CSAM NEWS

Newsletter of the California Society of Addiction Medicine /Summer 1995, Vol. 22, No. 2

INSIDE

- *California Court Undermines the Confidentiality of Medical Staff Peer Review Records, p. 4*
- *California Legislation: LAAM, Medical Use of Marijuana, Diversion Program, p. 7*
- *Results from the 1995 Survey of Members, p. 6*

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The California Society is a specialty society of physicians founded in 1973. Since 1989, it has been a State Chapter of the American Society of Addiction Medicine.

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ROHYPNOL: QUAALUDE OF THE NINETIES?

David E. Smith, MD, Donald R. Wesson, MD, Sarah R. Calhoun, MPH

Rohypnol is the brand name of a sleeping pill that is marketed by Roche Pharmaceuticals, Inc., in Mexico, South America, Europe and Asia. Although it is not marketed in the US, it is widely available by prescription in Mexico and many other countries in 1 or 2 mg dosage forms under trade names such as Narcozep, Rohipnol, Roiphol, and Rohypnol. Rohypnol (flunitrazepam) is an intermediate to long-acting benzodiazepine.

Rohypnol is an effective sleeping pill marketed in 1 and 2 mg tablets. The hypnotic dose varies from .5 mg to a maximum of 2 mg. Following oral administration, flunitrazepam is almost completely absorbed. Ten to 15 percent is destroyed by first-pass liver metabolism, resulting in a bioavailability of about 85 percent. The elimination half-life of flunitrazepam following intravenous administration is between 15 and 35 hours. There is accumulation with daily dosing. With a 1 mg oral dose, blood levels peak one to two hours after ingestion and fall to one half their peak after 16 to 35 hours. The principal metabolites are 7-amino-flunitrazepam and N-desmethyl-flunitrazepam. The latter is pharmacologically active and has a half-life of 23-33 hours. (Rohypnol package insert, February 1994). Flunitrazepam is also well absorbed when snorted and is sometimes abused by this route (Bond 1994).

Like other benzodiazepines, flunitrazepam taken alone is unlikely to produce death, even if an overdose is taken. When taken in combination with alcohol, the safety margin is greatly reduced, and the combination may be lethal. Intoxication is generally associated with impaired judgment and impaired motor skills. There are anecdotal reports that persons who become intoxicated on a combination of alcohol and flunitrazepam often "wake up" eight to 24 hours later with no memory of events that happened after the ingestion.

Illicit Market

During the past few years, there has been an increasing number of reports of street use of Rohypnol and even mention on the front page of *USA Today* (Levy, 1995). The first police seizure of Rohypnol was in Miami, Florida, and mentioned in *USA Today*, June 15, 1989. The reports came initially from Florida and Texas, but now use is apparently becoming more widespread. Much of the Rohypnol that appears in the United States is obtained by prescription in Mexico and transported across the border. There are billboards on the US side of the border advertising that medications can be purchased in Mexico. People can

enter the US with a 90 day supply of medication that has been purchased in Mexico if the bottle has not been opened and they have a prescription. Mexican prescriptions can be obtained for a small fee in physicians' offices. There are kids on the streets who stop visitors and show them lists of medications that are available. Prescriptions are typically for various combinations of benzodiazepines: Rohypnol, diazepam, and alprazolam, all on the same prescription form and all for the maximum allowable amount. Physicians own or have an arrangement with the pharmacies. "Patients" usually do not see the physicians. The office personnel complete the presigned prescription and direct the purchaser to a particular pharmacy. There is no charge for the physician's office visit if the "patient" takes the prescription to the designated pharmacy.

There are anecdotal reports that persons who become intoxicated on a combination of alcohol and flunitrazepam often "wake up" eight to 24 hours later with no memory of events that happened after the ingestion.

There is also some larger scale smuggling of Rohypnol from Colombia, primarily through Miami.

Street Names

Flunitrazepam, dubbed the "Quaalude of the nineties," has many street names including rophies, ropies, roopies, roofies, ruffes, rofinol, rib, loops, wheels and Roche (pronounced "row-shay") (Roche Pharmaceutical Company is the only manufacturer of flunitrazepam). In Australia, one street name is "stupefi" (McCamey, 1995).

The name "roofies" refers to the "roofers from hell," members of the construction crews repairing the damage from Hurricane Andrew, who were often thought to be working under the influence of Rohypnol.

Abuse Patterns

Several patterns of use have evolved in the United States. Flunitrazepam is occasionally taken alone as a primary intoxicant, but much more often is used in combination with beer as an "alcohol extender" by teenagers and young adults. The combination is particularly hazardous because the combined effects of alcohol and flunitrazepam on memory and judgment are greater than the effects resulting from either drug taken alone.

Heroin abusers use flunitrazepam to "boost" the effects of heroin, or to self-medicate heroin withdrawal. In Europe, flunitrazepam use has been widely associated with heroin use. In the US, flunitrazepam does not currently appear to be widely abused by heroin addicts, although the use of other benzodiazepines such as clonopin, diazepam, and alprazolam is common both among heroin addicts and methadone maintenance patients. Patients who are being maintained on inadequate doses of methadone may use benzodiazepines to ameloriate interdose opiate withdrawal symptoms.

Cocaine abusers use flunitrazepam to "parachute down" from a cocaine binge.

The word is out among teenagers: the school newspaper of Miami Palmetto Senior High School carried a detailed description of Rohypnol use among the students there, including its use for "date rape."

The Texas Commission on Alcohol and Drug Abuse sponsored a survey of 1,030 youth entering Texas Youth Commission facilities during the last half of 1994. There was not a specific question concerning use of Rohypnol, but the survey form did allow for write-in answers. Forty-two (4%) spontaneously mentioned Rohypnol.

Because of recent reports of trafficking in the US, the WHO has rescheduled flunitrazepam from international Schedule IV, where all the other benzodiazepines are, to Schedule III. (The international scheduling is slightly different from the US scheduling.)

The combination of alcohol and flunitrazepam is particularly hazardous because the combined effects on memory and judgment are greater than the effects resulting from either taken alone.

Physical Dependence

Like other sedative-hypnotics, flunitrazepam can produce physical dependence, and abrupt cessation may cause signs and symptoms such as anxiety, insomnia, intense dreaming, paresthesia, increased sensitivity to light and sounds, and grand mal seizures. Judging from the pharmacological profile of flunitrazepam, one expects the withdrawal intensity from flunitrazepam alone would peak three to five days after cessation. Since flunitrazepam is commonly taken in combination with alcohol, and since patients may be physically dependent on both alcohol and flunitrazepam, alcohol withdrawal may occur during the first two days of abstinence.

Patients who have been taking more than 5 mg/day of flunitrazepam for a month or more will have significant sedative-hypnotic tolerance and should be presumed to have a medically significant level of physical dependence on flunitrazepam. If the

patient has also been using alcohol daily, they may be dually dependent.

Patients who are episodically using flunitrazepam and who are abstinent from both flunitrazepam and alcohol for three to five days between use episodes would be not expected to be physically dependent but should be observed for signs of withdrawal, and treated if they appear.

With other benzodiazepines, prolonged therapeutic or low-dose use, even if episodic, may lead to protracted withdrawal syndromes. This effect has not yet been documented with Rohypnol, but it may reasonably be anticipated. These syndromes can produce acute withdrawal symptoms in the weeks and months following cessation of use, especially with reexposure to any intoxicant. There can be ongoing sequelae, particularly in cognitive functioning and memory, for over one year. If symptoms are severe, treatment with phenobarbital may be indicated; in most instances, these syndromes gradually resolve with continued abstinence.

Patients who are physically dependent on either alcohol or flunitrazepam or both should not be abruptly withdrawn or withdrawn without medical supervision because unmanaged withdrawal signs and symptoms may be life-endangering.

Pharmacologic Management of Withdrawal

A patient who is physically dependent but taking only flunitrazepam could be withdrawn using phenobarbital. Thirty milligrams of phenobarbital can be substituted for each 1 mg of flunitrazepam. Thus, a person taking 5 mg/day of flunitrazepam would initially be administered 180 mg of phenobarbital per day. The phenobarbital can be discontinued at 30 mg/day. If the patient is vomiting and cannot reliably absorb oral medications, phenobarbital may be administered intramuscularly.

Patients who combine alcohol and flunitrazepam may need additional medication to prevent alcohol withdrawal. After patients have received their initial phenobarbital doses, a benzodiazepine, such as chlordiazepoxide or diazepam, can be administered as needed to alleviate emerging alcohol withdrawal signs and symptoms (e.g., rising pulse and blood pressure, tremulousness, diaphoresis). If an intramuscular benzodiazepine is required for alcohol withdrawal, lorezepam should be used.

Overdose

Following overdose with oral benzodiazepines, vomiting should be induced (within one hour) if the patient is conscious, or gastric lavage undertaken with the airway protected if the patient is unconscious. Beyond one hour, activated charcoal should be given to reduce absorption. Respiratory and cardiovascular function should be monitored as they may evidence depression. CNS depression may manifest in degrees ranging from drowsiness, mental confusion, lethargy, to coma.

The specific benzodiazepine antagonist flumazenil may be useful for reversing the severe effects of overdose caused by benzodiazepines. □

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News About Members

Maureen Strohm is now the Director of the Family Practice Residency associated with USC and located at California Hospital Medical Center in downtown Los Angeles. She is also the new Chair of the Coalition of Medical Educators in Substance Abuse (CMESA), a group made up of representatives from each medical school in California and Nevada.

Max Schneider is the Physician of the Year in Orange County. The Orange County Medical Association gave him the award in July to honor his work in the treatment of alcohol and chemical dependence.

Leland Whitson chairs the local activities committee for the 1996 meeting of the International Doctors in Alcoholics Anonymous, July 31 to August 4, 1996, in Anaheim.

Ken Saffier is now the Chair of the Department of Family Medicine at Merrithew Memorial Hospital and Health Centers, in the Department of Health Services for Contra Costa County. □

California Court Undermines the Confidentiality of Medical Staff Peer Review Records

In July, the California Court of Appeal ruled in a case involving Alameda Hospital and an anesthesiologist re-entering practice after treatment for chemical dependence, saying that the Medical Board of California *can* have access to the medical staff's records of the handling of the case. The ruling is "a major setback to the peer review process" according to the California Medical Association (CMA), the California Association of Hospitals and Health Systems (CAHHS), and the Union of American Physicians and Dentists.

Alameda Hospital relied on Evidence Code 1157 in refusing an MBC investigative subpoena for the medical staff's records related to the treatment and monitoring for "Doctor A," an anesthesiologist who had returned to practice after treatment for chemical dependence.

According to the information reported by the CMA, the physician had successfully completed an inpatient course of treatment, was participating in ongoing follow-up care on an outpatient basis and was back at work being monitored by the hosptial medical staff — all well before the Medical Board even began its investigation. Furthermore, the CMA said that the Medical Board had refused to allow the physician to participate officially in the Diversion Program until the Medical Board Enforcement Division's investigation was complete.

Following is a description and discussion of the case as it appeared in *Law Watch*, a legal newsletter from the law offices of Weissburg and Aronson, Inc.

The Facts

In 1992, the Board received confidential information alleging that Dr. A was addicted to narcotics and had administered anesthesia while under the influence of controlled substances. The Board instituted an investigation and its investigator learned that: Dr. A had admitted his drug abuse to the hospital's medical staff executive committee; he had been granted a leave of absence from the staff in 1992 to enter a drug treament program; and he subsequently had agreed to be monitored for drug use by the hospital. The Board served investigational subpoenas on two substance abuse treatment programs, seeking treatment records and testimony regarding Dr. A. When the treatment programs refused to comply with the subpoenas, the Board issued another investigational subpoena to William J. Dal Cielo, Chief Executive Officer of the hospital, requesting production of documents and records pertinent to Dr. A and his drug problem. The hospital refused to honor the subpoena, claiming that it did not establish good cause for disclosure and that all of the records were privileged under Evidence Code section 1157.

Dixon Arnett, Executive Director of the Board, then sought court orders compelling production of the hospital's and the treatment programs' records. The trial court ordered production, and a consolidated appeal addressing the discoverability of both the peer review and the treatment records ensued.

The Decision

Evidence Code section 1157 protects from discovery the records and proceedings of "peer review bodies," including organized peer review committees of hospital medical staffs, HMO's, certain professional societies, and other entities (such as medical groups, IPAs, and integrated delivery system components) made up of more than 25 physicians, dentists, clinical psychologists, or podiatrists. In ordering production of the subpoenaed documents, the court found that section 1157's discovery prohibitions should be narrowly construed and only appled to pre-trial disccovery in adversary proceedings — in other words, civil lawsuits. In so ruling, the court relied heavily upon *People v. Superior Court,* which held that section 1157 prohibits discovery only by medical malpractice plaintiffs seeking a physician's peer review and credentialing records.

The hospital argued that the legislature intended section 1157's protections to extend to administrative subpoenas, but the court rejected the hospital's contentions on this issue.

The hospital also noted that Business and Professions Code section 805.1 provides for limited disclosure to the Board of peer review documents after a facility has filed an "805 report" of disciplinary action against a physician. When the report is filed, the Board is entitled to: any statement of charges; any documents entered into evidence at a judicial review committee hearing; and any opinion, findings, or conclusions. The hospital argued that this provision's limited disclosure of peer review documents after disciplinary action sugggested that the legislature did not intend broad disclosure when the Board is conducting an investigation. The court disagreed, reasoning that the Board's need for information might be greater at the investigatory stage than after the peer review body has taken action.

Finally, the court acknowledged the hospital's serious concern that effective medical peer review will be "chilled" by enforcement of the Board's subpoena. However, it suggested that if, in fact, damage to the re-

view process results, the legislature is the proper forum in which to seek a solution.

The court did refuse, however, to order production of Dr. A's treatment records unless the Board could establish (in further trial court proceedings) probable cause related to the purpose for which it sought the records. The court found that more stringent state law standard (probable cause) took precedence over a less exacting Federal standard (good cause) governing discovery of treatment records.

Impact of Decision

The Dal Cielo decision, if not modified or overturned on further appeal, will very likely have a significant negative impact on the ability of organized peer review bodies to conduct candid and confidential peer review. The decision as it now stands permits the Board to issue a subpoena for committee minutes, physician credentials files, and witness testimony whenever it determines that a physician should be investigated. Peer review bodies will retain some limited means to protect the confidentiality of their work. If, for example, a peer review body can establish that the subpoena seeks irrelevant information; is based upon little more than unsubstantiated rumor; or that the Board has made no effort to obtain documents from other available, non-privileged, sources, it may be possible to convince a court that the subpoena is not supported by good cause. In any event, it is clear that if Dal Cielo remains the law, providers may be forced to challenge subpoenas to require the Board to narrow their scope or to establish that it is, indeed, entitled to the sought-after documents.

A petition for Review has been submitted to the California Supreme Court. According to CMA, if the Supreme Court does not accept the case, it will "not bode well for peer review." It may be that a legislative solution will be needed. □

ADDICTION MEDICINE
1995 STATE OF THE ART

CSAM 22ND ANNUAL MEETING

November 2-4 Ritz-Carlton Hotel, Marina del Rey

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Awards Dinner — Friday evening, November 3

1995 Vernelle Fox Award to
Anthony B. Radcliffe, MD

1995 Community Service Award to
Larry Gentile

President's Column

INTERESTING TIMES

In preparing this column, my last as president of CSAM, it occurred to me that the ancient Chinese curse had come home to roost in my tree: "May you live in interesting times."

Certainly these past two years have seen dramatic changes both in CSAM and in medicine at large. I doubt that any of our members haven't been affected by the virtual take-over of addiction medicine treatment (at least in the private sector) by managed care organizations. Most, if not all, medical directorships in our field have been eliminated or reduced to part-time positions. Many programs have simply closed down. In those programs which are still operating, staff members spend enormous amounts of time and energy on the phone with distant "case managers" — all too often pleading for patients to have access to their medical insurance benefits.

None of these changes has been good for patients; nevertheless, we must all acknowledge that medical care (including addiction treatment) has simply become too costly to go unregulated. The current "system," while it has reduced costs to employers, has shifted large amounts of resources away from patient care and into corporate profits.

At the same time that these broad changes in medical practice have been occurring, CSAM has been going through some important changes of its own. Most notably, this past year we gave up our autonomy in favor of becoming a state chapter of ASAM. With this unification has come mandatory combined membership in both organizations and a large influx of new members who previously belonged only to ASAM.

The end result of all these changes has been a period of some uncertainty for CSAM. As a consequence of budgetary constraints we have had to trim our office staff and workload. The Executive Council continues to seek to redefine our priorities in order to serve our membership, the field at large, and our patients.

At the annual meeting this November, the presidency of CSAM will pass to the capable hands of Bill Brostoff — a long time member of both CSAM and the Executive Council. Bill has been particularly active with the Diversion program of the Medical Board of California and other issues regarding treatment of impaired physicians — trying to find ways to balance the needs of the public and of impaired physicians.

I'm sure I speak for Bill, the Executive Council, and our very able Executive Director, Gail Jara, when I say that we all need and welcome your thoughts and suggestions. □

— Richard Sandor, MD

A Profile of CSAM Membership

California Society surveys its members every other year to gather descriptive information and to learn how members evaluate the services and benefits provided. The 1995 survey holds particular significance because it is the first opportunity to hear from the 200± who became CSAM members automatically on January 1, 1995 by virtue of being members of ASAM who reside in California.

The total number of CSAM members at the end of August is 457, but 75 have not paid 1995 dues to CSAM and/or ASAM. Those who do not respond to the final dues notices from ASAM will be dropped from the rosters of both CSAM and ASAM. By the end of 1995, when members are dropped for non-payment of dues, the percentages in this profile of members will change.

Response rate for 1995 is lower

The number of responses for 1995 shown in these comparisons is 93 (20%). The response rate is lower than previous years — 1993 was 47% and 1991 was 35%. The difference may be accounted for by the fact that no second mailing of the survey was done in 1995 as was done in 1993 and 1991.

Specialty distribution

	1995 *457 members*	*1993* *278 members*	*1991* *323 members*
Psychiatry	30% (61% are ASAM certified))	26% (71% are ASAM certified)	26% (65% are ASAM certified)
Internal Medicine	24% (62% are ASAM certified)	26% (68% are ASAM certified)	23% (72% are ASAM certified)
Family Practice	16% (70% are ASAM certified)	17% (83% are ASAM certified)	19% (83% are ASAM certified)
Addiction Medicine	9% (93% are ASAM certified)	16% (97% are ASAM certified)	12% (90% are ASAM certified)
Other	21%	15%	20%

What percent of your practice is devoted to addiction medicine?

Percent of practice	*1995*	*1993*	*1991*
100%	18% (17)	18% (24)	23% (26)
80-99%	10% (9)	10% (14)	8% (10)
50-79%	14% (13)	15% (20)	19% (21)
20-49%	24% (22)	25% (34)	27% (34)
less than 20%	26% (24)	21% (29)	15% (17)
no response	3% (3)	11% (16)	7% (8)

What percent of your income is derived from your practice in addiction medicine?

Percent of Income	*1995*	*1993*	*1991*
100%	13% (12)	16% (21)	22% (25)
80-99%	12% (11)	9% (12)	8% (9)
50-79%	14% (13)	17% (23)	17% (19)
20-49%	16% (15)	17% (22)	21% (24)
less than 20%	19% (18)	27% (37)	17% (19)
no response	20% (19)	14% (19)	14% (6)

Do you treat patients for diseases other than chemical dependency

(Respondents marked as many answers as were applicable; therefore, the total percent of responses for this question does not equal 100%.)

	1995	*1993*	*1991*
Gambling	22% (19)	16% (22)	21% (22)
Eating Disorders	41% (37)	36% (48)	39% (44)
Sexual Compulsion	22% (19)	19% (26)	21% (24)
Co-dependency	54% (47)	52% (70)	53% (59)

Over the last four years, has the percentage of your income derived from addiction medicine gone up, down, or has it remained the same?

Income from ADM work	*1995*	*1993*	*1991*
Gone up	24% (22)	17% (24)	26% (29)
Remained the same	35% (33)	42% (57)	52% (57)
Gone down	23% (21)	23% (31)	18% (2)

1995 Survey Responses

Q: What is the *one* most important thing CSAM can accomplish in the next 12 months?

- Successful implementation of unified membership with ASAM.
- Addressing adolescent chemical dependency.
- Education. Continue excellent newsletter and up-to-date articles. Be there as an advocate for the specialty.
- Establish criteria for acceptable success for outcome studes. AA and non-AA treatment — compare outcomes.
- Representation on California Medical Board. Help keep the Diversion Program the same.
- Promotion of harm minimization programs — needle exchange programs, condoms, etc., to IV drug users. Free prenatal drug testing.
- Enhance the understanding of Addiction Medicine by primary care physicians so they can do early intervention and ask for a consult.
- Speak with louder voice in the public arena, so that managed care organizations will give better benefits for chemical dependency.
- Continue attempts to penetrate the medical schools and residencies with information. Improve medical school teaching
- Focus on public policy issues: i.e., the effect of drug war incarceration policies on local health and human assistance services, money going from public health to criminal justice system to incarcerate users at 8-12 times the cost of treatment.
- Keep us up-to-date on clinical and public policy issues in addiction medicine. □

California Legislation

Marijuana: medicinal use
A bill in the California legislature (AB 1529) would allow for the personal, medicinal use of marijuana when it has been approved in writing by a licensed physician for the treatment of glaucoma, AIDS, cancer or multiple sclerosis.

AB 1529 would amend California's Health and Safety Code to say that the penalties for possession of marijuana shall not apply to any person who possesses or cultivates it for such personal treatment. In August, the bill had passed the Assembly and was pending in the Senate. Introduced by John Vasconcellos, this is similar to bills which have passed the legislature twice previously, only to be vetoed by Governor Wilson.

LAAM
Legislation awaiting the Governor's signature will move levo-alpha-acetylmethadol (LAAM) from Schedule I to Schedule II in California's Uniform Controlled Substances Act, one step that is necessary before narcotic treatment programs in California can use LAAM. FDA approved the use of LAAM in July of 1993 but before it can be dispensed by state-licensed methadone treatment programs, State legislation was required to place it in Schedule II and new State regulations must be put in place. Regulations are required from the California Department of Alcohol and Drug Programs (ADP) Methadone Licensing Branch. They are expected to follow the Federal regulations closely. For information, contact the ADP at 916/323-2032.

From "FDA Approval of LAAM," CSAM NEWS, Vol 20 No 3, Fall 1993:

> Although LAAM is often referred to as "long-acting methadone," its comparison to methadone is misleading and may interfere with realization of LAAM's full clinical potential. LAAM is a pro-drug, which itself has little opiate effect. It is well absorbed orally and is metabolized by the liver to two active, long-acting metabolites — nor-LAAM and dinor-LAAM — which account for LAAM's opiate activity. Effects develop slowly and, as the long-acting metabolites accumulate, are prolonged. Because the metabolites are long-acting, most patients can be successfully maintained with doses of LAAM administered three times a week, instead of daily. Parenteral injection of LAAM produces no immediate effects. The slow onset of the opiate effects after oral or parenteral administration reduces the chances that addicts will want to inject it or even ingest it. LAAM should have minimal street value as a drug of abuse, and consequently, patients should have little incentive to divert it.

Diversion Program
Legislation has passed to authorize the Medical Board's Diversion Program to accept a physician who is under investigation by the Medical Board. The Enforcement Division shall refer the physician to a Diversion Evaluation Committee for evaluation of eligibility even if the physician is currently under investigation, as long as the investigation is for self-administration of drugs or alcohol or the illegal possession, prescription or nonviolent procurement of drugs for self-administration and does not involve actual harm to the public or to the physician's patients. This new legislation (AB 779) puts an end to the Medical Board's two-year-old policy that a physician cannot sign a Diversion agreement and be a formal participant in the Diversion Program if there is a complaint against him or her. A copy of the full bill is available from the CSAM office. □

CONTINUING MEDICAL EDUCATION

ASAM's 8th Annual National Conference on Nicotine Dependence

October 12-15, 1995
Toronto Marriott Eaton Centre Hotel, Toronto
Sponsored by the American Society of Addiction Medicine
Workshop topics include Weight Gain Post Cessation, Use of Nicotine Replacement in Specific Populations, Behavioral Pharmacology for the Clinician, Motivational Interviewing, Harm Reduction in Working with Refractory Smokers, What Does the Tobacco Industry Know and When Did They First Learn It?
Fees: $300 for ASAM members
Credit: Up to 14.5 hours of Category 1 credit
For information, contact ASAM, 4601 North Park Avenue, Suite 101, Chevy Chase, MD 20815, (301) 656-3920.

ASAM's State of the Art Conference

Expanding Role of Neurobiology in Addiction Medicine

October 19-21, 1995
Marriott at Metro Center, Washington, DC
Sponsored by the American Society of Addiction Medicine
Fees: $350 for ASAM members; $425 for non-member physicians
Credit: Up to 21.5 hours of Category 1 credit
For information, contact ASAM, 4601 North Park Avenue, Suite 101, Chevy Chase, MD 20815; (301) 656-3920.

CSAM's State of the Art Conference

Addiction Medicine: State of the Art 1995

November 2-4, 1995
Ritz-Carlton Hotel, Marina del Rey, Los Angeles, CA
Sponsored by the California Society of Addiction Medicine
Fees: $350 for ASAM members; $425 for non-member physicians
Credit: Up to 21.5 hours of Category 1 credit
For information, contact CSAM, 3803 Broadway, Oakland, CA 94611; (510) 428-9091, FAX (510) 653-7052.

19th Annual National Conference

AMERSA

November 9-11, 1995
Sheraton City Centre Hotel, Washington, DC
Sponsored by the Association for Medical Education and Research in Substance Abuse
Topics include Brief Interventions/Motivational Interviewing, Thomas Babor, PhD, Michael Fleming, MD, MPH, William Miller, PhD; Alcohol, Drugs, and Violence, Richard Gelles, PhD, Clarence Lusane, PhD
For information, contact AMERSA, Brown University Center for Alcohol & Addiction Studies, Box G, Providence, RI 02912, (401) 863-2960.

Southeastern Conference on Alcohol and Drug Abuse (SECAD)

Wednesday, December 6 through Saturday, December 9, 1995
Marriott Marquis, Atlanta, GA
Sponsored by Charter Medical Corporation
Speakers include David Smith, MD; Beny J. Primm, MD; Joseph Pursch, MD; James Halikas, MD
Fees: $325
Credits: 22 hours of Category 1 credit
For information: contact SECAD-1995, Charter Medical Corporation, PO Box 209, Macon, GA 31298, (800) 845-1567.