Special 50th Anniversary Issue
Volume 19, Number 2

ASAM News

Newsletter of The American Society of Addiction Medicine

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This special issue of ASAM News is published to mark the Society's 50th Anniversary.

Don't miss an issue; join ASAM or renew your membership today!

www.asam.org

ASAM Celebrates Its 50th Anniversary at Annual Medical-Scientific Conference

Eileen McGrath, J.D., Executive Vice President/CEO

ASAM's 35th Annual Medical-Scientific Conference in Washington, DC, also marked the Society's 50th Anniversary. The conference was preceded by three special events—the Ruth Fox Course for Physicians, an ASAM Forum on Pain and Addiction: Common Threads, and an ASAM Legislative Day—and concluded with a Buprenorphine Training Course.

A highlight of the conference was a festive 50th Anniversary Gala on Saturday evening, April 24. At the event, ASAM bestowed awards for outstanding service on Andrea G. Barthwell, M.D., FASAM, Deputy Director of the Office of National Drug Control Policy, and Alan I. Leshner, Ph.D., former director of the National Institute on Drug Abuse. The John P. McGovern Award and Lecture on Addiction and Society, for highly meritorious contributions to public policy, was presented to David C. Lewis, M.D.

We are pleased that so many members joined us to celebrate ASAM's progress over the past 50 years, and to begin the journey that will take us forward through the next 50. For Med-Sci photos and complete coverage, watch for the June-July issue of **ASAM News**.

ASAM: *Celebrating 50 Years of Progress*

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

ASAM's 50th Anniversary invites us to appreciate how far we have come, and how far we have yet to go. Consider that 50 years ago, the field of addiction medicine did not exist. In 1954, when Ruth Fox and her associates agreed that alcoholism was a preventable and treatable disease, there were few physicians and lay persons who shared their vision. There was no infrastructure for demonstrating that addiction truly *is* a disease. There was no group of physicians within organized medicine to treat the disease, and to speak out on behalf of the patients who suffered from it. All that existed was a handful of men and women who believed that alcoholism is a disease that is both preventable and treatable.

Those were the days of "drunk tanks," when public inebriates were locked up in jail, when alcoholics were committed to mental asylums, and when hospital bylaws expressly forbade the admission of alcoholics. In those days, nearly everyone—physicians and laypersons alike—felt that alcoholism and other drug addictions were moral weaknesses. The federal and state governments had little, if any, interest. And there certainly was no concept of a special field called "addiction medicine."

Yet that small handful of pioneers—led by Ruth Fox, Stan Gitlow, LeClair Bissell, Percy Ryberg, Marty Mann, Brinkley Smithers and others—held a conviction that impelled them to action. As a result, 50 years later, we have two Institutes of the National Institutes of Health dedicated to research on the addictions: the National Institute on Alcohol Abuse and Alcoholism (NIAAA) and the National Institute on Drug Abuse (NIDA). We have the federal Center for Substance Abuse Prevention, and a federal agency, the Center for Substance Abuse Treatment (headed by an ASAM member), whose mission is to improve access to and the effectiveness of addiction treatment. We have a special office in the White House, the Office of National Drug Control Policy, to provide coordination and national leadership.

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American Society of Addiction Medicine
4601 North Park Ave., Suite 101
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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).

ASAM: *Celebrating 50 Years of Progress*

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

Today ASAM is a vibrant national organization of more than 3,000 members—physicians who are dedicated to the belief that the treatment of addiction should be granted parity with the treatment of any other chronic medical disorder, that all physicians should receive education in addiction medicine, and that physicians who wish should be trained and board-certified in addiction medicine.

In 1954, when our colleagues organized as the New York Medical Society on Alcoholism and held their first scientific meeting, fewer than 25 persons registered. At this year's ASAM Medical-Scientific Conference, we expect close to 1,000 persons to register.

In 1954, there was no textbook in addiction medicine. In 2003, ASAM published the Third Edition of its *Principles of Addiction Medicine*, which in 1,600 pages reflects the vast body of scientific knowledge in this field.

In 1954, there were no national guidelines for determining the need for treatment and the appropriate level of treatment. Today, the *ASAM Patient Placement Criteria* are required or recommended many states and by an increasing number of managed care companies.

In 1954, there were no practice guidelines. Today, ASAM has published two guidelines in *JAMA*, with three more nearing completion.

None of these accomplishments came easily. Each required the concerted effort of many dedicated individuals. But the results of their struggles have improved the lives of countless patients and their families. So too will our efforts to overcome the challenges that confront us today. A brief review of the distance we have traveled should give us confidence as we move forward.

The 1950s: *Founding the Movement*

The New York Medical Society on Alcoholism held its first annual meeting in September 1954, with 14 physicians in attendance. The group was organized by Ruth Fox, M.D. (who was elected its first president), Stanley Gitlow, M.D., and Percy Ryberg, M.D. Dr. Fox had found that alcoholic patients in her practice did not respond to conventional psychoanalytic approaches, so she began to teach them about alcoholism as a disease, introduced them to Alcoholics Anonymous, prescribed Antabuse®, and used group therapy and psychodrama as therapeutic modalities.

The 1960s: *Becoming a National Presence*

In 1967, the New York group—approaching 100 members—changed its name to the American Medical Society on Alcoholism (AMSA) and resolved to "henceforth be a national organization." This momentous change was reported in the *Physicians' Alcohol Newsletter*, published by the Society from 1965 to 1978 under the editorship of Frank Seixas, M.D. The group conducted its first national meeting in 1968 at the offices of the Medical Society of the District of Columbia.

The 1970s: *Years of Growth*

By 1970, AMSA's membership had reached 500. In California, Jess Bromley, M.D., and Gail Jara organized the California Society for the Treatment of Alcoholism and Other Drug Dependencies (now the California Society of Addiction Medicine) in 1973.

Thanks to the leadership of Sen. Harold Hughes and other advocates, Congress created the National Institute on Alcohol Abuse and Alcoholism in 1971 and the National Institute on Drug Abuse in 1974, and approved the Career Teacher Program to encourage development of a cadre of medical school faculty knowledgeable about alcohol and drug addictions.

The 1980s: *Unifying the Field*

By the early 1980s, there were three distinct national efforts in addiction medicine: AMSA, which had grown out of the New York Society, the California Society, and the American Academy of Addictionology, organized in Atlanta, Georgia, by G. Douglas Talbott, M.D., FASAM, to focus on treating impaired physicians and other health professionals. At the suggestion of Emanuel M. Steindler of the American Medical Association, leaders of the

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three groups agreed to meet to discuss a joint credentialing effort. Joan Kroc (wife of Ray Kroc, owner of the McDonald's fast food chain) offered the use of the Kroc Ranch in Santa Barbara, CA (adjacent to President Reagan's Rancho del Cielo) as the site of the meetings, which were funded with the help of the AMA. Two "Unity Meetings" at the Kroc Ranch in 1983 brought together leaders of the New York, Georgia, and California organizations with representatives of NIAAA, NIDA, the American Psychiatric Association, and other interested groups. The meetings resulted in agreement that there ought to be a "national society of physicians" concerned with alcohol and drug addiction.

AMSA changed its name to the American Medical Society on Alcoholism and Other Drug Dependencies (AMSAODD) as its membership reached 1,400. The organization acquired a full-time staff and two offices, as Mr. Steindler retired from the AMA and assumed the role of AMSAODD Executive Director in Chicago, while Claire Osman staffed an administrative office in New York. And the newsletter was reborn as *ASAM News*, under the editorship of Lucy Barry Robe.

Meanwhile, the California Society offered its first certification examination in 1983, followed by the new national society in 1986.

The addiction field took a major step toward unifying with organized medicine in 1988, when the American Medical Association voted to admit AMSAODD representatives to its House of Delegates. Jess Bromley, M.D., served as the society's first delegate to the AMA, with David E. Smith, M.D., FASAM, as alternate delegate.

ASAM assumed its current identity in 1989, when AMSAODD members voted to change the group's name to the American Society of Addiction Medicine. Also in 1989, Mr. Steindler retired as Executive Director and was replaced by Dr. James F. Callahan, who established ASAM's headquarters office in Washington, DC. In the same year, ASAM chartered its first state chapters in Florida, Georgia, and Maryland, while the California Society agreed to become a state affiliate.

The 1990s: *Striving Toward Excellence*

In 1990, the AMA officially recognized addiction medicine as a medical specialty. From that moment, addiction medicine has gained wide recognition as a primary medical specialty, and ASAM certification in addiction medicine has become accepted as the equivalent of board certification. For example, in 1996, the National Committee on Quality Assurance (NCQA)—the body that accredits managed care organizations—recognized that physicians certified in addiction medicine are eligible treatment providers for addictive disorders. And in 2000, President Clinton signed into law the Addictions Treatment Act, which affirms that physicians certified in addiction medicine by the American Society of Addiction Medicine are recognized as qualified providers to prescribe for treatment of opiate dependence.

Throughout the 1990s, ASAM demonstrated its commitment to achieving excellence in clinical care and recognition of addiction medicine as a field of medical specialization in multiple ways. In 1992, the Society took part in the national health care reform agenda by creating a Task Force on Health Care Reform under the leadership of Sheila B. Blume, M.D., FASAM. It also formed a coalition of national organizations and federal agencies to refine and promote the use of its *Patient Placement Criteria*. By 1993, ASAM completed work on its "Core Benefit in Addiction Treatment," which it submitted to the White House for consideration by the President's Task Force on National Health Care Reform.

ASAM achieved another landmark in 1994 with publication of the first edition of its landmark textbook, *Principles of Addiction Medicine*, under the editorship of Norman Miller, M.D., FASAM. A second edition of *Principles* was published in 1998 under the editorship of Allan W. Graham, M.D., FASAM, and Terry K. Schultz, M.D., FASAM. Supported by grants from the McGovern and Scaife Foundations, ASAM sent copies of *Principles* to the chairpersons of medicine, family practice and psychiatry, and medical librarians in every medical school in the country.

The Society expanded its certification program in 1994 when it offered its first recertification examination, and inaugurated the Fellows program to recognize members who have made outstanding contributions to the Society and the field of addiction medicine.

Over the decade, ASAM expanded its Education, Certification, Standards and Economics of Care, Treatment and Clinical Issues, Membership and Publication programs, with the help of grants from public and private funders. It also raised $3 million through the Ruth Fox Memorial Endowment Fund.

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

ASAM PRESIDENTS

1954-1961: Ruth Fox, M.D.
1961-1962: Stanley E. Gitlow, M.D., FASAM
1963-1964: Luther A. Cloud, M.D.
1965-1966: Percy E. Ryberg, M.D.
1967-1968: Arnold S. Zentner, M.D.
1969-1970: Ruth Fox, M.D.
1971-1972: Stanley E. Gitlow, M.D., FASAM
1973-1974: Maxwell E. Weisman, M.D.
1975-1976: Charles S. Lieber, M.D.
1977-1978: Joseph Zuska, M.D.
1979-1980: Sheila B. Blume, M.D., FASAM
1981-1982: LeClair Bissell, M.D.
1983-1984: Irvin Blose, M.D.
1985-1986: Max A. Schneider, M.D., FASAM
1987-1988: Margaret Bean-Bayog, M.D.
1989-1990: Jasper Chen-See, M.D.
1991-1992: Anthony B. Radcliffe, M.D., FASAM
1993-1994: Anne Geller, M.D., FASAM
1995-1996: David E. Smith, M.D., FASAM
1997-1998: G. Douglas Talbott, M.D., FASAM
1999-2000: Marc Galanter, M.D., FASAM
2001-2002: Andrea G. Barthwell, M.D., FASAM
2002-2005: Lawrence S. Brown, Jr., M.D., M.P.H., FASAM

Into the New Century

Entering the new century, ASAM has established itself as the preeminent organization for physicians specializing in addiction medicine. With xx chartered State Chapters and 3,200 members, ASAM has become a national voice for the interests of addiction specialists and the patients in their care. Now we are taking the next step: with funding support from the John J. McGovern, M.D., Foundation and under the direction of retired ASAM EVP James F. Callahan, D.P.A., ASAM has created a State Medical Specialty Society Program to help the state chapters become self-supporting, fully functioning state medical specialty societies.

ASAM will offer its Certification Examination in three cities in 2004. ASAM staff have redesigned the application forms, booklets, and promotional materials to attract more applicants to the exam and reduce administrative expenses. This was accompanied by development of a comprehensive certification section—including a directory of ASAM-certified physicians—on the Society's web site (WWW.ASAM.ORG) to increase awareness of the exam and provide timely information to examinees. To date, ASAM has certified more than 3,500 physicians in addiction medicine, and recertified another 300. (The Canadian Society of Addiction Medicine has certified an additional 35 physicians.) For the current examination cycle, the Board has approved an alternate pathway to certification for physicians who have not completed an ACGME-approved residency training program. Moreover, the National Committee for Quality Assurance has recognized physicians certified by ASAM as providers in managed behavioral health care organizations.

The U.S. Department of Defense has adopted ASAM's *Patient Placement Criteria*, as have the alcohol and drug treatment agencies in more than 20 states. ASAM's practice guidelines have been published in the *Journal of the American Medical Association*, and the ASAM web site, launched through the tireless efforts of William Hawthorne, M.D., FASAM, has won awards for its design and contents and attracted more than 50,000 visitors. The Society also continues to publish its scholarly *Journal of Addictive Diseases* under the editorship of Barry Stimmel, M.D., FASAM.

The Third Edition of ASAM's flagship publication, *Principles of Addiction Medicine*, was published in 2003 to wide acclaim. A review in the *Journal of the American Medical Association* called the text "detailed, practical, and clearly written," and said that it is "an essential resource" for physicians, nurse practitioners, social workers, and addiction counselors, as well as managers and supervisors of addiction treatment programs.

Founding member Ruth Fox, M.D.

Founding member LeClair Bissell, M.D.

AMSA Administrator Claire Osman (now ASAM's Director of Development) with founding member Percy Ryberg, M.D.

ASAM's first delegation to the AMA House of Delegates: Jess W. Bromley, M.D., and ASAM Past President David E. Smith, M.D., FASAM

ASAM's first Executive Director, Emanuel M. Steindler

ASAM's second Executive Vice President/CEO, James F. Callahan, D.P.A.

ASAM's current Executive Vice President/CEO, Eileen McGrath, J.D.

Public policy remains a key ASAM activity, as ASAM continues to work with private-sector organizations such as the American Managed Behavioral Healthcare Association as well as federal agencies and members of Congress. In recent years, the ASAM Board has approved policy statements on the management of pain, the use of opioids, screening for addiction in primary care settings, and the relationship between self-help programs and formal addiction treatment. ASAM also played a major role in the legislative, regulatory and court battles against tobacco addiction. In 1999, ASAM persuaded the Internal Revenue Service to reverse a 20-year-old position by allowing smokers who participate in cessation programs to itemize the cost of their treatment as a medical expense. ASAM also is working vigorously to attain parity in health care benefits for addiction services. For example, following a very successful initial effort, ASAM's second Legislative Day takes place April 21, immediately preceding the Medical-Scientific Conference. Once again, ASAM members will meet with their members of Congress to advocate for parity, including: (1) full access to treatment for patients and their families, equal to access given for other diseases; (2) reimbursement to physicians who provide treatment; and (3) the opportunity for physicians to be trained as specialists in addiction medicine. Parity thus is a three-part concept, and we will not have true parity until all three parts are realized.

ASAM's relationship with the American Medical Association continues to be productive, as Stuart Gitlow, M.D., and Lloyd Gordon III, M.D., FASAM, ably represent the Society in the AMA House of Delegates. With the collaboration of Michael M. Miller, M.D., FASAM, who represents the Wisconsin Medical Society but works closely with the ASAM delegation, Dr. Gitlow and Dr. Gordon have had influence on all AMA reports and policy statements, including groundbreaking initiatives on alcohol, nicotine, and other addictive agents. In addition, Dr. Gordon recently was appointed chair of the AMA's Task Force on Alcohol.

With guidance and support from ASAM, the International Society of Addiction Medicine formally came into being in 1999, at a meeting hosted by President and Mrs. Gerald Ford and keynoted by General Barry McCaffrey, then Director of the Office of National Drug Control Policy. Delegates from over 25 countries elected Nady el-Guebaly, M.D., first President of the new organization, and G. Douglas Talbott, M.D., FASAM, Vice President. The group now meets annually,

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Founding member Stanley E. Gitlow, M.D., FASAM

. . . THE NINETEEN SEVENTIES . . . . . THE EIGHTIES . . .

Senior editor Terry K. Schultz, M.D., FASAM (right) presents a copy of ASAM's textbook, Principles of Addiction Medicine, to ASAM member Enoch Gordis, M.D., former Director of NIAAA

Senior editor David Mee-Lee, M.D., shows off a copy of ASAM's Patient Placement Criteria

Benefactor Adele Smithers-Fornaci accepts an award from ASAM Immediate Past President Marc Galanter, M.D., FASAM, acknowledging the generous support of the Smithers Foundation for ASAM's educational mission

with the sixth such meeting scheduled for Helsinki, Finland, in June 2004.

A special Task Force, chaired by Richard Tremblay, M.D., FASAM, created a Strategic Plan for ASAM through a careful process that involved gathering input from members and identifying future challenges and opportunities for the Society. Board members assigned priorities to the various strategies and appointed an Implementation Committee, chaired by Lloyd J. Gordon III, M.D., FASAM, to guide completion of the plan.

One of my priorities as ASAM President has been to realign our governance structure to conform to the Strategic Plan. Ihrough the leadership of Louis Baxter, Sr., M.D., FASAM, Region IV Director, Board member, and Chair of the Constitution & Bylaws Council, the Board has approved amendments to achieve this realignment. Each committee associated with an ASAM product now is required to submit standard operating procedures for approval by the Board. In this way, the Board—the elected governance vehicle of the society, responsible for meeting member needs and wants—can ensure that the organization is positioned to reach our goals.

Following Jim Callahan's retirement in 2002, Eileen McGrath, J.D., became ASAM's Executive Vice President and CEO.

Benefactor John P. McGovern, M.D., whose grants have supported ASAM's outreach to educational institutions and the development of state societies

ASAM's vision and mission will not be achieved without strategic action on our part, and on the part of those who come after us. Today, our actions must be focused on parity, for that is today's opportunity. Each of our members must work for parity within their states and other medical societies. Your Society will work, too, at the national level, to have parity legislation passed in the Congress, and to have managed care organization policies changed to provide for parity.

To help us achieve these goals, ASAM has an intelligent, well-trained and dedicated staff, led by Ms. McGrath—a highly qualified Executive Vice President with a proven track record, who is effectively managing the Society and working in partnership with the officers and Board.

No doubt challenges lie ahead that will require our sustained commitment. But looking back at all that has been accomplished through the efforts of a group of visionary physicians, how can we do other than to meet the future with a sense of optimism?

ASAM Past President G. Douglas Talbott, M.D., FASAM, meets with Gen. Barry McCaffrey, then Director of the Office of National Drug Control Policy

ASAM Past President Andrea G. Barthwell, M.D., FASAM, now Deputy Director for Demand Reduction in the Office of National Drug Control Policy, shares an insight with Stuart Gitlow, M.D., ASAM's current delegate to the AMA House of Delegates

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Please see Full Prescribing Information on adjacent page.

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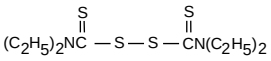

$C_{10}H_{20}N_2S_4$ M.W. 296.54

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 occurring in the blood may be 5 to 10 times higher than that found during metabolism of the same amount of alcohol alone.

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

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

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

INDICATIONS 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.

References: 1. O'Farrell TJ, Allen JP, Litten RZ. Disulfiram (Antabuse) contracts in the treatment of alcoholism. *NIDA Res Monogr.* 1995;150:65-91. **2.** Chick J, Gough K, Falkowski W, et al. Disulfiram treatment of alcoholism. *Br J Psychiatry.* 1992;161:84-89.

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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 PIOPA-521

ASAM's Strategic Plan In Action

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

Dr. Baxter

One of the goals articulated in ASAM's Strategic Plan is the development and implementation of programs to educate physicians and the general public about the addictions. The overarching goal is to weave addiction medicine and its issues into the general fabric of mainstream medicine. When this is accomplished, addictive disorders and the physicians who treat them will receive the same serious consideration now accorded other chronic diseases.

In keeping with this component of ASAM's Strategic Plan, the New Jersey Society of Addiction Medicine (NJSAM) co-sponsored a half-day educational program for primary care providers in May 2004, in concert with the Physicians' Health Program of the Medical Society of New Jersey. Assistance also was provided by the New Jersey Department of Health and Human Services' Division of Addiction Services. The course, entitled "Addiction Medicine for the Primary Care Provider," targeted primary care physicians, as well as addiction counselors, nurses, dentists, pharmacists, psychologists, and pharmaceutical company representatives.

The Course

The course had its genesis nearly two years ago, as NJSAM's CME Committee was planning its first Review Course for addiction medicine physicians who planned to sit for the 2002 ASAM Certification Examination. At that time, it was suggested that an educational program for non-specialists in addiction medicine also would be useful. The organizers' objectives were quite clear, and supported ASAM's Strategic Plan: (1) to define addiction medicine as a specialty, (2) to explain how addictive disorders affect general medical care, (3) to explore special issues in patient management (such as the management of pain or pregnancy in addicted patients), (4) to describe the appropriate treatment of addictive disorders, and (5) to offer an opportunity for providers to meet each other and develop future referral networks.

In the resulting course, these issues were addressed in lectures on "Addiction Medicine 101," "Medical Complications in Substance Use Disorders," and "The Use of Buprenorphine in Office Practice." The faculty consisted of NJSAM President Michael DeShields, M.D., Edward Reading, Ph.D., LCADC, Assistant Director of the Physician's Health Program of New Jersey, and Louis E. Baxter, Sr., M.D., FASAM, Course Director.

The Results

Participants' evaluations indicate that the planning committee's goals were met. A certified addiction counselor called the quality and depth of information presented "extraordinary." Primary care physicians in attendance said they found the course enlightening and use the information presented in their practices; in fact, many participants said what they had learned would change the way they practice. Still others said they benefited most from the opportunity to network with other attendees representing multiple disciplines.

The Lesson

The New Jersey course is only one example of what an organized, active state society can accomplish by effectively employing ASAM's Strategic Plan. ASAM's chapters are well-situated to bring together many stakeholders in addiction treatment who ordinarily would not meet. Such stakeholders include academic educators, addiction medicine specialists, primary care providers, and state government officials. Addiction specialists find such sessions helpful in developing the network of services they need to provide effective outpatient addiction treatment today. Educational events organized by state societies also provide an opportunity to disseminate policies and practice guidelines developed or approved by ASAM, and they are helpful in alerting ASAM members to practice and career opportunities.

ASAM's state chapters thus have an extraordinary opportunity and a responsibility to advance the field of addiction medicine as a specialty. Through the development of a strong infrastructure and leadership, state societies can begin to provide consultative services and support to state alcohol and drug abuse agencies, other state authorities, and legislative committees concerning vital issues such as parity in treatment benefits. This can only happen, however, if individual members become involved. Now is the time to join ASAM and to get activated!

For additional information on this or other NJSAM programs, contact Chapter Administrator Linda Pleva by phone at 609/896-1766, ext. 206, or by email at NJSAM5@HOTMAIL.COM. Dr. Baxter is Executive Medical Director of the Physician's Health Program, Medical Society of New Jersey. He also represents Region IV on the ASAM Board of Directors.

REGION VII CONFERENCE RESCHEDULED

The Second Annual Conference to be hosted by Region VII (Arkansas, Iowa, Kansas, Louisiana, Missouri, Nebraska, Oklahoma, Texas) has been rescheduled to September 17-18, 2004, in San Antonio, Texas.

Program information is available from Region VII Administrator Lisa Stolier by email at ESTOLIER@BELLSOUTH.NET.

SAMHSA: Buprenorphine Guide Released

In a press conference at ASAM's annual Medical-Scientific Conference, officials of the Substance Abuse and Mental Health Services Administration (SAMHSA) announced publication of Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction. The volume is the 40th in SAMHSA's Treatment Improvement Protocol (TIP) series.

In making the announcement, ASAM member H. Westley Clark, M.D., J.D., M.P.H., FASAM, who directs the Center for Substance Abuse Treatment, said that the new TIP will become the basis for training thousands of physicians in the United States to use buprenorphine to treat patients addicted to heroin and prescription pain medications such as oxycodone, hydrocodone or meperidine.

The guide is a consensus document produced by a panel of expert researchers and clinicians. "The TIP process brought together the best and brightest in addiction medicine to provide the general medical world with the tools needed to help thousands of patients who are addicted to prescription pain medications or heroin," Dr. Clark said.

TIP 40 contains detailed protocols for use of buprenorphine under a variety of clinical scenarios. It also covers screening, assessment, and diagnosis of opioid addiction and associated problems; determining whether buprenorphine is an appropriate treatment option; and referring patients to professionals who can provide the counseling and participation in self-help programs that should accompany medication therapy. The TIP also provides guidance for physicians who need to know how to use buprenorphine with patients who have co-occurring pain or psychological disorders, or addiction to more than one substance.

TIP 40 will be available in June at SAMHSA's clearinghouse; to order, phone 1-800/729-6686.

USPSTF: Guidelines Support Alcohol Screening

Revised guidelines for screening adults for alcohol-related problems have been published by the U.S. Preventive Services Task Force (USPSTF). The guidelines recommend screening and behavioral counseling in primary care settings to reduce alcohol misuse by adults, including pregnant women.

The USPSTF based its recommendations on evidence that screening in primary care settings can accurately identify patients whose levels or patterns of alcohol consumption do not meet criteria for alcohol dependence, but place them at risk for alcohol-related morbidity and mortality. The Task Force also found evidence that brief behavioral counseling interventions with follow-up is associated with small to moderate reductions in alcohol consumption, and that reduced alcohol intake is sustained for at least six to 12 months and, in some studies, positive health outcomes four or more years later. Effective behavioral interventions were defined as involving an initial 15-minute counseling session, feedback, advice, goal-setting, assistance, and follow-up.

The guidelines identify suitable screening instruments as the Alcohol Use Disorders Identification Test (AUDIT) and the four-item CAGE. Screening tests recommended for use in pregnant women include the TWEAK and T-ACE. Because safe levels of alcohol consumption during pregnancy, if any, are unknown, the Task Force advised that pregnant women should be counseled to abstain completely. *[Editor's note: Detailed information on screening techniques and instruments, as well as brief interventions, is found in Section 3 of ASAM's textbook, Principles of Addiction Medicine, Third Edition.]* *Source: Annals of Internal Medicine, April 6, 2004.*

HHS: Increase in Agency Funding Proposed

Tommy Thompson, Secretary of Health and Human Services (HHS), has released the Administration's proposed health budget for FY 2005. While many non-defense, non-homeland security discretionary programs face either cuts or level funding, the Bush administration has proposed significant increases for alcohol and drug programs. Specific amounts include:

- *Substance Abuse Prevention and Treatment (SAPT) Block Grant:* $1.832 billion (a $53 million increase over the $1.779 billion allocated in FY 2004).
- *Center for Substance Abuse Treatment (CSAT):* $517 million (an increase of $98 million over FY 2004), plus an additional $100 million for the Access to Recovery voucher program.
- *Center for Substance Abuse Prevention (CSAP):* $196 million (down from $199 million in FY 2004).
- *National Institute on Drug Abuse (NIDA):* $1.019 billion (an increase of approximately $28 million over FY 2004).
- *National Institute on Alcohol Abuse and Alcoholism (NIAAA):* $442 million (an increase of approximately $13 million over FY 2004).

All appropriations requests must be submitted to the Congress, where they receive close scrutiny from the various appropriations committees. Updates on the Substance Abuse and Mental Health Services Administration (SAMHSA) budget are available at http://www.samhsa.gov/funding/funding.html. *Source: National Association of State Alcohol and Drug Abuse Directors, March 13, 2004.*

NHTSA: Coalition on Impaired Driving Organized

A coalition organized by the National Highway Traffic Safety Administration (NHTSA) aims to raise awareness about alcohol-impaired driving and the need for more physician intervention. The coalition, known as "Our United Response to Preventing Alcohol Related Tragedies" (O.U.R.P.A.R.T.), is led by physicians, nurses and emergency medical service personnel. "We believe the coalition will be a highly effective way to disseminate key messages around impaired driving in order to modify driver behavior and increase physician-screening practices," said William Kootsikas, acting regional administrator for NHTSA Region IV.

NHTSA has set a goal to reduce annual alcohol-impaired traffic fatalities to 0.53 per 100 million vehicle miles traveled by the end of 2004. *Source: NHTSA press release.*

NIAAA HAS NEW ADDRESS

The National Institute on Alcohol Abuse and Alcoholism (NIAAA) has moved its offices to 5635 Fishers Lane, Bethesda, MD 20892-9304.

Staff telephone numbers are unchanged.

Nominating Petitions Being Accepted for ASAM Officer, Board Positions

Marc Galanter, M.D., FASAM, Nominating & Awards Council

ASAM members are invited to nominate candidates for Officer and Board positions to be voted in December 2004 balloting. Nominations for President-Elect, Secretary, or Treasurer require at least 100 signatures from active members of the Society. Nominations for Regional Director required at least 25 signatures of active members who reside the Region. Before initiating a petition, those who wish to nominate an individual by petition should determine whether he or she (1) wishes to be a candidate and (2) meets the qualifications stipulated in the Society's Constitution and By-laws, as follows:

Officer Nominees

Candidates for the position of President-Elect, Secretary, or Treasurer must have served on the Board of Directors within the past four years (except that a nominee for Treasurer may be from the general membership if he or she has qualifications for the position and has served on the Finance Committee within the past four years).

Regional Director Nominees

Candidates for Regional Director must have been active members of ASAM for at least three years; must have demonstrated a commitment to ASAM's mission through service on a committee, task force, or other significant national or state endeavor; and must be willing to attend two Board meetings a year at his or her own expense.

Schedule

Nominating petitions must be received at the Society's headquarters office no later than July 1, 2004. Profiles of the candidates will be published in a future issue of **ASAM News**.

Ballots will be mailed to members in good standing by November 1, 2004, and must be completed and returned by December 1. In addition to a ballot, the election packages will contain campaign statements, biographical sketches and photos of the candidates. ASAM's campaign guidelines prohibit the use of "restricted or unrestricted written or electronic communication" by candidates or their advocates. Election results will be announced in the January-February 2005 issue of **ASAM News**.

If you have not already done so, be sure to renew your ASAM membership so that you are eligible to vote!

CERTIFICATION & TRAINING

ASAM Offers Review of Addiction Medicine

The ASAM Review Course in Addiction Medicine will be held November 4-6, 2004, at the Sheraton Centre Hotel, Toronto, Ontario, Canada. Co-chaired by Shannon Miller, M.D., CMRO, FASAM, and Edwin Salsitz, M.D., FASAM, the course is approved for up to 21 hours of Category 1 CME credit. It is designed for several audiences:

- Physicians who are planning to sit for the 2004 ASAM Certification/Recertification Examination.
- Addiction specialists who seek an update on recent developments in addiction practice.
- Primary care physicians, nurses, counselors and others who seek a succinct review of the knowledge needed to successfully identify and manage patients whose problems are caused or exacerbated by alcohol, tobacco or other drug use.

ASAM's textbook, *Principles of Addiction Medicine*, is the basic text for the course and must be purchased separately (phone 1-800/844-8948). As a supplement to *Principles*, Review Course registrants will receive the 2004 Study Guide (with accompanying CD-Rom), containing key readings, sample questions from past examinations, and other study aids. The Study Guide will be mailed September 1, 2004, to all persons who have registered for the course by that date. Late registrants will be sent the Guide as their registrations are received.

Questions about the Review Course or Study Guide should be emailed to REVIEWCOURSE@AOL.COM. To register for the course, check the box on the application form for the Certification/Recertification Examination, visit ASAM's web site (WWW.ASAM.ORG), or phone ASAM's Department of Meetings and Conferences at 301/656-3920. The course fee is $375 for ASAM members and $450 for nonmembers. Space is limited, so register today!

COVER THE UNINSURED WEEK IS MAY 10-16

ASAM is joining the AMA, the Robert Wood Johnson Foundation, and more than 150 other national organizations in supporting "Cover the Uninsured Week," the nation's largest coordinated effort to promote the goal of health coverage for all Americans. Co-chaired by former Presidents Gerald Ford and Jimmy Carter, the week-long series of national and local activities is part of a year-round, nonpartisan effort to make it a national priority to find solutions for the nearly 44 million Americans who have no health coverage. Current statistics show that 8 out of 10 Americans who lack health insurance are in working families. In 2002, the number of persons without health coverage increased by more than 2 million, the largest one-year increase in a decade.

Cover the Uninsured Week activities are designed to highlight the issue, demonstrate broad support for coverage for all Americans and, in some cases, offer direct assistance to the uninsured. For example, the campaign has set up a toll-free hotline that will provide information in English and Spanish about low-cost or free health coverage, discounted or free pharmaceuticals, and the locations of community health centers and free clinics.

ASAM members are invited to join the members of many other national organizations in working with Cover the Uninsured Week field staff in their local communities (a list of local and national field staff can be found at WWW.COVERTHEUNINSUREDWEEK.ORG/FIELD). Also, free Cover the Uninsured Week materials can be viewed, downloaded and ordered at WWW.COVERTHEUNINSUREDWEEK.ORG/MATERIALS.

Addiction and the Law

Peter J. Cohen, M.D., J.D., has published a text that deals comprehensively with important medical, legal, and political aspects of illegal drug use in the United States. Titled *Drugs, Addiction, and the Law: Policy, Politics, and Public Health*, the book engages in a discussion of the major legal, medical, ethical, political, and policy considerations faced by society as it deals with issues related to substance use, misuse and addiction.

Readers are challenged by topics such as (1) a comparison of "legal" and "scientific" reasoning; (2) the history and science of addiction; (3) balancing individual liberties and autonomy with the needs of society (an analysis demanded by the medical and legal discipline of public health); (4) the role of criminalization as a tool to control what many believe to be a medical problem; (5) applying disability law to addiction; (6) "legitimizing" the use of smoked marijuana for medical purposes; and (7) the concept that if addiction is a public health problem, it should be amenable to therapy similar to other medical conditions and should receive parity in regulation, treatment, and research.

The book is published by Carolina Academic Press, Durham, NC, and is available through university booksellers and Amazon.com.

Professional Impairment

A chapter on "Health Care Professional Impairment," co-authored by Louis E. Baxter, Sr., M.D., FASAM, has been published in a new textbook from the American College of Legal Medicine, entitled *Legal Medicine, 6th Edition*. Dr. Baxter and co-author Mark F. Seltzer, Esq., wrote the chapter to provide impaired physicians and their advocates with expert advice on issues such as licensure, employment reinstatement, medical liability insurance, and recredentialing.

Dr. Baxter notes that "the mere publication of such a chapter by another entity, not immediately related to the addiction medicine field, accepting and addressing the issues of addiction in general and the issues of health care professional impairment in particular, signal the acceptance of the ideals and precepts that ASAM has been working to achieve over the past 50 years. ASAM members have an extraordinary opportunity to impact other fields of medicine and professional practice with the evidence-based ideas, practices, and policies that the field of addiction medicine has developed and that ASAM endorses."

Directory of Treatment Programs

The Substance Abuse and Mental Health Services Administration (SAMHSA) has published the *2004 edition of its National Directory of Drug and Alcohol Abuse Treatment Programs*. The new edition provides current information on more than 11,000 substance abuse treatment programs nationwide.

Designed to facilitate quick access to key program data, the directory contains information on:

- Types of services provided: detoxification, treatment, methadone, or halfway house;
- Levels of care offered: outpatient, residential, and hospital inpatient;
- Types of payment accepted;
- Any special language services provided, such as assistance for hearing impaired or non-English speakers.
- Availability of programs for special populations, such as adolescents, seniors, women or men only, or criminal justice populations.
- Contact information for state-level substance abuse treatment agencies.

The directory complements SAMHSA's Internet-based Substance Abuse Treatment Facility Locator. The Internet-based service, which is updated continuously, provides road maps to the nearest treatment facilities, as well as addresses, phone numbers and information on services available. Through this service, both public and private addiction treatment facilities in any state, city or community anywhere in the nation are easily located by following simple instructions at the Treatment Locator web site http://findtreatment.samhsa.gov.

To obtain a free copy of the National Directory of Drug and Alcohol Abuse Treatment Programs 2004, contact SAMHSA's National Clearinghouse for Alcohol and Drug Information, PO Box 2345, Rockville, MD 20847, or phone NCADI at 1-800/729-6686.

WARNING TO ASAM MEMBERS: THE NIGERIAN SCAM

The so-called "Nigerian scam," which has been around for decades, has reached epidemic proportions, according to the Federal Trade Commission (FTC). Agency staff report that some consumers are receiving dozens of email offers a day from supposed Nigerian dignitaries, who promise huge profits in exchange for help in moving funds out of Nigeria. Consumers who respond may even receive official-looking documents and invitations to travel to Nigeria or a bordering country to complete the transaction.

FTC staff caution that anyone tempted to respond to such an offer should ask two important questions:

(1) Why would a perfect stranger offer to share a fortune with you? and

(2) Why would you share your personal or business information—including banking information—with a perfect stranger?

Moreover, the U.S. Department of State advises against travel to the destinations mentioned in the scams, warning that individuals who have done so have been subject to threats and extortion, beatings, and even murder.

ASAM members who receive one of these appeals are urged to forward it to the FTC at UCE@FTC.GOV. If you have lost money to such a scheme, call your local Secret Service field office, or phone 202/406-5572 for more information. ASAM is cooperating with the Secret Service in its efforts to shut down the scammers and has taken a number of steps to protect Society members, including controlling distribution of the Membership Directory.

Students Launch Advocacy Initiative

A group of medical, nursing and physician assistant students at schools across the country have launched a student-run, student-created web site, www.hpssat.org, as part of an advocacy effort to improve addiction prevention and treatment training on their campuses. The newly formed group, Health Professional Students for Substance Abuse Training (HPSSAT), has created the web site as a tool for empowering students to advocate for more substance abuse training at their schools and increasing students' access to educational resources. The site facilitates "one stop shopping" for information about curriculum development, state and national news, and educational opportunities.

"As medical students, we're taught to identify and treat diseases, but not always their underlying causes," said Jennifer Lee, a second-year student at Brown Medical School and HPSSAT member. "By the time we graduate, we may know the treatment for acute pancreatitis, but we won't necessarily have been taught anything about treating the drinking problem that caused it. HPSSAT is taking the steps toward changing that."

Studies show that this change is needed. At present, only 8% of U.S. medical schools include an addiction medicine component in the curriculum. Additionally, the primary source of adolescent referrals for the treatment of alcohol or drug problems is the juvenile justice system; health care providers represent just 5% of referrals.

In addition to creating the web site, HPSSAT members have initiated a range of activities on their campuses—hosting lectures, forming student interest groups and committees on substance abuse issues, piloting surveys, and developing a curriculum report card—to assess and improve the quality of training in health professional programs.

The new project stems from an effort of the Physician Leadership on National Drug Policy (PLNDP), a group of national medical leaders that advocates for a public health approach to substance abuse, to promote the need for an expanded role of health professionals in the screening, diagnosis, intervention and referral of individuals with alcohol and other drug problems. In February 1998, the PLNDP conducted a national survey and found that 76% of medical students surveyed reported receiving little or no training on addictive disorders during medical school, and that 90% of all respondents felt physicians played an important role in the issue.

Last November, PLNDP selected 10 health professional students to participate in an advocacy workshop where the students formally created HPSSAT and discussed the need for building the web site. Primary funding for this effort was provided by the Hanley Family Foundation with additional support from The Josiah Macy, Jr. Foundation and the Robert Wood Johnson Foundation (through the PLNDP project). Although HPSSAT members currently represent physician assistant, nursing and medical schools, the students plan to expand and diversify their membership nationwide to reach all health professional students, including but not limited to those in the fields of dentistry, pharmacy, social work, and psychology.

For more information on HPSSAT, contact Kathryn Cates-Wessel at 401/444-1816.

Funds Available for Services Research

The U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) is announcing the availability of funds to support dissertation research involving data analysis on services issues related to alcohol or drug problems. The dissertation must examine in a quantitative way a problem or issue in the area of substance abuse.

Approximately $150,000 will be available for five grants in FY 2004. The average annual award will range from $20,000 to $30,000 in total direct and indirect costs. Actual funding levels will depend on the availability of funds. Awards may be requested for a period not to exceed two years. The second year of the award will depend both on the availability of funds and progress achieved.

Students may apply if they are registered and in good standing in an accredited doctoral program that requires a dissertation based on original research. The student must apply through a public or private nonprofit institution that will administer the grant on his or her behalf. Students in such fields as sociology, psychology, social work, biostatistics, epidemiology, economics, policy, management, nursing, public health, or health services research are encouraged to apply.

The due date for applications is June 1, 2004. A program announcement (No. PA-04-001) and application forms are available from the SAMHSA web site at WWW.SAMHSA.GOV. Click on "Grant Opportunities" and then on FY 2004 Funding Opportunities." An application kit can be obtained by contacting Jane Feldmann by phone at 301/443-5628 or by email at JFELDMAN@SAMHSA.GOV. Questions about program issues should be directed to Sarah Duffy, Ph.D., at SDUFFY@SAMHSA.GOV or 301/443-8565.

Ruth Fox Memorial Endowment Fund

Dr. Ruth Fox

Dear Colleague:

As we observe ASAM's 50th Anniversary, we recall the efforts of founding members Jasper G. Chen See, M.D., and William B. Hawthorne, M.D., FASAM, who worked for years to help ASAM achieve a sound fiscal foundation. As a major step toward that goal, Dr. Chen See and Dr. Hawthorne helped to establish the Ruth Fox Memorial Endowment Fund in 1990 as a living tribute to ASAM's first President, Ruth Fox, M.D.

Dr. Chen See and Dr. Hawthorne—along with ASAM's Board of Directors and staff—were the Fund's first donors. In 1991, the Fund began to solicit donations from ASAM members. Indeed, it was the commitment and support of ASAM members that helped the Endowment reach its first million dollars in March 1992, and to achieve nearly $4 million in pledges and gifts to date.

Dr. Jasper Chen See

Dr. William B. Hawthorne

The goal of the Endowment Fund is to assure ASAM's continued ability to realize its mission of providing ongoing leadership in the field of Addiction Medicine and to continue its commitment to educating physicians, increasing access to care, and improving the quality of care. With your professional and financial support, ASAM and the Fund will achieve this goal.

For example, the interest income from the Endowment Fund once again will support the 2004 Ruth Fox Memorial Endowment Scholarship Program. As in 2002 and 2003, the program will offer seven scholarships to physicians-in-training, to allow them to attend ASAM's 35th Annual Medical-Scientific Conference.

Please continue to support the Endowment Fund so that we can continue to offer such scholarships in the future. 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 email Claire at ASAMCLAIRE@AOL.COM. Please let us know if you have included the Endowment Fund in your estate plans so that we can acknowledge your generosity. 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, Chair, Resources & Development Committee
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Dr. Hawthorne Honored by NAATP

The National Association of Addiction Treatment Providers (NAATP) has bestowed its Nelson J. Bradley Lifetime Achievement Award on ASAM member William B. Hawthorne, M.D. The award recognizes consistently outstanding contributions to addiction treatment. Dr. Hawthorne thus joins a distinguished group of Bradley Award recipients that includes former President Gerald R. Ford and Mrs. Betty Ford.

Dr. Hawthorne has served ASAM in many capacities, most recently as the founder and first webmaster of ASAM's web site. He also is a founder and a generous benefactor of the Ruth Fox Memorial Endowment Fund.

The award will be presented to Dr. Hawthorne during NAATP's annual conference, May 15-18 in Tampa, Florida. *Source: National Association of Addiction Treatment Providers.*

Dr. Hingson Joins NIAAA Staff

Ralph W. Hingson, Sc.D., M.P.H., has joined the National Institute on Alcohol Abuse and Alcoholism (NIAAA) as Director of the Division of Epidemiology and Prevention Research, according to an announcement from NIAAA Director Ting-Kai Li, M.D.

Dr. Hingson comes to NIAAA from the Boston University School of Public Health, where he was Associate Dean for Research and also served as Professor and Chair of the Social and Behavioral Sciences Department.

A popular speaker at ASAM conferences, Dr. Hingson is widely known for his research on the relationship between blood alcohol levels and traffic crashes. His data have been used by advocates in many states to support a reduction in the blood alcohol limit to 0.08% (now the law in 47 states).

In addition to overseeing NIAAA's portfolio of epidemiologic and prevention research, Dr. Hingson is expected to play a lead role in developing an initiative for underage drinkers from 9 to 15 years of age that will be patterned after NIAAA's highly regarded college drinking initiative. *Source: NIAAA press release.*

IN MEMORIAM

Conway W. Hunter, Jr., M.D., FASAM

Dr. Conway Hunter, of Sea Island, Georgia, died in January 2004 of congestive heart failure.

A long-time member of ASAM, Dr. Hunter was widely known for his annual educational conferences, which drew speakers and participants from across the country. Dr. Hunter also was a contributor to many ASAM conferences and a benefactor of the Ruth Fox Memorial Endowment Fund.

George W. Nash, M.D., FASAM

Dr. George W. Nash died in late 2003 in Tucson, Arizona, where he was affiliated with the Cottonwood de Tucson addiction treatment program.

A long-time member of ASAM, Dr. Nash co-authored a chapter on surgical complications of addiction in the Second Edition of ASAM's textbook, *Principles of Addiction Medicine*. He also was a popular speaker at ASAM's Ruth Fox courses.

ASAM Development Director Claire Osman, who knew Dr. Nash for many years, cited his many gifts to the Ruth Fox Memorial Endowment Fund and recalled that he was a "wonderful and kind person."

Condolences may be sent to Dr. Nash's widow, Mary Gayle Nash, at 4800 Winged Foot Drive, Tucson, AZ 85718.

Larry Siegel, M.D.

Dr. Larry Siegel died in November 2003 in Puerto Vallarta, Mexico, from injuries sustained in a fall. He was the founder of Old Town Medical Center in Key West, Florida, and later was an official of the Department of Health of the District of Columbia.

Trained in nephrology, Dr. Siegel became interested in addiction medicine as a young physician. He also became expert in the treatment of HIV/AIDS, serving as medical director of the Whitman-Walker Clinic and training physicians in Africa, the Caribbean, and the Americas. He published several texts on HIV disease and served on the editorial board of the *Journal of Addictive Diseases.*

In 2001, at the time of the September 11 attack on Washington, DC, Dr. Siegel was co-chief of emergency services for the District of Columbia. In that capacity, he assumed responsibility for coordinating the activities of hospital emergency departments, fire rescue, and other activities. He subsequently worked to detect and prevent anthrax attacks on the Nation's capital. Dr. Siegel's brother, Wayne Siegel, recalls that "his patients always loved and respected him, for he was a real humanist."

ASAM Conference Calendar

ASAM

July 16-18, 2004
ASAM Medical Review Officer (MRO) Training Course
Chicago, IL
18 Category 1 CME credits

November 4-6, 2004
Review Course in Addiction Medicine
Sheraton City Centre Hotel
Toronto, Ontario, Canada
21 Category 1 CME credits

November 18, 2004
Forensic Issues in Addiction Medicine
Washington, DC
8 Category 1 CME credits

November 19-21, 2004
ASAM Medical Review Officer (MRO) Training Course
Washington, DC
18 Category 1 CME credits

December 4, 2004
ASAM Certification Exam
Atlanta, GA
Los Angeles, CA
New York, NY
5 Category 1 CME credits

July 16-18, 2004
ASAM Medical Review Officer (MRO) Training Course
Westin Michigan Avenue Hotel
Chicago, IL
18 Category 1 CME credits

2005

April 14, 2005
Ruth Fox Course for Physicians
Hyatt Regency Hotel
Dallas, TX
8 Category 1 CME credits

April 14, 2005
Pain & Addiction: Common Threads VI
Hyatt Regency Hotel
Dallas, TX
8 Category 1 CME credits

April 15-17, 2005
ASAM's 36th Annual Medical-Scientific Conference
Hyatt Regency Hotel
Dallas, TX
20 Category 1 CME credits

OTHER EVENTS OF NOTE

June 2-5, 2004
International Society of Addiction Medicine
6th Annual Medical-Scientific Conference
Helsinki, Finland
[For information, visit www.paly.fi/isam2004.htm]

November 11-13, 2004
Association for Medical Education and Research in Substance Abuse
28th Annual National Conference
Hilton Embassy Row Hotel
Washington, DC
[For information, visit www.amersa.org]

Except where otherwise indicated, additional information is available on the ASAM web site (www.asam.org) or from the ASAM Department of Meetings and Conferences at 4601 No. Park Ave., Suite 101, Chevy Chase, MD 20815-4520; phone 301/656-3920; fax 301/656-3815; email email@asam.org.

BUPRENORPHINE TRAINING COURSES

May 5, 2004
Chicago, IL

May 15, 2004
Orlando, FL

May 22, 2004
Fall River (Boston), MA

Spring/Summer 2004
New Haven, CT
Houston, TX
Salt Lake City, UT

CSAT's toll-free information hotline for Buprenorphine questions: 1-866/287-2728.

To register for these courses, phone 1-888/362-6784 or visit the ASAM web site at www.asam.org/conf/buprenorphineconferences.htm.