Special Election Issue 2004
Volume 19, Number 5

ASAM News

Newsletter of The American Society of Addiction Medicine

Inside

This issue of ASAM News contains candidate profiles and ASAM election information.

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

www.asam.org

ASAM's MRO, Forensic Courses to Meet in Washington, DC

A comprehensive review of federal drug-free workplace requirements, as well as the clinical aspects of MRO practice, is presented in ASAM's Medical Review Officer Training Course, set for November 19-21, 2004, in Washington, DC. Under the direction of course chair James L. Ferguson, D.O., an expert faculty will review the impact of the federal Part 40 rule and recent developments in alcohol and drug testing technologies in terms of their implications for the work of Medical Review Officers. The course, which is approved for 18 Category 1 CME credits, also prepares candidates to sit for the MRO certifying examination.

The MRO course is preceded by a workshop on Forensic Issues in Addiction Medicine, scheduled for November 18, also in Washington, DC. Chaired by Robert L. DuPont, M.D., FASAM, the Forensics workshop examines the legal, ethical and procedural aspects of forensic science in addiction medicine, with an emphasis on cutting-edge issues such as the civil and criminal law and topics related to drug testing. It is approved for 8 Category 1 CME credits.

For additional information or to register, consult the ASAM website at WWW.ASAM.ORG or contact ASAM's meetings staff at 301/656-3920.

ASAM Guideline on Alcohol Withdrawal Published

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

A new ASAM-developed practice guideline has been published in the AMA journal, *Archives of Internal Medicine* (Vol. 164, No. 13, July 12, 2004, pp. 1405-1412). Entitled "Management of Alcohol Withdrawal Delirium: An Evidence-Based Practice Guideline," the document was produced by ASAM's Practice Guidelines Committee, under the leadership of Michael F. Mayo-Smith, M.D., M.P.H. In addition to Dr. Mayo-Smith, committee members who contributed to the guideline are Lee H. Beecher, M.D.; Timothy L. Fischer, D.O.; David A. Gorelick, M.D., Ph.D.; Jeanette L. Guillaume, M.A.; Arnold Hill, M.D.; Gail Jara, B.A.; Chris Kasser, M.D.; and John Melbourne, M.D.

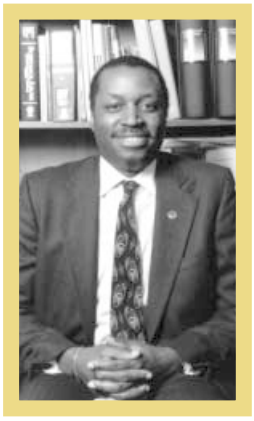
The guideline addresses the prevention and management of delirium, which is the most serious manifestation of alcohol withdrawal. Its findings and recommendations are based on the Guidelines Committee's structured review and meta-analysis of articles with original data on management of alcohol withdrawal delirium, and were approved by ASAM's Board of Directors.

The guideline recommends that withdrawal-related agitation be controlled through use of parenteral rapid-acting sedative-hypnotic agents that are cross-tolerant with alcohol. It advises that doses adequate to maintain light somnolence should be used for the duration of delirium. It also counsels that, when coupled with comprehensive supportive medical care, this approach is highly effective in preventing withdrawal-related morbidity and mortality.

Like earlier ASAM practice guidelines, the new guideline on management of alcohol withdrawal delirium advances the care of patients with addictive disease. It also supports the Society's Strategic Plan, which calls on ASAM to become a trusted source of evidence-based scientific and clinical information for the entire medical community. ASAM owes a debt of gratitude to Dr. Mayo-Smith and his co-authors for their important contribution to the medical literature. (*The guideline can be accessed on AMA's website at HTTP://ARCHINTE.AMA-ASSN.ORG/CGI/CONTENT/ABSTRACT/164/13/1405?ETOC&EAF.*)

Looking Back, Looking Forward

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



Your Board of Directors and ASAM as a whole should be proud of our accomplishments. There are many, and restating them serves a number of purposes. First, it allows us to appreciate how far we have come. Second, it provides us an appreciation of the challenges (some monumental, others less so) that we have met and overcome. Third, it provides us with a revised agenda of challenges that remain. Fourth—and on a personal note—it allows me an opportunity to thank the Board for their leadership, insights, critical thinking and decision-making. This last purpose is important, as physicians generally have no dearth of ideas and perspectives and for these reasons and others, it is often challenging to develop consensus in an efficient and effective manner. Certainly, we all appreciate that opinions and attitudes do matter (no matter what the level of objective support), yet as a Board we have a responsibility (fiduciary and otherwise) to our members to protect and advance their interests, prudently using the resources that are made available to the Society. Now, let's turn our attention to our successes.

Governance

We have approved a major change in governance with the purpose of using the skills, competencies, experience, and expertise of non-Board entities (such as our councils, committees, work groups, and members). At the same time, this new governance also offers the ASAM Board the opportunity to appreciate and exercise its obligations, to establish standard operating procedures and to review the performance of its products (education programs, policies, publications, etc.) that are so important to ASAM members. Other accomplishments include a continuing review of Board policies, reinforcing those of importance and sun-setting those that are no longer relevant. To help us understand our needs as a Board, we participated in the first Board self-assessment survey. To appreciate the needs and desires of our members, we conducted the most sophisticated survey in Society history. The Board also has dealt with (and will continue to examine) the issues of conflict of purpose and interest, an area of continuing discussion in medicine and society.

While the strength of ASAM often is associated with the effectiveness of the national organization, we have witnessed an amazing phenomenon in the development of our chapters into state medical specialty societies (SMSS). This represents the realization of the dreams and hopes of past and present ASAM leaders, including Drs. Chen See, Radcliffe, Smith, Earley, Fischer, Beach and others. We certainly are grateful for Dr. Callahan's efforts in bringing these dreams into reality.

Finally and somewhat related to governance is the relationship between the Board and its CEO/EVP. Eileen McGrath has been an amazing asset, yet part of the Society's good fortune in hiring her was a consequence of the wisdom of the Board in retaining external consultation to successfully recruit such an outstanding Executive Vice President/Chief Executive Officer.

Governance-related activities enhanced our appreciation of the importance of ASAM's participation in public policy issues. The outcomes of these efforts included the establishment of a public policy plenary session at ASAM's annual meeting, which was well attended. Our outcomes included the enhancement of old collaborations, as with the National Council on Alcoholism and Drug Dependence, and the establishment of new ones.

Finances

From a financial viewpoint, we have reinforced the importance of the responsibilities of Board members to support fund raising and fiscal accountability. As a result, we have turned the Society's fiscal deficit (which was due primarily to the cancellation of the Toronto meeting secondary to the SARS epidemic) to a more favorable state of fiscal health. This was accomplished through fund-raising at the level of the Board, spurred-on by Paul Earley's leadership and by the ASAM members who donated their registration fees for the cancelled Toronto meeting to the Society as a gesture of support. Just as important was our first fund-raising gala, which was a smashing success!

We have approved policies that include a review of the Ruth Fox Endowment Fund and establishment of a reserve fund. While fiscal issues are not the only basis for determining the value of an ASAM product, we have begun to appreciate the need for information about the return on each dollar spent for each of ASAM's products.

Another important development is worthy of mention, especially since it represents a major initiative and a new frontier for ASAM. As many of you may know, ASAM was awarded $1.5 million (over 3 years) in a cooperative agreement by the Center for Substance Abuse Treatment to

(continued on page 18)

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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Web Site
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).

Supreme Court to Hear Medical Marijuana Case

The U.S. Supreme Court has agreed to consider a case on the medical use of marijuana. The government's appeal of a lower court decision in favor of two California women has been placed on the docket for November, when the justices will hear arguments on whether the federal government can prosecute seriously ill persons whose physicians recommend marijuana to ease chronic pain or other medical problems.

"It's a term likely to be filled with blockbuster decisions," noted Duke University law professor Erwin Chemerinsky.

One in 10 Americans Has Addictive Disorder

More than 17 million Americans (8.5% of the population) have an alcohol use disorder, while another 4.2 million meet the criteria for other drug use disorders, according to a new survey from the National Institute on Alcohol Abuse and Alcoholism (NIAAA).

Results of the 2001-2002 National Epidemiology Survey on Alcohol and Related Conditions show that, overall, 9.4% of the U.S. population (19.4 million adults) have a diagnosable alcohol or drug disorder.

About one in five persons with such a disorder also has a co-occurring mental disorder, NIAAA reported. The study was published in the August 2004 issue of the *Archives of General Psychiatry*.

Survey: Use of Addiction Treatment Declining

An unremarked sidelight of the latest report from the National Household Survey on Drug Use and Health is a sharp decline in the number of Americans who received specialized treatment for alcohol and other drug disorders. According to the survey, 22.2 million Americans (9.3% of the population) needed addiction treatment in 2003, but only 3.3 million people received it.

The decline would be even more dramatic except for the fact that the 2003 data include an estimated 1.9 million persons who participated in mutual help groups such as Alcoholics Anonymous. Specialty treatment programs—defined as inpatient or outpatient addiction rehabilitation centers, hospital-based inpatient programs, and mental health centers offering addiction services—treated a total of 1.9 million persons in 2003. This represents a 17.3% decline from 2002, when an estimated 2.3 million Americans were treated in specialty programs.

Of those individuals who felt they needed treatment in 2003 but were unable to obtain it, about a third said cost or insurance barriers prevented them from obtaining care, while another 20% said they were deterred by stigma. "I don't think people are consciously making a decision [to avoid treatment]," said Ron Hunsicker, executive director of the National Association of Addiction Treatment Providers. "I think they are being... blocked from specialty treatment and seeking help elsewhere." He added, "The barriers to treatment continue to mount."

DEA Withdraws Opioid FAQs

In a move that surprised both pain and addiction experts, the Drug Enforcement Administration has withdrawn "Prescription Pain Medications: Frequently Asked Questions and Answers for Health Care Professionals and Law Enforcement Personnel."

The document, which attempts to clarify appropriate use of opioid analgesics in the management of pain, was released by DEA in a press conference and published on DEA's web site in August 2004. In place of the document, DEA's web site now offers a statement saying that the document "contained misstatements and has therefore been removed.... DEA wishes to emphasize that the document was not approved as an official statement of the agency and did not and does not have the force and effect of law."

The document was reviewed favorably in the September 8, 2004, issue of the *Journal of the American Medical Association*. ASAM members Douglas Gourlay, M.D., FASAM, Howard Heit, M.D., FASAM, and Walter Ling, M.D., were among a panel of more than 30 pain and addiction experts who consulted on development of the FAQs.

Feds: Cigarette Makers Lied for 50 Years

Tobacco industry executives have been misrepresenting the dangers of smoking for half a century, according to opening arguments in the U.S. government's $280 racketeering lawsuit against tobacco manufacturers.

Justice Department attorney Frank Marine told a federal district court that at a 1953 meeting in a New York City hotel, tobacco industry executives set the framework for a conspiracy to lie about the link between cancer and cigarettes. "This case is about a 50-year pattern of misrepresentation, half-truths and lies," he said.

The government also presented evidence that the tobacco industry developed an extensive public relations campaign designed to create confusion about the health effects of smoking. Justice Department attorney Sharon Eubanks showed the court a 1964 memo in which a Philip Morris executive wrote that the industry had to provide "a psychological crutch and a self-rationale to continue smoking."

The tobacco companies countered that the government's allegations are false. They also claimed that they have changed their marketing practices since the 1998 nationwide tobacco settlement with state attorneys general.

The trial is expected to last at least six months.

New Tool for Estimating Alcohol-Related Deaths

A new report from the Centers for Disease Control and Prevention (CDC) estimates that about 75,000 alcohol-related deaths occur in the U.S. each year. The deaths are divided almost evenly between those from chronic causes such as liver disease and those from acute causes such as traumatic injuries, including automobile crashes. The study also estimates that each alcohol-related death costs an average of 30 years of lost life. ASAM member Richard Saitz, M.D., M.P.H., one of the study's authors and associate professor of medicine at the Boston University School of Medicine, notes that a number of study limitations, such as self-reported data, suggest that the estimates of alcohol-related deaths are, if anything, conservative.

"These results emphasize the importance of adopting effective strategies to reduce excessive drinking, including increasing alcohol excise taxes and screening for alcohol misuse in clinical settings," the authors write.

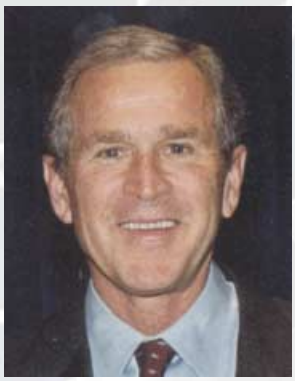
The data can be accessed through the CDC's Alcohol Related Disease Impact (ARDI) system, which allows researchers, policymakers, advocates and others to generate estimates of alcohol-related deaths and lost years of life on a state and national level. To use the calculator, visit the ARDI website at WWW.CDC.ADRI.GOV.

Presidential Candidates Discuss Addiction Policies

Editor's Note: To say that alcohol and drug issues have not figured large in the 2004 Presidential campaign would be an understatement. Nevertheless, both the candidates have spoken on the record about issues of interest to ASAM members. The following remarks—all direct quotes from the candidates and their campaigns—were obtained from the Bush-Cheney and Kerry-Edwards official websites and other public venues.

★ ★ ★ ★ GEORGE W. BUSH ★ ★ ★ ★

"Addiction crowds out friendship, ambition, moral conviction, and reduces all the richness of life to a single destructive desire....Let us



bring to all Americans who struggle with drug addiction this message of hope: The miracle of recovery is possible, and it could be you....

"We must stand with our families to help them raise healthy, responsible children. And when it comes to helping children make right choices, there is work for all of us to do. One of the worst decisions our children can make is to gamble their lives and futures on drugs. Our government is helping parents confront this problem with aggressive education, treatment and law enforcement. Drug use in high school has declined by 11% over the past two years....

"Drug-testing in our schools has proven to be an effective part of this effort. So tonight I propose an additional $23 million for schools that want to use drug-testing as a tool to save children's lives. The aim here is not to punish children, but to send them this message: We love you, and we do not want to lose you." *Source: State of the Union address, January 20, 2004.*

ACCESS TO RECOVERY INITIATIVE

"The Access to Recovery (ATR) program increases funding for substance abuse treatment by $100 million in FY 2004. This additional funding will complement existing programs to ensure that those struggling with addiction have access to a comprehensive continuum of treatment and support service options, including faith-based and community programs. This new program will provide individuals with more treatment options by using vouchers to obtain services from a broader range of providers...."

"As a part of this program, the Department of Health and Human Services is making $100 million available in FY 2004 for up to 15 states to extend drug treatment to 50,000 more Americans, allowing them a choice of providers, including faith-based organizations. The President has proposed to double this funding level in FY 2005." *Source: Campaign website (www.GeorgeWBush.com), August 29, 2003.*

ROLE OF FAITH-BASED ORGANIZATIONS

"Last year, approximately 100,000 men and women seeking treatment for drug addiction did not receive the help they needed. The President's plan is designed to complement existing programs and ensure that Americans struggling with addiction have access to a comprehensive continuum of effective treatment and support service options, including faith-based and community-based programs, and ensure that these options are more readily available." *Source: Campaign website (www.GeorgeWBush.com), August 29, 2003.*

★ ★ ★ ★ JOHN F. KERRY ★ ★ ★ ★

"In order to deal with the problem of illegal drugs in this country, efforts must be focused on keeping drugs out of the country and our communities, as well as reducing demand for illegal drugs. John Kerry supports aggressively targeting traffickers and dealers, as well as making a commitment to sufficiently fund drug prevention and treatment programs." *Source: Campaign website (www.JohnKerry.com), March 21, 2004.*

INTERDICTION, TREATMENT AND PREVENTION

"....[T]he drug trade in Colombia is not simply a Colombian problem. The United States is the largest and most reliable market for the Colombian cocaine and heroin that is at the center of this conflict....Clearly we are making a large contribution to the problem and should therefore contribute to finding a solution....Plan Colombia is an opportunity to help an important ally attack the sources of illegal drug production reduce the flow of cocaine and heroin to the United States....

"As we support Colombia's efforts to attack the sources of illegal drugs, we need to make sure we are addressing our own problems. According to recent estimates, approximately five million drug users needed immediate treatment in 1998, while only 2.1 million received it. It was also found that some populations—adolescents, women with small children, and racial and ethnic minorities—are badly underserved by treatment programs. Only 37% of substance-abusing mothers of minors received treatment in 1997. Drug offenders, when released from jail, are often not ready or equipped to deal with a return to social pressures and many return to their old habits if they are not provided with effective treatment while incarcerated and the social safety net they so desperately need upon release.

"Increasing funding and expanding drug treatment and prevention programs are absolutely imperative if we are to coordinate an effective counterdrug campaign, particularly if we are to expect any real improvement in the situation in Colombia. Levels of drug abuse in the United States have remained unacceptably high, despite stepped-up interdiction efforts and increased penalties for drug offenders.

"It is clear that drug treatment works, and there is no excuse for the high numbers of addicts who have been unable to receive treatment. As we increase funding for supply reduction programs in Colombia, we must increase funding for treatment to balance and complement it." *Source: Speech in the United States Senate, June 22, 2000; accessed at the website of the Center for International Policy (www.ciponline.org).*

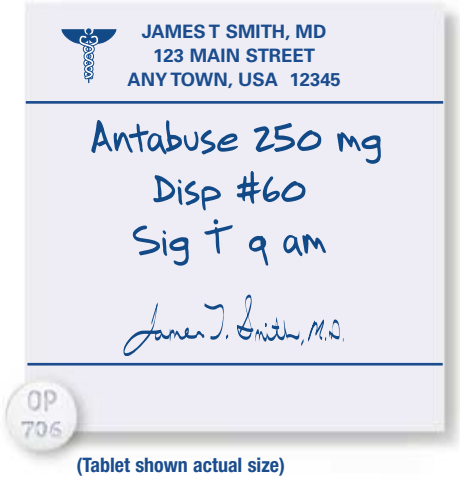
HELPS ALCOHOL ABUSERS SUCCESSFULLY STAY SOBER

Antabuse: Proven to reduce alcohol consumption for committed quitters

- Patients who are economically and socially stable, compared with those who are not, experience greater positive outcomes with Antabuse[1,2]
- Supervision and support are crucial to patient compliance with treatment with Antabuse[3,4]
- Adequate dosing and appropriate duration of therapy also impact treatment success with Antabuse[4,5]

Prescribe Antabuse with confidence—once a day, every day for patients who have too much to lose

Patients who have recently received metronidazole, paraldehyde, alcohol, or alcohol-containing products should not receive Antabuse. Antabuse is contraindicated in the presence of severe myocardial disease or coronary occlusion, psychoses, and hypersensitivity to disulfiram. Antabuse should be used with caution in patients receiving phenytoin and its congeners.



(Tablet shown actual size)

Please see full prescribing information on adjacent page.

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

Complimentary patient education materials and identification cards are available from your Odyssey representative or through our Web site at www.OdysseyPharm.com.

In alcoholism

ANTABUSE®

(Disulfiram, USP)

250-mg Tablets

Support for the committed quitter

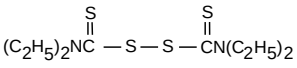
Odyssey PHARMACEUTICALS, INC.®

Visit our Web site at www.OdysseyPharm.com

Antabuse® (Disulfiram, USP) Tablets IN ALCOHOLISM

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

DESCRIPTION: 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 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.

In alcoholism

ANTABUSE®

(Disulfiram, USP)

250-mg Tablets

Support for the committed quitter

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 afters have 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]

Distributed by Odyssey Pharmaceuticals, Inc., East Hanover, NJ 07936
Manufactured by PLIVA, Inc., East Hanover, NJ 07936

Iss. 1/03

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 PIOPA-775 4/04

ASAM MEMBERS TO ELECT NEW SLATE OF OFFICERS

ASAM members are about to choose the Society's next President-Elect, Secretary, and Treasurer, as well as a full slate of Regional Directors. Ballots will be mailed to members in good standing by November 1, 2004, and must be returned to ASAM's New York office by December 1.

The election packages mailed to members in October will contain, in addition to the ballots, biographical sketches and photos of the candidates. Profiles of the candidates, with their platform statements, follow.

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

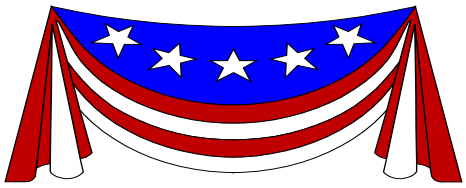
Election results will be announced in the January-February 2005 issue of **ASAM News**. Newly elected officers and Regional Directors will be installed during the Society's April 2005 Medical-Scientific Conference in Dallas, Texas. President-Elect Elizabeth F. Howell, M.D., FASAM, will assume the Presidency at that time.

CANDIDATES FOR THE OFFICE OF PRESIDENT-ELECT

Voters may choose between two candidates for the office of President-Elect: Louis E. Baxter, Sr., M.D., FASAM, and Michael M. Miller, M.D., FASAM.

The ASAM Constitution and Bylaws state that "The President-Elect shall, in the absence or disability of the President, exercise the powers of the President. The President-Elect shall perform such other duties as may be assigned by the President."

Candidates for the office of President-Elect



were selected by the Nominating and Awards Committee. Nominees for this office must have served on the Board of Directors within the past four years.

The President-Elect serves a two-year term and is expected to assume the Presidency of ASAM in April 2007. No member may hold the office of President-Elect or President for more than one term, successively.

CANDIDATES FOR THE OFFICE OF SECRETARY

Voters are asked to choose between two candidates for the office of Secretary: Richard A. Beach, M.D., FASAM, and A. Kenison Roy III, M.D., FASAM.

The ASAM Constitution & Bylaws require that "The Secretary shall: (a) keep an accurate record of the proceedings of the meetings of the Society and the Board of Directors; (b) preserve records, documents and correspondence; (c) cause notice to be given of elections and of meetings of the Society and the Board; (d) advise the Board on parliamentary procedure in the conduct of its meetings, and (e) perform all other duties incident to the Office of the Secretary."

The Constitution & Bylaws also require that nominees for the office of Secretary must be from or have served on the Board of Directors within the past four years. Officers, including the Secretary, have a two-year term of office. A Secretary may succeed himself/herself once without hiatus, and may subsequently be reelected after a hiatus of two years.

CANDIDATES FOR THE OFFICE OF TREASURER

Voters may choose between two candidates for the office of Treasurer: James A. Halikas, M.D., FASAM, and Donald J. Kurth, M.D., FASAM.

The ASAM Constitution & Bylaws state that "The Treasurer shall be the custodian of the Society's funds from whatever source those may derive. The Treasurer or individual designated by the Board of Directors shall deposit these funds in the Society's name in such depositories as the Finance Committee, following the guidelines of the Bylaws and the Board of Directors, shall recommend. The Treasurer shall dispense funds as authorized by the Board of Directors. The Treasurer shall report an accurate amount of all transactions at the Annual Meeting of the Society, and at all Board meetings. The Treasurer shall be a member of the Finance Committee."

The Constitution & Bylaws also require that nominees for the office of Treasurer must be from or have served on the Board of Directors within the past four years or, in the case of a nominee from the general membership who has qualifications for the position, must have been active on the Finance Committee within the past four years. Officers, including the Treasurer, have a two-year term of office. A Treasurer may succeed himself/herself once without hiatus, and may subsequently be reelected after a hiatus of two years.

ASAM'S MISSION

The American Society of Addiction Medicine is an association of physicians dedicated to improving the care of alcoholism and other addictions, educating physicians and medical students, promoting research and prevention, and enlightening and informing the medical community and public about these issues. The Society serves its members by providing opportunities for education and sharing of a body of professional knowledge and scientific literature to enhance the quality and increase the availability of appropriate health care for persons who suffer from or are at risk for the disease of addiction.

ASAM has more than 3,000 members and 32 state chapters. The Society's members are physicians who specialize in medical education, research, and clinical care of addiction, physicians in many specialties who are interested in the identification and management of patients who suffer from this disease, medical students, and residents. Members who are designated Fellows of the American Society of Addiction Medicine (FASAM) are recognized for distinguished contributions to the Society and the field of addiction medicine.

ASAM's Presidential officers gather during a recent Med-Sci Conference. From left: President-Elect Elizabeth F. Howell, M.D., FASAM; Past President Andrea G. Barthwell, M.D., FASAM; Immediate Past President Marc Galanter, M.D., FASAM; and President Lawrence S. Brown, Jr., M.D., M.P.H., FASAM.

ASAM OFFICERS, 2003-2005

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

President-Elect
Elizabeth F. Howell, M.D., FASAM

Immediate Past President
Marc Galanter, M.D., FASAM

Secretary
David C. Lewis, M.D.

Treasurer
James A. Halikas, M.D., FASAM

CANDIDATE FOR THE OFFICE OF PRESIDENT-ELECT

LOUIS E. BAXTER, SR., M.D., FASAM

LAWRENCEVILLE, NEW JERSEY

What do you consider your greatest contribution to ASAM and the field of addiction medicine? I believe that my dedication and absolute commitment to ASAM and its mission, as evidenced by my professional activities and accomplishments, is my greatest contribution to ASAM and the field of addiction medicine.

Over the past 16 years, I have successfully raised and injected many of ASAM's core ideals and beliefs into the development of education and training programs, government programs and regulatory schemes in the Departments of Health in New Jersey and Pennsylvania, the federal Center for Substance Abuse Treatment, Food and Drug Administration, and Substance Abuse and Mental Health Services Administration, and the National Football League.

As the national chair of CSAT's Healthcare Professional Impairment Task Force, I contributed a recommendation to the national Strategic Plan for Interdisciplinary Faculty Development that calls for addiction education to become part of "the core curriculum of all allied health education programs in the nation."

As Medical Director of the Physicians' Health Program of the Medical Society of New Jersey, I have had an opportunity to address issues regarding medical licensure and treatment of health care professionals, as well as to advocate for many physicians in the states of Region IV and elsewhere.

At every opportunity, I have endeavored to advance and promote the mission, goals, and policies of ASAM—represented in part by our Strategic Plan—in the various local, state, and federal policymaking and medical education arenas in which I have been active.

I have gladly served on ASAM committees, including the Membership, Physicians' Health, Forensic Medicine, and Nominating & Awards Committees. I have served as co-director of the Ruth Fox Program Committee and chair of the Cross-Cultural Clinical Concerns Committee. Concisely put, I am dedicated to ASAM.

How would your election benefit ASAM and the field of addiction medicine? My election to the office of President-Elect of ASAM would allow me to continue to advocate, promote, and disseminate ASAM's ideals and mission, as outlined in the Society's Strategic Plan.

I believe that, as President, I can help ASAM further develop its position and authority as *the* medical specialty society for addiction medicine specialists, and help it embody expertise in all matters pertaining to addiction medicine, prevention, and treatment.

I believe that my relationships with the aforementioned agencies, and my experience at the state chapter level in motivating, organizing, and successfully executing Society programs make me the best candidate to continue ASAM's growth and development and its incorporation and acceptance into mainstream medicine.

I recognize the value and worth of every ASAM member and I intend to make ASAM membership a "true value" by providing career opportunities for our members.

ASAM's 2004 Review Course Set for November 4-6 in Toronto

ASAM's 2004 Review Course in Addiction Medicine will be hosted by the Canadian Society of Addiction Medicine November 4-6 at the Sheraton Centre Hotel in Toronto, Ontario. The course is preceded by five half-day workshops sponsored by the Canadian Society of Addiction Medicine and the Illinois Society of Addiction Medicine.

Co-chaired by Shannon C. Miller, M.D., CMRO, FASAM, and Edwin A. Salsitz, M.D., FASAM, the course is designed to meet the needs of several audiences: (1) physicians who are planning to sit for the ASAM Certification/Recertification Examination; (2) addiction specialists who seek an update on recent developments in addiction practice; and (3) 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.

To register for the Review Course and pre-conference workshops, phone the ASAM Department of Conferences and Meetings at 301/656-3920 or consult the ASAM web site at WWW.ASAM.ORG. On-site registrations also will be accepted. Questions about the Review Course should be emailed to REVIEWCOURSE@AOL.COM.

Newly elected officers and Regional Directors will be installed during the Society's April 2005 Medical-Scientific Conference in Dallas, Texas. President-Elect Elizabeth F. Howell, M.D., FASAM, will be installed as President at that time.

CANDIDATE FOR THE OFFICE OF **PRESIDENT-ELECT**

Michael M. Miller, M.D., FASAM

Madison, Wisconsin

What do you consider your greatest contribution to ASAM and the field of addiction medicine? My key contributions have focused on enhancing ASAM's visibility and effectiveness among physicians and other medical organizations. For instance, as ASAM's representative to the American Medical Association's policymaking body, the House of Delegates, I have tried to increase ASAM's visibility and prestige as we shaped AMA policy on issues important to ASAM, such as parity. At the AMA, ASAM's representatives interact with physician leaders from state medical associations and other specialty societies. This networking allows for collaboration, providing the synergies that ASAM, as a small society, needs.

Within the Wisconsin Medical Society, I have promoted ASAM and addiction issues as a long-term member of the Physicians Health Program, as chair of the Commission on Addictive Diseases, as Dane County delegate to the state House of Delegates, as President of my county medical society, as well as in the state society's AMA delegation and on its Board of Directors. Through these activities, I facilitated the Wisconsin Society of Addiction Medicine's successful effort to win a seat in the state medical society's House of Delegates. I testify on behalf of the state society at the state capitol and have won support for WisSam in return: today, one of the overall legislative priorities of the state medical society is addiction parity.

Within ASAM, as past chair of ASAM's Public Policy Committee and as a past member of ASAM's Board of Director, I have helped shape ASAM's Policy Compendium and drafted many policy statements. I also have promoted leadership development for younger physicians and trainees. Finally, within my own medical staff, I contribute to the field of addiction medicine every day by collaborating with other physicians through Meriter/NewStart's Addiction Medicine Consultation and Evaluation Service, which I established.

How would your election benefit ASAM and the field of addiction medicine? My career has provided many experiences: with public health, with managed care, with the Joint Commission on Accreditation of Hospitals, with community hospitals and large medical groups, with clinical practice, medical education, policy formulation, advocacy, physician health, quality improvement, and especially organized medicine. Therefore, I believe I can relate to a broad spectrum of ASAM's members, and their interests and needs.

In my daily work and outside activities, I am very comfortable working with professionals from multiple disciplines. With my experience in delivering legislative testimony, I believe I can be an effective spokesperson for ASAM in communicating our message to other physicians, to policymakers, and to the media. Building on past contacts and experiences, my vision would be to further increase ASAM's visibility and effectiveness with other physicians and medical organizations.

CANDIDATES FOR THE OFFICE OF SECRETARY

Richard A. Beach, M.D., FASAM

Navarre, Florida

What do you consider your greatest contribution to ASAM and the field of addiction medicine? My practice and professional goals parallel those of ASAM. I began my fourth decade of medical practice in 2004, with the last 17 years having been dedicated exclusively to addiction medicine. I have been actively involved with the mission of ASAM throughout my career in addiction medicine. I earned my ASAM certification in 1989 and was recertified in 1998. I was honored to be named a Fellow of ASAM in the first class of Fellows in 1997.

I feel the most significant contribution I have made to ASAM is through my service as chair of the State Chapters Committee and the State Medical Specialty Society (SMSS) program. To better carry out ASAM's strategic plan—especially those objectives involving education and parity reimbursement issues—we need to strengthen our state chapters. In less than two years, with what began as six pilot states, the SMSS program has helped 14 chapters better organize and focus their efforts by establishing central administrative offices and staffs, providing CME conferences to establish specialty credibility and financial stability, and securing a presence in their state medical societies as representatives of addiction medicine and ASAM.

Through the vision, dedication, and hard work of SMSS members, we have begun a truly grassroots process of re-organizing ASAM's chapters that will extend to 28 of our original states in 2005.

How would your election benefit ASAM and the field of addiction medicine? As chair of ASAM's State Medical Specialty Society (SMSS) program, I have had the honor of working with some of the finest and most dedicated individuals in our ASAM membership. As Secretary of ASAM, I would bring this spirit of commitment, vision, hard work, and fellowship—learned from my fellow SMSS members—to all of ASAM.

With my long tenure of service to ASAM, I believe that, as your Secretary, I can continue to contribute to realizing the mission and goals of our Society and to promoting the practice of addiction medicine and better care for our patients.

A. Kenison Roy III, M.D., FASAM

Metairie, Louisiana

What do you consider your greatest contribution to ASAM and the field of addiction medicine? In the 1980s, as a general practitioner in recovery, I developed an interest in addiction medicine and later became a full-time worker in the field of treating addictive diseases. I joined ASAM in 1984, was certified in 1986 and have worked to develop addiction treatment programs at several New Orleans area hospitals, as well as an outpatient and residential programs for a non-profit private sector agency. In December 1994, I completed a residency program in psychiatry at Tulane University School of Medicine. I am board-certified by the American Academy of Psychiatry and Neurology and hold the academic rank of clinical assistant professor.

Currently, I admit patients to two area hospitals, maintain a private psychiatric practice, teach medical students, sit on the Board of Certification for Substance Abuse Counselors and work with organized medicine. My primary practice focus, however, is Addiction Recovery Resources of New Orleans, a non-profit agency that provides ambulatory detoxification, intensive outpatient and residential addiction, dual diagnosis and chronic pain management services in the private sector.

I was first elected to the Board of Directors of ASAM in 1988 and re-elected in 1992, 1998 and 2002. In April 1997, I was named a Fellow of ASAM. I have served on the Review Course Committee and have chaired the Membership Committee. Currently, I am active in the State Medical Specialty Society (SMSS) program.

How would your election benefit ASAM and the field of addiction medicine? In my work in ASAM, I have helped maintain a focus on the development of criteria-based, medically-directed treatment models across multiple levels of care, as well as the implications of addiction as a primary disease and a brain disease. I have identified parity in insurance coverage as essential to the adequate treatment of addictive disease, attraction of physicians to the field, development of training for physicians, and the development of an active addiction medicine specialty in medicine. As Secretary, I would continue attention to these issues at a higher level of leadership.

Election results will be announced in the January-February 2005 issue of ASAM News.

CANDIDATES FOR THE OFFICE OF **TREASURER**

JAMES A. HALIKAS, M.D., FASAM
(INCUMBENT)
NAPLES, FLORIDA

What do you consider your greatest contribution to ASAM and the field of addiction medicine? I am engaged in the private practice of addiction medicine and general psychiatry in Naples, Florida. I have been an active participant in ASAM for more than 25 years, as Treasurer, as chair of the Medical Education Committee, as co-chair of the Fellowship Committee, as a member of the Executive Committee, and as an active presenter at our annual Medical-Scientific Conferences. In fact, if you've ever taken an ASAM course or received CME credits from ASAM, I probably helped organize or approve the course, and my signature is on your certificate.

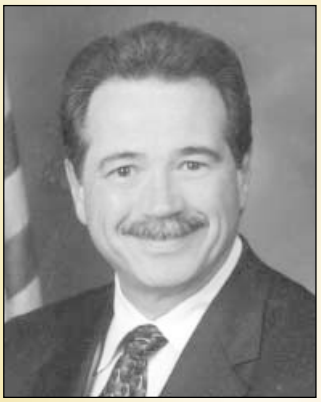
I've also contributed more than 100 articles to the addiction medicine professional literature, including reports on the development of cocaine pharmacotherapies. I am particularly proud to be the senior author of the original patient placement criteria in 1987, known as the "Cleveland Criteria," along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

How would your election benefit ASAM and the field of addiction medicine? My goals are to strengthen our Society and its membership so that ASAM can be an effective voice for our specialty, in order to improve reimbursement for our services and establish ASAM's position as a medical specialty society.

I also want to spread the good news that treatment works! I want to try to steer ASAM into activities that demonstrate treatment response and effectiveness. In all conferences and CME activities that we are involved in, I want to try to stimulate presentations on treatment and its effectiveness.

Finally, in this period of focus on medical cost containment, I believe that the most important duty of the Treasurer will be to see to it that our members can survive professionally, have a place at the table of managed care, and continue to have the opportunity to treat chemically dependent patients.

DONALD J. KURTH, M.D., FASAM
RANCHO CUCAMONGA, CALIFORNIA



What do you consider your greatest contribution to ASAM and the field of addiction medicine? Sound financial management has been the hallmark of my success throughout my career in both the private and public sectors. My experience in both for-profit and non-profit organizations has galvanized my knowledge and insight into financial matters.

How would your election benefit ASAM and the field of addiction medicine? Through my willingness to help others in difficult financial straits, I have become an expert in "turnaround economics." Hearing rumblings of financial challenges ahead for ASAM, I volunteered to serve on the ASAM Finance Committee in 2001. ASAM had been financially strong for many years, and no one could have predicted what lay ahead. However, at my very first meeting, it was announced that ASAM was headed rapidly for red ink.

The entire Finance Committee was stunned by the news, but we quickly buckled down to try to understand the problems and to develop a realistic plan to rebuild the financial health of our Society. We struggled to cut expenses, increase income, and develop a turnaround strategy. Monthly Finance Committee meetings were scheduled, a new chairperson was selected, financial controls were instituted, and innovative ways to generate new income were created. As chair of ASAM's Membership Committee, my challenge was doubly difficult: not only did we have to find ways to cut expenses, we had to continue to attract new members and retain current members as well.

Initially, ASAM's financial condition continued to worsen. However, the Finance Committee stayed the course and the Membership Committee team pulled together. We developed a realistic budget and held the line on expenses. At the same time, new sources of revenue were developed and our financial situation began to stabilize.

Through diligence and hard work, ASAM has come through the financial darkness and there is sunshine ahead. But we must continue to enforce sound financial management. As Treasurer, I can assure you that ASAM will not go down the road of financial instability on my watch.

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

CANDIDATES FOR REGIONAL DIRECTOR AND ALTERNATE REGIONAL DIRECTOR

As specified in the Bylaws, the candidate in each Region who receive the most votes will be elected Regional Director, and the candidate who receives the next largest number of votes will be elected Alternate Regional Director.

TERM OF OFFICE

The term of office of Regional Directors and Alternate Regional Directors is four years (for the candidates to be voted in 2004, the term of office will be 2005-2009).

NOMINATING PROCESS

Candidates for Regional Director and Alternate Regional Director are selected by Regional Nominating Committees and by petition. Regional Directors and Alternate Regional Directors who have not already served two consecutive four-year terms are eligible for nomination as candidates. All candidates for Regional Director, including incumbents, are subject to nomination by the respective Regional Nominating Committee of State Chapter Presidents and State Chairs of the Region.

QUALIFICATIONS

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/her own expense.

CURRENT REGIONAL DIRECTORS & ALTERNATE REGIONAL DIRECTORS

REGION	REGIONAL DIRECTOR	ALTERNATE REGIONAL DIRECTOR
Region I	Peter A. Mansky, M.D.	Merrill S. Herman, M.D.
Region II	Lori D. Karan, M.D., FACP, FASAM	Donald J. Kurth, M.D., FASAM
Region III	Ronald F. Pike, M.D., FASAM	Peter Rostenberg, M.D., FASAM
Region IV	Louis E. Baxter, Sr., M.D., FASAM	R. Jeffrey Goldsmith, M.D.
Region V	Paul H. Earley, M.D., FASAM	Timothy L. Fischer, D.O.
Region VI	Thomas L. Haynes, M.D., FASAM	Norman S. Miller, M.D., FASAM
Region VII	A. Kenison Roy III, M.D., FASAM	John P. Epling, Jr., M.D., FASAM
Region VIII	Berton J. Toews, M.D., FASAM	Richard E. Tremblay, M.D., FASAM
Region IX	Raju Hajela, M.D., M.P.H., FASAM*	Saul Alvarado, M.D.
Region X	Lloyd J. Gordon III, M.D., FASAM	C. Chapman Sledge, M.D., FASAM

** Named in 2004 to fill the seat of the late Peter Mezciems, M.D., FASAM*

CANDIDATES FOR DIRECTOR OF REGION I (NEW YORK)

Marc Galanter, M.D., FASAM

New York, New York

What do you consider your greatest contribution to ASAM and the field of addiction medicine? My greatest contribution has been in promoting the availability of progressive addiction care through advanced knowledge and support for treatment. As program chair for the Medical-Scientific Conferences since 1983, I have worked to bring the very best information to our members. As President, I made sure that our members' concerns over constraints on treatment were heard nationwide, as well as our recommendations for improvement.

How would your election benefit ASAM and the field of addiction medicine? A number of important issues are apparent, and I would like to represent Region I in addressing them:

Managed care restricts access to treatment. A survey that I initiated for ASAM three years ago showed that within the previous decade, reimbursement for substance abuse services had declined by 75%. Parity for addiction treatment in New York State and nationally must be our highest priority.

Clinically relevant research should be available to our members. As Chair of ASAM's Medical-Scientific Program Committee, I have worked to assure that our annual meeting is of the highest caliber. We need to continue this mission in ASAM and in our state societies.

Training in addiction medicine is critical. We should strengthen ASAM's CME programs nationally and statewide. We also must assure that ASAM certification is widely accepted. Finally, we should promote postgraduate fellowships in addiction medicine to train the next generation of specialists.

The *ASAM Patient Placement Criteria* have been highly influential in assuring recognition of our Society. We need to promote widespread use of the Criteria and full recognition of the Society's role in developing them.

Support for physicians' health is crucial. We need to ensure that physicians who have substance use disorders get the help and support they need to return to work in full recovery. Our Society and our New York State chapter have come a very long way in the 20 years that I have been a member. I hope to serve ASAM in the future as well.

CANDIDATES FOR DIRECTOR OF REGION I (continued)

Edwin A. Salsitz, M.D., FASAM

NEW YORK, NEW YORK

What do you consider your greatest contribution to ASAM and the field of addiction medicine? I have been a full-time faculty member in the Chemical Dependency Division of Beth Israel Medical Center, New York City, since 1983. I am board-certified in internal medicine and pulmonary disease. I was certified by ASAM in 1998 and elected a Fellow in 2003.

Entering addiction medicine from an internal medicine background, I immediately noticed the difference in terminology. Addiction practitioners used many "street" terms, which are distinctly absent from other medical specialties. For example, clinicians routinely referred to "clean" and "dirty" urines, or called patients "crack heads" or "hard-core addicts." I began to understand how this vocabulary stigmatizes both the patient and the field, and how it had obscured my own understanding of the disease of addiction.

I began speaking out on this issue in 1998, and continued as co-chair of ASAM's Review Course in Addiction Medicine in 2002 and 2004 and in opinion pieces in *ASAM News* and *Addiction Treatment Forum*.

How would your election benefit ASAM and the field of addiction medicine? I have served on the faculty of the ASAM Review Course, the State of the Art Course, and the Common Threads Course, and presented workshops at three Med-Sci meetings. Currently I am co-chair of the 2004 ASAM Review Course and a member of the Opioid Treatment subcommittee.

I have a special passion for reducing the stigma that surrounds methadone maintenance treatment. I have tried to educate other physicians about the efficacy and safety of this treatment modality. My area of greatest involvement is in office-based opioid treatment (OBOT). I am the principal investigator of an ongoing study of OBOT—the oldest and largest in the Nation. Over a 20 year follow-up, we have shown that OBOT is both safe and effective in stable, socially rehabilitated patients.

If elected, I will continue to advocate that addiction is a brain disease, similar medically to all other chronic diseases, and will work to eliminate stigma on the part of treatment providers and the general public.

Norman Wetterau, M.D., FASAM

NEW YORK, NEW YORK

What do you consider your greatest contribution to ASAM and the field of addiction medicine? My greatest contribution to ASAM has been as a member of ASAM's Strategic Plan Task Force, where I argued strongly that ASAM should be outward-looking as well as inward-looking. To achieve this, I encouraged ASAM to develop strong state chapters, which can lobby for legislation at the state level and influence education about addictive disorders in medical schools. In New York, I helped to create the New York Society of Addiction Medicine and am a public policy leader in that organization.

I also have helped to develop relationships with other medical specialty groups, and have worked with and through them to position addiction medicine within the mainstream of medical care. This is now part of ASAM's Strategic Plan. I have tried to put this principle into practice by organizing ASAM's Family Practice Work Group, which works with the American Academy of Family Physicians (AAFP) and the state chapters to provide education and influence policy. Our New York State chapter of AAFP is a good example of physician leaders working together to promote drug treatment rather than incarceration.

How would your election benefit ASAM and the field of addiction medicine? The specifics of my ideas already are part of ASAM's Strategic Plan and are being addressed by the Family Practice Work Group. As an ASAM Board member, I can do even more in this area by helping to foster relationships between ASAM and various specialty societies; by working to educate primary care physicians to recognize addictive disease and refer such patients to addiction specialists; and by enlisting the help of other organizations in promoting ASAM's public policy goals for addiction treatment and parity.

As a Board member, I will support specialty status for addiction medicine, but also argue for developing liaisons with emergency medicine, internal medicine, obstetrics, pediatrics, family practice, and other specialties in an effort to assure that all persons who have addiction problems receive the treatment they need.

CANDIDATES FOR DIRECTOR OF REGION II (CALIFORNIA)

Peter Banys, M.D.

San Francisco, California

What do you consider your greatest contribution to ASAM and the field of addiction medicine? My most significant contribution to the field has been 25 years of directing an addiction fellowship program. Our graduates have assumed academic, institutional leadership, and clinical positions in several states. Along with other early fellowships, ours helped to make addiction medicine a genuinely respected and evidence-based profession.

I also have been active for several decades in the California Society of Addiction Medicine (CSAM). I chaired CSAM's Education Committee for six years and was President from 2000–2002, during a time of organizational change within our Society and important legislative activity and ballot initiatives in California. In those roles, I brought CSAM's voice to questions vital to the integrity and effectiveness of our field. I demonstrated leadership by restructuring the CSAM Board so that each member now is responsible for a specific activity, and helped lead the Society into a politically active role in the state.

Finally, I am active in clinical research as a co-investigator in several NIDA-sponsored research centers at the University of California, San Francisco.

How would your election benefit ASAM and the field of addiction medicine? ASAM is at an historic moment, when the organizational structures of a young organization struggling for legitimacy no longer are fully adequate to the tasks at hand. Consequently, I will support the President Brown in his reorganization of ASAM Board roles.

The political struggle for parity has to be the single most important issue for ASAM at this time, and I will work to achieve it.

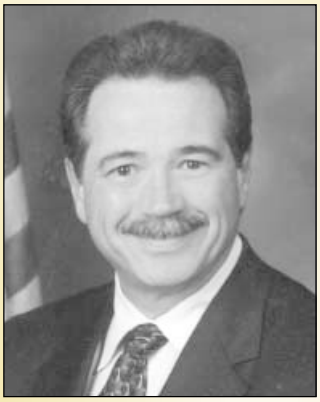
While I will continue to support the very high quality of our conferences, our unequalled textbook, and our public policy statements, I also will continue to oppose affiliate or associate membership for non-physicians.

I will support fiscal responsibility and more conservative income projections. And I will voice concerns about our journal, which appears to have difficulty competing with others in the field.

If elected, I will continue to talk straight, work respectfully with colleagues, contribute to solving complex problems, and stand up for evidence-based medicine in public forums. I cherish the warmth, lack of pretentiousness, and collegiality of ASAM colleagues, and I want to serve.

Donald J. Kurth, M.D., FASAM

Rancho Cucamonga, California



What do you consider your greatest contribution to ASAM and the field of addiction medicine? Four years ago, you elected me to represent you as California's Alternate Delegate to the ASAM Board of Directors. I have worked hard to represent you at every national meeting ASAM has held. You also elected me to serve as President of the California Society of Addiction Medicine and I am privileged to have had that opportunity.

How would your election benefit ASAM and the field of addiction medicine? We have a truly great specialty and the work we do helps many thousands of people who suffer from addiction to regain their families, their self-respect, and their lives. To be able to participate in that process is the greatest reward I can imagine as a physician.

By working together, our achievements in California have been even greater, as evidenced by enactment of Proposition 36, breakthroughs in buprenorphine treatment, progress in office-based opioid therapy, stellar advances in educational programming, public policy, and many more. We have held the first and second CSAM Legislative Days and brought dozens of physicians to Sacramento to meet with our legislators. We even have co-sponsored the Legislative Day of the California Medical Association and inspired ASAM to create a national Legislative Day to help carry the message of recovery and sound addiction policy to our Nation's capital.

We still face problems as a specialty, including discrimination against our patients, declining reimbursement, shrinking job opportunities, and managed care interference with our ability to practice medicine as we know it should be practiced. These are big problems, but we can overcome them if we are willing to stick together and work hard.

I pledge to you that I will work tirelessly to solve these problems. But I need your help and support. Elect me to the ASAM Board of Directors so that I can continue to work hard to win a better future for our patients, our members, and our Society.

CANDIDATES FOR DIRECTOR OF REGION II (continued)

LORI D. KARAN, M.D., FACP, FASAM
(INCUMBENT)
SAN FRANCISCO, CALIFORNIA

What do you consider your greatest contribution to ASAM and the field of addiction medicine? My numerous contributions to ASAM include co-chairing ASAM's Second and Third National Forums on AIDS and Chemical Dependency (1988, 1989), chairing ASAM's National Conference on Nicotine Dependence (1998), and organizing the Nicotine Research Roundtable Discussions, which ran annually from 1991 to 1999 and from which the Society for Research on Nicotine and Tobacco originated.

I helped pioneer the treatment of nicotine addiction within chemical dependency treatment, and collected the experiences of similarly innovative programs around the country in a seminal issue of the Journal of Substance Abuse Treatment, entitled "Towards a Broader View of Recovery."

Since 2000, I have been active on the Executive Board, Educational, Opiate Agonist, and Pain and Addiction Committees of CSAM. In 2000, I co-chaired CSAM's State of the Art Course.

During the past few years, I co-edited the pharmacology section of ASAM's *Principles of Addiction Medicine, Third Edition*, and was first author of two of the 12 chapters.

How would your election benefit ASAM and the field of addiction medicine? My initial role was to facilitate bi-directional communication between CSAM and ASAM and to represent California Society's views in important decisions by the ASAM Board. This progressed exceedingly well. Although other Regions do not always agree with us, CSAM's opinion is well respected. ASAM looks to CSAM as a model state chapter. In turn, CSAM warmly supports ASAM. CSAM understands that a strong national organization is needed to benefit our joint mission.

ASAM has undergone a dramatic reorganization during the past four years. ASAM's priorities have been identified. The structure to fulfill these functions now is tied to our Strategic Plan. Each of ASAM's products is under active review so that it might be optimized.

Today, I am an active member of the Finance and Publication Councils. Our publications strategy is being revised to maximize capabilities for demand-driven electronic communications.

The next four years are critical to nurture incipient ideas and solidify the changes that have been made to continue to revitalize our organization. I would be honored to continue as Region II Director.

★ ★ ★ ★ ★ ★ ★ ★

Ballots will be mailed to members in good standing by November 1, 2004, 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!

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CANDIDATES FOR DIRECTOR OF REGION III (CT, MA, ME, NH, RI, VT)

John P. Femino, M.D., FASAM

NORTH KINGSTOWN, RHODE ISLAND

What do you consider your greatest contribution to ASAM and the field of addiction medicine? As one of the first formally trained addiction medicine specialists in Rhode Island, and as an educator in the medical school and the community, I have helped define our field and represented our interests to the general medical community and to insurance companies. I have been involved in ASAM-related activities for many years, and currently am a member of the State Medical Specialty Society (SMSS) program.

I am board-certified in internal medicine, was certified by ASAM in 1986 and recertified in 2000, and I have been named a Fellow of ASAM. My greatest contribution to ASAM has been in organizing our local ASAM membership to form a new chapter, the Rhode Island Society of Addiction Medicine (RISAM), which I serve as President.

My greatest contribution to the field has been in representing addiction medicine issues to major insurance companies in Rhode Island, and in the education of patients, family members and health care professionals. I have successfully developed innovative addiction treatment programs, including founding the Meadows Edge Recovery Center, a state-licensed substance abuse treatment program.

I am a frequent lecturer on the neurobiology of addiction and received a grant from the NorthEast Addiction Technology Transfer Center to produce an educational curriculum for high school students, entitled "The Academy Curriculum: The Biology of Addiction."

How would your election benefit ASAM and the field of addiction medicine? I feel that my election as Regional Director would benefit ASAM by allowing me to share my experience in practicing addiction medicine in multiple settings and in organizing other physicians to become interested in our field. My longstanding expertise as an insurance company consultant, medical educator, and owner of an addiction treatment program give me the ability to meet the needs of our membership.

I will focus on the practical aspects of making a living in the addiction medicine field and helping ASAM's members market their services to our patients and to insurance companies.

Mark L. Kraus, M.D., FASAM

WATERBURY, CONNECTICUT

What do you consider your greatest contribution to ASAM and the field of addiction medicine? I am a general internist who is certified by ASAM and a Fellow of ASAM. I work as Medical Director of Addiction Medicine at Waterbury Hospital and as a staff member at St. Mary's Hospital, both in Waterbury, CT.

My greatest contribution to the field of addiction medicine is my clinical research into a beta blocker (atenolol) in conjunction with a benzodiazepine (oxazepam) for the treatment of alcohol withdrawal syndrome. In addition to clinical research, I teach addiction medicine and general internal medicine to residents at the Yale Primary Care Center's general internal medicine unit. I also have written numerous articles and book chapters on addiction medicine and have lectured on the topic locally, nationally and internationally. In addition, I hold an appointment as Assistant Clinical Professor of Medicine at the Yale University School of Medicine.

My greatest contributions to ASAM have been in helping to form a productive state chapter in Connecticut (which I chaired), and serving as chair of the Development Committee of ASAM's Strategic Plan Task Force and as a member of ASAM's Practice Guidelines Committee.

How would your election benefit ASAM and the field of addiction medicine? I believe my enthusiasm and my determination to make ASAM and the field of addiction medicine more visible to the public and the medical community at large would be a major contribution to ASAM and the field of addiction medicine.

As examples of my work in this area, I have chaired the Connecticut State Medical Society's Committee on Alcohol and Other Drug Dependencies and I currently serve as co-chair of the Physicians' Task Force on Addiction Medicine of the Association for Medical Education and Research in Substance Abuse (AMERSA).

I also have co-chaired a Governor's Blue Ribbon Task Force on Addiction Services for the State of Connecticut, and currently serve as a member of the Connecticut Alcohol and Drug Policy Council and the Connecticut Mental Health Policy Council.

CANDIDATES FOR DIRECTOR OF REGION IV (NJ, OH, PA)

LOUIS E. BAXTER, SR., M.D., FASAM

(INCUMBENT)

LAWRENCEVILLE, NEW JERSEY

What do you consider your greatest contribution to ASAM and the field of addiction medicine? My dedication and absolute commitment to ASAM and its mission, as evidenced by my professional activities and accomplishments, have been my greatest contribution to ASAM and the field of addiction medicine.

As Medical Director of the Physicians' Health Program of the Medical Society of New Jersey, I have had an opportunity to affect issues regarding medical licensure and the treatment of health care professionals, and to advocate for many physicians in the states of Region IV and elsewhere.

As the national chair of CSAT's Healthcare Professional Impairment Task Force, I contributed to the National Strategic Plan for Interdisciplinary Faculty Development a recommendation that addiction education become part of the core curriculum of all allied health educational programs in the nation.

At every opportunity, I have endeavored to advance and promote the mission, goals, and policies of ASAM—represented in part by our Strategic Plan—in the local, state, and federal policymaking and medical educational arenas, including my work with the Departments of Health in New Jersey and Pennsylvania, the federal Center for Substance Abuse Treatment, the Food and Drug Administration, the Substance Abuse and Mental Health Services Administration, and the National Football League.

How would your election benefit ASAM and the field of addiction medicine? My re-election as Director of Region IV would allow me to continue to advocate, promote, and disseminate the ideals and mission of ASAM, as outlined in the Society's Strategic Plan, with greater authority.

I believe that my relationships with the aforementioned agencies and my experience at the state chapter level in motivating, organizing, and successfully executing ASAM programs make me the best candidate to continue ASAM's growth and development and its incorporation and acceptance into mainstream medicine.

I recognize the value and worth of every ASAM member, and I want those members to see their ASAM membership as a source of real value to them.

TRUSANDRA E. TAYLOR, M.D.

PHILADELPHIA, PENNSYLVANIA

What do you consider 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 would your election benefit ASAM and the field of addiction medicine? If I am elected to the Board as Director of Region IV, I will continue my commitment to addiction medicine and to advocate for ASAM. Specifically, I will work to carry out ASAM's Strategic Plan involving the six identified goals.

For example, I will focus on increasing membership in ASAM by actively campaigning and recruiting new members regionally, as well as participating 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.

CANDIDATES FOR DIRECTOR OF REGION IV (continued)

John J. Verdon, Jr., M.D., FASAM

Shrewsbury, New Jersey

What do you consider your greatest contribution to ASAM and the field of addiction medicine? In 1995, the emerging New Jersey chapter of ASAM was languishing. I was asked to represent the chapter at the state chapter presidents' meeting at ASAM's Med-Sci Conference in Atlanta. There, inspired by Paul Earley and Jim Callahan, I accepted the challenge to participate in the resurrection of the New Jersey Society of Addiction Medicine (NJSAM), a demanding yet rewarding task.

Under my leadership, NJSAM became a model chapter, even gaining tax-exempt status from the IRS under the ASAM umbrella. (Tax-exempt status allows new chapters to avoid the expense—and headaches—encountered by the New Jersey chapter.)

How would your election benefit ASAM and the field of addiction medicine? I am fortunate to have matured as a physician during the evolution of addiction medicine as a recognized specialty. The breadth of my experience—in medical student and resident education, administration, consultant to the courts, jails, lawyers, industry, and as a clinician caring for myriad patients and their families—provides me with the perspective of a "Doc" who has "worn many hats." For example, in my private office-based practice, I recently evaluated and treated severely ill, acutely decompensated opioid-dependent patients with buprenorphine and engaged them, as medically appropriate, in opioid agonist maintenance therapy.

I am committed to bring to the Board the concerns of all Region IV members. From first-hand experience, I know the diverse problems encountered by the private practice physician who toils alone in his or her office, treating patients and their loved ones who are afflicted with the devastating but highly treatable disease of addiction.

Accordingly, I will vigorously pursue parity in access to treatment and reasonable reimbursement for those services. I encourage all of you to advise me of any problems you face and ideas you wish me to bring to the Board. You will find me accessible and interested in forcefully representing your needs to the Board of Directors of ASAM.

Looking Back, Looking Forward *continued from page 2*

establish a mentoring program for primary care physicians and other non-addiction medicine specialists who wish to prescribe buprenorphine. There are many beneficial consequences of this award, one of which is that ASAM will establish a federally-approved indirect cost rate, which will be useful in pursuing other federal funds to meet the needs of ASAM members.

Because of our appreciation of the importance of the Society's finances, this fall's Board meeting is dedicated to enhancing our knowledge and understanding of our responsibilities as a Board for the fiscal well-being of the Society.

ASAM Products

Among the legacies of which ASAM can be proud, its products stand out for their importance to our members, to the field, and to the public health as a whole. These products include ASAM's textbook, *Principles of Addiction Medicine* (the third edition of which is now in its second printing), the *ASAM Patient Placement Criteria, Second Edition-Revised* (used by nearly 30 of the 50 states), *ASAM News*, the ASAM-sponsored *Journal of Addictive Diseases*, the ASAM certification examination, and ASAM's portfolio of educational conferences and meetings.

While recognizing these "victories of products," we have matured to ask prudent questions as to their continued value and/or whether there exists opportunities for improvement. This has not been an easy task. We have had to review the history of these products to fully understand decisions that occurred prior to our tenure as a Board. We learned the breadth of their value and their relevance to the needs of current members and the future of the Society. Although this effort has been challenging, it will be ongoing.

Our Short-Term Objectives

Now, let us turn to what is ahead for the Society for the remainder of the term of the current Board (which ends in April 2005).

From the standpoint of governance, our "to do" list includes:

1. Populating the Councils with non-Board ASAM members and arranging for two conference calls for each Council between now and April 2005.
2. Using the Councils and Committees to assist in clarifying issues prior to Board action, except when the timing of decision-making does not allow it.
3. Re-administering the Board self-assessment survey to measure our progress.

The next steps in enhancing the fiscal health of the Society include:

1. Enhancing Board members' understanding of their fiduciary responsibilities.
2. Providing the Board with information about the economic yield of each of ASAM's many products.
3. Reaching further decisions about the Ruth Fox Memorial Endowment Fund.
4. Reaching further decisions about the proposed reserve fund.
5. Considering other fund-raising opportunities.

As far as ASAM products, the next steps include:

1. Protecting the ASAM brand in the use of its products.
2. Understanding the Board's inherent responsibilities in avoiding unintentional negative outcomes of ASAM's products.
3. Refining the standard operating procedures of the decision-making process with regard to implementation of ASAM's products.
4. Conducting more focused member surveys of our products.

In summary, ASAM has made major steps in achieving nothing short of a renaissance over the last few years, and especially during the tenure of the current Board. We all should feel a great sense of accomplishment. At the same time, this experience has enhanced our appreciation that there is much that still can be done and should be done. Clearly, these efforts are more analogous to a relay race or a marathon than to a sprint. Let us continue our gold medal performance, so that the leaders who succeed us will appreciate that they are well-positioned to further enhance the needs of ASAM members, the stature of the Society, the substance abuse treatment field, and the welfare of our patients.

CANDIDATES FOR DIRECTOR OF REGION V (DC, DE, GA, MD, NC, SC, VA, WV)

Timothy L. Fischer, D.O.

ORANGEBURG, SOUTH CAROLINA

What do you consider your greatest contribution to ASAM and the field of addiction medicine? I am board-certified in family medicine by the American Osteopathic Board of Family Physicians. I also am certified by ASAM. I currently serve as Medical Director of The Dawn Center and the William J. McCord Adolescent Treatment Center.

As founder and first President of the South Carolina Society of Addiction Medicine (SCSAM), I saw our membership grow by almost 100% in our first two years as a chapter. Our chapter also has sponsored or co-sponsored conferences, holds a seat on the Substance Abuse Committee of the Governor's Maternal, Infant and Child Health Council, and is an active participant in state legislative issues. For example, we helped to pass an Omnibus Highway Safety Act and won a contract with the South Carolina Department of Alcohol and Other Drug Abuse Services to provide training and conferences in addiction medicine and to serve as consultants to the department. We will be paid for this as a chapter and individually. All of this is possible because we are an ASAM state chapter.

Within ASAM, I have served on the Membership Committee, the Membership Campaign Task Force, the Strategic Plan Task Force and the Practice Guidelines Committee. I also have chaired ASAM's State Chapters Committee.

My goals for our Society are, first, to help all states develop a state chapter, and second, to strengthen the existing chapters so that they are organizationally strong and sustaining. Many chapters are only as good as the current president and, when that individual no longer is president, the chapter founders. We need each chapter to be organizationally strong so that these valleys can be eliminated.

How would your election benefit ASAM and the field of addiction medicine? I feel that I would be able to help ASAM and addiction medicine in the areas of organization, public relations, public policy, and in the political arena. I also feel that I am skilled at seeing what is possible, developing a plan, and getting it done.

Martha J. Wunsch, M.D.

BLACKSBURG, VIRGINIA

What do you consider your greatest contribution to ASAM and the field of addiction medicine? My experience as a board-certified pediatrician, my cross-cultural work with Native Americans, and my experience as a primary care physician provide me with experiences that will contribute to ASAM.

What skills does a pediatrician bring to addiction medicine, other than knowledge of fetal alcohol syndrome? From my perspective, the problem behaviors, attitudes, and lack of coping skills in addiction resemble the arrested developmental stages of adolescence persisting into adulthood. I have seen the impact of addiction on the family. Who but the pediatrician is looking out for problems in children before they become troubled, addicted teens? I have been a member of ASAM's Pregnancy and Neonatal Committee since 1990, the Committee on Children and Adolescents since 2002, and currently serve as liaison between ASAM and the American Academy of Pediatrics.

My initial exposure to substance abuse was while treating women at the Pascua Alcohol Treatment Home in Southwestern Arizona. I learned to integrate culturally appropriate approaches, to respect and utilize traditional healers, to implement traditional tribal practices, and to acknowledge opinions and suggestions from recovering Native American patients.

My approach to healing and addiction changed as a result of that experience. To be successful in treating addiction, we have to consider unique and different approaches to treatment for culturally diverse populations. This unusual perspective for addiction medicine is one of my contributions to the field.

How would your election benefit ASAM and the field of addiction medicine? My primary care colleagues are frustrated by their lack of knowledge in diagnosing and managing addictive disorders in patients and their families. In the rural area where I practice, prescription drug abuse is rampant, and diversion of opioid analgesics jeopardizes the appropriate treatment of pain. Our colleagues need tools to intervene, stabilize, and refer such patients.

I am interested in providing validated, efficient, effective education for primary care physicians, using ASAM resources. We need to carry our message beyond ASAM to our colleagues in primary care.

CANDIDATES FOR DIRECTOR OF REGION VI (IA, IL, IN, MI, MN, WI)

Paul S. Board, M.D.

DES PLAINES, ILLINOIS

What do you consider your greatest contribution to ASAM and the field of addiction medicine? I have been involved in the care of chemically dependent patients since 1990, when I observed that physician-directed care was lacking in the large HMO where I was employed. I served as Medical Director for Addiction Services for Humana HMO in the Chicago area, with responsibility for the treatment of more than 300,000 members and several intensive outpatient programs. During that time, I was an advocate for treatment innovations and extension of benefits (such as coverage for methadone maintenance) and created programs for outpatient detoxification, dual diagnosis, and psychiatric resident education, and the implementation of ASAM patient placement standards well before they were required.

My greatest contribution to ASAM and the field of addiction medicine has been my active and enthusiastic participation as an informed, ASAM-trained and certified physician in a variety of clinical and administrative settings, including my involvement as a member of the board of directors of the Illinois Society of Addiction Medicine (ISAM).

I have integrated many of the things I have learned from ASAM conferences and policies into my professional practice as a clinician, educator and administrator, and have always sought to promote addiction medicine and ASAM whenever possible.

How would your election benefit ASAM and the field of Addiction Medicine? ASAM and the addiction medicine field would benefit from my election as Region VI Director because I am an informed, well-trained, dedicated individual who would work on their behalf.

Following the AA slogan, "Principles before Personalities," I offer the physicians in Region VI open-minded representation on issues of concern, as well as the communication and organizational skills necessary to help implement any new policies or programs.

My enthusiasm for addiction medicine is evident, whether I am caring for a patient, interacting with colleagues, facilitating a staff meeting, or engaged in other duties. I believe I have the experience and skills necessary to represent Region VI and ASAM well.

Thomas L. Haynes, M.D., FASAM

(INCUMBENT)

GRAND RAPIDS, MICHIGAN

What do you consider your greatest contribution to ASAM and the field of addiction medicine? I have engaged in the full-time and very active practice of addiction medicine since 1985, and a member of ASAM since 1983. In that time, I have served on several committees and task forces. I also attend and support the State Medical Specialty Society (SMSS) meetings and believe that this is one of the most important initiatives that ASAM has ever undertaken.

In Michigan, I helped to establish the Michigan Society of Addiction Medicine and served as its first president. I also served a five-year term as chair of the Michigan Health Professionals Recovery Committee.

As Region VI Director, I have reorganized the Region to be a more culturally and politically cohesive part of ASAM. I feel that I have represented the Region well at ASAM Board meetings because I canvass the presidents of the state chapters in my Region before every Board meeting to be sure I represent the activities and needs of every chapter in Region VI.

At present, I am actively pursuing the development of chapters in Indiana and Minnesota. When this is accomplished, Region VI will have chapters in every one of its component states.

How would your election benefit ASAM and the field of addiction medicine? I believe that I can benefit ASAM by promoting the acceptance of the primary treatment of addiction in mainstream medical practice, and by doing whatever I can to bridge the gap between the need for addiction treatment and the lack of support for that treatment by government, industry, and third-party payers. Toward this end, I have participated in the first two ASAM Legislative Days. I also have attended every ASAM Board meeting for the last nine years.

As a business owner and practicing addiction medicine specialist, I understand the pressures faced by those of us who work outside academia or government. Therefore, I am able to bring a strong voice to the Board on behalf of ASAM members who practice addiction medicine in clinical settings.

CANDIDATES FOR DIRECTOR OF REGION VII (AR, KS, LA, MO, NE, OK, TX)

John P. Epling, Jr., M.D.

SHREVEPORT, LOUISIANA

What do you consider your greatest contribution to ASAM and the field of addiction medicine? I have a private practice in addiction medicine and was certified by ASAM in 1990. I was certified in my original specialty, diagnostic radiology, in 1965. I hold an appointment as Associate Clinical Professor in the Department of Psychiatry at Louisiana State University Center in Shreveport, where I conduct various seminars for medical students and residents.

I am the medical director of Step Up Inc., a non-profit organization dedicated to supplying transitional living facilities, detoxification, and outpatient treatment for men and women with addictive disease. We supply more than 100 beds within the community of Shreveport and receive diverse community funding.

In the past, I opened an addiction medicine clinic in Lake Charles and worked at various intervals as medical director for Charter and the Council for Alcoholism in northwest Louisiana. During Operation Desert Storm, I worked to strengthen the addiction services at Baynes-Jones Army Hospital. I also have been a consultant for the VA hospital in Shreveport. All of these positions have provided me with the opportunity to educate and promote up-to-date treatment and interventions.

Through all these activities, I have continued to promote and support ASAM as the leading national organization in the field of addiction treatment and education. I was the founding President of the Louisiana Society of Addiction Medicine and have served on its Committee on Parity in Addiction.

How would your election benefit ASAM and the field of addiction medicine? I will work to implement ASAM's goals and keep an active line of communication open between the chapters and the national ASAM organization. I believe that communication stimulates interest and involvement in both local and national activities. I have the desire to serve and the means and commitment to carry ASAM's leadership role into the future.

Howard C. Wetsman, M.D.

NEW ORLEANS, LOUISIANA

What do you consider your greatest contribution to ASAM and the field of addiction medicine? I am an Assistant Professor of Psychiatry at Louisiana State University's Medical School, where I carry a large teaching load in psychiatry, addiction, and ethics. Until recently, I also was the lead psychiatrist and the only addictionologist at LSU's Charity Hospital HIV Outpatient Clinic. I recently left Charity to take a position in the VA. I am board-certified in general and forensic psychiatry, and was certified by ASAM in 2000.

Through other teaching activities, I have been able to reach diverse non-medical groups (such as lawyers, judges, and community organizations) with information about the disease of addiction and its treatment. I have enjoyed teaching about the neurobiology of addiction, non-pharmacologic treatments and the important role of Twelve-Step Recovery, and I co-directed the Region VII Annual Addiction Review in 2004.

I serve as Secretary-Treasurer of the Louisiana Society of Addiction Medicine (LSAM), where I have instituted an email newsletter to keep members updated about our activities and to pass along new findings about addiction medicine. I also was the founding secretary-treasurer of the military chapter of the American Psychiatric Association.

Finally, and perhaps most important, I have been an avid recruiter of new members for ASAM. With the expanding knowledge base about addiction and the consequent expanding interest in addiction medicine, it is paramount that those who wish to treat addiction are educated members of a national professional organization. For us, of course, ASAM is the organization of choice.

How would your election benefit ASAM and the field of addiction medicine? My primary goal as Regional Director is to serve as a conduit for information. With the same energy and commitment I have brought to my other activities, I will work to provide a flow of information from the national to the regional level, as well as to bring the concerns of Region VII members to ASAM's national leadership.

The election packages mailed to members in good standing will contain, in addition to the ballots, campaign statements, biographical sketches and photos of the candidates.

CANDIDATES FOR DIRECTOR OF REGION VIII (AK, AZ, CO, HI, ID, MT, ND, NM, NV, OR, SD, UT, WA, WY)

Marvin Seppala, M.D.

NEWBERG, OREGON

What do you consider your greatest contribution to ASAM and the field of addiction medicine? My career has been devoted to the care and treatment of people with addictive disease, so my greatest contributions are found in those I've had the privilege of working with, both patients with this disease and my colleagues. I dropped out of high school because of this disease, but have experienced a remarkable turn of events since entering recovery at age 19. I completed medical school, psychiatric training, and an addiction medicine fellowship with the specific intent of working in addiction medicine.

I have worked in almost every type of addiction treatment program: adolescent, Native American, Southeast Asian, methadone maintenance, and women's programs; public and private programs; outpatient and residential programs and halfway houses; HMOs and private practice; dual diagnosis and psychiatric hospitals. Currently, I am the chief medical officer of the Hazelden Foundation.

I am a founding board member of the Oregon Society of Addiction Medicine and serve on the Oregon Governor's Council on Alcohol and Drug Abuse Programs. I have been a member of ASAM's Publications Committee and a lecturer at the ASAM Medical-Scientific Conference.

How would your election benefit ASAM and the field of addiction medicine? I believe I have a responsibility to those who have addictive disease, and wish to work within ASAM to do what I can to help addiction medicine fulfill its role in addressing this devastating illness.

I would bring addiction medicine expertise and significant, broad experience in this field to the ASAM Board, but just as important, I bring the perspective and commitment of a person in recovery from addictive disease. I would bring a very balanced, thoughtful perspective to the ASAM Board, based on my training and experience.

My position with Hazelden permits me to commit my time and energy to ASAM in the manner required of a Board member. If elected, I would be able to contribute an experienced, passionate, and educated perspective to ASAM's activities.

Berton J. Toews, M.D., FASAM

(INCUMBENT)

CASPER, WYOMING

What do you consider your greatest contribution to ASAM and the field of addiction medicine? I have practiced addiction medicine in Wyoming for more than 20 years and still am the only full-time addiction medicine specialist in the state.

I am a child of the Rocky Mountains—I was born near Calgary, Alberta, grew up in the Idaho panhandle, was educated at the University of Northern Colorado, and was a charter member of Wyoming's first residency program. I am board-certified in family practice.

In the public sector, I spend time regularly at two county mental health clinics, where I see addiction psychiatry patients, and I have done consultation and training work with several other programs and the state Health Department. I have helped to plan and present educational programs around the state, and have worked to improve detox services and methamphetamine awareness in particular.

My principal work involves running a small non-hospital treatment program, which has 17 beds—the only integrated multilevel treatment in the state. I also am medical director of the Wyoming Professional Assistance Program, with which I have been involved since it was established in Wyoming in 1983.

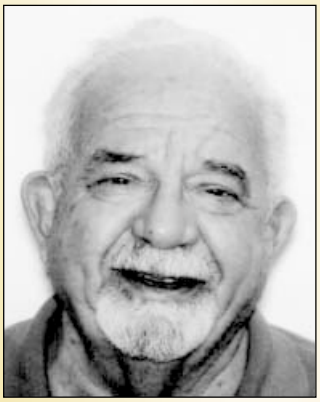
My contributions to ASAM are primarily as a Board member since 2001. I have faithfully attended Board meetings and conference calls, and have tried to add a perspective of the Western part of the U.S. while learning to create direction for all of ASAM. Region VIII comprises 49% of the Nation's land area and our voice is a significant one that has much in common with, and occasionally in contrast to, other parts of the continent.

How would your election benefit ASAM and the field of addiction medicine? If elected, I will be able to build on my experience as an ASAM Board member over the past several years. I will continue to represent the interests of Western states to the best of my ability. My efforts at increasing communication in Region VIII can be expanded and lead to a more concrete presence for the Region within ASAM.

CANDIDATES FOR DIRECTOR OF REGION VIII (continued)

Richard E. Tremblay, M.D., FASAM

OLYMPIA, WASHINGTON



What do you consider your greatest contribution to ASAM and the field of addiction medicine? My contributions in addiction medicine have been through two avenues: my clinical practice and my work in ASAM. In both, I have worked to make contributions to ASAM and the field of addiction medicine at the local, state and national levels.

As a clinical practitioner, I have worked in the field of addiction medicine for many years, both in private practice and as medical director of both private and public sector inpatient and outpatient treatment programs, serving adult and adolescent patients. This gives me great empathy with the barriers to patient care that so many of our members encounter on a daily basis.

As a member of ASAM, I have participated in every Medical-Scientific Conference, served on numerous committees (including the Membership, Chapters, Fellowship, Methadone, Physician's Health, and Constitution & Bylaws Committees). I have served one term on the ASAM Board as a Regional Director and currently am the Alternate Director representing Region VIII. I also was entrusted by the Board with the chairmanship of ASAM's Strategic Plan Task Force.

At the state level, I was the founding President of the Washington State Society of Addiction Medicine, and have worked to build our chapter to reflect the unique character of our region, its medical community and population.

More than simply experience in the organization, I believe that these multiple opportunities for service have given me a chance to learn what ASAM can do to improve the quality of life for our members and the quality of care for their patients.

How would your election benefit ASAM and the field of addiction medicine? My election would benefit ASAM and the field of addiction medicine by allowing me to dedicate my administrative experience within ASAM and my practical experience as a caregiver to the goal of strengthening the relationship between the states in Region VIII and the national organization, as well as preserving the strength and vitality of ASAM as the paramount voice of addiction medicine.

CANDIDATES FOR DIRECTOR OF REGION IX (CANADA AND INTERNATIONAL)

João C. Dias da Silva, M.D.

RIO DE JANEIRO, BRAZIL

What do you consider your greatest contribution to ASAM and the field of addiction medicine? My greatest contribution has been to introduce ASAM and the specialty of addiction medicine into one of the most important Latin American countries. I have specialized in psychiatry and forensic psychiatry since 1983, with Brazil's Occupational Health and Hospital Administration. I also have worked in the private sector and have been head of the Alcoholism Department of the Psychiatric Service of the Hospital Santa Casa da Misericórdia do Rio de Janeiro.

I am a past president of the Brazilian Association of Studies on Alcohol and Other Drugs, and represent the Brazilian Medical Association in the National Antidrug Council—Brazil's most important policymaking body about drugs.

Currently, I am the Coordinator of the Chemical Addiction Department of the Brazilian Psychiatry Association (ABP). The ABP is composed of 4,500 psychiatrist members and maintains relations with national and international associations, such as the Latin American Psychiatric Association and the World Psychiatric Association.

I had the honor of participating as a founding member of the Board of Directors of the International Society of Addiction Medicine (ISAM), which afforded me an opportunity for constant interchange with colleagues in the United States and all over the world. ISAM's potential for strengthening our association in South America will be very valuable in disseminating knowledge about addiction medicine internationally.

How would your election benefit ASAM and the field of addiction medicine? The possibility of bringing together physicians who, in a direct or indirect manner, deal with the misuse and abuse of alcohol and drugs and the medical consequences of such abuse in an association such as ASAM would be extremely beneficial to our efforts to consolidate this specialty in many countries that do not yet recognize addiction medicine. Likewise, the scientific interchange through continued educational initiatives—such as ABP's Internet program (WWW.ABPBRASIL.ORG.BR) and events that attract specialists from different countries—will be a valuable contribution to ASAM's growth at an international level.

CANDIDATES FOR DIRECTOR OF REGION IX (continued)

Raju Hajela, M.D., M.P.H., FASAM

KINGSTON, ONTARIO, CANADA

What do you consider your greatest contribution to ASAM and the field of addiction medicine? My greatest contribution to ASAM has been through promoting its ideals and encouraging membership and certification among interested and suitable colleagues since 1988.

I have been a founding member of the Canadian Society of Addiction Medicine (C*SAM) since 1989 and a founding member of the International Society of Addiction Medicine (ISAM) since 1999. I earned my ASAM certification in 1990, was named a Fellow of ASAM in 1998, and earned my certification from C*SAM in 2000. I plan to sit for the ASAM recertification examination in 2004. I am tremendously grateful for all the support I have received, personally and collectively, for C*SAM and ISAM from the members and the leadership of ASAM.

Collaboration with ASAM has been instrumental in developing a certification process for C*SAM, which remains under my leadership as chair of C*SAM's Standards Committee. I have led the C*SAM Definitions in Addiction Medicine project, which has established 31 important definitions, a majority of which also have been adopted by ISAM. I have provided input to various ASAM committees, especially in matters related to adolescents and pain and addiction.

I have developed and delivered training programs in addiction medicine for medical students and practicing physicians, in addition to presenting papers, posters and workshops at various conferences, and have contributed to scientific publications.

How would your election benefit ASAM and the field of addiction medicine? My election as Region IX Director would allow me to provide a strong voice on behalf of ASAM's international members from Canada and other parts of the world. My long years of involvement with ASAM and ISAM have provided me with numerous opportunities to get to know the Region IX membership. I look forward to getting to know the members and their professional issues even better so that we can promote a vibrant specialty nationally and internationally. I hope to strengthen the ties among ASAM, ISAM, C*SAM and other national addiction medicine organizations, thus making our individual and collective voices stronger.

CANDIDATES FOR DIRECTOR OF REGION X (AL, FL, KY, MS, PR, TN, VI)

James A. Halikas, M.D., FASAM

NAPLES, FLORIDA

What do you consider your greatest contribution to ASAM and the field of addiction medicine? I have been an active participant in ASAM for more than 25 years, as Treasurer, as chair of the Medical Education Committee, as co-chair of the Fellowship Committee, as a member of the Executive Committee, and as an active presenter at our annual Medical-Scientific Conferences. In fact, if you've ever taken an ASAM course or received CME credits from ASAM, I probably helped organize or approve the course, and my signature is on your certificate.

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

How would your election benefit ASAM and the field of addiction medicine? My goals are to strengthen our Society and its membership so that ASAM can be an effective voice for our specialty, in order to improve reimbursement for our services and solidify ASAM's position as a medical specialty society.

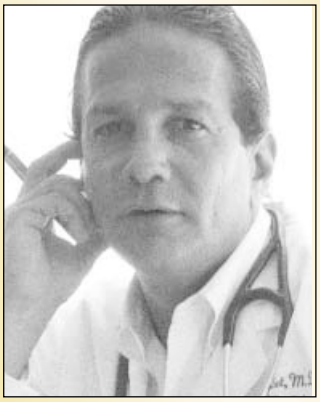
I also want to spread the good news that treatment works! I want to try to steer ASAM into activities that demonstrate treatment response and effectiveness. In all conferences and CME activities that we are involved in, I want to try to stimulate presentations on treatment and its effectiveness.

Finally, in this period of focus on medical cost containment, I believe that the most important duty of the Director of Region X will be to see to it that our members can survive professionally, have a place at the table of managed care, and continue to have the opportunity to treat chemically dependent patients.

CANDIDATES FOR DIRECTOR OF REGION X (continued)

JEFFREY D. KAMLET, M.D.

MIAMI, FLORIDA



What do you consider your greatest contribution to ASAM and the field of addiction medicine? I joined ASAM in 1997 and was certified in 1998. Currently I am President-Elect of the Florida Society of Addiction Medicine (FSAM), after chairing the Scientific Planning Committee for several years. I have served on national ASAM committees and have had the honor of speaking at various ASAM functions.

In addition to the full-time practice of addiction medicine, I serve as Director of Medical Services for the Healing Transitions Institute of Addiction Recovery Ltd., where I am involved in FDA testing of the drug Ibogaine as an addiction interrupter.

I also am active in several research protocols studying the efficacy and safety of new addiction treatment modalities and the nutritional aspects of the post-acute withdrawal syndrome. I am an addiction consultant to several South Florida treatment centers and hospitals. I am an active evaluator for the Florida Intervention Project for nurses, the Florida Physicians' Recovery Network, the Florida Lawyer's Assistance Program, and the Agency for Health Care Administration.

I have Diplomat status in bariatric medicine, forensic medicine, forensic examination, and forensic psychology. I have been a professor at Nova, Miami and Barry Universities and was voted "Professor of the Year" at Barry University in 1998. My work has appeared in *JAMA*, the *New York Times*, and *Omni Magazine,* and on radio and television.

How would your election benefit ASAM and the field of addiction medicine? Over the last several years, I have seen attendance at state conferences and functions decrease. FSAM membership and attendance at its functions has recently been on the decline.

In order to promote the continued growth of ASAM at the state and regional levels, Region X and its component state chapters need to share resources. Holding a joint Region X conference and providing continuing education credits to addiction professionals who are not physicians will market Region X activities to a broad field of addiction professionals. State chapters and Region X must actively attract new ASAM members who are willing to work and grow with the organization.

C. CHAPMAN SLEDGE, M.D., FASAM

HATTIESBURG, MISSISSIPPI

What do you consider your greatest contribution to ASAM and the field of addiction medicine? The field of addiction medicine has reaped tremendous benefits from academicians and researchers who bring science to the table. My strength, however, is at a grassroots level. Without question, I believe that my greatest contribution to the field of addiction medicine has been in the realm of day-to-day, hands-on patient care.

Since 1989, I have been engaged in the full-time practice of addiction medicine. I was certified by ASAM in 1992, recertified in 2002, and named a Fellow of ASAM in 1998. For the past 10 years, I have been affiliated with Pine Grove Recovery Center and Pine Grove Next Step, overseeing treatment at all levels of care.

I have been extremely active in promoting basic education about the disease of chemical dependency and the specialty of addiction medicine at the community, state, and regional levels through my memberships in the Mississippi State Medical Association, the Southern Medical Association, and the American Medical Association.

I have been President of the Mississippi Society of Addiction Medicine and have represented Mississippi on ASAM's State Chapters Committee. I also have been a member of ASAM's Nominating & Awards Committee and, since 1994, of the Credentialing Committee. For the last two examination cycles, I have chaired that committee, and I currently chair the Credentialing Council. I also have represented ASAM in the AMA's House of Delegates.

How would your election benefit ASAM and the field of addiction medicine? My election as Director of Region X would maintain the perspective of abstinence-based, Twelve Step-oriented treatment on the Board. I will be a strong advocate for pursuing specialty status for addiction medicine and will work tirelessly for parity.

The Region X annual meeting has the potential to develop into a wonderful opportunity for addiction medicine specialists in the Southeast to network and stay abreast of the most recent developments in the field. I would continue to foster the regional meeting and to promote state-level meetings to further the specialty of addiction medicine.

Ruth Fox Memorial Endowment Fund

Physicians' Health Program

The North Carolina Physicians' Health Program, one of the most widely recognized organizations of its kind, is recruiting a physician in recovery for Associate Medical Director.

Play an integral role in helping your colleagues deal with career-threatening health issues such as addiction and depression!

Visit WWW.NCMEDSOC.ORG classified section for more details.

Send CV, bio, two reference letters and salary expectations *(marked confidential)* to:

KIM McCALLIE
NC Physicians Health Program
220 Horizon Drive, Ste. 218
Raleigh, NC 27615

Closing Date: November 5, 2004

SAMHSA Moves to New Quarters

Staff of the Substance Abuse and Mental Health Services Administration (SAMHSA) moved to a new office building in September. All staff have new phone and fax numbers. The address for all SAMHSA agencies is now 1 Choke Cherry Road, Rockville, MD 20857. The main phone numbers for SAMHSA's principal offices and agencies are as follows:

Office of the Administrator (OA) 240/276-2000
Office of Applied Studies (OAS) 240/276-1250
Center for Mental Health Services (CMHS) 240/276-1310
Center for Substance Abuse Prevention (CSAP) 240/276-2420
Center for Substance Abuse Treatment (CSAT) 240/276-1660

Concurrent with the move, many staff also changed email addresses. The new addresses are developed from the individual's name according to the following formula: FIRSTNAME.LASTNAME@SAMHSA.HHS.GOV. Contact information for individual SAMHSA employees can be found in the HHS employee locator at HTTP://DIRECTORY.PSC.GOV/EMPLOYEE.HTM.

Dr. Ruth Fox

Dear Colleague:

With the support of our members and friends, the Endowment Fund has come very close to achieving its next goal of $4 million. Among other worthy activities, the Fund supports the Ruth Fox Scholarship Program. Since 2002, when the Scholarship program was established, we have sponsored 20 physicians-in-training to attend ASAM's Med-Sci Conference and Ruth Fox Course, and we look forward to hosting another group of physicians-in-training in Dallas at the 2005 Medical-Scientific Conference.

The next Ruth Fox Donor Reception will be held during that conference on Friday evening, April 15, 2005. Invitations to the reception are limited to Ruth Fox donors only, so if you have not already contributed or pledged to the Endowment Fund, please do so now and help us reach our goal. Also let us know if you have included the Endowment in your estate plans so that we can acknowledge your generosity. Your support will be greatly appreciated.

For information about making a pledge, contribution, bequest, memorial tribute, or to discuss other types of gifts in confidence, please contact Claire Osman by phone at 1-800/257-6776 or 1-718/275-7766, or email Claire at ASAMCLAIRE@AOL.COM. She welcomes your calls.

Now may be an opportune time to examine the amount and timing of your gifts in order to maximize your tax savings this year. All contributions to the Endowment Fund are tax-deductible to the full extent allowed by law.

Max A. Schneider, M.D., FASAM, Chair,
Ruth Fox Memorial Endowment Subcommittee
Claire Osman, Director of Development

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STOP PERPETUATING THE "CRACK BABY" MYTH

David C. Lewis, M.D.

After 16 years of research and more than a decade of following the development of children thought to have been at serious risk, medical experts have not identified a recognizable condition, syndrome or disorder that merits the label "crack baby." With no basis in science, the term serves only to stigmatize and slander children and their mothers and should be eliminated.

The term "crack baby" is an urban legend masquerading as a medical diagnosis. It is a label that stigmatizes, marginalizes and endangers children and their mothers who are desperately in need of care. Born from the combination of an ongoing crisis in urban health care and draconian zero-tolerance drug policies, the crack-baby myth thrives even though it has no basis in science. This is in dramatic contrast to the specific and well-established criteria for a diagnosis of fetal alcohol syndrome.

Due to a combination of insufficient data and public fears that followed the crack cocaine epidemic of the mid-1980s, crack was alleged to be harmful to the cognitive and emotional development of unborn children. Sensational news stories warned of the damage that crack would inflict on a generation of children and thus on society in general. A few scientists went beyond the data from incomplete research and contributed to the hype with inaccurate comments.

Now, with the benefit of additional research and better data, we know that those fears and early stories were wrong. In fact, medical and psychological research suggests that we should eliminate a number of terms from use—not only "crack baby," but "crack-addicted baby," "ice baby" and "meth baby." That these terms do not correspond to a proper diagnosis is not simply an academic question; there are serious practical implications for our Nation's health and welfare. But change comes slowly, and we persist in mislabeling the children.

Recently a New Jersey family allegedly starved several of its adopted foster children. The foster parents claimed that the children looked emaciated because they were "crack babies" and therefore could never grow. Thus, the family was able to fend off outside attempts to intervene. Newspaper and television reports added legitimacy to their rationale by describing at least one of the children as a "crack baby."

If crack cocaine was not responsible for the children's emaciated condition, what could account for their symptoms? Research now shows that the fetal and infant health problems previously associated with crack cocaine are better explained by malnutrition and a lack of prenatal care. In fact, a comprehensive research review shows no consistent negative association between maternal cocaine exposure and children's physical growth, developmental test scores, or performance on receptive and expressive language tests. Furthermore, standardized parent and teacher reports of student behavior show no independent effects on children of maternal cocaine use.

Thirty of the nation's top scientists and physicians are trying to set the record straight. They have united to document the current status of scientific evidence regarding the effects on children of exposure to drugs during their mothers' pregnancies. This scientific statement is available for public review at WWW.JOINTOGETHER.ORG/SA/FILES/PDF/SCIENCENOTSTIGMA.PDF.

Our Nation's prowess in science and medicine is only worthwhile if it can help us dispel myths and provide better care. An obvious positive step in achieving both these goals is to finally eliminate the "crack baby" myth from our professional lexicon.

***DR. LEWIS** is the Donald G. Millar Distinguished Professor of Alcohol and Addiction Studies at Brown University. Among his many leadership activities in the addiction field, he is Secretary of ASAM.*

ASAM Conference Calendar

ASAM

November 4-6, 2004
ASAM 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
Westin Embassy Row Hotel
Washington, DC
7 Category 1 CME credits

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

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

October 13-16, 2004
American Medical Association
and Canadian Medical
Association
2004 International Conference
on Physician Health
Oak Brook, IL
[For information, email
PHC@AMA-ASSN.ORG]

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

October 29-30, 2004
ASAM – Ohio SAM
Cincinnati, OH
Contact: GGRAETZ@ASAM.ORG

November 6, 2004
ASAM – Texas SAM
Houston, TX
Contact: GGRAETZ@ASAM.ORG

November 13, 2004
ASAM – New York SAM
New York, NY
Contact: TBALDWIN@XPERIENCE-NY.COM

November 20, 2004
ASAM – Massachusetts SAM
Boston, MA
Contact: TBALDWIN@XPERIENCE-NY.COM

December 4, 2004
ASAM – California SAM
Los Angeles, CA
Contact: TBALDWIN@XPERIENCE-NY.COM

PAIN WORK GROUP SEEKS NEW MEMBERS

Howard A. Heit, M.D., FACP, FASAM, Chair, ASAM Pain Work Group

ASAM's Pain Work Group (formerly the Pain Committee) welcomes new members who are interested in the interface of pain and addiction. Current and new members will have an opportunity to define the goals and projects to be undertaken by the group. Most of our work will be accomplished by closed-group email; I anticipate that our next face-to-face meeting will take place at the 2005 Med-Sci Conference.

If you are interested in joining this Work Group, which addresses one of the most exciting and rewarding areas of addiction medicine, please email me at HOWARD204@AOL.COM. Once I receive the responses, I will be in touch with all members to organize our next meeting.

***DR. HEIT** chairs the Pain Work Group and co-chairs the annual ASAM meetings on "Pain & Addiction: Common Threads." He is in private practice, specializing in pain and addiction medicine, in Fairfax, VA.*