ASAM NEWS

American Society of Addiction Medicine

Vol. V, No. 6 **November - December 1990** Published Bimonthly

AMA Designates Addiction Medicine Code:

ADM

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Inside

ASAM Sets Sights on Conjoint Board

Report to the Board of Directors from the Task Force on Specialty Status

Background

The Task Force on Specialty Status was appointed in the fall of 1989 to study and evaluate various avenues and options that may be available for the eventual establishment of an ABMS-recognized specialty or sub-specialty certification in addiction medicine. The task force was also directed to evaluate the possible creation of a certifying entity independent of ABMS and ASAM.

The task force members visited the leaders of specialty societies, specialty boards, and organizations such as the American Board of Medical Specialties (ABMS).

The task force requested comments from ASAM members through announcements in *ASAM NEWS*, and held an open hearing at the time of the 1990 Medical-Scientific Conference in Phoenix.

The task force held three face-to-face meetings and two conference calls. A background paper, organizing the information which had been gathered and identifying ten possible options for ASAM, was prepared.

This report to the ASAM Board described the direction which ASAM should take in achieving specialty status for addiction medicine.

Two partially dissenting opinions were expressed during the last phase of our discussion. One held that ASAM should continue to pursue the possible establishment of a primary Board as an ultimate long term goal. The other held that ASAM should not strive for a conjoint Board, even in the very long term, because "full specialty training in a clinical residency such as medicine or psychiatry should precede addiction subspecialty training. ASAM should not pursue and independent specialty in conjunction with the ABMS; the only activity which ASAM should pursue with the AMA or the ABMS should be the promotion of the establishment of CAQs or CSQs as subspecialties *under*

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ASAM is a specialty society of physicians who are concerned about alcoholism and other drug dependencies and who care for persons affected by these illnesses.

CONFERENCE DIGEST

CSAM Review Course, Annual Meeting, in San Francisco

With a faculty of 33 (27 physicians), the California Society of Addiction Medicine held its 5th annual Review Course for 257 registrants Nov. 8-10 in San Francisco. Also offered: workshop tracks in clinical updates, legal aspects, and public policy policy issues (a first). Conference chair: **Donald Gragg**, MD. CSAM president: **P. Joseph Frawley**, MD.

The Review Course covered alcohol, amphetamines, cocaine, hypnotics, marijuana, nicotine, opiates, psychedelics and pharmacology, as well as urine drug screens, medical complications of alcoholism, denial, HIV and CD, treatment and recovery models, psychiatric concomitants, pregnancy/newborns, family/relationship issues, and handled five case discussions in small groups.

The CSAM gave its two annual awards during the meeting. The Community Service Award went to Mrs. C. W. Roddy, of East Palo Alto, who has taken a nationally publicized stand against the drug dealers in her neighborhood. This generated 35 bullet holes in her home and a $10,000 contract on her life. "I'd like for the children of America to grow up in a drug-free country. Hugs not drugs," she said. "If speaking out against drugs will help, I'll continue to do it."

The annual **Vernelle Fox** Award went to **Peter Banys**, MD, of the Veterans Administration Medical Center in San Francisco and Department of Psychiatry, University of California at San Francisco, for his fellowship program. Five of his former fellows spoke at the ceremony, including **Westley Clark**, MD, JD, MPH, who was on the CSAM conference faculty.

Addiction Medicine Code: ADM

At the CSAM annual dinner, white buttons with "ADM" in red were given out to announce that the AMA had designated ADM as the code for Addiction Medicine in the AMA Masterfile. *(See story p. 7)*

Ethical Conflicts

Kevin Olden, MD, of Martinez VAMC, president-elect of CSAM, described seven relationships with potential ethical conflict or pressure points that can face physicians who practice addiction medicine. Dr. Olden is triple boarded, in internal medicine, gastroenterology, and psychiatry, is doing a fellowship in the liver, and was certified by ASAM in 1986.

1) *Physician-Patient:* Confidentiality issues (often used by patients to block intervention); sexual issues; diagnostic issues (hard to turn down a patient these days); choice of treatment vs. abandonment of patient.

1) *Physician-Staff issues:* Delegation of authority (a staff which includes psychologists, social workers, EAP's, recovering counselors, may have blurred lines); lines of responsibility-authority; physicians' ethics vs. non-physicians' ethics are not defined; we need clearly drawn lines for staff re issues such as romances with patients.

3) *Physician-Treatment Program ethics:* Corporate ethics (or lack of) vs. physician ethics. Industry or medical specialty. A medical specialty can survive in an industry because doctors are vital, and as the industry contracts, they will become even more so. But how should doctors behave if the people who pay them and who hold their contracts are in violent contradiction to the doctors? The best defense is a code of ethics from a specialty society such as ASAM. [ASAM's Ethics committee, chaired by **LeClair Bissell**, MD, is currently working on such a code--Ed.]

4) *Physician-12 Step Program Relationships:* The Twelve Traditions are not ethics. The Twelve Steps are for personal recovery and not to set ethics in clinical practice. All staff should go to AA and Al-Anon meetings, but there is no one answer to the question: should a recovering physician go to AA meetings with staff? Equally problematical are dating, sponsors, AA friendships, and physician confidentiality vs. Twelve Step anonymity.

5) *Physician-pharmaceutical industry relationship:* Advocating particular drugs, therapeutic strategies, treatment locations or hospitals, while receiving monies and/or employment from these companies/ hospitals. We need standards, which should include: no control of the conference program or published proceedings by the pharmaceutical company.

6) *Medical specialty society (APA, ASAM, etc.) -physician relationships:* Requirements for membership disciplines; resource for patient complaints.

7) The APA (American Psychiatric Association) has four levels of sanction, which are suggested for addiction medicine: a) admonishment - an informal watching. If repeat, or more serious event; b) reprimand - a formal censure, then, c) suspension (APA's is not to exceed five years) which is very serious, and finally, d) expulsion (from APA) but hopefully with criteria to readmit.

Bean-Bayog on Denial

According to the dinner speaker, psychiatrist **Margaret Bean-Bayog**, MD, immediate past president of ASAM, alcoholics wind up acting alike because they are masters at masquerade. They present to their doctors as normally as possible, particularly about their drinking.

During the late teens and early 20s, an alcoholic might have 30 to 40 alcohol-related experiences, but won't evaluate them as such. Why? Because very early in addiction, a machine of denial is installed in the teenager - a way to rationalize making the experiences coherent. As these experiences accumulate, the machine stays the same at continuing to reject reality, but the material fed into it differs.

Alcoholics cling to denial because denial helps protect them against pain. Too many physicians take this denial personally, or they don't believe that the patient is telling the truth. Threatened, they cannot deal with alcoholic patients. And the alcoholic patient's goal is to get the physician to join in refusing to look at the addiction, which makes denial contagious.

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Report to the Board of Directors from the Task Force on Specialty Status

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established specialties such as medicine, psychiatry, and the like."

Actions of the Board

The board adopted the following recommendations:

1) **In the short term, 1990 through 1994, ASAM should:**

A) continue to offer certification, and

B) consider methods of making ASAM certification available to physicians who are not members of ASAM, and

C) stimulate education in addiction medicine within as many specialties as possible: through ASAM specialty caucuses, approach as many specialties as possible to stimulate training programs and educational approaches of all sorts, with a view to encouraging and fostering potential interest in the establishment of Certificates of Added Qualifications (CAQs) and/or Certificates of Special Qualifications (CSQs) in as many specialties as possible.

2) In the intermediate term, 1995 through 1998, ASAM should continue to offer certification and seek establishment of CAQs and/or CSQs in as many specialties as possible, trying to engage cooperation in the efforts necessary to arrive at mutually acceptable training standards and an exam, with the understanding that using the same training standards and exam may not be feasible but is worth initial efforts to achieve it. ASAM should move toward this objective with an inclusive approach, and not take any action that would appear to restrict or exclude any specialty, or to force a method or approach on any specialty. ASAM certification would still be available to individuals who do not meet eligibility requirements for sitting for specialty board exams.

3) In the very long term, from 1998 onward, ASAM should seek a Conjoint Board under the auspices of the American Board of Medical Specialties (ABMS).

The Task Force concluded that the quest for specialty status is a dynamic, developmental process, and that ASAM should start the process and continually evaluatewhat develops.

As the implementation proceeds, information will be gathered on how best to achieve these goals. The information will be reviewed and reevaluated by the board in April and at subsequent meetings.

Feedback from members is requested; please send comments on implementation as well as reactions to the board's action to: James F. Callahan, DPA, Executive Director, at the ASAM Washington office, 5225 Wisconsin Avenue NW, Washington, DC 20015.

CAQ in Psychiatry

As it completed its study, the ASAM Task Force learned that the American Board of Psychiatry and Neurology had notified ABMS of its intention to request establishment of a CAQ in addiction psychiatry. The 33 member boards of ABMS must vote on the request to offer any new certificate. The earliest a vote could be taken is September 1991.

[The board voted on Nov. 11 that the task force not be disbanded at this point. Chair is **Anne Geller**, MD ... Ed.]

Florida Society of Addiction Medicine presents the

4th ANNUAL CONFERENCE ON ADDICTION

JANUARY 18-20, 1991
RADISSON PLAZA HOTEL
Orlando, Florida
60 South Ivanhoe Blvd. (Exit 42 Off I-4)

★ 11 CME CREDITS ★

TOPICS:

- Alcoholism
- Homosexual patients
- Living with the system
- Women in treatment
- Caring for the AIDS patient
- Newest data on prevalence of addiction in physicians

KEYNOTE SPEAKER:

Anne Geller, M.D., Medical Director, Smithers Alcoholism Treatment and Training Center, N.Y.C.

REGISTRATION FEES:

Before January 10. Physicians: $150, Non Physicians: $80
After January 10. Physicians: $175, Non Physicians: $100

FOR INFORMATION & REGISTRATION
CALL KAREN BARNUM (904) 356-1571, ext. 307

CONFERENCE ON ADDICTION
Send Registration Fee to FSAM
c/o Karen Barnum
P.O. Box 2411, Jacksonville, FL 32203

NAME: _____
ADDRESS: _____
CITY/STATE/ZIP: _____
PHONE: ( ) _____

(or use the coupon)
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(Identify yourself with the FSAM)

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If you are interested in exploring these opportunities, please call or send your curriculum vitae to **Irwin P. Goldstein, M.D., Associate Medical Director, SCPMG, Dept. 853, Walnut Center, Pasadena, CA 91188-8013, 1-800-541-7946.**

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Physician Drinking and Patient Care

ASAM Submits Resolution to AMA

The following resolution was referred on Dec. 5 by the AMA House of Delegates to the AMA Board of Trustees. The resolution had been approved by the ASAM Board in November.

G. Douglas Talbott, MD, is chair of the ASAM Committee on Physicians' Health Customs.

Whereas, there is widespread public concern over the use of alcohol and other psychoactive drugs by persons engaged in sensitive occupations which involve public health and safety; and

Whereas, patients are concerned in particular about the effects that drinking by physicians might have on the quality of care they receive; and

Whereas, relatively small amounts of alcohol have been shown to have significant adverse effects on dexterity, judgment, and decision-making ability; and

Whereas, other professions and industries, most notably the airline industry, have examined this issue and have established specific time-limit guidelines regarding drinking; and

Whereas, the AMA recognizes that physicians should not engage in the practice of medicine under the influence of alcohol; therefore be it

Resolved, that the [AMA] Board of Trustees review and correlate existing studies of the effects of alcohol on cognitive ability and other aspects of professional performance in order to develop appropriate guidelines regarding the relationship between physicians' ingestion of alcohol and engaging in patient care; and be it further

Resolved, that the Board of Trustees report to the House the findings and conclusions of its review, and submit any policy recommendations for the medical profession at the 1991 Annual Meeting.

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Call/write: Lucy B. Robe, Ed. *ASAM News*, 303D Sea Oats Drive, Juno Beach, FL 33408

☎ (407) 627-6815

CLINICAL FELLOWSHIP IN ADDICTION MEDICINE available to board eligible, board certified primary care physicians at Charter Hospital of Dallas. Hands-on private practice training with two experienced addictionists. Opportunities for inpatient, outpatient, extended care, consultation, teaching, intervention, and administration. Research and preparation of papers encouraged. Openings are January/February 1991, and July 1991. One-year program, competitive salary. *Send resume and call for onsite visit to:* Michael J. Healy, M.D., CADAC, Medical Director, Adult Chemical Dependency Unit, Charter Hospital of Dallas, 6800 Preston Road, Plano, Texas 75024. *For further information, call :* 1-800-255-3312

FACULTY POSITION IN ALCOHOL AND DRUG ABUSE

The University of Arkansas for Medical Sciences invites applications for a faculty position at the Associate Professor or Professor level to fill an endowed chair in alcoholism and substance abuse. The position will be supported by an endowment of approximately $1.5 million and will be occupied by a clinician/investigator with interest and experience in the biological origins and effects of alcoholism and substance abuse. *Send applications, curricula vitae, and letters of interest to:* George L. Ackerman, M.D., Professor and Vice-Chairman, Dept. of Medicine (640), 4301 West Markham St, Little Rock, Arkansas 72205

JUNIOR LEVEL ACADEMIC PSYCHIATRIST INPATIENT PSYCHIATRY AND DUAL DIAGNOSIS PROGRAMS The Dept. of Psychiatry and Behavioral Sciences, Univ. of Washington in Seattle is recruiting for a full-time jr. level academic psychiatrist for inpat. psychiatry and dual diagnosis programs. Dedicated research time with existing clinical programs and grants. Collaborative relationships between Univ. and regional psychiatric and CD systems allow for clinical, research and training endeavors. Work closely with medical students, residents and other inpatient attendings. Exp. or int. in CD or dual Dx important. ***Contact:*** Dept. Psychiatry & Behav. Sciences RP-10, Univ. of Washington, Seattle, WA 98195

Substance Abuse Chief

Psychiatrist/Addictionist wanted for comprehensive VA outpatient substance abuse program in downtown Los Angeles. Affiliated with University of Southern California School of Medicine. Position involves faculty appointment, opportunities for patient care, teaching and research. EOE. *For information contact:* Shri K. Mishra, MD, Chief of Staff, VA Outpatient Clinic, 425 S. Hill Street, Los Angeles, CA 90013.
☎ (213) 894-4841

Charter Hospital of Lake Charles, LA

currently seeks a psychiatrist to assume responsibilities of medical service director, addictive disease. This opportunity will involve a part-time administrative role and a fee-for-service clinical practice mixing both psychiatric and addiction medicine cases. *For more information, please call* Charter Medical, Physician Relations Department, at 800-248-0922 *or send your c.v. to* PO Box 209, Macon, GA 31298.

CORPORATE MEDICAL DIRECTOR

for INSIGHT, a major provider of substance abuse + medical health treatment in Michigan. Position reports to Pres. of INSIGHT, has responsibility for coordinating client care activities with clinical, nursing and medical staff. The ideal candidate will have completed a psychiatric residency and have completed or be actively seeking certification as an addictionist. INSIGHT provides a comprehensive, fully paid benefit program + malpractice/liability insurance. *Interested individuals submit resumes with salary requirements to:* Mr. Stephen LeBel, President, INSIGHT, 1110 Eldon Baker Drive, Flint, MI 48507. EOE

IN MEMORIAM

Luke Reed 1909-1990
IDAA Secretary

Internist Lewis K. "Luke" Reed, MD, of Youngstown, Ohio, who oversaw International Doctors in Alcoholics Anonymous from 1960 to 1988, died Oct. 24 of pneumonia complicating metastatic prostate cancer. He was 81, and had been sober for 34 years.

When Luke took over IDAA in 1960, "the entire membership fit on 3" x 5" file cards in a small recipe box," IDAA secretary Dr. Dick McK. told *ASAM NEWS*. "In 1988, when he turned the reins over to me in Baltimore, we had 2,400 members. I know Luke would have loved to see our membership arrive at 3,500 the weekend of his funeral (Oct. 27), when two more membership forms arrived at his Youngstown house."

Gift for Twelfth Stepping

"He had an uncanny ability to deal with alcoholic docs, a special telephone technique that enabled isolated, frightened physicians to open up to him and ask for help," said Dick McK. "He was in touch with people all over the country, so he could introduce new docs to people who lived near them." No names or phone numbers were, or *are*, exchanged by IDAA without the permission of those involved. "Luke felt a special kinship with every recovering doctor in IDAA. He wanted to be of help to them all, and he *was*." The Twelfth Step work didn't always take right away; some doctors carried Luke's card around with them for years before they took that critical First Step. Others, once sober, carried his card just so they could call him if they felt like sharing.

Luke was not the only sober member of his family: his late wife Harriet's AA anniversary was June 21, 1956, nine days after Luke's. "Recovery saved my father's life, my mother's life, and our lives," their son David Reed, MD, told Dick.

Dr. Joe C., who chaired the 1988 Baltimore IDAA meeting, told *ASAM NEWS* that Luke "was our friend, our model, and our godfather. We will follow his lead." Luke proudly wore a long, bright yellow, Baltimore 'Godfather' ribbon to the last few IDAA meetings.

Dr. Jim W. of California, who many times m.c.'s the IDAA annual Newcomers Dinner, joined IDAA in 1960. "Luke made the essential connection between the goals of IDAA and the medical community. He encouraged us to teach our fellow academics about alcoholism, and to get courses about alcoholism into medical schools. We'll miss Luke a lot."

"I used to call Luke when I was a medical student; he was awfully nice to me and to everyone," said Dr. LeClair B., who joined IDAA in the early 1960s. "The man was warm, honest, and gentle during his years as IDAA secretary. He was unusually available by telephone to docs in trouble all over the U.S. and Great Britain."

In the mid-70s, Dr. Jane S. of Michigan was one of the first psychologists to join IDAA, "Luke's ability to network was uncanny. He'd call me about psychologists from all over the country. I'd do a Twelfth Step call on the phone, and then try to hook them up with a sober psychologist in their area. Belonging to IDAA was one of the things that kept me sober and still does. I'd never miss the annual IDAA meeting."

"Luke was a real big part of my sobriety," said Dr. Joe C. of South Dakota. "He invited me to the IDAA annual meeting in upstate New York in the early 70s, but I got drunk on the way and wound up in Hazelden. The next year, I set out from California for Estes Park, and wound up drunk in Honolulu . The third year I drank on the plane to San Antonio, but Luke had me first in line at the Newcomers Dinner when I arrived. The m.c. was an ophthalmology professor at my medical school. That 1973 IDAA date was my last drink.

"His letters were classics," added Joe. "He never questioned his mission with IDAA any more than he questioned the miracle of all our recoveries. I miss him, and I envy him and Hattie going to those big AA Roundups in the Sky."

"I saw a little ad in *JAMA* in 1972 and wrote him," said Dr. Ann B. of upstate New York, who has been sober since 1974. "We wrote back and forth for two years. Luke wrote me lovely letters suggesting that I try an AA meeting, but I always had an excuse for not going. We finally met in Morristown, New Jersey, in 1974."

"I considered him a sponsor," said Dr. Stan S. of Ohio, who attended Luke's 81st birthday party last January, and had corresponded with Luke for seven years before he stopped drinking. "To me, the fact that he didn't push or confront me made him effective. Twelfth-stepping on the phone, he had an uncanny ability to interpret inflections, pauses, and nuances. "

Friend of Bill W.

Luke was always proud of his friendship with AA's co-founder Bill W. He liked to reminisce about this when he spoke at IDAA annual meetings. (See conference reports in *ASAM NEWS* Sept.-Oct.1988, Jul.-Aug. 1989 and 1990.) Luke attended the IDAA annual meeting last August in Boca Raton in a wheelchair, but he was alert, clearly enjoyed seeing and greeting his hundreds of friends, and gave two moving speeches. Bill W. had tried repeatedly to obtain IDAA's mailing list from Luke, in order to promote niacin as therapy for recovering alcoholics. [In the 1960s, there was a notion that megadoses of vitamin B-3 could help alcoholics stay sober, an idea originally fostered through some work in Canada with schizophrenics who were also alcoholics.] Luke never yielded to Bill's pleas. Over and over, he told Bill that the niacin premise was not "scientifically valid" and that, in any event, the IDAA mailing list was strictly confidential, as it is to this day.

About IDAA

IDAA's next annual meeting will be Aug. 1-4, 1991, at the Hyatt Regency Hotel in Vancouver, British Columbia. ASAM will again co-sponsor the CME portion of the program.

IDAA's new address: PO Box 199, Augusta, MO 63332.

New telephone (as of Nov. 14): (314) 781-1317.

There is a "Luke Reed Memorial Scholarship Fund" which was started at the Louisville meeting in 1987; contributions help destitute recovering doctors to attend the IDAA annual meetings.

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ABOUT ASAM

Specialty Sections Launched

ASAM established three "specialty sections" last summer for the major specialties represented within the society. Purpose: to create grass roots support and visibility for addiction medicine within each specialty. Each section, or caucus, is to be the voice of ASAM within that specialty: in the specialty society, with the specialty board, and with any other organized professional associations in that specialty. Family Practice was the pilot.

Family Practice: **Michael D. Fleming**, MD, MPH, chair

A four-page survey was mailed to 947 ASAM members who list their specialty as family medicine or general practice AS of Oct. 31, 230 had responded. In answer to question #11, "What issues to you want the ASAM Family Medicine Section to address now in its dialogue with AAFP and ABFP?" the majority focused on gaining recognition for addiction medicine within family practice, education for all family physicians, and reimbursement issues.

An eight-person steering committee met Nov. 1 at the AAFP offices. Also present: the chair of the AAFP Subcommittee on Mental Health and Substance Abuse, Neal Brooks, MD, and ABFP's executive director, Paul R. Young, MD. Liaison was also established with the Society of Teachers of Family Medicine (STFM).

Psychiatry: **Joseph Westermeyer,** MD, PhD, chair.

Expects to conduct a survey of the psychiatrists in ASAM; provide information to all ASAM members regarding dual diagnosis problems; and maintain communication and liaison with the APA (American Psychiatric Association) regarding areas of possible common interests.

Internal Medicine: **David C. Lewis**, MD, chair

Expects to write all ASAM internists announcing the section; to establish liaison with the American College of Physicians (ACP); and to explore feasibility of projects which could be jointly sponsored by ASAM and ACP.

Each of the three sections expects to hold an open meeting at the Medical-Scientific Conference in Boston this April.

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ASAM Limits Promotion

at Annual Meeting in Boston

The ASAM Board has decided that "promotion of treatment programs or proprietary materials should only take place in rented booths at the annual meeting, and not in symposia, courses, or workshops. In the latter program components, programs will be mentioned only for purposes of identifying a speaker's affiliations."

ASAM does plan to have a Take One Table for members.

ASAM's 22nd Annual Medical Scientific Conference will be April 18-21, 1991, at the Boston Marriott Copley Place in Boston, Mass.

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ASAM/NAATP Placement Criteria

Approved for Field Testing and Review

Patient placement criteria developed by a task force of ASAM members and representatives of the National Association of Treatment Providers (NAATP) have been approved by the boards of both organizations for field testing and field review.

The criteria, which give clinicians and providers their own integrated and consistent foundation for internal utilization review, address four levels of care for both adult and adolescent patients. The levels are outpatient treatment, intensive outpatient/partial hospitalization treatment, medically monitored intensive inpatient treatment, and medically managed intensive inpatient treatment.

Selected ASAM members who hold office in the society and in state chapters, or who serve on certain ASAM committees, will be among those receiving copies of the criteria for review and comment. The criteria will not be available for final approval and distribution until modifications are made on the basis of this review, and of field testing at approximately 20 treatment programs throughout the country. That process is expected to be completed by mid-February.

For each of the four levels of care, the criteria cover the intensity and frequency of services, describe the settings, staffing and types of services to be expected, and delineate specific indications for admission, continued stay and discharge of patients in the following six problem-area dimensions: 1) intoxication and potential withdrawal; 2) biomedical conditions and complications; 3) emotional and behavioral conditions and complications; 4) treatment acceptance and resistance; 5) relapse potential; and 6) recovery environment.

A conference under the joint sponsorship of the two organizations will be held March 14-15, 1991, in Atlanta, to interpret the criteria and provide practical "hands-on" information on how they are to be applied. Details about the conference will be sent to all ASAM members.

ASAM members who served on the joint task force include **David Mee-Lee**, MD, chair of the Standards and Economics of Care Committee; **P. Joseph Frawley**, MD; **Don Nauts**, MD; **Martha A. Morrison**, MD; **Peter Rogers**, MD; and **R. Jeremy Stowell**, MD ... [EMS]

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Newest State Chapter

The ASAM Board approved Iowa as the newest state chapter, bringing the total up to eight.

Applications for state chapters were approved from Arkansas, New York, Oregon, Tennessee, Utah, and Washington.

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Membership

The ASAM Board approved a $50 registration fee for members-in-training for all ASAM conferences and courses. As of Oct. 23, there were 114 intern/fellows and 34 student members.

On that date ASAM had 44 members with retired status. In November the board approved 14 more retirees.

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As of November 1, all ASAM members whose 1990 dues were unpaid have been dropped from active membership status.

The next membership directory will be published in early 1991.

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Medical Education

ASAM "co-sponsored" 50 conferences in 1990. The CME's offered through ASAM ranged from two hours to 50.

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Harold Hughes Speaker at April Meeting

Former Senator Harold Hughes has agreed to address the ASAM Medical-Scientific meeting in Boston next April 20. Senator Hughes, who was one of the initiators of the NIAAA, has formed a new advocacy organization named SOAR (Society of Americans for Recovery), which will headquarter in Washington, DC. Purpose: "To end the financial, social, legal and health care discrimination against alcoholics, and persons dependent on other drugs and their families through mobilization of a national constituency to assure their rights." SOAR is a grass roots organization for all those with an interest in its mission. Senator Hughes can be reached at 600 East 14th Street, Des Moines, IA 50316. (515) 265-7413.

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Code ADM for AMA Masterfile

In June, as previously announced in *ASAM NEWS*, the AMA approved adding addiction medicine to the self-designated specialty (SDPS) areas which are assigned a code in the AMA Physician Masterfile.

The AMA Department of Professional Activities Information wants ASAM members to know that beginning January, 1991, a physician will be able to designate his or her specialty as "addiction medicine" by filling out an AMA Record of Physicians' Professional Activities (PPA) census questionnaire. To ensure accuracy of a personal profile in the AMA Masterfile of all U.S. physicians, ASAM members may call collect (312) 464-5159 and request a PPA form. The information provided is also used in distributing AMA professional and scientific information, and complimentary materials and journals from pharmaceutical companies.

The designation of a given practice specialty indicates the field(s) of practice in which the physician spends the majority of time and does not necessarily mean that the physician has been trained, certified, or has special competence to practice the self-designated specialty. Self-designated practice specialty classifications listed on the AMA Masterfile have historically related to the record-keeping needs of the American Medical Association and do not imply "recognition" or "endorsement" of any field of medical practice by the AMA.

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*Note: Names **in boldface** are ASAM members.*

Core Curriculum Committee to Survey Membership

by **David Lewis**, MD, committee chair

The core curriculum committee will be sending a short questionnaire to all ASAM members asking how your medical colleagues who are not specialists in addiction medicine can be brought up to speed in basic diagnosis and referral of chemically dependent patients.

The questionnaire is part of a new project funded by the Office of Substance Abuse Prevention (OSAP) via Macro systems. The project is a joint effort of ASAM, Project ADEPT at Brown University, and the American Medical Association (AMA) to prepare a CME teaching package.

The first step is this survey which asks what topics you believe should be taught and what kinds of CME programs you think your colleagues will attend.

The survey also asks if you want to volunteer to be part of the pilot test of the teaching materials. In the pilot, we will train the volunteers to use the new curriculum and to evaluate its effectiveness.

Watch for the survey and send it back right away so we can tally the results before our next meeting. Watch for further information on this project in ASAM NEWS and at ASAM's annual medical-scientific conference in April in Boston.

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CSAM *(continued from p. 2)*

Although it may be terribly painful at the time, a doctor must believe that it's beneficial to talk about drinking in the long term, for this is the beginning of letting go of denial. It may seem paradoxical, but the worse the patient's denial and the more stubborn he or she is about it, the better the prognosis for a solid recovery. It's a chess game - a long term process.

AA and Denial

AA has taught physicians a great deal about how to deal with denial. Members of AA seem to know when to confront or to empathize; they acknowledge pain and suffering as being real, but do not allow it to distract the alcoholic from getting sober. They save the personality exploration until later in recovery.

The tactics Dr. Bean-Bayog uses to get past denial: "Bludgeon past it in a crisis situation, which occurs in about 20% of patients. A physician can express the anxiety that the alcoholic dares not feel. Remember that being addicted hurts, but entering treatment hurts much, much more. If the patient can bear to see reality, he or she *will* enter recovery, with you or with someone else. Remember, too, that alcoholics die for denial, addicts get AIDS from denial, whole families are demolished and crippled by denial, so please don't trivialize denial!"

Conference Tapes

Infomedix taped the Review Course and the three tracks. Tapes from ASAM Review Courses given in Chicago, New York, and Atlanta are also available: Infomedix, 12800 Garden Grove Blvd, Suite F, Garden Grove, CA 92643.

☎ (714) 530-3454. Toll-free: 800-367-9286.
In California: 800-992-9286. FAX: 714-537-3244

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ASAM NEWS

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ASAM Defining Addiction Terms

Seeks Evaluation from Membership

The following terms and definitions were recently approved by the ASAM Nomenclature Committee and ASAM Board. Now the committee wants feedback from ASAM members. How functional are these terms in your practice? Based on comments from members, the committee will modify pertinent terms before disseminating the definitions more widely.

"Although the primary impact of the definitions should be on how these terms are used by ASAM members," Nomenclature chair **David E. Smith**, MD, told the ASAM Board, "the ultimate objective is to seek standardization in terminology across the entire field of addiction treatment."

"This nomenclature work is a very important step in trying to standardize terms in addiction medicine," added Certification Council chair and ASAM president-elect **Anthony B. Radcliffe**, MD.

• **Abstinence**. Non-use of a specific substance. In recovery, non-use of any addictive psychoactive substance. May also denote cessation of addictive behavior, such as gambling, over-eating, etc.

• **Abuse**. Harmful use of a specific psychoactive substance. The term also applies to one category of psychoactive substance use disorder.

While recognizing that "abuse" is part of present diagnostic terminology, ASAM recommends that an alternative term be found for this purpose because of the pejorative connotations of the word "abuse."

• **Addiction**. A disease process characterized by the continued use of a specific psychoactive substance despite physical, psychological, or social harm.

• **Addictionist**. A physician who specializes in addiction medicine.

• **Alcoholism**. A primary, chronic disease with genetic, psychosocial, and environmental factors influencing its development and manifestations. The disease is often progressive and fatal. It is characterized by continuous or periodic: impaired control over drinking, preoccupation with the drug alcohol, use of alcohol despite adverse consequences, and distortions in thinking, most notably denial. *(This definition was conceived by a joint ASAM / NCAdd committee; it was first published in ASAM NEWS March-April 1990, page 1.)*

• **Blackout**. Acute anterograde amnesia with no formation of long-term memory, resulting from the ingestion of alcohol or other drugs; i.e., a period of memory loss for which there is no recall of activities.

• **Decriminalization**. Removal of criminal penalties for the possession and use of illicit psychoactive substances.

• **Dependence**. Used in three different ways:

a) *Physical dependence* - physiological state of adaptation to a specific psychoactive substance characterized by the emergence of a withdrawal syndrome during abstinence, which may be relieved in total or in part by re-administration of the substance;

b) *Psychological dependence* - a subjective sense of need for a specific psychoactive substance, either for its positive effects or to avoid negative effects associated with its abstinence;

c) one category of psychoactive substance abuse disorder.

• **Detoxification**. A process of withdrawing a person from a specific psychoactive substance in a safe and effective manner.

• **Enabling**. Any action by another person or an institution that intentionally or unintentionally has the effect of facilitating the continuation of an individual's addictive process.

• **Impairment**. A dysfunctional state resulting from use of psychoactive substances.

• **Intervention**. A planned interaction with an individual who may be dependent on one or more psychoactive substances, with the aim of making a full assessment, overcoming denial, interrupting drug-taking behavior, or inducing the individual to initiate treatment. The preferred technique is to present facts regarding psychoactive substance use in a caring, believable and understandable manner.

• **Legalization**. Removal of legal restrictions on the cultivation, manufacture, distribution, possession, and/or use of a psychoactive substance.

• **Loss of Control**. The inability to consistently limit the self-administration of psychoactive substances.

• **Misuse**. Any use of a prescription drug that varies from accepted medical practice.

• **Problem drinking**. An informal term describing a pattern of drinking associated with life problems prior to establishing a definitive diagnosis of alcoholism. Also, an umbrella term for any harmful use of alcohol, including alcoholism. ASAM recommends that the term not be used in this latter sense.

• **Recovery**. A process of overcoming both physical and psychological dependence on a psychoactive substance, with a commitment to sobriety.

• **Relapse**. Recurrence of psychoactive substance-dependent behavior in an individual who has previously achieved and maintained abstinence for a significant period of time beyond withdrawal.

• **Sobriety**. State of complete abstinence from psychoactive substances by an addicted individual, in conjunction with a satisfactory quality of life.

• **Tolerance**. State in which an increased dosage of a psychoactive substance is needed to produce a desired effect.

• **Withdrawal Syndrome**. The onset of a predictable constellation of signs and symptoms following the abrupt discontinuation of, or rapid decrease in, dosage of a psychoactive substance.

The Nomenclature Committee is not looking for editorial changes, but for comments on how practical these definitions are in terms of day-to-day practice ... EMS

Send comments to: ASAM Committee on Nomenclature, 5225 Wisconsin Avenue N.W., Suite 409, Washington, DC 20015.

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POSITION STATEMENTS

ASAM Public Policy Statement

Physician Policy on Third-Party Coverage for Addiction Treatment

Background

As America confronts unprecedented problems from the widespread prevalence of alcoholism and other drug dependencies, access to treatment for addictive diseases is becoming increasingly important. Many persons in need of such treatment are covered for their overall health care by a variety of public and private third-party payment plans that severely restrict or exclude addiction treatment services, thereby denying patients access to quality care. These patients face limits on duration of treatment and on total dollar benefits that are far narrower than the limits placed on other medical care they receive.

This situation persists despite the fact that the American Medical Association since 1956 has encouraged the treatment of alcoholism by physicians, that psychoactive substance use disorders have been specifically categorized in the Diagnostic and Statistical Manuals of the American Psychiatric Association, and that addictive disease diagnoses also are integrated into the International Classification of Diseases of the World Health Organization. Regrettably, to provide their patients access to medical care, physicians often are forced into the awkward position of documenting the treatment of a secondary diagnosis, such as cirrhosis, gastritis, angina, or fracture, when the primary diagnosis clearly is alcoholism or another addictive disorder, leading to little or no attention being paid to the underlying addiction.

Position of ASAM

In view of the inequity and destructive potential of the current situation, the American Society of Addiction Medicine strongly supports:

1. Coverage for all patients, including Medicare and Medicaid recipients, of the full range of appropriate services for the treatment of addiction. Such services should encompass consultation and evaluation, as well as treatment in in patient, residential, outpatient, and partial hospitalization settings, as indicated by the patient's individual clinical condition.

2. Non-discriminatory reimbursement for addiction treatment, on a parity with reimbursement for other health care treatment, in commercial and government sponsored insurance plans, be they traditional (indemnity-type) plans, prepaid (HMO-type) plans, or self-insured plans.

Adopted by the ASAM Board of Directors on November 11, 1190.

3. State and federal government legislative and regulatory mandates to third-party payers to make non-discriminatory coverage available to group health insurance purchasers at premium levels that are both reasonable and equitable.

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ASAM Public Policy Statement

Reimbursement for the Treatment of Nicotine Dependence

Background

The American Society of Addiction Medicine (ASAM) recognizes nicotine dependence is the most common form of chemical dependence in the United States. Chronic tobacco use causes much illness and disability, as well as more than 390,000 premature deaths annually in this country alone. This exceeds the number of premature deaths attributed to the use of alcohol (100,000/year) or other drugs of abuse (6,000/year). Smoking-related health care expenses, absenteeism, and lost productivity cost the nation an estimated 65 billion dollars per year.

About 30% of adult Americans smoke and young people continue to begin smoking Some individuals quit smoking but it has been estimated that, unless the rate of quitting increases, in the year 2000, 22% of adults, some 40 million people, will still be active smokers and will continue to incur smoking-related expenses.

Many of the adverse health effects of smoking are common knowledge. Surveys indicate up to 90% of active smokers would quit if it were easy to do. Up to 65% of active smokers have made one or more serious attempts to quit, but relapse to smoking has been the rule rather than the exception. Such persistence of behavior, despite adverse consequences, is characteristic of addictive illnesses.

Like other addictive illnesses, nicotine dependence can be treated. Some treatment approaches are well established and newer, individualized treatment approaches are continually being developed since not all approaches work for each addicted person. Treatment methods that are reimbursed when applied to alcohol dependence and other chemical dependencies are now being applied to nicotine dependence.

Improved third-party reimbursement for the treatment of nicotine dependence would make treatment more accessible to individuals with limited resources and would facilitate treatment at earlier stages. Earlier treatment would reduce overall long-term health care costs and other expenses. Each employee who smokes costs the employer an estimated one to four thousand dollars per year.

Position of ASAM

ASAM supports the use of reimbursement mechanisms that promote the effective treatment of nicotine dependence. Specific recommendations include, but are not limited to, the following:

1. Third-party payers, whether private, not-for-profit, government insurers, or health plan administrators, are encouraged to make coverage for the treatment of nicotine dependence available to all group and individual enrollees. This should be viewed as coverage for treatment of a primary medical problem, addiction to nicotine, not a preventive service.

2. Employers are encouraged to request coverage for the treatment of nicotine dependence among the health benefits they purchase for employees.

3. Unions are encouraged to include coverage for the treatment of nicotine dependence among the health benefits provided for their members, either directly or through collective bargaining.

4. Employers are encouraged to consider on-site programs to help employees quit smoking.

5. Governments are encouraged to allow, as tax deductions, expenses for the treatment of nicotine dependence, whether the expenses be incurred by an individual or an employer.

6. The federal government's Department of Health and Human Services is encouraged to convene a joint task force to develop standards of treatment for nicotine dependence, including standards on data collection, treatment methods, monitoring treatment outcome, and provider credentialing.

Adopted by the ASAM Board of Directors on November 11, 1990

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Public Policy Committee chair:
Sheila B. Blume, MD

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BOOKSHELF

Names in boldface are ASAM members.

ASAM Syllabus

published by ASAM Oct. 1990

The *ASAM Syllabus* is planned to enhance the society's review courses, which help physicians prepare to take ASAM's certification examinations. The syllabus offers a comprehensive review of the field of addiction medicine and can also be used as a self-contained text for physicians and non-physicians.

ASAM's first review course syllabus, published in 1987, had 394 pages. This new book has 636 pages, divided into 30 chapters. Each chapter has an "overview" of the topic, written by an expert in that area, and a list of recommended "related reading." Almost all have one or more pertinent original or reprinted articles. Fifteen ASAM policy statements are included in appropriate chapters. The book ends with an annotated list of 22 addiction journals, magazines, and newsletters.

A large number of ASAM physicians were involved in producing this impressive work:

Anne Geller, MD, and her Review Course Committee of 15 physicians guided the syllabus' development: Drs. **Raymond C. Anderson, Andrew G. Barthwell, David G. Benzer, Amin N. Daghestani, Martin C. Doot, James Fine, Donald M. Gallant, Donald M. Gragg, Lynn M. Hankes, Joseph C. MacMillan, Al J. Mooney III, Ken Roy, Terry Rustin, Stephan John Sorrell, Herbert D. Trace.**

Editorial Board for the Syllabus: Drs. **LeClair Bissell, Sheila B. Blume, Dolores Burant, Timmen Cermak,** Dorynne Czechowicz, **Daniel K. Flavin, Marc Galanter, James Halikas, Martha A. Morrison, Anthony Radcliffe, Sidney H. Schnoll, Richard H. Schwartz, David E. Smith, G. Douglas Talbott, Donald R. Wesson.**

Eight physicians wrote original articles: **Dolores G. Burant**, MD, "Management of Withdrawal;" **Mark G. Fuller**, MD, "Effects of Alcohol on the Endocrine System;" **Donald M. Gallant**, MD, "Recent Advances in Research and Treatment of Alcoholism and Drug Abuse;" **Anne Geller**, MD, "Protracted Abstinence;" **Joseph MacMillan**, MD, "Drug Interactions;" **H. Thomas Milhorn, Jr.**, MD, "Screening, Assessment and Diagnosis;" **John Slade**, MD, "Tobacco and Nicotine;" **G. Douglas Talbott**, MD, "Intervention in the Health Professional - Success and Failure: the Georgia Experience."

Of 35 reprinted articles, 25 were by physicians.

ASAM's executive director James F. Callahan, DPA, and consultant Emanuel M. Steindler, were greatly involved. Bonnie B. Wilford, MS, again edited the book.

Section One: General Principles

10 chapters: Basic Science/Theories of Addiction; Nomenclature; Principles of Pharmacology and Biopharmaceutics; Epidemiology; Screening, Assessment and Diagnosis; Prevention and Intervention; Management of Acute Intoxication and Overdose; Management of Withdrawal; Treatment, Relapse and Recovery; Psychiatric Issues in Addiction Medicine.

Section Two: Drug-Specific Issues

11 chapters: Alcohol; Other Sedative-Hypnotics; Cocaine; Other Psychomotor Stimulants; Heroin and Methadone; Other Opioids; Marijuana; Perceptual Distorters and Inhalants; Tobacco and Nicotine; Steroids; Other/Multiple Drugs.

Section Three: Special Issues

9 chapters: Management of the Addicted Mother and Child; AIDS and HIV Infection; Disorders of the Family; Adolescents; Special Populations; Impaired Health Professionals; Prescription Drug Abuse; Legal Concerns; Recent Advances in Research and Treatment of Alcoholism and Drug Abuse.

Ordering info: ASAM, Ste 409, 5225 Wisconsin Ave NW, Washington, DC 20015. ☎ (202) 244-8948

Price: ASAM members $50; nonmembers $75, prepaid.

(The book was included with course materials at ASAM's 1990 Review Courses in October and November. [LBR]

◆

"Medical Aspects of Tobacco"

This 27-minute video presents an informative lecture about tobacco and nicotine, interspersed with a subplot about an individual's coming to terms with her addiction to this drug. The lecture segments, given by **Max A. Schneider**, MD, cover psychopharmacology and toxicology, the consequences of smoking, and the basics of quitting. The material is presented in the straightforward, no-nonsense manner which is Dr. Schneider's trademark.

The subplot develops around a crew member of the team that is making this video. She is a producer, she is responsible for interviewing patients with cigarette-caused disease and children recently addicted to nicotine ... and she smokes! During the video, she gradually, if unwillingly, confronts her own addiction. By the end, she has managed to stop smoking.

The dramatic tension that develops between the lecture segments and the unfolding personal story works well to hold the viewer's attention, and to involve the audience in the rational and the emotional issues around nicotine addiction. The video addresses the CD field's historical avoidance about tobacco, in a way that informs but does not threaten.

The tape will probably find its widest use in addiction treatment programs. This audience will find "Medical Aspects" to be a sympathetic but firm exploration of the issues.

In short, "Medical Aspects of Tobacco" is a welcome addition to such standard videos as "Death in the West" for helping patients to confront smoking.

John Slade, MD
New Brunswick, NJ
[Dr. Slade chairs ASAM's Nicotine Dependence Committee.]

Ordering info: FMS Productions, PO Box 4428, 520 E. Montecito St, Ste F, Santa Barbara, CA 93140.
☎ toll free (800) 421-4609. In CA (805) 564-2488.
or: Max A. Schneider, MD Inc., Education Division, 3311 E. Kirkwood Ave, Orange, CA 92669.
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Price: $460/video; $550/16 mm. film; rental $50/week.

◆

LETTERS TO THE EDITOR

Dear Editor:

This letter is in reference to the article "Obstacles to a Smoke-Free CDU" in *ASAM NEWS*, September-October 1990.

I commend Drs. Twerski and Ramsey of Gateway for their efforts to responsibly treat addiction. The resistance they met from patients, staff, administrators, referral sources, and NA/AA serves well to emphasize the magnitude of nicotine addiction. It also demonstrates the degree of denial by addicts in general when their disease or drug supply is threatened. The antagonism toward, and undermining of, these physicians' attempts to treat nicotine addictions parallels to the antagonism and undermining that takes place in a family, when a member enters treatment for alcoholism, if other members are in denial about their own alcoholism.

Physicians who treat addictions should remove their blinders and stop colluding with those who persist in denying that nicotine is a lethal, psychoactive, and highly addicting drug. Nicotine injures and kills many times more people annually than all other chemical addictions combined. Even when administrative constraints force us to restrict our treatment strength, we as physicians should at least include nicotine addiction on the discharge diagnosis, to emphasize that this problem is on a par with other chemical dependencies.

James Krag, MD
Charlottesville, VA

◆

Dear Editor:

Regarding the use of the word "detoxification" [In "Letters to the Editor" from **Paul Russell**, MD, *ASAM NEWS*, July-August 1990] many years ago a very learned AA member wrote a two-page scholastic commentary about the word "detox," beginning with its etymological derivation. The upshot was an academic criticism of its improper use, but as the years go by, "detox" still has a definite meaning for all of us. There is a little virus called "usage," and once that settles in, we can forget proper use!

The basic issue, which has been strongly recommended for many years, is that the level of suspicion must be raised so that possible withdrawal from any drug should be detected almost at onset. It does not matter what you call it. All of us at one time or another have been called to see a patient post-operative, or post- anything, who was in a severe state of withdrawal. The only way to avoid that is to routinely check a patient's substance use history, possibly from a family member or friend, or better still to perform a drug screening on admission. No surgeon will wait a few days to see if there are incipient withdrawal symptoms when a patient has a broken leg, or neck, or any other surgical emergency. Nor, for that matter, will a physician dealing with a medical emergency.

So much for nomenclature!

Percy Ryberg, MD
Central Valley, NY

◆

Dear Editor:

I note the position statement adopted by the ASAM Board of Directors on April 25, 1990, regarding methadone treatment (*ASAM NEWS*, July-August, p. 9). While I concur that the methadone maintenance patient should not be eschewed by the treatment community, I am unaware of scientific data that supports the implied conclusion of this position statement that patients with opioid addiction are absolutely unable to recover without synthetic opiate, methadone.

I am confused by the message in paragraph two that states: "Ideally, methadone treatment includes behavioral, psychodynamic, and 12-step approaches combined with pharmacological interventions to provide a broad spectrum treatment for opioid dependent patients." It seems clinically impossible to separate treatment with a 12-Step orientation from the traditions of those programs, all of which indicate the requirement for membership in those programs is a desire to be free from addictive agents.

Our credibility with the 12-Step community, which is vastly important to the recovery of our patients, will be severely compromised by implying that methadone maintenance patients, who have no intention of ever withdrawing from methadone, can be members of Narcotics Anonymous, for which freedom from opioid agents is a paramount consideration.

The ASAM Board of Directors possess extensive clinical background. Therefore, their positions in this matter leave me utterly perplexed. I certainly do not have the answer regarding the most effective manner to bridge the gap between methadone maintenance and the 12-Step Programs. These programs are based upon honesty, and I do not believe we can in good conscience advise our patients to ignore the traditions of their recovery programs.

I wish to commend you on the very fine ASAM newsletter which has evolved over these past years.

John J. Verdon, Jr., MD
Tinton Falls, NJ

◆

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RUTH FOX MEMORIAL ENDOWMENT FUND

The ASAM Board voted in November that the principal of the Ruth Fox Memorial Endowment Fund be held intact in perpetuity. The interest is to be left with the principle to accrue, or be utilized as the ASAM Board directs.

The following information is from Development Director Claire Osman:

We are delighted to announce that we are approaching the halfway mark on our goal of $1,000,000. As of Dec. 6, 1990, we have received $428,571 in pledges. These pledges are from the board, staff, participants of the campaign, some members, and a few individual donors (a total of only 150 people). The general membership has not yet been solicited.

People who want information about the campaign, or who are willing to help, should call me directly. My number is (212) 206-6770.

The importance of the campaign is to give the society financial security to carry out its goals for the future. Some important goals are:

- American Board of Medical Specialties' recognition of addiction medicine.
- Fellowship, residency and other graduate training in addiction medicine.
- Advocacy for adequate public and private health insurance for addiction treatment.
- Development of treatment guidelines and protocols.
- Participation in clinical research on treatment outcome and effectiveness.

Just a reminder: as a donor, you may make pledges over a 36-month period, which can be spread over four tax years. A pledge enables you to make a maximum contribution with minimum financial strain. The schedule of payments can be arranged at your convenience, and extended times can be provided, if necessary.

You may use one of the following ways to plan your gift to ASAM: cash; appreciated stocks, bonds, or real estate; life insurance; corporate giving; employee matching gifts program;bequests.

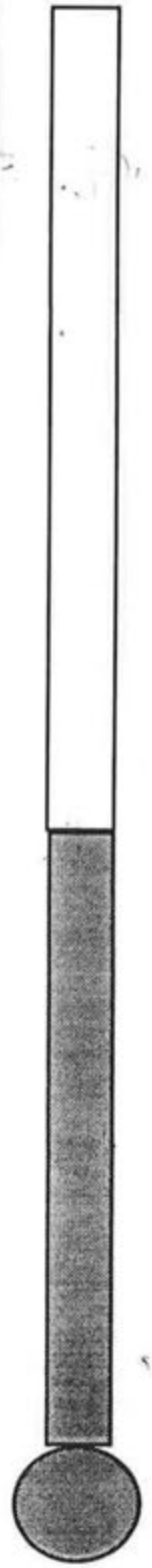
ASAM is a 501 (c)(3) non-profit organization and all gifts are tax deductible to the full extent of the law.

Once again, we ask you to please be generous. Help us to reach our goal of $1,000,000 by April, 1991. It is an investment in your future, and the future of addiction medicine. We need your support!

We are starting to approach foundations. If you have any person contact with a foundation, and can assist us, please call me, Claire Osman, at (212) 206-6770.

Campaign co-chairs are **Jasper G. Chen See**, MD, ASAM president, and **William B. Hawthorne**, MD, ASAM treasurer.

Goal: $1,000,000



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ASAM certified primary care physician with practice restricted to addiction medicine, looking for same to associate and do 1/2 time psychiatric residency in **southeast.**
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303D Sea Oats Drive,
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Psychiatrist needed part-time to help run Dual Dx units: adult, adol, IP and OP components. Existing FP and Psych Docs. Opportunities for private practice.
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ASAM CALENDAR

Meetings sponsored or co-sponsored by ASAM (one-time listing for co-sponsored conferences) For conference listing on this calendar, please send information directly to Lucy B. Robe, Editor, at least two months in advance.

For information about ASAM co-sponsorship of conferences, contact Claire Osman, ASAM-New York.

❑ **6th Annual Pacific Institute of Chemical Dependency: Honolulu, Jan. 3-12, 1991**
PCICD: 1188 Bishop St, Ste 1701, Hololulu, HI 96813
☎ (808) 526-2841

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❑ **Florida Society of Addiction Medicine (FSAM) Annual Meeting: Orlando, FL, Jan. 18-20, 1991**
Karen Barnum, PO Box 2411, Jacksonville, FL 32203
☎ (904) 356-1571

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❑ **Seniors at Risk: The Critical Role of the Health Care Professional the Prevention and Treatment of Substance Misuse and Abuse in Older Adults. Fort Lauderdale, FL, Feb. 1-3, 1991.**
Gale Bouchillon, Conference Coordinator, Nova University, 3301 College Ave, Ft. Lauderdale, FL 33314.
☎ 800-541-6682, or (305) 424-5736.

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❑ **11th Betty Ford Center Conference on Chemical Dependency. Rancho Mirage, California, Feb. 18-20, 1991**
Annenberg Center, 3900 Bob Hope Dr, Rancho Mirage, CA 92270.
☎ 800-321-3690; 800-621-7322 (in Cal.)

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❑ **ASAM 5th National Forum on AIDS & Chemical Dependency: San Francisco, Feb. 21-24, 1991**
MTS, Conference Information (AIDS), PO Box 81691
Atlanta, GA 30366 ☎ (404) 458-3382

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❑ **ASAM/NAATP Criteria Conference Atlanta, March 14-15, 1991**
ASAM, 5225 Wisconsin Ave NW, Washington, DC 20015
☎ (202) 244-8948

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❑ **ASAM Board Meeting: Boston, Wed. Apr. 17**

❑ **Ruth Fox Course: Apr. 18**

❑ **ASAM 22nd Annual Medical Scientific Conference: Boston, Apr. 18-21, 1991**
Cluny Conference Services, (Louisa Macpherson)
1013 Rivage Promenade, Wilmington, NC 28412
☎ (919) 452-4920

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❑ **NECAD 91: Newport, RI, May 19-22, 1991**
Edgehill-Newport, 200 Harrison Ave, Newport, RI 02840.
☎ 800-252-6466, Ext. 252

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❑ **ASAM 1st National Medical Conference on Adolescent Addictions: Atlanta, June 20-23, 1991**
MTS, Conference Information (Adol.), PO Box 81691,
Atlanta, GA 30366 ☎ (404) 458-3382

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❑ **ASAM 4th National Conference on Nicotine Dependence: Raleigh, NC, Sept. 13-15, 1991** (Info ASAM Washington office)

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❑ **ASAM Co-Dependency Conference: Warrenton, VA, Oct. 17-20, 1991**
Steven J. Wolin, MD, 5410 Connecticut Ave, NW,
Washington, DC 20015.

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❑ **ASAM State of the Art in Addiction Medicine: Orlando, FL, Oct. 24-26, 1991**

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❑ **ASAM Board Meetings:**
Dallas, Oct. 5-6, 1991
Washington, DC, Apr. 1, 1992
Site TBA, 1st Oct. weekend 1992
Los Angeles, Apr. 28, 1993
Site TBA, 1st Oct. weekend, 1993

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