ASAM NEWS

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Newsletter of The American Society of Addiction Medicine

Substance Abuse: Older Adults at Serious Risk, New Federal Report Warns

Abuse of alcohol and legal drugs—prescribed and over-the-counter—is a serious health problem among older Americans, according to a report released by the federal Center for Substance Abuse Treatment (CSAT). This "invisible epidemic" affects up to 17 percent of adults age 60 or older, a rapid-growth segment of America's population.

Substance Abuse Among Older Adults was released to alert health care providers that substance abuse in the older population is a serious problem. One of a series of Treatment Improvement Protocols (TIPs) developed by CSAT, the new report is designed to assist physicians and other health care providers in detecting and treating alcohol and medication abuse among older patients.

According to Camille Barry, Ph.D., R.N., CSAT acting director, it is more difficult to diagnose alcoholism in older patients because a third of those with problems had not abused alcohol in their earlier years, nor did they have health problems, trouble with the law, or difficulties with family relationships associated with problem drinking. These older problem drinkers and drug users typically begin abusing alcohol and/or medications following the death of a spouse, a divorce, retirement, or some other major life change.

Citing recent studies, the report says that 15 percent of male alcoholics report that their first symptoms of alcoholism occurred between ages 60 and 69; and 14 percent report that their first symptoms occurred between the ages of 70 and 79. For women the percentages are even higher, with 24 percent reporting their first signs of alcoholism between ages 60 and 69; and 28 percent reporting their first signs occurred between ages 70 and 79.

The report also finds that "Prescription drug misuse and abuse is prevalent among older adults, not only because more drugs are prescribed to them, but also because, as with alcohol, aging makes the body more vulnerable to drugs' effects," adding that "any use of drugs in combination with alcohol carries risk; abuse of these substances raises that risk; and multiple drug abuse raises it even further."

"Sharp growth in the elderly population is anticipated with the aging of the baby-boomer generation," said Nelba Chavez, Ph.D., administrator of the Substance Abuse and Mental Health Administration, "so we must begin now to educate health care providers on the need to carefully screen their older patients for signs of alcohol abuse and medication misuse and abuse."

"As we age, there are physical changes in the body that lead to a lower tolerance for alcohol," Dr. Barry explained. "Often relatives of older individuals try not to notice if they see signs of inebriation. However, that cocktail or two may be taking away a loved one's independence and health."

The report looks at adults age 60 and older. The effects of aging in the body vary from person to person. Many individuals may not be affected at age 60, but others will be impacted earlier, the report said. "The age at which such changes occur varies from person to person, but invariably they do occur. Because many of the definitions, models, and classifications of alcohol consumption levels are static and do not account for age-related physiological and social changes, they simply do not apply to older adults," the report said, explaining why older adults cannot continue to drink the equivalent amount of alcohol consumed safely in earlier years.

Camille Barry, Ph.D., R.N.

Substance Abuse Among Older Adults (TIP 26) adds another volume to CSAT's Treatment Improvement Protocol (TIP) series. The series is a compendium of best practice guides produced for health care and substance abuse treatment providers. TIPs are produced by non-federal consensus panels composed of clinical, educational, research and administrative experts. These volumes are key information tools and are used to improve treatment services available to people in need through the Substance Abuse Prevention and Treatment Block Grant and other programs. TIPs are available on the CSAT web page at **www.samhsa.gov** or can be ordered by contacting the National Clearinghouse for Alcohol and Drug Information (NCADI) at 800/729-6686, or TDD (for hearing impaired) 800/487-4889.

*For more on this subject, see "Focus On . . . Alcohol, Drugs and the Elderly," on page 9 of this issue of **ASAM News**.*

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American Society of Addiction Medicine

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

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301/656-3920, or
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4601 North Park Avenue
Upper Arcade, Suite 101
Chevy Chase, MD 20815

REPORT FROM THE EXECUTIVE VICE PRESIDENT

NEW FEDERAL STUDIES BUILD CASE FOR PARITY

Dr. James F. Callahan

Two new federal studies add weight to a growing body of evidence that benefit parity for addictions treatment is not only humane but economically sound.

The first study, entitled "The Cost and Effects of Parity for Mental Health and Substance Abuse Insurance Benefits," was released in March by the federal Substance Abuse and Mental Health Services Administration. The study found that full parity for substance abuse and mental health benefits in private health insurance plans under managed care will increase premiums less than one percent and that composite health plans that reflect insurance coverage nationwide would average a 3.6 percent increase. The report includes case studies from Maryland, Minnesota, New Hampshire, Rhode Island and Texas—states that have had at least one year of experience with parity. Other key findings in the report are that: (1) most state parity laws are limited in scope or application; (2) state parity laws have had a small effect on premiums; (3) employers have not attempted to avoid parity laws by becoming self-insured and do not tend to pass the cost of parity onto employees; (4) costs have not shifted from the public to the private sector; and (5) premium increases vary by type of plan.

The second study, released in May by the National Institute on Drug Abuse (NIDA) and the National Institute on Alcohol Abuse and Alcoholism (NIAAA) estimates that the economic cost of alcohol and drug abuse was $246 billion in 1992, the most recent year for which sufficient data were available. This estimate represents $965 for every man, woman, and child living in the United States in 1992. The new study reports that alcohol abuse and alcoholism generated about 60 percent of the estimated costs ($148 billion), while drug abuse and dependence accounted for the remaining 40 percent ($98 billion).

The report summarizes earlier cost-to-society research. After comparing their current findings to the four major costs studies conducted in the past two decades, again adjusting for inflation and population growth, they concluded that the alcohol estimates for 1992 were very similar to the average of cost estimates produced over the past 20 years.

Estimates of the costs of drug abuse, however, have shown a steady and strong pattern of increase since 1977. The authors

state that rising drug abuse costs can be explained by the emergence of the cocaine and HIV epidemics, an eightfold increase in state and federal incarcerations for drug offenses, and about a three-fold increase in crimes attributed to drugs.

The distribution of alcohol and drug costs differed significantly. Two-thirds of the costs of alcohol abuse related to lost productivity, either due to alcohol-related illness (45.7 percent) or premature death (21.2 percent). Most of the remaining costs of alcohol abuse were in the form of health care expenditures to treat alcohol use disorders and the medical consequences of alcohol consumption (12.7 percent), property and administrative costs of alcohol-related motor vehicle crashes (9.2 percent), and various additional costs of alcohol-related crime (8.6 percent).

For drug abuse, more than one-half of the estimated costs were associated with drug-related crime. These costs included lost productivity of victims and incarcerated perpetrators of drug-related crimes (20.4 percent); lost legitimate production due to drug-related crime careers (19.7 percent); and other costs of drug-related crime, including Federal drug traffic control, property damage, and police, legal, and corrections services (18.4 percent). Most of the remaining costs of drug abuse resulted from premature deaths (14.9 percent), lost productivity due to drug-related illness (14.5 percent), and health care expenditures (10.2 percent).

About 45 percent of the costs of alcohol abuse is borne by those who abuse alcohol and members of their households; 39 percent by Federal, State, and local governments; 10 percent by private insurance; and 6 percent by victims of abusers. For drug abuse, 44 percent of the cost burden is car-

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IN JAILS, DRUG HISTORY RATE RISES

A rising proportion of inmates in the nation's jails is dependent on drugs, the Justice Department has reported. More than a third of the inmates were taking drugs at the time of the offense that got them locked up and more than 60 percent were using drugs or alcohol or both. More than half said they used narcotics in the month before the offense. Moreover, a higher percentage of inmates in 1996 than in 1989 reported use for every type of drug except cocaine. Overall, 82 percent of all jail inmates in 1996 said they had ever used an illegal drug, up from 78 percent in 1989.

The findings emerged from a profile of U.S. jail inmates, conducted by the Bureau of Justice Statistics in 1996 when there were 507,026 people in local lockups. The survey was based on hour-long interviews of 6,133 inmates in 431 jails in late 1995 and early 1966.

The survey found that marijuana was the most widely used drug. The percentage of inmates who said they had used the drug at some point in their lives went from 71 percent in 1989 to 78 percent in 1996; stimulants, from 22 to 34 percent; hallucinogens, 24 to 32 percent; depressants, 21 to 30 percent; and opiates, 19 to 24 percent. Half of the inmates in both years reported trying cocaine.

Alcohol use also was high. Sixty-two percent of convicted inmates said they drank regularly—at least once a week for at least a month—and 64 percent said they had regularly used drugs. At the time they committed their offense, about 41 percent said they had been drinking and 36 percent said they were using drugs. In all, six in 10 convicted inmates were using alcohol or drugs or both at the time of the crime.

NEW AIDS TREATMENTS MASK RISING HIV INFECTION RATE, CDC SAYS

Although the rate of new AIDS cases in the United States has slowed in recent years, HIV continues to spread through the population essentially unabated, according to data released by the federal Centers for Disease Control and Prevention. The data, reported in the CDC's *Morbidity and Mortality Weekly Report*, are based on HIV test results compiled by 25 states from January 1994 to June 1997. They indicate that the number of new infections during that period remained "stable," with just a "slight" decline of 2 percent from 1995 to 1996, the most recent full year included in the new analysis. By contrast, deaths from AIDS declined 21 percent in 1996 and dropped another 44 percent in the first six months of last year.

This first direct assessment of HIV infection trends shows that the recent decline in U.S. AIDS cases is not due to a notable drop in new infections. Rather, improved medical treatments are allowing infected people to stay healthy longer before coming down with AIDS, overshadowing the reality of an increasingly infected populace.

The report shows continuing high numbers of new infections among intravenous drug users, a population that has recently been the focus of a political debate over the value of needle exchange programs that offer drug users clean syringes to prevent the spread of HIV, the virus that causes AIDS. The findings also confirm previously identified trends showing that women and minorities are increasingly at risk. Especially worrisome, officials said, is that the annual number of new infections in young men and women 13- to 24-years old—a group that has been heavily targeted for prevention efforts—is virtually unchanged in recent years.

From 1995 to 1996, the number of HIV infections increased 3 percent in women. And it jumped 10 percent in Hispanics, although officials said that figure was imprecise. Infections declined by 2 percent in whites and 3 percent in African Americans. All told, the study tallied 72,905 infections during the survey period. The number nationwide is much higher, since participating states account for only about 25 percent of U.S. infections.

SOURCES OF NEW CASES OF AIDS

Source	Percent
Male homosexual sex*	32%
Injecting drugs	**18%**
Heterosexual sex	18%
Drugs & homosexual sex	4%
Other/unreported	28%

*Thought to be underreported.

SOURCE: Centers for Disease Control and Prevention, 1998.

MROCC FUNDS RESEARCH INTO HEMP SEED TEA INGESTION

The Medical Review Officer Certification Council (MROCC) has approved funding for research into the study of hemp seed tea consumption to determine whether or not the use of this tea preparation could yield positive results on workplace urine drug screens. The research, entitled "The Concentration of Marijuana Metabolites in the Urine Following Ingestion of Hemp Seed Tea", will be co-authored by Gordon C. Steinagle, D.O., Fellow, and Mark J. Upfal, M.D., M.P.H., F.A.C.O.E.M, Director, Division of Occupational and Environmental Medicine, Wayne State University, Detroit, Michigan.

According to the researchers, "Illicit drug use among employees may be associated with adverse employment outcomes such as lower productivity, higher absenteeism, injuries, accidents and increased health care costs. Companies are using drug testing to screen for potential problem employees (drug abusers) before hire, and to identify drug problems in current employees in order to help keep corporate costs down in this highly competitive business environment." The research project is aimed at studying under what circumstances ingestion of hemp seed tea (made with legally obtained sterile hemp seeds) could result in a positive drug test, and to determine urine concentrations of cannabinoids following a subject's ingestion of hemp tea.

MROCC was incorporated in March 1992 to develop and conduct a certification examination that identifies and recognizes the competence of physicians who are qualified to interpret and evaluate workplace drug test results. Since then, over 3000 physicians have become MROCC-Certified. Through its certification process, research grants, and other activities, MROCC promotes the highest quality of service rendered by physicians involved in substance abuse prevention programs.

FROM THE PRESIDENT'S DESK

Dear Colleague:

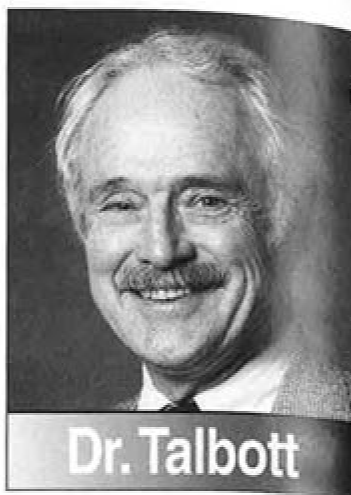
As we move into my second year as ASAM President, I want to review for you our Society's accomplishments and the challenges that confront us, as well as to encourage response from you via E-mail, letters and phone calls. Our individual members are our strength: indeed, the individual member who calls Jim Callahan, the ASAM staff, or me is the most important person in our lives today.

As I see it, here are some of the greatest challenges facing ASAM and the field of addiction medicine today:

- Discrimination by the medical community, the lay public, legislators and other policymakers against addicted persons on the grounds that addiction is a moral or ethical weakness rather than a disease.
- Lack of access to addiction treatment.
- Lack of fellowships for training in addiction medicine.
- Lack of certification of non-psychiatrist physicians who are addiction medicine specialists to participate in managed care networks.
- Lack of adequate funding for both public and private treatment programs.
- Insufficient integration of addiction medicine into general medical care. There still is an unfortunate tendency to see addiction as an adjunct health issue, rather than a mainstream medical problem.

On the positive side, our accomplishments address many of these challenges. I can report to you that, on my watch, they include:

- Acceptance of ASAM-provided national guidelines—through our *Patient Placement Criteria*—by multiple states and several federal agencies.
- Publication of the second edition of ASAM's seminal textbook, *Principles of Addiction Medicine*, under the editorship of ASAM members Allan W. Graham, M.D. and Terry K. Schultz, M.D.
- Vigorous pursuit of specialty status for addiction medicine. Recognizing that training is critical to specialty recognition, fellowships in addiction medicine are being explored from a fiscal, academic and specialty viewpoint.
- International expansion of ASAM. With the involvement of your President, Immediate Past President, and President-Elect, chapters are being developed in Panama, Germany, Australia, New Zealand, Portugal, England, etc. This will not only lead to increased worldwide membership, but will stimulate the introduction of addiction medicine into the mainstream of international medicine.


Dr. Talbott

- A high priority on benefit parity for addiction treatment. Fighting for parity in the Congress and at the level of the individual states, we are making progress.
- In one of the most important agenda items of my presidency, ASAM is working to overcome discrimination against physicians who suffer from the disease of addiction. Addressing such discrimination on the part of licensing boards, managed care organizations, and the legal system, Dr. Mike Sucher, chairman of ASAM's Physicians Health Committee, continues to develop new and innovative ways to combat such discrimination.

There are other exciting programs and projects that I will address in subsequent editions of ***ASAM News***. It is important for you to know that ASAM continues to be the voice of addiction medicine throughout the world.

Paramount to this role, and to the future of ASAM, is your individual effort to vote. Please know that your vote in the upcoming elections for leadership posts in ASAM is one of the most important achievements that you can accomplish for the future of addiction medicine. The future of ASAM, and the future of countless addicted patients, all will be influenced by your individual vote.

Best wishes,

Doug

G. Douglas Talbott, M.D., FASAM

Callahan – Continued from page 2

ried by those who abuse drugs and members of their households, 46 percent by governments, 3 percent by private insurance, and 7 percent by victims of drug abusers.

Prior to this study, the most recent comprehensive estimates of these costs were based on data for 1985. The new estimates are 42 percent higher for alcohol and 50 percent higher for drugs than the estimates reported in the earlier study, after accounting for the increases that would be expected due to inflation and population growth. Over 80 percent of the increase in estimated costs of alcohol abuse can be attributed to changes in data and methodology employed in the new study; this suggests that the previous study significantly underestimated the costs of alcohol abuse. In contrast, over 80 percent of the increase in estimated costs of drug abuse is due to real changes in drug-related emergency room episodes, criminal justice expenditures, and service delivery patterns.

Because population increases and inflation have increased the costs further since 1992, the study authors also projected the costs for alcohol and drug abuse for 1995. By adjusting the 1992 estimates for population growth and inflation, they estimated that the 1995 costs to society were $276 billion.

In commenting on the findings, NIAAA Director Enoch Gordis, M.D., said: "This study confirms the enormous damage done to society by alcohol- and drug-related problems. The magnitude of these costs underscores the need to find better ways to prevent and treat these disorders." NIDA Director Alan I. Leshner, Ph.D., added, "Substance abuse and addiction have serious medical and social consequences. The rising costs from these and other drug-related public health issues warrant a strong, consistent, and continuous investment in research on prevention and treatment."

COMMITTEE REPORTS

MEMBERS IN TRAINING COMMITTEE: "A LONG WAY TO GROW"

Chris Delos Reyes, M.D., Chair

According to the September 1997 Membership Campaign Report, one-half of the entire membership of ASAM is aged 55 or older. Four percent of ASAM members are residents, while only one percent of ASAM members are students. Other statistics from the ASAM national office reveal that 30 residents and 27 students have attended the annual Med-Sci Conference in the past two years.

Clearly, we have a long way to go in "growing" the younger sections of ASAM. If ASAM hopes to remain a vibrant and vital organization into the 21st century, it must recruit and serve students, residents, and other young physicians.

How has ASAM responded to the challenge of "growing younger"? First, the Board of Directors at its April meeting approved free registration for students and reduced registration fees (from $325 to $150) for residents who attend the annual Medical-Scientific Conferences in 1999 and 2000. If these efforts prove successful in increasing attendance, this fee schedule is likely to continue in 2001 and beyond.

Second, at the State Chapters Development Workshop (held at the April Med-Sci Conference), states *without* chapters were encouraged to include voting positions for students and residents in their state charters. States *with* chapters were challenged to change their bylaws to include similar positions for students and residents.

Third, ASAM has begun an initiative to appoint an Assistant Chair to each of its Committees. Criteria for the Assistant Chair post are that the member be "age 40 or less and/or less than five years in practice."

A number of other developments also are of interest to Members-in-Training:

- The current term of the Members-in-Training Committee Chair ends in April 1999. This position is an appointed one and has a two-year term (April 1999—April 2001). Students and residents interested in this post should submit a curriculum vitae and a statement of interest to Catherine Davidge, Director of Membership, at the ASAM office. Questions should be directed to the current Chair by E-mail at chris.delosreyes@uhhs.com.
- Many students and residents wonder, "How can I join the Members-in-Training Committee?" It's as easy as E-mailing or calling Catherine Davidge at the national office or the Committee Chair.
- The ASAM Board of Directors recently approved the formation of an AMA Delegation Committee, which includes Delegates and Alternate Delegates to the American Medical Association's House of Delegates, Young Physician Section, Resident Physician Section, and Medical Student Section. Anyone interested in joining this committee should contact Joanne Gartenmann at the ASAM office.
- Contributions to the Members-in-Training section of the ASAM Web Page can be sent to the committee chair or to Webmaster Bill Hawthorne, M.D., in care of the ASAM office.

News and comments for the Members-in-Training column in ***ASAM News*** should be sent to the Members-in-Training committee chair.

ASAM ELECTION OF OFFICERS

ASAM TO ELECT NEW OFFICERS, DIRECTORS-AT-LARGE

David E. Smith, M.D., FASAM
Chair, Nominating and Awards Committee

In April 1999, terms of office will expire for all ASAM officers and Directors-at-Large. The slate of candidates for the 1999 election is under development by the Nominating and Awards Committee and will be announced in the next issue of ***ASAM News***. (The Nominating and Awards Committee is composed of the Immediate Past President; two committee chairs, who are elected by all committee chairpersons; two Regional Directors, who are elected by all Regional Directors; and two ASAM members, who are appointed by the President and approved by the Board of Directors.)

Profiles of the candidates, with their platform statements, will be published in a special election issue of ***ASAM News***.

Ballots will be mailed to all active, voting members of ASAM on **November 1, 1998**. The deadline for return of voted ballots is **December 1, 1998**. Results will be announced in the January-February 1999 issue of ***ASAM News***. President-Elect Marc Galanter, M.D., will assume the ASAM Presidency, and all other newly elected officers and directors will take office in April 1999 during ASAM's annual Medical-Scientific Conference.

Selection of candidates is governed by ASAM's Bylaws, which require that candidates for President-Elect, Secretary, and Treasurer be from, or have served on, the Board of Directors within the past four years (except for the Treasurer, who may be from the general membership, have qualifications for the position, and have served on the Finance Committee within the past four years). Candidates for Director-at-Large must have been active members of ASAM for three years, must have demonstrated a commitment to ASAM's mission by having engaged in activities such as service on a committee, task force, or other significant state or national endeavor, and must be willing to attend two Board meetings a year for four years at his or her own expense.

In addition to candidates selected by the Nominating and Awards Committee, candidates may be nominated by petition of at least 25 active members of the Society. Candidates by petition must meet the same requirements as candidates slated by the Nominating and Awards Committee.

New Directors Fill Interim Vacancies on ASAM Board

Two new Directors have been elected by the ASAM Board of Directors to fill interim vacancies on the Board.

Peter Rostenberg, M.D., FASAM, has been elected Regional Director for Region III to replace Alan A. Wartenberg, M.D., FASAM, who resigned from the Board for health reasons. Dr. Rostenberg will complete Dr. Wartenberg's term, which expires in 2001.

Anthony H. Dekker, D.O., FASAM, will serve as the liaison representative from the American Osteopathic Association on Addiction Medicine. Dr. Dekker replaces William Vilensky, D.O., R.Ph., FASAM, who resigned the liaison post.

ASAM ACTIVE AT AMA ANNUAL MEETING

Michael M. Miller, M.D., FASAM
ASAM Delegate to the AMA

Major topics at the annual meeting of the American Medical Association's House of Delegates were the roll-out of a "new framework" for the HCFA E&M Documentation Guidelines, the AMA's own AMAP program (the AMA's nascent program for accrediting individual physicians and their practices), an update from the Federation Coordination Team, efforts to decriminalize physician activity and keep medical practice in the civil realm of state professional practice acts, and continued focus on AMA governance. The AMA also inaugurated its first woman president, Nancy W. Dickey, M.D., and introduced its new Executive Vice President, E. Ratcliffe "Andy" Anderson, M.D. (see accompanying article).

ASAM was represented at the June session in Chicago by Delegate Mike Miller, M.D., FASAM, Alternate Delegate Stuart Gitlow, M.D., and Delegate-Designate Rich Beach, M.D., FASAM.

A highlight of the meeting was the presentation of a major award to ASAM member Charles S. Lieber, M.D. Dr. Lieber was honored with the Scientific Achievement Award, the highest scientific award bestowed by the AMA. In accepting the award, Dr. Lieber thanked the organization for recognizing alcohol studies as part of the mainstream of medical research. (Dr. Lieber joins ASAM member David E. Lewis, M.D., in being honored by the AMA. Dr. Lewis was the recipient of AMA's 1997 Medical Education award.)

Also significant was Stu Gitlow's election to head the governing council of AMA's Young Physicians' Section. As chair-elect, Dr. Gitlow will enhance the visibility and effectiveness of ASAM's delegation to the AMA.

Every medical society that is represented in AMA's House of Delegates must undergo a review every five years to determine whether it still qualifies to retain its seat in the House. ASAM successfully completed its review in 1998 and was readmitted to the House.

AMA Governance at Issue

The overriding topic of discussion at the 1998 meeting was the need for the AMA to make internal changes, to attend better to the needs of its "customers" (America's physicians), and to resolve what was widely described as a "disconnect" between the AMA and practicing physicians. In fact, the AMA provides a wide array of member services and its advocacy in Washington has yielded many successes. But many physicians have little awareness of these actions and thus do not perceive the benefits of AMA membership. It is fashionable to criticize the AMA as too distant, too bureaucratic, too irrelevant, too old, too disconnected from the practice life and concerns of the average physician. The AMA has made a major commitment to improve communications and "connectedness," to enhance the real value of membership, and to increase physicians' awareness of those benefits. The newly elected Board of Trustees and the newly appointed chief executive officer say they are committed to substantive improvements. All acknowledge that if they do not succeed, AMA membership will continue to decline. (Currently, a bit less than half of ASAM members are dues-paying members of the AMA.)

ASAM Resolutions Succeed

ASAM-sponsored resolutions fared well at the meeting, as ASAM crafted strategic partnerships with other medical specialty societies and state medical associations. For example, ASAM joined with the American Psychiatric Association, the American Academy of Child and Adolescent Psychiatry, and the American Association for Geriatric Psychiatry to cosponsor a resolution urging "managed care organizations and insurers to consider self-help as a complement to, not a substitute for, treatment directed by physicians," and calling on them to "refrain from using their patients' involvement in self-help activities as a basis for denying authorization for payment for the treatment of patients and families who need such care." The resolution was adopted by the House of Delegates by unanimous vote.

Michael M. Miller, M.D., FASAM

In an effort to promote and improve screening for alcoholism, ASAM submitted a resolution calling on the federal Health Care Financing Administration to reverse its decision not to reimburse GGTP assays as part of a chemistry panels; the House agreed to commission a study of the matter.

Another ASAM resolution, regarding needle exchange, was reaffirmed by the House as AMA policy. ASAM offered the resolution and testified successfully in opposition to another resolution in order to retain clarity about AMA policy on the matter.

In ASAM's only setback of the meeting, the Society failed to win endorsement of its resolution calling for substance use information to be entered in the biomedical section of the patient medical record rather than in the social history section. Extensive work by the ASAM delegation with Reference Committee H did not lead to language that could be acted on favorably. ASAM will resubmit a resolution on this topic at a future meeting of the House of Delegates.

ASAM was more successful in supporting implementation of a fascinating report by the Council on Scientific Affairs, which called for the reduction of nicotine content in cigarettes to a clinically insignificant level. ASAM worked closely with the Council, the Minnesota, Pennsylvania and Michigan delegations, and the American College of Preventive Medicine to facilitate adoption by the House of a set of recommendations from this report, including one calling on the AMA to "encourage that FDA and other appropriate agencies to conduct or fund research on how tobacco products might be modified to facilitate cessation of use, including elimination of nicotine and elimination of additives (e.g., ammonia) that enhance addictiveness." Another

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recommendation was that "the AMA continue to support development of an infrastructure for tobacco dependence treatment; education of health care professionals and the public about the effects of tobacco use and the benefits of cessation; and ready availability of and insurance treatment for pharmacologic and behavioral treatment of nicotine dependence." This matter won some national press attention and is an example of ASAM's partnering activities and influence within the House of Delegates.

ASAM also testified in favor of a resolution from the New Jersey delegation asking "the entertainment industry, including movies, videos and professional sporting events, to stop portraying tobacco products (cigarettes, cigars and smokeless tobacco) as glamorous and sophisticated." ASAM then partnered with the American College of Preventive Medicine and the Minnesota Medical Association to co-author an emergency resolution responding to the Chicago Bulls' lighting up cigars to mark their basketball championship. Using the moment for the public good, the House passed the resolution, which urges professional athletes to "avoid the use of cigars and other tobacco products during sporting events, on television, and at post-game events seen by the public," and encouraging "professional sports associations and their teams and players to develop or participate in educational programs and mass media campaigns to discourage the use of cigars and other tobacco products by children and adolescents."

In other actions, ASAM testified in support of a resolution, adopted by the House, that "AMA seek the requirement that state Medicaid programs, prepaid health plans and insurance companies provide evidence-based approaches for smoking cessation and nicotine withdrawal, including FDA-approved pharmacotherapy, as part of their standard benefit packages."

E&M Documentation Debated

A contentious issue at the meeting was how to revise the 1994 Documentation Guidelines for Evaluation and Management of patients in the CPT system jointly developed by AMA and HCFA (see adjoining article). While HCFA issued new documentation guidelines in 1997, they have been put on hold in response to an overwhelmingly negative reaction from physicians and medical organizations. In the interim, the 1994 Guidelines remain in effect, and physician audits continue under those guidelines.

The AMA is preparing a "new framework," which may become known as the 1999 Guidelines. The single organ system examination—a cornerstone of the 1997 Guidelines—has been scrapped. ASAM has prepared a sample guide for how an addiction medicine specialist might document evaluation and management visits using the "new framework" (visit ASAM's website for a copy). The "new framework" is to be discussed by the AMA's CPT Editorial Advisory Panel at its August 21-23 meeting; comments or information for consideration at the meeting should be submitted to AMA in advance of that session.

The House took its own action to affect the organization of the "new framework" by resolving that the AMA oppose "any documentation system that requires quantitative formulas or assigns numeric values to elements in the medical record to qualify as medically appropriate recordkeeping." The final report of Reference Committee H addresses the many steps the House took on this issue; consult the AMA's website for details. ASAM plans to partner with the Council of Subspecialty Societies of the American College of Physicians to further rework the E&M Documentation Guidelines.

JCAHO "Sentinel Events" Policy

Other heated debate centered on the new "Sentinel Events" policy of the Joint Commission on Accreditation of Healthcare Organizations. ASAM testified in support of a resolution from the Illinois delegation urging JCAHO to "suspend implementation of this new policy" until concerns regarding the potential for the damaging release or discovery of confidential information can be addressed.

The House also voted to study the possibility of preparing a report of the Council on Scientific Affairs on the implications of recent research into brain development during pregnancy and the first five years of life. ASAM testified in favor of this effort and will attempt to influence the Council to address the effects on the developing brain of exposure to alcohol, nicotine, cocaine and other drugs.

The Wisconsin delegation submitted a resolution to "inform physicians and patients of the dangers of addiction associated with Internet gambling" and asking the AMA to "support the prohibition of government-sponsored Internet gambling" (Wisconsin and other states offer on-line games). The House adopted the measure with an amendment offered by the American Academy of Pediatrics, asking the AMA to "pursue other avenues to prohibit the availability of Internet gambling to children."

The American Psychiatric Association and the American Academy of Child and Adolescent Psychiatry submitted a resolution, adopted by the House, to "coordinate the development of updated national guidelines for the safe and clinically appropriate use of seclusion and restraint techniques with children and adolescents."

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Former Air Force Surgeon General is New AMA Chief Executive

Newly named chief executive of the American Medical Association is E. Ratcliffe "Andy" Anderson, Jr., M.D., a decorated combat veteran and former medical school dean, retired from the Air Force as a lieutenant general in 1996. As the Air Force's Surgeon General from 1994 to 1996, Dr. Anderson managed more than 50,000 personnel assigned to 87 medical facilities worldwide with an annual budget of nearly $5 billion. Previously, he was a Vietnam-era combat fighter pilot, medical test pilot, and chief flight surgeon. He also served, from 1984 to 1986, as command surgeon for all Pacific Air Forces, and as command surgeon for the Strategic Air Command (SAC) from 1986 to 1990. From 1990 to 1994, he was CEO of the Air Force's flagship, 1,000-bed Wilford Hall Medical Center at Lackland Air Force Base in Texas. Dr. Anderson received his MD from the Louisiana State University School of Medicine, with post graduate work at Philadelphia General Hospital, Boston City Hospital and New York University Medical Center. He is past president of the Association of Military Surgeons of the United States and a former member of the AMA's House of Delegates.

AMA Annual Meeting – Continued from page 7

A report by the AMA Board of Trustees addressed HCFA's policy of excluding from the Medicare and Medicaid programs any physician who has been convicted of a felony. The Board's report concluded that "a distinction can and should be drawn between those convicted of a drug-related crime involving others and those related to personal drug use." The report also called for a "second chance for those individuals who enter a first offender, deferred adjudication, or other arrangement or program where judgment of conviction has been withheld for the purpose of treatment and rehabilitation." The Board asked the AMA's Council on Legislation to draft an amendment to federal and state law to achieve these goals.

AMA staff reported that they have information on a lawsuit involving an employee who claimed discrimination on the basis of having a chronic illness. The AMA Litigation Center has asked that any physician who has or wishes information on similar cases contact the center. Discrimination against employees with the chronic disease of addiction clearly fits under this rubric.

In two hallmark decisions, the House voted that the AMA should "review and report under what circumstances…decisions of medical appropriateness made by a medical director of an insurer, HMO or related entity are within 'the practice of medicine'."

Also adopted was a policy calling on the AMA to develop, for the December 1998 House of Delegates meeting, "a negotiating unit within organized medicine, and with no affiliation with national trade unions, free of antitrust constraints for all its members in order to help level the playing field with health care payers." The resolution also asked the AMA to "provide increased financial resources to the Division of Physician and Patient Advocacy to increase private sector advocacy and assist physicians in negotiating collectively with health care payers."

Reports of the Council on Ethical and Judicial Affairs are not on the AMA web page, but they are on file at the ASAM office. For other AMA reports, consult the AMA website at www.ama-assn.org. Look under "What's New" to find "Annual Meeting"; all resolutions and most reports are posted.

AMA Membership Key

ASAM members are encouraged to join the AMA and their state medical associations, and to become active in their state association, either through its committee on alcohol and drug dependence and/or physician health, or through the state House of Delegates. In this way, ASAM members can, and should, shape the actions and direction of organized medicine. ASAM members who already are members of a state medical association House of Delegates are asked to notify the ASAM office.

Such involvement is not just an issue for ASAM "leaders"—rather, every physician can be a leader in his or her own local and state medical organizations, and every addiction medicine specialist has unique expertise to contribute to program and policy development at the local, state and national level.

ASAM PARTICIPATES IN AMA'S RESPONSE TO E&M CRISIS

Michael Miller, M.D., ASAM Delegate to the AMA

On April 27, the American Medical Association sponsored a special meeting on the "Documentation Guidelines for Evaluation and Management Services," recently published by the federal Health Care Finance Administration (HCFA).

Percy Wootton, M.D., AMA President, opened the session by referring to the guidelines as "one of the greatest issues facing medicine in the last 10 years." Bob Berenson, M.D., Director of the HCFA Office for Health Plans and Providers, described as "unfortunate" the way in which the Evaluation and Management (E&M) Guidelines have become entwined with HCFA's effort to root out fraud and abuse in Medicare billing.

The AMA previously secured a six-month delay in the original January 1998 implementation date for the new guidelines, and recently asked HCFA for a further postponement. Responding to issues raised by the AMA, Nancy-Ann Min DuParle, newly named HCFA Administrator, said in a letter that she would "do what I can to allay fears" of physicians. Ms. DuParle acknowledged "flaws in the Documentation Guidelines" and noted that "neither the AMA nor HCFA fully understood the magnitude of the problems" with the Guidelines as drafted. Her letter supported further delay in implementation and echoed comments made by speakers at the AMA meeting, who declared that documentation guidelines must be simple, understandable, and reliable (consistently applicable); there must be time for revised guidelines to be pilot-tested before implementation (ideally, in different geographic areas and with different specialties); and there must be time for education of physicians and state-by-state training of Medicare carriers (so that reviewers as well as physicians can apply them). Participants in the April meeting expressed concern that the guidelines could "induce physicians to do more for their patients than their clinical judgment dictates," as physicians attempt to avoid charting shortfalls.

AMA has called for more emphasis on education of physicians, rather than punitive interventions, when documentation deficits are detected. Participants repeatedly raised fears about penalties, and Dr. Wootton's comments addressed this: "A commitment to ethics is a part of our oath; physicians must be treated as ethical professionals."

Dr. Wootton also insisted that revisions in the E&M process should allow medical specialties to define the content of their examinations, and that there should be advance notice to physicians regarding review criteria to which they will be subject. ASAM has assisted AMA in this regard by contributing recommended guidelines for how the Evaluation and Management activities of physicians serving patients with addiction problems could be documented in patient records and hence reviewed by chart auditors. Dr. Wootton affirmed his intent to use ASAM's draft as a resource in discussing E&M issues with the Federation of State Medical Boards, which often deal with medical records of physicians who are evaluated and treated for their own addictive disorders.

Anticipating the avalanche of complaints voiced at the April meeting, the AMA established a task force to draft a "New Framework for Documentation Guidelines." Discussed with those gathered on

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IDENTIFYING ALCOHOL AND DRUG PROBLEMS IN OLDER PATIENTS

As older patients undergo key life transitions or take on a new and stressful roles, vulnerability to alcohol or prescription drugs may increase. Risk factor life transitions include menopause, a newly "empty nest," and approaching retirement. Assuming new roles such as caretaker for an ailing relative or custodian of young grandchildren also makes older adults more vulnerable. Any of these changes should trigger an alcohol screen.

Screening questions should be asked in a confidential setting and in a nonthreatening, nonjudgmental manner. Many older adults are acutely sensitive to the stigma associated with alcohol and drug abuse and are far more willing to accept a "medical" as opposed to a "psychological" or "mental health" diagnosis as an explanation for their problems. Prefacing questions with a link to a medical condition can make them more palatable. For example, "I'm wondering if alcohol may be the reason why your diabetes isn't responding as it should," or, "Sometimes one prescription drug can affect how well another medication is working. Let's go over the drugs you're taking and see if we can figure this problem out." It is vitally important to avoid using stigmatizing terms like *alcoholic* or *drug abuser* during these encounters.

Screening and Assessment

The CAGE Questionnaire (Ewing, 1984) and the Michigan Alcoholism Screening Test—Geriatric Version (MAST-G) (Blow et al., 1992a) are two well-known alcohol screening instruments that have been validated for use with older adults. One of the most widely used alcohol screens, the CAGE consists of four questions, can be self-administered even by those with low literacy reading skills, and can be modified to screen for use of other drugs. Positive responses on the CAGE are for lifetime problems, not current ones. Before administering the CAGE, the MAST-G, or any other screen, ascertain that the person does currently drink alcohol and that the questions that are endorsed are for problems that they have experienced recently, usually within the last year.

Although two or more positive responses are considered indicative of an alcohol problem, a positive response to any one of these questions should prompt further exploration among older adults. The CAGE is most effective in identifying more serious problem drinkers, including those with abuse and dependence, and less effective for women problem drinkers than their male counterparts.

The MAST-G was developed specifically for older adults and has high sensitivity and specificity among older adults recruited from a wide range of settings, including primary care clinics, nursing homes, and older adult congregate housing locations.

The existence of comorbid medical and psychiatric disorders will influence treatment choice and priorities and will affect treatment outcome. Frail or medically compromised alcohol abusers, for example, may require more intensive monitoring during the detoxification period of treatment than their more

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BARRIERS TO DIAGNOSIS AND TREATMENT

Physicians often unwittingly create obstacles to intervening effectively with older patients who have drinking problems. These obstacles can be summed up as follows:

Denial is foremost—refusal to recognize or admit that alcoholism is present. Denial is as ubiquitous as alcoholism itself. It is shared by the patient, the family, and the physician alike. It is manifest regardless of the age of the patient, but it is intensified for the elderly, to whom behavioral stereotypes of the alcoholic often don't apply: the elderly alcoholic seldom is drunk and disorderly, rarely is arrested for driving while intoxicated, and, though often a victim, almost never is a perpetrator of family violence. Elderly patients frequently do not view alcoholism as a disease; rather they see it as a sin or weakness and are reluctant to admit to symptoms.

Uncertainty is also prevalent. The physician often is not sure which signs he/she should be looking for to make a diagnosis of alcoholism, is not prepared to convince the patient to accept treatment, or is not familiar with long-term treatment resources in the community and how to participate in effective referral.

Pessimism about treatment outcome is another roadblock to physician involvement. The physician may think "Why should I invest the considerable time and energy it will take to help this recalcitrant patient when he (or she) can expect to live only a few more years? Why bother at this late date? Why not let the patient drink and be happy?"

Elder discrimination is a fourth factor. The physician may be uncomfortable about treating alcoholism in a patient of any age, but is likely to be more interested in, and concerned about, the drinking problems of younger as opposed to elderly persons, and prefers to accept the former as patients who, as a group, he/she believes may have a better prognosis. Subconsciously, the physician may identify with adult children of the patient and share in *their* hostility.

Realization that overcoming drinking problems can made a major improvement in the quality of later life, and extend that life as well, will make the physician and the patient more optimistic about treatment outcome. Recognizing that alcoholics are not that much more difficult as patients than those who suffer from other chronic relapsing diseases, such as cancer or diabetes, will give the physician the necessary perspective to accept the challenges of identifying, diagnosing and treating this addictive disorder in the elderly.

[Reprinted with permission from "Alcoholism in the Elderly: Diagnosis, Treatment, Prevention: Guidelines for Primary Care Physicians," published by the American Medical Association, Chicago, IL, 1995 (Endorsed by the American Society of Addiction Medicine)].

Identifying Problems – Continued from page 9

robust peers. When disorders such as uncontrolled hypertension or depression are detected, reducing alcohol consumption becomes a priority; until drinking is curbed, medication prescribed for those conditions will not work effectively. In contrast, for older adults suffering from chronic pain, the priority would be to identify an effective painkiller, then taper the amount of alcohol consumed.

Acute alcohol withdrawal syndrome is more protracted and severe in older adults than in younger adults (Brower et al., 1994; Liskow et al., 1989). Because there is no research on the recent practice of outpatient detoxification for older adults, very careful assessment is warranted before detoxification from any drug; outpatient detoxification may not be appropriate for older adults who are frail or who have a comorbidity.

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Life Changes Associated With Substance Abuse in Older Adults

Emotional and Social Problems

- Bereavement and sadness
- Loss of
  - Friends
  - Family Members
  - Social Status
  - Occupation and sense of professional identity
  - Hopes for the future
  - Ability to function
- Consequent sense of being a "nonperson"
- Social isolation and loneliness
- Reduced self-regard or self-esteem
- Family conflict and estrangement
- Problems in managing leisure time/boredom
- Loss of physical attractiveness (especially important for women)

Medical Problems

- Physical distress
- Chronic pain
- Physical disabilities and handicapping conditions
- Incomnia
- Sensory deficits
  - Hearing
  - Sight
- Reduced mobility
- Cognitive impairment and change

Practical Problems

- Impaired self-care
- Reduced coping skills
- Decreased economic security or new poverty status due to
  - Loss of income
  - Increased health care costs
- Dislocation
  - Move to new housing, or family moves away
  - Homelessness
  - Inadequate housing

Source: CSAT TIP No. 26.

MOVING THE OLDER ADULT INTO TREATMENT

[The following information is excerpted from CSAT Treatment Improvement Protocol No. 26, "Substance Abuse Among Older Adults," published by the Center for Substance Abuse Treatment, Rockville, MD, April 1998.]

After determining that an older adult may benefit from a reduction in or complete abstention from alcohol use, the clinician must next assess the patient's understanding of this benefit. Many older adults may not know that their alcohol use is affecting their health. Because patient understanding and cooperation are essential both in eliciting accurate information and following through on the treatment plan prescribed, clinicians should use the assessment process as an opportunity to educate the older adult and to motivate him or her to accept treatment.

Older adults present unique challenges to those applying brief intervention strategies for reducing alcohol consumption. Because many older at-risk and problem drinkers are ashamed about their drinking, intervention strategies need to be especially nonconfrontational and supportive. In addition, the consumption level that constitutes at-risk drinking is lower than that for younger individuals (Chermack et al., 1996), so even low levels can be dangerous. Chronic medical conditions may make it more difficult for clinicians to recognize the role of alcohol in decreases in functioning and quality of life. These issues must be kept in mind during brief interventions with this vulnerable population.

One approach devised to facilitate brief interventions is known by the acronym *FRAMES*. This approach emphasizes:

- **Feedback** of personal risk or impairment as derived from the assessment
- Personal **responsibility** for change
- Clear **advice** to change
- A **menu** of change options to increase the likelihood that an individual will find a responsive treatment (although multiple attempts may be necessary)
- An **empathic** counseling style
- Enhanced client **self-efficacy** and ongoing follow-up (Miller & Sanchez, 1994).

For some older adults, especially those who are late onset drinkers or prescription drug abusers with strong social supports and no mental health comorbidities, pretreatment approaches may prove quite effective, and follow-up brief interventions and empathic support for positive change may be sufficient for continued recovery. There is, however, a subpopulation of older adults who will need more intensive treatment.

Despite the resistance that some older problem drinkers or drug abusers exert, treatment is worth pursuing. Studies show that older adults are more compliant with treatment and have treatment outcomes as good as or better than those of younger patients (Oslin et al., 1997; Atkinson, 1995).

Patients who are brittle, frail, acutely suicidal, or medically unstable or who need constant one-on-one monitoring, should receive 24-hour primary medical/psychiatric/nursing inpatient care in medically managed and monitored intensive treatment settings. Recent changes in the health care system have dramatically reduced the availability of this level of care. Inpatient rehabilitation (traditional 14-, 21-, or 28-day programs) are not readily available and often no longer reimbursed by health care insurers. Because of these reimbursement gaps, inpatient care may have to be arranged on a medical or psychiatric unit of an acute care hospital.

Treatment Approaches

The Consensus Panel recommends the following general approaches for effective treatment of older adult substance abusers:

- Cognitive-behavioral approaches
- Group-based approaches
- Individual counseling
- Medical/psychiatric approaches
- Marital and family involvement/family therapy
- Case management/community-linked services and outreach.

Not every approach will be necessary for every client. Instead, the program leaders can individualize treatment by choosing from this menu to meet the needs of the particular client. Planning information comes from interviews; mental status examinations; physical examinations; laboratory, radiological, and psychometric tests; and social network assessments, among others.

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RESOURCES

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AgePage: Aging and Alcohol Abuse, published by the National Institute on Aging and the National Institute on Alcohol Abuse and Alcoholism, is a handy one-page leaflet summarizing key information for patients, including physical effects of alcohol, how to recognize a drinking problem, and where to get help.

Effect of Aging on Response to Drug Effect

Drug	Action	Effects of Aging
Analgesics		
Aspirin	Acute gastroduodenal mucosal damage	No change
Morphine	Acute analgesic effect	Increased
Pentazocine	Analgesic effect	Increased
Anticoagulants		
Heparin	Activated partial thromboplastin time	No change
Warfarin	Prothrombin time	Increased
Bronchodilators		
Albuterol	Bronchodilation	No change
Ipratropium	Bronchodilation	No change
Cardiovascular Drugs		
Adenosine	Minute ventilation and heart rate	No change
Diltiazem	Acute antihypertensive effect	Increased
Enalepril	Acute antihypertensive effect	Increased
Isoproterenol	Chronotropic effect	Decreased
Phenylephrine	Acute vasoconstriction	No change
	Acute antihypertensive effect	No change
Prazocin	Chronotropic effect	Decreased
Timol	Chronotropic effect	No change
Verapamil	Acute antihypertensive effect	Increased
Diuretics		
Furosemide	Latency and size of peak diuretic response	Decreased
Psychotropics		
Diazepam	Acute sedation	Increased
Diphenhydramine	Psychomotor function	No change
Haloperidol	Acute sedation	Decreased
Midazolam	Electroencephalographic activity	Increased
Temazepam	Postural sway, psychomotor effect, and sedation	Increased
Triazolam	Psychomotor activity	Increased
Others		
Levodopa	Dose elimination due to side effects	Increased
Tolbutamide	Acute hypoglycemic effect	Decreased

Source: CSAT TIP No. 26.

ALTERATIONS WITH ADVANCING AGE THAT AFFECT REACTIONS TO PRESCRIPTION AND NON-PRESCRIPTION DRUGS

Marc A. Schuckit, M.D.

There are six areas of change in functioning with advancing age that impact on the effects of alcohol, drugs, or medications. The first is how well an individual *absorbs* the substance. With increasing age there is likely to be a decrease in the amount of blood that flows to the stomach and intestines, a decrease in the efficiency with which the stomach contents move through the digestive tract. These issues have only a modest impact on the overall absorption of alcohol, drugs of abuse, or most medications, although they are likely to result in a slightly longer period of time before these substances find their way into the bloodstream.

The second important aspect of change in body functioning with advancing age involves how the alcohol, drug, or medication is distributed throughout the body after it has been absorbed. There are two major factors that affect this *distribution*. The first is that with advancing age most people have a higher proportion of body fat. Therefore, drugs that are dissolved in fat can often remain within the body for longer periods of time. A corollary of the higher body fat is a lower proportion of body muscle. Muscle has a much higher proportion of water than fat, with the result that with advancing age the amount of water in which any substance can dissolve is decreased. These changes can have a major impact in a variety of substances. Therefore, with advancing age people have higher and higher blood alcohol concentrations after they drink, a finding likely to be related to the lower levels of body water. Similarly, most other medications, lithium, for example, will accumulate at higher levels in the body as a reflection of the lower amount of body water.

The third important change with aging involves the levels of protein available in the bloodstream. While not true of alcohol, many drugs of abuse and most medications with psychological side effects are present in the bloodstream in two forms: an active form which is unbound to protein or free, and an inactive form of the substance which is bound or tied to proteins. As we age, the level of many proteins (e.g., albumin) decreases, with the result that we are likely to have higher levels of active or free forms of medications or drugs. This presents a heightened risk for toxic side effects.

The fourth attribute involved with the body's reactions to substances is how rapidly the material is broken down or *metabolized* in the liver. As we age, there is a small but significant decrease in the rapidity of the flow of blood to the liver, with the result that more of the alcohol, drug of abuse, or medication is likely to find its way around the liver and into the bloodstream to be distributed to the rest of the body. Similarly, with advancing age many of the enzymes in the liver decrease in amount, with the result that less of the alcohol, drug of abuse, or medication is being broken down per hour in the average 70-year-old than is true in the average 40-year-old. The final result is higher blood levels.

The fifth step of handling alcohol, drugs, or medications occurs through *excretion* via the kidney. With advancing age, there is a decrease in the rate with which blood flows to the kidney, and the organs (called glomeruli) within the kidney responsible for filtering out substances or their breakdown products do not function as well. It has been estimated that there is a decrease in the ability of the kidney to eliminate substances of about 30% over the lifetime. These changes also contribute to higher blood levels of most substances with advancing age.

The final component involves the *sensitivity* with which the *brain or other organs* respond to the substance of abuse or medication. Most of these substances have their impact on receptors attached to the nerve cells. With advancing age, there are changes in these cells so that they are likely to show increased responses to any drug that affects the usual neuron chemical such as dopamine or acetylcholine.

In summary, while the result of all these changes can differ from person to person, there are some generalizations that can be made. Substances (such as Valium® or diazepam) that are easily dissolved in fats are likely to remain in the body for longer periods of time with advancing age. Also, since almost all drugs are dissolved in body water, and since levels of body water decrease with advancing age, almost all substances (including alcohol, the Valium-type drugs, lithium, amphetamines, and so on) will occur at higher levels in the bloodstream as people get older. While there are few

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CAUTIONS IN PRESCRIBING FOR OLDER ADULTS

Health care professionals need to keep abreast of current information about appropriate prescribing practices for older patients as well as new drugs with less hazardous profiles. Older adult-specific protocols must stress medication assessments for all patients; lower initial doses and time-limited dosing patterns for psychoactive and other agents; use of new and less complex drugs with simple metabolic pathways and less dangerous side effects; avoidance of more hazardous substances with long half-lives that cannot easily be absorbed or eliminated by older adults; and appropriate, consistent monitoring of patients' reactions to prescribed drugs.

Health care professionals also need be reminded of ways to convey information that are easily understood and used by older patients (e.g., written as well as spoken, disseminated to family caregivers and advocates as well as patient). When prescribing medications for older adults, it is also useful to consider the family situation. Are other family members likely to share their medication with the patient or use it themselves? Is there a family member who will help the older patient track his medications, comply with the practitioner's request to bring unused medications to the practitioner, remind the patient to discard expired medication, or remove the medication at the practitioner's request? Family members can be important allies in preventing problems from developing or escalating.

[This information is excerpted from CSAT Treatment Improvement Protocol No. 26, "Substance Abuse Among Older Adults," published by the Center for Substance Abuse Treatment, Rockville, MD, April 1998.]

Older Adult – Continued from page 11

The multiple causes of older adults' problems require multiple linkages to community services and agencies. The treatment program that seeks to be the sole source of all services for its older clients is likely to fail. Even in very isolated areas, programs can strengthen their services for older adults through linkages to local resources such as the faith community.

Discharge Plans and Aftercare

Effective discharge planning is essential to case management for older clients because their social networks may have shrunk as a result of their substance abuse problems, physical limitations, or the loss of family members and friends. In this context, it is vitally important for clients' counselors or case managers to help them tap into available community resources by assisting them in identifying ongoing needs (e.g., income maintenance, housing), scheduling services (e.g., Homemakers, eye care, hearing tests, financial planning), and obtaining equipment (e.g., large-number telephones, home banking systems, walkers and other devices).

As part of the discharge process, a counselor or case manager also develops an aftercare program with the client. For older adults, this may entail arranging transportation to follow-up appointments and reminders to note dates and times on the calendar, as well as fulfilling more traditional functions like monitoring progress to prevent or reduce the negative impact of relapse. Standard features of most discharge plans for older adults include

- Age-appropriate Alcoholics Anonymous, Pills Anonymous, Rational Recovery, women's or other support groups.
- Ancillary services needed to maintain independence in the community
- Ongoing medical monitoring
- Involvement of an appropriate case manager if needed to advocate for the client and ensure needed services are provided.

Aftercare and recovery services for older clients differ in some respects from those typically offered by some substance abuse treatment programs where fraternization is discouraged. Programs oriented to older clients often sponsor socialization groups or weekly treatment alumnae meetings run by long-sober peer counselors. Others allow clients to return to the program to participate in group therapy. Still others initiate a network of contacts for older clients and teach them how to expand it.

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Reactions to Drugs – Continued from page 13

changes in how well alcohol, drugs of abuse, or medications are absorbed with increasing age, there are decreases in the efficiency through which the liver breaks down the substance, and by which the kidney excretes it. The result of all these changes is similar to what happens to a bathtub when the water continues to enter at the same (or even a slightly slowed) rate, while the rate of the drainage is even more obstructed. Thus, alcohol, most drugs of abuse, and many medications take a longer period of time to reach a steady blood level, and are likely to maintain a higher level for an extended period of time. To make matters worse, the brain and other body organs are likely to be supersensitive to even normal blood levels of most substances.

[Reprinted with permission from Vista Hill Foundation, San Diego, California. "Changes in Reactions to Alcohol, Drugs and Medications with Advancing Age," Drug Abuse & Alcoholism Newsletter, 26(5):2-3, October 1997.]

AMA Response to E&M Crisis – Continued from page 8

April 27, by Doug Henley, M.D., of the CPT Editorial Panel, this new framework proposes that the "General Multi-System Exam" and the "Single Organ System Exam" format be dropped. The principle under which this proposal was drafted is that the medical record content should be determined by the examining physician, based on clinical judgment, the patient's history and the presenting problem, and not determined by documentation guidelines. The new framework is linked to three key components: history, examination, and medical decision-making. It is proposed that if two of these three components are documented at a certain level of complexity, that the encounter should be coded at that high level of complexity.

A key point is that HCFA chart audits will continue, using the 1994-1995 E&M guidelines. Implementation of the revised guidelines (referred to as the 1997 version) has been deferred indefinitely. Thus, an audited physician has the option of specifying that he or she uses either the "old" (1994-95) guidelines or the "new" (1997) ones. It is important to note that accountability for documentation has not disappeared simply because implementation of the new guidelines has been postponed.

Where do we go from here? There is the "New Framework", which was offered for consideration April 27. There will be intensified dialogue with medical specialty societies such as ASAM regarding this "framework", as the AMA (in collaboration with the state associations and specialty societies) determines how to respond to HCFA. It is hoped that the response of organized medicine can be crystallized by August, and field-testing of pilots of a new version of the Documentation Guidelines can be completed in the third quarter 1998. ASAM will work with the AMA in refining the position of organized medicine, and will continue to emphasize the elements of the examination and medical decision-making involved in the evaluation and management of the patient with an addictive disorder. Input from ASAM members is welcomed; comments should be sent to Mike Miller by E-mail at mmiller@meriter.com, or faxed to 608/258-3265. Details of the AMA's activities (including reports from the break-out sessions at the April 27 meeting) can be found on the E&M page of AMA's website at www.ama-assn.org.

ASAM BESTOWS AWARDS AT ANNUAL MEETING

Recipients of the 1998 Annual ASAM Awards, which were presented at the Awards Luncheon during the annual Medical-Scientific Conference, are:

David Mee-Lee, M.D., and John Slade, M.D., FASAM, have been honored for their "outstanding contributions to the growth and vitality of our Society, for thoughtful leadership in the field, and for deep understanding of the art and science of Addiction Medicine."

Stanton A. Glantz, Ph.D. received an award recognizing his work in "expanding the frontiers of the field of Addiction Medicine, and broadening our understanding of the addictive process, through research and innovation."

Rita Aszalos, M.D., won the Young Investigator Award "for the best abstract submitted for presentation at the Society's Annual Medical-Scientific Conference."

Daniel Anderson, Ph.D., received the first John P. McGovern Award. The John P. McGovern Award and Lecture on Addiction and Society was established in 1997 to recognize and honor an individual who has made highly meritorious contributions to public policy, treatment, research, or prevention which has increased our understanding of the relationship of addiction and society. The award consists of a commemorative medallion, a modest honorarium, and travel expenses. This award is sponsored by an endowment from the John P. McGovern Foundation.

Lee N. Robins, Ph.D., received the Society's R. Brinkley Smithers Distinguished Scientist Award "for pioneering work on the epidemiology and social correlates of addictive illness, and for training leading physicians in the addiction research field."

In addition to the annual awards, special awards were presented to the following individuals:

The Honorable Janet Reno, Attorney General of the United States "In recognition of her significant contributions to preventing and reducing problems associated with addictive disorders."

Donald M. Gallant, M.D., for outstanding contributions to the field of Addiction Medicine.

P. Joseph Frawley, M.D., Chair of the Finance Committee, 1993-1997.

Allan W. Graham, M.D., FASAM, Chair of the Review Course Program and State of the Art Conference, 1994-1997.

Terry K. Schultz, M.D., FASAM, Co-Chair of the Review Course Program and State of the Art Conference, 1994-1997.

Christine L. Kasser, M.D., Chair of the Practice Guidelines Committee, 1992-1997, and for her accomplishments in the development and publication of ASAM *Practice Guidelines*.

William B. Hawthorne, M.D., "for extending ASAM's educational and outreach programs into the medium of the 21st century as creator and Webmaster of ASAM's Website."

Dr. Ziegler Publishes on the Disease of Addiction

Penelope P. Ziegler, M.D., FASAM, discusses "The Disease of Addiction" in an article published in a recent issue of *Virginia Pharmacist*. In the article, Dr. Ziegler writes that "Alcoholism and dependence on other drugs are part of a spectrum of diseases known as addictive or substance use disorders. They are complex illnesses which have a basis in the biology of the brain, but are also influenced by psychological and social factors."

Dr. Canavan Recognized for Service to Medicine

David I. Canavan, M.D. has been given the Edward J. Ill Award, the highest award of the Academy of Medicine of New Jersey, in recognition of his "dedication and extraordinary service to the profession and to the citizens of [the] State." The honor was bestowed at an awards gala in May.

Dr. Smith Honored for Compassionate Care Giving

Immediate Past President David E. Smith, M.D., FASAM, has been honored by Western University of Health Sciences with an award for compassionate care giving. Citing Dr. Smith's work as founder and president of the Haight Ashbury Free Clinics in San Francisco, the award notes that Dr. Smith "provided accessible health care to transient and indigent populations since the migration of 'flower children' to the Bay area more than 30 years ago. Catering to a patient base deeply immersed in the drug culture; he was among the first to pave a clinical pathway to recovery and sobriety for addicts on the street."

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CHAPTER UPDATES

Arkansas

President: James Tutton, M.D.
Regional Director: Ken Roy, M.D., FASAM

The Arkansas Chapter's May quarterly meeting featured reports on ASAM's Med-Sci Conference in New Orleans updates and election of officers. Bernie Miller, M.D., was elected ARSAM President and Jim Waldron, M.D., Ph.D. was elected Vice President.

California

President: Gail N. Schultz, M.D., FASAM
Regional Director:

The CSAM Committee on Treatment of Opioid Dependence has prepared a White Paper titled "Guideline for the Role and Responsibilities of Physicians in Narcotic Treatment Programs." The Committee began the project to focus on what physicians do in methadone maintenance treatment programs, to describe the clinical aspects of their work and to discuss the areas for which such physicians are responsible. The document began as a companion document to the California regulations for methadone programs. When the first draft of the 41-page document was complete, it was sent for review to over 150 interested organizations, agencies and individuals. All members of the ASAM Committee on Methadone Maintenance Treatment received a copy of the paper, with a request for comments. The final version of the White Paper will be available from CSAM in summer 1998.

Florida

President: Richard Keesal, M.D.
Regional Director: Richard Beach, M.D., FASAM

The 12th Annual FSAM/ASAM Conference on Addictions is scheduled for February 5-7, 1999, in Orlando. FSAM sponsors this continuing education program each year (with joint sponsorship from ASAM) for its members and other health professionals interested in addiction medicine. Continuing education credit is provided for the physicians, nurses, social workers, counselors, and addiction therapists who attend the conference to update their knowledge and network with peers. Over the three and a half days of the conference, presentations are scheduled in the mornings, leaving the afternoons free for participants to explore all the attractions Orlando offers.

FSAM has extended an invitation to members of other chapters and related organizations to schedule special afternoon breakout sessions to meet with their own members during the course. For more information, contact Robert Donofrio at the FSAM office, 850/484-3560.

FSAM continues to support the national membership and ASAM growth goals. Robert Donofrio represented FSAM at the State Chapter Workshop and luncheon during ASAM's annual Medical-Scientific Conference. The Florida Chapter was recognized for its regional leadership in ASAM and was commended for its progress over the past decade.

Kentucky

President: Robert J. Middleton, M.D.,
Regional Director: Norman S. Miller, M.D., FASAM

Kentucky received its charter as a State Chapter during ASAM's 29th Annual Medical-Scientific Conference in New Orleans. At that meeting, chapter officers also were elected.

The State of Kentucky was recognized at the Medical Scientific Conference as a State Chapter of ASAM. KYSAM will hold its annual meeting in conjuction with the annual meeting of the Kentucky Medical Association, set for Louisville in September.

KYSAM President Robert Middleton, M.D., will participate in the Medical Specialty Council of the Kentucky Medical Association.

Alabama

Immediate Past President David E. Smith, M.D., FASAM (third from left), represented ASAM at the annual meeting of the Alabama Society of Addiction Medicine.

Michigan

President: Thomas Peter Kane, D.O., FASAM
Regional Director: Norman S. Miller, M.D., FASAM

Chapter President Thomas Kane, D.O., FASAM, and President-Elect Stephen Bendix, M.D., report that the chapter's first annual conference was a great success. The April conference, entitled "Chemical Dependency into the Next Millennium," was jointly sponsored by ASAM. Presenters included Regional Director Norman S. Miller, M.D., FASAM, who discussed benzodiazepine dependence; Milton Burglass, M.D., FASAM, who reviewed opiate dependence and gave a luncheon presentation on "Forensic Issues in Addiction Medicine." Also among the faculty were Paul Earley, M.D., FASAM, who presented on cocaine dependence, and Richard Hurt, M.D., FASAM, who discussed nicotine dependence. Based on the success of the event, a second Annual Conference is being planned for April 1999.

New Jersey

President: John J. Verdon, Jr., M.D., FASAM
Regional Director: R. Jeffrey Goldsmith, M.D.

NJSAM'S next business meeting is scheduled for Saturday, September 19. Members will be contacted by mail with meeting specifics, or are invited to contact Dr. Verdon with any questions at 732/842-9468.

New York

President: Merrill Herman, M.D.
Regional Director: Lawrence S. Brown, Jr., M.D., M.P.H., FASAM

The New York Chapter held its Annual Business/CME meeting in March in New York City. Guest presenter was Marc Galanter, M.D., ASAM President-Elect, who spoke on "Network Therapy with Substance Abuse." The meeting also welcomed representatives of the New Jersey Chapter.

Continued on next page

Continued from previous page

Ohio

President: Ted Hunter, M.D.
Regional Director: R. Jeffrey Goldsmith, M.D.
The Ohio Chapter held a general Membership Meeting on July 11. Newly elected officers are Gregory Collins, M.D., President; Robert Liebelt, M.D., Vice President; Stan Sateren, M.D., Secretary; and Chris Adelman, M.D., Treasurer. New Board members are Edna Jones, M.D., David Goldberg, D.O., and Sybil White, M.D.

Oklahama

President: C. R. Roberts, M.D.
Regional Director: Ken Roy, M.D., FASAM
OKSAM received its official Chapter Charter during the 1998 ASAM Med-Sci Conference. To celebrate the milestone, chapter members who were present in New Orleans held an informal business meeting and dinner.

The chapter's next regular business meeting will be held in late summer. In the interim, OKSAm members are encouraged to contact President C. R. Roberts, M.D., with suggestions for the annual fall meeting, held in concert with the Texas Chapter. Members also are reminded to support the Harold Hughes Parity Bill, which would require equal benefits for addiction treatment.

Oregon

President: Douglas L. Bovee, M.D., FASAM, F.A.C.P.
Regional Director: Richard Tremblay, M.D., FASAM
ORSAM again is co-sponsoring a conference on "Addictive Disease Issues for the 21st Century: Integrating Science and Practice." The meeting is scheduled for August 21-22 in Vancouver, B.C. Speakers include ASAM President G. Douglas Talbott, M.D., FASAM, and Robert DuPont, M.D., FASAM. ORSAM members Gregory Skipper, M.D., FASAM, and Judith Bjorndal, M.D. will present at a break-out session. Information is available from the Foundation of Medical Excellence at 503/636-2234.

With support from Roxane Laboratories, ORSAM recently hosted a dinner meeting program on "Marinol, Dronabinol and Medical Marijuana" in Tualatin, OR. Featured speakers included ASAM Immediate Past-President David Smith, M.D., FASAM, Lonnie Bristow, M.D., and Gary Cohan, M.D. ORSAM officials report that the meeting drew 50 attendees and featured a stimulating discussion of the issues.

ORSAM's April quarterly meeting featured a presentation on pathological gambling, while the June meeting focused on the treatment of chronic pain in addiction.

The chapter has extended its congratulations to members Douglas Bovee, M.D., FACP, FASAM, and Gregory Skipper, M.D., FASAM, for achieving fellowship in ASAM.

South Carolina

President: John E. Emmel, M.D.
Regional Director: Paul H. Earley, M.D., FASAM
SCSAM held a Board meeting in May, at which the Board heard a report of Dr. John E. Emmel's continuing activities in support of state legislation to reduce the BAC level for drinking and driving offenses.

In April, Dr. Emmel met with the director of the state's Alcohol and Drug Authority to discuss possible collaborative activities with SCSAM. Dr. Emmel also attended the State Chapter Development Seminar at ASAM's Med-Sci Conference in April.

Wisconsin

President: Dean Whiteway, M.D.
Regional Director: Norman S. Miller, M.D., FASAM
WISAM has scheduled a symposium for primary care physicians on "How To Write Right" for September 18th and 19th in Madison, WI. The meeting will include presentations on Basics of Addiction; Basic Opioid and Benzodiazepine Pharmacology; Use of Opioids for Chronic Pain; Use of Benzodiazepines for Chronic Anxiety; Insomnia; Panic Disorder; Regulatory State Board Updates; and other prescribing issues. Information on the symposium is available from Dr. Dean Whiteway at 800/362-9567, by E-mail at DWHITEWA@GC.GUNDLUTH.ORG or by mail at Gundersen-Lutheran Medical Center, 1836 South Ave., La Crosse, WI 54601.

International

Regional Director: Peter Mezciems, M.D., FASAM
Momentum continues to build for an International Society of Addiction Medicine. International members who met during a special workshop at the 1998 ASAM Med-Sci Conference have formed a steering committee to move forward on the idea, with the support and assistance of ASAM President G. Douglas Talbott, M.D., President-Elect Marc Galanter, M.D, and Immediate Past President David E. Smith, M.D.

The American Society of Addiction Medicine
gratefully acknowledges receipt
of an unrestricted educational grant from
Roxane Laboratories, Inc.
in support of *ASAM News*.

DONORS HONORED AT RUTH FOX FUND RECEPTION

A festive reception at ASAM's annual Medical-Scientific Conference honored major donors to the Ruth Fox Memorial Endowment Fund. Singled out for special recognition by Fund Chairman Max Schneider, M.D., FASAM, were: Ken Roy, M.D., FASAM (Gold Embedment); Joseph E. Dorsey, M.D. (Gold Medallion); Andrew DiBartolomeo, M.D., FASAM (Silver Medallion); and Dorothy Mae C. Bennett, M.D., Paul H. Earley, M.D., FASAM, Stanley J. Evans, M.D., Timothy B. Gibson, M.D., Lee Gladstone, M.D., FASAM, and Charles W. Morgan, M.D., FASAM (Bronze Medallions).

Pictured enjoying the Ruth Fox Fund reception at ASAM's annual Medical-Scientific Conference in New Orleans are (standing, left to right): Max Schneider, M.D., FASAM, Charles S. Lieber, M.D., Charlotte Anne Hunter (Mrs. Conway Hunter), David E. Smith, M.D., FASAM, [unidentified], Conway Hunter, M.D., David R. Gastfriend, M.D., Stanley E. Gitlow, M.D., FASAM, [unidentified]. Seated, at center, is Maxwell N. Weisman, M.D.

IN MEMORIAM

Violet Eggert, M.D. passed away in Chicago earlier this year. A long-time leader in the addictions field, Dr. Eggert was the first recipient of the Lifetime Achievement Award of the Illinois Society of Addiction Medicine. Since 1987, she had been associated with the Illinois State Medical Society Physician Assistance Program as medical director, consulting medical director, and case manager. She began her career in the field working with the alcohol detox unit of Evanston Hospital as a resident in 1973. She was the medical director of Interventions in Chicago from 1980 to 1987.

Dr. Eggert had served on planning committees for AMA conferences on impaired physicians, and was a member of the medical advisory board of the Illinois State Department of Alcoholism and Substance Abuse, and of the editorial review board of the *Journal of Psychoactive Drugs*.

Roger A. Goetz, M.D., FASAM, 63, of Amelia Island, Florida died in March after a brief illness. Dr. Goetz was a native of Milwaukee, Wisconsin, and a graduate of Marquette University School of Medicine. Dr. Goetz entered the practice of addiction medicine in 1979. Dr. Goetz served as the Director of the Florida Medical Association's Physicians Recovery Network (the State of Florida's Impaired Practitioners Program) and as Consultant to the Florida Department of Health and the Florida Department of Business and Professional Regulation. He also was instrumental in the development of the Florida Bar Association's Lawyer's Assistance Program (FLA) and the Florida Intervention Project for Nurses (IPN).

Dr. Goetz was a Diplomate of the American Board of Anesthesiology, as well as a Fellow of the American College of Anesthesiology. He was a member of the Florida Society of Addiction Medicine (FSAM), as well as a member of the Florida Alcohol and Drug Abuse Association (FAADA). In recent years, Dr. Goetz had served as Chairman of the Board for the Federation of State Physician Health Programs and was a member of the American Medical Association Committee on Physician Health.

Dr. Goetz is survived by his wife, Kay Orr-Goetz, his mother, six children, six grandchildren and innumerable peers and colleagues. Donations in his memory may be made to the Roger A. Goetz, M.D. Memorial Loan Fund, to assist health care practitioners in need of treatment, via the Florida Medical Foundation/PRN, P.O. Box 1881, Fernandina Beach, Florida 32035-1881.

Mrs. Richard Tremblay. Laurie S. Tremblay, wife of ASAM Board member Richard Tremblay, M.D., died in June at Olympia, Washington. Mrs. Tremblay was a counselor and teacher at South Puget Sound Community College, where a memorial fund has been established in her name.

In addition to Dr. Tremblay, Mrs. Tremblay is survived by three sons, three stepsons, and six grandchildren.

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1998

July 17–19
ASAM MRO Course
San Diego, CA
19 Category 1 CME credits

September 26–29
American Methadone Association Conference
New York, NY
(Jointly sponsored by ASAM)

September 28–30
ICAA 1998 Annual Research Conference
"Women and Adolescent Females in Community Corrections"
(ASAM is a Supporting Organization)

October 7–10
CSAM Review Course in Addiction Medicine
Los Angeles, CA
21 Category 1 CME credits

October 22–24
Review Course in Addiction Medicine
Chicago, IL
21 Category 1 CME credits

November 5–8
11th National Conference on Nicotine Dependence
Marina del Ray, CA
17.5 Category 1 CME credits

November 13–15
Medical Review Officer Training Course
Toronto, Ontario
19 Category 1 CME Credits

November 21
Certification/Recertification Examination
Atlanta, GA
LaGuardia, NY
Los Angeles, CA
5 Category 1 CME credits

1999

April 29–May 2
30th Annual ASAM Medical-Scientific Conference
New York, NY

November 4–6
ASAM State of the Art Conference
Washington, DC
20 Category 1 CME credits

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ASAM STAFF ONLINE

James F. Callahan, D.P.A.
Exec. Vice President/CEO
JCALL@ASAM.ORG

Susan Blaz
Office Manager
SBLAZ@ASAM.ORG

William Brown, C.P.A.
Accountant
WBROW@ASAM.ORG

Catherine Davidge
Dir. of Membership & Chapter Relations
CDAVI@ASAM.ORG

Caprice Falwell
Membership Assistant
CFALW@ASAM.ORG

Linda Fernandez
Asst. Director of Meetings & Conferences
LFERN@ASAM.ORG

Joanne Gartenmann
Exec. Assistant to the Exec. Vice President
JGART@ASAM.ORG

Dennis Matos, C.P.A
Director of Finance
DMATO@ASAM.ORG

Sandy Schmedtje Metcalfe
Director of Meetings and Conferences
SMETC@ASAM.ORG

Claire Osman
Director of Development
ASAMCLAIRE@AOL.COM

Christopher Weirs
Credentialing Project Manager
CWEIR@ASAM.ORG

Bonnie B. Wilford
Editor, ASAM News
BBWILFORD@AOL.COM

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