, you can pass without knowing trivia, or like, a very specific back like that last question.

54:16

Yes, and I'm also typing into the chat now, the sort of explanation in the differentiation between the Harrison Act and other controlled substance acts with the with the references in there.

54:27

Okay, that's great.

Okay, that's great.

54:34

In the meantime, are there any additional questions if anybody wants to unmute and chime in?

54:45

So I was gonna ask if we can also have a section for epidemiology in subsequent meetings?

54:54

Yes, epidemiology. So actually great timing. I believe it's either next week or the week after we're gonna have Dr. Leslie Hayes who will be covering pregnancy, newborns, but also go over all the epidemiological concepts. So we do have that scheduled. And I am hoping, I know that there's a couple of sort of like shorthand tricks that Dr. DeVido used for his presentation and kind of taught you how to work through certain problems. So I'm going to try to put that together as a handout also. So you can all have that as a tool.

55:30

So Giulia, put a good comment. And you know, such so the I'll just say that. So the interpretation by the Supreme Court was late later, a physician named Linder, L-i-n-d-e-r, then sued, claiming Linder v. the US, actually, that claiming that the United States should not be- to have an act that impacts the practice of medicine. And Dr. Linder lost, so that was really the interpretation of the Supreme Court case.

56:07

And then I just threw in the definition of the Controlled Substances Act and the link to that as well. And yeah, just stay tuned. Next week, I will pull back, I'll figure out the three cases that were mentioned and bring that into next week. And so stay tuned for that recording, or for the actual live session. And then, just to note, as well, we had a question earlier about some of the questions not being directly related to addiction medicine. And it was just a tip that we got from previous learners and from faculty that sometimes you might be quizzed on items that are not directly or obviously related to addiction, but that relate to effective patient care in that population. So either like pain- treatment of pain or treatment of something like HIV, or Hep C or something like that. So it's not directly an Addiction Medicine topic, but it often impacts the patients.

57:02

Yes, so that's correct. And I can tell you from what I took the exam that there was a question, specifically to Hep C treatment. Right? So that's correct. So there'll be- it's indirect to addiction.

57:16
All right.

57:17
So I have, I have a question on statistics, sensitivity, specificity...

57:25
Yeah, so that will go... Sorry, I can't remember if it's week nine or week 10. But we will have that in the epidemiology session. And then as I as I mentioned, I've collected a lot of sort of like shorthand, things that can help you with that. And so I'll try to compile that into a handout as well. So y'all can have that. And if you could hear- you talked about your Brooklyn accent you can hear my y'all from the South coming through every time. All right, I think this is it. So thank you all so much for watching, and thank you, Dr. Michael Fingerhood for being here with us today. Thank you.