ASAM NEWS

American Society of Addiction Medicine

Vol. VI, No. 4 **July-August 1991** Published Bimonthly

ASAM 1992 Annual Meeting to Washington, DC

Although a different city and dates were originally announced for ASAM's annual meeting and medical-scientific conference next April, the event will now take place as follows:

Place: Washington, DC

Ramada Renaissance Hotel, Techworld.

Dates: April 2-5, 1991.

ASAM Board meeting: April 1.

ASAM has chosen to honor a contract between the Ramada and NCAdd (National Council on Alcoholism and Other Drug Dependencies, a former co-sponsor with ASAM of the annual conference).

Inside

AMA House Approves Five Main CD-Related Resolutions

At the American Medical Association's annual House of Delegates meeting in Chicago in late June, attended by ASAM delegate **Jess Bromley**, MD, alternate delegate **David E. Smith**, MD, ASAM executive vice president James F. Callahan, DPA, and ASAM consultant E. M. Steindler, the following new AMA policies that are of special interest to the CD field were approved:

• *disabled physicians:* the AMA is to develop and implement a program for disabled physicians as part of its Physician Health Program. "This resolution will augment the AMA's impaired physicians program in a major way," said Dr. Bromley. "It includes offering an AIDS insurance package that begins at discovery of positive HIV serology, and covers retraining and treatment. The AMA will make a major effort to fund the program from insurance companies and malpractice carriers."

(The AMA has had this stated policy: "The AMA pledges its support and protection of [HIV infected] physicians and believes the profession and the public have a need and obligation to insure that they continue to be productive as long as they practice medicine safely and effectively.")

• *drinking standards for patient care:* the AMA is to urge that physicians engaging in patient care have no significant body content of alcohol; that all physicians prior to being available for scheduled patient care, refrain from ingesting an amount of alcohol that has the potential to cause impairment of performance or create a "hangover" effect.

• *teenage drunk drivers:* the AMA is to draft model legislation to include revoking an under-21 driver's licence if his or her BAC is over .019% (and that amount of alcohol to be derived only from medications and religious practices.)

• *alcohol and nicotine as addictive and gateway drugs:* the AMA is to 1) identify alcohol and nicotine as drugs of addiction which are **gateways to the use of other drugs by young people,** 2) urge physicians to intervene as early as possible with their patients who use tobacco products and have problems related to alcohol use, *(continued on page 4)*

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

ASAM Adolescent Addictions Conference

CONFERENCE DIGEST

With "The First Medical Conference on Adolescent Addictions" on June 20-23 in Atlanta, ASAM added another distinguished first conference in addiction medicine to its roster: AIDS and chemical dependency (1987), nicotine dependence (1988).

The majority of the 270 attendees were most enthusiastic about the conference, on evaluations and in comments to *ASAM NEWS*. The 154 physicians were a larger percentage than have come to ASAM's other special interest conferences. Many were pediatricians; some had been unaware of ASAM before they received a large informational mailing about this conference. The faculty of 30 included 26 physicians from all over the United States. Co-chairs were **Peter Rogers**, MD, of Youngstown, Ohio, and **Martha Morrison**, MD, of Atlanta, who was hospitalized before the conference for neck surgery but is now recovering at home.

How To's in the Office

In "Office Assessment for Substance Abuse," **George D. Comerci**, MD, pediatrician of Tucson, Arizona, said the physician needs about 40 minutes per visit, instead of the "old standard 15-minute well baby visit," in order to identify and manage a substance abusing adolescent patient. Dr. Comerci believes that the following are guaranteed to fail, therefore *do not:* lecture patient; enforce compliance through disapproval, scare tactics, coercion; avoid seeing youth alone; direct most questions and give most information to parent; function as parent surrogate. *Do:* see adolescent without a desk between you; focus attention on the adolescent (no phone calls, etc.); try not to take sides with either patient or parent; be alert to real meaning of "no;" ask questions about suicide thoughts, hallucinations; be alert to physical signs of drug abuse.

David E. Smith, MD, said that the adult model of CD treatment revolves around rehabilitation, but most adolescents don't have psychosocial skills to which to return. A rehabilitation model is critical for adolescent chemically dependents, and treatment should be longer term than adult, particularly if the family is dysfunctional. Dr. Smith recommended doing a thorough family history to see if any CD is present, which could mean a predisposition to it. Unlike adult CD recovery, where experts recommend waiting a least a year before addressing CoA (children of alcoholics) issues, adolescents must deal with dysfunctional family issues very soon in recovery.

David Mee-Lee, MD, chair of ASAM's Standards & Economics of Care Section, described the history of ASAM's just-published "Patient Placement Criteria." One section of the book, which was available for the first time at the conference, is devoted to adolescents. (The book can be obtained from ASAM, $65 members, $80 nonmembers, postpaid, prepaid.)

Dr. Mee-Lee with ASAM's new book

"Resiliency Factors in Children at Risk"

When psychiatrist **Steven Wolin**, MD, of Washington, DC., studied 200 families with multiple generations of alcoholism, he found that the theory of inevitable damage to children "was not in fact an accurate one. The message that *all* CoA's need to recover from the injuries that they suffered in childhood, and that they *all* can, at any moment, deteriorate into an addicted, incompetent and dysfunctional pseudo-childhood, is simply wrong."

What are the statistics on children growing up in alcoholic families? Although everyone knows that CoA's have a higher than normal likelihood of becoming alcoholic themselves, "No study has yet compared the impact of growing up in a group of alcoholic families with comparable groups of nonalcoholic families, and included *all* the children in the evaluation."

In Dr. Wolin's own research on over 200 families with at least one alcoholic parent, he is impressed with the variability in outcomes to both parents and children. "Some families handle the experience of having an alcoholic parent quite badly. We all know them. They are deeply and permanently affected."

But, he has found "many families who could keep the negative impact of parental alcoholism in check. Their children did not become as frequently substance abusers. Nor did they appear to have other serious problems associated with being CoA's. How did these healthier families do it?"

Importance of Family Traditions

Dr. Wolin believes that the answer "focuses on the whole family behaviors associated with carrying out family rituals. That is, the family's ability to do:

- •dinner time;
- •holidays;
- •celebrations;
- •rites of passage;
- •traditions, such as family vacations.

"Our non-transmitter family seems to protect their cherished rituals to a significant degree, and in so doing appear to convey to their children a nonalcoholic family and individual identity, which these children seem to carry into their own adulthood into the next generation ... Protecting family rituals may be the process by which families can help their children break with an alcoholic heritage."

Dr. Wolin is chair of ASAM's first conference on Co-Dependency, Oct. 17-20 in Warrenton, Virginia.

Statistics

"Does treatment work?" Norman G. Hoffman, PhD, of CATOR in Minnesota, presented statistics on 826 adolescents (4/5 were ages 15-17, 2/3 were male, 9/10 were white) who were followed up one year after residential CD treatment. Their regular drug use: 86% alcohol, 81% tobacco, 78% marijuana, 22% stimulants, 21% cocaine. Not surprisingly, best results were adolescents who attend support groups/aftercare two or more times a week during the first year after treatment; and who have parents who attend their own support groups.

R. Jeremy Stowell, MD, and **Todd W. Estroff**, MD, presented a pilot study of psychiatric disorders in 226 adolescents treated inpatient for

primary substance abuse disorders. Diagnoses were made in their fourth week. Met DSM-IIIR criteria for an Axis 1 psychiatric disorder: 82%. Two or more psychiatric disorders: 72%. Mood disorders: 61%; conduct disorders: 54%; anxiety disorders: 43%. Substance-induced organic mental disorders: 16%. The authors believe that "a major implication of this finding is the need for simultaneous evaluation of both the substance and psychiatric disorders in this type of adolescent population."

Audiotapes

Audiotapes of conference presentations are available from Infomedix, 12800 Garden Grove Blvd, Ste F, Garden Grove, CA 92643. ☎ 1-800-367-9286. FAX: 714-537-3244.

Next Year

A second adolescent addictions conference is tentatively planned for June 1992, exact dates and place to be announced. Chair of the Adolescent Committee is Peter Rogers, MD.

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Below: Sandra Jo Counts, MD, (L) Chair of Conference Proceedings, with presenter Renee Jenkins, MD, of Washington, DC.

L: ASAM executive vice president James F. Callahan, DPA (at podium)with Peter Rogers, MD.

R: Presenters Steven Wolin, MD, and NIDA's Dorynne Czechowicz, MD (on his left))

AMA House Approves

(continued from page 1)

3) encourage physicians who treat for one to be alert to the other at the same time (high probability for co-existence), 4) reaffirm that individuals who suffer from **addiction** in any of its manifestations are persons with **treatable disease.** "This language is critically important to the CD field," said Dr. Bromley.

• *smoking in public places:* the AMA is to encourage state or local legislation to prohibit smoking in enclosed and open stadia and all indoor public places, restaurants, bars and workplaces.

• *trauma tests:* (referred to the AMA Board for further study) that the AMA urge all hospitals to perform BAC tests and urine drug screens for all emergency admitted trauma patients age 14 or older. [See ASAM Trauma Policy page 8.]

The AMA Interim House of Delegates will meet in early December in Las Vegas.

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Exam Application Deadline Jan. 15, 1992

Info Booklet Available in September

ASAM will publish a new document, *ASAM Certification Booklet of Information*, which will provide guidelines for requirements to apply for and to take the 1992 ASAM certification examination. The booklet, available in September, will review the history of the ASAM certification process, which began in 1986; 2,320 physicians have passed the exam and been awarded certified status by ASAM.

Applications to take the 1992 exam will be available Oct. 1. Deadline for application materials: postmark no later than Jan. 15, 1992.

The exam will be given on Saturday, Dec. 5, 1992, at three sites: Atlanta, Chicago, and Los Angeles.

Credentialing chair: **Blair Carlson**, MD. Certification section chair: **John Griffin**, MD. Examination chair: **Sidney Schnoll**, MD, PhD.

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Nearly $400,000 in Grants to ASAM

Two foundations and a federal government agency have awarded ASAM $399,000 in grants for specific projects.

From the Scaife Family Foundation of Pennsylvania: "$300,000 to support the two-year examination development project with the National Board of Medical Examiners," according to ASAM's executive vice president James F. Callahan, DPA. Another $20,000 goes to a follow-up study of the 1,300 medical students who have received scholarships since 1984 to summer schools in alcoholism and other drug dependencies, from Scaife Family and the J.M. Foundation of New York, which also gave $20,000 to this study.

In addition, the J.M. Foundation gave $25,000 to ASAM "to be used for achieving subspecialty status," said Dr. Callahan, and $5,000 to the Ruth Fox Memorial Endowment Fund

ADAMHA's Office of Treatment Improvement gave ASAM $19,000 to develop and publish a monograph from the forthcoming Co-Dependence Symposium Oct. 17-21 in Virginia, and another $10,000 toward printing and marketing the society's "Patient Placement Criteria" which was published in June.

Committee and section chairs involved in these grants: **David Gastfriend**, MD, Members-in-Training; **David Mee-Lee**, MD, Standards and Economics of Care; Dr. Schnoll, Examination; **Steven Wolin**, MD, Family and Generational Issues.

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Pediatric Section of ASAM Seeks Members

All members of ASAM with a primary specialty or interest in pediatrics are invited to join a newly established Pediatric Section.

Chair **Larry Patton**, MD, told *ASAM NEWS* that the section will offer networking opportunities, and will relate specific pediatric concerns back to the ASAM Board. In addition, it hopes to be a "bridge to pediatric organizations such as the American Academy of Pediatrics, American Board of Pediatrics, and the Society of Adolescent Medicine, to increase awareness of CD, and to foster cooperation in cosponsoring meetings and educational efforts," said Dr. Patton.

Anyone interested in this "exciting new direction for ASAM" please contact Dr. Patton, 100 N. Cottonwood, Richardson, TX 75080. ☎ (214) 231-4605.

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Psychodrama at State of the Art Course

ASAM will offer a four-hour, experiential workshop on the use of psychodrama in addiction treatment at the State of the Art in Addiction Medicine course in Orlando, Oct. 24-26. This session will be offered during the scheduled "afternoon off" (free time). Leader: internist **Terry Rustin,** MD. Further information from the ASAM office.

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Nicotine Conference Adds Pre-Conference

This year's Fourth Annual Nicotine Dependence Conference will be in Raleigh, North Carolina, Sept. 13-15, site of corporate headquarters for RJR (RJ Reynolds).

One featured topic will be the effects of nicotine on adolescents, including targeted advertising, tobacco-free policies in schools, chemical use patterns, children's access to tobacco products, and smokeless tobacco.

Preceding this conference on Thursday, Sept. 12, will be "The First Nicotine Research Round Table Discussions: CNS Effects." Purpose: dialogue between basic science researchers and clinicians. An additional faculty of 14 experts from various universities and addiction research institutes will present. Proceedings to be published in *Neuroscience and Biobehavioral Reviews*. No charge; more info from the ASAM office.

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William Kennedy Dies

William J. Kennedy, MD, of Granville, Ohio, died of a stroke on June 4. Formerly a general practitioner, then an A/D specialist in Newark, Ohio, Dr. Kennedy was certified by ASAM (AMSAODD) in 1986. He served on the Credentialing Committee.

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*Names in **boldface** are first mentions of ASAM members.*

ABOUT ASAM

ASAM Defines More Terms

Seeks Evaluation from Membership

The ASAM Board approved the publication of the following definitions in *ASAM NEWS*, with a request for feedback from ASAM members. Twenty-one other terms were previously published in the November-December newsletter (p. 9). Again, the Nomenclature Committee is not looking for editorial changes, but for comments on how practical these definitions are in terms of your day-to-day practice.

The committee hopes that all ASAM committees will conform to these definitions in future publications or other written communications. Committee chair: **David E. Smith**, MD.

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

• **Alcoholics Anonymous (AA).** "A fellowship of men and women who share their experience, strength and hope with each other that they may solve their common problem and help others to recover from alcoholism. The only requirement for membership is a desire to stop drinking." (AA Preamble)

• **Chemical Dependency.** Generic term relating to psychological or physical dependency, or both, on one or more psychoactive substances.

• **Cross-tolerance.** Tolerance, induced by repeated administration of one psychoactive substance, that is manifested toward another substance to which the individual has not been recently exposed.

• **Drug Free.** A term which refers to the absence of use of any potentially addictive psychoactive substance(s).

• **Drug Intoxication.** Dysfunctional changes in physiological functioning, psychological functioning, mood state, cognitive process, or all of these, as a consequence of consumption of a psychoactive substance; usually disruptive, and often stemming from central nervous system impairment.

• **Familial Alcoholism.** Pattern of alcoholism occurring in more than one generation within a family, due to either genetic or environmental factors, or both.

• **Family Intervention.** Specific form of intervention, involving family members of an alcoholic/addict, designed to benefit the patient as well as the family constellation.

• **Overdose.** The inadvertent or deliberate consumption of a dose much larger than that either habitually used by the individual, or ordinarily used for treatment of an illness, and likely to result in a serious toxic reaction or death.

• **Polydrug Dependence.** Concomitant use of two or more psychoactive substances in quantities and with frequencies that cause the individual significant physiological, psychological, and/or sociological distress or impairment.

• **Prevention.** Social, economic, legal, medical and/or psychological measures aimed at minimizing the use of potentially addicting substances, lowering the dependence risk in susceptible individuals, or minimizing other adverse consequences of psychoactive substance use. Primary prevention consists of attempts to reduce the incidence of addictive diseases and related problems in a general population. Secondary prevention aims to achieve early detection, diagnosis and treatment of affected individuals. Tertiary prevention seeks to diminish the incidence of complications of addictive diseases.

• **Rehabilitation.** The restoration of an optimum state of health by medical, psychological, and social means, including peer group support, for an alcoholic/addict, a family member, or a significant other.

• **Treatment.** Application of planned procedures to identify and change patterns of behavior that are maladaptive, destructive, and/or injurious to health; or to restore appropriate levels of physical, psychological, and/or social functioning.

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LETTERS TO THE EDITOR

Dear Editor:

When I was a panelist at your annual medical-scientific conference ("American Drug Policy: Need for Reform or Reinforcement?" Boston, April 19), I found many addiction experts who do not agree with the extreme law enforcement emphasis of current drug policy. While the doctors with whom I talked held diverse viewpoints, there seemed a sincere desire to create a more humane and effective drug policy. I see two issues:

1) In my Boston presentation, I said that I could not understand how a doctor, whose first responsibility is to not hurt his patient, could support jailing a patient. Some in the audience expressed understanding, others were offended. I did not intend to offend anyone, but to put the prohibition issue in its simplest terms. People go to jail because of the drug laws. A record-setting 1.2 million Americans are behind bars, half incarcerated for drug offenses. Whether your concerns for the patient are psychological, physical, or social, jail is not a healthy place to be.

If you believe that drug addiction is an illness, then the absurdity of putting someone in jail for an illness is obvious. But if, as others believe, drug use is a choice that many individuals can control without hurting themselves, then why should we hurt those people by incarcerating them? If, for some of these people, the choice becomes a compulsive, difficult-to-control one, then jail is not the way to help that person get control of his or her compulsive behavior.

2) From what I saw, the views on the legalization/prohibition debate are too diverse for ASAM to take a position -- yet. However, I encourage you to keep debating and discussing it; by doing so you will better understand the choices, and help us all to develop better drug policies.

We at the Drug Policy Foundation would welcome your participation in our efforts. Our next conference is Nov. 13-16 in Washington, DC. Our members hold diverse views. Some support continued prohibition but with a change in emphasis away from law enforcement dominance; others oppose continued prohibition. We hope the diverse views will result in sensible alternatives to our current approach.

Kevin Zeese, Esq.
Counsel and Vice President
Drug Policy Foundation
4801 Mass. Ave. N.W., Ste 400
Washington, DC 20010-2087

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Residencies

The Addiction Research Foundation, University of Toronto, a premier alcohol and drug treatment research facility is now recruiting clinical and research residents/fellows for July 1, 1992. For applicants in internal medicine, family and community medicine, and psychiatry, this clinical position includes consult-liaison, outpatient clinics and an inpatient withdrawal program. Research fellowships are available in neurology, clinical pharmacology, gastroenterology, psychiatry, and clinical epidemiology.

Please contact **Dr. J. Schneiderman, Addiction Research Foundation, 33 Russell Street, Toronto, Ontario, Canada M5S 2S1, (416) 595-6070.**

ARF
Addiction Research Foundation
Fondation de la recherche sur la toxicomanie

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Editor: Lucy Barry Robe
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303D Sea Oats Drive
Juno Beach, FL 33408
Phone: (407) 627-6815
Thru Aug 91:
(516) 367-6692.
FAX available
ASAM Headquarters
James F. Callahan, DPA
Executive Vice President
Suite 409,
5225 Wisconsin Ave, NW,
Washington, DC 20015.
Phone: (202) 244-8948.
FAX: 202-537-7252

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		Pharmacologic Issues (forming) John Morgan					

Note: all are physicians

POLICY STATEMENT

Trauma and Chemical Use/ Dependency Policy

American Society of Addiction Medicine

Trauma is the leading cause of death attributable to alcohol use and, along with other drugs, the most important contributing factor to injuries seen in hospitalized trauma patients.

These injuries represent an enormous public health problem and an opportunity to provide appropriate medical care that is usually ignored. Physicians are reluctant to obtain basic screening tests, and when they do, positive results are not used as indicators of patient management, assessment, and intervention. This omission frequently occurs because of physician attitudes toward alcoholism and other drug dependencies resulting in patient mismanagement.

Alcohol and drug testing of hospitalized trauma patients, and the assessment of those with positive results, is an appropriate approach to the problem because the procedure contributes to differential diagnoses; provides objective data for making appropriate clinical choices concerning the use of pharmacologic agents; permits an evaluation of the likelihood of medical complications of alcoholism; aids in determining those at risk of withdrawal syndromes; and serves as a basic screening test for those with possible substance use problems.

The American Society of Addiction Medicine believes it is medically proper to identify these patients so that their immediate medical care is improved and the risk of future suffering reduced. Therefore, the society supports the following as standards of clinical practice:

• 1. All hospitalized trauma patients over age 14 should have blood alcohol concentration (BAC) determinations and urine drug screens performed on admission. Children under 14 years of age should be tested if there is suspicion of alcohol or other drug involvement.

• 2. Attending physicians responsible for care of trauma patients should promptly address positive BAC and urine drug screen determinations in their trauma patients and obtain:

a) consultation or referral for evaluation of underlying chemical use/dependency problems; and

b) treatment for these problems.

• 3. Ongoing periodic quality assurance review of these policies should be performed.

Approved by the American Society of Addiction Medicine Board of Directors on April 17, 1991.

Prepared by the ASAM Trauma Committee:

***Peter Rostenberg**, MD*

***Carl A. Soderstrom**, MD, co-chairs*

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Reshape Board?

MY POINT OF VIEW

by **Michael M. Miller**, MD

When it's time to vote, and I look at the illustrious CV's and the immeasurable experience of past ASAM presidents, I have never been able to bring myself to *not* vote for any of them. This year, the power of incumbency on the ASAM Board may have paralleled that of the US House of Representatives! ... I wonder if we might consider an alternate approach to allow broader and newer representation, while preserving the benefits of what we have:

• Create a council of past presidents to meet periodically as an indispensable advisory group. One to which all ASAM members could look for wisdom, it might even be given voting powers for special issues or at special times. This council would free up slots on the board for other persons.

My other concern is representation of specialties on the board. Alcoholism crosses all specialties of medicine. I was surprised to discover the breakdown of specialists in ASAM so heavily weighted to psychiatry, and I've had some concerns about the power that psychiatrists seem to wield in the politics within ASAM. I was initially boarded in psychiatry. In my view, the participation of psychiatry should not be curtailed, but that of family medicine and general internal medicine should emphatically be increased. Thus I suggest:

• Consider designating certain spots on the board for certain types of members.

For instance, we might have 11 members-at-large on the board to be voted in each year, and as the ballots are tallied, the people taking board seats could be the two highest vote getters who were family practitioners; the two who were internists; the two who were psychiatrists. This would insure representation from those three specialties. The next three seats could go to the next three highest overall vote getters, regardless of discipline. One seat, either elected or assigned by its parent organization, could be a formal RSA voting representative to the board who would be also an ASAM member, and another a representative from AMERSA--also an ASAM member.

[Dr. Miller of Madison, Wisconsin is chair of the Reimbursement Committee, Standards & Economics of Care Section.]

Alcohol, Tobacco Companies Woo NAACP

by **Terry A. Rustin**, MD

At the recent NAACP (National Association for the Advancement of Colored People) annual meeting in Houston, the delegates debated the many serious issues that face African-Americans today. Meanwhile, the exhibit hall was filled with eager purveyors of information and products targeted at the African-American community. Two of the largest booths, each as large as a house and located at the hall's entrance, were taken by Philip Morris (makers of Marlboro cigarettes and Miller beer) and Anheuser-Busch (makers of Budweiser beer).

Philip Morris had separate gazebos for its Kraft Foods, cigarette, and beer divisions. Each gave away knickknacks such as t-shirts, beer can holders, and calendars honoring African-Americans. Free cigarettes were also available. I counted 12 staff at these booths.

Although Anheuser-Busch did not provide free beer, part of its building resembled a bar; another was a small recording studio where delegates could tape themselves singing with a prerecorded band. One giveaway: a poster honoring ancient African kings and queens. I saw ten employees at this pavilion.

Coors, the American Tobacco Company, and the Brown and Williamson Tobacco Company also had booths which touted their products and their company's records in minority hiring. Coors gave away an attractive calendar with reproductions of original paintings of notable African-Americans (punctuated regularly by the Coors logo).

With some effort, I located the National Black Alcoholism Council's small, bleak booth far from the center of the hall, staffed by two volunteers. They were quietly giving away posters that warned about driving drunk. The American Cancer Society had a booth on the opposite side of the exhibit hall; it offered stacks of literature about the dangers of smoking, and other cancer prevention information. At a medical supply company booth, nurses took blood pressures. These exhibitors came to remind NAACP delegates that African-Americans consume more alcohol and tobacco, and suffer more heart disease, hypertension, lung cancer, and drug dependence than do other ethnic groups.

I was overwhelmed by the contrast between the naivete of the health promoters and the sophistication of the merchants of addicting products; but few others appeared to be similarly affected. The National Black Alcoholism Council staffer had "no opinion" on my observation, stating that their goal was strictly "education." The scene resembled the contrast between the struggling social worker in a stark little office and the garish drug dealer in a Mercedes-- a common condition a few short blocks from the George R. Brown Convention Center.

I did find NAACP delegates and members who deplored the organization's reliance on the alcohol and tobacco industries; they said they believe that African-Americans who could afford to do so should support the organization in order to eliminate this unhealthy dependence. However, this was clearly not the prevailing attitude, as NAACP members queued up for free cigarettes and paste-on beer logos.

This submission to the huckstering of the alcohol and tobacco industries permeates the African-American community. Small newspapers which focus on African-American issues rely heavily on beer, liquor and cigarette advertising; jazz festivals, "Juneteenth" celebrations, and other events expressing African-American self-determination are routinely sponsored by alcohol and tobacco interests. Of course, such support is ultimately purchased with the dollars and the lives of African-Americans.

Paradoxically, throughout the NAACP conference the energy of African-American pride filled the meeting halls and corridors. Delegates debated crucial issues and heard inspiring speeches. I could not help but think, however, that tobacco and alcohol products will have more of an impact on the health and welfare of African-Americans over the next 30 years than will Clarence Thomas' Supreme Court nomination.

[Dr. Rustin of Houston, Texas is co-chair of ASAM's State of the Art in Addiction Medicine, Orlando, FL, Oct. 24-26]

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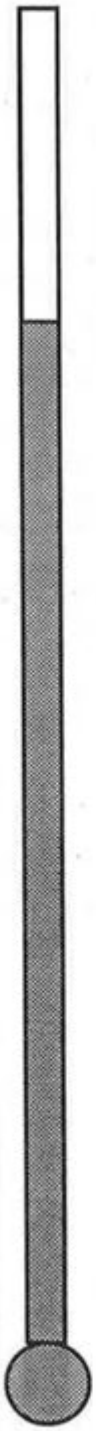

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Ruth Fox News -- July-August We are extremely grateful t o our members who have already pledged/contributed to the Ruth Fox Memorial Endowment Fund. We have reached 77.8% of our $1 million goal. Because of your demonstration of support, we are confident that we will reach our goal before 1991 is out. We trust that those of you who have not yet pledged, received our second appeal letter which was sent in late July. Your pledge/contribution is an investment in your future and the future of addiction medicine, and is tax deductible. We are counting on your support to reach our campaign goal. Join your colleagues...send your pledge today! -- C.O.

ASAM CALENDAR

Information about ASAM conferences available at Washington headquarters: 5225 Wisconsin Avenue N.W., Suite 409, Washington, DC, 20015.
☎ (202) 244-8948

❑ **ASAM 4th National Conference on Nicotine Dependence: Raleigh, NC Sept. 13-15**
Pre-conference Sept. 12: "The First Nicotine Research Round Table Discussions: CNS Effects"
North Raleigh Hilton & Towers

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❑ **Drug Free Workplace : Anaheim, CA, Sept. 16-17.**
The Drug-Free Workplace Conference, 90 W. Montgomery Ave, Ste 313, Rockville, MD 20850
☎ 1-800-822-2517

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❑ **First Annual Summit Conference: Houston, Sept. 19-22.**
Ernest Gibson,. Exec. Dir., Riverside General Hospital, 3204 Ennis, Houston, TX 77004
☎ (713) 526-2441

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❑ **Triangular Hemispheric Disorders: Traverse City, MI, Sept. 27; Grand Rapids, MI, Oct. 18; Detroit, Nov. 1.**
R.A.P.P. Seminars,. 21901 Mada, Southfield, MI 48075
☎ (313) 355-5860

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❑ **GASAM (Georgia chapter) 3rd Annual Fall Conference:**
St. Simons Island, GA, Oct. 4-6. *King and Prince Hotel*
GASAM, Suite 104, 1996 Cliff Valley Way, Atlanta, GA 30320
☎ (404) 636-2766

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❑ **ASAM Board Meeting:**
Dallas, Oct. 5-6, *Fairmont Hotel*

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❑ **ASAM Co-Dependency Conference:**
Warrenton, VA, Oct. 17-20
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 , *Marriott Airport Hotel*

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❑ **Addiction Medicine: Getting Better Every Year:**
Austin, TX Nov. 1-2 *Sheraton Austin Hotel*
Texas Research Society on Alcoholism, 4314 Medical Parkway, Ste 300, Austin, TX 78756
☎ (512) 454-0022

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❑ **California Society State of the Art in Addiction Medicine :**
San Diego, CA, , Nov. 21-23 *San Diego Hilton Beach & Tennis Resort*
CSAM, 3803 Broadway, Ste 2, Oakland, CA
☎ (415) 428-9091

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❑ **SECAD 1991 - The Southeastern Conference on Alcohol and Drug Abuse: Dec. 4-8, Atlanta.**
Charter Medical Corp., PO Box 209, Macon, GA 31298
☎ 1-800-845-1567. In GA: (912) 742-1161

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❑ **Florida Society of Addiction Medicine (FSAM) Annual Meeting: Orlando, FL, Jan. 17-19, 1992**
Radisson Hotel Downtown Orlando
Conference on Addiction, c/o Karen Barnum, PO Box 2411, Jacksonville, FL 32203
☎ (904) 356-1571

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❑ **ASAM/NAATP Criteria Conference: San Diego, Jan. 22-26, 1992**
Sheraton Harbor Island Hotel

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❑ **ASAM 23rd Annual Medical-Scientific Conference:**
Washington DC, April 3-5, 1992
Ruth Fox Course for Physicians: April 2
Board Meeting: April 1
Ramada Renaissance Hotel, Techworld

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Calendar includes only meetings that are sponsored or co-sponsored by ASAM (onetime listing for co-sponsored conferences).
For inclusion on this calendar, please send information directly to Lucy B. Robe, Editor, at least two months in advance.
To arrange for ASAM to co-sponsor a conference (CME credits) contact Claire Osman at:
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