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ASAM News

Newsletter of The American Society of Addiction Medicine

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New Jersey requires medical directors of addiction treatment programs to be certified by ASAM; see story on page 23.

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Addiction Medicine Reviewed in Chicago Course

The core knowledge of addiction medicine will be presented by an expert faculty at ASAM's biennial Review Course in Addiction Medicine, set for October 24-26 in Chicago. The course is designed for multiple audiences. Physicians who are planning to sit for the ASAM Certification/Recertification Examination in Addiction Medicine will find it a highly effective adjunct to their preparations for the examination. Addiction specialists will find the Review Course a useful "refresher" because of its clinical orientation and focus on recent developments in addiction practice. Non-specialist physicians will find in the course a succinct summary of the knowledge they need to identify and manage patients' problems related to alcohol, tobacco and other drug use. For more information, see page 24.

ASAM Members to Elect New Officers, Board Members

Marc Galanter, M.D., FASAM
Chair, Nominating and Awards Committee

ASAM members are about to choose the Society's next President-Elect, Secretary, and Treasurer, as well as a full slate of Directors at Large. Ballots will be mailed by November 1, 2002, to all members in good standing. Voted ballots must be returned to ASAM by December 1.

Candidates for the office of President-Elect are Elizabeth F. Howell, M.D., FASAM, and James W. Smith, M.D., FASAM. Candidates for the post of Secretary are Lloyd J. Gordon III, M.D., FASAM, and David C. Lewis, M.D. Candidates for the office of Treasurer are Paul H. Earley, M.D., FASAM, and James A. Halikas, M.D., FASAM.

Three Directors at Large are to be chosen from the following candidates: David R. Gastfriend, M.D., Stuart Gitlow, M.D., M.P.H., R. Jeffrey Goldsmith, M.D., Elizabeth F. Howell, M.D., FASAM, Donald J. Kurth, M.D., FASAM, Michael M. Miller, M.D., FASAM, James W. Smith, M.D., FASAM, Trusandra E. Taylor, M.D., FASAM, and Penelope P. Ziegler, M.D., FASAM.

One Director at Large representing Osteopathic Medicine will be chosen from the two candidates for that post, who are Anthony H. Dekker, D.O., FASAM, and Timothy L. Fischer, D.O.

Election results will be announced in the January-February 2003 issue of **ASAM News**. Newly elected officers and Regional Directors will be installed during the Society's May 2003 Medical-Scientific Conference in Toronto, Canada. Profiles of the candidates, with their campaign statements, begin on page 13 of this issue of **ASAM News**.

Beginning a Dialogue

Eileen McGrath, J.D.

As I begin my tenure as ASAM's Executive Vice President, I want to share with you my enthusiasm for ASAM as an organization and for ASAM's mission: improving the treatment of alcoholism and other addictive disorders, educating physicians and medical students, promoting research and prevention, and enlightening and informing the public.

I have been warmly welcomed into the ASAM "family" by ASAM's leaders, members, and staff. In fact, I'm already feeling "at home." Someone once said, "the personal is political." My personal experience with addiction is as the adult child of a mother who, this year, celebrates 40 years in recovery from alcoholism. I share this with you with her permission. I am profoundly grateful to addiction treatment and self-help groups for both my mother's recovery and for my own recovery as a family member. It is this personal involvement that fuels my passion to achieve ASAM's inspiring and ambitious goals.

I developed the skills I bring to this position from prior experience: 8 years as administrator of an alcohol and drug treatment program, 14 years as executive director of a national society of 10,000 women physicians, and 3 years in the practice of law. Even with this experience, I realize that I have a lot to learn about ASAM and addiction medicine. I ask for your help in this educational process, and invite you to open a dialogue by sharing your thoughts, ideas, and suggestions with me.

Eileen McGrath, J.D.

Looking forward, I want you to know that I strongly support ASAM's mission and goals. Specifically, the staff and I are committed to working with ASAM's Officers, Board, Chapters and Committees—indeed, with each of you—to achieve the 29 carefully focused strategies identified by the Strategic Plan Task Force (see the May/June issue of **ASAM News**). Beginning immediately and over the next five years, we will work in unison to implement ASAM's Strategic Plan. In **ASAM News** and in other venues, I will report to you regularly on our progress, and I invite your active participation in what can and should be an important dialogue about the future of ASAM and the medical specialty of addiction medicine.

Meeting on Capitol Hill to discuss federal treatment legislation are (from left): Eileen McGrath, J.D., ASAM Executive Vice President; John Avery, LICSW, M.P.A., NAADAC Director of Public Policy; Joanne Warwick, Esq., Legislative Assistant to the Hon. John Conyers, Jr.; Jonathan S. Westin, Vice President for Government Relations, National Council for Community Behavioral Healthcare; Robert L. Morrison, NASADAD Director of Public Policy; Pat Ford-Roegner, M.S.W., R.N., FAAN, NAADAC Executive Director; (kneeling) Joel Segal, Staff to the Hon. John Conyers, Jr.

American Society of Addiction Medicine
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ASAM is a specialty society of physicians concerned about alcoholism and other addictions and who care for persons affected by those illnesses.

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For members visiting ASAM's web site (WWW.ASAM.ORG), entrance to the on-line Membership Directory requires the Username "asam" and the password "asam" (in lower case letters).

FDA Rejects Acamprosate

The U.S. Food and Drug Administration (FDA) has issued a nonapproval letter in response to the new drug application (NDA) for acamprosate, which is used in Europe for the treatment of alcoholism. Despite a favorable report from FDA's own advisory committee, which concluded that clinical trial data submitted with the NDA showed acamprosate to be effective, FDA staff said the data did not adequately establish the drug's safety and efficacy. FDA asked Forest Laboratories, Inc., which submitted the NDA, for at least one additional U.S. clinical trial evaluating safety and efficacy, as well as additional pharmacokinetic analyses and pre-clinical studies.

In three European trials, acamprosate was found to be more effective than placebo in helping patients maintain abstinence from alcohol; however, a recent U.S. study did not show similar results. The advisory panel was tasked with interpreting the differences in the studies.

Acamprosate was developed by an affiliate of the German drug company Merck. If approved, it would have been only the third medication approved by FDA for the treatment of alcoholism. Acamprosate currently is available in 40 countries under the brand name Campral®. It is designed for use in conjunction with counseling and other behavioral therapies. **Sources:** *Crain's New York Business, July 3, 2002; Psychopharmacology Alert, July 4, 2002.*

Recovering Worker Covered by ADA, Court Finds

In finding that recovering persons are protected by the federal Americans with Disabilities Act (ADA), the Ninth U.S. Circuit Court of Appeals in San Francisco ruled against an employer that refused to rehire an employee who completed addiction treatment. "A policy that serves to bar the reemployment of a drug addict despite his successful rehabilitation violates the ADA," said Judge Stephen Reinhardt in the 3-0 ruling.

With its ruling, the court reinstated a lawsuit filed against Hughes Missile Systems by Joel Hernandez, a 25-year Hughes employee who resigned while facing dismissal after testing positive for cocaine. Nearly three years later, Hernandez reapplied for a job with the company and supplied documents describing his treatment and recovery. The company refused to rehire him, asserting that he was ineligible for consideration under its hiring policy.

"Part of rehabilitation is returning to work successfully," commented Hernandez's lawyer, Richard Martinez. **Source:** *San Francisco Chronicle, June 12, 2002.*

School Drug Tests Upheld

In a 5-4 ruling, the U.S. Supreme Court has ruled that public high schools can conduct random drug tests on students participating in after-school activities. The majority argued that eliminating drugs from schools outweighs students' right to privacy. "We find that testing students who participate in extracurricular activities is a reasonably effective means of addressing the school district's legitimate concerns in preventing, deterring, and detecting drug use," Justice Clarence Thomas wrote for the court.

However, most school officials commenting for publication say they are not in a rush to implement such programs, explaining that random drug testing brings privacy concerns, high costs, combative atmospheres, and can hinder participation in extracurricular activities.

Addiction professionals were no more enthusiastic. The National Association for Alcohol and Drug Abuse Counselors (NAADAC) charged that the court's decision supports "misguided and ineffective efforts to address drug use." Added Bill B. Burnett, president of NAADAC, "Protecting America's youth from alcohol and drugs requires more than a simple drug test. We need a greater commitment to prevention and treatment." **Source:** *Associated Press, June 27, 2002; Chicago Daily Herald, June 28, 2002.*

Compromise Could Result in FDA Regulation of Tobacco

Several members of the U.S. Senate are working with tobacco-growing states to reach a compromise that would result in regulation of tobacco products by the U.S. Food and Drug Administration (FDA). "There is an opportunity now to solve farmers' problems and support public health," said Matthew Myers, president of the Campaign for Tobacco-Free Kids.

In the past, tobacco farmers have opposed regulation by the FDA. But a proposal to pay the farmers to switch to other crops has changed their position. "Farmers want a buyout, and they're willing to try to negotiate to get that done," said Rod Kuegel, a tobacco farmer in Owensboro, KY, and former chair of a Presidential commission that examined the plight of tobacco growers.

Mr. Kuegel said growers support a bill introduced by Senators Edward Kennedy (D-MA) and Mike DeWine (R-OH), which would give FDA authority to regulate the manufacturing process but not the growing of tobacco. Sen. Kennedy said he would work toward a buyout for growers as well. **Source:** *Associated Press, June 14, 2002.*

FDA Bans Nicotine Water

Before it could even make its way to store shelves, the recently introduced Nico Water® has been banned by the U.S. Food and Drug Administration (FDA).

In imposing the ban, FDA said that the nicotine water is a drug that needs approval before it can be sold. The action follows a recent FDA ban on nicotine-laced lollipops.

According to Quick Test 5, the California company that manufactures Nico Water, the product is designed for smokers to consume when they are in places where smoking is not allowed. The company had planned to market the water as a dietary supplement, which does not require FDA approval.

Antismoking groups, including the American Medical Association, the Campaign for Tobacco-Free Kids, and the American Lung Association, organized to urge the ban. "The FDA's decision recognizes nicotine as a powerful and addictive drug that has to be regulated," said Matthew Myers, president of the Campaign for Tobacco-Free Kids.

Officials of Quick Test 5 said they would discuss the ban with FDA before deciding on next steps. **Source:** *Wall Street Journal, July 3, 2002.*

We've Come a Long Way, But There is Much Yet to Do

Lawrence S. Brown, Jr., M.D., M.P.H., FASAM

[NOTE: The following is excerpted from remarks by Dr. Brown at ASAM's Annual Business Meeting, April 26th in Atlanta.]

I am honored by the responsibility entrusted to me and I am energized by the opportunity to serve as the Society's new President.

At this Medical-Scientific Conference, we will be joining some of our nation's leading experts in discussing the latest developments in addiction research and treatment. And we will periodically take time to express our thanks to many within our ranks, some of whom are no longer among us, and to other colleagues in related disciplines. We will share our hypotheses, findings, and conclusions with fellow ASAM members and our partners in health care and public policy. This we must do, not because it is a privilege, but because it is our joint obligation. We dare not, we cannot, and we must not take this time away from our patients lightly!

We are indeed fortunate to have Atlanta, a city blessed with progressive leadership, host our Annual Conference. Like Atlanta, our society and its leaders have made significant strides over the past few decades.

It is unequivocal that, as a medical specialty society, ASAM has had an enviable history. Still, just two years into the new century, many challenges remain. I think of them in four broad categories: (1) integration of public health and addiction, (2) partnerships between science and clinical care, (3) the medical specialty of addiction medicine and its relationship to other medical specialties, and (4) access to care.

Public Heath and Addiction

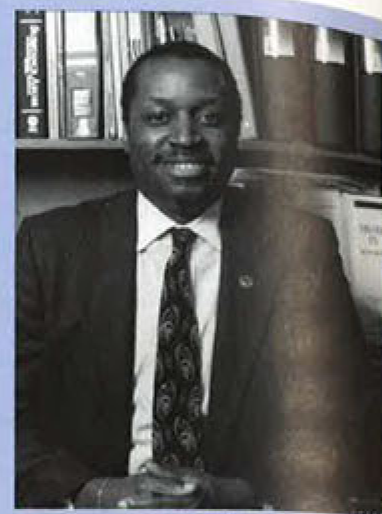
Despite the undeniable relationship between the use of a wide range of substances (including and especially tobacco and alcohol) and many medical and mental health disorders, there remains a major disconnect. Even though public health approaches have been instrumental in responding to various causes of excess morbidity and mortality in the history of this nation, this is not the case for substance abuse and addiction. In most states, the Departments of Health are distinct entities, separate from the state agencies that have program authority for substance abuse and addiction.

ASAM has advanced a number of public policy statements related to the medical consequences of addiction and the need for a strong and unrelenting public health response. It is the intent of this President to encourage not only the wide communication of these statements, in concert with other like-minded collaborators, but to solicit the opinions of our members and our colleagues in public health in order to win for substance abuse and the addictive disorders a high priority in the nation's public health agenda. This is extremely important in light of the wealth of scientific support for the clinical interventions available to treat addicted persons.

Partnerships Between Science and Clinical Care

Speaking of science, another major challenge is posed by our failure to integrate the results of basic and clinical science into the daily provision of health care. As the Institute of Medicine's report on the subject so eloquently stated, this also is a challenge in the delivery of care to the addicted. There are at least two reasons for this state of affairs. First, the relationship between clinician and researcher often has been a challenging one. The second reason, which is just as profound as the first, is that substance abuse and addiction are not integrated into the training of physicians (at either the undergraduate or graduate levels) to a degree that even approximates the extent to which physicians must address these issues in their clinical practices. We have known this for some time and have had periodic reminders, most recently in the superb article in the April 10th issue of JAMA by our very own Chris Delos Reyes, who has served as Chair of ASAM's Physicians in Training Committee.

In the past, ASAM has promoted the integration of clinical care and research through its many products, including its textbook, its newsletter, its journal, and, of course, the Medical-Scientific conferences. This President intends to continue to foster the relationship between science and clinical care by encouraging ASAM members to be advocates in developing and reviewing the research agendas of our scientific institutions, to participate as clinical investigators in appropriate trials, and to incorporate research findings into the practice of addiction medicine as appropriate.



ASAM President
Lawrence S. Brown, Jr., M.D., M.P.H., FASAM

The principles of evidence-based practice are just as important to the internal operations of our organization. I intend to support our Board and ASAM members in developing and implementing a culture of measurable objectives and outcome-driven projects to achieve optimal results from our Chapters, our Committees, and other vehicles associated with the work of the Society.

The Specialty of Addiction Medicine

This is extremely important in our current economic environment, in which physician compensation has been stagnant over the past decade and almost every physician organization has seen a significant decrease in its membership. ASAM has worked diligently to advance the specialty of addiction medicine, as evidenced by its representation in the House of Delegates of the American Medical Association and Stu Gitlow's nomination to the AMA's Board of Trustees. Additionally, ASAM certification was recognized by the federal government in the Drug Abuse Treatment Act of 2000, and my good friend and respected colleague, ASAM Board Member Lou Baxter, has informed us that the great state of New Jersey requires that physicians who direct addiction treatment programs

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AMA Addresses Tort Reform, Other Issues

Michael M. Miller, M.D., FASAM

The 2002 Annual Meeting of the American Medical Association's House of Delegates was an historic one for ASAM. ASAM's Delegate to the AMA House, Stuart Gitlow, M.D., M.P.H., was a candidate for a position on the AMA's Board of Trustees. Being a candidate in an AMA election, especially for the office of Trustee, gives tremendous visibility to the individual and the organization he or she represents. Dr. Gitlow, who ran as the candidate of ASAM and the Pennsylvania Medical Society, conducted a most commendable race against another outstanding young physician leader, receiving 42% of all votes cast. While Lt. Col. John Armstrong, M.D., Alternate Delegate to the AMA from the U.S. Army Medical Corps, was elected AMA Young Physician Trustee, ASAM came out a winner. Stu's candidacy received support from many state delegations and tremendous support from the American Psychiatric Association, the American Academy of Child and Adolescent Psychiatry, and the American Academy of Family Physicians. Collaboration between psychiatry and addiction medicine in the AMA House has never been closer, and the esteem in which ASAM is held in the AMA House has never been greater. ASAM members should be proud of Stu and grateful to him for the positive light he has directed on our organization.

Restructuring Continues

The AMA began a process of restructuring itself (and of the federation of medical organizations) several years ago. At its June meeting, the House voted to establish a Committee on an Organization of Organizations, through which state and specialty medical societies will be convened with the AMA to develop a business plan that describes a totally new AMA organization—an organization whose members would be state and specialty medical societies rather than individual physicians. At present, about a third of U.S. physicians are dues-paying members of the AMA; another third are members of their county, state or specialty medical societies but not of the AMA; and about a third belong to no medical organization. The AMA as it is envisioned would be able to identify as members all physicians who belong to any medical organization. Individual dues would be paid to the component organizations rather than to the AMA itself. The business plan for this proposed new organizational structure is to be presented to the House at the 2003 Annual Meeting, and it is expected that ASAM and other organizations will be asked to comment on the draft business plan before next June.

The argument for the new plan is that, when the AMA tries to advocate for a legislative agenda, its effectiveness is undercut by its dwindling membership. Members of Congress, when dealing with competing agendas (as from business, labor, farmers, municipalities, professional groups, and the like), sometimes ask, "what do the doctors think?" Whatever physicians can do to "speak with one voice" will give them more authority on the many issues (such as medical liability reform, funding for medical education, and Medicare rules) that affect medical practice. We are all physicians before we are addictionists, internists, surgeons, psychiatrists, or the like; we become our own worst enemy when one of our medical organizations works against another in Congressional testimony or at the state level, or when we drop out of the AMA over a single issue (see the June 16 address of Richard Corlin, M.D., outgoing AMA President, on the WWW.AMA-ASSN.ORG web site).

Report on Impaired Driving Adopted

A report of the AMA Board of Trustees on "Impaired Drivers" was approved. It directs the AMA to draft model state legislation that would allow physicians to voluntarily report to their state Departments of Motor Vehicles or similar agencies an individual who has an impairment that could prevent safe operation of a motor vehicle. The measure also would protect from liability any physician who reports, or decides not to report, such information. (ASAM members should be aware that even if such legislation is enacted in the states, federal guidelines pertaining to substance use disorder patients still pertain and likely would be found to prohibit such voluntary reporting.)

The House also directed the AMA to develop, by 2003, practical guidelines for physicians on how to assess and counsel drivers, and to identify other materials that would be beneficial in informing physicians and their patients about the effects of impairment on safe operation of motor vehicles.

Prescribing Authority an Issue

In response to legislation enacted in New Mexico that grants prescribing authority to psychologists, the House acknowledged that AMA needs to work in concert with state medical associations and national specialty societies (1) to review the circumstances that led to enactment of the New Mexico legislation, and which directly affect physician scope-of-practice issues; (2) to provide the best possible assistance to other states when they face the expected introduction of similar bills; and (3) to lend the full lobbying resources of the AMA to assist local medical organizations faced with scope-of-practice initiatives.

The reference committee that deliberated this resolution (submitted by the American Psychiatric Association) heard testimony that the lack of psychiatrists to serve rural areas helped to create support for the New Mexico bill; some delegates also commented that the relative scarcity of psychiatrists to admit or attend to psychiatric inpatients or to provide consultation services in hospital emergency departments creates pressure to provide scope-of-practice expansions for non-physicians into medical service areas.

Carve-Outs Considered

Another reference committee heard testimony on an AMA Council on Medical Service report on "Carve-Outs" (CMS Report 7, A-02), which the CMS defined as "financial arrangement[s] for the provision and/or management of a clinically defined subset of a health plan's benefits, which is separate from the financial arrangements for the provision and/or management of most or all of the plans' other health benefits."

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This was the fifth report on carve-outs in less than eight years. The scientific literature on the subject actually is quite mixed, the CMS found. The reference committee heard testimony from both psychiatrists and addiction medicine specialists who receive referrals from carve-outs, as well as from primary care and emergency services physicians who attempt to refer patients for addiction medicine and psychiatric services. The consensus from a clinical perspective is that carving out "behavioral" care from general medical care is a barrier to integrated service delivery.

In response to the passionate testimony received, the reference committee reaffirmed an AMA policy adopted by the House in 2001, which directs the AMA to oppose and work to eliminate carved out benefits for mental health and addiction services, and it recommended a new directive that the AMA develop model state legislation that would prohibit the implementation of behavioral health carve-out arrangements. The House adopted this recommendation by unanimous consent.

In other action, the House voted that all references to the term "Complementary and Alternative Medicine (CAM)" in the AMA policy database should be changed to the term "Complementary and Alternative Therapy (CAT)." It accepted a Board report (BOT Rep. 36, A-02) making it AMA policy that physicians inform patients who choose CAT modalities about the risks inherent in such therapies, and directing the AMA to consider legislation that would require health plans to indemnify physicians for referrals to CAT that are mandated by health plan contracts. The report urges physicians to become better informed about CAT modalities, to be knowledgeable about their state licensing laws and regulations pertaining to CAT, and to obtain informed consent for treatments involving CAT.

The House also adopted a resolution calling for the AMA to be on record as condemning any physician who would harm a colleague with false "expert witness" testimony. The resolution also encourages medical specialty societies to establish a registry of depositions and testimony given by members of that society, and encourages medical specialty societies to sanction members who give false "expert witness" testimony.

Contracting Rights Affirmed

The AMA Principles of Medical Ethics was amended, by addition, to read that "A physician shall, in the provision of patient care, except in emergencies, be free to choose whom to serve, *with whom to contract*, with whom to associate, and the environment in which to provide medical care." Referred for further study was a report from the AMA Council on Ethical and Judicial Affairs regarding the physician's role in disclosing information about medical errors to patients.

Another key event was the adoption by the House of a new policy on liabili[ty] reform, in response to resolutions submi[t]ted by various organizations. The new pol[]icy calls on the AMA to make liability reform its highest legislative priority, and directs that enactment of tort reform legis[]lation be pursued in the Congress through various coalitions and a grassroots net[]work. The tentative fiscal note on this item authorizes the AMA to spend $3 million on the initiative, and up to another $12 mil[]lion for print and media advertising if the task force determines that such advertising would be appropriate.

The AMA Council on Scientific Affair[s] presented an outstanding report on "Saf[e] Disposal of Used Needles and Syringes i[n] the Community: An Update on AMA Activities" (CSA Report 3, A-02). Intereste[d] ASAM members and committees are urge[d] to review it. Another excellent repo[rt] approved by the House, from the Counc[il] on Medical Education, addressed "Th[e] Effect of the Nursing Shortage on Medic[al] Education" (CME 8, A-02).

Prescribing Regulations

The Missouri delegation presented a res[o]lution asking AMA to address a regulatio[n] of the federal Drug Enforceme[nt] Administration, which prohibits pharm[a]cies from dispensing the balance of a pr[e]scription for controlled drugs that initia[lly] was only partially dispensed (for examp[le] because the patient could not afford [to] purchase the full amount of drugs pr[e]scribed, or because the pharmacy did n[ot] have sufficient stock on hand to fill the f[ull] prescription). In response, the Hou[se] directed the AMA to ask DEA to change regulation 21 CFR 1306.13 so that patie[nts] can obtain the balance of a legally writt[en] prescription for a controlled drug if, [for] whatever reason, only part of the amou[nt] prescribed had been dispensed.

Another resolution that was adopt[ed] amends AMA policy to read that the AM[A] "in order to protect patient confidentia[lity] and to minimize administrative burdens [on] physicians, will (1) work to elimin[ate] requirements by pharmacies, prescript[ion] services, and insurance plans to incl[ude] such information as ICD-9 codes, DEA nu[m]bers, and diagnoses on prescriptions; [and] (2) inform physicians of their rights [to] withhold DEA numbers from prescripti[ons] that do not require them." (See the AM[A] web site at WWW.AMA-ASSN.ORG for copie[s of] the reports cited here.)

ASAM's Web Site Offers "Hot Button" for New Members

ASAM's Membership Department has developed a special "hot button" on ASAM's web site (WWW.ASAM.ORG) exclusively for the use of new members. By clicking on the hot button, new members can instantly access orientation information and other news about ASAM.

With the advent of the new system, new members no longer need wait to receive a new member orientation kit in the mail. Instead, every new member will be given a special password that affords access to the special new member section of the web site.

New members will continue to receive a paper copy of ASAM's membership directory. Also, those who prefer to receive a paper version of the new member kit in the mail can request one.

For more information on this or other membership matters, contact Stacey Kocan-McCormick, ASAM Membership and Chapter Development Assistant, at 301/656-3920, Ext. 110, or e-mail SMCCO@ASAM.ORG.

Effects of Managed Care on Addiction Treatment Studied

A review article in the journal *Alcoholism: Clinical & Experimental Research* gathers four studies of managed care and its influence on addiction treatment. The studies were presented at a symposium during the June 2001 meeting of the Research Society on Alcoholism.

"Managed care companies seem to be more accepting of mental health treatment than of AOD treatment," noted Stephen Magura, Ph.D., Deputy Executive Director of National Development and Research Institutes (NDRI) and lead author of the review. "This is largely because of the continuing development of effective medications for mental disorders that can be prescribed through the regular medical care system. AOD treatment, however, is not at this time primarily based on medications, with the rare exception such as methadone treatment for opiate addiction. AOD treatment has a greater burden of proof because it is more difficult to demonstrate the effectiveness of the more multifaceted behavioral therapies upon which the field continues to depend."

One of the studies summarized in the review found that analyses of access to and utilization of addiction treatment need to distinguish among treatment seeking, entry, and completion. "Distinguishing among these three successive 'stages' is important because many treatment seekers do not return to the agency after intake and admission," wrote Dr. Jacqueline Laudet, a co-author of the review, "and many clients who begin to attend treatment drop out before completing the planned duration of services.... Treatment programs should also be held accountable not only for the number of patients they admit, but also for the number that stay long enough to get some real therapeutic benefit."

Another study provided an analysis of the introduction of managed care into the Massachusetts Medicaid program. Researchers found that a reduction in payments for addiction treatment services were not accompanied by a reduction in the total services delivered, but rather reflects a redirection of patients to less expensive services. "The finding is surprising...in that it goes against the popular belief, or should I say fear, about the effects of managed care on service delivery," said Dr. Laudet. "However, closer examination of the data suggests that the findings are in fact quite logical.... The most significant decrease in expenditures was observed for the most intensive, and therefore costly, area of 24-hour services." In contrast, expenditures for ambulatory services increased significantly less, and expenditures for methadone treatment doubled.

The final study found that the *ASAM Patient Placement Criteria* hold promise for matching alcoholism patients to the appropriate level of care, thereby avoiding ineffective undertreatment and inefficient overtreatment. "Using the ASAM Criteria can help AOD programs give patients the right intensity of treatment," wrote Dr. Magura, "instead of not giving enough or giving more than the patients really need. If patients don't get enough treatment, then their addiction will continue and any money spent on treatment may be wasted. In the same way, if patients get more treatment than they really need, money is also wasted." *Source: Alcoholism: Clinical & Experimental Research, March 2002.*

"Using the ASAM Criteria can help AOD programs give patients the right intensity of treatment, instead of not giving enough or giving more than the patients really need."

Court: States Can Regulate HMO Practices

In a blow to health maintenance organizations (HMOs), the U.S. Supreme Court has ruled that state laws allowing patients to obtain second opinions or requiring independent review of benefit denials do not conflict with the 1994 federal ERISA statute. About 40 states have adopted such laws.

The ruling came in the case of an Illinois woman whose HMO refused to pay for surgery to treat a debilitating nerve problem. The HMO, Rush Prudential HMO, Inc., since has been purchased by Wellpoint Health Network.

HMOs long have argued that the federal ERISA statute exempts their practices from regulation by the states. The court's ruling is expected to spur state efforts to rein in HMO practices, as well as to increase patient requests for second opinions and independent review of benefit denials. *Source: Associated Press, June 20, 2002.*

AGs Oppose "Behavioral Health" Carve-Outs

Several prominent state attorneys general are pushing for state laws and regulations that would hold health insurers and their "behavioral health" subcontractors more accountable for complaints about access to care. "There is a stunning absence of safeguards to insulate the coverage decisions from the bias of subcontractor officials with a personal financial interest in denying coverage and care," said Connecticut Attorney General Richard Blumenthal. Mr. Blumenthal is urging reform of Connecticut's state laws and regulations in an effort to eliminate what he characterized as patient abuse and financial mismanagement by managed behavioral health organizations (MBHOs).

In Pennsylvania, Attorney General Mike Fisher recently testified before a state legislative committee about problematic practices by MBHOs in denying access to addiction treatment.

Managed care officials have dismissed the increased scrutiny, arguing that it is not unique to the behavioral health field. Pamela Greenberg, executive director of the American Managed Behavioral Healthcare Association (AMBHA), said the focus on behavioral health has intensified recently because MBHOs are serving greater numbers of people. *Source: Alcoholism & Drug Abuse Weekly, May 13, 2002.*

SAMHSA: Funding Priorities Shift

Funding for addiction research and services is being realigned in accord with a broad reorganization of federal health agencies. For example, funding for addiction research will be consolidated in the National Institutes on Health (NIH), while the Substance Abuse and Mental Health Services Administration (SAMHSA) will focus on funding service delivery. Experts point to the elimination earlier this year of the Center for Substance Abuse Treatment's (CSAT's) research-oriented Comprehensive Community Treatment Program as an example of this shift in funding and agency priorities. "We're placing greater efforts on the service-delivery aspects of the agency's mission," SAMHSA spokesman Mark Weber told *Alcoholism & Drug Abuse Weekly*. "Instead of doing studies, we're delivering services. We'll let NIH do the studies." Both the National Institute on Drug Abuse and the National Institute on Alcohol Abuse and Alcoholism are part of NIH.

SAMHSA Administrator Charles Curie recently testified before Congress that SAMHSA will work with NIH to improve the translation of research into practice. "SAMHSA will focus on what we do best and our original mission: working with states and helping communities use the latest research findings to implement effective prevention and treatment strategies," he said, adding that funding cuts at SAMHSA proposed in the administration's budget would be offset by funding increases at NIDA and NIAAA. *Source: Alcoholism & Drug Abuse Weekly, March 25, 2002.*

NIDA: Journal Targets Researchers, Providers

A new journal for addiction researchers and treatment providers has been launched by the National Institute on Drug Abuse (NIDA). The peer-reviewed journal, *Science & Practice Perspectives*, is to be published twice a year. Designed to promote dialogue between scientists and service providers, the journal's content will focus on exchange of information, observations and insights to help clinicians adopt new research findings into their practices and improve treatment outcomes, while helping researchers construct new hypotheses and design studies that are relevant to the needs of providers and patients.

David Anderson of NIDA's Office of Science Policy and Communications, who also edits *NIDA Notes*, is the Editor of *Perspectives*. The editorial board is composed of leaders in the addiction research and practice communities. In announcing publication of the journal, NIDA Acting Director Glen Hanson, Ph.D., D.D.S., remarked that "Drug abuse researchers and clinicians share a common dedication to reducing the devastation caused by drug abuse and addiction. By combining forces, researchers and clinicians are able to produce treatment results and improvements that far surpass the results that either could achieve on their own."

No-cost subscriptions to *Perspectives* may be ordered by e-mail from NIDAPERSPECTIVES@MASIMAX.COM, or through the on-line order form at NIDA's web site, WWW.DRUGABUSE.GOV. *Source: NIDA Notes, June 2002.*

DOJ: Drug Court Grants Awarded

Drug courts in 31 states will receive funding from the U.S. Department of Justice, the agency has announced. The funds will be used to plan, establish, or improve drug courts for nonviolent adult and juvenile offenders. Ninety-four jurisdictions in 31 states and 2 territories will receive awards through the Office of Justice Programs.

"Drug courts are a valuable tool for communities fighting substance abuse and drug-related crime," said Attorney General John Ashcroft. "Through intensive judicial supervision, drug treatment and graduated sanctions, drug courts are holding nonviolent drug offenders accountable, while helping them to lead productive lives. Local groups of judges, prosecutors, defense attorneys, treatment professionals and law enforcement officials are using the coercive power of the criminal justice system to achieve abstinence and alter criminal behavior among nonviolent drug offenders." *Source: DOJ press release, June 6, 2002.*

CDC: DUI Program Report

Strong state action can reduce the incidence of drinking and driving, says a new report from the Centers for Disease Control and Prevention (CDC). The agency's analysis shows that rates of self-reported drinking and driving were inversely related to the strength of state activities to prevent DUI.

"Each year, alcohol is involved in nearly 40% of all traffic-related deaths, said David Fleming, M.D., M.P.H., acting director of CDC, adding: "these deaths can be prevented. The report is available at WWW.CDC.GOV/NCIPC/DUIP/SPOTLITE.

FDA: Ephedrine Products Regulated

The U.S. Food and Drug Administration (FDA) has announced that it will aggressively pursue the illegal marketing of products containing non-herbal synthetic ephedrine alkaloids.

Herbal ephedrine alkaloids, known as ephedra, are marketed in the U.S. as nutritional supplements and promoted for weight loss and energy enhancement. Reported adverse reactions include rapid or irregular heartbeat, chest pain, severe headache, shortness of breath, dizziness, loss of consciousness, sleeplessness, and nausea. In an effort to improve market surveillance and better monitor the safety of all dietary supplements, the FDA has begun to strengthen its adverse-event monitoring system. The effort incorporates existing reporting systems into a new, unified system to track and analyze such reports.

The Department of Health and Human Services (HHS) also has announced new efforts to expand scientific research into the safety of ephedrine alkaloids. "It is crucial that we have a full understanding of these dietary supplements," HHS Secretary Tommy Thompson said in a press release. "By increasing our breadth of knowledge about these supplements, we can give consumers the information they need to make informed decisions." *Source: FDA press release, June 14, 2002.*

Study Probes Brain Mechanisms that Sustain Drinking

New research has uncovered independent mechanisms in the brain that produce a common cellular response, helping to sustain voluntary alcohol consumption. Researchers at the Ernest Gallo Clinic and Research Center at the University of California-San Francisco found that the chemical messenger dopamine and ethanol work together—albeit through independent mechanisms—to produce a biological response that contributes to increased desire for alcohol.

As part of the research, Ivan Diamond, M.D., Ph.D., and colleagues showed in rat-cell cultures that, when dopamine binds to one of its receptors (D2 subtype), it generates signaling proteins known as beta gamma dimers. Through a series of events, these cause the activation of protein kinase A (PKA), another protein involved in intracellular communication, gene expression, and animal behavioral responses to alcohol.

Although acting through a different receptor (adenosine type 2, or A2), ethanol generates the same signaling protein and subsequent activation of PKA. Moreover, dopamine and ethanol applied together to the cells—at concentrations that individually would not activate PKA signaling—increased beta gamma dimer formation and, in turn, PKA signaling.

To determine whether the cellular effects are capable of producing a behavioral response, the researchers injected rats with a molecule designed to reduce the level of beta gamma dimers. The injection reduced the animals' alcohol consumption and alcohol preference, lending further support to the theory that beta gamma dimers play a significant role in voluntary drinking.

"Our experiments suggest that synergy of dopamine D2 and adenosine A2 receptors creates hypersensitivity to ethanol and that beta gamma dimers are required to sustain voluntary drinking," Dr. Diamond concluded. *Source: Cell, June 14, 2002.*

Neurodegeneration from Binge Drinking

Scientists agree that alcohol is toxic and that chronic alcohol abuse can damage all organs to varying degrees. There is less agreement, however, as to whether or how much neurodegeneration is triggered by alcohol's toxic effects during alcohol consumption, as opposed to the hyperexcitability caused by alcohol withdrawal. To answer this question, researchers examined the effects on neuronal function of the equivalent of just a few days of binge drinking.

"Most studies of alcohol-induced brain damage have looked at humans who have been alcoholic for decades or rats treated with alcohol for six to 18 months," said lead investigator Fulton T. Crews, Ph.D., Director of the Center for Alcohol Studies at the University of North Carolina. "Our study shows significant damage in several regions of the brain after only four days, that it occurs during intoxication, and that the process is similar to a dark-cell degeneration that is primarily necrotic."

For the study, male rats (n=120) were surgically implanted with intragastric catheters. Experimental rats (n=80) were given alcohol at a rate equivalent to binge drinking, every eight hours for four consecutive days. Control rats (n=40) were given an alcohol-free yet calorie-equivalent diet at the same rate. Some rats were sacrificed at two days, some at four days, and some after four days of alcohol and three days of withdrawal.

"This study showed significant damage in the olfactory bulb after just two days of heavy drinking," said Dr. Crews, "which is a short period of time relative to the decades of drinking that alcoholics do, and may be an important early process in the progression from experimentation with alcohol to addiction. In addition, the major current hypothesis regarding alcohol-induced brain damage suggests that damage occurs during withdrawal.... Our findings...indicate that alcohol-induced brain damage occurs during intoxication," he said.

Commenting on the durability of the neurodegeneration, Michael A. Collins, Ph.D., professor of biochemistry at Loyola University Chicago, said that "when the brain—the limbic cortex and dentate gyrus of the hippocampus, in this case—loses its excitable cells, for all practical purposes they are gone for good. In the day-to-day life of an alcoholic, this means a decreased ability to learn, to recall, to make decisions, and perhaps to sense and appreciate life in its fullest." *Source: Alcoholism: Clinical & Experimental Research, April 2002.*

Genetic Mutation in Addictive Disorders

Addiction may be linked to a genetic mutation, say researchers from the Scripps Research Institute, La Jolla, CA. Dr. Jack C. Sipe and colleagues in the Institute's department of molecular and experimental medicine found that study subjects who had two mutated copies of a gene that controls levels of the fatty acid amide hydrolase (FAAH) enzyme were more at risk for alcohol and other drug addiction than were persons with two normal copies of the gene, or only one copy of the damaged gene. FAAH breaks down cannabinoid molecules, which occur naturally in the human body and are similar to marijuana's main active ingredient, tetrahydrocannabinol (THC).

In an earlier mouse study, the researchers found that animals lacking the FAAH gene had excessively high levels of cannabinoids in their systems. They then tested for the mutation in persons who were users of illicit drugs, alcoholics, smokers, social drinkers, and controls. They found that individuals who were dependent on alcohol and illicit drugs were nearly five times as likely to have inherited two copies of the mutated gene as were the non-drug using controls. However, smokers and social drinkers were no more likely to inherit two copies of the gene than the general population. *Source: Proceedings of the National Academy of Sciences, June 11, 2002.*

Drug Relieves Symptoms of Alcohol Withdrawl

Results of a small study suggest that the muscle relaxant baclofen may ease the symptoms of alcohol withdrawal. Baclofen (marketed in the U.S. as Lioresal®) is prescribed for multiple sclerosis and spinal injuries because it acts on the central nervous system.

The study focused on five patients who were suffering severe withdrawal symptoms, including tremors, sweating, nausea, and agitation. After receiving baclofen, the withdrawal symptoms diminished within three hours or less in four of the patients, while the fifth patient saw improvement within three days. Participants remained on the drug for 30 days. Lead author Dr. Giovanni Addolorato of the Universita Cattolica del Sacro Cuore, Rome, Italy, suggested that baclofen be studied further. *Source: American Journal of Medicine, April 2002.*

Continued from page 4

must be ASAM-certified. We are certainly living in phenomenal times!

With success, however, there are new challenges. Our membership, like other physician organizations, is graying. Without bold, progressive thinking on our part, younger physicians may not benefit from the accomplishments of past and current ASAM members. Despite the fact that the percentage of women in medical schools has risen steadily over the past two decades, the pathway to leadership in ASAM remains very different for women than for men. A higher percent of male leaders come from the ranks of state chapters, compared to the pathway taken by our women leaders.

You may ask why this is important. My answer is simple: we need to recognize that young physicians have different and probably more diverse needs and interests than those who preceded them. This nation, which we have come to appreciate at a different level of passion in the aftermath of September 11th, is based on diversity of thought, diversity of experience, and diversity of culture. If our nation can thrive on diversity, then why not ASAM?

Speaking of diversity, I fully recognize that you elected me President because I was the best person for the job at this stage in ASAM's history, even though I came to this position a lot sooner than either you or I planned. Like every ethnic-racial group represented in the rainbow of the United States, I am proud of my African American heritage. I also am proud to be a member of, and now to serve as President of, an organization that has as one of its unwritten legacies the belief that leadership comes from diversity. I do not take this responsibility lightly, and I recognize the needs of our members in this regard.

Access to Care

A major unmet need of our members and the patients we serve is the concept of parity; that is, coverage for substance abuse and addiction clinical care at the same level as services for other medical disorders. Despite a wealth of scientifically sound evidence that parity achieves better clinical outcomes and is cost-effective, a substantial portion of the American public does not have adequate coverage for the diagnosis and treatment of substance abuse and addictive disorders.

ASAM will continue to educate policymakers and the public, working alone and in collaboration with other organizations, to address what is clearly another manifestation of stigma. As your President, it is my intention to speak loudly and boldly about this issue. By advocating for the needs of our patients, we become more empowered as a medical specialty and as a Society. With this empowerment comes value to our members.

This reminds me of an article by Robert Seltzer in the March 2002 issue of th *Journal of Urban Health/Bulletin of th New York Academy of Medicine.* The art cle discussed the relationship between sc ence and policy. On the one hand, mo people (scientists, clinicians, and the publ at large) would agree that, where scienti ic evidence is clear and compelling, publ policy should be based on it. However, w know from experience that much of ou public policy is not so grounded. Whi policymakers may be interested in wh the scientists say, policy decisions often a the result of a balancing act among con peting interests: economic, social, an political. As scientists, we should not b surprised that there may be competin interpretations of the data, often unintel gible to all but the most erudite read Appreciating this phenomena, we mu recognize that, while we continue to acc mulate scientifically sound informatio science for many Americans does not p food on their tables or a roof over th heads, and science surely does not make to the voting booth on election day.

Nevertheless, Americans (and especia that subset of Americans who are phy cians), armed with evidence-based da and knowledgeable about the politi process, can win the day for the econo cally disenfranchised and the socially st matized. At this point in my life, I ha been the recipient of a number of awa and accolades, chiefly because I have be the beneficiary of the support of my fa ly, friends, and colleagues. Yet, at the of my career, the greatest award would the recognition by all that I devoted career to the most vulnerable.

The challenges ahead are significant. we struggle with the emotional impac September 11th, it is important to focu restoring our own emotional wellbein we provide care to those in need, an we blend clinical practice with rese Stressful times are particularly difficul people who are at risk for substance a or recovering from addiction. You are leaders of this battle, but we must co ue to work as partners. Most of all need you to stay involved. For the rea son we gather together at Med-Sci other conferences is to teach each and to improve the quality of and acc care. Your leadership will help us achieve that mission.

Addiction Fellowships Available
University of Florida

Beautiful beach community fellowships in Jacksonville, St. Augustine, and Daytona Beach, as well as Gainesville, Florida. Positions available for Board Certified or Board Eligible physicians who can be licensed by the State of Florida. One-year or two-year positions as ASAM or AAAP Addiction Fellows in the University of Florida, College of Medicine's Division of Addiction Medicine, under the direction of Mark Gold, M.D.

Extensive training in tobacco, alcohol and other drug evaluations, as well as detox, forensic evaluation, drug court, impaired physician, and treatment. Addiction Fellows also have research and teaching opportunities at the University of Florida, College of Medicine in Gainesville. Contact William Jacobs, M.D., FASAM, University of Florida, Department of Psychiatry, College of Medicine, at (352) 392-6686. EEO/AA Employer.

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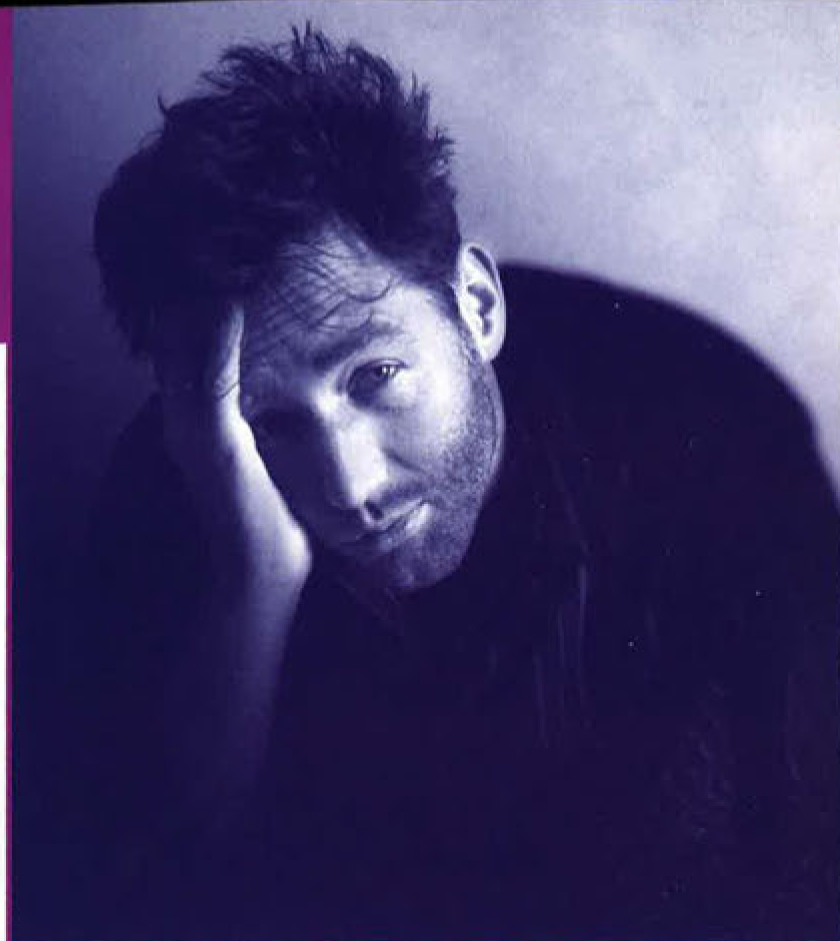

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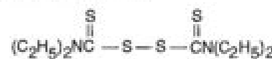
WARNING:
Disulfiram should *never* be administered to a patient when he is in a state of alcohol intoxication, or without his full knowledge. The physician should instruct relatives accordingly.

DESCRIPTION: Disulfiram is an alcohol antagonist drug.
CHEMICAL NAME:
bis(diethylthiocarbamoyl) disulfide.
STRUCTURAL FORMULA:



$C_{10}H_{20}N_2S_4$ M.W. 296.54

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 occuring 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 AND USAGE: 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 thiuram 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 uneasiness, 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.

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.

PRECAUTIONS: Patients with a history of rubber contact dermatitis should be evaluated for hypersensitivity to thiuram 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.

Hepatic toxicity including hepatic failure resulting in transplantation or death have been reported. Severe and sometimes fatal hepatitis associated with disulfiram therapy may develop even after many months of therapy. Hepatic toxicity has occurred in patients with or without prior history of abnormal liver function. Patients should be advised to immediately notify their physician of any early symptoms of hepatitis, such as fatigue, weakness, malaise, anorexia, nausea, vomiting, jaundice, or dark urine.

Baseline and follow-up liver function tests (10-14 days) are suggested to detect any hepatic dysfunction that may result with disulfiram therapy. In addition, a complete blood count and serum chemistries, including liver function tests, should be monitored.

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.

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.

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.

Pediatric Use: Safety and effectiveness in pediatric patients have not been established.

Nursing Mothers: It is not known whether this drug is excreted in human milk. Since many drugs are so excreted, disulfiram should not be given to nursing mothers.

Geriatric Use: A determination has not been made whether controlled clinical studies of disulfiram included sufficient numbers of subjects aged 65 and over to define a difference in response from younger subjects. Other reported clinical experience has not identified differences in responses between the elderly and younger patients. In general, dose selection for an elderly patient should be cautious, usually starting at the low end of the dosing range, reflecting the greater frequency of decreased hepatic, renal or cardiac function, and of concomitant disease or other drug therapy.

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, as well as hepatic failure resulting in transplantation or death, have been reported 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, acneform 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.

OVERDOSAGE: No specific information is available on the treatment of overdosage with disulfiram. It is recommended that the physician contact the local Poison Control Center.

DOSAGE 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, carbogen (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: OP 706
Dispense in a tight, light-resistant container as defined in the USP.
Store at controlled room temperature 15°-30°C (59°-86°F). [SEE USP]

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Candidates for the Office of President-Elect

The President-Elect serves a two-year term, beginning in May 2003, and is expected to assume the Presidency in April 2005.

Elizabeth F. Howell, M.D., FASAM
Atlanta, Georgia

What do you consider to be your greatest contribution to ASAM and the field of addiction medicine? I joined ASAM in 1985 during my residency. Since then, I have had the pleasure of working on many ASAM committees, and have been on the Board as Treasurer for the past four years. I have worked to assure the organization's financial stability and security, fostered the development of our publications through the years, served on the Strategic Plan Task Force over the past two years, participated in the development of the Ruth Fox Memorial Endowment Scholarships, and most recently served as a member of the search committee for ASAM's new EVP/CEO. I am gratified that I have been able to contribute to ASAM in so many ways.

I consider my greatest contributions to the field of addiction medicine to be my work in the spectrum of addiction treatment--academic, private practice, public, government, private non-profit, consulting, teaching, and training—and my work within ASAM. I have been committed to providing excellent addiction care; educating residents, fellows, other physicians, medical students, and others about addiction medicine; working with medical boards; communicating hopefulness about recovery and respect for addicted patients; mainstreaming addiction medicine; and improving care for all who need it.

How do you feel your election would benefit ASAM and the field of addiction medicine? I am excited about and committed to the mission and goals of ASAM, and interested in the "bigger picture" of medicine. I enjoy working with stimulating colleagues, and have many ideas about how to strengthen and grow our organization. I bring financial and fiscal awareness from my role as Treasurer and also from state government, non-profit, and private practice experience. My work in a variety of addiction medicine experiences, organized medicine activities, and non-medical activities has given me a unique perspective about the field and a wealth of ideas, and I would love to bring my awareness and strengths to the ASAM Presidency.

Although I am full of ideas, I realize that ASAM must first and foremost remain a financially sound organization that serves its members and fulfills its mission. I would be honored to serve ASAM as its President-Elect.

James W. Smith, M.D., FASAM
Seattle, Washington

What do you consider to be your greatest contribution to ASAM and the field of addiction medicine? Since 1978, I have actively participated in building ASAM from a few members to a respected specialty society with significant influence on organized medicine, government, insurers, and public policymakers. I have done this through membership in the Public Policy, Certification, Fellowship, and Practice Guidelines Committees. I also have been active in making ASAM a financially stable organization as Chair of the Finance and Operating Fund Committees and as Treasurer. I have been active in policymaking for ASAM as a member of the Executive Committee of the Board of Directors.

However, I believe my greatest contribution to the field of addiction medicine is teaching the disease concept of addiction to medical students, nurses and counselors-in-training. As President of ASAM, I will work to attract younger physicians to the field by working to increase the instruction on addiction medicine in all years of medical school, as well as to establish fellowship and residency programs leading to recognition of addiction medicine as a specialty by the American Board of Medical Specialties.

How do you feel your election would benefit ASAM and the field of addiction medicine? I am committed to gaining recognition for physicians who practice addiction medicine, for increasing access to treatment and to securing reimbursement for physicians who provide treatment. I also am committed to improving addiction treatment by influencing policy and communicating with decision makers.

My experience in persuading my State's Insurance Commission to require use of the *ASAM Patient Placement Criteria* demonstrates that it is possible to cause regulatory changes that liberalize reimbursement for addiction treatment. As President of ASAM, I will push for that and for the goal of parity at all state and federal levels so that the practice of addiction medicine will be reimbursed fairly. I believe that ASAM, not third parties, must set the clinical guidelines and standards for levels of care, and I will work toward that end. In addition, I will work to extend ASAM's influence by strengthening ties with relevant government agencies and with coalitions of organizations that share ASAM's goals.

Candidates for the Office of Secretary

The Secretary has a two-year term of office, beginning in May 2003. A Secretary may succeed himself or herself once without hiatus, and subsequently may be reelected after a hiatus of two years.

Lloyd J. Gordon III, M.D., FASAM
Brandon, Mississippi

What do you consider to be your greatest contribution to ASAM and the field of addiction medicine? My greatest contribution to ASAM at the present time would be as Regional Director to the Board of Directors and Alternate Delegate to the AMA. I feel that my efforts are contributing to advancing the cause of addiction medicine and making it part of mainstream organized medicine.

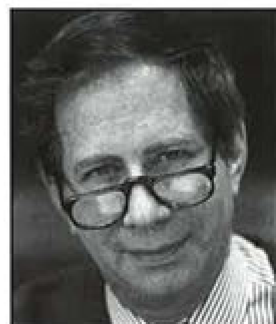
As chairman of the Implementation Committee of ASAM's Strategic Plan Task Force, I will have the honor of participating in taking ASAM through its next growth phase.

I feel that being Medical Director of a residential treatment facility, actually seeing patients, and being part of clinical medicine has been my greatest contribution to the field of addiction medicine, as it has helped me to see both the practical and political aspects of addiction medicine in my efforts to help individuals, one by one, get sober.

How do you feel your election would benefit ASAM and the field of addiction medicine? I feel that my election would enable me to continue to represent ASAM at the national level to organized medicine. I think that being an officer would help me in my role as chairman of the Implementation Committee to see that ASAM's Strategic Plan is not just so many words on paper, but that the goals and objectives become reality.

I also believe that ASAM will go forward and prosper only if we have representatives at the highest level who have experienced both the clinical and practical aspects of addiction medicine, and have expertise in the policy and bureaucratic realms also. I see the pain and suffering caused by the disease every day and try to lessen it as a physician. In addition, I would like to attempt to lessen it as an organizational leader.

I believe in ASAM. I believe in its members and purpose. I believe ASAM has the ability to draw together physicians of many divergent beliefs to work as one to make a difference in a disease where stigma is still part of the substance of the disease.



David C. Lewis, M.D.
Providence, Rhode Island

What do you consider to be your greatest contribution to ASAM and the field of addiction medicine? My specialties are internal medicine and addiction medicine. I am Professor of Medicine and Community Health and Donald G. Millar Distinguished Professor of Alcohol and Addiction Studies at Brown University.

I have been on the ASAM Board of Directors for several years and would like to remain on the Board in this crucial period for the organization. My work in addiction medicine has focused on medical education, research, and policy. In policy, most of the focus has been on a major expansion of addiction treatment, including parity of reimbursement with other chronic diseases. I have represented ASAM on the Council of Medical Societies of the American College of Physicians, arranged for ASAM to participate in the organization, Physician Leadership on National Drug Control Policy (PLNDP), and facilitated ASAM's links with national primary care organizations.

How do you feel your election would benefit ASAM and the field of addiction medicine? ASAM has remarkable accomplishments over the past decade as the primary multispecialty voice for addiction medicine in the United States. The *ASAM Patient Placement Criteria* and the *Principles of Addiction Medicine* and our journal are widely used and high regarded. ASAM state chapters contribute in an important way to our mission of advocating for high-quality addiction care.

Yet, with the exception of the AMA, many in medical leadership positions and the public are still unaware of our accomplishments. Implementation of evidence-based treatment, including pharmacotherapies, should enhance the positive relationship of ASAM to the rest of medicine and will be critical for our growth.

Also, we need to be in the forefront of the transformation that electronic communication will make in the relationship between primary care physicians and specialists of all kinds. Finally, we now have the infrastructure to grow into greater force for advocating for the benefit of our patients and, thereby, becoming a more major force in influencing public policy.

The policy arena and communicating with a wide range of physician leadership are already high on my personal agenda and would be so on my agenda as Secretary of ASAM.

Candidates for the Office of Treasurer

The Treasurer has a two-year term of office. A Treasurer may succeed himself or herself once without hiatus, and subsequently may be reelected after a hiatus of two years.

Paul H. Earley, M.D., FASAM
Smyrna, Georgia

What do you consider to be your greatest contribution to ASAM and the field of addiction medicine? I have been involved in ASAM for more than 15 years. During that time, I have worked for ASAM in two distinct areas. The first is membership and state chapter development. I helped to organize the Georgia State Chapter more than 14 years ago, and helped to develop ASAM's State Chapters Committee and the Membership Campaign Task Force. Both the committee and the task force have been crucial to ASAM's ongoing strength and stability. Today, ASAM's membership is stronger than ever, and due to the close scrutiny of the fiscal status, we are more solid financially than we have ever been.

Over the past three years, I have focused my efforts in ASAM on development of the ASAM PPC-2R Algorithm Software. This product was developed through a joint effort with my colleagues, David Mee-Lee and David Gastfriend. The eventual goal is a lofty one: to standardize and improve addiction care in the U.S., and to move addiction medicine to a true evidenced-based field through the collection and analysis of data on assessment and treatment.

I have been on the ASAM Board of Directors for more than 10 years. During this time, I have learned from many of the Board members who established ASAM. Many of these original Board members have stepped aside in order to encourage a new leadership to emerge. By my continuous membership on the Board during this transition, my view has been a unique one, that of learning and eventually guiding the leadership of our organization. As Treasurer, I could continue to serve as a steward to ASAM along its path of continued growth, focusing my efforts on measured fiscal growth.

How do you feel your election would benefit ASAM and the field of addiction medicine? I believe my ability to think simultaneously as a member and a businessman will help ASAM continue its path of fiscal stability. A strong organization is needed to have a strong voice in the care of addicted patients. To be a strong organization ASAM must, of necessity, be fiscally sound. I believe I can continue the tradition of fiscal stability established by our Board.

James A. Halikas, M.D., FASAM
Naples, Florida

What do you consider to be your greatest contribution to ASAM and the field of addiction medicine? I have been an active participant in ASAM for more than 20 years, as chairman of the Medical Education Committee, co-chairman of the Fellowship Committee, member of the Executive Committee, and an active presenter at our annual Medical-Scientific Conferences. In fact, if you've ever taken an ASAM course or gotten CME credits from ASAM, I probably helped organize or approved the course, and my signature is on your certificate.

I've also contributed more than 100 articles to the addiction medicine professional literature, including the development of cocaine pharmacotherapies. I am particularly proud to have been the senior author of the original patient placement criteria in 1987, the "Cleveland Criteria," along with David Mee-Lee and Norman Hoffman, which subsequently became the *ASAM Patient Placement Criteria*, the national standard for our field. Yet, I believe that my most important contribution to ASAM and to the field of addiction medicine is still to come.

How do you feel your election would benefit ASAM and the field of addiction medicine? My goals for the next six years will be to organize our membership, 3,000 expert addiction medicine clinicians and scientists, into an effective voice for our specialty in order to improve reimbursement for our services and establish our position as a medical specialty.

My agenda for ASAM is twofold: Internally, I would try to guide ASAM's committees and members to define, clearly and specifically, the actions and activities of an addiction medicine specialist. This definition of our clinical activities would be used with both managed care organization and with medical specialty organizations to demonstrate the uniqueness of the specialty of addiction medicine.

Externally, I would "spread the good news" that treatment works! And I would try to steer ASAM into activities that demonstrate treatment response and effectiveness at every opportunity. In all conferences and CME activities that we are involved in, I would try to stimulate presentations on treatment and its effectiveness, and encourage NIDA and NIAAA to publicize treatment efficacy reports and develop public health proposals that stimulate public interest in the effectiveness of addiction treatment delivered by specialists in addiction medicine.

Candidates for Director at Large

Candidates for Director at Large, 2003-2007, were selected by the Nominating & Awards Committees and nominated by petition. Candidates must have been active members of ASAM for at least three years, must have demonstrated a commitment to ASAM's mission by engaging in activities such as service on a committee, task force, or other significant national or state endeavor, and must be willing to attend two Board meetings a year for four years at his or her own expense.

Four Directors at Large are to be chosen. The three candidates who receive the most votes, and the one candidate representing osteopathic medicine who receives the most votes, will be elected.

The candidates for Director at Large are:

David R. Gastfriend, M.D. (incumbent)

Stuart Gitlow, M.D., M.P.H. (nominated by petition)

R. Jeffrey Goldsmith, M.D.

Elizabeth F. Howell, M.D., FASAM

Donald J. Kurth, M.D., FASAM (nominated by petition)

Michael M. Miller, M.D., FASAM

James W. Smith, M.D., FASAM (incumbent)

Trusandra E. Taylor, M.D., FASAM (incumbent)

Penelope P. Ziegler, M.D., FASAM (incumbent)

Candidates for Director at Large representing Osteopathic Medicine are:

Anthony H. Dekker, D.O., FASAM (incumbent)

Timothy L. Fischer, D.O.

ASAM's campaign guidelines prohibit the use of "restricted or unrestricted written or electronic communication" by candidates or their advocates.

Newly elected officers and Regional Directors will be installed during the Society's May 2003 Medical-Scientific Conference in Toronto, Ontario, Canada.

Election results will be announced in the January-February 2003 issue of ASAM **News.**

Ballots will be mailed to members in good standing by November 1, 2002, and must be returned to ASAM by December 1. If you have not already done so, be sure to renew your membership so that you are eligible to vote!

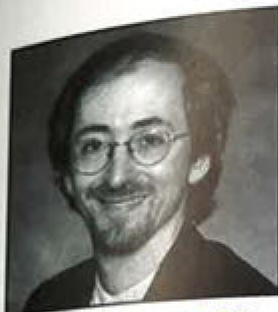
David R. Gastfriend, M.D.
Boston, Massachusetts

What do you consider to be your greatest contribution to ASAM and the field of addiction medicine? My greatest contribution is to demonstrate—rigorously, objectively, quantitatively, undeniably—that treatment works. Our field is the most severely damaged by the past decade of managed care. Our patients are under attack by a financial industry that exploits the stigma of their illness to convert the costs of patient care into short-term profits.

We all are doing something to address this attack, every day, when we help patients into recovery in our offices and programs. My personal contribution to this battle is to shine the light of science through this dismal fog. I have applied research techniques to show employers, insurers, and policymakers that the *ASAM Patient Placement Criteria* are superior to current managed care review criteria. With the clarity of real numbers, it has been much easier to combat brute-force dollar-cutting program closures.

I have pushed the federal government to use outcome studies to write "performance measures" that can hold managed care organizations accountable. To do this, I have been participating in the Washington Circle Group (a national policy coalition) on behalf of ASAM. This group is working to compare and contrast how managed care companies screen and refer addicted patients, how they engage patients, how they sustain longitudina care through active treatment and mainte nance of recovery. I believe that manage care does this pretty badly, in general, an I want the public, regulators, and legisla tors to know about it. The combination c the *ASAM Criteria* and performance mea ures is the key.

How do you feel your election woul benefit ASAM and the field of addictio medicine? If I am honored by your vo and re-elected to ASAM's remarkab Board of Directors, I promise to continue strive for our rightful, legitimate pla among the other disciplines and disea states in medicine. Addiction medicine surprisingly effective and scientifical valid, and it needs to be valued not ju with financial parity, but with priority cl ical status within American medicine.



Stuart Gitlow, M.D., M.P.H.
Providence, Rhode Island

What do you consider to be your greatest contribution to ASAM and the field of addiction medicine? Since 1993, I've been representing our organization within the American Medical Association's semi-annual meetings, first to the Resident Physician Section, then the Young Physician Section, and more recently to the AMA House of Delegates. Thanks in no small part to those who came before me, and with the help of many others, addiction medicine now is an accepted specialty within the AMA. This has allowed us to directly affect medical policy and advocacy activities, ranging from the pursuit of parity to the goal of reducing substance use among our youth.

Last year saw the publication of my textbook, "Substance Use Disorders: A Practical Guide," based in part on my activities within ASAM and the AMA. This text presents an extensive discussion not only of patient care issues, but of ethical dilemmas and our own public policies as well.

How do you feel your election would benefit ASAM and the field of addiction medicine? As we move into a new era with a wonderful new Executive Vice President, it is critical that we combine the best of the past with the best of the future. I have attended all but one of the ASAM Board meetings since 1993, either as a guest or as an ex-officio member. I have presented courses at ASAM annual meetings and have chaired ASAM's Members-In-Training and Electronic Communications Committees.

I understand where ASAM has come from, and I have a solid feel for the possibilities that represent ASAM's future. One example of our future needs is that of differentiating between addiction medicine and addiction psychiatry. ASAM has achieved much over the past decades, but many wonder about how the two possible pathways and career options overlap and vary from one another. It is up to us to define, educate, and to pursue the goal of continued acceptance of addiction medicine. I look forward to serving your goals as a member of the ASAM Board of Directors.

R. Jeffrey Goldsmith, M.D.
Cincinnati, Ohio

What do you consider to be your greatest contribution to ASAM and the field of addiction medicine? My greatest contribution to ASAM has been in the area of continuing medical education. As a member of the Continuing Medical Education Committee for 15 years, of the Addiction Medicine Fellowship Task Force, and of the program committees for the Nicotine Dependence Conference and Medical-Scientific Conferences, I have worked hard to provide state-of-the-art information that is relevant to addiction medicine practitioners.

In doing so, I have participated in two site visits of the Accreditation Council on Continuing Medical Education, gaining a four-year accreditation for ASAM last year. This allows ASAM to remain in its leadership position in addiction medicine by providing CME credits for its own members, as well as to organizations vital to the field.

In my own work, continuing medical education has been paramount. I am fellowship director of the addiction fellowships at the University of Cincinnati, in both addiction psychiatry (ACGME accredited) and addiction medicine. I have written on continuing medical education for medical students, psychiatrists, and primary care specialists. I have directed and participated in local and regional CME activities throughout my entire professional career.

How do you feel your election would benefit ASAM and the field of addiction medicine? If elected, I would continue the negotiations for medical specialty status, but I also would look to expand continuing education for addiction medicine. ASAM must provide continued leadership in the area of certification and fellowship training for specialties that are not allowed to provide CAQ's in addiction medicine by the American Board of Medical Specialties. Furthermore, I would look for ways that ASAM could provide more leadership to medical specialties that have a substantial number of members interested in addiction issues.

As parity in reimbursement becomes a reality, ASAM must be situated as the national leader for training of primary care specialists in addiction medicine, who must be well-trained in the management of tobacco dependence, alcoholism, and narcotic dependence (including that among chronic pain patients).

Candidates for Director at Large (continued)

Elizabeth F. Howell, M.D., FASAM
Atlanta, Georgia

What do you consider to be your greatest contribution to ASAM and the field of addiction medicine? I joined ASAM in 1985 during my residency. Since then, I have had the pleasure of working on many ASAM committees, and have been on the Board as Treasurer for the past four years. I have worked to assure the organization's financial stability and security, fostered the development of our publications through the years, served on the Strategic Plan Task Force over the past two years, participated in the development of the Ruth Fox Memorial Endowment Scholarships, and most recently served as a member of the search committee for ASAM's new EVP/CEO. I am gratified that I have been able to contribute to ASAM in so many ways.

I consider my greatest contributions to the field of addiction medicine to be my work in the spectrum of addiction treatment—academic, private practice, public, government, private non-profit, consulting, teaching, and training—and my work within ASAM. I have been committed to providing excellent addiction care; educating residents, fellows, other physicians, medical students, and others about addiction medicine; working with medical boards; communicating hopefulness about recovery and respect for addicted patients; mainstreaming addiction medicine; and improving care for all who need it.

How do you feel your election would benefit ASAM and the field of addiction medicine? I am excited about and committed to the mission and goals of ASAM, and interested in the "bigger picture" of medicine. I enjoy working with stimulating colleagues, and have many ideas about how to strengthen and grow our organization. I bring financial and fiscal awareness from my role as Treasurer and also from state government, non-profit, and private practice experience. My work in a variety of addiction medicine experiences, organized medicine activities, and non-medical activities has given me a unique perspective about the field and a wealth of ideas.

Although I am full of ideas, I realize that ASAM must first and foremost remain a financially sound organization that serves its members and fulfills its mission.

Donald J. Kurth, M.D., FASAM
Alta Loma, California

What do you consider to be your greatest contribution to ASAM and the field of addiction medicine? As physicians and addictionists, our most important gift is to share our skills with our patients who suffer from the disease of addiction. Beyond face-to-face patient care, however, I can think of no more important mission for addictionists than that of sharing our enthusiasm for the treatment of addictive disease with new physicians who are eager to learn the skills that we employ in treating our patients. At Loma Linda University, I enjoy the privilege of teaching medical students, residents, and Addiction Medicine Fellows. I believe that no single philosophy has a monopoly on the treatment of addictive disease: different approaches work for different patients. In this work, I hope that I have been able to convey my own enthusiasm for addiction medicine.

How do you feel your election would benefit ASAM and the field of addiction medicine? ASAM is a great organization with an important mission. It is up to all of us at ASAM to take a leadership role in national drug policy to end discrimination against those who suffer from addictive disease, as well as those who treat it. At the ASAM Public Policy Committee Component Session that I organized for the recent Atlanta Medical Scientific Conference, I was excited to hear of the progress other ASAM members are making in the fight for parity.

I ask for the opportunity to serve you as a Director and to use my experience to help guide ASAM to an even brighter future. As Chairperson of the CSAM Public Policy Committee, I have worked hard to set the course of legislative addiction policy in California in a positive direction. I have visited with many legislators both in Sacramento and in Washington, DC, to help educate them about the disease of addiction.

As a member of ASAM's Board, I will work to serve ASAM's members through education, research, patient care, and public policy, so as to benefit our patients and our specialty.

Michael M. Miller, M.D., FASAM
Madison, Wisconsin

What do you consider to be your greatest contribution to ASAM and the field of addiction medicine? Until recently, I'd have looked to the past when asked this question. I'd have looked to serving on the Health Care Reform Task Force, which drafted ASAM's still-relevant "Core Benefit" statement. Or to serving on the Work Group that drafted ASAM's *PPC-2*. Or to serving ASAM in the AMA as our Delegate, and our successes there; or in JCAHO, where I chaired the Hospital PTAC. Helping to found a state Chapter of ASAM was a contribution. Serving as Secretary of the Board for two terms has been, as well. The work as Public Policy Committee chair may have lasting contributions, especially the work with AMBHA, as in the Credentialing and Privileging statement.

But today, I'd say that my greatest contributions have been to ASAM's future. In the past year, I have served as Deputy Chair of the Strategic Plan Task Force. This really charts the course for ASAM as we look ahead. Most recently, I have served on the Search Committee for our new EVP/CEO, a most rewarding experience. Through these contributions, I have been trying to position our Society for what we hope will be its best years, as ASAM builds upon past successes as the preeminent physician organization in the addiction field.

How do you feel your election would benefit ASAM and the field of addiction medicine? From a position on the Board, I would continue to be an official spokesperson for our Society and our field. The energies I have put into so many projects—including responding to calls to ASAM's office, responding to the media, commenting on proposed regulations and legislation—would remain a part of ASAM's visibility. My past experiences will provide context and continuity to future Board work. And continued close familiarity with Board activities, including implementation of our new Strategic Plan, will position me for further leadership roles in ASAM in the event I were asked to assume office in the future.

James W. Smith, M.D., FASAM
Seattle, Washington

What do you consider to be your greatest contribution to ASAM and the field of addiction medicine? Since 1978, I have actively participated in building ASAM from a few members to a respected specialty society with significant influence on organized medicine, government, insurers, and public policymakers. I have done this through membership in the Public Policy, Certification, Fellowship, and Practice Guidelines Committees. I also have been active in making ASAM a financially stable organization as Chair of the Finance and Operating Fund Committees and as Treasurer. I have been active in policymaking for ASAM as a member of the Executive Committee of the Board of Directors.

However, I believe my greatest contribution to the field of addiction medicine is in teaching the disease concept of addiction to medical students, nurses, and counselors in training. I carried these concepts to the general public as President of the Washington State Council on Alcoholism (an affiliate of NCADD).

How do you feel your election would benefit ASAM and the field of addiction medicine? I am committed to gaining recognition for physicians who practice addiction medicine, increasing access to treatment, and securing reimbursement for physicians who provide treatment.

I also am committed to improving addiction treatment by influencing policy and communicating with decisionmakers.

My experience in persuading my State's Insurance Commission to require use of the *ASAM Patient Placement Criteria* demonstrated that it is possible to achieve regulatory changes that liberalize reimbursement for addiction treatment. I will push for similar regulations in all states and for the goal of parity at the state and federal level so that the practice of addiction medicine will be reimbursed fairly. I believe that ASAM, not third parties, must set the clinical guidelines and standards for levels of care, and I will work toward that end.

I also will work to attract younger physicians to the field by working to increase the instruction on addiction medicine in all years of medical school, as well as to establish fellowships and residency programs leading to recognition of the specialty of addiction medicine.

Candidates for Director at Large (continued)

Trusandra E. Taylor, M.D.
Philadelphia, Pennsylvania

What do you consider to be your greatest contribution to ASAM and the field of addiction medicine? I have practiced addiction medicine since 1986 and consider it to be my primary specialty. I have been a member of ASAM since 1988 and was certified in addiction medicine in 1990. Presently, I am a member of ASAM's Opioid Maintenance Treatment, Practice Guidelines, Criminal Justice, and Nicotine Dependence Committees.

For the past 16 years, I have had the privilege of caring for patients with substance use disorders in a broad range of treatment settings for detoxification and psychosocial rehabilitation. My collective experiences in addiction medicine have been challenging and rewarding. My professional experience in addiction medicine also has afforded me an opportunity to work regionally with managed care in executive management, involving strategic planning and advocacy for improvements in access, delivery, and quality of care for the treatment of substance use disorders. I also have received tremendous professional satisfaction from many hours spent in providing education and training to clinicians and non-clinicians in the principles of addiction medicine.

Overall, I have committed my career to the practice of addiction medicine, which I consider is my greatest contribution to the field of addiction medicine.

How do you feel your election would benefit ASAM and the field of addiction medicine? If I am re-elected to the Board of Directors of ASAM as a Director at Large, I will continue my commitment to addiction medicine and to advocate for ASAM. I will work to carry out ASAM's Strategic Plan involving the six identified goals.

Specifically, I will focus on increasing membership in ASAM by actively campaigning and recruiting new members regionally, as well as other active participation in activities focused on membership development, involvement and recognition.

Further, I will continue my commitment to the improvement of medical education involving addiction medicine for medical students, physicians in training, and practicing physicians. I also will continue to educate other clinicians and non-clinicians about recognition of addiction as a medical disorder and the overall importance and effectiveness of treatment.

Penelope P. Ziegler, M.D., FASAM
Williamsburg, Virginia

What do you consider to be your greatest contribution to ASAM and the field of addiction medicine? I believe that my greatest contribution has been to devise strategies to address the shame-based denial systems and self-blaming defensive styles typical of women physicians, nurses, and other health care professionals with the disease of addiction.

In my clinical and advocacy work, I have observed that the techniques developed for working with male health care professionals often are ineffective when working with women. I have used opportunities within ASAM and at conferences sponsored by ASAM to encourage use of more supportive, less confrontational approaches when treating female medical professionals. I also have promoted development of treatment plans that address issues of sexual and physical trauma, psychiatric comorbidity, and shame, which are so common in this population.

How do you feel your election would benefit ASAM and the field of addiction medicine? As a Director at Large, I hope to serve the organization during a time of great challenges. Resources for treatment are decreasing in both the private and public sectors as government funding streams are cut back at the federal, state and local levels and managed care continues to reduce access to insurance benefits, even as the need and demand for treatment continue to grow. For addictionists, practice is becoming less about helping our patients and more about fighting the system and struggling against our own sense of frustration and futility.

ASAM must represent both the medical profession and the public interest by continuing to support research, education, prevention, and treatment. The ASAM Board will be at the forefront of this essential work as the new Executive Vice President/CEO assumes leadership of the Society. I also would work to maintain a focus within ASAM on the needs of special populations with addictive disorders, including women (especially pregnant women and mothers of young children); racial and ethnic minorities; gay, lesbian, bisexual and transgendered persons; individuals with HIV/AIDS and other infectious diseases; children and adolescents; and addicted persons with comorbid psychiatric illnesses.

Candidates for Director at Large Representing Osteopathic Medicine

Anthony H. Dekker, D.O., FASAM, FAOAAM
Phoenix, Arizona

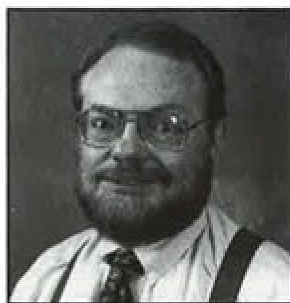
What do you consider to be your greatest contribution to ASAM and the field of addiction medicine? I have been honored to serve as Co-Director of ASAM's Ruth Fox Course for Physicians, which continues to provide clinical education and cutting edge information for addiction medicine practitioners. Since joining the American Society of Addiction Medicine in 1987, I also have been active in the Adolescent Committee and have chaired the Osteopathic Medicine Committee. I was honored to serve as the liaison member from the ASAM Board to the American Osteopathic Academy of Addiction Medicine, and recently was selected to fill the Board position left vacant by the retirement of Dr. William Vilensky.

The experience I bring to this post includes my current work as Associate Director at the Phoenix Indian Medical Center of the Indian Health Service (U.S. Public Health Service). In addition to administrative responsibilities, I am frequently called on to provide addiction medicine consultation for my own center as well as other Indian Health Service units in Arizona, Nevada, and Utah. Before joining the Indian Health Service, I practiced adolescent and addiction medicine in Chicago at the College of Osteopathic Medicine and the Rush Medical College. I also served as Director of the Adolescent and Young Adult Program and Fellowship at the Chicago Osteopathic Medical Center until 1994.

From Chicago, I moved to Kansas City, MO, where I served as Professor and Chair of the Department of Family Medicine at the University of Health Sciences-College of Osteopathic Medicine. I am board-certified by the American Osteopathic Board of Family Practice, with CAQs in adolescent and young adult medicine, sports medicine, and addiction medicine.

How do you feel your election would benefit ASAM and the field of addiction medicine? I will continue to work on enhancing the collaborative relationships between ASAM and other organizations to expand the field of addiction medicine.

My hope is that the expertise of ASAM members will become more visible and available to patients, their families, and the organizations who would benefit from our services.



Timothy L. Fischer, D.O., FASAM
Saint Matthews, South Carolina

What do you consider to be your greatest contribution to ASAM and the field of addiction medicine? My greatest contribution has been starting the South Carolina chapter of ASAM, the South Carolina Society of Addiction Medicine, or SCSAM. As founder and first President, I saw SCSAM's membership grow by almost 100% in our first two years as a chapter. Also, our society gained a seat on the Governor's Maternal, Infant and Child Health Council Substance Abuse Committee, an active role in state legislative issues, helped to pass an Omnibus Highway Safety Act, and won a contract with the Department of Alcohol and Other Drug Abuse Services (our single state agency) to provide training and conferences and to serve as a consultant to the state. As a result, ASAM members in South Carolina now have a significant voice and help to shape addiction-related policy and legislation. The chapter also works intimately with the professional recovery program for the state, and sponsors one to two conferences each year.

My goals for ASAM are to extend this success to every state, by helping every state form a state chapter. Second, I want to strengthen current chapters so that they are organizationally strong and sustaining. Many chapters are only as good as the current president. When that one is no longer president, the chapter flounders. We need each chapter to be organizationally strong so as that these valleys can be eliminated.

How do you feel your election would benefit ASAM and the field of addiction medicine? My election would benefit ASAM and the field of addiction medicine through my ability to work with people. I know how to get a group of diverse people to come together to set goals and get them accomplished.

My experience in developing public policy will benefit the addiction field by helping to change the environmental norms for alcohol, tobacco, and drug use. Specifically, I would focus on helping ASAM in the areas of organization, public relations, and public policy.

Ruth Fox Memorial Endowment Fund

Dear Colleague:

A major goal of ASAM and of the Ruth Fox Memorial Endowment Fund is to foster the development of new opportunities for physicians and residents to learn about the diagnosis and treatment of addictive disorders. In pursuit of this goal, ASAM inaugurated a program in 2002 through which interest income from the Ruth Fox Memorial Endowment Fund is used to underwrite scholarships for selected physicians-in-training to participate in the Society's annual Medical-Scientific Conference. The first seven scholarship recipients were warmly welcomed at ASAM's 2002 conference in Atlanta.

In 2003, scholarships again will be offered to physicians-in-training. Stipends will underwrite the costs of travel, hotel, registration for the Ruth Fox Course and the Medical-Scientific Conference, the ASAM Awards Dinner, a per diem, and a one-year membership in ASAM. Scholarship recipients will meet once a day with a member of the Scholarship Committee.

You can help make the 2003 program a success by encouraging young physicians to apply (use the form enclosed with this issue of **ASAM News**). Completed applications must be received by November 15, 2002.

And you can show your support of this and other educational programs of the Society by making a generous contribution to the Ruth Fox Memorial Endowment Fund. For information about making a pledge, contribution, bequest, or memorial tribute, or to discuss other types of gifts in confidence, contact Claire Osman at 1-800/257-6776 or 718/275-7766. Or e-mail Claire at ASAMCLAIRE@AOL.COM. All contributions to the Endowment Fund are tax-deductible to the full extent provided by law.

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

James W. Smith, M.D., FASAM, and Howard G. Kornfeld, M.D., Co-Chairs, Resources & Development Committee

Claire Osman, Director of Development

Dr. Ruth Fox

As of July 15, 2002

Total Pledges: $3,360,817

Leadership Circle ($5,000-$9,999)

Terry L. Alley, M.D.

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New Jersey Requires that Treatment Program Directors be ASAM-Certified

Jeanne Erdmann

Under a new state requirement, medical directors of addiction treatment programs in New Jersey must become members of ASAM and be certified by ASAM (or APA or AOAAM) within two years of assuming their posts. This groundbreaking requirement was adopted through the persistence and creativity of ASAM Board member Louis E. Baxter, Sr., M.D., FASAM, who also is Executive Medical Director of the Physician's Health Program of the Medical Society of New Jersey. Dr. Baxter also credits the hard work of his colleagues, Drs. Michael S. De Shields, Susan Neshin, and Dan Greenfield—all of whom are fellow ASAM members and enthusiastic volunteers.

Dr. Baxter explains: "We were able to accomplish this by getting involved in various committees within the state's Division of Addiction Services, such as the methadone committee, hepatitis committee, and HIV committee. As ASAM members, we slowly but surely started to espouse ASAM's philosophies and policies on various addiction medicine issues." He adds, "So much has changed in the field of addiction medicine, and many physicians have not kept up with the changes."

Armed with his own experience, knowledge gleaned from ASAM conferences, and his influence as a representative of the state medical society, Dr. Baxter challenged outdated treatment protocols. On the administrative side, he examined rules and regulations for the operation of methadone facilities, and reviewed job descriptions and qualifications of a wide range of personnel. "In reality," he explains, "some physicians who take on medical directorships on a part-time basis are really only doing it because of the money—they want to supplement their primary income. We thought it was important that the medical director should know what he or she is talking about and should be knowledgeable about addiction," he says.

Once Dr. Baxter and his colleagues convinced state health officials that ASAM is the authoritative source of information on the medical specialty of addiction medicine, they had a receptive audience. Their next step was to persuade the state to cover the cost of ASAM membership. "Treatment providers were looking for a better way to provide care," he recalls. "To have a large-scale statewide or national entity provide educational programs is really a big deal for them." As a result, 50 New Jersey physicians became ASAM members.

But the "reformers" still faced a hurdle. After the state published the requirement that medical directors of facilities become ASAM members and be ASAM-certified, some New Jersey physicians objected that out-of-state travel for continuing education and ASAM certification would impose a financial burden on them. After brainstorming, the committee asked the objecting physicians whether, if the obstacles of travel and expense were removed, they would be willing to participate. The answer was "yes." ASAM's leadership agreed to collaborate in a course open only to New Jersey physicians and ASAM staff helped to coordinate certification efforts. The state of New Jersey is paying the fee for certification, test registration, ASAM membership, and the cost of the review course, which is set for November 2002, just before the next Certification Examination.

Louis E. Baxter, Sr., M.D., FASAM

Although changes in standards and regulations brought resistance from some private owners of facilities that receive state funds, in the end, they had no choice. "Once the state makes a rule, you have to follow it," says Dr. Baxter. "There are some, I would imagine, who do not wish to become certified, and who do not wish to join ASAM, and if that's the case, I question whether or not they should be medical directors of an addiction treatment facility," he says. "On the other hand, it's been my impression that most of the physicians who are medical directors of treatment facilities are interested in pursuing ASAM membership and certification, and that makes me very happy."

Dr. Baxter encourages other ASAM members to work in their own states toward adoption of similar requirements. The first step, he says, is to volunteer for committee work. "Even though it requires a sacrifice of time, the work is rewarding personally and you can raise the standard of care by bringing your knowledge to mainstream medicine," he says. "You can have a significant impact on policy and procedures."

Today, Dr. Baxter continues to volunteer, for what he calls "selfish reasons." As it turns out, the experience changed him as well. "It helped me understand that one person or a few people can in fact make a difference, and it was very exciting to be part of the solution as opposed to just sitting on the sidelines decrying the problems."

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

Advocacy Handbook for Nonprofit Organizations

A booklet designed to help not-for-profit groups decide whether and how to be effective advocates is available at no cost from the Minnesota Council of Nonprofits. The booklet also outlines new methods to reinvigorate the approach of organizations and individuals experienced in advocacy work. Topics covered include: (1) the not-for-profit's role in shaping state and local public policy, (2) how advocacy can help fulfill an organization's mission and goals, (3) setting up systems to support advocacy efforts, (4) how to initiate, support, or defeat bills, (5) using the media to build and mobilize support, and (6) complying with federal and state regulations.

The 226-page booklet can be obtained by writing the Minnesota Council of Nonprofits, 2700 University Ave. West, Suite 20, St. Paul, MN 55114-1059, or by phoning 651/642-1904.

ASAM Conference Calendar

ASAM

July 18, 2002
Forensic Issues in Addiction Medicine
Washington, DC
8 Category 1 CME credits

September 20-22, 2002
Medical Review Officer (MRO)
Training Course
Scottsdale, AZ
20 Category 1 CME credits

October 24-26, 2002
Review Course in Addiction Medicine
& ISAM Pre-Conference Symposium
Chicago, IL
21 Category 1 CME credits

November 16, 2002
Certification/Recertification Examination
in Addiction Medicine
Atlanta, GA; Los Angeles, CA; New York, NY

May 1, 2003
Pain & Addiction: Common Threads IV
Toronto, Ontario, Canada
7.75 Category 1 CME credits

May 1, 2003
Ruth Fox Course for Physicians
Toronto, Ontario, Canada
8 Category 1 CME credits

May 2-4, 2003
34th Annual Medical-Scientific Conference
Toronto, Ontario, Canada
21 Category 1 CME credits

Other Events of Note

August 7-11, 2002
International Doctors in Alcoholics
Anonymous (IDAA) Conference
Palm Desert, CA
[For information, visit www.IDAA2002.com]

September 2002
National Alcohol and Drug Addiction
Recovery Month
(Sponsored by the Substance Abuse
and Mental Health Services Administration)
[For information, phone 1-800/729-6686]

September 15-17, 2002
Addictions 2002: Integrating Substance
Abuse Treatment & Prevention
in the Community
Eindhoven, The Netherlands
[For information, visit
www.addictions2002.com]

September 19-22, 2002
15th Cape Cod Symposium on Addictive
Disorders: Addiction as a Brain Disorder
—Prevention, Treatment and Healing
Hyannis, Cape Cod, MA
[For information, phone 1-800/767-9061 or
e-mail nriverfound@earthlink.net]

October 2-5, 2002
4th Annual Conference of the
International Society of Addiction Medicine
& SAA 25th Annual Conference
(ASAM is a supporting organization)
Reykjavik, Iceland
[For information, visit www.saa.is
or e-mail conference@saa.is]

October 16-19, 2002
International Conference on Physician
Health: "Physician Health
—Self, Service, Leadership"
(Co-sponsored by the American Medical
Association and the Canadian Medical
Association)
Vancouver, British Columbia
[For information, e-mail
Roger_Brown@ama-assn.org]

October 28-30, 2002
International Society for the Prevention
of Tobacco-Induced Diseases
First Annual Scientific Meeting
Essen, Germany
[For information, e-mail toxicol@aol.com]

November 13-15, 2002
7th Stapleford International Conference
on Addiction—From Addiction to
Abstinence: New Pharmacological
Techniques for Change
[For information, visit www.staplefordcentre.co.uk/ConferenceNov2002.htm]

For additional information, visit the ASAM web site at www.asam.org or contact the ASAM Department of Meetings and Conferences at 4601 No. Park Ave., Suite 101, Chevy Chase, MD 20815-4520, or phone 301/656-3920, or fax 301/656-3815, or e-mail BBoeg@asam.org.

Review and Update on Addiction Medicine!

October 24-26, 2002
Westin O'Hare Hotel, Chicago

Join a panel of experts in discussing the most important topics in Addiction Medicine today! Attend the ASAM Review Course in Addiction Medicine for a timely review and update of the core content of Addiction Medicine. This course is designed for:

- Physicians who are planning to sit for the ASAM Certification/ Recertification Examination in Addiction Medicine.
- Addiction specialists who seek a timely "refresher" on recent developments in addiction science and practice.

Participants will receive a Study Guide and CD-Rom containing outlines of the speakers' talks, copies of their slides, and key readings. To maximize study time for registrants who are preparing for the Certification/ Recertification Examination in Addiction Medicine, the Study Guide will be mailed September 1, 2002, to all who have registered for the Review Course by that date. The course is approved for up to **21 credit hours** in Category 1 CME Credits.

REGISTER TODAY! Phone ASAM's Department of Conferences and Meetings at 301/656-3920, or fax ASAM at 301/656-3815.

Thursday, October 24, 2002

The Scientific Basis of Addiction
Carlton K. Erickson, Ph.D.

A Review of Epidemiology
Rosa M. Crum, M.D., M.H.S.

HIV, TB, Hepatitis, and Other Infectious Diseases
Lawrence S. Brown, Jr., M.D., M.P.H., FASAM

Other Medical Complications
Edwin A. Salsitz, M.D.

Screening, Assessment, and the Medical Approach
Allan W. Graham, M.D., FACP, FASAM

Case Discussion

Friday, October 25, 2002

Optional Session: What to Expect of the Certification Examination

Alcohol Dependence and Its Management
Steven Ey, M.D.

Tobacco Dependence
Terry A. Rustin, M.D., FASAM

An Overview of Treatment
Allan W. Graham, M.D., FACP, FASAM

Opioid Dependence
Andrew Saxon, M.D.

Opioid Agonist Therapy
J. Thomas Payte, M.D.

Psychiatric Comorbidities
Andrew Saxon, M.D.

Medicolegal and Ethical Issues
Theodore V. Parran, M.D., FACP

Case Discussion

Saturday, October 26, 2002

Optional Session: A Report on Credentialing

Twelve Step Programs
John N. Chappell, M.D., FASAM

Marijuana Dependence and Its Management
Billy R. Martin, Ph.D.

Amphetamines, Methamphetamine, MDMA, and Steroids
Glen R. Hanson, Ph.D., D.D.S.

Hallucinogens, PCP, Ketamines and LSD
John Pichot, M.D.

Benzodiazepines and Other Sedative-Hypnotics
Gantt Galloway, Pharm.D.

Medical Review Officers and Workplace Issues
Donald Ian Macdonald, M.D., FASAM