

ASAM NEWS

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NEWSLETTER OF THE AMERICAN SOCIETY OF ADDICTION MEDICINE

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Dr. Barthwell Assumes ASAM Presidency

Andrea G. Barthwell, M.D., FASAM, was installed as ASAM's President during the Society's recent Medical-Scientific Conference in Los Angeles. Dr. Barthwell succeeds outgoing President Marc Galanter, M.D., FASAM. Also assuming office were Lawrence S. Brown, Jr., M.D., M.P.H., FASAM, President-Elect; Michael M. Miller, M.D., FASAM, Secretary; and Elizabeth F. Howell, M.D., FASAM, Treasurer.

Newly elected members of the Board of Directors installed at the meeting are Regional Directors Louis E. Baxter, Sr., M.D., FASAM; Paul H. Earley, M.D., FASAM; Lloyd J. Gordon III, M.D., FASAM; Thomas L. Haynes, M.D., FASAM; Lori D. Karan, M.D., FACP, FASAM; Peter A. Mansky, M.D.; Peter E. Mezciems, M.D., FASAM; Ronald F. Pike, M.D., FASAM; A. Kennison Roy III, M.D., FASAM; and Berton E. Toews, M.D., FASAM. The new officers' terms extend to April 2003, while Directors serve four-year terms.

Dr. Barthwell is Executive Vice President, Human Resources Development Institute, Inc., a multifaceted



ASAM EVP James F. Callahan, D.P.A., congratulates new officers installed during ASAM's recent Medical-Scientific Conference in Los Angeles. From the left: Dr. Callahan; Secretary Michael M. Miller, M.D., FASAM; Treasurer Elizabeth F. Howell, M.D., FASAM; President Andrea G. Barthwell, M.D., FASAM; Immediate Past President Marc Galanter, M.D., FASAM; and President-Elect Lawrence S. Brown, Jr., M.D., M.P.H., FASAM.

health and human service, private not-for-profit organization. She also serves as senior advisor on women's health to the National Women's Resource Center and is active as a consultant and lecturer. She describes herself as a "generalist in Addiction Medicine with training in many modalities and settings." She has experience in treating diverse populations, such as incarcerated persons, pregnant or parenting women, adolescents, and ethnic minorities.

Dr. Barthwell's professional activities encompass service as a board member at large and immediate past president of the Illinois Society of Addiction Medicine, past board member of the Chicago Area AIDS Task Force and the AIDS Pastoral Care Network, co-chairperson of the Illinois AIDS Advisory Council and chair of its medical subcommittee, member of the National Advisory Board of the federal Center for Substance Abuse Treatment and the National Institute on Drug Abuse, and past member of the Drug Abuse Advisory Committee of the U.S. Food and Drug Administration.

► **DR. BARTHWELL** continued on page 4

ASAM Publishes New Patient Placement Criteria

ASAM has published a major revision of its widely used patient placement criteria. The *ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition-Revised (ASAM PPC-2R)* was released during ASAM's Medical-Scientific Conference in April. Development of the new edition was spearheaded by David Mee-Lee, M.D. and co-editors Gerald R. Shulman, M.A., FACATA, Marc Fishman, M.D., David R. Gastfriend, M.D., and Julia Harris Griffith, M.A.

The new edition is the product of an exhaustive consensus-building process involving all areas of addictions and mental health expertise, including clinical staff and administrators of public and private treatment programs, third-party payers and managed

care organizations, state alcohol and drug agency directors, addiction researchers and educators, and public policymakers.

Through this process, the criteria have been completely revised to better respond to the needs of public and private treatment programs. Unique features of the *ASAM PPC-2R* are new criteria for patients with co-occurring mental and substance-related disorders ("dual diagnosis"); refined criteria for adolescents; development



► **PATIENT CRITERIA** continued on page 22



Support the Fairness in Treatment Act

James F. Callahan, D.P.A.

Senator Paul Wellstone (D-MN) and Congressman Jim Ramstad (R-MN) once again have introduced federal legislation to achieve parity in insurance benefits for addiction treatment. The Fairness in Treatment: Drug and Alcohol Addiction Recovery Act of 2001 (S.595/H.R.1194) would require that addiction treatment benefits be offered in the same manner as all other medical and surgical conditions.

Of the 70% of Americans insured by private health plans, few receive benefits for treatment on a par with other diseases because their health plans employ a number of discriminatory practices. These include:

- Annual and lifetime caps that are more restrictive than those imposed on other diseases;
- More stringent limits on days of inpatient care and number of outpatient visits than are imposed on other diseases;
- Higher co-pays and deductibles for employees and their families who seek treatment for addiction; and
- Arbitrary and often undisclosed criteria used by insurers and employers to determine whether treatment services are "medically necessary."

The Fairness in Treatment Act would remove these restrictions and bring coverage of addictive disorders into parity with other medical problems.

The Fairness in Treatment Act would remove these restrictions and bring coverage of addictive disorders into parity with other medical problems. While the act would not require that addiction treatment benefits be covered by a health plan, it would prohibit discrimination by plans that do offer such benefits.

The Act comes at an opportune time, as policymakers debate more effective ways to address the nation's problems with alcohol and other drug addiction. A recent study by the Robert Wood Johnson Foundation documents that addiction is the number one health problem in America today. No disease costs society more. The Physician Leadership on National Drug Policy (PLNDP) at Brown University points out that

untreated addiction costs the nation six times more than heart disease, six times more than diabetes and four times more than cancer.

A recent Congressional hearing convened by Senator Orrin Hatch (R-UT) resolved unanimously to make addiction treatment one of the primary focuses of U.S. drug policy. And President Bush has promised unprecedented attention to addiction treatment.

While these are hopeful signs, we must continue to fight for parity. Senator Wellstone and Congressman Ramstad are doing their part. Please do your part by writing, phoning, faxing or e-mailing your Senators and member of Congress to tell them that you support the Fairness in Treatment: Drug and Alcohol Addiction Recovery Act of 2001.

Five Steps

Here are five specific steps you can take to help enact the Fairness in Treatment Act:

1. Download the constituent letter, issue brief and fact sheet from www.partnershipforrecovery.org. (If you've not written to your Congressional delegation, click on the Capitol icon to send a letter, and encourage your friends and colleagues to send one too!)
2. Call your Congress member's local office. Tell the contact person you are interested in a 5- to 10-minute meeting with the Senator or Congressman/Congresswoman to discuss legislation introduced in Washington that would end discrimination in private health plans for addiction treatment. If the member is not available, ask to meet with the staff person who handles health issues.
3. Arrive early for the meeting and stay only for the agreed upon amount of time. Tell the Congress member or staff person that you are asking for support of the Fairness in Treatment Act (S.595/H.R.1194). Talk about your personal experiences as a physician and an advocate for treatment. Let him or her know how important this legislation is to saving lives, reducing dollars and helping the families of his or her district.
4. Wrap up by thanking him or her for the meeting and leaving a copy of your constituent letter. You also may wish to leave a copy of a Fairness in Treatment Act fact sheet and issue brief that can be downloaded from the Web site (www.partnershipforrecovery.org).
5. Follow up the meeting with a thank-you letter, encouraging the Congress member or staff person to support the Fairness in Treatment Act.



American Society of Addiction Medicine

4601 North Park Ave., Suite 101
Chevy Chase, MD 20815

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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High Court Strikes Down Marijuana Initiative

In a unanimous decision, the U.S. Supreme Court has ruled that marijuana cannot be distributed for medical purposes because it has been classified as having no medical value under federal law. The court noted that by placing marijuana in Schedule I of the federal Controlled Substances Act, the Congress determined that marijuana has no medical use, undermining a cannabis buyers' club's attempt to seek protection from prosecution by arguing a medical-necessity defense.

"In the case of the Controlled Substances Act, the statute reflects a determination that marijuana has no medical benefits worthy of an exception outside the confines of a government-approved research project," Justice Clarence Thomas wrote for the court. "It is clear from the text of the act that Congress has made a determination that marijuana has no medical benefits worthy of an exception," he added. "Unwilling to view this omission as an accident, and unable in any event to override a legislative determination manifest in a statute, we reject the cooperative's argument."

The case reached the court after the federal government sought an injunction in 1998 against the Oakland Cannabis Buyers Cooperative and five other marijuana distributors in California. The ruling means the Oakland Cooperative may not resume distributing marijuana to patients. Lawyers for the club said they would pursue other arguments. For example, the Court's ruling did not address whether states have the right to pass their own laws pertaining to medical marijuana.

California voters approved a 1996 ballot initiative that allowed seriously ill patients to use marijuana for pain relief with a physician's recommendation. Voters subsequently have approved similar ballot initiatives in Arizona, Alaska, Colorado, Hawaii, Maine, Nevada, Oregon, and Washington State.

"I can see how on the issue of medical necessity they might have come down as they did, but I was surprised that the Supreme Court chose completely to sidestep the other issues we raised," said Robert Raich, an Oakland attorney who worked on the case. "The next step is to go back to the lower courts and address fully these important constitutional questions."

Medical marijuana advocates also are expected to focus on amassing the medical research necessary to convince federal officials that marijuana should be re-categorized as a Schedule II drug. Under such a classification,

marijuana would be defined as potentially addictive, but with potential medicinal value.

Source: *Associated Press and Reuters News Service, May 14, 2001.*

President Orders Study of Treatment Capacity

Calling for an "all out effort" to reduce demand for illegal drugs, President George W. Bush has ordered the Department of Health and Human Services to conduct a state-by-state study of treatment needs and capacity. The President also promised \$1.6 billion in federal funding for treatment programs over the next five years.

"As of today, the federal government is waging an all-out effort to reduce illegal drug use," the President said. "The most effective way to reduce the supply of drugs in America is to reduce the demand for drugs in America. This administration will focus unprecedented attention on the demand side of this problem. We recognize that the most important work to reduce drug use is done in America's living rooms and classrooms, in churches and synagogues and mosques, in the workplace and in our neighborhoods."

President Bush also ordered a government-wide review of anti-drug programs, including a White House review of faith-based programs. He also called on the Justice Department to develop a plan that would make federal prisons drug-free.

Source: *Reuters News Service, May 10, 2001.*

Addiction Tops U.S. Health Problems, Foundation Says

In a newly released report, the Robert Wood Johnson Foundation calls alcohol and other drug use and addiction "the leading health problem in the United States."

According to the report, released in March, illegal drug use is the cause of nearly 16,000 deaths annually, alcohol use leads to 100,000 deaths, and tobacco use is the cause of 430,700 deaths. The report compiles data from hundreds of studies on addiction conducted over the past 30 years.

On the positive side, the report showed that there has been an overall decline in drug use in the U.S. since the late 1970s, a drop in smoking rates starting in the mid-1960s, and a drop in alcohol consumption since the early 1980s. The declines are attributed to growing awareness of the risks of addiction, an increase in government

intervention and prevention programs, implementation of smoking bans, and grassroots efforts to reduce drug use. The report can be accessed through the foundation's Web site at www.rwjf.org.

Source: *Reuters News Service, March 9, 2001.*

Supreme Court Bans Drug Testing of Pregnant Women

Public hospitals cannot test pregnant women for drugs without consent, the Supreme Court said in a ruling that buttressed the Constitution's protection against unreasonable searches. The 6-3 ruling was made in a case brought against the Medical University of South Carolina, which operates a public hospital in Charleston. The justices found that testing without patients' consent violates the Constitution, even though its goal may be to prevent women from harming their fetuses by using crack cocaine. Several women who tested positive for cocaine have been arrested for violating the state's child-endangerment law.

During oral arguments in the case, several justices expressed concern that the program effectively makes physicians "agents of the police" and results in "the co-option of the medical community." They also questioned whether the program actually risks harm to the fetus by discouraging women from seeking prenatal care.

In its decision, the court said that the program is unlawful because it violates the Constitution's Fourth Amendment protection against unreasonable searches. In order for drug testing to be conducted, the justices said, a search warrant or consent is required. "While the ultimate goal of the program may well have been to get the women in question into substance abuse treatment and off of drugs, the immediate objective of the searches was to generate evidence for law enforcement purposes in order to reach that goal," Justice John Paul Stevens wrote for the court.

"It's a very, very important decision in protecting the right to privacy of all Americans," said Priscilla Smith, lawyer for the Center for Reproductive Law and Policy, which represented the South Carolina women. "It reaffirms that pregnant women have that same right to a confidential relationship with their doctors."

South Carolina Attorney General Charles Condon, who as a local prosecutor in Charleston began the testing program, issued a statement saying that the program can continue if police get a search warrant or the

► **ADDICTION** continued on page 6

Looking to the Future

Andrea G. Barthwell,
M.D., FASAM



ASAM has done very well for a young organization — a collection of components, really, trying to become a nationally recognized body with active, effective local chapters. In a relatively short time, our Society has achieved tremendous credibility as an organization. We are an incredible array of credible experts. ASAM-certified physicians are seen as the experts in this field. We have structured the clinical work of the field with our products such as ASAM's *Patient Placement Criteria* and the *Principles of Addiction Medicine*.

Now we are ready to define our strategic vision for the future. At the 2000 Medical-Scientific conference, ASAM members clearly conveyed that they want our activities to focus on a number of central concerns:

- ▶ The disease of addiction should be recognized as a treatable medical disorder;
- ▶ All persons who need treatment should be able to access it;
- ▶ Such treatment should conform to scientifically validated, clinically informed practice guidelines;
- ▶ Appropriate treatment should be widely available and covered by health insurance; and
- ▶ All physicians, at every level of their development, should have the knowledge they need to identify, treat and appropriately refer patients with addictive disorders.

The membership also clearly wants ASAM to engage in public advocacy to achieve these goals.

In response, the Society's leadership has reviewed our previous choices in important areas. We have evaluated our successes, our failures, our satisfactions and disappointments. We have spent time reworking our previous long-range plan in the context of old aspirations and wishes. We have seen our limitations, fixed roles, finiteness of opportunities and time, and had an opportunity to develop our identity. At times, we have been overwhelmed by too many obligations and duties, pulled back and pushed forward, but we also have experienced satisfactions from most of what we have done.

We are sufficiently established to have a wide array of relationships. We intend to use our membership and strategic links to change the way this country thinks about treatment. We know that treatment works when it is done right. The science and the art of addiction medicine are available. We can fix this broken system. We are developing or have developed the tools for diagnosis, for treatment planning and for removing artificial barriers that keep people from getting well.

Over the next two years, I will work with a core of committed members to move our Society and the field forward. We want to partner with like-minded organizations to create opportunities for ASAM to have the kind of impact no other group could be expected to have. ■

OxyContin® and Pain

To the Editor:

To balance the reports of diversion and abuse of OxyContin® [see the *March-April ASAM News*], it is important to understand that there are 50 to 70 million patients in the U.S. whose pain is undertreated or not treated at all. In fact, pain is the most common presenting complaint in doctors' offices. The use of oral long-acting opioids with adjunctive analgesics is the regimen of choice for treatment of chronic moderate to severe pain syndromes.

It is imperative for any physician who treats chronic pain to Believe the patient, Evaluate the patient and, if indicated, Treat the patient with opioids (BET). Once the physician determines that opioids are indicated, the patient should agree (either verbally or in writing) to abide by all the rules established by the physician.

Both Morphine Sulfate Contin and OxyContin are indicated for the treatment of severe chronic pain. If the patient has renal or hepatic impairment, OxyContin should be the opioid of choice because it has no toxic metabolites, whereas morphine has a build-up of toxic metabolites. These toxic metabolites are morphine-3-glucuronide (M3G), which can cause myoclonus, tremors and seizures, and morphine-6-glucuronide (M6G), which is associated with opioid side effects such as sedation and respiratory depression. M6G is a more potent analgesic than morphine.

The current controversy surrounding OxyContin (a long-acting oxycodone formula) with regard to abuse, diversion and trafficking should not cause the health professions to deny valid treatment of pain, consistent with state and federal regulations, using medications approved by the FDA. The aberrant behavior of a very few people should not prevent the overwhelming majority of our patients in pain from receiving the care they deserve. Morphine Sulfate Contin and OxyContin, prescribed and taken appropriately, are safe medications in the treatment of moderate to severe pain.

Howard A. Heit, M.D., FACP, FASAM
Fairfax, VA

Rural Drug Courts

To the Editor:

This letter is prompted by the discussion of Arizona Drug Courts on page 12 [of the *January-February ASAM News*].

I am sorry the Yuma County Drug Court was not referred to since, in the Yuma County Superior Court jurisdiction, the drug court has proven extremely effective with helping to deal with chemical dependency in a rural setting. (Maricopa County is dominated by Phoenix and Pima County is dominated by Tucson, neither rural!)

Drug courts work extremely well in rural and in semi-rural settings, as demonstrated by Judge Tom Cole's drug court in Yuma County. Those of us who live and work in rural counties need as much help and support as we can get!

William S. Masland, M.D.
Yuma, Arizona

▶ DR. BARTHWELL continued from page 1

Within ASAM, Dr. Barthwell has served as Secretary and member of the Board of Directors. She has chaired Review Courses and State of the Art Courses in Addiction Medicine, and ASAM Nicotine Conferences. In addition to chairing the Clinical Issues Section, Dr. Barthwell was the organizing Chairperson of the Cross Cultural Concerns Committee and chair of the Resources and Development Committee. She also has been active in the Methadone, Membership, and Review Course committees and on the Strategic Plan Task Force. Dr. Barthwell was certified in Addiction Medicine in 1986. ■

ASAM Mourns the Death of Manny Steindler

Retired ASAM Executive Director Emanuel M. Steindler, 76, died at his home in Chicago on May 19, 2001, of a cerebral hemorrhage. Manny joined ASAM in 1985 as the Society's first Executive Director, a post from which he retired in 1989. Recalling those early years, ASAM Past President Max Schneider, M.D., FASAM, said that "as our first full-time Executive Director, Manny — in his quiet, efficient way — rescued the Society and helped guide it into a new era.... He was a diplomat, knowledgeable, and indefatigable. He was a gentleman, kind and considerate, and taught by example. He was a true mentor."



In fact, Manny was instrumental in the creation of ASAM. In the 1980s, he organized a series of "unity meetings" through which physician groups in New York, Georgia and California joined forces to become the American Medical Society on Alcoholism (later the American Society of Addiction Medicine). A physician who was present in those meetings, Dr. Jokichi Takamine of California, hailed Manny's personal integrity and diplomacy as essential to successful completion of the negotiations. ASAM Past President Anthony B. Radcliffe, M.D., FASAM, who also was present, noted that "Manny could clearly articulate an argument so that both sides could see a path neither had seen before. He had a patience that amazed me and a sense of vision that few have....and he was always working to be sure the vision became reality."

Gail Jara, recently retired Executive Director of the California Society of Addiction Medicine, agreed that Manny helped develop ASAM into a strong national presence. "Manny guided ASAM to membership in the American Medical Association [House of Delegates] and then guided us within the AMA. He helped us become a real voice within that important organization."

Jim Callahan, who followed him as director of ASAM, remarked on Manny's "selflessness, humility and, of course, his sense of humor." Jim recalled that Manny, even after his retirement, "was always available to help move ASAM's mission forward. I consulted with him often and called on him to work with us at the AMA and in our endeavors to achieve specialty status. I will miss him personally and professionally. ASAM has suffered a great loss."

Manny knew the AMA well. He served on the staff of that organization for 24 years, first at JAMA and then, for many years, as director of the AMA's departments of mental health and substance abuse. Through his efforts, the AMA assumed a leadership role in the destigmatization of addictive and mental health disorders and in advocating for appropriate medical care for persons so afflicted.

He campaigned tirelessly for the recognition of alcoholism and mental illness as medical disorders, urging that physicians treat them with the same skill and compassion they brought to other health problems. A gifted writer and graduate of the Northwestern University School of Journalism, he authored "The AMA Manual on Alcoholism," published in 1979 as one of the first treatises on alcoholism for primary care physicians. "Manny conceptualized addiction medicine before most of us knew what it was and cajoled many skeptical physicians to believe that treatment did work," Dr. Radcliffe recalled. He also was instrumental in developing medical society programs to identify and rehabilitate physicians who themselves suffered from alcohol or drug problems.

In the 1970s, Manny worked with Senator Harold Hughes of Iowa and other members of the Congress to create the National Institute on Alcohol Abuse and Alcoholism and the National Institute

on Drug Abuse (now units of the National Institutes of Health) to spur scientific research into the prevention and treatment of alcohol and drug addiction.

In 1978, he led the AMA to become the first national health organization to call public attention to the problem of Fetal Alcohol Syndrome (FAS) and to urge women to abstain from alcohol use during pregnancy.

During the Carter Administration, Manny served as the AMA's liaison to the White House, assisting in reforms of the mental health system spearheaded by First Lady Rosalynn Carter. In another collaborative effort, he aligned the AMA with the American Psychiatric Association in a joint initiative to assure better care of the chronically mentally ill.

In 1983, he crafted the AMA's policy calling for a .08% blood alcohol concentration as the standard for drunk driving. While the policy was controversial at a time when few states had adopted even a .10% BAC level, Manny amassed scientific data on alcohol-related impairment to support the AMA's position, which subsequently was adopted by most states and recently was embodied in federal legislation enacted by the Congress and signed by President Bill Clinton. Bonnie Wilford, who succeeded Manny as director of the department of substance abuse at the AMA, recalled that "he was enormously creative in understanding what the reputation of the AMA and the resources of the AMA could accomplish."

Manny is survived by his wife of 55 years, Maureen, as well as by two sons, Arthur and Wallace, a daughter, Kathryn, and three grandchildren: Nathan, Corynne, and Ellen. His passing also is mourned by professional colleagues and friends around the country. "Humanity will have a hole in it with the passing of this man," Dr. Takamine said. "We will all miss his wisdom, his humor and his loving kindness," Ms. Jara added.

A memorial service is planned for September in Chicago. To ensure that Manny's work continues, his family has asked that memorials be directed to ASAM's Ruth Fox Memorial Endowment Fund. ■

SAN FRANCISCO

Department of Veterans Affairs Medical Center Full-Time Position

The Mental Health Service at the SFVAMC is seeking a board-certified or eligible psychiatrist for a full-time position on the 12-bed Psychiatric Intensive Care Unit (PICU). The position will emphasize multidisciplinary team assessment, treatment and dispositional planning in addition to psychopharmacologic therapies.

This position also includes administrative leadership of the PICU and the Acute Psychiatry Services (APS). The APS includes the PICU, a Partial Hospital Program and a Transitional Community Care program. There are opportunities to teach and receive a Clinical Faculty appointment at the University of California School of Medicine, San Francisco.

Competitive salary is negotiable, depending on qualifications; excellent benefits and retirement package. The Department of Veterans Affairs is an Equal Opportunity Employer. U.S. citizenship is required. The selected applicant may be subject to random pre-employment drug screening. Submit CV and three references by June 15, 2001, to:

John Straznickas, M.D., at VA Medical Center (116N)
4150 Clement Street, San Francisco, CA 94121
or call 415/221-4810 x2074 for further information.

► **ADDICTION** *continued from page 3*

patient's consent. "There is no right of a mother to jeopardize the health and safety of an unborn child through her own drug abuse," Condon said.

Source: *Associated Press, March 21, 2001.*

Alcohol Industry Plans TV Ads

The Distilled Spirits Council of the U.S., a trade group for beverage alcohol manufacturers, announced that it will end a voluntary ban on television advertising of distilled alcohol products by launching a campaign to encourage local stations to accept advertisements for hard liquor.

Jim Rogers, owner of Sunbelt Communications in Las Vegas, NV, appears in the promotional advertisement aimed at convincing local television stations to accept liquor commercials to help their business. "For the past year and a half, I've chosen to run distilled-spirits ads just like these on my eight stations," said Rogers, who controls seven NBC-affiliated stations and one Fox affiliate. "The ads are legal, tasteful and responsible and they are a great source of revenue."

The beverage alcohol industry is hoping that Rogers' testimonial will change some minds, especially since advertising revenue at local broadcast stations is expected to drop 11% in the coming year. In the past, most local television stations refused to accept liquor commercials because they feared harsh criticism from the public. But Mr. Rogers claims that he has had no complaints during the 18 months he has aired the commercials.

"If ever there were a time when local stations would consider revising their rules, this would be it," said Jack Myers, chief media economist at Myers Reports in New York.

Source: *The Wall Street Journal, May 7, 2001.*

U.S. Criticized for Stance on International Tobacco Treaty

The U.S. government has come under fire for hindering progress towards an international tobacco control treaty.

"The U.S. contribution has been entirely negative — weakening, delaying and deleting anything that might have substance," said Clive Bates, director of the British group Action on Smoking and Health (ASH). Bates made the comments as negotiations over the treaty drew to a close in Geneva, Switzerland. The treaty, sponsored by the World Health Organization (WHO), is aimed at curbing the increase in tobacco-related deaths worldwide.

Bates said that the U.S. should withdraw from the negotiations rather than forcing other countries to weaken the treaty to a point that it could not be ratified.

U.S. negotiators denied Bates' accusations. "The administration feels strongly focused on public health — especially prevention in kids and stopping smuggling," said U.S. delegation chief Tom Novotny. But Vince Willmore of the U.S.-based Campaign for Tobacco Free Kids sided with Bates, saying that the U.S. delegation has tried to weaken several treaty provisions, including a ban on "low-tar," "light," and "mild" labeling claims; an end to duty-free sales; and a ban on smoking in public places.

Source: *Associated Press, May 4, 2001*



Political Contributions Hinder Tobacco Regulation Efforts

Political contributions by tobacco makers are hampering efforts to regulate tobacco, according to leading anti-smoking groups. A new report by the American Heart Association, the American Lung Association, the Campaign for Tobacco-Free Kids, and Common Cause says that cigarette makers have contributed \$32 million to state and federal candidates and political parties since 1995.

The report asserts that there is a "strong correlation" between political contributions to lawmakers from Philip Morris, R.J. Reynolds Tobacco and other tobacco interests, and how those lawmakers vote on tobacco-related issues. For example, the report claims that recipients of tobacco donations acted to block legislation opposed by the tobacco industry. One such bill would have given the U.S. Food and Drug Administration authority to restrict the sale of tobacco products to minors and to limit advertising and marketing by tobacco companies.

"This is all about purchasing the desired degree of inaction from a compliant Congress. Sadly, the evidence indicates that their money was well spent," said Common Cause President Scott Harshbarger.

Source: *Reuters News Service, March 14, 2001.*

California Treatment Programs Lack Funds to Help New Clients

With California's Proposition 36 scheduled to go into effect in July, addiction treatment programs in the state may lack the resources to treat the expected influx of patients. Proposition 36 sends first- and second-time, non-violent drug offenders to treatment rather than to prison. The law allocated \$120 million annually to be shared by treatment agencies, probation officers and others, who will determine how to expand treatment services, enforcement and supervision.

Many of the community-based treatment programs in the state's 58 counties are worried that they may not be prepared financially for the flood of new patients. "It's the most wonderful thing to make substance abuse a priority," said Barbara Farrell, executive director of Ohloff Treatment Centers. "But you have to be careful what you wish for. Where are we going to put all of these people?"

The urgency to implement plans before the July deadline has forced some treatment centers to come up with creative solutions. For example, some of those unable to obtain zoning permits for new facilities have arranged to use space at nearby hospitals.

In addition to funding, treatment leaders say they need local government's help to obtain zoning permits to expand their facilities. "People may vote for treatment, but not in their neighborhood. They want it in the next county over," notes Susan Blacksher, executive director of the California Association of Addiction Recovery Resources, which is composed of 150 nonprofit groups.

Source: *The Chronicle of Philanthropy, May 3, 2001.*

Appeals Court Dismisses Tobacco Lawsuits

The U.S. tobacco industry won victories in three cases as a U.S. appeals court dismissed two separate lawsuits brought by foreign governments and one by several union health funds.

The lawsuits by Guatemala and Nicaragua and the Ukraine accused the tobacco industry of fraud and racketeering violations. The suit brought by the union health funds sought reimbursement for smoking-related health-care costs.

In issuing the U.S. Court of Appeals' unanimous ruling, Judge Judith Rogers wrote for the three-judge panel in the District of Columbia that the claims were "too remote, contingent, derivative, and indirect."

Source: *Reuters News Service, May 22, 2001.*

A Quiet Revolution is Under Way



A quiet revolution is under way in the addiction research community, overturning a variety of long-held beliefs ranging from how the disease is defined to

how success in treatment is measured. Enoch Gordis, M.D., director of the National Institute on Alcohol Abuse and Alcoholism (NIAAA), spoke of these changes during an NIAAA-sponsored symposium at ASAM's Medical-Scientific Conference.

By way of example, Dr. Gordis pointed to a 30-year study of 10,000 veterans conducted by Charles O'Brien, Ph.D., M.D., at the University of Pennsylvania, which has helped clarify the distinctions between alcohol and other drug use, abuse and addiction. Increasingly, addiction has come to be equated with loss of control, not necessarily daily use. "Unfortunately, this information has not gotten out to the community, including physicians," Dr. Gordis said.

Using this definition of addiction, the O'Brien study concluded that tobacco is the most addictive drug used by humans because 31.9% of tobacco users become addicted to nicotine. That is more than double the percentage of drinkers who become addicted to alcohol, and significantly higher than the 23.1% of heroin users who become addicts, Dr. Gordis said.

Similarly, Dr. Gordis cited the work of researcher Tom McLellan, Ph.D., of the University of Pennsylvania, who has helped to reshape the science of outcomes measurement. Rather than judging the success of addiction treatment programs solely on the subsequent abstinence of those in treatment, the McClellan study posits that a whole host of positive outcomes should be considered, including improvements in mental health, legal problems, employment status, and family relationships. "When we look at treatment outcomes, we need to consider these other factors," Dr. Gordis said.

Advances in biological and genetic research and medications development also have the potential to change the fundamental nature of addiction treatment, he said. "The human genome project probably will have a major impact on treatment," he added, pointing out that 40% of human genes have proteins that affect the nervous system. With the human genome now

completely mapped, researchers will find it easier to develop medications that address the genetic underpinnings of addiction.

Unlike other drugs...alcohol works on many chemical receptor sites in the brain, not just one, making medication development especially challenging.

The development of medications to help fight addiction over the last decade has been driven in large part by research showing how various drugs of abuse affect the chemical systems of the brain, Dr. Gordis said. Unlike other drugs, however, alcohol works on many chemical receptor sites in the brain, not just one, making medication development especially challenging. "We're working to find the sensitive sections on receptors in order to fight alcoholism," he added.

New anti-addiction medications like naltrexone, acamprosate, and bupropion attempt to fight craving for drugs by regulating brain chemistry. The federal COMBINE study is expected to provide valuable information about how well these drugs perform in combination with addiction counseling, which Dr. Gordis said is absolutely critical to success. As with treatment outcomes, however, research findings can be skewed if the bar for success is set artificially high. For example, Dr. Gordis noted that some naltrexone studies of alcoholics yield far more impressive results if the occasional "slip" is not counted as a treatment failure.

Another trouble spot for addiction treatment is noncompliance; relapse. "Research shows that video cues activated the brains of former cocaine users in a way similar to sexual arousal in young men, only more so," he noted. "Drugs essentially hijack a part of the brain, so you can see that this is an incredibly enticing behavior."

Source: ASAM Medical-Scientific Conference, April 20, 2001.

How are we developing one of the world's most advanced health care environments?

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ADDICTION MEDICINE PHYSICIAN

The Addiction Medicine Division of Advocate Medical Group (AMG) and the Addiction Treatment Program of Advocate Lutheran General Hospital (ALGH) are seeking a BC Psychiatrist, Internist or Family Physician who is board certified in Addiction Psychiatry or certified by ASAM to work collaboratively within a multi-specialty group practice. Both AMG and ALGH are part of Advocate Health Care - a large, integrated healthcare system in the Chicago area and cited by *Chicago Magazine* as one of 25 "Best Places to Work". ALGH, previously known as Parkside Medical Services, has a proud history of offering a network of nationally and internationally recognized addiction treatment programs. Today, ALGH continues to provide a continuum of addiction services for adults and adolescents which represent nearly all ASAM levels of care. Additionally, AMG administers the Illinois Professionals Health Program, the case management services sponsored by the Illinois State Medical Society, ISMIE, other professional societies and the Illinois Department of Professional Regulations.

This role is responsible for providing medical care to patients in the hospital, structured outpatient programs and outpatients referred by the medical group and other providers. Other responsibilities include staffing and supervising the clinical staff, teaching medical students and residents, participating in research opportunities and promoting programs and services to the community. Assisting in case management and medical review functions of the Professionals Health Program, is also involved.

A thorough understanding of assessment, medical detoxification, patient placement according to the ASAM-PPC and diagnosis and management of concurrent psychiatric and medical problems is essential. Certification as a Medical Review Officer is preferred.

If you would like to join a dynamic team of professionals who provide care in Chicago's northwest suburbs and case management services across the State, please send CV or contact: **Martin Doot, MD, Director of Medical Management, AMG, 701 Lee St., Ste. 220, Des Plaines, IL 60016. Ph: 847-795-2875. E-mail: martin.doot@advocatemedical.com**

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CHAPTER UPDATE

Arkansas

President:

Harley J. Harber, M.D., P.A., FASAM

Regional Director:

A. Kennison Roy, M.D., FASAM

Members of the Arkansas Society of Addiction Medicine have elected Harley J. Harber, M.D., P.A., FASAM, new President of the chapter and James E. Tutton, M.D., Vice President. Forrest "Bernie" Miller, M.D., was elected Secretary.

Dr. Miller reports that the chapter plans to sponsor educational meetings and dinners, and is working to establish a speaker's bureau. All ASAM members in Arkansas are invited to become involved. Further information is available from Dr. Miller at FMiller56@aol.com.

Michigan

President: Michael L. Fox, D.O.

Regional Director: Thomas L. Haynes, M.D.

Members of the Michigan Society of Addiction Medicine mourn the passing of their chapter President, Stephen Alan Bendix, M.D., who died in March.

Michael L. Fox, D.O., will serve as President for the remainder of Dr. Bendix' term, which extends through 2003.

ISAM: 2nd Annual Meeting Scheduled

The International Society of Addiction Medicine has scheduled its 2001 Annual Meeting, "Addictions: Sharing International Responsibilities in a Changing World," for September 12-14 in Trieste, Italy. A satellite symposium is set for Saturday, September 15, in Ljubljana, Slovenia.

ASAM is a cooperating organization, as are the National Institute on Drug Abuse and the National Institute on Alcohol Abuse and Alcoholism, the World Health Organization, the Pompidou Group, and other prestigious scientific organizations.

Detailed information about the meeting is available on the ISAM Web site (www3.sympatico.ca/pmdoc/ISAM) or from the organizing committee (www.theoffice.it/ISAM).

New Directors Installed

The following Regional Directors and Alternate Directors, elected in November 2000, were installed as members of ASAM's Board of Directors during the Medical-Scientific Conference in Los Angeles:

Region I (New York)

Regional Director: Peter A. Mansky, M.D.

Alternate Director: Merrill Scot Herman, M.D.

Region II (California)

Regional Director: Lori D. Karan, M.D., FACP, FASAM

Alternate Director: Donald J. Kurth, M.D., FASAM

Region III (CT, ME, MA, NH, RI, VT)

Regional Director: Ronald F. Pike, M.D., FASAM

Alternate Director: Peter Rostenberg, M.D., FASAM

Region IV (NJ, OH, PA)

Regional Director: Louis E. Baxter, Sr., M.D., FASAM

Alternate Director: R. Jeffrey Goldsmith, M.D.

Region V (DC, DE, GA, MD, NC, SC, VA, WV)

Regional Director: Paul H. Earley, M.D., FASAM

Alternate Director: Timothy L. Fischer, D.O.

Region VI (IL, IN, KY, MI, MN, ND, SD, TN, WI)

Regional Director: Thomas L. Haynes, M.D., FASAM

Alternate Director: Norman S. Miller, M.D., FASAM

Region VII (AR, IA, KS, LA, MO, NE, OK, TX)

Regional Director: A. Kennison Roy III, M.D., FASAM

Alternate Director: John P. Epling, Jr., M.D., FASAM

Region VIII (AK, AZ, CO, HI, ID, MT, NV, NM, OR, UT, WA, WY)

Regional Director: Berton E. Toews, M.D., FASAM

Alternate Director: Richard E. Tremblay, M.D., FASAM

Region IX (Canada and International)

Regional Director: Peter E. Mezcicms, M.D., FASAM

Alternate Director: Saul Alvarado, M.D.

Region X (AL, FL, MS; PR, VI)

Regional Director: Lloyd J. Gordon III, M.D., FASAM

Alternate Director: C. Chapman Sledge, M.D., FASAM

Medical Director for Detoxification and Methadone Services

HOLYOKE, MASSACHUSETTS

We are seeking a half-time Medical Director to provide medical oversight for the Providence Hospital Detoxification, Methadone Maintenance Treatment Programs, and the inpatient Psychiatric Services. Providence Hospital provides the only methadone-based detoxification for opiate withdrawal in Western Massachusetts on its 27-bed inpatient unit.

The Hospital also runs two large outpatient Methadone Treatment Programs, one at the Hospital in Holyoke and the other in Springfield. You would provide supervision to the Physician Assistants and work with the dedicated multidisciplinary staff. In addition, you would provide medical support to the psychiatric units at Providence Hospital, including consultations and supervision of PAs.

We seek an internist or family practitioner with previous experience and expertise in Addiction Medicine.

Please contact:

Jonathan Chosen, M.D., Medical Director
Providence Hospital

1233 Main Street • Holyoke, Massachusetts, 01040

Phone: (413) 539-2405 • Fax: (413) 539-2992

Email: jonathan.chosen@sphs.com

SAN FRANCISCO

Department of Veterans Affairs Medical Center Half-Time Position

The Mental Health Service at the SFVAMC is seeking a board-certified or eligible psychiatrist for a half-time position on the 12-bed Psychiatric Intensive Care Unit (PICU). The position will emphasize multi-disciplinary team assessment, treatment and dispositional planning in addition to psychopharmacologic therapies.

There are opportunities to teach and receive a Clinical Faculty appointment at the University of California School of Medicine, San Francisco.

Competitive salary is negotiable, depending on qualifications; excellent benefits and retirement package. The Department of Veterans Affairs is an Equal Opportunity Employer. U.S. citizenship is required. The selected applicant may be subject to random pre-employment drug screening. Submit CV and three references by June 15, 2001, to:

John Straznickas, M.D., at VA Medical Center (116N)
4150 Clement Street, San Francisco, CA 94121

or call 415/221-4810 x2074 for further information.

Physicians Don't Like to Be Called "Providers"

Replacement of the word "physician" or "doctor" with "provider" is deliberately promoted by the insurance industry to undermine the physician-patient relationship, minimize physicians' role in health care and wrest more authority from them — and more concessions at contract time, according to physicians interviewed for a recent report in *American Medical News*.

It's all part of a plan that benefits insurers' bottom lines, physicians say — a plan to wean the public from medical doctors and replace physicians with lower-cost nurse practitioners and physician assistants.

"It's a bait-and-switch term," said Harvey F. Wachsman, M.D., a New York lawyer and neurosurgeon. "It's a term that's meant to mislead the public by virtue of them not knowing who is taking care of them." Dr. Wachsman said he has had 20 years of training as a neurosurgeon. By contrast, a certified nursing assistant — also a health care provider — might have trained for as little as two weeks. "It's an opportunity for the HMOs to mislead the public and avoid paying for physicians," he said.

Use of the word is dangerous because it helps open doors to other problems that eventually affect physicians, said Patrick Prevoto, M.D., an obstetrician-gynecologist in Austin, Texas. "In every legislature in every state, there's always a scope-of-practice issue coming up," Dr. Prevoto said. "We have to defend our medical license, and when you start using the term 'provider,' that's just another step toward blurring the lines."

The American Medical Association has adopted a policy encouraging the use of "physician" rather than "vendor" or "provider," and "patient" rather than "recipient" or "consumer." It also requires that health care entities, when using the term "provider" in contracts, advertising and other communications, specify the type of provider being referred to by using the provider's recognized title, which details education, training, license status and other recognized qualifications.

The State Medical Society of Wisconsin, at its March annual meeting, adopted a policy calling for use of the word "physician" when referring to an M.D. or D.O., and "nonphysician clinician" when referring to all other health care professionals.

Those outside the medical community have taken note of the shift from the word "physician" to "provider." "The word itself is going to drive a wedge between doctors and HMOs," said J. Gregory Payne, director of the Center for Ethics in Political and

NEWS FROM THE AMA

Health Communication at Emerson College in Boston. "There's a concern that they're going to lose their identity and become a part of the assembly-line process in health care."

Source: *American Medical News*, May 7, 2001.

Privacy Rule Called Burdensome to Physicians

A new federal rule governing the privacy of patients' medical information is causing some apprehension among physician groups, according to the AMA. President Bush's April 12 decision to release a medical records privacy rule initially issued by the Clinton administration came as a surprise to many who had urged the new administration to hold off on the regulation's release until substantial changes were made. Physicians and other health care entities will have until April 14, 2003, to comply with the new rule, required under the 1996 Health Insurance Portability and Accountability Act. The new standards allow patients to determine who has access to their medical records, to limit disclosure and, in some cases, to modify what is in those records.

Any revisions to the rule are to come in the form of administrative modifications and guidelines issued by the Department of Health and Human Services over the next year. The Bush administration has all but promised that modifications are in the offing, and both the rule's supporters and detractors are counting on changes to ease the path to implementation.

Although a staunch supporter of the privacy of medical records, the AMA has faulted the new rule for placing additional administrative burdens on physicians while absolving others, including health plans, of similar responsibilities. For example, in many instances health plans are not required to get consent to use or disclose patients' health records, said AMA Trustee Donald J. Palmisano, M.D. "Ironically, the rule does substantially increase the administrative burdens for physicians — the one sector of the health care system already ethically bound to safeguard patient privacy."

AMA policy calls for getting informed consent whenever possible before personally identifiable health information is used for any purpose. Under the rule, physicians will be required to obtain patient consent prior to using personal medical information for treatment, payment and performing such health care operations as quality assessments, training and case management. Physicians must have patients sign those consent forms when they come into the practice and will have to be aware of the

information's use for any other purpose, said David Kibbe, M.D., chair and cofounder of Canopy Systems Inc., a health care Internet company based in Chapel Hill, NC. Doctors also will have to make available a statement of their privacy policy that says to patients, "Here are your rights, and here's how we as a practice are complying with those rights," Dr. Kibbe said.

But obtaining consent and authorization forms represents only the "tip of the iceberg," he said. Physicians also will need to be aware of confidential patient information that is available to their lawyers, accountants and others identified in the rule as "business associates."

For now, the AMA and other medical groups recommend that physicians familiarize themselves with the provisions in the rule. They caution against spending a lot of money on consultants and seminars. "Physicians should reflect on where they are now with regard to consents and authorizations," Dr. Kibbe said. "Begin to think about where the protected health information goes now. Does it leave your practice?"

"We're telling everybody not to rush out and try to do everything today," Dr. Palmisano said. Separate HIPAA rules governing the physical security of health information have yet to be released, and the AMA would like the Bush administration to start the compliance clock running when all the rules are in place. In addition, Congress may yet step in and legislate postponement or changes in the HIPAA rules. "Our point is, if you are going to comply with a law, it is good to have all the components of the law or regulation," Dr. Palmisano said.

Source: *American Medical News*, May 7, 2001.

Maine College Town

Excellent, private group practice opportunity for internist or family physician who is ASAM eligible/certified. The practice encompasses primary care and addiction medicine. Live in a college community close to the coast, mountains and lakes. Salary plus full benefits and assistance with student loans. Call or fax your CV to:

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NAATP Honors Jasper G. Chen See, M.D.

Jasper G. Chen See, M.D., is the recipient of the Nelson J. Bradley Lifetime Achievement Award of the National Association of Addiction Treatment Providers (NAATP). Dr. Bradley pioneered what today is known as the Minnesota Model of addiction treatment.

In announcing the award, NAATP noted that Dr. Chen See "has unselfishly given himself to his community, the state of Pennsylvania [and] the nation, providing leadership and guidance to establish programs to effectively diagnose, treat and counsel" addicted persons and their families.

ASAM Executive Vice President James F. Callahan, D.P.A., was present at the awards ceremony and saluted Dr. Chen See on his award as follows:

"Before formally introducing Dr. Chen See, I want, as CEO of ASAM, to express my thanks to you, the members of NAATP and to your predecessors, and to your CEO, Ron Hunsicker and his predecessors for the outstanding work you have done and continue to do to bring high quality and effective treatment to thousands of men and women and their families who suffer from the diseases of alcoholism and other addictions.



"I also want to thank NAATP for a unique achievement and gift to ASAM and to the field: the *ASAM Patient Placement Criteria*.

"In 1989, the first year of Dr. Chen See's term as ASAM President, NAATP's first Executive Director, Michael Ford, and your Board of Directors invited me, Dr. David Mee-Lee and Dr. Joe Frawley to meet with members of your Board in Boston. I believe Ben Underwood was your Board Chairman and Bill Hawthorne was on both the ASAM and NAATP boards. Your Board proposed that ASAM and NAATP jointly publish a revised version of the *NAATP Criteria*.

"Dr. Chen See and the ASAM Board accepted your invitation. After the *Criteria* were published in 1991, NAATP and ASAM jointly sponsored a training conference in Atlanta. Following the conference, Michael Ford and Ben Underwood met with me and Dr. Mee-Lee and offered to give ASAM copyright to the *Criteria*, and proposed that the *Criteria* be known as the *ASAM Criteria*.

"The Second Edition was published in 1996. In April of this year, the Second Edition-Revised was published. It is dedicated to Michael Ford. The dedication reads: 'This volume is dedicated to the memory of Michael Ford, founder and first Executive Director of the National Association of Addiction Treatment Providers and Director of Public Policy with the National Council on Alcoholism. It was Mr. Ford who initiated the meetings between ASAM and NAATP that ultimately led to the development of these *Patient Placement Criteria*. In this initiative as in so many aspects of his work, Mr. Ford's legacy is the notion that "with hard work, public policy change is possible." Mr. Ford always saw the larger picture and was an outspoken champion for ASAM to lead the way in developing patient

placement criteria that would be recognized and utilized by a broad spectrum of addiction treatment providers. The continued evolution and acceptance of the ASAM Criteria are the legacy of Mr. Ford's vision and leadership."

"So I thank you for what NAATP has achieved for the field, and for what you have allowed ASAM to achieve. And now let me speak of our honoree, Dr. Jasper Chen See. I'll begin by telling you a story of my first encounter with Dr. Chen See.

"I was in my fifth year at the National Cancer Institute at NIH, having gone there from NIDA, when I learned that ASAM — at that time called AMSAODD — was looking for a new Director.

"I applied for the position and received a phone call from Dr. Chen See. I had never met Dr. Chen See, nor had I spoken to him. He told me he would like to meet with me to discuss my interest in ASAM and what I would bring to the organization. We agreed to meet at the New York Hilton for lunch.

"He asked me to describe myself so that he could recognize me, and I did. I then asked Jasper to describe himself, and he did, in what I learned was vintage Jasper. He has a beautiful Jamaican accent, having been raised there, and he spoke softly and slowly, as he always does, and said: 'I'm a Chinaman with a crewcut and handsome as hell.' And Jasper is 'handsome as hell' in every way.

"I would like to quote from the Caron Foundation's nomination essay and list some of the 'handsome' reasons why you have chosen him as the Award recipient: 'For more than half a century, Dr. Chen See has unselfishly given of himself to his community (in Reading, PA), to the state of Pennsylvania, as well as nationally, providing leadership and guidance to establish programs to effectively diagnose, treat and counsel chemically dependent individuals and families that are impacted by this chronic, devastating disease.

"Dr. Chen See is a Villanova University graduate and received his medical degree from Jefferson Medical College in Philadelphia.

"His involvement in the addiction field began in his home community. While serving as chairman of the Berks County Medical Society's Physical Fitness Committee, he was approached by Richard J. Caron, Founder of Chit Chat Farms, now known as the Caron Foundation. Dick Caron invited Jasper to offer a series of lectures on alcoholism and physical fitness.

"Jasper told Dick Caron that he knew nothing about alcoholism, but, as a practicing pathologist at St. Joseph Hospital in Reading, he knew alcohol's effects on the body, and he

Faculty Positions in Addiction Medicine and Addiction Psychiatry

The Department of Psychiatry of Michigan State University and Sparrow Health Systems offer a position at the Assistant/Associate Professor level in the Division of Addictions Medicine in the College of Human Medicine and the College of Osteopathic Medicine. Responsibilities include clinical care in inpatient settings and outpatient settings, detoxification and short-term treatment in addiction and psychiatric populations, supervision of psychiatric medical residents and medical students, and opportunities for clinical research. Experience and/or interest in working with student athletes highly desirable. Physician applicants must be M.D. or D.O. and Board certified or eligible in Psychiatry. Certification in Addiction Psychiatry and/or Addiction Medicine is highly desired. Salary is commensurate with experience and clinical activity. Starting dates are immediate but negotiable. Prospective candidates should send a letter of application and resume to:

Gerald G. Osborn, D.O., M. Phil.
Professor and Interim Chairperson
Department of Psychiatry
Michigan State University
A222 East Fee Hall
East Lansing, MI 48824-1316
(517) 353-4363

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said he had an intense interest in learning more about this disease which had such devastating consequences for individuals and their families.

"Dr. Chen See served on the Board of the Caron Foundation and gave regular lectures to patients on the pathology of the disease. On retiring from the Board, Dr. Chen See was named Director Emeritus. He also served on the Board of Trustees of Villanova University and of Alvernia College, where he helped to establish a degree program in alcoholism and drug addiction counseling and administration.

"He was a founding board member of the local chapter of the National Council on Alcoholism and served as Vice-chair of the National Council on Alcoholism and Other Drug Dependencies. He was President of the Alcoholism and Addiction Association of Pennsylvania and chairman of the President's Task Force of the Pennsylvania Governor's Council on Drug and Alcohol Abuse. Dr. Chen See was the recipient of the 1984 Keystone Award of the Alcohol and Addiction Association of Pennsylvania.

"In 1991, he received an honorary degree from Villanova for his unselfish service to mankind as a national pioneer in the treatment of chemical dependency.

"In 1994, ASAM honored him with its Annual Award "For his outstanding contribution to the growth and vitality of the Society, for thoughtful leadership in the field, and for his deep understanding of the art and science of addiction medicine".

"When the Caron Foundation nominated Dr. Chen See, I was asked to send a letter of support. I would like to close my remarks by reading to you from my letter.

"Dear Mr. Eaton:

"I was pleased to learn that Jasper G. Chen See, M.D., has been nominated to be the recipient of the Nelson J. Bradley Lifetime Achievement Award. Dr. Chen See is the very embodiment of the purpose for which the Award was established. I can say in all sincerity that there is no one whom I could recommend more highly for the Award than Dr. Chen See.

"Dr. Chen See served as President of the American Society of Addiction Medicine from 1989 to 1991. It was under his presidency that the Society set forth its first long-range plan for establishing Addiction Medicine as a medical specialty, and for integrating prevention, treatment and research of alcoholism and other addictive disorders into our nation's healthcare system.

"He had the vision to recommend to the ASAM Board that the Society establish its national headquarters in Washington, D.C., in order to play a first-hand role in the establishment of our nation's prevention, treatment and research policies in addictive disorders. It was under Dr. Chen See's presidency that the American Medical Association recognized Addiction Medicine as a medical specialty. It was under Dr. Chen See's presidency that the Society, at the invitation of and with the full support and collaboration of the National Association of Addiction Treatment Providers, issued the *ASAM Patient Placement Criteria*, building on NAATP's work and that of the authors of the *Cleveland Criteria*. It was also under Dr. Chen See's presidency that, at his recommendation, the ASAM Board of Directors established the Ruth Fox Endowment to assure the Society's permanence and its lasting influence in assuring treatment for addictive disorders.

"Dr. Chen See's vision and his genius for administration and strategic planning are matched by the largeness of his love and sincerity, and by his total commitment to those who suffer from addictive disorders. He is a person of unique and genuine humility, who moves those who work with him to action, both by the persuasiveness of his insight and foresight, and by the genuineness of his personal commitment.

"It is my fervent hope that you will choose to honor Dr. Chen See with the Nelson J. Bradley Award. In doing so, you will not only be honoring one of the giants of our field, but you will also be giving further witness of NAATP's enduring commitment to the values and purpose for which Addiction Medicine stands.

"And with that, Jasper, we present to you the Nelson J. Bradley Lifetime Achievement Award."



Please visit our booth at this year's ASAM meeting

What do the leading medical authorities say about alcohol and drug abuse?

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- The American Medical Association
- The American Society of Addiction Medicine
- The National Institute on Alcohol Abuse & Alcoholism
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AGENCY REPORTS

CSAT: Methadone Regulations Issued

The Center for Substance Abuse Treatment (CSAT) has issued new regulations to improve the quality and oversight of treatment programs that use methadone and other pharmacotherapies for heroin and related addictions. The regulations create a new accreditation program that replaces a 30-year-old inspection program conducted by the U.S. Food and Drug Administration (FDA). They became effective May 18 as part of the Code of Federal Regulations 42 Part 8, "Certification of Opioid Treatment Programs."

Under the new regulations, treatment programs that dispense or administer methadone or levo-alpha-acetylmethadol (LAAM) will be accredited by private sector organizations, using standards established by CSAT. The standards emphasize factors relevant to the quality of care, such as individualized treatment planning, increased medical supervision, and assessment of patient outcomes.

CSAT Director H. Westley Clark, M.D., J.D., M.P.H., FASAM, explained that the accreditation system will "set a higher standard of care for those receiving methadone treatment. It should improve the quality of treatment programs overall by allowing

for more clinical judgement in treatment, helping mainstream the medical treatment of opioid dependence, and continue a federal role" through CSAT oversight.

Details on the new regulations are available at the CSAT Web site (www.csat.gov). In addition, CSAT is sponsoring a series of eight training sessions around the country to help treatment programs that use methadone and LAAM understand how to meet the new accreditation standards.

ONDCP: John Walters Named Director

President Bush has named John P. Walters to head the White House Office of National Drug Control Policy (ONDCP).

The new director is well known to the field, having served previously at ONDCP as deputy director for supply reduction under William Bennett in the administration of former President George Bush. He also co-authored, with Mr. Bennett and John DiJulio, Jr. (who now heads the White House Office of Community and Faith-Based Initiatives) a book entitled *Body Count: Moral Poverty and How to Win America's War Against Crime and Drugs*.

Mr. Walters long has opposed exemptions for the medical use of marijuana and has stressed criminal penalties for drug users. "Our country has made great progress in the past in reducing drug use, and we will do it again," he told the press during a ceremony to announce his nomination, which requires Senate confirmation. He added that he hopes to "shield our communities from the terrible human toll taken by drug use."

HRSA: Faculty Training Initiative Launched

In an effort to educate those who teach future physicians and other health care professionals, the Health Resources and Services Administration (HRSA) and the Center for Substance Abuse Treatment (CSAT) are collaborating to support the development of a training program to teach medical school faculty about screening and referral of patients who exhibit signs of alcohol or drug addiction.

The Interdisciplinary Faculty Development Program to Improve Substance Abuse Education will provide educators with the background and resources to teach students how to recognize addictive disorders, how to talk to their patients about alcohol and drug problems, and when to refer patients to addiction treatment. In addition to medicine, the effort will involve educators in 15 health professions.

The \$1 million program will be conducted by the Association for Medical Education and Research in Substance Abuse (AMERSA). Program details can be found on AMERSA's Web site at www.amersa.org.

NIDA: Reports Released on Rx Abuse, Hallucinogens

The National Institute on Drug Abuse has released two reports of interest to addiction medicine specialists.

In a conference cosponsored by the American Association of Retired Persons, the American Pharmaceutical Association, the Pharmaceutical Research and Manufacturers of America, the National Council on Patient Information and Education, the National Association of Chain Drug Stores, and the National Community Pharmacists Association, NIDA announced that it has updated its research report on "Prescription Drugs: Misuse, Abuse, and Addiction."

A second research report, on "Hallucinogens and Dissociative Drugs," examines abuse of drugs with street names like "acid," "angel dust," and "Vitamin K" that distort the way a user perceives time, motion, colors, sounds, and self. The report notes that such drugs can disrupt a person's ability to think and communicate rationally, or even to recognize reality, sometimes resulting in bizarre or dangerous behaviors.

The full texts of both reports can be downloaded from NIDA's Web site at www.nida.nih.gov.

SAMHSA: National Treatment Directory Updated

The Substance Abuse and Mental Health Services Administration (SAMHSA) has released its updated *National Directory of Drug and Alcohol Abuse Treatment Programs*, a guide containing information on thousands of local treatment programs.

The new directory includes a nationwide inventory of publicly funded drug and alcohol treatment programs, as well as private facilities that are licensed, certified or otherwise approved by state agencies. The directory is organized on a state-by-state basis to facilitate reference by health care professionals, social workers, managed care organizations and the general public.

Single copies of the directory are available at no charge from SAMHSA's National Clearinghouse for Alcohol and Drug Information (NCADI), PO Box 2345, Rockville, MD 20847, or can be ordered by phone at 1-800/729-6686.

Medical Director LOS ANGELES

We are a statewide health care organization providing substance abuse treatment and primary medical care services. We have a great opportunity available in our Los Angeles region for a physician to assume responsibility for the medical department and to perform medical services for patients. This includes authorizing and supervising dispensing of daily narcotic replacement therapy and other medications by medical staff and training all staff in Universal Precautions and emergency medical procedures.

The successful candidate will be licensed in good standing to practice medicine in California and will have a current and valid DEA registration. The applicant must never have had an application for a DEA license denied, a DEA registration revoked or denied, or have surrendered a DEA registration for cause. The ability to communicate with a diverse patient population is required, and at least one year of primary medical care and substance abuse treatment experience is strongly preferred.

We offer a competitive salary and benefits package, which includes incentive pay, fully paid medical leave and dental insurances, regular hours (generally 6:00 a.m. to 2:00 p.m. Monday through Friday), a generous time-off policy, a 401(k) plan and a business casual work environment.

BAART/CDP values diversity and is an equal opportunity employer.

Please send your resume and a cover letter with your salary history and requirements to:

BAART/CDP, Attn: Human Resources Manager,
1111 Market St., 4th Floor, San Francisco, CA 94103,
or fax to 415/552-3455,

or e-mail your resume as an MS Word attachment to
Human_Resources@baart-cdp.com.

For more information, please visit our Web site at
www.baartcdp.com.

The moment of truth for the committed quitter.

Help him conquer the moment with Antabuse®

Now, for alcoholism, from Odyssey Pharmaceuticals — Antabuse, an integral part of an integrated system of support for the patient with chronic alcoholism.

When your patient with chronic alcoholism needs a behavioral modification tool to keep his commitment to sobriety, Antabuse can help.

Unique and effective, but it won't work alone.

Use Antabuse as part of an integrated program that includes professional counseling and family support, and it can help the committed quitter look the moment of truth in the eye — and win.

Disulfiram should *never* be administered to a patient who is in a state of alcohol intoxication or without their full knowledge. Relatives should be instructed accordingly.

Patients who have recently received metronidazole, paraldehyde, alcohol or alcohol-containing products should not receive Antabuse. Antabuse is contraindicated in severe myocardial disease or coronary occlusion, psychoses, and hypersensitivity to disulfiram. Antabuse should be used with caution in patients receiving phenytoin and its congeners. Please see complete prescribing information on next page for more information.

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Pharmaceutical From

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PHARMACEUTICALS, INC.™

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East Hanover, NJ 07936
Tel: 1-877-427-9068

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In alcoholism

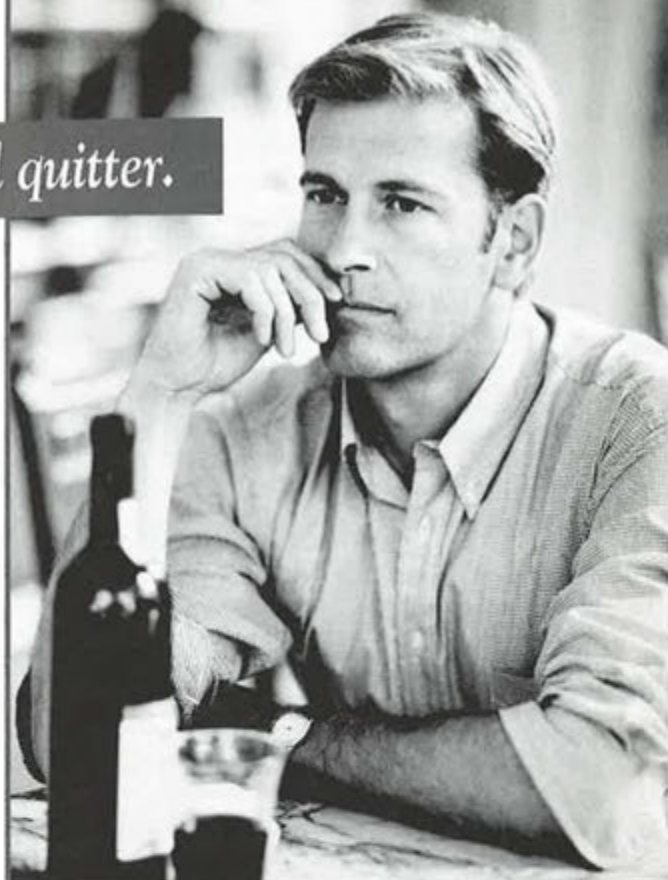
ANTABUSE®
(Disulfiram, USP)

250-mg tablets

Support for the committed quitter

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Antabuse Identification Cards are available free of charge to patients. Call 1-877-427-9068 or visit our web site at www.OdysseyPharm.com for details.

Antabuse® (Disulfiram, USP) Tablets IN ALCOHOLISM

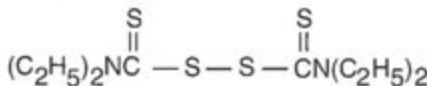
WARNING:

Disulfiram should never be administered to a patient when he is in a state of alcohol intoxication, or without his full knowledge. The physician should instruct relatives accordingly.

DESCRIPTION: CHEMICAL NAME:

bis(diethylthiocarbamoyl) disulfide.

STRUCTURAL FORMULA:



C₁₀H₂₀N₂S₄

M.W. 296.55

Disulfiram occurs as a white to off-white, odorless, and almost tasteless powder, soluble in water to the extent of about 20 mg in 100 mL, and in alcohol to the extent of about 3.8 g in 100 mL.

Each tablet for oral administration contains 250 mg disulfiram, USP. Tablets also contain colloidal silicon dioxide, anhydrous lactose, magnesium stearate, microcrystalline cellulose, sodium starch glycolate, and stearic acid.

CLINICAL PHARMACOLOGY: Disulfiram produces a sensitivity to alcohol which results in a highly unpleasant reaction when the patient under treatment ingests even small amounts of alcohol. Disulfiram blocks the oxidation of alcohol at the acetaldehyde stage. During alcohol metabolism following disulfiram intake, the concentration of acetaldehyde occurring in the blood may be 5 to 10 times higher than that found during metabolism of the same amount of alcohol alone.

Accumulation of acetaldehyde in the blood produces a complex of highly unpleasant symptoms referred to hereinafter as the disulfiram-alcohol reaction. This reaction, which is proportional to the dosage of both disulfiram and alcohol, will persist as long as alcohol is being metabolized. Disulfiram does not appear to influence the rate of alcohol elimination from the body.

Disulfiram is absorbed slowly from the gastrointestinal tract and is eliminated slowly from the body. One (or even two) weeks after a patient has taken his last dose of disulfiram, ingestion of alcohol may produce unpleasant symptoms.

Prolonged administration of disulfiram does not produce tolerance; the longer a patient remains on therapy, the more exquisitely sensitive he becomes to alcohol.

INDICATIONS: Disulfiram is an aid in the management of selected chronic alcohol patients who want to remain in a state of enforced sobriety so that supportive and psychotherapeutic treatment may be applied to best advantage.

Disulfiram is not a cure for alcoholism. When used alone, without proper motivation and supportive therapy, it is unlikely that it will have any substantive effect on the drinking pattern of the chronic alcoholic.

CONTRAINDICATIONS: Patients who are receiving or have recently received metronidazole, paraldehyde, alcohol, or alcohol-containing preparations, e.g., cough syrups, tonics and the like, should not be given disulfiram.

Disulfiram is contraindicated in the presence of severe myocardial disease or coronary occlusion, psychoses, and hypersensitivity to disulfiram or to other thiazuram derivatives used in pesticides and rubber vulcanization.

WARNINGS:

Disulfiram should never be administered to a patient when he is in a state of alcohol intoxication, or without his full knowledge. The physician should instruct relatives accordingly.

The patient must be fully informed of the disulfiram-alcohol reaction. He must be strongly cautioned against surreptitious drinking while taking the drug, and he must be fully aware of the possible consequences. He should be warned to avoid alcohol in disguised forms, i.e., in sauces, vinegars, cough mixtures, and even in aftershave lotions and back rubs. He should also be warned that reactions may occur with alcohol up to 14 days after ingesting disulfiram.

The Disulfiram-Alcohol Reaction: Disulfiram plus alcohol, even small amounts, produce flushing, throbbing in head and neck, throbbing headache, respiratory difficulty, nausea, copious vomiting, sweating, thirst, chest pain, palpitation, dyspnea, hyperventilation, tachycardia, hypotension, syncope, marked weakness, vertigo, blurred vision, and confusion. In severe reactions there may be respiratory depression, cardiovascular collapse, arrhythmias, myocardial infarction, acute congestive heart failure, unconsciousness, convulsions, and death.

The intensity of the reaction varies with each individual, but is generally proportional to the amounts of disulfiram and alcohol ingested. Mild reactions may occur in the sensitive individual when the blood alcohol concentration is increased to as little as 5 to 10 mg per 100 mL. Symptoms are fully developed at 50 mg per 100 mL, and unconsciousness usually results when the blood alcohol level reaches 125 to 150 mg.

The duration of the reaction varies from 30 to 60 minutes, to several hours in the more severe cases, or as long as there is alcohol in the blood.

Drug Interactions: Disulfiram appears to decrease the rate at which certain drugs are metabolized and therefore may increase the blood levels and the possibility of clinical toxicity of drugs given concomitantly.

DISULFIRAM SHOULD BE USED WITH CAUTION IN THOSE PATIENTS RECEIVING PHENYTOIN AND ITS CONGENERS, SINCE THE CONCOMITANT ADMINISTRATION OF THESE TWO DRUGS CAN LEAD TO PHENYTOIN INTOXICATION. PRIOR TO ADMINISTERING DISULFIRAM TO A PATIENT ON PHENYTOIN THERAPY, A BASELINE PHENYTOIN SERUM LEVEL SHOULD BE OBTAINED. SUBSEQUENT TO INITIATION OF DISULFIRAM THERAPY, SERUM LEVELS OF PHENYTOIN SHOULD BE DETERMINED ON DIFFERENT DAYS FOR EVIDENCE OF AN INCREASE OR FOR A CONTINUING RISE IN LEVELS. INCREASED PHENYTOIN LEVELS SHOULD BE TREATED WITH APPROPRIATE DOSAGE ADJUSTMENT.

It may be necessary to adjust the dosage of oral anticoagulants upon beginning or stopping disulfiram, since disulfiram may prolong prothrombin time.

Patients taking isoniazid when disulfiram is given should be observed for the appearance of unsteady gait or marked changes in mental status, the disulfiram should be discontinued if such signs appear.

In rats, simultaneous ingestion of disulfiram and nitrite in the diet for 78 weeks has been reported to cause tumors, and it has been suggested that disulfiram may react with nitrites in the rat stomach to form a nitrosamine, which is tumorigenic. Disulfiram alone in the rat's diet did not lead to such tumors. The relevance of this finding to humans is not known at this time.

Concomitant Conditions: Because of the possibility of an accidental disulfiram-alcohol reaction, disulfiram should be used with extreme caution in patients with any of the following conditions: diabetes mellitus, hypothyroidism, epilepsy, cerebral damage, chronic and acute nephritis, hepatic cirrhosis or insufficiency.

Usage in Pregnancy: The safe use of this drug in pregnancy has not been established. Therefore, disulfiram should be used during pregnancy only when, in the judgement of the physician, the probable benefits outweigh the possible risks.

PRECAUTIONS: Patients with a history of rubber contact dermatitis should be evaluated for hypersensitivity to thiazuram derivatives before receiving disulfiram (see CONTRAINDICATIONS). It is suggested that every patient under treatment carry an Identification Card stating that he is receiving disulfiram and describing the symptoms most likely to occur as a result of the disulfiram-alcohol reaction. In addition, this card should indicate the physician or institution to be contacted in an emergency. (Cards may be obtained from ODYSSEY PHARMACEUTICALS upon request.)

Alcoholism may accompany or be followed by dependence on narcotics or sedatives. Barbiturates and disulfiram have been administered concurrently without untoward effects; the possibility of initiating a new abuse should be considered. Baseline and follow-up transaminase tests (10-14 days) are suggested to detect any hepatic dysfunction that may result with disulfiram therapy. In addition, a complete blood count and a sequential multiple analysis-12 (SMA-12) test should be made every six months.

Patients taking disulfiram tablets should not be exposed to ethylene dibromide or its vapors. This precaution is based on preliminary results of animal research currently in progress that suggest a toxic interaction between inhaled ethylene dibromide and ingested disulfiram resulting in a higher incidence of tumors and mortality in rats. A correlation between this finding and humans, however, has not been demonstrated.

ADVERSE REACTIONS: (See CONTRAINDICATIONS, WARNINGS, and PRECAUTIONS.) OPTIC NEURITIS, PERIPHERAL NEURITIS, POLYNEURITIS, AND PERIPHERAL NEUROPATHY MAY OCCUR FOLLOWING ADMINISTRATION OF DISULFIRAM.

Multiple cases of hepatitis, including both cholestatic and fulminant hepatitis, have been reported to be associated with administration of disulfiram.

Occasional skin eruptions are, as a rule, readily controlled by concomitant administration of an antihistaminic drug.

In a small number of patients, a transient mild drowsiness, fatigability, impotence, headache, acneiform eruptions, allergic dermatitis, or a metallic or garlic-like aftertaste may be experienced during the first two weeks of therapy. These complaints usually disappear spontaneously with the continuation of therapy, or with reduced dosage.

Psychotic reactions have been noted, attributable in most cases to high dosage, combined toxicity (with metronidazole or isoniazid), or to the unmasking of underlying psychoses in patients stressed by the withdrawal of alcohol.

DOSE AND ADMINISTRATION: Disulfiram should never be administered until the patient has abstained from alcohol for at least 12 hours.

Initial Dosage Schedule: In the first phase of treatment, a maximum of 500 mg daily is given in a single dose for one to two weeks. Although usually taken in the morning, disulfiram may be taken on retiring by patients who experience a sedative effect. Alternatively, to minimize, or eliminate, the sedative effect, dosage may be adjusted downward.

Maintenance Regimen: The average maintenance dose is 250 mg daily (range, 125 to 500 mg). It should not exceed 500 mg daily.

Note: Occasionally patients, while seemingly on adequate maintenance doses of disulfiram, report that they are able to drink alcoholic beverages with impunity and without any symptomatology. All appearances to the contrary, such patients must be presumed to be disposing of their tablets in some manner without actually taking them. Until such patients have been observed reliably taking their daily disulfiram tablets (preferably crushed and well mixed with liquid), it cannot be concluded that disulfiram is ineffective.

Duration of Therapy: The daily, uninterrupted administration of disulfiram must be continued until the patient is fully recovered socially and a basis for permanent self-control is established. Depending on the individual patient, maintenance therapy may be required for months or even years.

Trial with Alcohol: During early experience with disulfiram, it was thought advisable for each patient to have at least one supervised alcohol-drug reaction. More recently, the test reaction has been largely abandoned. Furthermore, such a test reaction should never be administered to a patient over 50 years of age. A clear, detailed and convincing description of the reaction is felt to be sufficient in most cases.

However, where a test reaction is deemed necessary, the suggested procedure is as follows: After the first one to two weeks' therapy with 500 mg daily, a drink of 15 mL (1/2 oz) of 100 proof whiskey, or equivalent, is taken slowly. This test dose of alcoholic beverage may be repeated once only, so that the total dose does not exceed 30 mL (1 oz) of whiskey. Once a reaction develops, no more alcohol should be consumed. Such tests should be carried out only when the patient is hospitalized, or comparable supervision and facilities, including oxygen, are available.

Management of Disulfiram-Alcohol Reaction: In severe reactions, whether caused by an excessive test dose or by the patient's unsupervised ingestion of alcohol, supportive measures to restore blood pressure and treat shock should be instituted. Other recommendations include: oxygen, carbon dioxide (95% oxygen and 5% carbon dioxide), vitamin C intravenously in massive doses (1 g) and ephedrine sulfate. Antihistamines have also been used intravenously. Potassium levels should be monitored, particularly in patients on digitalis, since hypokalemia has been reported.

HOW SUPPLIED: Disulfiram Tablets, USP: 250 mg - White, round, unscored tablets in bottles of 100.

Debossed: DP 706

Dispense in a tight, light-resistant container as defined in the USP.

Store at controlled room temperature 15°-30°C (59°-86°F).

Distributed by Odyssey Pharmaceuticals, Inc., East Hanover, New Jersey 07936
Manufactured by Sidmak Laboratories, Inc., East Hanover, NJ 07936

FUNDING OPPORTUNITIES

Funds to Study AOD Treatment in Managed Care Settings

Funds are available to study addiction treatment service delivery in managed care settings, through a special funding opportunity announced by the Center for Substance Abuse Treatment (CSAT). The agency seeks studies to evaluate computerized decisionmaking systems that assist clinicians and patients in selecting the best treatment options and to assess whether performance measures employed by managed care organizations actually lead to better treatment outcomes.

Approximately \$500,000 will be available to support up to five awards of \$50,000 to \$150,000 each for a period not to exceed three years. State and local governments (including tribal organizations) and public and nonprofit organizations such as community-based organizations, faith-based organizations, universities, colleges and hospitals are encouraged to apply.

The managed care pilot study grants have been added to CSAT's Community Treatment Program, PA 99-050. Applications will be accepted under a one-time receipt date of September 10, 2001. Questions about program issues should be directed to Sarah Wattenberg, CSAT project officer, at 301/443-0092. Grants management questions should be addressed to Pilar Carrillo at 301/443-6284. Details about this and other CSAT funding opportunities are posted on the SAMHSA Web site (www.samhsa.gov).

Grants Fund Opiate Treatment in Rural Areas

The Center for Substance Abuse Treatment (CSAT) has announced a special funding opportunity to support development of treatment services in rural communities for persons with addiction to heroin or prescription pain medications such as OxyContin®. This targeted grant opportunity is part of the ongoing CSAT Community Action Grants Program, which provides support for the adoption and implementation of best practices in addiction treatment.

The special funding opportunity will result in award of up to five grants of \$50,000 to \$150,000 each. Grantees will be expected to implement best medication-assisted therapy practices, including the use of opioid agonists such as methadone or LAAM, in rural communities where access to treatment services is limited or nonexistent.

Grants are available to state and local governments (including tribal organizations) and public and nonprofit organizations such as community-based organizations, faith-based organizations, universities, colleges and hospitals.

Applications for the grants will be accepted under a one-time receipt date of September 10, 2001. Questions about the Opioid Agonist Treatment Exemplary Practice Model grants should be directed to Mike Bacon, CSAT project officer, at 301/443-7749. Grants management questions should be addressed to Kathleen Sample at 301/443-9667. Details about this and other CSAT funding opportunities are posted on the SAMHSA Web site (www.samhsa.gov).

RWJF Funds Available

The Robert Wood Johnson Foundation's Substance Abuse Policy Research Program (SAPRP) is requesting proposals on the following research topics through a special solicitation: policies and systems surrounding the medicinal uses of marijuana; legalization/decriminalization of marijuana and other drugs; illicit drug use harm

reduction policies; office-based opiate agonist therapy; alternative nicotine delivery systems; and alcohol and tobacco addiction.

SAPRP funds research projects that seek policy-relevant information about ways to reduce the harm caused by substance abuse in the United States. Experts in public health, law, political science, medicine, sociology, criminal justice, economics, and other behavioral and policy sciences are encouraged to apply. Project awards are funded up to \$400,000 and may extend up to three years.

The deadline for receipt of letters of intent for this special solicitation is August 20, 2001. For the full text of the call for proposals, visit the foundation's Web site (www.rwjf.org). Once at the site, click on "Applying for a Grant," then "Calls for Proposals."

Drug Abuse Funding Monitor

Drug Abuse Funding Monitor is a monthly newsletter on federal and private-sector funding and financial assistance for drug and alcohol programs, law enforcement agencies and drug courts. The Grants & Regulation Alert section highlights upcoming grant application deadlines for receiving financial and technical assistance from the federal government, foundations and corporations. The newsletter also includes a conference calendar and profiles of private funding sources.

For more information, contact Capitol City Publishers at 3030 Clarendon Blvd., Suite 219, Arlington, VA 22201; or phone 703/525-3080; or fax 703/525-3044. ■

MEDICAL DIRECTOR, CDRP (Oakland)

Responsible for providing direct medical care and supervising the clinical care of a multi-disciplinary staff. Requires BE/BC in Adult Psychiatry, ASAM Certification or CAQ in Addiction Psychiatry, previous CD experience and the ability to provide leadership to a multi-disciplinary team.

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Please contact: Andrew Carota, The Permanente Medical Group Inc, 1814 Franklin St, 4th Floor, Oakland, CA 94612; Ph: (800) 777-4912; Fax: (510) 873-5006; Email: Andrew.J.Carota@kp.org. Refer to Job Code #: A77. www.kp.org/ca. EEO/AA/M/F/D/V.



KAISER PERMANENTE®

Friends Recruit New ASAM Members

A group of enthusiastic ASAM members were honored at the annual Medical-Scientific Conference as "Friends of ASAM" for their success in recruiting new members for the Society. Each Friend received a special certificate and the thanks of ASAM's officers for their efforts to support the Society's continued growth and success.

Named Friends of ASAM were:

Steven L. Batki, M.D.
Daniel J. Blake, M.D., Ph.D.
Robert Stephen Brandram-Adams, M.B.B.S.
Lawrence S. Brown, Jr., M.D., M.P.H., FASAM
Carl J. Brueggermann, M.D.
Brady M. Burns, M.D.
Alfredo Cerdan-Assad, M.D.
George L. Chappell, M.D.
Christina M. Delos-Reyes, M.D.
Paul H. Earley, M.D., FASAM
John Peter Femino, M.D., FASAM
Donald E. Fischer, Jr., M.D.
Stephen Neal Fisher, M.D.
Gregory Fuller, D.O.
Marc Galanter, M.D., FASAM
David R. Gastfriend, M.D.
Douglas Graham, M.D., FASAM
William Frees Haning, III, M.D., FASAM
William B. Hawthorne, M.D.
Thomas L. Haynes, M.D., FASAM
Carlos Antonio Hernandez-Avila, M.D.
Frederick Karaffa, M.D.
Timothy J. Kelly, M.D.
Robert A. Liebelt, M.D.
Robert Mallin, M.D.
Elinore F. McCance-Katz, M.D., Ph.D.
Norman S. Miller, M.D., FASAM
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Arturo E. Morales, M.D.
Joel A. Nathan, M.D.
Ronald J. Oehler, M.D.
John Osei-Tutu, M.D.
Ashwin A. Patkar, M.D.
Christopher Douglas Prater, M.D.
Mark R. Plickler, M.D., FASAM
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Virginia S. Roberts, M.D.
Terry K. Schultz, M.D., FASAM
Gregory Seeger, M.D.
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Jack R. Woodside, Jr., M.D.

MED-SCI

2001 Medical-Scientific Conference Sets Records for Attendance, Quality of Sessions

More than 1,000 physicians and other health care professionals attended ASAM's 32nd Annual Medical-Scientific Conference, April 19-22 in Los Angeles. The conferees — ASAM members as well as nonmember physicians, nurses, psychologists, counselors, students and residents — also participated in the Ruth Fox Course for Physicians and an ASAM Forum on Pain and Addiction, and in the groundbreaking Buprenorphine training course, which is designed to qualify ASAM members and other physicians to prescribe this promising new anti-addiction medication.



The annual Business Meeting and Breakfast was gavelled to order by Immediate Past President Marc Galanter, M.D., FASAM.



A highlight of the opening ceremony was the R. Brinkley Smithers Distinguished Scientist Lecture, delivered by Charles P. O'Brien, M.D., Ph.D., Professor and Vice Chair, Department of Psychiatry, the University of Pennsylvania, and Chief of Psychiatry at the Veterans Administration Medical Center, Philadelphia. Dr. O'Brien spoke on "Science-Based Treatment of Addictions."

REPORT

The Smithers Lecture inaugurated a three-day program rich in scientific and clinical presentations. Program chair Edward Gottheil, M.D., FASAM, and his committee won accolades for the exciting selection of symposia, courses, workshops, invited papers and poster sessions.



Immediate Past President Marc Galanter, M.D., FASAM (left), congratulates co-chairs Seddon Savage, M.D., FASAM and Howard Heit, M.D., FACP, FASAM, on the success of the second annual ASAM course on "Pain and Addiction: Common Threads," which preceded the Med-Sci conference.



The well-attended exhibit area featured displays by groups ranging from pharmaceutical manufacturers to federal agencies, and included treatment programs, publishers and service providers.



SAN FRANCISCO

Department of Veterans Affairs Medical Center Medical Director

The SFVAMC is seeking a board-certified or eligible psychiatrist for a full-time position in clinical care in the Opioid Replacement Treatment (ORT) Team in the Substance Abuse Section of the Mental Health Service. The position will emphasize clinical care of a dual-diagnosis population whose presenting drugs of choice are opioids such as heroin and whose primary modality of care is the use of agonist medications (methadone, LAAM, buprenorphine).

This position also affords opportunities for participation in smoking cessation programs and other section activities. Research collaboration is available in existing and planned protocols. There are opportunities to teach UCSF psychiatry residents and Substance Abuse Fellows and to receive a Clinical Faculty appointment at the University of California at San Francisco (UCSF) School of Medicine.

ASAM or AAAP certification in Addiction Medicine/Psychiatry is desirable. We have a competitive salary, depending on qualifications and experience, and an array of benefits. The Department of Veterans Affairs is an Equal Opportunity Employer. U.S. citizenship is required. The selected applicant may be subject to random pre-employment drug screening. Submit CV and three references by June 15, 2001, to:

Peter Banyas, M.D., at VA Medical Center (116E)
4150 Clement Street, San Francisco, CA 94121
or call 415/221-4810 x2356 or bany@itsa.ucsf.edu
for further information.

New ASAM Fellows Honored

Kevin O'Brien, M.D., FASAM, Chair of the ASAM Fellows Subcommittee and Richard Tremblay, M.D., FASAM, Chair of the ASAM Membership Committee congratulated 21 newly elected Fellows of the Society at ASAM's Annual Awards Dinner in April.

These Fellows join a group of 148 ASAM colleagues who have been elected Fellows in recognition of their certification in addiction medicine, their significant contributions to the field of addiction medicine, and their service to ASAM.

The new Fellows are:

- Terry L. Alley, M.D., FASAM
Blount Springs, AL
- Jacob Bobrowski, M.D., B.Sc., FASAM
Toronto, Ontario, Canada
- David W. Brook, M.D., FASAM
New York, NY
- William G. Campbell, M.D., FASAM
Calgary, Alberta, Canada
- Robert D. Daigle, M.D., FASAM
San Jose, CA
- John P. Epling, M.D., FASAM
Shreveport, LA
- Stanley J. Evans, M.D., FASAM
Portland, ME
- Charles F. Gehrke, M.D., FASAM
Saline, MI
- William Glatt, M.D., FASAM
South San Francisco, CA
- John Harsany, Jr., M.D., FASAM
Hemet, CA
- Henry E. Irby, M.D., FASAM
Jackson, MS
- Gary A. Jaeger, M.D., FASAM
Carson, CA
- Donald J. Kurth, M.D., FASAM
Alta Loma, CA
- Thomas E. Lauer, M.D., FASAM
High Point, NC
- Richard F. Limoges, M.D., FASAM
Philadelphia, PA
- Lance P. Longo, M.D., FASAM
Whitefish Bay, WI
- Robert J. Middleton, M.D., FASAM
Louisville, KY
- Gary D. Olbrich, M.D., FASAM
Nashville, TN
- Jeffrey D. Roth, M.D., FASAM
Chicago, IL
- Mark T. Schreiber, M.D., FASAM
Virginia Beach, VA
- Will W. Ward, Jr., M.D., FACP, FASAM
Louisville, KY

For information on the Fellows program, contact ASAM Membership and Chapter Relations Manager at CKIM@asam.org.

Awards Dinner Honors Dr. Primm, Dr. Gordis, Dr. Radcliffe, New ASAM Fellows



The ASAM Awards Dinner on Saturday, April 21, featured presentation of the John P. McGovern Award on Addiction and Society to Beny J. Primm, M.D., Executive Director, Addiction Research & Treatment Corp., Brooklyn, NY, and former director of the federal Center for Substance Abuse Treatment. The McGovern Award 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 is sponsored by an endowment from the John P. McGovern Foundation.

An ASAM Annual Award for "expanding the frontiers of the field of Addiction Medicine and broadening our understanding of the addiction process, through research and innovation" was presented to ASAM member Enoch Gordis, M.D., Director of the National Institute on Alcohol Abuse and Alcoholism of the National Institutes of Health.



An ASAM Annual Award for "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" was presented to ASAM past President and Board member Anthony B. Radcliffe, M.D., FASAM.



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Archived	Binge Drinking on College Campuses	Charles P. O'Brien, MD, PhD
Archived	Optimizing Naltrexone Treatment	Joseph R. Volpicelli, MD, PhD
March	Brain Imaging as an Aid to Patient Assessment	Daniel G. Amen, MD
May	Physician Diversion Programs	G. Douglas Talbot, MD
November	Avoid Slips and Relapses During the Holidays	Terence T. Gorski

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ASAM's Young Investigator Award went to Renee M. Cunningham-Williams, Ph.D., MPE, for the best abstract submitted by an author who is within five years of receipt of a doctoral degree.



Also recognized was Peter L. Selby, M.D., who received the first Medical-Scientific Program Committee Award as author of the abstract judged best overall of those submitted for the conference.

**SEE YOU
IN ATLANTA
NEXT YEAR!**

ASAM CERTIFICATION

Certified in Addiction Medicine

Geetha N. Aakalu
Shashikala Abkari
Saleh M. AlShebil
Husam K. Alathari
Syed Asif H. Ali
Theodore Elias Allen
Ammar Alrefai
Segundo B. Amarga
Mohammad Basil Amin
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Armin Ansari
Davarr Aram
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Mark Robert Austein
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Clifford A. Bernstein
Mahomed Suleman Bhana
Ralph Bharati
Bharat Bhushan
James Blair Blankenship
Steven C. Boles
Roy Dewayne Book
Judith L. Boyer-Patrick
Jonathan Cross Campbell, III
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Edgar Hugo Castellanos
Sanjay S. Chandragiri
Rany Antony Cherian
Fernando Andres Cobos
Stuart Allen Conrad
Michael Richard Crosser
Yolanda I. Dagnino
Winthrop C. Dillaway, III
Santosh Doddamane
Joselito Borja Domingo
Marisela Dominguez
Lawrence Michael Dowden
Ricardo O. Dunner
Evelyn R. Edelmuth
Robert C. Erwin, Jr.
Kenneth W. Faistl
Matthew Felgus
David A. Fiellin
Peter Kenneth Finelli
Kevin Anthony Fiscella
Enrique Jose Roberto Flechas
James L. Flowers
William R. Ford
Joyce Foster-Hartsfield
Tay G. Gaines
Devang H. Gandhi
Carol V. Garner
Daniel Ray Gaskin, Jr.
Ralph Ervin Gauen
Harbinder S. Ghulldu
George Carlton Gilbert
Sheldon Glass
Daniel Jay Glatt
Scott Golden
Cristina Goldizen
Marc N. Gourevitch
Marilyn Granger

284 Physicians Certified and Recertified in Addiction Medicine

Chapman M. Sledge, M.D., Chair of the ASAM Credentialing Committee, has announced that 213 physicians passed the ASAM examination in November 2000 and thus won certification in addiction medicine. Certificates were presented to the successful candidates during the Annual Awards Dinner at the 2001 Medical-Scientific Conference.



Richard Tremblay, M.D., FASAM, Chairman of the ASAM Membership Committee, presented certificates to newly certified physicians during the Annual Awards Dinner.

Alberto Grinstein
Vishwanath S. Gundur
George D. Hall
William Lloyd Hay
Carlos Antonio Hernandez-Avila
Sheldon Hershkop
Richard Ray Hill
Gray Hilsman
John Byron Hunt
Adrian Francis Mary Hynes
Thomas Glenn Ingram
Joseph Richard Ippolito
Robin J. Iversen
William Solomon Jacobs, Jr.
Gary Phillip Jacobs
Mark Getty Jameson
Carmen Leah Johnson
Kimberly Toland Jones
Nenita Jusayan
Mina C. Kalfas
Robert A. Karp
Soma Sekharam Kaza
Sunil Dharamdas Khushalani
Wang K. Kim
Ebenezer Adekunle Kolade
Puskoor Manmadh Kumar
Rajiv Kumra
Joseph Peter Laurelli
Ottis L. Layne
Anne E. Linton
Fred Warde Llewellyn
Antony David Loebel
Marcelo Enrique Lopez-Claros

Ronald Joseph Lotesto
Robert E. Lowenstein
Michael Howard Lowenstein
Shao-Hua Lu
Stephen Douglas Lykins
Monica K. MacDougall
Donna Marie Mackuse
Howard Samuel Mahler
William Bernard Mahoney
Nayyera Batoool Malik
Timothy D. Malone
Thomas J. Markoski
Mavis B. Marks
Don Alfredo Marshall, Jr.
Katherine Robinson Marshall
Craig Mell Martin
Lawrence D. Mass
John J. McCarthy
Gary Lynn McGrew
Rekha P. Mehta
Malini Mehta
Matilda M. Mengis
Rosa Frances Merino
Joseph Owen Merrill
Manuel Meza
Medhat Migeed
Robert Alan Miller
Jayshri M. Mody
Joseph Molea
Eric T. Moolchan
Edward A. Moore
Richard C. Moore
Carlos Mora

Michelle Ruth Moran
Karen A. Moriah
Judith Morishima-Nelson
Robert Dennis Mullan
Mark E. Mullendore
Meenakshi Nayak
Lucila Nerenberg
Richard Ng
Robert G. Niven
Ravinder Kumar Ohri
Jorge A. Oldan
Raquel L. Oldan
Ahmet Husamettin Ozturk
Gopakumar P. Panikkar
Vipul R. Patel
Chandrakant A. Patel
Vidya Patil
Jagannath J. Patil
Steven Alexander Peligian
Maria D. Perez
David Paul Petrie
Dorota Katarzyna Poluha
R. Paul Post
Rajeswar Rajagopalan
Jeri Lynn Rasch
Nicholas Rathe
Elise K. Richman
Carole Yvonne Rivers
James S. Robbins
Samuel H. Rosen
Nicholas Z. Rosenlicht
Mike Allan Royal
Valgerdur A. Runarsdottir
David Andrew Sack
Patricia Denise Salvato
Gregory Lytton Sathananthan
William Dmitry Savanin
Mark H. Scheutzow
John Schmitz
Michael E. Schorsch
Leslie H. Schwartz
Mark G. Schwei
Mohammed S. Seedat
David Robert Semeyn
Intezar Hussain Shah
Stephanie Shaner
Robert C. Sherrick
Kay Shiu
Gowamma Shivashankar
Scott Brian Smolar
Paul W. Sobey
Jose M. Soto
Ravindra P. Srivastava
William D. Stanley
James Johnston Stockard
Raymond Lee Struck
C. Lee Sturgeon, Jr.
Eva Styrsky
Stephen Mark Taylor
Peter L. Tenore
Paul Aloysius Terpeluk
Laila Tewfik-Moussa
Shanthi Thangam
Gabriel Kazuo Tsuboyama
Craig Joel Uthe
Daniel N. Valicenti
Edward R. Verde
Joseph Marc Verret
Kenneth E. Warner

ASAM CERTIFICATION

William E. Washington
Robert William Watrous
Mark D. West
Laurence M. Westreich
Howard Wetsman
James Gregory White
Robert Seth Wiesen
Michael Wayne Wilkerson
Hyacinth Leonie Williamson
Edward Paul Woloszyn
David Joseph Zoeller

Recertified in Addiction Medicine

An additional 71 physicians passed the examination for recertification in addiction medicine.

Patricia Louise Ashley
Ray Paul Baker
Paul T. Bakule
Roger J. Balogh
Lou Gene Bartram
Jonathan Hugh Bevers
Ethan E. Bickelhaupt
Milton M. Birnbaum
John Calvin Chatlos
Jerry Lee Clausen
Dale C. Dallas
Timothy Edward Davis
Philomena Jacintha Dias
Dora Dixie
Christine Dian Ellis
John E. Emmel, II
John P. Epling, Jr.
John Peter Femino
David Hirsch Fram
J. Gilbert Freeman, Jr.
Lawrence D. Ginsberg
Richard N. Goldberg
Lester Sherwin Goldstein
Daniel P. Golightly, Jr.
Karen Mae Gosen
Gurdon H. Hamilton
William Frees Haning, III
Joseph S. Haraszti
Kenneth Alexander Harris
Masoud S. Hejazi
Eric J. Ittner
Gary A. Jaeger
Steven Manley Juergens
Bruce Jay Arthur Kerr
Steven S. Kipnis
Thomas J. Kuettel
Wolfgang F. Kuhn
George Louis Lagorio
Neil Stanton Levy
Nicola Jane Longmuir
Robert Douglas MacFarlane
Arnold Walter Mech
Rohinton K. Merchant
Stephen I. Merlin
Roy Haynes Morton
James T. Mulry
Jagadeeswararao Musunuru
Beatrice Alexandria Nelson
David Drew Pinsky
Joseph Anthony Piszczor
Terry E. Ptacek

A special moment was shared by the Glatt family when William Glatt, M.D., FACP, FASAM (seated, left) was recognized as a newly elected Fellow of the Society on the same night his son Daniel Jay Glatt, M.D., M.P.H., was awarded his certificate in addiction medicine. Congratulating father and son on their achievement are (standing) ASAM Immediate Past President Marc Galanter, M.D., FASAM, and President Andrea G. Barthwell, M.D., FASAM.



Allan H. Rabin
Jay Shireman Reese
James L. Reinglass
Richard D. Roark
Barry M. Rosen
Harold R. Rosenblatt
Neal B. Schofield
Michael Edward Scott
James E. Sellman
Edward C. Senay
Danny R. Sessler
Agha Shahid
William M. Short
George K. Shotick
Gregory Earl Skipper
George Peter Tardelli
Matthew Bernard Teolis
Donald D. VanDyken
Charles Vincent Wadle

MRO Certification

The following physicians passed the special subsection of the examination for Medical Review Officers.

Ammar Alrefai
Davar Aram
Mark Robert Austein
Ray Paul Baker
Hector D. Barreto
Michelle Bauer
James Edward Beckett
Clifford A. Bernstein
James Blair Blankenship
Steven C. Boles
Jonathan Cross Campbell, III
Thomas G. Carlton
John Calvin Chatlos
Michael Richard Crosser
Dale C. Dallas
Timothy Edward Davis
Dora Dixie
John E. Emmel, II
John P. Epling, Jr.
Matthew Felgus

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Kevin Anthony Fiscella
James L. Flowers
William R. Ford
David Hirsch Fram
J. Gilbert Freeman, Jr.
Tay G. Gaines
Devang H. Gandhi
Carol V. Garner
Daniel Ray Gaskin, Jr.
Ralph Ervin Gauen
Harbinder S. Ghulldu
Daniel Jay Glatt
Scott Golden
Karen Mae Gosen
Marc N. Gourevitch
George D. Hall
Gurdon H. Hamilton
William Frees Haning, III
Joseph S. Haraszti
William Lloyd Hay
Sheldon Hershkop
Richard Ray Hill
Gray Hilsman
John Byron Hunt
Adrian Francis Mary Hynes
Eric J. Ittner
William Solomon Jacobs, Jr.
Gary A. Jaeger
Steven Manley Juergens
Carmen Leah Johnson
Mina C. Kalfas
Robert A. Karp
Bruce Jay Arthur Kerr
Sunil Dharamdas Khushalani
Steven S. Kipnis
Rajiv Kumra
Joseph Peter Laurelli
Ottis L. Layne
Michael David Lester
Neil Stanton Levy
Fred Warde Llewellyn
Antony David Loebel
Nicola Jane Longmuir
Ronald Joseph Lotesto
Stephen Douglas Lykins

Monica K. MacDougall
Robert Douglas MacFarlane
William Bernard Mahoney
Nayyera Batool Malik
Timothy D. Malone
David Clarence Charles Marsh
Katherine Robinson Marshall
John J. McCarthy
Arnold Walter Mech
Matilda M. Mengis
Stephen I. Merlin
Joseph Owen Merrill
Medhat Migeed
Joseph Molea
Edward A. Moore
Richard C. Moore
Judith Morishima-Nelson
Roy Haynes Morton
James T. Mulry
Lucila Nerenberg
Robert G. Niven
Jorge A. Oldan
Ahmet Husamettin Ozturk
Vipul R. Patel
Joseph Anthony Piszczor
Dorota Katarzyna Poluha
Terry E. Ptacek
Jeri Lynn Rasch
Nicholas Rathe
Elise K. Richman
Carole Yvonne Rivers
Barry M. Rosen
Samuel H. Rosen
Nicholas Z. Rosenlicht
David Andrew Sack
Gregory Lytton Sathananthan
William Dmitry Savanin
Mark H. Scheutzow
Neal B. Schofield
Michael E. Schorsch
Mark G. Schwei
Michael Edward Scott
David Robert Semeyn
Edward C. Senay
Danny R. Sessler
Stephanie Shaner
Saleh M. al-Shebil
Robert C. Sherrick
Kay Shiu
George K. Shotick
Gregory Earl Skipper
Scott Brian Smolar
Paul W. Sobey
William D. Stanley
James Johnston Stockard
Raymond Lee Struck
C. Lee Sturgeon, Jr.
George Peter Tardelli
Peter L. Tenore
Donald D. Van Dyken
Edward R. Verde
Charles Vincent Wadle
Kenneth E. Warner
Howard Wetsman
Robert Seth Wiesen
Michael Wayne Wilkerson
Edward Paul Woloszyn
Hunter E. Woodall
David Joseph Zoeller

► **PATIENT CRITERIA** *continued from page 1*

of a wider range of options for detoxification; and improved criteria for the management of long-term recovery and opioid maintenance.

The ASAM PPC-2R continues to offer separate guidelines for adults and adolescents, with five broad levels of care defined for each population. As in past editions, the levels of care are: Level 0.5 (early intervention); Level I (outpatient treatment); Level II (intensive outpatient treatment/partial hospitalization); Level III (residential/inpatient treatment); and Level IV (medically managed intensive inpatient treatment). Within this broad framework, the criteria define a range of specific levels of care. The ASAM PPC-2R continues to "unbundle" clinical services from treatment setting, in recognition of the fact that clinical care can be and often is provided separately from environmental supports.

The diagnostic terminology used in the ASAM PPC-2R has been updated to conform to the language of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)*. The new edition also been totally reformatted to facilitate comparisons across levels of care.

The ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders is an essential tool for use in treatment planning and in working with public and private treatment providers, third-party payers and managed care organizations.

The 400+ page book is available at a cost of \$70 to ASAM members and \$85 to nonmembers. Quantity discounts are available. To place an order, contact the ASAM Publications Distribution Center at 1-800/844-8948. ■

TENNESSEE

MEDICAL DIRECTOR FOR PHYSICIANS HEALTH PROGRAM

The Tennessee Medical Foundation has an immediate opening for a licensed physician to serve as full-time Medical Director for its statewide Physicians Health Program. Responsibilities include interventions on, referrals and aftercare oversight of, physicians impaired by chemical dependence or mental/emotional illnesses, or both. Experience in addiction treatment required, and ASAM certification a plus.

Attractive salary and benefits package.

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E-mail peggy@tma.medwire.org

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Ruth Fox Memorial Endowment Fund

Dear Colleague:

The generosity of many donors was acknowledged during the annual Ruth Fox Memorial Endowment Fund reception at ASAM's Medical-Scientific Conference in Los Angeles, .

The reception itself was underwritten by a generous gift from Joseph E. Dorsey, M.D., FASAM, and Mrs. Dorsey. Their current gift is in addition to many previous gifts to the endowment fund by Dr. and Mrs. Dorsey, for which they have been named members of the fund's Distinguished Fellows' Circle.

Singled out for special recognition with a Gold Medallion were Lawrence S. Brown, Jr., M.D., M.P.H., FASAM, John Alonzo Luker, M.D., Michael I. Michalek, M.D., and Jokichi Takamine, M.D. Silver Medallions went to Stanley J. Evans, M.D., FASAM, Barry M. Rosen, M.D., and John P. McGovern, M.D., FASAM. Bronze Medallions were awarded to Sandra Jo Counts, M.D., FASAM, Ronald J. Dougherty, M.D., Camilo A. Martin, M.D., David Mactus, James M. Merritt, M.D., John E. Milner, M.D., Teresa Reed, M.D., and Thomas Stammers, M.D.

We especially wish to thank long-time member Conway W. Hunter, M.D., FASAM, for his very generous bequest in addition to his previous contributions. It gives us great pleasure to add his name to the Benefactors' Circle.

For information about providing a life insurance policy or making a deferred gift, pledge, contribution, bequest or memorial tribute, or to discuss in confidence other types of gifts, please contact Claire Osman at 1-800/257-6776 or 718/275-7766. Of course, financial decisions should be discussed with your personal tax advisor. All contributions are completely tax deductible, as ASAM is a 501(c)(3) organization under the Internal Revenue Code.

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As of May 10, 2001...Total Pledges: \$3,220,966

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MY PRACTICE

Dr. Ferry Carves a Niche in Preventive Medicine

ASAM News is proud to showcase the many ways in which ASAM members contribute to the field of addiction medicine.

Jeanne Erdmann



Like many busy academic physicians, Linda Hyder Ferry, M.D., M.P.H., combines patient care, research, and teaching. Like many of her colleagues in ASAM, she often adds "crusader" to her job description.

As Chief of Preventive Medicine at the Jerry L. Pettis Memorial Veteran's Administration Medical Center at Loma Linda Hospital, Loma Linda, CA, Dr. Ferry cares for patients with obesity, high cholesterol, poor control of diabetes, and tobacco addiction. Although today, Dr. Ferry is a sought-after expert on smoking cessation, in 1987, only 5% to 7% of her patients remained cigarette-free after one year — numbers so discouraging that she wondered if the program was worthwhile.

Not ready to give up, she asked her patients questions: What didn't we give you that you needed? How should we change what we do? Their answers changed the course of her career and changed the lives of many smokers. The patients said that tips, brochures, and weekly sessions weren't enough. Often divorced or widowed, they were alone and lonely. When Dr. Ferry served as Medical Director of the VA's addiction treatment unit, she wondered why patients who had overcome drug addiction and alcoholism had such difficulty stopping smoking. Because, she learned, veterans saw how alcohol, cocaine, or heroin was destroying their lives, but cigarettes were with them in the battlefield when buddies were dying all around.

"It dawned on me that this is a much more serious problem than I ever gave credit for," says Dr. Ferry. "This was not like giving up bananas on your oatmeal in the morning." If her patients wanted to quit smoking, then she would work equally hard to help them find a way.

In 1987, the only medication for nicotine addiction was Nicorette® gum, which the VA pharmacy would not approve, and which Dr. Ferry believes can perpetuate addiction by replacing one form of nicotine with another. Searching the medical literature, she found that addicts in a trial of clonidine for the symptoms of heroin withdrawal had the worst outcome if they also had a previous history of depression. She knew that people used tobacco to self-medicate. Finding a drug that treated depression and that worked like nicotine might help people stop smoking, she reasoned. Conversations with psychiatrists, pharmacologists and physiologists led her to bupropion, an antidepressant that works on norepinephrine and dopamine — two neurotransmitters responsible for tobacco withdrawal symptoms.

Funding her research proved difficult — two grants were turned down and pharmaceutical companies rejected her proposals as well. In 1990, she scaled down the pilot study and Loma Linda University gave her \$5,000 to fund it. A medical student and residents helped, and her mother, a retired nurse, administered the study.

The trial lasted throughout 1991 and 1992. At the end of that period, all of the placebo subjects had relapsed, but 55% of the bupropion subjects had quit smoking. "I looked at that and thought I had done something wrong," recalls Dr. Ferry. "I thought, 'no one is going to believe this. I am going to be the laughing stock of the smoking research community.'" But larger studies supported her initial results and, in 1997, the FDA approved bupropion (under the trade name Zyban®) for smoking cessation.

Much work remains to be done. Dr. Ferry says physicians are reluctant to become involved in smoking cessation. "Their skepticism stems from the fact that doctors in general don't like dealing with addicts," she

finds. "Once you tell them smoking is an addictive disorder, they are not thrilled about being involved, because addicts can be difficult to treat. They relapse, they don't tell you the truth. Doctors like treating a disease that they can examine, test, diagnose, treat, and it goes away. Then they feel good and their patients feel good. That is not the way addictions work."

If every medical school had one champion of tobacco dependence education, says Dr. Ferry, medical students would learn that smoking is addictive but treatable. Dr. Ferry, who teaches a course on smoking cessation at Loma Linda Medical School, would like to see training extended to nursing schools, dental schools and pharmacy schools. She also has created FIND, the Foundation for Innovations in Nicotine Dependence. The foundation's Web site (www.findhelp.com) serves physicians and smokers alike by providing lists of articles, advice, resources and smoking cessation lectures.

Help from other parts of the community are needed in this effort. Dr. Ferry wants insurance plans to cover screening and advice, counseling and medications. "If you can imagine someone in the health care system saying 'no, we aren't going to treat your hypertension. That is not a benefit. If you want to be screened and treated for hypertension, you will pay for it on your own' — that is just ludicrous," she says. "But that is what they do to the smoker."

Dr. Ferry also would like to see employers in large companies bargain for smoking cessation coverage when they negotiate with health insurers, making the contract contingent on coverage of smoking cessation and other addiction treatment. She takes satisfaction in the June 2000 report of the Agency for Healthcare Research and Quality that called for health plans to cover therapies for smoking cessation. The AHRQ report called for reimbursement of physician services as well. "Now why did they throw that last thing in?" asks Dr. Ferry. "Because physicians do not get paid. You get paid for taking care of asthma and COPD caused by smoking, and you get paid for treating their heart attack. But no one pays you one cent to help them quit smoking."

"If every physician got training on how to deal with tobacco addiction and then got paid to do it," predicted Dr. Ferry, "we would see things change in five years." ■

Jeanne Erdmann is a St. Louis-based medical writer who also writes for Science and CBS HealthWatch.

ASAM

June 1-3, 2001

Medical Review Officer (MRO) Training Course
St. Louis, MO
20 Category 1 CME credits

September 13-16, 2001

ASAM Conference on Tobacco Dependence
Atlanta, GA
15.5 Category 1 CME credits (plus 6 CME credits for preconference workshops)

November 1-3, 2001

Conference on the State of the Art in Addiction Medicine
Washington, DC
20 Category 1 CME credits

November 29, 2001

Forensic Issues in Addiction Medicine
Washington, DC
7 Category 1 CME credits

November 30-December 2, 2001

Medical Review Officer (MRO) Training Course
Washington, DC
20 Category 1 CME credits

April 25, 2002

Pain & Addiction: Common Threads III
Atlanta, GA
7.5 Category 1 CME credits

April 25, 2002

Ruth Fox Course for Physicians
Atlanta, GA
8 Category 1 CME credits

April 26-28, 2002

33rd Annual Medical-Scientific Conference
Atlanta, GA
Up to 19 Category 1 CME credits

OTHER EVENTS OF NOTE

June 16

Addiction Symposium: An Update for the Primary Care Physician
Toms River, NJ
[For information, phone 732/557-8991 or e-mail hmatty@sbhcs.com]

July 19-20

MDMA/Ecstasy Research: Advances, Challenges, Future Directions (Sponsored by the National Institute on Drug Abuse)
Bethesda, MD
[For information, visit the conference Web site at www.drugabuse.gov]

July 19-21

6th Annual Rocky Mountain Mental Health Symposium
Whitefish, MT
12 Category 1 CME Credits
[For information, phone 406/752-1775 or e-mail education@krmc.org]

August 9-10

2nd National Conference on Drug Abuse Prevention Research
Washington, DC
(Sponsored by the National Institute on Drug Abuse)
[For information, contact Mildred Prioleau at 301/467-6008 x431]

September 7-11

Addictions 2000+1: Challenges and Opportunities for a New Millennium
Jerusalem, Israel
[For information, e-mail jorge.gleser@moh.health.gov.il]

September 12-14

ISAM Annual Conference: Addictions — Sharing International Responsibilities in a Changing World
Trieste, Italy
[For information, e-mail isam@theoffice.it]

September 26-29

Carolina Conference on Addiction and Recovery
Charlotte, NC
22.5 Category 1 CME Credits
[For information, phone 877-392-9973 or e-mail info@carolinaconference.com]

October 18-21

Canadian Society of Addiction Medicine 13th Annual Scientific Meeting
Rimrock Resort Hotel, Banff, Alberta
[For information, e-mail sweeney@ucalgary.ca]

For additional information, visit the ASAM Web site at www.asam.org, or contact the ASAM Department of Meetings and Conferences at 4601 North Park Ave., Suite 101 Upper Arcade, Chevy Chase, MD 20815-4520, or phone 301/656-3920, or fax 301/656-3815, or e-mail email@asam.org. Information on ASAM's Web site will be updated as meetings are scheduled.

Carolina Conference on Addiction and Recovery

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September 26-29, 2001

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For more information
see our Web page at

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Our Mission: To provide education, inspiration, and training to help addiction professionals meet the needs of their clients in ways that better serve individuals, families and communities.

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[Except where noted below, ASAM staff can be reached by phone at 301/656-3920, or by fax at 301/656-3815]

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

Nancy Brighindi
Director of Membership
& Chapter Development
NBRIG@ASAM.ORG

Caprice Falwell
Meetings Assistant
CFALW@ASAM.ORG

Joanne Gartenmann
Exec. Assistant to the EVP
JGART@ASAM.ORG

Lynda Jones
Director of Finance
LJONE@ASAM.ORG

Sherry Jones
Office Manager
SJONE@ASAM.ORG

Cheryl Kim
Manager, Membership
and Chapter Relations
CKIM@ASAM.ORG

Katherine May
Director of Meetings
& Conferences
KMAY@ASAM.ORG

Peter Miller
Office of Finance
PMILL@ASAM.ORG

Claire Osman
Director of Development
Phone: 1-800/257-6776
Fax: 718/275-7666
ASAMCLAIRE@AOL.COM

Noushin Shariati
Accounting Assistant
NSHAR@ASAM.ORG

Christopher Weirs
Credentialing
Project Manager
CWEIR@ASAM.ORG

Bonnie B. Wilford
Editor, **ASAM News**
Phone: 703/538-2285
Fax: 703/536-6186
ASAMNEWS@AOL.COM