

# ASAM NEWS



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Newsletter of The American Society of Addiction Medicine

## NIDA Director: Addiction is a Brain Disease

Alan I. Leshner, Ph.D., Director, National Institute on Drug Abuse

Dramatic advances over the past two decades in both the neurosciences and the behavioral sciences have revolutionized our understanding of drug abuse and addiction. Scientists have identified neural circuits that subsume the actions of every known drug of abuse, and they have specified common pathways that are affected by almost all such drugs. Researchers have also identified and cloned the major receptors for virtually every abusable drug, as well as the natural ligands for most of those receptors. In addition, they have elaborated many of the biochemical cascades within the cell that follow receptor activation by drugs. Research has also begun to reveal major differences between the brains of addicted and nonaddicted individuals and to indicate some common elements of addiction, regardless of the substance.

That is the good news. The bad news is the dramatic lag between these advances in science and their appreciation by the general public or their application in either practice or public policy settings. There is a wide gap between the scientific facts and public perceptions about drug abuse and addiction. For example, many, perhaps most, people see drug abuse and addiction as social problems, to be handled only with social solutions, particularly through the criminal justice system. On the other hand, science has taught that drug abuse and addiction are as much health problems as they are social problems. The consequence of this gap is a significant delay in gaining control over the drug abuse problem.

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Part of the lag and resultant disconnection comes from the normal delay in transferring any scientific knowledge into practice and policy. However, there are other factors unique to the drug abuse arena that com-



Alan I. Leshner, Ph.D.

pound the problem. One major barrier is the tremendous stigma attached to being a drug user or, worse, an addict. The most beneficent public view of drug addicts is as victims of their social situation. However, the more common view is that drug addicts are weak or bad people, unwilling to lead moral lives and to control their behavior and gratifications. To the contrary, addiction is actually a chronic, relapsing illness, characterized by compulsive drug seeking and use (1). The gulf in implications between the "bad person" view and the "chronic illness sufferer" view is tremendous. As just one example, there are many people who believe that addicted individuals do not even deserve treatment. This stigma, and the underlying moralistic tone, is a significant overlay on all decisions that relate to drug use and drug users.

Another barrier is that some of the people who work in the fields of drug abuse prevention and addiction treatment also hold ingrained

ideologies that, although usually different in origin and form from the ideologies of the general public, can be just as problematic. For example, many drug abuse workers are themselves former drug users who have had successful treatment experiences with a particular treatment method. They therefore may zealously defend a single approach, even in the face of contradictory scientific evidence. In fact, there are many drug abuse treatments that have been shown to be effective through clinical trials (1, 2).

These difficulties notwithstanding, I believe that we can and must bridge this informational disconnection if we are going to make any real progress in controlling drug abuse and addiction. It is time to replace ideology with science.

### Drug Abuse and Addiction as Public Health Problems

At the most general level, research has shown that drug abuse is a dual-edged health issue, as well as a social issue. It affects both the health of the individual and the health of the public. The use of drugs has well-known and

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**Recognizing addiction as a chronic, relapsing brain disorder characterized by compulsive drug-seeking and use can impact society's overall health and social policy strategies and help diminish the health and social costs associated with drug abuse and addiction.**

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## American Society of Addiction Medicine

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

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### AMA ADOPTS POLICY ON MEDICAL USE OF MARIJUANA

At its December meeting, the House of Delegates of the American Medical Association adopted a policy report calling for more scientific inquiry to determine the therapeutic value of marijuana. Specifically, the Council on Scientific Affairs report recommends that adequate, well-controlled studies of smoked marijuana be conducted with patients who have conditions for which preclinical, anecdotal or controlled evidence suggests marijuana may have value. Such conditions include AIDS wasting syndrome, glaucoma, multiple sclerosis and severe nausea and vomiting related to chemotherapy.

The Council also urged the National Institutes of Health to implement administrative procedures to facilitate grant applications and well-designed clinical research. The report also urged that NIH use its resources to support the development of a smoke-free delivery system for marijuana to reduce the health hazards associated with the combustion and inhalation of marijuana.

### EARLY DRINKING FOUND TO INCREASE ALCOHOLISM RISK

Recently published findings from the National Longitudinal Alcohol Epidemiologic Survey show that children who begin drinking regularly by age 13 have a 47 percent risk of becoming an alcoholic in their lifetimes, as compared to a 10 percent risk for those who delay alcohol use to age 21 or older. The findings, which are drawn from a study of nearly 20,000 people, are the first to show a powerful link between the age of onset of alcohol use and the lifetime risk of alcoholism.

The study, which is funded by the National Institute on Alcohol Abuse and Alcoholism, differentiates between tasting or having a sip of alcohol and drinking regularly. Researchers found that, for each year drinking is delayed, the likelihood of developing alcoholism is reduced by 14 percent, and the lifetime risk of alcohol abuse is reduced by 8 percent. According to Dr. Bridget F. Grant, lead author of the report, the risk was greater for boys than for girls at every age level, and was greatest for those who had a strong family history of alcoholism.

### ACCURACY OF FEDERAL DRUG USE DATA CHALLENGED

An investigative report in the *Washington Post* has used independent statistical analysis and interviews with addiction field experts to challenge the accuracy of federal studies of alcohol and drug use. The report points out, for example, that over the past 10 years, different epidemiological studies funded by the federal government have produced "wildly different" estimates of the number of weekly cocaine users.

"It's clear that these things are badly mismeasured and nobody cares about it," Peter Reuter, former co-director of drug research for RAND and now a University of Maryland professor, told the *Post* reporters. Reuter said he has pointed out discrepancies in data in the annual National Drug Control Strategy document, for example, but the errors reappear from year to year without correction. "I can't seem to get the machinery that cranks out these reports to pay attention to these inconsistencies," he added.

Other analysts point out that a major contributor to the problem is the large number of measurements, currently numbering more than 50 federal drug-related "data systems" with hundreds of "drug variables" produced by an array of federal agencies. A second obstacle to accuracy, researchers say, is that hard-core drug users are hard to find and harder to question, and that many lie on drug use surveys. They cite a recent study showing that two-thirds of adolescents give deceptive answers.

The difficulty in measuring and evaluating the nation's illegal drug problem makes it difficult to set policy or to match treatment capacity to treatment need, observers noted. "You really can't tell from the big debate going on in public what the big picture is, said David Musto, M.D., a Yale University medical historian who has studied drug trends for three decades.

## AMA HOUSE OF DELEGATES ADOPTS ASAM RESOLUTIONS

Michael M. Miller, M.D., FASAM, ASAM Delegate to the AMA

The 1997 Interim Meeting of the AMA House of Delegates convened December 6-10 in Dallas, Texas. ASAM was represented by Michael M. Miller, M.D., Delegate; Stuart Gitlow, M.D., a member of the Governing Council of the Young Physicians Section, who served as ASAM's Alternate; Chris Delos Reyes, M.D., a member of the Resident Physicians Section; and several ASAM members who were representatives of their state or specialty society delegations—including Cesar Aristeiguieta from the California delegation, who is Vice Chair of the Governing Council of the AMA Medical Student Section.

### ASAM Resolutions

As described in the December issue of *ASAM News*, ASAM presented resolutions on educating physicians about the risks of misuse of Rohypnol and other sedative-hypnotic drugs, as well as the misuse of dextromethorphan. ASAM's resolution regarding Rohypnol was amended based on friendly input from the American College of Obstetricians and Gynecologists, and approved with the following language: "that our AMA re-emphasize to physicians and public health officials the fact that Rohypnol (a benzodiazepine), other benzodiazepines, and other sedatives and hypnotics, carry the risk of misuse, morbidity and mortality, and...that our AMA support public education and public health initiatives regarding the dangers regarding the dangers of the use of sedatives and hypnotics in sexual abuse and rape, especially when mixed with ethanol ingestion."

ASAM's resolution regarding the potential misuses of dextromethorphan was adopted as submitted. Also adopted were a resolution from the California delegation calling for prompt access to treatment for chemical dependency and a resolution from the Young Physicians Section asking that AMA contact representatives of the movie industry and other media and entertainment groups to ask them to discontinue showing use of tobacco products in images promoted to minors.

ASAM's resolution on the proposed tobacco settlement generated intense debate on the floor of the House but finally was adopted. The resolution called on the AMA to oppose "any form of civil immunity for the tobacco industry and remain opposed to giving the tobacco industry any other special legal ad-

vantages that would abridge the rights of individuals or groups of individuals who have been harmed by this industry." The resolution was drafted for ASAM by John Slade, M.D., who traveled to Dallas to testify on this item before the Reference Committee on Public Health. The House heard some testimony about the need to allow the AMA to be flexible in negotiations and not to tie the negotiators' hands by taking ironclad positions. This argument was countered by delegates from Minnesota and Nebraska, who pointed out that "no immunity" already is AMA policy and as such should not be softened in any way. The voice vote was firmly in favor of ASAM's position.

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**For those who wonder, "What ever happens when these Resolutions get adopted?", the AMA provided a report demonstrating that AMA staff do move aggressively to implement the directives of the House of Delegates.**

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In further action, the House of Delegates resolved that "our AMA continue to work with the Congress and the Administration for comprehensive tobacco control legislation which significantly strengthens the June 20, 1997 proposed tobacco settlement agreement."

A highlight of the meeting was the presentation of the AMA Education and Research Foundation's McGovern Award for Health Education to ASAM member David C. Lewis, M.D., and the AMA's Scientific Achievement Award to ASAM member Charles S. Lieber, M.D.

### Other AOD-Related Issues

The House adopted a resolution submitted by the Hawaii delegation that changes AMA policy to a 0.04% from a 0.05% BAC as the *per se* limit for alcohol ingestion, and recommends incorporation of that provision in all state drinking and driving laws.

The House also adopted an amended version of a resolution from the Medical Student Section urging that AMA "encourage state and local legislation prohibiting smoking around the public entrances to public buildings."

The House accepted two outstanding reports from the AMA's Council on Scientific Affairs (CSA). Both reports are available on the AMA Web site ([www.ama-assn.org](http://www.ama-assn.org)) or from the ASAM National Office. The first report, on "Alcoholism and Alcohol Abuse Among Women," addresses gender-specific issues in alcohol use and illness. The report does not attend to the fetal effects of maternal alcohol use, and the Council may address this issue in the future by updating its existing report on fetal alcohol syndrome. Recommendations in the report are that the AMA "encourage all medical education programs to provide greater coverage on alcohol as a significant source of morbidity and mortality in women."

The House also accepted a CSA report on the controversial topic of medical use of marijuana. The AMA report is consistent with the recently updated ASAM Public Policy Statement on Marijuana, a copy of which was given to the Reference Committee as part of Dr. Gitlow's testimony. These reports were accepted following extended debate on the floor of the House, which gave Dr. Miller an opportunity to place ASAM and its issues before the assembled Delegates. Drawing directly from ASAM Policy language, the Reference Committee on Public Health amended the CSA report to add a recommendation that "effective patient care requires the free and unfettered exchange of information on treatment alternatives" and that "discussion of these alternatives between physicians and patients should not subject either party to criminal sanctions."

Also paralleling an ASAM policy was a Board of Trustees Report on "Protection for Physicians Who Prescribe Pain Medication." As adopted, the report says that "the AMA supports the position that physicians who appropriately prescribe and/or administer controlled substances to relieve intractable pain should not be subject to the burdens of excessive regulatory scrutiny, inappropriate disciplinary action, or criminal prosecution; and that state medical societies and boards of medicine develop or adopt mutually acceptable guidelines protecting [such] physicians...before seeking the implementation of legislation to provide that protection." The report also called for "educational programs for physicians and members of medical boards about pain management."

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## MESSAGE FROM THE PRESIDENT-ELECT

### INTERNATIONAL ADDICTIONS MEETING AT THE 1998 MEDICAL-SCIENTIFIC CONFERENCE: REQUEST FOR MEMBER ASSISTANCE

Marc Galanter, M.D.

In recent decades, the treatment of alcohol and drug dependence has emerged as a major component of medical care worldwide. We have witnessed major advances in treatment, research and education, and have also witnessed a growth in collaboration across national borders among interested physicians. New techniques are developed in one country and applied in others; professional journals are read by doctors in many national settings; conferences are attended by international as well as domestic participants. Given these developments, the time has come to develop an international collaboration of physicians in the addiction field.

In representing the American Society of Addiction Medicine, ASAM President G. Douglas Talbott, Immediate Past President David E. Smith, M.D., and I have lent considerable thought to the growth of this communication worldwide. We have located the planning meeting at the site of the three-day annual ASAM program, in order to justify the considerable expense of travel to the meeting.

As a result, we are convening a planning meeting of specially selected international physicians who are leaders in addiction medicine. The group will meet from 2 to 5 p.m. on April 16, 1998, in advance of ASAM's Annual Medical-Scientific Conference in New Orleans. We anticipate that this meeting will provide a unique opportunity to develop a set of priorities and a structure for a future international organization of specialists in addiction medicine. Specifically, we hope to lay the groundwork for an international meeting at the Carter International Center in Atlanta in 1999.

#### MEMBER REPLY FORM

International members are invited to indicate the issues they find most important for international collaboration in addiction medicine, and that they would find most useful in their own national setting when such an initiative is developed.

Please rank, from 1 (most important) to 6 (least important) each of the areas listed below, to indicate how you would rate their general importance in an international initiative.

- Treatment modalities
- Research issues
- Medical education
- Policy development
- Prevention
- Certification in addiction medicine

Please note your ratings on this page and fax it back to ASAM headquarters at 301/656-3815, or E-mail to [jgart@asam.org](mailto:jgart@asam.org).

All international members of ASAM are invited to attend. In addition, we ask your help in identifying physicians from around the world who are leaders in the field but who are not now active in ASAM. In order to facilitate their attendance in April, I urge you to send your suggestions for international invitees as soon as possible to Joanne Gartenmann, ASAM Executive Assistant, by fax at 301/656-3815 or by E-mail at [jgart@asam.org](mailto:jgart@asam.org).



Our principal focus for the April 16 session will be:

- To define national representatives and organizations interested in a collaborative initiative.
- To define issues around which collaboration will be most useful.
- To establish a structure for an ongoing collaboration.
- To define specific plans to pursue this initiative further, and to frame the basis for an International Society of Addiction Medicine.

With your assistance, we look forward to a vigorous and fruitful discussion with our international counterparts on April 16 in New Orleans.

#### DEADLINE TO APPLY FOR ASAM CERTIFICATION EXAMINATION NEARS

Physicians who wish to sit for the ASAM certification or recertification examination have until April 30, 1998, to file an application.

The examination is to be offered on Saturday, November 21, 1998, at three locations: LaGuardia, NY; Los Angeles, CA; and Atlanta, GA. Physicians who pass the examination are awarded ASAM Certification or Recertification in Addiction Medicine. Since the examinations were first offered in 1986, over 2,939 physicians have passed the examination, including many of the nation's top addiction treatment professionals.

To request an application for the examination, contact:

**Christopher Weirs**  
ASAM Credentialing Program Manager  
Phone 301/656-3920  
or E-mail [CWEIR@ASAM.ORG](mailto:CWEIR@ASAM.ORG)

**BILL MOYERS EXAMINES ADDICTION IN NEW PBS SERIES**

How does addiction happen? Why is it so widespread and so hard to overcome? Who is at risk? What can be done to help addicts recover? Journalist Bill Moyers believes that these questions are keys to understanding what has been called America's number one health problem. Hoping to raise awareness about an issue that has affected his own family, as well as millions of Americans, Moyers reports on the latest scientific inquiry, public policy analysis, and the personal experiences of recovering people to create a comprehensive portrait of addiction and recovery in America.

"Moyers on Addiction: Close to Home," a five-part series about the science, treatment, prevention and politics of addiction, premieres for three consecutive nights beginning Sunday, March 29, at 9:00 p.m. Eastern time on PBS (check local listings). The series was produced by WNET in New York for public television.

"My wife Judith and I thought we knew about addiction, until it came close to home," says Bill Moyers, referring to his oldest son's struggle with drugs and alcohol. "What we learned about addiction, and are still learning, prompted this series. It's not about use, or even the occasional abuse of a substance. We're talking about obsessive desire—when something you take, drink or smoke becomes the master of your mind and the tyrant of your life."

To tackle one of society's most misunderstood phenomena, the Moyers assembled a production team to create the series from locations across the country. Each of the five episodes takes on a different facet of addiction and recovery, from studies of brain pathology and genetic risk to various approaches to treatment. In each case, the experience of addiction is told by different people, ranging from parents to prisoners to young children.

The series begins with testimony from recovering addicts, through a montage of intense interviews with nine people from various walks of life. In the second episode, Moyers interviews leading researchers—including National Institute on Mental Health Director Dr. Steven Hyman, National Institute on Drug Abuse Director Dr. Alan Leshner, Dr. Marc Schuckit of the San Diego VA Hospital and Dr. Anna Rose Childress of the Treatment Research Center at the University of Pennsylvania—to discuss what we know about how addiction affects the brain.

In the third episode, for example, Moyers visits Ridgeview Institute on Alumni Weekend to interview program director Paul H. Earley, M.D., and graduates of the Ridgeview program. Episode four focuses on the effects of addiction on children, and asks what can be done to break the cycle of addiction.

In the final hour, the series looks at the public policy challenge of addiction, pointing out that more Americans are addicted to alcohol and tobacco than to all illegal drugs combined. In this episode, Moyers interviews members of Congress, public health advocates, and federal officials such as General Barry McCaffrey of the Office of National Drug Control Policy and Dr. David Kessler, former director of the Food and Drug Administration, who led the federal effort to treat tobacco as a drug.

**Journalist Bill Moyers takes a look at addiction and recovery in America in a five-part series, premiering March 29, 30 and 31 at 9:00 p.m. Eastern time on PBS.**

A number of activities related to the series have been scheduled to challenge outdated perceptions of addiction, to help engage citizens in community activities, and to inform people about the resources available to seek help for themselves, their family members, friends and co-workers. A videoconference on February 24 will be geared specifically toward educators, while a series of activities on April 1, designated "National Take a Step Day," are designed to encourage Americans to learn about addiction, find out about local prevention and intervention programs, and make a personal assessment.

To support the series, WNET will publish six comprehensive viewers' guides geared toward the following groups: (1) the general public, (2) corporations, (3) health professionals, (4) families, (5) elementary schools, and (6) high schools. The family guide will be published in both English and Spanish. To receive a free copy, viewers should send a postcard specifying the guide they would like to: WNET, PO Box 245, Little Falls, NJ 07424-0245. The five-tape video set of the series also will be available to viewers and educators for purchase by calling Films for the Humanities and Sciences at 800/256-5127.

**Wayne State University**

The Department of Psychiatry and Behavioral Neurosciences of Wayne State University School of Medicine seeks a Board Certified Addiction Psychiatrist or ASAM certified Psychiatrist or Internist to develop and direct a substance abuse treatment unit (faculty rank open).

The services provided by this unit include inpatient and outpatient detoxification and an Intensive Outpatient Treatment Program. The development and evaluation of new detoxification treatment approaches would be strongly encouraged.

The successful applicant is expected to have experience with pharmacological, psychosocial and behavioral interventions for the treatment of substance use/dependence. The candidate will be expected to provide leadership to a multidisciplinary treatment team and administrative support staff. The candidate also will be expected to provide resident medical training and medical student teaching in the medical/psychiatric aspects of addictive disorders. In addition, fellows in Addiction Psychiatry will rotate through this unit for training.

The department offers strong encouragement for research and numerous opportunities exist for collaboration with faculty members in the Clinical Research Division on Substance Abuse.

Send CV and letter stating interest to Charles R. Schuster, Ph.D. (Director of the Clinical Research Division on Substance Abuse), c/o Thomas Uhde, M.D., Chair, Department of Psychiatry and Behavioral Neurosciences, 9B, University Health Center, 4201 St. Antoine, Detroit, MI 48201. Wayne State University is an equal opportunity/affirmative action employer. All buildings, structures, and vehicles at WSU are smoke-free.

**Wayne State University**  
**People working together to provide quality service.**

In response to a resolution from the American Society of Internal Medicine, the House resolved "that the AMA strongly encourage its members to contact the AMA Litigation Center with examples of the problem of employer knowledge of confidential employee health information leading to discrimination against employees with chronic illness" and "that the AMA urges employers and health insurance companies to adopt policies and practices that preserve employee confidentiality of medical information, including medical claims information, in the workplace." The Reference Committee on Medical Service noted that "the AMA is aware that employees' and job applicants' medical information may be inappropriately shared with employers in other, more subtle ways and that such information could provide the basis for employer discrimination." It notes that "the AMA will continue to monitor such reports...and take appropriate action, as needed."

Given that our patients with addictive diseases are clearly the subject of such workplace discrimination at times, ASAM members should consider making use of this AMA vehicle to advocate for and assist our patients, and should recognize this as one of many ways in which the AMA advocates for issues of concern to ASAM.

In response to a Resolution from the Section on Medical Schools, the House acted by unanimous consent to endorse and support a National Alcohol Screening Day planned for April 1999 by the National Mental Illness Screening Project (of which ASAM, NIAAA, and the APA are cosponsors) and to encourage physician participation in this event. Also adopted by the House was a Resolution submitted by the Organized Medical Staff Section that, except in the case of summary suspension necessary to protect patients from imminent harm, that no adverse action be taken against the privileges of a physician by a hospital, managed care organization or insurers based on a claim of physician impairment, unless there is due process and, where appropriate, a careful clinical evaluation of the physician. Basically, the AMA recognized the importance of regarding cases of alleged impairment (e.g., due to addiction) or disruptive physician behavior as allegations only, which should not be the basis of disciplinary/administrative action unless the allegations are appropriately reviewed. Almost approved, but referred for further study because of its obvious significance, was a resolution from the Indiana delegation regarding physician privacy; the Indiana resolution

called on the AMA to oppose any attempt by HMOs and other organizations that contract with physicians to require access to the physician's personal medical records as a criterion for participation in a provider contract.

The House referred for further study a resolution supporting the inclusion of medical students under the umbrella of state medical society and state medical board impaired physician programs; there are concerns about how to include students (non-physicians) under programs covered by state laws that establish physician licensing boards.

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### **ASAM's resolution on the proposed tobacco settlement generated intense debate on the floor of the House but finally was adopted.**

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Finally, ASAM is marking the 25th Anniversary of the Specialty Section Council on Preventive Medicine by preparing a summary of all the resolutions and reports adopted by the AMA House of Delegates in response to initiatives of ASAM. We plan to make this historical review available on the ASAM Web Page when it is completed.

### **AMA Accreditation Program**

The House of Delegates heard extensive discussion of the AMA's American Medical Accreditation Program (AMAP), which is designed to accredit individual physicians based on their credentials, experience, the quality of their practice locations, and outcomes of clinical practices. AMAP grows out of AMA policy that "board certification is not the only measure of physician quality."

Much feedback focused on concerns that the AMA has not done a good enough job of partnering with specialty societies and state medical associations in developing and rolling out AMAP. New Jersey is the first state to implement AMAP.

The House debated a resolution suggesting that the AMAP program attempt to differentiate between rigorous non-ABMS-approved medical specialty boards, and non-ABMS boards that offer certification after, for example, a weekend course only. There are currently 24 Boards approved by ABMS; there are over 125 non-ABMS-approved Boards of one kind or another. ASAM members need to keep themselves informed (through *ASAM News* and other sources) about the evolution of AMAP.

### **HCFA Evaluation Codes**

Another issue that proved controversial involves the new Evaluation & Management (E&M) codes being implemented by the Health Care Financing Administration for Medicare reimbursement (many private insurers are expected to emulate HCFA's E&M format). Testimony was long and complex, befitting the realities of this issue.

The AMA has persuaded HCFA to defer implementation of the new format until July 1, 1998. The House voted that the AMA should "seek Federal regulatory changes to reduce the burden of documentation for E&M services; use all available means to ensure appropriate safeguards for physicians so that insufficient documentation in the patient record, in and of itself, does not constitute fraud; and...continue to facilitate additional review of the E&M documentation guidelines in collaboration with the national medical specialty societies."

ASAM members, like all physicians, will be greatly affected by this issue. Dr. Miller is following up with the AMA regarding application of these new guidelines in addiction treatment settings.

### **Regulation of Managed Care**

The House voted that the AMA should "initiate or support changes in federal law to prohibit exemption from liability of managed care organizations, including ERISA plans, for damages resulting from their policies, procedures, or administrative actions taken in relation to patient care."

In a tight vote after detailed testimony, the House voted to establish the policy that "the giving of expert witness testimony by physicians constitutes the act of practicing medicine"; and referred for further study "the feasibility of developing mechanisms by which peer review of medico-legal expert witness testimony may be established" and mechanisms by which the AMA could "assist state, county, and specialty medical societies to discipline physicians who testify falsely by reporting its findings to the appropriate licensing authority." It was noted that in California, it is already policy that providing expert medical testimony constitutes the practice of medicine.

The House did not affirm a resolution from the Michigan delegation that all peer review should be conducted by "peers in the same specialty"; it did, however, vote that "the AMA strongly recommend that public and private sector review entities conduct their reviews using evidence-based guidelines or

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practice parameters developed by national medical specialty societies."

The House also adopted major new policy on two approaches used increasingly to influence or control the utilization of health services: disease management and demand management through telephone triage. It approved a Council on Medical Service report which described similarities and differences between these approaches, reviewed their growth, presented evidence on their effectiveness, and established 19 principles that should apply in their operation (see the AMA Website for further details).

The House defeated a resolution calling for AMA to support the granting of prescriptive privileges for controlled substances to Physicians Assistants. It adopted a resolution reaffirming AMA's "long-standing support for ample federal funding of medical research, including basic biomedical research, translational research, clinical research and clinical trials, health services research, outcomes research, and prevention research, and...that our AMA continue to support efforts by Research America and others to double the current federal medical research budget by the year 2002."

The AMA recognized the need to provide a voice of reason to counter animal rights activists who would limit medical research. The House voted "that the AMA study physicians' legal and ethical obligations with respect to reporting physical and medical conditions which may impair a patient's ability to drive"; ASAM will watch for the report on this matter at a future session of the HOD, given its relevance to physicians and their patients with addiction.

**Reports of the AMA Council on Scientific Affairs and Board of Trustees can be accessed on the AMA Web site at [www.ama-assn.org](http://www.ama-assn.org).**

#### **Follow-Up Action**

For those who wonder, "What ever happens when these Resolutions get adopted?", the AMA provided delegates with a report reviewing the results of past actions of the House of Delegates. As a follow-up to ASAM's resolution on training as a prerequisite to achieving expertise in addiction treatment, for example, a draft survey for other medical specialty societies has been created and a report of the AMA Board on

this topic will be presented to the 1998 Annual Meeting of the HOD.

In another example, AMA staff followed up ASAM's resolution on disclosure of addiction treatment history in applications for public housing by lobbying actively and initiating negotiations to influence legislative sponsor Sen. Phil Gramm (R-TX), and have succeeded in stalling a bill that would have mandated such disclosure.

Acting on resolutions concerning nutritional labels on alcoholic beverages, the AMA Council on Legislation drafted model federal legislation and sent a letter to the federal Bureau of Alcohol, Tobacco and Firearms.

These examples clearly demonstrate that AMA staff do move aggressively to implement the directives of the House of Delegates.

#### **Sunbeam Aftermath**

Most press coverage of the meeting focused on the aftermath of AMA's decision to withdraw from a product endorsement agreement with Sunbeam, and Sunbeam's subsequent lawsuit against the AMA. There has been tremendous scrutiny of this issue by the AMA Board of Trustees, and equal scrutiny of the Board itself and communications between AMA staff and the AMA Board. The House voted to establish an Ad Hoc Committee of the House to examine any otherwise unaddressed items in the Sunbeam arrangement.

Several senior AMA staff had been asked to resign by the Board, and AMA Executive Vice President John Seward, M.D., announced his resignation just prior to the Interim Meeting. The Board appointed Lynn E. Jensen, Ph.D., as Interim EVP while a national search is conducted for a new EVP. Dr. Jensen is an economist by training who has served on the AMA staff for many years. He has been Vice President for Strategic Planning and Development and most recently has served as Acting Chief Operating Officer.

The ASAM delegation to the AMA is concerned that the Sunbeam matter could adversely affect AMA membership. The delegates believe that this would be very unfortunate, as the mission of the AMA is important; the mission of ASAM through the AMA is important; and to be excessively preoccupied with the Sunbeam matter could divert the AMA from its mission to represent medicine and all our patients in Congress, the media, etc. The ASAM delegates welcome any questions from ASAM members who are considering their own membership status in the AMA in light of the Sunbeam affair.

## **Senior Research Scientists**

The Research Institute on Addictions is recruiting for four State of New York permanent Senior Research Scientist positions (starting in 1998) and two Postdoctoral Research Associates (temporary 2-3 year positions, Foundation funding).

Candidates for either position must have a Ph.D. in criminal justice, epidemiology, health sciences, psychology, sociology, or some other relevant field. For the Senior Research Scientist positions, experience as a Principal Investigator on externally-funded research projects or prior grant funding (preferably from NIAAA and/or NIDA) is highly desired, and preference will be given to candidates with current funding. For the junior positions, evidence of strong likelihood of future funding is required. All successful candidates are expected to obtain funding in areas of addiction research which answer important scientific questions, account for previously unexplained phenomena, and open significant new avenues for further study.

Applications are welcome from individuals at all levels of experience beyond the doctorate. Permanent positions are subject to New York State Civil Service regulations. Salary and fringe benefits are competitive. Secondary faculty appointments at SUNY-Buffalo are available. Applications from minority candidates are particularly welcome.

**Visit the RIA website at:  
<http://www.ria.org>.**

Send cover letter outlining research experience and future plans, curriculum vitae, and three letters of support to: Mark Ruda, Personnel, Research Institute on Addictions, 1021 Main Street, Buffalo, NY 14203. Application review will begin February 1, 1998. AA/EOE

## THE AMA-RPS AND MSS ASSEMBLY INTERIM MEETINGS

Mohammed A. Khan, M.D., Members-in-Training Committee

ASAM's delegates to the AMA were very active, as usual, at the Resident Physician Section (RPS) and the Medical Student Section (MSS). The RPS delegation was led by Dr. Christine Delos Reyes and the MSS delegation by Susan Lane.

The most controversial issue debated in the RPS assembly was resident collective bargaining, initially raised when residents at the Boston Medical Center approached the National Labor Relations Board to form a union to negotiate with Medical Center administrators on matters related to resident well-being. Much confusion was evident among residents, as was mistrust of hospital administrators about the issue. In reality, however, what the residents want is relatively straightforward. "Problems should be solved locally," was the consensus among residents at the RPS interim meeting. Residents do not want to form a union with the ability to strike. What they really want is to reach solutions to problems via collaboration between ACGME-sanctioned resident negotiation groups at individual institutions and the hospital administration. Most residents prefer to work through the ACGME rather than the NLRB because, if the NLRB recognizes residents as employees and grants them the right to affiliate with professional labor organizers (unions), residents will potentially gain the ability to strike.

The AMA's Board of Trustees advised the RPS against filing an *amicus* brief with the NLRB at this time. However, it promised to do so in the event the ACGME fails to adopt a mechanism for the local resolution of grievances in a timely and effective manner. Resident leaders, who pressed the AMA to file a brief immediately, did so because of their distrust of the American Association of Medical Colleges, which is one of the parent organizations of the ACGME. The AAMC has opposed the right of residents at the Boston Medical Center to collectively bargain.

Delegates departed from the meeting with an understanding that the AMA will work with the ACGME to require teaching institutions to initiate arrangements for local resident organizations to negotiate collectively with the institutions' administration on issues of resident well-being and patient care. Moreover, teaching institutions will be forbidden by the ACGME to seek retribution against individual residents involved in activities related to these resident organizations.

Other significant resolutions supported by the ASAM Delegates and approved by the RPS assembly favored: (1) establishment of a legislative internship for residents in the AMA's Washington, D.C. office; (2) a request that AMA work with the appropriate agencies to develop recommendations regarding the limitation of medical school seats consistent with current work force needs; (3) the need to study the effect of HCFA teaching physician reimbursement regulations on resident education; (4) AMA opposition to any legislative or regulatory attempt to mandate a DNR order as a condition for patient admission to a nursing home.

In the Medical Student Section, controversy centered on the Sunbeam controversy and the need to formulate policy for future interactions between the AMA and other business corporations. The assembly finally approved a resolution opposing AMA endorsement of any

*Continued next column*

## NEW SUBSTANCE ABUSE SERVICES GUIDE AVAILABLE TO PHYSICIANS

Because primary care physicians and other clinicians, through their regular, long-term contact with patients, are in an ideal position to screen for alcohol and drug problems, the federal Center for Substance Abuse Treatment (CSAT) has developed a new guide to help physicians manage or appropriately refer patients.

The new publication, "A Guide to Substance Abuse Services for Primary Care Clinicians," provides practical information about screening patients for alcohol and other drug problems, conducting brief interventions in the early stages of problem development, and referring more severely affected patients for in-depth assessment and treatment. The publication also reviews the types of treatment available and outlines the physician's role in aftercare.

"Primary care clinicians have an important role to play in solving the serious problem of substance abuse in America," said Nelba Chavez, Ph.D., Administrator of the Substance Abuse and Mental Health Services Administration, parent agency of CSAT. "Studies have found that primary care clinicians can have a dramatic impact on substance abuse and its harmful consequences through office-based interventions that take only 10 or 15 minutes. Yet, this potential for improving lives and reducing costs to society is largely untapped."

The guide gives specific guidance on identifying signs of substance abuse, how to broach the subject with patients, and which screening and assessment instruments to use. It explains how to perform an office-based brief intervention in which patient and physician establish mutually agreed upon goals and reach a "contract" that the patient will stop or cut back.

"A Guide to Substance Abuse Services for Primary Care Physicians" (TIP 24) also includes recommendations about pharmacotherapy and reviews legal issues surrounding privacy and confidentiality. Single copies of the publication are available at no charge from the National Clearinghouse for Alcohol and Drug Information (NCADI) at 1-800/729-6686, or can be downloaded from the CSAT Web page at [www.samhsa.gov](http://www.samhsa.gov).

product or service marketed to consumers unless such an agreement is first approved by the AMA's Board of Trustees. In addition, the medical students opposed endorsements made on an exclusive basis.

The issue of affirmative action also was extensively debated and a consensus eventually reached that the AMA should investigate and report on strategies used by medical schools to increase minority enrollment and retention.

Other notable resolutions supported by the ASAM delegates and adopted by the MSS assembly involved:

- The enforcement of quality and safety standards for domestically manufactured and imported hand guns;
- Opposition to government agency access to confidential patient records without the patient's informed consent;
- Endorsement of making AMA Board and Council reports more accessible by posting them on the Internet;
- Advocating the acceptance of blood donated by hemochromatosis patients as a measure to overcome the shortage of blood supply.



# Criteria for Substance Dependence Diagnosis

## Diagnostic & Statistical Manual - III - R

[DSM - III - R is not currently used but has historical utility.] At least three of the following are necessary; some of the symptoms of the disturbance must have persisted for at least one month or have occurred repeatedly over a longer period of time.

## Diagnostic & Statistical Manual - IV

A maladaptive pattern of substance use leading to clinically significant impairment or distress as manifested by three (or more) of the following, occurring at any time in the same 12-month period:

## International Classification of Diseases - 10

[ICD - 10 research criteria differ from the clinical diagnostic guidelines listed here.] Three or more of the following must have been experienced or exhibited at some time during the previous year.

Substance is often taken in larger amounts or over longer period than intended	Substance is often taken in larger amounts or over longer period than intended	Difficulties in controlling substance-taking behavior in terms of its onset, termination, or levels of use
Persistent desire or one or more unsuccessful efforts to cut down or control substance use	Persistent desire or unsuccessful efforts to cut down or control substance use	A strong desire or sense of compulsion to take the substance
A great deal of time is spent in activities necessary to get the substance (e.g. theft), taking the substance (e.g. chain smoking), or recovering from its effects	A great deal of time is spent in activities necessary to obtain the substance (e.g. visiting multiple doctors or driving long distances), use the substance (e.g. chain smoking), or recover from its effects	Progressive neglect of alternative pleasures or interests because of psychoactive substance use, increased amount of time necessary to obtain or take the substance or to recover from its effects
Important social, occupational, or recreational activities given up or reduced because of substance abuse	Important social, occupational, or recreational activities given up or reduced because of substance abuse	
Continued substance use despite knowledge of having a persistent or recurrent social, psychological, or physical problem that is caused or exacerbated by use of the substance	Continued substance use despite knowledge of having a persistent or recurrent social, psychological, or physical problem that is caused or exacerbated by use of the substance	Persisting with substance use despite clear evidence of overtly harmful consequences, depressive mood states consequent to heavy use, or drug-related impairment of cognitive functioning
Marked tolerance: need for markedly increased amounts of the substance (>50% increase) in order to achieve intoxication or desired effect, or markedly diminished effect with continued use of the same amount	Tolerance, as defined by either: a) need for markedly increased amounts of the substance in order to achieve intoxication or desired effect; or b) markedly diminished effect with continued use of the same amount	Evidence of tolerance, such that increased doses of the psychoactive substance are required in order to achieve effects originally produced by lower doses
Characteristic withdrawal symptoms	Withdrawal, as manifested by either: a) characteristic withdrawal syndrome for the substance; or b) the same (or closely related) substance is taken to relieve or avoid withdrawal symptoms	A physiological withdrawal state when substance use has ceased or been reduced, as evidence by: the characteristic withdrawal syndrome for the substance; or use of the same (or a closely related) substance with the intention of relieving or avoiding withdrawal symptoms
Substance often taken to relieve or avoid withdrawal symptoms		
Frequent intoxication or withdrawal symptoms when expected to fulfill major role obligations or when use is physically hazardous		
	<p><b>National Institute on Drug Abuse</b>            National Institutes of Health            Bethesda, Maryland</p> <p><a href="http://www.nida.nih.gov">http://www.nida.nih.gov</a></p>	

### California

*Chapter President: Gail Shultz, M.D.*

*Regional Director: Gail Shultz, M.D.*

Max Schneider, M.D. will be honored (and roasted) at a CSAM Fundraising Gala on Saturday evening, February 28, at the Center Club, adjacent to the Orange County Performing Arts Center. CSAM members and their guests will come together to celebrate CSAM's 25 years and raise funds to support future activities and to underwrite scholarships for residents. The foundation associated with CSAM, the Medical Education and Research Foundation for the Treatment of Alcoholism and other Drug Dependencies, gives free tuition and pays for some travel and overnight costs for residents throughout the State. For example, at the 1997 State of the Art Program in San Francisco, 10 Residents attended the program on MERF scholarships, which are underwritten by donations to the Foundation.

The purpose of the fundraising gala is to bring colleagues together for an evening of fun. CSAM members have always ranked "interaction with colleagues" as one of the top three reasons they join CSAM—and some of the interaction at this meeting may be outrageous! (You can't roast Max Schneider and be conventional).

New CSAM officers elected at the 1997 business meeting in November are Peter Banys, M.D., President-Elect; and H. Westley Clark, M.D. and Walter Ling, M.D., new members-at-large of the Executive Council.

### Hawaii

*Chapter President:*

*Gerald McKenna, M.D., FASAM*

*Regional Director:*

*Richard Tremblay, M.D., FASAM*

The Hawaii Chapter looks forward to hosting the first Region VIII conference on February 12-14, 1998, in Honolulu. For program information, contact Dr. Gerald McKenna at 808/246-0663. For hotel reservations, call 800/645-5687.

### Illinois

*Chapter President: Norman S. Miller, M.D.*

*Regional Director: Norman S. Miller, M.D.*

ISAM will provide a course for the Midwest Clinical Conference of the Chicago Medical Society on February 21, 1997.

At ISAM's Annual Meeting in November 1997, Norman S. Miller, M.D. assumed the Presidency and Daniel Angres, M.D., became President-Elect.

### Michigan

*Chapter President: Thomas Kane, D.O.*

*Regional Director: Norman S. Miller, M.D.*

The Michigan Chapter has scheduled a conference for April 4, 1998, in Detroit, to focus on practical treatment issues and an overview of Michigan's Health Professionals Recovery Program.

### New Jersey

*Chapter President:*

*John Verdon, Jr. M.D., P.A.*

*Regional Director:*

*R. Jeffrey Goldsmith, M.D.*

The New Jersey Chapter is in the process of incorporation and has developed and adopted its constitution and by-laws. The chapter also is dealing with the state Board of Medical Examiners regarding Withdrawal Management.

James R. O'Neill, M.D., will coordinate a study group for the ASAM Certification Examination in November 1998. Members interested in joining the group are invited to contact Dr. O'Neill by phone at 732/776-6947 or by fax at 732/776-5690.

Minutes of the New Jersey chapter meeting at the ASAM State of the Art Conference in Washington, D.C. are available from Secretary Lance Gooberman at 609/663-4447 or by fax at 609/488-6380.

### New York

*Chapter President: Merrill Herman, M.D.*

*Regional Director:*

*Lawrence S. Brown, Jr., M.D., M.P.H., FASAM*

The annual state chapter educational business meeting will be held in March 1998. ASAM President-Elect Marc Galanter, M.D. has been invited to present on Network Therapy.

ASAM sponsored a Medical Plenary at the first annual conference of the New York State Association of Alcoholism and Substance Abuse Providers (NYSAAASAP), held in September 1997 at Saratoga Springs. Entitled "Addiction Medicine: Science, Not Ideology," the plenary was chaired by Dr. Herman and featured a presentation on ambulatory detoxification by Dr. Peter Szilagyi (chapter Secretary).

### Ohio

*Chapter President: Ted M. Hunter, M.D.*

*Regional Director:*

*R. Jeffrey Goldsmith, M.D.*

Members who wish to participate in the state Chapter activities are encouraged to contact Ted Hunter at 513/867-0015 if they are will-

ing to serve on the Board, as elections will be held soon.

### South Carolina

*Chapter President: John E. Emmel, M.D.*

*Regional Director:*

*Paul H. Earley, M.D., FASAM*

The SCSAM Board met in January 1998. The chapter co-sponsored the recent University of South Carolina Annual Update on Alcohol & Drug Issues. ASAM President G. Douglas Talbott, M.D., addressed the conference and also participated in the SCSAM Business Meeting.

New officers elected for the 1998-1999 term at the December meeting are: John E. Emmel, M.D., President; Ron Paolini, D.O., President-Elect; Tim Fischer, D.O., Immediate Past President; Robert E. Sylvester, D.O., Secretary; and Hugh Coleman, M.D., Treasurer.

### Region IV

*Regional Director:*

*R. Jeffrey Goldsmith, M.D.*

A Region IV luncheon meeting was held during the ASAM State-of-the-Art meeting in cooperation with the New Jersey and Pennsylvania Chapters.

In conjunction with the Ohio chapter of Physicians for Social Responsibility, the Ohio Chapter of ASAM sponsored Dr. Ziata Zigic from the Republic of Bosnia and Herzegovina. Dr. Zigic teaches embryology at the Medical School of the University of Tuzla and is President of the Tuzla Drug/Tobacco Prevention Society.

### Region VIII

*Regional Director:*

*Richard E. Tremblay, M.D., FASAM*

Region VIII will hold its first annual meeting February 12-14, 1998, in Honolulu, Hawaii. For program information, contact Dr. Gerald McKenna at 808/246-0663. For hotel reservations, call 1-800/645-5687.

The Washington Chapter sponsored a course entitled "Addiction 101," presented by ASAM members, at the annual meeting of the Washington State Medical Association. William Dickinson, D.O., served as coordinator of the course, which was well-attended and received.

Washington State ASAM Members were very active in the defeat of a ballot initiative to legalize or decriminalize the use of marijuana and all other Schedule I drugs in the November 1997 elections.

*Continued on next page*

## INTERNATIONAL Bangladesh

Contact Person:  
Talukder A. Razzaque, M.D.

Regional Director:

Peter Mezciems, M.D., FASAM

A seminar on Heroin Addiction in Bangladesh was held in Rajshahi Division at the City Hall in January 1998. Information is available from Dr. N. Nasrin at GPO Box 96, Dhaka-1000, Bangladesh.

A seminar on drug abuse was held in February 1997 at the project office of the Organization, and a rally was held to create awareness of anti-drug issues in 1996.

Goals articulated by the members include coordination with the public to create awareness concerning the adverse effects of drug abuse, as well as coordination with other organizations to establish policies that discourage drug abuse. Members also called for more organized seminars and symposia on scientific issues related to drug abuse.



ASAM Past President David E. Smith, M.D., brought greetings from the Society to the 9th Annual Chemical Dependency Conference of the Panamanian Society of Addiction Medicine, held in August 1997. Pictured (from left to right) are Panamanian Society members Carlos Smith, M.D., Carlos Del Rey, M.D., Dr. Smith, and Saul Alvarado, M.D.

## BASIC SCIENCE CONFERENCE ANNOUNCED

A conference on "The Glutamate Cascade: Common Pathways of Central Nervous System Disease States" has been scheduled for May 4-5, 1998, on the NIH campus in Bethesda, MD. Co-sponsored by the National Institute on Drug Abuse, the conference features presenters from a variety of disciplines. Additional information is available from Robyn Semsler at 301/468-6004, ext. 431, or by E-mail at [rsemsler@md.capconcorp.com](mailto:rsemsler@md.capconcorp.com).

## IN MEMORIAM

Chester A. Swinyard, M.D., died November 11, 1997, at Menlo Park, CA; he was 91. Dr. Swinyard was professor of anatomy at the University of Utah and later visiting professor emeritus in the Division of Orthopedic Surgery at Stanford University. An accomplished violinist, Dr. Swinyard also made seminal contributions to the field of addiction medicine as a founder of the Summer School on Alcohol Studies at the University of Utah and through a key role in arranging for ASAM to receive its first ACCME accreditation. Donations in his memory may be made to the Chester Swinyard Research Fund at the Spina Bifida Association of America, 4590 McArthur Blvd., N.W., Suite 250, Washington, DC 20007. Dr. Swinyard is survived by his wife of 68 years, Vivian Swinyard.

Janieth K. Wise, M.D., 48, died January 3, 1998, at Arlington, VA. Dr. Wise, a psychiatrist, was medical director of Arlington Hospital's Addiction Treatment Program. She also was affiliated with the Psychiatric Institute of Washington and maintained a private practice in Arlington. Dr. Wise, who was certified by ASAM, served on the board of the Washington Area Council on Alcoholism and was a member of the American Association of Psychiatrists in Alcoholism and Addiction. She is survived by her husband, Quinn H. Bishop.

## CORRECTION

Melissa Lee Warner, M.D. is co-author with Charles W. Morgan, M.D., of the Members Speak Out article on "Spirituality and HIV Infection" in the October-November issue of *ASAM News*. Dr. Warner's name was inadvertently omitted from the byline.

## UPDATES TO ASAM'S WEBSITE

William Hawthorne, M.D., ASAM Webmaster

Recent additions to ASAM's website at <http://www.asam.org> include the following:

- Caron Foundation gives Stan Gitlow its highest award.
- Mixing drinks may cause liver damage.
- A drink a day keeps the Grim Reaper away.
- Joint ASAM-AMBHA statement on benefits.
- Search for ASAM's AMA delegate.
- ASAM PPC-2 new training approach.

ASAM's Website keeps you current on activities between meetings and brings you an on-line version of *ASAM News*. All of ASAM's public policy statements are available for downloading, as are abstracts from recent issues of the *Journal of Addictive Diseases*. A conference calendar gives you the opportunity to check upcoming events, with hyperlinks to full programs as they become available. The recently added *ASAM Membership Directory* updates the hard copy, which is two years old and not scheduled for revision until later this year.

The site also contains lists of ASAM staff (with E-mail addresses and areas of responsibility), Committee chairs, Board members, and state chapter dues. It's all there—only a few clicks away! A Conference Channel provides links to the cities (and hotels) where ASAM conferences are held, so that members can easily find the information needed to make their travel plans, down to plotting out local sightseeing and ground transportation.

For all of these reasons, you should take full advantage of what our Website brings to your membership and visit us soon at <http://www.asam.org>!

severe negative consequences for health, both mental and physical. But drug abuse and addiction also have tremendous implications for the health of the public, because drug use, directly or indirectly, is now a major vector for the transmission of many serious infectious diseases—particularly acquired immunodeficiency syndrome (AIDS), hepatitis, and tuberculosis—as well as violence. Because addiction is such a complex and pervasive health issue, we must include in our overall strategies a committed public health approach, including extensive education and prevention efforts, treatment, and research.

Science is providing the basis for such public health approaches. For example, two large sets of multisite studies (3) have demonstrated the effectiveness of well-delineated outreach strategies in modifying the behaviors of addicted individuals that put them at risk for acquiring the human immunodeficiency virus (HIV), even if they continue to use drugs and do not want to enter treatment. This approach runs counter to the broadly held view that addicts are so incapacitated by drugs that they are unable to modify any of their behaviors. It also suggests a base for improved strategies for reducing the negative health consequences of injection drug use for the individual and for society.

### What Matters in Addiction

Scientific research and clinical experience have taught us much about what really matters in addiction and where we need to concentrate our clinical and policy efforts. However, too often the focus is on the wrong aspects of addiction, and efforts to deal with this difficult issue can be badly misguided.

Any discussion about psychoactive drugs inevitably turns to the question of whether a particular drug is physically or psychologically addicting. In essence, this issue revolves around whether or not dramatic physical withdrawal symptoms occur when an individual stops taking a drug, what is typically called physical dependence by professionals in the field. The assumption that often follows is that the more dramatic the physical withdrawal symptoms, the more serious or dangerous the drug must be.

This thinking is outdated. From both clinical and policy perspectives, it does not matter much what physical withdrawal symptoms, if any, occur. First, even the florid withdrawal symptoms of heroin addiction can now be easily managed with appropriate medication. Second, and more important, many of the most addicting and dan-

gerous drugs do not produce severe physical symptoms upon withdrawal. Crack cocaine and methamphetamine are clear examples: Both are highly addicting, but cessation of their use produces few physical withdrawal symptoms, certainly nothing like the physical symptoms accompanying alcohol or heroin withdrawal.

What does matter tremendously is whether or not a drug causes what we now know to be the essence of addiction: compulsive drug seeking and use, even in the face of negative health and social consequences (4). These are the characteristics that ultimately matter most to the patient and are where treatment efforts should be directed. These behaviors are also the elements responsible for the massive health and social problems that drug addiction brings in its wake.

### Addiction Is a Brain Disease

Although each drug that has been studied has some idiosyncratic mechanisms of action, virtually all drugs of abuse have common effects, either directly or indirectly, on a single pathway deep within the brain. This pathway, the mesolimbic reward system, extends from the ventral tegmentum to the nucleus accumbens, with projections to areas such as the limbic system and the orbitofrontal cortex. Activation of this system appears to be a common element in what keeps drug users taking drugs. This activity is not unique to any one drug; all addictive substances affect this circuit (5).

Not only does acute drug use modify brain function in critical ways, but prolonged drug use causes pervasive changes in brain function that persist long after the individual stops taking the drug. Significant effects of chronic use have been identified for many drugs at all levels: molecular, cellular, structural, and functional (6, 7). The addicted brain is distinctly different from the nonaddicted brain, as manifested by changes in brain metabolic activity, receptor availability, gene expression, and responsiveness to environmental cues. Some of these long-lasting brain changes are idiosyncratic to specific drugs, whereas others are common to many different drugs (6–9). The common brain effects of addicting substances suggest common brain mechanisms underlying all addictions (5, 7, 9, 10).

That addiction is tied to changes in brain structure and function is what makes it, fundamentally, a brain disease. A metaphorical switch in the brain seems to be thrown as a result of prolonged drug use. Initially, drug use is a voluntary behavior, but when that switch is thrown, the individual moves into the state of addiction, characterized by compulsive drug seeking and use (11).

Understanding that addiction is, at its core, a consequence of fundamental changes in brain function means that a major goal of treatment must be either to reverse or to compensate for those brain changes. These goals can be accomplished through either medications or behavioral treatments [behavioral treatments have been successful in altering brain function in other psychobiological disorders (12)]. Elucidation of the biology underlying the metaphorical switch is key to the development of more effective treatments, particularly antiaddiction medications.

### But Not Just a Brain Disease

Of course, addiction is not that simple. Addiction is not just a brain disease. It is a brain disease for which the social contexts in which it has both developed and is expressed are critically important. The case of the many thousands of returning Vietnam war veterans who were addicted to heroin illustrates this point. In contrast to addicts on the streets of the United States, it was relatively easy to treat the returning veterans' addictions. This success was possible because they had become addicted while in a setting almost totally different from the one to which they had returned. At home in the United States, they were exposed to few of the conditioned environmental cues that had initially been associated with their drug use in Vietnam. Exposure to conditioned cues can be a major factor in causing persistent or recurrent drug cravings and drug use relapses even after successful treatment (13).

The implications are obvious. If we understand addiction as a prototypical psychobiological illness, with critical biological, behavioral, and social-context elements, our treatment strategies must include biological, behavioral, and social-context elements. Not only must the underlying brain disease be treated, but the behavioral and social cue components must be addressed, just as they are with many other brain diseases, including stroke, schizophrenia, and Alzheimer's disease.

### A Chronic, Relapsing Disorder

Addiction is rarely an acute illness. For most people, it is a chronic, relapsing disorder. Total abstinence for the rest of one's life is a relatively rare outcome from a single treatment episode. Relapses are more the norm. Thus, addiction must be approached more like other chronic illnesses—such as diabetes and chronic hypertension—than like an acute illness, such as bacterial infection of a broken bone (1). This requirement has tremendous implications for how we evaluate treatment effectiveness and treatment outcomes. Viewing addiction as a chronic, relapsing disorder means that a good treatment outcome, and the most reasonable expecta-

tion, is a significant decrease in drug use and long periods of abstinence, with only occasional relapses. That makes a reasonable standard for treatment success—as is the case for other chronic illness—the management of the illness, not a cure (1, 2).

### Conclusion

Addiction as a chronic, relapsing disease of the brain is a totally new concept for much of the general public, for many policymakers, and, sadly, for many health care professionals. Many of the implications have been discussed above, but there are others.

At the policy level, understanding the importance of drug use and addiction for both the health of individuals and the health of the public affects many of our overall public health strategies. An accurate understanding of the nature of drug abuse and addiction should also affect our criminal justice strategies. For example, if we know that criminals are drug addicted, it is no longer reasonable to simply incarcerate them. If they have a brain disease, imprisoning them without treatment is futile. If they are left untreated, their recidivism rates to both crime and drug use are frighteningly high; however, if addicted criminals are treated while in prison, both types of recidivism can be reduced dramatically (14). It is therefore counterproductive to not treat addicts while they are in prison.

At an even more general level, understanding addiction as a brain disease also affects how society approaches and deals with addicted individuals. We need to face the fact that even if the condition initially comes about because of a voluntary behavior (drug use), an addict's brain is different from a nonaddict's brain, and the addicted individual must be dealt with as if he or she is in a different brain state. We have learned to deal with people in different brain states for schizophrenia and Alzheimer's disease. Recall that as recently as the beginning of this century we were still putting individuals with schizophrenia in prisonlike asylums, whereas now we know they require medical treatments. We now need to see the addict as someone whose mind (read: brain) has been altered fundamentally by drugs. Treatment is required to deal with the altered brain function and the concomitant behavioral and social functioning components of the illness.

Understanding addiction as a brain disease explains in part why historic policy strategies focusing solely on the social or criminal justice aspects of drug use and addiction have been unsuccessful. They are missing at least half of the issue. If the brain is the core of the problem, attending to the brain needs to be a core part of the solution.

## The American Society of Addiction Medicine

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ferent from the effects of large amounts of drugs. The individual, once addicted, has moved from a state where drug use is voluntary and controlled to one where drug craving, seeking, and use are no longer under the same kind of voluntary control, and these changes reflect changes in brain function. The exact mechanisms involved are not known. For example, it is not clear whether that change in state reflects a relatively precipitous change in a single mechanism or multiple mechanisms acting in concert, or whether the shift to addiction represents the sum of more gradual neuroadaptations. Moreover, there are individual differences in the vulnerability to becoming addicted and the speed of becoming addicted. For some individuals, the metaphorical switch moves quickly, whereas for others the changes occur quite gradually (6–10).

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## RUTH FOX MEMORIAL ENDOWMENT FUND

Dear Colleague:

The Ruth Fox Memorial Endowment Fund ended 1997 with a total of \$2,285,816 in pledges, contributions and other gifts. We thank you, our donors, for your commitment and generosity. Our goal is to reach \$3 million by the end of 1998. We can do this with your support. Every pledge and contribution, large or small, will bring us closer to accomplishing this goal. Bequests, insurance policies, trust funds, and stocks are other ways to contribute to the Endowment Fund.

We especially want to thank The Yasuda Bank and Trust Company (USA), New York City, for making an additional contribution in December, bringing their total contributions over the years to \$12,000. ASAM is extremely grateful to the bank's officers for their ongoing support and for helping secure the Society's future and the future of Addiction Medicine.

**Reminder:** A special program will be presented by Paul E. Dow, J.D., on "Protecting Your Assets from Malpractice Suits, Estate and Other Financial Strategies," Thursday, April 16, 1998, at 7:30 p.m. during ASAM's Annual Medical-Scientific Conference in New Orleans. If you plan to attend, please check the session on the conference program/registration form when you return it. Everyone is invited!

The Ruth Fox Memorial Endowment Fund Reception (by invitation only) is scheduled for Friday, April 17, 1998, at the Conference. All donors will receive an invitation.

Would you like to discuss various ways that you can help support the Endowment Fund, or would you like to make a pledge/upgrade a pledge, contribution or bequest? If so, please contact Ms. Claire Osman at ASAM, 12 West 21st Street, New York, NY 10010. Telephone 1-800/257-6776.

*Max A. Schneider, M.D., FASAM  
Chair, Endowment Fund*

*Jasper G. Chen See, M.D.  
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**As of January 20, 1998  
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EOE,M/F,V/H

# ASAM

# CONFERENCE CALENDAR

## ASAM STAFF ONLINE

1998

### February 18-22, 1998

Southern Coastal Conference:  
A Medical-Legal Conference on Addiction  
(jointly sponsored by ASAM)  
Jekyll Island, GA

### February 19

Forensic Issues in Addiction Medicine  
Atlanta, GA  
6 Category 1 CME credits

### February 20 - 22

ASAM MRO Course  
Atlanta, GA  
19 Category 1 CME credits

### March 5 - 6

The Forum on Regulatory Management of  
Chemically Dependent  
Health Care Practitioners  
Arlington, VA  
(ASAM is a cooperating organization)

### March 6 - 8

14th Annual Meeting of The Carolina's  
Medical Professional Group:  
"Spirituality and Physiologic Healing:  
Newer Concepts"  
Wilmington, NC  
(jointly sponsored by ASAM)

### April 16

The Ruth Fox Course for Physicians  
New Orleans, LA  
7 Category 1 CME credits

### April 16

Forum on AIDS and Addictions  
New Orleans, LA  
7 Category 1 CME credits

1998

### April 17-19

29th Annual ASAM  
Medical-Scientific Conference  
New Orleans, LA  
23 Category 1 CME credits

### July 16-18

ASAM MRO Course  
San Diego, CA  
19 Category 1 CME credits

### September 28 - 30

ICAA 1998 Annual Research Conference  
"Women and Adolescent Females in  
Community Corrections"  
(ASAM is a Supporting Organization)

### October 22-24

Review Course in Addiction Medicine  
Chicago, IL  
21 Category 1 CME credits

### November 5-8

11th National Conference  
on Nicotine Dependence  
Marina del Ray, CA  
17.5 Category 1 CME credits

### November 13 - 15

Medical Review Officer Training Course  
Toronto, Ontario  
19 Category 1 CME Credits

### November 21

Certification/Recertification Examination  
Atlanta, GA  
LaGuardia, NY  
Los Angeles, CA  
5 Category 1 CME credits

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## Important Dates for Addiction Medicine ASAM Treatment Providers!



The American Society  
of Addiction Medicine's  
29th Annual  
Medical-Scientific  
Conference  
April 16-19, 1998

New Orleans Marriott Hotel  
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