ASAM NEWS

Volume IX, No. 5 November-December 1994

ASAM Buys Condo for Headquarters

ASAM HAS PURCHASED AN OFFICE CONDOMINIUM IN CHEVY CHASE, Maryland to serve as the Society's permanent administrative headquarters.

The acquisition was approved by the board of directors at its April 1994 meeting. Settlement and transfer of ownership to ASAM took place in August.

Dr. James F. Callahan, executive vice president, told the board at its October meeting that the purchase of the new headquarters symbolizes the board's commitment to giving permanence to the Society, as well as to its efforts to establish addiction medicine as an integral and permanent part of medical practice and medical education.

The board's action saves the Society approximately $80,000 a year in previous office rental fees, lowers its overhead, and enables the organization to offer its educational programs in a more cost-effective way. ASAM paid the $435,000 purchase price from its reserves.

"The site was chosen for its location and investment potential," Dr. Callahan told *ASAM NEWS*. "It is conveniently located midway between Capitol Hill and the NIH (National Institutes of Health) close to the Friendship Heights (Red Line) Metro subway stop."

ASAM members are invited to visit headquarters whenever their travels find them in the Washington, DC area.

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Chevy Chase, MD 20815
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Inside

Departments

ASAM 26th Annual Medical-Scientific Conference Chicago April 27-30

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ASAM
American Society of Addiction Medicine

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

Board Meeting Actions

by **Ray Baker,** MD

Planning Day

YOUR BOARD SPENT THE ENTIRE BEAUtiful day of October 1st, a Saturday, cloistered in the basement of a San Diego Marriott hotel engaged in a naval gazing exercise. As **Tony Radcliffe,** MD, firmly but diplomatically facilitated, we performed a fearless and thorough inventory. Where is ASAM now as an organization? What is our current environment? Where do we want to go and how shall we get there?

As health care changes, and addiction is being reframed as a behavioral or social problem, the future of addiction medicine remains uncertain. ASAM needs adequate numbers of members—to legitimize this new field, to generate money for top quality educational products, and to have enough influence to be an effective lobby. Continued representation on the AMA demands that we remain a certain minimum size.

Marketing Strategies

AS THE DAY PROGRESSED, WE MOVED from introspective reflection to developing strategies for maintaining or increasing ASAM membership. Questions of ASAM products, placement, promotion and pricing forced us to define some of our future goals. What do we want ASAM to look like? How will the society remain relevant to its members so they will want to stay? Whom should we target as potential new members? Should we restrict membership or make it easier to join?

We ended the planning day by formulating who, what, when, where, why and how—committees to do the work, and deadlines for reports and action.

A new Subcommittee on Membership Recruitment was formed, with **LeClair Bissell**, MD, as chair.

It was a thrilling day, filled with hope and re-commitment to the conviction that originally attracted us to this unique and caring organization.

Specialty Status

DESPITE A TREND AWAY FROM CREATing new medical specialties, ASAM executive vice president James F. Callahan, DPA, told the board that he believes it is important for ASAM to continue its quest for specialty status. This would ensure recognition of a specialized body of knowledge and skills that comprise addiction medicine. The debate about whether addiction medicine should be the realm of specialists or part of every physician's armamentarium is a false dichotomy, according to Dr. Callahan. By creating a medical specialty based on a body of knowledge, addiction medicine can be integrated into all areas of medicine. All physicians in North America theoretically could be potential ASAM members.

Membership

THE BOARD DISCUSSED BARRIERS TO membership based upon current or previous limitations on licenses. For many reasons, it decided that ASAM will not exclude potential members based on previous limitations or disabilities. Membership chair is **Ken Roy**, MD.

Publications

PATIENT PLACEMENT CRITERI SUPPLEments are being developed.

Plans are to publish *ASAM NEWS* six times in 1995 (there are only five issues in 1994). Publications chair is **Elizabeth Howell**, MD.

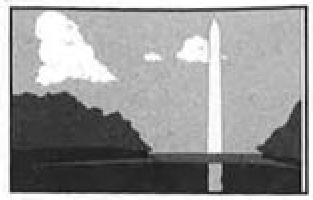
"What do you do in the practice of ADM?"

ASAM PRESIDENT ANNE GELLER, MD, presented a draft document that lists the components of the body of knowledge which comprises addiction medicine. This extensive listing is for review and comment; it is available upon request from ASAM headquarters.

Members in Training

TO ENCOURAGE THEIR INVOLVEMENT IN ASAM, medical students, residents, and addiction medicine fellowship candidates will be invited to the exhibit hall at the annual Medical-Scientific conference free of charge. (Conference registration not included.) Committee chair is **Stuart Gitlow**, MD.

State-of-the-Art Course to Washington in '95



IN ORDER TO encourage increased enrollment, the annual ASAM State-of-the-Art in Addiction Medicine Course, held recently in Orlando, FL, will move to Washington, DC, for the next meeting in October 1995. Course chair is **Allan Graham**, MD.

This report is excerpted from a newsletter for Canadian ASAM members published by Ray Baker, MD. He is Region IX (Canada) representative to the ASAM Board.

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Grant to Study ASAM Criteria

A MASSACHUSETTS GENERAL HOSPITAL research team, headed by **David R. Gastfriend**, MD, has received a $1.7 million grant from NIDA (the National Institute for Drug Abuse) to test the ASAM *Patient Placement Criteria*. Although in use by some states, managed care companies, and others, until now the *Criteria* have not been subjected to rigorous scientific analysis. The four year study will focus on patients at the Boston hospital who would be assigned to treatment at either Level II (intensive outpatient) or Level III (inpatient in a nonhospital facility) by the *Criteria*. In each group, half will be randomly assigned to treatment prescribed by the *Criteria*, half to the other treatment level.

"$1.7 million grant to study the PPC"

Dr. Gastfriend notes that all will receive treatment considered safe and effective by conventional community standards—which are broader than the ASAM *Criteria*. The study will determine whether patients treated in accordance with the ASAM *Criteria* are more successful in remaining substance free, and whether factors such as gender or ethnicity make any difference.

Chair of the ASAM Criteria Committee is **David Mee-Lee**, MD.

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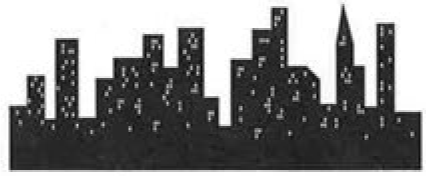
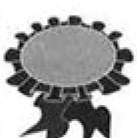
Medical-Scientific Conference April 27-30 in Chicago



ASAM Annual Awards



Senay and Steindler

THE 1995 ASAM ANNUAL AWARD TO A MEMber goes to **Edward C. Senay**, MD, Professor of Psychiatry, University of Chicago. Dr. Senay has been active in state drug abuse programs for Illinois, been a consultant to WHO, and published over 100 articles and books on substance abuse treatment and research.

The other 1995 ASAM Annual Award goes to Emanuel M. Steindler, MS, also of Chicago, who was ASAM's first executive director (1987-1989) and continues to serve the society as a consultant. Mr. Steindler was previously with the AMA.

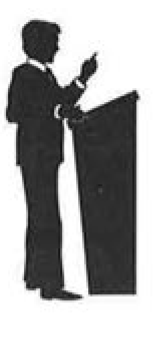
Distinguished Scientist Award

ASAM's 1995 Distinguished Scientist Award will be presented to Harold Kalant, MD, PhD, Professor Emeritus of the Pharmacology Department, University of Toronto. Dr. Kalant will give the annual Distinguished Scientist Lecture which officially opens the Medical Scientific conference on April 28. The award is supported this year by a grant from the Christopher D. Smithers Foundation of Mill Neck, NY. Dr. Kalant will give his lecture in memory of R. Brinkley Smithers who died last December.

Ruth Fox Course

THE 1995 ANNUAL RUTH FOX COURSE FOR PHYSICIANS WILL CONtinue to reflect and underscore some of the continuing interests, developments, diversity and richness in the field of addiction medicine. Course director **Lynn Hankes**, MD, and co-director **Charles Whitfield**, MD, "promise an exciting, entertaining, and educational evont consistent with past years' rave reviews." Dr. Hankes told *ASAM NEWS* that "A partial list of topics includes an updated literature review, practical benzodiazepine detox, acute and chronic pain management in recovery, and litigation stress. This year's special population will be women, and there will be economic and spirituality presentations as well. The speakers have been instructed to allocate time for audience discussion so that controversies may be addressed and practical applications explored."

Symposia



Ten symposia will be offered at ASAM's 26th annual medical-scientific conference this year. "New Approaches to Drug Abuse Treatment: A Report from NIDA"—NIDA (Dorynne Czechowicz, MD); "Disassociation of Withdrawal and Addiction"—**Marc Gold**, MD; "Impact of Drinking Restrictions"—**John Morgan**, MD; "Perinatal Addiction: Where Are We Now?"—**Sidney H. Schnoll**, MD, PhD; "A Quarter Century of Alcohol Research: Milestones and Challenges"—NIAAA (**Enoch Gordis**, MD); "Treatment of Pain in Individuals with Addictive Disorders"—**Seddon Savage**, MD; "Intensive Outpatient Treatment"—**Edward Gottheil**, MD, PhD; "Emerging Ambulatory Therapies"—**Alfonso Paredes**, MD; "Substance Abuse, Domestic Violence and Battery"—**James A. Halikas**, MD; "Integration of Pharmacotherapy & Non-Pharmacotherapy"—**Norman Miller**, MD.

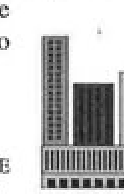
The conference also will include courses and workshops (two to three hours each) by ASAM members and others in addiction medicine, and oral and poster sessions of submitted abstracts. Deadline for submitting applications to present courses and workshops, and abstracts for oral papers and posters, was Oct. 10. In the evenings, many ASAM committees and sections will present individual component sessions based on their activities and concerns.

The ASAM board will meet (open to all members) on Wednesday April 26. Since many committees handle their other meetings during the year by mail or telephone conference call, this annual conference offers the chance to see fellow committee members face-to-face.

Other events will include the traditional ASAM annual awards luncheon, dessert reception, and exhibits.

AA meetings will be offered in the hotel by IDAA mornings and evenings.

Conference chair is again **Marc Galanter**, MD. This year, the conference will be dedicated to the memory of **Stephan Sorrell**, MD, who died in September (see obituary p. 4).



About Chicago

ALONG WITH A NUMBER OF NOTABLE ACD treatment programs, distinguished hospitals and medical schools, Chicago is home to the American Medical Association. ASAM representatives to its House of Delegates are **Jess Bromley**, MD, and **David E. Smith**, MD.

Chicago is noted for its architecture. The conference site—Marriott Downtown Hotel—is conveniently located in the busy downtown area, near Lake Michigan and within walking distance of the Art Institute, the Chicago Symphony Orchestra, Northwestern University Medical Center, and the AMA. Choose from a wide selection of nearby department stores and restaurants. Sightseeing tours by bus or trolley are available.

Conference Information

REGISTRATION MATERIAL, HOTEL AND TRAVEL INFORMATION will be mailed to ASAM members in January. Non-members can contact Sandy Schmedtje at ASAM headquarters (note new address as of Sept. 1994)—ASAM, Suite 101, 4601 No. Park Ave., Chevy Chase, MD 20815. *Phone:* 301-656-3920. *Fax:* 301-656-3815.

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

News of ASAM

In Memoriam
Stephan Sorrell, MD

STEPHAN JON SORRELL, MD, DIED unexpectedly in late September. A 1972 graduate of N.Y.U. School of Medicine, Dr. Sorrell specialized in addiction medicine. He was one of the first physicians to be certified by ASAM (in 1986), lectured frequently at ASAM conferences, directed several ASAM Review Courses, and was president of the New York state chapter. This year's annual Medical-Scientific Conference (in Chicago, April 27-30) will be dedicated to his memory.

At the time of his death, Dr. Sorrell was a Senior Attending Physician of the Department of Medicine and Medical Director of the Substance Abuse Program at St. Luke's-Roosevelt Hospital Center in New York City. He worked extensively with drug addicted and with AIDS patients.

"He was committed to educating physicians about the addictions, and in particular about HIV-AIDS," said ASAM executive vice president James F. Callahan, DPA. "He was one of the most enthusiastic, intelligent, generous people I've ever known. Whenever there was an obstacle or problem in program planning, Dr. Sorrell had some kind of creative solution. He supported our fund-raising campaigns through encouraging members to contribute to our Ruth Fox Endowment, and through his generous personal contributions as well."

"Dr. Sorrell carved new trails in search of 'why' of drug abuse in this town," wrote Msgr. William B. O'Brien, president of Daytop Village, in the *New York Times* on Sept. 21. "Armed with incredible resources of dedication, courage and intelligence, he quickly became the one his fellow physicians looked to for guidance in the field of addition medicine. All the while, he was 'family' to all of us on the frontiers of treatment at Daytop, where he served as a Governor."

ASAM Journal Preferred

ASAM'S *JOURNAL OF ADDICTIVE Diseases* is now included in the CD-ROM index *Physician's Medline Plus*.

Based on a statistical study of physician usage of journals in *Index Medicus*, this makes ASAM's journal one of the top 200 of 3,600 periodicals—ranking in the top 5% of physician usage.

Journal editor is **Barry Stimmel**, MD.

Membership Directory

AS *ASAM NEWS* WENT TO PRESS, so did another publication—the new ASAM *Membership Directory*. All ASAM members who paid 1994 annual dues are included and will receive a copy. Headquarters reports that the directory will be mailed in December.

Reimbursement Cmte Seeks Chair

"THE REIMBURSEMENT COMMITTEE IS looking for new leadership, directions and energies," current chair **Michael M. Miller**, MD, told *ASAM NEWS*. "In the past two years, much of ASAM's energy with respect to economics of care issues has focused on health care reform. I encourage former and future Reimbursement Committee members to write or phone me if interested in committee participation. I hope to arrange a conference call—perhaps in January—of an enlivened Reimbursement Committee, at which point a chair can emerge from the group to set forth an action plan."

Michael M. Miller, MD, NewStart, Meriter Hospital, 202 S. Park St;Madison, WI 53715. Phone—608-267-6291. Fax—608-267-6419.

Illinois Chapter Award

VIOLET EGGERT, MD, IMMEDIATE PAST president of the Illinois Society of Addiction Medicine (ISAM), received the state chapter's first Lifetime Achievement Award on Oct. 27. Dr. Eggert has been with the Illinois State Medical Society Physician Assistance Program since 1987, and was medical director of Interventions in Chicago. She helped develop the first ISAM training event at the ASAM Review Course in Chicago; this year ISAM presented another such preconference in October.

Andrea Barthwell, MD, is president of ISAM.

Women Prisoners

WOMEN IN STATE PRISONS INCREASED by 75% in the five years prior to 1992, according to a special report released in August.

"ASAM members need to become informed about the special needs of female AOD (alcohol and other drug) offenders and their children in order to educate and assist legislators, judges, colleagues and others in planning for an appropriate societal response to this difficult problem," says **Blair Carlson**, MD.

"By mid-1991, 39,000 women prisoners were mothers of 58,000 minor children. One-third were sentenced for non-violent, drug-related offenses—12% for possession (vs. 4% in 1986); 20% for trafficking (vs. 7% in 1986). It is likely that many of these women were chemically dependent and needed treatment.

ADM in Correctional Institutions is a new committee chaired by Dr. Carlson.

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

Bookshelf

Nicotine Addiction:

Principles and Management

by C. Tracy Orleans, PhD, and John Slade, MD
Oxford University Press, 1993. 435 pages, $55.
To order—Phone: 800-451-7556. *Fax* 919-677-1303.
Reviewed by **Terry A. Rustin**, MD

TRACY ORLEANS AND JOHN SLADE HAVE CO-EDITED AN important addition to the addictions field, *Nicotine Addiction: Principles and Management.* Its 21 chapters, authored by 35 leading researchers and clinicians in nicotine dependence, cover this disease in the same fashion that a cardiology text would cover myocardial infarction—examining epidemiology, pathophysiology, clinical presentation, management and public health aspects.

The volume is divided into three sections. "The Disease of Nicotine Dependence" discusses pharmacology and epidemiology, "Management" includes chapters on treating nicotine dependence in practitioners' offices, other medical settings, addiction treatment programs, and psychiatric practices. These tend to be descriptive; most material is not sufficiently detailed for a clinician to read and then counsel patients.The last section focuses on public health issues.

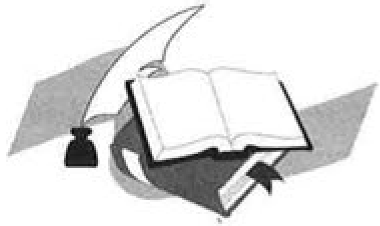
In the management section, two strong chapters deserve note. The chapter on incorporating nicotine dependence therapies into addiction treatment programs, authored by Hurt, Eberman, Slade and Karan, reviews the steps taken by programs that have made this transition, and identifies the pitfalls inherent in the process. Orleans, Glynn, Manley and Slade contributed a well-designed chapter on a strategic approach that office-based clinicians can utilize.

This otherwise useful book has more deficiencies than the one mentioned earlier. Prochaska and DiClemente's "Stages of Change" model is mentioned in seven chapters— reflecting its importance—but it is accorded no more than two paragraphs in any one of them. A full chapter should have been devoted to the theory, research on the theory, and use of this model in counseling. This approach is easily taught to clinicians, who find it fitting comfortably into a variety of practice settings.

Similarly, little mention is made of recovery-oriented methods of treatment, methods in which smokers work through their denial on their way to acceptance, examine their relationship with tobacco, accept and give support to peers who are also working on recovery, and make amends to those they may have harmed by their dependence on tobacco and nicotine. These strategies are widely used, both in professional treatment programs and in 12-Step meetings of Nicotine Anonymous.

These limitations aside, Orleans and Slade's book represents a valuable contribution to the field. Physicians and addictions counselors who had the usual instruction in nicotine dependence while in training—none at all—will benefit from reading it.

Dr. Rustin is the author of **Quit & Stay Quit** *(Hazelden).*



A Bridge to Recovery,

An Introduction to 12-Step Programs

by Robert L. DuPont, MD and John P. McGovern, MD
American Psychiatric Press, Inc., 1994. 131 pages, $22.50
To order—Phone: 800-368-5777. *Fax* 202-789-2648.
Reviewed by **Stanley E. Gitlow**, MD

A "BRIDGE" IS THE AUTHORS' HOPE THAT 12-STEP PROGRAMS increasingly join with professional groups in health care, education, religion, criminal justice, and the workplace. This reviewer is delighted that two eminent clinical professors (of psychiatry and medicine respectively) conclude that Alcoholics Anonymous [AA] requires neither further proof of its clinical effectiveness, nor modification of its basic tenets, in order to represent a major social mechanism—one by which various professionals can deal effectively with addicted individuals and their relatives, coworkers and intimate friends. Of perhaps greater import, the publishing arm of the American Psychiatric Association has seen fit to undertake this publication.

Under the presidency of Dr. **Robert DuPont**, the Institute for Behavior and Health, Inc. gathered a committee of 31 experts for two days in 1990. This group collaborated on "A Bridge to Recovery." While this offers the strength of diverse experiences, it may also have caused occasional subtle unevenness in clinical attitude, evident in certain paragraphs that deal with issues about which AA has experienced some controversy. It may also explain some recurrent difficulties with nomenclature which seems to plague addiction medicine.

For example, the book says: "In the language of recovery, being 'sober' usually refers to not using alcohol, being 'clean' usually refers to not using non-medical drugs, and being 'abstinent' refers to refraining from either alcohol or non-medical drug use." In *my* neighborhood, being 'abstinent' means not using any mind altering drug—alcohol included—whereas being 'sober' implies all that *plus* having experienced the ethical/spiritual changes of a happier and more functional life.

Chapter 3 offers a clear though somewhat simplified view of AA and some of the other self-help 12-step programs. Types of meetings, where, when, and how long they are; the sort of thing that a professional who has yet to attend any AA meetings might well not know. The authors suggest attending a handful of open meetings. Might it not be better to require such professionals to attend a few dozen meetings, including at least one visit to each of the different types of groups to which referrals might be made? Chapters 5 through 8 offer quite good descriptions of AA function for the inexperienced professional.

All in all, an excellent start for a task too-long delayed. Many of us might purchase a few copies and give them strategically to professionals we know.

Dr. Gitlow is editor of **Alcoholism: A Practical Treatment Guide** *(Grune & Stratton).*

Please send all review books to ASAM headquarters. Mark package "Elizabeth Howell, MD—Publications Chair."

New Members

Joined ASAM Jan. 1 - Sept. 30, 1994

Alabama
Martha T. Brou, MD—P
David H. Karney, MD—AM
Warren L. Wallace, MD—GP
Alaska
Thomas A. Hallee, MD—P
Arizona
Judith E. Dixon, MD—EM
Martha L. Hauk, MD—FP
Brenda G. Neufeld, MD—FP
Ivy L. Schwartz, MD—GPM
John A. Walck, MD—FP
Arkansas
Curtis L. Lowery, MD—MFM
James E. Tutton, MD—EM
California
Martin M. Anderson, MD, MPH— PD
Donald K. Blake, MD—FP
Mel Blaustein, MD—P
Kailash R. Dhamija, MD—FP
John R. Donaldson, III, DO—P
Sara A. Epstein, MD—P
Tracy A. Flanagan, MD—OBG
Constante J. Gean, MD—OM
Billie C. Harman, MD—P
Harold M. Henry, MD—OBG
Tim B. Hopkins, MD—
Russell B. Hubbard, MD—P
Jayson A. Hymes, MD—AN
F. G. Kassebaum, MD—P
Amy J. Khan, MD—IM
Donald J. Kurth, MD—EM
John A. Leonard, MD—EM
Roy J. Levin, MD—FP
Richard J. Mize, MD—EM
John T. Moranville, MD—P
C. D. Nelson, MD—GP
Jack A. Palmer, MD—IM
Theodor S. Parada, MD—IM
Raghavendra S. Prasad, MD—FP
Robert L. Ross, MD—P
Jeffrey S. Shelby, MD—IM
S. A. Stalcup, MD
Frank J. Stass, MD—P
Deborah K. Stephenson, MD—GPM
Clifford J. Straehley, III, MD—P
Ramin Tayyanipour, MD—OPM
Frederick N. Thomas, MD
William A. Weathers, MD—P
William D. Zigrang, MD—IM
Rony Zodkevitch, MD—P
Connecticut
Douglas R. Budde, MD—P
Delaware
Patricia D. Lifrak, MD—P
Florida
Richard Bennett, DO—FP
C. D. Chacko, MD—P
Manuel L. Escoto, MD—P
Speros G. Hampilos, DO
Alfredo L. Hernandez, MD—P
John E. Kallich, MD—AN
Eugene J. Linberg, MD—TS
Richard L. Milholm, MD—FP
Eric A. Moore, MD—FP

Ernest P. Palmer, MD
Raymond M. Pomm, MD—P
Georgia
David J. Cadenhead, MD—P
M. Kathy Easterling, MD—U
Kenneth A. Hirsch, MD,PhD—P
Barry H. Lubin, MD—IM
Ronald M. Rosen, MD—P
Robert E. Shervette, MD—CHP
Hawaii
Stephen H. Denzer, MD—IM
Idaho
Thomas B. Eschen, MD, PhD—GPM
Illinois
Julia B. Ashenhurst, MD—IM
Richard L. Butler, MD—EM
Renato C. De Los Santos, MD—P
Daisy M. Felarca, MD—FP
Katherine L. Gorham, MD—CHP
Charles E. Kaegi, MD—P
Jane L. Kotecki, MD—EM
Leon S. Kuhs, MD—P
Ellen D. Mason, MD—IM
Sarz Maxwell , MD—P
Robert T. Mitrione, MD—P
Helen L. Morrison, MD—P
Darren E. Wethers, MD—IM
Indiana
Robert J. Porte, MD—FP
Iowa
Teresa Bylander, DO—P
Jack L. Dodd, MD—P
Billy E. Hukill, DO
Kenneth H. Moon, Jr., DO—FP
Reid E. Motley, MD
Frederick W. Strickland, Jr, DO—FP
Kansas
Larry D. Vande Garde, MD—OBG
Kentucky
Magdalena E. Jaszczak, MD—IM
Melvin Shein, MD—IM
William L. Shuffett, MD—GP
Will W. Ward, MD—IM
Louisiana
Tony L. Alleman, MD—FP
Russell E. Brown, Jr., MD—P
Milton L. Harris, Jr., MD—P
Denese O. Shervington, MD—P
Maine
Thaddeus H. Jozefowicz, MD—N
Maryland
Joseph A. Adams, MD—IM
Jose A. Arias, MD
Zdenka Cebasek-Travnik, MD, MSc—P
Rosa M. Crum, MD, MHS— P
Franklin T. Evans, MD—ADM
Vijaya A. Ganta, MD
Charles M. Harrison, MD—AN
Joyce M. Johnson, DO—P
Janet K. Oneal, DO—FP
Flavio Pechansky, MD—P
Richard H. Schlottman, MD—FP
John D. Stafford, MD—GPM
Reginald W. Stalling, MD—GS
Massachusetts
Michael F. Bierer, MD—IM
William Caruso, MD—IM
John A. Fromson, MD—P
Edward J. Khantzian , MD—P
Neelam Sihag, MD—P
Susan V. Stanton, MD
Michigan
Raymond C. Edison, MD—IM
Bernard Goldstein, DO—CD
Kenneth J. O'Neill, MD—IM
David A. Picone, DO—P
Richard H. Wakulat, MD—IM
Minnesota
David W. Cline, MD—CHP
Farrokh Ghamgosar, MD—FP
Arne H. Graff , MD—FP
David D. Gulden, MD—P
Debra L. Williams, DO—P
Missouri
Abraham Barake, MD—IM
William D. Cone, MD—P
John F. Patterson, MD—P
Luzviminda R Santos, MD—P
Montana
J. Thomas Bulger, MD—IM
New Jersey
Prakash P. Amin, MD—P
SergeDumay, MD—PUD
Ira J. Ellen, MD
Russell A. Ferstandig, MD—P
Thomas C. Fleming, MD—PA
Jude Germaine-Munoz, MD—FP
Arthur M. Gold, MD—P
Lee Hindin, MD—P
Marvin W. Leifer, MD—P
New Mexico
John D.Abrums, MD—IM
Robert A. Buser, MD—P
Virgle O. Herrin, Jr., MD—EM
Dharma S. Khalsa, MD—AN
New York
Pierre R. Arty, MD—IM
Robert W. Ballard, MD—FP
Clarence E. Beverly, MD—AN
Catherine L. Bilodeau, MD—FP
Joyce E. Braak, MD—P
Joseph E. Charles, MD—P
Mark D. Cooper, MD—P
Randall R. Dwenger, MD—P
Barbara A. Edlund, MD—EM
Kevin E. Gallagher, MD—IM
Ann L. Haag, MD—I
Sami Kaddouri, MD—ADM
Hugo S. Kierszenbaum, MD, MPH —P
James T. Marron, MD—FP

Robert J. Mascitelli, MD—IM
Mary S. Nobilski, MD—P
Julia Pettrone, MD—IM
Salvatore A. Ricotta, MD—IM
Sam U. Yoon, MD—IM

North Carolina

Lionel G. Fernando, MD—ADL
Gary G. Leonhardt, MD—P
William Sadowsky, MD—P
Marshall C. Simpson, MD—FP
Barry C. Weed, MD

North Dakota

Peter A. Funk , MD—FP
Benn A. Haynes, MD—P

Ohio

Peter S. Balashov, MD—P
James W. Campbell, MD, MS—FP
Donald L. Cundiff, MD—IM
Daniel A. Deutschman, MD—P
Mahjabeen Islam-Husain, MD—FP
Martin F. Loftus, MD—FP
Harry Nguyen, MD—EM
Alvin D. Pelt, MD—P
Thomas M. Robb, DO—N
Albert G. Snedden, MD—IM

Oklahoma

William P. Becker, DO—FP
William B. Mitchell, MD—IM

Oregon

Michael E. Price, MD—FP
James R. Thayer, MD—IM

Pennsylvania

David R. Battista, MD—FP
Judith Eaton, MD—P
Stephen N. Fisher, MD
Malcom S. Harris,.MD—FP
Thomas R. Hobbs, MD, PhD—IM
Stephen O. Laucks, MD—AN
Deborah M. McMillan, MD—FP
Rodolfo M. Medina, MD—P
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ASAM NEWS was published five times in 1994:. January-**February**, March-**April**, May-June-**July**, August-September-**October**, November- **December.**

Subscriptions: ASAM NEWS is sent free to members. Nonmembers may subscribe for $25 per year. Call/write/FAX ASAM headquarters.

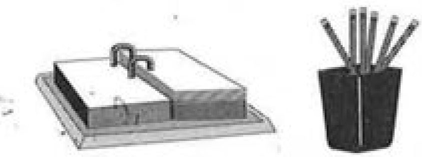
Advertising Rates: Start at $60. Call/write/FAX editor, or ASAM headquarters.

 ISSN # 0889-9215

ASAM gratefully acknowledges the unrestricted educational grant from BioDevelopment Corporation of McLean, Virginia.

American Society of Addiction Medicine 1993 Annual Report

Dr. Anne Geller



From the President

Dear Colleague: *November 1994*

In 1994, ASAM members have continued the efforts begun in 1993 to educate members of Congress and state legislatures about the need to include addiction treatment in health care reform (both at the national and the state level); have increased the use nationally of the ASAM Patient Placement Criteria*; have published* Principles of Addiction Medicine*, the first edition of what will become the standard textbook in addiction medicine; have completed and will soon publish ASAM's first in a planned series of clinical guidelines; and have continued to meet with managed care corporations and third party payers to assure access to and payment for addiction treatment.*

The 1993 Annual Financial Report of the American Society of Addiction Medicine (ASAM) and the society's 1993 accomplishments indicate that—despite a fiscal deficit for that year—the society effectively carried out its mission to educate physicians and improve the availability and quality of addiction treatment. The deficit was caused by a decline in attendance at the society's conferences and courses, and by what appears to be the final phase of a decline in membership. Our 1992 audit reported a fiscal surplus, and our forecast for the year ending December 1994 likewise promises a surplus of income over expenses. Also, 1994 membership figures show that our retention rate has improved (89% vs. 84% in 1993) and that 331 new members joined during 1994 (vs. 264 in 1993).

The officers and board of directors once again pledge their commitment to work to increase access to care and the quality of care, and to establish addiction medicine as a boarded specialty for all qualified physicians.

Sincerely yours,

Anne B. Geller, MD
President

William B. Hawthorne, MD
Treasurer

1993 Accomplishments

- AMA approved ASAM's resolution on ethics in advertising, which called for a study of the ethical implications of accepting financial support from the alcoholic beverage industry. Three other ASAM resolutions, which were referred for further study, asked the AMA to: 1) recommend that questions about *past* treatment for or problems with addiction should not be included on licensing, certifying, and credentialing examinations; 2) urge the recognition, by third-party payers and managed care, of all physicians qualified and trained in addiction medicine, and 3) advocate health care coverage for addiction treatment on the same basis as other medical care.
- ASAM Board approved an ASAM public policy statement on the *Core Benefit for Primary Care and Specialty Treatment and Prevention of Alcohol, Nicotine, and other Drug Abuse and Dependence.* The *Core Benefits* were publicized widely before members of the US Congress and state legislatures, and the AMA.
- Attained first milestone of ASAM's specialty status goals with the establishment of the addiction psychiatry subspecialty by the American Board of Psychiatry and Neurology.
- Increased use of the *ASAM Patient Placement Criteria* by providers, managed care, and third party payers.
- Educated more than 1,500 physicians and other health professionals through ASAM conferences and courses.
- Chartered state chapters grew to 21 from 18 in 1992 (there were five in 1989).
- ASAM Board reviewed fiscal history (82 - 93) and adopted policies to maintain balanced budgets in 1994 and subsequent years.
- Received $300,000 in grants from the Scaife Family Foundation to underwrite the Certification Examination, with $150,000 pledged for 1994 and $150,000 for 1995. In addition, the Rosenstiel Foundation contributed $30,000 to support the ASAM Examination.
- Established two new ASAM committees: the Committee on Practice Guidelines, and the Committee on Addiction Medicine in Correctional Institutions.

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ASAM is an association of physicians dedicated to improving the treatment of alcoholism and other addictions, educating physicians and medical students, promoting research and prevention, and enlightening and informing the medical community and the public about these issues. The society serves its members by providing opportunities for education and sharing of experiences and by promoting the development of a body of professional knowledge and literature to enhance the quality and increase the availability of appropriate health care for people affected by the addictions.

ASAM Income
Year Ended Dec. 31, 1993

Support and Revenue

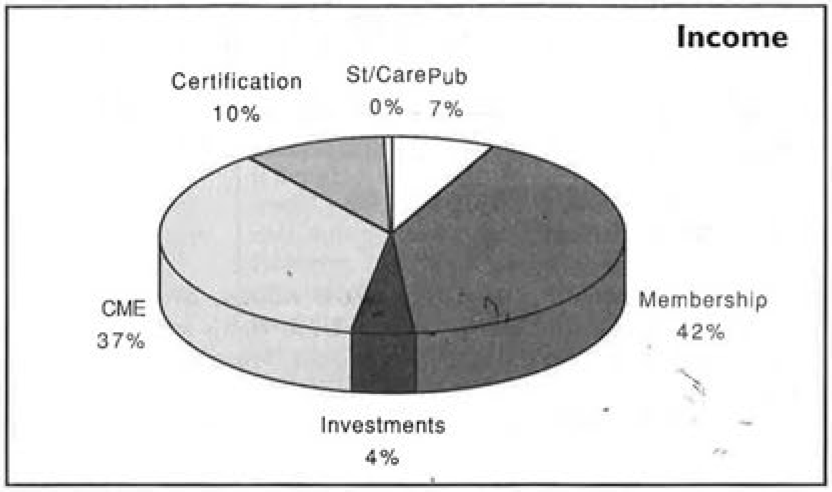
Membership	$603,072
CME	538,091
Publications	107,227
Certification	150,000
Standards/Econ. Care	4,181
Investment Income	64,813
Total Support & Revenue	**$1,467,384**

ASAM Expenses
Year Ended Dec. 31, 1993

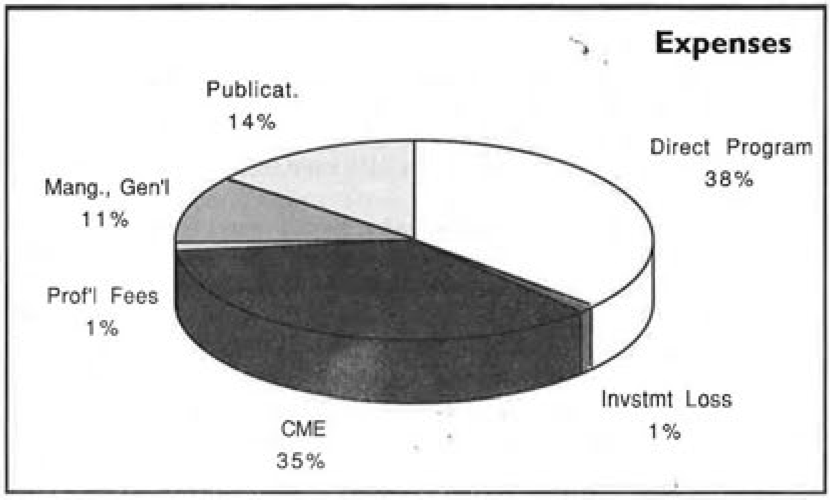
Direct Program	$598,993
Continuing Medical Educ.	572,985
Publications	232,779
Management & General	178,041
Professional Fees	22,145
Unrealized Loss on Investments	18,370
Total Expenses	**$1,623,313**

Excess (Deficiency) Revenue over Expenses after Capital Additions ($155,929)

As of 12/31/93, $1,309,649 was pledged to the Ruth Fox Endowment Fund. Actual monies received were $665,869. This fund is a restricted fund and is not reflected in the financial statement above.



Year Ended Dec. 31, 1993



The financial information presented herein is condensed from the audited financial statements of ASAM for the year ended December 31, 1993. ASAM will be pleased to provide upon written request copies of the complete financial statement from which this information was taken, together with all footnotes and the unqualified report of our independent auditors.

Health Care Reform Alert

A Report from the Executive Vice President

Harris Poll—Public Supports Addiction Treatment

A NATIONWIDE POLL OF 1,249 ADULTS (50% WOMEN, 20% minorities) conducted in July 1994 by Louis Harris and Associates Inc. on behalf of the National Treatment Consortium, revealed the following results:

88% think alcohol and drug addiction requires medical treatment;

89% believe professional treatment for addiction is effective (6% extremely effective, 21% very effective, 62% somewhat effective);

75% think that alcoholism and drug addiction will increase over the next 10 years;

63% believe the federal government should increase its spending on chemical dependency treatment;

87% say the cost of treatment should be included in health care reform benefits (12% said all costs, 21% most of the costs, 54% some of the costs);

66% favor paying for treatment through a special sales tax on alcohol or cigarettes;

Contrary to the current legislative belief that addiction is primarily a law enforcement problem,

52% describe alcoholism as a social problem, while only 5% saw alcoholism as a law enforcement problem;

55% describe drug addiction as a social problem, while only 16% saw drug addiction as a law enforcement problem.

Critical points include:

- The public supports coverage of addiction treatment in health care reform and increased Federal spending on addiction treatment.
- The public sees addiction as a medical problem needing treatment; an individual's improved quality of life as a more important goal than a reduction of theft, crime, and violence.

"Congressmen and other legislators who look to law enforcement as a solution to our nation's alcohol and drug problem are out of touch with the public's needs and demands," declared Jeffrey T. Kramer, Executive Vice-President of the National Treatment Consortium (NTC). David Bralove, Esq., President of NTC, stated, "Through this survey, the American public has shown a greater awareness of the devastating effects of addictions and an understanding of what needs to be done. We believe the survey demonstrates the need for our nation's legislators to respond to their constituents' concerns by placing a higher priority on demand reduction strategies."

The Harris poll will be the centerpiece of the White Paper being funded by private foundations and national organizations, including the Robert Wood Johnson Foundation, JM Foundation, Scaife Family Foundation, National Council on Alcoholism and Drug Dependence, and New Standards, Inc. For more information, contact the ASAM Washington office (301-656-3920) or the National Treatment Consortium, 444 North Capitol Street, NW, Suite 200, Washington, DC 20001; telephone 202-434-4780, fax 202-434-4783.

by James F. Callahan, DPA

States Take Action

AS THE POLITICAL PUNDITS PONDER CONGRESS' FAILURE TO enact national health care reform, savvy observers are turning their attention to the states. In 1994 sessions, most of the states took steps to contain costs and improve access to care. In the 1994 legislative session alone, more than 200 universal coverage bills were introduced in 44 states. Of that lot, at least 21 bills in 15 states contained language related to addiction treatment and mental health.

Eight states have adopted comprehensive health care reform legislation: **Florida**, **Hawaii**, **Massachusetts**, **Minnesota**, **Montana**, **Oregon**, **Vermont** and **Washington**. A second group of states, including **California**, **Colorado**, **Maine**, **Maryland**, **South Carolina**, and **Virginia**, have opted for more incremental reforms. The particular mix of strategies incorporated in the reform plans varies considerably from state to state.

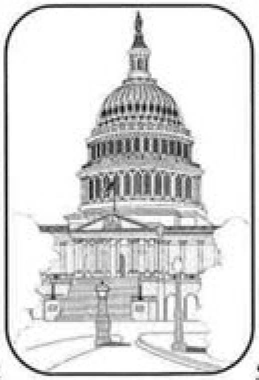
Debate on addiction treatment coverage was not limited to the universal coverage arena, as the issue of *parity* (coverage for addictive disorders on the same basis as other medical conditions) emerged as a central theme of the 1994 state legislative sessions. This year, parity laws were enacted in **Maryland, New Hampshire, North Carolina** and **Rhode Island**.

One significant option available to the states, which **Tennessee** and several others are adopting, is the use of managed care to control costs. Actuarial analyses documenting that managed addiction treatment is effective and affordable were responsible, in part, for the inclusion of such benefits in many reform proposals.

Perhaps the most controversial aspect of managed care (particularly for providers of mental health and addiction treatment) is utilization review (UR). Laws containing language related to utilization review of addiction treatment services were enacted in four of the 21 states considering UR legislation this year (**Indiana, Maine, Maryland** and **Vermont**).

Washington State Uses Data to Persuade Legislators

Implementation of last year's reform law is progressing one step at a time, with legislative debate over the uniform benefits package due to take place in the 1995 session. For each of the three alternative plans currently under consideration, the cost of addiction treatment coverage is estimated at $2 per person per month. Meanwhile, both the Division of Alcohol and Substance Abuse (DASA) and the Division of Mental Health contracted with independent actuaries to develop data on the cost of various combined mental health and addiction treatment benefit packages. Actuarial studies conducted by DASA by William Mercer Inc. estimated the costs of addiction treatment benefit (with no caps, no limitations and co-payments similar to those specified by the Cost Effectiveness Committee) to be $1.50 per person per month. Adding coverage for tobacco cessation treatment increased the monthly cost by 30 cents, to $1.80 per person.



Despite evidence that the cost of covering addiction treatment is not prohibitive, one state official noted that "the fight to keep caps and lids off substance abuse is going to be an uphill battle"—a sentiment echoed in **Florida** and several other states. Nevertheless, it appears that lawmakers can be convinced to support the benefit, if they are given accurate data relevant to their state.

Montana Plan: Comprehensive Addiction Benefit

AFTER MONTHS OF PUBLIC HEARINGS AND BEHIND-THE-SCENES detail work, the **Montana** Health Care Authority—established last year as a bipartisan effort to develop two comprehensive, statewide health care reform strategies—is ready to report. In early November, the Authority sent the legislature blueprints for both a tax-financed single-payer system and a regulated multi-payer system. Each contains a benefit package designed to provide all Montanans with improved access to high quality, affordable health care. State Senator Chris Christiaens, a member of the state Alcohol and Drug Abuse Council, has urged the inclusion of an addiction treatment benefit—including evaluation, detoxification, residential treatment, hospitalization, family treatment and aftercare—in any reform proposal.

California Drug and Alcohol Treatment Assessment

A MAJOR, $2.4 MILLION STUDY (THE CALIFORNIA DRUG AND Alcohol Treatment Assessment [CALDATA]) issued by the California Department of Alcohol and Drug Programs (CADP) finds that substance abuse treatment in California saves $7 for every $1 invested in treatment, and has a substantial, positive impact on crime rates and alcohol and drug use.

The effects of treatment were defined as the differences in behavior and experience reported by respondents before and after treatment. The costs of treatment were calculated from financial records collected directly from the providers involved with CALDATA. The economic value of treatment was based largely on the costs avoided due to reduction in the burden of crime and illness, as well as a review of shifts of income sources.

- The cost of treating approximately 150,000 people in California in 1992 was $209 million, while the benefits received during treatment and the first year afterwards was roughly $1.5 billion—attributable mostly to crime reductions.
- Each day of treatment paid for itself on the day it was received, also primarily through crime avoidance.
- The level of criminal activity by participants decreased by two-thirds from before treatment to after treatment. There was a direct link between longer treatment periods and greater crime reduction percentages.
- Approximately one-third reductions in hospitalizations were reported after treatment.
- Treatment for problems with the major stimulants (crack cocaine, powdered cocaine, and methamaphetamine) was just as effective as treatment for alcohol problems, and even somewhat more effective than treatment for heroin abuse.

The report also noted that benefits persisted through the second year of follow-up for the limited number of participants followed for as long as two years, which suggests that long-term benefits would be even greater.

DC to Wait for Federal Reform

AT THE REQUEST OF MAYOR SHARON PRATT KELLY, the **District of Columbia's** (D.C.) City Council has drafted legislation to postpone implementation of portions of the Drug Abuse, Alcohol Abuse and Mental Illness Insurance Coverage Act, originally scheduled for February, 1994. The new benefits would have included minimum coverage levels for substance abuse and mental health treatment. However, in spite of the eight-year old statute, city officials failed to budget funds in 1994 for implementation—the price tag for which is reported to be $5 to $10 million. Kelly and other proponents of the delay argue that the city, which is facing lean times, can save itself a significant sum, if officials wait for federal reform before extending such coverage.

Hawaii Law Acknowledges ASAM Certification

A NEW LAW IN **HAWAII** PERMITS THE EXCHANGE OF ONE DAY OF inpatient addiction treatment services for two outpatient visits, provided the patient's condition is such that an interruption of outpatient services would make hospitalization imminent. (Existing statute already permits the exchange of inpatient care for non-hospital residential or partial hospitalization services or day treatment services.) HB 3165 also redefines "certified substance abuse staff" to mean, in addition to professionals and paraprofessionals with current full certification as substance abuse counselors or program administrators, "physicians who hold a current [ASAM] certificate."

Connecticut Considers Addiction Coverage

MEETING IN SPECIAL SESSION, **CONNECTICUT** LAWMAKERS reached agreement on Gov. Lowell Weicker's reform proposal. The new law creates a Department of Health with an Office of Health Care Access (OHCA), through which a plan for health system reform will be developed. Universal access to care, with all residents enrolled in certified health plans, must be in place by January 1, 1997. By January 1, 1995, OHCA will present various legislative committees with recommendations regarding health care reform plans. The reform legislation requires that standard benefits offered through any plan must include addiction treatment.

Kentucky Plan includes a Limited Addiction Benefit

ENACTED IN APRIL, THE KENTUCKY REFORM PACKAGE REPRESENTS a compromise between Gov. Brereton Jones and legislative leaders. While falling short of achieving universal coverage, the new law is nonetheless a comprehensive package from which future action may spring. It is a modest, incremental proposal, based on managed competition, that emphasizes publicly funded health care purchasing. Key ingredients include authorization for the development of five standard benefit plans, one of which must be comparable to Kentucky Kare standard benefits offered as of January 1, 1994. For addiction treatment, that equates to 21 inpatient days per year (with a $200 deductible per admission and 20% co-pay); intensive outpatient care may be substituted for inpatient care on a 2:1 basis. Outpatient visits are limited to 20 per year.

Utah Calls for A/D Treatment Coverage Study

WITH THE GOAL OF UNIVERSAL ACCESS, **UTAH** LAWMAKERS created a health policy commission and charged it with developing a strategy to achieve the governor's plan for market-oriented, incremental reform. The 1996 objectives include development of alternatives to capitated reimbursement and evaluation of the feasibility of including alcohol and drug treatment and long-term care in a benefit plan.

CME Survey

Every year, the Continuing Medical Education Committee tries to assess the educational needs of ASAM members. We would like information about what you see as your ongoing educational needs.

Name ______________________

Sex ________ *Age* ______________

Type of Practice (check primary activity)

Private Practice [ ] Group Practice [ ] Public Facility [ ]

Private Treatment Facility [ ]

Medical School or Research [ ] Industrial/Administrative [ ]

Other type of practice [ ] Not practicing [ ]

1. What Addiction Medicine CME credits did you seek or obtain during the previous calendar year?

____

____

2. During the next twelve months, what educational need for yourself would you like to fulfill in the field of Addiction Medicine?

____

____

____

3. How could this need be handled most efficiently by ASAM?

____

____

4. What other areas of educational need would you like ASAM to address?

____

____

5. How would addressing these areas of educational need enhance or improve your delivery of Addiction Medicine services?

____

____

____

Reminder—
CME Joint Sponsorship Ends

ASAM NO LONGER JOINTLY SPONSORS EDUCATIONAL ACTIVITIES. The board had made this decision after the ACCME (Accreditation Council for Continuing Medical Education) revised its standards to the point that ASAM cannot supply necessary staff time for the extensive paperwork and close supervision now required to grant CMEs through joint sponsorship.

Exception: State Chapters

The only exception is ASAM state chapters.

If a state chapter considers organizing a conference or other educational activity that grants credits through ASAM, please contact ASAM's CME manager, Claire Osman, *before* the activity is planned. The committee will assign someone to work with the state chapter. Ms. Osman will send you the procedures for joint sponsorship, and will work with you on fulfilling them.

Claire Osman, ASAM, 12 W. 21 St., New York, NY 10010
Phone: 212- 206-6770 *Fax:* 212-627-9540

6. In your local setting, would you be interested in participating in, organizing, or directing a CME presentation for other non-addiction medicine physician colleagues?

Yes [ ] No [ ]

7. What sort of assistance might ASAM provide that would help you accomplish this educational goal?

____

____

____

____

Name ______________________
please print

State ____________

Do you have an **Internet** (computer online) **address**? If yes, please note below for ASAM's files:

____

James A. Halikas, MD, is chair of the CME Committee.
Please return survey to Claire Osman, CME Committee, ASAM, 12 West 21 St., New York, NY 10010

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Progress in Heroin & Cocaine Addiction

by **David R. Gastfriend**, MD

A NEW MEDICATION LICENSE, WHICH IS under consideration for treating heroin dependence, may also be the first agent for combined heroin and cocaine dependence. The FDA has licensed two agents, methadone and L-acetyl-methadol (LAAM), for treating heroin dependence, but buprenorphine (Buprenex®) is currently being reviewed as well. The latter drug may be a modest breakthrough for the many heroin addicts who also inject cocaine, including those who simultaneously inject the combination known as "speedball."

Nearly one-third of US hospital visits for heroin-related emergencies also involve cocaine use. Combining heroin and cocaine increases the risk for HIV infection due to more frequent needle use and sharing.

Buprenorphine, a molecular hybrid of a potent opiate agonist and an opiate antagonist, is as effective as is methadone for treating heroin dependence. The drug offers several advantages over methadone, however, because of its partial agonist properties—more moderate withdrawal and less risk of lethal overdose, even at approximately 10 times the analgesic dose.

After Mello, *et al.*, found that buprenorphine reduced cocaine self-administration by rhesus monkeys, NIDA funded several investigations to test its potential use for human cocaine addiction. Two controlled studies by Kosten, *et al.*, and Johnson, *et al.*, did not show a clear benefit over methadone for opiate dependence with cocaine abuse. However, studies of patients with the full dual dependence syndrome by Gastfriend, *et al.*, showed a benefit, and a dose-ranging study by Schottenfield, *et al.*, suggested a uniqu dose-benefit curve.

The US Veterans Administration and leading medical centers recently completed a large, multi-center trial of buprenorphine's use for heroin dependence. Results currently under review by the FDA may lead to the drug's licensure for the opiate treatment indication. Since the clinical trial tested a range of doses and included some subjects with combined opiate and cocaine dependence, it may determine whether buprenorphine is indeed medicine's answer to speedball addiction.

"...medicine's answer to speedball addiction"

Dr. Gastfriend is Chief, Addiction Services, at Massachusetts General Hospital in Boston.

New IDAA Phone *ASAM NEWS* recently listed a wrong number for International Doctors in AA. It is **314-482-4548**.

Ruth Fox Memorial Endowment Fund

Dr. Ruth Fox
1895-1989

As another year draws to a close, we wish to thank those whose generosity and continued support means so much to us. We are very grateful to you for your pledges and contributions to the Ruth Fox Memorial Endowment Fund. We hope that you will remember the Fund as you plan your year-end contributions.

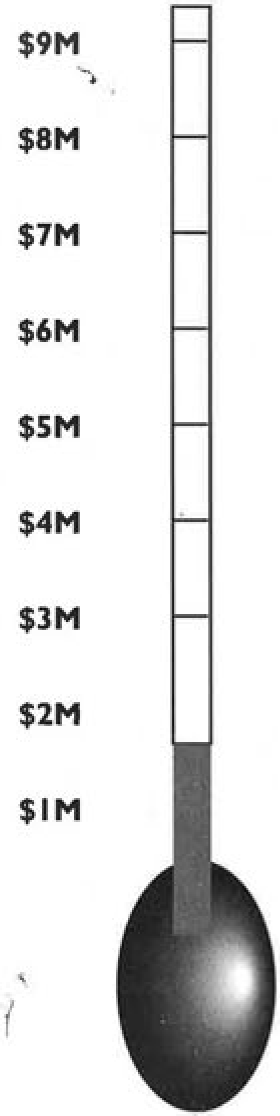
Just a reminder—that pledges can be paid over three to five years (longer if needed). All contributions to the Endowment Fund are fully tax-deductible since ASAM is a 501(c)(3) organization.

For information about the Endowment Fund and how to make a Planned Giving gift, i.e., bequests, insurance, trusts, etc., please contact Ms. Claire Osman, Director of Development, ASAM, 12 West 21st Street, New York, NY 10010. 212-206-6770. She will be glad to discuss this with you in confidence.

We wish to extend to you and your family warm wishes for a wonderful holiday season and a happy and prosperous new year.

William B. Hawthorne, MD—Chair, Endowment Fund
Jasper G. Chen See, MD—Chair Emeritus, Endowment Fund
Max A. Schneider, MD—Chair, Resources & Development Committee
Claire Osman—Director of Development

Goal
$10,000,00



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$1,413,099

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ASAM Calendar

Information about ASAM conferences is available at Washington headquarters.
Note new address:
Sandy Schmedtje, ASAM
4601 North Park Ave., Suite 101
Chevy Chase, MD 20815
301-656-3920
Fax: 301-656-3815

ASAM staff contact for ***CME*** *information::*
Claire Osman, ASAM
12 W. 21 Street
New York, NY 10010
212-206-6770
Fax: 212-627-9540

1995

- **Jan. 20-22—FSAM 8th Annual Conference on Addictions (Florida Chapter)** *(ASAM joint sponsor)*
  Orlando *Hotel Royal Plaza*
  Lucy B. Robe, FSAM, 303-D Sea Oats Drive, Juno Beach, FL 33408.
  407-627-6815. Fax 407-627-4181
- **Feb. 24-26—Medical Review Officer(MRO) Training Course**
  Marina Del Rey, CA *Ritz-Carlton*
- **April 27-30—ASAM Annual Meeting & 26th Annual Medical-Scientific Conference**
  Chicago *Marriott Downtown*
  ASAM Board Meeting—Apr. 26
  Ruth Fox Course for Physicians—Apr. 27
  Medical-Scientific Conference—Apr. 28-30
- **July 7-9—MRO Training Course**
  Washington, DC *The Capitol Hilton*
- **Oct. 12-15—8th National Conference on Nicotine Dependence**
  Toronto, Ontario *Toronto Marriott Eaton Center*

1995 *(continues)*

- **Oct.** (TBA)**— State of the Art in Addiction Medicine Conference**
  Washington, DC *Hotel TBA*
- **Nov. 2-4—CSAM/ASAM State of the Art in Addiction Medicine Conference**
  Marina del Rey, CA *Ritz-Carlton*
- **Nov. 17-19—MRO Training Course**
  New Orleans *Intercontinental New Orleans*

1996

- **April 18-21—ASAM Annual Meeting & 27th Annual Medical-Scientific Conference**
  Atlanta *Atlanta Marriott Marquis*

1997

- **April 17-20— ASAM Annual Meeting & 28th Annual Medical-Scientific Conference**
  San Diego *San Diego Marriott*

1998

- **April 16-19—ASAM Annual Meeting & 29th Annual Medical-Scientific Conference**
  New Orleans *New Orleans Marriott*

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Address Correction Requested

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