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01 MAR-1982

C-F

February 25, 1982

Betty Smith
Better Infant Births
- March of Dimes
158 West Wesley Road, N.W.
Atlanta, Georgia 30305

Dear Ms. Smith:

Your letter of February 14, inquiring about scientific evidence of the hazards of maternal marijuana use to the health of unborn children, has been referred to me. I am happy to send you the enclosed information.

The American Medical Association's position on this question is best summed up in the 1980 report of the Council on Scientific Affairs (see page 4) and in our recently published handbook for physicians, Drug Abuse (see pages 68-69 and 193-198). Of course, the AMA would counsel against the use of any drug during pregnancy that is not prescribed by a physician. We are particularly concerned about the embryocidal and teratogenic effects of marijuana now being reported in the scientific literature because of the widespread use of marijuana among women of child-bearing age and because of the popular belief that marijuana is a "harmless" drug.

In addition to these AMA documents, I am enclosing two articles from the literature that deal directly with your question.

I hope this information will meet your needs and that you will call on us in the future whenever we may be of assistance.

Sincerely,

Bonnie B. Wilford

BBW/amo
Enclosures

cc: Carlton Turner, Ph.D.

# BETTER INFANT BIRTHS

MARCH OF DIMES
BIRTH DEFECTS FOUNDATION
METRO ATLANTA CHAPTER
1135 SHERIDAN ROAD, N.E. • ATLANTA, GEORGIA 30324
404/325-9800

BW
Can you respond to this?
Sue
2-23-82

COUNTIES SERVED
CLAYTON
DEKALB
FULTON
GWINNETT
HENRY
NEWTON
ROCKDALE

February 14, 1982

Health Education
FEB 22 1982

American Medical Association
535 North Dearborn Street
Chicago, Illinois 60610

Your agency was suggested to us as a possible source of information by Dr. Carlton Turner, Senior Advisor for Drug Policy, White House Office of Policy Development.

As a longtime member and officer of Better Infant Births, an educational arm of March of Dimes Birth Defects Foundation, I am concerned that March of Dimes literature may not realistically reflect the health hazards of marijuana smoking that I understand can now be verified with statistics.

I am convinced that many young people of childbearing age are not aware of the particular dangers to their unborn children that marijuana use could cause.

If there is scientific evidence currently available that would justify a stronger warning by March of Dimes, I would appreciate it if you would send such information to:

Betty Smith
Better Infant Births-March of Dimes
158 West Wesley Road, N.W.
Atlanta, Georgia 30305.

Thank you for your cooperation.

Sincerely,

Betty Smith

Betty Smith
Better Infant Births-March of Dimes

copies: Judy Kiely
Anne Parker
Nance White

# PRESCRIPTION DRUG ABUSE

By EMANUEL M. STEINDLER, M.S.—Director, Department of Mental Health American Medical Association, Chicago, Illinois

The abuse of prescription drugs is a wide-ranging and emotional subject, especially so because hard data is hard to come by. I want to make an attempt at defining the problem, and examine some of its major aspects, but more importantly I would like to discuss how those of us in medicine, law enforcement, regulatory agencies, pharmacy and other concerned professions might together get a better handle on preventing and controlling the circumstances and situations that contribute to and stem from this kind of abuse.

In all of this, I will be proceeding from the following set of assumptions:

1. That prescription drug abuse is not monolithic, but varies from state to state, and from city to city, with respect to the nature of drug sources and the kinds of drugs being abused.
2. That all the professions that have a stake in this issue can benefit from increased understanding and appreciation of each other's concerns and methods.
3. That cooperative relationships among these groups is essential for effective action, but that such relationships also must vary from place to place according to personalities involved, and to differences in practices, laws and regulations.
4. That one group or organization needs to take the lead in any given place in order to get things moving and sustain momentum.
5. That the public and the media constitute an appreciable part of the problem, and therefore need to be part of the "solution".
6. That stopping prescription drug abuse will not solve the drug abuse problem.

In a broad sense, any abuse of any prescribable controlled substance, regardless of how it came to be produced or possessed, is prescription drug abuse. Under this definition would come abuse of drugs not only actually prescribed or dispensed, or diverted from prescribers or dispensers, but also drugs that are counterfeited here and abroad, those that are stolen from manufacturers and wholesalers, and those that are smuggled into this country. Using such a definition, a case could be made for the banning of one or more of these drugs from the licit market on the grounds that thefts or even counterfeiting would cease if there were no drug to steal or copy. I hope that no one seriously entertains that alternative today. It has been amply demonstrated and acknowledged that drugs in Schedules II through V have a legitimate place in medical practice and in the treatment of numerous diseases and disorders.

For this reason, I prefer a narrower definition of prescription drug abuse, one that encompasses drugs actually prescribed or dispensed, or diverted by theft or forgery from prescribers or dispensers. Moreover, the narrower definition provides the kind of common ground for practitioners, public officials and enforcement officers that would not be possible under the larger rubric.

How big a problem are we talking about? At the White House Conference on Prescription Abuse held last November the assertion was made that on the top 10 drugs reported by medical examiners as being responsible for death, eight are prescription drugs. Does this mean that prescribers and dispensers are responsible for 80 per cent of overdose fatalities? Not necessarily. We don't know how many of these drugs might have been counterfeited, or how many were stolen from manufacturers or wholesalers.

Or take the claim that about half the mentions of the most popular prescription drug items in the DAWN system can presumably be traced to prescription writing. Does this mean that half of the total abuse of these drugs can be laid at the doorstep of physicians and other practitioners? Not necessarily. The DAWN system covers only casualties. An undetermined number of other abusers of prescription drugs never get into the system, and we really have little evidence of where their supplies come from.

Methaqualone is an example of a prescription drug whose abuse cannot be blamed entirely or even primarily on prescription writing. This drug has been one of the most widely abused substances in many parts of the country. The medical society in Dade County, Florida, and later other county medical societies in the state, became so concerned about the situation there that they got pharmacists to agree not to stock the drug and, along with amphetamine, to put a 48-hour hold on all prescriptions.(1) That did put a big dent in the wanton abuse caused by a few errant prescribers. But it didn't do away with methaqualone abuse in the streets.

And we can readily see why just by comparing the total licit production of methaqualone with what is estimated to be the counterfeit supply smuggled into the United States: 3.5 tons legitimately produced against 100 tons entering the country illegally.(2) Even if all the legally produced methaqualone were diverted, it would constitute less than 4 per cent of the supply in the streets.

Admittedly, methaqualone is an extreme example. But it drives home the point that abuse of prescription drugs is not the same as prescription drug abuse as we are defining it.

There are other, less dramatic examples. In a study of 100 abusers of phenmetrazine (Preludin), only 26 reported obtaining the drug through a prescription. (3) From 1973 to 1980, the prescribing of pentazocine (Talwin) dropped by nearly one half in tablet form and two-thirds in injectable form, (4) yet abuse does not seem to have abated and has even increased in some areas, particularly in combination with pyrobenzamine. Again in Dade County, a study of more than 400 abusers of hydromorphine (Dilaudid) in a treatment program over a four-year period showed that only 7 per cent received the drug through prescription, with another 21 per cent reporting that they got it from pharmacies without a prescription.(5)

I am not trying to minimize the fact that we have a serious problem with prescription drug abuse. I am also aware that the large number of street buys that can be attributed to the sale of drugs originally secured by prescription writing, forgeries and pharmacy thefts makes the problem of greater magnitude than the above examples would indicate. All I am asking is that we place the problem in its proper context and examine it from a realistic perspective.

Although I realize that pharmacy thefts and other retail diversions are a major concern, I will be focusing attention, in the balance of this paper, on the prescriber or the misprescriber, actually the physician-misprescriber—who he is, why he practices as he does, and how he can best be dealt with.

Borrowing somewhat from my good friend Dave Smith,(6) I will characterize the misprescriber in four ways, with the understanding that such physicians don't always fall into separate and mutually exclusively compartments.

There is first the dishonest doctor. Then, there is the duped doctor. There is also the dated doctor. And finally there is the disabled doctor.

**The dishonest doctor** is known to us as the "script doctor." He willfully, and with full knowledge of what he is doing, prescribes or dispenses controlled substances outside of, or beyond, a bona fide physician-patient relationship. He does so for profit, usually substantial profit. He is not only a misprescriber. He is a mass-prescriber. Everyone acknowledges that, although the script doctor represents a very small percentage of prescribing physicians, he is responsible for an extremely large proportion of the drugs that are channeled from the prescription pad into non-medical uses.

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**The duped doctor** is one who falls prey unwittingly to the conning tactics of alleged patients or even actual patients who are drug abusers or who wish to obtain drugs for sale to others. Typically, prescriptions are for excessive amounts, and the prescriptions continue for longer periods than would seem to be medically indicated. Many physicians are duped once in awhile. Only a few are chronically deceived.

**The dated doctor** is one who has not kept up with developments in pharmacology or in drug therapy. He is a poor prescriber, not intentionally so, but because he lacks information or understanding. Not only may he be prescribing excessive amounts for inordinately long stetches of time, but we may be utilizing drugs where other therapy is indicated, or he may be using types of drugs that are not appropriate to the conditions being treated. If it sounds like these physicians may be having trouble with their practice in general, you are right. In Maryland, of 39 physicans identified through peer review as being poor prescribers, six were persuaded to retire from medicine because other defects in their office practice surfaced.(6) It is also interesting to note that of this group in Maryland, none of the 39 poor prescribers was under age of 40, and 25 of them had been in practice over 20 years.

**The disabled doctor** is the physician whose professional competence has been impaired because of alcoholism, mental illness or abuse of drugs. In studying 50 out of 100 such physicians referred to it over a three-year period, the Indiana State Medical Association's Commission on Physician Impairment found that overprescribing of controlled drugs was common among physicians who themselves were substance abusers.(7)

You may say "Wait, we haven't covered everybody. What about the decent doctor, the dutiful doctor, the devoted doctor? Doesn't he also contribute to drug abuse by relying too much on quick chemical solutions to complex medical problems?" In other words, aren't we really an overmedicated society? We hear this often and read it in newspapers and magazines, particularly in relation to diazepam (Valium) and other anti-anxiety agents.

I won't try to take sides on these questions. They shouldn't be dismissed out of hand, but neither should they be accepted in the affirmative without looking more closely at some of the evidence. Critics, for example, will point to the billions of dosage units of controlled substances that are prescribed each year for relief of anxiety, insomnia and pain, with women more often than men being recipients of such medication. All of this can't be necessary, they say.

The makers of Valium, on the other hand, state in their advertising that their product is used by only one in 10 U.S. adults, even though one in four has moderate to severe anxiety problems.

Are we becoming more medicated or less medicated? You can find indications in both directions. Alcoholics Anonymous just released results of a survey in which 24 percent of its members reported being addicted to a drug in addition to alcohol, compared with 18 per cent three years earlier.(8) Yet, analysis of the total prescription drug market has shown a slight decline over the years in the proportion of that market represented by substances that affect the central nervous system.(9)

If, in fact, there is unjustified overprescribing of psychoactive drugs, it may be of some interest to know that these aren't the only substances subject to overuse. A headline just last week in *American Medical News* read: "Antibiotics Abuse Threatening Therapy, Scientists Warn."(10)

And to the extent that overprescribing does take place, physicians, although they must bear the ultimate responsibility, are not always solely to blame. Many are under considerable pressure from patients to prescribe drugs that they may have heard or read about in the public media as being new discoveries or having new applications. Moreover, the prescription in itself has a symbolic meaning for patients, a kind of tangible evidence of the physician's concern for their well-being.(11) Patients sometimes feel that they haven't really been treated unless they can leave the doctor's office with a prescription form in hand. In Texas, a survey by the state medical association indicated that 23 per cent of physicians are reluctant to turn down their patients' requests for drugs.(12)

But there is little if any evidence that the country is being "turned on" by physicians, as some of the scare stories in the press might lead us to believe. In the Texas survey, only 6 per cent of the physicians felt that prescribing minor tranquilizers like Valium was the most effective treatment for persistent anxiety, and 18 per cent thought it was the least effective.(12)

Other studies have shown that people frequently will refuse to take phychotherapeutic drugs when they need them or up to the levels that prescriptions call for. (13, 14) Many patients never have their prescriptions filled, and some just let their medication sit unopened in a drawer or on a shelf.(15) Non-compliance is not uncommon, even with other types of drugs. Of patients receiving antihypertensive medication at a clinic in Pennsylvania, fewer than half were found to comply with directions for use.(16)

There will, of course, always be patients who take too much rather than too little. Chambers and White interviewed 87 such individuals, all women, and found that hardly any of them realized that what they were doing might be dangerous.(17)

"A significant number," they reported, "are taking more than one (prescription psychoactive drug) as well as drinking alcoholic beverages regularly; and once use begins, people seem to use these medications for a long time."

(Incidentally, at least twice as many women as men are treated for "psychic distress," and they also receive and use twice the amount of medication for their symptoms.)(14, 18)

Despite widespread use, however, the minor tranquilizers, or bensodiazepines, are seen by several knowledgeable observers as being prescribed quite conservatively, considering the prevalence of anxiety and the low risk-benefit ratio of these substances.(19, 22) Unlike the barbiturates, for example, they are seldom fatal even if taken in extremely large doses. Occasionally people who have been using large amounts of a benzodiazepine for extended periods will experience withdrawal symptoms when they stop, but such symptoms do not necessarily result from physical dependence. They could be the reappearance of symptoms for which the drug was originally prescribed.(23)

There has been, unfortunately, considerable misinformation and misguided apprehension about addiction from the medical use of psychoactive drugs. When given in therapeutic doses for limited periods, benzodiazepines are not likely to cause detectable physical dependence. Neither are the barbiturates, even the short-acting ones, in moderate doses of less than 300 mg./day.(24) And is it reasonable to withhold narcotics from terminally-ill patients because they might become addicted? Addiction in these cases would seem to be irrelevant in light of the fact that 90 per cent of severe pain can be controlled by opiate analgesics.(11, 25)

The AMA has advised that even if there are sound medical reasons for using a psychotropic drug, the physician should take the following factors into account when deciding on the dosage and the duration of drug therapy: (a) the severity of symptoms in terms of the patient's ability to accomodate them; (b) the patient's reliability in taking medication; and (c) the dependence-producing potential of the drug.(25) There is no reason to believe that the vast

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# PRESCRIPTION DRUG ABUSE

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majority of physicians are not prescribing psychotropic medication judiciously and in the best interests of patients.

But let us return to the minority, where there is a problem and where there is also opportunity for collaborative effort among the professions of medicine, pharmacy and drug regulation and enforcement. I am sure that many of you have a feeling of **deja vu** at this point. Some of you, I know, can recall with me the first formal conference we had on this general subject in 1967—when the AMA, the AMA, the Old Federal Bureau of Narcotics (FBN) and the new York State Medical Society got more than 100 key people together to discuss ways to improve liaison between medicine and enforcement, especially on a state level. Although the concern then was strictly with the narcotic drugs (the Controlled Substances Act was still three years away), the main recommendations emanating from that meeting have broad significance and are still relevant today.(27) They called for establishment of multi-disciplinary committees in state and local jurisdictions that could act as mediators between government and physicians suspected of misprescribing. They proposed that mechanisms be created whereby individual physicians and enforcement agents could secure authoritative opinion on whether certain instances of prescribing are or are not appropriate. They asked for better pharmacology education for physicians and medical students. And they urged joint action in promoting resources for treatment of addicts and research into more effective prevention.

Although all of these recommendations have not been carried out to their fullest extent, it would be unfair to suggest that little if any progress has been made during the past 15 years. Much has been accomplished.

The Drug Enforcement Administration (DEA) has formed a Prescribers Committee made up of representatives of the major national professional associations. The Committee meets quarterly to discuss problems of compliance, and recently it issued a set of guidelines on prescribing of controlled substances. The DEA also has sponsored drug investigation units (DIUs) in several states, involving enforcement and regulatory bodies and professional associations, and has encouraged on-going "voluntary working committees of concerned professionals" in such states.(28)

The AMA has produced four editions of its *Drug Evaluations* book, has published *Drug Abuse: A Guide for the Primary Care Physician,* has issued policy statements on the use of amphetamines, barbiturates and narcotics in medical practice, has conducted continuing education courses on prescribing psychoactive drugs, has participated in ADAMHA's "Project Sleep," and was a co-sponsor of the White House Conference on Prescription Drug Abuse. One of the hardest working panels of the AMA's Council on Scientific Affairs is the Panel on Drug Abuse, which was responsible for the Council's report on prescription drug abuse adopted by the AMA House of Delegates last June.

Among state medical associations, Florida already has been mentioned. Similar cooperative efforts between physicians and pharmacists have been carried forward in Texas. The medical society in Illinois has a long record of working closely with enforcement and regulatory agencies, as has the medical society in New York. Here in Minnesota the medical association has supported strict drug utilization review in the state's Medicaid program and in health maintenance organizations (HMOs), and it sponsored legislation requiring all drugs to have identifiable markings to discourage counterfeiting and "look alikes." Utah's medical society also has been active in peer review of prescribing practices. The medical association in Wisconsin cooperated with the regulatory board in the restriction of the medical uses of amphetamine and the consequent reduction of the medical uses of amphetamine and the consequent reduction in illicit use. In Maryland, the state medical society serves as an official investigatory arm of the Commission on Medical Discipline, and the chairman of the society's drug abuse committee is a consultant to the Division of Drug Control. The California Medical Association works with the Board of Medical Quality assurance in providing courses on prescribing for Board probationers. These are only illustrations, not a complete picture.

In many, if not most, states, then, much of the groundwork has been prepared for effective impacting on prescription drug abuse. The task before us is not so much to break new ground but to build on the foundations already in place.

Can we, in other words, work together to build comprehensive state-wide programs to curtail abuse and to promote more appropriate prescribing? The AMA believes there are five essential ingredients for such programs:(1)

1. The nature and extent of prescription drug abuse in the state must be identified and measured as accurately as possible.
2. Medical societies must assert their willingness to help single out script doctors and bring them to justice, and combat wanton diversion in other ways.
3. Educational, rather than simply punitive, approaches must be taken toward physicians who unwittingly misprescribe, and therapeutic approaches must be taken toward physicians who themselves are drug dependent.
4. Medical societies and medical schools offer additional opportunities for students and practitioners alike to develop and maintain sound prescribing practices.
5. Authoratative information on the beneficial aspects of proper medical uses of controlled substances, as well as on the deleterious effects of their abuse, must be furnished to patients and the general public.

I will elaborate briefly on the first three points.

**Determination of the Problem.** It is important to find out which drugs are being most frequently abused and diverted on the retail level, because the situation will vary from state to state, and from city to city. It is important also to correctly identify prescribers who are either intentionally or unknowingly contributing to the diversion problem. These facts can be ascertained by enforcement officers. Stories in the press, although often sensationalized, can furnish leads. Also of help can be data compiled through state information and record systems, and through federal systems, such as DAWN and the Automated Reports and Consolidated Orders System (ARCOS). All systems have inevitable time lags between data gathering and reporting, which can result in misleading information in a fast-changing area such as drug abuse. Nevertheless, these systems should be utilized whenever possible, recognizing and taking into account their dificiencies.

**Combating Wanton Diversion.** Medical societies should urge their members to assist law enforcement in every possible way in the investigation and prosecution of script doctors. To safeguard against thefts and forgeries, physicians should protect their prescription blanks and avoid pre-printing their DEA number on them. Pharmacy programs like those in Florida and Texas should be considered, although the advantages of placing a delay of up to two days on filling prescriptions for certain drugs need to be weighed against potential adverse implications for the health of patients. In the case of amphetamine and methaqualone, the Florida experience indicates such effects would be minimal. This may not be true with other substances, especially if adequate substitutes are not available.

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**Educational Approaches to the Unwitting Misprescriber.** Several avenues are possible. Medical associations can set up panels to review and evaluate physicians who have been referred by enforcement agencies because of possible misprescribing. Formal courses can be devised, patterned after the California experience. Medical societies can help enforcement and regulatory agencies monitor physicians who have been contacted or who have taken courses, to assure that their prescribing improves.

Education need not be limited to physicians. Enforcement and regulatory personnel also often benefit from courses on the medical aspects of prescribing. They may gain a better appreciation of the importance of exceptional prescribing to the well-being of certain patients, and they are better able to differentiate between intentional and inadvertant misprescribing, to realize, as Smith and Seymour have said, that "good faith medicine, even if inadequately implemented, is the major differentiation between criminal 'script' doctors and poorly-informed 'dated doctors.'"(29)

I think everyone agrees that it would be a mistake to overload the enforcement and regulatory system by the punitive handling of physicians who misprescribe unwittingly. Limited enforcement resources should not be diluted by pursuing "dated doctors," for whom education is the better alternative. In fact, vigorous and well-publicized prosecution of script doctors can itself be educational for other misprescribers.

Before ending my remarks, I want to acknowledge the outstanding work that is being done by state medical societies throughout the country in behalf of drug addicted, alcoholic and mentally-ill physicians. Nearly every state association has an impaired physicians committee to encourage the early detection, treatment and rehabilitation of these physicians, and to ensure that they temporarily relinquish their practices if their professional competence is affected.(30, 32) Most of these programs have close ties with state boards of medical licensure and discipline, and provide and excellent example of how the public and private sectors, medicine and enforcement, can together bring about mutually-desired results.

As it has with the impaired physician effort, the AMA, with prescription drug abuse, will do its utmost to stimulate effective intervention and cooperative endeavors in the states. It will continue to explore with other national and international organizations, such as INEOA, the best ways to accomplish that objective. I hope that representatives of all key associations and agencies can meet soon, and agree that, now that we have workable models, the next order of business is to make them work even better, and to encourage their replication.

In the course of preparing this paper, I came across an unedited verbatim transcript of yet another meeting between AMA and INEOA representatives. This one was held in 1973 in yet another nice place—Paradise Island. The subject then, too, was how medicine and enforcement could collaborate better on drug abuse problems. Henry Giordano was at that meeting, and after listening for quite a while, he said this: "You have to get something started and then develop it. It's the only way it's going to go. Otherwise, we just talk about it."

Well, eight years later, I think we have a great deal started. Let's not just talk about it. Let's finish it.

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# Medical School Education on Abuse of Alcohol and Other Psychoactive Drugs

This statement is directed toward the broad question of drug use and abuse. It includes principles pertaining to the long pressing problems of alcohol use and alcoholism, the currently conspicuous problems associated with dangerous and illicit drugs, and the overlooked abuses of drugs thought harmless.

*The Need.*—Although there has long been a need for effective medical education on the use and abuse of drugs, this need has recently been focused to a point of urgency by several convergent factors:

(*a*) There have been relatively recent changes in the nature and distribution of drug use, with an apparent rising prevalence of inappropriate, dangerous, and illegal uses of drugs by many segments of the population. Especially has there been an increase in the use of psychotropic drugs by young people. At the same time, the recognized magnitude of alcoholism and other alcohol-related problems has continued to grow.

*For editorial comment see page 1757.*

(*b*) There is currently an aroused public concern and intensive interest in the subject of drug abuse. This interest is accompanied by considerable speculation, conflicting assertion, confusion, and so-called facts, all complicated by a tendency to apply a two-value orientation (eg, good vs evil; law abiding vs criminal; conservative vs radical). The subject of drug abuse also is exploited by some persons who deliberately foster polarization.

(*c*) There are logical key roles which physicians can fill professionally because of their knowledge, training, and the expectations of society, with respect to the prevention and treatment of drug abuse. Also, as responsible citizens of their communities, they can try to help bring order out of confusion.

(*d*) Medical students are particularly receptive to educational material regarding drugs. Students bring varied experiences and attitudes concerning drugs with them when they enter medical school. These include the misconceptions, stereotypes, and prejudices which prevail in society at large; their own personal experiences; the values and convictions of their peers; and a perceived need to develop some expertise quickly. They are motivated to become knowledgeable so that they can be objective and responsible in their professional roles. They also have an immediate need to answer their own questions and those of their peers regarding personal drug use.

(*e*) Alcoholics and other drug-dependent persons tend to have much higher rates of morbidity than persons who do not abuse drugs. They are, therefore, frequently encountered as patients with symptoms other than those associated with alcohol or drug abuse. The effective treatment of these patients requires that cognizance be taken of their drug dependence or alcoholism.

(*f*) Physicians are the "gatekeepers" and their prescription blanks the "keys" for many pharmacological agents. The education of future physicians should encompass consideration of the dangerous implications of encouraging patients to rely on pills to "solve" psychological and social problems. The potential danger to physicians themselves inherent in their easy access to psychoactive drugs must also be clearly identified.

*Complex Nature of Drug Problems.*—The problems of alcohol and drug use are varied and complex. For society, they are related to major legal, moral, economic, and social questions, to the unprecedented rates of change which are affecting almost every aspect of social living, and to a severely impaired network of communication between successive generations. For the individual, they invariably involve an interdigitation of such factors as the chemistry, structure, and function of the human organism, unique personality characteristics, life experiences, and the meaningful social roles and identifications and cultural values which impinge upon and help mold individual behavior.

*Current Status of Medical Education.*—Medical education throughout the United States is in the process of change, with most schools revising their curricula in the direction of more varied options. It is therefore not appropriate at this time to suggest a specific plan or model for a program of psychoactive drug education according to the format of traditional medical education. Instead, emphasis should be on a conceptual approach and on delineating key areas of content. It is assumed that each school will find the best way of implementing its educational goals within its own curriculum.

Much of the content of drug educa-

Position Statement of the AMA Council on Mental Health and Committee on Alcoholism and Drug Dependence.

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tion should be distributed throughout the curriculum, whenever and wherever appropriate, and within the purview of basic science and clinical subjects. High priority should be given to pedagogical methods which will encourage students to sort out their personal experiences and subjective feelings, and attain the goal of professional objectivity. It must be stressed that contemporary medical students have a concern about questions of drug use and abuse which extend beyond their educational needs, ie, today's students have grown up in a generation beset by pressures for and against drug use; many have, themselves, experimented with psychotropic drugs; some will still be using drugs; nearly all will feel an urgency to find answers to their questions. Because the experiences of students will be highly individualized, the curriculum should be sufficiently flexible so that students can study drug use and abuse with varying degrees of intensity and personal involvement in treatment and teaching programs.

*A Unifying Concept of Behavior.*—Because the problems of alcohol and drug abuse are associated with almost every aspect of human behavior, it is important that these aspects be identified within a unifying concept which stresses the fundamental relationship and continuing interaction among factors such as (*a*) the structure, function, chemistry, and genetic characteristics of the human organism; (*b*) the pharmacological properties of specific drugs, and the action of these drugs at certain dose levels and under various conditions on the human mind and body; (*c*) personality factors as influencing patterns of drug use and responses to particular drugs; (*d*) motivations behind the initiation and continuation of drug abuse as a basically self-destructive form of behavior; (*e*) social group membership and the place of the individual in society; (*f*) cultural attitudes, beliefs, and values; (*g*) the physical environment; (*h*) the dimension of time: historical traditions; sociocultural orientation to the past, present, and future; human biological rhythms; temporal aspects of personality; duration of drug action.

A unifying conceptual model should ideally be introduced rather early in the student's medical school experience. It can be introduced in formal courses such as "Introduction to the Profession," "Human Ecology," "Health and Society," "Behavioral Science," or it can be incorporated in the general philosophical and pedagogical orientations with which numerous schools are introducing their curriculum. A unifying concept not only should be identified, it should be reinforced by the entire faculty as the individual elements of education on drug abuse are developed.

*Spectrum of Pharmacological Agents.*—Education on drug abuse should, of course, provide an opportunity for learning about the broad spectrum of pharmacological agents which are susceptible to abuse, and the circumstances under which the use of such agents can be inappropriate, dangerous, or illegal. These agents include many substances very commonly consumed by large segments of the population without being specifically identified as drugs (eg, alcohol). They also include substances that are not strictly classified as drugs (eg, glue). Students should have ready access to the most reliable scientific information about the pharmacological properties of such drugs, their primary physiological and psychological effects on the human body, their common secondary or side effects, the media in which they are commonly used, and the factors of timing, frequency, and dose which may influence their effect on the user. Such information is logically provided in courses on pharmacology and therapeutics. In this connection, it should be noted that modern pharmacy education is preparing pharmacists to play a new role as authorities on drugs on the health team. Medical students should be alerted to the potential contributions which modern pharmacists can make to their overall effort.

The study of pharmacological agents should be extended to consideration of common clinical disorders which reflect drug use and which are associated with drug abuse. Such consideration should be a standard part of the student's learning experience in his various clinical courses. Clinical aspects should include the physician's direct responsibility for and role in the treatment and long-term management of alcoholics and drug-dependent persons, as well as familiarity with the other resources often required for the effective comprehensive care of such patients. Every medical school should inventory the nature, consistency, thoroughness, and effectiveness of its treatment of these subjects.

*Status of Scientific Literature.*—Unfortunately, much of the available scientific literature on drug use and abuse is inconclusive, and based on poorly controlled and often inappropriately designed research. A valuable concomitant to medical education on drug abuse can be a provision for the *systematic critical analysis* of the research literature on the efficacy, side effects, uses, and misuses of various kinds of pharmacological agents, as well as the literature on the broader aspects of drug abuse. Such exercises should aim toward developing an appreciation of what is not known about drugs and their immediate and long-term impact on man and an ability to discriminate between inappropriate and appropriate research methods.

*Status of Public Beliefs and Attitudes.*—Physicians should know what their patients and members of society who influence their patients think, believe, and feel about health matters. Therefore, medical students should have an opportunity to become acquainted with prevailing stereotypes and misconceptions, as well as correct perceptions. Because public understanding is significantly influenced by the mass media, some review of the messages being conveyed by the media to the public is relevant to the medical student's education with respect to drugs among other health matters. Available studies on attitudes and beliefs should be critically evaluated.

*Viewing Abnormality in the Context of "Normal."*—Much of the study of human behavior has followed the strategy of approaching the normal through the abnormal, health through disease, customary behavior through deviant behavior, the functional through the dysfunctional. Consideration of the problems of drug abuse should include a view of abnormality in the context of the usual everyday use of various kinds of drugs by most people for various reasons. Such an

approach would provide a perspective for understanding the cultural and historical basis for the use of drugs, the significance of drugs in folk medical beliefs and in faith medicine, the relationship between drinking customs and alcohol problems, and the common prevailing beliefs about the efficacy of a wide variety of proprietary medicines and of other substances containing quite powerful pharmacological agents.

*Demographic Considerations.*—Although there are few reliable data on the incidence, prevalence, and distribution of various forms of drug use and abuse, it is important for students to become familiar with those data which are available on such basic facts as who uses what, where, when, how often, how much, for what purposes, and with what effects. It is also important for students to recognize the economic implications of drinking, smoking, and other drug use, both legitimate and illegitimate, and the economic pressures associated with the "pushing" of drugs by both the legitimate businesses and the criminal elements of society. Drug use should be viewed in relation to other social problems, such as poverty, alienation, unemployment, school dropout rate, rebellion, criminal activities, dangerous operation of vehicles or machinery, industrial absenteeism, spoilage and job turnover, suicide, rates of morbidity and mortality, psychopathology, moral conflict with deep-seated family or religious teachings, and the disintegration of effective interpersonal relationships.

*Common Routes to Drug Abuse.*—There are several distinct, though somewhat overlapping, routes by which people may come to abuse drugs. These should be clearly recognized by medical students. They include the following.

SOCIAL CUSTOMS.—Participation in widespread and sometimes deep-seated social customs involving drugs which have a potential for abuse is one route. Examples include alcohol, tobacco, coffee, and, in some societies, marihuana.

SELF-MEDICATION.—This may be in response to the experience or advice of families, friends, or respected persons, or to advertising or other publicity about drugs through the mass media. Examples include the widespread use of pharmaceutical items sold over the counter or stocked in family medicine cabinets, especially "tonics," analgesics, antihistamines, antiseptics, sedatives, stimulants, and vitamins.

SELF-EXPRESSION.—This includes drug abuse associated with the deliberate cultivation of drugs by individuals who are seeking pharmacological effects and are using drugs as a way of trying to assert their individuality, seek acceptance in peer groups, or express social alienation. Common examples include some forms of drinking and certain uses of lysergic acid diethylamide (LSD) and other strong hallucinogens, marihuana, stimulants, sedatives and, sometimes, narcotics.

CRIMINAL EXPLOITATION.—Some drug dependence results from the deliberate and calculated exploitation of the user by organized criminal enterprises. Examples are the pushing of narcotics, barbiturates, and, to some extent, hallucinogens and stimulants, especially to ghetto populations and to youth.

IATROGENIC DRUG ABUSE.—Although physicians serve as gatekeepers of prescribed drugs, two other influences are continually being brought to bear upon the practitioner: the drug manufacturers who furnish information about new drugs, and patients who are constantly informed by the mass media about the potential benefits of such drugs. Drug abuse involving prescribed medications can result from, among other things, poor judgment of the prescribing physician, inadequate or ineffective communication regarding the appropriate and safe use of drugs, or failure of patients to follow medical direction. Of special concern at this time are the abuses associated with prescriptions for analgesics, sedatives, tranquilizers, and stimulants.

The physician's task in avoiding iatrogenic drug abuse in his patients is complicated by the fact that certain drugs, in addition to having a useful medical function, have some effects which make their use attractive to the patient. Often there is only a fine line between achieving desired therapeutic goals without side effects and incurring liabilities which may out-weigh the sought-for benefits. Appropriate prescribing of drugs, therefore, generally requires responsible, continuing, and skillful medical administration and supervision. This is particularly essential to prevent the most insidious of all the side effects of drug use—drug dependence. The physician must also take into account the fact that the effect of a drug on a particular individual will vary, depending upon the amount of the drug used, how often it is taken, whether it is taken in combination with other drugs, the physical and psychological status of the user, and possibly the social and cultural milieu in which the drug is used.

*Special Exposure of Physicians.*—Because physicians are accessible to most types of dangerous drugs and because they often work under sustained pressure which may enhance seeking of drugs for relief, physicians appear to be a high-risk population in terms of exposure to drug abuse. This potential should be clearly recognized by medical students and there should be opportunities in the cirriculum for them to explore their personal posture with respect to drug use and, if desirable, its impact on their role as therapists. They should also have opportunities to discuss these matters with appropriate experienced physicians.

*Legal Considerations.*—Medical students should become familiar with federal, state, and local laws pertaining to drug use and abuse and to questions of legal possession or distribution of drugs. Particularly of value is knowledge of the physician's duties and responsibilities in prescribing and administering psychoactive drugs, and the privileges and obligations he has under state and local laws in connection with reporting to authorities cases of drug abuse among his patients.

*Multiple Drug Use.*—Although it is well known that the actions of drugs can be markedly increased or altered by their interaction with other drugs which are used simultaneously or sequentially, discussions in medical education of the synergistic actions of drugs generally are limited to pharmacological aspects. Rarely are they concerned with the prevalence of multiple drug use or the widespread dangers associated therewith. Although some use of multiple drugs oc-

curs under the careful direction and with the deliberate prescriptions of a physician, an unknown but significant amount occurs when patients use drugs prescribed independently by more than one physician, when patients combine a prescribed drug with other pharmacological agents, or when patients combine proprietary drugs of significant potency. A common example is the simultaneous use by patients of two or more drugs with sedative properties such as alcohol, antihistamines, and tranquilizers. The principles and potential problems of multiple drug use should be emphasized to medical students so that as physicians they can discuss such problems routinely with their patients as a preventive measure, and can be alert to avoid inadvertently contributing to iatrogenic problems of multiple drug use.

*Communication.*—The question of multiple drug use highlights a basic problem which the physician faces in relation to his role as a prescriber of drugs. This is his responsibility to communicate effectively with his patients. The need for medical students to study the science and art of communication is basic to nearly every aspect of their professional activity. Communication is a crucial factor in accurate diagnosis and in the effective management of patient care. It is crucial in terms of the physician's relationships to other members of the health team and, of course, a crucial aspect of personal daily living. Communication skills must be applied specifically to the physician's role with respect to drug use. It is essential that a physician obtain from his patient an accurate and full description of the patient's drug use history and current experiences with respect to pharmacological agents. Communication is also vital to the success of any drug regime which the physician may prescribe. It is common for serious gaps to occur between the information which a physician believes he conveys to a patient regarding the use of a particular drug, the message which is actually conveyed, the information which is perceived and understood, and the translation of such information into the patient's actual use of a drug. As a result, there frequently are serious variations between physicians' intended directions and patients' practices with respect to the amount, the frequency, the timing, and the duration of drug use, the use of drugs with or without food, and the use of the prescribed drugs with or apart from other pharmacological agents. An understanding of major barriers to communication and the cultivation of skill in observing and listening and in conveying information are essential aspects of medical education. They can be particularly important to the physician in his prescribing practices.

*Integrating Experiences.*—At some time toward the end of their medical school experience, medical students should have a chance to integrate their varied considerations of alcohol and drug use and abuse. Such integration could be provided through a variety of individual and group experiences including participation in research projects, preparing papers on literature review, attending specific case conferences, participating in optional or required seminar-type discussions, assuming some responsibility for education about alcoholism and drug abuse, and participating in preventive and therapeutic programs. Whatever activities are chosen, they should be designed to integrate the student's total knowledge and understanding and reinforce the unifying conceptual model.

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Invitational Conference on Prescription Drug Abuse
November 4, 1981, Washington, D.C.

# DISCUSSION NOTES

I. Dimensions of the problem

A. An estimated one-quarter to one-third of all disciplinary actions against physicians involve drug-related problems.

B. Even if only a small percentage of practicing physicians are poor prescribers, they represent a large group numerically, and their actions affect an even larger group of patients.

C. In a recent DEA pilot project, 20 "script doctors" were found to have prescribed 21 million dosage units of controlled drugs.

II. Consideration of the Report on Prescription Drug Abuse of the AMA Council on Scientific Affairs

A. Determine the nature and extent of the prescription drug abuse problem in each state.

1. Consensus is needed on definitions of "use" vs. "misuse" vs. "abuse."

2. Assessing the dimensions and character of prescription drug abuse is the essential first step in attacking this problem.

3. Future efforts must recognize the inter-relatedness of poor prescribing of controlled drugs and inappropriate prescribing of any drug (including underprescribing and failure to prescribe for valid medical indications).

4. In assessing the extent of the problem in each state, ARCOS and DAWN data could be supplemented with data collected from treatment programs.

B. Develop cooperative relationships between medicine and law enforcement, regulatory agencies, pharmacists and other professional groups to identify "script doctors" and prevent forgeries, thefts and other unlawful activities.

1. More cooperation is needed at the national and state levels.

2. Results of the AMA Survey of State Medical Societies show that widely varying degrees of cooperation exist now in the 22 states from which reports were received.

C. Cooperate with other interested groups to educate "duped" and "dated" doctors to improve their prescribing practices.

1. Perhaps "maverick" doctors should be added to the categories of "duped" and "dated" doctors. Mavericks know they are prescribing outside normal indications, but do so intentionally, claiming they do so for research purposes or because there are no adequate guidelines and standards.

2. AMA and the state medical societies are logical organizing points for this effort, in cooperation with other interested groups and government agencies.

D. Provide physicians with basic materials on prescribing practices, including material already published.

1. The forthcoming fifth edition of AMA Drug Evaluations will contain specific information on prescribing controlled substances.

2. Wider distribution of the AMA handbook, Drug Abuse, would be helpful, since it contains a chapter specifically dealing with prescription drug abuse.

3. The NIDA medical monograph, Commonly Prescribed and Abused Drugs, is an excellent resource.

4. Information on prescribing controlled drugs should be presented to practicing physicians and medical students within the context of overall education on prescribing.

5. AMA should assume NIDA's role (shortly to be curtailed by budget cuts) in working with the National Board of Medical Examiners to develop examination questions on the prescribing of controlled substances.

6. Self-assessment questionnaires in publications such as JAMA could sensitize physicians to deficiencies in their own prescribing practices.

7. Drug company detail men might be educated in the abuse potential of the drugs they sell.

8. Residency training programs can be a key to changing overall prescribing practices, as residents influence the actions of both medical students and attending physicians.

9. Practicing physicians can best be reached through established educational programs: hospital grand rounds, consultation with medical society committees, CME programs at medical society meetings, and articles in medical society and specialty journals.

E. Educate patients and the public on appropriate use of controlled drugs and the hazards of abusing these substances.

1. Public education may be best accomplished by educating physicians.

2. Some effort should be made to educate reporters for the popular media, which recently has escalated the magnitude of misinformation about prescription drugs.

3. It might be useful to compile a directory of experts on prescribing and prescription drug abuse and provide it to the media.

4. State medical societies and/or drug abuse agencies could identify and work with reporters who write regularly on medical or drug abuse topics. Regular backgrounding sessions could be used to educate these reporters.

5. Medical society auxiliaries could be useful in educating the public (it was noted that AMA Auxiliary staff recently developed an information package on drug abuse for use by auxiliaries; perhaps something similar could be done on responsible use of prescription drugs).

6. Community colleges might be encouraged to offer courses in pharmacology for the layman.

7. AMA might want to work with the National Center for Health Education on this issue.

F. Provide instruction and consultation to practicing physicians on the treatment of drug abuse and dependence.

1. The AMA Survey of State Medical Societies showed that 6 state societies have committees in place to provide this type of consultation.

2. Standards and guidelines are needed in this area.

3. The Career Teachers or AMERSA might be good groups to develop such standards.

4. Development of standards should involve input from hospital and nursing associations, as well as all of the organizations represented at the meeting.

5. States need to develop guidelines for drug abuse treatment under block grant programming, to replace the current federal guidelines.

III. Discussion of specific issues raised by the Council report

A. How can systems for identifying prescription drug abuse be best utilized and improved?

1. The most effective methods currently in use are the triplicate prescription systems and Medicaid drug utilization reviews.

2. Peer review systems probably would be the most acceptable and the most effective in deterring poor prescribers at an early stage.

3. State drug abuse agencies could coordinate all the information presently available (as from DAWN, ARCOS, treatment programs, etc.).

B. How can individual poor prescribers be identified and the nature of their poor prescribing practices be determined?

1. Voluntary methods would involve peer review by physicians and pharmacists, combined with monitoring by medical society committees.

2. Involuntary methods would rely on triplicate prescription systems and the use of pharmacy inspectors to detect problems.

3. Follow-up referral of "dated" and "duped" doctors to educational programs would be more constructive than punitive measures alone, although threatened loss of licensure or lawsuit can be a powerful motivator of change.

C. What kinds of approaches are most effective in dealing with the various types of poor prescribers?

1. Script doctors: Cooperative action by medical societies, pharmacists, pharmacy inspectors, enforcement agencies and licensing boards should be directed toward identifying these doctors and removing them from practice.

2. "Dated" and "duped" doctors: An effort should be made to detect these doctors earlier, before they face serious problems. An educational and monitoring system like that used in California (where courses in appropriate prescribing are required of physicians who have been identified by the state licensing board as poor prescribers) provides the incentive and the means for effecting change and is effective in rehabilitating these doctors.

D. What professional education approaches have been most effective in the past?

1. Haight-Ashbury Training and Education Projects has developed a course outline and syllabus for a two-day program on appropriate prescribing of controlled drugs.

2. Another approach is to reach physicians through grand rounds in hospitals. This requires developing a program and then offering it to hospitals through outreach efforts.

E. How can we best engage the cooperation of all interested groups?

1. Develop a group to provide liaison to all the health professions, similar to the working group formed by NIDA.

2. AMA is the logical organizing focus of such a group.

3. The organizations represented at this conference would be an excellent nucleus for such a group.

IV. Discussion of the concept of regional meetings

A. Organizing programs along regional lines presents problems.

1. Cost is an issue with almost everyone now.

2. A regional approach makes it difficult to recognize the differences in problems and legal liabilities in participating states.

3. Follow-through on regional meetings is difficult because there are no permanent organizations at the regional level to keep the effort going.

B. State meetings probably would be more effective.

1. All of the organizations that should be involved in such meetings are, or could be, active at the state level.

2. State meetings can more precisely reflect the types of problems found at the local level.

3. Costs of state programs can be held to more affordable levels.

4. State medical societies would be the most logical convenors of such meetings.

V. What should the "next steps" be?

A. The participants in the conference should constitute an informal steering committee and continue to meet as needed.

B. AMA staff will contact the 6 states identified through the Survey of State Medical Societies as having committees active in the area of prescription drug abuse.

1. These state societies will be encouraged to sponsor state meetings of interested organizations.

2. Members of the steering committee will encourage their counterparts in those states to participate in such meetings.

3. The focus of the first meeting in each state should be on diagnosing the nature and extent of the prescription drug abuse problem in that state.

4. AMA staff will compile a list of indicators of the problem that can be used at the state level.

5. Reports of the results of state meetings will be shared with the members of the steering committee and will be used to refine this approach.

6. After the first round of "diagnostic" meetings, the steering committee probably should meet again to consider the best direction for the second stage of this effort.

C. AMA staff will further refine the results of the Survey of State Medical Societies and share this information with committee members.

D. Members of the steering committee will share information that may be of interest to other members of the group.

1. A formal newsletter is not desirable at this time because of the time and costs involved.

2. Informal information-sharing is preferable. Committee members who have information to share with the group should send it to Bonnie Wilford at the AMA for copying and distribution to all participants in the Washington meeting.

3. Members of the committee are encouraged to further disseminate appropriate information through newsletters published by their organizations and other means of communication to which they have access.

E. Bonnie Wilford will send every participant in the conference a list of mailing addresses and telephone numbers for the committee members.

F. The agenda for the next meeting of the steering committee might include the nature and extent of the prescription drug abuse problem in the U.S., using data and measures supplied by members of the committee and gathered from outside sources.

# Survey of State Medical Societies on Prescription Drug Abuse

1. Which of the following types of activities are being planned (P) or have been implemented (I) by your association?

| P | I | |
|---|---|---|
| 7 | 10 | Cooperation with enforcement agencies in identifying and prosecuting "script doctors" -- those who prescribe controlled substances solely for profit, rather than for medical indications. |
| 2 | 16 | Cooperation with regulatory agencies (e.g., board of licensure, board of medical examiners) in evaluating or monitoring prescribing practices of physicians who either knowingly or unwittingly misprescribe controlled drugs. |
| 6 | 7 | Continuing education courses or symposia at scientific meetings on prescribing psychoactive drugs. |
| 2 | 12 | Cooperation with other professional associations (pharmacy, nursing, etc.) in programs aimed at prevention of prescription drug abuse. |
| 6 | 8 | Public information on the dangers of misusing or abusing prescription drugs. |
| 4 | 9 | Other activities |

2. Which drug or drugs do you believe constitute the most serious prescription abuse problem in your state?

| Number of mentions | Drug (with proprietary names cited, if any) |
|---|---|
| 9 | Methaqualone (Quaalude) |
| 8 | Amphetamines |
| 6 | Benzodiazepines (Valium, Librium, Dalmane, Tranxene) |
| 5 | Oxycodone (Percodan) |
| 3 | Codeine (singly or in compounds) |
| 2 | Hydromorphone (Dilaudid) |
| 2 | Meperidine (Demerol) |
| 2 | Pentazocine and pyribenzamine ("T's & Blues") |
| 2 | Propoxyphene (Darvon) |
| 1 | Barbiturates (Seconal, Nembutal) |
| 1 | Butalbital and APC (Fiorinal) |
| 1 | Methadone |
| 1 | Morphine |
| 1 | Nalbuphine hydrochloride (Nubain) |

3. Please indicate if this belief is based on any of the following information sources.

| Number of Mentions | Information Source |
|---|---|
| 13 | State or local enforcement or regulatory agencies |
| 8 | State drug abuse department or bureau |
| 5 | Stories in the public media |
| 3 | ARCOS |
| 2 | DAWN |
| 1 | Other (state pharmacy monitoring project) |

4. Does your association have a committee or sub-committee concerned with drug abuse?

Yes: 17

No: 7

5. If "yes," does this committee serve as an expert panel for physicians who seek consultation on the diagnosis and treatment of drug abuse and drug dependence?

Yes: 8

No: 9

6. If regional meetings were held on cooperative methods for reducing prescription drug abuse, would your association be interested in participating?

Yes: 17 Possibly: 4

No: 0 No response: 4

Medical societies reporting as of 11/30/81:

| | | | |
|---|---|---|---|
| Alabama | Kansas | Oklahoma | Texas |
| Arizona | Maryland | Oregon | Vermont |
| California | Nevada | Pennsylvania | Virginia |
| Colorado | New Jersey | Puerto Rico | Washington |
| Connecticut | New York | South Carolina | West Virginia |
| Illinois | North Dakota | South Dakota | Wyoming |
| Iowa | | | |

# AMA Newsletter

A Weekly Report from the Executive Vice President's Office

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Volume 15, Number 14
April 4, 1983



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AMA WILL FILE AN AMICUS BRIEF in a suit challenging new regulations on the treatment of severely handicapped newborns. The friend-of-the-court brief will be in support of a suit filed last month by the American Academy of Pediatrics and the National Assn. of Childrens' Hospitals. The suit seeks to block enforcement of rules requiring all hospital maternity wards, obstetrical wards, and nurseries to post notices warning that failure to feed and care for handicapped infants is prohibited by law.

> The notices encourage anyone who thinks an infant is being denied food or "customary medical care" to call a hot line at the Dept. of Health and Human Services, or to telephone the state's child protection agency.

"The purpose of a rule like this goes beyond the decision between physicians and families concerning a handicapped infant," said AMA Executive Vice President James H. Sammons, MD. "Once a government agency has interjected itself into the practice of one medical specialty, that kind of interference could be expanded to other specialties. Then each of us--physicians and patients--would have our decisions subjected to review by strangers making arbitrary and perhaps capricious judgments about our own life and death events," he said.

> The AMA will object to the unusually brief public comment period before the rules went into effect. The AMA also is opposed to a provision that allows HHS investigators to have 24-hour access to facilities if necessary to protect the life or health of a handicapped infant.

The HHS rule was developed in response to the death last year of a 6-day-old boy afflicted with Down's syndrome. "Baby Doe" died in Bloomington, Ind., after his parents requested that food and medical treatment be withheld.

AMA COMMISSIONERS TO THE JCAH have approved principles to be incorporated in future drafts of the medical staff chapter of the Accreditation Manual for Hospitals. After hearing from members, the AMA officials approved these principles:

- Replace the term "organized staff" with "medical staff" throughout the document.

- o Continue to delete references to dentists, podiatrists, oral surgeons, and other limited licensed practitioners in the medical staff chapter.

- o Ensure access to hospitals for limited license practitioners.

- o Require greater than a majority of fully licensed physician members on the medical staff executive committee in acute care general hospitals. Another principle provides exceptions for other types of hospitals.

- o Ensure that all hospitalized patients receive the same standard of care through appropriate language relating to admissions and the responsibility for medical care of patients.

Instead of sending specific language to the Joint Commission on the Accreditation of Hospitals board, the JCAH Standards-Survey Procedures Committee, with the AMA commissioners' support, voted to ask "JCAH staff, with professional assistance, including attorneys," to draft new language for review at the committee's July meeting.

> The revision of the medical staff standards has been under way since 1981. Three drafts have been circulated publicly for review. The AMA has commented on each draft in an effort to ensure high quality patient care.

THE COLLEGE OF AMERICAN PATHOLOGISTS announced that it intends to file suit in opposition to final regulations covering Medicare reimbursement for hospital-based physicians. The challenged federal rules, which were written to implement section 108 of the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982, would reclassify clinical pathology from a Part B to a Part A service for the purpose of Medicare reimbursement. Part A professional services are those that benefit a hospital's patients generally, while Part B medical services are those that a physician furnishes to individual patients.

> "The federal government has issued regulations that state, in essence, that pathologists' clinical services will cease to be regarded as part of the practice of medicine on May 31," when the rules are scheduled to go into effect, said CAP President James D. Barger, MD. "These regulations show that the government's primary concern is dollars and not the provision of quality patient care," he said.

CAP anticipates that the contested TEFRA regulations may encourage severe restructuring of contractual arrangements between hospitals and pathologists. Hospitals will seek new contracts with pathologists in order to lower costs, CAP sources said. State Medicaid programs and private insurers could follow Medicare's lead, they said.

The new definition of Part A services to a hospital, skilled nursing facility, or similar institution, would encompass virtually all clinical pathology activities. These services no longer would be billable to Part B Medicare. Instead, compensation to the pathologist for clinical pathology services would have to be obtained from the hospital.

The amount of compensation the hospital may claim for the physician's input is subject to maximum limitations called Reasonable Compensation Equivalents (RCEs). For a full-time pathologist who works in a metropolitan area of less than one million people and spends 55% of his time in Part A clinical pathology and 45% in Part B anatomic pathology, the RCE limit on Part A reimbursement to the hospital--assuming that all patients were on Medicare--would be $61,765.

A PROPOSED CONSTITUTIONAL AMENDMENT authorizing the federal and state governments to restrict or prohibit abortions was opposed by the AMA in comments to the Senate Subcommittee on the Constitution. The purpose of the proposal is to overturn the decision of the U.S. Supreme Court holding that a woman has a constitutional right to an abortion, the AMA said. If the amendment were adopted, "women could potentially be denied a necessary medical procedure," according to the comments. Abortion is a recognized medical procedure for ectopic pregnancy, incomplete spontaneous abortion (miscarriage), malignant embryo, cardiovascular conditions of the mother, and the use of prescription drugs by the mother that may have an adverse effect on the fetus, the statement said. "We are concerned with the possibility of improper governmental interference into medical practice by singling out a medical procedure for banning or restriction," the AMA told Sen. Orrin G. Hatch (R, Utah).

If enacted, the proposed amendment could establish a national policy that gives a fetus the legal status of a person. Under that policy, physicians would be faced with serious dilemmas in advising pregnant patients. "The physician would be responsible for the welfare of every fetus whose legal and health interest would be equal to, but may be in conflict with, those of the woman," the AMA said in its comments.

LOOK-ALIKE DRUGS POSE HEALTH RISKS to persons using them and have been linked to deaths across the country, the AMA said in comments submitted for a congressional hearing on imitation controlled substances. Look-alike drugs are manufactured to resemble such products as Fastin, Ionamin, and Biphetamine. These imitations typically contain a combination of caffeine, appetite suppressants, and nasal decongestants. Imitation Dilaudid and Quaalude usually contain one or more antihistamines that are found in cold tablets and sleep aids.

Because look-alikes are legal, manufacturers can solicit business through magazine advertisements. Dealers can order pills in quantities of 1,000 or more through the mail, and sell them on the street as controlled substances.

In comments to the Senate Subcommittee on Alcoholism and Drug Abuse, the AMA supported Senate bills 503 and 497. The bills would give federal authorities the necessary tools to deal effectively with the look-alike drug traffic. At the same time, the proposed legislation would not interfere with the legitimate use of placebos in research or by a practitioner.

PHARMACISTS AND DENTISTS HAVE JOINED PHYSICIANS in distributing the AMA's Patient Medication Instruction sheets. William Apple, PhD, president of the American Pharmaceutical Assn., urged pharmacists to distribute PMIs and to remind physicians to use them. The availability of PMI sheets has been advertised in pharmacy and dental journals since the program began last October. Hospital pharmacists, in particular, are considered prime targets for the AMA's PMI marketing campaign because they are in a position to distribute PMIs in hospitals. Oral surgeons, who are high prescribers, also are viewed as important to the success of the program.

GLENDA (MRS. JOHN G.) BATES WILL BE INSTALLED as 1983-84 AMA Auxiliary president June 22 at the Auxiliary's Annual Session, which will be held in conjunction with the AMA Annual Meeting in Chicago. Betty Payne (Torrence P. B.), 1982-83 president, will serve on the Auxiliary Board of Directors for the forthcoming year.

13,000 RANDOMLY SELECTED RESIDENTS and fellows will be asked to disclose information regarding their career choices, educational indebtedness, and working conditions in a questionnaire currently being distributed by the AMA Center for Health Policy Research. Results of the 1983 Survey of Resident Physicians are expected by late summer or early fall, center officials said.

The survey's 30 questions seek information on such items as the number of hospitals that students included on their National Resident Matching Program lists, their current annual residency salaries and fringe benefits, and the amounts they earn by moonlighting.

Residents are being asked about the number of hours they spend in training, research, or service functions during each week. The survey also addresses possible problem areas, such as communication with program directors or the amount of on-call duty.