ASAMNEWS

November / December / 1995

New ! ALCOHOL ALERT Inside: see page 8

Newsletter of The American Society of Addiction Medicine

ASAM Board Establishes Managed Care Task Force

Michael M. Miller, M.D.

Responding to members' reports of problems with managed care organizations and processes, the ASAM Board has voted to establish a Task Force on Addiction Care Service Delivery and Financing. The Board created the new task force on the model of its 1993 Task Force on Health Care Reform, which brought together the activities of several ASAM committees to provide a coordinated strategy and action plan for addressing critical and complex issues.

The new task force, to be chaired by Sheila B. Blume, M.D., is expected to interact with a number of ASAM committees, including those on managed care, treatment outcome, practice guidelines, public policy, state chapters, publications, and membership.

Meeting in a strategic planning session in September, the Board heard presentations describing how managed care organizations specializing in "behavioral health" management are contracting with insurance companies, state governments and even some HMOs to assume the financial risk and clinical responsibility for delivering and managing psychiatric and substance abuse services. Presenters estimated that within the past three years, the enrollment in such plans has increased from 60 to 120 million persons.

The Board's concern with this development is that many plans do not accept ASAM Certification as a credential adequate for physician membership in managed care provider panels.

The Board is concerned that many MCOs do not accept ASAM Certification as a credential

Instead, many seek non-physician providers of mental health and addiction services to provide the bulk of patient care, supervised by physicians who are board certified in psychiatry (even without the CAQ in addiction psychiatry). As a result, a growing number of ASAM members report that they are barred from caring for patients with addiction diagnoses.

Issues to be addressed by the task force involve reimbursement practices; addiction care structures, processes, providers and outcomes; and quality of care.

Anticipated activities include defining the range of services that should be covered in an addiction benefit under Medicare, Medicaid and private sector health plans; and collecting data to document the extent to which ASAM members are being excluded from managed care provider panels.

The Board also charged the task force with developing programs to provide direct assistance to ASAM members. These are expected to include helping ASAM members to build their knowledge and skills regarding how to interact with managed entities; teaching them how to use the ASAM Patient Placement Criteria to design and lead delivery systems that offer individually-planned addiction care; and helping ASAM members flourish professionally without having to be financially dependent on institutions that deliver program-driven care.

The task force also will survey ASAM members about their concerns related to addiction care service delivery and financing (see related story, page 9).

(Dr. Miller is Chair of the ASAM Quality Assurance Committee.)

INSIDE

ASAM
American Society
of
Addiction Medicine

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ASAM is a specialty society of physicians concerned about alcoholism and other addictions and who care for persons affected by these illnesses.

ASAM News is an official publication of the American Society of Addiction Medicine, and is published six times a year. Please direct all editorial and advertising inquiries to ASAM News, c/o the ASAM office.

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EXECUTIVE VICE PRESIDENT'S REPORT

BOARD DEDICATES NEW HEADQUARTERS

On September 30, ASAM President David E. Smith, M.D., presided over the official dedication of ASAM's permanent headquarters in suburban Washington, D.C. In dedicating the facility, Dr. Smith said, "On behalf of the members of the American Society of Addiction Medicine and their patients, I dedicate this national ASAM headquarters to serve the mission of the Society, which is to promote compassionate understanding of and expert treatment for persons who suffer from the diseases of alcoholism and other drug dependencies."

Dr. David Smith cuts the red ribbon as members of the ASAM Board of Directors, guests and staff look on. Dr. Smith noted that ASAM is indebted to Dr. Anne Geller, Immediate Past President, during whose Presidency the building purchase was undertaken.

G. Douglas Talbott, M.D., ASAM President-Elect, reviews the guest book with Linda Fernandez, ASAM Assistant Director of Meetings and Conferences.

Executive Vice President and CEO James F. Callahan, D.P.A. (center) welcomes Board member Thomas Payte, M.D. (R), and Treasurer James W. Smith, M.D. (L) to the new ASAM headquarters.

Dr. Smith and Claire Osman, ASAM Director of Development, inspect the "Wall of Honor," featuring portraits of ASAM's past presidents.

While the new offices, which ASAM owns, have been occupied since September 1994, the October Board meeting offered the first opportunity for the entire Board to visit.

COURT DECISION REINS IN ALCOHOL, TOBACCO ADS

A federal court has dealt a setback to alcohol and tobacco industry advertising practices in a case that could go all the way to the U.S. Supreme Court. In an October decision, the U.S. Court of Appeals for the Fourth Circuit affirmed a lower court ruling that the city of Baltimore has the right to restrict outdoor advertising of alcohol and tobacco products. Anheuser-Busch Inc. and Penn Advertising of Baltimore Inc. had challenged the city ordinance prohibiting alcohol advertising on billboards, sides of buildings and freestanding signboards in residential zones. Penn Advertising filed a separate lawsuit protesting the same limits on tobacco advertising. The Baltimore City Council and Mayor Kurt M. Schmoke endorsed the ordinances as measures to curb the influence of alcohol and tobacco advertising messages on underage youth.

The Court said that Baltimore's restriction on billboard advertising was no more extensive than necessary to serve the city's interest in reducing the level of inducements for young people to drink, ruling that the fit between the billboard regulation and the city's interest need not be perfect, but only reasonable. It specifically rejected Anheuser-Busch suggestions of less onerous "alternatives," including stricter enforcement of underage drinking laws and expanded alcohol education programs.

Anheuser-Busch Vice President and Group Executive Stephen K. Lambright immediately announced that the company will appeal the decision to the U.S. Supreme court. "The Fourth Circuit has set a dangerous precedent under which state and local governments can ban any advertising simply on the basis of their belief," he said.

Any judgement in the case at the Supreme Court level could lay the groundwork for municipalities' control over advertising, but getting that far will not be easy. "The chances of getting a Supreme Court review are not great," said Burton Levin, senior city solicitor for Baltimore's Department of Law. Still, Levin said, "other communities that want to enact similar ordinances can turn to this case for the legality of doing just that."

George Hacker of the Center for Science in the Public Interest (CSPI), a national consumer group specializing in health, nutrition, and alcohol policy issues, praised the decision. CSPI had filed a friend-of-the court brief in the case supporting the city of Baltimore's position. Hacker said he expects other communities to follow Baltimore's example by passing their own alcohol billboard control laws. "The decision also should embolden state legislatures and the Congress to impose reasonable restrictions on other forms of alcoholic advertising, including beer advertising on television," he said.

TEEN USE OF MARIJUANA RISES SHARPLY

U.S. teenagers are smoking marijuana at nearly twice the rate they did three years ago, according to a new federal study. Illicit drug use among all Americans remained at the same level in 1994 as in 1992, after more than a decade of decline from the peak year of 1979.

According to the 1994 National Household Survey on Drug Abuse, marijuana use among 12- to 17-year olds nearly doubled from 1992 to 1994, though it remained well below the peak reached in 1979. Marijuana use among adolescents declined steadily throughout the 1980s.

The survey found that 7.3 percent of 12- to 17-year olds reported using marijuana monthly, up from 4 percent in 1992, and that only about 40 percent of adolescents said that occasional use of the drug is dangerous, down from more than half those polled five years ago.

Cocaine use was reported by 1.4 million Americans (0.7 percent of the population), a figure that has remained unchanged since 1985. However, the survey did find that the number of occasional cocaine users had declined dramatically. It also found that 11 million persons between 12 and 20 drink alcohol and that two million were heavy drinkers; that is, they consumed five or more drinks at least five times a month.

TREATERS HAVE VARIED VIEWS OF MANAGED CARE

Provider ambivalence toward managed care is reflected in a study of 11 drug treatment programs for the government's National Institute on Drug Abuse by Research Triangle Institute's Center for Economics Research. Most programs surveyed said that "attempts to control costs through managed care practices and the treatment limits proposed by some reforms will significantly reduce funding and resources available to drug treatment. The result will be lower quality of care and fewer treatment slots." Others thought that managed care practices such as gatekeeping and utilization review will bring needed program accountability into the drug abuse treatment system.

The report's authors add that managed care's constant push to hold down costs has prompted a new era of accountability for a field in which data on outcomes and cost effectiveness has been sparse. They also predict that managed care will force greater involvement of primary care physicians in substance abuse treatment. These managed care "gatekeepers," responsible for early detection of chronic illness, will need to become better versed in addiction medicine and to learn what therapies are effective and available, they said.

FROM THE PRESIDENT

Dear Colleague:

As we prepare this report of our fiscal year 1994 audited financial statements and accomplishments, the ASAM Board of Directors is about to undertake two days of discussions on issues facing the membership at large, particularly managed care. The Board will prepare a strategic plan on how to deal with managed care organizations, state legislatures, regulatory and other organizations that control policies on access to care, payment for services and recognition of physicians as providers of addictions treatment. A copy of that plan will be sent to all ASAM members.

In 1994, ASAM was heavily involved in the health care reform debate at both the Congressional and state levels. Out of that debate emerged an increased acceptance of addiction as a disease, an understanding of the health care costs that result from untreated addictions and associated medical and psychiatric illnesses, and an increased awareness and acceptance of addiction medicine as a field of medical specialty practice.

Looking to the future, it is clear that the health care reform debate has moved from the national to the state level. It is there that our members need to work with their state chapters, with the state medical societies, with legislatures and with managed care organizations, to educate them about the addictions and to assure access to care and recognition of physicians in addictions practice.

ASAM's 1994 organizational accomplishments were significant. The Society is fiscally sound. Conference attendance was high, the ASAM *Patient Placement Criteria* were more widely used than ever before, and our landmark textbook, *Principles of Addiction Medicine,* will go into a second printing 18 months after its September 1994 publication. All of this signals an increased interest in addiction medicine. Activity has remained strong through 1995, and the forecast for the remainder of the year is equally good. Chapters are gaining strength and becoming more active. The *Supplement to the ASAM Patient Placement Criteria* will be published early in 1996. In addition, membership is on the rise, and a national membership campaign was launched at the October 1995 Board meeting. Paul Earley, M.D., chairs the International Membership Campaign Task Force.

All of this aims at one thing: namely, achieving ASAM's mission to make addictions treatment an integral part of all health care, and education in the addictions an integral part of all levels of medical education.

The officers and Board of Directors pledge their commitment to increase access to care and the quality of care, and to establish addiction medicine as a boarded specialty for all qualified physicians.

Sincerely yours,

David E. Smith, M.D.
President

James W. Smith, M.D.
Treasurer

ASAM Home Page Launched

ASAM is now available to those on the Internet via its new World Wide Web page. Thanks to a no-cost offer from America Online, ASAM has access to up to 2 MB of space for use by its membership. The home page address is:

http://users.aol.com/asamoffice

To access the home page, America Online users must have the latest AOL software (version 2.5 for Windows users). In America Online, select the "Go to" menu, then choose "Keyword" and type the address as it is shown above (using no additional characters or spaces). The page is growing weekly, so check often to see all the updates.

The home page is a project of ASAM's Online Committee, chaired by Stuart Gitlow, M.D., M.P.H. The home page was designed by Bill Hawthorne, M.D. Any comments or suggestions should be e-mailed to Bill at **BenBill@aol.com** or to Stu at **AFAGitlow@aol.com.**

ANNUAL REPORT

Condensed Statement of Support, Revenue and Expenses, Year Ended December 31, 1994

Support And Revenue

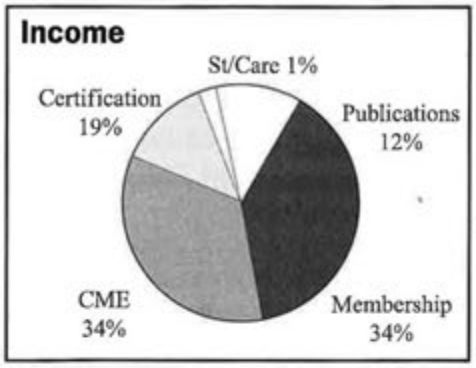
Membership	$ 575,547
Continuing Medical Education	585,300
Publications	208,280
Certification	331,445
Standards & Economics of Care	15,000
Investment Income (NET)	1,474
Total Support and Revenue	$ 1,717,046

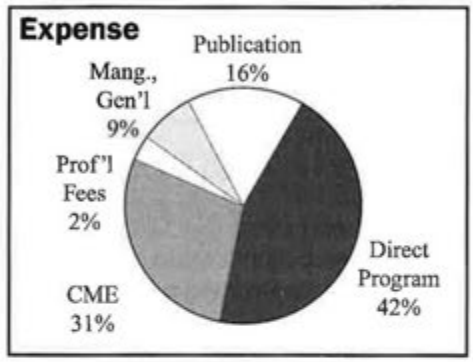
Expenses

Direct Program	$ 712,036
Continuing Medical Education	529,434
Publication	280,712
Management & General	146,586
Professional Fees	33,486
Total Expenses	$ 1,702,254

Excess Revenue over Expenses after Capital Additions $ 14,792

As of 12/31/94, $1,418,374 had been pledged to the Ruth Fox Endowment Fund. Actual monies received were $755,827.





The financial information presented here is condensed from the audited financial statements of ASAM for the year ended December 31, 1994. On written request, ASAM will be pleased to provide copies of the complete financial statement from which this information is taken, together with all footnotes and the unqualified report of our independent auditors.

American Society of Addiction Medicine

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1994 Accomplishments

• The first ever ASAM competitive election for officers was held. Officers elected were: G. Douglas Talbott, M.D. (President-Elect), James W. Smith, M.D. (Treasurer), and Marc Galanter, M.D. (Secretary). Directors-at-Large elected were: Sheila B. Blume, M.D., H. Westley Clark, M.D., Stanley E. Gitlow, M.D., James A. Halikas, M.D., Christine Kasser, M.D., David C. Lewis, M.D., and Anthony B. Radcliffe, M.D.

• 198 ASAM members received their certificates in addiction medicine, having successfully passed the 1994 Certification Examination. This brings the total number of certified physicians to 2,791.

• Fund balances all were positive, with an end-of-year operating balance of $14,792, a Ruth Fox Memorial Endowment Fund cash balance of $879,840, and $292,000 received in grants.

• The number of chartered state chapters grew to 25, from 21 in 1993 (there were five in 1989).

• The ASAM Board approved eight ASAM Public Policy Statements.

• The society published Principles of Addiction Medicine (the most comprehensive textbook in the field), and an ASAM Practice Guideline on "The Role of Phenytoin in the Management of Alcohol Withdrawal Syndrome."

• A Task Force on Addiction Care Service Delivery and Financing was established to address managed care issues facing ASAM members.

• Through ASAM's work with the American Medical Association, the AMA House of Delegates adopted an ASAM resolution affirming treatment of addictions as a "demonstrably viable and efficient method of reducing the harmful personal and social consequences of the inappropriate use of alcohol and other psychoactive drugs."

• ASAM purchased a permanent headquarters, an indication of the administrative maturity and stability of the organization, and a signal of the Board's commitment to aggressively pursuing the Society's mission.

FOCUS ON . . . NICOTINE

PRESIDENT LIGHTS FDA'S FIRE

President Clinton has announced a national intitiative to curb youth access to tobacco, and approved new regulatory authority that will allow the Food and Drug Administration to:

- Prohibit cigarette vending machines, free samples, mail-order displays and self-service displays.
- Require retailers to verify that purchasers are at least 18 years old.
- Require a text-only format for advertising and labeling to which children and adolescents are exposed.
- Ban the sale or distribution of non-tobacco items such as hats and T-shirts that carry tobacco logos.
- Restrict sponsorship of events to the corporate name only.
- Require manufacturers to spend $150 million per year on a national public education campaign on the hazards of smoking.

The goal of the initiative is to reduce by half the number of children who use tobacco products within the next seven years. If the goal is not met, stricter measures would be introduced.

Studies show that 80 to 90 percent of people who smoke begin before age 18. Currently, more than 3 million children and adolescents smoke cigarettes, and 1 million boys use smokeless tobacco. That number has risen sharply over the past few years.

PUBLIC SUPPORTS BAN ON YOUTH ACCESS TO TOBACCO

In a survey of 2,345 adults in late 1994, the Robert Wood Johnson Foundation found "broad-based support for specific actions to limit children's access to tobacco products and to restrict advertising and promotion that may encourage children to smoke."

For example, 91% of respondents supported banning vending machines accessible to children, while 73% said "tombstone" advertising would make smoking less attractive to youths. Similarly, a 1993 poll by the Gallup Organization found that 68% of Americans think that cigarette advertising is designed to be attractive to youths.

Polling data from various sources uniformly demonstrate that the types of regulations being pursued by the FDA are widely supported by the voting public, including people who live in the tobacco-growing states. "That is critical, because it means President Clinton can help himself politically by giving meaningful tobacco regulation the green light.

STUDIES SHOW ADVERTISING PROMOTES TEEN SMOKING

Two recent studies support the argument that cigarette advertising plays an important role in encouraging children to smoke. The studies add fuel to the debate over whether the [FDA] should restrict cigarette advertising to reduce youth smoking. Both studies are authored by Dr. John Pierce of the University of California at San Diego.

In the first study, Dr. Pierce found a number of years when smoking increased markedly; many corresponded with major tobacco advertising campaigns. Pierce said, "Every successful tobacco marketing campaign was associated with a major increase in 14 to 17 year-old smoking." The study also found that shortly after the Virginia Slims campaign of the 1960's and 70's by Philip Morris, the number of 14 to 17 year-old girls who started smoking jumped to 8 percent from 4 percent over two years. The study was published in the November issue of Health Psychology.

In the second study, Dr. Pierce interviewed 3,536 California nonsmoking adolescents to measure their "willingness or tendency to begin smoking." He found that peer pressure, the example of family members who smoke, or a combination of the two were not as powerful in promoting smoking as tobacco advertising. Moreover, children who could name their favorite cigarette ad and who coveted promotional merchandise from tobacco companies were the most likely to succumb to peer pressure over time.

Dr. Pierce summed up: "kids come out of elementary school so obviously anti-smoking, and yet as they get into middle-school that result weakens dramatically. When you look at what is associated with that move, . . . tobacco marketing is the strongest predictor."

LETTERS

CIGARETTE MAKERS KNEW NICOTINE TO BE ADDICTIVE

In an extensive analysis in the July 19 *Journal of the American Medical Association,* researchers report on their review of thousands of pages of internal documents of the Brown and Williamson Tobacco Corp. and its parent, British American Tobacco. The analytical report, by researchers John Slade, M.D., Stanton A. Glantz, Ph.D. and colleagues, shows that B&W knew more than 30 years ago that nicotine is addictive and tobacco smoke carcinogenic.

The *JAMA* issue also carries a joint JAMA/AMA editorial outlining a national action plan that includes FDA regulation of tobacco.

ASAM SUPPORTS BENEFIT FOR TREATMENT OF NICOTINE DEPENDENCE

John Slade, M.D.

(The following is excerpted from a letter by Dr. Slade to the Executive Director of the New Jersey Small Employer Health Benefits Program. Dr. Slade chairs the ASAM Nicotine Dependence Treatment Committee.)

I write on behalf of the American Society of Addiction Medicine in support of the Board's proposed benefit for nicotine dependence treatment. This step promises to substantially improve the health of the Program's beneficiaries who are addicted to nicotine. . . . Tobacco products are responsible for 12,000 deaths each year in New Jersey. A quarter of all adults and 15 percent of adolescents in the state smoke cigarettes.

Thirty thousand youth begin to smoke regularly each year. Up to half of those who continue to smoke will die prematurely (15 years early, on average) because of cigarettes if they do not stop. Most who smoke (up to three-quarters), including youth, want to stop but find this a difficult thing to do. Many eventually do stop, but only after repeated efforts and often only after a major complication of nicotine dependence, such as coronary artery disease, has occurred. Treatment has been proven to help people become abstinent. With treatment, there are fewer false starts and dashed hopes . . . . As with other drug addictions, nicotine dependence presents with an enormous range of severity. It is not uncommon for me to encounter patients ravaged by COPD or CAD who have not been able to stop smoking. This is partly because adequate treatment for their addiction has not been available. Such patients can require treatment for nicotine addiction with an intensity comparable to that which is often [seen in] alcohol or heroin problems. . . .

[T]he proposed benefit for nicotine dependence treatment that the Board has proposed will be . . . an enormous step forward. It is timely in that it will complement other efforts to reduce the toll that tobacco exacts from us and thus contributes to the control of New Jersey's worst epidemic.

ASAM President David E. Smith reports that tobacco advertising was mailed to his home, addressed to his 15-year-old son. Dr. Smith says that he and his wife "are enraged that this ad was specially targeted to [my son]."

PHYSICIAN'S ADVICE KEY IN STOPPING SMOKING

Analysis of 188 studies of ways to help people quit smoking concludes that the most effective incentive is low-tech, old-fashioned and cheap: encouragement from a doctor. "People stop smoking as a result of brief, unsolicited advice from their family practitioners," say the researchers, from the Wolfson Institute of Preventive Medicine and the Medical College of St. Bartholomew's Hospital, both in London. Their findings are reported in the October *Archives of Internal Medicine.*

MEMBERS URGED TO SPEAK OUT ON TOBACCO

Dear ASAM Member:

Last November, I was honored to speak at the American Society of Addiction Medicine's Nicotine Dependence Conference in Boston. Since then remarkable progress has been made toward our common goal of holding the tobacco industry accountable for its campaign to addict our youth. . . .

Commissioner David Kessler and the Food and Drug Administration (FDA) have asserted regulatory jurisdiction over tobacco products to protect our nation's children. Further, Attorney General Janet Reno and the Department of Justice (DOJ) have opened an inquiry into the potential criminal activity of the tobacco industry. . . .

While we have made historic progress, only a concerted effort on the part of all who care about public health will sustain our drive to protect America's youth and thwart any attempt by the tobacco industry to counter-attack. . . . [W]e now have an unprecedented opportunity. The American people are tired of having their children targeted by an industry that hopes to trap another generation of Americans into fatal addiction. I will fight as hard as I can to support the President and demand accountability from the tobacco industry. However, Congress and the Administration cannot act alone. We need your help.

As an expert in nicotine addiction, you can bear witness to the human pain nicotine causes. Write opinion columns to your local newspaper, call your local representatives in Congress and speak out as often as you can. In doing so, you will be helping us on Capitol Hill make a difference. Enclosed are a number of recent news articles about my efforts to hold the tobacco industry accountable.

Please feel free to contact me with any thought you may have. I look forward to hearing from you soon.

Rep. Marty Meehan
Member of Congress
from Lowell, MA

FROM THE LITERATURE

ROHYPNOL: QUAALUDE OF THE NINETIES?

Rohypnol (flunitrazepam), a long-acting benzodiazepine marketed by Roche Pharmaceuticals, Inc., in Mexico, South America, Europe and Asia, has appeared increasingly in street studies of illicit drug use, according to a report by David E. Smith, M.D., Donald R. Wesson, M.D., and Sara R. Calhoun, M.P.H., in the Summer 1995 issue of *CSAM News*, journal of the California Society of Addiction Medicine.

The authors report that while the earliest reports of abuse came from California and Texas, availability now appears more widespread. Dubbed the "Quaalude of the '90s," flunitrazepam has many street names, including "rophies," "rib," "loops" and "wheels." As with all benzodiazepines, adverse effects are intensified by concomitant use of alcohol. The authors cite anecdotal reports that persons who become intoxicated on a combination of alcohol and Rohypnol often wake up eight to 24 hours later with no memory of events that occurred following ingestion.

WOMEN: MORE CARDIAC DAMAGE FROM ALCOHOL?

Alcohol has a greater effect on the cardiac systems of women than men, according to a study in the July 12, 1995 issue of the *Journal of the American Medical Association*. Alvaro Urban-Marquez, MD, and colleagues at the University of Barcelona, Spain, compared the cardiac and muscular status of male and female alcoholics to determine if the response of women to alcohol is different from that of men.

They report that the resulting data "indicate that alcoholic cardiomyopathy and skeletal myopathy are as common among women as among men, despite that fact that the mean total dose of ethanol in female alcoholics was only 60% of that in male alcoholics." The study included 50 asymptomatic alcoholic women, 100 asymptomatic alcoholic men, and 50 female nonalcoholic controls. The authors conclude that "in practical terms, a 121 lb. woman who drinks about 9 ounces of 86 proof spirits or about a liter of wine a day puts herself at risk for cardiomyopathy."

HEROIN USE PATTERNS SAID TO BE SHIFTING

A report in the July/August issue of *NIDA* Notes, published by the National Institute on Drug Abuse, describes a perceived upward trend in heroin use among young people, concurrent with a shift in favored mode of administration away from injection and toward smoking or snorting.

In the report, Dr. Wayne Weibel of the University of Illinois at Chicago speculates that fear of AIDS is driving many heroin users to change their preferred mode of ingestion. Dr. Edward Cone of NIDA's Addiction Research Center suggests that smoking heroin also may make it easier for some people to start using the drug, particularly those who in the past were deterred by the prospect of injecting themselves with needles.

"Many people just hate the idea of needles," says Dr. Weibel. The shift to snorted or smoked drug, he adds, may be contributing to increased rates of first-time heroin use among teenagers and young adults in U.S. inner cities. Dr. Weibel predicts that use of heroin may eventually supplant cocaine in this population.

GUIDELINES FOR SOCIAL DRINKING BY PHYSICIANS

New public perceptions and attitudes concerning drinking are changing the model of acceptable alcohol use by physicians and other health care professionals, according to G. Douglas Talbott, M.D., writing in the October issue of *Epikrisis,* newsletter of the North Carolina Governor's Institute on Alcohol and Substance Abuse.

Dr. Talbott offers five "prophylactic" guidelines for such use: (1) the physician should regard alcohol as a sedative-hypnotic drug; (2) the physician should avoid drinking for effect rather than for occasion; (3) the time-dose relationship should be calculated; (4) the physician should consider the effect of his or her own drinking on patients; and (5) factors that affect alcohol metabolism (such as stress, food, and use of other medications) should be weighed.

ABUSE "DRAINING" FEDERAL ENTITLEMENT PROGRAMS?

The cost of untreated smoking and drug and alcohol disorders to federal entitlement programs will be at least $77.6 billion in 1995, according to a report from the Center on Addiction and Substance Abuse (CASA) at New York's Columbia University in the May 15 issue of the *American Journal of Health-System Pharmacy.* Study authors claim the dollars will be paid out through Medicaid, Medicare, Social Security Disability Insurance, Veteran's health care and other entitlement programs.

ALCOHOL ALERT TO BE PART OF *ASAM NEWS*

Beginning with this issue of *ASAM News*, NIAAA's *Alcohol Alert* will be published as a regular feature of the newsletter. Bringing readers cutting edge information on a variety of research and clinical topics, *Alcohol Alert* is published six times a year by the National Institute on Alcohol Abuse and Alcoholism. Dr. James F. Callahan, ASAM Executive Vice President, said that he sees the co-publishing arrangement as a step toward fulfilling ASAM's mission of bringing the best current information to practitioners of addiction medicine.

The insert in this issue focuses on alcohol and tolerance. In February, look for an *Alcohol Alert* on patient placement criteria, bound into the center of *ASAM News!*

ALCOHOL ALERT

National Institute on Alcohol Abuse and Alcoholism No. 28 PH 356 1995

Alcohol and Tolerance

Alcohol consumption interferes with many bodily functions and affects behavior. However, after chronic alcohol consumption, the drinker often develops tolerance to at least some of alcohol's effects. Tolerance means that after continued drinking, consumption of a constant amount of alcohol produces a lesser effect or increasing amounts of alcohol are necessary to produce the same effect (1). Despite this uncomplicated definition, scientists distinguish between several types of tolerance that are produced by different mechanisms.

Tolerance to alcohol's effects influences drinking behavior and drinking consequences in several ways. This *Alcohol Alert* describes how tolerance may encourage alcohol consumption, contributing to alcohol dependence and organ damage; affect the performance of tasks, such as driving, while under the influence of alcohol; contribute to the ineffectiveness or toxicity of other drugs and medications; and may contribute to the risk for alcoholism.

Alcohol Alert, a publication of the National Institute on Alcohol Abuse and Alcoholism; provides timely information on alcohol research and treatment to health professionals and other interested people. This issue is the twenty-eighth in the series.

Functional Tolerance

Humans and animals develop tolerance when their brain functions adapt to compensate for the disruption caused by alcohol in both their behavior and their bodily functions. This adaptation is called functional tolerance (2). Chronic heavy drinkers display functional tolerance when they show few obvious signs of intoxication even at high blood alcohol concentrations (BAC's), which in others would be incapacitating or even fatal (3). Because the drinker does not experience significant behavioral impairment as a result of drinking, tolerance may facilitate the consumption of increasing amounts of alcohol. This can result in physical dependence and alcohol-related organ damage.

Tolerance to different alcohol effects develops at different rates.

However, functional tolerance does not develop at the same rate for all alcohol effects (4–6). Consequently, a person may be able to perform some tasks after consuming alcohol while being impaired in performing others. In one study, young men developed tolerance more quickly when conducting a task requiring mental functions, such as taking a test, than when conducting a task requiring eye-hand coordination (4), such as driving a car. Development of tolerance to different alcohol effects at different rates also can influence how much a person drinks. Rapid development of tolerance to unpleasant, but not to pleasurable, alcohol effects could promote increased alcohol consumption (7).

Different types of functional tolerance and the factors influencing their development are described below. During repeated exposure to low levels of alcohol, environmental cues and processes related to memory and learning can facilitate tolerance development; during exposure to high levels of alcohol, tolerance may develop independently of environmental influences.

Acute tolerance. Although tolerance to most alcohol effects develops over time and over several drinking sessions, it also has been observed within a single drinking session. This phenomenon is called acute tolerance (2). It means that alcohol-induced impairment is greater when measured soon after beginning alcohol consumption than when measured later in the drinking session, even if the BAC is the same at both times (8–10).

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Acute tolerance does not develop to all effects of alcohol but does develop to the feeling of intoxication experienced after alcohol consumption (4). This may prompt the drinker to consume more alcohol, which in turn can impair performance or bodily functions that do not develop acute tolerance.

Environment-dependent tolerance. The development of tolerance to alcohol's effects over several drinking sessions is accelerated if alcohol is always administered in the same environment or is accompanied by the same cues. This effect has been called environment-dependent tolerance. Rats that regularly received alcohol in one room and a placebo in a different room demonstrated tolerance to the sedative and temperature-lowering effects of alcohol only in the alcohol-specific environment (11). Similar results were found when an alcohol-induced increase in heart rate was studied in humans (12). When the study subjects always received alcohol in the same room, their heart rate increased to a lesser extent after drinking in that room than in a new environment.

Tolerance develops more rapidly if alcohol always is consumed in the same environment.

Environment-dependent tolerance develops even in "social" drinkers in response to alcohol-associated cues. In a study analyzing alcohol's effects on the performance of an eye-hand coordination task, a group of men classified as social drinkers received alcohol either in an office or in a room resembling a bar. Most subjects performed the task better (i.e., were more tolerant) when drinking in the barlike environment (13). This suggests that for many people, a bar contains cues that are associated with alcohol consumption and promote environment-dependent tolerance.

Learned tolerance. The development of tolerance also can be accelerated by practicing a task while under the influence of alcohol. This phenomenon is called behaviorally augmented (i.e., learned) tolerance. It first was observed in rats that were trained to navigate a maze while under the influence of alcohol (14). One group of rats received alcohol before their training sessions; the other group received the same amount of alcohol after their training sessions. Rats that practiced the task while under the influence of alcohol developed tolerance more quickly than rats practicing without prior alcohol administration.

Humans also develop tolerance more rapidly and at lower alcohol doses if they practice a task while under the influence of alcohol. When being tested on a task requiring eye-hand coordination while under the influence of alcohol, people who had practiced after ingesting alcohol performed better than people who had practiced before ingesting alcohol (15). Even subjects who only mentally rehearsed the task after drinking alcohol showed the same level of tolerance as those who actually practiced the task while under the influence of alcohol (15).

Practicing a task while under the influence of alcohol facilitates tolerance development.

The expectation of a positive outcome or reward after successful task performance is an important component of the practice effect on tolerance development. When human subjects knew they would receive money or another reward for successful task performance while under the influence of alcohol, they developed tolerance more quickly than if they did not expect a reward (16). The motivation to perform better contributes to the development of learned tolerance.

Learned and environment-dependent tolerance have important consequences for situations such as drinking and driving. Repeated practice of a task while under the influence of low levels of alcohol, such as driving a particular route, could lead to the development of tolerance, which in turn could reduce alcohol-induced impairment (16). However, the tolerance acquired for a specific task or in a specific environment is not readily transferable to new conditions (17,18). A driver encountering a new environment or an unexpected situation could instantly lose any previously acquired tolerance to alcohol's impairing effects on driving performance.

Environment-independent tolerance. Exposure to large quantities of alcohol can lead to the development of functional tolerance independent of environmental influences. This was demonstrated in rats that inhaled alcohol vapors (19). In another study, mice demonstrated tolerance in environments different from the one in which the alcohol was administered (20). Significantly larger alcohol doses were necessary to

establish this environment-independent tolerance than to establish environment-dependent tolerance (20)

Metabolic Tolerance

Tolerance that results from a more rapid elimination of alcohol from the body is called metabolic tolerance (2). It is associated with a specific group of liver enzymes that metabolize alcohol and that are activated after chronic drinking (21,22). Enzyme activation increases alcohol degradation and reduces the time during which alcohol is active in the body (2), thereby reducing the duration of alcohol's intoxicating effects.

However, certain of these enzymes also increase the metabolism of some other drugs and medications, causing a variety of harmful effects on the drinker. For example, rapid degradation of sedatives (e.g., barbiturates) (23) can cause tolerance to them and increase the risk for their use and abuse. Increased metabolism of some prescription medications, such as those used to prevent blood clotting and to treat diabetes, reduces their effectiveness in chronic drinkers or even in recovering alcoholics (24). Increased degradation of the common painkiller acetaminophen produces substances that are toxic to the liver (25) and that can contribute to liver damage in chronic drinkers.

Metabolic tolerance contributes to the ineffectiveness or toxicity of medications.

Tolerance and the Predisposition to Alcoholism

Animal studies indicate that some aspects of tolerance are genetically determined. Tolerance development was analyzed in rats that were bred to prefer or not prefer alcohol over water (26,27). The alcohol-preferring rats developed acute tolerance to some alcohol effects more rapidly and/or to a greater extent than the nonpreferring rats (26). In addition, only the alcohol-preferring rats developed tolerance to alcohol's effects when tested over several drinking sessions (27). These differences suggest that the potential to develop tolerance is genetically determined and may contribute to increased alcohol consumption.

In humans, genetically determined differences in tolerance that may affect drinking behavior were investigated by comparing sons of alcoholic fathers (SOA's) with sons of nonalcoholic fathers (SONA's). Several studies found that SOA's were less impaired by alcohol than SONA's (28,29). Other studies found that, compared with SONA's, SOA's were affected more strongly by alcohol early in the drinking session but developed more tolerance later in the drinking session (30). These studies suggest that at the start of drinking, when alcohol's pleasurable effects prevail, SOA's experience these strongly; later in the drinking session, when impairing effects prevail, SOA's do not experience these as strongly because they have developed tolerance (30). This predisposition could contribute to increased drinking and the risk for alcoholism in SOA's.

The genetic predisposition for tolerance may increase the risk for alcoholism.

Alcohol and Tolerance—A Commentary by NIAAA Director Enoch Gordis, M.D.

Tolerance can be a useful clue for clinicians in identifying patients who may be at risk for developing alcohol-related problems. For example, younger patients who are early in their drinking histories and who report that they can "hold their liquor well" may be drinking at rates that will place them at risk for medical complications from alcohol use, including alcoholism. The fact that tolerance to all of alcohol's effects does not develop simultaneously is also important; people who are mildly tolerant may exhibit more symptoms of impairment when faced with unfamiliar activities, such as driving in an unknown area, than when they are engaged in routine actions, such as driving home from work. Lastly, although we know that initial sensitivity to alcohol may play a role in the development of alcoholism, the role of tolerance in maintaining addiction to alcohol needs further exploration.

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Telephone: 301–443–3860.

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COMMITTEE REPORTS

MANAGED CARE

The Managed Care Committee is asking ASAM members to contact Martin Doot, M.D., at Lutheran General Behavioral Health, 1775 Dempster Street, Park Ridge, IL 60068-1174, IF:

- You are an addiction medicine specialist who has been denied membership in a managed care panel or on a hospital medical staff solely on the basis that you are not board certified in psychiatry; or
- You were initially excluded from membership in a managed behavioral care "carved-out" provider panel because you are not a board certified psychiatrist, but appealed the denial and subsequently were granted enrollment in the panel.

The Managed Care Committee wants to develop a workable response process for ASAM members to use when they are excluded from access to a patient with addiction care. To do so, the committee needs a database on the extent of the current problem, as well as "success stories" that suggest useful strategies for assuring that addiction medicine providers have access to medical staffs and managed care provider panels.

CONTINUING MEDICAL EDUCATION

James Halikas, M.D., Chair

ASAM has been resurveyed by the Accreditation Council for Continuing Medical Education (ACCME) and awarded accreditation for four years as a sponsor of continuing medical education for physicians.

ACCME accreditation seeks to assure both physicians and the public that continuing medical education activites sponsored by ASAM meet the high standards of the Essentials for Accreditation as specified by the ACCME.

The ACCME rigorously evaluates the overall continuing medical education programs of institutions according to standards adopted by all seven sponsoring organizations of the ACCME.

These are: the American Board of Medical Specialties; the American Hospital Assocation; the American Medical Assocation; the Association for Hospital Medical Education; the Association of American Medical Colleges; the Council of Medical Specialty Societies; and the Federation of State Medical Boards.

NEW IN PRINT

ALCOHOLISM IN THE ELDERLY: DIAGNOSIS, TREATMENT, PREVENTION

The American Medical Association has released a set of guidelines, endorsed by ASAM, to help primary care physicians better diagnose alcoholism in their elderly patients, and to encourage them to refer such patients for treatment. Guideline authors call alcoholism "a medical problem that sends as many elderly Americans to the hospital as do heart attacks." James Campbell, M.D., medical director of Alcoholism Services of Cleveland and member of the AMA's advisory panel on the guidelines, said, "This problem takes a horrendous toll on society. Not only are the financial implications staggering, but more importantly it results in a tragic loss of productive years."

According to the AMA, doctors often miss signs of alcohol abuse in their older patients, signs that can mimic the symptoms of aging or Alzheimer's disease. The AMA estimates that doctors identify the problem in only 22% to 37% of actual cases seen in hospitals. Copies of the guidelines are available from the AMA at 1-800/262-3211

HOW AL-ANON WORKS

Published by Al-Anon, this book is designed to answer questions such as: How can another's alcoholism affect me? What is denial? What does "work the program" mean? Will I ever be better? Can Al-Anon really help? The book (Code B-22) is available at $9.95 (plus $1 shipping and handling) from Al-Anon Family Group Headquarters, Inc., PO Box 862, Midtown Station, New York, NY 10018-0862.

THE PHYSICIAN'S GUIDE TO HELPING PATIENTS WITH ALCOHOL PROBLEMS

New from the National Institute on Alcohol Abuse and Alcoholism, the Guide reviews steps for alcohol screening and brief intervention, recommendations to patients for low-risk drinking, and what to do about patients who are not ready to change their drinking behavior. Selected references and sources of additional information also are listed. Single copies of the Guide are available at no cost from NCADI at 1/800-729-6686.

NEW VIDEOS FROM NIDA

Treatment of substance-abusing patients in prison settings, reducing the spread of AIDS among injecting drug users, and use of LAAM in treatment are the subjects of three new videos from the National Institute on Drug Abuse. Developed under NIDA's research dissemination and application program, the videos are intended to make new research findings rapidly available to treatment practitioners.

"Drug Abuse Treatment in Prison" discussed two comprehensive treatment approaches that have proved effective with male and female prisoners. "Drug Abuse and HIV: Reaching Those at Risk" provides an overview of three intervention models that have helped injecting drug users reduce their risk of contracting HIV infection. "LAAM: Another Option for Maintenance Treatment of Opiate Addiction" describes patient selection, potential side effects, and the decision to use LAAM vs. methadone. All three videos are available from NCADI at 1-800/729-6686.

ASAM MEMBER NEWS

DR. BREWER WINS SCIENCE AWARD

The 1995 Charles C. Shepard Science Award went to Robert Brewer, M.D., M.S.P.H., and his colleagues in injury prevention for a study of the relationship between arrests for drunk driving and the risk of dying in an alcohol-related crash. Their study, "The Risk of Dying in Alcohol-Related Motor Vehicle Crashes among Habitual Drunk Drivers," was published in *The New England Journal of Medicine* (August 25, 1994).

In their study, Dr. Brewer and colleagues found that drivers aged 16-29 years who were arrested for drunk driving were over four times as likely to die in subsequent crashes involving alcohol than were those who had not been arrested for drinking and driving. Adult drivers 30 years of age or more who were arrested for drinking and driving were more than eleven times as likely to die in subsequent crashes involving alcohol than were those who had not arrested.

The authors recommend that substance abuse treatment be linked with strict legal sanctions to prevent later deaths in an alcohol-related crash. Moreover, because the association between arrests for DWI and death in an alcohol-related crash increases substantially with the number of arrests, they call for aggressive intervention after the first arrest.

In addition to Dr. Brewer, the recipients of the award are: Peter Morris, M.D., M.P.H.; Thomas Cole, M.D., M.P.H.; Stephanie Watkins, M.S.P.H.; Michael Patetta, M.A.; and Carol Popkins, M.S.P.H.

THIRD MOONEY HOLDS MEDICAL DIRECTOR POST

Bobby Mooney, M.D., has been appointed Medical Director of Willingway Hospital, Statesboro, GA, succeeding his older brother Al Mooney, M.D., and his father John Mooney, M.D., who founded the hospital. Before returning to medical school, Bobby Mooney was Associate Director of Willingway.

DR. STROHM HEADS EDUCATOR GROUP

Maureen Strohm, M.D., Director of the Family Practice Residency associated with the University of Southern California and located at California Hospital Medical Center in downtown Los Angeles, is the new chair of the Coalition of Medical Educators in Substance Abuse (CMESA), composed of representatives of each medical school in California and Nevada.

DR. SCHNEIDER NAMED "PHYSICIAN OF THE YEAR"

Max Schnieder, M.D., has been named Physician of the Year in Orange County, CA. The Orange County Medical Association bestowed the award in July to honor Dr. Schneider's work in the teaching and treatment of alcohol and chemical dependence.

IN MEMORIAM

George Drake, M.D., passed away in summer 1995 in Texas City, Texas. Dr. Drake was actively involved in educating physicians, nurses, counselors and other health care providers in addiction prevention and treatment.

IDAA GROUP MEETS

Penelope P. Ziegler, M.D.

"Celebration of Life" was the theme for the 46th annual meeting of International Doctors in Alcoholics Anonymous, held in August in Great Gorge, New Jersey. Conference chairs Russ F., M.D. and Joe C., M.D. welcomed 1,050 members and guests. Five concurrent tracks featured AA and Al-Anon meetings and study groups; CME presentations; Alateen activities, including a field trip, ropes course and rock climbing; Aladude and Alatot structured activities and child care services for children under 12 and infants. In addition, Twelve-Step meetings were offered for many special interest groups including women, gay men and lesbians, couples, unlicensed professionals, and licensed professionals in a variety of disciplines.

At the Newcomers' Banquet, 95 persons introduced themselves as attending their first IDAA meeting. While most of these doctors were new to recovery, several had been sober for extended periods but had never before had the opportunity to attend a national meeting. Between newcomers and "old timers," a wide range of professional disciplines was represented, including medicine, dentistry, clinical psychology, podiatric medicine, chiropractic, pharmacy and veterinary medicine. Students, interns and residents from several disciplines attended. Member contributions allowed many participants who would not have been able to manage the financial costs of the meeting to attend on scholarships.

The Continuing Medical Education program, coordinated by Vince V., Ph.D., offered presentations on a broad variety of topics in the fields of addiction medicine, recovery and related areas of concern. Many ASAM members participated as speakers and discussion facilitators, including David Smith, M.D.; Anne Geller, M.D.; David Canavan, M.D.; LeClair Bissell, M.D.; Robert Millman, M.D., Richard Irons, M.D.; John Slade, M.D.; Russell Ferstandig, M.D.; and Penelope Ziegler, M.D.

IDAA now claims 5400 members worldwide. The meeting was attended by at least 25 members from outside the U.S., with the largest numbers coming from Canada and England. The first IDAA meeting in 1949, held in the garage of Clarence P., M.D. in upstate New York, attracted 13 doctors. The 1996 meeting is set for Anaheim, CA, July 31-August 4.

ARKANSAS

The Arkansas Chapter meets on the second Sunday of each month at 2:30 pm at the Wolfe Street Center in Little Rock. The chapter also conducts quarterly meetings for CME credit. The next election of officers is set for January 1996. For more information, contact Harley Harber, M.D. or chapter President John R. Baker, M.D.

CALIFORNIA

William Brostoff, M.D. was installed as President at the 22nd Annual Meeting of the California Society of Addiction Medicine (CSAM) held November 2-4 with the State-of-the-Art Course in Los Angeles. The two-year term of Richard Sandor, M.D., concluded at the Awards and Installation Ceremony. Anthony Radcliffe, M.D., received CSAM's highest tribute, the Vernelle Fox Award, for his role in shaping and refining outpatient treatment programs widely used today, and for the lasting impact his teaching has had on physicians in the field of addiction medicine.

FLORIDA

Chapter President Marilyn Moss, M.D., reports that the Florida Society of Addiction Medicine will hold its annual meeting January 18-21, 1996, at the Grosvenor Resort in Orlando. Information is available from Robert Donofrio at the FSAM office, 904/484-3560.

ILLINOIS

Martin Doot, M.D., acceded to the Presidency of the Illinois Society of Addiction Medicine in November. New President-Elect is Norman Miller, M.D. The 1995 ISAM Lifetime Achievement Award goes to James W. West, M.D., Medical Director of the Betty Ford Center in Ranch Mirage, California. The award recognizes Dr. West's leadership of the physician recovery movement. On December 31, 1975, Dr. West and Monsignor McDermott opened the first social setting detoxification program (Haymarket House) in the state of Illinois. Dr. West also worked for adoption of the state's Alcohol and Public Intoxication Act, which mandated that persons intoxicated in public be taken to a detox center or hospital rather than to jail.

MARYLAND

The Maryland chapter's October meeting attracted 30 participants to hear a lecture by Dr. Howard Heit of Virginia. The chapter plans semi-annual meetings in the future.

MICHIGAN

The Michigan Chapter was chartered in April 1995 during the ASAM Annual Awards Dinner. Thomas Haynes, M.D., who was instrumental in organizing the chapter, has been elected its first president.

NEW YORK

Under the leadership of President Merrill Herman, M.D., the New York chapter is working with medical schools and the New York Committee for Physicians Health to set up a conference/exchange on the issue of impaired medical students.

OHIO

The Ohio chapter (OHSAM) conducted a September symposium featuring ASAM President David E. Smith, M.D. The chapter will hold election of officers in January 1996.

PENNSYLVANIA

PSAM held its annual Medical-Scientific Conference in Harrisburg on October 20th. ASAM President David E. Smith, M.D. was a featured speaker. The chapter's first newsletter was published in November.

SOUTH CAROLINA

ASAM members in South Carolina met October 2 and appointed two committees: the first will assess the potential for sponsoring public service announcements on addiction topics, while the second will plan a major conference in late 1996 or early 1997 in Myrtle Beach, Charleston, or Hilton Head. Dr. Timothy Fischer, who is establishing the state chapter, felt it could help adolescents and adults with alcohol and/or other drug related addictions. According to Dr. Fischer, of the approximately 47,000 young people in the state who meet the criteria for alcohol or other drug dependence and have used the drug in the preceding 30 days, only about 20% actually receive treatment. Of the adult population meeting the criteria for diagnosis of alcohol or other drug dependence, only 15% actually receive treatment. Dr. Fischer also noted that approximately 30% of hospital patients have an alcohol problem.

VIRGINIA

The ASAM Board recently approved Virginia's initial petition to form a chapter. Local ASAM members met October 20th (during the ASAM State-of-the-Art Conference) and agreed to contact the Virginia Medical Society in order to establish a closer relationship and perhaps offer conjoint meetings in the future.

WASHINGTON

The Washington Chapter (WASAM) received a grant from DuPont Pharma for student and resident training, and a second grant through the Washington State Medical Association (PACE) to develop a brochure on teenage drinking related to domestic violence. WASAM conducted its most recent meeting September 29 in Spokane, Washington. The meeting was entitled "Addiction 101: The Basics" and was conducted in conjunction with the Washington State Medical Association's Annual Meeting.

WISCONSIN

The Wisconsin Society of Addiction Medicine held its Annual Business Meeting in conjunction with a day long Educational Conference targeted to primary care physicians and addiction counselors. Keynote speaker Carlton Erickson, Ph.D., addressed the 60 participants on the Neurochemical Basis of Addiction. The Wisconsin chapter increased its membership by over 7% through its marketing efforts at this conference.

CERTIFICATION NEWS

APPLICATIONS ACCEPTED FOR 1996 CERTIFICATION/RECERTIFICATION EXAM

Lloyd Gordon, M.D. and Stanley E. Gitlow, M.D.

The 1996 examination cycle is upon us! The standard registration deadline is January 15, 1996 and the late deadline is February 15, 1996. The examination will take place December 7, 1996.

1996 marks the tenth anniversary of the first ASAM ceritification examination. As many members know, the ASAM Board of Directors has determined that recertification is required every ten years in order to maintain current standing. The ASAM membership directory shows the year of initial certification and the year of recertification. Those who passed the exam in 1986, 1987 or 1988 should consider recertifying in 1996 to keep their certification current.

As the deadline approaches, committee members receive many questions from potential applicants. Answers to some of the most frequently asked questions are provided here.

Certification Questions

What criteria must be met to take the certification examination? Applicants must have graduated from a medical school in the United States or Canada that is approved by either the Liaison Committee on Medical Education (LCME) or the Committee on Accreditation of Canadian Medical Schools (CACMS); or graduated from a school of osteopathic medicine approved by the American Osteopathic Association (AOA). If the applicant graduated from a medical school outside the U.S. or Canada, he/she must have a currently valid standard certificate from the Educational Commission for Foreign Medical Graduates (ECFMG), or have passed the Medical Council of Canada Evaluating Examination (MCCEE). Additional criteria are:

- Completion of at least 1,920 hours of involvement in addiction medicine (outside of the time of residency).
- 50 hours of Category 1 credits accrued between October 1, 1994 and November 12, 1996 for CME on topics related to the diagnosis and treatment of persons with alcoholism or other drug dependencies.
- Certification by a member board of the American Board of Medical Specialties (ABMS), or certification by the American Osteopathic Association (AOA), or successful completion of a residency training program in any medical specialty. The residency program must be accredited by one of the following: the Accreditation Council for Graduate Medical Education (ACGME); the Post-doctoral Training Committee of the AOA; the Professional Corporation of Physicians of Quebec; the College of Family Physicians of Canada; the Royal College of Physicians and Surgeons of Canada; the United Kingdom's Member of the Royal College of Physicians; the Australia and New Zealand's Fellow of the Royal Australasian College of Physicians; South Africa's MRCP; or Ireland's MRCP.
- Good standing in your medical community, as evidenced by three letters of recommendation.
- A valid medical license at the time of application, as well as at the time of the examination.

What is the deadline for submitting an application for the 1996 exam?

	Deadline Date	Fees
Early	October 31, 1995	$550 member/$750 nonmember
Standard	January 15, 1996	$650 member/$850 nonmember
Late	Febuary 15, 1996	$850 member/$1050 nonmember

Your application must be postmarked by October 31, January 15, or February 15 to be accepted as early, standard, or late. Please note that in determining a mailing date, metering is not an acceptable substitute for a postmark.

Can I obtain an application by overnight mail? We can send an application via Federal Express, if you provide us with: your Federal Express account number or a Mastercard or Visa number, your daytime telephone number, and your street address for delivery (no P.O. boxes).

Do I have to be an ASAM member to take the exam? No. The exam is open to both members and nonmembers; however, nonmembers pay a higher examination fee. You may wish to consider becoming a member in order to qualify for the lower examination fee.

Can I pay for the certification exam in installments? No. Unfortunately, we are not able to offer a staggered payment plan. Full payment must accompany the application.

I filled out the exam application in 1994 and withdrew or did not pass the exam. Must I complete the entire application form again? Yes. Each applicant must complete a current application and meet the current requirements to write the exam.

My license is valid now, but will expire before the exam date and I have not yet received the renewal forms. Is this a problem? No. In order to keep your application valid, simply send us a copy of your renewed license as soon as you receive it.

Must I include all three letters of reference when I submit my application? No. In fact, the "Letter of Reference" pages should be sent from the physicians providing the references directly to ASAM by January 15, 1996.

I am not certified by an ABMS member Board or by the AOA, and I have not completed a qualified residency training program. Are there any circumstances under which this requirement can be waived? No. Under the current criteria, you would not qualify to write this examination.

I cannot meet the full-time involvement (FTE) requirement (1,920 hours) within either a one- or a two-year time frame. How many years can I go back to document enough involvement to meet this requirement? The FTE requirement can be met in a variety of ways, including "varied periods of involvement over time." No specified period has been established as the maximum acceptable to complete the hours needed for this requirement. You should document your involvement clearly in the FTE section of the application and write an explanation in the "Personal Statement" section if you feel it necessary.

I do not yet have all 50 hours of Category 1 CME credit. Can I still apply for the 1996 exam? Yes. All 50 hours of Category 1 credit must be accrued after October 1, 1994 and before November 12, 1996. If you have not completed all 50 hours at the time you submit your application, please complete the CME portion of the application by listing those hours you already have accrued, and those you intend to accrue. After you complete the remaining hours, please mail verification to the ASAM Credentialing Manager.

When will I learn whether my application has been accepted to take the examination? You will be notified no later than August 30, 1996.

When will I receive the results of the certification examination? The results will be mailed no later than March 15, 1997.

How can I determine whether a physician is certified? That information is listed in the ASAM Directory, which all members receive. The information also can be obtained through a phone call to the ASAM office.

Recertification Questions

What criteria must be met to take the recertification examination? Applicants must be ASAM Certified; they must have a valid medical license that is in good standing at the time of application and at the examination date; and they must be in good standing in their medical community, as evidenced by one letter of recommendation.

When must I recertify? Physicians must recertify every ten years to keep their certification current.

How do I apply for recertification? In order to recertify, applicants must fill out a recertification application and submit it to the ASAM office. (See the Certification Questions).

What is the recertification fee? The recertification fee is the same as the certification fee.

Will I have to sit for an exam in order to recertify? Yes. Candidates for recertification sit for the same examination as candidates for certification. Scoring policies are the same.

Physicians who have questions that are not answered here should call John Keister, ASAM Credentialing Project Manager, at (301) 656-3920.

ASAM AND CERTIFICATION

(ASAM EVP James F. Callahan, D.P.A., sent the following letter to Linda C. Chandler, M.A., Editor of the ***Federation Bulletin: The Journal of Medical Licensure and Discipline,*** *to clarify ASAM's position on certification.)*

Dear Ms. Chandler:
I recently received a copy of the enclosed article from the 1995 issue (Volume 2, Number 2) of the Federation Bulletin, "What do the Certificates on Your Doctor's Wall Really Mean?," which includes the "American Board of Alcoholism and Other Drug Dependencies" in a list of "self-designated boards" (page 85). AMSAODD (American Medical Society on Alcoholism and Other Drug Dependencies) is the former name of the American Society of Addiction Medicine (ASAM). ASAM offers certification in addiction medicine to physicians who meet the credentialing criteria, which are requirements for education and training, and who pass a six-hour written examination. Recertification is required after ten years.

ASAM is explicit in helping members and the public understand the distinction which your article discusses: the difference between those certifying groups which are Boards recognized by the ABMS and those which are not so recognized. All of ASAM's information about its certification program states that the examination is not a board examination. It states, "ASAM is not a member of the American Board of Medical Specialties, and ASAM certification does not confer Board certification." ASAM does not call itself a "Board."

To our dismay, there does exist an "American Board of Addiction Medicine," headquartered in Palm Beach, Florida. It confers certification upon psychiatrists who meet its criteria. ASAM is in no way affiliated with the group, nor does ASAM endorse it.

ASAM's commitment is to educating physicians about appropriate diagnosis and treatment of alcoholism and drug dependencies. The certification program is an integral part of our education efforts.

James F. Callahan, D.P.A.
Executive Vice President and CEO

RUTH FOX MEMORIAL ENDOWMENT FUND

Ruth Fox
(1895-1989)

Dear Colleague:

As the holiday season approaches, we want to extend special wishes of peace, prosperity and happiness to you and your families, and to thank you for your continued support.

We hope that you received our mailing with the booklet, *Giving Before December 31,* which describes various tax planning opportunities. This is the time to make your 1995 tax-deductible contribution or pledge.

If you are not a Ruth Fox Memorial Endowment donor, please join your colleagues now. If you are a donor, please consider an additional contribution. All donors are invited to the Endowment Reception at the Society's 1996 Medical-Scientific Conference in Atlanta.

Here's a reminder to attend the program on "Estate Planning for Physicians" and "How to Protect your Pension Plan" at Med-Sci. Presented by Paul E. Dow, J.D., the program is offered Thursday, April 18, 1996 from 7:00 p.m. to 8:30 p.m., following the opening reception. Your life partner also is invited. Happy Holidays!

Max A. Schneider, M.D.
Chair, Endowment Fund

Jasper G. Chen See, M.D.
Chair Emeritus, Endowment Fund

Claire Osman, Director of Development

TOTAL PLEDGES: $1,522,121

GOAL: $10,000,000

New Donors, Additional Pledges and Contributions As of October 12, 1995

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Brown University

Brown University, Department of Psychiatry and Human Behavior, is seeking an academic psychiatrist for the position of Director of Substance Abuse Treatment Program. Demonstrated record of independent research, which includes laboratory, basic science and clinical research in alcohol and other addiction disorders is expected. Research experience should include the interface between substance abuse disorders and other psychopathology. Candidate must be eligible for full-time academic appointment as Assistant Professor or Associate Professor.

Interested individuals should send application letter and curriculum vitae to: Martin B. Keller, M.D., Mary E. Zucker Professor and Chairman, Department of Psychiatry and Human Behavior, Brown University, Psychiatrist-in-Chief, Butler Hospital, 345 Blackstone Blvd., Providence, RI 02906. Butler Hospital is an Affirmative Action, Equal Opportunity Employer and actively solicits applications from minorities and protected groups. Applications are expected by six weeks after date of publication. Screening will begin on that date and continue until a successful candidate has been identified or until the search is closed.

** Dr. Lauer was listed in the wrong category in the Aug-Sept issue of ASAM NEWS*

Medical Director - Chemical Dependency

Santa Clara Valley Health and Hospital System, Department of Alcohol and Drug Services, is seeking a Medical Director. Responsibilities include: management of medical services for outpatient alcohol/drug treatment, including methadone, perinatal and adolescent services; oversight and coordination of all medical activities and services; and supervision of program physicians to ensure compliance with Federal, State, and local regulations.

Successful candidate will be a California-licensed (or eligible) M.D. with Internal Medicine background and minimum of five years' experience in managing medical services in the alcohol and drug service field; experience in working with methadone is highly desirable. Excellent salary (DOE) and benefit package. Submit letter of application and CV to Bruce Copley, Department of Alcohol and Drug Services, 976 Lenzen Avenue, 3rd Floor, San Jose, CA 95126 or Fax to 408/279-1843.

CAREER OPPORTUNITIES

Highland Drive VA Medical Center

✦ ✦ ✦

Opening for a board-certified family practitioner or internist experienced with substance abuse treatment exists at the VA Medical Center, Highland Drive, Pittsburgh, PA. This well-established Center for the Treatment of Addictive Disorders includes a 45-bed Inpatient 14-Day Program, Outpatient Clinics and Methadone Maintenance Clinic. Highland Drive is a Neuropsychiatric Medical Center affiliated with the University of Pittsburgh. Faculty appointment is available to qualified applicants. There is a full range of mental health treatment programming. Opportunity to develop research projects in respective areas of interest. Excellent supporting staff with a multidisciplinary team approach.

Licensure in any state required. Excellent fringe benefits, including special pay in addition to competitive salary and 30-day paid vacation per year for full-time physicians. Send CV to Jeffrey L. Peters, M.D., Chief, Psychiatry Service, VA Medical Center, 7180 Highland Drive, Pittsburgh, PA 15206, or call 412/365-5160. The VA is an Equal Opportunity Employer.

Seattle Area

Certified Addictionist needed for 50-bed CD Unit. Non-profit organization, excellent staff, competitive salary & benefits, no state income tax. Located in medium-sized community, college town with performing arts center. Close to ocean, year-round abundant outdoor recreation.
Contact Eva Page & Associates, Physician Recruiting, 1-800/833-3449. Fax 360/647-8006 (WA state).

Parkside Human Services

Parkside Human Services, an outpatient Drug Free & Methadone Treatment Program, needs a PA-licensed physician to oversee comprehensive treatment program. 20 to 30 hours per week, benefits negotiable. Contact Human Resources Department, PHS, 4950 Parkside Ave., Philadelphia, PA 19131, or phone 215/871-0661.

Addiction Specialists/Medical Directors

St. Francis Medical Center, one of the largest medical centers in Southwestern Pennsylvania, has a tradition of service and leadership in health issues since its founding in 1865. Its nationally recognized Center for Addiction Services provides care to over 7,000 persons a year and provides a diverse array of treatment modalities to many distinct populations. There are two immediate openings for addiction medicine specialists to serve as Medical Director of Dual Diagnosis Services or as Medical Director of Detoxification and Rehabilitation Services. These positions will both include direct clinical services with administrative, supervisory and teaching responsibilities. Opportunities exist to develop research interests and an academic appointment is possible through the University of Pittsburgh. Candidates will find salary and benefits to be very competitive and that they would be joining an organization reputed for its good will toward the community and excellent relations with its employees. For further information please contact: Wesley Sowers, M.D., Medical Director, Center for Addiction Services, St. Francis Medical Center, 400 45th Street, Pittsburgh, PA 15201-1198. Phone: 412/622-6717.
An Equal Opportunity Employer.

Medical Director

Private Substance Abuse Treatment Center

An excellent opportunity is available at a successful behavioral health center located in theSoutheast. We seek a psychiatrist with ASAM certification and solid leadship experience to assume the role of medical director. The ideal candidate will have had personal experience in a substance-abuse program and the ability to develop a new outpatient counseling program.

Universal Health Services is a leader in hospital management, with 30 acute care and behavioral health centers and 22 surgery and radiation oncology centers nationwide.

For complete details, call **Eloise Gusman, Physician Recruiter, TOLL FREE 1-800-535-7698**, or send your C.V. to: **P.O. Box 1685, Covington, LA 70434-1685.**
Fax 1-504-898-0694. Equal Opportunity Employer.

UHS

ASAM CONFERENCE CALENDAR

1996

Feb. 7-10
Uncertain Times: Preventing Illness, Promoting Wellness: International Conference on Physician Health
Co-sponsored by ASAM
Chandler, AZ
23 Category 1 CME credits

March 1-3
MROs/SAPs: Medical Review Officer and Substance Abuse Professional Training Course
Chicago, IL
19 Category 1 CME credits

March 3
MROCC Medical Review Officer Certification Examination
(Following ASAM's MRO Course)
Chicago, IL

April 18
Ruth Fox Course for Physicians
Atlanta, GA
7 Category 1 CME credits

April 19-21
27th Annual Medical-Scientific Conference
Atlanta, GA
22 Category 1 CME credits
(Registration materials available 1/96)

1996

July 12-14
MROs/SAPs: Medical Review Officer and Substance Abuse Professional Training Course
Denver, CO
19 Category 1 CME credits

July 14
MROCC Medical Review Officer Certification Examination
(Following ASAM's MRO Course)
Denver, CO

October 24-26
Review Course in Addiction Medicine
Chicago, IL
21 Category 1 CME credits

November 1-3
MROs/SAPs: Medical Review Officer and Substance Abuse Professional Training Course
Washington, DC
19 Category 1 CME credits

November 3
MROCC Medical Review Officer Certification Examination
(Following ASAM's MRO Course)
Washington, DC

1996

November 14-17
9th National Conference on Nicotine Dependence
Washington, DC
15 Category 1 CME credits

December 7
Certification/Recertification Examination
Atlanta, GA,
Los Angeles, CA,
and Newark, NJ
5 Category 1 CME credits

1997

April 17
Ruth Fox Course for Physicians
San Diego, CA
7 Category 1 CME credits

April 19-21
28th Annual Medical-Scientific Conference
San Diego, CA
22 Category 1 CME credits

October
Adolescent Substance Abuse and Addiction Conference
14 Category 1 CME credits

For additional information, call Sandy Schmedtje Metcalfe, ASAM Director of Meetings and Conferences, at (301) 656-3920

ASAM NEWS
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