DEER PARK WAR ON DRUGS COMMITTEE
Steve Glenn Sr. -- President
201 Ivy Street -- Deer Park, Texas 77536 -- (713) 479-2831 -- (713) 479-8246

10-13-83

Dr. Turner,

Although I am pleased to see the AMA recognize the dangers of marijuana, I am concerned that they lack conviction. Don't these people check with you or your people before they issue papers like these?

I have commented in the margins of this paper and would like your opinion since I am in the process of arranging a drug talk for doctors in Harris County, Texas.

I am sincerely grateful to you for all of your efforts. When one is out on the firing line making speeches about drug abuse, it is nice to be supported by research like yours.

Sincerely,

Steve Glenn Sr.

Steve Glenn Sr.

AMA NEWS FEATURES

FOR IMMEDIATE RELEASE

For further information contact:
Frank Chappell
Office: 312/751-6606
Home: 312/644-2426

MARIJUANA IS TERMED
A DANGEROUS DRUG

CHICAGO -- Marijuana is now the third most frequently used drug in the United States, after alcohol and cigarettes.

Two-thirds of young adults say they use marijuana.

So what? Marijuana doesn't really hurt you, does it?

Wrong. Marijuana can (does!) hurt you. There is now no doubt at all that marijuana is a dangerous drug, with great potential for serious harm to young American users. (why just young amer. users?)

Studies point to a growing body of evidence from both animal and human experiments and from the observations of physicians coping with its effects on behavior, performance and functioning of various organ systems that marijuana is by no means the harmless amusement that many believe it to be.

Despite the increase in use of marijuana in the United States, a majority of persons in all age groups continue to disapprove of regular use and to advocate its continued prohibition, says the American Medical Association's DRUG ABUSE, the handbook for physicians on the problem.

(MORE)

Street marijuana has increased markedly in potency over the past five years, the AMA points out. Prior to 1975 it rarely exceeded one percent of THC, the active ingredient. In 1979, concentrations of 5 percent were not uncommon. Hash oil, a marijuana extract that was unavailable less than 10 years ago, has a THC content of 15 percent to 20 percent. Street grades of hashish have THC concentrations of around 10 percent.

Also, the AMA says, the practice of combining marijuana and alcohol use is becoming more common, and poses a hazard of more widespread and severe reactions to the combined effects of the drugs.

Cannabis (marijuana) is obtained from the flowering tops, leaves and stems of the hemp plant, found throughout most of the tropic and temperate zones of the world.

Marijuana and hashish are the principal drug-type products of the hemp plant.

Marijuana is composed of the cut and dried stems, leaves and tops of the hemp plant. It usually is rolled in paper and smoked like a tobacco cigarette.

Is this still true?

Most marijuana grown in the United States is considered inferior because it contains a low concentration of THC. Jamaican, Colombian and Mexican varieties contain much more. Most potent varieties come from Thai, Nepalese and Indian stock.

Hashish is a concentrated preparation of the secretions of the hemp plant, which are collected, dried and compressed into balls, cakes or cookie-like sheets. It is stronger than marijuana.

(MORE)

Marijuana use often begins at a much earlier age than it did in 1970, and is more likely to be frequent rather than occasional experimental use. Most older adolescents and young adults have had some experience with marijuana, the AMA book reports.

Recent research shows that cannabinoids contain psychoactive substances of high potency and rapid onset. Marijuana affects the brain, circulatory system, heart, lungs and nervous system.

Repro. System

Target organ for marijuana is the brain. Structural changes occur in the brain with marijuana use, as well as changes in the patterns of brain waves. Acute marijuana intoxication impairs learning, memory, thinking, comprehension and general intellectual performance. Even at moderate levels of social use, driving skills are impaired

Shouldn't there be more about dangers due to reduction in reaction time? Endorphins?

Marijuana smoke contains larger amounts of cancer-causing hydrocarbons than tobacco smoke. With daily use, lung damage can appear in three months. Bronchitis and emphysema are common in regular users.

The most marked effect on the heart and circulatory system is an increase in heart rate. Heart action of up to 140 beats per minute is not uncommon under marijuana influence.

Chronic use of marijuana may be associated with disruption of the menstrual cycle and at least temporary infertility. Miscarriage is more common among users. Among lab animals, sperm abnormalities have been noted, along with damage to the male reproductive organs.

Has this ever been seen with human o??

Many physicians experienced in treating drug abusers believe that regular marijuana may seriously interfere with

(MORE)

psychological functioning, personality development, and emotional growth and learning, especially in childhood and adolescence. The psychological damage may be permanent. Large doses of THC can induce hallucinations, delusions and paranoid feelings. Thinking becomes confused and disoriented. The initial euphoria may give way to anxiety reaching panic proportions.

Even moderate use is associated with school drop-outs, psychoses, panic states and adolescent behavior disorders.

Why use marijuana?

Users report a feeling of euphoria and well being, feelings of relaxation and heightened sexual arousal vivid visual imagery and a keen sense of hearing. Senses of taste, touch and smell may be enhanced. Time seems to pass more slowly.

These effects usually are not achieved with the first try. With continued use, the user learns to get a high.

Several genuine therapeutic uses have been suggested for THC. These include treatment of asthma, glaucoma and nausea arising from drug treatment of cancer patients. For the latter use it has been proved helpful. In glaucoma, THC has been of some help, largely when used in combination with other drugs. Medical use of marijuana in clinical research is now authorized in more than 20 states.

I think this may lead some Dr's to advocate its use for cancer patients.

The American Medical Association is clearly on record as opposing legalization of marijuana for recreational use.

"Legislators should keep in mind the primary need to give young people a clear message that marijuana use may be hazardous and is not sanctioned or endorsed by society.

(MORE)

Fines, although more appropriate penalties than prison sentence when applied to possession for personal use, should be large enough to constitute a deterrent to use," the AMA has declared.

#

July 24, 1981

← distributed at a recent meeting Oct-1983. Still this position

THE WHITE HOUSE

Office of the Press Secretary
(Chicago, Illinois)

For Immediate Release June 23, 1983

REMARKS OF THE PRESIDENT
TO THE ANNUAL MEETING OF THE
AMERICAN MEDICAL ASSOCIATION
HOUSE OF DELEGATES

Grand Ballroom
Chicago Marriott Hotel
Chicago, Illinois

11:27 A.M. CDT

THE PRESIDENT: Thank you. (Applause.) Thank you very much for a very warm welcome. Thank you for inviting me today and I know Nancy would want me to thank you for your donation to the National Federation of Parents for Drug-Free Youth.

I'm delighted to address this annual meeting of the AMA House of Delegates and I want to congratulate Dr. Jirka and Dr. Boyle on their new positions. (Applause.) I can't help but think that -- what a great place this would be and what a great moment to have a low back pain. (Laughter.) But I left him in Washington. (Laughter. Applause.)

One thing I've always liked about doctors is that you generate lots of anecdotes which is very good for -- (laughter) -- very good for those of us who have to travel the mash potato circuit like the one about the fellow who went to the hospital for a complete check-up, very depressed, and said to the doctor, "I look in the mirror, I'm a mess. My jowls are sagging. I have blotches all over my face. My hair has fallen out. I feel ugly. What is it?" And the doctor said, "I don't know what it is, but your eyesight is perfect." (Laughter.)

Today I'd like to take a clear-eye look at our health care system and let me start by saying as strongly as I can the quality of American medicine is unsurpassed and on that we don't need a second opinion. (Applause.) What our space shuttle is to technology, our health care is to medicine. In life-saving discoveries, in innovative treatment, in the overall quality of services, America's doctors have no peers. Your medical accomplishments are a gift to mankind that honors us all. And I have a special appreciation for the skill of some Washington doctors and nurses who patched up an inner tube for me and had me back on the road very early and in quick time. (Applause.) My respect for your profession is deep and personal. Let me add here that Judy Buckalew, who recently joined my staff as a special assistant, is the first registered nurse to serve in such a capacity. Her duties aren't medical, although with what's going on in Congress, Judy, it might be a good idea if you carry smelling salts. (Laughter.)

A moment ago, I mentioned the space shuttle which, as you know, is scheduled to land tomorrow, weather permitting. And now it's beginning to look

as if weather isn't going to permit. But medicine, as well, is becoming high tech, increasingly so, in some instances, high bio. Through computers, lasers, nuclear devices and various Star Wars technologies, your diagnostic and healing powers have multiplied over the last decade.

We're going to make sure that trend continues by promoting solid math and science skills in our schools. We'll also further that trend with an active federal role in quality research.

I believe the Orphan Drug Act that I signed in January eventually will add to your curing powers. As you know, the sad fact is that many diseases still cripple or kill hundreds of thousands of Americans because no drugs have yet been developed. Statistically, they are rare diseases. Yet, that's small comfort for those afflicted and their families. The cost of discovering and developing a new drug, of course, is often staggering. This legislation provides incentives for the private sector to develop drugs to treat these rare diseases. And I'm proud to say the FDA under this administration has proposed new initiatives to help streamline the drug approval process. We want a process that genuinely promotes the public health, not only by keeping unsafe and ineffective drugs off the market, but by enabling beneficial new drugs to reach those who need them more rapidly. We recognize full well that if the burdens of excessive regulation are lifted, the American medical community can do an even better job in protecting the health of the American people.

While the quality of health care in this nation is unsurpassed, unfortunately, so are the costs. In fact, many patients believe that a hospital should have the recovery room adjoining the cashier's office. (Laughter.)

I know cost is a matter that concerns you as well. The AMA deserves congratulations for its cost-effectiveness programs and its health-policy agenda. And, as I did at the White House in April, let me again thank those medical societies that have private sector programs to assure cost will not prevent anyone from receiving medical care. (Applause.) The problem of health care costs is so pressing you can't carry that full burden alone.

For the last 12 month period, health care costs went up almost two-and-a-half times the overall inflation rate. In 1982, the cost of health insurance rose nearly 16 percent. Health care costs are consuming a growing portion of the nation's wealth and this is wealth that cannot be spent on education, housing, or other social needs.

Health care costs are not just the concern of the sick in our society. Everyone is affected. The taxpayer picks up the tab for 40 percent of all hospital bills, mainly through Medicaid and Medicare. Because of rising costs, the poor on Medicaid have seen their coverage reduced as states make cutbacks. Because of the increased cost of health insurance, employees have received lower cash wages. Consumers have paid higher prices for goods and services

since the costs of employee health benefits must be included in the price of products. And the elderly who are covered by Medicare face the threat of catastrophic illness expense, against which Medicare offers no protection.

It's high time that we put health care costs under the knife, and cut away the waste and inefficiency. The growth in medical costs is malignant, and must be removed for the continued health of the American people.

The danger is that high medical inflation may soon jeopardize the quality and access of our health care. And America won't be able to sustain its unequalled health care system if citizens can't afford it. Not all Americans have the fancy, gold-plated, all-option insurance plans that cover every sneeze and itch. Yes, the big corporations can look after their people. But let's not forget that little guy down at the donut shop.

Don't get me wrong. It's not bad to spend money on health care, far from it. The nation's high level of health expenditures is testimony to our people's compassion. We can't and we will not scrimp on the health of America's citizens. But on the subject of compassion, let me clear something up. Inspite of all the stories you hear on television -- and I would turn flips down the halls of the White House if this next statement made the evening news. (Laughter.) The truth is that this administration, in 1984, will devote more moeny to health care than any administration in history. (Applause.) That probably surprises you. But 49 million elderly, poor and disabled persons -- one out of every five Americans -- will have health care needs met through Medicare and Medicaid in 1984. That's a million more than this year and three million more than in 1980.

With this kind of solid record, you can understand why I get a little irritated by those who say that we're cutting health care. The critics remind me of the hypochondriac who was complaining to the doctor. He said, "my left arm hurts me and, also, my left foot and my back -- oh, and there's my hip and -- oh, yes, my neck." And the doctor muttered something to himself and, then, sat him down and crossed his legs and tapped him with the little rubber hammer. He says, "how are you now?" And the patient said, "well, now my knee hurts, too." (Laughter.)

Many of our critics are simply political hypochondriacs. (Applause.) They're complaining about every little ache. I've, also, read those know-nothing stories about this administration ignoring childhood diseases. Well, let me just tell you that in the last two years, the reported cases of diphtheria, measles, mumps, polio, rubella and tetanus, as I'm sure many of you know, have reached all-time lows. The measles rate is down by nearly half over '81. The problem is that Washington is full of special interest groups passing around

self-serving studies that are, then, reported as fact. They serve up headlines. But too many of them don't serve up the truth. (Applause.)

In understand why doctors are torn by our attempts to put the brakes on the budget. Like most citizens, you want to slow the growth in federal spending. Yet, at the same time, professionally, you worry about this braking action and that it may affect our health care, especially the health care of the poor. Well, let me reassure you. We're not trying to limit the quality and access of America's health care. We're trying to save it. We want a health care system that is affordable and fair to all Americans. There are some who, no matter what the problem is, think money is the answer. If you told them that you had walking pneumonia, they'd give you five bucks and tell you to take a cab. (Laughter.) And if they're not proposing more money, they're proposing more government controls over the practice of medicine. (Applause.)

Back in 1847, a group of 250 physicians convened in Philadelphia to establish this American Medical Association. Well, I'm going to tell you what I told them. (Laughter.) (Applause.) We have the best health care in the world, because it has remained private. And, working together, we'll keep it that way. (Applause.) The government plays a role, of course. I believe Medicare and Medicaid have filled genuine needs in our society. But our federal health care system was designed backward. The incentives have not been to save, but to spend. Medicare and Medicaid costs have gone up nearly 600 percent since 1970. For too long the federal government has had a blank check mentality. The hospital simply filled in the amount they wanted. And then, Uncle Sam or -- to be more precise -- the hard-pressed American taxpayer paid the bill.

Today, for example, Medicare payments for treating a heart attack can average $1,500 at one hospital and $9,000 at another with no apparent difference in quality. Likewise, Medicare payments for hip replacements can vary from $2,100 to $8,200. And payments for cataract removal can vary from $450 to $2,800.

One of our reform measures to control hospital costs has already been passed. No longer will we pay virtually whatever the hospital asks. With our Prospective Payment Program, we'll pay one, fair rate. And the hospital that delivers its services at a cost less than that rate can keep the difference. In the past, the government actually subsidized and encouraged inefficiency by paying more to the inefficient hospital than to the efficient one.

Medicare cost sharing is often seen backward as well.

Under current law, unbelievable as it seems, Medicare hospital coverage can actually expire in the event of catastrophic illness -- just when it's needed most. And even when the coverage has not expired, those in a hospital with stays for 60 days must make every high out-of-pocket payment. In contrast, those with shorter hospital stays pay nothing out-of-pocket after the first day. It's cheaper for the patient to be at the hospital than at home.

We're trying to make coverage fairer by using moderate cost-sharing early in an illness, rather than imposing severe costs later when the patient has little choice over the length of the hospital stay.

Under current law, the average patient hospitalized in 1984 for 150 consecutive days would owe $13,475 from his or her pocket, and then bear the total cost of all subsequent hospital care. Under our plan, the patient would owe only $1,530 with absolutely no cost for subsequent hospital care.

The co-payments proposed for Medicaid are nominal -- $1 to $2 a day -- and intended only to discourage the unnecessary use of services. We also propose limiting the current tax subsidy for high-priced health plans. Most employer contributions for employee health benefits should be tax free because this encourages employee health insurance. Our plan would simply cap this tax-free treatment in order to correct the bias toward high-priced first dollar coverage. Health insurance should cover hepatitus and whooping cough, not hiccups. The proposed -- (Applause.)

The proposed cap is an effort to make the tax law neutral in the choice between added wages and added health benefits. The Bible tells us that in creating the universe God made order out of chaos. Well at times I think even the Almighty would have His hands full making order out of the regulatory tangles that afflict our health care system. (Applause.)

But our reforms are a conscientious start. Some of these reforms, such as prospective pricing, catastrophic coverage, and capping tax-free health insurance, many of you either support or remain flexible. And I want to thank you for these positions. I realize that other of our reforms, such as Medicare vouchers or competitive bidding, many of you don't support.

Well, I'd like to explain an additional proposal you don't support -- the 1-year freeze on Medicare physician reimbursement. These payments have been increasing at highly inflationary rates. In 1982 they increased 21 percent and are expected to rise 19 percent more in 1983. We believe physicians, too, must share the burden of slowing the rise in health care costs.

As the patient in the movie often says, "Give it to me straight, Doc." Well, we believe the straight answer is that a 1-year freeze is

painful but necessary medicine. In spite of occasional differences of opinion, our goals are the same as the AMA's. As written in your Constitution more than a century ago, the purpose of the AMA is to promote the science and art of medicine and the betterment of public health. Well, we, too, are looking for ways to improve the health of the American people and we need your support and your ideas.

I want to insert something here. I want to applaud the efforts by the AMA to become more involved in the public debate regarding environmental health risks. Yesterday, in a speech before the National Academy of Sciences, EPA Administrator William Ruckelshaus urged the scientific community to take an active role to help clear up confusion over the health dangers of chemicals. Your resolution on dioxin contamination is a positive step to a more reasonable public discussion of these important issues. And I commend you and thank you for it. (Applause.)

I think sometimes we want health and we don't want public hazards, dangers to our people, wherever they may be, but a very imminent scientist once said that he questioned whether there were any dangerous or harmless substances. He said there were only dangerous or harmless amounts. And I think that sometimes we have, with the fantastic and the dramatic, melodramatic treatment of some of these things, we have frightened a great many people unnecessarily. And the answer is not to take risks, not at all, but to make sure also that we haven't frightened people unless there is truly a reason for them to be frightened. (Applause.)

Before I go, let me briefly mention an issue important to you both as citizens and as doctors. Last week I sent another message to -- or a message to another group of doctors who were gathered in an international conference in Holland. They were not meeting on heart disease or nerve disorders. They were meeting on the matter of preventing nuclear war. And I told them that we have an unprecedented opportunity to reduce nuclear arsenals. Very serious negotiations are proceeding in Geneva between the United States and the Soviet Union on the means of achieving substantial, equitable and verifiable reductions in our nuclear arsenals and on building the mutual confidence necessary to reduce the risks of nuclear war. No task has greater significance for us, our allies and for the entire world than to work for the success of the Geneva negotiations and reverse the growth in nuclear arsenals. (Applause.)

We've been making a great effort to move these negotiations forward. Just two weeks ago, I announced that our negotiator, Ambassador Ed Rowny, would be going to Geneva with new instructions to give us greater flexibility in the talks and to take account of concerns the Soviets have expressed to us. I told the doctors meeting in Holland, those negotiations deserve the full support of all who seek genuine progress toward peace.

That was my message to the international group of physicians -- to reaffirm that nuclear war cannot be won and must never be fought. (Applause.) I invited their support for the important arms reduction negotiations underway in Geneva. And today I invite your support as well so that we can make real progress toward the genuine peace that we all seek for ourselves and for our children. (Applause.)

Charles Kettering once said that the greatest thing any generation can do is to lay a few stepping stones for the next generation. And that's what we're trying to do. We want to lay stepping stones to better health care and a more secure peace for America. And with your help we can do it. Thank you and God bless you all.

END 11:49 A.M. CDT

January 28, 1983

Dear Carlton,

My thanks to you for a delightful breakfast this morning. It was a special treat for me to be invited to the White House Mess and to dine with such fine company.

I am confidant that a print

SDc

AMERICAN MEDICAL ASSOCIATION

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DIVISION OF PERSONAL AND PUBLIC HEALTH POLICY

HEALTH AND HUMAN BEHAVIOR PROGRAM

EMANUEL M. STEINDLER, M.S.
Director 751-6577
SUELLEN MULDOON 751-6268
BONNIE B. WILFORD 751-6579
JANICE J. ROBERTSON 751-6574

March 4, 1983

Mrs. Sue H. Daoulas
Drug Abuse Policy Office
The White House
Old Executive Office Building
Washington, D.C. 20500

Dear Sue:

When we met in Chicago last week, Carlton was kind enough to give my husband the enclosed photograph of the President and Mrs. Reagan meeting with the President of Lions International and Mrs. Grindstaff.

Carlton further suggested that you might be able to have the photo autographed. This possibility delighted my husband, as Dave is a member of one of the leading Lions Clubs in Illinois.

Once again, your kind assistance is very much appreciated.

Sincerely,

Bonnie

Bonnie B. Wilford
Assistant Director

BBW/amo
Enclosure

Pic sent for sig. 3/7 SD

mailed 3/14 SD

AMA NEWS February 25, 1983

Plan launched to stem prescription drug abuse

Physicians who push pills — watch out. The American Medical Association and 19 other organizations have a new plan to shut you down.

The new computerized system sponsored by the groups also will spot physicians who funnel prescription drugs to abusers because they are duped, emotionally impaired, or out of touch with modern drug therapy.

Several systems already exist to find dishonest and other problem physicians, but the Prescription Abuse Data Synthesis (PADS) model meshes the fragmented methods to make a tighter net.

The PADS system reflects cooperation among members of its sponsoring group, the Informal Steering Committee on Prescription Drug Abuse. This organization, founded by the AMA late in 1981, has brought together prescribers, dispensers, regulatory agencies, and law enforcement officials to work on several possible projects.

At its last meeting in mid-February, the group approved a near-final draft of PADS, which it hopes to test in possibly three states in the spring. From there, state medical societies will be asked to analyze the program and to encourage state agencies to participate. Nationwide use of PADS will depend on states' acceptance and finding funds from several groups so that the steering committee can promote and teach PADS. So far the AMA is the only group to support PADS financially.

Although groups such as the steering committee have popped up for years, participants and even the federal General Accounting Office (GAO) are encouraged about this group's prospects of success. Committee Chairman Joseph Skom, MD, (of the AMA's Council on Scientific Affairs and other AMA groups) said that in the past there had been "almost an adversary relationship between enforcement and the medical profession."

Accusations were more plentiful than

(See Prescription . . . , page 7)

Prescription drug abuse is target of new program

(Continued from page 1)

cooperation as groups worked alone on the prescription drug abuse problem and accused others of not helping to solve it. A White House conference in 1980 produced several good recommendations on cooperation, Dr. Skom said, but a change in administrations squashed any implementation.

Urged on by a House of Delegates policy adopted in June, 1981, the AMA formed the steering committee. Member Barry Rhodes of Odyssey Inc., a drug rehabilitation group, said: "The thing that is really important to me is the effort the AMA put into this when there was momentum built up at the White House conference but no follow-up on the national level. Without the AMA's guidance, this effort would have fallen flat."

A GAO report also cited the AMA's efforts as "steps in the right direction . . . The AMA is to be commended for its initiatives."

Several states such as Wisconsin, Illinois, Arizona, and New Hampshire already have accomplished some form of interagency cooperation to spot and stop prescription drug abuse, said David Joranson of Wisconsin's Office of Alcohol and Other Drug Abuse. The GAO report also mentioned some areas in Florida.

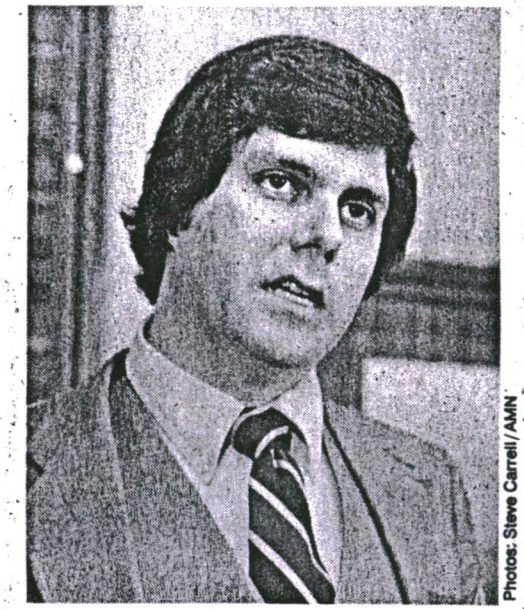
Some statistical systems used in such cooperative efforts have been around for more than 15 years. Groups finally started combining systems successfully in the last five years for several reasons, said Rhodes, who formerly headed New Hampshire's drug abuse office. Instead of looking at the problem as a monolithic monster, people began to realize it was made of smaller pieces, such as several classes of physicians who divert drugs. They also realized one type of physician might need education, while another might need license revocation.

Small successes integrating statistical systems encouraged further exploration. "No one was born using these data systems. It is done through trial, error, and activity," Rhodes added.

PADS developers hope to help states avoid errors by showing them how to handle up to about 12 different sets of statistics. Massaging these facts can take officials all the way from asking, "Do we have any problems in our state?" to identification of individual practitioners.

After officials identify how their state's usage patterns, arrests, or other statistics differ from others, more intensive analysis of PADS data can spot regions where diversion may be high. At this point traditional investigative techniques may take over. Since statistics may be able to pinpoint a problem region down to the first three digits on a ZIP code, investigators then can move in to inspect a relatively small number of pharmacies. They generally are looking at sales of only one or two drugs so officials can sift records quickly and spot individual physicians or pharmacists who may be diverting drugs, Rhodes said.

ONCE OFFICIALS spot a problem practitioner, several actions can be taken. Arrest is a possibility for the small number of all physicians who are intentionally dishonest. Sometimes quicker action is available by restricting or removing a license. In other instances, especially where physicians are unintentionally dishonest, the threat of losing the license is enough to motivate them to reform their prescribing habits.



Photos: Steve Carrell/AMN

In the past, almost an adversary relationship existed between enforcement and the medical profession, said Joseph Skom, MD (left). Barry Rhodes pointed to the importance of AMA efforts in getting the new program moving.

. After action is taken, PADS data also can monitor the effectiveness of those efforts.

No single computer program is necessary to crunch all the data together, Rhodes said, because just looking at several print-outs makes problem areas obvious.

Some of the data systems PADS can incorporate include:

- Automated Reports and Consolidated Orders System (ARCOS), which records retail sales of narcotics and other drugs by dispensers. A PADS resource document states ARCOS is well-managed information, but it cannot be used alone to determine if diversion exists. The report is produced quarterly.
- Drug Abuse Warning Network (DAWN), which includes information on reimbursements for prescribed substances. It provides "the only national information system capable of a reasonable scientific measurement of demand-side levels of prescription drug abuse," the PADS document said, but its coverage is too limited.
- Drug abuse treatment program admissions. These data can provide "a useful source of ongoing trend information," the report stated, but "this information is not routinely or uniformly available from all drug treatment programs."

The cooperation and data available in each state will help determine which combinations will yield more and better information.

—Steve Carrell

Crossing many organizational lines

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February 28, 1983

TO: Members of the Informal Steering Committee on Prescription Drug Abuse

FROM: Bonnie B. Wilford BBW

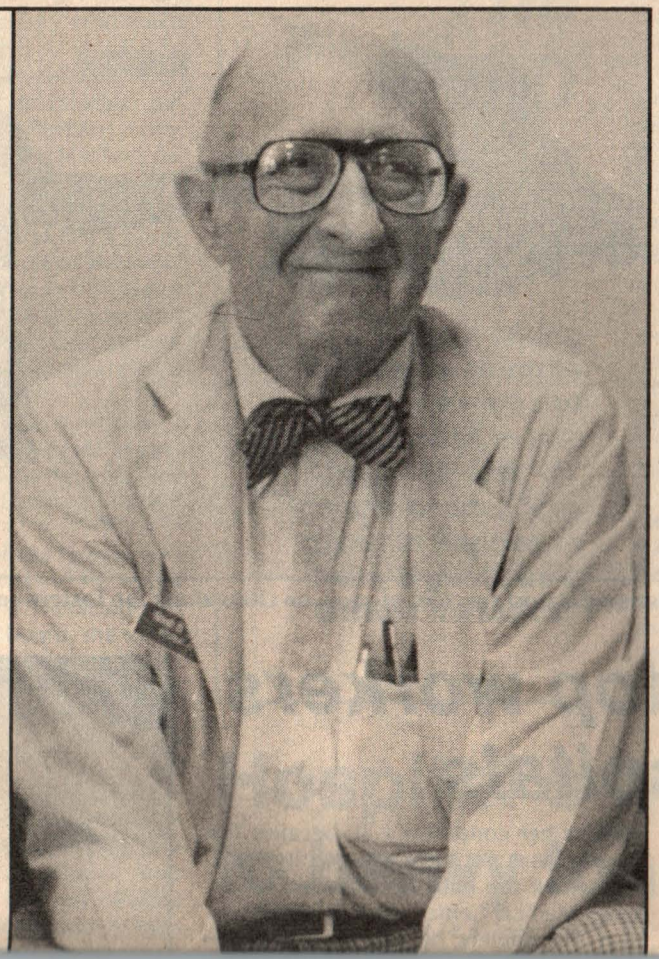
SUBJECT: Information-Sharing: Eighth Mailing - Part 1

The February 25th edition of American Medical News contains two articles about the activities of the Steering Committee (pages 1 and 17) that I wanted to share with you as quickly as possible.

In the second part of this mailing, I will send you notes of the Committee's most recent meeting and additional items for your information-sharing files.

BBW/amo
Enclosure

American Medical
NEWS
FEBRUARY 25, 1983



New California PPOs producing tumult among physicians

"Physicians are frantic," says Thomas C. Paton, president of Blue Shield of California. "They're more nervous than I've ever seen them," adds Paton, who has headed the insurer for the past 16 years.

"They're feeling threatened that their style of living will be diminished. I can't say I blame them for being worried. We're going through a really tumultuous time now."

The Blue Shield chief executive officer is discussing physicians' reactions to the rapid proliferation of preferred provider organizations (PPOs) throughout California. In recent months, most California physicians have been recruited by several PPOs, asking the MDs whether they're interested in joining a panel of so-called "preferred providers" who agree to provide services to patients at an agreed upon fee-for-service rate, often discounted from their usual charge.

Providers who join a PPO also must agree to abide by the PPO's utilization review program and to accept the reimbursement

providers but is given an economic incentive (often first-dollar coverage) to use member providers. Patients who select providers outside the panel usually are responsible for a co-payment of at least 20%.

Over the past six months, at least 30 PPOs have been established throughout the state. The majority have been founded by hospitals and by entrepreneurs hoping to act as intermediaries between payers and patients. Their rapid growth stems in part from legislation approved last year allowing private insurance carriers to contract with hospitals and physicians at discounted rates and to offer subscribers economic incentives to use these providers. The legislation also says that, beginning July 1, insurers may contract with so-called exclusive provider organizations (EPOs), which would operate similarly to a PPO but which would not reimburse patients who choose providers outside the group. The legislation was backed by Blue Cross and commercial

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This is not a presidential record. This marker is used as an administrative marker by the Ronald W. Reagan Presidential Library Staff. This marker identifies that there was an object in this folder that could not be scanned due to its size.

AMA NEWS February 25, 1983

Plan launched to stem prescription drug abuse

Physicians who push pills — watch out. The American Medical Association and 19 other organizations have a new plan to shut you down.

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Several systems already exist to find dishonest and other problem physicians, but the Prescription Abuse Data Synthesis (PADS) model meshes the fragmented methods to make a tighter net.

The PADS system reflects cooperation among members of its sponsoring group, the Informal Steering Committee on Prescription Drug Abuse. This organization, founded by the AMA late in 1981, has brought together prescribers, dispensers, regulatory agencies, and law enforcement officials to work on several possible projects.

At its last meeting in mid-February, the group approved a near-final draft of PADS, which it hopes to test in possibly three states in the spring. From there, state medical societies will be asked to analyze the program and to encourage state agencies to participate. Nationwide use of PADS will depend on states' acceptance and finding funds from several groups so that the steering committee can promote and teach PADS. So far the AMA is the only group to support PADS financially.

Although groups such as the steering committee have popped up for years, participants and even the federal General Accounting Office (GAO) are encouraged about this group's prospects of success. Committee Chairman Joseph Skom, MD, (of the AMA's Council on Scientific Affairs and other AMA groups) said that in the past there had been "almost an adversary relationship between enforcement and the medical profession."

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(See Prescription . . . , page 7)

Prescription drug abuse is target of new program

(Continued from page 1)

cooperation as groups worked alone on the prescription drug abuse problem and accused others of not helping to solve it. A White House conference in 1980 produced several good recommendations on cooperation, Dr. Skom said, but a change in administrations squashed any implementation.

Urged on by a House of Delegates policy adopted in June, 1981, the AMA formed the steering committee. Member Barry Rhodes of Odyssey Inc., a drug rehabilitation group, said: "The thing that is really important to me is the effort the AMA put into this when there was momentum built up at the White House conference but no follow-up on the national level. Without the AMA's guidance, this effort would have fallen flat."

A GAO report also cited the AMA's efforts as "steps in the right direction . . . The AMA is to be commended for its initiatives."

Several states such as Wisconsin, Illinois, Arizona, and New Hampshire already have accomplished some form of interagency cooperation to spot and stop prescription drug abuse, said David Joranson of Wisconsin's Office of Alcohol and Other Drug Abuse. The GAO report also mentioned some areas in Florida.

Some statistical systems used in such cooperative efforts have been around for more than 15 years. Groups finally started combining systems successfully in the last five years for several reasons, said Rhodes, who formerly headed New Hampshire's drug abuse office. Instead of looking at the problem as a monolithic monster, people began to realize it was made of smaller pieces, such as several classes of physicians who divert drugs. They also realized one type of physician might need education, while another might need license revocation.

Small successes integrating statistical systems encouraged further exploration. "No one was born using these data systems. It is done through trial, error, and activity," Rhodes added.

PADS developers hope to help states avoid errors by showing them how to handle up to about 12 different sets of statistics. Massaging these facts can take officials all the way from asking, "Do we have any problems in our state?" to identification of individual practitioners.

After officials identify how their state's usage patterns, arrests, or other statistics differ from others, more intensive analysis of PADS data can spot regions where diversion may be high. At this point traditional investigative techniques may take over. Since statistics may be able to pinpoint a problem region down to the first three digits on a ZIP code, investigators then can move in to inspect a relatively small number of pharmacies. They generally are looking at sales of only one or two drugs so officials can sift records quickly and spot individual physicians or pharmacists who may be diverting drugs, Rhodes said.

ONCE OFFICIALS spot a problem practitioner, several actions can be taken. Arrest is a possibility for the small number of all physicians who are intentionally dishonest. Sometimes quicker action is available by restricting or removing a license. In other instances, especially where physicians are unintentionally dishonest, the threat of losing the license is enough to motivate them to reform their prescribing habits.

Photos: Steve Carrell/AMN

In the past, almost an adversary relationship existed between enforcement and the medical profession, said Joseph Skom, MD (left). Barry Rhodes pointed to the importance of AMA efforts in getting the new program moving.

After action is taken, PADS data also can monitor the effectiveness of those efforts.

No single computer program is necessary to crunch all the data together, Rhodes said, because just looking at several print-outs makes problem areas obvious.

Some of the data systems PADS can incorporate include:

- Automated Reports and Consolidated Orders System (ARCOS), which records retail sales of narcotics and other drugs by dispensers. A PADS resource document states ARCOS is well-managed information, but it cannot be used alone to determine if diversion exists. The report is produced quarterly.
- Drug Abuse Warning Network (DAWN), which includes information on reimbursements for prescribed substances. It provides "the only national information system capable of a reasonable scientific measurement of demand-side levels of prescription drug abuse," the PADS document said, but its coverage is too limited.
- Drug abuse treatment program admissions. These data can provide "a useful source of ongoing trend information," the report stated, but "this information is not routinely or uniformly available from all drug treatment programs."

The cooperation and data available in each state will help determine which combinations will yield more and better information.

—Steve Carrell

Crossing many organizational lines

AMA NEWS February 25, 1983

Plan launched to stem prescription drug abuse

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AMERICAN MEDICAL ASSOCIATION NEWS
March 4, 1983

Alcohol tied to home injuries

Accidents and injuries at home, burnings, falls, drownings, and other non-highway injuries often involve excessive alcohol consumption, according to the U.S. Centers for Disease Control (CDC).

Citing accident and injury studies in Washington, California, Massachusetts, Maryland, and New York, the CDC report concluded that the role of alcohol abuse is as important in non-highway accidents as it is in highway accidents.

THE CDC URGED emergency-room physicians and others to consider testing injured people for evidence of alcohol consumption, both to ensure proper medical treatment and to determine the need for treatment of alcoholism.

The CDC report cited:

- A study in Washington state that found alcohol use associated with 10% of all fall injuries reported in a large hospital emergency room, and 22% among those who had sought treatment for more than one fall during one year.
- A California study found high blood alcohol concentrations in 37% of those who died from non-highway injuries; among those persons who died from burns, 60% had high blood-alcohol concentrations.
- A Baltimore study found high alcohol levels in 47% of all drowning victims in three years.
- A New York City report saying that 41% of fatal fall victims, 46% of fatal fire victims, and 53% of drowning victims in two years were found to have high blood-alcohol concentrations.

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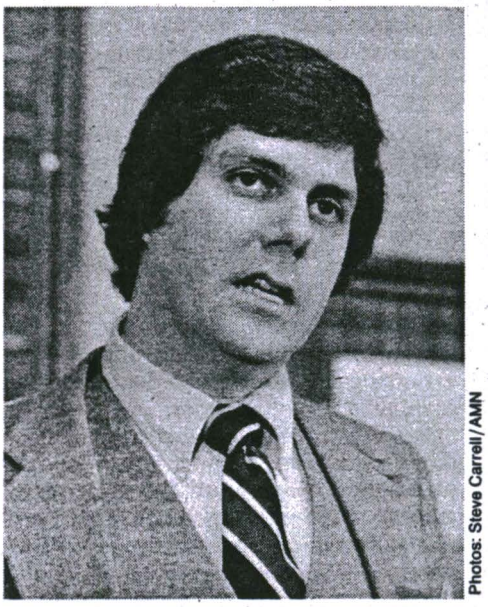

Photos: Steve Carrell/AMN

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