Spring 2005/Med-Sci Issue
Volume 20, Number 1

ASAM News

Newsletter of The American Society of Addiction Medicine

Inside

ASAM at Work for You:

Also see:

Plan to attend ASAM's Med-Sci Conference in Dallas, Texas, April 14-17, 2005

www.asam.org

ASAM Med-Sci Conference to Convene in Dallas

Dallas, Texas, will attract addiction medicine specialists from around the world during ASAM's 36th Annual Medical-Scientific Conference, April 14-17th. The conference welcomes ASAM members as well as nonmember physicians, nurses, psychologists, counselors, students and residents. It is preceded by two special events: the Ruth Fox Course for Physicians and a Course on Pain and Addiction: Common Threads VI, both scheduled for Thursday, April 14th. It concludes on Sunday, April 17th, with a training course designed to qualify ASAM members and other physicians to prescribe the recently approved drug buprenorphine.

For additional information and registration, consult the ASAM web site or contact ASAM's meetings staff at EMAIL@ASAM.ORG.

ASAM Members Elect New Officers, Members of the Board of Directors

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

ASAM members have elected the Society's next President-Elect, Secretary, and Treasurer, as well as a full slate of Regional Directors. In balloting completed December 1, Michael M. Miller, M.D., FASAM, was chosen President-Elect, A. Kenison Roy III, M.D., FASAM, was elected Secretary, and Donald R. Kurth, M.D., FASAM, was named Treasurer.

Those elected Regional Directors are Marc Galanter, M.D., FASAM (Region I); Peter Banys, M.D. (Region II); John P. Femino, M.D., FASAM (Region III); Louis E. Baxter, Sr., M.D., FASAM (Region IV); Martha J. Wunsch, M.D. (Region V); Thomas L. Haynes, M.D., FASAM (Region VI); Howard C. Wetsman, M.D. (Region VII); Marvin Seppala, M.D. (Region VIII); Raju Hajela, M.D., M.P.H., FASAM (Region IX); and C. Chapman Sledge, M.D., FASAM (Region X).

The newly elected officers and Regional Directors will be installed during the Society's 2005 Medical-Scientific Conference in Dallas. At that time, Elizabeth F. Howell, M.D., FASAM, will assume the Presidency of ASAM and Lawrence S. Brown, Jr., M.D., M.P.H., FASAM, will become Immediate Past President. Profiles of the new officers and directors appear on pages 4-8 of this issue of **ASAM News**.

ASAM to Bestow Awards for Distinguished Service

Eileen McGrath, J.D.

Each year, ASAM honors a distinguished group of individuals who have made outstanding contributions to the field of Addiction Medicine and to the Society itself. Our 2005 awards will be presented to the following outstanding leaders in addiction medicine:

The 2005 R. Brinkley Smithers Distinguished Scientist Award goes to Herbert D. Kleber, M.D., researcher, educator, and former Deputy Director of the Office of National Drug Control Policy. The award will be presented at the Opening Plenary Session on Friday, April 15th.

The John P. McGovern Award on Addiction and Society to Congressman James Ramstad, The McGovern Award was established in 1997 to recognize and honor an individual who has made "highly meritorious contributions to public policy, treatment, research, or prevention which has increased our understanding of the relationship of addiction and society." The award is sponsored by an endowment from the John P. McGovern Foundation.

An ASAM Annual Award for "expanding the frontiers of the field of Addiction Medicine and broadening our understanding of the addiction process through research and innovation" will be presented to ASAM member Walter Ling, M.D.

An ASAM Annual Award for "outstanding contributions to the growth and vitality of our Society, for thoughtful leadership in the field, and for deep understanding of the art and science of addiction medicine" will be presented to ASAM past President Anne Geller, M.D., FASAM.

The Medical-Scientific Conference Award for the abstract receiving the highest rating for scientific merit goes to Richard N. Rosenthal, M.D., past President of the American Academy of Addiction Psychiatry.

The Young Investigator Award for the best abstract submitted by an author who is within five years of receiving a doctoral degree goes to Matthew W. Warren and Steven L. West, Ph.D., CRC.

The awards will be presented at a gala awards luncheon during the annual Medical-Scientific Conference in Dallas. I hope you will join us in congratulating these deserving individuals and celebrating their accomplishments.

American Society of Addiction Medicine
4601 North Park Ave., Suite 101
Chevy Chase, MD 20815

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

ASAM, Other Groups Decry DEA Policy on Pain Meds

ASAM has joined the American Pain Society (APS) and the American Academy of Pain Medicine (AAPM) in submitting a written response to a November 2004 statement from the U.S. Drug Enforcement Administration (DEA) that repudiated some parts of a jointly negotiated set of guidelines for the management of patients with pain. The letter, signed by the presidents of all three organizations, said a DEA policy statement published in November in the Federal Register represented "an unfortunate step backward" that will foster "an adversarial relationship between [doctors] and the DEA." ASAM President Lawrence S. Brown, Jr., M.D., M.P.H., FASAM, joined the other presidents in cautioning that, despite the DEA's assurances that it does not want to discourage doctors from providing proper medication to patients in pain, the new guidelines "will undoubtedly have the exact opposite effect on any practitioner reading them."

The DEA's November guidelines replaced an earlier guidance—in the form of answers to 29 frequently asked questions (FAQs)—that were the product of two years of discussions and negotiations between the organizations and the DEA. The FAQs were released with much fanfare in August 2004 and posted on the DEA's web site. They received an enthusiastic review in the *Journal of the American Medical Association* and were hailed by pain and addiction experts as marking the beginning of a new relationship between law enforcement and health care professionals. Less than 60 days later, however, the DEA abruptly withdrew the FAQs from its web site. Initially, the FAQs were replaced with a DEA announcement alleging they were removed because they contained "misstatements" and did not represent DEA policy. In November, the new, more stringent DEA guidelines were posted in their place.

The DEA's actions spurred shock and concern among medical organizations and advocates for pain patients. In their letter, Dr. Brown and the other presidents took particular aim at the DEA's new interpretation of prescribing practices that can trigger an investigation. For example, the DEA document that replaced the FAQs states that physicians who prescribe "high doses" of opioid analgesics for long periods of time are subject to investigation, even in the absence of any evidence of wrongdoing. It also said the government can investigate a physician merely to "verify that there is no improper activity."

Explaining their members' concerns, the three presidents wrote: "Reading that the government can investigate merely on suspicion that the law is being violated will send chills down the spines of practitioners who are treating patients and will certainly contribute to the under-treatment or non-treatment of moderate to severe chronic pain." In addition to ASAM's Dr. Brown, the letter was signed by APS President Dennis C. Turk, M.D. and AAPM President Samuel J. Hassenbusch, M.D. *Source: The Washington Post, December 21, 2004.*

Bills to Lift 30-Patient Buprenorphine Limit Introduced

Bills that would lift the current limit on the number of patients that may be treated by a medical group in office-based practice were introduced in the Congress in early March. Senator Carl Levin (D-MI) and Rep. Mark Souder (R-IN) introduced SB 45 in the Senate and HR 869 in the House to amend the Drug Abuse and Treatment Act of 2000 (DATA).

At the time it was adopted, DATA was seen as a breakthrough because it allows physicians to use medications to treat opioid addiction in office settings—a practice banned since adoption of the Harrison Narcotic Act in 1914. While lawmakers had intended the 30-patient limit to apply only to individual physicians, the language of the DATA act has been interpreted to apply to group practices as well. The newly introduced bills would retain the 30-patient limit for solo practitioners but erase it for medical groups. Addiction experts and treatment providers have been vocal advocates for the change. *Source: Legal Action Center, March 10, 2005.*

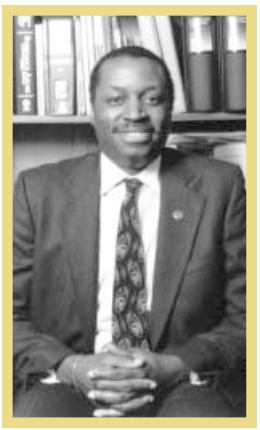
GAO Warns of "Flood" of Combat Vets with PTSD

Addiction experts long have argued that untreated post-traumatic stress disorder (PTSD) among returning Vietnam veterans contributed to the surge in heroin and other drug use in the 1960s and 70s. Now, the federal government's investigative arm is predicting a similar sequel to the conflicts in Iraq and Afghanistan.

In a recently released report, the Government Accountability Office (GAO) raises concerns that the Veterans Administration (VA) may not be prepared to cope with the number of returning veterans who are experiencing PTSD as a result of the stress and carnage of war. Military medical experts and veterans' organizations predict that as many as 100,000 returning soldiers will need treatment for the disorder. As evidence, they point to an Army study showing that 15% of soldiers in Iraq have reported symptoms of major depression, serious anxiety, or PTSD.

VA officials counter that the system already has treated 6,400 veterans of the Iraq and Afghan wars for PTSD. However, the GAO report claims that less than half of returning vets are even screened for PTSD. "I have a very strong sense that the mental health consequences are going to be the medical story of this war," concludes Dr. Stephen Joseph, who served as Assistant Secretary of Defense for Health Affairs from 1994 to 1997.

The report, "VA Should Expedite the Implementation of Recommendations Needed to Improve Post-Traumatic Stress Disorder Services" (GAO-05-287), can be downloaded without charge from the GAO's web site (**WWW.GAO.GOV**). *Sources: U.S. Government Accountability Office, February 23, 2005; New York Times, December 16, 2004.*



IT'S BEEN A LONG TRIP, BUT WELL WORTH THE JOURNEY

Lawrence S. Brown, Jr., M.D., M.P.H., FASAM
ASAM President, 2002- 2005

This issue of ASAM News signals both a beginning and an end. ASAM members have elected the Society's next slate of officers, who will be installed during the Business Meeting of the Society's 2005 Medical-Scientific Conference. At the helm, Dr. Elizabeth Howell will assume the Presidency for the period 2005–2007. Please plan to attend the Business Meeting to welcome your new leaders and to express gratitude for the service of the outgoing leaders.

This biennial renewal is vital to the Society, because it provides an opportunity for new ideas and new and revitalized energies. For the Society to remain relevant to addiction medicine, its members, and-most importantly-our patients with substance use disorders, it is critical that there be a continuous and uninterrupted process for the development and engagement of new leaders.

In charting a course for ASAM's future, there is immense value in recognizing the path we have traveled to arrive at our current situation as a Society. As many you know, I assumed the Presidency of ASAM a year and a half before originally planned, making my term the longest of any sitting President since ASAM's founding President, Dr. Ruth Fox. There have been challenges and successes; and I'd like to take this opportunity to highlight a few of each.

The first challenge involved the retirement of our Executive Vice President, Dr. James F. Callahan, who led the Society for many decades. Because of the SARS epidemic in Toronto, the Society was forced to cancel its annual Medical-Scientific meeting for the first time, with the attendant economic implications and unmet educational needs of the Society's members. Also, ASAM's committee structure prior to 2003 did not provide the best mechanisms to implement its newly approved Strategic Plan.

Thanks to a loyal and dedicated staff and a wise and committed Board of Directors, we were able not only to overcome the challenges, but also to establish new precedents in the history of the Society. This process began with the successful recruitment of an Executive Vice President, Ms. Eileen McGrath, Esq., who brought new energy and a different approach to the position. Last year's Medical Scientific Conference and educational programs saw significant increases in attendance. The gala celebrating the Society's 50th anniversary was extremely successful. These combined efforts resulted in a dramatic reversal of ASAM's financial position, from challenging to robust health.

With the realignment of ASAM's committee structure and its first rigorous member survey came a renewed sense that ASAM's educational and other products must be monitored and evaluated for their continued relevance to member needs. The establishment of a Policy Plenary during the Med-Sci Conference, the inauguration of ASAM's Legislative Days, and establishment of a SAMHSA-sponsored buprenorphine mentoring program are other new ventures that respond to member needs. The State Medical Specialty Society (SMSS) program, under the mentorship of Dr. Callahan, has proved to be a phenomenal success, enabling select chapters to place themselves on sound footing as a force in their states. Finally, but no less important, ASAM's textbook, Principles of Addiction Medicine, and its Patient Placement Criteria continue to be standards in our field.

None of these accomplishments would have been possible without a vibrant membership. In this regard, I salute you, the ASAM members. At the same time, I invite you to continue to contribute ideas, suggestions, and efforts. While these victories of products and services are owed to the members, they also represent obligations of membership. It is the responsibility of members to guide ASAM, monitor its progress, constructively criticize ASAM's efforts, and demand more of the Society. It is only with active, vocal, and participatory membership that ASAM can fully achieve its potential.

Let me now offer, briefly, some recommendations for important next steps. The Society needs to enhance its focus on the next generation of ASAM leaders and attract more members who are earlier in their addiction medicine careers. This will mean retooling some of ASAM's products and reconsidering the structure of ASAM's annual meeting. There continues to be inadequate attention on addiction and substance use disorders in medical education, postgraduate training, and in continuing medical education among practicing physicians. It is also clear that many ASAM members remain desirous of addiction medicine becoming a medical specialty similar to other specialties recognized by the American Board of Medical Specialties. ASAM's success in achieving these and other objectives is contingent on three ingredients: a fiscally sound and growing society, a Board that appreciates its governance role and responsibilities, and a Society in which advocacy plays a major role in enhancing member benefits and patient care.

In summary, like ASAM's outgoing Board members, ASAM's new leaders have been given a sound platform from which to advance addiction medicine, meet the needs of ASAM's members, and attend to the care of our patients. For each Board, service to ASAM offers a journey containing formidable challenges and significant opportunities. While for me, it has been a longer trip, I feel extremely honored and fortunate to have made the journey. I recommend it enthusiastically and without reservation.

RUTH FOX COURSE FOR PHYSICIANS

Thursday, April 14, 2005 • 8:00 am – 5:30 pm
Hyatt Regency Hotel • Dallas, Texas

COURSE DIRECTORS:
Louis E. Baxter, Sr., M.D., FASAM, and Anthony H. Dekker, D.O., FASAM

The Ruth Fox course is designed to highlight new directions and concepts in clinical practice and to offer an update on selected areas of research. The 2005 course reflects the continuing interests, developments, diversity and richness in the field of Addiction Medicine by presenting a variety of important and timely topics.

This course is eligible for 8 credit hours of Category 1 Continuing Education credit. Course registrants will receive a Syllabus containing copies of speakers' slides and related materials.

To register, visit the ASAM web site (**WWW.ASAM.ORG**)
or email **EMAIL@ASAM.ORG**.

New President, Officers, Board Members to Take Office at Med-Sci Conference

The following Officers and Regional Directors will be installed at the Annual Business Meeting April 15th during ASAM's Annual Medical-Scientific Conference in Dallas, Texas. At that time, Elizabeth F. Howell, M.D., FASAM, will assume the Presidency of ASAM and Lawrence S. Brown, Jr., M.D., M.P.H., FASAM, will become Immediate Past President. All of the officers serve two-year terms (2005-2007).

PRESIDENT-ELECT

MICHAEL M. MILLER, M.D., FASAM, FAPA
Madison, Wisconsin

Since 1989, Dr. Michael Miller has been Medical Director of NewStart, the alcohol and drug treatment program of Meriter Hospital, a large non-profit community hospital in Madison, Wisconsin. From 1996-2001, he also worked in hospital administration for Meriter as Program Director for Behavioral Services. A graduate of Tulane Medical School, Dr. Miller now is an Associate Clinical Professor at the University of Wisconsin Medical School with appointments in three departments.

Dr. Miller has served on many ASAM task forces, chaired committees on Reimbursement, Managed Care, and Quality Improvement, and was founding President of the Wisconsin Society of Addiction Medicine (WisSAM). From 1999 to 2003, he was Secretary of ASAM's Board. He has been a faculty member at Med-Sci, the Ruth Fox Course, the State of the Art Course, the Review Course, and Buprenorphine Training Courses, and has authored chapters for *Principles of Addiction Medicine*. He also was a member of the Work Group for the Second Edition of the *ASAM Patient Placement Criteria*. Dr. Miller was certified by ASAM in 1986 and recertified in 1994 and 2004.

In addition to ASAM, Dr. Miller is a member of the American Medical Association, the American Psychiatric Association, the American Academy of Addiction Psychiatry, and the Association for Medical Education and Research in Substance Abuse. He also is active in the Wisconsin Medical Society, the Wisconsin Psychiatric Association, and the Wisconsin Society of Addiction Medicine, and is Past President of the Dane County Medical Society. Named by ASAM, the National Association of Addiction Treatment Providers, and the National Association of Alcohol and Drug Abuse Counselors to the Joint Commission on Accreditation of Healthcare Organizations, he was elected to chair JCAHO's Hospital Accreditation Program PTAC (1998). His honors include being elected a Fellow of ASAM (1997), an APA Fellow (2004), and the 2001 Citizen of the Year of the Wisconsin Association on Alcohol and Other Drug Abuse (WAAODA).

Dr. Miller says: "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 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 the Public Policy Committee and as a past member of ASAM's Board of Director, I have helped shape the 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.

"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."

SECRETARY

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

Metairie, Louisiana

Dr. Ken Roy joined ASAM in 1984 and was certified in 1986. He has worked to develop addiction treatment programs at several New Orleans area hospitals, as well as an outpatient and residential private sector agency. In December 1994, Dr. Roy completed a residency program in psychiatry at Tulane University School of Medicine. He is certified by the American Board of Psychiatry and Neurology and holds the academic rank of Clinical Assistant Professor. While he admits patients to two area hospitals, maintains a private psychiatric practice, teaches medical students, sits on the Board of Certification for Substance Abuse Counselors, and works with organized medicine, Dr. Roy's primary focus is Addiction Recovery Resources of New Orleans, a non-profit agency that provides ambulatory detoxification, intensive outpatient and residential addiction and Dual Diagnosis services in the private sector. Dr. Roy was first elected to the ASAM Board of Directors in 1988 and was re-elected in 1992, 1998 and 2002. In April 1997, he was elected a Fellow of ASAM. He has served on the Review Course Committee and chaired the Membership Committee. He currently is active in the State Medical Specialty Society (SMSS) program.

Dr. Roy says: "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."

TREASURER

Donald J. Kurth, M.D., FASAM

Rancho Cucamonga, California

Dr. Donald Kurth began his career as Medical Director of a busy southern California emergency department. He helped to develop the Trauma Center System in Los Angeles and opened his own urgent care center, with more than 50 employees and an annual budget of several million dollars. Later, he founded and developed his own IPA for managed care contracting purposes. In 1993, he received the Small Business Person of the Year Award from the U.S. Small Business Administration. During that period, he also served as a physician volunteer for the Flying Samaritans (who provide free medical care in impoverished areas in Baja, Mexico) and founded the Free Pediatric Immunization Clinic in his hometown.

Dr. Kurth joined ASAM in 1995. Soon after, he joined the faculty at Loma Linda University, where he now serves as Associate Professor of Psychiatry. In 1997, he became ASAM certified and was promoted to Chief of Addiction Medicine at the university. He currently serves as Medical Director of the inpatient Chemical Dependency Unit and of a large outpatient program at Loma Linda's Behavioral Medicine Center. He also is President of the California Society off Addiction Medicine.

Dr. Kurth says: "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."

REGIONAL DIRECTORS AND ALTERNATES

As specified in the Bylaws, the candidate in each Region who receives the most votes is elected Regional Director, and the candidate who receives the next greatest number of votes is elected Regional Alternate Director. The term of office of Regional Directors and Alternates is four years (2005-2009).

REGION I (New York)

REGION I Director:

Marc Galanter, M.D., FASAM

New York, New York

Dr. Marc Galanter is Immediate Past President of ASAM and Professor of Psychiatry at the New York University Medical School. As Chair of ASAM's Medical-Scientific Program Committee since 1983, Dr. Galanter has worked to assure that the Society's annual meeting is of the highest caliber. He also is committed to expanding training opportunities in addiction medicine and conducts an annual survey of addiction fellowship programs that is widely used in the field.

Dr. Galanter says: "Our Society and our New York State chapter have come a very long way..., [but] a number of important issues are apparent: Managed care restricts access to treatment. A survey 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. We also must assure that ASAM certification is widely accepted, and promote post-graduate fellowships in addiction medicine to train the next generation of specialists.

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

REGION I Alternate Director:

Edwin A. Salsitz, M.D., FASAM

New York, New York

REGION II
(California)
REGION II Director:

Peter Banys, M.D.
San Francisco, California

Dr. Peter Banys is Director of Substance Abuse Programs at the VA Medical Center in San Francisco and Director of the Substance Abuse Physician Fellowship Program jointly sponsored by the Veterans Administration and the University of California, San Francisco. A graduate of Harvard University and the Case-Western Reserve University School of Medicine, Dr. Banys is Associate Clinical Professor of Psychiatry at UCSF. He holds a CAQ in addiction psychiatry and is certified by ASAM.

Dr. Banys has been active for several decades in the California Society of Addiction Medicine. He chaired CSAM's Education Committee for six years, chaired the Society's Ad Hoc Work Group on Office-Based Methadone Treatment, and was CSAM President from 2000 to 2002. He also has been a member of the Advisory Board to the State of California Department of Alcohol and Drugs, and of the Advisory Committee on the state's Substance Abuse & Crime Prevention Act (Proposition 36). He also is a co-author of the report of the state's Co-Occurring Disorders Task Force.

Dr. Banys says: "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. I will continue to support the very high quality of our conferences, our unequalled textbook, and our public policy statements. 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."

REGION III
(CT, MA, ME, NH, RI, VT)
REGION III Director:

John P. Femino, M.D., FASAM
North Kingstown, Rhode Island

Dr. John Femino graduated from Brown University School of Medicine and completed his residency training in internal medicine, as well as post-doctoral fellowships in clinical psychopharmacology and drug and alcohol abuse. He received a Career Teacher in Alcohol and Drug Abuse grant at Brown University and was one of the first faculty members at the Brown University Center for Alcohol and Addiction Studies. In 1996, Dr. Femino founded Meadows Edge Recovery Center, a state licensed substance abuse treatment program and multidisciplinary medical and mental health group practice in North Kingstown, RI.

Dr. Femino was certified by ASAM in 1986, was re-certified in 2000 as an MRO, and has been elected a Fellow of the Society. He has been involved in ASAM activities for many years, and currently is a member of the State Medical Specialty Society (SMSS) Program. He was instrumental in organizing the new Rhode Island Society of Addiction Medicine and has led RISAM into a cooperative project with the state community prevention task forces, entitled the "Rhode Island Physician Initiative."

Dr. Femino says: "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 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."

REGION IV
(NJ, OH, PA)
REGION IV Director:

Louis E. Baxter, Sr., M.D., FASAM
Lawrenceville, New Jersey

Louis E. Baxter, Sr., M.D., FASAM, is Executive Medical Director of the Physicians' Health Program of the Medical Society of New Jersey. He also serves as a consultant to the New Jersey Department of Health, Alcohol Division, and as a member of the National Advisory Councils of the Center for Substance Abuse Treatment and the National Football League.

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

Director of the Physicians' Health Program of New Jersey, Dr. Baxter has addressed issues regarding medical licensure and treatment of health care professionals, and advocated for many physicians in Region IV and elsewhere.

Dr. Baxter has served ASAM in a number of committee assignments, including the Membership, Physicians' Health, Forensic Medicine, and Nomination and Awards committees, as Co-Director of the Ruth Fox Program Committee, and as chair of the Cross-Cultural Clinical Concerns Committee. He currently chairs the Constitution and Bylaws Council.

Dr. Baxter says: "My re-election as Director of Region IV will 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 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."

REGION II Alternate Director:

Lori D. Karan, M.D., FACP, FASAM
San Francisco, California

REGION III Alternate Director:

Mark L. Kraus, M.D., FASAM
Waterbury, Connecticut

REGION IV Alternate Director:

John J. Verdon, Jr., M.D., FASAM,
Shrewsbury, New Jersey

ASAM Election Results

REGION V
(DC, DE, GA, MD, NC, SC, VA, WV)
REGION V Director:

Martha J. Wunsch, M.D.
Blacksburg, Virginia

After graduating from the Uniformed Services University of the Health Sciences and completing a pediatric residency at Los Angeles Children's Hospital, Dr. Martha Wunsch practiced pediatrics and was a general medical officer in the Indian Health Service.

In 1988, Dr. Wunsch trained at the Betty Ford "Professional in Residence" Program. In 1990, she was certified by ASAM and became the founding clinical director of the Pascua Alcohol Treatment Home for Native American women. From 1990-1992, she participated in a multidisciplinary community-based team approach to maternal addiction and its effects on children. During the same period, Dr. Wunsch was appointed Assistant Clinical Professor of Pediatrics at University of Arizona. From 1993-2000, she worked as a general pediatrician in private practice and was affiliated with the University of Colorado as a clinical instructor.

In 2000-2002, Dr. Wunsch was named Clinical Research Fellow in addiction medicine at the Medical College of Virginia/Virginia Commonwealth University (MCV/VCU) and then was appointed Assistant Professor of Pediatrics and Psychiatry. Currently, she is Associate Professor and Discipline Chair of Addiction Medicine at the Virginia College of Osteopathic Medicine. Her research interests include prescription drug abuse, the overlap of pain and addiction, and neonatal opioid withdrawal.

Dr. Wunsch says: "My primary care colleagues are frustrated by their lack of knowledge in diagnosing and managing addictive disorders in patients and their families. 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."

REGION VI
(IA, IL, IN, MI, MN, WI)
REGION VI Director:

Thomas L. Haynes, M.D., FASAM
Grand Rapids, Michigan

Dr. Thomas Haynes has been engaged in the full-time practice of addiction medicine since 1985 and is the owner, president and medical director of West Michigan Addiction Consultants, PC (WeMAC) in Grand Rapids, Michigan. WeMAC's long-term treatment program, the Professional Recovery System, specializes in the treatment of addicted professionals. Dr. Haynes also is a member of the Associate Clinical Faculty for the Michigan State University College of Human Medicine, and lectures regularly at the University of Michigan and Western Michigan University.

Dr. Haynes was instrumental in organizing the Michigan Society of Addiction Medicine and served as its founding President. He also served a five-year term as the chair of the Michigan Health Professional Recovery Committee. He has been an active member of ASAM since 1983. Dr. Haynes was certified in addiction medicine in 1986 and recertified in 1994 and 2002. He was elected a Fellow of ASAM in 1997 and has served on several ASAM Committees and Task Forces. Currently, he is active in the State Medical Specialty Society (SMSS) program and is Region VI Director.

Dr. Haynes says: "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 will bring a strong voice to the Board on behalf of ASAM members who practice addiction medicine in clinical settings."

REGION VII
(AR, KS, LA, MO, NE, OK, TX)
REGION VII Director:

Howard C. Wetsman, M.D.
New Orleans, Louisiana

Dr. Howard Wetsman graduated medical school in 1985 and, after a psychiatric internship at Bethesda Naval Hospital, went to sea as a General Medical Officer (GMO). Following two tours of duty, he completed his psychiatric training at Louisiana State University (LSU) in New Orleans. Thereafter, he returned to active duty with the Navy for an additional four years. After a tour at Portsmouth Naval Hospital, where he was both a ward attending physician and head of the research division, he returned to New Orleans and private practice. At present, Dr. Wetsman is an Assistant Professor of Psychiatry at LSU, as well as serving as lead psychiatrist and the only addictionologist at the Charity Hospital HIV Outpatient Clinic.

Dr. Wetsman is board-certified in general and forensic psychiatry, as well as being certified by ASAM in 2000. In addition to ASAM, he is a member of the American Psychiatric Association, the American Medical Association, and the Louisiana Psychiatric Association.

Dr. Wetsman says: "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."

REGION V Alternate Director:

Timothy L. Fischer, D.O.
Orangeburg, South Carolina

REGION VI Alternate Director:

Paul S. Board, M.D.
Des Plaines, Illinois

REGION VII Alternate Director:

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

REGION VIII
(AR, AZ, CO, HI, ID, MT, ND, NM, NV, OR, SD, UT, WA, WY)
REGION VIII Director:

Marvin Seppala, M.D.
Newberg, Oregon

Dr. Marvin Seppala is the Chief Medical Officer for the Hazelden Foundation. A graduate of the Mayo Medical School, he completed his psychiatric training and a fellowship in addiction at the University of Minnesota Hospitals. He has provided psychiatric services at essentially every level of addiction treatment, and is the author of the *Clinician's Guide to The Twelve Step Principles*.

Dr. Seppala describes himself as "having worked in almost every type of addiction treatment program that exists," including programs for adolescents, Native Americans, Southeast Asian immigrants, methadone maintenance and women's programs; public and private programs; outpatient, residential, halfway houses, HMOs and private practice; dual diagnosis and psychiatric hospitals. His particular expertise is the care of patients with co-occurring addiction and psychiatric disorders.

Dr. Seppala is a founding board member of the Oregon Society of Addiction Medicine. He also has served as a member of ASAM's Publications Committee and has been a lecturer at the ASAM Medical-Scientific Conference. He says: "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 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."

REGION IX
(International)
REGION IX Director:

Raju Hajela, M.D., M.P.H., FASAM
Kingston, Ontario, Canada

Dr. Raju Hajela earned his medical degree at Dalhousie University in Halifax, Canada, in 1982. After working as a general physician for five years, he earned a master of public health degree at the Harvard School of Public Health and completed a one-year residency in addiction medicine at the Addiction Research Foundation in Toronto, Canada. He served in the Canadian armed forces from 1979 to 1995, including assignments with the United Nations in the Middle East (1983-84) and with NATO in Lahr, Germany (1985-87). From 1989 to 1991, Dr. Hajela was a staff officer at the Surgeon General's office in Ottawa, Canada. His final military assignment was as Director of the Addiction Rehabilitation Centre in Kingston, Ontario, Canada. Dr. Hajela now practices family and addiction medicine in Kingston, Ontario. He was certified by ASAM (CSAM) in 1990 and elected a Fellow of the Society in 1998. He also is certified in family medicine and has been elected a Fellow in that specialty.

Dr. Hajela was a founding member of the Canadian Society of Addiction Medicine and continues to hold leadership positions in that organization. He also helped found the International Society of Addiction Medicine, which he currently serves as a member of the Board of Directors.

Dr. Hajela says: "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."

REGION X
(AL, FL, KY, MS, PR, TN, VI)
REGION X Director:

C. Chapman Sledge, M.D., FASAM
Hattiesburg, Mississippi

Dr. C. Chapman Sledge has been engaged in the full-time practice of addiction medicine since 1989. Originally trained in family medicine, Dr. Sledge completed a family practice residency in 1986 and was certified by the American Board of Family Practice. For the past 10 years, he has been affiliated with the Pine Grove Recovery Center and Pine Grove Next Step. While his primary practice is with Next Step, he also is Medical Director of Addictive Disease Services at Pine Grove, where he oversees treatment at all levels of care.

Dr. Sledge currently is President of the Mississippi Society of Addiction Medicine. He has served ASAM as a member of the State Chapters Committee, the Nominating and Awards Committee, and the Credentialing Committee. He currently chairs the Credentialing Council.

Dr. Sledge is a member of the American Medical Association, the Mississippi State Medical Association, and the Southern Medical Association. Dr. Sledge was certified by ASAM in 1992 and recertified in 2002. He was elected a Fellow of the Society in 1998.

Dr. Sledge says: "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. 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."

REGION VIII
Alternate Director:

Berton J. Toews, M.D., FASAM
Casper, Wyoming

REGION IX
Alternate Director:

João C. Dias da Silva, M.D.
Rio de Janeiro, Brazil

REGION X
Alternate Director:

Jeffrey D. Kamlet, M.D.
Miami, Florida

Treating Impaired Physicians Bolsters Patient Safety

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

The newspaper *USA Today* recently hosted opposing editorials on the subject of addicted physicians. The debate was sparked by the disclosure that Vice President Richard Cheney's personal physician had a history of opioid addiction. The exchange of views revolved around whether patients would be better protected if the identities of all impaired physicians were to be reported to licensing boards, or whether anonymous programs protect the public by encouraging addicted physicians to come forward and seek help.

Unfortunately, those arguing both sides of the issue failed to make a distinction between physicians who are currently impaired and those who are in recovery. There is a real difference between the two groups, and the way the distinction is handled has a significant effect on patient safety and welfare.

In fact, it is in this dichotomy that we find a source of the confusion that bedevils many states' physician health programs. For example, officials of some programs believe that maintaining anonymity is essential. Unfortunately, when physicians in their programs relapse and become unsafe, it is very difficult to remove them from practice without the assistance of the regulatory agencies. In other programs —particularly those funded by the states—all participants are reported to the licensing board, regardless of their status in recovery. Thus, recovering physicians are "punished" for their disorder and future reporting is discouraged.

As explained in the *USA Today* editorial, programs that strike a balancebetween public safety and advocacy for recovering physicians work best. The Physicians' Health Program (PHP) of the Medical Society of New Jersey employs such a balanced approach. Working in partnership with the state's Board of Medical Examiners, the PHP is able to enroll participants in the board's Alternative Resolution Program, which provides for anonymous monitoring of physicians in treatment and recovery. Every physician participating in the PHP is evaluated and removed from practice until it is determined that he or she can practice medicine safely and with the requisite skill and judgment. This approach encourages self- and colleague-reporting of physicians with impairing conditions, because those who report are assured that the physician will have an opportunity to recover without penalty if he or she is compliant with the program. This approach assures patient safety because it does not force sick physicians to "go underground." Therefore, what is good care for the sick physician also is a sound safeguard for the public health.

The members of ASAM's Committee on Physician Health agree that physicians who are actively under the influence of substances or who are impaired by current psychiatric disorders should not practice until they have been thoroughly evaluated and treated. The committee does *not* advocate for actively impaired physicians to continue to practice. Instead, ASAM and its Physician Health Committee advocate for physicians who are *in recovery* from impairing medical disorders, including substance use disorders, to be able to resume their medical careers.

Dr. Baxter is a Fellow and Board Member of the American Society of Addiction Medicine. He is certified in Addiction Medicine through examination by ASAM. He is the Executive Medical Director of the Physicians' Health Program Medical Society of New Jersey and Medical Director of the New Jersey Department of Health's Division of Addiction Services.

ASAM to Co-Sponsor National Alcohol Screening Day

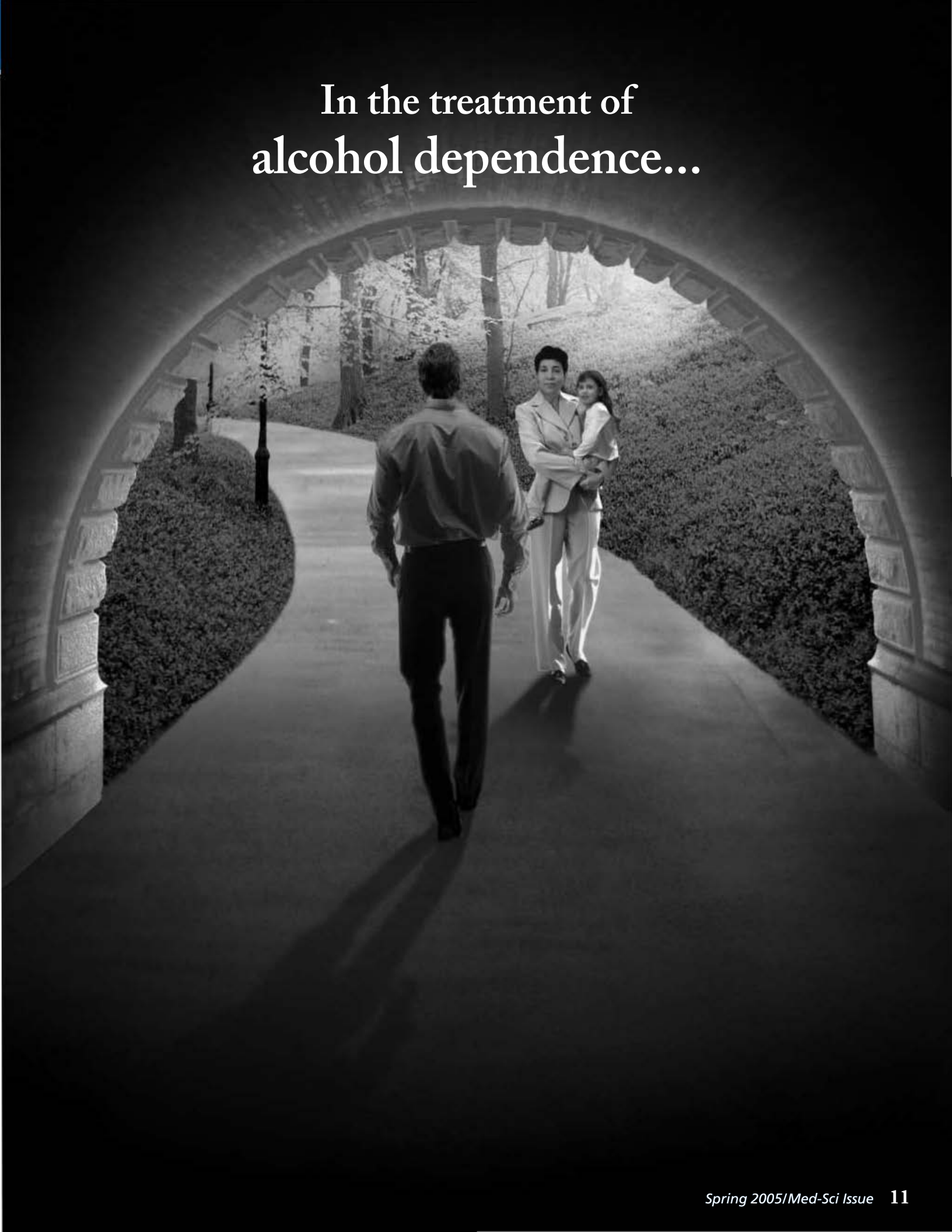
This April 14th, tens of thousands of Americans are expected to participate in the sixth National Alcohol Screening Day at thousands of locations across the U.S. ASAM is an official co-sponsor of the event, which offers free and confidential screening at workplaces, hospitals, shopping centers, health clinics and churches, as well as online at **WWW.ALCOHOLSCREENING.ORG**. Simply getting screened has been shown to motivate some individuals to cut back on their drinking. For others, it opens the door to treatment and recovery.

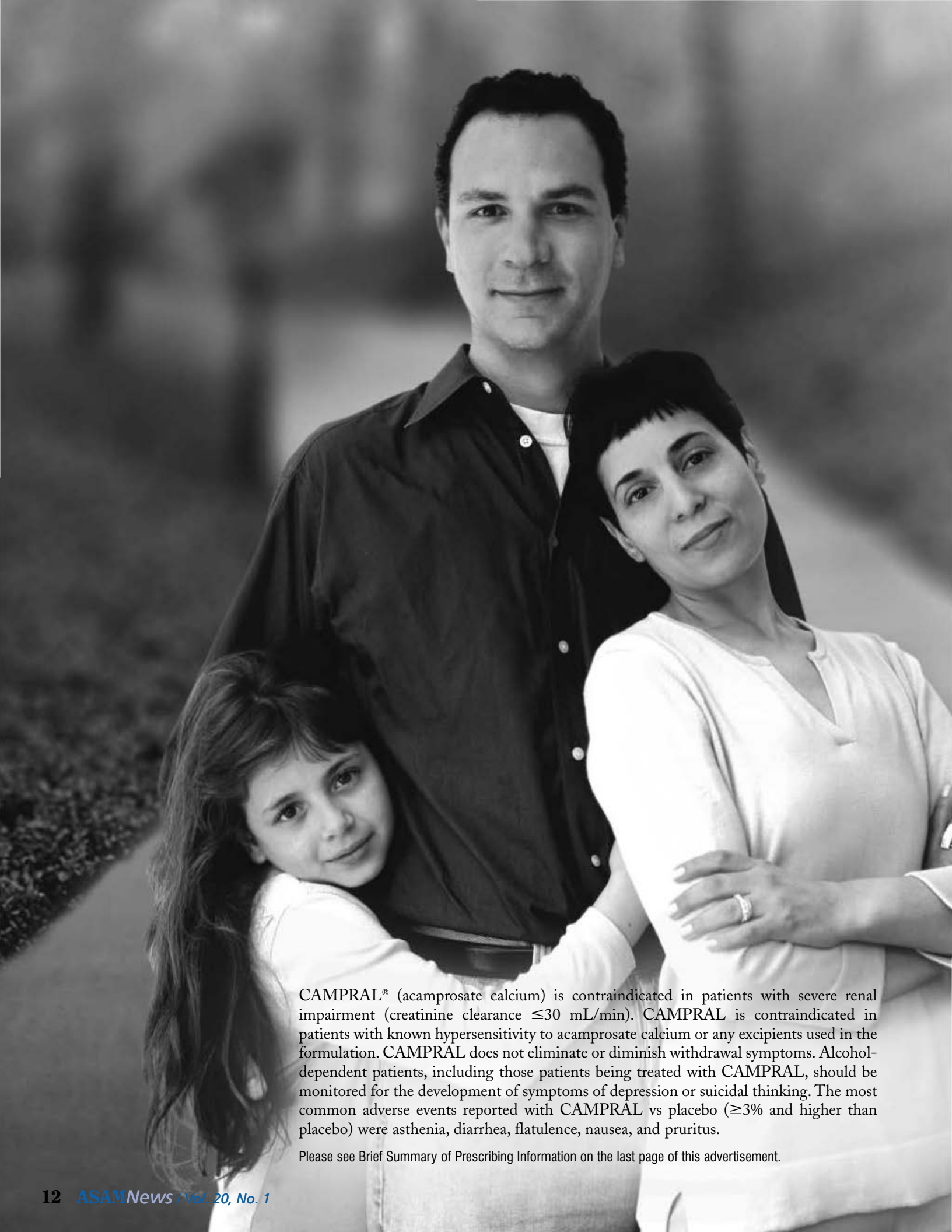
"For people who may not know how much is too much to drink or that the amount they are drinking puts them at risk for injury, illness and possibly addiction, alcohol screening is very useful," said Stacia Murphy, Executive Director of the National Council on Alcoholism and Drug Dependence. "What they learn can prompt them to diminish or curtail their drinking or signal the need for more detailed evaluation and treatment."

National Alcohol Screening Day is a highlight of activities marking April as Alcohol Awareness Month, which draws public attention to the ways that employers, loved ones, friends and neighbors can promote the identification and treatment of alcohol problems that affect them and the people they care about. According to the National Institute on Alcohol Abuse and Alcoholism, nearly 8 million Americans have the disease of alcoholism. An additional 6 million have problems because of their drinking. More than half of all adults have a family history of alcoholism or problem drinking.

For more information on National Alcohol Screening Day, visit the web site **WWW.ALCOHOLSCREENING.ORG**.

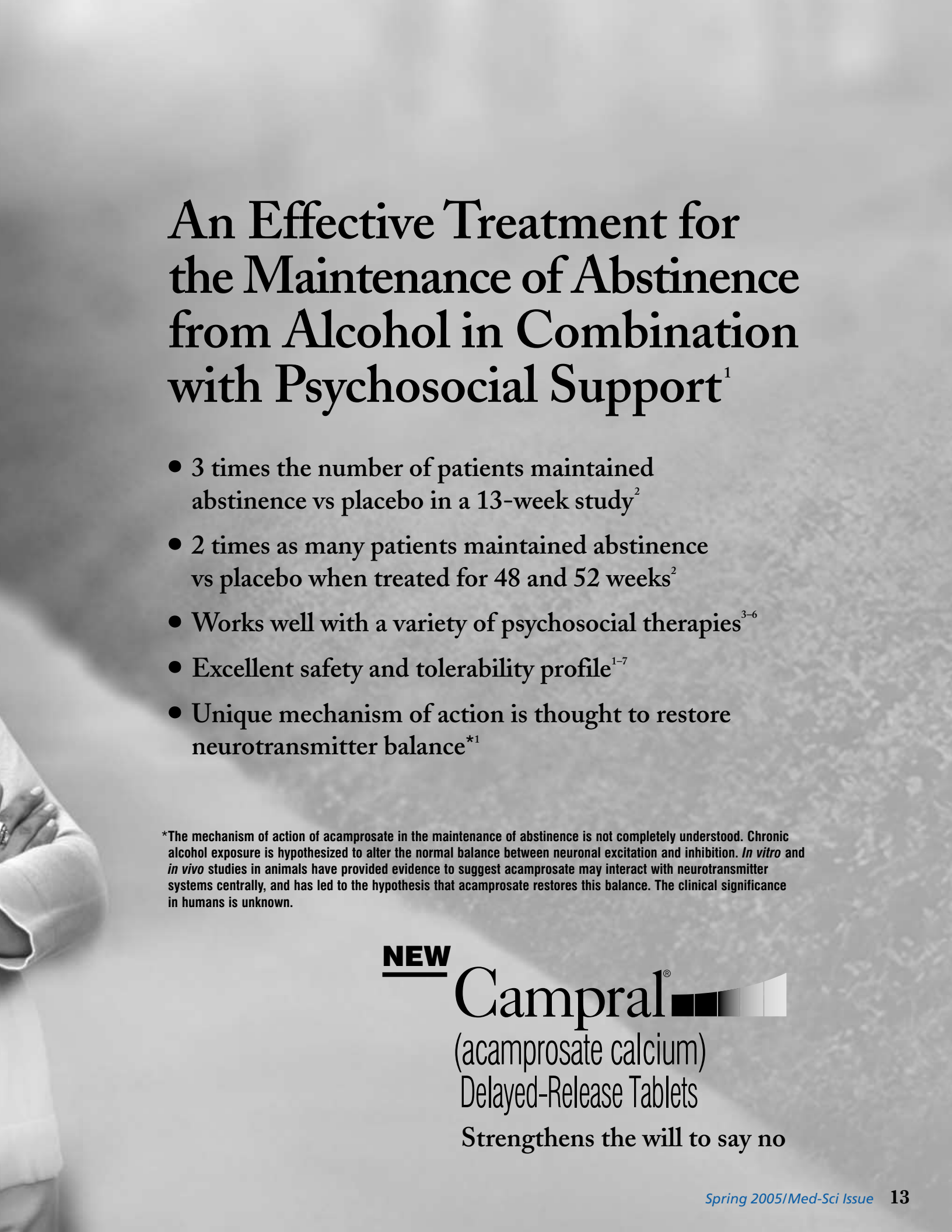
In the treatment of alcohol dependence...





CAMPRAL® (acamprosate calcium) is contraindicated in patients with severe renal impairment (creatinine clearance ≤30 mL/min). CAMPRAL is contraindicated in patients with known hypersensitivity to acamprosate calcium or any excipients used in the formulation. CAMPRAL does not eliminate or diminish withdrawal symptoms. Alcohol-dependent patients, including those patients being treated with CAMPRAL, should be monitored for the development of symptoms of depression or suicidal thinking. The most common adverse events reported with CAMPRAL vs placebo (≥3% and higher than placebo) were asthenia, diarrhea, flatulence, nausea, and pruritus.

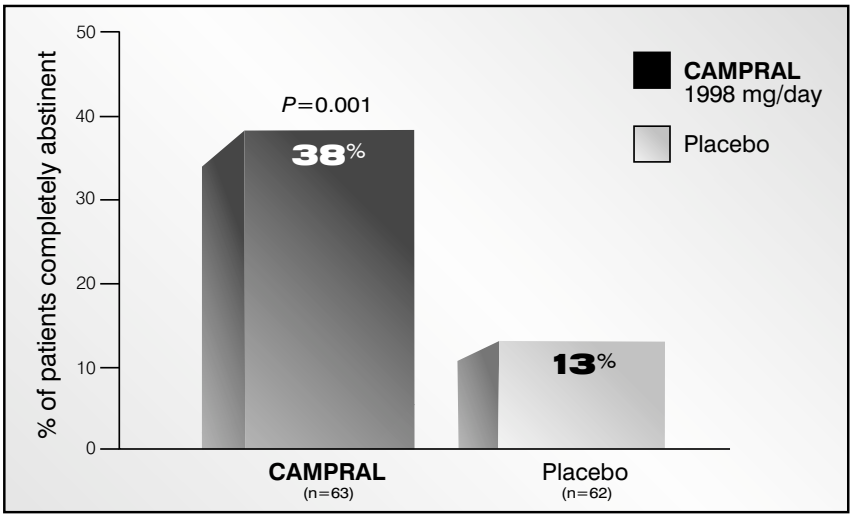
Please see Brief Summary of Prescribing Information on the last page of this advertisement.


An Effective Treatment for the Maintenance of Abstinence from Alcohol in Combination with Psychosocial Support[1]
• 3 times the number of patients maintained abstinence vs placebo in a 13-week study[2]
• 2 times as many patients maintained abstinence vs placebo when treated for 48 and 52 weeks[2]
• Works well with a variety of psychosocial therapies[3–6]
• Excellent safety and tolerability profile[1–7]
• Unique mechanism of action is thought to restore neurotransmitter balance*[1]
*The mechanism of action of acamprosate in the maintenance of abstinence is not completely understood. Chronic alcohol exposure is hypothesized to alter the normal balance between neuronal excitation and inhibition. In vitro and in vivo studies in animals have provided evidence to suggest acamprosate may interact with neurotransmitter systems centrally, and has led to the hypothesis that acamprosate restores this balance. The clinical significance in humans is unknown.
NEW
Campral®
(acamprosate calcium)
Delayed-Release Tablets
Strengthens the will to say no

Effective Treatment for

In a 13-week study*†[2]

CAMPRAL helps 3 times more patients maintain complete abstinence‡ vs placebo, in combination with psychosocial support



Study design: Multicenter, randomized, double-blind, placebo-controlled study of CAMPRAL in alcohol-dependent patients. 188 patients were randomized at study start to receive acamprosate 1332 mg/day (63 patients), CAMPRAL 1998 mg/day (63 patients), or placebo (62 patients). Patients were 18 to 65 years old, met DSM-III-R criteria for alcohol dependence, and had undergone a 14-day detoxification program prior to treatment start. All patients in this study received counseling based on the routine practices of the individual participating study sites.[2,3]

In separate long-term studies*†‡[2]

- 28% of patients treated with CAMPRAL maintained abstinence vs 13% for placebo (48-week study [*P*=0.002])
- 16% of patients treated with CAMPRAL maintained abstinence vs 9% for placebo (52-week study [*P*=0.044])

*All efficacy studies included psychosocial support.

†Results are for the intent-to-treat population over the study treatment phase.

‡Complete abstinence was defined as no alcohol consumption. Assessment included patient and/or family reports, laboratory tests, and either urine alcohol levels, blood alcohol levels, or breathalyzer tests.[3–5]

References: 1. CAMPRAL® (acamprosate calcium) Delayed-Release Tablets Prescribing Information, Forest Laboratories, Inc., St Louis, Mo, 2004. **2.** Data on file, Forest Laboratories, Inc. **3.** Pelc I, Verbanck P, Le Bon O, Gavrilovic M, Lion K, Lehert P. Efficacy and safety of acamprosate in the treatment of detoxified alcohol-dependent patients: a 90-day placebo-controlled dose-finding study. *Br J Psychiatry.* 1997;171:73–77. **4.** Sass H, Soyka M, Mann K, Zieglgansberger W. Relapse prevention by acamprosate: results from a placebo-controlled study on alcohol dependence. *Arch Gen Psychiatry.* 1996;53:673–680. **5.** Paille FM, Guelfi JD, Perkins AC, Royer RJ, Steru L, Parot P. Double-blind randomized multicentre trial of acamprosate in maintaining abstinence from alcohol. *Alcohol Alcohol.* 1995;30:239–247. **6.** Pelc I, Ansoms C, Lehert P, et al. The European NEAT Program: an integrated approach using acamprosate and psychosocial support for the prevention of relapse in alcohol-dependent patients with a statistical modeling of therapy success prediction. *Alcohol Clin Exp Res.* 2002;26:1529–1538. **7.** Mason BJ. Acamprosate. *Recent Dev Alcohol.* 2003;16:203–215.

Please see Brief Summary of Prescribing Information on the last page of this advertisement.

Alcohol Dependence*

Excellent safety and tolerability[1–7]

CAMPRAL has a favorable side-effect profile

- Discontinuation rates due to adverse events were similar to placebo (8% for CAMPRAL-treated patients vs 6% for placebo)[1]

CAMPRAL has minimal potential for drug interactions

- Not metabolized by the liver; no CYP450 enzyme inhibition[§1]
- Can be taken with antidepressants,[‖] anxiolytics, hypnotics, sedatives (including benzodiazepines), nonopioid analgesics, disulfiram, and naltrexone[1]

CAMPRAL has been used safely in a variety of patients

- Can be used in patients with hepatic impairment[¶1]
- No evidence of abuse or dependence liability[1]
- Used for more than a decade; over 1.5 million patients treated worldwide[7]

NEW

Campral®

(acamprosate calcium)
Delayed-Release Tablets

Strengthens the will to say no

Visit our website at **www.campral.com**

[§]The clinical significance of *in vitro* data is unknown.

[‖]Patients taking CAMPRAL concomitantly with antidepressants more commonly experienced weight gain or weight loss than patients taking either agent alone.

[¶]Groups A and B of the Child-Pugh classification.

Forest Pharmaceuticals, Inc.
Pharmaceuticals • Therapeutics • Healthcare • Ethicare • Managed Care • Specialty Sales

 42-125923 12/04

Campral®
(acamprosate calcium)
Delayed-Release Tablets

Rx only

Brief Summary:
For complete details, please see full Prescribing Information for CAMPRAL

INDICATIONS AND USAGE
CAMPRAL (acamprosate calcium) is indicated for the maintenance of abstinence from alcohol in patients with alcohol dependence who are abstinent at treatment initiation. Treatment with CAMPRAL should be part of a comprehensive management program that includes psychosocial support. The efficacy of CAMPRAL in promoting abstinence has not been demonstrated in subjects who have not undergone detoxification and not achieved alcohol abstinence prior to beginning CAMPRAL treatment. The efficacy of CAMPRAL in promoting abstinence from alcohol in polysubstance abusers has not been adequately assessed.

CONTRAINDICATIONS
CAMPRAL is contraindicated in patients who previously have exhibited hypersensitivity to acamprosate calcium or any of its components. CAMPRAL is contraindicated in patients with severe renal impairment (creatinine clearance ≤30 mL/min).

PRECAUTIONS
Use of CAMPRAL does not eliminate or diminish withdrawal symptoms. **General: Renal Impairment** Treatment with CAMPRAL in patients with moderate renal impairment (creatinine clearance of 30-50 mL/min) requires a dose reduction. Patients with severe renal impairment (creatinine clearance of ≤30 mL/min) should not be given CAMPRAL (see also CONTRAINDICATIONS). **Suicidality** In controlled clinical trials of CAMPRAL, adverse events of a suicidal nature (suicidal ideation, suicide attempts, completed suicides) were infrequent overall, but were more common in CAMPRAL-treated patients than in patients treated with placebo (1.4% vs. 0.5% in studies of 6 months or less; 2.4% vs. 0.8% in year-long studies). Completed suicides occurred in 3 of 2272 (0.13%) patients in the pooled acamprosate group from all controlled studies and 2 of 1962 patients (0.10%) in the placebo group. Adverse events coded as "depression" were reported at similar rates in CAMPRAL-treated and placebo-treated patients. Although many of these events occurred in the context of alcohol relapse, no consistent pattern of relationship between the clinical course of recovery from alcoholism and the emergence of suicidality was identified. The interrelationship between alcohol dependence, depression and suicidality is well-recognized and complex. Alcohol-dependent patients, including those patients being treated with CAMPRAL, should be monitored for the development of symptoms of depression or suicidal thinking. Families and caregivers of patients being treated with CAMPRAL should be alerted to the need to monitor patients for the emergence of symptoms of depression or suicidality, and to report such symptoms to the patient's health care provider. **Information for Patients** Physicians are advised to discuss the following issues with patients for whom they prescribe CAMPRAL. Any psychoactive drug may impair judgment, thinking, or motor skills. Patients should be cautioned about operating hazardous machinery, including automobiles, until they are reasonably certain that CAMPRAL therapy does not affect their ability to engage in such activities. Patients should be advised to notify their physician if they become pregnant or intend to become pregnant during therapy. Patients should be advised to notify their physician if they are breast-feeding. Patients should be advised to continue CAMPRAL therapy as directed, even in the event of relapse and should be reminded to discuss any renewed drinking with their physician. Patients should be advised that CAMPRAL has been shown to help maintain abstinence only when used as a part of a treatment program that includes counseling and support. **Drug Interactions** The concomitant intake of alcohol and CAMPRAL does not affect the pharmacokinetics of either alcohol or acamprosate. Pharmacokinetic studies indicate that administration of disulfiram or diazepam does not affect the pharmacokinetics of acamprosate. Co-administration of naltrexone with CAMPRAL produced a 25% increase in AUC and a 33% increase in the Cmax of acamprosate. No adjustment of dosage is recommended in such patients. The pharmacokinetics of naltrexone and its major metabolite 6-beta-naltrexol were unaffected following co-administration with CAMPRAL. Other concomitant therapies: In clinical trials, the safety profile in subjects treated with CAMPRAL concomitantly with anxiolytics, hypnotics and sedatives (including benzodiazepines), or non-opioid analgesics was similar to that of subjects taking placebo with these concomitant medications. Patients taking CAMPRAL concomitantly with antidepressants more commonly reported both weight gain and weight loss, compared with patients taking either medication alone. **Carcinogenicity, Mutagenicity and Impairment of Fertility** A carcinogenicity study was conducted in which Sprague-Dawley rats received acamprosate calcium in their diet at doses of 25, 100 or 400 mg/kg/day (0.2, 0.7 or 2.5-fold the maximum recommended human dose based on an AUC comparison). There was no evidence of an increased incidence of tumors in this carcinogenicity study in the rat. An adequate carcinogenicity study in the mouse has not been conducted. Acamprosate calcium was negative in all genetic toxicology studies conducted. Acamprosate calcium demonstrated no evidence of genotoxicity in an *in vitro* bacterial reverse point mutation assay (Ames assay) or an *in vitro* mammalian cell gene mutation test using Chinese Hamster Lung V79 cells. No clastogenicity was observed in an *in vitro* chromosomal aberration assay in human lymphocytes and no chromosomal damage detected in an *in vivo* mouse micronucleus assay. Acamprosate calcium had no effect on fertility after treatment for 70 days prior to mating in male rats and for 14 days prior to mating, throughout mating, gestation and lactation in female rats at doses up to 1000 mg/kg/day (approximately 4 times the maximum recommended human daily oral dose on a mg/m^2 basis). In mice, acamprosate calcium administered orally for 60 days prior to mating and throughout gestation in females at doses up to 2400 mg/kg/day (approximately 5 times the maximum recommended human daily oral dose on a mg/m^2 basis) had no effect on fertility. **Pregnancy Category C Teratogenic Effects** Acamprosate calcium has been shown to be teratogenic in rats when given in doses that are approximately equal to the human dose (on a mg/m^2 basis) and in rabbits when given in doses that are approximately 3 times the human dose (on a mg/m^2 basis). Acamprosate calcium produced a dose-related increase in the number of fetuses with malformations in rats at oral doses of 300 mg/kg/day or greater (approximately equal to the maximum recommended human daily oral dose on a mg/m^2 basis). The malformations included hydronephrosis, malformed iris, retinal dysplasia, and retroesophageal subclavian artery. No findings were observed at an oral dose of 50 mg/kg/day (approximately one-fifth the maximum recommended human daily oral dose on a mg/m^2 basis). An increased incidence of hydronephrosis was also noted in Burgundy Tawny rabbits at oral doses of 400 mg/kg/day or greater (approximately 3 times the maximum recommended human daily oral dose on a mg/m^2 basis). No developmental effects were observed in New Zealand white rabbits at oral doses up to 1000 mg/kg/day (approximately 8 times the maximum recommended human daily oral dose on a mg/m^2 basis). The findings in animals should be considered in relation to known adverse developmental effects of ethyl alcohol, which include the characteristics of fetal alcohol syndrome (craniofacial dysmorphism, intrauterine and postnatal growth retardation, retarded psychomotor and intellectual development) and milder forms of neurological and behavioral disorders in humans. There are no adequate and well controlled studies in pregnant women. CAMPRAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. **Nonteratogenic Effects** A study conducted in pregnant mice that were administered acamprosate calcium by the oral route starting on Day 15 of gestation through the end of lactation on postnatal day 28 demonstrated an increased incidence of still-born fetuses at doses of 960 mg/kg/day or greater (approximately 2 times the maximum recommended human daily oral dose on a mg/m^2 basis). No effects were observed at a dose of 320 mg/kg/day (approximately one-half the maximum recommended human daily dose on a mg/m^2 basis). **Labor and Delivery** The potential for CAMPRAL to affect the duration of labor and delivery is unknown. **Nursing Mothers** In animal studies, acamprosate was excreted in the milk of lactating rats dosed orally with acamprosate calcium. The concentration of acamprosate in milk compared to blood was 1.3:1. It is not known whether acamprosate is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when CAMPRAL is administered to a nursing woman. **Pediatric Use** The safety and efficacy of CAMPRAL have not been established in the pediatric population. **Geriatric Use** Forty-one of the 4234 patients in double-blind, placebo-controlled, clinical trials of CAMPRAL were 65 years of age or older, while none were 75 years of age or over. There were too few patients in the ≥65 age group to evaluate any differences in safety or effectiveness for geriatric patients compared to younger patients. This drug is known to be substantially excreted by the kidney, and the risk of toxic reactions to this drug may be greater in patients with impaired renal function. Because elderly patients are more likely to have decreased renal function, care should be taken in dose selection, and it may be useful to monitor renal function (See CLINICAL PHARMACOLOGY, ADVERSE REACTIONS, and DOSAGE AND ADMINISTRATION).

ADVERSE REACTIONS
The adverse event data described below reflect the safety experience in over 7000 patients exposed to CAMPRAL for up to one year, including over 2000 CAMPRAL-exposed patients who participated in placebo-controlled trials. **Adverse Events Leading to Discontinuation** In placebo-controlled trials of 6 months or less, 8% of CAMPRAL-treated patients discontinued treatment due to an adverse event, as compared to 6% of patients treated with placebo. In studies longer than 6 months, the discontinuation rate due to adverse events was 7% in both the placebo-treated and the CAMPRAL-treated patients. Only diarrhea was associated with the discontinuation of more than 1% of patients (2% of CAMPRAL-treated vs. 0.7% of placebo-treated patients). Other events, including nausea, depression, and anxiety, while accounting for discontinuation in less than 1% of patients, were nevertheless more commonly cited in association with discontinuation in CAMPRAL-treated patients than in placebo-treated patients. **Common Adverse Events Reported in Controlled Trials** Common, non-serious adverse events were collected spontaneously in some controlled studies and using a checklist in other studies. The overall profile of adverse events was similar using either method. Table 1 shows those events that occurred in any CAMPRAL treatment group at a rate of 3% or greater and greater than the placebo group in controlled clinical trials with spontaneously reported adverse events. The reported frequencies of adverse events represent the proportion of individuals who experienced, at least once, a treatment-emergent adverse event of the type listed, without regard to the causal relationship of the events to the drug.

Table 1. Events Occurring at a Rate of at Least 3% and Greater than Placebo in any CAMPRAL Treatment Group in Controlled Clinical Trials with Spontaneously Reported Adverse Events

Body System/ Preferred Term	CAMPRAL 1332 mg/day	CAMPRAL 1998 mg/day[1]	CAMPRAL Pooled[2]	Placebo
Number of Patients in Treatment Group	**397**	**1539**	**2019**	**1706**
Number (%) of Patients with an AE	**248(62%)**	**910(59%)**	**1231(61%)**	**955(56%)**
Body as a Whole	**121(30%)**	**513(33%)**	**685(34%)**	**517(30%)**
Accidental Injury*	17 (4%)	44 (3%)	70 (3%)	52 (3%)
Asthenia	29 (7%)	79 (5%)	114(6%)	93 (5%)
Pain	6 (2%)	56 (4%)	65 (3%)	55 (3%)
Digestive System	**85 (21%)**	**440(29%)**	**574(28%)**	**344(20%)**
Anorexia	20 (5%)	35 (2%)	57 (3%)	44 (3%)
Diarrhea	39 (10%)	257(17%)	329(16%)	166(10%)
Flatulence	4 (1%)	55 (4%)	63 (3%)	28 (2%)
Nausea	11 (3%)	69 (4%)	87 (4%)	58 (3%)
Nervous System	**150(38%)**	**417(27%)**	**598(30%)**	**500(29%)**
Anxiety**	32 (8%)	80 (5%)	118(6%)	98 (6%)
Depression	33 (8%)	63 (4%)	102(5%)	87 (5%)
Dizziness	15 (4%)	49 (3%)	67 (3%)	44 (3%)
Dry mouth	13 (3%)	23 (1%)	36 (2%)	28 (2%)
Insomnia	34 (9%)	94 (6%)	137(7%)	121(7%)
Paresthesia	11 (3%)	29 (2%)	40 (2%)	34 (2%)
Skin and Appendages	**26 (7%)**	**150(10%)**	**187(9%)**	**169(10%)**
Pruritus	12 (3%)	68 (4%)	82 (4%)	58 (3%)
Sweating	11 (3%)	27 (2%)	40 (2%)	39 (2%)

*includes events coded as "fracture" by sponsor; **includes events coded as "nervousness" by sponsor
[1] includes 258 patients treated with acamprosate calcium 2000 mg/day, using a different dosage strength and regimen. [2] includes all patients in the first two columns as well as 83 patients treated with acamprosate calcium 3000 mg/day, using a different dosage strength and regimen.

Other Events Observed During the Premarketing Evaluation of CAMPRAL
Following is a list of terms that reflect treatment-emergent adverse events reported by patients treated with CAMPRAL in 20 clinical trials (4461 patients treated with CAMPRAL, 3526 of whom received the maximum recommended dose of 1998 mg/day for up to one year in duration). This listing does not include those events already listed above; events for which a drug cause was considered remote; event terms which were so general as to be uninformative; and events reported only once which were not likely to be acutely life-threatening. Events are further categorized by body system and listed in order of decreasing frequency according to the following definitions: frequent adverse events are those occurring in at least 1/100 patients (only those not already listed in the summary of adverse events in controlled trials appear in this listing); infrequent adverse events are those occurring in 1/100 to 1/1000 patients; rare events are those occurring in fewer than 1/1000 patients. **Body as a Whole** – *Frequent:* headache, abdominal pain, back pain, infection, flu syndrome, chest pain, chills, suicide attempt; *Infrequent:* fever, intentional overdose, malaise, allergic reaction, abscess, neck pain, hernia, intentional injury; *Rare:* ascites, face edema, photosensitivity reaction, abdomen enlarged, sudden death. **Cardiovascular System** – *Frequent:* palpitation, syncope; *Infrequent:* hypotension, tachycardia, hemorrhage, angina pectoris, migraine, varicose vein, myocardial infarct, phlebitis, postural hypotension; *Rare:* heart failure, mesenteric arterial occlusion, cardiomyopathy, deep thrombophlebitis, shock. **Digestive System** – *Frequent:* vomiting, dyspepsia, constipation, increased appetite; *Infrequent:* liver function tests abnormal, gastroenteritis, gastritis, dysphagia, eructation, gastrointestinal hemorrhage, pancreatitis, rectal hemorrhage, liver cirrhosis, esophagitis, hematemesis, nausea and vomiting, hepatitis; *Rare:* melena, stomach ulcer, cholecystitis, colitis, duodenal ulcer, mouth ulceration, carcinoma of liver. **Endocrine System** – *Rare:* goiter, hypothyroidism. **Hemic and Lymphatic System** – *Infrequent:* anemia, ecchymosis, eosinophilia, lymphocytosis, thrombocytopenia; *Rare:* leukopenia, lymphadenopathy, monocytosis. **Metabolic and Nutritional Disorders** – *Frequent:* peripheral edema, weight gain; *Infrequent:* weight loss, hyperglycemia, SGOT increased, SGPT increased, gout, thirst, hyperuricemia, diabetes mellitus, avitaminosis, bilirubinemia; *Rare:* alkaline phosphatase increased, creatinine increased, hyponatremia, lactic dehydrogenase increased. **Musculoskeletal System** – *Frequent:* myalgia, arthralgia; *Infrequent:* leg cramps; *Rare:* rheumatoid arthritis, myopathy. **Nervous System** – *Frequent:* somnolence, libido decreased, amnesia, thinking abnormal, tremor, vasodilatation, hypertension; *Infrequent:* convulsion, confusion, libido increased, vertigo, withdrawal syndrome, apathy, suicidal ideation, neuralgia, hostility, agitation, neurosis, abnormal dreams, hallucinations, hypesthesia; *Rare:* alcohol craving, psychosis, hyperkinesia, twitching, depersonalization, increased salivation, paranoid reaction, torticollis, encephalopathy, manic reaction. **Respiratory System** – *Frequent:* rhinitis, cough increased, dyspnea, pharyngitis, bronchitis; *Infrequent:* asthma, epistaxis, pneumonia; *Rare:* laryngismus, pulmonary embolus. **Skin and Appendages** – *Frequent:* rash; *Infrequent:* acne, eczema, alopecia, maculopapular rash, dry skin, urticaria, exfoliative dermatitis, vesiculobullous rash; *Rare:* psoriasis. **Special Senses** – *Frequent:* abnormal vision, taste perversion; *Infrequent:* tinnitus, amblyopia, deafness; *Rare:* ophthalmitis, diplopia, photophobia. **Urogenital System** – *Frequent:* impotence; *Infrequent:* metrorrhagia, urinary frequency, urinary tract infection, sexual function abnormal, urinary incontinence, vaginitis; *Rare:* kidney calculus, abnormal ejaculation, hematuria, menorrhagia, nocturia, polyuria, urinary urgency. **Serious Adverse Events Observed During the Non-US Postmarketing Evaluation of CAMPRAL (acamprosate calcium)** Although no causal relationship to CAMPRAL has been found, the serious adverse event of acute kidney failure has been reported to be temporally associated with CAMPRAL treatment in at least 3 patients and is not described elsewhere in the labeling.

DRUG ABUSE AND DEPENDENCE
Controlled Substance Class Acamprosate calcium is not a controlled substance. **Physical and Psychological Dependence** CAMPRAL did not produce any evidence of withdrawal symptoms in patients in clinical trials at therapeutic doses. Post marketing data, collected retrospectively outside the U.S., have provided no evidence of CAMPRAL abuse or dependence.

OVERDOSAGE
In all reported cases of acute overdosage with CAMPRAL (total reported doses of up to 56 grams of acamprosate calcium), the only symptom that could be reasonably associated with CAMPRAL was diarrhea. Hypercalcemia has not been reported in cases of acute overdose. A risk of hypercalcemia should be considered in chronic overdosage only. Treatment of overdose should be symptomatic and supportive.

Manufactured by: Merck Santé s.a.s.
Subsidiary of Merck KGaA, Darmstadt, Germany
37, rue Saint-Romain
69008 LYON FRANCE

Manufactured for FOREST PHARMACEUTICALS, Inc.
Subsidiary of Forest Laboratories, Inc.
St. Louis, MO 63045
07/04

IN MEMORIAM:
Joseph Leo Galletta, M.D.

Donald J. Kurth, M.D., FASAM
President, California Society of Addiction Medicine

Joseph L. Galletta, M.D., died December 8, 2004, at age 64. Dr. Donald Kurth has offered the following appreciation of his friend and mentor:

"One Friday evening at the 1996 ASAM Med-Sci Conference, I attended the Pain and Addiction Committee Workshop. The topic was pseudoaddiction. The room was packed—every seat was filled and interested physicians were even sitting on tables set up across the back of the room. Most of us had not heard much about pseudoaddiction and there were lots of questions from the audience. Knowing almost nobody in ASAM at the time and feeling like I had nothing to lose, I got up to the microphone and asked, "I think I understand what you mean by pseudoaddiction. My question is, 'When the pseudoaddicted patients come to my office asking for help, are there Pseudo Twelve Step programs I can send them to'?"

"Apparently, the panel did not appreciate my sense of humor, and they looked at me grim-faced while the table-sitters along the back wall chuckled audibly. I took my seat feeling that I was not winning a lot of friends. After the workshop, however, a group of doctors came over to introduce themselves and shake my hand. One was Joe Galletta. After the introductions, still standing outside the doorway of the workshop, he said, "Loma Linda needs somebody like you to work with our chronic pain patients. Why don't you come work at our Pain and Addiction Program at the Behavioral Medicine Center?" Joe was Medical Director of the program at that time and one of the founders of Loma Linda's Pain Track—an abstinence-based chronic pain and addiction program. I thought to myself, "This guy is recruiting me right here on the spot!" I explained that I already had a practice and was not looking for a job, but he insisted that I at least come by to visit and see the program. That was the start of a long and warm friendship with Joe.

"Joe's recruitment effort was successful and a year later I came to work at Loma Linda University. Joe soon moved on to bigger and better things and I took over his role as Medical Director of the Chronic Pain and Addiction Program, where I still practice today. Joe Galletta's shoes, however, have been very big shoes to try to fill.

In 1983, Joe was one of the first 160 physicians in the nation to become certified in addiction medicine.

"In 1983, Joe was one of the first 160 physicians in the nation to become certified in addiction medicine. Between 1983 and 1986, he served as Medical Director for Hemet Valley Medical Center's Outpatient Chemical Dependency Center. From 1993 to 1996, he served as Medical Director of the Chemical Dependency Unit at Loma Linda University's Behavioral Medicine Center. He later became Medical Director of the Hemet Valley Recovery Center, where he practiced until his passing.

"Joe also served for many years as Chair of the Membership Committee of the California Society of Addiction Medicine. In addition, he helped to launch the highly successful State Medical Specialty Societies (SMSS) program. He also was author of the *"ABC's of Addictive Behaviors"* and the inventor of the Flexisplint Flexed Armboard for IV therapy.

"Joe was a member of the Riverside County Medical Association since 1979 and Chair of the Riverside County Medical Association Physician's Wellbeing Committee. In 1997, he became chair of that committee's nationally recognized Western States Regional Conference on Physicians' Wellbeing, which is co-sponsored by CSAM.

"Joe Galletta was a dear friend and mentor to many of us who are now stepping into leadership roles in addiction medicine, both in California and nationally. His commitment to all those who suffer from the disease of addiction will live on in all of us whose lives he touched. He also is survived by his wife of 43 years, Teresita Soler Galletta, and by his six children, three siblings, and five grandchildren."

The case of a Seattle woman who fell while leaving a restaurant, badly breaking her ankle, illustrates a dilemma faced by physicians, patients and hospitals as the result of little-known state legislation collectively titled the Uniform Accident and Sickness Provision Laws (UPPLs). Because the woman had consumed champagne with her dinner, the Washington state UPPL allowed her insurance carrier to deny benefits for $22,000 in medical expenses for her treatment, which included two surgeries to repair her ankle.

UPPLs are based on a model law promulgated in 1947 by the National Association of Insurance Commissioners (NAIC), the organization of state insurance regulators. A recent survey of all 50 states and the District of Columbia found that 38 states still base their insurance codes on it. Four states (Minnesota, New York, Oklahoma and South Dakota) limit the exclusion to injuries incurred as a result of ingesting narcotic drugs. Only eight states (Utah, Colorado, Connecticut, Massachusetts, Michigan, New Hampshire, New Mexico and Wisconsin) have no exclusionary provision in their insurance codes, while just two states (North Carolina and South Dakota) have statutes that expressly forbid insurance companies from excluding coverage [1].

The Seattle woman's experience illustrates the dramatic and costly effect that UPPLs can have even on individuals who use alcohol in moderation, because some insurers have cited the UPPLs in denying coverage in cases where the patient wasn't legally drunk and alcohol use was not the cause of the injury.

Moreover, many emergency physicians, aware that UPPLs could cost their patients and hospitals huge financial losses if insurance claims are denied, avoid screening patients for alcohol or other drug use. They reason that if such use is not recorded in the medical record, the insurer cannot use the UPPL to deny coverage. By using this tactic to circumvent the laws, emergency physicians try to protect both their patients and their hospitals from serious medical debt.

However, that practice also discourages screening, even though CDC data suggest that 20% to 30% of emergency department visits are related to alcohol. [2] "Patients who could be helped will remain unidentified and won't receive the help they need," observes Dr. Eric Goplerud, Director of Ensuring Solutions to Alcohol Problems at The George Washington University. "Without treatment, they are more likely to drink and hurt themselves again or eventually develop serious alcohol-related medical conditions."

For these reasons, the laws have not reduced insurance costs—their original intent. As head of a trauma department, Larry Gentilello, M.D., is well-positioned to see how the UPPLs contribute to the $19 billion the Nation pays in alcohol-related health care costs. By reducing the number of patients who receive alcohol screening and treatment, the laws indirectly increase insurance costs if patients continue to drink, become re-injured or develop costly alcohol-related medical problems such as cirrhosis of the liver, heart disease or cancer. Dr. Gentilello, who chairs the Division of Burns, Trauma and Critical Care at the University of Texas Southwestern Medical School, led a three-year federally funded study of the impact of brief interventions in emergency settings, which was reported in 1999 in the *Annals of Surgery*. The study followed 760 trauma patients from 1995 to 1998. The patients were divided into two groups: members of one group received screening and 30 minutes of alcohol counseling, while those in the second group did not. Follow-up data showed that patients in the control group did not reduce their drinking levels. Patients in the intervention group, on the other hand, reported drinking an average of 28 fewer drinks per person each week. As a result, there were 48% fewer hospital re-admissions and 50% fewer emergency department visits in the treatment group than in the control group. [3]

In response to such research demonstrating the effectiveness of screening and brief intervention, the Centers for Disease Control and Prevention, the National Highway Traffic Safety Administration, and the American College of Emergency Physicians all support wider screening for alcohol problems in emergency rooms. Even the NAIC revised its model law in 2001 to permit coverage for treatment of alcohol-related injuries. ASAM, the American Medical Association, and other health organizations support state adoption of the new model law that excludes the UPPL.

Working in opposition is the Health Insurance Association of America (HIAA), which argues that the evidence supporting screening and brief intervention of emergency patients is "inconclusive." Dr. Goplerud counters that "We've learned so much more in recent years about how to effectively treat alcohol dependence and other alcohol problems. Increasingly, decision-makers in the public and private sectors are working to make these treatments more accessible. UPPLs remain one of the most significant barriers to achieving improved access to treatment."

Dr. Gentilello agrees, saying: "Doctors want to do what is right for their patients, but trauma centers that admit hundreds of intoxicated patients every year cannot afford to write off these costs. Patients who could be helped by alcohol treatment will remain unidentified and won't receive the help they need [because of UPPLs]. Without treatment, they are more likely to drink and hurt themselves again or eventually develop serious alcohol-related medical conditions." *Source: Marlene Cimons, Ensuring Solutions to Alcohol Problems, The George Washington University, Washington, DC.*

UPPLs a Hidden Obstacle to Diagnosis, Treatment

"Surveys have shown that the vast majority of trauma surgeons believe that it is important to talk to their patients about alcohol use, and believe that a trauma center is an appropriate place to begin to address alcohol problems However, UPPLs have prevented them from putting these potentially life-saving protocols into practice."

– Larry Gentilello, M.D.
University of Texas
Southwestern
Medical School

1. Rivara FP et. al. (2000). Screening trauma patients for alcohol problems: Are insurance companies barriers? *Journal of Trauma, Injury, Infection and Critical Care* 48:115.
2. Centers for Disease Control and Prevention (2002). *Injury Fact Book*. Available at WWW.CDC.GOV/NCIPC/FACT_BOOK/09_ALCOHOL_%20INJURIES_%20ED.HTM.
3. Gentilello LM, Rivara FP et al. (1999). Alcohol interventions in a trauma center as a means of reducing the risk of injury recurrence. *Annals of Surgery* 230(4):473-483.

ASAM Chapters and State Societies Focus on UPPL, Other Legislative Issues

Richard A. Beach, M.D., FASAM
Chair, State Medical Specialty Societies Program

CALIFORNIA

Reporter: Donald J. Kurth, M.D., FASAM

CSAM's third Legislative Day, February 2, 2005, saw 135 physicians and other health care professionals visit the California state legislature to educate legislators about addiction and public policy. As in past years, the California Society of Addiction Medicine organized the event.

CSAM President Don Kurth, M.D., FASAM, addressed the legislators on the need for addiction treatment. Eric Goplerud, Ph.D., research professor in the Department of Health Policy at The George Washington University, flew to Sacramento specifically to address the need to repeal the UPPL law in California. (UPPL allows insurers to refuse to pay for traumatic injuries that result from intoxication. This has been devastating to trauma centers across the country, because up to 70% of trauma patients may have alcohol and/or drugs in their bloodstream at the time of injury.) In the last legislative session, both the Senate and Assembly voted to repeal UPPL, but Governor Schwartzenegger vetoed the legislation. As a result of CSAM's efforts and the Legislative Day, a bill to repeal UPPL (SB 573) has been reintroduced by Senator Gloria Romero.

CONNECTICUT

Reporter: Mark Kraus, M.D.

The Connecticut Society of Addiction Medicine is working for repeal of the UPPL in Connecticut, and opposing (for the third time) a ballot initiative on medical marijuana.

CtSAM also is collaborating with the Connecticut Community for Addiction Recovery (CCAR) to encourage the state's Congressional delegation to join the addiction caucus in the U.S. House of Representatives, and to ask Senators Lieberman and Dodd to do the same thing in the Senate.

NEW YORK

Reporter: John Coppola

NYSAM's first newsletter has been published. For 2005, the newsletter will be published twice a year, then will move to quarterly distribution in 2006.

The 2nd annual NYSAM Medical-Scientific Conference was held January 29-30 in conjunction with a Buprenorphine Training Course. About 75-100 physicians attended. A Board retreat was held prior to the meeting, on January 28th, to focus on how to set goals and garner more participation from NYSAM members to strengthen the Society, as well as how to strengthen ties with other medical organizations.

RHODE ISLAND

Reporters: Cynthia Jordan and Laurie Roberts

RISAM has relocated its offices to share space with DATA (an advocacy group). Laurie Roberts is the DATA representative who will be working closely with RISAM. A RISAM website and logo are in development.

Plans are underway to establish three committees: Legislative, Membership and CME. RISAM's most recent regional meeting was held February 5, 2005, and quarterly conferences are being considered. RISAM also is collaborating with the Connecticut South County Physician group to sponsor a March 9th meeting.

The Physician's Initiative is progressing well. Kathryn Cates-Wessel has helped RISAM representatives identify screening instruments, which will be tested at seven sites, in addition to some hospital emergency departments. The state Blue Cross/Blue Shield Plan has agreed to reimburse for use of the validated instrument.

REGION VII (AR, KS, LA, MO, NE, OK, TX)

Reporter: Lisa Stolier

Region VII recently submitted a grant application to the Center for Substance Abuse Treatment to fund the next regional conference. The Region also is planning to offer a Buprenorphine Training Course on September 9th, immediately prior to the annual meeting.

300 Physicians Earn ASAM Certification, 33 Are Recertified

ASAM's Certification Council has announced that the following physicians have met the requirements for ASAM Certification or Recertification in Addiction Medicine. Their achievement will be recognized during ASAM's annual Medical-Scientific Conference, April 14-17th in Dallas, Texas.

CERTIFIED IN ADDICTION MEDICINE

Vincent T. Abad, M.D.
Brian Keith Adler, M.D.
Chisara Adonai, M.D.
Kwami D. Agbodza, M.D.
Homaira Ahad-Amiri, M.D., M.P.H.
Seeme V. Ahmad, M.D.
Danesh A. Alam, M.D.
Michael Alexandrov, M.D.
Hussein Abdullah Alhumaid, M.D.
Jeffery Lynn Allyn, M.D.
Roger Amick, M.D.
Marilyn Ann Ancel, M.D.
Arash Ansari, M.D.
Michael Anthony Arcuri, M.D.
Felipe Antonio Arias, M.D.
Pauline Douglas Armour, M.D.
Jose F. Artecona, M.D.
Rob Ruddell Ashby, M.D.
Stephen Christopher Ayers, M.D.
Jerry Daniel Ayers, M.D.
Olasimbo Mulikat Babatope, M.D.
Bruce Henry Baker, M.D.
John Robert Baker, M.D.
Karim Bakhtiar, M.D.
Massarat A. Bala, M.D.
Washington D. Baquero, M.D.
Alvydas John Baris, M.D.
Gail M. Basch, M.D.
Jeffrey D. Baxter, M.D.
Barbara R. Bellar, M.D.
Grant Bennett Belnap, M.D.
Andre William Benson, M.D.
Susan Kaye Blank, M.D.
Michael P. Bogenschutz, M.D.
Dan George Boone, M.D.
Doyle John Borchers III, M.D.
Bernard Charles Borkowski, M.D.
Jennine M. Brandt, M.D.
William Clay Brown, M.D.
Randall Todd Brown, M.D.
Robert E. Bryan, Jr., M.D.
Lance Everett Bullock, M.D.
Jana Kaye Burson, M.D.
Roberto Lagria Caga-Anan, M.D.
Joseph A. Campagna, M.D.
Robert Perry Campbell, M.D., M.P.H.
Nicholas J. Campo, M.D.
Horacio A. Capote, M.D.
Christopher John Carbo, D.O.
George Lewis Carlson, M.D.
Janis Rosemary Carlton, M.D., Ph.D.
Gary Dwain Carr, M.D.
Chris Andrew Cavacuiti, M.D., CCFP
Rick Chavez, M.D.
Michael Roger Chiarottino, M.D.
Carol Lynn Childers, M.D.
Susan J. Chirayil, M.D.
Carl Woodrow Christensen, M.D.
Sharon Louise Cirone, M.D.
Kelly J. Clark, M.D.
Karen Helen Clements, M.D.
Christine Anderson Curley, M.D.
Scott Mitchell Davis, M.D.
Thomas John Deal, M.D.
Judith Del Valle, M.D.
Dilek S. Delvers, M.D.
Jerry L. Dennis, M.D.
Timothy Derstine, M.D.
Constantine Diakolios, M.D.
Patricia Anne Dobbins-Sullivan, M.D.
Philip B. Eatough, D.O., J.D.
Emmanuel Ifeanyi Elueze, M.D., Ph.D.
Paul Joseph Erickson, M.D.
Moronkeji Olapade Fagbemi, M.D.
Abdel R. Fahmy, M.D.
Christopher Scott Famy, M.D.
J. Ramsay Farah, M.D., M.P.H.
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Michael Patrick Frost, M.D.
James Michael Gaither, M.D.
Prashant Gajwani, M.D.
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Stanislaus Gunadi, M.D.
Gawtham Gutta, M.D.
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Zhila Haghbin, M.D.
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Sydney Hughes, M.D.
David Justin Hutnyk, M.D.
Muhammad Ali Hyder, M.D.
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Paul Davis Johnson, M.D.
Joseph Shaw Jones, M.D.
Sumabala Kasibhotla, M.D.
Michael Edward Kelley, M.D.
Reginald Joseph Kendall, M.D.
Cheryl Ann Kennedy, M.D.
Muslim Khan, M.D.
Shahid Khan, M.D.
Aqueel A. Khan, M.D.
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Imran Shuja Khawja, M.D.
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Juan Carlos Pequeno, M.D.
James Darian Pierre, M.D.
Reed Michael Pitre, M.D.
Wojciech Poluha, M.D.
Ian R. Powell, M.D.
Michael Ernest Price, M.D.
Gita Pujari, M.D.
Manikanda Grandhe Raja, M.D.
Naipaul Rambaran, M.D.
Hayman Kumar Rambaran, M.D.
Louis Nathaniel Randall, M.D.
Kokeela R. Rathi, M.D.
Kaushik Jitendra Raval, M.D.
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Maurice Howe Richardson, M.D., FACEP
James Edward Richardson, M.D.

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William Manion Scott III, M.D.
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Stacy Elizabeth Seikel, M.D.
Hayden D. Severin, M.D.
Mouna G. Sfeir, M.D.
Ketki S. Shah, M.D.
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David Shane Sherbondy, M.D.
Conrad John Sichler, M.D., B.Sc.
Imtiazuddin M. Siddiqui, M.D.
Jose Maria Alves Silveira, M.D., FRCPC
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Marvin L. Sponaugle, M.D.
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Jacquelyn Jennifer Starer, M.D.
Gerry A. Steiner, M.D.
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Pamela Stewart, M.D.
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Richard L. Stieg, M.D.
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Carmen M. Suarez, M.D.
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Kevin Lynch Walsh, M.D.
James Steven Walsh, M.D.
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Ruth Fox Memorial Endowment Fund

Joseph E. Dorsey, M.D., FASAM, and Mrs. Dorsey are steadfast benefactors of the Ruth Fox Memorial Endowment Fund. Once again this year, Dr. and Mrs. Dorsey will underwrite the cost of the annual Ruth Fox Fund Donor Reception during ASAM's Med-Sci Conference. ASAM and the Fund express their gratitude to the Dorseys for their ongoing generosity.

The Ruth Fox Memorial Endowment Fund thanks all of our donors and especially our major donors, who have contributed or pledged the following significant gifts over the years:

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Dr. Ruth Fox

Dear Colleagues:

As we prepare to gather at ASAM's annual Med-Sci Conference, we hope you will look at the amount and timing of your gifts to the Ruth Fox Memorial Endowment Fund in order to support our Society and maximize your 2005 tax savings.

The Endowment was established to create a fiscally sound base to assure ASAM's continued ability to realize its mission: to provide ongoing leadership in newly emerging areas affecting the field of addiction medicine, to continue its commitment to educating physicians, to increasing access to care and to improving the quality of care. With your professional and financial support, ASAM will achieve its mission

This year, as it has every year since 2002, the Ruth Fox Scholarship Program will sponsor an outstanding group of physicians-in-training to attend ASAM's Annual Medical-Scientific Conference and Ruth Fox Course for Physicians. Please make a point of greeting these young colleagues at the Ruth Fox Donor Reception, which is scheduled for Friday evening, April 15th.

Invitations to the Ruth Fox reception are extended only to donors, so if you have not already contributed or pledged to the Endowment Fund, please do so now. 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. 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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2005
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36th Annual
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April 14 -17, 2005
Hyatt Regency Hotel, Dallas, Texas
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ASAM Conference Calendar

ASAM

April 12, 2005
Buprenorphine & Office-Based Treatment of Opioid Dependence
Washington, DC
8 Category 1 CME credits

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

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

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

April 17, 2005
Buprenorphine & Office-Based Treatment of Opioid Dependence
Hyatt Regency Hotel
Dallas, Texas
8 Category 1 CME credits

OTHER EVENTS OF NOTE

January 29-30, 2005
New York Society of Addiction Medicine
2nd Annual Conference
"Diversity, Addiction and Recovery"
New York City
(co-sponsored by Albert Einstein College of Medicine)
9 Category 1 CME credits
[For information, phone 518/689-0142]

March 3-4, 2005
Washington Society of Addiction Medicine
7th Annual Conference
"Fundamentals of Addiction Medicine"
Seattle, WA
(co-sponsored by Providence-Everett Medical Center)
15 Category 1 CME credits
[For information, phone 425/261-3691]

March 28-30, 2005
ASAM Region X Conference on Addictions
Kissimmee, FL
(hosted by the Florida Society of Addiction Medicine)
[For information, e-mail FSAM.ASAM@USA.NET]

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(The following courses are approved for 8 Category 1 CME credits)

April 15, 2005
San Francisco, CA
ASAM – CSAM
Contact: www.DocOptIn.com
or 888/362-6784

April 17, 2005
Dallas, TX
ASAM
Contact: www.DocOptIn.com
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April 29-30, 2005
Columbus, OH
ASAM – CWRU School of Medicine
Contact: Case Western Reserve University
at 216/368-2408

May 14, 2005
New Orleans, LA
ASAM – LSAM
Contact: www.DocOptIn.com
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May 21, 2005
Portland, ME
ASAM - Region III
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or 888/362-6784

June 4, 2005
Cincinnati, OH
ASAM
Contact: www.DocOptIn.com
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June 18, 2005
Chicago, IL
ASAM – ISAM
Contact: www.DocOptIn.com
or 888/362-6784

August 6, 2005
St. Louis, MO
ASAM
Contact: www.DocOptIn.com
or 888/362-6784

September 9, 2005
San Antonio, TX
AOAAM – ASAM – Region VII
Contact: www.DocOptIn.com
or 888/362-6784

October 8, 2005
San Francisco, CA
ASAM - CSAM
Contact: www.DocOptIn.com
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Register for ASAM's 2005 Med-Sci Conference
TODAY!
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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.