



# ASAMNews

Newsletter of The American Society of Addiction Medicine

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[www.asam.org](http://www.asam.org)



## State of the Art Course Set for October 22-24

ASAM's 2009 Course on the State of the Art in Addiction Medicine will meet October 22nd – 24th at the Hyatt Regency Capitol Hill Hotel in Washington, DC. The course focuses on cutting-edge research and the potential of such research to enrich the clinical practice of addiction medicine. It is offered only once every two years so that each event presents true advances in the field.

Course Director Frank Vocci, Ph.D. and Planning Committee Members Markus Heilig, M.D., Ph.D., Robert Lubran, M.S., M.P.A., Edwin A. Salsitz, M.D., FASAM, Bonnie B. Wilford, M.S., and Stephen A. Wyatt, D.O., have designed the course to meet the needs of multiple audiences. These include: (1) addiction specialists who seek an update on recent developments in addiction research and practice; (2) individuals who are engaged in or who wish to obtain funding for addiction research; (3) educators who are concerned with translating scientific knowledge to *continued on page 4*

## ASAM Publishes New Edition of Principles Textbook

Publication of the Fourth Edition of ASAM's landmark textbook, *Principles of Addiction Medicine*, was announced at the recent Med-Sci Conference by senior editor Richard K. Ries, M.D. Edited by Dr. Ries and Shannon C. Miller, M.D., FASAM, FAPA, CMRO, David A. Fiellin, M.D., and Richard Saitz, M.D., M.P.H., FACP, FASAM, the textbook was developed for all physicians and other health care professionals who specialize in addiction medicine and who treat patients with addictive disorders.

At 1408 pages and with 276 illustrations, *Principles-Fourth Edition* presents a comprehensive review of the scientific principles underlying addiction and the practical essentials of clinical care. As in past editions, many of the contributors are affiliated with government agencies and research institutions, such as

the National Institute on Alcohol Abuse and Alcoholism, the National Institute on Drug Abuse, and the Center for Substance Abuse Treatment.

In announcing the book's publication, Dr. Ries also announced an innovative feature of the Fourth Edition, in that purchasers of the book also will have access to an online version of the text, "so that wherever you are, you can go online and have the book right in front of you."

*Principles of Addiction Medicine, Fourth Edition* can be ordered from the publisher, Lippincott Williams & Wilkins, online at [HTTP://WWW.COM/PRODUCT/?978-0-7817-7477-2](http://www.lww.com/Product/?978-0-7817-7477-2) or through medical bookstores. The \$199 price includes both the printed text and the online version (the ISBN number is 978-0-7817-7477-2).



## ASAM Honors Achievements in Science, Education and Policy

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



*Eileen McGrath, J.D.*

**A**t this year's Medical-Scientific Conference, ASAM honored a distinguished group of individuals who have made outstanding contributions to the field of Addiction Medicine and to the Society itself. The awardees were honored at a gala Awards Luncheon on Saturday, May 2nd. Our 2009 awards were presented to the following outstanding leaders.

The John P. McGovern Award on Addiction and Society went to Congressman Patrick Kennedy for his seminal contribution to the enactment of federal parity legislation. 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.

The 2009 R. Brinkley Smithers Distinguished Scientist Award went to our own Marc Galanter, M.D., FASAM,

Director of the Division of Alcoholism and Drug Abuse at New York University School of Medicine and a Past President of ASAM. The award was presented at the Opening Plenary Session at 9:00 a.m. Friday, May 1st. At that time, Dr. Galanter delivered the award lecture, "Spirituality, Social Affiliation, and Alcoholics Anonymous: Broadening the Base of Empirical Medicine."

The ASAM Annual Award for "outstanding contributions to the growth and vitality of our Society, for thoughtful leadership in the field, and for deep understanding of the art and science of addiction medicine" was presented to Lawrence S. Brown, Jr., M.D., M.P.H., FASAM.

An ASAM Annual Award for "expanding the frontiers of the field of Addiction Medicine and broadening our understanding of the addiction process through research and innovation" was presented to Nora D. Volkow, M.D., for her multiple contributions as a researcher, educator, and Director of the National Institute on Drug Abuse.

The Young Investigator Award for the best abstract submitted by an author who is within five years of receiving a doctoral degree was given to Philip P. Lobmaier, M.D.

The Medical-Scientific Program Committee Award for the abstract receiving the highest rating for scientific merit was awarded to Walter Ling, M.D.

ASAM salutes all the award recipients for their accomplishments — they are truly leaders of our field.

### 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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#### ASAM News

is an official publication of the American Society of Addiction Medicine. It is published six times a year.

Please direct all inquiries to the Editor at ASAMNEWSLETTER@AOL.COM or phone 410/770-4866.

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For members visiting ASAM's web site ([www.asam.org](http://www.asam.org)), entrance to the on-line Membership Directory requires the Username "asam" and the password "asam" (in lower case letters).



**WOULD YOU LIKE A RECORDING OF A MEMORABLE PRESENTATION TO ADD TO YOUR PROFESSIONAL LIBRARY?**

Recordings of sessions at the Med-Sci conference, the Common Threads course, and the Ruth Fox course can be purchased on-site or ordered from **Digital Conference Providers at 630-963-8311.**

## Dr. McLellan Named Deputy Director of ONDCP

President Barack Obama has nominated A. Thomas McLellan, Ph.D., to the post of Deputy Director of the Office of National Drug Control Policy (ONDCP) in the Executive Office of the President. Dr. McLellan is Professor of Psychology in Psychiatry at the University of Pennsylvania and Chief Executive Officer of the Treatment Research Institute (TRI), a not-for-profit research and development institute.

In March, President Obama nominated Seattle Police Chief Gil Kerlikowske to head ONDCP. Chief Kerlikowske's reputation for innovative approaches to law enforcement and Dr. McLellan's stature as a treatment expert make them "a perfect match," said Steve Pasierb, president and CEO of the Partnership for a Drug-Free America.

Dr. McLellan is nationally and internationally recognized for his 30+ years of research into treatment effectiveness. As a scientist at the Veterans Administration Medical Center in Philadelphia in the 1980s, he developed two instruments, the Addiction Severity Index (ASI) and the Treatment Services Review (TSR) — measurement instruments that characterize the multiple dimensions of problems confronting substance abusing patients and the types and duration of treatment services offered in response. Now translated into more than 20 languages, the ASI and TSR are the most widely used instruments of their kind in the world.



A. Thomas McLellan, Ph.D.

In 1991, Dr. McLellan co-founded TRI to translate the results of research to policy-makers, addiction treatment professionals, prevention organizations, and the families of individuals affected by addiction. Helping primary care physicians recognize and respond to symptoms of alcohol and drug use in their patients is a major thrust of TRI's work, as is its emphasis on removing bureaucratic impediments to high-quality treatment and translating evidence-based practices for populations such as substance-using offenders.

Through TRI and other endeavors, Dr. McLellan has promoted better understanding of the factors that lead to treatment success and fostered better understanding of addiction as a chronic illness that must be continually monitored and managed in the same manner as other chronic medical

conditions such as diabetes and hypertension.

The author of more than 400 articles and textbook chapters on addiction, Dr. McLellan is Editor-in-Chief of the *Journal of Substance Abuse Treatment*. He also is an advisor to many government and nonprofit scientific organizations. Among his many honors are awards from ASAM and from the Swedish Medical Association, the British Medical Association, and the Robert Wood Johnson Foundation.

Addiction field leaders were unanimous in their praise for the appointment. Former White House Drug Policy Director Robert L. DuPont, M.D., who also was first director of the National Institute on Drug Abuse (NIDA) and is now President of the Institute for Behavior and Health, said: "The nomination of Tom McLellan, Ph.D., to be Deputy Director of ONDCP is the most important White House appointment for substance abuse treatment in over a decade. Tom is widely recognized as the leading drug treatment researcher in the world. He has no peers and no detractors. He enjoys a unique position of respect from this field that seldom agrees on anything. Dr. McLellan is the man and this is the hour to revitalize drug abuse treatment and to raise the national priority for demand reduction. This appointment brings great credit to the Obama Administration. It fulfills the President's ambition to bring new ideas to solve long-neglected, urgent national priorities."

## MERGER OF NIAAA, NIDA PROPOSED

A long-simmering controversy within the addiction research community was reignited in February when a special review board publicly raised the issue of merging the *National Institute on Drug Abuse* (NIDA) and the *National Institute on Alcohol Abuse and Alcoholism* (NIAAA).

When the National Institutes of Health (NIH) were reauthorized by Congress in 2006, a Scientific Review Management Board (SRMB) was created to report on the way NIH was organized. The NIDA-NIAAA merger is one of two inaugural SRMB recommendations (the other involves the NIH Intramural Research Program).

The main argument in favor of merger is that efficiencies can be attained by joining the two addiction-focused institutes. In theory, a single agency would yield lower overhead costs and a leaner bureaucracy. Ideally, savings would be realized not only by eliminating redundancies within the two institutes, but for NIH as a whole.

This is not the first time such a suggestion has been made. A merger was considered most recently in 2003 at the request of the National Academy of Sciences. Former NIAAA Director Enoch

Gordis, M.D., was one of the most vocal opponents of that merger. He argued that alcohol-focused research was already receiving only a fraction of the funding that it deserved, and there was no way a merger would improve that situation. To the contrary, he said, a merger risked overshadowing alcohol as it became subsumed by NIDA's pre-existing agenda and objectives. (NIDA's fiscal year 2009 budget was \$1,032,700,000, while NIAAA's was less than half that amount at \$450,200,000).

One ironic effect of a merger would be a renewed chance to re-name the institutes — a push that was made during Congress's last session but ultimately fell short. A bill supported by NIDA and NIAAA themselves would have re-named NIDA the National Institute on Diseases of Addiction and NIAAA the National Institute on Alcohol Disorders and Health.

No merger is imminent, as the number of bureaucratic steps that must be taken before any merger could be realized is daunting. Some field organizations, such as the National Association of Addiction Treatment Providers (NAATP), are opposing the merger proposal. ASAM has not taken a position on the matter.

## A Commitment to Meet ASAM's Future Challenges

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



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

The challenges that lie ahead for our ASAM organization are numerous and quite formidable, not unlike those challenges that are facing our Nation. Even in the wake of ASAM's historic and monumental accomplishments of successfully supporting the enactment of parity legislation and establishing the American Board of Addiction Medicine (ABAM), our work has just begun.

These accomplishments were made possible only by the efforts of so many of our determined and talented ASAM members. The work that lies ahead will require continued extraordinary effort on the part of our members — those addiction experts who've made parity and ABAM a reality. The challenges that lie ahead — some known, others as yet unknown — may be difficult, but they are not insurmountable for us as a specialty society.

For example, ASAM must closely monitor the implementation of the parity legislation to ensure that it provides meaningful access to the patients who rely on our care, and affords a full range of necessary treatment services.

ASAM also needs to continue to focus on affirming its role *the* resource for state-of-the-art addiction medicine education, as well as evidence-based treatment recommendations and related guidelines. This must include a special focus on medical student and resident education, while also providing continuing medical education to our Board-certified and Board-eligible practicing addiction medicine specialists.

ASAM also must focus on developing educational programs and other resources

for our colleagues in other specialties who collaborate in caring for many of our patients. Moreover, ASAM is invested in emphasizing the value of early recognition and prevention of addiction, as evidenced by our Society's support for Screening, Brief Intervention, and Referral to Treatment (SBIRT) and the practice of Adolescent Medicine, respectively.

ASAM will continue to pursue and publicize advances in the basic sciences and clinical research by nurturing our close relationships with Governmental and non-Governmental agencies that support and conduct research and demonstration projects (e.g., CSAT, NIAAA, NIDA), education (AMERSA, AAAP, AOAAM, and other medical specialty societies), and evaluations of treatment outcomes (ONDCP, HRSA, SAMHSA, and the VA).

There will be many opportunities for interested ASAM members to be involved in these and other efforts. In fact, there is a role in ASAM for every willing member.

Finally, I believe it is essential that ASAM continues to support advocacy, not only for our patients, but also for our colleague physicians and other allied health professionals during their own personal journeys in recovery. Addiction is an equal opportunity disease and has affected many of those within and outside our addiction treatment workforce. As ASAM seeks to expand the number of providers in our workforce, it also needs to advocate for prevention while at the same time working for the reintegration of our fellow health care professionals who have fallen ill but are now in recovery and who are willing to cooperate with any ongoing monitoring that their continued wellness may require.

As President of ASAM, I pledge to represent and serve you and your highest aspirations as caregivers. I cannot do this alone. I will continue to call upon you, confident that you will continue to lend us the rich talent and expertise that characterizes our membership. Only in this way can we, together, redefine and further develop this unique organization called ASAM, in its evolving role as a well-recognized, well-established, and increasingly respected professional specialty society. I especially look forward to representing ASAM in cooperating with our newly formed and closely related specialty Board, the American Board of Addiction Medicine. *Thank you for this opportunity to serve.*

### STATE OF ART COURSE *continued from page 1*

clinical services, and (4) physicians, nurses, counselors and other professionals who seek a succinct review of the latest knowledge about the causes, identification, and management of addictive disorders.

ASAM's State of the Art Courses consistently receive very strong evaluations for their effectiveness in translating research findings into clinical practice. They also are widely known for attracting an outstanding faculty (including a recipient of the Nobel Prize) and providing an international perspective. For example, at the 2009 course, Professors Trevor Robbins and Barbara Sahakian of England's Cambridge University will bring an international perspective to the

discussion of cognition in addiction. The courses also are topical: at the 2009 course, Joshua Sharfstein, M.D., who is Principal Deputy Commissioner of the U.S. Food and Drug Administration, will discuss FDA's plans to implement the new FDA authorization to oversee tobacco products.

The 2009 course is approved for up to 21 hours of Category 1 continuing education credits. Attendance is limited, so be sure to register early! For more information or to register, visit the ASAM Website at [WWW.ASAM.ORG](http://WWW.ASAM.ORG), phone the ASAM Meetings staff at 301/656-3920, or register on site (on-site registration opens at 5:00 p.m. on Wednesday, October 21st.)

## Addiction Public Policy Goals For the Next Century

Donald J. Kurth, M.D., M.B.A., M.P.A., FASAM  
ASAM President-Elect



Donald J. Kurth, M.D., M.B.A.,  
M.P.A., FASAM

**C**ONGRATULATIONS! Congratulations to all of you who care about those suffering from addictive disease! Congratulations to all who have worked these many years to change the course of our Nation toward a more sensible public policy regarding addiction treatment. The signing into law of the mental health parity act by President George W. Bush on October 3, 2008, brought the right to treatment to all those Americans covered by private insurance and Medicare who suffer from this ageless malady. But the work is not done yet, even at the most basic level. We still have to be sure that the implementation regulations are written in a way that actually manifests the spirit of the law — that is, access to treatment for addiction — but the framework has been created and it is up to us to continue to build on that structure.

We have achieved our goal; parity is ours, what more needs to be done? As far as we have come, we still have a long, long way to go. Let me give you two obvious suggestions for public policy goals for the addiction field. Our first goal must be to end the national, institutionalized discrimination against all those who suffer, or who have ever suffered, from addiction to alcohol or other drugs. I spoke recently to a group of adolescents in the Daytop Village treatment center in New York City and answered questions at the end of my talk. One of their major concerns — perhaps their greatest concern — was how they would ever get into college or get a job if they were honest about their drug addiction and treatment. This is a sad state of affairs. These were teenagers, mind you. Instead of focusing on getting well and getting on with their lives, they are worrying about how they will overcome the stigma and discrimination that they know is waiting for them down the road.

I recently attended a talk on discrimination in the workplace. During the talk I realized that, along with race, gender, national origin, and other protected classes of people, some areas of California law include “medical condition” as a protected class of individuals. Yet, for the most part, federal law offers no such protection. Think about this: Should somebody who has had a cancer excised, or even is in long term remission, be refused employment because of their medical condition? Should someone who has suffered a myocardial incident, and who is now healthy and active, be passed over for advancement based on their medical history? Similarly, should an alcoholic or addict who is clean and sober for years or decades have to continue to answer the question, “Have you **ever** been treated for drug or alcohol dependence?” These are egregious examples of institutionalized discrimination perpetuated against recovered and recovering people every day. And we have to put a stop to this sort of stigma if we ever hope to help our patients fully recover and fully reintegrate into society.

Our second goal should be to provide unfettered access to

treatment on request for every American suffering from addiction. Those who understand the chronicity of this disease and the concomitant denial so often present, understand that over the years- or even decades-long course of the disease, the windows of during which individuals are receptive to treatment may open only for a few weeks, days, or even hours. If we are ever to bring this disease to its knees, we must address addiction at the level of a public health malady.

Think about this. If we wanted to prevent the spread of tuberculosis bacilli or syphilitic treponemes, we would not make those suffering from those disorders beg, scrape, or demand treatment. To the contrary, we would welcome them into treatment. We would make treatment easily accessible whenever and

wherever they wanted it. At the very least, we would want to make treatment readily available so that infected patients do not continue to spread their diseases to others. And so our public health policies encourage people with these sorts of communicable diseases to access treatment.

Similarly, with alcohol and other drug addiction — particularly among our youth — we should want to stop the spread of this disease. We should not want sufferers to continue to have peer pressure or adult role models of socially accepted addiction and alcoholism on television, in their communities, or in their homes. The only way to accomplish this, however, is to provide a nationwide public health environment in which every American, even at the earliest stages of addiction, is welcomed into treatment whenever it is needed.

In July 2008, then-Senator Barack Obama said, “Anybody who sees the devastating impact of the drug trade in the inner cities, or the methamphetamine trade in rural communities, knows that this is a huge problem. I believe in shifting the paradigm, shifting the model, so that we focus more on a public-health approach.” Our President is right. This disease has to be addressed on a public health level. ASAM’s role must be to educate our policymakers and lead the way for our Nation. Come join us in changing the world for all those who suffer from this lethal disease. Write your Congressman; write your Senator; and come join us at the next ASAM Addiction Treatment Legislative Day. The world is ours to change if we are willing to get involved.

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*DONALD J. KURTH, MD, MBA, MPA, FASAM is President Elect of the American Society of Addiction Medicine and Mayor of the City of Rancho Cucamonga, California. He is the founder of both the California and the National Annual Addiction Treatment Legislative Days and a past recipient of the prestigious Robert Wood Johnson Foundation Fellowship for Developing Leadership in Reducing Substance Abuse. You can learn more about his work at [WWW.DONKURTH.COM](http://WWW.DONKURTH.COM).*

## Nominees Sought for ASAM Officer, Board Posts

Michael M. Miller, M.D., FASAM, FAPA, Chair of ASAM's Nominations & Awards Council, has announced the eligibility requirements for the Society's 2010 election of officers, and released a list of ASAM members who are eligible to run for office.

Nominees for the offices of ASAM President-Elect, Treasurer and Secretary must be current members of the Board of Directors or have served on the Board within the past four years. An exception may be made in the case of a nominee for the office of Treasurer, who may be a member who possesses other qualifications for the position and who has been active on the Finance Council within the past four years. The term of office for these positions is 2011-2013.

Candidates also are sought for the position of Director-at-Large. Nominees must have been an active member of ASAM for at least three years; must have demonstrated a commitment to ASAM's Mission by having engaged in activities such as service on an ASAM Committee/Council, Task Force, or other significant national or state endeavor; and must be willing to attend two Board meetings per year for four years at his/her own expense. The term of office for Directors-at-Large is 2011-2015.

The deadline to submit nominations is October 15, 2009. Nominations can be emailed to Claire Osman at ASAMCLAIRE@AOL.COM. Those who submit nominations should first verify that the candidate meets the criteria cited above and is willing to run, if nominated. A slate of candidates will be approved by the Board of Directors at its January 2010 meeting. A petition process will be announced in the Spring 2010 issue of **ASAM NEWS**. Voting takes place October 2010.

**Eligible for Nomination.** The Nominations & Awards Council has determined that the following members are eligible to be nominated for the office of President-Elect, Secretary or Treasurer:

Peter Banyas, M.D.

Gavin Bart, M.D.

Jeffrey A. Berman, M.D., MS, FASAM

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

Marc Galanter, M.D., FASAM

J. Ramsay Farah, M.D., M.P.H., FAAP, FASAM

John P. Femino, M.D., FASAM

Stuart Gitlow, M.D., M.P.H., M.B.A., FAPA  
*(ineligible for re-election as Treasurer because he has served two terms)*

R. Jeffrey Goldsmith, M.D.

Lloyd Gordon, III, M.D., FASAM

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

Thomas L. Haynes, M.D., FASAM

Elizabeth F. Howell, M.D., FASAM, DFAPA

Brian Hurley, M.D., M.B.A.

Margaret A.E. Jarvis, M.D., FASAM

Lori D. Karan, M.D., FACP, FASAM

Mark L. Kraus, M.D., FASAM

Petros Levounis, M.D., M.S.

Herbert L. Malinoff, M.D., FACP, FASAM

Daniel J. McCullough, M.D.

David R. Pating, M.D.

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

Marvin D. Seppala, M.D.

C. Chapman Sledge, M.D., FASAM

*(eligible for re-election as Secretary)*

Richard G. Soper, M.D., J.D., M.S.

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

Howard J. Wetsman, M.D.

Martha J. Wunsch, M.D., FAAP, FASAM

Penelope P. Ziegler, M.D., FASAM

*The following members are eligible to be nominated for the office of Treasurer:*

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

James A. Halikas, M.D., FASAM

### RESIDENT COVERAGE NEEDED

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## President Obama Addresses AMA's House of Delegates

The 220th Meeting of the AMA House of Delegates took place June 13-17, 2009, in Chicago as part of the American Medical Association's 158th Annual Meeting.

ASAM was represented by Delegate Stu Gitlow, M.D., ASAM's Treasurer, and Alternate Delegate Don Kurth, M.D., ASAM's President-Elect. Also attending were several ASAM members from other delegations, including ASAM Immediate Past President Michael Miller, M.D.

ASAM is a member of the Section Council on Preventive Medicine and the Section Council on Pain and Palliative Medicine and, along with more than 100 other national medical specialty societies and physicians in the armed services, a member of the over-arching caucus, the Specialty and Service Society (SSS) of the AMA. ASAM also caucuses with the Section Council on Psychiatry and its Delegate and Alternate caucus with their respective state societies, the Medical Society of the State of New York and the California Medical Association.

The highlight of the meeting was the appearance of President Barack Obama. While some of the press focused on 30 seconds of the speech in which the President said he would not support caps on malpractice awards as a means of tort reform – prompting a chorus of boos from the audience — his remarks also received dozens of standing ovations over the course of the hour-long speech. A description of the event can be accessed at [HTTP://WWW.AMA-ASSN.ORG/AMA/PUB/NEWS-EVENTS/NEWS-EVENTS/OBAMA-RECEIVES-WARM-WELCOME.SHTML](http://www.ama-assn.org/ama/pub/news-events/news-events/obama-receives-warm-welcome.shtml). The full speech can be accessed at [HTTP://WWW.AMA-ASSN.ORG/AMA/PUB/ABOUT-AMA/OUR-PEOPLE/HOUSE-DELEGATES/2009-ANNUAL-MEETING/SPEECHES/PRESIDENT-OBAMA-SPEECH.SHTML](http://www.ama-assn.org/ama/pub/about-ama/our-people/house-delegates/2009-annual-meeting/speeches/president-obama-speech.shtml).

Nor was the President's speech the only highlight of the meeting. Major issues discussed included health reform, scope of practice issues (*including the emerging Doctor of Nursing Practice, Doctor of Physical Therapy, Pharm.D., and other professional designations that might confuse consumers*), medical education, and the Food and Drug Administration's initiatives regarding availability and prescribing of opioids.

In caucusing with the Section Council on Pain and Palliative Medicine, members of the ASAM delegation shared the working draft of ASAM documents that may be submitted to the FDA, calling for physician education and a mentoring program comparable to the Physician Clinical Support System



President Obama

(PCSS) programs on buprenorphine and methadone that are administered by ASAM for SAMHSA.

Reports adopted by the House included the following:

- Board of Trustees Report 1, Guidelines for Handling Derogatory Conduct in the Patient-Physician Relationships
- Board of Trustees Report 9, Environmental and Green Initiatives
- Board of Trustees Report 28, Practice Agreements between Physicians and Advance Practice Nurses and the Physician to Advance Practice Nurse Supervisory Ratio
- Council on Medical Service Report 8, The Patient-Centered Medical Home
- Council on Ethical and Judicial Affairs Report 2, Financial Barriers to Health Care Access
- Council on Ethical and Judicial Affairs Report 5, Quality
- Council on Ethical and Judicial Affairs Report 4, Physician Employment by a Nonphysical Supervisee

CEJA Report 4 carries interesting implications for addiction medicine specialists and psychiatrists, as well as occupational medicine specialists who may be employed by a clinic owned by a physical therapist. Physicians who have contracted to serve as Medical Director for an addiction clinic owned by a non-physician (such as a Certified Addiction Counselor, Ph.D., or R.N.) may want to arrange for clinical supervision of the non-physician owner to be provided by someone other than yourself, in order to avoid ethical conflicts. In this regard, AMA policy states:

Given their comprehensive training and broad scope of practice, physicians have a professional responsibility for the quality of overall care that patients receive, even when aspects of that care are delivered by nonphysician clinicians. When nonphysicians employ physicians to supervise the employer's clinical practice, conditions are created that can lead to ethical dilemmas for the physician. If maintaining an employment relationship with a midlevel practitioner contributes significantly to the physician's livelihood, a physician's personal and financial interests can be put at odds with patient care interests. Physicians in such arrangements must give precedence to their ethical obligation to act in the patient's best interest by always exercising independent professional judgment, even if that puts the physician at odds with the employer/supervisor.



## SAMHSA Consensus Statement: Reform Package Must Include Addiction Care

Any effort to reform the U.S. health care system must include coverage of addiction and mental health services, treat the “whole person” rather than just the symptoms of disease, and eliminate the stigma and system fragmentation that stand in the way of patients receiving preventive and treatment services, according to a consensus statement issued by the Substance Abuse and Mental Health Services Administration (SAMHSA).

“As lawmakers seek to revamp America’s health care system, the prevention and treatment of mental and substance use disorders must play a foundational role in reforms and be given equal weight to medical care provisions,” according to the statement, titled “Ensuring U.S. Health Reform Includes Prevention and Treatment of Mental and Substance Use Disorders — A Framework for Discussion.” It continues: “There is no health without addressing mental and substance use disorders and it is time to give Americans the comprehensive care and support they need and deserve.”

The consensus statement was released by SAMHSA in late May, just as health care reform discussions were heating up in earnest on Capitol Hill. ASAM provided input to the statement, as did the National Alliance on Mental Illness, the National Council of Community Behavioral Health care, the Community Anti-Drug Coalitions of America, and other organizations.

The statement features a list of nine “Core Consensus Principles for Reform” based on input from “hundreds of stakeholder and consumer groups and dozens of nationally and internationally recognized experts in the fields of mental health and addictions,” according to the SAMHSA. The Core Principles are:

1. **Articulate a national health and wellness plan for all Americans** that “provides for comprehensive, community-wide prevention, screening, health and wellness services from infancy through old age. The plan should provide for public education, prevention, early intervention, treatment, and recovery services, and must be a holistic, standardized system that emphasizes promoting wellness and resilience, preventing risky and unhealthy behaviors before they occur to avoid the onset of illness or drug use, and addressing symptoms when they first emerge

rather than waiting until they become acute or chronic.”

2. **Legislate universal coverage of health insurance with full parity.** “Simply talking about parity in private insurance coverage for mental and substance use disorders is not enough. Equal treatment for people with serious mental illness and substance use disorders must mean access to effective services and high-quality care.”
3. **Achieve improved health and long-term fiscal sustainability.** “There is a substantial body of evidence to demonstrate that providing adequate levels of mental and substance use disorders prevention and treatment services, as well as integrating these services with primary health care can improve outcomes; cut and/or control the growth of overall health care costs; lessen the rate, duration, and intensity of disability of many illnesses; improve productivity; and control the size and growth of other social costs.”
4. **Eradicate fragmentation by requiring coordination and integration of care** for physical, mental, and substance-use conditions.
5. **Provide for a full range of prevention, early intervention, treatment and recovery services** that embodies a whole-health approach. “Addressing physical health including mental and substance use disorders through effective prevention efforts that promote healthy environments, norms, and behaviors rather than waiting for the development of full-blown acute or chronic diseases is the most cost-effective approach.”
6. **Implement national standards for clinical and quality outcomes tied to reimbursement and accountability.** The statement says that establishing “specific and measurable” outcomes criteria is an “essential element” of health care reform, adding, “Reimbursement guidelines and benefits should be tied to need and severity regardless of payer. These guidelines must link quality improvement with reimbursement and both encourage and reward the use of evidence-based practices without restricting coverage for those consumers who may not achieve

desired outcomes with the least-costly alternative.”

7. **Adopt and fully utilize health information technology,** including electronic health records that allow providers to share information and improve data collection aimed at improving access to and quality of care.
8. **Invest in the prevention, treatment and recovery-support workforce.** “Lack of adequate health care for mental and substance use conditions is a constant cycle exacerbated by a system that has failed to grow with the needs of a quickly expanding society and has not equipped its workforce with the right tools and experience to provide sorely needed care,” the consensus group stated. “It must become a national priority to increase the mental and substance use disorders workforce and provide appropriate compensation and professional support for these key members of the U.S. health system.”
9. **Ensure a safety net for people with the most serious and disabling mental and substance use disorders.** “We can ill afford to dismantle the current safety net of block grants to states and other resources that in many states and communities are the only blockade between even higher rates of risky behaviors, illness, disability, death, health care costs, and lost productivity. Assuming expanded access to private and public insurance (Medicaid) for people with mental and substance use disorders will require a reexamination of the role of the public system at the local, state, and federal levels. Absent clear evidence that newly substituted health reform programs, systems, and processes are fully implemented and effective, it is imperative that our Nation’s current safety net that finances health services, including school and community-based prevention programs and treatment programs for mental and substance use disorders, not be dismantled prematurely.”

Coverage of addiction and mental illness treatment is included as part of the “essential” benefit outlined in both the House bill and the Senate Health, Education, Labor and Pensions (HELP) Committee bill.



# CASA President Rosenbloom: Strategies for Covering Addiction in Reform Legislation

*In remarks at the Public Policy Forum during ASAM's recent Medical-Scientific Conference, David Rosenbloom, Ph.D., President and CEO of the National Center on Addiction and Substance Abuse at Columbia University, discussed the status of health care reform efforts and outlined strategies for assuring that addiction prevention and treatment are included in the final package.*

*The following are excerpts from his remarks.*

From my perspective, there seem to be four goals currently on the table for health reform. Like all things in Washington, you need to understand that these are not necessarily consistent and may even be contradictory.

Access is the first goal. Cost containment is the second. Today, costs are being shifted to average consumers, who are now much more concerned about cost containment than they were the last time around. (And by the way, health reform has come up every 19-and-a-half years for the last century, so if it doesn't happen now, we're not going to see it again for a long time.)

The third big goal is prevention. There's usually a lot of talk about prevention and very little money, but there does seem to be a very serious conversation about prevention this time. Senator Max Baucus' proposals say a lot about prevention and wellness.

The fourth goal is quality improvement, because if we improve quality we might save money. All of these goals get reduced to slogans because at the national policy level there's no room for nuance, so a lot of what's being said now about quality improvement is being summarized as electronic medical records. In the addiction field, electronic medical records are a big deal, because people are worried that if information about their patients becomes part of electronic medical records, their confidentiality may be compromised. However, the government is about to spend \$16 billion on electronic medical records. If we say as a field that we don't want our patient's information in electronic medical records, the response is going to be, "Good; we'll leave you out, and you'll continue to be outside the medical system." So as a field we are going to have to figure out how addiction treatment can be integrated into electronic medical records.

So the four goals — all being discussed at a very high level — are not necessarily consistent. But as advocates, you need to listen to the goals and relate your interests to them.

## KEY DECISIONS TO BE MADE

Reform is going to happen fast or it's not going to happen at all. Leaders of both the House and Senate say they're going to have bills this session. In both chambers, there are very senior leaders who want to get this done while they're still around, and that's a driving factor.

The Democrats have decided that, as a fallback position, they will pass a health reform bill as part of the budget reconciliation process, because reconciliation requires only a simple majority vote (for example, 51 votes in the Senate rather than 60). For this reason, controversial measures often are tucked into the reconciliation process by whichever party has control of the Congress. Health care reform fits that model.

I do believe there will be some kind of public option put up against the private plans. Seventy-seven percent of the American people think Medicare is very important and, insofar as a public option is

characterized as something akin to Medicare, there will be support for a public option to compete with the private plans. The details are what will matter.

You need to be sure that addiction medicine is represented on the independent board that I believe will ultimately emerge. I could be dead wrong about the independent board, but I have a feeling that, at the end of the day, it's going to be attractive because it shifts controversy away from the Congressional deliberations.

## HONING THE MESSAGE

Your role in all of this is that you are experts, and policymakers like to hear from experts. So what should your message be? I really thought about this, because how you frame your message will determine whether you're successful.

Your message shouldn't necessarily be about what's important to you, but what's important to the policymakers; that is, whether you can position addiction treatment as a solution to the problems and goals of health care reform. I think you need to talk about how addiction treatment is the solution to the problems of cost and access. For example, Senator Christopher Dodd (D-CT), who's on the relevant committees, has said that his particular concern is the \$23 billion we spend every year on premature births. Well, an important solution to premature births is addiction treatment. So if Senator Dodd is concerned about premature births, you talk to Senator Dodd about treating addicted pregnant women.

Congresswoman Mary Bono Mack (D-CA) is very concerned about young people and their access to prescription medications. Better access to addiction prevention and treatment services is a solution to the problem she's worried about.

There is no question that treatment reduces future medical costs. Congress is worried about future medical costs. You can tell stories about how treating someone has reduced that person's (and their family's) use of the health care system. You can tell stories about how untreated addiction is filling 25 percent of all hospital beds in the U.S. and, insofar as you can relate that figure to real patients, you will be more effective in selling your message that addiction treatment is a solution to the cost problem.

Addiction treatment also is a solution to the access problem, because so many people with addiction don't have access to treatment. So if Congress wants to increase access, they have to cover the disease that afflicts the people who don't have access.

The second part of your message should be that screening and brief intervention and alcohol tax increases are solutions to the health reform prevention goals. Screening and brief intervention are now recommended as part of routine medical care. Studies in this country and elsewhere demonstrate that when done properly, screening and brief intervention lead to sustained reductions in problem drinking, which lead to sustained reductions in hospital use. A recent

*continued on page 10*

## **POLL: Americans Want Addiction Treatment in Health Care Reform**

Almost three-quarters of Americans support including alcohol and other drug treatment in national health care reform to make it more affordable, and two-thirds of survey participants (68 percent) support increasing the amount of Federal and State funding for preventing and treating addiction, according to a new poll by the Closing the Addiction Treatment Gap (CATG) initiative. The survey was conducted among a nationally representative sample of 1,001 adults ages 18 and older.

The study also found that three-quarters of Americans (75 percent) are concerned that persons with addiction may not be able to afford treatment because of their lack of insurance or other financial resources.

"The facts support this concern," said Victor Capocchia, CATG's director. "We are treating just 10 percent of the 23 million people in the United States who need addiction treatment." Regardless of age, race, income or residence, 76 percent of Americans know someone who has been addicted to alcohol or drugs, the researchers found.

The CATG initiative seeks to ensure that quality services are available to all who need alcohol or other drug addiction treatment.

## **STRATEGIES FOR COVERING ADDICTION** *continued from page 9*

mega-study in Canada suggests that screening and brief intervention can lead to a 22 percent reduction in inpatient hospital days. These numbers show that screening and brief intervention are a critical part of the prevention solution.

Alcohol tax increases also are a critical part of health care reform. First, they generate a lot of money. Increasing alcohol taxes also has an immediate impact on reducing problem drinking, particularly by young people and by heavy drinkers. Tax increases also reduce alcohol-related diseases and therefore yield an immediate reduction in hospital days, leading to cost savings.

Don't be abstract in your message, because politicians don't deal in abstracts. Don't be too detailed or too academic. The message has to target what the policymakers are worried about. (None of this is rocket science, but it just doesn't get said.)

### **DELIVERING THE MESSAGE**

How you deliver your message is critically important. I would argue that, in the next few months, you should deliver your message in person. You've got to find ways to get face-to-face with members of Congress. If they have fundraisers, go to them. Write a check to get yourself in the door and talk about how addiction treatment is a solution to the goals they seek in health care reform. When you get to them, tell real stories about how it works, why it will work, how addiction treatment is a solution to their problems.

You can send something in writing, such as short emails. I can make this easy for you: go to [WWW.JOINTOGETHER.ORG](http://WWW.JOINTOGETHER.ORG). Click on the "get involved" section and you'll be linked to your members of the House and Senate and can send them an email very easily. Email is not as effective as it used to be, but it's still a way.

Don't send a letter through the U.S. Mail. The Congress doesn't receive mail. Since the anthrax scare, mail is no longer delivered to Congressional offices except after huge delays, so if you want to send something in writing it's got to go in overnight packages. Somehow or another they get through. But to be most effective, do it in person.

Educate your newspaper editors (forget about the Internet; politicians still read newspapers). Insofar as you can get information about your issue into your local newspapers on the op ed page or the editorial page, you will be talking to your members of Congress.

You also need to look for partners to help deliver your message. Other health care providers, the recovery community, police and judges, parents — those are people who listen to you and who can be mobilized to join the effort.

### **OVERCOMING CHALLENGES**

You face real challenges in the next couple of months. Addiction treatment is not part of today's medical system. You have to ignore that reality for the next few months and focus on the message that addiction is a disease like other diseases. There is continuing confusion about the nature of addiction and the fact that it is a chronic disease. That message hasn't really been driven home within the medical care system or with policymakers.

There is still broad skepticism about the efficacy of addiction treatment. Part of that skepticism is grounded in the other challenge: there's still huge discrimination against people who have addictive disorders. In fact, most of the public hates addicts. But in the next few months, you have to say: "You can hate addicts all you want, but they're costing you a fortune and if you don't do anything about it, they're going to continue to cost you a fortune."

There are ideological divisions within the addiction field. You need to either cover them over or make believe they're not there. The easiest thing to do in the face of a divided profession is nothing, and Congress would be more than happy to do nothing if the addiction field doesn't have its act together. So for the next few months, we must not circle the wagons and shoot at each other — we have enough enemies on the outside.

You do not go into this fight without competitors and you need to understand that even though you are on God's side on this issue, there are other groups who also believe they are on God's side, and there are other specialty groups who will be saying: "Spend more money on us and we'll save you lots of money." Therefore, you have to be very, very clear about why addiction treatment is a solution to present and future cost, access, prevention and quality issues. You also will be competing with cost hawks who want what they call a "minimal package." Of course, this is nonsense, but you will have those competitors.

There will be ideological competitors. There will be snake oil salesman saying that the way to solve addiction is through God knows what, but not medicine. You'll have those who really do hate addicts and everybody who wants to help them, and you'll need to face that.

Finally — and perhaps most important — you're competing with time. You are competing for the time and attention of decisionmakers, and you're competing against a clock that says we've got to get this done fast. I believe something called health reform is going to pass this year and the contents of it will be determined in large part by what you and your colleagues do over the course of the next few months.

# Guiding Pain Management Outcomes Today

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Do you have challenging questions about pain management and addiction?
- **State Your Case**  
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## FDA Given Authority to Regulate Tobacco Products

The Family Smoking Prevention and Tobacco Control Act, signed by President Obama on June 22, grants the Food and Drug Administration (FDA) authority to regulate the manufacture, marketing and sale of tobacco products. The Act establishes a new FDA Center for Tobacco Products, which is to be funded through fees from U.S. tobacco manufacturers and importers. Below are some of the primary provisions of the Act that the Center for Tobacco Products will oversee.

**Tobacco Standards:** Allows the FDA to require changes in current and future tobacco products, including the reduction or elimination of ingredients, additives, if the changes will protect public health. Gives the FDA authority to regulate nicotine yields.

**Disclosure of Ingredients:** Requires tobacco companies to provide the FDA with a listing of all ingredients in their products, including additives, nicotine content, and smoke constituents.

**Disclosure of Research:** Requires tobacco companies to provide all of their research on the effects of tobacco products and marketing research.

**Claims of Reduced Harm:** Bans the use of descriptors such as "light", "mild", and "low" on labels or in advertising. Manufacturers must get approval before marketing or selling any product as a "modified risk" product.

**Restriction on Additives:** Prohibits the use of artificial or natural flavor other than menthol.

**Warning Labels:** Requires warning labels that cover the top 50% of the front and rear panels of a cigarette pack and 20% of an advertisement area. Within 24 months, warning labels must also include color graphics depicting the negative health consequences of smoking.



## Dr. Baxter Helps Launch NIDA-MED

*Dr. Louis Baxter addresses NIDA press conference announcing NIDA Med*

ASAM President Louis E. Baxter, Sr., M.D., FASAM, joined a group of leaders in the public and private sectors for the launch of a new comprehensive drug use screening tool for physicians.

At the April event, Dr. Nora Volkow, Director of the National Institute on Drug Abuse (NIDA), was joined by public officials including U.S. Senator Carl Levin (D-MI); Rear Admiral Steven K. Galson, M.D., M.P.H., Acting Surgeon General of the United States; H. Westley Clark, M.D., J.D., M.P.H., CAS, FASAM, Director of the Center for Substance Abuse Treatment; and Ed Jurith, J.D., Acting Director of the Office of National Drug Control Policy.

In addition to Dr. Baxter, leaders of private sector organizations who shared the dais with Dr. Volkow were Michael Maves, M.D., Executive Vice President of the American Medical Association; and Maristela Monteiro, M.D., Ph.D., Senior Advisor and Team Leader with the Pan American Health Organization.

The event marked the unveiling of NIDA's Physician's Outreach Initiative, known as NIDA-MED, which features tools and resources to help medical professionals screen their patients for substance use. Dr. Volkow noted that the NIDA-MED tools are designed to fit into busy clinical practices. The resources, all of which can be downloaded from the NIDA website, include the following:

- A clinical screening tool, the **NIDA-Modified Alcohol, Smoking, and Substance Involvement Screening Test, or NMASSIST**. This Web-based interactive tool guides clinicians through a series of brief screening questions and, based on the patient's responses, generates a substance involvement score that suggests the appropriate level of intervention. The tool also provides links to resources for conducting a brief

intervention and treatment referral, if warranted. (Access at [HTTP://WWW.DRUGABUSE.GOV/NIDAMED/INDEX.PHP](http://www.drugabuse.gov/nidamed/index.php))

- A **Quick Reference Guide**, which provides a "snapshot" of the online screening tool and serves as a handy resource for clinicians when they are away from their computers. Designed to fit in a coat pocket, the guide provides an abbreviated version of the tool and instructions for its use. (Access at [HTTP://WWW.NIDA.NIH.GOV/NIDAMED/QUICKREF/SCREENING\\_QR.PDF](http://www.nida.nih.gov/nidamed/quickref/screening_qr.pdf))
- A **Clinician's Resource Guide**, which supplements the NIDA-Modified ASSIST and provides more detailed instructions on how to use the screening tool, how to discuss the screening results with patients, how to offer brief interventions, and how to make necessary referrals. The guide also includes information on how conducting biological specimen screening, accessing training materials, and locating substance abuse treatment. (Access at [HTTP://WWW.NIDA.NIH.GOV/NIDAMED/RESGUIDE/](http://www.nida.nih.gov/nidamed/resguide/))
- **Patient Postcards**. To complement the physician screening materials, a patient-tested postcard is designed to encourage patients to discuss any and all drug use with their physicians. NIDA encourages physicians to place the postcards in their waiting rooms. (Access AT [HTTP://WWW.NIDA.NIH.GOV/DRUGPAGES/PSAARTCARDS.HTML](http://www.nida.nih.gov/drugpages/psaartcards.html))

In his remarks to the members of the press and other participants in the event, Dr. Baxter hailed NIDA's efforts to increase screening and brief intervention in primary care settings, and emphasized ASAM's role as a resource for health care professionals who seek consultation or assistance with patients who are identified with substance use disorders.

## FDA Approves Analgesic with New Risk Management Plan



The FDA has approved Onsolis to help manage breakthrough pain in cancer patients. Onsolis is a formulation that delivers the fentanyl through the mouth's mucous membranes via an absorbable film that sticks to the inside of the cheek. The drug is indicated for the management of breakthrough pain in patients with cancer, ages 18 and older, who already use opioid pain medication around the clock and who need and are able to safely use high doses of an additional opioid medicine. Such patients are considered opioid

tolerant because of their current opioid medication use.

Because fentanyl is subject to abuse and misuse, Onsolis was approved with a Risk Evaluation and Mitigation Strategy, or REMS, which is a required plan for managing risks associated with a drug or biological product. The Food and Drug Administration Amendments Act of 2007 gave the FDA the authority to require that drugs and biological products have a REMS to ensure that the benefits of a drug or biological product outweigh its risks. Onsolis is one of the first agents for which a REMS is required, although FDA is moving to require them for other extended-release agents (like methadone) that already are on the market.

As part of the REMS, Onsolis will be available only through a restricted distribution program, called the FOCUS program. Under this program, only those prescribers, patients and pharmacies registered with the program will be able to prescribe, dispense, and receive Onsolis. The FOCUS program will provide training and educational materials to prescribers and pharmacy personnel, and a counseling call will be placed to patients prior to dispensing to ensure they have been adequately educated about the appropriate use of the drug. Prescription orders will be filled only by participating pharmacies that send the product directly to the patients' homes.

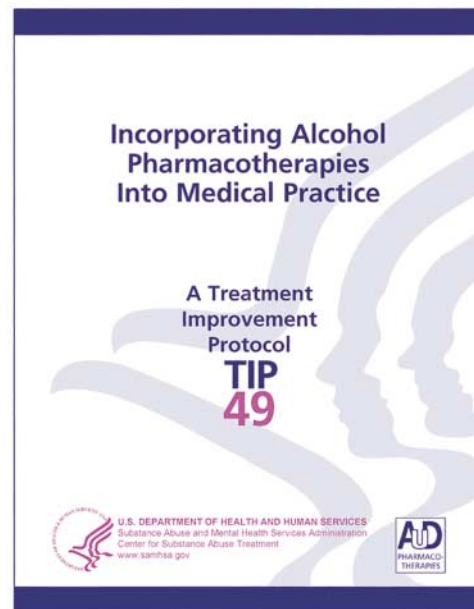
Onsolis was approved with a boxed warning, which states that the medication should not be used for the management of migraines, dental pain, or postoperative pain or by patients who use opioids intermittently, or on an as-needed basis. It also warns that the drug should be kept out of the reach of children and should not be substituted for other fentanyl products.

"The REMS for Onsolis was specifically tailored to that drug and should not be viewed as a model REMS for long-acting and extended-release opioid products," said Douglas Throckmorton, M.D., deputy director of CDER. "Developing the comprehensive REMS for these other products is a complex undertaking. We will take the time necessary to review all of the public comments and will proceed in a deliberate manner toward the mutual goals of patient access and patient protection."

"Onsolis can provide strong pain relief to patients who are opioid tolerant. But for patients who are not opioid tolerant, it can lead to overdose, sudden serious breathing difficulties and death," said Bob Rappaport, M.D., director, Division of Anesthesia, Analgesia and Rheumatology Products in the FDA's Center for Drug Evaluation and Research (CDER). "For this reason, Onsolis should be prescribed only under the safeguards provided by the FDA-required REMS and by health care professionals knowledgeable about Onsolis and the use of potent opioid medications."

Onsolis is manufactured by Aveva Drug Delivery Systems, Miramar, Fla., and marketed under license from BioDelivery Sciences International Inc. of Raleigh, N.C., by Meda Pharmaceuticals Inc., based in Somerset, NJ.

## CSAT Releases TIP on Pharmacotherapies for Alcoholism



The Center for Substance Abuse Treatment (CSAT) has announced publication of *Treatment Improvement Protocol (TIP) 49, "Incorporating Alcohol Pharmacotherapies Into Medical Practice."* The new TIP provides clinical guidelines for the proper use of medications in the treatment of alcohol use disorders. The underlying objective is to expand access to information about the effective use of these medications, not only in specialty substance abuse treatment programs but also in physicians' offices and other general medical care settings.

The TIP includes discussions of medications approved for treating alcohol use disorders by the Food and Drug Administration: acamprosate, disulfiram, oral naltrexone, and extended-release injectable naltrexone. The TIP discusses each medication's history, the reasons for its use, how to use it, who should use it, and other clinical information about medication.

Members of the Clinical Research Roundtable of the Institute of Medicine have identified failure to disseminate information about and implement new therapies proven effective in clinical trials as a principal roadblock to health-care improvement in the U.S. TIP 49 addresses this problem for the pharmacotherapy of alcohol use disorders.

## Genes Influence Impulsive Behavior, Preceding the Development of Alcoholism

Numerous studies have shown that highly impulsive behavior — defined as the tendency to choose small, immediate rewards over larger, delayed rewards — is more prevalent in drug addicts and alcoholics compared to individuals without addictions. A new study using mice has found that genes influence impulsivity, which may then contribute to the risk for developing alcoholism. The study results were published in the July issue of *Alcoholism: Clinical & Experimental Research*.

“There is increasing evidence that the character trait of impulsivity predisposes towards addiction in all its forms, such as drugs, alcohol, gambling,” explains Nicholas J. Grahame, Ph.D., associate professor of psychology at Indiana University-Purdue University at Indianapolis. “Data from the National Epidemiologic Survey on Alcoholism and Related Conditions suggest that a variety of disorders that increase impulsivity — from bipolar disorder, to conduct disorder, and antisocial personality disorder (ASPD) — are associated with an increase in risk for alcoholism.”

“The relationship between high impulsivity and drug use raises many questions,” adds Suzanne H. Mitchell, Ph.D., associate professor in behavioral neuroscience at Oregon Health & Science University. “For example, is an impulsive individual more likely to experiment with drugs, and then develop a problem? If such a relationship was found, identifying children or adolescents with high levels of impulsivity might, in theory, allow us to

identify individuals at risk for developing a substance-use disorder like alcoholism.”

Dr. Grahame and his colleagues tested several selected lines of alcohol-naïve mice: offspring of High Alcohol Preferring (HAP) mice, HAP1 and HAP2; offspring of Low Alcohol Preferring (LAP) mice, LAP2; as well as offspring of low-drinking progenitor (HS/lbg) mice. All of the mice were tested on a delay-discounting task, which employs two levers to provide subjects with a choice between a small, immediate or a large, delayed saccharin reward.

“We first used selective breeding to obtain mice genetically predisposed to drink alcohol,” said Grahame. “The experiment was to create lines of animals that differ in genes related to alcohol drinking, and the central question was: ‘Are any of the genes affected by this manipulation related to impulsivity?’ To study this, we used a task that is widely used in both human and animal studies, which was to give a choice between an immediate but small reward and a delayed but large reward. The mice that had the genes to drink (the HAP1 and HAP2 mice) were more impulsive than their low-drinking counterparts (the LAP2 and HS/IBG mice).”

“Given that these differences in impulsivity were present in alcohol-naïve animals,” added Dr. Mitchell, “neural changes brought about by alcohol consumption could not be responsible for the differences between the two groups of mice.”

“I think these data can clearly be extrapolated to humans,” concluded Dr. Grahame, “because the same task can be used in a variety of species, including humans, to assess ability to plan for the future. The data suggest that if humans are like mice, their differences in impulsive behavior may also be affected by their genes, and these differences in impulsivity could confer some of the familial risk for alcoholism that we already know about.”

Dr. Mitchell agreed. “The results imply that a subset of individuals who are ‘family-history-positive’ for alcoholism behave more impulsively,” she said. “However, the results do not mean that individuals with high levels of impulsivity are doomed to a life of substance use, just as having genes associated with alcoholism does not destine you for a life of alcoholism. The interaction between genes and environment is critical. However, the study supports other work indicating that there is a genetic component to impulsivity. Future work could shed light on which genes are important in impulsive decision making, and which genes are shared with the propensity to develop a substance-use disorder.”

*SOURCE: Oberlin BG & Grahame NJ. High-alcohol preferring mice are more impulsive than low-alcohol preferring mice as measured in the delay discounting task. Alcoholism: Clinical & Experimental Research (ACER). Jul 2009;33(7): 1294-1303.*

## Self-Evaluation May be Key to Readiness for Treatment

Studies have shown that individuals have varied motivations for entering addiction treatment, and that those motivations have a significant effect on treatment attendance and outcomes. Now a new study has re-evaluated the University of Rhode Island Change Assessment Scale (URICA) and found that motivational readiness is much more self-reflective than merely trying to avoid the negative consequences of drinking. Results were published in the May issue of *Alcoholism: Clinical & Experimental Research*.

“The initial motivation of patients is a critical issue for treatment and for changing their drinking behaviors,” said Carlo C. DiClemente, Ph.D., professor of psychology and director of the MDQUIT Resource Center at the University of Maryland, Baltimore County. “Individuals differ on important dimensions of motivation for change and motivation for treatment in terms of their goals, intentions, attitudes, and changes in activities,” Dr. DiClemente added.

These differences have important consequences for patients as well as treatment professionals. “Differences in motivation and readiness to change often have an impact on patient retention and engagement in treatment, changes in drinking as patients enter both

psychosocial and pharmaceutical therapies, patient and therapist perceptions of the therapeutic relationship, and drinking outcomes at the end of treatment and at follow-ups that extend up to three years after the initial treatment,” said Dr. DiClemente, who is also the study’s corresponding author.

For the study, researchers used data gathered from 1,383 adult participants (955 males, 428 females) in the COMBINE Study, a multi-site trial evaluating the relative efficacy of two different pharmacotherapy agents – naltrexone and acamprosate – administered individually and in combination along with two intensities of behavior therapies. The COMBINE data were used to evaluate psychometric properties of a URICA-derived measure, while looking at patient characteristics such as severity of drinking, drinking consequences, craving, quality of life, and psychiatric symptoms as predictors of motivation at intake.

The results challenge some of our views of what influences motivation, according to Dr. DiClemente. “Findings indicated that motivation and readiness to change are not just a reflection of being

*continued on page 15*

## Adolescent Binge Drinking May Compromise Information Relay in the Brain

Researchers know that the integrity of the brain's white matter is compromised in adult alcoholics, but it is unclear when during the course of drinking white matter abnormalities become apparent. "White matter refers to brain areas that appear light in color due to being primarily lipids," added Duncan Clark, M.D., associate professor of psychiatry at the University of Pittsburgh Medical Center. Dr. Clark explained that white matter is composed of bundles of myelinated axons connecting grey matter areas of the brain, and has been shown to continue to develop throughout adolescence. Systematic changes in white matter organization reflect not only maturation of interconnections but continued maturation of the brain as a whole, he said.

A study of adolescent binge drinkers has found that even relatively infrequent exposure to large doses of alcohol during youth may compromise white matter fiber coherence. "Because the brain is still developing during adolescence, there has been concern that it may be more vulnerable to the effects of neurotoxins, such as high doses of alcohol," said Susan F. Tapert, M.D., associate professor of psychiatry at the University of California, San Diego and director of Substance Abuse/Mental Illness in the VA San Diego Healthcare System.

Dr. Tapert and her colleagues used diffusion tensor imaging (an MRI technique sensitive to the random movement of water in cells of a target tissue) to examine fractional anisotropy, a measure of directional coherence of white matter tracts, among 28 teens. Of the 28, 14 (12 males, 2 females) had and 14 (12 males, 2 females) did not have histories of binge drinking. No participants had a history of an alcohol use disorder; drinkers were matched to non-drinkers on age, gender and education. The study results were published in the July issue of *Alcoholism: Clinical & Experimental Research*.

"White matter, and its integrity, are essential to the efficient relay of information within the brain," explained Dr. Tapert, who noted that indicators of white matter integrity are linked to performance on a range of cognitive tests, including measures of reading, copying complex figures, and speeded coding of information. Abnormalities in white matter health could relate to compromised ability to consider multiple sources of information when making decisions, and to emotional functioning, she said.

The researchers concluded that "adolescents with histories of binge drinking episodes have lower coherence of white matter fibers, suggesting poorer white matter health, in a variety of brain regions." Dr. Tapert added, "Frankly, I was surprised we found this, because the drinkers did not meet criteria for alcohol abuse or dependence."

Dr. Clark agreed: "These findings indicate that adolescents who engage in binge drinking show low levels of brain organization," he said. "This characteristic could be a risk factor for accelerated alcohol use or an effect of alcohol. We need to know more about how alcohol influences adolescent brain development, [given] that alcohol may disrupt brain development."

*SOURCE: McQueeny T, Schweinsburg BC, Schweinsburg AD, Jacobus J, Bava S, Frank LR & Tapert SF. Altered white matter integrity in adolescent binge drinkers. Alcoholism: Clinical & Experimental Research; July 2009;33(7): 1278-1285.*



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HEALTH AND HUMAN SERVICES  
Substance Abuse and Mental Health  
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## SEPTEMBER IS 20TH ANNUAL RECOVERY MONTH

The Center for Substance Abuse Treatment (CSAT) has produced special materials to mark the 20th anniversary of National Alcohol and Drug Addiction Recovery Month (Recovery Month) in September. The theme of the 2009 Recovery Month is "Join the Voices for Recovery: Together We Learn, Together We Heal."

The purpose of Recovery Month is to mark the gains made by individuals in recovery from alcohol and/or drug addiction and to celebrates the support and commitment they have received from addiction professionals.

To mark the occasion, CSAT has produced public service announcements (PSAs) for radio and television that direct viewers to CSAT's 24-hour information and treatment referral helpline, 1-800-662-HELP. The PSAs were produced in both Spanish and English.

Additional materials developed by CSAT include a Recovery Month kit, posters, and other collateral materials. For more information, visit [HTTP://CSAT.SAMHSA.GOV/](http://CSAT.SAMHSA.GOV/).

## SELF-EVALUATION *continued from page 14*

overwhelmed or having a number of negative consequences," he explained, adding: "Readiness is, rather, an independent self-evaluation that is related to the perceived severity of the drinking problem and its consequences, and is also influenced by the drinker's sense of confidence to change, positive expectations about whether treatment can help, less stress, and an acknowledgement that the person needs to take responsibility for change."

Dr. DiClemente added that some observers seem to regard motivation as an "on-off" switch, which is too simplistic. "[C]linicians should avoid focusing simply on consequences to increase motivation," he said. "[They] need to remember that motivation is complicated by a number of personal factors which need to be examined in greater depth."

*SOURCE: DiClemente CC, Doyle SR & Donovan D. Predicting treatment seekers' readiness to change their drinking behavior in the COMBINE study. Alcoholism: Clinical & Experimental Research, May 2009;33(5): 879-892.*



## We Celebrate ASAM's Members and Their Achievements

*Michael M. Miller, M.D., FAPA, FASAM  
ASAM Immediate Past President*

*The following is excerpted from remarks delivered at the Annual Awards Luncheon, where Dr. Miller was honored with the ASAM President's Award. They were read by James F. Callahan, D.P.A., because Dr. Miller was attending his daughter's college graduation.*

First, I'd like to congratulate all of ASAM's honorees at this 40th annual conference, including Drs. Nora Volkow and Larry Brown, the other award winners, the recipients of ASAM Certificates, and the recipients of ABAM Diplomas.

Indeed, many thanks are in order. The ASAM staff is incredibly dedicated, and specifically supported my activities as President and Board Chair. Similarly, none of ASAM's successes could have happened without the volunteer contributions of our Board of Directors. I've never seen an ASAM Board as good as this one. The engagement in the discussions, the thoughtful analysis before making important decisions, the participation in all the conference calls and traveling at their own expense — that's right, with no reimbursement for travel — to ASAM Board meetings: I couldn't have had a better experience with the governing Board than I've had. And thanks to our tireless CEO, Eileen McGrath, who guides the Board and provides all of us with information to consider as they make the decisions vital to ASAM's present and future.

I also must thank my partners back home at Meriter Hospital's NewStart Program. I just celebrated 20 years as Medical Director of NewStart, but I couldn't meet the clinical needs there without other physicians who have been wonderful colleagues over those 20 years, beginning with Roy Yeazel and Fritz Koeneke, and then a number of ASAM members whom you know — David Hendricks, Ian Powell, Randy Brown, Aleksandra Zgierska, Basil Spyropoulos, and Michael Witkovsky. These last six who have covered call while I have been away on ASAM, AMA and other activities — two internists, two family physicians and two psychiatrists — have comprised a wonderful team to meet patients' needs the way the ABAM motto says

it — “with skill, with knowledge, with compassion.”

My thanks also go to ASAM members from every state and every Chapter, who work so faithfully for their patients, and so many of whom work so faithfully for ASAM. Appreciation also to the ASAM-certified physicians who not only sought a credential for themselves but also understood that they were contributing to the future of Addiction Medicine through their decision to go through the application process to become “grandfathered” into the status of Diplomate of the American Board of Addiction Medicine. And thanks to Dr. James Callahan, newly named head of ABAM.

So yes, my professional life is very important to me, but my family is even more important. Kathy has been a wonderful mother to our children for more than 29 years now. Space doesn't permit me to gush and gloat as a parent about Courtney and her sister Annie, a University of Michigan graduate from 2002, but my closest friends in ASAM know how proud Kathy and I are of our daughters.

I'm quite proud as well of what's happened to ASAM during my Presidency. During my tenure, ASAM has focused on “the Big Two” — the establishment of an American Board of Addiction Medicine to increase recognition of our field, and enactment of federal parity legislation to provide better access to treatment for our patients. ASAM has accomplished many things in the past two years, but when you look at the Big Two, has ASAM ever delivered! The evidence is in our midst, with Dr. Nora Volkow handing out Diplomate certificates from a new independent Certification Board, and Representative Patrick Kennedy being honored for co-authoring mental health and addiction parity legislation that is now the law of the land. These accomplishments are rewards that all of us can share!

## AMA Board Chair Patchin on Health Care Reform

*Rebecca Patchin, M.D., Chair of the Board of Trustees of the American Medical Association, addressed the Public Policy Plenary on the AMA's approach to health care reform. Excerpts from her remarks follow.*

We have a new President who ran on a platform of change and who has linked health care reform to the economy. We at the AMA met with the President's transition team and continue to meet with his health care advisors, just as your leadership did. Our message is that we need thoughtful reform that also improves the quality of care. That's why the AMA was founded in 1847: to improve the quality of medical care and medical education in this country. We still stand for those principles.

Reducing costs is important — we want to eliminate wasteful spending, and we think there are ways it can be done. One way is to put money into comparative effectiveness

research so we really know which product is better or which test is better, which way to care for a patient. Health care reform should increase the focus on wellness and prevention. Certainly, the care coordination and medical home concepts hold a lot of promise for ways to help patients achieve better coordinated care. A number of disease management programs and registries deserve to be supported and highlighted. We also need anti-trust relief so that we can talk to each other about all of these issues, and we need professional liability protection when we follow nationally accepted guidelines for appropriate care. We believe proposed

reforms should be pilot-tested before they're implemented across the board.

To achieve such reform, individual physicians must become involved. Get to know your member of Congress, get to know your Senator, talk to them so that they know your issues as a physician and as a specialist in addiction medicine. We at the AMA are prepared to do whatever we need to do to pass the right kind of health care reform, but we need your help: (1) get involved, (2) become a member, if you are not, so that we speak for the greatest number of physicians, and (3) join with us to improve the health care of this country.



## Director Clark: CSAT Promotes Hope and Healing from Addiction

Participants in the Opening Scientific Plenary welcomed H. Westley Clark, M.D., J.D., M.P.H., CAS, FASAM, Director of the Center for Substance Abuse Treatment (CSAT) of the Substance Abuse and Mental Health Services Administration (SAMHSA), who offered the following thoughts on the role of addiction medicine specialists, excerpted here from his address.

SAMHSA's role is to support recovery from substance abuse disorders. We work to ensure that science – rather than ideology or anecdote – forms the foundation of the Nation's addiction treatment system. We serve health professionals and the public by disseminating scientifically sound, clinically relevant information on best practices in the treatment of addictive disorders and by working to enhance public acceptance of that treatment.

We help to translate addiction science into addiction medicine. We reach out to physicians in different organizations. ASAM currently receives about a million dollars in grant funds from CSAT to help mentor physicians in appropriate use of buprenorphine and methadone, and ASAM has played a major role in providing education about buprenorphine to a range of physicians.

About 20 percent of our annual grant awards support medication-assisted treatment. We know that medication-assisted treatment is important and effective. It's also cost-effective: every dollar spent on methadone treatment saves \$12 in social costs. However, we also have to confront challenges. For example, at any given time, 250,000 patients are receiving care in 1,200 opioid treatment programs. Contrast that with almost 750,000 individuals who are prescribed methadone for the treatment of pain. Now we're seeing an increase in the number of unintentional overdoses and deaths associated with methadone. Although some uninformed individuals point to the opioid treatment system as the source, the real cause – and there is substantial evidence supporting this conclusion – is the increase in use of methadone to treat pain.

To address the problem, CSAT is helping to teach primary care physicians how to prescribe methadone and other controlled substances. Working with State health agencies and medical organizations (including ASAM's State Chapters), CSAT is supporting the delivery of CME courses to provide physicians with the specific knowledge and skills they need to safely prescribe opioids for chronic pain. To date, CSAT has supported 24 such courses in 19 States, with more to come.

We're also working to promote physician and patient awareness of the appropriate use of methadone through a joint initiative with the Food and Drug Administration. The campaign features a public outreach effort called "Follow Directions - How to Use Methadone Safely," which is designed to inform consumers, health care professionals and treatment clinics about the safe use and misuse of methadone for pain relief and the treatment of addiction.

Our theme this year is to help bring hope and healing to others. I ask you to support us by reaching out to opinion leaders in your communities. Reach out to the Red Hat groups, reach out to the Elks Club, the Lions Club, the Kiwanis Club, the Police Guild. Reach out to community coalitions. We need to educate others about the effectiveness of treatment and the hope of recovery. You play a critical role in that as physicians, as nurses and psychologists and social workers, as addiction medicine specialists. We need to work together as health care professionals to promote recovery.

## Dr. Galanter Delivers the Smithers Lecture

ASAM former President Marc Galanter, M.D., FASAM, received the R. Brinkley Smithers Award and delivered the traditional lecture at the Opening Scientific Session on Friday, May 1<sup>st</sup>. Dr. Galanter is Professor of Psychiatry at New York University's Langone Medical Center. The following is excerpted from his lecture.

It's truly an honor to be able to speak to you about what has been, in many ways, the moving spirit behind our organization since its inception — spirituality, social affiliation and AA — which were really central to the zeal and commitment of our members as this organization was established. At the time, these were viewed as not scientifically grounded, but as our organization and the field have progressed, we have found an empirical basis for the effectiveness of AA and its spiritual and social components. Currently, there are over two million AA members and 100,000 AA groups worldwide. AA is a ubiquitous resource at times and in places where long-term professional care is not likely to be fully supported.

I'm going to briefly describe four studies that illustrate some aspects of AA that we need to understand. The first is a study done on alcoholic patients in the VA system, which followed the patients for 16 years. After six months, it became clear that AA attendance, more than any other intervention, was associated with a positive outcome. Questions have been raised as to whether the patients who are most strongly motivated for addiction treatment are the ones who go to AA. However, a study of a very large sample of patients showed that their outcomes through AA were not associated with their motivation for treatment. In fact, AA was effective with patients who were both more and less motivated.

A third study showed that success in AA was not associated with prior religiosity, although, very significantly, persons who achieved abstinence were more likely to have had a spiritual awakening during their time in AA. And finally, there are a number of studies in which AA and spirituality have been shown to be mediators of outcome.

I also want to point out that AA is a very effective modality in achieving full abstinence. We have good evidence from studies of physicians, where relapse raises concerns about the health and survival of patients. We did a study in conjunction with the New York State Committee on Physician's Health, in which we followed physicians during their recovery and examined how their involvement in 12-Step programs influenced their progress. We found that 83 percent of all physicians enrolled in the New York program were actively involved in 12-Step recovery.

Significantly, when we compared the outcome of individuals who initially were reluctant to go to 12-Step groups and those who were more willing, we found no difference in outcomes. So the opportunity to go to AA is something we can offer our patients without hesitation and without feeling that it won't be as effective for those who are less eager to go.

## Should Non-Physicians Be Admitted to Membership in ASAM? The Case **FOR** Associate Membership

Daniel J. McCullough, M.D., M.Phil., FAAFP  
and Brian Hurley, M.D., M.B.A., C0-Chairs, ASAM Membership Committee

Over the past few years, your Membership Committee has been considering the pros and cons of creating a new category of Associate Member of ASAM.

The calls for Associate Membership have grown louder with the formation of the American Board of Addiction Medicine and last fall's enactment of the Paul Wellstone Mental Health and Addiction Parity Act. Many senior leaders of ASAM have voiced the opinion that arguments against Associate Membership have been weakened by these impressive accomplishments.

At the Membership Committee, we have been charged with designing a new category of membership that would allow non-physician stakeholders in Addiction Medicine to become members of ASAM. Our Society's incoming President, Dr. Louis Baxter, has told us: "There are a number of reasons to offer an Associate Membership category, but perhaps one of the best reasons is to bring Addiction Medicine and treatment back under the direction of physicians. In the early days, dating back to the 1970s, counselors ran addiction treatment and physicians co-signed the "treatment plan." Over the past 25 years, physicians have begun to reassert medical leadership by taking leadership positions in treatment facilities. Moreover, with the advent of medication-assisted therapies, it is becoming more important to actually have Medical Directors and physician leadership. ASAM's acceptance of non-physician members will directly increase ASAM's ability to influence and guide the policies and best practice principles utilized in addiction treatment to a greater degree than we already realize and enjoy."

**What is Associate Membership?** Associate Membership would be a new membership category that would be marketed to non-physicians who work in the addiction field or who have an interest in Addiction Medicine topics. Associate Members would receive the following benefits:

- Free access to *ASAM News* and the *Journal of Addiction Medicine*
- Discounts on registration fees for meetings, conferences, and online educational programs

- Discounts for other ASAM publications and products
- Affiliation as a member of the Society.

### Associate Members would not have privileges to:

- Sit on any ASAM committee (*except with the approval of the Board of Directors, as at present*)
- Run for election to ASAM governance posts (*e.g., officer or member of the Board of Directors*)
- Vote in any ASAM election.

**How would ASAM benefit from Associate Membership?** ASAM's mission is to improve the care and treatment of people with the disease of addiction and to advance the practice of Addiction Medicine. The treatment of addiction involves a multidisciplinary team of practitioners and partners, each of whom contribute toward the common purpose of providing care. No medical society can operate in isolation and the proper locus of interaction is at the membership level, during our meetings. Associate membership reinforces the multi-disciplinary and collaborative nature of the addiction field within our medical society.

Expanding ASAM's membership to include non-physician members is an integral part of a strategy to position ASAM as the premier organizational voice for addiction medicine. By involving those who would contribute to our mission, we make ASAM the true "umbrella organization" or interaction ground for discussion and debate, education, and advocacy for Addiction Medicine practitioners and patients. Because the elected leadership of ASAM would continue to be drawn from the ranks of physicians, we can retain the benefit of representing physicians and physicians-in-training in the public eye. However, involving associate members creates real opportunities to foster the multi-disciplinary approach required by the modern delivery of addiction care.

### How would Associate Members benefit from joining ASAM?

 Associate Memberships:

- Position ASAM as the umbrella group representing the entire practice of Addiction Medicine (including allied health professionals).

- Deliver ASAM's educational content to a broader audience
- Bring the voice of our non-physicians partners to our meetings and educational events, making them an even more enriching experience for all of our members.
- Enhance our credibility as an organization that promotes the appropriate role of the physician in the care of patients with addiction, as the leading member of the multidisciplinary team.
- Open the possibility that ASAM could play a role in credentialing non-physician in Addiction Medicine.

Other issues considered by the Membership Committee include:

- ▶ **Marketability:** Associate memberships are in demand by a number of market segments, each of whom we can readily reach out to. Associate members are not asking for governance roles; they are looking for the tangible opportunity to connect with the society.
- ▶ **Financial sustainability:** By reaching to a broader segment, this creates a broader financial base for us to build the expanded work we know must happen: parity, ABAM, state chapter expansion, et al. It is in our financial interest to bring in more members.
- **Credibility:** We retain our physician credibility by maintaining our physician governance. However, we become more credible when we leverage this credibility and reach out to a broader membership base that is truly multi-disciplinary.
- **The "slippery slope" argument:** Many societies maintain associate memberships with no breakdowns in governance structure. ASAM would simply maintain our choice to remain physician governed to avoid the slippery slope of including non-physicians in governance.

This is an important decision for ASAM, and one that has multiple ramifications for the future of our Society. It is not one that we at the Membership Committee take lightly. Therefore, we plan to conduct a formal membership survey and to bring the results to the entire ASAM Board of Directors, which will make a final decision in October.

## Should Non-Physicians Be Admitted to Membership in ASAM? The Case **AGAINST** Associate Membership

James F. Callahan, D.P.A.

Former ASAM Executive Vice President

I present the following personal views as a friend of ASAM and a friend of Addiction Medicine. I write also as a friend of every addicted person, and of every parent or relative who worries what to do about a child's or spouse's or family member's alcohol or other drug use, and who, in hope of help, may visit his or her physician, only to find that the physician is at a loss for what to say or do, because the physician has had no education or training in Addiction Medicine.

**Has ASAM achieved its primary mission, so that it can go on to a new mission?** The only scenario in which I could see ASAM having non-physician or non-medical student members is one in which the ASAM leadership and members can say that ASAM has accomplished its mission to educate physicians and medical students about the prevention and treatment of alcoholism and other addictions (ASAM Constitution, Article 1. Section 2. Purposes). The fact that there are more than 800,000 physicians in the U.S. but only 3,000 ASAM members (.00375%) should instill such a sense of mission-urgency among the ASAM leadership, membership and staff that any suggestion to recruit and educate non-physician members would be dismissed out of hand.

While many of the health care disciplines make valuable contributions to the treatment of addictive disorders, and while the Addiction Medicine physician is a member of a larger treatment team made up mostly of non-physicians, ASAM is the only organization that has as its primary focus the education of doctors of all specialties about addiction.

No other organization in the U.S. was founded for this purpose. If ASAM does not dedicate 100% of its resources to the education of physicians, it is failing in its mission. To dedicate even one iota of an ASAM member's time and energy, or one iota of an ASAM staff member's time and energy, or one dollar of the ASAM budget to the recruitment and education of non-physicians is to divert those resources from serving ASAM's mission to educate physicians.

**Can ASAM turn over to ABAM the task of achieving ABMS recognition?** In April 2007, the ASAM Board of Directors did what no other ASAM Board had been able to achieve; it passed an historic resolution: *That ASAM encourage and assist in the development of the American Board of Addiction Medicine (ABAM) and its application for recognition of ABAM by the American Board of Medical Specialties (ABMS)...*

Rather than divert resources to recruit non-physician members, all the energies that ASAM can muster and all the energies that ABAM and The ABAM Foundation can muster must be focused on the recruitment, education and certification of physicians in these eight specialties (many of whom practice Addiction Medicine, but are not ASAM members), and on meeting the requirements for recognition of Addiction Medicine by the American Board of Medical Specialties (ABMS), especially the requirement to develop accredited training programs in Addiction Medicine for physicians from all specialties who wish to be trained.

We have to keep front and center the fact that the ASAM members' number one priority is ABMS Board certification for Addiction Medicine. The 2003 Member Survey reported "board certification" as the number one interest. The survey report says, *It is clear that members should pursue one major initiative in the future: advancing the specialty by gaining ASAM's "board certified" status on addiction medicine. A variety of other potential new initiatives...are supported by about two-thirds of ASAM's members but none of these potential program-service-benefits have the same degree of member support found for gaining "board certified" status for the addiction medicine specialty in the short-term.*

(81% selected this as the major initiative) (Suvey, p.13).

**Would non-physician members be an asset gain, or would they create new costs?**

While the ASAM Membership Committee may make the non-physician membership

recommendation as a means of strengthening ASAM, I believe that allowing non-physician members will weaken the Society and drain resources from ASAM's mission.

Some may argue that non-physician membership dues and other payments will financially strengthen ASAM. In fact, having non-physician members will bring additional costs and service demands. To name only a few such demands, non-physician members will want to (1) have time allocated for workshops and symposia at the Annual Medical Scientific conference (and other conferences), in order to address issues pertinent to non-physician members (but which may not be pertinent to physician members), (2) have space in the ASAM News (and other publications) and the Website, in order to represent and discuss issues pertinent to non-physicians (but which may not be pertinent to physicians), and (3) have ASAM represent their concerns (which may not coincide with physician member concerns) in state legislatures, at Congressional Committee hearings, with third-party payers and others.

**Does ASAM have sufficient staff and money to recruit and support non-physician members?**

If non-physician members are viewed as an asset to the Society, then they should be recruited with vigor. This means that the ASAM staff must design recruiting materials targeted to the non-physician audiences, and those materials must speak to the needs of the several types of potential non-physician members.

If ASAM invites non-physician members to join the Society, then ASAM is also inviting the non-physician members to bring their professional desires and concerns with them, so that these concerns may be aired and addressed within the halls of the Society.

The ASAM staff cannot currently give adequate support to the important requests of ASAM members who want to organize and administer their state Chapters. It is hard to imagine that ASAM will have the staff and the money to recruit and service the concerns of non-physician members.

*The question of Associate Membership was discussed at a special Membership Forum during Med-Sci. ASAM members are invited to join this important discussion, which will continue in the pages of ASAM News. Email your comments to ASAM News1@aol.com.*

## 317 PHYSICIANS EARN ASAM CERTIFICATION; 81 ARE RECERTIFIED IN ADDICTION MEDICINE

*ASAM's Certification Council has announced that the following physicians meet the requirements for ASAM Certification or Recertification in Addiction Medicine. Their achievement was recognized at the Awards Luncheon during ASAM's 40th Annual Medical Scientific Conference.*

### CERTIFIED IN ADDICTION MEDICINE

Adebukola Omotoso Abiola, M.D.  
Gregory Alexander Acampora, M.D.  
William Joaquin Adamas-Rappaport, M.D.  
Akinola O. Adebisi, M.D.  
Adegoke Adeyinka Adeyemo, M.D.  
Hoover Adger, Jr., M.D., M.P.H., M.B.A.  
Kami Adibi, M.D.  
Lawrence Ogagaoghene Adu, M.D.  
Mahmoud Mostafa Ahmed, M.D.  
Nadejda Alekseeva, M.D.  
Arthur Mark Altbuch, M.D.  
Arastou Aminzadeh, M.D.  
William G. Anderson, M.D.  
Guadalupe Aranguena-Sharpe, M.D.  
Albert Joseph Arias, M.D.  
John Anthony Bailey, M.D.  
Brian David Barash, M.D.  
David Lawrence Beck, M.D.  
Cesar Luis Benarroche, M.D.  
Timothy Gerard Benson, M.D.  
Daniel William Berland, M.D.  
Elizabeth Bhargava, M.D.  
Suzy Bibawy, M.D.  
Sherrie Ann Bieniek, M.D.  
Jill K. Billions, M.D.  
James E. Black, M.D., Ph.D.  
Robert Livingston Boyd, M.D.  
Mary Shealy Boyd, M.D.  
Greg A. Brown, M.D.  
Robert Douglas Bruce, M.D., M.A., M.S.  
Ann Bruner, M.D.  
Joan Elizabeth Brunson, M.D.  
Judy Ann Burk, M.D.  
Neil Prakash Butani, M.D.  
Jeffrey W. Buttle, M.D., FRCP(C)  
Jeffrey Lee Butts, D.O.  
Stephen Lee Byrd, M.D.  
Richard Anthony Campana, M.D.  
Melinda Marie Campopiano, M.D.  
Richard H. Carmona, M.D., M.P.H.  
Michael Anthony Carnevale, D.O.  
Carlos Rafael Carretero, M.D.  
Ian Richard Carroll, M.D.  
Laurie Rashidi Casaus, M.D.  
Barbara Herman Center, M.D.  
Maureen Nicole Ceresney, M.D., FRCP(C)  
Michael Louis Cesta, M.D.  
Robert Andrew Chambers, M.D.

Laura Mae Chapman, M.D.  
Amina Chaudhry, M.D.  
Sreekrishna M. Cheruvu, M.D.  
David Chim, D.O.  
Angelo Chirban, M.D.  
Yasin Mohsin Choudry, M.D.  
Indra Kumar Cidambi, M.D.  
Josie Ann Cigarroa, M.D.  
Aaron Jason Cleveland, M.D.  
Nelson Collins, M.D.  
Eric D. Collins, M.D.  
Hubert Anthony Colohan, M.D., BAO, BCh, LMCC,  
Kevin Paul Cotterell, M.D.  
Joseph Cox, M.D., MSc, FRCP(C)  
Benita L. Cushingberry-Turner, M.D.  
Gail D'Onofrio, M.D., M.S., FACEM  
Itai Danovitch, M.D.  
Christopher Jackson Davis, D.O.  
Timothy Charles Dawson, M.D.  
Antonio F. De Filippo, M.D.  
Paula Vanessa De La Cruz, M.D.  
Michael Anthony Denicole, D.O.  
Krisanna Lee Deppen, M.D.  
Juan Carlos DeVirgiliis, M.D.  
Gregory Oran Dill, M.D.  
Greg C. Dobash, M.D.  
James Stonewall Dorsey, M.D.  
Mario Douyon De Azevedo, M.D.  
Mary Dowd, M.D.  
David M. Dranetz, M.D.  
Bridget P. Early, M.D.  
John Charles Echols, M.D.  
Sherif Samy El Asyouty, M.D.  
Gregory Lee Ellison, M.D.  
Ashraf Elshafei, M.D.  
Todd H. Engles, M.D.  
Mary Ann Evans, M.D.  
Daniel Rey Faber, M.D.  
Richard L. Falzone, M.D.  
Carl Alvin Faulks, M.D.  
Susan Callaway Ferguson, M.D., M.S.  
Lyle Beverly Forehand, Jr., M.D.  
Thomas Neil Franklin, M.D.  
Lawrence Frederick Fredeen, M.D., CCFP BSc  
Gregory Eugene Freed, M.D.  
David Arthur Frenz, M.D.  
Robert Zachery Friedman, M.D.  
Katya Frischer, M.D.

Mary Elizabeth Fry, M.D.  
Carl Edward Fulwiler, M.D.  
Joseph Michael Garbely, D.O.  
Larry M. Gentilello, M.D., FACS  
Jason Erik Giles, M.D.  
Trevor Allan Gillmore, M.D.  
Daniel M. Glick, M.D.  
James William Golden, M.D.  
Harry David Goldwasser, M.D.  
Eugene S. Gorman, M.D.  
Jon Edgar Grant, M.D., J.D.  
William Samuel Grass, M.D.  
William Morgan Greene, M.D.  
Barry Jan Gross, D.O.  
Brian Guan, M.D., FRCP(C)  
Jeffrey Alan Gudin, M.D.  
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**Dr. Ruth Fox**

Dear Colleague:

The 2009 Ruth Fox Donor Reception was held on Friday evening, May 1st, during ASAM's Medical-Scientific Conference in New Orleans. The reception honors the generosity of those who have made donations to the Fund. As in years past, the cost of the reception was underwritten by a generous gift from ASAM members Dr. Tommie F. Lauer and Dr. Joseph E. Dorsey and Mrs. Dorsey. We thank them for their generosity in making the evening possible.

The Reception provides an opportunity to celebrate the achievements of this year's recipients of the Ruth Fox Scholarships, given to an outstanding group of physicians-in-training. To date, 28 such scholarships have been awarded. Scholarships cover travel, hotel and registration expenses for recipients to attend ASAM's Annual Medical-Scientific Conference and Ruth Fox Course, as well as one year's free membership in ASAM. The four scholarship recipients for 2009 are:

- **Bethany C. Arber Calkins, M.D.**, Rochester, New York (Family Medicine — University of Rochester Medical Center)
- **James Fausto, M.D.**, New York City (Family Medicine — Albert Einstein College of Medicine/ Montefiore Medical Center)
- **Jennifer J. Nadeau, M.D.**, San Diego, California (Psychiatry — University of California San Diego)
- **Sam Schwendiman, M.D.**, Clawson, Michigan (Addiction Psychiatry — Henry Ford Hospital/ Case Western Reserve University)

Invitations to the Ruth Fox Donor Reception are extended only to donors, so if you have not already contributed or pledged to the Endowment Fund, please do so now. 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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*ASAM's 40th Annual Medical-Scientific Conference was dedicated to the memory of three outstanding leaders in the field.*

**IN MEMORIAM:  
LECLAIR BISSELL, M.D.**

**L**ECLAIR BISSELL, M.D., an internationally known and much-published expert on addiction, died August 20, 2008, in Sanibel, Florida. She was 80.

Dr. Bissell and her life partner of 48 years, Nancy Palmer, moved to Florida in 1968, buying one of the oldest homes in Sanibel. After sharing the home for more than 40 years, the couple donated it to the Sanibel Historical Village, where it is now open for tours. Ms. Palmer died in 2007 after a long battle with Alzheimer's disease.

An outspoken champion of women's rights, the Democratic Party, animal rescue groups and many other causes, Dr. Bissell's opinions often appeared in local and national newspapers. However, many readers did not know she was a pioneer in addiction research. Awards for her professional contributions included the ASAM Annual Award in 2000 and the Elizabeth Blackwell Award for outstanding contributions to the cause of women and medicine in 1997. In 2007, she was honored by the Florida Commission on the Status of Women for her life's work.

Dr. Bissell's work also was known internationally. Long-time friend Steve Mullins, M.D., reported that he'd heard from dozens of doctors around the world who learned of Dr. Bissell's death with real sorrow and shock. Noting that "No one could have been more honest, straightforward, and sincere than LeClair," Dr. Mullins described Dr. Bissell as "a pioneer in the humane management of alcoholism and drug addiction. . . [who] was deeply loved by many medical personnel whom she helped overcome addiction over the years."

**IN MEMORIAM:  
RON DAVIS, M.D.**

**R**ONALD DAVIS, M.D., aged 52, passed away November 6, 2008, after a courageous 10-month battle with pancreatic cancer.

A graduate of the University of Chicago medical school, Dr. Davis trained at the U.S. Centers for Disease Control and Prevention (CDC) as a field epidemiologist and a preventive medicine resident. He went on to serve as the first director of the Office on Smoking and Health (OSH), where he worked with Surgeon General C. Everett Koop, M.D., on three landmark reports: *Nicotine Addiction*, *25 Years of Progress*, and *Smoking Cessation*. Subsequently, he was the chief medical officer for the Michigan Department of Public Health until assuming his most recent position as Director of the Center for Health Promotion and Disease Prevention for the Henry Ford Health System in Detroit, Michigan.

Dr. Davis reached the pinnacle of American medicine at a relative young age when he was elected the 162nd President of the American Medical Association in June 2007 – the first preventive medicine specialist ever to serve in that post. On behalf of the AMA, he advocated for improved access to health care and the importance of prevention and sound public policy.

A gifted educator, Dr. Davis gave countless lectures and educational seminars. He also was a prolific writer and the founder of *Tobacco Control: An International Journal*, which he served as editor between 1992 and 1998.

Dr. Davis' career-long fight against alcohol, tobacco and other drugs was recognized with numerous awards and honors. However, his legacy is much deeper. In a moving speech to the AMA House of Delegates in June 2008 (which can be accessed at [HTTP://WWW.AMA-ASSN.ORG/AMA/PUB/CATEGORY/18670.HTML](http://www.ama-assn.org/ama/pub/category/18670.html)), Dr. Davis offered hope to those with cancer, and urged his audience to take the time to remember to love those around them. As one of his many friends noted, "Ron's legacy is the example he set for all of us...through the strength of his character, impeccable integrity, graciousness and style, and his dedication to serve his fellow man."

**IN MEMORIAM:  
MARTY DOOT, M.D.**

**M**ARTIN (MARTY) DOOT, M.D., FAAPP, FASAM, passed away suddenly on November 14, 2008, at age 60.

At the time of his death, Dr. Doot was chief of addiction medicine at Lutheran General Hospital and associate medical director of Advocate Medical Group in Park Ridge, Illinois, where he was responsible for clinical informatics and directed the Advocate Addiction Treatment Program. He also served as director of the Illinois Professional Health Program.

Before joining Advocate, Dr. Doot was director of medical education for Parkside at Lutheran General Hospital and served as vice president of medical services with Lutheran General Behavioral Health. Before joining Lutheran General in 1984, he worked at McNeal Memorial Hospital in Berwyn, Illinois, as medical director of the alcohol treatment program and assistant director of family practice.

A Fellow of the American Society of Addiction Medicine and the American Academy of Family Physicians, Dr. Doot published numerous articles and book chapters on addiction topics and the practice of addiction medicine. He also was an early and articulate advocate for employing therapeutic rather than punitive interventions with physicians and other health care professionals who were impaired by alcohol or other drug use, and was a frequent advisor to the American Medical Association as it worked to build the first national network of state Physician Health Programs.

John Sage, M.D., medical staff president at Lutheran General, observed that "Marty (leaves) a legacy as friend, educator, and thought leader for our community. [His] compassionate and whole-patient approach to addiction treatment defined the addiction programs at AMG and Lutheran General, and attracted the attention of peers, clinicians, social workers and patients from around the globe. Indeed, just days before his passing, Dr. Doot hosted a delegation of addiction treatment providers from Minsk, Belarus." And just a week earlier, he shared his knowledge with other addiction medicine specialists as a lecturer at a course sponsored by the Illinois Society of Addiction Medicine.

# ASAM CONFERENCE CALENDAR

## ASAM EVENTS

**October 22-24, 2009**

ASAM Course on the State of the Art in Addiction Medicine  
Hyatt Regency Capitol Hill Hotel, Washington, DC  
[21 Category 1 CME Credits]

**December 4-6, 2009**

Comprehensive MRO Course: Toxicology Testing and the Physician's Role in the Prevention and Treatment of Substance Abuse  
Washington, DC  
[18 Category 1 CME Credits]

**April 15, 2010**

Ruth Fox Course for Physicians  
San Francisco Marriott  
San Francisco, California  
[8 Category 1 CME Credits]

**April 15, 2010**

Pain & Addiction: Common Threads  
San Francisco Marriott  
San Francisco, California  
[8 Category 1 CME Credits]

**April 15-18, 2010**

41st Annual Medical-Scientific Conference  
San Francisco Marriott  
San Francisco, California  
[21 Category 1 CME Credits]

## OTHER EVENTS OF NOTE

**September 23-25, 2009**

16th National TASC Conference on Drugs & Crime: A Brighter Tomorrow — Health, Hope & Healing  
Hilton Charlotte Center City  
Charlotte, North Carolina  
View the program or register online at [HTTP://WWW.NATIONALTASC.ORG/CONFERENCE.PHP](http://www.nationaltasc.org/conference.php)

**September 26, 2009**

Responsible Prescribing of Opioids for Chronic Pain: Balancing Safety and Efficacy in Today's Regulatory Environment  
Jointly sponsored by the Maryland Society for Addiction Medicine and the American Society of Addiction Medicine  
Hilton Baltimore BWI Airport Hotel  
Baltimore, Maryland  
[5 Category 1 CME credits]  
For more information or to register, phone Christina Sacco of MD-SAM at 301-992-1460 or email [CFSACCO1@AOL.COM](mailto:CFSACCO1@AOL.COM)

**October 23-24, 2009**

Managing Chronic Pain While Keeping the "Control" in Controlled Substances

Sponsored by the Vermont Dept. of Health, the Vermont Medical Society, and the Brattleboro Retreat, with support from CSAT  
Hampton Inn Conference Center  
Colchester, Vermont,  
and at multiple Webinar sites  
[4 Category 1 CME credits]  
For more information or to register, email [JKELLIHER@BRATTLEBORORETREAT.ORG](mailto:JKELLIHER@BRATTLEBORORETREAT.ORG) or phone 802/258-4359

**November 5-7, 2009**

33rd National Conference of the Association for Medical Education and Research in Substance Abuse (AMERSA)  
DoubleTree Bethesda Hotel  
Bethesda, Maryland  
View the program or register online at [HTTP://WWW.AMERSA.ORG/CONFREG.ASP](http://www.amersa.org/confreg.asp)

**December 3-6, 2009**

American Academy of Addiction Psychiatry 20th Annual Meeting and Symposium  
Hyatt Regency Century Plaza  
Los Angeles, California  
View the program or register online at [HTTP://WWW2.AAAP.ORG/MEETINGS-AND-EVENTS](http://www2.aaap.org/meetings-and-events) or phone AAAP at 401/524-3076

*Except where otherwise indicated, additional information is available on the ASAM website ([WWW.ASAM.ORG](http://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](mailto:EMAIL@ASAM.ORG).*

## Medical Education Opportunity: Adolescent Substance Abuse Curriculum

The American Academy of Child and Adolescent Psychiatry offers an online CME program, "Alcohol and Other Substance Use Disorders Curriculum for Child and Adolescent Psychiatry Practitioners, Residents and Other Health Professionals."

This 11 section course is taught by national leaders and researchers. Topics include assessment, neurobiology, prevention, co-occurring disorders, motivational interviewing, nicotine addiction, CBT, family therapy, pharmacology, and practical family and community issues.

This curriculum can be viewed for free. The fee for 5.5 CME credits is \$55 for AACAP members and \$110 for non-members. The website can be accessed at [HTTP://WWW.CEMEDICUS.COM/SUBSTANCEABUSE/](http://www.cemedicus.com/substanceabuse/).

## MEDICAL DIRECTOR

### *Hospital-based inpatient addiction and pain management programs*

We are seeking a personable, energetic Medical Director to provide administrative and clinical leadership for our addiction treatment and pain management programs and services. The Medical Director will lead a team of physicians, the Director of Nursing as well as conduct their own internal medical practice. The Medical Director should have a broad range of experience and have knowledge of addiction, infectious disease and pain management. Knowledge of regulatory body requirements (JCAHO, etc.) and Board certification in a medical specialty (Internal medicine, Infectious disease) required.

#### **ABOUT US**

Since 1973, Valley Forge Medical Center and Hospital, an 86 bed facility, has provided comprehensive treatment to adults with substance abuse and associated physical, social, and psychological disorders. Our professional staff provides high-quality treatment services and support to individuals and their families seeking freedom from addiction.

#### **WE OFFER...**

- ▶ Small Privately Owned Hospital
- ▶ Caring, Friendly, Team oriented environment
- ▶ Good Working Relationships with our Physicians
- ▶ Voluntary Hospital
- ▶ Restraint Free Facility
- ▶ Addiction Free Pain Management program — cutting edge, provisional center of excellence for those suffering from chronic pain and prescription drug abuse.

#### **VFMC offers a Full range of benefits —**

Health, STD, LTD, Life, Dental, Vision, Medical FSA, Dependent Care FSA, 401K & profit sharing, Paid Time Off, tuition reimbursement, education days.

*Your confidential application and resume may be sent to:*

### **Valley Forge Medical Center & Hospital**

1033 West Germantown Pike • Norristown, PA 19403  
610-539-8500 ext. 391 • Fax 610-539-0910 • [lcollier@vfmc.net](mailto:lcollier@vfmc.net)

*For more information about our Hospital, please visit our website at [www.vfmc.net](http://www.vfmc.net).*

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