ASAM NEWS

American Society of Addiction Medicine

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New Column

Clinical Case Report

In this issue, *ASAM NEWS* introduces a new feature from the Standards and Economics of Care Section. Called **SEC News**, the column will be a clinical case report about managed care and/or insurance problems, with commentary by an ASAM physician.

The first case is insurance denial for continuing care to a suicidal inpatient. *ASAM NEWS* hopes that readers will submit case reports to be considered for future issues. *See p. 3*

Inside

Adolescents and AIDS

Workshop at ASAM Conference

"You've missed half the kids if you wait till 9th grade to educate them about AIDS ," declared **Anthony H. Dekker**, DO, director of Adolescent and Young Adult Medicine, Chicago Osteopathic Health System. This is because the average age in the U.S. to start having sex is 16, the median is 14 to 15.

Dr. Dekker organized a workshop about adolescents and AIDS for ASAM's Second Medical Conference on Adolescent Addictions, held in San Antonio June 25-28.

The average teen has three coital partners by age 18. Promise Ahlstrom, MD, of the Division of Adolescent and Young Adult Medicine at National Children's Medical Center in Washington, DC, tells adolescents "your boy friend may not have injected drugs, but someone he's been involved with has" via multiple partners. In order to avoid HIV infection, condoms are a must for teens who continue to have sex, but only about one-third know how to use them correctly. This is because half of teens get the bulk of their education about contraceptives from brochures, according to Dr. Dekker; 30% from their best friends; 10% from their Moms; and *only 5% from a health care provider* (doctor or nurse practitioner). Helpful hint when taking a patient history about condom use: the standard "always," "sometimes," "occasionally" queries are not as effective as asking "what about last night?"

Dr. Ahlstrom said that these days, the main HIV risk factors for teens are: anal intercourse, intercourse without barrier protection (condoms), injected drug use, multiple sexual partners, sex for drugs, money and goods, sex with a member of a traditional risk group.

From two percent to seven percent of high-risk adolescents are HIV positive. The average number of years between HIV infection and diagnosis of AIDS is eight to 12.

Adolescents tend to minimize risks. A study at the University of Washington, Seattle, showed that even after HIV education, there was no change in the students' behavior: *(continued on p. 2)*

ASAM is a specialty society of 3,500 physicians who are concerned about alcoholism and other addictions and who care for persons affected by these illnesses.

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CONFERENCE REPORT

Adolescents and AIDS

(continued from p. 1)

they universally rejected sexual abstinence, held a different monogamy concept than adults (an adolescent's concept of monogamy is measured in weeks, or sometimes only days, rather than an adult's gauge of years), were ambivalent about condoms, and did not see themselves at risk.

Pretest Counseling

"Many people in the field believe we should not be overenthusiastic about testing for HIV," said Dr. Dekker. "I don't feel that way. I assertively pursue kids who are at risk. It's important to identify risk behaviors and provide early treatment."

Dr. Dekker believes in a comprehensive informed consent. "We require our medical students and residents to learn pretest and post test counseling," he said. "Think about all the possible negatives before you test anyone. It's also important to know where to test. In some cases you don't want HIV testing on their insurance records; those kids could leave the premises and have it done anonymously."

Another problem with adolescents: "A large number of teenagers have participated in high risk behavior. They get tested, the results are negative, and they say, 'Wow! I can't get this disease, can I? I'm invulnerable.' It's important to tell them: 'You've been lucky so far. This does not give you license to continue doing what you've been doing. A lot of patients have become HIV positive later on, after first testing negative.'"

HIV Positive Adolescent

If a patient is positive, the doctor and team must be ready to deal with a catastrophe. Suicide is a very real possibility, but most doctors are too busy with their other patients to take the necessary time to counsel the HIV positive patient at length the day he or she receives the news. That's where a trained team, with someone always on duty, is critical to the patient's survival. Dr. Dekker's team includes medical, psychological/social service, and legal people; spiritual/pastoral counselors; and educational services.

Early symptoms of AIDS to look for in adolescents: pneumocystis pneumonia with significant hypoxemia, esophageal candidiasis (diagnosed by gastroscope), extrapulmonary tuberculosis, recurrent bacterial sepsis, cryptococcal meningitis.

Is HIV in teens the same as in adults? According to Dr. Ahlstrom, "We have no answer to that."

There has been one somewhat encouraging change in the last five years: previously, doctors thought that an HIV positive mother's newborn had a 50% chance of becoming HIV. Now that risk has dropped to 20% to 30%. But a typical inner city HIV-infected girl still tells Dr. Ahlstrom that "everyone she knows has a baby and she doesn't want to be different."

Dr. Dekker said that in one recent study of middle-class, mostly white, Catholic kids age 16 to 17, the girls said that their boyfriends would drop them if they didn't have sex. "The girls deal with having sex twice a week, because it only lasts between 30 seconds and two minutes in the woods," and the rest of the relationship is worth it. "But 19% of these 400 girls were chlamydia-infected," said Dr. Dekker. "One goal should be to reach the girls who are not sexually active: find a way to get them to delay initiation of sex."

On any CD unit, "If you have kids who are dealing with issues of drug abuse, you'd better be ready to deal with issues of sexuality, because the two go hand in hand. You cannot ignore one and deal with the other. A lot of us think that abstinence is something that just naturally occurs. *Not!*"

Due to the consistent use of condoms, the seroconversion rates in gay males in the U.S. have dropped off. There has been an exceptional education job in that population, according to Dr. Dekker, but at the same time, a "dismally embarrassing job of education in the heterosexual community." He believes that adolescents should be educated about condoms, shown how to use them, and that condoms should be made available to them.

All this *before* ninth grade.

"Never lose hope in working with teens," said Dr. Dekker. He has "patients diagnosed HIV positive back in 1983 who are doing well today."

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Commentary by ASAM President on Adolescent ADM

by **Anthony B. Radcliffe**, MD

Dr. Radcliffe, gave this address at the conference on June 27. Conference chair was ***Peter D. Rogers, MD; chair of conference proceedings was Larry H. Patton, MD.***

As the practice of addiction medicine (ADM) comes of age, we must realize the special needs of adolescents. We tend to treat them simply as younger adults, and to hope that primary care physicians, or those who practice Adolescent Medicine, can handle any drug use trouble. I suspect that neither path holds much hope for improved adolescent drug use treatment in the 90s.

Other difficulties around adolescent treatment focus on where those services should best be provided, at what cost, and what training is appropriate. Family members, fed up with a child's behavior, often view treatment as a place removed from their home. Yet adolescent drug use is often only one of many other issues, not the least of which is use of mind-altering drugs by adults in that family.

Most adolescents are raised in an environment where drug use -- albeit *legal* drugs -- is accepted. Thus is drug use promoted as being part of growing up in America.

In a society that promotes drug use as acceptable, where kids want the right to use themselves, and where parents want their kids fixed at minimal expense, why would anybody in their right mind want to do what many of you profess you really enjoy doing?

What model do we use in addressing this problem? Is *any* use harmful? Does nicotine count? Do current theories of addiction fit for adolescents? Must families be treated in order for their kids to have any chance at recovery? How do we distinguish those who will develop addictive disease from those who just use? There are many more questions now than we have answers. But *that* is the hope: that *you* won't let it stay that way.

(continued on p. 14)

SEC News is a new feature from ASAM's Standards & Economics of Care Section.

SEC NEWS

Case Report

Robert A., 31, *(name and age changed to protect confidentiality)* was my patient in a private, nonprofit, psychiatric hospital for 19 days in Nov. 1991.

The essential clinical features of this case were a history of severe, recurrent addiction (intravenous heroin, Xanax, and alcohol) and additional diagnoses of an active mood disorder (bipolar disorder) and an eating disorder. There was a history of several failed, shorter term inpatient treatments, as well as suicide attempts and convulsions as an outpatient.

He required inpatient detoxification from Xanax and opiates. After detoxification, stabilization to some degree of his mood and eating disorders was essential. Both the director of the treatment unit and I are specialists in psychiatry as well as in addiction medicine. Neither he nor I believed that discharge to the community was feasible if this patient was to have any chance of survival. We believed that he required direct transfer to a residential dual diagnosis halfway house. All this was accomplished in 19 days, a short time considering the complexity of his case.

Insurance Denied

Through Blue Cross of my state, the patient had the necessary insurance to pay for his hospitalization. Although the managed care company for Blue Cross would not commit itself to paying for the hospitalization, we kept the patient there, for we believed it to be a matter of life and death for him.

Action Requested: Extension of current services

Stated Reason for Denial of Request: Level of care not medically necessary because of insufficient degree of biomedical comorbidity and psychiatric comorbidity.

Level of Care Recommended by Managed Care Agency: Outpatient ongoing care and addiction medicine, with or without pharmacotherapy.

Name of Third Party Payer: Blue Cross of New Jersey

Name of Managed Care Agency: Green Springs of New Jersey

Credentials of person you spoke with: physician

Party Denying Access to Care: managed care company subcontracted by insurance carrier.

We made an extensive written appeal to this managed care organization, as per their review procedures. It declined to pay for any hospitalization. As a result, the entire bill of $12,000 will now fall upon the patient's retired, elderly parents, who are on Social Security. The patient himself is too destitute and ill to pay this bill.

Stefan Lerner, MD

Belle Mead, NJ

Dr. Lerner, a psychiatrist, was certified by ASAM in 1990.

Dr. Publicker of Pittsburgh, a family practitioner, was certified by ASAM in 1988. He is president of the Pennsylvania chapter of ASAM. *(Also see p. 15.)*

Commentary

by **Mark Publicker**, MD

This case report illustrates the problems that addictions treatment providers face when dealing with the multitude of new managed care companies. Nearly all addictionists would probably agree that this patient required inpatient management, yet a physician reviewer denied the claim. The problem appears to arise from the application of conflicting criteria for patient placement.

There are fundamental differences between the *ASAM Patient Placement Criteria* and Greenspring's. Whereas the *ASAM PPC* are explicit and normative, based on empirical research, the Greenspring criteria are implicit and subjective. As such, they are open to a variety of interpretations, with a strong bias toward outpatient care.

In this instance, inpatient treatment was denied because the reviewer felt that there was insufficient biomedical and psychiatric comorbidity. Thus, the argument hinges on the definition of medical necessity. Addiction, like other chronic diseases, is biopsychosocial in etiology and expression. The *ASAM PPC* bases its definition of medical necessity on six biopsychosocial dimensions: intoxication/withdrawal, biomedical, emotional/behavioral, treatment acceptance/resistance, relapse potential, and recovery environment. With a history of cross addiction to narcotics, benzodiazepines and alcohol, and of convulsions when withdrawing as an outpatient, the patient's risk of major withdrawal is high, necessitating initial inpatient, medically managed care. Likewise, the existence of active bipolar disease requires more intensive, medically monitored treatment. Thus, the *ASAM PPC* would have supported the course of treatment chosen by Dr. Lerner.

Although Greenspring rejects the *ASAM PPC*, addictionists should base their treatment decisions on comprehensive, multidimensional assessments and on explicit placement criteria. Appeals of denials of care can then be based on objective data.

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Has anyone had experience with this managed care company, or a similar experience with another company? Is there a managed care or payer perspective on a case like this? Is this a problem that could have been solved if both parties had used common clinical criteria, such as the ASAM Patient Placement Criteria? Does anyone have a case report they would like to share with ASAM NEWS readers? Send to David Mee-Lee, MD, Parkside, Little Harbor, Marblehead, MA 01945.

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PPC News

The *ASAM Patient Placement Criteria* is now in a second printing; the first printing of 2,500 copies was distributed. Because production costs have been met, ASAM is pleased to adjust the price for the book to $45 for members (a 30% saving) and $65 nonmembers, postpaid, prepaid. The book is available at ASAM headquarters.

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First National Survey of Physicians' Drug Use

U.S. physicians are more likely to use alcohol and prescription drugs, such as benzodiazepines and opiates, than their age and gender peers in the general population. However, they are less likely to use tobacco, or illicit drugs such as cocaine, marijuana, hallucinogens and heroin.

These findings are from the first national study on the prevalence of substance use among U.S. physicians, published recently in *JAMA* .

Senior author was Patrick H. Hughes, MD, of the Institute for Research in Psychiatry, University of South Florida, Tampa.

The 5,426 physicians (in a 59% response rate) were drawn from the AMA Masterfile. They represented all 12 major medical specialties and included doctors at all stages of their careers. In 1989-90, they filled out anonymous, seven-page surveys on their use of 13 substances during their lifetimes, the previous year, and the past month; their reasons for use; any self-admitted substance abuse, dependence, or treatment. These were compared with a NIDA (National Institute of Drug Abuse) survey on drug use in American households.

The physicians' questionnaire identified prescription substances as amphetamine-type drugs, barbiturate-type sedatives, benzodiazepine-type tranquilizers, anabolic steroids, inhalants, minor opiates (e.g. codeine and propoxyphene hydrochloride), and major opiates (e.g. meperidine hydrochloride and fentanyl citrate) or opiate agonists-antagonists (e.g. pentazocine).

Respondents were asked to report only prescription medications that were "not prescribed by another physician for a legitimate medical or psychiatric condition."

Other substances in this survey were alcohol, tobacco, marijuana, hallucinogens, heroin, and cocaine. Heavy use of alcohol was defined as five or more drinks per day, of tobacco as smoking at least half a pack daily.

The five choices for using: recreation, self-treatment, to improve performance, to improve appearance (anabolic steroids only), and other.

Alcohol First Choice

Most frequently used substance? Alcohol. Ten percent of the physicians reported daily use, 9.3% had five or more drinks a day at least once in the previous month, and 0.6% were heavy drinkers.

Although half had tried tobacco at least once, only 3.9% currently smoked heavily.

Minor opiates and benzodiazepines were the most frequently used prescription substances. Although one-third of the physicians had tried marijuana, fewer than 5% used it in the previous year and only 2% the month before the survey. About 10% had tried cocaine, but less than 1% had used that drug, or amphetamines or major opiates, within the past year, and a "negligible number reported using heroin, anabolic steroids, inhalants, or psychedelics."

The general population, on the other hand, preferred marijuana and cocaine.

Physicians used prescription drugs such as benzodiazepines, minor opiates, and barbiturates, primarily for self-treatment. One in nine (11.4%) physicians used benzodiazepines in the previous year without another physician's supervision, and one in six (17.6%) similarly used minor opiates. The authors wrote that "Unlike the general population, physicians have ready access to controlled prescription substances and the expertise to diagnose and treat many of their own ailments."

The authors continued, "Does this higher prevalence of alcohol, benzodiazepine and opiate use mean our nation's physicians are intoxicated or drug-impaired when seeing patients? For the vast majority of cases, the answer is no. The rate of heavy, daily use of alcohol is low (0.6%), and daily use of benzodiazepine (0.5%) and both major and minor opiates (0.2%) is even lower ... Nevertheless, a small proportion of physicians do appear to be engaging in high-risk drug behaviors. The challenge is to identify these physicians early and help them avoid the adverse effects of substance abuse and dependence....

"Canada has adopted a national policy to address this problem. It describes self-treatment as unethical and states that practitioners should not prescribe or administer a narcotic or controlled drug to themselves or members or their immediate families in other than emergency situations....similar guidelines have been adopted by half of the states in this country but no uniform national policy has been endorsed, nor is the AMA code of ethics explicit on this point. The current variation in state guidelines also communicates mixed messages about the acceptability of self-treatment."

Dr. Hughes described preliminary data on this study to the Florida Chapter of ASAM at its 1991 annual meeting. As reported in *FSAM News* (March 1991) he said that "doctors start using not to party but for self-treatment and/or for stress. Residents begin to self-prescribe." Availability of drugs often means that they are more popular, such as benzodiazepines (psychiatrists reported a significantly higher use rate) and minor opiates.

Drug Dependence

Almost 8% of the physicians in Hughes' study reported substance abuse or dependence at some time in their lives. Of this group, about half used only alcohol; one-quarter, alcohol and other drugs; one-quarter, drugs other than alcohol.

The corresponding rate for the general population, as estimated from NIMH Epidemiologic Catchment Area data, is 13% to 16%. Other studies have shown rates of alcohol abuse in physicians at 13% to 14%.

Only one-third of the physicians in the Hughes study who admitted drug problems in the previous year, reported receiving treatment during that period.

Vaillant Commentary

In an editorial "Physician, Cherish Thyself, the Hazards of Self-prescribing," George E. Vaillant, MD, of Dartmouth Medical School, wrote that the study's "most important finding" is that "physicians are *five* times as likely to take sedatives and minor tranquilizers without medical supervision."

"Good physicians know that *self*-treatment with sleeping pills, opiates, and minor tranquilizers is rarely appropriate. No physician would tell a sleepless, unhappy patient, 'Here is a set of signed prescription blanks. Use whatever tranquilizers seems to help, but don't bother me. You ought to be able to find some

pill to set you right.'"

Dr. Vaillant points out that substance-abusing physicians are at very high risk for death. He suggests that "state medical societies should create guidelines for self-prescription. Physicians are reluctant to bother other busy physicians with their own problems, and thus physicians need to be protected from their altruistic wish to self-prescribe. I believe that all societies should follow the lead of the 25-plus states that now prohibit physicians from prescribing controlled substances for themselves or for their immediate families. Second, the physicians of physicians should be encouraged to seek urine tests for opiates and blood tests for sedatives in any physician patient who represents a diagnostic enigma. Third, hospitals should have procedures in place to refer addicted physicians for appropriate treatment, including well-supervised and long-term random screening of their urine for drugs. Fourth, I propose that some medical staffs establish trial programs of random urine screening tests for all their members....In any case, no physician, whatever the rationalization, should write a self-prescription for a drug that will make her or him feel better, sleep better, or work better."

["Prevalence of Substance Use Among U.S. Physicians." Patrick H. Hughes, MD, et al, Journal of the American Medical Association, May 6, 1992 . Vol. 267, No. 17, pp. 2333-2339; Editorial by George Vaillant, MD, pp. 2373-2374].

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ASAM Commentary

"The value of this report in JAMA is to increase awareness of the issue of chemical use among physicians," **Penelope P. Ziegler**, MD, director of Pennsylvania's Physician Health Program, told *ASAM NEWS*.

"We as ASAM members should be alert to the risk that some of our medical colleagues who are not well informed about addictive diseases might use this report as a false sense of security by pointing to the low numbers. Unfortunately, there are still physicians who don't think there is anything wrong with having a few drinks and then going to the hospital to see patients. They believe it's no worse than driving home after a few drinks -- even though in both cases, they are at higher risk for affected judgment and accidents. Also, we might remind our colleagues that a self-survey like this one doesn't accurately peg everyone who has serious CD problems: many either don't return the survey, or they don't answer it honestly.

"*Any* amount of alcohol can impair judgment, and alcohol remains a major cause of chemically related health problems in physicians."

AMA Policy

Last year (1991) the AMA debated this issue, and passed a new policy:

> "The AMA ... urges 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."
>
> *(ASAM NEWS, July-August 1991, p. 1)*

"This AMA policy does not define any amounts of alcohol, as do all DUI policy statements," said Dr. Ziegler.

ASAM delegates to the AMA were planning to bring this point up at the June 1992 AMA meeting in Chicago.

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State Physician Health Programs Annual Meeting

by **Penelope P. Ziegler**, MD

The National Federation of State Physician Health Programs held its annual meeting in Washington, DC, Mar. 31 and Apr. 1, at the same hotel as ASAM's annual meeting. The federation serves as a forum for the exchange of information among state programs devoted to the rehabilitation of physicians whose professional and/or personal lives have been disrupted by health problems including addictive disease, neuropsychiatric disorders, and other illness or disabilities.

This year over 50 persons from 23 state programs participated in the conference.

ASAM members who are among the new officers: **David T. Dodd**, MD (TN) *president;* **Walton E. Byrd**, MD (OR) *vice president;* **Robert C. Vanderberry**, MD, (NC) *vice chair of the board;* **D. Kete Cockrell**, MD (IN), **John C. Dalco,** MD (MA), **Penelope P. Ziegler**, MD (PA) *board members.*

Violet M. Eggert, MD, (IL) and **Roger Goetz**, MD (FL) are immediate past president and immediate past board chairman, respectively.

Federation members participated in a review of the status of each state's program, sharing ideas about staffing, fund raising, and relationships with licensure boards. There were workshops on "The Problem Physician -- Behavior and Personality" facilitated by Dr. Dodd, and on "Uniform Agreements and Records," sexual misconduct and sexual harassment, and the psychiatric and legal concerns raised by inappropriate sexual behavior in physicians.

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ASAM Review Courses

by **Terry A. Rustin,** MD

The Review Courses in Addiction Medicine, scheduled to take place in Chicago (Oct. 8-10), Atlanta (Oct. 22-24) and Long Beach, CA (Nov. 5-7) will offer an opportunity for ASAM members to review the entire addiction medicine field, as well as to prepare for the ASAM Certification Exam. Each conference runs from Thursday afternoon through Saturday afternoon.

New this year are a series of "pre-conferences" on Thursday mornings at each site. The Illinois Society of Addiction Medicine will sponsor a set of pre-conferences in Chicago, including sessions on methadone maintenance, relapse issues in recovery, management of nicotine dependence, managed cared, and psychodrama therapy. In Atlanta, ASAM will sponsor a pre-conference workshop on psychodrama, and in Long Beach, the California Society of Addiction Medicine will sponsor a pre-conference workshop on spirituality.

Watch your mail for the Review Course brochure and registration form, or call ASAM headquarters for more information.

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AMA Annual Meeting

by Emanuel M. Steindler, MS

Several issues of interest and concern to ASAM members were debated and acted upon at the 1992 Annual Meeting of the AMA House of Delegates held in Chicago in June. The 434-member House of Delegates is the policy-making body of the 290,000-member AMA. ASAM has one delegate, **Jess W. Bromley**, MD, and one alternate, **David E. Smith**, MD.

MRO

The House approved a resolution introduced by ASAM that reaffirmed AMA policy regarding medical review officers (MROs) in employee drug testing programs. That policy states that MROs should be physicians who receive adequate training in their duties and responsibilities and that such training be provided by recognized medical specialty societies. The resolution also called for AMA opposition to legislation pending in Congress which would permit nurses and other non-physicians to serve as MROs.

During the meeting, ASAM convened a session on medical society interests in MROs. Representatives of six specialty societies agreed that it would be important to reach consensus on credentialing MROs, and, if possible, to coordinate efforts to that end. Dr. Smith, who chaired the session, and Dr. James F. Callahan described the training courses for MROs being offered by ASAM, which are open to ASAM and non-ASAM members alike. They stressed that the ASAM board wishes to involve other medical organizations in dialogue before taking further steps in training or credentialing processes.

In another issue of interest to ASAM, the House of Delegates placed the AMA on record as opposing discrimination against physicians who are under the supervision of state medical licensing boards. Originally pointing to exclusionary practices against such physicians in employment, business opportunities, and insurance coverage, this resolution was strengthened to incorporate "specialty board certification or recertification, and other benefits, solely because the physician is either presently, or has been in the past" under such supervision. The wording followed testimony offered by Dr. Smith in a reference committee hearing that instances of this kind of discrimination against physicians in recovery have come to the attention of ASAM's Physicians Health Committee.

In special ceremonies, Dr. Bromley was recognized for having recruited eight or more new AMA members for three consecutive years, and Dr. Smith for eight or more members in one year. ASAM was the only medical specialty society with both delegates thus recognized. Dr. Bromley was also named to serve on the House reference committee dealing with AIDS and other public health matters.

HIV

Regarding AIDS, the AMA extended and sharpened its policy on HIV infection and physicians by approving a series of 17 recommendations contained in a board of trustees report that was modified by Dr. Bromley and the other members of the reference committee who heard testimony on the report.

Included among the new recommendations that were adopted are provisions that any HIV-infected physician should disclose his/her serostatus to a public health official, that a physician who performs procedures that pose a significant risk of transmission of infection should voluntarily determine his/her serostatus at appropriate intervals, and that physicians and other health care workers who are HIV-infected should be aware that they are susceptible to tuberculosis infection and take necessary preventive, diagnostic, and therapeutic steps to deal with this vulnerability.

Tobacco

Tobacco captured its usual share of the limelight, being the focus of a plethora of resolutions dealing with various aspects of smoking and health. Approved with little or no debate were resolutions that oppose cigarette advertising, supported counter-advertising, call for a ban on smoking during all domestic and international airline flights, seek federal legislation for cigarette warning labels to be 25% of the front and back panels, urge various groups to divest themselves of financial holdings in tobacco companies, favor smoke-free college campuses, ask the AMA to help the Centers for Disease Control collect data on tobacco prevention education, and ask the AMA to "use active political means" to promulgate an OSHA standard to protect workers from the toxic effects of environmental smoke. The House discussed extensively the last resolution concerning additional government intrusion; Dr. Bromley joined other delegates to resist attempts to water down the provisions.

Other Business

The AMA House took the following actions:

• Asked the AMA to conduct an intensive campaign to encourage physicians to take an alcohol history from all their teenage and adult patients and warn them of the serious sequelae of alcohol consumption.

• Approved recommendations by the Council on Scientific Affairs that drug treatment, prevention, intervention, research, and education efforts focus more sharply and with greater compassion on pregnant women. Approved a recommendation that "transplacental drug transfer should not be subject to criminal sanctions or civil liability."

• Established a policy that a physician's medically necessary referrals to an off-site facility in which he/she has a financial interest is ethical if the patient is fully informed of the ownership interest and the existence of any available alternate facilities.

ASAM Caucus

The first-ever "ASAM caucus" was held at this year's AMA meeting. Delegates who are ASAM members were **Lee McCormick**, MD (Ohio) (chair of the Hospital Medical Staff Section), **Silvana Menendez**, MD (Illinois), **Samuel Cullison**, MD (Washington state), and Drs. Bromley and Smith. Other ASAM members who were unable to attend were **Dennis E. Wolf**, MD (North Dakota) and **H. Constance Bonbrest**, MD (Illinois). It will be a regular event at future AMA House of Delegates meetings.

Mr. Steindler, former executive director of ASAM, was o staff of the AMA for 25 years in the Mental Health and Substance Abuse departments.

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CD Fellowship Guidelines

ASAM-proposed guidelines for fellowship training programs in the addictions will be presented to the ASAM Board for action at its October meeting.

The 30-page document is a detailed listing of all the elements that the Fellowship Committee believes are necessary to "provide the training to assure the competence of a specialist in the field."

"A specialist in the addictions," says the paper, "integrates the science and clinical techniques of the field into his/her general medical knowledge and is an effective teacher of the discipline."

The document specifies the characteristics which are required for an appropriate level of quality of training. These areas are covered: the program's sponsor, facilities for the training, program director and faculty, curriculum content, opportunities for clinical experience, scholarly activity required of the fellow, eligibility requirements and selection of the fellow, conditions of his/her employment, and evaluation for satisfactory completion of the fellowship.

This document was a key part of the workshop "Fellowships in Addiction Medicine: Curriculum, Evaluation, Funding," sponsored on April 4 by the ASAM Fellowship Committee during the ASAM 1992 Medical Scientific Conference in Washington, DC. Copies of the document are available at no cost from ASAM headquarters.

Fellowship Center Participates

These guidelines incorporate "Guidelines for Postgraduate Medical Fellowships in Alcoholism and Drug Abuse," which was prepared in 1989 by the Center for Medical Fellowships in Alcoholism and Drug Abuse at New York University. Center's director is **Marc Galanter**, MD.

ASAM's document has been in development for well over a year. The Fellowship Committee, which is chaired by **Dolores M. Burant**, MD, of Madison, Wisconsin, and includes co-chair **James Halikas**, MD, **R. Jeffrey Goldsmith**, MD, **David Gorelick**, MD, PhD, **Elizabeth F. Howell**, MD, **Richard Sandor**, MD, and **Doyle P. Smith**, MD, has circulated drafts to interested persons and groups since early 1991. The cover sheet identified it as a work in progress, and invited comments from readers. Copies were distributed at the Fellowship Committee's open meetings during the 1991 and 1992 Medical Scientific Conferences.

Copies were also distributed twice at meetings of the Consortium on Medical Fellowships in Alcoholism and Drug Abuse. Consortium meetings are attended by members of the following organizations: ASAM; AMERSA (the Association of Medical Educators and Researchers in Substance Abuse); aaPaa (the American Academy of Psychiatrists in Alcoholism and the Addictions); APA (the American Psychiatric Association); the Society of Teachers of Family Medicine; the Society of General Internal Medicine; the American Academy of Pediatrics; and the American Academy of Neurology... [by Gail B. Jara, staff consultant]

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ASAM/AMERSA to Collaborate

The presidents of ASAM (**Anthony B. Radcliffe**, MD) and of AMERSA (**Anderson Spickard**, MD) want suggestions for projects that the two organizations can carry out together.

What Is AMERSA?

The Association for Medical Education and Research in Substance Abuse (AMERSA) was founded in 1976 to provide networking, information-sharing, and support, to teachers of chemical dependence in medical schools and in other professional schools in the health care field.

AMERSA offers its 500 members, most of whom are physicians, a scholarly, interdisciplinary forum. A faculty appointment is required for full (voting) membership, but associate memberships are open to those with "demonstrated interest and involvement." Annual dues for everyone are $100.

David C. Lewis, MD, is the director of AMERSA's national office, located in the Center for Alcohol and Addiction Studies at Brown University, Providence, RI 02912. Past presidents have included **Robert M. Morse**, MD, **Sidney H. Schnoll**, MD, PhD, and **John N. Chappel** MD.

AMERSA publishes *Substance Abuse*, a quarterly journal of original papers and abstracts based on the presentations at its annual conference, which is always held in Washington, DC, in November. Editor-in-Chief is **Marc Galanter**, MD. This year's meeting will take place Nov. 12-15, 1992, at the Hyatt Regency Hotel in Bethesda, MD. Contact is Kathryn Cates-Wessel. at Brown.

In a letter mailed last May to all ASAM and AMERSA members, the two presidents solicited ideas for joint projects. Suggestions will be presented to the governing bodies of both organizations this fall. "Our purpose is to find tasks that will get our two groups working together in 1992-93," Dr. Radcliffe told *ASAM NEWS*. "It is not too late to send your ideas to me." Write him at ASAM headquarters, 5225 Wisconsin Avenue NW, Washington, DC 20015.... [by Gail B. Jara, staff consultant]

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Names in boldface are first mentions of ASAM members.

NEW MEMBERS

Recent Joiners

Physicians who joined ASAM between May 1 and June 30:

Alaska
David E. Johnson, MD - *Pediatrics*
California
Louis Joseph Biscotti, MD - *Fam. Prac.*
Stephan R. Bochner, MD - *Ob/Gyn*
Barrett G. Levine, MD - *Psych.*
Connecticut
Neil J. Greg, MD - *Int. Med.*
DC
Mavis B. Marks, MD - *Derm.*
Florida
Brian J. Ellis, MD - *Fam. Prac.*
Georgia
Gloria Joco Abad, MD - *Psych.*
William E. Green, III, MD - *Psych.*
Sharon Lee Roberts, MD - *Int. Med.*
Illinois
Harold F. McGrath, MD - *Psych.*
Juan F. Valdivia, MD - *Psych.*
Louisiana
G. Daniels Edwards, III, MD
Van A. Snider, MD - *Int. Med.*
Maine
George Preston Lord, MD - *Int. Med.*
Maryland
Carlo S. Contoregi, MD - *Int. Med.*
Linda L. George, MD - *Ped.*
Massachusetts
Joanna R. Louis, MD - *Psych.*
Nebraska
Donald Aaron Singer, MD - *Clin. Path.*
New Jersey
Terence J. Aherne, MD - *Int. Med.*
Eugene H. Markham, MD - *Ob/Gyn*
New York
Alexander Medakovich, MD - *Int. Med.*
Jean D. Miller, DO - *Gen. Pract.*
Edward Vernon Nunes, Jr., MD - *Psych.*
North Carolina
Jeffrey R. Grimes, MD - *Int. Med.*
Pennsylvania
Roy Farias Kruzel, DO - *Fam Prac.*
Carl E. Meyer, III, DO - *Ped.*
Thomas H. Turner, MD - *Fam. Prac.*
Rhode Island
Conrad J. Granito, MD - *Psych.*
Texas
Scott Samuels Douglas, MD - *Psych.*
Raul Rivera, MD - *Fam. Prac.*
Wisconsin
Barry Spiegel, DO - *ADM*
Canada
S. Paul Bonisteel, MD - *Fam. Prac.*
Austria
Walter Reichelt, MD - *Psych.*
Wolfgang Werner, MD - *Psych.*
Nigeria
Harry Oyeyinka Ladapo, MD - *Psych.*

Information from ASAM headquarters.

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ASAM NEWS

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CHAPTER REPORT

Dr. LeClair Bissell on Ethics in Addictions

LeClair Bissell, MD, is chair of the ASAM Ethics Committee and is co-author with James E. Royce, SJ, of the book "Ethics for Addiction Professionals." A former ASAM president, and immediate past president of the Florida chapter of ASAM, she was the keynote luncheon speaker at FSAM's annual meeting in Orlando Jan. 18. This report was in FSAM NEWS April 1992.

According to Dr. Bissell, there isn't a great deal of information available on ethics in the addiction medicine field. Indeed, medical schools tend to devote only about 1-1/2 hours to teaching ethics.

"What's different about recovering doctors?" she asked the audience. "If you belong to a subculture, such as AA, depending on its size in the community, the chance of contacts outside the office can increase because of joint doctor/patient participation." This is true for either a small town, or a subculture such as the gay/lesbian community. At times it is impossible to avoid contact; for example, many physicians see former patients at IDAA meetings. A physician must decide to attend or to skip certain social events if a patient mentions planning to attend.

Dr. Bissell advised watching for dual relationships, such as family, close friends, or colleagues with whom you work closely, before accepting them as patients. "Get these people to someone else if possible, particularly if it's a 28-day treatment center you're running, and there are others in the state. Of course, you may be the only treatment provider within 300 miles. But, don't treat your own staff because their anonymity is virtually impossible to protect."

Can a doctor form a personal relationship with a patient after he/she is no longer a patient? "This is a very tricky issue," said Dr. Bissell. "Since it's based on transference/counter transference, is that a time-limited phenomenon that will automatically go away in a certain number of days, weeks or months? My hunch is no. I don't believe I can treat a patient really well until I renounce that patient as a potential close friend, now or later. If I'm always planning what you and I might do after this relationship stops -- even though I'm going to postpone my experience with you for a couple of years -- if, after the two years you'll be fair game, I probably won't treat you the same way I do my other patients." The doctor won't free that patient to be with other people; won't take a chance on offending that patient; will have a subtle but distorted doctor/patient relationship.

Involvement with a Patient

"Suppose we do get involved with a patient? What happens? What's the harm?"

Dr Bissell said studies show these common complaints:

- distrust of members of the opposite sex;
- end of therapy itself;
- depression;
- serious impairment of sexual relationships;
- anger;
- devastation;
- rejection;
- feelings of exploitation and abandonment;
- hospitalizations and suicide attempts;
- once sexualized, therapy tends to end abruptly or impulsively, terminated by one or the other, leaving a bad taste in the mouth;
- abuse of trust and power;
- abandonment of professional role and fiduciary duties;
- your malpractice insurance will not pay;
- loss of reputation; possible loss of licence, job, freedom;
- gain of guilt;
- failure to mature as individual and therapist.

According to Masters & Johnson, the patient's experience is like rape, or being incested. "Technically the patients assent, but they feel raped," said Dr. Bissell.

ASAM's Role

What can ASAM do? "Our certification exam won't do much here," said Dr. Bissell. "We have to find other ways of teaching." She said she didn't know if "hearing a lecture from me is a good way to begin."

She does think talking to psychiatric colleagues about all this would be a good idea She also recommended:

- avoiding patients who might be problematic;
- reading "Ethics in Psychology" by Patricia Keith-Spiegel and Gerald P. Koocher, published in 1985, and also "Sex in the Forbidden Zone" by Peter Rutter, MD;
- having a hugging policy: deciding who hugs whom; and what each kind of hug means;
- looking at favorite patients as if they're celebrities and asking yourself the same questions you would ask about a celebrity patient:Are you altering your behavior?Are you relaxing the rules?
- watching yourself if you make *any* changes for a patient, including record-keeping.;
- being clear about the patient's expression of erotic feelings for you;
- if in any doubt about your feelings, seeing the patient in your office only, or in business-like situation. Don't take medications to his or her house!
- when decorating it, don't turn your office into a "pad."

"If you're already in a sexual relationship, you have some hard work to do," she announced. "First and foremost: stop covering up! Go rapidly to your most trusted professional colleague and talk about it. Say that you can't have the patient as a patient any longer, and work out a way to transition that patient out. This will have to be done whether or not you go on with the relationship. Then work with this trusted colleague to look at some of the issues, e.g. would you be attracted to this person if the power relationship were different? Will the patient still want you if you take off the white coat and have clay feet?

"Be willing to listen to what you don't want to hear. "

She closed the speech by saying,"Let's not give up the power to discipline ourselves."

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ASAM NEWS welcomes reports from its chapters about meetings and activities. Send to editor Lucy B. Robe, 303-D Sea Oats Dr., Juno Beach, FL 33408.

Frank Seixas Dies

Former NCA Medical Director

Nearly 27 years ago, the following announcement appeared on page one of a new publication, *Physician's Alcohol Newsletter*, Vol. 1, No. 1, Dec. 1965.:

"Alcoholism is one disease that every physician is likely to confront. The New York City Medical Society on Alcoholism [NYMSA] is publishing this newsletter to bring to the medical community information that may help in treating this widespread, incompletely understood illness."

The newsletter's editor-in-chief was **Frank A. Seixas**, MD, who died on May 8 of Alzheimer's disease in a nursing home near his home at Hastings-on-Hudson, New York. He was 72 years old.

According to *The New York Times* obituary May 11, he was best known for his efforts "for society and especially the medical profession to recognize and treat alcoholism as a major health problem rather than as a moral or behavioral lapse."

Dr. Seixas (pronounced SAY shuss) was born in New York City to a prominent Jewish family. With a BA from Cornell, an MA in English, and then an MD from Columbia (after five World War II years in the U.S. Navy), he trained in both internal medicine and psychiatry. He was affiliated with several hospitals in the New York City area, and was director of medical services of the ACCEPT Clinic for five years in the late 1960s, followed by ten years as the second medical director (after **Ruth Fox**, MD, retired) of the National Council on Alcoholism (now NCADD), both in Manhattan.

"He took me to my first AMSA meeting (then the NYMSA) while I was still a house officer and he a medical attending at Roosevelt Hospital," **LeClair Bissell**, MD, a former ASAM president, told *ASAM NEWS*. "That meeting was in his living room in Hastings-on-Hudson. Through it, I met Ruth Fox, **Stan Gitlow, Percy Ryberg,** and the other pioneers in the field.

"Frank was one of the first to admit alcoholics to Roosevelt as alcoholics, specifically for the purpose of addressing their alcoholism," continued Dr. Bissell. "That required courage. He took a lot of criticism from colleagues and house officers for doing it. I very much admired what he was trying to do. Although we had some conflicts over methods, we both had the same goal: for alcoholics to be treated for their disease and to get well."

NCA Criteria for Diagnosing Alcoholism

Charles S. Lieber, MD, another former ASAM president, said at Dr. Seixas' memorial service May 31: "He saw early on that for alcoholism to become a true science it needed a scientific definition. This he successfully achieved by bringing together world experts [65 of them] to define the criteria for diagnosing alcoholism as a disease. There was such a crying need for these criteria that not just one, but two medical journals published them." ["Criteria for the Diagnosis of Alcoholism:" *Ann. Intern. Med.*, 1972, 77:248-258. *Am. J.*

Psychiatry, 1972, 129: 127-35. There was also an Editorial: *JAMA*, 1972, 1:2.]

Dr. Seixas was secretary of the ASAM board of directors from 1968-72. He was co-chair of the Publications Committee in the late 1970s, and chair of the International Committee in the early 1980s. ASAM gave him its Annual Award in 1981, and a special honorary membership in 1989.

Stanley E. Gitlow, MD, also a former ASAM president, told *ASAM NEWS* that Dr. Seixas' "early years in the field of addiction medicine sparkled with his single-handed undertaking of the original alcoholism newsletter of this medical society. It was published through the largess of Mr. Brinkley Smithers. His major editorial and organizational talents reached fruition when he helped to develop the NCA 'Criteria.' Within a few years he had organized medical meetings on various topics of chemical dependency, and edited textbooks that served as excellent resources for evaluating the state of the medical art in this field. At about the same time, he played a major role in developing a basic science organization, the Research Society on Alcoholism."

Dr. Seixas was on the board of the International Council of Alcohol and Addictions. "One of the nicest things about Frank was that he really enjoyed people from all over the world," said Dr. Bissell. "When they visited NCA, he would host them graciously and usually recruit them to join AMSA."

He was on nine editorial boards. These included being editor-founder of *Alcoholism: Clinical and Experimental Research* from 1977-82 (Dr. Lieber was chair of its editorial board at the time) and editor of four volumes of *Currents in Alcoholism* in 1977-78. These publications were issued under the aegis of NCA, ASAM, and the Research Society on Alcoholism. He was author or co-author of 48 scientific papers and articles on alcoholism, of 13 book chapters, and of 10 book reviews.

When Dr. Seixas started *Physician's Alcohol Newsletter* in 1965, the NYMSA's membership of nearly 100 included "strong representation from the fields of psychiatry and internal medicine." Now, ASAM's some 3,500 members still include a good proportion of these specialists.

"In his lifetime," said Dr. Lieber, "Frank had the satisfaction to see his efforts come to fruition, and to witness alcoholism being recognized as a legitimate medical field in which physicians and other professionals could work without any more being subject of scorn. Those afflicted could be treated as patients and not simply rejected as depraved individuals."

Added Dr. Gitlow, "He is survived by his wife, Judy Seixas, who is a respected writer in the same discipline." [Her books include *Children of Alcoholism* and the *What It Is, What it Does* substance misuse series for young people.]

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IN MEMORIAM

Drs. Frank Seixas (L), Ruth Fox (C), and Luther Cloud (R) in 1968.

Dr. Kilhorn of Canada

Leo H. Kilhorn, MD, of Prince Edward Island, Canada, died in late June in an auto accident en route home from the Caron Foundation in Pennsylvania, where he was on the board of trustees. A longtime member of ASAM and a specialist in addiction medicine, Dr. Kilhorn was certified by ASAM in 1987.

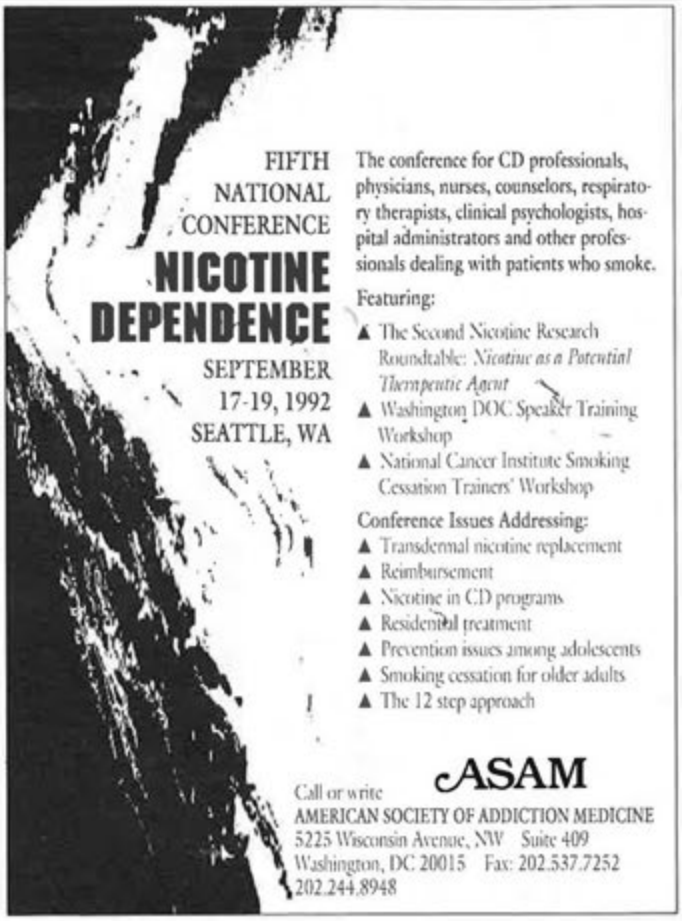
*Names in **boldface** are first mentions of ASAM members.*

Addiction Medicine Specialist

Roger Williams Medical Center seeks a staff physician, Board Certified in Internal Medicine, with training and competence in Alcoholism and Substance Abuse. Candidates must qualify for appointment to the Brown University faculty as Assistant or Associate Professor of Medicine and must have demonstrated skills and interest in teaching medical students and housestaff. The successful candidate will be expected to develop research in the area of substance abuse. Appointment at the Associate Professor level in the Teaching Scholar track would require experience and a major teaching role in medical education. A well-established national reputation is therefore preferred in order to direct and develop teaching programs in the areas of alcoholism and other substance abuse for medical students, housestaff and post-graduate medical education sessions. Approximately 40% of appointee's time will be devoted to research. Other responsibilities include service as an attending as well as providing medical leadership in the operation of the inpatient and outpatient units.

Please send CV to:
David Lewis, MD, Chairman, Search Committee
Roger Williams Medical Center
825 Chalkstone Ave., Providence, RI 02908

Roger Williams Medical Center is an Equal Employment Opportunity/Affirmative Action employer and actively solicits applications from minority and protected groups.



ADDICTIONIST

The Capital Area Permanente Medical Group is a 300-physician multi-specialty group practice serving the 270,000 patients enrolled in the **Kaiser Permanente** Medical Care program, **Washington, D.C./Baltimore** metropolitan area.

We are recruiting for a physician to lead our program's efforts in the treatment of addicted members. A competitive salary and benefit package is offered along with an opportunity to start innovative treatment programs in this area.

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Suite 300
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Or call in confidence:
1-800-326-2232

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Now in process of recruiting Addiction Medicine Specialists to several **southern California** facilities. Seeking physicians specializing in Addiction Medicine, ASAM certified or in process of seeking certification, who are team oriented. Ongoing training and supervision will be provided. These positions are most suitable for recent graduates from a psychiatric or family practice residency.

Send CV or requests for further information to:

James Miner, MD
Medical Director, or

Jill S. Brandenburger, RN
Vice President

Addiction Medicine Services
24502 Pacific Park Drive
Laguna Hills, CA 92656

714-831-1166
714-831-2202 (FAX)

ASAM International Activities

by James F. Callahan, DPA
Executive Vice President

ASAM can truly be called an international medical specialty society: 117 of our members represent 18 countries. Their goals, worldwide, are the same as those of our U.S. members; namely, to improve the treatment of alcoholism and other addictions, to educate physicians and medical students, to promote research and prevention, and to enlighten and inform the medical community and the public about these issues.

This reality was clearly evident at the April 1, 1992, meeting of the ASAM International Committee in Washington, DC. Eleven members attended: **Maris Andersons**, MD, Toronto, Canada; **Joaquim Carrilho**, MD, Lisbon, Portugal; **Jean-Pierre Chiasson**, MD, Montreal, Canada; **Nady el-Guebaly**, MD, Calgary, Canada; **Anne Geller**, MD, New York, New York; **Garrett O'Connor**, MD, Los Angeles, California; **Anthony B. Radcliffe**, MD, Redlands, California; **Ferguson Reid**, MD, Glen Allen, Virginia; **Max A. Schneider**, MD, Orange, California; and **George Wilson**, MD, Sydney, Australia. Mr. Manny Steindler also attended. Members who sent regrets were **Christian Haverbeck**, MD, Santiago, Chile; **Flavio Poldrugo**, MD, PhD, Trieste, Italy; **James G. Rankin**, MD, and Juan Negrete, MD, Toronto, Canada.

This committee had been inactive since the tenure of **Conway Hunter, Jr.**, MD, as chair. Last year, ASAM president Dr. Radcliffe met with his Canadian colleagues at the Canadian Medical Society on Alcohol and Other Drugs (CMSAOD) and expressed his intent to reconvene the committee. Dr. Rankin (past president of CMSAOD) and Dr. Negrete (its current president) said that they were pleased, especially because Dr. Radcliffe emphasized collaboration with physicians worldwide, as opposed to seeking participation in ASAM-initiated activities.

The Washington meeting underscored that theme. While the committee took no formal actions, members agreed that its mission should be should be to "serve as a forum where ASAM international members and others might meet to discuss issues of worldwide concern on the clinical problems of addictions and their consequences, including AIDS and chemical dependency, and to internationally promote the education of physicians, prevention of drug dependence, the improvement of access to care, and the quality of care for those suffering from the addictions."

The committee suggested that its membership be limited to physicians, and that it underscore the primacy of the disease model of addiction.

Plans and Projects

The committee made several recommendations for international activities during the coming year and beyond, including:

- Promoting world dialogue among physicians to share knowledge and education.
- Obtaining information on international and national addiction medicine organizations and physicians, and inviting them to correspond with the ASAM committee.
- Planning a physician education program for the August 1995 International Council on Alcohol and Addictions (ICAA) Congress on Alcohol and Drug Dependence (San Diego, CA).

After the committee meeting, ASAM wrote to the medical officers of all the U.S. embassies, inviting them to join the society and sending each a complimentary copy of our *Journal of Addictive Diseases*. The committee has asked the Director General of WHO for names and addresses of the ministers of health of all nations, and **Enoch Gordis**, MD (Director, NIAAA) and Richard Millstein (Acting Director, NIDA) to identify international organizations and physicians in the addictions. **George Wilson**, MD, and **Henk Wechgelaar**, MD, have given us names and addresses of physicians and organizations in Australia, New South Wales, and England.

The committee hopes that there might one day be a 'World Society of Addiction Medicine,' and that the extensive work by ASAM members in the U.S. to establish addiction medicine as a recognized and board-certified field of medical practice might contribute to the work of physicians worldwide.

FROM THE EXECUTIVE VICE PRESIDENT

Dr. Callahan

Our members may be pleased to know that ASAM is not the only national medical society in addiction medicine. Societies now exist, and have for some years, in Canada (CMSAOD) and in Portugal (Portuguese Association of Addiction Medicine). And now there is the Panamanian Society of Addiction Medicine (PSAM).

Dr. Rankin, the president of CMSAOD, attended the ASAM board meeting in April 1991 and made a presentation about CMSAOD's work. Dr. Carrilho made a presentation to the board at its April 1992 meeting. The board welcomes such presentations by representatives of medical societies from other nations, and hopes that **Carlos Smith**, MD, president of PSAM, will make one at the April 1993 meeting in Los Angeles.

We would be happy to have comments or suggestions about the new undertakings of the ASAM International Committee.

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

About ASAM

CME/ASAM CoSponsorship

Reminder to anyone who is planning a conference that offers CME credits through ASAM: it is now necessary to submit an application signed by an ASAM member, certifying to his/her actual participation in the the development of the program.

This is to insure compliance with the Accreditation Council for Continuing Medical Education (ACCME) Essentials for Sponsorship. In accordance with this, the ASAM Continuing Medical Education Committee has prepared an application for cosponsorship, which is available from Claire Osman, ASAM, 12 West 21st Street, New York, NY 10010. ☎ (212) 206-6770. FAX: 212-627-9540. Applications for this cosponsorship must be made three months in advance of the program. As before, 50% (half) of the program speakers must be doctoral level in order for a conference to qualify.

ASAM Journal Pub Dates

New schedule for *Journal of Addictive Diseases:*

Volume 12,.
No. 1 - December 1992
2 - March 1993
3 - June 1993
4 - September 1993

Editor: **Barry Stimmel**, MD.

Syllabus Errata

The May-June issue of *ASAM NEWS* reported in two places (pages 4 and 7) that the next ASAM Review Course Syllabus would be published in the spring of 1993. The correct date is spring, 1994. Editor: **Norman S. Miller**, MD, in collaboration with **Martin S. Doot**, MD and the Review Course Committee.

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Adolescent Addiction Medicine

(continued from p. 2,

Against many odds, those who seek to help adolescents with their drug use will find the best solutions, because as a society it is in our best interest to do so.

Usage patterns will change, but if there is any truth to what we have learned about drug use and health, a core group will develop health problems from use -- not because they want to, but because that is the nature of addictive disease. Many societies before ours have decried the next generation, just ask your parents. There is only one thing of which we can be fairly certain: these adolescents will be the adults of tomorrow, and the parents of a new generation. What do we want them to know about drug use and health? And what knowledge do we want them to pass on to *their* children?

Some of my hopes would be to teach them what it means to be physically, mentally, emotionally, and spiritually healthy, not just as adolescents or adults, but for all of their lives. To teach them to learn to take responsibility for their health as the most precious thing they will ever have. To teach them it is healthy to have some loss and suffering, that pain is neither good nor bad, but is to be expected. That spiritual health is much greater than their religious denomination. And that emotions can be shared without assessing guilt or blame.

ADM is a specialty by practice. It is up to you whether adolescent ADM ever becomes a special practice. That depends on how well you take care of adolescents and what you learn that can be published and learned by others. Right now it is easier for someone who has some knowledge about adult ADM to take care of adolescents with drug use problems. If this is to change, then lead the way: show physicians what one needs to know in order to practice Adolescent ADM.

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

RUTH FOX MEMORIAL ENDOWMENT FUND

Recognition Roster by Giving Level

May 1 - June 30, 1992

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Errata

In the May-June Donors listing, the name Daniel E. Wolf, DO, was spelled incorrectly.

Mark R. Publicker, MD

Ruth Fox News July/August

Special thanks to Mark R. Publicker, MD, of Pittsburgh, PA, for joining the Benefactors' Circle by making a Planned Giving Gift to the Ruth Fox Memorial Endowment Fund. ASAM gratefully appreciates his generosity and dedication to the society.

The Endowment has now reached $1,078,104 toward its goal of $10 million by the year 2000. Please join your colleagues, if you have not already done so. Send your pledge/contribution now. If you need information about the different categories of giving, and details about a Planned Giving Gift,please call Ms. Claire Osman at (212) 206-6770.

By giving to the Endowment you will ensure that ASAM's work and its goals will be pursued well into the future.

We continue to be grateful to our members and friends for their support.

Jasper G. Chen See, MD
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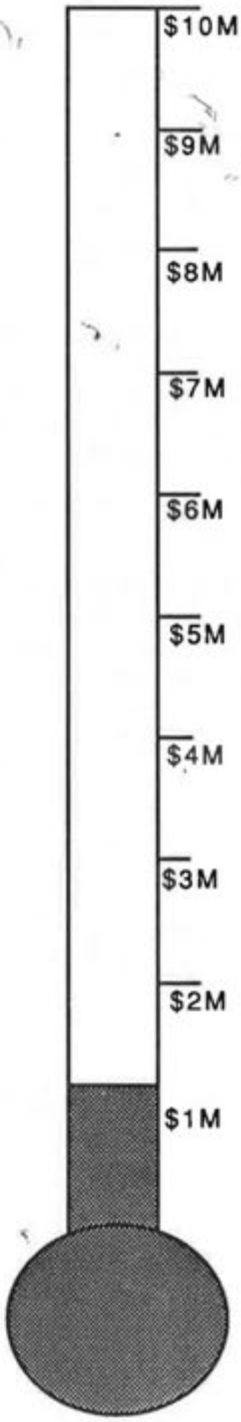
ASAM, 12 W. 21 St, New York, NY 10010 ☎ (212) 206-6770

Goal: $10,000,000



Pledged: $ 1,078,104
as of 6/30/92

ASAM CALENDAR

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

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❑ **Panama Society of Addiction Medicine:**
Panama City, Aug. 27-29.
Carlos Smith, MD, Sociedad Panamania De Medicina Addicion, Apartado 87-0967, Panama 7, Panama

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❑ **ASAM 5th National Conference on Nicotine Dependence: Seattle, Sept. 17-20** *Seattle Sheraton*

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❑ **GASAM/GA-aaPaa 2nd Joint Fall Scientific Conference:**
St. Simons Island, GA, Sept. 25-27.
The King and Prince Beach Resort
Louisa Macpherson, Cluny Conference Services, 1013 Rivage Promenade, Wilmington, NC 28412. ☎ (919) 452-4920.

❑ **ASAM Board Meeting: Scottsdale, AZ, Oct. 2-4**
Marriott Mountain Shadows

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❑ **Pre-Conference Intensives:** Sponsored by the Illinois Society of Addiction Medicine, **Chicago, Oct. 8** (morning).

❑ **ASAM Review Course in Addiction Medicine:**
Chicago, Oct. 8-10 *O'Hare Marriott*
Atlanta, Oct. 22-24 *Marriott Marquis (downtown)*

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❑ **ASAM MRO - Medical Review Officer Course:**
San Francisco, Oct. 16-18 *San Francisco Marriott*

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❑ **ASAM/CSAM Review Course in Addiction Medicine:**
Long Beach, CA Nov. 5-7 *Ramada Renaissance Hotel*
Pre-Conference on Spirituality and Addiction Medicine:
Nov. 5 (morning).
California Society, 3803 Broadway, Ste 2, Oakland, CA 94611
☎ (510) 428-9091

◆

❑ **AMERSA Annual Meeting: Bethesda, MD, Nov. 12-15.**
Kathryn L. Cates-Wessell, AMERSA, Brown University, Center for Alcohol & Addiction Studies, Box G, Providence, RI 02912. ☎ (401) 863-1102

◆

❑ **SECAD: Atlanta, Dec. 2--6. (The 17th Annual Southeastern Conference on Alcohol and Drug Abuse)**
Pat Fields, Charter Medical Corp, PO Box 209, 577 Mulberry St, Macon, GA 31298. ☎ 1-800-845-1567

◆

❑ **ASAM Certification Examination:**
Atlanta, Chicago, Los Angeles, Dec. 5
(Deadline for applications to take exam was Jan. 15, 1992)

◆

❑ **Florida Chapter 6th Annual Conference on Addiction:**
Orlando, FL Jan. 14-17, 1993
Royal Plaza Hotel (Walt Disney World Village)
Lucy B. Robe, FSAM, 303-D Sea Oats Dr., Juno Beach, FL 33408 ☎ (407) 627-6815

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❑ **ASAM/GASAM Patient Placement Criteria Seminar:**
Atlanta, Feb. 19-21, 1993

◆

❑ **Ruth Fox Course for Physicians: Los Angeles, Apr. 29**

❑ **National Forum on AIDS and Chemical Dependency:**
Los Angeles, Apr. 29

❑ **ASAM 24th Annual Medical-Scientific Conference:**
Los Angeles, Apr. 30-May 2.

◆

Calendar includes only meetings that are sponsored or co-sponsored (CME credits) by ASAM; one time listing for co-sponsored conferences. For inclusion on this calendar, ***please send information directly to Lucy B. Robe, Editor, at least three months in advance.***

For information about conferring CME credits through ASAM, contact Claire Osman, ASAM, 12 West 21 St, New York, NY 10010. ☎ *(212) 206-6770.*

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