ASAMNEWS

Money for Treatment Page 5

May / June 1997 Volume 12, Number 3

Newsletter of The American Society of Addiction Medicine

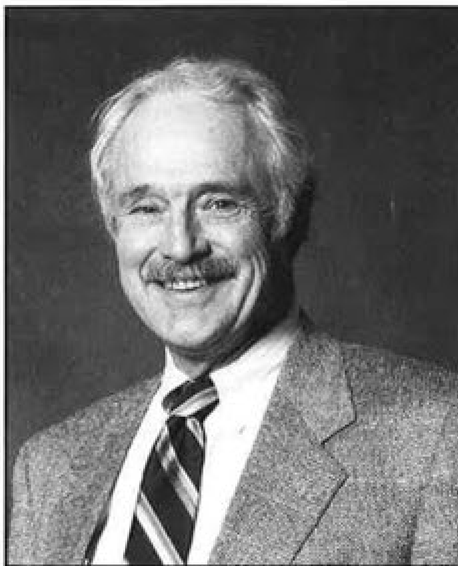
New President Says ASAM Has "Talent, Energy, Experience" to Meet Challenges

G. Douglas Talbott, M.D., FASAM

I assume the Presidency of ASAM with humility, excitement and a sense of exultation.

To follow Dr. David Smith's Presidency is by definition a humbling experience. It is also humbling to be elected President of ASAM, for this is truly a great and unique organization.

Nor can I assume the presidency of this organization without exultation. I have been with ASAM from the birth of the Southeastern addiction movement, the California movement, and the New York movement. The New York programs were much older than the California and Georgia programs, but I learned of the New York program through the work of Drs. Frank Seixas, Sheila Blume, Stan Gitlow, and through my long-time friend Max Weisman. At the Kroc Ranch unity meeting, we wrestled with nomenclature—I remember stumbling over the acronym "AMSAODD." I also remember visiting Manny Steindler at the American Medical Association and his suggestion that I call a very talented and professional woman in California, Gail Jara. Gail guided me into meetings with Jess Bromley, David Smith, Tony Radcliffe, and Max Schneider. Shortly, the California and Georgia programs joined together to form the American Academy of Addictionology at the second meeting of the AMA's Physicians Health Committee. I subsequently approached Drs. Gitlow and Seixas and the basis of the first Kroc Ranch unity meeting was established.



G. Douglas Talbott, M.D.
ASAM President, 1997-1999

The Caduceus Foundation once again has agreed to support ASAM in a workshop exploring pain management. (Some ASAM members may not be aware that it was the Caduceus Foundation, supported by the Kroc Foundation, that organized the first Kroc Ranch meeting.) Other Caduceus Foundation meetings have been staged at the Carter Center in Atlanta, as well as in Chicago and in Washington, D.C., to study, define and implement the Physicians Health Habit Program. This program explored and set the standards for zero to minimal blood alcohol levels for physicians engaged in patient care. Subsequently, the AMA accepted the standards. As a result, we finally have standards regarding the intake of alcoholic beverages while physicians care for patients, even over the telephone.

The Caduceus Foundation also has convened a number of expert meetings on caffeine, chaired by Dr. Max Schneider. The findings from these sessions were reported at the 1993 Medical-Scientific Conference in a symposium on the role of caffeine in addiction treatment.

I exult in the richness of this history, and in the current accomplishments represented by the ASAM Patient Placement Criteria under the leadership of Dr. David Mee-Lee and the efforts on tobacco, led by Dr. John Slade.

Goals for the Future

As we look toward the future, I want to dedicate my presidency to the establishment of residencies in addiction medicine in a number of university medical centers. With such residencies funded and implemented, specialization with certificates of added qualifications can be effectively pursued. Under the experienced and able leadership of Dr. Sidney Schnoll, the academic structure of such multiuniversity programs are being developed. As a next step, I am taking responsibility for the CURAM (Consortium of University Residencies in Addiction Medicine) project. We have completed preliminary discus-

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President Clinton greets ASAM President G. Douglas Talbott, M.D. as EVP Dr. James Callahan looks on.

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ASAM

American Society of Addiction Medicine

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

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EXECUTIVE VICE PRESIDENT'S REPORT

REVIEWING ASAM'S GOALS AND ACCOMPLISHMENTS

Dr. James F. Callahan

Few individuals in medicine have had the opportunity to influence the development of the profession, to actually define how medicine is practiced. Each ASAM member has precisely that opportunity through your pursuit of ASAM's mission, which is unique in the history of medicine. That mission is:

❑ To establish the prevention and treatment of addictive disorders as a basic health benefit (parity), and
❑ To establish the specialty of addiction medicine.

While ASAM's mission is historic, we are in a period in the history of medicine in which treatment for all illnesses, including addictive disorders, is being rationed. We also are in a period in which specialty training is being de-emphasized, and training of generalists is being given greater emphasis. All of this is being done with almost total disregard for the consequences of these changes for patient care and the medical profession.

We live in harsh and brutal times, times that challenge the truth and validity of our mission and of our resolve to pursue our mission. And so it is appropriate for us to ask: Is ASAM's mission true? Is its attainment feasible in bad times such as the present, as well as in the good? Is our resolve to pursue our mission firm? The answer to all these questions is "Yes." The evidence shows that our accomplishments and our ability to envision goals for advancing even further toward attainment of our mission.

Accomplishments

Let us review our accomplishments in several areas: first, achievements in the science of addiction medicine; second, achievements in defining what it means to practice addiction medicine; third, achievements in the integration of that basic and clinical science into medical education and into the health care system.

❑ Developments in the Science: In recent years, we have demonstrated and described what characterizes addiction, through both animal and human studies, as Dr. Ting-Kai Li so clearly described in his lecture on animal models and alcoholism, and as Dr. Enoch Gordis and his colleagues presented in their symposium on the Genetics of Alcoholism during the ASAM Medical-Scientific Conference. In recent years, we have shown how addictive substances act on the reward center of the brain, the nucleus accumbens. We have learned that continued assault of the brain with addictive drugs alters brain circuitry and triggers a craving for more drugs. In short, we have shown that it is this biologically driven compulsiveness to repeatedly consume the drug, despite physical or other consequences, that characterizes addictive disorders. One of ASAM's proudest 1996 achievements in linking the science and practice of addiction medicine was its State-of-the-Art Course in Addiction Medicine, chaired by Drs. Allan Graham and Terry Schultz.

❑ Advances in Defining the Practice: The practice of addiction medicine has been a reality since physicians first recognized intoxication and its consequences and tried to intervene and treat. But it is only in the past few years that we have formally codified what constitutes the body of clinical knowledge that we call addiction medicine. The most complete description of the science and

Continued on next page

ASAM'S MISSION

At its April 1997 meeting in San Diego, the ASAM Board of Directors reaffirmed the following mission statement for the Society:

The mission of the American Society of Addiction Medicine is to:

❑ establish medical education in prevention and treatment of addictive disorders as an integral part of medical school, graduate and continuing medical education, and

❑ establish prevention and treatment of addictive disorders as a basic health benefit for all who suffer from addictive disorders (parity).

practice of addiction medicine is presented in *Principles of Addiction Medicine,* edited by Drs. Norman Miller and Martin Doot.

Further definition of the practice of addiction medicine is contained in the ASAM Practice Guidelines. Drs. Kasser Chris Kasser, Michael Mayo-Smith, and the members of the Practice Guidelines Committee recently were informed that ASAM's practice guideline on *Pharmacologic Management of Alcohol Withdrawal* has been accepted for publication in the *Journal of the American Medical Association.*

❑ Integration of Science and Practice into the Health Care System: It is one thing to have demonstrated the scientific basis of a disorder and define how that disorder may be identified and treated. It is still another thing to integrate teaching about that disorder into the medical education system, and treatment of the disorder into the health care system. Over the past five years, ASAM has made significant strides in each of the following areas.

In education and training, ASAM has published its *Guidelines for Fellowship Training Programs in Addiction Medicine*, and has established AMA policies calling for increased training in addiction medicine in each of the primary care residencies. Several ASAM members have been key actors in the ASAM-supported establishment of the subspecialty of addiction psychiatry by the ABPN, and in the formation of the subspecialty of addiction medicine by the American Osteopathic Academy of Addiction Medicine.

To date, ASAM has certified 2,939 physicians. Every ASAM-certified physician will be pleased to know that the National Committee for Quality Assurance (NCQA) revised its accreditation standards in 1997 to stipulate that managed care organizations must hire psychiatrists and/or physicians who are certified in addiction medicine to treat the addicted patient.

❑ Integration of Addiction Medicine Treatment into the Health Care System: The ultimate basis for assuring the practice and, therefore, the education, training and specialty of addiction medicine is assuring that prevention and treatment of addictive disorders are a basic health benefit. We have accomplished the following in this regard.

Several states have told ASAM that they will use the *ASAM Patient Placement Criteria*, including Connecticut, Florida, Hawaii, Illinois, Iowa, Virginia, Washington and Tennessee. All organizations doing business in these states, including all managed care companies, will be required to use the *ASAM Criteria.*

In a major breakthrough, the Department of Defense recently issued its new policy on substance abuse treatment, which will establish a continuum of care "compatible with the *Patient Placement Criteria* of the American Society of Addiction Medicine." This treatment policy will apply to all servicemen and women and their dependents in all regions of the United States, Europe and the Pacific.

In an equally significant breakthrough, the Department of Veterans Affairs recently announced its decision to incorporate the *ASAM Patient Placement Criteria* into its addiction treatment guidelines for use in the VA's 171 facilities treating over 150,000 patients worldwide. The *ASAM PPC-2* are available both in hard copy and in software, thanks to the work of Dr. David Mee-Lee and the ASAM Software Task Force, chaired by Dr. Ken Hirsch.

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MANAGED CARE NEWS

JOINT STATEMENT APPROVED BY ASAM, AMBHA

ASAM and the American Managed Behavioral Healthcare Association (AMBHA) have developed the following joint statement, which has been approved by the AMBHA membership and the ASAM Board of Directors.

Drafters of the statement were (for ASAM) Christine Kasser, M.D., David Mee-Lee, M.D., Michael M. Miller, M.D., Anthony Radcliffe, M.D., and Executive Vice President James Callahan, D.P.A., and (for AMBHA) David Nace, M.D., Gary Petersen, M.B.A., E. Clarke Ross, D.P.A., and Ian Shaffer, M.D.

Effective Treatment of Addictive Disorders: A Basis for an AMBHA - ASAM Dialogue

Sharing an interest in the delivery of high-quality, cost-effective treatments of addictive disorders, the American Managed Behavioral Healthcare Association (AMBHA) and the American Society of Addiction Medicine (ASAM) have entered into an ongoing dialogue and, as a beginning, make the following observations:

1) Substance related problems span a range from problems associated with use, misuse and addiction. Patients may present requesting care at any time during this spectrum.

2) We accept the need to match the severity of patients' disorders with appropriate interventions for that intensity of problem.

3) Some individuals experience single or isolated episodes of illness; others experience periodic recurrences in their lifetimes; others have severe and persistent addictive disorders. For some persons with addictive disorders, especially those with severe and persistent disorders, there is a need for ongoing management and periodic acute treatment interventions to appropriately respond to situations of relapse.

4) Addictive disorders are primary disorders which require their own unique and specialized treatment. Individuals with addictive disorders may also experience mental illness and may also experience primary health problems.

5) A purpose of managed behavioral health care is to deliver clinically effective and cost efficient services within the constraints of finite resources. This involves using the least intensive available treatment setting, appropriate to the needs of the patient, while maintaining patient safety. As for all chronic medical conditions, payers/purchasers of addiction services have limited resources. Effectiveness requires provider accountability for clinical outcomes that improve patients' health and provide acceptable consumer satisfaction.

6) The history of addiction expenditures is one characterized by stigma, prejudices, and biases which have led to inadequate treatment resources and a misallocation of resource use.

7) Managed behavioral health care is attempting to build organized and integrated delivery systems targeted to a population-based approach. But treatment must also be individualized and tailored to each individual's unique situation and needs.

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PRACTICE GUIDELINES

APA TO PUBLISH GUIDELINE FOR NICOTINE DEPENDENCE

The American Psychiatric Association has announced that it will publish a *Practice Guideline for the Treatment of Patients with Nicotine Dependence*. The guideline complements the advice developed by the federal Agency for Health Care Policy Research by focusing on three specific groups of smokers: (1) smokers who have failed initial treatments for smoking cessation and who need more intensive treatment; (2) smokers who are being seen by a psychiatrist for a psychiatric disorder other than nicotine dependence; and (3) psychiatric patients who smoke and who are temporarily confined to a smoke-free inpatient or residential setting. Recommendations are concrete and detailed and carry ratings from I to III based on the adequacy of the supporting data.

The guidelines recommend 10 therapies (categories I or II), classifies 11 others as promising and possibly worthy of recommendation based on individual circumstances (category III), and lists 21 others as not recommended. Evidence from studies other than randomized trials and clinical expertise are reflected in the recommendations, so that the resulting guidelines tend to recommend treatment more often and to be more specific about recommendations than other guidelines.

In treating smokers who have failed initial therapy (usually nicotine gum or patch and/or group behavior therapy), the guideline recommends assessing the adequacy of prior treatments, screening for psychiatric or addictive disorders, and trying to determine whether the relapse was due to withdrawal symptoms or psychosocial problems. Recommended therapies include combined nicotine patch and nicotine gum (II), clonidine (II), and nicotine nasal spray (II), combined with intensive, individual behavior therapy (III).

For smokers who are being treated for other psychiatric disorders, the guideline recommends incorporating smoking cessation into all treatment plans (I), motivating patients to stop smoking during noncrisis periods (I), and providing initial therapy (I). It also recommends that physicians closely monitor those patients who do stop smoking to detect any remission in psychiatric disorders or changes in blood levels of medications (II).

For patients on smoke-free medical or residential units, the guideline recommends clear instructions about nonsmoking policies, advice to stop smoking, and education about management of withdrawal (III). It also recommends behavioral strategies (III) and use of nicotine gum or patch (II) to reduce withdrawal symptoms.

The approximately 40-page guideline will be published as a supplement to the October issue of the *American Journal of Psychiatry* and can be obtained from the American Psychiatric Press by calling 1/800-368-5777.

APA Guideline on Recommended Treatments for Nicotine Dependence

Psychosocial Therapies	Somatic Therapies
Multicomponent behavior therapy (I)	Nicotine gum (I)
– Skills training/relapse prevention (II)	Transdermal nicotine (I)
– Stimulus control (II)	Nicotine gum or transdermal nicotine plus behavior therapy (I)
– Rapid smoking (II)	Clonidine (II)
Self-help materials (II)	Nicotine nasal spray (II)

Managed Care News –Continued from page 3

8) To successfully assess and treat individuals with addictive disorders, providers must possess a core set of knowledge and experience. There are multiple and many professional providers of addiction services; each must demonstrate that he/she individually possesses a core set of knowledge and experience. AMBHA and ASAM have a shared interest in articulating what a minimum and standardized set of knowledge and experience should be.

9) All providers should deliver treatment that is effective, efficient, and has value. This will require sophisticated screening, assessing and tracking systems for measurement of outcomes and agreement on common screening tools, diagnostic criteria and nomenclature. There is increasing awareness that health plans, networks and individual providers must be more publicly accountable for the clinical outcomes they deliver.

10) Quality should be measured. Standardized data sets, including administrative, clinical, and performance, should be developed. AMBHA and ASAM will strive to articulate possible data set guidelines. AMBHA and ASAM share the goal of seeing that guidelines are produced to oversee the development, articulation and application of data sets and data accumulation processes.

MONEY FOR TREATMENT

Marc Galanter, M.D., FASAM

You don't have to look far in the daily press or at your own practice to know that American medical care is in a state of crisis. Attempts to cut back on rising medical costs have led to a topsy-turvy system in which corporate entities are doing battle for the money that should be going for treatment.

Nowhere is this more apparent than in the field of addiction medicine. What we need to do in ASAM--and what I emphasized as our primary goal in my candidacy statement--is to assure that our patients are provided with the insurance coverage necessary to underwrite their needed care. This is a real battle for out patients' welfare, and ASAM is involved in many activities to promote this cause. We must now keep our current efforts focused on this issue, and move on to secure the practice of addiction medicine. The ASAM Board of Directors will be meeting this October and will review information on this issue, in order to ascertain how we can best fight this battle for our members and their patients.

ASAM already has articulated this issue in the policy on Core Benefits for Addiction Treatment, which says that "no limits on numbers of treatment visits, days, or payments shall be applied, in the same manner as with any chronic disease."

Here are some relevant points:

❑ Health maintenance organizations and managed care plans have starved out coverage for all but the most acute and life-threatening consequences of addiction and, in some cases, even those. Rehabilitation and recovery are hardly supported at all. Our ASAM Patient Placement Criteria are directed at defining appropriate levels of care, and have achieved wide acceptance, including adoption by seven states and the Department of Defense, as well as some insurers. We need to develop further our strategies to assure that the ASAM Criteria are applied so that all needed care is recognized as a medical necessity, not just the patients who are at death's door.

❑ ASAM has strong ties to a number of organizations with which we have collaborated to extend coverage for treatment. In order to enhance our influence, we will turn to these groups and extend our cooperation with them. For example, we will need to use our role in the American Medical Association, which already has demonstrated value in securing the identification of our specialty area. We will work with the National Council on Alcoholism and Other Drug Dependencies, whose Committee on Benefits is formulating an approach to assuring appropriate benefits for treatment. The National Institute on Drug Abuse, the National Institute on Alcohol Abuse and Alcoholism, and the Center for Substance Abuse Treatment are valuable allies as well in providing research-based support to validate current and emerging treatment options.

❑ ASAM will focus on organizations representing managed care and HMOs to make our needs clear. These include the National Council for Quality Assessment, a group that is developing standardized criteria for evaluating coverage by managed care providers, and the American Managed Behavioral Healthcare Association, an industry organization for managed care, with which we have engaged in active discussions regarding the need for better coverage (see the related story on page 15).

❑ Another major consideration is the possibility of providing relevant case material for attorneys who are formulating class action suits on behalf of patients whose poor

treatment is the result of inadequate coverage. Some of these suits are already under way, aided by other organizations. The remarkable success of class action suits in changing the course of the country's relationship with nicotine addiction suggests that this may be a valuable and even promising avenue for us to pursue.

I look forward to bringing you periodic updates on this issue of vital interest to us all, on the efforts we undertake, and on what results we have achieved. I want to express deep appreciation for the opportunity you have given me to participate in ASAM's leadership, and look forward to a highly productive collaboration with you, the members; with our President, Doug Talbott; with our highly successful immediate Past President, David Smith; and with the other officers of the Society.

1998 ASAM CERTIFICATION EXAM ANNOUNCED

The next Certification/Recertification Examination for physicians in addiction medicine is to be offered Saturday, November 21, 1988, at three sites: Atlanta, GA; Newark, NJ; and Los Angeles, CA.

Physicians who wish to sit for the examination must complete and submit an application. Applications will be available by July 1997, and will be sent automatically to all ASAM members. Completed applications will be accepted on the following schedule: Early Registration, through Friday, October 31, 1997; Standard Registration, through Friday, January 30, 1998; Late Registration, through Thursday, April 30, 1998. All applications will be reviewed and candidates notified by mail as to whether they qualify to sit for the examination.

Physicians who pass the examination become ASAM Certified/Recertified in Addiction Medicine. Since the examinations first were offered in 1986, 2,939 physicians have passed the examination, including many of the nation's top addiction treatment professionals.

For more information on ASAM Certification and the examination, contact John Keister at the ASAM office.

ASAM CONVENES 28TH ANNUAL MEDICAL-SCIENTIFIC CONFERENCE IN SAN DIEGO

ASAM's 28th Annual Medical Scientific Conference convened April 17-20 in San Diego, CA. More than 700 physicians and guests participated in the program of scientific symposia, clinical courses and workshops, as well as special sessions sponsored by the National Institute on Alcohol Abuse and Alcoholism and the National Institute on Drug Abuse. The Medical-Scientific Conference was preceded by the Ruth Fox Course for Physicians, the ASAM Forum on AIDS and Addictions, and the ASAM Computer and Online Course.

Forum on AIDS and Addictions

ASAM's first annual Forum on AIDS and Addictions provided participants with up-to-date information on current and future research into HIV infection and AIDS, reviewed the efficacy of complementary treatments for HIV/AIDS and addictions, and offered a special focus on the needs of HIV/AIDS-affected women and adolescents. Chaired by Mel Pohl, M.D., the Forum's faculty included Andrea Barthwell, M.D., Brenda Chabon, Ph.D., Harry Haverkos, M.D., Don Des Jarlais, M.D., Mark Katz, M.D., Harold Kessler, M.D., and Larry Siegal, M.D.

Ruth Fox Course for Physicians

Speakers during the Ruth Fox Course, which is dedicated to the founding President of ASAM, provided information on new directions and concepts in clinical practice and updates on selected areas of research. Chaired by Alan A. Wartenberg, M.D., the 1997 Ruth Fox Course was co-sponsored by the American Osteopathic Academy of Addiction Medicine. Topics included a "Review of Recent Advances in the Alcohol and Drug Fields" by Marc Schuckit, M.D.; "Hot Topics in Opioid Detoxification/Maintenance Treatments" by Richard Schottenfeld, M.D.; "Treatment of Pain and Addiction" by Karen Lea Sees, D.O.; "Forensic Considerations in Addiction Medicine" by William Vilensky, D.O.; "Spirituality and Recovery" by Garrett J. O'Connor, M.D.; "Taking the 'Duel' Out of Dual Diagnosis" by Daniel E. Wolf, D.O.; "Adolescent Substance Abuse" by Anthony Dekker, D.O.; and "Max's Moments" by Max Weisman, M.D.

Awards Dinner

The R. Brinkley Smithers Distinguished Scientist Award was presented to Ting-Kai Li, M.D., Distinguished Professor of Medicine and Biochemistry, Indiana University School of Medicine. Awards also were presented to George D. Lundberg, M.D., Editor-in-Chief of the *Journal of the American Medical Association*, and to ASAM Past President Maxwell N. Weisman, former head of the Alcoholism Control Commission of the Maryland Department of Health and Mental Hygiene. The Young Investigator Award was presented to Pamela Bean, Ph.D. and David M. Gudeman, M.D.

Certificates of recognition also were presented to 108 ASAM Fellows, as well as to physicians who passed the 1996 Certification/Recertification Examination and those who passed the MRO Examination.

ASAM BOARD APPROVES NEW LOGO

At its April meeting, the ASAM Board of Directors approved a new logo design proposed by the Membership Committee. The logo reflects ASAM's status within mainstream medicine as the national medical specialty society for addiction medicine. Following a transition period, the new logo will be displayed on all ASAM products, including *ASAM News* and other publications, letterhead, and the Web site.

ASAM WEB SITE

If you've not browsed our site on the World Wide Web lately, be sure to drop by http://www.asam.org. Our new and improved site gives you access to general information about ASAM and ASAM certification, text only versions of the *Journal of Addictive Diseases and ASAM News*, order forms for ASAM publications and staff E-mail.

COMPUTER AND ONLINE COURSE

Thomas L. Haynes, M.D., FASAM

The second annual Computer and Online Course was divided into two sessions. The morning session, which was for beginning computer users, addressed the elements of hardware and software, how to purchase a computer, what types of software are commonly used by physicians, and an introduction to online services and the Internet. The afternoon session addressed more advanced topics, such as more in-depth knowledge of the Internet and its components (especially the World Wide Web), how to design a Web page, telemedicine, networking the medical office, and issues of privacy and confidentiality, as well as virus protection.

Both PC and Macintosh equipment were used to demonstrate the material, and the presentation equipment included a projection system that could be switched between two computers for quick comparisons and illustrations of the topics being discussed. This was a distinct improvement over the setup used last year. This year's faculty included course director Stuart Gitlow, M.D., Thomas L. Haynes, M.D., FASAM, Elizabeth F. Howell, M.D., and Peter E. Mezciems, M.D., FASAM.

The Communications Committee met immediately after the course to review the feedback that we received from the approximately 70 participants, and to map out the structure and content of the 1998 course. Be sure not to miss it, because it promises to be another good one!

AWARDS DINNER RECEIVES GREETINGS FROM NATIONAL DRUG POLICY DIRECTOR

Gen. Barry R. McCaffrey, Director of the Office of National Drug Control Policy, sent the following message to ASAM at the Awards Dinner during the Medical-Scientific Conference:

"The *1997 National Drug Control Strategy*...organizes a collective American effort to achieve a common purpose and provides general guidance and specific direction for more than 50 federal agencies involved in the struggle against illegal drugs and substance abuse. This *Strategy* also offers a common framework to state and local government agencies, to educators and health care professionals, to law enforcement officials and community coalition groups, parents, religious organizations, mass media and American business to build a unified American counterdrug effort. The common purpose of that collective effort is to reduce illegal drug use and its consequences in America....

"The *1997 Strategy* sets forth five strategic goals, intended to ensure that the message of the *Strategy* is unambiguous and that our commitment is clear. These goals clearly underscore our central purpose and mission--reducing illicit drug use and its consequences. Further, these goals acknowledge that anti-drug efforts do not occur in isolation and must be long-term and global in focus. Our efforts must be linked with companion efforts to curb the use of alcohol and tobacco by those who are under age. We fully recognize the need for prevention programs to deter first-time drug use among adolescents and other high-risk populations and to reduce the progression from casual use to addiction. Additionally, the goals reflect the need for law enforcement to remove violent and predatory criminals, and to arrest, prosecute, and dismantle criminal drug networks at home and abroad.

"The goals demonstrate the importance of providing treatment to those who use drugs and need help stopping. Finally, they aim to reduce the supply of drugs to the U.S. through coordinated domestic and comprehensive international programs....

"Our country's drug problem cannot be solved overnight. Our task must be to break the cycle of addiction so that we can significantly reduce both illicit drug use and its consequences....

"The *Strategy's* goals and objectives require a long-term commitment to help ensure that resources are brought to bear against the drug problem in the most efficient way. The focus must be on working hard, over a sufficient span of time, to properly develop and implement programs....

"I am honored to have been invited to address the American Society of Addiction Medicine. I look forward to the next opportunity to be a part of your organization's anti-drug efforts. Your contributions twoard meeting the substance abuse challenge are important to our nation and our society."

Meeting to discuss future collaborative efforts between ASAM and ONDCP are (left to right) ASAM EVP Dr. James Callahan, ASAM President Doug Talbott, M.D., ONDCP Director Gen. Barry McCaffrey, and ASAM member Tom Kosten, M.D.

Dr. Talbott – Continued from page 1

sions with some national foundations and universities, in which we explored the possibility of creating a consortium of universities to approach the national foundations for a three-year grant to fund five residencies in addiction medicine at each university. We are approaching this carefully, to be certain that all the pieces are in place before we approach the foundations. A number of ASAM members are contributing their time and expertise to this effort.

When I helped to organize and chaired the first Kroc Ranch meeting, our objective was to bring together the disparate organizations that both directly and indirectly touched on the then-infant field of addiction medicine. I truly believed then, as I do now, that addiction medicine needs to work in partnership with psychiatry, each respecting the other's boundaries. I believed then, as I do now, that we need to be related and to relate to the disciplines of family practice, internal medicine, preventive medicine, emergency medicine, and more. Addiction medicine has much to learn from each of these specialties.

In a second area of effort, we must progress in obtaining independent funding of all of ASAM's projects. This must be done to avoid the razor-edge budgeting we now must practice in our central office. A group of ASAM's officers are being convened to explore these basic problems.

A third major theme I want to pursue in my presidency is suggested by Dr. David Smith's remark in his farewell address that "there is a light at the end of the tunnel, but the tunnel seems to be getting longer." I believe that we can and will make the journey to the end of that tunnel, but to do so we need to infuse young and energetic new members throughout the organization. I believe our Board of Directors should make a deliberate effort to engage young ASAM members in leadership roles wherever possible.

There are daunting problems on the horizon. They include the fight for parity, discrimination against our recovering brothers and sisters, winning acceptance for the Patient Placement Criteria, and the creation of addiction medicine residencies and CAQs. Many of these problems seem to resist solution, but I believe that we can accomplish our goals. We in ASAM have the talent, the energy, and the experience to do this. Impossible dreams do come true.

EVP Report – Continued from page 3

Another significant advance in integrating addiction treatment into health care has been the establishment of a joint ASAM-AMBHA workgroup. AMBHA, the American Managed Behavioral Healthcare Association, represents 19 major behavioral healthcare organizations that collectively cover 120 million lives. AMBHA has agreed to issue four papers with ASAM on: (1) Parity in Benefit Design, (2) Treatment Protocols, (3) Treatment Outcome Measures, and (4) Credentialing of Providers of Addiction Services. If successful, the dialogue between ASAM and AMBHA can open doors that have long been closed to our patients and our members, so that our patients will receive appropriate treatment, and our members will be given credentials to provide treatment. ASAM members who are working with AMBHA are Drs. Christine Kasser, David Mee-Lee, Michael Miller, and Tony Radcliffe.

Another significant advance in assuring addiction treatment is the dialogue that Drs. David Smith and Doug Talbott have undertaken with the White House. Dr. David Smith and I had the pleasure of an extended meeting with General Barry McCaffrey, where we briefed him on ASAM's work, including the development of our state chapters. In addition, Dr. Talbott and I have had an opportunity to meet President Clinton and give him greetings from ASAM.

Goals: 1997 - 2002

I have spoken of our mission and our accomplishments in pursuit of our mission. I presented our accomplishments as evidence that our mission is true and realizable, even in the painful times iny which we now live. Before closing, I want to say a word about our goals, which I present to you both as further evidence that our mission is attainable, and as evidence of our continued resolve to achieve our mission. We have much work to do.

❑ State Chapter - National ASAM Partnership: The next five years will be characterized by a partnership between state chapters and the national ASAM organization. To strengthen our chapters, Dr. Earley and the State Chapters presidents will continue their excellent work in increasing state and national membership. Last year, 90 percent of our members renewed their membership, and the number of new members increased by 50 percent. At the national level, ASAM will form a close working relationship with the National Association of State Alcohol and Drug Abuse Directors (NASADAD) and continue its collaboration with NCQA, AMBHA and other national associations. We will work closely with the White House, the Institutes and CSAT, and with Congress to the extent that our charter allows. We also will seek monies to fund the Parity Advisory Board, to be chaired by Senator George McGovern.

❑ Parity: Our goal is to establish the *ASAM Patient Placement Criteria* as the national guideline governing decisions on need for treatment and level of treatment. We have begun work on a third edition which will include guidelines for dual diagnosis and an update of the adolescent guidelines. We also will produce an algorithm software version. Our goal is to have each state chapter work with the governor's office or the director of the state agency responsible for addiction treatment to assure the use of the *ASAM PPC-2*. We will encourage our chapters to work with their state medical societies and state legislatures to pass laws mandating parity for addiction treatment.

❑ Specialty: To promote recognition of the specialty of addiction medicine, we will work with each specialty to increase the teaching of addiction medicine in residencies and establish accredited residencies in addiction medicine. Dr. Talbott has committed himself to raising the monies necessary to establish training. Dr. Sid Schnoll has agreed to chair the ASAM workgroup on accredited training.

We will publish a second edition of *Principles of Addiction Medicine,* with Drs. Allan Graham and Terry Schultz as Co-Editors, and Dr. Chris Kasser's committee will continue to publish practice guidelines.

❑ Prevention of Tobacco Use: I would be remiss if I failed to mention a special achievement and an ongoing goal to which ASAM, in the persons of Dr. John Slade and the members of the Nicotine Dependence Committee, has made a significant contribution. I am speaking, of course, of the recent advances in the prevention of tobacco use, especially among young people.

ASAM's members include many who are giants in the field of addiction medicine prevention, research, treatment, education, training and public policy. Scarcely a week goes by when I do not receive a call or letter from John suggesting that he take action in ASAM's name to prevent or reduce the use of tobacco or to increasingly eliminate its harmful contents. Dr. Slade played a major role in the disclosure of tobacco industry documents and in helping to formulate the FDA regulations on advertising and marketing.

Conclusion

ASAM has and will continue to commit itself to the only goal which will one day give addiction medicine both its rightful place at the table of medical specialties, and provide the scientific and clinical content from which general medical education can draw. That goal and that mission is to define the specialty through defining the practice, and through assuring its integration into all medical education and health care.

Jess Bromley, M.D., Elected Emeritus Member

Long-time ASAM member Jess Bromley, M.D., was elected an Emeritus Member during the April Board meeting, in recognition of his outstanding service to the organization as Delegate to the American Medical Association. Dr. Bromley currently is Delegate Emeritus and serves as Parliamentarian to the Board of Directors.

Emeritus status is bestowed by vote of the Board of Directors to recognize the accomplishments of senior members who have been ASAM members for at least 15 years, are at least 65 years old, and are retiring or retired from the practice of addiction medicine. Emeritus members have their membership dues waived and receive complimentary subscription to *ASAM News* and the society's *Journal of Addictive Diseases*. Nomination forms are available from the ASAM Membership Department at 301/656-3920.

ALCOHOL ALERT

National Institute on Alcohol Abuse and Alcoholism No. 35 PH 371 January 1997

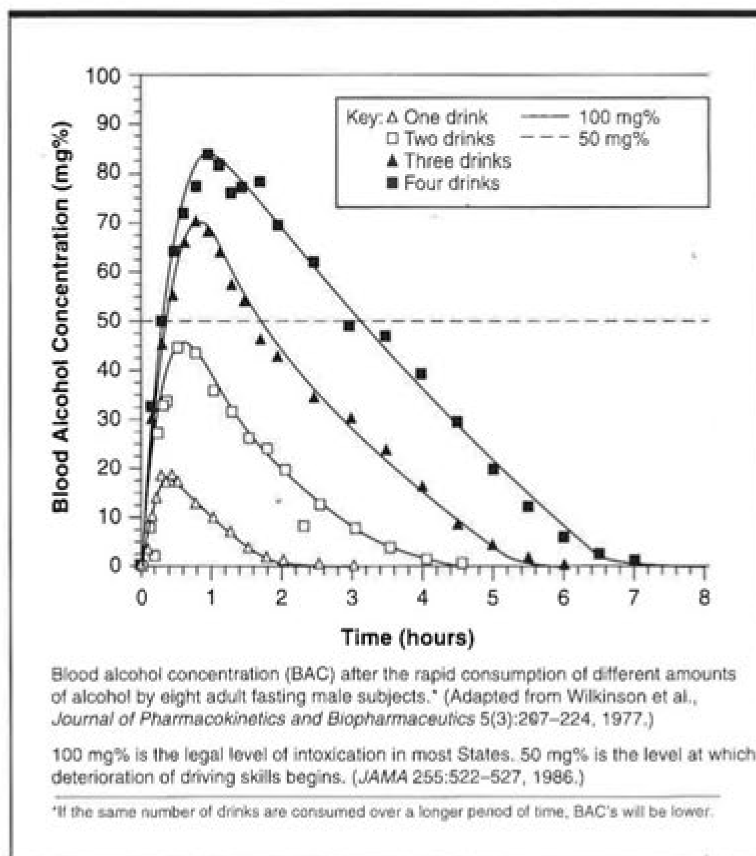
Alcohol Metabolism

Metabolism is the body's process of converting ingested substances to other compounds. Metabolism results in some substances becoming more, and some less, toxic than those originally ingested. Metabolism involves a number of processes, one of which is referred to as oxidation. Through oxidation, alcohol is detoxified and removed from the blood, preventing the alcohol from accumulating and destroying cells and organs. A minute amount of alcohol escapes metabolism and is excreted unchanged in the breath and in urine. Until all the alcohol consumed has been metabolized, it is distributed throughout the body, affecting the brain and other tissues (1,2). As this *Alcohol Alert* explains, by understanding alcohol metabolism, we can learn how the body can dispose of alcohol and discern some of the factors that influence this process. Studying alcohol metabolism also can help us to understand how this process influences the metabolism of food, hormones, and medications.

Alcohol Alert, *a publication of the National Institute on Alcohol Abuse and Alcoholism, provides timely information on alcohol research and treatment to health professionals and other interested people. This issue is the thirty-fifth in the series.*

The Metabolic Process

When alcohol is consumed, it passes from the stomach and intestines into the blood, a process referred to as absorption. Alcohol is then metabolized by enzymes, which are body chemicals that break down other chemicals. In the liver, an enzyme called alcohol dehydrogenase (ADH) mediates the conversion of alcohol to acetaldehyde. Acetaldehyde is rapidly converted to acetate by other enzymes and is eventually metabolized to carbon dioxide and water. Alcohol also is metabolized in the liver by the enzyme cytochrome P450IIE1 (CYP2E1), which may be increased after chronic drinking (3). Most of the alcohol consumed is metabolized in the liver, but the small quantity that remains unmetabolized permits alcohol concentration to be measured in breath and urine.



Blood alcohol concentration (BAC) after the rapid consumption of different amounts of alcohol by eight adult fasting male subjects.* (Adapted from Wilkinson et al., *Journal of Pharmacokinetics and Biopharmaceutics* 5(3):207–224, 1977.)

100 mg% is the legal level of intoxication in most States. 50 mg% is the level at which deterioration of driving skills begins. (*JAMA* 255:522–527, 1986.)

*If the same number of drinks are consumed over a longer period of time, BAC's will be lower.

The liver can metabolize only a certain amount of alcohol per hour, regardless of the amount that has been consumed. The rate of alcohol metabolism depends, in part, on the amount of metabolizing enzymes in the liver, which varies among individuals and appears to have genetic determinants (1,4). In general, after the consumption of

A Commentary by NIAAA Director Enoch Gordis, M.D. 3

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Public Health Service • National Institutes of Health

one standard drink, the amount of alcohol in the drinker's blood (blood alcohol concentration, or BAC) peaks within 30 to 45 minutes. (A standard drink is defined as 12 ounces of beer, 5 ounces of wine, or 1.5 ounces of 80-proof distilled spirits, all of which contain the same amount of alcohol.) The BAC curve, shown on the previous page, provides an estimate of the time needed to absorb and metabolize different amounts of alcohol (5). Alcohol is metabolized more slowly than it is absorbed. Since the metabolism of alcohol is slow, consumption needs to be controlled to prevent accumulation in the body and intoxication.

Factors Influencing Alcohol Absorption and Metabolism

Food. A number of factors influence the absorption process, including the presence of food and the type of food in the gastrointestinal tract when alcohol is consumed (2,6). The rate at which alcohol is absorbed depends on how quickly the stomach empties its contents into the intestine. The higher the dietary fat content, the more time this emptying will require and the longer the process of absorption will take. One study found that subjects who drank alcohol after a meal that included fat, protein, and carbohydrates absorbed the alcohol about three times more slowly than when they consumed alcohol on an empty stomach (7).

Gender. Women absorb and metabolize alcohol differently from men. They have higher BAC's after consuming the same amount of alcohol as men and are more susceptible to alcoholic liver disease, heart muscle damage (8), and brain damage (9). The difference in BAC's between women and men has been attributed to women's smaller amount of body water, likened to dropping the same amount of alcohol into a smaller pail of water (10). An additional factor contributing to the difference in BAC's may be that women have lower activity of the alcohol metabolizing enzyme ADH in the stomach, causing a larger proportion of the ingested alcohol to reach the blood. The combination of these factors may render women more vulnerable than men to alcohol-induced liver and heart damage (11–16).

Because women metabolize alcohol differently from men, women may be more vulnerable to liver and heart damage.

Effects of Alcohol Metabolism

Body Weight. Although alcohol has a relatively high caloric value, 7.1 Calories per gram (as a point of reference, 1 gram of carbohydrate contains 4.5 Calories, and 1 gram of fat contains 9 Calories), alcohol consumption does not necessarily result in increased body weight. An analysis of data collected from the first National Health and Nutrition Examination Survey (NHANES I) found that although drinkers had significantly higher intakes of total calories than nondrinkers, drinkers were not more obese than nondrinkers. In fact, women drinkers had significantly lower body weight than nondrinkers. As alcohol intake among men increased, their body weight decreased (17). An analysis of data from the second National Health and Nutrition Examination Survey (NHANES II) and other large national studies found similar results for women (18), although the relationship between drinking and body weight for men is inconsistent. Although moderate doses of alcohol added to the diets of lean men and women do not seem to lead to weight gain, some studies have reported weight gain when alcohol is added to the diets of overweight persons (19,20).

Alcohol may lead to further weight gain in persons who are already overweight.

When chronic heavy drinkers substitute alcohol for carbohydrates in their diets, they lose weight and weigh less than their nondrinking counterparts (21,22). Furthermore, when chronic heavy drinkers add alcohol to an otherwise normal diet, they do not gain weight (21).

Sex Hormones. Alcohol metabolism alters the balance of reproductive hormones in men and women (23–28). In men, alcohol metabolism contributes to testicular injury and impairs testosterone synthesis and sperm production (24,29). In a study of normal healthy men who received 220 grams of alcohol daily for 4 weeks, testosterone levels declined after only 5 days and continued to fall throughout the study period (30,31). Prolonged testosterone deficiency may contribute to feminization in males, for example, breast enlargement (32). In addition, alcohol may interfere with normal sperm structure and movement by inhibiting the metabolism of vitamin A, which is essential for sperm development (30,33). In women, alcohol metabolism may contribute to increased production of a form of estrogen called estradiol (which contributes to increased bone density and reduced risk of coronary artery disease) and to decreased estradiol metabolism, resulting in elevated estradiol levels (28). One research review indicates that estradiol levels increased in *premenopausal* women who consumed slightly more than enough alcohol to reach the legal limit of alcohol (BAC of

Alcohol metabolism affects male and female reproductive hormones.

0.10 percent) acutely (28). A study of the effect of alcohol on estradiol levels in *post-menopausal* women found that in women wearing estradiol skin patches, acute alcohol consumption significantly elevated estradiol levels over the short term (34).'

Medications. Chronic heavy drinking appears to activate the enzyme CYP2E1, which may be responsible for transforming the over-the-counter pain reliever acetaminophen (Tylenol™ and many others) into chemicals that can cause liver damage, even when acetaminophen is taken in standard therapeutic doses (3,35,36). A review of studies of liver damage resulting from acetaminophen-alcohol interaction reported that in alcoholics, these effects may occur with as little as 2.6 grams of acetaminophen (four to five "extra-strength" pills) taken over the course of the day in persons consuming varying amounts of alcohol (35,37). The damage caused by alcohol-acetaminophen interaction is more likely to occur when acetaminophen is taken after, rather than before, the alcohol has been metabolized. Alcohol consumption affects the metabolism of a wide variety of other medications, increasing the activity of some and diminishing the activity, thereby decreasing the effectiveness, of others (35).

Medications may be rendered harmful or ineffective as a result of alcohol metabolism.

Alcohol Metabolism—A Commentary by NIAAA Director Enoch Gordis, M.D.

The study of metabolism has both practical and broader scientific implications. On the practical side, information on how the body metabolizes alcohol permits us to calculate, for example, what our blood alcohol concentration (BAC) is likely to be after drinking, including the impact of food and gender differences in the rate of alcohol metabolism on BAC. This information, of course, is important when participating in activities for which concentration is needed, such as driving or operating dangerous machinery.

With respect to its broader scientific application, metabolism, which has long been studied, is emerging with new implications for the study of alcoholism and its medical consequences. For instance, how is metabolism related to the resistance of some individuals to alcoholism? We know that some inherited abnormalities in metabolism (e.g., flushing reaction among some persons of Asian descent) promote resistance to alcoholism. Recent data from two large-scale NIAAA-supported genetics studies suggest that alcohol dehydrogenase genes may be associated with differential resistance and vulnerability to alcohol. These findings are important to the study of why some people develop alcoholism and others do not. Studies of metabolism also can identify alternate paths of alcohol metabolism, which may help explain how alcohol speeds up the elimination of some substances (e.g., barbiturates) and increases the toxicity of others (e.g., acetaminophen). This information will help health care providers in advising patients on alcohol-drug interactions that may decrease the effectiveness of some therapeutic medications or render others harmful.

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NEW COMMITTEE ENCOURAGES STUDENT, RESIDENT INVOLVEMENT

A small but enthusiastic group of medical students, residents, and guests participated in the first-ever teleconference of ASAM's Members-in-Training Committee. Participants in the March meeting included Sara Babai (student); Chris Delos Reyes, M.D. (resident and Committee Chair); Mike Patterson, M.D. (resident); and Lauren Walton, M.D. (resident). Joining the call as quests were V'Anne Singleton, Training Coordinator for the "Summer Institute for Medical Students" at the Betty Ford Center in Rancho Mirage, CA, and Dr. Antoinette Graham, Associate Professor of Family Medicine and Director of the HELP Program at Case Western Reserve University in Cleveland, OH.

Discussion centered around four main topics: (1) increasing communication among current student/resident members of ASAM; (2) increasing the visibility of ASAM to students/residents who have an interest in addiction medicine but are not yet ASAM members; (3) encouraging student and resident involvement in the American Medical Association; and (4) developing a campaign to link ASAM members-in-practice with trainees.

Of ASAM's 3200 members, approximately 150 are students or residents. Suggestions for increasing communication among current ASAM student/residents included: a "Members-in-Training Column" in each issue of *ASAM News* and an e-mail directory of student and resident members.

The following ideas were suggested as means to engage the interest of medical students and residents who have an interest in addiction medicine but who are not yet ASAM members:

- ❑ Writing to the Deans of medical schools to introduce ASAM, and to ask the Deans to forward information on ASAM to their Departments Of Psychiatry, Family Practice, Family Practice, and/or Internal Medicine.
- ❑ Networking with larger student and resident organizations to spread the word about ASAM (e.g., American Medical Association, American Medical Student Association, National Association of Residents and Interns, etc.);
- ❑ Writing letters-to-the-editor and/or articles for medical student/resident magazines such as *The New Physician* and *Resident & Staff Physician*;
- ❑ Distributing ASAM materials to students and residents participating in addiction medicine programs or fellowships (such as those at the Betty Ford Center Summer Institute).

The Members-in-Training Committee is one forum in ASAM that encourages student and resident involvement in the American Medical Association. Students and residents, who are interested in learning about and creating national AMA health policy, are invited to represent ASAM as a Delegate or Alternate Delegate at the June and December Assembly meetings of the AMA. Delegates and Alternate Delegates must be AMA members and are appointed by the ASAM Board of Directors based on a curriculum vitae and a statement of interest.

Finally, participants in the conference call discussed a strategy to join ASAM members-in-practice with members-in-training. Too often, students and residents are confronted with negative attitudes and therapeutic pessimism regarding patients with alcoholism and other drug addictions. An ASAM member may be the only person to expose trainees to effective addictions treatment and the possibility of long-term recovery.

Participants in the "Sponsor-a-Student/Recognize-a-Resident" Campaign would provide mentoring and financial support to trainees (e.g., pay for one year of membership dues for the trainee).

In return, sponsors would receive recognition in *ASAM News* and additional benefits (i.e. discounts on conferences, publications, etc.). Efforts to gain and retain student and resident members are crucial to ASAM's future as an organization, as the trainees of today will be the leaders of ASAM and the "voice of addiction medicine" in the 21st century.

Individuals interested in participating in the Members-in-Training Committee are encouraged to contact Theresa McAuliffe at the ASAM office (phone: 301/656-3920, ext. 108; E-mail: tmcau@asam.org) or Chris Delos Reyes, M.D. at 10007 Parkview Ave, Garfield Heights, OH 44125; E-mail: chris.delosreyes@uhhs.com.

Haymarket Center

presents

The Third Annual Summer Institute on Addiction

at

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June 23-25, 1997

Presentations include:

Domestic Violence, Child Development, Case Management, Methamphetamines and Violence, Nutrition, Anger and Addiction, Adolescent Treatment, Criminal Justice, Spirituality, Dual Diagnosis, Co-Dependency, Prostitution, and Stress Management. Keynote speakers include David E. Smith, M.D., FASAM, the founder and Executive Editor of the Journal of Psychoactive Drugs, and the Immediate Past President of the American Society of Addiction Medicine, speaking on "Current Trends in Addiction," Earnie Larsen, M.R.E., M.S., author of "Stage 2 Recovery: Life Beyond Addiction," and Ron Potter-Efron, M.S.W., Ph.D., CADCIII, author of "Anger, Alcoholism and Addiction: Treating Individuals, Couples and Families."

For more information or to rent an exhibit table for your agency, please contact Mary Jane Miller at Haymarket Center (312) 226-7984, ext. 378.

California

Chapter President:
William S. Brostoff, M.D., FASAM
Regional Director: Gail Shultz, M.D.

President William Brostoff, M.D., is representing CSAM on a California Medical Association Technical Advisory Committee on Medical Marijuana. ASAM Immediate Past President David Smith, M.D., also is a member of the committee. A CSAM Task Force on the same subject is drafting a White Paper.

CSAM's 1997 survey of members asked "What is the one most important thing this state chapter can accomplish for its members in the next 12 months?" Answers included: "Helping physicians measure quality in their workplace so that we may truly measure the effect of managed care (good or bad)!" "Upholding standards of practice in addiction medicine." "Promote the position that physician leadership is necessary in creating and maintaining acceptable quality in our treatment programs." "Set standards for what quality chemical dependency treatment should cost." "Validate modalities of therapy so that inpatient admission, where justified, is accepted." "Educate residents." "Refocus awareness of chemical dependence issues to the public." "Work toward a credible means of converting currently antidrug, punitive government policy to one of identifying problems, education and treatment." "We need to advocate for our patients. Very few people have coverage for treatment for chemical dependency."

Florida

Chapter President: Richard Keesal, M.D.
Regional Director: Rick Beach, M.D.

FSAM and ASAM jointly sponsored the 10th Annual Conference on Addictions in January at Walt Disney World Village. ASAM guest speaker Andrea Barthwell, M.D., addressed "Cultural Issues to be Considered in Treatment of the Chemically Impaired." Other speakers included Richard J. Bagby, M.D., President of the Florida Medical Association, on "Directions in Managed Care" as it relates to the treatment of our special population of patients. FSAM members Ronald Catanzaro, M.D., John Eustace, M.D., Michael Newberry, M.D., and Vineet Mehta, M.D., discussed treatment modality issues in spirituality, pain management, and working with the challenging patient. The conference ended with a special guest presentation on "Sexually Compulsive Behaviors" by Bonnie Saks, M.D., Psychiatrist and Fellow of the American Psychiatric Association, and Associate Professor at the University of South Florida and Founding Fellow American Academy of Clinical Sexologists.

The Florida chapter elected the following new officers to two-year terms: Richard Keesal, M.D., President; John Eustace, M.D., President-Elect; Michael Newberry, M.D., Treasurer; Paul T. Nakule, M.D., Secretary; Marilyn C. Moss, M.D., Immediate Past President; Vineet Mehta, M.D., Chair, Scientific Planning Committee; and Kenneth W. Thompson, M.D., Legislative Representative.

The chapter holds its annual meeting and conference each January in Orlando, and invites members of other chapters to join them. Breakout sessions will be provided for other state groups. Information is available from Robert Donofrio at the FSAM office, 904/484-3560.

FSAM continues to work to have the ASAM MRO certification approved under new Florida state law. (Chapter leaders were assured that this would happen when the law was adopted in 1996, but ASAM was omitted from the list of approved MRO certifications.)

Hawaii

Chapter President:
Gerald McKenna, M.D., FASAM
Regional Director:
Richard Tremblay, M.D., FASAM

HISAM jointly sponsored a two-day meeting in Honolulu in January, to provide an update on addiction issues for primary care physicians. This annual medical track meeting is part of the Pacific Institute of Chemical Dependence Annual Meeting. ASAM members from around the state presented.

HISAM plans to repeat the conference in January 1998. To allow more physicians to attend, the 1998 meeting will be scheduled for a Friday and Saturday. A preliminary agenda will be available by summer, enabling mainland members to attend.

Illinois

Chapter President:
Martin Doot, M.D., FASAM
Regional Director:
Norman Miller, M.D., FASAM

ISAM and the National Institute on Drug Abuse will co-sponsor a Town Meeting on Addictions May 30 at the Hyatt Regency Chicago. The chapter's next Annual Meeting has been scheduled for November 21-22, 1997, at the Radison Hotel in Rosemont, IL. Additional information is available from Hermese Bryant by phone at 630/968-6477 or via Fax at 630/968-5744.

Maryland

Chapter President: John Steinberg, M.D.
Regional Director:
Paul H. Earley, M.D., FASAM

The Maryland Chapter has scheduled a July 12, 1997, CME conference on "The Return to Work: Impaired Health Professionals." A chapter business meeting will follow. Registration information is available from the ASAM Office.

Michigan

Chapter President:
Thomas L. Haynes, M.D., FASAM
Regional Director:
Norman Miller, M.D., FASAM

The Michigan chapter will hold election of officers in July 1997.

Missouri

Chapter Representative: Winston Shen, M.D.
Regional Director: Ken Roy, M.D., FASAM

Jack L. Croughan, M.D., an ASAM member and Director of the Missouri Program for Impaired Physicians, presented a grand round at Saint Louis University Medical School in January. Dr. Croughan educated the audience, mostly medical students, about getting help for substance abuse problems.

The program was co-presented by Hershel P. Wall, M.D., of Memphis, who discussed addictive disorders among physicians and medical students.

New Jersey

Chapter President:
John J. Verdon, Jr., M.D., FASAM
Regional Director:
R. Jeffrey Goldsmith, M.D.

At the New Jersey chapter's meeting in San Diego during the ASAM Med-Sci Conference, chapter constitution and Bylaws were a main topic of discussion. Chapter members expressed their appreciation to David I. Canavan, M.D., of the Physicians Health Medical Program of New Jersey for his support of chapter activities, particularly the mailing of minutes and memoranda.

New York

Chapter President: Merrill Herman, M.D.
Regional Director: R. Jeffrey Goldsmith, M.D.

The New York chapter held its Annual CME/ Business Meeting in March. Guest Presenter

Herbert Peyser, M.D. discussed "Managed Care and Substance Abuse." The lively meeting featured stimulating discussion of addiction issues. The chapter is committed to enhancing its linkage with the Medical Society of the State of New York. It also is in the final phases of incorporation.

Ohio

Chapter President: Ted Hunter, M.D.
Regional Director:
R. Jeffrey Goldsmith, M.D.

The Ohio chapter has scheduled a general membership business meeting for Saturday, July 26, in conjunction with the Summer Institute of Addiction Studies of Ohio State University. Information on the meeting is available from Stan Soteren, M.D., at 614/868-6710.

The Ohio State Medical Association currently is engaged in several projects that involve addiction medicine. The Ohio chapter's Board encourages any ASAM member who has the interest in OSMA to become involved.

Oklahoma

State Contact: Linda Gore-Lantrip, D.O.
Regional Director: Ken Roy, M.D., FASAM

ASAM members in Oklahoma have been working hard and meeting regularly. Chapter business meetings were held in March and May at the Oklahoma State Medical Association. Members are proceeding with formation of an official ASAM chapter in Oklahoma (OKSAM). Information is available from the ASAM Office.

Oregon Chapter

Chapter President:
Douglas Bovee, M.D., FACP
Regional Director:
Richard E. Tremblay, M.D., FASAM

The April Oregon chapter meeting featured Steve Gallon, Ph.D., speaking on "Motivational Interviewing." The next meeting, scheduled for June 17, will feature Marshall Bedder, M.D., speaking on "Rapid Anesthesia Assisted Opioid Detoxification (RAAD)."

Lee McCullough, M.D., has been elected to the five-member ORSAM Board, replacing Phil Unger, M.D., who gave many years' service to ORSAM.

Washington State

Chapter President:
Steven Juergens, M.D., FASAM
Regional Director:
Richard E. Tremblay, M.D., FASAM

The Washington chapter met for a business/scientific meeting in March, at which speakers discussed "Rational Recovery" and "The Medical Quality Assurance Commission." The group agreed to buy a fax machine to facilitate distribution of information to members in a timely fashion.

Region III

Regional Director:
Alan Wartenberg, M.D., FASAM

Regional Director Alan Wartenberg, M.D., reports that early planning is taking place for a Regional Meeting in November 1997, tentatively set for a northern New England location. The last Region III meeting, chaired by Dr. P. Kishore, was very successful.

INTERNATIONAL

Iceland

Contact:
Gudbjorn Bjornsson, M.D.
Regional Director:
Peter Mezciems, M.D., FASAM

Two Icelandic Members of ASAM were in attendance at the 28th Annual Med-Sci Conference in San Diego. An international conference, the "SAA 20th Anniversary Conference on Alcohol and Substance Abuse," is scheduled for Reykjavik, Iceland, October 16-18, 1997.

THOUGHTS ON ASAM BY AN OLD ADDICTIONIST

James H. Sanders, Jr., M.D.

It has always been that those vitally interested in severe, difficult-to-treat illnesses work out a treatment regimen that seems best and then promote it with almost religious zeal. I had a child with cystic fibrosis and the treatment regimen with mist tents, chest clapping and prophylactic antibiotics was rigid and accepted by faithful physicians, families, and patients. Now, advances in knowledge about the disease and new treatments have changed the picture and a new regimen is accepted by the faithful.

This has happened in the treatment of addiction. When I started in the field over 15 years ago, AA and AA principles were the cornerstone of treatment. We worked on detoxification regimens, debated the efficacy of each, and worked on various types of inpatient and outpatient treatment programs, but AA was promoted with religious zeal. In retrospect, there was too much emphasis on AA, to the exclusion of other ideas. We were too rigid in trying to eliminate the use of any "addictive drugs" in the addicted.

I don't think the new age of addiction treatment is an improvement. AA has been replaced by drugs as the new savior of patients. Methadone clinics, which were controversial, are not advocated unconditionally. Some think they are successful if the patients on methadone are not injecting heroin or other drugs, even if they are smoking marijuana and crack cocaine. AA is honored by quoting statistics showing its effectiveness, but its principles are in the background now.

Researchers have made great strides in making addiction medicine a more scientific discipline. Neurochemistry is giving us more knowledge about how addiction works and what drugs should be tried in treatment. It is also helping with treatment of dual diagnosis patients. [However] we have now swung overboard in the other direction....Even though we are doing a better job of coordinating different levels of inpatient and outpatient treatment, managed care limitations dictate that we often have the patient treated by one treatment team for a very short period.

During and immediately after detoxification, psychological and psychiatric examinations are done and drug treatment of depression and personality disorders is started immediately. Reevaluation of these tentative diagnoses and prescriptions later in treatment by another physician is problematical. It doesn't take a genius to see that the number of drugs of all kinds prescribed to addiction patients is completely out of hand.

Continued on page 17

AMA GRAPPLES WITH PHYSICIAN WORKFORCE, ACCREDITATION ISSUES

Michael M. Miller, M.D., FASAM

The American Medical Association held its year-end 1996 meeting in Atlanta. Attending for ASAM were Delegate Michael Miller, M.D., Alternate Delegate David Smith, M.D., President G. Douglas Talbott, M.D., and EVP Dr. James Callahan. ASAM also was represented by Stuart Gitlow, M.D., ASAM's Delegate to the AMA's Young Physician Section (and a member of the Section Governing Council); Christina Delos Reyes, M.D., ASAM Delegate to the Resident Physician Section; and Sarah Babai, ASAM Delegate to the Medical Student Section.

Two major AMA initiatives on the meeting agenda were the American Medical Accreditation Program (AMAP) and a work group on federal support of physician workforce development.

American Medical Accreditation Program

AMAP is to be the first national program that certifies individual physicians. It will involve a comprehensive set of standards that will lead to recognition of physicians who meet or exceed professional and practice requirements in the areas of credentials, personal qualifications, clinical performance, and patient care outcomes. A standard portfolio of information on applicant physicians would incorporate data on clinical outcomes and patient satisfaction as well as "structural aspects of quality" such as licensure, board certification, and the like.

The activity would be physician-led and would be designed to reduce costs by replacing existing duplicative and fragmented physician credentialing and review processes. AMA expects that AMAP will win universal recognition and acceptance by physicians, hospital medical staffs, managed care organizations, regulators and consumers.

This AMA-sponsored activity is to be a joint undertaking of all the members of the Federation: the AMA, state medical associations, and special societies such as ASAM. ASAM will follow the development with great interest. The impression of the ASAM delegation is that the clinical performance variables developed for AMAP will have to take into account the types of patients and conditions treated by the physician, as well as the care environment in which the physician practices. Moreover, the AMAP credential will have to be accompanied by the development of practice guidelines so that there is a benchmark against which to measure physician performance.

Physician Workforce Development

The Physician Workforce Development project involves the AMA, the National Medical Association, the American Osteopathic Association, the Institute of Medicine, and other organizations, including those representing schools of medicine and osteopathy. In order to avoid antitrust implications, the only mission of this consortium at present is to provide advice to the federal government with regard to mechanisms by which the government supports graduate medical education.

Variables to be explored in the future include an analysis of actual marketplace needs for physician supply. A preliminary report released in September 1996 concludes that there either is, or soon will be, an oversupply of physicians in the United States.

These issues have huge implications for current and future residents and medical students, as well as for physicians practicing in areas such as California, where marketplace forces are actively reducing the size of the physician workforce. A three-hour open hearing on physician workforce matters heard testimony from dozens of organizations; ASAM was one of 80 organizations that submitted written testimony.

ASAM Resolutions

ASAM presented three resolutions to the AMA House of Delegates. The first relates to identification of physician specialty in the information included in physicians' personal Web pages. (AMA members can set up personal Web pages, free of charge, that include a photo and current information on the physician's training and current practice.) ASAM's resolution asked that ASAM members be allowed to include this information in their Web pages. The House approved this action.

Other ASAM resolutions asked the AMA to endorse a reversal of 1996 Congressional decisions to terminate the Social Security and disability benefits of individuals suffering from addictive disorders, and to support employment protections for individuals who are addicted to alcohol or other drugs. Both resolutions were referred for further study and are to be returned to the House for action at the June 1997 meeting.

The AMA Council on Medical Education presented a report on physicians without specialty board certification. The report recommended that the AMA reaffirm its policy that decisions regarding staff appointment should be based on the training, experience and demonstrated competence of candidates, and should not rely exclusively on the presence or absence of board certification; that third-party payers not exclude non-certified physicians as a class from participating in their programs without regard to their training, experience and current competence; and that the AMA continue to develop and implement its proposed AMAP program. Dr. Miller testified on behalf of ASAM in favor of the recommendations in this report.

ASAM also testified in support of a resolution introduced by the American Association of Public Health Physicians concerning intravenous drugs use, syringe and needle availability, needle exchange programs and HIV prevention, and other efforts by state and local health departments to assure the safe disposal of used syringes and needles. This issue was referred by the House for further study.

The Minnesota Medical Association submitted a very creative resolution suggesting that tobacco companies by required to accurately label the nicotine content in tobacco products, and that they be required to reduce the nicotine content in tobacco products by an appropriate, graduated, incremental reduction process so that tobacco products would be nicotine-free within six years. ASAM supported the labeling provisions, which were adopted as AMA policy. ASAM also provided scientific testimony regarding the benefits of nicotine replacement therapy via more predictable nicotine delivery systems (e.g., transdermal patches) instead of inhalation of tobacco smoke. The House of Delegates referred this item for further study.

Other Resolutions

A number of resolutions focused on managed care. There was much debate regarding Medicare, RBRVS and fee structures, HCFA,

Continued on next page

AMA Report – Continued from previous page

telemedicine, genetic testing, and genetic information and insurance coverage. A feature of importance to ASAM included findings of AMA's Study of the Federation of Medicine. A feature of importance to ASAM included ballots ASAM members were asked to complete in late 1996 concerning the specialty society they designated to represent them in the Federation of Medicine. (Hopefully ASAM members all voted "425" for ASAM!).

ASAM continues to work closely with other medical organizations through its contact at the AMA. We discovered that one of the major initiatives of the American College of Emergency Physicians is to improve the training and practice of emergency physicians with regard to substance abuse and addiction. Members of the ASAM delegation meet regularly at AMA meetings in caucuses with delegations from Preventive Medicine, Occupational and Environmental Medicine, Psychiatry, Child Psychiatry, Insurance Medicine and the U.S. Armed Forces and Public Health Services, as well as representatives of other medical specialty societies and state medical associations.

AMA SEEKS ASAM INPUT IN REVISING GUIDES TO PERMANENT IMPAIRMENT

The American Medical Association has asked ASAM to participate in revising AMA's *Guides to the Evaluation of Permanent Impairment* to produce a fifth edition. The *Guides* have been widely adopted by state Workers' Compensation Commissions and other official bodies as a standard reference in evaluating workers' disability claims and establishing fitness for duty criteria.

At AMA's request, ASAM has nominated the following experts to participate in the advisory panel to the revision: G. Douglas Talbott, M.D., FASAM, Andrea G. Barthwell, M.D., Sheila B. Blume, M.D., FASAM, Marc Galanter, M.D., FASAM, and David E. Smith, M.D., FASAM.

AMA also has invited ASAM members to submit their comments about the book through the AMA Web site at www.ama-assn.org (go to the Medical Science and Education section). Alternatively, ASAM members can obtain a survey questionnaire via fax or mail by calling 1/800-937-8783.

COMMITTEE NEWS

AD HOC COMMITTEE ON FORENSIC ADDICTION MEDICINE

Robert L. DuPont, M.D., Chair

ASAM's *Ad Hoc* Committee on Forensic Addiction Medicine got off to a fast start with a well-attended three-hour component session at the 1996 Medical-Scientific Conference in Atlanta. (Building on the outstanding performance of the Medical Review Officer Committee led by Donald Ian Macdonald, M.D., the committee held an initial one-day training session in Washington, D.C., in January 1997.)

The *Ad Hoc* committee focuses on court-related aspects of addiction medicine, including workplace drug testing and return-to-work issues (hence the active connection with ASAM's MRO activities), as well as a wide range of civil and criminal issues, including claims of diminished capacity secondary to intoxication—a major issue in death penalty cases—and liability issues related to rcent use of alcohol or other drugs.

ASAM members have a broad expertise in these areas, which are proving to be of interest to many members as American society begins to shed its denial of the effects of addiction and begins to confront the remarkably diverse problems caused by addiction.

Members of the new Ad Hoc Committee on Forensic Addiction Medicine meet in San Diego: (bottom row, left to right) H. Westley Clark, M.D., J.D., M.P.H. and Robert L. DuPont, M.D., FASAM, committee chair; (top row) ASAM Meetings Coordinator Linda Fernandez, Norman S. Miller, M.D., FASAM, committee organizer William Vilensky, D.O., R.Ph., FASAM, conference speaker Robert Willette, Ph.D., Raymond M. Deutsch, M.D., David E. Smith, M.D., FASAM, and ASAM Meetings Manager Sandy Metcalfe.

Letters – Continued from page 15

It would appear that the leadership and direction of ASAM have passed from those treating addiction, who were from many different medical backgrounds, to psychiatrists who are primarily researchers in neurochemistry. In recent ASAM review courses and the certification examination, the emphasis was on theories of neurochemistry in addiction and very little about detoxification, medical complications and treatment problems....ASAM members who practice outside major medical centers are becoming more isolated and are increasingly not having our problems addressed by our Society. Membership is become less relevant to our practice....

Years ago I realized that I was isolated from my colleagues in addiction medicine. I was medical director of a small treatment center in a small town and I had no peer review of my work. After several years of delays locally and then by ASAM, Dr. Christine L. Kasser, a member of the ASAM board, visited our treatment center to review our work. She was thorough and took time before, during and after her visit to make an expert assessment of the medical care in our facility.

I learned more from that experience and make more positive changes in my practice of addiction medicine than I have before or since. Those of us in the boondocks make pilgrimages to the Ivory Towers. Maybe if those in the towers could come to the sticks, not just to lecture, but to see what we do, we could all benefit.

I am not discouraged. Great strides have been made in addiction medicine. It is vital, however, that we not lose sight of the forest as we concentrate on our favorite tree.

[Replies to Dr. Sanders' letter are welcome and should be addressed to the Editor, ASAM News.]

MEMBER NEWS

DR. BISSELL TO RECEIVE AMWA AWARD

The American Medical Women's Association has selected LeClair Bissell, M.D., as 1997 recipient of AMWA's prestigious

LeClair Bissell, M.D.

Elizabeth Blackwell Award. In announcing the award, AMWA noted that "Dr. Bissell's life as innovator, researcher, author, teacher, and social activist embodies the very spirit of the Blackwell Award. She has dedicated her life to healing the impaired physician and has contributed a wealth of information for the training, treatment, and understanding of the addicted patient, particularly women."

DR. PAYTE EDITS NEW MEDICAL JOURNAL

J. Thomas Payte, M.D., is editor of the new *Journal of Maintenance in the Addictions*, published by The Haworth Medical Press.

Described as focusing on "innovations in research, theory and practice," the journal's first issue features a commentary by Dr. Vincent Dole defining methadone maintenance treatment, a report by Czechowicz, Hubbard et al. on NIDA's Methadone Treatment Quality Assurance System (MTQAS), as well as a study by Rowan-Szal, Joe et al. on increasing early engagement in methadone treatment.

Future issues are to include articles on useful predictors of outcome in methadone-treated patients, a clinical perspective on dose in methadone maintenance, and a comparison of two methods for estimating the costs of drug treatment.

MEMBERS ELECTED ASAM FELLOWS

With the addition of the 18 Fellows listed below, a total of 108 physicians who are members of the Society have been elected Fellows of the American Society of Addiction Medicine. All the Fellows were recognized at ASAM's 1997 Annual Medical-Scientific Conference. ASAM inaugurated the Fellow program in 1996 to recognize substantial and lasting contributions to the Society and the field of addiction medicine. Candidates must meet certain criteria to quality for Fellow status: they must have been an ASAM member for at least five consecutive years; (2) they must be ASAM-certified; (3) they must have taken a leadership role in ASAM through committee service, or have been an officer of a state chapter; and (4) they must have made and continue to make significant contributions to the addictions field.

The following new ASAM Fellows were presented certificates denoting their achievement during the Awards Dinner in San Diego:

Richard Artis Beach, M.D., FASAM
Gulf Breeze, FL

John N. Chappel, M.D., FASAM
Reno, NV

Robert A. Collen, M.D., FACP, FASAM
Fountain Valley, CA

Donald Cornelius, M.D., FASAM
Clayton, GA

Louis Edward Deere, D.O., FASAM
Dallas, TX

Anthony Dekker, D.O., FASAM
Kansas City, MO

Anne Geller, M.D., FASAM
New York, NY

Caroline M. Gellrick, M.D., FAAFP, FASAM
Lakewood, CO

Douglas Graham, B.Sc., M.D., FASAM
Victoria, British Columbia CANADA

William Hazle, M.D., FASAM
Los Gatos, CA

Conway W. Hunter, Jr., M.D., FASAM
Sea Island, GA

Geoffrey P. Kane, M.D., M.P.H., FASAM
Nashua, NH

Michael R. Liepman, M.D., FAPA, FASAM
Worcester, MA

J. Paul Martin, M.D., FASAM
Ashville, NC

Michael M. Miller, M.D., FASAM
Madison, WI

Seddon Savage, M.D., FASAM
Lebanon, NH

James W. Smith, M.D., FASAM
Seattle, WA

Lance S. Wright, M.D., FAPA, FASAM
Darby, PA

MEMBERS IN SERVICE TO ASAM

❑ Julian Keith, M.D., ASAM member and Director of the North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services, initiated a meeting with Drs. Enoch Gordis (Director of the National Institute on Alcohol Abuse and Alcoholism) and Alan Leshner (Director of the National Institute on Drug Abuse) and Mr. David Mactas (Director of the federal Center for Substance Abuse Treatment) to discuss how to reach consensus on the definition of alcoholism, as a necessary step in achieving parity in addictions treatment.

❑ Dr. Michael Miller is working with the Managed Care Coalition on Substance Abuse Disorders (MCCSUD) to foster the development and common adoption of treatment guidelines.

❑ Dr. David Mee-Lee recently met with representatives of the Department of Defense and of the branches of the military to discuss implementation of the DOD's newly enacted TRICARE addictions treatment policy, which calls for use of criteria that are compatible with the ASAM *Patient Placement Criteria* in determining the need for treatment of military personnel and their six million dependents. Among those representing the military services at the meeting were Drs. Terry Schultz and Ken Hoffman.

Position: Physician, Psychiatric Specialist

Location: Orofino, in scenic North Central Idaho

Idaho Department of Health and Welfare, State Hospital North, is recruiting a staff psychiatrist for its 60-bed Adult Psychiatric Hospital and Drug Dependency/Dual Diagnosis Program components. The Hospital will hire a Board Certified or Board eligible psychiatrist who is seeking an opportunity for a progressive and innovative practice in the treatment of patients who are severely mentally ill and drug dependent. A physician with expertise in addictions treatment is desired.

State Hospital North is one of two state hospitals in Idaho, and an important link in the State and Regional Mental Health network. The Hospital values participative and collaborative management, and team approach to treatment.

The Hospital is located on a beautiful campus in a modern facility less than two years old. Orofino is an attractive rural community located on the Clearwater River at the base of the Selway-Bitterroot Wilderness Area. Professionals enjoy a quality lifestyle and outdoor recreational activities.

The compensation package includes competitive salary, relocation assistance, and excellent State benefits. For more information, contact:

Debbie Manfull
Assistant Administrator
State Hospital North
300 Hospital Drive
Orofino, Idaho 83544

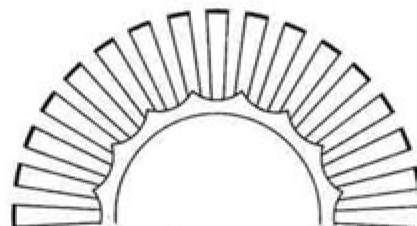
Phone: 208/476-4511

Jefferson Medical College is seeking an academically credentialed psychiatrist, established in the substance abuse field, to assume the position of Director of the Division of Substance Abuse Programs, Department of Psychiatry and Human Behavior.

Responsibilities include teaching, training, and supervision of medical students and residents; ant the administration of methadone, cocaine, and outreach drug-free drug and alcohol clinics. There are research projects being conducted in all clinics, with funded biological, genetic and clinical outcome investigations ongoing. Faculty rank and compensation commensurate with qualifications.

The position will be available on July 1, 1997 and selection will be based on experience and accomplishments in administration, teaching, patient care, and research.

Send resume to:
Dr. Stephen P. Weinstein,
Chair, Search Committee
Division of Substance Abuse Programs
1201 Chestnut Street, 15th Floor
Philadelphia, Pennsylvania 19107
Fax: 215/568-3596.



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FAX (520) 684-4247

ASAM ACCEPTS NOMINATIONS FOR EMERITUS MEMBERSHIP

ASAM members are invited to recognize the accomplishments of senior members of the Society by nominating them for Emeritus membership. Emeritus members have their membership dues waived and receive complimentary subscription to *ASAM News* and the society's *Journal of Addictive Diseases*.

Emeritus status is bestowed by the ASAM Board of Directors, which reviews all nominations. To qualify, a nominee must be: (1) an ASAM member for at least 15 years; and (2) at least 65 years old; and (3) retiring or retired from the practice of addiction medicine. (However, in special cases, the Board reserves the right to bestow Emeritus membership independent of any of the criteria listed.)

Nomination forms are available from the ASAM Membership Department at 301/656-3920.

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ASAM CONFERENCE CALENDAR

1997

July 18-20
ASAM MRO Conference
Dallas, TX

August 6-10
IDAA Medical-Scientific Conference
(Jointly sponsored by ASAM)
Minneapolis, MN

September 6-21
South Africa People-to-People Conference
(jointly sponsored by ASAM)
Contact Max A. Schneider, M.D., FASAM
Fax: 714/639-0062
E-mail: Alexron@aol.com

October 16-18
SAA 20th Anniversary Conference
on Alcohol and Substance Abuse

October 16-19
ASAM 10th Annual Conference on
Nicotine Dependence
Minneapolis, MN

October 23-25
State of the Art in Addiction Medicine
Washington, D.C.
20 Category 1 CME credits

1997

October
Adolescent Substance Abuse and
Addiction Conference
14 Category 1 CME credits

October
5th Annual
Southeast Regional
Addiction Conference

November 6-8
CSAM State of the Art Course
San Francisco

November 14-16
ASAM MRO Conference
Seattle, WA

1998
ASAM 29th Annual Medical-Scientific
Conference
New Orleans, LA

1999
ASAM 30th Annual Medical-Scientific
Conference
New York, NY

***For additional information**, call the ASAM office at 301/656-3920.*

ASAM STAFF NOW ONLINE

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