ASAM NEWS

American Society of Addiction Medicine

Vol. VII, No. 5 | September - October 1992 | Published Bimonthly

Mark Your Calendars!

ASAM's 24th Annual Medical-Scientific Conference
Los Angeles
April 29 - May 2,1993

Symposia, workshops, courses, Oral and poster sessions, Committee component sessions, Awards dinner, Ruth Fox Course for Physicians, National Forum on AIDS.

Inside

JAMA Publishes NCADD/ASAM Definition of Alcoholism

The Journal of the American Medical Association published on Aug. 26 the new definition of alcoholism, developed by a joint committee of ASAM and the National Council on Alcoholism and Other Drug Dependence (NCADD).

The new definition was first published in *ASAM NEWS (March-April 1990, p. 1).* The multidisciplinary committee, chaired by **Robert M. Morse**, MD, and staffed by **Daniel K. Flavin**, MD, met several times -- beginning in early 1988 -- t o revise the 1976 Definition of Alcoholism and the 1972 Criteria for the Diagnosis of Alcoholism. These had been crafted by a committee of physicians for the NCADD.

"The Definition of Alcoholism" *(JAMA, 1992; Vol. 268, No. 8, pp. 1012-1014).* Authors: Dr. Morse of the Mayo Clinic, and Dr. Flavin, medical director of NCADD and an ASAM board member (ex officio). Both are psychiatrists.

Abstract

"To establish a more precise use of the term alcoholism, a 23-member multidisciplinary committee of the National Council on Alcoholism and Drug Dependence and the American Society of Addiction Medicine conducted a 2-year study of the definition of alcoholism in the light of current concepts. The goals of the committee were to create by consensus a revised definition that is 1) scientifically valid, 2) clinically useful, and,3) understandable by the general public. Herein, the committee presents its revised definition of alcoholism and discusses its concerns about the diagnostic criteria for alcohol dependence that currently are widely used."

Revised Definition

"Alcoholism is a primary, chronic disease with genetic, psychosocial, and environmental factors influencing its development and manifestations. The disease is often progressive and fatal. It is characterized by continuous or periodic: impaired control over drinking, preoccupation with the drug alcohol, use of alcohol despite adverse consequences, and distortions in thinking, most notably denial."

(continued on p. 9)

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.

ASAM 2nd Adolescent Addictions Conference

CONFERENCE DIGEST

ASAM's Second Medical Conference on Adolescent Addictions, held in San Antonio, Texas, June 25-28, drew 138 participants. Most of the faculty of 28 (25 physicians) were not speakers at last year's conference. **Peter D. Rogers,** MD, of Chattanooga, TN, was conference chair; conference proceedings chair was **Larry H. Patton,** MD, of Argyle, TX, who chairs ASAM's Pediatrics Specialty Section. *(See ASAM NEWS July-August issue, p. 1, for a report on the workshop Adolescents and AIDS organized by* ***Anthony H. Dekker,*** *DO. Dr. Dekker is new chair of ASAM's Adolescents Committee.)*

Wolin on Resilient CoA's

Psychiatrist **Steven J. Wolin,** MD, of Washington, DC, has been studying children from alcoholic homes who showed considerable strengths -- along with mild damage. He has found that instead of merely coping with parental alcoholism, which Dr. Wolin sees as a more passive reaction, these children developed resiliencies, or enduring aspects of the self, which have resulted in a basically healthy adult life.

Dr. Wolin described the seven resiliencies at the conference. He later sent the following more formal definitions of the resiliencies to *ASAM NEWS*:

• *Insight:* a form of psychological sophistication, beginning with the child's inchoate sense that life in the troubled family is strange, untrustworthy, or not quite right; growing into systematic knowledge of the family problem; and culminating in empathy, capacity for understanding the self and others, and a tolerance for ambiguities.

• *Independence:* separating from the troubled family, beginning with selective distancing during stress or family disruption, growing into emotional disengagement and greater physical distancing; culminating with the capacity to live apart and relate to family members out of freely chosen, rational beliefs, not internal pressures and unreasonable demands.

• *Relationships:* intimate and fulfilling ties to others, beginning with selective attempts to engage outsiders or troubled parents when emotionally available; growing into active recruitment of parent surrogates and friendship networks; culminating in mutually gratifying personal ties characterized by a balanced give and take and a mature regard for the well-being of others as well as oneself.

• *Initiative:* the push for mastery, beginning with trial and error experiments in the physical surround; growing into goal directed behavior in a wide range of activities; culminating in a zest for projects and for tackling difficult problems.

• *Creativity:* presentation and resolution of inner conflicts in aesthetic forms, beginning with dramatic play aimed at compensating the self for loss; growing into experiments with self-expression through art; culminating in the serious art.

• *Humor:* is finding the comic in the tragic. An offshoot of creativity, humor also begins with playing: grows into the capacity to see the troubled family's behavior as absurd; and culminates in an ability to laugh at one's own emotional pain.

• *Morality:* an informed conscience, first seen in a capacity to differentiate good from bad both in and outside the family; growing into a sense of moral obligation to serve others, neighborhood, and society

Dr. Wolin pointed out that nobody has all seven resiliencies. Therapy can be designed to utilize the resiliencies that do exist, and to change survivors' views of themselves from one who is damaged to one who prevails.

Dr. Wolin's book, *The Resilient Self: How Survivors of Troubled Families Rise Above Adversity,* will be published this winter by Villard Books (a division of Random House).

Risk Factors for Adolescent Substance Abuse

J. David Hawkins, PhD, of the Social Development Research Group at the University of Washington in Seattle, described risk factors for adolescent substance abuse that exist before drug use begins. (These were published in *Psychological Bulletin*, Vol. 112, Issue No. 1, pp. 64-105, July 1992; Dr. Hawkins is senior author.)

• family history of alcoholism. Between 17% and 28% of CoA's become alcoholics.

• failure by parents to set clear expectations for behavior, and to monitor their children.

• inconsistent and excessively severe discipline by parents.

• aggressive behavior in kindergarten through second grade, often with attention deficit disorder.

• parental drug use, and positive/permissive attitude by them toward the child's use of alcohol and certain other drugs.

• academic failure in third to sixth grade.

• low degree of commitment to school, associated with academic failure and playing hooky.

• vandalism, shoplifting, prior to first use of drugs.

• friends who use drugs.

• favorable attitudes toward drug use, usually beginning between elementary and middle schools.

• early first use: the earlier children begin their drug use, the greater the risk of later chronic drug abuse.

Dr. Hawkins believes that there are at least three factors which can reduce the risk for substance abuse: 1) children who are born with resilient (easy going, sociable) temperaments; 2) children who have a strong relationship to someone: bond to mother, caretaker, teacher, some other adult; 3) children raised in communities with high expectations for behavior and clear standards about what is acceptable behavior.

Managed Care

William B. Hawthorne, MD, of Mediplex, presented tactics for dealing with representatives of managed care organizations. "Try to make the review MD to MD," he said. "Most seem to be willing to do this. In addition, be sure you're really talking to a peer, e.g. someone who is certified by ASAM, or experienced in adolescent psychiatry."

Since a good deal of review is done by phone, Dr. Hawthorne suggested finding out about the credentials of the doctor. "Some don't have a license in the state where the patient resides, or even a valid license anywhere. You don't really know if they're a doctor. Sometimes 'doctor' can mean PhD psychologist, or PhD social worker. Some are nurses. You might never know, unless you ask. *(continued on p. 3)*

"Remind reviewers that the APA (American Psychiatric Association) Canon of Ethics clearly says that no physician may render an opinion on a patient he or she has not seen. Reviewers have never seen the patient. They haven't even read the chart. They deal by phone. But any attack on managed care has to be broad-based. Let's start to use the ASAM Criteria to justify admissions in our conversations with managed care."

Pediatrics Academy President

Keynote speaker Daniel W. Shea, MD, president of the American Academy of Pediatrics, emphasized financial access to health care for children and pregnant women. He described the Academy's campaign, beginning to 1989, to abolish barriers to care for these uninsured and underinsured groups. Two years later, Congressman Robert T. Matsui (D-CA) introduced HR 3393, "The Children's and Pregnant Women's Health Insurance Act of 1991," which would establish a one-class system of medical care through insurance. Of interest to ASAM, there would be three "baskets" of care, one of which would include extended services for mental illness and substance abuse.

Tapes

Conference audiotapes are available from InfoMedix, 12812 Garden Grove Blvd, Suite F, Garden Grove, CA 92643. ☎ 1-812-367-9286 or (714) 530-3454.

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

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ASAM Amicus Curiae Brief Helps Free Addicted Mother

In the strongest judicial decision to date against prosecution and punishment of women addicts who carry pregnancies to term, the Supreme Court of Florida unanimously reversed the conviction of Jennifer Johnson on July 23.

In 1989 Johnson, now 26, was the first woman in the U.S. to be arrested for delivering drugs to a minor: she had given birth to two substance-exposed (cocaine) neonates. Johnson was found guilty under laws intended to apply to drug traffickers. Sentenced to 15 years of probation, she was also ordered to complete the drug treatment program she had voluntarily entered after the second child was born.

"Had her conviction, which was upheld by the Florida Court of Appeals in 1991, been affirmed by the Supreme Court, it would have set a destructive precedent," said **Sheila B. Blume**, MD, chair of ASAM's Public Policy committee.

During Johnson's pregnancies, she had called a drug hot line looking for help but was told there was nothing available for a pregnant medical recipient with a cocaine problem. Both children were born healthy and full term.

Johnson told her doctors that she used cocaine the day before the first delivery; that neonate tested positive for benzoylecgonine (a cocaine metabolite). She smoked crack cocaine and pot three to four times every other day during the second pregnancy, overdosed the month before that baby was born, and used rock cocaine at about 6:00 AM the morning she delivered that newborn at 1:00 PM.

How Was Drug Delivered?

Prosecutors argued that Johnson delivered the drug to her children (who were of course "minors") through the umbilical cord in the 60 to 90 seconds after the neonates were delivered and before each umbilical cord was cut, since a measurable amount of blood is transferred from the placenta to the baby through the umbilical cord during delivery and after birth.

The defense argued that the only way Johnson could have prevented the "delivery" of cocaine to these newborns would have been to sever the umbilical cord before each child was born, which would probably have killed both herself and her child, and illustrates the "absurdity" of applying the delivery-of-drug statute.

ASAM opposes criminal sanctions for harmful behavior by a pregnant CD woman toward her fetus and advocates that pregnant substance abusers be provided with appropriate education, intervention, and treatment. (This ASAM Public Policy Statement "Chemically Dependent Women and Pregnancy" is available at ASAM headquarters.)

ASAM joined nearly three dozen organizations, including the AMA, the American Public Health Association, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, and the Florida Medical Association, in filing Amici Curiae (friend-of-the-court) briefs.

In its opinion, the State Supreme Court said, "The court declines the state's invitation to walk down a path that the law, public policy, reason and common sense forbid it to tread."

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AMA Health Care Plan Includes Detoxification

The second edition of the American Medical Association's plan of action to improve our nation's health system, called "Health Access America," now includes detoxification services. Due to efforts by several ASAM members, this 22-page plan, which "incorporated changes based on attentive listening to all sides of the health reform debate," has added detoxification services to the AMA Minimum Benefits Package (Appendix B, p. 18) as listed under Physician Services, and Outpatient Facility Services, and Inpatient Hospital Care.

After the AMA announced Health Care America in 1990, whose "principles emphasize a comprehensive private/public approach to expand access and control rising health care costs," ASAM's delegate to the AMA, **Jess W. Bromley**, MD, argued for inclusion of detoxification at the June 1991 AMA House of Delegates meeting. But the House voted to maintain detox as "not covered." At the Dec. 1991 AMA meeting, Sheila B. Blume, MD, was instrumental in persuading the Medical Society of the State of New York to introduce a resolution to include detox. ASAM delegates Dr. Bromley and **David E. Smith**, MD, and the MSSNY, argued in favor of inclusion, and the House voted to add detox to the Minimum Benefits Package.

This second edition of "Health Access America" was published in June 1992.

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SEC News is a new, regular feature from ASAM's Standards & Economics of Care Section. SEC Chair is ***David Mee-Lee****, MD. Also see p. 10.*

Call for Volunteers

by **Michael M. Miller**, MD

Individual ASAM members are often concerned about a specific reimbursement issue: a problem with one insurance company, or managed care company, or a specific predicament that they hope ASAM can act upon. Currently, ASAM has no mechanism either to receive or to act upon such member concerns. Our Incident Report Form (published several times in *ASAM NEWS*) does not really "flesh out" the details of a case. Members seem to be looking for something more definitive than the case discussion column that appears on this page.

Therefore, ASAM is establishing a group to design and implement a *process* to receive, tabulate, and act upon specific member concerns. We envision this to be a sort of mail-in "hot line" for concerns, a "clearing house" and a mechanism for consistent response.

We are calling for ASAM members to volunteer for one or both functions:

- design and establish the process;
- be a member of the committee that will eventually act in this clearing house capacity.

If interested, please contact me at:

NewStart, 309 W. Washington Ave., Madison, WI 53703.

Catch-22

I recently came across a new scenario that typifies to me how attempts at case management can result in "mangled care" rather than in efficiently managed care:

A patient presenting with an addiction problem is evaluated. The clinician recommends inpatient rehabilitation.

The "pre-certification" process by one managed care organization certifies that Level III care is medically necessary, but that Level IV care is not.

The next day the clinician receives a call saying that "prior authorization" for Level III care is not possible, because the patient's insurance contract requires that inpatient services be offered in Level IV facilities.

Nobody calls this a Catch-22. But it sounds like one to me, when what is pre-certified is not prior authorized, and what is prior authorized is not pre-certified. The end result is that the patient must self-pay for any inpatient rehabilitation, despite its clinical indication, even as substantiated by the ASAM *Patient Placement Criteria.*

ASAM NEWS welcomes your response to the following:

- Have you ever had cases exemplifying this version of Catch-22?
- If so, what is the name of the insurance company? The name of the managed care company?

ASAM ought to take the lead in helping to remedy this problem facing our patients. We have written the Health Insurance Institute of America and the Managed Health Care Association of America. Do any readers have ideas on specific people or other institutions that ASAM could contact?

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SEC NEWS

CSAM Conference

Addiction Treatment Outcome

The California Society of Addiction Medicine (CSAM), a state chapter of ASAM, held a meeting of providers, managed care organizations, database directors, and government research agency officials in Los Angeles in July.

The conference was part of CSAM's Collaborative Study of Addiction Treatment Outcome. Its mission: to explore ways to improve the quality and effectiveness of treatment through increasing reliance on treatment outcome data.

According to a report by **P. Joseph Frawley**, MD, in *California Society of Addiction Medicine NEWS (summer 1992)*, the 30 participants included data users (managed care firms, payers, providers), data collectors and analyzers (researchers), and research funders. Dr. Frawley is chair of ASAM's Treatment Outcome Research Committee in the SEC Section, and chairs the CSAM Collaborative Study's steering committee .

Conference focus was on matching patient to treatment, and whether observational databases can help to answer clinicians' questions. According to Dr. Frawley, "the most challenging idea to come out of the workshop is for a clinical database of high quality which can work in tandem with randomized controlled trials. Such databases have been developed in other areas of medicine." Another recommendation is for secondary analysis of existing databases, including research "to see if patients matched to treatment according to the ASAM Patient Placement Criteria are more successful in treatment (have better outcomes) than those who would be considered mismatched according to the Criteria."

Quoting the Institute of Medicine: "Instead of asking, does treatment work? we should ask which kinds of individuals, with what kinds of alcohol problems, are likely to respond to what kinds of treatments, by achieving what kinds of goals, when delivered by which kinds of practitioners, for what cost?"

The 500-page conference syllabus is available for $30 from CSAM, 3803 Broadway, Suite 2, Oakland, CA 94611. Available separately for $6.50 is a 30-page paper "The Use of Databases to Study Addiction Treatment Outcome" by Dr. Frawley and Thomas Babor, PhD; this paper is included in the conference syllabus.

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

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(continued column at right, lower half)

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▲

Notes:

All are physicians.

This committee chart was previously published in the July-August 1991 issue of *ASAM NEWS*.

* Committee or subcommittee not on previous chart.

¶ Appointed since previous chart.

There are 52 committees .

IDAA In Grand Rapids

Nearly 370 members of IDAA attended the 43rd annual meeting of International Doctors in Alcoholics Anonymous Aug. 5-9 in Grand Rapids, MI. Also present: 210 spouses and significant others, and 57 children. Conference chair was Dr. **Tom H.**

This year the conference was divided into four concurrent tracks: two AA, one Al-Anon, and one Alateen (and "Ala-preteen" for ages 5-12).

Presentations by 54 AA speakers from all over the U.S. included couples workshops on "Recovering Intimacy and Sexuality" (72 couples signed up). A variety of meetings for specific groups were offered: veterinarians, dentists, optometrists, psychologists, pharmacists, physicians, and -- a first for IDAA -- the "physically challenged." The latter was planned by an IDAA physician who was told that three other registrants were bringing wheel chairs; five people attended that first meeting. AA meetings were held for women; gays/lesbians; couples in recovery for 0-2 years, for 2-5 years, for 5+ years; for families in recovery, singles in recovery; and by NA (Nicotine Anonymous), OA (Overeaters Anonymous), SA (Sexaholics Anonymous) and SAA (Sex Addicts Anonymous).

Al-Anon held meetings on each of the 12 Al-Anon Steps, a lecture about the effects of chemical dependency on the family by **Martha Morrison**, MD, and Al-Anon and ACoA meetings in the evenings.

Alateens discussed the Steps, their own feelings and general feelings, held Alateen meetings, went sightseeing, and chose a speaker to represent them at the Saturday banquet (Myra, a poised young lady of 15 whose first IDAA was in 1987 in Lexington, KY).

Newcomers Banquet

Over 100 people attending their first IDAA conference introduced themselves briefly by microphone to the 630 others in a now-traditional newcomers' banquet ceremony. Longest sobriety was 13 years, shortest was three weeks. These "newcomers" to a national IDAA meeting represented 12 medical specialties (at least 9 family practitioners, 7 anesthesiologists, 7 surgeons, 6 GP's, 5 internal medicine). There were 7 medical students/residents. Non-physician newcomers included 4 psychologists, 4 dentists, 1 veterinarian, and 1 neurophysiologist/psychopharmacologist. (IDAA membership is open to any alcoholic or drug dependent "doctor" whose degree is in the field of health care. Members include DDS's, DVM's, PhD's in psychology, nursing, social work, and the health sciences.)

Ten Al-Anons or "co-dependents" introduced themselves this year; far more than usual. Another first: two IDAA physicians brought their AA baby to the microphone.

This year, more speakers than usual were women; in addition, 27 of the newcomers' banquet speakers were women -- up from 16 last year, and 12 each in 1989 and 1990.

CME Program

Two concurrent scientific sessions were offered this year: 1) Forward to the Fundamentals and 2) Barriers to Recovery. ASAM speakers were **Herb Malinoff**, MD, on mechanisms of addictive disease, **Mike Boyle,** MD, on relapse prevention, **Dolores Burant**, MD, on country music, alcoholism and sobriety (complete with slides and sound track), **Penelope Ziegler**, MD, about how thinking can be the ultimate barrier to recovery, **Richard Morin**, MD, on dual diagnosis, and **Larry Siegel**, MD, on gay and lesbian issues. CME program chairs were Dr. Morin, and Jane Skorina, PhD.

CONFERENCE DIGEST

Next Year's Meeting

Dates: Aug. 4-8, 1993.

Place: The Camelback Inn, Scottsdale, AZ

IDAA will have the whole resort: bars will become coffee bars. A full program for families will again be offered.

Information: Dr. **John C.**, Chairman, IDAA 1993, 6243 E. Monterosa, Scottsdale, AZ 85251. ☎ (602) 852-0200

4,250 IDAA Members

According to Secretary-Treasurer Dr. **Dick McK.** , IDAA membership is at an all time high of 4,250, a ten percent rise over last year. Dick holds the strictly confidential membership list at IDAA; he is the *only person* permitted to see it.

The 4th edition (published July 4, 1992) of IDAA's *International Directory of Meetings for Doctors in Recovery* now lists 150 meetings. IDAA members can purchase the 156-page book by mail from Dick.

The Directory's introduction includes an explanation of AA groups vs. meetings: "If a number of alcoholics meeting together are to call themselves an 'AA group,' they are asked to be open to all alcoholics. If membership is to be restricted, the word 'meeting' should be used instead."

The directory also discusses intervention: "A major frustration for many doctors has been the slowness of committees and organizations to reach out to the colleague who is in obvious trouble. AA groups quite rightly stick to 'attraction, not promotion.' At their best, they do not in any way push people around so that one is left with nothing and no one to fight by oneself and one's addiction. Meanwhile the local impaired physician committee may not be doing very much. To expect it may not be realistic. What to do? Some groups have responded by taking on the dual function of outreach and subsequent support.... This is not a game for amateurs but there are techniques to be learned and when this is well done, the success rate of such well planned interventions can be impressive."

According to Dick, IDAA's "basic aims are those of AA. Our primary purpose is to carry the message of recovery to other alcoholics, particularly alcoholic doctors, their families, and significant others. There are no dues; we are self-supporting through our own contributions. A modest registration fee at the annual meeting covers costs of that meeting, IDAA expenses for the year, and a contribution to GSO. The only requirement for membership is the doctor's desire to belong."

IDAA address: Dick McK., Sec.-Treas., IDAA
PO Box 199, August, MO 63332
☎ (314) 781-1317

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Names in boldface are first mentions of ASAM members.

NEW MEMBERS

Recent Joiners

Physicians who joined ASAM between July 1 and August 31:

Arizona
Jerry Armand Biggs, MD - *Psychiatry*
Jeffrey A. Sharp, MD - *Family Practice*
Bronson Stilwell, MD - *Psychiatry*

California
Harvey Y. Feinberg, MD - *Emergency Med*
Joan M. Kotun, MD - *Psychiatry*
CarolyN Rees, MD - *Internal Medicine*
Colleen C. Rissell, MD - *Emergency Med*
Arthur H. Weintraub,l MD - *Internal t Med*

Connecticut
Julia M. Shi, MD - *Internal Medicine*
Joseph S. Pachman, MD - *Preventive Med*
Jeffrey S. Robbins, MD - *Internal Medicine*

Florida
Robert J. Auston, MD - *Family Practice*
Edward L. Cagen, MD - *Family Practice*
Matthew C. Deutscher, MD - *Physical Med & Rehabilitation*
Gregory P. Vastner, MD - *Internal Medicine*
Patricia T. Major, MD - *Internal Medicine*

Georgia
Gloria J. Abad, MD - *Psychiatry*

Illinois
John F. Hill, MD - *Internal Medicine*

Indiana
H. M. Trusler, MD - *Plastic Surgery*

Kentucky
Carl J. Brueggeman, MD - *Family Practice*

Louisiana
Dorothy Mae C. Bennett, MD - *Internal Med*
William W. Crenshaw, MD - *Family Prac*

Maine
Rita C. Heidisch, MD - *Pediatrics*

Massachusetts
Martin L. Cimovsky, MD - *Ob/Gyn*

Minnesota
Mary Margaret Desch, MD - *Psychiatry*
Thomas C. Jetzer, MD - *Occupational Med*
Kathleen Sullentich, MD - *Ob/Gyn*

Mississippi
Patricia D. Allred, MD - *Anesthesiology*

Missouri
Alvin R. May, DO - *Family Practice*

Nebraska
Mary A. Wampler, MD - *Internal Medicine*

New Jersey
Serverino J. Ambrosie, MD - *Family Prac*
Kenneth R. Heilbrunn, MD - *Internal Med*
PhiLIP M. Torrance, II, MD - *Psychiatry*

New York
Jose M. DAvid, MD - *Family Practice*
G. Ernest Lofton, MD - *Preventive Medicine*
Edward V. Nunes, MD - *Psychiatry*
Rasmia Mowafy, MD - *Family Practice*

North Carolina
Charles W. Stewart-Carballo, MD - *Ob/Gyn*

Ohio
Michael A. Newton, MD - *Psychiatry*

Oregon
Marva C. Graham, MD
Willis E. Peacock, MD - *Family Practice*

Pennsylvania
Oscar G. Bukstein, MD - *Psychiatry*
Carl L. Pierce, MD - *Internal Medicine*

Puerto Rico
Dennis A. Velez-Cutura - *Student*

South Carolina
John M. Moore, MD - *Pediatrics*

Tennessee
Bernard L. Parham, MD - *Internal Med*

Texas
Leoncio A. Carza-Valoes, MD - *Pediatrics*
Radha K. Kambhampati, MD - *Psychiatry*
Abid R. Mian, MD - *Psychiatry*
Gerardo J. Moreira, MD - *Psychiatry*

West Virginia
Abdel-Fatah S.M. Massoud, MD - *Psychiatry*
Kathleen C. Perkins, MD - *Adolescent Med*

Wisconsin
Edward Slade Friedrichs, MD - *Internal Med*

International Members

Canada
Jane E. Brasher, MD, FRCP - *Anesthesiology*
Errol Nathan Billinkoff, MD
Peter K. Chan, MD - *Fellow*
G. Brently Dickson, MD - *Family Practice*
Richard C. Frecker, MD - *Clin Pharmacol*

Chile
Juan V. Roa, MD

Iceland
Bradley M. Anderson, MD - *Family Prac*

Information is from ASAM headquarters.

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In Memoriam

Anthony J. Puentes, MD, of San Francisco; public health specialist, certified by ASAM 1988, member of the Methadone Treatment and Pregnancy/Neonatal Addiction Committees.

Condolences to his father: Richard Puentes, 4942 Calida Dr, San Jose, CA 95136.

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ASAM NEWS

Editor: Lucy Barry Robe, MA
303-D Sea Oats Drive
Juno Beach, FL 33408
Phone: (407) 627-6815
FAX available

ASAM Headquarters
James F. Callahan, DPA
Executive Vice President
Suite 409
5225 Wisconsin Ave, NW
Washington, DC 20015
Phone: (202) 244-8948
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ASAM NEWS is published bimonthly. January-**February**, March-**April** May-**June**, July-**August**, September-**October**, November-**December**

Advertising Rates:
Start at $60. Call/write: Editor, or ASAM Headquarters

ISSN # 0889-9215

New Definition of Alcoholism

(continued from p. 1)

The authors explain the thinking that went into the revised definition during two years of committee meetings all over the country, as well as numerous drafts by mail :

"The revised definition proposed by the committee recognizes alcoholism as a heterogeneous disease (that is, biopsychosocial factors are implicated in the cause, signs and symptoms, complications, and treatment of alcoholism). The definition acknowledges a genetic vulnerability in the evolution of alcoholism in many alcoholics; broadens the scope of the 1976 definition to include the basic behavioral changes that are symptomatic of the disease; and, for the first time, formally incorporates denial as a major concept. By giving greater consideration to these factors, the committee hopes that the revised definition will encourage earlier intervention in the course of alcoholism by professionals and the general population."

Denial as a Major Concept

One concept that interested committee members was the absence of denial in the 1970s definition. Particular attention was paid to its inclusion this time. The JAMA article explains:

"Denial is used in the definition not only in the psychoanalytic sense of a single psychologic defense mechanism disavowing the significance of events but more broadly to include a range of psychologic maneuvers that decrease awareness of the fact that alcohol use is the cause of a person's problems rather than a solution to those problems. Denial becomes an integral part of the disease and is nearly always a major obstacle to recovery. Denial in alcoholism is a complex phenomenon determined by multiple psychologic and physiologic mechanisms. These include the pharmacologic effects of alcohol on memory, the influence of euphoric recall on perception and insight, the role of suppression and repression as psychologic defense mechanisms, and the impact of social and cultural enabling behavior."

Committee Members

The NCADD/ASAM Joint Committee to study the Definition and Criteria for the Diagnosis of Alcoholism included 15 physicians who were members of ASAM (five ASAM presidents, two NIAAA directors, three NCA medical directors, two NCA board chairmen):

Drs. **Margaret Bean-Bayog, Sheila B. Blume, Jasper Chen See,** Daniel K. Flavin, **Jean L. Forest, Stanley E. Gitlow, Enoch Gordis, James E. Kelsey,** Robert M. Morse, **Robert G. Niven, Barton Pakull, Max A. Schneider, Frank A. Seixas, David E. Smith, Robert D. Sparks.**

ASAM staff members on the committee were James F. Callahan, DPA, E. M. Steindler, and Lucy Barry Robe.

"Publication in *JAMA* means that the definition will finally be disseminated to the audience that can make the best use of it," said Dr. Morse. "The definition, which explicitly specifies the genetic, psychosocial and environmental components of the disease, will make it easier for the nation's physicians to identify alcoholism."

Within the context of the new definition, the article offers a critical look at the criteria now being used to diagnose alcoholism in the DSM-IIIR and the ICD-9. The authors emphasize the importance of recognizing that alcoholism is a primary disorder. They suggest that denial be incorporated into any new criteria that are developed, that alcoholism vs. alcohol dependence/alcohol abuse be clarified, and that several less objectionable terms, such as "harmful use"or "dysfunctional use" of alcohol be used instead of "alcohol abuse."

A reprint of "The Definition of Alcoholism" will be sent to all ASAM members in October. Nonmembers may request a copy in writing from ASAM headquarters.

Abbreviated Definition

In 1990, the committee suggested the following short form of the definition, which was published in *ASAM NEWS*:

"Alcoholism is a disease characterized by continuous or periodic: impaired control over drinking, preoccupation with the drug alcohol, use of alcohol despite adverse consequences, and distortions in thinking, most notably denial."

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Names in boldface are first mentions of ASAM members.

ASAM'S 3rd National Conference
Patient Placement Criteria

"Making It Work: Practical Strategies for Implementation & Reimbursement" is the theme of ASAM's third PPC Conference, to be held in Atlanta Feb. 19-21, 1993. Co-sponsor is GASAM, Georgia chapter of ASAM.

While many clinicians, EAP's, and managed care professionals are increasingly comfortable with concepts of continuum of care, levels of care, severity of illness, and intensity of service, they still struggle with how to use Patient Placement Criteria; how to modify programs to provide levels of care; and how to change old ways of documentation for better individualized treatment and reimbursement and utilization review.

This conference is designed to give participants hands-on experience with changing their program structure, improving documentation skills for assessment and treatment planning; and enhancing the utilization review and related reimbursement of services.

The focus of the conference will be on specific practical changes and skill-building, as well as providing ample opportunity to practice skills and network with others already successful in "Making It Work."

The conference is designed to provide practical strategies for structuring programs, enhancing treatment efficacy and efficiency, improving assessment and documentation, controlling costs, optimizing reimbursement, appealing treatment authorization denials.

ASAM headquarters will mail registration brochures to all members. Or call now for more information.

PPC Conference Program
Feb. 19-21, 1993

Day 1: What's New with the ASAM Patient Placement Criteria *David Mee-Lee, MD*

Blueprint for Criteria Implementation. Learn how to: Design or Modify Programs; Develop a Master Plan for Criteria; Implementation

Michael M. Miller, MD, Christine L. Kasser, MD

Coping with Resistance *Drs. Kasser and Miller*

Day 2: Implementing the Criteria Part I

Facilitating Criteria-Focused Patient Assessment

Practice: Assessing Cases for Level of Care; Using Criteria Focused Assessment Tools; Documenting Level of Care Justification; *Drs. Kasser and Mee-Lee*

Implementing the Criteria Part II

Facilitating Criteria-Focused Treatment Planning
Developing Criteria Focused Problem Statements
Developing Problem Focused Goals and Objectives
Developing Criteria Focused Treatment Plans
Writing Effective Progress Notes
Drs. Mee-Lee and Miller

Day 3: Making Successful Appeals

Learn How To: State Your Case Effectively with Managed Care; Utilize Criteria for Successful Appeals;
David H. Bralove, Esq.

Closing Session: Questions & Answers; Future Discussions
all faculty

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Myths and Misconceptions About Alcoholics Anonymous

An Alcoholism Counselor's View

Psychologist John Wallace, PhD, director of a New England alcoholism treatment center, shared his views about Alcoholics Anonymous in the AA newsletter 'About AA--A Newsletter for Professionals' in 1984. His article was reprinted this year (Spring issue). The following excerpts are exact, but were arranged under headings devised by ASAM NEWS that used the phrasing and sequence of Dr. Wallace's article.

Misconception: The concept of an AA treatment center

There are no "AA treatment facilities" -- but many hospitals and rehabilitation centers use AA's Twelve Steps as the basis of their treatment plans, and welcome AA members who bring AA's program of recovery [including AA meetings] to the patients.

Myth: AA a "prohibitionistic" organization... The AA Fellowship emphasizes abstention for its members since alcoholics have proven time and time again that they cannot consistently manage either their drinking and/or their behavior while drinking.

Issue: "Dry" vs. "sober" Dryness refers only to not drinking alcohol; sobriety ... to major changes in the recovering person's approach to physical health, emotional well-being, mental clarity, social relations, family life, work, love, and spirituality. Only the First Step ... deals with alcohol: *"We admitted we were powerless over alcohol -- that our lives had become unmanageable."* The remaining eleven Steps deal with learning how to live comfortably ... with oneself, with others, and with one's Higher Power.

Myth: AA an organized religion The Fellowship ... does not require members to accept a single conception of a deity, has no religious ritual, and enforces no single body of religious beliefs. The Steps to recovery do suggest that belief in a higher power, as each member understands that concept, is of great value in the restoration of sanity and in finding a life of personal satisfaction and fulfillment without alcohol. ...

Misconception: AA's simple, naive concept of alcoholism .. AA, from its beginning, embraced a subtle, complex, and multidimensional concept of the illness. By attending to the physical, mental, emotional and spiritual aspects of alcoholism, AA anticipated very recent developments in modern medicine, psychiatry, and psychology ... AA in 1935 was already embracing a psychosomatic view in which body (allergy to alcohol) and mind (obsession with alcohol) were joined to explain the origins and maintenance of the illness. Over the years, several disciplines have brought to bear many of the magnificent achievements of modern 20th century biological sciences on the problem of alcoholism. These scientific advances in neurochemistry, neuropharmacology, neuroanatomy, and behavior are ... consistent with AA's early emphasis upon psychosomatic relationships. ...

Myth: AA hostile to psychological & psychiatric knowledge Some AA members may have received inadequate treatment in the hands of poorly trained and inadequately educated professionals in the past. However, this unhappy situation is changing rapidly as the curricula of professional and graduate schools reflect the realities of the illness of alcoholism, and more and more professionals are achieving accurate and sensitive understanding. ...

Many of [AA's] concepts and procedures are psychology in action at its very best. In AA, members recognize the importance of psychological matters such as resentments, self-pity, egotism, unrealistically high expectations, frustration, stress, sexual and love relationships, self-esteem, fear, anxiety, guilt, grandiosity, self-will, melancholy, depression, security needs, envy, power over others, control and domination of others, and fear of financial failure. ...

The AA group meeting could be a textbook example of the social psychological processes that characterize healthy, strong, and positive human relationships; open, honest, and trusting communication; caring, respect, and consideration for others; commitment to the growth and well-being of self and others; and empathy for and identification with others. Many of AA's other processes and Steps either implicitly or explicitly recognize the importance of both individual and interpersonal psychological processes in the recovery from alcoholism.

Misconception: AA forces public admission of alcoholism AA does not require anybody to do anything ... AA does not diagnose anything. Professionals diagnose illnesses. AA members help each other to stay sober. The AA Preamble states: "The only requirement for membership is a desire to stop drinking." Many AA members, perhaps most, eventually choose to call themselves alcoholics, but this is not a condition for belonging.

Issue: AA's position on the necessity of abstention if alcoholics are to recover from alcoholism is purely an ideological [one] with no empirical basis ... [Certain] persons believe that modern science has proved AA wrong ... that alcoholics can be taught normal, controlled, or non-problem drinking. ...

The AA belief in abstention for alcoholics did not just appear out of the blue in a burst of ideological inspiration. It grew out of empirical observation in the real world. It grew out of direct observation of suffering too painful to bear, of tragedy and shattered dreams, of broken bodies, alcohol-related diseases, ended careers, and destroyed families. ... AA's beliefs have come from literally hundreds of thousands of direct observations of men and women in the real worlds of small towns, cities, the suburbs, ghettos, and megalopolises. AA's have had plenty of direct experience with drinking alcoholics and with sober alcoholics. They don't report seeing much controlled or non-problem drinking at all. What they do report is that life for countless alcoholics and their families improves beyond imagination when they get the message, stop drinking, and begin to work a Twelve Step program of recovery.

The scientific evidence against abstention, when viewed objectively, is unimpressive. The numbers are simply too small for any responsible and ethical professional to announce to the world that a cure for alcoholism has been achieved.

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If you would like more information on this topic or about the fellowship's Newsletter for Professionals, write:
AA General Service Office, Box 459, Grand Central Station, New York, NY 10163.

How to Succeed With the Media

by **Donald M. Gragg**, MD

With the burgeoning of cable TV, physicians are more frequently invited to appear on TV and radio, particularly local stations. The California chapter of ASAM gave a conference Feb. 29 in San Francisco called "How to Succeed with the Media." Presenter was John T. O'Neill, LCDC, director of the Alcoholism and Drug Research Communications Center in Austin, Texas. This article was excerpted from the California Society of Addiction Medicine News, spring 1992, p. 11.

O'Neill is a media maven; he has the gift of gab and a talent for effective communication that he maximizes with specialized knowledge of media techniques. He says the key to success is to know what point you want to make, and to keep the focus of the media interview on that point. "Your agenda probably is not the same as the interviewer's, so you have to exercise some control over how and where the interview goes."

According to O'Neill, 55% of communications is body language, 38% voice, and 7% content. He recommends practicing talking in lower registers, as "the voice of authority is a low, deep voice." He suggests you request makeup for TV.

Main points for successful interviews:

• Develop a core message, a statement of your major point that is simple, graphic and appealing.

• Answer questions in a way that returns you to your core message. For example, "And what seems even more important is..."

• Avoid arguments with the interviewer. Convert differences of opinion into questions or issues that can be discussed. "It looks like the real issue here is..."

• On TV, look at the interviewer, not at the camera or the monitor. Don't shift your gaze from one to the other; otherwise viewers will see -- and might think -- "shifty eyes."

• Don't say "no comment." Instead, try "I don't have that information, but I'll refer you to someone who can answer your questions."

• In response to a hard question, acknowledge the difficulty or complexity of the question; then answer it.

• In response to a hostile question, rephrase it, then answer it. Or ask the interviewer's opinion on the subject, then discuss.

O'Neill stresses preparation and practice.

• Find many ways to rephrase your core message. Prepare "sparklers:" catchy phrases that relay your core message, such as "Addictions are contagious; you get them from your parents and give them to your children."

• Develop a "Mother Teresa" statement: a short message that is basic and not arguable, one which you can always use if you get a seemingly impossible question, and/or for which the only appropriate answer would require far more time than you have. An example is: "All I know is that I'm here to stop the pain any way I can," or "My role is to heal, and what I'm suggesting will contribute to the healing process."

Dr. Gragg is from Glendale, California.

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Ethics and Head Hunters

by **Eck G. Prud'homme**, MD

On Jan. 16, 1992, Dr. Prud'homme, a Fort Worth family practitioner who is president of the Texas Chemical Dependency Association, gave testimony to the Texas Senate Interim Committee on Health & Human Services. He sent a copy to LeClair Bissell, MD, chair of ASAM's ad hoc Ethics Committee, asking if her committee has an answer to this simple question: "Does a physician behave unethically when he/she accepts a patient/client whom a facility obtained illegally or unethically?" Excerpts of that testimony are below.

Drs. Prud'homme and Bissell would like to hear what other physicians have done about this problem. Please write c/o ASAM NEWS, 303-D Sea Oats Drive Juno Beach, FL 33408. We will publish your letters space permitting.

A physician who accepts a patient who was illegally or unethically procured behaves as unethically as she/he would have had she done the procuring herself. Some patients are being fraudulently deprived of the $1,000 to $2,000 they are directly or indirectly paying to "headhunters." A physician may try to plead that "it was not me -- the *hospital* paid the bounty." But any physician who doesn't discover the circumstances surrounding the patient's arrival at the hospital has performed an unacceptable admitting medical history.

If physicians decide to make their concerns known to the appropriate licensing and accrediting agencies, state action is essential to protect them against intimidation by the threat of lawsuits for interfering with the performance of contracts, or for sullying the name of the institute. This is because those hospital owners who are most likely to behave unethically have a majority of their medical staff either on salary or dependent upon referrals from that hospital; accrediting bodies do not yet effectively prohibit patient headhunting; and hospitals generally have by-laws that discourage physicians with complaints from deviating from the "chain of command." You must mandate that licensing agencies take effective action when questionable practices are discovered.

It may sound as if I am asking state government to make physicians become ethical, and indeed I am. But the task is not so daunting as it might seem.

Any straight-forward prohibition against paying head hunters for patients must contend with the Federal Trade Commission's determination that no one shall infringe in any way upon doctors' and hospitals' ability to "market themselves." If you undertake to regulate the quality of the health insurance policies which insurance companies sell to employers and therefore indirectly to all citizens of our state, you are thwarted by the federal ERISA laws, and if you attempt to reduce the conflict of interest between practicing physicians and their patients by outlawing the corporate practice of medicine, you are blocked by the federal laws authorizing HMOs. Those statutes explicitly promote and extol the corporate practice of medicine.

The sanctity of the doctor-patient relationship places the patient at risk for being exploited by his physician. The federal substitute places the patient at risk of being exploited by the entrepreneurial corporations which own and operate HMOs. At least the former were selected, educated, trained, and licensed by the state to be technically and ethically competent, in making independent medical judgments. The incorporated entrepreneurs were subjected to no such selection, education or licensure.

MY POINT OF VIEW

The goal of all of us is to protect citizens from exploitation at the hands of providers and payers of health care. The bedrock of medical ethics is simple and as old as Hippocrates himself -- "Do Thy Patient No Harm" -- and that certainly includes financial harm. Its ingredients include the right to know that no conflict of interest exists between doctor and patient ...

I suggest language such as:

> "Prior to admission, or as soon after admission as the patient's condition permits, each patient or potential patient will be fully informed of all financial arrangements between the hospital and any professional entity involved directly or indirectly in the treatment of that patient or in referring the patient to that hospital. The same disclosure will be made prior to discharge concerning any entity to which the patient may be referred after discharge.
>
> If pre-admission or post-discharge professional services such as interventions or evaluations and/or aftercare are provided patients, the hospital bill shall reflect a reasonable estimate or the actual cost of providing these services. That is, such charges shall not be hidden within inclusive categories such as charges for 'room and board,' 'programs,' etc.
>
> Payment to any entity including physicians from which the hospital either accepts or makes referrals shall be reasonably related to the actual services documented as having been delivered."
>
> Payment shall not be contingent upon the number of referrals made."

Some hospital corporate executives assert that it costs them as much to "generate" a patient by TV ads, etc. as they pay "headhunters" for a patient, and they had as soon pay the one as the other. Federal regulations being what they are, nothing can be done about unreasonable advertising costs. But we can hope that some who now use expensive patient procurement procedures will eliminate them, thus allowing competitors to spend less on ads. After that, both could pass the savings on to patients in the form of lower charges and improved care, and this could be their preferred method of competing. At the very least, prospective patients and third party payers know who is paying for the expensive ads and can, with a little inquiry, make very close guesses about the amount that he or she -- that is the patient -- is paying for such ads.

These suggestions would virtually eliminate head hunting solely by enhancing professional ethics. They would in no way impair patient care, the effectiveness of therapy, or the profitability of ethical providers.

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LETTERS TO THE EDITOR

Dear Editor:

While attending the recent annual meeting of ASAM in Washington, I joined the committee on AIDS. I was chagrined to learn that the Annual Forum on AIDS and Chemical Dependency was not approved for 1993, and that there would no longer be a freestanding conference on this subject.

I was fortunate enough to be a participant in the Third National Forum on AIDS and Chemical Dependency in February, 1989. This conference was not only extremely educational, but also stimulated me to do further work in the field. What I learned there helped me to formulate a rational policy of testing for HIV and treating AIDS at Malvern Institute, where I work. I wrote a paper on HIV testing in CD treatment programs, so others might benefit from the material. And I recently mounted a local conference on AIDS and chemical dependency to help educate the treatment community in my area.

As we all know, AIDS and CD are closely related. *More* education is needed -- not less. I would highly recommend that the board of directors of ASAM seriously consider reinstituting an annual freestanding conference on AIDS and chemical dependency. This dual diagnosis is too great a public health concern to ignore.

Steven A. Mersky, MD
Malvern, PA

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Dear Editor:

I am happy to see that ASAM is planning another AIDS and Chemical Dependency meeting in April 1993. The three I attended (Miami, Phoenix, San Francisco) were among the most informative, challenging, and spiritual of any medical education seminars, workshops, or courses that I have ever attended, in over 50 years of going to such events.

Since both HIV-AIDS and addictive disease are currently high on the list of our national health crises, and since our current programs to combat both are far from adequate to meet the crises and stem their growth, it seems of more than intellectual/educational value to restart this splendid series. However, I believe that *one day*, preceding the ASAM annual meeting, is far from adequate. Also, this conflicts with the Ruth Fox Course, which many long-time ASAM members make a habit of attending, and which is always valuable to new entrants in our field. For most of these Ruth Fox habitues *and* new people, an update on AIDS and CD would be especially valuable, and I believe that they should not be forced to make such a choice.

I hope the separate national forums of two to three days on AIDS and chemical dependency will be resumed as soon as logistically possible. I have spoken to several other physicians recently who share this hope.

Ann Birch, MD
Seneca Falls, NY

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

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

Dear Editor:

Regarding the survey by the ASAM Standards of Care Committee published in the March-April newsletter, "Role of Phenytoin (Dilantin) in the Management of Alcohol Withdrawal Syndrome," (p. 3): in 1974 we did an unpublished study at what was then Beverly Manor Hospital in Orange, CA. We studied a series of 100 patients with a past history of alcohol withdrawal seizures.

Half of the patients were given Phenytoin in five day loading doses; the others were given loading doses of sedative-hypnotics with gradual decreasing doses over a five day period (so-called "comedowns.")

The Phenytoin group had twice as many withdrawal seizures as did the sedative-hypnotic group. All other factors were equal.

We have seen many patients who were on Phenytoin over months to years, prescribed by physicians who believed they had a seizure disorder even though the histories suggested withdrawal seizures. We have noted "breakthrough" alcohol withdrawal seizures in many of these patients, even with an adequate serum level of Phenytoin.

For these reasons, we have not used Phenytoin for alcohol withdrawal seizures.

I look forward to a survey report.

Max A. Schneider, MD
Orange, CA

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Dear Editor:

The History Committee seeks anecdotes about ASAM and its members. For example, back in the 1950s when ASAM founder **Ruth Fox**, MD, a psychiatrist, would leave town, she asked several of us to take calls from her alcoholic patients. One evening a very annoyed patient telephoned. "Doctor," he said, "Dr. Fox put me on Antabuse. I waited the five days before taking a drink, but I *still* got a reaction!" I forget my response, but I do remember that he was not at all appeased.

Dr. **Stanley Gitlow** and I plan to write about Dr. Fox's pioneering efforts with Antabuse and of helping her to "indoctrinate" her patients on its effects.

Anyone else have an ASAM story to tell? Contact me at PO Box 658, Central Valley, NY 10917.

Percy Ryberg, MD, Chair
ASAM History Committee

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Dear Editor:

Your article in the newsletter on Frank was exactly right. *(Obituary on **Frank Seixas, MD**, July-August issue, p. 10-11).* I want to thank you for it and for being so tuned in to the right information and good journalism. Last week our three children and I sprinkled his ashes on Gardiner's Bay; our six grandchildren watched from the beach. A wonderful ceremony and a fitting way to say goodbye.

Judy (Mrs. Frank) Seixas
Hastings-on-Hudson, NY

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RUTH FOX MEMORIAL ENDOWMENT FUND

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In Memory of Eunice Hennessey

Dr. & Mrs. Patrick Hennessey

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Ruth Fox News September/October

We will soon be approaching the "year end," and want to remind you about making a tax-deductible gift, upgrading your pledge, or making an additional contribution to the Ruth Fox Memorial Endowment Fund.

We sincerely appreciate the generosity demonstrated by you, our members, and are grateful for your continued support toward the endowment's goal of $10 million by the year 2000.

We invite you to join your colleagues, if you have not already participated in this campaign. Just a reminder: as a donor you may make pledges over a three to five year period. A pledge enables you to make a maximum contribution with minimum financial strain. The schedule of payments can be arranged at your convenience, and extended times can be provided, if necessary.

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

If you would like more information about the endowment, or if you are considering a planned gift and would like more details, please contact Ms. Claire Osman, ASAM, 12 West 21st Street, New York, NY 10010. Or call her at (212) 206-6770 (all calls will be strictly confidential).

Jasper G. Chen See, MD
William B. Hawthorne, MD
National Co-chairmen
Claire Osman
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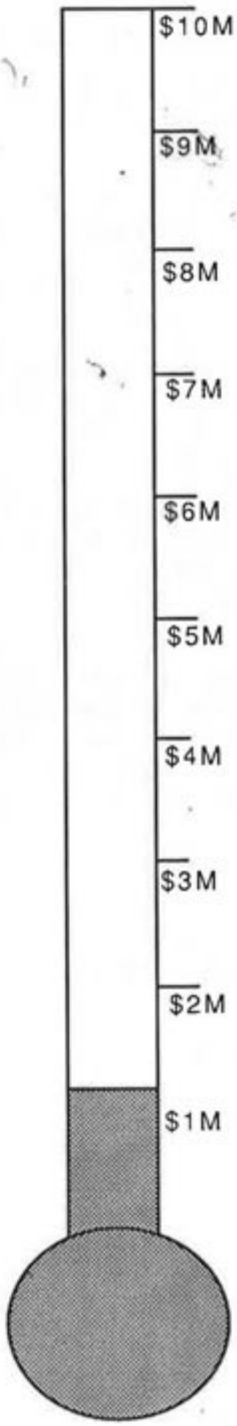
Goal: $10,000,000



Pledged: $1,112,054
as of 9/9/92

ASAM CALENDAR

Information about ASAM conferences available at Washington headquarters: 5225 Wisconsin Avenue N.W., Suite 409, Washington, DC, 20015. ☎ *(202) 244-8948*
FAX: 202-537-7252

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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

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❑ **Drugs, Medicine & Health: Washington, DC Nov. 11-14**
Drug Policy Foundation, 4801 Mass. Ave. NW, Ste 400, Washington, DC 20016
☎ (202) 895-1634

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❑ **3rd Annual Addiction Medicine Conference:**
"We Can Help!" Austin, TX, Nov. 13-14
Research Society on Alcoholism, 4314 Medical Parkway #300, Austin, TX 78756
☎ (512) 454-0022

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❑ **CMSAOD 4th Annual Scientific Meeting:**
Vancouver, B.C. Nov. 22-23. *Four Seasons Hotel*
Mrs. Pat Muss, Conference Secretariat,
350 - 1665 W. Broadway, Vancouver, BC V6J 1X1
☎ (604) 736-6400 FAX: 604-736-4675

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

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❑ **Florida Chapter 6th Annual Conference on Addiction:**
Orlando, FL Jan. 14-17, 1993
Hotel Royal Plaza (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:**
"Making It Work: Practical Strategies for Implementation & Reimbursement"
Atlanta, Feb. 19-21, 1993 *J. W. Marriott at Lenox*

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❑ **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. *Westin Bonaventure Hotel*

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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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