M.D. NEWS

Special Medical Feature

Q and A with P. S. Kishore, M.D.

Rapidly Growing Primary Care Model Is Key to Addiction Treatment and Sobriety Maintenance

By Michael Jones

It has been a little over a year since we last talked to Punyamurtula S. Kishore, M.D., about his unique methods of treating addiction. In that time, his network of primary care addiction treatment centers has mushroomed to 17 locations across the state, and his patient volume has more than doubled. There are plans for still greater expansion in the coming year.

So we decided it was time for an update. We met with Dr. Kishhore in the conference room of a new location he has recently opened in Brookline, started the tape rolling and captured his views on a wide range of addiction issues that offer fascinating food for thought for anyone in the medical community.

You've been known to refer to your patients as "accidental tourists." What do you mean by that?

There is an old saying: "All roads lead to Rome." People come to addiction via many different roads. Alcohol and drugs are used for 101 reasons. But once addiction sets in, all addicted individuals behave similarly. Addiction can happen at any time during the lifespan, from a very young age to senescence. It could happen the very first time you use, or it could happen at the 10,000th time. All of us have the potential to become addicted to chemicals, physiological processes and other processes such as gambling and the Internet. Science is still in its infancy where it comes to causality.

Punyamurtula S. Kishore, M.D., M.P.H.

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You seem to believe there are significant deficiencies in the way the traditional medical community, particularly the insurance companies, view addiction. Can you elaborate a little bit on that?

In the past, addiction was considered a willful self-destructive behavior. There was no insurance reimbursement for addiction treatment until the late 1970s. Once addiction was decriminalized, the $64,000 question then became whether it is a mental health issue, a medical issue or a social issue. Basically people were going from pillar to post to get their care. Patients sought out psychiatrists, psychotherapists, counselors, social workers or joined AA groups, usually without any coordination of their care. In reality, addiction should be treated in the primary care system. Pioneers such as Drs. David C. Lewis at Brown University and A. Thomas McLellan at University of Pennsylvania currently are strong proponents of this model. This is what I adopted in my practice.

> With addiction, we are now where we were with diabetes in the 1920s, or cancer in the 1970s. You have to observe the natural history of the disease, and learn from that.
>
> — Punyamurtula S. Kishore, M.D.

Can you explain some of the ways a patient's life is affected when they become addicted?

Human beings have four dimensions to their lives. They are the physical, the psychological, the social and the spiritual. Unfortunately, addiction corrodes and corrupts all of these dimensions. Physically they are ill, psychologically they are hurt and traumatized, socially they are outcasts in many ways and spiritually they may be bankrupt. To treat this kind of a smorgasbord of problems, you need multiple disciplines. Not only that, it has to be done in a cost-effective way. The difficulties are that there still are not enough providers with the necessary skills. There is also not an agreement on what is a good model of care. Consensus is evolving that addiction should be treated as a chronic disease rather than looking for finite cures.

Can you explain what you see as the problem with Methadone as a treatment method?

It is not so much that Methadone is good or bad. It's the system that has evolved around it. We need Methadone. It is a medicine. There are some people whose damage has been such that they need a maintenance medication. The process whereby people have to go every day to pick up the medicine is not humane. Without checks and balances, however, the system can degrade very easily. Only about 18 percent of the patient population on Methadone actually stays true to maintenance modality. Many use other illicit and prescription drugs along with Methadone. It is a good drug, but there has to be good case matching and case management.

Who is the better candidate for Methadone?

Studies show that Methadone is a good drug for people above 39 years of age, for pregnant, addicted women, and pain and addiction cases. It's a good drug for people who really have spent up to a decade or more in various programs without successful abstinence. For the younger patients it may not be appropriate.

You stress the crucial role of family in any kind of recovery plan. Can you talk a little bit about the importance of family?

Addiction is a family disease and a community disease. When somebody is addicted and they get sick, it is the family that sees the suffering. They tend to enable them to continue their substance use out of genuine concern. In fact, they become "codependent" on the sick person. When the time comes and the crisis really hits home, they come to the ER, the Detox Center or to a doctor like me. We then not only have to undo the damage done to this person from addiction, but often also the enabling behaviors that the families adopted. Unless we take on the whole family, true recovery does not happen.

Is this why you are such a strong proponent of home detoxification?

The advantage of home detoxification is that a lot of the cues and triggers are at the home. By abstaining in the home environment, they begin the process of extinguishing those cues.

We found that once we started training and teaching our staff, patients did really well and began to use us for regular medical care.

PHOTO BY DEBRA TROYANOS

The Science of Addiction

William M. Burke, M.D., who works with Dr. Kishore helping orient new staff for the practice and reviewing the latest literature on addiction treatment, believes that the science of addiction is being helped by recent advances in our understanding of neuroscience.

"There is a better understanding now of the architecture of the brain," he says, "although it's really at the beginning stages. There are now ways to understand how using one drug can make you more likely to use another drug, because the brain may interpret the stimulation of common neural pathways by different drugs as the same thing."

There has been a long time interest in the possible role of pharmacotherapy in the treatment of addictions, a trend that Dr. Burke traces back to the development of Antabuse in the 1940s.

The improved level of understanding about how the brain works has renewed interest in the role of pharmacotherapy in the treatment of addictions and stimulated a robust research effort that already has led to the development of new pharmacological modalities as adjuncts in the treatment of addiction. In fact, there is research being carried now to see if Antabuse can be used in the treatment of cocaine addiction.

There now is also great potential in studying the activity of the brain using PET scans that can show precisely which areas of the brain are active, when certain substances are taken by an addict.

But for all the pharmacological and technological advances that have been made, Dr. Burke emphasizes that there is more to treating addiction than merely prescribing medication.

"The people who have developed the pharmacological approaches come back to the thinking that there is more to treating addictions than just fooling around with receptors," he says. "They have recognized the importance of psycho-social behavioral supportive therapies that must accompany pharmacotherapy."

He cites a study performed decades ago in England that found that, even a relatively small amount of education on the subject of addiction, along with the involvement of family members, helped a sample group of alcoholics to stay sober as compared to a group that was just given medication with no educational intervention.

Dr. Burke has been following research that is being conducted in the areas of public health- and community-oriented primary care that are at the heart of Dr. Kishore's treatment model. The evidence strongly suggests that there has to be more that just a medical response to the problem.

"Addiction is very complex," he says. "It's not like an uncomplicated acute medical or surgical problem where, in many cases, the technical aspects of care may be more important than phycho-social support provided. Addiction is a chronic relapsing problem that requires long-term care. There always has to be a psycho-social support system in place when addictions are being treated."

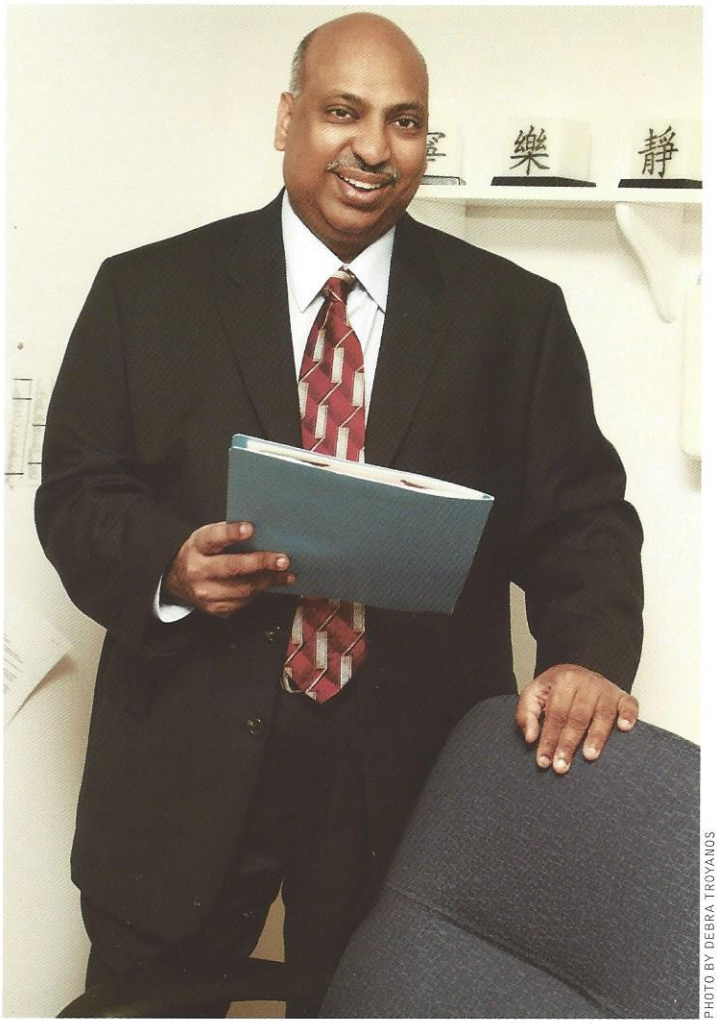
No doubt Dr. Kishore would concur.

You also mentioned that treatment works, even if the patient is not willing. The traditional myth has always been that the patient has got to hit rock bottom and has to feel the need themselves to seek recovery. But you're saying that's not necessarily the case?

Not at all. Somebody has to take an activist role. The addicted person cannot make sensible choices. A physician has to motivate and start the process. For a patient to hit rock bottom takes a long time and is not necessary.

You received your medical degree and early training in India. Could you talk a little bit about how you think that background has impacted the way you treat people here in the United States?

United States health care is geared to be a curative system. Preventive health is more of an Eastern concept. We need both sides of the equation to treat addiction. By using acupuncture and yoga alongside pharmacotherapy with drugs such as Naltrexone and Camprosate, we prolong the odds of relapse from happening. I would say that my education at Harvard School of Public Health is instrumental in my adopting this public health model. To be a good addictionologist you need to have 18 to 20 disciplines under your belt. You must be a good primary care doctor, you must be good with behavioral sciences, you must know toxicology, clinical pharmacology, psychology, you have to know social sciences and



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you have to know the law. How you manage your time and resources is critical. Otherwise, with the multiple needs this clientele has, you cannot manage the cases effectively. In business we say, in order to win the game, you must know the rules. And to win the complex game of addiction, you must have competencies in many specialties.

A large part of your philosophy involves destigmatizing addiction. Do you think we're making progress within the medical community?

Addiction is essentially a primary care illness. Every primary care doctor sees the gamut of problems, whether it be coughs, colds, bronchitis or irregular heartbeat. Alcoholism and drug addiction should be seen as part of this constellation. Asthma, diabetes, hypertension and addictions should all be treated with the same vigor. To do that, we have to get the primary care physicians to take on the challenges of treating addictions. We have to think in terms of disease management. With addiction we are now where we were with diabetes in the 1920s and cancer care in the 1970s. Hopefully methods available for office based addiction treatment will improve with time.

Let's talk a little bit about your practice, which is growing rapidly. Can you tell us a little about your growth strategy, and perhaps what your plans are for the future?

We started out in a small office in Brighton in 1996. Right now we have 17 centers across the state. What we have noticed is that people are looking for a service like this, where they can come and get help through a regular doctor's office. Managed care likes it too, partly because it is cost-effective. We found that once we started training and teaching our staff, patients did really well and began to use us for regular medical care. We are building a model that is consumer and community responsive.

So there are some 300 or more towns in Massachusetts. Does that mean that you can envision maybe 60 or 70 of these clinics?

If need be. Alcohol and drugs are here to stay. We need practices that are allied with local public health departments to ensure not only treatment, but also engage in prevention.

You invested tens of thousands of dollars of your own money to start the National Library of Addictions. Can you elaborate upon the National Library of Addictions as a resource, and what this resource means to your patients?

The Business of Addiction

Pharrel S. Wener, Chief Operating Officer of Medical Business Management Limited of Boston, states that addiction treatment has become a huge industry. "What Dr. Kishore has done is to bring quality care to John Q. Public," said Mr. Wener. "Two-thousand-eight-hundred dollars for a year's worth of care, compared with roughly $10,000 for a three-day inpatient detox makes a compelling case that patients, physicians and insurance companies can all relate to."

Substance abuse is a growing part of the health care industry, and Dr. Kishore expects the major growth area to be in sober living communities. "We already have Sober High Schools and Sober Colleges. Sober Housing will be the next step," said Dr. Kishore. With the growing demand and an overstressed health care system, this model could point the way to the future.

The National Library of Addictions was founded as an information source for patients and their families. At the NLA, we sponsor an educational lecture series, facilitate grant administration for addictions research, encourage volunteer services for the recovery community, serve as an addiction law center, sponsor events and awards and host various recovery support groups. Through activities such as these, we aim to provide the community with information to understand addictions, and ultimately bridge the gap between academic health care and the needs of the local community. Through this nonprofit foundation, physicians and allied practitioners can access our Core Curriculum Training Program for free by indicating an interest.

For more information on Dr. Kishore's Preventive Medicine Treatment Centers, please either call (800) 770-1904, e-mail psk@pmai.net or visit www.homedetox.net. ■

The Home Detox Program that Dr. Kishore has pioneered allows patients to continue with their work lives and visit the clinic at the end of the day.

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