# Addiction medicine

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***Professor Ross McCormick*** *is Director of the Goodfellow Unit, University of Auckland. He is immediate past chair of the New Zealand branch of the Chapter of Addiction Medicine, RACP. His research and teaching is primarily in the field of primary care provider behaviour in relation to the detection and management of inappropriate drug and alcohol use. He was the recipient of the 2004 Gary Harrison memorial scholarship awarded by the Alcohol Advisory Council of New Zealand. Ross steps down as Goodfellow Unit Director in January next year to become Associate Dean Postgraduate Faculty of Medical and Health Sciences, University of Auckland. The university will shortly be advertising for his successor as Director.*

General practice is probably the toughest of all specialities. Mind you, I didn't think that when I started in my 1979 Parnell practice. My first five years were new and exciting and the next five were *'Hey I'm getting good at this'*. But by the time I reached 15 years out of medical school I was starting to think, *'What comes next?'*

My 1979 practice was an inner city practice before Parnell became yuppified. There were lots of drug-seeking patients and my predecessor had about 100 addicts on his books. They were an interesting and rather diverse group and I struggled trying to manage their many problems, let alone their frequent requests for drugs of abuse. Odyssey House was just being established around the corner from my practice so, in what became typical of the serendipitous nature of my career, I said yes when they asked if I would be their visiting doctor. They were an abstinence-based drug and alcohol treatment clinic.

My learning about addictions began with this experience and through mentorship from leading addiction specialists, in particular Dr Fraser McDonald. When I think back to my time with Odyssey House, later with Higher Ground (another residential clinic), and still later as a methadone prescriber, I would say it was both a continuous learning experience about how to be an addiction specialist and it was also pure general practice.

Can it be both? Oh yes – the principles of general practice are more important when dealing with addicted patients than ever. Knowledge of the patient and their family, continuity of care, good communication skills, empathy, listening, quiet determination, setting boundaries, knowledge of the community and relationship building all spring to mind. The differences from traditional general practice are that the doctor can be part of the problem if you prescribe too freely, that your patient may not see being addicted as quite the problem that we may, and that there is a higher incidence of some specific medical and psychiatric problems.

Some of my biggest highs in medicine have come in this field. The young girl in Odyssey who wouldn't look me in the eye or let me examine more than her eyes and ears but who six months later bounced down the stairs with a cheery *'Gidday doc'*, or being a very junior member of an early 1980s' committee which discussed setting up needle and syringe exchange schemes because of the coming HIV epidemic. I'm not sure whether what I said contributed to their establishment, but the low rate of HIV amongst New Zealand drug addicts makes me feel that being there was well worthwhile.

As the years moved by I returned to academia. Teaching and researching how to manage problem use of alcohol and drug addiction in primary care was an obvious direction. Serendipity again.

In about 2000, the Royal Australasian College of Physicians set up the Chapter of Addiction Medicine and invited existing addiction specialists to apply to be grand-parented. By then my clinical experience, research, medico-political activities and teaching met all the criteria, so suddenly I was a member of two colleges. The only trouble was it meant paying two sets of college fees.

What do I do now? Well I appear in court on issues where drug use or alcohol use may be a feature, e.g. a recent employment court argument between a union and their employer about drug testing in the workplace, or a recent high profile rape trial (pure theatre that one). I assess impaired professionals for various regulatory bodies. I teach a postgraduate course called *'Biology of addiction'* which is a mixture of neurophysiology, anatomy and psychology, I go

to major overseas conferences about research on alcohol issues, I am medical advisor to the Australasian Association of Brewers and I supply advice (wanted and unwanted) to government agencies. And, of course, I keep churning out papers because that is what academics do – publish or perish – but more because they are fun to write; I'm still idealistic enough to want to make a difference.

Accreditation is a problem. In the Chapter of Addiction Medicine we all do our 'Parent College's' re-accreditation programme. That's fine, but the RNZCGP programme is devoted to the generalist general practitioner and so it should. Even worse, this is the last year I can say, *'Yes, I've worked 10 half days a year in general practice'* – (not much is it!) – so after this year I've got a problem. Maybe I'll have to switch to the RACP programme, which appears more flexible and whose new version appears devoted to self identification of learning needs and showing how you address them.

Tony wanted comment about credibility and competing with specialists. To be blunt, if you are specialised you are a specialist. To quote an ex North Health manager of mine: *'If you want to be a Rangitira act like a Rangitira.'* So once you have the specialised training, research, teaching, clinical experience and political action under your belt, just get out there and do it, but with one huge caveat: you need support from your college and peers. Just remember you are the last port of call so you can't make a mistake – any doubts (and make sure you have plenty of them), go and talk with a colleague, after all a problem shared is a problem half solved. And you must keep up-to-date with the literature in your field.

What happened to my general practice? Well I sold my Parnell practice in 1996 and, until recently, worked one evening a week out in West Auckland. But general practice is tough – that's how this article started – the politicians are always interfering, you need to know too much about too many topics and no-one wants to pay general practice's tiny fees. *'How much for the drug assessment doc?' '$315'. 'Sure, here you are.'* A GP can only dream of that.

But, having said all that, I look back on my 32 years in general practice as one continuous learning experience and a great way to live and work. My general practice background makes me a far better academic and much better as an addiction specialist. I sit and have a conversation with an anxious impaired professional, dead scared that their job is on the line and, at the end of the hour or so, they are much more relaxed and can see hope on the horizon. Can you do that without general practice training? No way.

## Competing interests

None declared.