ASAM NEWS

Volume IX, No. 3 May-June-July 1994

ASAM Annual Award Winners

Henri Begleiter, MD, (l) and Jasper G. Chen See, MD

April—New York City

770 Attend ASAM Medical-Scientific Conferenc

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by ASAM EVP—p. 10

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ASAM
American Society of Addiction Medicine

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

Medical Scientific Conference

by **Terry A. Rustin, MD**

Ruth Fox Course for Physicians

The 1994 Ruth Fox Course for Physicians , directed by **Lynn Hankes**, MD, with co-director **Charles L. Whitfield**, MD, and aided by sage advice from director-emeritus **Maxwell N. Weisman**, MD, attracted 367 participants on April 14. This year included an update on addiction medicine by **Robert B. Millman,** MD; the relationship between addictions and HIV disease by **Mel Pohl**, MD; methadone maintenance therapy by **J. Thomas Payte**, MD; the neurobiology of addictions by Carlton Erickson, PhD; medical management of alcoholism by **Robert M. Morse**, MD; motivational interviewing approach by **William D. Clark**, MD; and ethics in addiction medicine by **LeClair Bissell**, MD. The program overall was a great success, combining scientific reviews with skill-building presentations and an invitation to the audience to reflect on their lives.

Medical Marriage in Crisis

While all the presentations were well received, the one that caught the group's interest most was "The Medical Marriage in Crisis: Sources of Conflict." As Donald Rosen, MD, discussed physicians and their relationships, many in the audience nodded their heads gravely. They could see themselves and their own relationships in his words.

"The traits that make us good physicians give us problems as people," said Dr. Rosen. He identified seven:

1. Physicians are impatient, chronically dissatisfied, and perfectionists.
2. They are "workaholics," although not all overwork for the same reasons. Some work compul sively to deal with anger, some when threatened with loss of love, others to expiate a sense of guilt, still others to avoid intimacy.
3. They are markedly guilt-prone. They always blame themselves for not having done enough.
4. They have an exaggerated sense of responsibility. This is great for their patients, but hard on them and on their families.
5. They are emotionally constricted.
6. They avoid closeness and intimacy, which might require them to express themselves emotion ally.
7. They don't know how to have fun; they must work at this.

Dr. Rosen identified three core problems in dysfunctional physician marriages. Physicians and their spouses have differing needs for intimacy; perceptions of problems; communication styles. "When the wife gets mad, she withholds sex," he said, "when the husband gets mad, he withholds conversation."

What is at the root of these problems? Dr. Rosen presented data which suggest that physicians (male or female) perceive that they did not receive adequate nurturing as children. High parental expectations led them to believe that hard work and self-sacrifice would get them the love they sought. Because of this, they suppressed their hostile feelings, believing that any expression of anger would endanger their tenuous connection with their source of nurturing. This led them to convert concern for themselves into caring for others, and adamant refusal to depend on others but a need to take care of others.

Names in boldface are first mentions of ASAM members

Terry A. Rustin, MD

Course director Lynn Hankes, MD, (l) is also ASAM Board Secretary. He and ***Richard Tremblay,*** *MD taste ASAM 40th birthday cake!*

Dual Disorders Treatment

One of addiction medicine's greatest challenges is caring for the patient with two major disorders—chemical dependency and a major psychiatric disorder. Three researchers presented papers on dual disorders April 17 in New York. Chair was **Sidney H. Schnoll, MD, PhD.**

Linda Cottler, PhD, and Bridget Grant, PhD, focused on important conceptual and methodological issues that make the study of dual disorder patients and their treatment so difficult.

Marc A. Schuckit, MD, professor of psychiatry at the University of California at San Diego, discussed the problem of differential diagnosis when an alcoholic/addict presents with depressed mood or anxiety. Which is most accurate?

1.The addiction is the primary disorder, and the depressed or anxious mood results from the physical, social and emotional consequences of the chemical use. When the addiction is successfully treated, the depressed or anxious mood will improve.

2. The depression represents Major Depressive Disorder (or the anxiety represents Panic Disorder or Generalized Anxiety Disorder), and the chemical use represents an attempt at self-medication. When the depressive disorder or anxiety disorder is successfully treated, the chemical use will cease.

3. The patient has two primary disorders. Both require specific treatment.

Dr. Shuckit quoted several studies which support the position

that most of these mood disorders are consequences of the chemical use—not independent disorders. He presented data that supports the view that alcoholics have higher rates than the general population of symptoms of psychiatric disorders. Once sober, however, their rates parallel those of the general population. In a study of 200 alcoholics, 40% met the criteria for Major Depressive Disorder shortly after admission, but only 4% met these criteria four weeks later. A meta-analysis of 19 studies and 6,821 patients revealed that 7% met the criteria for Major Depressive Disorder (with 6% of the general population meeting these criteria). Rates of panic disorder and generalized anxiety disorder were higher in the alcoholics than in the general population, but rates of social phobia, obsessive-compulsive disorder, and agoraphobia were similar. Dr. Schuckit pointed out that observed differences could be due to social or non-heritable familial factors, associated with alcoholism but unrelated to the genetic or physiologic factors involved in alcoholism.

He suggested that clinicians concentrate on treating the depressed or anxious alcoholic with addiction treatment methods for six weeks before considering the use of medications for depression or anxiety.

Marvin L. Seppala, MD, a psychiatrist who also attended this session, told *ASAM NEWS* that Dr. Schuckit believes the new data to be clinically relevant. "The depression, anxiety and hallucinations of people with psychoactive substance use disorders should be specifically addressed and treated. He warned physicians, however, to discriminate between disorders that exist as a result of psychoactive substance use and will clear within a few weeks of abstinence, and disorders that are truly comorbid and independent of psychoactive substance use."

Distinguished Scientist Award to Dr. Guze

ASAM conferred its 1994 Distinguished Scientist Award on Samuel Guze, MD, chair of the Department of Psychiatry at Washington University/School of Medicine in St. Louis. He is a leader in the effort to improve the nomenclature and diagnostic accuracy in psychiatry and in addictions. Dr. Guze addressed the membership at the 1994 Medical-Scientific Conference in New York on the topic 'Is Substance Abuse a Disease? Does it Matter?'

Dr. Guze answered both questions in the affirmative. He defended the value of a medical model of addiction and psychiatric disorders versus the 'biopsychosocial' model currently in greater favor. "The medical model," he said, "puts the focus of illness on the individual who suffers from the condition." In treating addictions he thinks this preferable to the biopsychosocial model, which gives equal attention to the patient's environmental and social circumstances.

Dr. Guze encouraged his audience to place a greater emphasis on diagnostic accuracy, distinguishing between conditions having a common manifestation but different etiologies. While rigorous diagnosis is emphasized in medicine and surgery, psychiatry has not always valued diagnosis. Dr. Guze noted that some of psychiatry's greatest figures have denigrated diagnosis, calling it 'mere labeling,' preferring to emphasize their relationships with the patient and the patient's defense mechanisms. "Epidemiology—etiology—pathogenesis—treatment—complications—course and outcome," he said. "We should think about psychiatric and substance abuse disorders in these terms."

Dr. Guze left open the question of whether addictive disorders should be seen as a spectrum of illnesses having some common manifestations but having many different etiologies, or as a single disorder having a variety of presentations.

"How we think about a condition shapes how we deal with it," Dr. Guze asserted. He identified three approaches to evaluating illness: Epidemiological—that considers a condition in its social and environmental context; laboratory science—that conceptualizes illness as a series of biochemical and cellular events; clinical—that combines the two. The annual medical-scientific conference, in fact, reflects this concept: the majority of ASAM members are practitioners with a wealth of clinical experience. They attend to learn from scientists who are studying the epidemiological and biochemical aspects of addictive disorders.

Dr. Guze ended his address by reflecting that the leaders of the healthcare reform movement have been willing to sacrifice benefits for psychiatric and addictive disorders treatment in order to cover medical and surgical illnesses more completely. "The leaders of managed care do not believe that psychiatric illness is a real illness," he said. "They see it as a lack of will or as a moral failure." Dr. Guze's professional career, in contrast, has been focused on setting psychiatric and addictive disorders on an equal footing with medical disorders.

Healthcare Reform

A panel on April 14 informed ASAM members about impending healthcare reform changes, as President Clinton and Congress debate modifications. Chaired by former ASAM president **Sheila B. Blume**, MD, the panel included **David C. Lewis**, MD, **Paul Earley**, MD, **David Mee-Lee**, MD, **LeClair Bissell**, MD, ASAM's executive vice-president James F. Callahan, DPA, and Martha Alexander, state representative in NC.

Dr. Blume stressed two points: 1) if we don't get healthcare reform now, we won't get it for a long time; and 2) the ASAM *Criteria* will be crucial to successful inclusion of addiction treatment benefits in the final package.

These criteria (the *ASAM Patient Placement Criteria*), said Dr. Mee-Lee, have become a standard for facilities, regulatory agencies, third-party payers, and intermediaries. He served as chair of the ASAM committee that developed the criteria. "Treatment does not define diagnosis," said Dr. Mee-Lee. He believes that addiction medicine specialists must be as rigorous about tailoring treatment to the needs of each patient as are other medical practitioners.

Dr. Lewis presented a strong case for including comprehensive addiction treatment benefits in a healthcare reform package. Data from a Rand Corporation study contend that treatment is far more cost-effective in reducing cocaine use than is reducing production, interdiction, or domestic enforcement.

Dr. Lee of HHS

At the annual awards luncheon on April 16, Philip R. Lee, MD, Assistant Secretary for Health in the Department of Health and Human Services, talked about health care reform policies .

Dr. Lee said that we have today a window of opportunity in which to make significant improvements in the healthcare system. These windows open "about every 30 years." The current window is open due to three factors: the public agrees that there is a crisis in healthcare; current strong presidential leadership could make changes; greater consensus than ever before exists on the nature of necessary changes.

Dr. Lee summarized President Clinton's proposals in this way:

1. The policy will guarantee healthcare insurance for all Americans.
2. The benefits will be comprehensive.
3. There will be provisions for individuals to choose plans.
4. "Experience ratings" would be eliminated.
5. The benefits will be portable from one plan and one location to another.

He believes that the most important issue to ASAM members is the federal administration's intent to emphasize primary care rather than specialist care. Primary care physicians thus will become more responsible for addiction intervention and treatment. In turn, addiction specialists will be obliged to improve the education and experience of these doctors, so they can better identify and manage patients who have addictive disorders.

"The window of opportunity will not last very long," Dr. Lee said. It could close "quite soon." He encouraged ASAM members to work with their elected representatives to assure that the approved policies will meet the needs of the patients we serve.

Phillip R. Lee, MD (r) with ASAM president-elect David E. Smith, MD

*ASAM VP James F. Callahan, DPA (l) with NIAAA director **Enoch Gordis**, MD (c) and NIDA director Alan Leshner, PhD, at annual luncheon.*

Anne Geller, MD (c) with representatives of new Panama chapter Edgardo Della Sera, MD (l) and Saul Alvarada, MD.

Nicotine Dependence Studied

John Slade, MD, chair of ASAM's Nicotine Dependence Committee, opened "Managing Nicotine Dependence" at the ASAM Annual Medical-Scientific Conference by noting that nicotine in tobacco products and nicotine dependence have become major national issues.

Telephone Counseling

Shu-Hong Zhu, PhD, from the University of California at San Diego School of Medicine, described in detail the low-intensity telephone counseling program his group has developed. They studied three approaches: advising clients to use self-help materials that were mailed to them, a single telephone counseling session, and a series of telephone counseling sessions scheduled on days 1, 3, 7, 14 and 30 after enrollment.

At the 12-month follow-up, 14% of the self-help group, 20% of the single-session group and 27% of the five-session group reported being abstinent from smoking. The mean number of days abstinent at the 12-month evaluation was 80 in the self-help group, 130 in the single-session group and 231 in the five-session group.

Dr. Zhu's findings indicate that low-intensity interventions can have a significant effect. With a subject base exceeding 20,000, he was able to identify a number of significant factors in applying these findings:

1. The anonymity of telephone counseling enabled clients—especially men—to open up quickly. It also allowed what Dr. Zhu called "a wide range or transference values," meaning that clients could perceive their unseen counselors in any way they chose. This proved helpful for young counselors, who might seem older than they actually were.

2. The procedure encouraged client accountability, since clients knew when counselors would call and they had no legitimate excuses for not being available.

3. Sessions were initiated by counselors, not clients.

4. Sessions were structured, with specific content to be covered at each session.

5. Sessions were scheduled according to the risk of relapse—three of them in the first week.

6. Clients could not predict in which situations they would relapse; therefore, counselors had to identify relapse triggers as well as work with those that the clients identified.

Motivational Counseling

Theresa B. Moyers, PhD, of the University of New Mexico Medical School, described the motivational counseling approach to smoking cessation. Based on the work of William Miller, and the stages-of-change model by Prochaska and DiClemente, the motivational counseling approach does not necessarily set quitting smoking as a goal. Instead, it seeks to move a patient along a continuum of change towards quitting. 'Stages-of-change' places him/her in one of the following, based on readiness to change: precontemplation (not considering changing at all); contemplation (thinking about it); preparation (getting ready); action (having taken measurable actions); and maintenance. The goal of motivational counseling is to move a patient one stage at a time, and address the issues inherent in each current stage.

Rustin's report continues

Quitting During CD Treatment

Richard D. Hurt, MD, of the Mayo Clinic, described his team's research in integrating nicotine/tobacco dependence treatment into the context of addiction treatment. His data indicate that addressing nicotine dependence while patients are in treatment for alcohol or other drug dependencies does not detract from the effectiveness of the latter treatment; instead it can be effective. He said that 11% of patients who participated in a voluntary smoking cessation program during treatment were nonsmokers a year later, while none had quit who did not participate.

Dr. Hurt also quoted data from a large study of Minnesotans which showed that 63% of alcoholics who received treatment were smokers, that 29% of them were dead within eight years—and that 62% of these deaths were tobacco related.

About the Author

Terry A. Rustin, MD, wrote this 4-page conference report for ASAM NEWS. He is assistant professor of Psychiatry and Behavioral Sciences at the Univ. of Texas Medical School at Houston. He is medical director of a county addiction treatment program , and author of **Quit and Stay Quit, A Personal Program to Stop Smoking** *published by Hazelden.*

Dr. Rustin, a board-certified psychodramatist, will present a workshop "Psychodrama:Action Methods in Addiction Treatment" at the ASAM Review Course in Chicago, Oct. 27.

HIV/AIDS by Kevin O'Brien, MD

"Hot Topics in HIV Care for Addiction/Alcoholism Patients," workshop at the Medical-Scientific Meeting. Co-directors: Barbara Chaffee, MD, MPH, and Kevin O'Brien, MD.

Patients with HIV brain involvement may require psychotropic medications, said Marshall Forstein, MD, of Cambridge Hospital. These can include medications that addictionists are not accustomed to or comfortable about prescribing. Continual dialogue and cross-consultation between addictionist and psychopharmacologist are essential for maximal management.

According to Janet Mitchell, MD, of Harlem Hospital, most women seen with HIV infection are Latinos or women of color. These women may be the sexual partners of infected men, IV drug users themselves, or both. Many find blocks to accessing health care. Since HIV infection can progress rapidly in women, Dr. Mitchell was quite compelling in her call for physicians to be aware of the ways that HIV might present in women.

A major cofactor in the tuberculosis epidemic is HIV infection, said Marc N. Gourevitch, MD, of Montefiore Medical Center. Since physicians in the addiction field may not pick up these infections by standard tuberculin skin testing, co-testing with additional antigen(s) could be required.

The workshop's concluding panel, moderated by **Mel Pohl**, MD, ASAM AIDS Committee chair, addressed some rather controversial topics. These included optimal time in recovery for HIV antibodies testing. The AIDS Committee plans additional sessions for the 1995 meeting in Chicago, prompted by gratifying attendance and participation at this 1994 workshop.

New Board Members

R. Jeffrey Goldsmith, MD, of Cincinnati, replaces **Bruce Branin**, MD, of Pennsylvania as Region IV representative (New Jersey, Ohio, Pennsylvania) to the ASAM Board of Directors. Dr. Branin resigned because he is no longer practicing in the addiction medicine field.

Allan Graham, MD, of St. Johnsbury, Vermont, replaces **Margaret Bean-Bayog**, MD, who has been unable to attend recent board meetings. From 1989 to 1993 Dr. Graham was Region III representative (Northeast). He is chair of the Review Course.

Paul Earley, MD, of Atlanta, joins the board as State Chapters Committee chair, a new *ex officio* position.

New Committee Chairs

Publications Committee: **Elizabeth F. Howell**, MD, of Atlanta.

Methadone Treatment Committee: **Elizabeth T. Khuri**, MD, of New York (co-chair with **J. Thomas Payte**, MD).

New Policy Statements

The ASAM Board approved three new policy statements at its April meeting.

- "Persons with Alcohol and Other Drug (AOD) problems and the Criminal Justice System" includes seven recommendations for handling incarcerated alcoholics.
- "ASAM Position Statement on National Drug Policy" defines and discusses legalization and decriminalization, and recommends 15 principles to use in guiding formation of national drug policy.
- Trauma Policy Statement was revised for confidentiality.

The board approved "Resolution of Sub-Specialization in Addiction Medicine," for ASAM to introduce into the AMA House of Delegates in June. This asks the AMA to "formally request national medical specialty societies in internal medicine, family practice, emergency medicine, pediatrics, and preventive medicine to urge their respective specialty boards to study the desirability and feasibility of offering CAQs in addiction medicine."

Public Policy Committee chair: **Sheila B. Blume**, MD.

News About Members

Honors

The US House of Representatives awarded **Jasper G. Chen See**, MD, a Congressional Citation for his efforts in alcoholism education and treatment, particularly the Caron Foundation in Pennsylvania. **Max A. Schneider**, MD, a 1949 graduate of the University of Buffalo School of Medicine, received a Lifetime Achievement Award from its Alumni Association for his educational efforts in alcoholism and other drug dependence. Both are former presidents of ASAM.

In Memoriam

Psychiatrist **Joel Z. Spike**, DO, of North Miami Beach, died in January. He was certified by ASAM in 1987.

Surgeon **Edward J. Kitlowski**, MD, a founding member of the Maryland chapter, died in September.

About ASAM

Certification/Recertification

New Time Limit

Starting in 1998, ASAM certificates will have a time limit of 10 years. The 1996 exam will be the last for non time-limited certificates (no expiration).

Recertification

While initial certification received before 1998 will not expire, ASAM will continue to require recertification after 10 years in order to show mastery of *current* information in addiction medicine.

The 1995 Membership Directory will explain the significance of recertification, list the year of certification and that of recertification. A "Certified in 19xx" listing will always appear for members certified before 1998, even if they choose not to recertify. However, those certified in 1998 and after must be recertified after 10 years in order to retain their "certified" notations in the Membership Directory.

MRO Certificate

Certified 1986-1992

For over two years, ASAM has offered an MRO acknowledgment letter to those certified by ASAM *and* who attend a *complete* ASAM MRO course. ASAM will continue to offer this letter to physicians certified between 1986 and 1992 if they request it within 10 years of initial certification—that is, before the society requires recertification to show mastery of current information. Physicians who take the recertification exam after 1994 will be eligible to receive ASAM's MRO Certificate.

ASAM MRO Certificate

Starting in 1995, ASAM will offer an MRO certificate for those who meet the following criteria:

- Pass the ASAM Certification/Recertification Exam in 1994 or after;
- Score above a certain level on MRO items included in the ASAM Certification/Recertification Exam;
- Complete an accredited MRO course carrying a minimum of 12 hours CME credit (Category I AMA *or* Category 1B AOA).

1994 Exam

The 1994 Certification/Recertification Exam is Dec. 3, in Atlanta and Los Angeles. Deadline for applications was Jan. 10. The next exam will be in 1996. Dates and locations will be announced.

Chairs: Certification Section—**John B. Griffin, Jr.** MD; Examination Cmte—**Sidney H. Schnoll**, MD, PhD; Credentialing Cmte—**Lloyd Gordon**, MD; MRO Cmte—**Ian Macdonald**, MD.

For more information, call Theresa McAuliffe at ASAM headquarters, 202-244-8948.

Membership

Non-physician Membership

The January-February issue of *ASAM NEWS* included a survey "Should ASAM Accept Non-physicians as Associate Members?" Votes from 6% of the membership tallied at 83 opposed and 70 in favor. Many surveys included comments, which were given to the ASAM Board. In April, the board decided not to establish this new category of associate membership.

Two new state chairs: **Linda Layton Bowlby**, MD, of Alaska, and **William L. Mason, Jr.**, MD, of South Dakota. Open chairs: Delaware, Indiana, Kansas, Maine, New Hampshire, Virginia. If anyone from these states is interested, please call Pam Traylor at ASAM headquarters for more information.

Membership Campaign

The Membership Campaign began in April 1993. Between then and April 1994, 163 ASAM members recruited new members. Top recruiter was **G. Douglas Talbott**, MD, with five.

In 1992 and 1993, first quarter membership figures had decreased 10% compared to the previous years. Yet in the first quarter of 1994, membership increased by 7% over 1993's first quarter.

Membership Committee chair: **Ken Roy**, MD.

Unified Membership to Begin

Unified state and national membership will begin in January 1995. The State Chapters Committee and ASAM headquarters staff are putting the mechanisms in place for combined renewal billings, as well as combined application processing.

Those who practice in states that have an ASAM chapter can expect the first state/national combined invoice this fall for the 1995 membership year.

California and Florida plan to continue their own local billing. These members will receive two separate membership invoices—one national, one state.

Beginning in January 1995 all members of ASAM must belong to their state chapter if there is one and all members of state chapters must also belong to ASAM.

State Chapters Committee chair: **Paul Earley**, MD.

New State Chapters

New Jersey (**George J. Mellendick**, MD), North Carolina (**James P. Alexander**, MD) , Wisconsin (**Michael M. Miller**, MD), and Panama (**Carlos Smith Fray**, MD). Names in parentheses are chapter presidents. This brings the total to 24 chapters—23 state and one international.

1994 ASAM Membership Directory

From Pam Traylor, director of Membership Services: "The long-awaited new membership directory is in production! In June, ASAM headquarters mailed a membership information verification form. Our thanks to those who returned it. If you did not, please call the ASAM Membership Department at 202-244-8948. While it's too late to get your changes into the 1994 edition, we can serve you better with the correct information on file. ASAM will mail the *Directory* to all members this fall."

Names in boldface are first mentions of ASAM members.

Publications

by Elizabeth F. Howell, MD

This committee's responsibilities include "evaluating and making recommendations on all matters concerning publications" of ASAM. Recent efforts focused on *ASAM NEWS*, the *ASAM Review Course Syllabus*, and the *Journal of Addictive Diseases*. Other committees and groups within ASAM have develope publications such as *Patient Placement Criteria; ADM Fellowships Guidelines; AIDS Guidelines for Facilities; Principles of Addiction Medicine;* and *ASAM Clinical Guidelines*.

This list is impressive. The committee hopes that ASAM will continue expanding its educational endeavors in the print media. The committee's goal is to develop (or foster) excellent and clinically useful publications. We are shaping a long-range publication plan for ASAM, and we need and want comments from members about all publications.

Many thanks to those who took the time to complete the *ASAM NEWS* Survey at the recent annual meeting in New York! This important feedback will help us to plan the newsletter's future. We will incorporate members' suggestions into future issues whenever possible. Several respondents expressed interest in writing for this newsletter. The Publications Committee and the Newsletter Review Board encourage interested ASAM members to submit articles to *ASAM NEWS*. The Newsletter Review Board is responsible for approving and final editing all *ASAM NEWS* material, and will consider all submissions carefully. Please contact editor Lucy Barry Robe (see masthead) if you have an article or an idea for an upcoming ASAM NEWS issue.

If you have ideas about other current or potential ASAM publications, please contact me. I can be easily reached by electronic mail on America Online (EFH MD), CompuServe (72204,1605) or via the Internet (efhmd@aol.com or 72204.1605@compuserve.com). If you use conventional mail, my address is: 41-A Lenox Pointe NE, Atlanta, GA 30324-3162. My phone number is 404- 261-2464. I look forward to hearing from you.

Dr. Howell is new chair of the Publications Committee.

Emergency Physicians

by Andrew DiBartolomeo, MD

We invite all interested members to join our effort to develop a special section for addiction medicine within the American College of Emergency Physicians (ACEP). If you are a member of ASAM and of ACEP, you may join the petition for this special section. Or, you may want to be on a special ASAM mailing list to stay 'in the loop' for information about this liaison. For further details, call Theresa McAuliffe at ASAM: 202-244-8948.

Dr. DiBartolomeo is chair of the Committee on Emergency Medicine.

ASAM NEWS

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Newsletter Reduced

Due to budget cuts, *ASAM NEWS* will be published only five times this year instead of six. The next two issues will be August-September-**October**, published in October, and November- **December**, published in December.

Each will be shortened to 12 pages instead of the customary 16. Contact Editor Lucy B. Robe or ASAM headquarters for revised editorial and advertising deadlines.

Photos

Most photos by **Carlisle L. St. Martin**, MD, and Robert S. Robe, Jr.

Photos on p. 1—(clockwise l to r, beginning under podium) Drs. James A. Halikas, Marc Galanter, Allan Graham, Gail N. Shultz with Sheila B. Blume and Al J. Mooney, III, Da Mee-Lee, Christine L. Kasser.

Correction: mis-spelled in last issue: new member **Marvin Leifer**, MD, of N J .

"Principles of Addiction Medicine"

August '94

1994 ASAM Review Course Syllabus. Over 150 authors .. 18 sections .. over 100 chapters ..

Basic Science & Core Concepts
- Epidemiology
- Definitions
- Basic Science
- Clinical Neurology
- Pharmacology
- Genetic Influences
- Behavioral Models

Pharmacology
- Alcohol
- Sedative-Hypnotics
- Opiates
- Stimulants
- Nicotine
- Phencyclidine & the Hallucinogens
- Cannabis
- Steroids
- Inhalants

Prevention
- Roles of the Physician
- Assessing Individual Risks & Resiliencies
- Working with Community Coalitions

Diagnosis & Early Intervention
- Diagnostic Systems (DSM III-R, RDC, WHO, etc.)
- Biochemical & Psychometric Tests
- Assessment Instruments
- Clinical Diagnosis
- Laboratory Diagnosis
- Early Identification & Brief Interventions
- Referral

Medical Disorders in the Addicted Patient
- Protracted Withdrawal
- Medication Management
- AIDS/HIV Disease
- Neurological Complications
- Organ Pathology
- Trauma
- Nutrition

Psychiatric Disorders in the Addicted Patient
- Dual Diagnosis
- Affective and Anxiety Disorders
- Compulsive Disorders
- Psychotic Symptoms
- Pharmacological Treatment Of Dual Diagnosis

Surgery in the Addicted Patient
- General Surgery
- Anesthesia and Analgesia
- Neurosurgery
- Plastic Surgery
- Otolaryngology
- Opthalmology
- Genito-Urinary Disorders
- Cardio-Thoracic Surgery
- Orthopedics

Pain in the Addicted Patient
- Management of Acute & Chronic Pain
- Psychological Interventions
- Medications

Overview of Addiction Treatment
- Components of Contemporary Treatment
- Patient-Treatment Matching
- Neurobiology, Treatment and Relapse
- Relapse Prevention
- Discharge Planning and Selection of Continuing Care

Intoxication and Withdrawal
- Management of Acute Episodes
- Alcohol Withdrawal and Intoxication
- Sedative-Hypnotic
- Opioid
- Stimulant
- Marijuana
- Hallucinogen and Inhalant
- Multiple Drug/Alcohol
- Nicotine Withdrawal

Pharmacologic Therapies
- Alcohol
- Benzodiazepines & Other Sedative-Hypnotics
- Cocaine & Other Stimulants
- Opiates
- Nicotine
- Multiple Drugs & Alcohol

Behavioral Therapies
- Behavioral Therapies
- Network Therapy
- Aversion Therapy
- Contingency Contracting
- Alternative Therapies

Self-Help Programs
- Role of Twelve-Step Programs
- Cultural Points of Resistance to the Twelve-Step Recovery Process
- Spiritual Issues in Addiction Medicine
- Recent Research in Twelve-Step Programs

The Family in Addiction
- The Family in Addiction
- Psychiatric Perspective on Co-Addiction
- Current Family Treatment Methods

Women and Addiction
- Women & Addictive Disorders
- Management of the Addicted Woman in Pregnancy
- Management of the Alcohol- or Drug-Exposed Neonate

Adolescents and Addiction
- Developmental Biopsychosocial Disease Model
- Adolescent Dual Diagnosis
- Prevention
- Intervention & Treatment

Other Special Populations
- Gay Men & Lesbians
- Elderly Patients
- The Impaired Physician
- The MRO and Workplace Programs
- African-Americans
- Hispanic Americans
- Asian-Americans
- Native Americans

Quality Improvement in Addiction Treatment
- Managed Care and Reimbursement
- Caring for Patients in a Managed Care Environment
- Placement Criteria, Treatment Matching and Individualized Treatment
- Case Management
- Quality and Outcomes Management
- Key Issues in Treatment Outcome Research

Members: $115
Non-members: $140

"Principles of Addiction Medicine" (ASAM Review Course Syllabus) Order Form

Name: _____

Address: _____

_____

Telephone _____

Payment ❑ Check ❑ Credit Card (MC or VISA, circle one) ❑ Purchase Order

Credit Card No. _____ Expiration Date _____

Signature _____

August '94 Publication

_____ Book(s) at Member price ($115) $_____

_____ Book(s) at Non-member price ($140) $_____

Total Amount enclosed $_____

Return to: **American Society of Addiction Medicine, PO Box 80139, Baltimore, MD 21280-0139 FAX: 202-537-7252** *(postage & handling included in price)*

Health Care Reform Alert

A REPORT FROM THE EXECUTIVE VICE PRESIDENT

by James F. Callahan, DPA

Drug Use Up

Drug use is on the rise again, federal data show. New data from the federal Drug Abuse Warning Network (DAWN) show a 9% increase in drug-related emergency admissions during the first six months of 1993. In that period, 382,800 admissions were reported, compared to 214,600 for the first half of 1992. The survey found that the numbers increased for virtually all adult age groups and racial and ethnic categories. The study is likely to trigger more debate over how well the Clinton administration has done in addressing alcohol and other drug problems.

Treatment Saves Money

A comprehensive addiction benefit would save money, ASAM representatives told state legislative leaders who met to discuss addiction and mental health benefits in state plans of health care reform.

ASAM members **David C. Lewis**, MD, **Michael M. Miller**, MD, **Anthony B. Radcliffe**, MD. and **David E. Smith**, MD, addressed the legislators in four regional conferences sponsored by the Intergovernmental Health Policy Project of The George Washington University. Quoting from a new study commissioned by a coalition of field groups, they said that every dollar spent on addiction treatment saves $11.54 in related medical and social costs. Information provided by the ASAM spokespersons include the following data, from the State of Minnesota:

Parity for Addiction Treatment

A new poll backs parity for addiction treatment, according to the Bazelon Center, which released results of a nationwide survey of 800 likely voters in late February. The Center found that:

° 68% of respondents said it is important to cover addiction and mental health problems at the same level as coverage for physical problems, while 10% rated addiction and mental health coverage as more important;

° 81% favored coverage of outpatient and clinical services as alternatives to hospitalization;

° 63% said arbitrary limits on treatment are unacceptable; specifically, 3 out of 5 respondents opposed limiting coverage of mental health or addiction services to 30 days per year; and

° 60% said they would be willing to pay up to $100 more per year to assure that any package of health reform that is adopted contains comprehensive coverage of addiction and mental health care.

To order a copy of the report, call the Bazelon Center at 202-267-5730.

Kennedy Bill Generous to ADM

The most generous addiction benefit seen yet is a major selling point of new health reform legislation introduced Ma[illegible] 13th by Sen. Edward M. Kennedy (D-MA). Known as "Chairman's mark," Kennedy's plan is widely understood to be a first draft and subject to extensive modification. Nonetheless, it is significant that the bill includes addiction and mental health coverage superior to that of the Clinton Health Security Act and any rival plan yet unveiled. Insiders note that the Kennedy plan also hits a number of 'hot buttons' with key legislators, including cost containment and health insurance for all Americans.

Staff of the Senate Labor & Human Resources Committee, which Kennedy chairs, claim that the AOD benefit design in the Senator's bill reflects the experience of Fortune 500 companies and innoyative state systems, which demonstrate that a well-managed flexible benefit can serve more people at lower cost.

Thus, the Kennedy bill provides the following mental health and addiction benefits:

° *No lifetime limit on benefits.*

° *Unlimited outpatient treatment*, including screening and assessment, psychotherapy, medications management, and substance abuse counseling and relapse prevention. Cost-sharing is on par with other outpatient services.

° *Unlimited intensive nonresidential treatment*, including day treatment and psychiatric rehabilitation programs. Cost-sharing is on par with other extended rehabilitation services.

° *Unlimited residential substance abuse treatment* in settings that are inexpensive compared to hospital treatment, such as therapeutic communities. Cost-sharing is on par with hospital s[illegible]vices.

• *Organized systems of care* for children with emotional disturbances.

continues on next page

Health Care Reform Alert by James F. Callahan, DPA *continues*

° *60 days per year of residential mental health treatment.* Consumers may receive 4 days of residential treatment by substituting them for 1 day of hospital treatment, up to 15 days of the hospital benefit. Cost-sharing is on par with hospital services.

° *30 days per year of inpatient hospital treatment.* As above, consumers may substitute 15 days of this benefit for 60 days of residential treatment, leaving a base benefit of 15 days. Cost-sharing is on par with other hospital services.

° *Grants for states to integrate their public and private service delivery systems*, with priority on low-income adults with serious addictive disorders or mental illness and children with serious emotional disturbance.

° *All benefit limits removed in 2001* when public and private delivery systems become integrated.

° *Quality managed care standards* so that consumers can receive the right amount of care in the most clinically appropriate, least restrictive, cost-effective setting.

Action Needed

Visit your Senators and Representatives. If you don't know who your members of Congress are, call the Congressional Information Line at 202-224-3121. (All you have to provide is your zip code.) Let them know that any health reform plan adopted should contain addiction coverage comparable to the Kennedy "Chairman's Mark" bill.

If you can't visit in person, call or write. Tell your representatives why it's so important to have a sound addiction treatment benefit. You may want to share your own experiences in caring for addicted patients, or use the sample letter in the November-December 1993 issue of ASAM NEWS. *The full text of ASAM's recommended Core Benefit is found on pages 4-5 of the March-April 1993* ASAM News.

Let the ASAM office know who you contacted and how they responded. This will help us identify potential allies, as well as Congress members who need to be further educated about the ASAM core benefit.

Genetic markers

Genetic markers (like the long-sought marker for alcoholism) are being treated as pre-existing conditions, according to a report in the *Philadelphia Inquirer*. Reporting on recent breakthroughs, the report notes that genetic technology presents "immediate health insurance problems for people whose genes are suspected of being defective." Says the National Cancer Institute's Dr. Samuel Broder: "As the Human Genome Project proceeds and as we identify the genes that can predict the future development of disease, everyone...will have a pre-existing condition. Does that mean that none of us will be insurable?" The *Los Angeles Times* also reports on the issue of genetic discrimination: "All of this is occurring in a legislative vacuum; because the issue is so fresh, only a few states have laws barring genetic discrimination." The Health Insurance Association of America supports outlawing exclusions for pre-existing conditions in national reform, but has opposed state laws that would do the same. Currently, only Ohio and Wisconsin have laws prohibiting insurance companies from using genetic information to deny medical coverage. California and New York "have similar laws on the drawing boards."

Measuring quality

Are national standards coming? In the face of health care reform, the overriding concern remains: What effect will the final plan have on the quality of care Americans receive? The White House and health experts agree that the science behind measuring the quality is in its infancy, making it unlikely that it could be applied on a national scale any time soon, the *New York Times* reports. According to Duke University's Dr. David Eddy, "There is a tremendous need to develop measures of quality, but anyone who believes that we have all the measures we need right now is kidding themselves." New York University's Dr. Jesse Green adds: "I think we are raising the expectations of people far beyond the ability to deliver information." Long-time observers have noted that demands for proof of treatment efficacy have been common in the addiction field for some time; the controversy now involves efforts to broaden their application to encompass other areas of medicine.

Maintenance Therapies in the Addictions

'State Methadone Treatment Guidelines'

The "State Methadone Treatment Guidelines" were developed out of a joint effort between ASAM, the American Methadone Treatment Association (AMTA), and the Center for Substance Abuse Treatment (CSAT). The ASAM board of directors voted its approval.

The "Guidelines" are a blueprint for methadone maintenance treatment providers and state regulatory officials to provide up-to-date methadone maintenance treatment. The 12 chapters and appendices cover such topics as historical perspectives, clinical issues, admission policies, dose determination, multiple substance abuse, maintenance during pregnancy, infectious diseases, responsible take-home practices, treatment duration, community revelations, DEA regulations, and state and federal resources.

ASAM members who were instrumental in developing the "State Methadone Treatment Guidelines" are: **Andrea G. Barthwell, MD, Lawrence S. Brown, Jr., MD, MPH, David R. Gastfriend, MD, Elizabeth Khuri, MD, Susan F. Neshin, MD,** and **J. Thomas Payte, MD.** Drs. Payte and Khuri also co-chair the Methadone Treatment Committee.

Ordering Information

The "State Methadone Treatment Guidelines" were published in 1993 by the US Department of Health and Human Services as a CSAT Treatment Improvement Protocol (TIP). Single copies (soft-bound or loose-leaf—Document No. BKD98) are available from the National Clearinghouse for Alcohol and Drug Information. :

NCADI
PO Box 2345
Rockville, MD 20847-2345.
Phone: 800-729-6686.

LAAM Announcement

Levomethadyl Acetate Hydrochloride (LAAM) completed a long journey on July 9, 1993 when the FDA approved New Drug Application 20-315 recognizing LAAM to be safe and effective in the treatment of opiate addiction. LAAM is now available under the trade name ORLAAM.

Studies on LAAM began at Lexington in the late 1940s. ORLAAM is a methad derivative with a slower onset of action and a greatly extended duration of activity, allowing dosing three times per week, reducing the need for take-home medication and the risk of diversion. Product information is available from BioDevelopment Corporation in McLean, VA 22102.

New Column

A column on maintenance pharmacotherapies in the addictions will appear in more issues of *ASAM NEWS*. The editors and advisors for this column are Drs. J. Thomas Payte and Andrea Barthwell.

Future topics related to maintenance therapies include: pain management, the range of maintenance pharmacotherapies, pharmacology, medical maintenance, pregnancy, and outreach strategies.

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

CME Joint Sponsorship Ends

ASAM will no longer jointly sponsor educational activities. The board made this decision based on a recommendation by the CME (Continuing Medical Education) Committee, chaired by **James A. Halikas**, MD. The ACCME (Accreditation Council for Continuing Medical Education) recently revised its standards to the point that ASAM cannot supply the staff time necessary to handle the extensive paperwork and close supervision now required for granting CMEs through joint sponsorship (formerly defined as 'co-sponsorship').

Exception: State Chapters

The only exception will be ASAM state chapters. If a state chapter considers organizing a conference or other educational activity that grants credits through ASAM, it is absolutely necessary that you 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 a copy of 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

ASAM PPC Pilot Study

by **David R. Gastfriend, MD**

Initial results of a pilot study indicate that a "negotiated placement process" is the real-world result of introducing the ASAM *Criteria*:

The US Center for Substance Abuse Treatment (CSAT) approved our proposal to study how the *ASAM Patient Placement Criteria* are applied in the field. The agency authorized a naturalistic pilot study of the *Criteria* at the Massachusetts General Hospital Target Cities Central Intake unit, with the addendum for methadone and residential treatment known as the "Massachusetts crosswalk."

David Mee-Lee, MD, chair of ASAM's Standards of Care Section, trained intake nurses and counselors to use the *Criteria* to determine the "ASAM-recommended" treatment level for each new patient. Over 100 intakes were assigned to treatment based on the ASAM/ Massachusetts crosswalk.

"Negotiated Placement"

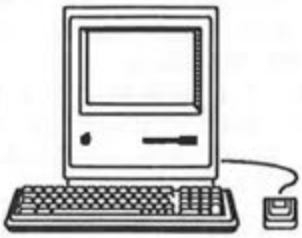
A typical patient at this downtown urban intake center requests a low level of care, e.g. outpatient counseling. He/she is told that the *Criteria* recommends a more intensive approach, e.g., non-hospital based residential rehabilitation. The patient finally accepts higher placement than originally requested, e.g., day treatment, but not up to that indicated by the *Criteria*..

The results raise the following questions: Do the Criteria represent an impossible ideal? Is such an ideal still valuable if it helps raise the intensity of treatment? Is the highest intensity of treatment that the patient will accept really the most effective? What are the outcomes of patients who are "negotiated up" vs. those who obtain treatment at levels that are very discrepant with the *Criteria*?

If these initial results are confirmed in a broader sample (soon under way), the impact of this negotiated placement process will need to be considered. The CSAT pilot indicates that considerable research on the *Criteria* is needed, to test both their efficacy (success of *Criteria* matches under ideal "laboratory-like" conditions) and their effectiveness (success under real-world conditions by line clinicians with a variety of patient populations).

Further work in this area is just beginning.

Dr. Gastfriend is Chief of Addiction Medicine at Massachusetts General Hospital in Boston. He is chair of the ASAM Committee on Outcome Research.



Online News

Communications Task Force chair **Stuart Gitlow**, MD, is exploring with the AMA setting up an online area for ASAM as part of AMA-NET. **Al J. Mooney**, III, MD, and **Thomas L. Haynes**, MD, are talking with CompuServe about starting an ASAM section within a planned new Recovery Forum. None would be configured as an official ASAM area unless recommended by this task force and approved by the ASAM Board. However, efforts to bring areas online under an addiction medicine banner are encouraged, so long as the ASAM name or materials are not used.

Correction: Instructions in the March-April *ASAM NEWS* for sending e-mail via Internet to CompuServe were somewhat incorrect. Use the phrase cis only if sending from America Online. Otherwise spell in full: compuserve.com.

Thus, Publications chair Dr. **Elizabeth Howell's** e-mail address via Internet is 72204.1605@compuserve.com.

When sending mail via Internet to people at America Online, leave spaces out of their addresses. Dr. Stuart Gitlow's AOL address is afagitlow@aol.com. (It is AFA Gitlow within America Online.)

ASAM e-mail List

Lucy B. Robe maintains a list of ASAM members' online addresses. While online addresses will not appear in the new 1994 Directory, we hope to include them in the future. Please help us start this process by sending yours to her at lubaro@aol.com; or to Drs. Howell or Gitlow (addresses above).

1995 Election of Officers and Directors-at-Large

The Nominating and Awards Committee is comprised of the immediate past president, as chair; two ASAM committee chairs, elected by all ASAM committee chair persons; two regional directors, elected by all regional directors, and two ASAM members appointed by the president and approved by the board of directors.

The Nominating & Awards Committee, chaired by **Anthony B. Radcliffe**, MD, selected candidates for the 1995 election. In accordance with the ASAM Bylaws, the Nominating & Awards Committee selected two candidates for the office of president-elect. Another candidate was nominated by petition signed by more than 25 active members.

Officers—1995-1997

President-elect—

Lynn Hankes, MD, Washington
David Mee-Lee, MD, Hawaii
G. Douglas Talbott, MD, Georgia

Secretary—

Sandra Jo Counts, MD, Washington
Marc Galanter, MD, New York

Treasurer—

Alfonso D. Holliday, MD, Indiana
James W. Smith, MD, Washington

Directors-at-Large—1995-1999

For seven board openings, four of seven incumbents will stand for re-election. The Committee chose 10 more candidates.

- **Sheila B. Blume**, MD, New York*
- **Lawrence S. Brown**, MD, New York
- **H. Westley Clark**, MD, JD, California
- **Paul H. Earley**, MD, Georgia
- **David Gastfriend**, MD, Massachusetts
- **Stanley E. Gitlow**, MD, New York*
- **Allan Graham**, MD, Vermont*
- **James A. Halikas**, MD, Minnesota
- **Elizabeth F. Howell**, MD, Georgia
- **Christine L. Kasser**, MD, Tennessee*
- **David C. Lewis**, MD, Rhode Island
- **Anthony B. Radcliffe**, MD, California
- **Seddon Savage**, MD, New Hampshire
- **Karen Sees**, DO, California

*Incumbents

Petitions

ASAM voting members may file petitions to place additional candidates on the ballot. Nominations for officers and for directors-at-large may be made upon petition signed by at least twenty-five (25) active members of the society. Before submitting, ASAM encourages members to review a candidate's qualifications. Board members are expected to attend all board meetings at their own expense.

Petition Deadline: Receipt at society's headquarters **Oct. 10, 1994.**

Criteria

Officer Nominees

Candidates must be from, or have served on, the Board of Directors within the past four years. Exception in the case of nominee for treasurer, who may be a nominee from the general membership, having qualifications for the position, and having been active on the Finance Committee within the past four years.

Director-at-Large Nominees

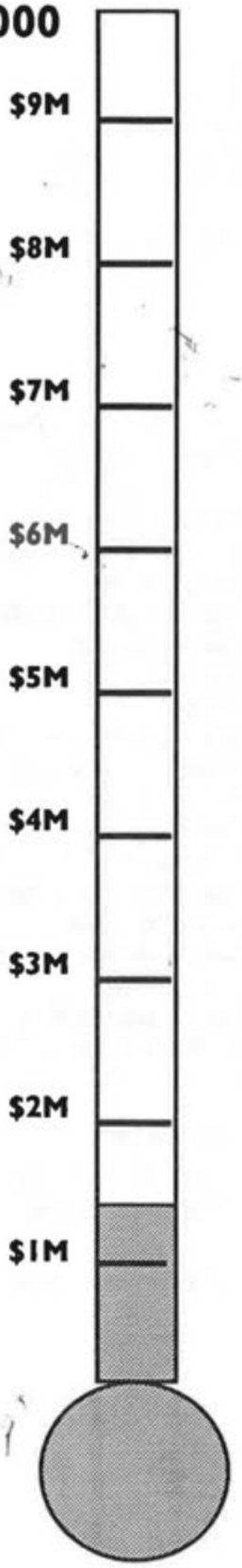
The Nominating & Awards Committee shall be responsible for putting forth a slate of candidates for Directors-at-Large position that will assure adequate representation on the board for the society's diverse membership and interests, thereby assuring that there are board members with academic/research credentials, and experience as committee chair persons, as well as members who represent the specialties that comprise the Society, especially psychiatry, family practice, internal medicine, and other specialties. The committee shall also take into account the need to provide representation of the society's geographic, public/private sector, male/female, minority, and other characteristics of the membership-at-large.

Elections

Ballots will be mailed to all active, voting members on Nov. 1, 1994. Deadline for their return—Dec. 1, 1994. Results will appear in the January-February issue of *ASAM NEWS*. **David E. Smith**, MD, will become president, and other new officers and directors-at large will take office in April 1995 at the society's Annual Medical-Scientific Conference in Chicago.

Ruth Fox Memorial Endowment Fund

Goal $10,000,000



The Ruth Fox Memorial Endowment Reception took place this year on April 15 at the Marriott Marquis Hotel, New York City during the Medical-Scientific Conference. The reception, which gives ASAM the opportunity to thank donors in person, was by invitation only for those who donated to the Fund at any time.

For the first time, ASAM presented Ruth Fox Memorial Endowment Medallions, inscribed with each donor's name, to those who have contributed/pledged $5,000 or more.

Special thanks to **Max A. Schneider**, MD, for increasing his bequest.

Just a reminder--a pledge can be paid out over three to five years (quarterly, semi-annually) and is fully tax-deductible since ASAM is a 501 (c)(3) corporation.

For more information about making a pledge/contribution, planned giving gift, or upgrading your current pledge, please contact:

Claire Osman, *Director of Development*
ASAM, 12 W. 21 St.
New York, NY 10010.
☎ 212- 206-6770. Fax 212-627-9540

William B. Hawthorne, MD, *Chair*
Jasper G. Chen See, MD, *Chair Emeritus*

Ruth Fox Fund Reception

(L to R clockwise)
William B. Hawthorne, MD, with Stephan Sorrell, MD of New York City; Anne Geller, MD, ASAM president; Dr. Hawthorne with Fund chair emeritus Dr. Chen See, MD; and with Max A. Schneider, MD, chair of Resources & Development; Gail N. Shultz, MD of Rancho Mirage, CA.

Recognition Roster by Giving Level

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($10,000-$24,999)
Michael A. Michalek, MD

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($5,000-$9.999)
William F. Haning, III, MD
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Gail N. Shultz, MD
Ralph E. Stolz, DO
Richard E. Tremblay, MD

Circle of Friends
($3,000-$4,999)
Kevin O'Brien, MD
Carlisle L. St. Martin, MD

Donors' Circle
(Up to $2,999)
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Donald Ian Macdonald, MD
Mr. Steve H. Osman
Jennifer P. Schneider, MD

March 8 - May 31, 1994

Pledged $1,372,503

ASAM Calendar

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

Information about ASAM conferences is available at Washington headquarters:
Sandy Schmedtje, ASAM, 5225 Wisconsin Avenue NW, Ste. 409, Washington, DC 20015.
☎ 202-244-8948.
Fax: 202-537-7252.

1994

- **Aug. 5-6— IDAA (International Doctors in AA)**
  Atlanta *(ASAM sponsor of scientific session)* *Swissotel*
  Connie Hyde, 3311 Brook Hill Cir., Lexington, KY 40502
  ☎ (606) 233-000. Fax 606-253-0862
- **Aug. 26-28—ASAM MRO Training Course**
  Arlington, VA *Crystal Gateway Marriott*
- **Sep. 30-Oct. 2—ASAM Board Meeting**
  San Diego, CA *Marriott Marina & Tower*
- **Oct. 27-30—ASAM 1994 Review Course**
  Chicago *O'Hare Marriott*
- **Nov. 3-5—CSAM Review Course (California Chapter)** *(ASAM co-sponsor)*
  San Francisco *Miyako Hotel*
  CSAM, 3803 Broadway, Suite 2, Oakland, CA 94611
  ☎ 510-428-9091. Fax 510-653-7052
- **Nov. 4-6—ASAM 7th National Nicotine Conference**
  Cambridge, MA *Cambridge Marriott*
- **Dec. 3—ASAM 1994 Certification/Recertification Examination**
  Atlanta and **Los Angeles**
  (deadline for applications was Jan. 10)

1995

- **Jan. 19-22 —FSAM 8th Annual Conference on Addictions (Florida Chapter)** *(ASAM joint sponsor)*
  Orlando, FL *Hotel Royal Plaza*
  Lucy B. Robe, FSAM, 303-D Sea Oats Drive, Juno Beach, FL 33408. ☎ 407-627-6815. Fax 407-627-4181
- **April 27-30—ASAM Annual Meeting & 26th Annual Medical-Scientific Conference**
  Chicago *Marriott Downtown*
- **Oct. 19-22—ASAM State of the Art in Addiction Medicine Conference**
  Orlando, FL *Disney's Contemporary Resort*

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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