

Meet Richard Saitz, M.D., MPH



Richard Saitz, M.D., MPH, is a professor of medicine and epidemiology at Boston University, and also primary care physician and director of the Clinical Addiction Research and Education (CARE) Unit in the Section of General Internal Medicine at Boston Medical Center. Dr. Saitz recently won the RSA Distinguished Researcher Award at the Research Society on Alcoholism's annual meeting in June 2012 in San Francisco, California.

Writer Sherry Wasilow interviewed Dr. Saitz from his office at Boston University.

SW: How did you begin your work in the field of alcohol studies?

RS: I trained as a resident physician in the late 80s at Boston City Hospital, which was an urban, public hospital. We saw many patients living with the consequences of alcoholism—like liver disease, seizures, internal bleeding, and pancreatitis. I learned how to take care of those medical conditions, but not their cause.

At that time, my colleagues were excited about advances in heart-disease treatment and were always citing the latest research as a basis for their care. I thought it surprising that we were ignoring the cause of some of the most common illnesses we saw, and were not basing our treatment on high-quality research. It was then I decided I wanted to address caring for the health consequences of alcoholism, and base that care on well-done, applicable research studies.

SW: How did this decision lead you to your current research focus?

RS: I started with studying a common problem in hospitalized medical patients: alcohol withdrawal. Standard treatment at the time – medication every six hours for three days regardless of what was going on with the patient – made no sense to me ... it gave too much medication to some and not enough to others. My first study found that giving medication according to symptoms gave the right amount and took less time. It is now standard practice for managing alcohol withdrawal.

Soon I became interested in people who either had problems from drinking *without* a diagnosis of alcoholism, or were drinking so much they were putting themselves at risk for harm. There are many more such people in the population than there are people with alcoholism. Many of them are seeing physicians but are not receiving advice or care for their alcohol-related health risks; they have never seen alcohol-treatment specialists, let alone entered a treatment program. Those realizations shaped the next two decades of my research.

I began studying questionnaires that could identify risky alcohol use but were brief enough to be used in general healthcare settings. Then I studied whether brief counselling could work for people identified by those questions in terms of decreasing or preventing consequences, and whether that sort of clinical practice could be put into place in primary-care settings by primary-care physicians. At the same time, I didn't forget about those with more severe problems. It seemed that people with alcoholism were never taken care of in the regular health system. They were always sent elsewhere, so there were separate records, and to practitioners who were not part of the health system in any meaningful way. This led to very fragmented and poor care when found, even if the specialists they saw were superb. To address this seemingly obvious problem, colleagues and I designed ways to integrate medical, alcoholism, and mental-health care into medical settings, similar to how clinicians care for health problems such as asthma, diabetes, and depression. We tested these methods well before health reform made them popular, finding some successes and some challenges, but I still think it is the best and safest way to deliver care.

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The last key characteristic of my research has been to demand, seek, and be true to what research studies tell us we should do in clinical practice with patients. Many people would be surprised to hear that much health care is not based on evidence, particularly with alcoholism. One recent concern has been to make sure we base our care on research, improve its quality, and get the evidence we need if there isn't any. One example of a practice that has been disseminated far in advance and even contrary to research evidence is called Screening, Brief Intervention, Referral and Treatment (SBIRT) (<http://www.samhsa.gov/prevention/sbirt/>). The concept makes sense, and early identification and brief counselling interventions make sense, and also work in some circumstances. But practice and

dissemination has gone way beyond the evidence, which risks harming patients, wasting resources, or both. We need to discuss the actual scientific findings, however unpopular discussion may be.

SW: What day-to-day applications do you think your research has for both clinicians and non-clinicians?

RS: I think my main contributions to date have been twofold. One, to help clinicians and researchers understand what the research evidence says about practice, and two, perhaps most importantly, to emphasize that we should care about the whole spectrum of what I call *unhealthy alcohol use*. This includes everything from drinking amounts that risk health problems, just like eating habits that risk high cholesterol, to alcoholism and everything in between. Unhealthy alcohol use is the only term that adequately covers the spectrum. The words we use matter, and when all we talk about is alcohol dependence or alcoholism, it restricts the conversation. The use of the word *unhealthy* clarifies we are talking about health and what affects it adversely, like unhealthy diets and unhealthy levels of physical activity. Clinicians can screen for the whole spectrum of unhealthy use with just one question (<http://pubs.niaaa.nih.gov/publications/Practitioner/CliniciansGuide2005/guide.pdf>), briefly counsel patients to reduce/abstain or get further help as needed, and to treat alcoholism as a real medical problem like any other. Clinicians can take care of what they feel capable of, and refer more complex patients to specialists.

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I hope my work helps people get help that is of the highest quality and based on research evidence. They should always ask if the treatment they are getting is the best supported by

research, not just whatever a program happens to offer. Imagine if you had heart disease and went to an emergency room and you were told they didn't believe in surgery, catheterization, or medication and if you wanted one of those you had to go somewhere else? That would be unacceptable. Yet, it still occurs in some alcoholism treatment programs.

SW: What does your recent award – the 2012 Distinguished Researcher Award – mean to you on a personal level?

RS: This award was particularly important to me because the majority of scientists in RSA are basic scientists and I am not. I think this award means that

RSA is open to considering clinical and health services research, and this is important because it means RSA members are interested in both key scientific advances and clinical research findings that will both help patients sooner as well as in the future. And of course, it means recognition by colleagues in my field to whom I have looked up for many years, and have emulated. For that reason it is quite an honor.

SW: What would you like to see happen in the addiction-research field?

RS: I would like to see more scientists from non-traditional areas enter the alcohol-research field. I think that clinicians and researchers who address alcoholism problems are somewhat marginalized. In addition, many scientists in fields like health services research, clinical epidemiology, and other fields have not generally committed to alcoholism research. I would like to see that happen. It also amazes me that the bulk of clinical research is not done with actual people in real-world settings.

For people with alcoholism and at risk of developing it, I would like to see three things happen that will only occur if the research gets there first. One, I would like to see the vast majority of people with these problems receiving care for them, the opposite of the current situation. Second, I would like to see that care occurring largely in general health settings—every physician, nurse, and clinical health professional should know about unhealthy alcohol use, and address it to the best of their abilities with specialized care integrated into the health system. Third, I would like to see discrimination (and stigma) reduced and eliminated for people with unhealthy alcohol use so that they can seek help and receive it without barriers. For this all to happen, research will need to set the foundation. This means funding for research, development of capable scientists who understand pragmatic studies, research on what is effective, and research in settings where people are, not just settings where a minority of people with these problems end up. It also means research that focuses on the whole spectrum of unhealthy use, not just the end-stage disease of alcoholism.

SW: What advice do you have for people now entering addiction research?

RS: First, get a good mentor who can commit to your success. That is the single most important step. Second, build a clear career trajectory in which most of what you do is clearly related to the next steps. Third, leave your comfort zone—get into real clinical settings and communities to study what matters, not what is convenient. Lastly, stay firm; even though research funding is tight and

competitive, I believe work in this area will always be in demand and there will be opportunity for great success, because unhealthy alcohol use is common, costly, and unfortunately, not likely to be addressed completely and successfully anytime soon.

SW: Any last words for the ATTC audience?

RS: I would like to encourage addiction clinicians and educators to integrate their work into the rest of healthcare.

Keeping specialty addiction treatment programs and educational programs separate from the rest of healthcare is an artefact from the last century. If addiction is a health problem, and there is no question that it is, there is no justification for not treating it like one. Other health problems are treated in the health care system, by health-care providers, yet addiction treatment is

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clearly not part of that system; however, not being a part of that system does a disservice to people with addictions and their clinicians. It keeps funding too low and maintains low status, stigma, discrimination, and facilitates more dangerous and poorer quality of care than it could or should be. Addiction specialty care should be no different than getting care for a heart condition or depression. Separate but equal is unacceptable in society, it should be unacceptable for the care of people with addictions.

Additional Links:

- www.bumc.bu.edu/care
- <http://www.bumc.bu.edu/care/faculty/richard-saitz/>