ASAM NEWS

American Society of Addiction Medicine

formerly American Medical Society on Alcoholism and Other Drug Dependencies (AMSAODD)

Vol. V, No. 5 **September - October 1990** Published Bimonthly

Specialty Status Task Force will report to ASAM Board in November
(see p. 10)

Inside

NIAAA Director Stresses Importance of Research

FROM MY POINT OF VIEW

by **Enoch Gordis, MD**

We have three major problems in the way the field of addiction medicine is perceived: skepticism about the disease concept, skepticism about the efficacy of treatment, and the issue of stigma -- stigma against our patients, against the professional kind of work that we do, and against the entire area of addiction medicine.

My contention is that the solution to these problems will be based on science, and that all the polemics in the world, and all the debates, and all the newspaper editorials, will do little compared to a commitment to science.

Disease Concept Still Controversial

I believe that the controversy over the disease concept will be resolved by arrival at a genuine understanding of the physiology of addiction, of what craving is about, of the genetic side of vulnerability. This also means an understanding of how psycho-social and environmental factors, which we have to quantify, interact with biogenetic mechanisms.

When such processes are more clearly defined, the disease will have a shape, predictability, new treatments, and we won't have to put up with these polemics any longer because the disease concept will be a moot question.

In other words, the solution to the controversy about the disease concept will come from research.

Removing Treatment Uncertainties

Most of our treatment now is based on wisdom, tradition, clinical experience and plausibility. These are valuable ingredients; you cannot have clinical practice without them. But a treatment world based solely on intuition and plausibility is headed for trouble. Almost every other branch of medicine relies mainly on evidence for new therapies that are introduced.

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ASAM is a specialty society of 3,600 physicians who are concerned about alcoholism and other drug dependencies and who care for persons affected by these illnesses.

CONFERENCE DIGEST

ASAM's 3rd National Nicotine Dependence Conference in San Diego

The turnout for ASAM's 3rd National conference on Nicotine Dependence, held in San Diego September 6-9, was lighter than last year. Of the nearly 200 who attended, 65 were physicians. Seven of the faculty of 26 were ASAM members: Drs. **John R. Hughes, Richard D. Hurt, Geoffrey Kane, James Keller, Terry A. Rustin, John Slade, and Abraham Twerski.**

The conference focused on three areas: nicotine dependence as a challenge for the addictive disorders field; the impact of cigarettes on minorities; update on pharmacology of nicotine dependence.

The conference arranged to have NA (Nicotine Anonymous) meetings available every morning and evening. (Nicotine Anonymous was formerly known as Smokers Anonymous. It is not affiliated with another NA: Narcotics Anonymous.) AA meetings were concurrently available.

Conference co-chairs were Drs. **Stephen F. Hansen, Richard D. Hurt,** and **Jay R. Miller.**

The best attended workshops were how-to's on helping people to stop smoking by Nina G. Schneider, PhD, (co-author of the journal article about the Fagerstrom Questionnaire on p. 3) and **Terry A. Rustin,** MD.

Most of the conference presentations are available on audiotape at $8.50 each from Infomedix, 12800 Garden Grove Blvd, Ste F, Garden Grove, CA 92643. Phone: 800-367-9286. In California: 800-992-9286.

ASAM has two relevant position statements: "Nicotine Dependence and Tobacco" (4/20/88, amended 9/25/89) and "Documentation of Nicotine Dependence on Death Certificates and Hospital Discharge Sheets" (4/26/89). Copies are available from the ASAM Washington office.

Next Year

ASAM's 4th National Conference on Nicotine Dependence will be held at the Raleigh Hilton Hotel in Raleigh, NC, Sept. 12-15, 1991.

ASAM Survey of Smoke-Free CDU's

Jeffrey Goldsmith, MD, has been collecting information about smoke-free CDU's from all over the country for the Nicotine Dependence Committee. In 1988, he surveyed 19 CDU's. The criterion then to be "smoke-free" was no smoking on the unit. Criteria in 1989 were amended to no smoking in the building and no smoking by staff on the job. These remain the ASAM committee's criteria today.

In other words, a CDU that permits patients to smoke outdoors, and staff to smoke at home, is considered smoke-free for purposes of this survey. Dr. Goldsmith has "39 confirmed smoke-free CDU's and another eight unconfirmed." Most report that the "strong opinion of a strong leader" is still the most helpful item. A major barrier is whether or not people believe it can be done.

Dr. Goldsmith continues to seek information about smoke-free facilities, inpatient or outpatient. Call him at (513) 558-2016; he will send you a short questionnaire, or will fill it out on the telephone. "Nobody should apologize if patients are allowed to smoke outside the building in 1990," he told *ASAM NEWS*. "We know there is enough hostility from some staff and some AA members to make going totally smoke-free very difficult."

Reimbursement

Most physicians are by now aware that treatment for nicotine dependence as a primary disorder generally is not reimbursable.

In a workshop, **Geoffrey Kane,** MD, of Brookside Hospital in New Hampshire, and Jeff Eagle, PhD, of Centerville, MA, said that about 90% of alcoholics smoke, as do two-thirds of psychiatric inpatients, three-quarters of adolescent psychiatric inpatients, and up to 100% of adolescent CD inpatients.

Some smoking cessation services can be reimbursed if they are piggy-backed onto other CD or psychiatric treatment. These services include consults, lab services, X-Rays, psychotherapy (usually by an MD or PhD), group therapy, pulmonary function tests, respiratory therapy in a hospital setting, abdominal diaphragmatic breathing instruction, bronchodilator instruction, psychiatric and psychological tests. Dr. Kane is chair of ASAM's Subcommittee on Reimbursement for the Nicotine Dependence Committee. The subcommittee's position statement will soon be submitted to the ASAM Board.

Dr. Eagle has had wide experience in reimbursement for nicotine dependence treatment. As reported in *ASAM NEWS* last year (September-October issue), he uses the following DSM-III-R diagnostic codes. He warned physicians not to use them as primary diagnoses, but as co-morbid ones:

- **psychological factors affecting physical condition** - specify the physical condition as Axis III - Code 316.00
- **nicotine dependence** - Code 305.10
- **nicotine withdrawal syndrome** - Code 292.00

Associated physical symptoms: wheezing, coughing, bronchitis, lung cancer, emphysema, asthma, high blood pressure, peripheral vascular disease, gastrointestinal disturbances.

ASAM, HHS, CDC Call for Insurance Coverage of Nicotine Dependence Treatment

Shortly after ASAM's conference and in conjunction with the release of the 1990 Surgeon General's Report on the benefits of quitting smoking, HHS Secretary ***Louis Sullivan,*** *MD, called for private health insurers to cover costs of treatment for nicotine addiction. The Assistant Secretary for Health and the Director of the CDC joined Dr. Sullivan in this recommendation, as did ASAM.*

"Stopping smoking saves lives. Some need professional help to do this," said ***Jasper G. Chen See,*** *MD, president of ASAM, in a press release issued Sept. 25. "We ask Dr. Sullivan to convene a task force of insurers, providers, and*

(continued on page 3)

consumers to reach agreement on how private health insurers will provide coverage for nicotine addiction treatment. We agree with him that the treatment of nicotine addiction should be considered as favorably by third-party payers as are treatment of alcoholism and illicit drug addiction."

Noted John Slade, MD, chair of ASAM's Nicotine Dependence Committee, "These services are already covered as a matter of routine in Great Britain. But, in the United States, among conventional insurance plans, only the Blue Cross/Blue Shield program in King County (Seattle) pays for treating addiction to nicotine. A substantial minority of people who are addicted to this drug need professional help."

Drs. Richard Hurt and Stephen Hansen

Pharmacology of Nicotine Addiction

Neal L. Benowitz, MD, of UC-San Francisco, said that nicotine enters the brain within ten seconds of a puff on a cigarette, where it binds to specific receptors that result in facilitation of neurotransmitter release.

Total circulation time is 19 seconds. Nicotine's half-life is about three hours, but it takes regular smokers nine to twelve hours to rid their bodies of the drug.

Nicotine withdrawal symptoms include anxiety, irritability, nervousness and impaired concentration.

Regular smokers find a comfortable level of nicotine and, probably unwittingly, regulate that level. Thus, when smoking lower yield or fewer cigarettes, a smoker puffs more intensely and/or more frequently to compensate for this reduced nicotine availability. And even if cutting down from 45 to 10 cigarettes a day, a smoker's calibration means that he or she obtains about the same amount of nicotine. Carbon monoxide levels remain the same no matter what the brand.

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John Slade, MD, presents a pack of Uptown Cigarettes to Jesse Brown, as a souvenir of Rev. Brown's successful campaign to halt the test marketing by RJR of this cigarette to African-Americans in Philadelphia.

Fagerstrom Tolerance Questionnaire

1. How soon after you wake up do you smoke your first cigarette?
   • within 30 minutes (1) • after 30 minutes (0)
2. Do you find it difficult to refrain from smoking in places where it is forbidden, e.g. in church, at the library, in cinema, etc.?
   • yes (1) • no (0)
3. Which cigarette would you hate most to give up?
   • the first one in the morning (1) • any other (0)
4. How many cigarettes/day do you smoke?
   • 15 or less (0) • 16-25 (1) • 26 or more (2)
5. Do you smoke more frequently during the first hours after awakening than during the rest of the day?
   • yes (1) • no (0)
6. Do you smoke if you are so ill that you are in bed most of the day?
   • yes (1) • no (0)
7. What is the nicotine level of your usual brand of cigarette?
   • low: 0.9 mg or less (0)
   • medium: 1.0 - 1.2 mg (1)
   • high: 1.3 mg or more (2)
8. Do you inhale?
   • never (0) • sometimes (1) • always (2)

Fagerstrom, Karl O., Schneider, Nina G.,*
"Measuring Nicotine Dependence: A Review of the Fagerstrom Tolerance Questionnaire"
Journal of Behavioral Medicine. v. 12, #2,159-182, 1989.

**The authors caution that this FTQ still needs study but "may help in the determination of appropriate dose levels in nicotine substitution treatment."*

Nicotine Dependence Treatment

Psychiatrist **John R. Hughes**, MD, of the University of Vermont, uses the Fagerstrom Tolerance Questionnaire as "the most widely proven instrument" to measure dependence (see sidebar above).

About 70% of smokers say that they want to quit. Although most take three to four tries, about 25% quit the first time they try. One-third gain weight, one-third lose weight, one-third stay the same.

Nine studies of nicotine gum treatment (polacrilex, a.k.a. Nicorette) vs. placebo show nicotine replacement to consistently improve long term quit rates. There is no evidence that patients relapse at higher rates after they stop using the gum, which is a common concern. Eight studies of transdermal patches show increased quit rates for this treatment, which patients find more convenient to use than the gum.

(conference coverage continued on page 5)

*Note: **names in bold** type are ASAM members.*

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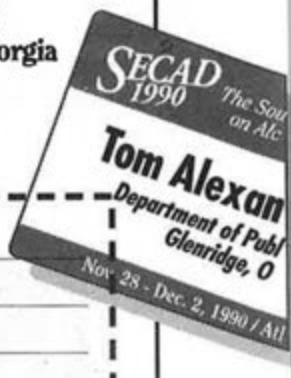

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Obstacles to a Smoke-Free CDU

When Gateway Rehabilitation Center near Pittsburgh decided to go totally smoke free, the 120-bed CD treatment center prepared with care, but "our preparation was inadequate," said **Abraham J. Twerski**, MD, medical director. Gateway's attempt, begun in the fall of 1989, lasted for six months.

Describing what happened at ASAM's Nicotine Dependence Conference must have taken a good deal of courage on the parts of Dr. Twerski, and of Gateway's president and CEO Kenneth S. Ramsey, PhD, who offered many first-hand observations and suggestions. Their experience should be helpful to other CDU directors who would like to attempt a completely smoke-free CDU.

Staff Smokers a Problem

A major hindrance: about half the staff of over 100 were heavy smokers. Dr. Twerski said that some staff had "many years of sobriety and did not consider themselves active addicts, a status which they were now to assume as smokers." They were offered cessation courses, and Gateway instituted a policy of hiring only non-smokers, but "legal counsel advised that dismissal of staff who refused to abstain from smoking was not permissible."

A chain is only as strong as its weakest link. Dr. Twerski now believes that *every single person* on a CDU staff, including *all* in maintenance, must be a non-smoker in order for a smoke-free unit to succeed. This poses a problem at Gateway, which was started in 1973 and has long term employees who still smoke at home. New employees should be smoke-free for at least six months.

The turmoil that followed the center's totally nicotine-free state was "far greater than expected." Problems included:

• Patients were told prior to admissions that smoking was completely prohibited, but some later claimed that they had not heard this message. Over 80% of the patients were heavy smokers. Some threatened to sue Gateway for not being allowed to smoke there. None did so, however.

Thirty-five percent of Gateway's gift shop revenues had been from cigarette sales. When it stopped selling smokes, the sale of candy bars "skyrocketed temporarily."

A smoke-free facility should inform patients and their families in a way that everyone will understand, which means not just on the telephone.

• The main motivations for becoming abstinent from chemicals -- e.g. job, family, court, finances -- simply do not apply to nicotine (cigarettes).

Other relevant problems: many referral sources smoke; no other treatment centers in the area plan to go smoke-free.

• Smokers on staff were uncomfortable disciplining patients who smoked. Dr. Twerski said that in particular night personnel who still smoked were loathe to squeal on patients. They "lent these patients a sympathetic ear," and would "look the other way" if patients smoked.

• Some patients' jobs were contingent on completing a CD rehab course. If they were dismissed from Gateway for breaking the no smoking rules, they would be deprived of their livelihood for a condition (smoking cigarettes) that they shared with superiors and employers at work. If patients were referred to Gateway by an EAP for, say, cocaine addiction, was it fair to discharge them prematurely for smoking cigarettes?

A smoke-free facility should have a clear cut policy in place for dealing with anyone who smokes on the premises.

• Surreptitious smoking undermined the honesty and trust that is crucial to a CD rehab program.

During the smoke-free period, some patients started a black market for cigarettes, which sold for as much as $5 *apiece*. "Policing patients was a nightmare." Patients smoked into the vent systems in bathrooms. A new, sensitive, smoke detection system was constantly going off, until the fire department threatened to charge for coming over.

• Treating nicotine as a "lesser" addiction is contrary to the all-or-none attitude toward other addictive chemicals.

• Smokers in local AA/NA (Narcotics Anon.) fellowships resisted the implication that they were still active addicts, and some were antagonistic toward Gateway's nicotine-free program. Some even actively undermined its nicotine treatment.

A facility should build bridges to the AA and NA groups in the communities that serve their patients, so patients will have non-smoking groups to attend when they leave treatment.

30% Left Treatment a.m.a.

Smoking Outdoors Permitted

Gateway's board of directors had approved the full nonsmoking policy for only six months, and contingent upon looking at the financial effects. One-half the board smokes.

The treatment center's a.m.a. rate (leaving against medical advice) had been between 8% and 10%. Now, however, despite the same bed census, the a.m.a. discharges rose to "30%, which was fiscally intolerable," said Dr. Twerski.

As a consequence, Gateway modified its non-smoking approach: all buildings are smoke- free but smoking is permitted outdoors "for now, until we regroup and try again."

The a.m.a. rate dropped back to "normal," according to Dr. Ramsey, who plans to make patients smoke outdoors all winter -- "not even in a small room indoors, and Pittsburgh winters are *cold!*"

Gateway now offers nicotine dependence treatment as an option to all patients, including Smokers Anonymous (now called Nicotine Anonymous) meetings, meditation, etc. Drs. Twerski and Ramsey intend that Gateway become smoke-free again, in the future, but after adequate preparation.

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NIAAA Director

(continued from page 1)

I believe that the standards for evaluating treatment research, which have long been automatic in other fields of medicine, *must* be applied to our field in order to legitimize our treatment efforts, and to dispel the skepticism toward treatment efficacy. I am referring to controlled trials, randomization, strict measures of outcome, and avoiding usual traps in outcome analysis -- such as not counting patients who are lost to treatment, or not acknowledging the selection bias of admitting certain patients and excluding others. These considerations are standard in other areas of health care and they have to be standard in ours.

Rather than being threatening to the treatment field, its security depends on this kind of research. True, some claims now being made for treatment may have to be surrendered. But, whatever becomes validated will be beyond challenge. Therefore, as far as skepticism about treatment efficacy is concerned, research seems to be the only secure answer. Another side has to do with the development of new treatments, which will be directed, for example, to the abolition of craving, the better management of withdrawal, the avoidance of relapse. The kind of pharmacology which I think will influence such treatment comes from basic neuroscience. *Dr. Gordis*

FROM MY POINT OF VIEW

Stigma

We all know how hard it is to get curricula into medical schools. We all have experienced somewhat condescending disdain from some of our colleagues in other branches of medicine. What are the reasons for this?

First, addiction medicine has no strong academic base. Departments such as surgery, psychiatry, and pathology have fixed bases, which implies recognition. Curricula in those departments do not depend on one or two charismatic people in the medical school to keep them going. They survive because it's obvious that they should. One day, I think it will be obvious that our field should survive in medical schools as well.

But another side of the story is more disturbing, and I am glad to see that it's really changing in ASAM. In any other medical specialty, even if a person is in full-time clinical practice and is not a researcher, he or she has the *automatic expectation* that new treatments, new devices, new medications, will come from science. One does not assume that the treatment of 30 years ago should be the treatment of today, nor does one think that today's treatment will be uninfluenced by science for the next ten years.

(continued on page 7)

NIAAA Director *(continued)*

Our field of addiction medicine, however, still has that feeling of estrangement; the notion that treatment has been a settled matter since 1935, when AA was started, and that basically it's an issue of motivating patients to enter treatment. It isn't. Because we know that most patients relapse. And unless we face that fact, we are not going to have the encouragement to do new things in treatment.

Despite all its remarkable achievements, if we accept Alcoholics Anonymous' numbers, less than five percent of all the alcoholics in this country are involved in AA -- 55 years after the fellowship's founding. This means a tremendous gap between what we now know how to do, and what science will eventually provide us.

AA's co-founder, Bill W., made a pledge in 1958 "to the whole medical fraternity that AA will always stand ready to cooperate, that AA will never trespass upon medicine, that our [AA] members who feel the call will increasingly help in those great enterprises of education, rehabilitation and research, which are now going forward with such great promise."

Those words are certainly true in 1990.

We sometimes hear that researchers are remote from our field, off in some ivory tower. In my opinion, this is false and short-sighted. False because the things that we take for granted today in every other branch of medicine came from basic research. Many who now enter a coronary unit with chest pains end up getting tPa, a product of the most obscure molecular biology that started 25 years ago. A heart transplant involves immune mechanisms which were studied by those ivory tower scientists 30 years ago. If we have a drug for AIDS now in AZT, with modest potential for helping people, it's because of very obscure chemistry of nucleic acid substitutions over 20 years ago.

If addictions treatment in 20 years is to be better than it is now; if two-thirds of our patients are not to relapse in half a year -- we need new treatment. This will come from the most obscure-looking sources, as well as the ones which are obvious extrapolations of what we know already.

On the issue of stigma, change must come from a shift in attitude toward science, toward scholarship, toward the role science can play in the future. I think ASAM has turned a very important corner, with its new medical scientific programs and its certification process. Whatever the struggle will be for specialization, one of the major payoffs is happening now: self-study. To learn, you have to feel the pressure. Those who have taken that ASAM Certification Exam have felt that pressure, have overcome it, and have learned.

Treatment and Research Should Unite

In conclusion, there are two unities:

• the unity of different branches of science. For example, genetics will permit us one day to do focused intervention with high-risk kids in a way we cannot do now. Thus what looks like remote molecular biology will be translated into prevention for young people. Another example: the very complicated and obscure neuroscience, which will help us to understand craving, will provide treatment for the addiction s of a potency that none of us can dream about now.

• the coming bridge-building between the treatment and the research fields. Ten years ago, I wouldn't have said it. But I see clinicians now thirsting for science. And I see researchers at the same time learning about the clinical picture, going out to meetings with counselors, social workers and physicians, and sharing their research. I am happy to say that the wall between the treatment and the research communities is finally coming down.

In my view, these communities are interdependent. Neither can go it alone, although there are people in each camp who mistakenly think otherwise. Research is justified by its ultimate help for human beings.

But treatment without research becomes simply dogma. Fortunately that is changing, and ASAM is in the forefront of those who are tearing down the walls.

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This is an edited version of a speech by ***Enoch Gordis****, MD, director of the National Institute on Alcohol Abuse and Alcoholism, given at the ASAM Annual Luncheon in Phoenix, Arizona, April 28, 1990.*

ASAM NEWS welcomes comments. Please send your thoughts about this article to Lucy B. Robe, editor; we will publish responses as space permits.

Note: names in ***bold type*** *are ASAM members.*

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ABOUT ASAM

In October 1985, Volume I Number 1 of this newsletter was published. Called AMSAODD Newsletter, the four-page publication was produced on Editor Lucy Robe's typewriter.

The president of the American Medical Society on Alcoholism and Other Drug Dependencies (AMSAODD) at that time was Max A. Schneider, MD, of Santa Ana, California. Five years later, Dr. Schneider reminisced for this issue of ASAM NEWS:

Fifth Anniversary of Newsletter

by **Max A. Schneider**, MD

It was an exciting time. Certification was taking root. New committees were blossoming. The society's new constitution was being formed, state chapters were evolving, and the board was discussing hiring the society's first executive director. *[In October 1985, Dr. Schneider functioned as ASMAODD's president and unofficial CEO -- both volunteer, of course -- on top of numerous 'real' jobs practicing medicine; lecturing all over the country; extensive writing, filming and taping!--Ed.]*

Dr. Schneider

Membership had "burgeoned" to 1,850. It was time for increased communication; a time for a national constituency of concerned physicians to share as the newest specialty of medicine emerged. And so what is now *ASAM NEWS* was born.

Under the stewardship of Ms. Lucy Barry Robe, the publication has expanded from four pages to 16, replete with ads of benefit to our membership, a Letters to the Editor column offering members the opportunity to express diverse opinions, and excellent coverage of ASAM's multiple activities. Ms. Robe can be seen at almost all of our major functions, darting in and out with camera and pad, enshrining our history.

Comments, suggestions, and ideas from ASAM members are always encouraged.

Congratulations, *ASAM NEWS!* And thank you, Lucy!!"

◆

Lucy Barry Robe
ASAM NEWS Editor

Dr. Chen See

New Adolescent Center Named for Chen See

The Caron Foundation of Wernersville, PA, has named its new $3 million adolescent center after ASAM's president, **Jasper G. Chen See**, MD. He is also president of the Caron Board of Trustees. The new CD facility will house up to 36 addicted teens.

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COMMITTEE NEWS

Commentary from the
Task Force on Specialty Status

The case for recognition of addiction medicine as a specialty or subspecialty rests in the advances being made in research, the development of the knowledge base, the progress being made in medical education at all levels, and the need for more physicians who can address the serious public health problem of drug and alcohol use and addiction.

However, the drive for recognition of addiction medicine, or any specialty or subspecialty area, cannot be viewed in isolation from other factors. The American Board of Medical Specialties (ABMS) Bylaws note that fact; they require that any Member Board's proposal for any new or modified type of certification "...should include the assurance that the ABMS Member Board will conduct an evaluation of the impact and effect of the proposed modification of the certificate." (Article IX, Section 9.3)

The factors which ASAM must take into account include:

1. Medical education in general is going through a time of financial retrenchment.

Even though availability of addiction medicine training has recently increased, further progress may be hard to come by. As one example, Medicare funds cannot be applied to hospital-based graduate training programs if that program does not lead to a certificate from an ABMS-Member Board. When resources are allocated, training programs in recognized fields will take priority.

2. In efforts to reduce costs, the economics of health care are coming under increased scrutiny and control . A subspecialist within a recognized specialty can command higher fees than can a generalist in that specialty, but the public is opposed to higher fees.

3. Having received requests from several groups that seek recognition, ABMS has developed mechanisms to avoid proliferation of new boards, or of subspecialties under existing boards.

Addiction medicine is only one of many areas in which groups seek recognition by ABMS. Others include adolescent psychiatry, forensic psychiatry, clinical nutrition, medical genetics.

Within the past two years, several areas have been given subspecialty status with CAQs: geriatric medicine, geriatric psychiatry, sports medicine, critical care.

4. Action by any one ABMS-Member Board to establish a subspecialty could be seen as either potentially facilitating, or potentially blocking, recognition of that subspecialty area by ABMS in other specialties.

Report to Board Nov. 11

All these factors have been considered by the ASAM Task Force in the preparation of its report and recommendations, which will be presented to the ASAM Board for consideration on Nov. 11. Chair: **Anne Geller**, MD ... *(EMS & GBJ)*

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Standards & Economics of Care

Criteria Near Completion

ASAM is working with NAATP (National Association of Addiction Treatment Providers) to develop a joint ASAM/NAATP workshop, tentatively scheduled for March 1991. This will be preceded by comments on the "Proposed NAATP and ASAM Patient Care Placement Criteria" from the ASAM and NAATP Boards and from the field, and a limited field test.

If any ASAM member is interested in receiving a copy of and participating in the field review of "Patient Care Placement Criteria," contact the Washington office.

Committee chair **David Mee-Lee**, MD, told ASAM NEWS "we are really trying to get a good national consensus on these admissions, continued stay, and discharge criteria, which will be meaningful to providers, payers, and policy makers."

Incident Report Form

The ASAM Washington office has already received a number of copies of the "Access to Care Denial Incident Report Form" which was published in the July-August newsletter (page 3). Dr. Mee-Lee hopes that this response will prompt other ASAM members to photocopy, fill out, and send in copies of the one-page form.

MRO (Medical Review Officer)

"This committee's big issue right now is the DOT Secretary's Notice of Proposed Rulemaking (NPRM) which we believe would downplay the MRO role," committee chair **Donald Ian Macdonald**, MD, told *ASAM NEWS*. The NPRM, put out by the Department of Transportation, was published in the Federal Register July 13, 1990.

ASAM committee members who wrote DOT protesting letters about the NPRM included **Drs. Macdonald, H. Westley Clark**, and **David E. Smith**. James F. Callahan, DPA, also wrote to object on behalf of ASAM.

Dr. Macdonald's letter told DOT: "'If it ain't broke, don't fix it.' The program is working ... The aim of [NPRM's backers] is to downgrade the role of physicians throughout the drug testing process. An upgrade makes more sense ... medical review [is especially valuable] in regard to the issue of false negatives." His letter also noted that "ASAM's MRO Committee has been asked to define the knowledge base required to perform adequately as an MRO and to make recommendations for inclusion of this base into the certification examinations given by ASAM."

Committee Meetings

The following ASAM committees will meet in San Francisco Nov. 8-11, in conjunction with the board meeting Nov. 10-11, and coincident with the California Society Review Course and its annual meeting:

Budget & Finance, Certification Council , Credentialing, NCAdd/ASAM Joint Definition, Nomenclature, Physicians' Health , Ad hoc committee on Physicians' Health Customs, Public Policy, Resource & Development.

Ensuing board meeting: April 17, 1991, in Boston.

Family and Generational Issues

Plans Co-Dependency Symposium

ASAM is planning a national consensus symposium for clinicians, researchers, and policy makers involved in the children of alcoholics and co-dependency movements.

Purpose: to review current knowledge in this area and produce a monograph with up-to-date definitions, recommendations for research, and guidelines for assessment and treatment.

Dates: October 17-20, 1991.

Place: Airlie Conference Center, Warrenton, Virginia.

Maximum attendance: 200, by invitation only.

Inclusive cost to each registrant: about $400 (airfare extra). An OSAP grant is covering other symposium costs.

"In the face of the tremendous swell of interest in the consequences of substance abuse in families and children, ASAM decided, in 1988, to establish a committee focussed on these concerns," committee chair **Steven J. Wolin**, MD, told *ASAM NEWS*. "Following a successful workshop at ASAM's 1988 Annual Meeting, we decided to apply for grant funds to hold a three-day symposium on the topic. OSAP approved and funded our request for a meeting where a serious, responsible, scientific group would advise the field at large.

"At our 1991 symposium we will examine theory and practice in the assessment and treatment of CoA's [children of alcoholics] and CoSA's [children of substance abusers]. We want to know what clinicians are doing, what recent research has shown, and what questions are being asked by the architects of public policy.

"We want to review protective and risk factors alike and not ignore the large group of CoA's who are doing well."

Dr. Wolin is a psychiatrist. He co-authored the book *The Alcoholic Family* with Peter Steinglass, Linda Bennett, and David Reiss.

Anyone who is interested in attending this conference please write to Dr. Steven J. Wolin at 5410 Connecticut Avenue NW, Washington, DC 20015. Give him "a little background about yourself and explain why you want to come."

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STAFF UPDATE

O. Jay Arwood, ASAM's new PC data technician, comes to ASAM's Washington office with a varied background of relevant jobs in government: National Cancer Institute, NIH Labs of Structural Biology and Biochemical Pharmacology, NIH Clinical Center, FDA Medical Library. He has overseen the transfer of membership data from New York City and is in charge of restructuring ASAM's data base to be more responsive to the members' needs. He also will manage membership data maintenance and provide technical support of computers.

Jay encourages phone calls or letters from ASAM members about changes of address, requests for information about membership status and dues, etc.

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LETTERS TO THE EDITOR

*In the January-February issue of ASAM NEWS, **John Slade's** editorial "Are We Facing Up to Nicotine Addiction?" (p. 9) included proposals that smokers should not participate in policy development about smoking or nicotine dependence treatment; and that nicotine-dependent therapists should avoid treating CD patients who are smokers, unless a nonsmoking therapist is available to deal with nicotine dependence issues.*

*Disagreeing with Dr. Slade on these points, **Puskoor M. Kumar**, MD, wrote in the May-June ASAM NEWS (p. 15) that the latter restriction would be "like telling social drinkers or people who have never suffered from CD and are not themselves in recovery that they cannot treat chemical dependency." Dr. Slade in turn responds:*

Dear Editor:

While most people who drink alcohol are not addicted to it, most people who smoke cigarettes *are* addicted to nicotine. A person who is addicted to a substance has a conflict of interest when making decisions about that substance. On the other hand, a nonsmoker who has rigid and uncaring attitudes about smoking does not have a conflict of interests, even though these attitudes may lead to bad policy.

Just as we would avoid asking someone who is addicted to alcohol to make policy about alcohol use, so should we avoid putting someone who is addicted to nicotine in the position of making policy decisions about nicotine use.

My suggestion that a therapist who is addicted to nicotine should not treat chemically dependent patients who smoke was contingent on there being no available co-therapist to address the nicotine problem. I recognize the practical short-term impossibility of all who treat addicted patients, and who are themselves addicted to nicotine, becoming abstinent from nicotine. This is very different from the widely accepted practice of therapists who do not have a drinking problem treating alcoholics.

Would it be good practice for a cocaine-addicted psychiatrist to treat a patient who abused both alcohol and cocaine? Wouldn't that patient's cocaine problem get short shrift in such a situation?

John Slade, MD
New Brunswick, NJ

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Dear Editor:

When we tried to go smoke-free, we found a major problem to be referral sources. These were EAP and outpatient facilities that refer clients to inpatient facilities which take Medicaid.

We discovered that they were telling their clients (the potential patients): "You have a choice. Here are two good rehabs in the area that both accept Medicaid. At one you can smoke, at the other, you cannot. Where would you like to go?"

Do other ASAM members who work in CD treatment have similar experiences?

Leah E. Williams, MD
Binghamton, NY

◆

Two psychiatrists responded to the "Letter a Recovering Patient Can Give to a Physician About Medications" by William H. C. Dudley, MD, in the July-August issue of ASAM NEWS (p. 7), in which Dr. Dudley wrote "Generally speaking, a person with addiction should not have any kind of chemotherapy for anxiety or depression, or for any psychiatric problem other than the major psychoses, such as schizophrenia and manic depressive illness."

Dear Editor:

I believe that this statement is too broad and could promote needless suffering among our patients. Indeed, I have treated many individuals who were in much discomfort and pain from anxiety and depression, that was left untreated by psychiatrists or addiction specialists who believed all medications to be bad for these patients.

In my experience, use of a non-addicting anti-depressant can produce a tremendous amount of symptom relief and can add dramatically to the quality of the individual's life.

I am no in way advocating the administration of any medication that would have addictive potential or could set off relapse in addictive situations. I feel the above quoted sentence is more rigorous than needed and could, if strictly adhered to, promote needless pain and suffering among our patients.

The rest of the letter is excellent. This form of communication among physicians is important. I urge all my patients to immediately tell their physicians they are addictive.

I would be interested in my fellow ASAM members' positions on this.

Todd W. Estroff, MD
West Palm Beach, FL

Dear Editor:

I find Dr. Dudley's letter most helpful. Therefore I am loathe to quibble, but ... it is my opinion that patients who suffer from major depressive illness deserve treatment with appropriate antidepressant medication. I concur that this should be done only after thorough evaluation, with determination that the depressive illness is not merely a manifestation of the addictive process. Medication such as alprazolam [Xanax], a benzodiazepine with anti-depressant action, is contraindicated in such patients. However, the tricyclic antidepressants and fluoxetine [Prozac] can be used safely with proper supervision.

In addition, non-psychotic conditions such as panic disorder and obsessive-compulsive disorder can be disabling, warranting comprehensive therapeutic intervention including non-addictive psychoactive medication. It is my contention that addictive illnesses protect from nothing and indeed may render our patients more vulnerable to psychiatric conditions of a biological nature.

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

◆

Dear Editor:

Regarding the debate on legalization of drugs between Drs. **LeClair Bissell** and **Max Schneider** last April in Phoenix *[reported in the May-June issue of ASAM NEWS (p. 1)]*, here are just a few questions that I believe require answers. I prepared them as part of a leaflet that was put out by the Los Angeles affiliate of the National Council on Alcoholism (now NCAdd).

- Which drugs would be legalized?
- Who would determine which drugs would be legalized?
- Who would control distributing the drugs?
- Would drugs be sold in the same way as are alcohol and tobacco?
- What quantity would be permitted each person who seeks the drug? And in what time frame: Every month? Every day? Every year?
- Who would determine the cost?

If taxation was to be low, anyone could afford to buy the drugs. Yet, if taxation was high, we would return to competition and/or the black market.

- Would legalization truly eradicate crime?

Jokichi Takamine, MD
Los Angeles, CA

[Drs. Bissell and Schneider will continue their debate in Atlanta on Nov. 29 during SECAD. ASAM NEWS will publish a report -- Ed.]

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ASAM NEWS welcomes letters to the editor. Send to Lucy B. Robe, 303D Sea Oats Drive, Juno Beach, FL 33408. We will publish as many as space permits.

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Errata

In July-August issue of *ASAM NEWS:*

- (p. 11) Correct phone number to order "Addiction Medicine" issue (May 1990) of *The Western Journal of Medicine* is (415) 882-5177.
- (p. 9) In Memoriam: **Edward** *(not Edwin)* **J. Schumack,** MD, died in May.

Thanks to readers for calling these errors to our attention ... Ed.

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RUTH FOX MEMORIAL ENDOWMENT FUND

This information is from Development Director Claire Osman and Executive Director James F. Callahan, DPA, in response to questions from ASAM members about the campaign.

The endowment fund's purpose is to place ASAM on a fiscally sound base, to assure the society's ability to realize its vision of discovering and providing effective treatment for everyone who suffers from alcoholism and other drug dependencies.

The more than 800 participants in this campaign are ASAM members, who volunteer their time and effort to help the society achieve its goal of $1,000,000.

Starting in October, campaign personnel plan to contact the entire ASAM membership. This is a face-to-face campaign; **we may not reach all of you before the end of this tax year.** If you wish to give in advance of being solicited, please call the New York office at (212) 206-6770, and we will send you a campaign packet and pledge card.

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"$1,000,000 Celebration"

A Ruth Fox Memorial Endowment Reception, "$1,000,000 Celebration," is being planned.

Date: Friday, **April 19, 1991.**

Time: 6:30-8:00 P.M.

Place: Boston Marriott Copley Place, during ASAM's 22nd Annual Medical-Scientific Conference.

Invitations will be sent only to endowment fund donors.

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Ruth Fox, MD
ASAM founder,
1st president

Giving Opportunities:

Distinguished Fellows' Circle	$250,000
Colleagues' Circle	100,000
Benefactors' Circle	50,000
Founders' Circle	25,000
President's Circle	10,000
Leadership Circle	5,000
Circle of Friends	3,000

Ways to Give

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.

Pledges of $3,000 will be acknowledged with a Ruth Fox Memorial Endowment Fund lapel pin. Other giving opportunities will be appropriately acknowledged.

Charter Membership in the Ruth Fox Memorial Endowment Fund is open until the April 1991 annual meeting.

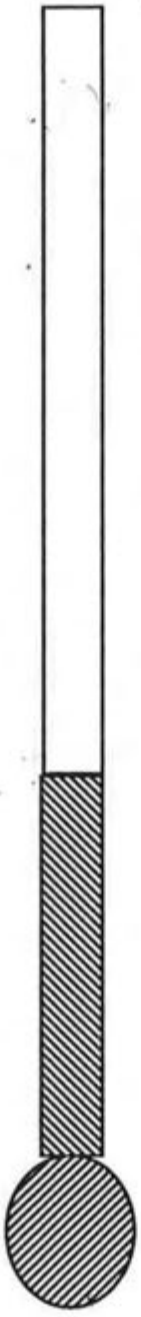
Campaign Goal: to raise $1,000,000. We have reached the one-third mark, and our goal is to reach the half mark by December 1990. Each member will be asked to pledge a minimum of $3,000, payable over a three-year period.

Please be generous. Your support is vital to our success!

Campaign co-chairs are **Jasper G. Chen See**, MD, ASAM president, and **William B. Hawthorne**, MD, ASAM treasurer. For more information, contact Claire Osman, development director, in ASAM's New York office ... *(CO & JFC)*

◆

Goal: $1,000,000



Pledged: $344,510

(as of Oct. 9)

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* *Participants of the Ruth Fox Endowment Campaign*

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.***

ASAM CALENDAR

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

- ❑ **ASAM 1990 Review Courses:** New York: Oct. 25-27; San Francisco: Nov. 8-10; Atlanta: Nov. 15-17

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- ❑ **CSAM Annual Meeting (California Society of Addiction Medicine): San Francisco, Nov. 9-10**
  California Society of Addiction Medicine, 3803 Broadway, Oakland, CA 94611-5615
  ☎ (415) 428-9091 FAX: (415) 653-7052

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- ❑ **ASAM Board Meeting: San Francisco, Sun. Nov. 11**

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- ❑ **ASAM 1990 Certification Examination: Sat. Dec. 1**
  Chicago; Newark, NJ; San Francisco; Atlanta.
  ASAM, 12 West 21 St, New York, NY 10010.
  ☎ (212) 206-6770
- ❑ **SECAD (Southeastern Conference on Alcohol and Drug Abuse): Atlanta, Nov. 28 - Dec. 2**
  Charter Medical Corp, Po Box 209, 577 Mulberry St, Macon, GA 31298
  ☎ (800) 845-1567 In GA: (912) 742-1161

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- ❑ **Chemical Dependency in Depth:**
  Bonaire, Netherland Antilles, Dec. 1-8
  Bruce E. Bassett, PhD, HUB Concepts in Medical Education, 11500 H-10 West, S/185, San Antonio, TX 78230
  ☎ (800) 547-3747

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- ❑ **ASAM Region III Annual Meeting: Worcester, MA, Dec. 8 (new date)**
  Michael Liepman, MD, CD Services, MCCM Memorial, OPD-2 119 Belmont St, Worcester, MA 01605
  ☎ (508) 793-6170

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- ❑ **Florida Society of Addiction Medicine (FSAM) Annual Meeting: Orlando, FL, Jan. 18-20, 1991**
  Larry Siegel, MD, 520 Southard St, Key West, FL 33040
  ☎ (305) 296-8593

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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 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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- ❑ **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**

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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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