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NEWSLETTER OF THE AMERICAN SOCIETY OF ADDICTION MEDICINE

INSIDE

Dr. Andrea Barthwell Chosen ASAM President-Elect

David E. Smith, M.D., FASAM

Chair, Nominating and Awards Committee

Andrea G. Barthwell, M.D., FASAM, has been voted ASAM's President-Elect in just-completed balloting. Joining Dr. Barthwell as new officers of the Society are Michael M. Miller, M.D., FASAM, who has been elected Secretary, and Elizabeth F. Howell, M.D., elected Treasurer. New Directors-at-Large are David R. Gastfriend, M.D., James A. Halikas, M.D., Christine L. Kasser, M.D., David C. Lewis, M.D., John Slade, M.D., FASAM, James W. Smith, M.D., FASAM, and William Vilensky, D.O., R.Ph., FASAM. (Drs. Halikas, Kasser and Lewis are incumbents.)

Newly elected officers will serve two-year terms, while Directors serve four-year terms. They will be installed during the Business Meeting at ASAM's 30th Annual Medical-Scientific Conference, April 29-May 2, 1999, in New York City. President-Elect Marc Galanter, M.D., FASAM, will assume the ASAM Presidency at that time, as current President G. Douglas Talbott, M.D., FASAM, assumes the duties of Immediate Past President.

Dr. Barthwell is president of Encounter Medical Group, a multispecialty practice providing medical services to behavioral health systems and psychiatric services in primary care settings. She describes herself as a "generalist in Addiction Medicine with training in many modalities and settings (i.e., medical model — all levels of care, methadone maintenance, therapeutic community, sanctuary, social setting, detoxification, etc.)." She has experience in treating diverse populations, such as incarcerated persons, pregnant or parenting women, adolescents, and ethnic minorities. She serves as a senior advisor on women's health to the National Women's Resource Center, and is active as a consultant and lecturer.

Dr. Barthwell

Dr. Barthwell's professional activities encompass service as a board member at large and immediate past president of the Illinois Society of Addiction Medicine, past board member of the Chicago Area AIDS Task Force and the AIDS Pastoral Care Network, co-chairperson of the Illinois AIDS Advisory Council and chair of its medical subcommittee, member of the National Advisory Board of the federal Center for Substance Abuse Treatment and the National Institute on Drug Abuse, and past member of the Drug Abuse Advisory Committee of the U.S. Food and Drug Administration.

Within ASAM, Dr. Barthwell currently serves as Secretary and member of the Board of Directors. She has chaired the Review Course in Substance Abuse Disorders (1989, 1990, 1992), the State of the Art Course in Addiction Medicine (1991, 1993), and the Nicotine Conference (1995, 1996). In addition to chairing the Clinical Issues Section, Dr. Barthwell was the organizing Chairperson of the Cross Cultural Concerns Committee and chair of the Resources and Development Committee. She also serves on the Methadone, Membership, and Review Course committees and on the Task Force on Addiction Medicine. Dr. Barthwell was certified in Addiction Medicine in 1986. ■

SAMHSA EVALUATES STATE EFFORTS TOWARD PARITY

James F. Callahan, D.P.A.

While the Congress has been unable to enact legislation requiring health plans to offer coverage of mental health and addiction treatment on the same terms as other health benefits, a number of states have enacted some type of parity legislation. Now the Substance Abuse and Mental Health Services Administration (SAMHSA) has evaluated these state laws in a report entitled "The Costs and Effects of Parity for Mental Health and Substance Abuse Insurance Benefits," and concluded that most such laws are limited in scope or application.

One of the most common limitations, SAMHSA found, was failure to require parity coverage for addiction treatment. Indeed, of the 12 states that adopted parity legislation through the end of 1997, only five — Arizona, Maryland, Minnesota, North Carolina, and Vermont — require that benefits cover addiction treatment. SAMHSA concluded that several facets of the Vermont law, including the fact that it covers both mental health and addictive disorders while avoiding widely used limitations and exemptions (such as language exempting small businesses), make it a model for other states. In fact, the Vermont measure builds on groundwork contained in 1996 Vermont legislation that required managed care organizations to register with the state and established an independent review panel to hear consumer grievances.

As advocates mark the first year of the Vermont parity law's enactment, they note that opponents' allegations that its passage would cause a stampede of companies into self-insurance (which is exempt from the parity provisions) have proved unfounded. Moreover, proponents' estimates that parity would cause premiums to rise by no more than 3% have proved accurate. Adds Ken Libertoff, executive director of the Vermont Association for Mental Health, "We have reason to believe that over the next year or two, the parity legislation will really be effective in terms of the way we saw it...[which was] as a way of creating a level playing field for consumers." Libertoff adds that public reaction has been positive, but that a comprehensive evaluation is needed to "sort out what the real access issues are. Are people really getting access to treatment? And is there some way of evaluating the quality?"

Lessons for Other States

Libertoff offers lessons from the Vermont experience that may assist parity advocates in other states:

- Begin with a goal of comprehensive parity legislation that covers both mental health and addiction treatment, without exemptions for specific groups such as small businesses. "The legislative process is one of compromise," Libertoff observes. "If you compromise too early...you're selling the issue far short."
- Establish a broad coalition to support the parity initiative, including consumers, family members, advocates and treatment professionals. Libertoff advises that practitioners take a secondary role, "because when practitioners come forward as leaders on this, they seem very self-serving....Legislators think they're supporting this because they're going to make more money."
- Remember that public testimony by persons whose lives have been personally affected by mental health and addiction treatment is a powerful tool.
- Be prepared for opposition based on both economic and philosophic grounds. Libertoff says that in Vermont, parity opponents argued that while mental illness is not an individual's own fault, problematic use of alcohol and other drugs is a matter of personal choice. Proponents countered that "it's time to treat substance abuse for what it is: a disease and a medical condition."

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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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Wisconsin Law Requires Treatment for Addicted Pregnant Women

A new Wisconsin state law mandates treatment for pregnant women who are abusing drugs or alcohol. The law makes Wisconsin the second state — after South Carolina — to require treatment in such circumstances. Unlike South Carolina's act, the Wisconsin measure carries no criminal penalties and no termination of parental rights. Other states are expected to consider similar proposals in their 1999 legislative sessions.

Popular support for the new law was sparked by several highly publicized cases. In the most notorious episode, Matthew Meyer, M.D., discovered through blood tests that a pregnant patient, Angela Wolfe, was using cocaine. According to Dr. Meyer, "There were repetitive positive tests showing cocaine exposure, and the social work department got concerned about it; we certainly did and advised her medically."

Dr. Meyer also took his concerns to William Domina, Waukesha County's senior assistant corporation counsel, spurred by a Wisconsin law requiring physicians to report child abuse. Dr. Meyer felt that Ms. Wolfe's conduct violated that law because she was 36 weeks pregnant and continuing to use cocaine, despite being advised of the potential adverse effects for her child.

Domina says Wolfe was ordered into treatment because lower courts ruled that her fetus could be considered a child when enforcing child abuse laws. However, the state Supreme Court reversed the lower court's opinion, on a vote of four to three, because the Wisconsin child abuse legislation did not expressly include the word "fetus" in the definition of a child.

Domina then approached State Senator Joanne Huelsman, who is from Angela Wolfe's hometown. Huelsman agreed that legislation was needed to address the problem of drug and alcohol abuse by pregnant women. Says Sen. Huelsman, "Looking at the total number of...kids that are born addicted to cocaine or alcohol, I decided that this was really something that was in the realm of a public health problem and that we should be doing something about [it]."

Sen. Huelsman says she also was influenced by a 1996 case in nearby Racine, WI, in which a pregnant woman, Deborah Zimmerman, arrived at St. Luke's Hospital very drunk. Ms. Zimmerman allegedly removed fetal heart monitors from her baby and told staff that "If you don't keep me here, I'm just going to go home and keep on drinking and drink myself to death, and I'm going to kill this thing because I don't want it anyway." Her blood alcohol level registered at .302 before delivery, well above the legal limit of .10. At birth, her baby had a blood alcohol level of .199 and was diagnosed with fetal alcohol syndrome.

The assistant district attorney in Racine County, Joan Korb, filed attempted homicide charges against Ms. Zimmerman, marking the first time in Wisconsin that criminal charges had been filed against a pregnant woman for attempting to kill her fetus by abusing alcohol. The case is pending before the Wisconsin Supreme Court.

Supporters say the new law is designed to provide treatment to pregnant women who are addicted to alcohol or drugs and unable to overcome that addiction on their own. On the other hand, opponents see it as a barrier to treatment, as women avoid seeking care because they fear being taken into custody and losing their children. They point out that, while the Wisconsin law is characterized as a treatment measure, it does allow the authorities to take women into custody.

The results may be evident at Meta House, a treatment program for pregnant women, which normally has a case load of 15 to 20 women. After the bill was signed into law, the census dropped to as few as three. One patient, Alice Logan, waited until after she had delivered a cocaine-affected infant to come to Meta House, saying she feared arrest. Authorities say that she never was in danger of arrest, but she could have been ordered into treatment. However, that distinction appears lost on the addict population.

Domina and Huelsman's experience with the Wisconsin legislation brought them to Congress last summer to testify before a House committee considering federal legislation addressing alcohol and drug abuse by pregnant women. Legislators also heard from politicians and practitioners from South Carolina, including the director of a residential treatment center in South Carolina who says the law has made a positive difference in many women's lives. On the other hand, Wisconsin's Francine Feinberg, who also testified, recounted the story of two pregnant women who left treatment because they could not be convinced that they would not be turned over to the authorities. "In an attempt to help a few women and their children," Feinberg adds, "these approaches will adversely impact many others who would have sought help but now will heighten fear."

The debate seems certain to continue as more states, as well as the Congress, consider legislation to protect the fetus from drug and alcohol abuse by their mothers.

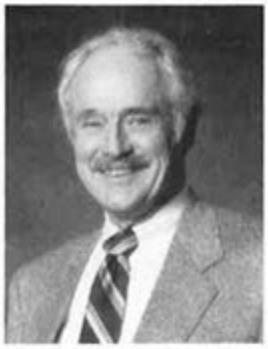
Source: The PBS News Hour, January 5, 1999; quotes reprinted by permission. See also the August/September 1998 issue of ***ASAM News****, page 15, for more on the South Carolina law.*

President Calls for More Funds for AOD Treatment in Prisons

In a preview of his Fiscal 2000 budget request, President Clinton has asked for $215 million to help states expand addiction treatment services for prisoners and parolees. The President also released $120 million in approved funds for drug-free prison initiatives in 1999. Of that amount, $63 million will go to state prisons for long-term drug treatment and supervision of prisoners with serious drug problems. The funds appear to be sorely needed: the federal Bureau of Prisons has estimated that 31% of inmates are addicted to drugs, but only 10% were in treatment in 1996.

Citing these and other federal data, President Clinton argued that better treatment and testing of prisoners and parolees could make a long-term dent in crime statistics. "Drug use stokes all kinds of crime," the President said. "It is clear to us that if we're going to

▶ **ADDICTION** *continued on page 11*



AMA BESTOWS HIGHEST AWARD ON ASAM CEO

G. Douglas Talbott, M.D., FASAM

During opening ceremonies of its Interim Meeting in December, the American Medical Association bestowed its 1998 Medical Executive Achievement Award on ASAM Executive Vice President James F. Callahan, D.P.A.

In presenting the award, Randolph D. Smoak, Jr., Chair of the AMA Board of Trustees, said: "It is my honor to present the Medical Executive Achievement Award to...James F. Callahan, D.P.A., Executive Vice President and Chief Executive Officer of the American Society of Addiction Medicine. Dr. Callahan has been an exemplary executive of a medical specialty society. He has provided uncommon leadership and vision to build the Society into a highly professional organization to serve as the national voice for addiction medicine."

Dr. Callahan spoke in reply:

"I thank Dr. Smoak and the Board, and AMA President Dr. Nancy Dickey. I also thank Dr. Palma Formica and the members of her Awards Committee for choosing me for this award. I thank AMA Executive Vice President, Dr. Anderson, and Mr. Neil Sutherland for inviting me and my wife to be the AMA's guests.

"I also thank our Society's President, G. Douglas Talbott, and the chairs of our Awards Committee, Dr. David Smith and Dr. Anne Geller, and the Awards Committee staff, Ms. Claire Osman, for nominating me.

"Most especially, I thank those whose work and achievements have led to this award, and on whose shoulders I stand. They are the members of the American Society of Addiction Medicine, and all who have been members during our 45 years as a national medical specialty society. I thank my Executive Assistant, Ms. Joanne Gartenmann, and my staff.

"Our members and staff have given me the joy and privilege of sharing in their dedication to prevent, treat, and promote research to find the causes of the terrible craving and compulsion which are the core of the diseases of addiction to alcohol, nicotine-tobacco, and other drugs.

Dr. Callahan (left) addresses the AMA House of Delegates after receiving the Medical Executive Achievement Award from AMA Board Chair Randy Smoak, M.D. (right).

"A special thanks to ASAM's Delegate and Alternate Delegate, Drs. Michael Miller and Stuart Gitlow, and to their predecessors, Drs. Jess Bromley and David Smith, and to Mr. Manny Steindler. They join me in thanking you, the members of the House of Delegates, for recognizing addiction as a disease and addiction medicine as a medical specialty, and for passing invaluable resolutions.

"My final word of thanks is to my wife, Claire Lyons Callahan, whose 30 years of love and professional consultation have sustained me. Thank you."

Doug

New Resources Available on ASAM's Web Site

William Hawthorne, M.D.,
ASAM Webmaster

New items of interest on ASAM's web site include results of the ASAM elections, a profile of 1999 MRO training programs, and an update on the 1998 AIDS Forum. Readers also will find a new state chapter page from the Oregon Society of Addiction Medicine and news of the Florida Society of Addiction Medicine. As always, the online version of ***ASAM News*** is available on the web site.

The ASAM web site can be accessed at *www.asam.org*.

Stroke Risk Varies with Level of Alcohol Use

Moderate use of alcoholic beverages can help prevent stroke, while heavy use dramatically increases stroke risk, a team of researchers reported in the January 8 issue of the *Journal of the American Medical Association*. The study found that the type of alcohol consumed was unimportant. Moderate use of beer, wine or distilled beverages, or any combination of them, all showed a protective effect.

The researchers, led by Dr. Ralph Sacco of Columbia University College of Physicians and Surgeons in New York, studied 677 New York City residents who had strokes between July 1993 and June 1997, as well as a control group of 1,139 similar residents who had not suffered strokes. About half of the subjects were Hispanic, just over one-fourth were black and the remainder were non-Hispanic whites. Slightly more than half were women. The mean age was 70.

After taking into account other factors that could affect stroke risk, such as high blood pressure, the researchers estimated that subjects who consumed up to two drinks of alcohol per day were only half as likely to have suffered clot-type strokes as nondrinkers. (Clot-type strokes account for 80% of all strokes.) However, stroke risk increased with heavier drinking: at seven drinks per day, risk was almost three times that of moderate drinkers.

Among groups where the protective effect exists, its mechanism appears to differ from the protective effect against heart attacks, which occurs through boosts in levels of so-called "good" cholesterol, or HDL. "In our analyses, much of the protective effect of alcohol on stroke risk was independent of HDL," the authors said. They speculated that alcohol may protect against stroke by acting on some other blood trait, such as the tendency of blood platelets to clump, which is key in forming the blood clots that can cause strokes.

In their report, the researchers note that while the protective effect of moderate drinking against heart attacks is well established, the data about alcohol's effect on stroke have been less clear. They said the new study helps settle that question and is the first to demonstrate a benefit to blacks and Hispanics. They called for more research on other groups, such as Asians, whom past studies suggest may receive no stroke protection from alcohol or may even be placed at greater risk by such use.

The new data support the guidelines of the National Stroke Association, which say that moderate drinkers may protect themselves from stroke by continuing to consume alcohol. However, the study authors caution that "No study has shown benefit in recommending alcohol consumption to those who do not drink."

Taxol® as a Source of Alcohol Intoxication

Paclitaxel (Taxol®), a plant extract used in the treatment of metastatic breast and ovarian cancer, contains sufficient alcohol to produce acute intoxication in some patients, according to a report in the *Annals of Pharmacotherapy*. The authors of the report caution that physicians who administer paclitaxel need to inquire whether the patient has ingested alcohol or CNS depressant drugs or is being treated for alcoholism, particularly with drugs that elicit a disulfiram-type reaction. They also note that informed consent forms may need to be changed to include the possibility that alcohol intoxication may occur. *Wilson D, Beck T, Gundlach C. Paclitaxel formulation as a cause of ethanol intoxication. Annals of Pharmacotherapy 1997;31:873-875.*

DATOS: All Types of Treatment Reduce Drug Use

Patients in four major treatment modalities — outpatient drug-free, outpatient methadone, short-term inpatient, and long-term residential — reported substantial reductions in drug use following treatment, according to data from the Drug Abuse Treatment Outcome Study (DATOS). Investigator Robert Hubbard and colleagues found that self-reported weekly cocaine use among long-term residential treatment clients declined from 66% in the year prior to treatment to 22% in the year after treatment. Similar reductions were reported for heroin, marijuana and alcohol use across all four treatment modalities. The reported improvements were supported by urinalysis results.

Additional data, which were reported initially in the journal *Psychology of Addictive Behaviors*, are available from the DATOS web site at *www.datos.org*. ■

▶ **CALLAHAN** *continued from page 2*

Information Sources

A number of information resources are available to ASAM members and others who are willing to work toward adoption of parity legislation:

- The SAMHSA report on "The Costs and Effects of Parity for Mental Health and Substance Abuse Insurance Benefits" can be ordered by calling 1-800/789-2647, or the document can be downloaded from the web site of the National Association of Alcoholism and Drug Abuse Counselors at *www.naadac.org*.
- Expert testimony on parity offered at a July 1998 hearing of the Senate Labor and Human Resources Committee — which included parental, corporate and clinical perspectives — can be found at the web site *www.senate.gov*.
- Recommendations from a Join Together National Policy Panel on Treatment and Recovery are available in the 1998 report, "Treatment for Addiction: Advancing the Common Good." Single copies are available at no charge from Join Together by phoning 617/437-1500 or e-mailing *info@jointogether.org*. The document also may be downloaded from the organization's web site *www.jointogether.org*. ■

(Information in this report was originally published in the Fall 1998 *Join Together Bulletin*, and is used here by permission of that organization.)

HIV/AIDS Programs Take Priority in SAMHSA Budget Increases

Fiscal 1999 budget increases for knowledge development and application (KDA) grants under the federal Substance Abuse and Mental Health Services Administration (SAMHSA) will target treatment and prevention efforts in communities with high incidences of HIV/AIDS.

Increases of $16 million for KDA grants under the Center for Substance Abuse Treatment (CSAT) and $6 million for similar grants under the Center for Substance Abuse Prevention (CSAP) were approved by Congress largely under the sponsorship of the Congressional Black Caucus, and the new money is expected to be allocated primarily to minority communities. CSAT's total KDA budget for FY 1999 is $172 million, compared with $157 million for CSAP.

NIAAA, NIDA Will Use New Funds to Expand Research

Increases in fiscal 1999 funding for the National Institute on Drug Abuse (NIDA) and the National Institute on Alcohol Abuse and Alcoholism (NIAAA) will allow both agencies to continue a flurry of addiction-related research that Congress has strongly supported in recent years. NIDA will receive approximately $603 million in FY 1999, while NIAAA will receive $260 million. These funds represent an increase of $77 million over NIDA's FY 1998 funding, and a $33 million increase for NIAAA.

NIAAA Director Enoch Gordis, M.D., says that Congress has instructed his agency to use its budget increase to continue research in areas such as epidemiology, fetal alcohol syndrome, drinking and driving, medication development, the neuroscience of addiction, and the genetic causes of alcoholism. New emphasis is expected on translating these research findings into practice.

NIDA's Addiction Research Center in Baltimore has augmented its neuroscience research activities with the addition of two new research branches: a Behavioral Research Branch (headed by veteran neuroscientist Dr. Roy A. Wise) and a Cellular Neurobiology Branch (headed by Dr. William J. Freed, who also edits the Cellular and Molecular Neuroscience Section of *Experimental Neurology*).

Funding to Prevent Underage Drinking Will Remain Flat in Fiscal 1999

The Office of Juvenile Justice and Delinquency Prevention (OJJDP) will receive $25 million to combat underage drinking in fiscal year 1999, the same as in FY 1998. Funds will be divided among the states, with each receiving $360,000 to underwrite development of comprehensive strategies to enforce underage drinking laws. Federal officials say that to be most effective, state plans should include enforcement, prevention, education and public policy components.

The federal program directs funds to state governors, each of whom selects a state agency to administer the activities. In some states, the state alcohol and other drug agency is chosen, while in others, the funds go to highway and traffic safety programs, alcohol beverage control administrations, or corrections agencies. Additional information is available from OJJDP at 202/307-0703. ■

False Hope

Hugo Perez Lara, M.D., CAP, MAC

The obsessive/compulsive behavior of the researchers trying to find a "magic drug" to "cure" addictions is one example of how society is looking for the eternal "quick fix." But this does not exist for addicts and is not realistic, probably because the researchers don't know that addicts are not looking for the flavor or the taste or the color or price or form of a drug; the addicts are looking for the effect that it produces in the complex emotional, moral, physical, family, and spiritual system, which never will be treated with a single pill or with genetic manipulation. In a case where a researcher found a cocaine antagonist that would prevent an addict from feeling the "high" of cocaine, the addict would immediately look for another drug that would produce the same "high." Cocaine in this case is only one substance that the addict is using to deal with his/her problem; the bottom of the problem is his/her complex system.

In my experience working in this field for more than 10 years (I hold my medical degree in Bolivia as a specialist in addictions), none of my patients uses drugs because the flavor is delicious. All of them use drugs to deal with anxiety that comes from dictatorial families, work stress, abuse, overprotection, immaturity, low self-esteem, etc. These are the real reasons why people look for the "magic drug" to mitigate his/her "problem." The problem is not the drug itself; the problem is the person as human being.

Let's be real in addressing the problem of addiction and not give false hope to a society that is waiting for the "magic drug" to "cure" this problem, in the same fashion as the families of addicts are looking for a "magic drug." The vicious cycle of the addictive family is being repeated in our addictive society with the false hope that a "cure" for addiction will be found. The same principle applies to other addictions, like sex, food, gambling, shopping, etc. ■

Modafinil Approved for Treatment of Narcolepsy

The drug modafinil (Provigil®, Cephalon) has been approved by the U.S. Food and Drug Administration for the treatment of narcolepsy. Although its precise mechanism of action is not known, the drug appears to interact much more specifically with the brain's sleep-wake centers than do stimulants such as amphetamines. Modafinil also is said not to have amphetamine-like effects on dopamine levels and the cardiovascular system.

While the drug has been studied and approved only for the treatment of narcolepsy, sleep experts quickly predicted that "off-label" use for other sleep problems and general fatigue may become widespread. In view of this potential for abuse, the drug has been listed by the Drug Enforcement Administration as a Schedule IV controlled substance. Despite these restrictions, several experts testified that they would not be surprised if a "gray market" for the pills quickly developed among persons who wish or need to stay awake for long periods of time, such as truck drivers, hospital emergency room personnel, and college students.

Efavirenz Approved as HIV/AIDS Therapy

State-funded AIDS Drug Assistance Programs in California and New York have added efavirenz (Sustiva®, DuPont), a once-daily anti-HIV treatment, to their ADAP formularies. Additionally, the Texas HIV Medications Advisory Committee has recommended that Sustiva be added to that state's formulary. When approved in Texas, 46 states plus the District of Columbia will have efavirenz on their ADAP formularies. The drug also has been added to the Medicaid formularies of 49 states and the District of Columbia since its approval by the Food and Drug Administration in September 1998.

Approved by the FDA as part of the agency's fast-track program, efavirenz is the first antiretroviral drug approved for once-daily dosing to be used in combination with other anti-HIV drugs in adults and children over three years of age. The accelerated approval of Sustiva was based on analysis of plasma HIV-RNA levels and CD4 cell counts in controlled studies of up to 24 weeks in duration. Full prescribing information is available at the manufacturer's web site at *www.sustiva.com* or by phone at 1-800/474-2762.

OTC Pain Relievers Must Carry Alcohol Warning

Over-the-counter pain relievers and fever reducers must carry a label warning against the concurrent use of alcohol under a rule adopted by the Food and Drug Administration in October 1998. The label warning is required on containers of aspirin (including Excedrin® and other aspirin-containing compounds), acetaminophen (e.g., Tylenol®), ibuprofen (Aleve®, Motrin®), naproxen sodium, and ketoprofen products. ■

AMA House Acts on ASAM Resolutions

Michael M. Miller, M.D., FASAM
Stuart Gitlow, M.D., M.P.H.

The 199th meeting of the American Medical Association's House of Delegates was held December 5-9 in Honolulu, HI. ASAM was represented by Michael M. Miller, M.D., FASAM, Delegate, Stuart Gitlow, M.D., M.P.H., Alternate, and James F. Callahan, D.P.A., Executive Vice President. A high point of the meeting for ASAM came during the opening ceremony, when AMA Chair Randy Smoak, M.D., presented Dr. Callahan with its Medical Executive Achievement Award, given annually to one state medical association executive and one medical specialty society executive. ASAM is most proud of this recognition, especially given how small the society is in relation to other organizations in the Federation (see full report on page 4).

Training in Addiction Treatment

In response to a 1997 Resolution submitted by ASAM, the AMA Council on Medical Education presented a Report on Continuing Medical Education (CME 10, I-98) entitled "Training in the Treatment of Addiction." The report is based on a survey of 93 medical specialty societies, 49% of which responded (complete results appear on the ASAM web site at *www.asam.org*). The Council recommended that the AMA also survey all Residency Review Committees regarding "their training requirements in the treatment and management of substance abuse and addiction and to make recommendations for strengthening this provision as needed." A second recommendation was that the AMA "encourage the development of specialty-specific needs assessment to determine whether targeted educational activities in substance abuse would be useful in their overall program of continuing medical education." At the Interim meeting, the full House unanimously approved both recommendations.

Other items deliberated by the House included HCFA's E&M Documentation Guidelines; a management consultant's detailed report on how the organizational structure of the AMA should be revised (involving the use of strategic plans, increased communication with internal and external stakeholders, better definitions of roles and responsibilities for the Officers, EVP, Board, and Board Chair, etc.); a report by the Council on Medical Service that contained new AMA definitions of "medical necessity" and "screening"; a second report of the Council on Medical Service, on the role of the medical staff within integrated delivery systems and health care networks; and the response of the AMA to the recent multistate settlement between the tobacco industry and over 40 state attorneys general. ASAM offered testimony on the latter three items, as well as testifying during debate on:

- Whether it should be considered an ethical obligation for physicians to report their patients who continue to drive despite their physicians' advice that an active health care condition warrants cessation of driving;
- Whether diacetyl morphine (heroin) should be made available for scientific research into its possible efficacy in addiction treatment;
- Whether there should be universal coverage for adults who have chronic diseases of genetic, perinatal, or pediatric origin; and
- Whether health plans should cover non-prescription drugs such as nicotine replacement agents.

ASAM testimony helped the process of referring back to the Board of Trustees an opinion by the Council on Ethical and Judicial Affairs regarding physician reporting of impaired drivers; ASAM will need to work with the AMA in coming months to address this matter in ways that would be more acceptable to addiction medicine specialists. On this as all matters, our Delegation welcomes input from ASAM members.

Tobacco a Key Topic

The keynote address was delivered by the new Surgeon General of the U.S. Public Health Service, David Satcher, M.D. As outlined, Dr. Satcher's goals for 1999 are ambitious and address many issues of interest to ASAM members (see his remarks on the AMA web page at *www.ama-assn.org*). Dr. Satcher also spoke to the open forum on tobacco issues, an event held at each meeting of the House of Delegates. This year, there also was a presentation on a recent issue of the British journal *Tobacco Control*, the lead article of which was an updated version of the groundbreaking AMA Council on Medical Service Report, adopted early in 1998, on how to eliminate the addictive component of tobacco cigarettes by systematically reducing their nicotine content to zero (see the accompanying article).

In a related action, Resolution 817 asked that the AMA work to develop ICD-10 codes for specific types of current and past use of tobacco and nicotine products; this was unanimously approved by the House.

Several ASAM-sponsored resolutions did not move forward. One, addressing the HCFA requirement that an ICD-10 diagnosis be attached to a laboratory test to confirm the "medical necessity" of the test (for Medicare payment), suggested that alcoholism be considered one of the "medically necessary" conditions for the ordering of (and subsequent HCFA reimbursement for) complete blood counts, hemograms, and platelet counts. At present, the justification for ordering a CBC on a patient with an alcohol problem appears in the HCFA nomenclature as "unspecified adverse effect of drug/medicinal/biological substance." The Reference Committee heard more than an hour of testimony on the broader issue of "negotiated rulemaking" with HCFA over laboratory tests, and decided that the House of Delegates is not the appropriate forum for establishing policy on a specific diagnosis for use in justifying the medical necessity of specific tests. ASAM will follow up with AMA representatives on the "negotiated rulemaking" process to address our issue.

A second ASAM-sponsored resolution encouraged physicians to include information on substance use or addiction in appropriate biomedical sections of the patient chart, rather than relegating substance use information to the "social history" section of the chart. Given the

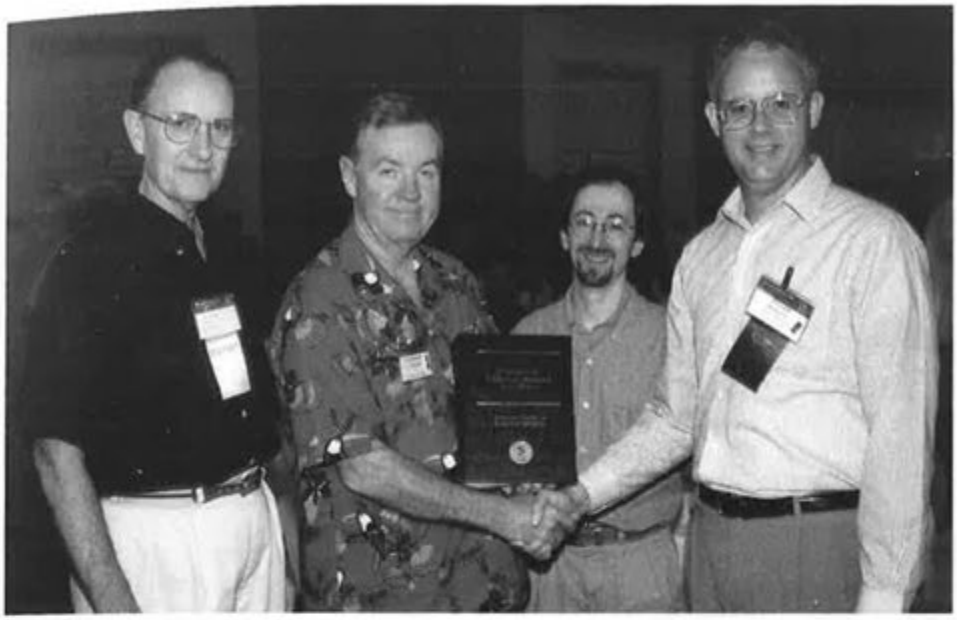
climate of disgruntlement about HCFA (via the E&M process) directing the contents of the patient medical record, it was not possible to move this initiative forward.

ASAM Shapes Action on Resolutions

ASAM's successes at this meeting involved shaping action on items offered by others. For example, ASAM brought to the AMA's attention the potential adverse effect of an AMA staff initiative under which AMA policies would "sunset" automatically when they become 10 years old. This would have led to removal from the AMA policy compendium of a hallmark 1966 AMA House of Delegates action affirming that "alcoholism is a chronic illness and that multiple hospital admissions under medical supervision may be essential to arresting the progress of this disease." Credit goes to ASAM consultant (and retired AMA executive) Manny Steindler for finding this needle in the haystack. As a result of Manny's vigilance, the oft-cited 1966 policy will be exempted from "sunsetting."

The AMA House voted (after Reference Committee testimony from ASAM and others) to:

- Have the AMA collect information from physicians who face employment discrimination (as through refusal of health plans to contract for their services) solely because they lack ABMS board certification (Resolu-tion 314).
- Support "research that identifies the types of education, support services, and professional caregiver roles needed to enhance the activities and reduce the burdens of family caregivers, including [per ASAM's amendment, co-sponsored by the APA] caregivers of patients with dementia, addiction, and other chronic mental disorders" (Resolution 308).
- Extend impaired physician programs to cover medical students (based on recommendations in Council on Medical Education Report 4, I-98).
- Have the AMA encourage health insurers and health plans to cover medically necessary over-the-counter drugs for which no prescription alternative exists (Council on Medical Service Report 1). The latter item was interesting; despite the AMA's opposition to mandated insurance benefits, the Reference Committee advised moving ahead with this encouragement to private sector plans after hearing ASAM's testimony describing how nicotine replacement therapy products have been transferred from prescription to OTC status (the AMA already has a policy in place that Medicaid should cover medically-necessary non-prescription drugs).



Presenting a copy of ASAM's new textbook, Principles of Addiction Medicine, *Second Edition, to AMA Executive Vice President E. Ratcliffe Anderson, Jr., M.D., (second from left) are (left to right): ASAM EVP James F. Callahan, D.P.A., Dr. Anderson, ASAM Alternate Delegate Stuart Gitlow, M.D., M.P.H., and ASAM Delegate Michael Miller, M.D., FASAM.*

ASAM presented testimony in Reference Committee and on the floor of the House of Delegates about its *Patient Placement Criteria* and how medical necessity can be discussed in terms of using "the lowest level of service intensity that a prudent physician would consider likely to be clinically effective and safe." Despite ASAM's best arguments, the House could not be persuaded, and the proposed language was not incorporated in the AMA's definition.

ASAM members should access the AMA web site at *www.ama-assn.org* for final language on the complex topics of AMA governance and structure, the AMA's "medical necessity" definition as adopted by the House (see Council on Medical Service Report 13, I-98, recommendations as amended), and updates on the AMA's activities regarding E&M coding. (It is worth noting that Stu Gitlow has been appointed by the AMA Board to the AMA's Online Oversight Panel.)

An interesting action of the House was to accept Board of Trustees Report 18 (I-98) on Expert Witness Testimony, with several amendments, including one affirming that the AMA "encourage each state medical society to work with its state licensing board to grant any out-of-state expert witness physician a temporary license at a nominal fee or at no cost for the express purpose of expert testimony on a per case basis, such that the expert witness is subject to the peer review process." Florida was mentioned as a state that has successfully implemented such a process, so that peer review can be utilized to hold physician "expert witnesses" accountable for their activities in a given state.

Finally, the American Psychiatric Association submitted Resolution 215, regarding parity; it was amended and then accepted by the House by unanimous consent. In it, the AMA reaffirms its existing policy H-185.974, under which the AMA supports parity for coverage of alcoholism, substance abuse and mental illness. The report also recommends that the AMA, in conjunction with the APA and other interested organizations, develop model state legislation for the use of state medical associations and specialty societies to promote legislative changes assuring parity for the coverage of mental illness, alcoholism, and substance abuse. ASAM will work with the AMA to develop such model legislation for parity at the state level. ■

Message to Young Physicians: Thank You for Being Here

Stuart Gitlow, M.D., M.P.H.
ASAM Alternate Delegate

[Dr. Gitlow delivered these remarks to the AMA Young Physicians Section, which he chairs, at the AMA Interim Meeting in Honolulu.]

"Welcome to Hawaii and thank **you** for being here. The other day, on a flight home, I sat with a civil engineer who told me of his doctor. He had confronted his physician (a young one, by the way) because his doc hadn't called him with results of a blood test — results that showed there to be no cause for alarm about an earlier suspicious result. He saw his doctor as being in a service profession, much as he is himself. He wanted and expected his doctor to call him the moment the results of the second test had arrived. His doctor didn't understand, telling his patient that he calls only when there is urgency and that patients are always welcome to call for results of any studies. My seatmate made the decision to see another doctor next time, fretting at the manner in which he has to choose a doctor from an everchanging list provided by his HMO.

"I didn't tell my seatmate that in the six years I've been practicing psychiatry, I've had to increase my patient schedule from two to four patients per hour to keep my income steady. I didn't embarrass myself by admitting that I had been confronted by a patient for a similar situation. I didn't tell him that the number of support staff we dedicated to health care at the hospital had been traded in for staff dedicated to collections.

"Earlier that same day, I was in a car with a doctor on faculty at a state-funded southern university. With us was a mutual friend who wasn't a physician. The doc and I were discussing the difficulty the University has recruiting doctors due to low salaries. He mentioned a figure in the high $100 thousands for an orthopedic surgeon. We both nodded in agreement that this was indeed a low figure. Our friend responded angrily, saying "How dare you both agree that an income many times the national average is low!"

"I didn't remind my friend that Federal Express pilots are considering striking because a salary higher than this figure is too low. I didn't remind him of the number of years invested or the amount of debt physicians incur just to get started. I didn't describe the lengthy hours, the frequent lack of benefits, or the high divorce rate. And I certainly didn't remind him how much people are paid for hitting a ball with a stick.

"I've presented examples of a doctor not respecting his patient and of an erstwhile patient not respecting a doctor.

"So I want to thank **you** for being here. Despite our country experiencing economic growth, stock market highs, low interest rates, low unemployment, and near-zero inflation — despite the tremendous amount of income being generated by the health care industry as a whole — we find ourselves, the young physicians, in the midst of economic turmoil. And here you are, giving your time and giving up income to be here.

"This is our opportunity to talk openly about these issues — issues we often don't discuss because we're embarrassed, uncomfortable, or misunderstood. We do earn reasonable incomes. But to earn that, we face overwhelming debt and rapidly increasing workloads. Many of us who have maintained our workload over the years have suffered dramatic decreases in income; those trying to maintain their income by increasing workload can suffer the loss of respect of our patients and the loss of relationships with family and friends.

"This is our opportunity to set policy that will lead to increased mutual respect between doctor and patient. I urge you to keep this in mind as you consider each of the issues that arise over the next week. Thank **you** for participating. And welcome!" ■

AMA and British Medical Association Team Up on Tobacco

In a unique partnership, the American Medical Association and the British Medical Association have teamed to promote a landmark report on reducing the addictiveness of cigarettes. Developed by the AMA's Council on Scientific Affairs, the report examines options for reducing tobacco-caused disease by gradually removing nicotine from cigarettes until they are no longer addictive. The Council concluded that gradually eliminating nicotine from cigarettes is possible and that a nicotine reduction strategy would prevent adolescent tobacco addiction and assist the millions of current cigarette smokers in their efforts to quit.

During a joint news conference on in October 1998, the AMA and BMA called on their respective governments to force the tobacco industry to reduce nicotine to non-addictive levels. "For years, the tobacco industry has deliberately manipulated its product to make it easier to addict smokers," said Reed Tuckson, M.D., AMA Senior Vice President. "Now we are asking our governments to force them to do the exact opposite."

"The result of this research shows that there is something we can do to turn the tide on addiction," added Sir Alexander Macara, chairman of the UK consultative committee on public health and former chair of the BMA council. "We are proud and pleased to join the AMA in their call for government mandated changes in tobacco products. This will help current smokers quit, and keep new smokers, children especially, from becoming addicted."

Electronic versions of the report and the accompanying editorial may be accessed from the table of contents of the Autumn issue of *Tobacco Control* on the journal's web site (*http://www.bmjpg.com/data/tobcur.htm*). ■

AMA REPORT

AMA Report Calls for "New Partnership"

In a widely anticipated report, the AMA Council on Long-Range Planning and Development has developed strategies that medical associations can employ to strengthen their positions in an increasingly competitive environment. The report also reviews the analysis that led the Council to conclude that strengthening the Federation of Medicine is a fundamental prerequisite to enhancing organized medicine's effectiveness in addressing the vast array of issues facing physicians and medical practice.

Overall, the Council has identified five factors that it believes are making the medical association sector more competitive. These factors are (1) the proliferation of medical associations, (2) the changing economics of medical practice, (3) the changing organizational structure of medical practice, (4) the attitudes of physicians, and (5) the reactions of medical associations to economic pressures. Taken together, the Council concludes that these factors will lead to a major restructuring of the medical association sector, in which some societies will engage in joint partnerships or mergers, while other societies will cease to exist.

As part of its recommendations to address this situation, the Council calls on the AMA House of Delegates to recommit itself to "achieving a transformation of the current Federation of Medicine into a more effective Federation" capable of accomplishing a series of specific goals, which are to: "(a) achieve a unified voice for organized medicine, (b) work for the common good of all patients and physicians, (c) promote trust and cooperation among members of the Federation, (d) advance the image of the medical profession, and (e) increase [the] overall efficiency of organized medicine for the benefit of our member physicians." ■

▶ **ADDICTION** *continued from page 3*

continue to reduce the rate of crime we have to do something to avoid releasing criminals with their dangerous drug habits intact."

The President referred to a newly-released report by the U.S. Department of Justice, showing that 22% of federal prisoners were on drugs at the time they committed the crimes that resulted in their imprisonment. The report also noted that 70% of federal prisoners had used drugs prior to their arrests. These statistics are an increase from 1991, when 60% of federal prisoners said they had used drugs and 17% said they had used them at the time of their crimes.

The report also found higher proportions of state prisoners using drugs. In 1997, 83% of state prisoners said they had used drugs, compared to 79% in 1991. Also, 33% of state prisoners said they had used drugs at the time of their crime, up from 31% in 1991.

According to Gen. Barry McCaffrey, Director of the Office of National Drug Control Policy, an untreated addict costs taxpayers about $43,000 per year, compared to $2,700 a year for prison-based treatment for an individual's drug use. General McCaffrey cited a 1998 report by the Center on Addiction and Substance Abuse at Columbia University (CASA), which claims that of the $38 billion spent on prisons in 1996, more than $30 billion dollars were paid for the incarceration of individuals who have a history of drug and alcohol abuse, were convicted of drug and alcohol violations, were high on drugs and alcohol at the time of their crime, or committed their crime to get money to buy drugs.

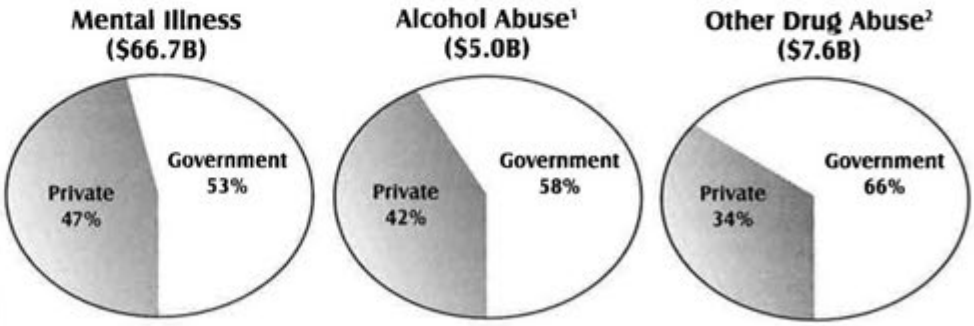
Source: The Associated Press and the Center on Addiction and Substance Abuse at Columbia University.

Most Treatment Costs Paid by Government

Two thirds of the funds spent on addiction treatment in 1996 came from federal, state and local governments, according to a study released by the federal Substance Abuse and Mental Health Services Administration. Specifically, 58% of the spending for alcohol treatment came from public sources, while 66% of other drug abuse treatment was funded by the government. Government programs that subsidize addiction treatment include Medicare, Medicaid, and the treatment block grant administered by the Center for Substance Abuse Treatment.

Also noteworthy in the study is the disparity in funding levels for various disorders: government funding for alcohol and drug problems totalled $12.6 billion, compared with $66.7 billion for mental illness. ■

Treatment Costs for Mental Illness, Alcohol, and Other Drug Abuse, by Payer, 1996



[1]Includes patients with primary alcohol problems.

[2]Includes patients with primary drug disorders and patients with combined alcohol and drug disorders.

Note: "Government" includes Medicare, Medicaid, and other federal, state and local government programs. "Private" includes private insurance, out-of-pocket expenditures, and other non-governmental sources.

Source: The Center for Substance Abuse Resesarch (CESAR) at the University of Maryland and Mark T, et al: National Expenditures for Mental Health, Alcohol and Other Drug Abuse Treatment, 1996 (prepared by the MEDSTAT Group for the Substance Abuse and Mental Health Services Administration, September 1998).

RESEARCH NOTES

Gender Influences Relapse Rates, Reasons

Women in drug abuse treatment experience relapse less frequently than do men, at least partly because women are more likely to engage in group counseling, according to a research study funded by the National Institute on Drug Abuse. Other NIDA-supported researchers have found that cocaine-addicted women and men differ in the factors that contribute to relapse. For example, Dr. James McKay and colleagues at the University of Pennsylvania found that women in treatment for cocaine addiction were more likely to report negative emotions and interpersonal problems before they relapsed. Men, on the other hand, were more likely to report positive experiences prior to relapsing and were more likely to engage in self-justification and rationalizing afterward.

These gender differences suggest that women might benefit from relapse prevention techniques that focus on dealing more effectively with unpleasant emotions and interpersonal problems, says Dr. McKay, while men might benefit more from strategies that counter the tendency to "let down their guard" when feeling good.

Gender differences are of intense interest to NIDA, according to Carol Cowell of NIDA's Division of Clinical and Services Research. "Researchers are finding gender differences across the broad spectrum of drug abuse research — from basic research to studies such as these on treatment and services — and we would like to encourage more study of these differences."

Memory Problems Persist After MDMA Use

Memory problems associated with use of the illicit drug MDMA (a derivative of amphetamines that is popularly known as "Ecstasy") may persist for weeks, according to a new study funded by the National Institute on Drug Abuse. When researchers compared the performance of 24 MDMA users with 24 non-users on tests of visual and auditory memory, they found that the drug users tended to perform more poorly on all measures. The users' memory problems appeared to increase with the amount of drug used, and to persist for about 14 days after drug use stopped. While a clear explanation for the effect is not yet known, MDMA is believed to decrease levels of the brain chemical serotonin, which plays a role in memory formation.

Anti-Anxiety Drugs Associated with Higher Rate of Auto Crashes

Drivers who use anti-anxiety drugs such as diazepam are more than twice as likely to be involved in motor vehicle crashes than are drivers who do not use anxiolytics, according to a Scottish study of 19,000 traffic crashes occurring between April 1992 and June 1995. Researchers found that the risk of crashes for persons under the age of 45 is more than three times greater for those who use the drugs. According to pharmacologist Tom Macdonald of the University of Dundee, who led the study, patients usually feel drowsy during the first few days they take anti-anxiety drugs, but the motor vehicle crashes occur at the same rate regardless of whether the drowsiness occurs. The report appeared in the October 23 issue of the British journal *The Lancet*. ■

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MEMBER NEWS

Hoover Adger, M.D., M.P.H., FAAP, assumed the Presidency of the National Association of Children of Alcoholics at NACOA's annual meeting in December 1998. Nationally recognized for his work in developing substance abuse curricula and clinical practice standards for health professionals, Dr. Adger spearheaded NACOA's Pediatric/Health Care Professional Initiative, which developed the widely accepted "Core Competencies for Involvement of Health Care Providers in the Care of Children and Adolescents in Families Affected by Substance Abuse." He has been an active member of ASAM and contributed a chapter on the care of children in drug-affected families to the Second Edition of ASAM's *Principles of Addiction Medicine*.

David E. Smith, M.D., FASAM, has been honored by the Northern California Psychiatric Association with the Geri Taylor Memorial Award, given to a non-member who has made an exceptional contribution to the field. ■

IN MEMORIAM

Janet King Johnson, M.D., of Oakland, TN died November 1, 1998. Certified by ASAM in 1986, Dr. Johnson was an active member of the Society and a generous benefactor of the Ruth Fox Memorial Endowment Fund. She is survived by her children, Miriam D. Johnson, M.D., David P. Johnson, M.D. and Allyn C. Johnson III.

MEMBERSHIP RENEWALS DUE

REMINDER! It's time to renew your ASAM membership! Don't miss out on future issues of ***ASAM News*** and other benefits of membership.

If you have questions about your membership or renewal rates, contact Cammy Davidge or Caprice Falwell at the ASAM office, 301/656-3920.

U.S. Drug Policy

Of the $16 billion the federal government spent in 1998 to eradicate drug abuse, fully two-thirds was spent on enforcement and interdiction and less than one-third on treatment and prevention. The 1999 allocation will be even more skewed toward interdiction as a result of budget negotiations that led the Congress to vote $942 million in emergency appropriations for drug enforcement.

The series of events that led the nation to this lopsided allocation of resources is outlined in *The Fix* by Michael Massing. In his study of U.S. drug policy since the 1960s, Massing asserts that the inadequate emphasis on treatment has created a situation in which "the United States has an estimated 4 million hard-core users of heroin, crack, cocaine and methamphetamine... [but] the nation's treatment programs can accommodate only about 50% of these users. In other words, nearly 2 million people who might benefit from help are unable to get it. According to the Office for National Drug Control Policy, making up this difference would cost an additional $3.4 billion a year — more than 10 times the amount appropriated by Congress."

"The Fix" by Michael Massing is published by Simon & Schuster. Available at bookstores.

Naltrexone and Alcoholism Treatment

Number 28 in a series of Treatment Improvement Protocols (TIPs) from the federal Center for Substance Abuse Treatment is intended to help providers eliminate barriers to use of the drug naltrexone in the treatment of alcoholism.

Naltrexone and Alcoholism Treatment takes a step-by-step approach to identifying patients who are good candidates for naltrexone, initiating use of the drug, clinical management of the naltrexone-treated patient, and helping the patient successfully transition to aftercare.

Developed by a consensus panel of researchers, clinicians and program administrators, the TIP advises that, when used as an adjunct to psychosocial therapy, naltrexone (marketed under the brand name Revia®) has been shown to reduce the rate of relapse to alcohol use, as well as the amount of alcohol consumed in each drinking episode. While the guide makes it clear that abstinence should be the goal of treatment, it notes that reduction in alcohol use is an acceptable intermediate outcome.

TIP No. 28; order from the National Clearinghouse for Alcohol and Drug Information, P.O. Box 2345, Rockville, MD 20857-2345; by phone at 1-800/729-6686 or 301/468-2600; by fax at 301/468-6433; or by e-mail at info@health.org.

Cognitive-Behavioral Approach to Cocaine Addiction

This 127-page manual describes cognitive-behavioral therapy (CBT) for the treatment of cocaine addiction. Developed at Yale University, CBT is a short-term, flexible approach that teaches coping skills to solve problems associated with drug use, such as difficult family relations or loss of employment. The manual provides an overview of the basic principles of CBT and explains the structure and topics to be used in treatment sessions.

NIDA Pub. No. 98-4308; order from the National Clearinghouse for Alcohol and Drug Information, P.O. Box 2345, Rockville, MD 20857-2345; by phone at 1-800/729-6686 or 301/468-2600; by fax at 301/468-6433; or by e-mail at info@health.org.

Community Reinforcement and Vouchers in Cocaine Treatment

This volume provides information on use of a community reinforcement approach (including individual counseling and skills training) with an incentive program using vouchers to treat patients for cocaine addiction. The 148-page manual provides step-by-step instructions for implementing the approach, including the style, technique and structure of counseling to be provided. The manual also describes a format to be used for initial counseling sessions and training in drug avoidance skills.

NIDA Pub. No. 98-4309; order from the National Clearinghouse for Alcohol and Drug Information, P.O. Box 2345, Rockville, MD 20857-2345; by phone at 1-800/729-6686 or 301/468-2600; by fax at 301/468-6433; or by e-mail at info@health.org.

Community Epidemiology and Surveillance

Designed to help communities, cities, counties and states determine the extent of drug abuse problems in their areas and develop the most effective prevention and treatment programs for their needs, this 124-page volume explains why community epidemiology surveillance networks are necessary and how communities can create such networks. The book also describes how to use drug use data and contains sample forms and other tools for data collection and organization.

NIDA Pub. No. 98-3614; order from the National Clearinghouse for Alcohol and Drug Information, P.O. Box 2345, Rockville, MD 20857-2345; by phone at 1-800/729-6686 or 301/468-2600; by fax at 301/468-6433; or by e-mail at info@health.org. ■

COMMITTEE REPORTS

Dr. Wetterau to Head ASAM Family Practice Committee

The ASAM Board of Directors has tapped Norman Wetterau, M.D., of Dansville, NY, to chair the Society's Family Practice Committee. Also appointed to the committee are Martin C. Doot, M.D., FASAM, Gary L. Patzkowsky, D.O., FASAM, Jerome E. Schulz, M.D., and Hunter E. Woodall, M.D. Other ASAM members who are interested in serving on the committee are encouraged to contact Dr. Wetterau.

Members also are invited to comment on the committee's proposed mission statement, which describes it as "a group of ASAM members who are family physicians who seek to encourage prevention, recognition and treatment of substance abuse by family physicians. We will try to do this through university family practice programs, the Society of Teachers of Family Medicine, state AAFP chapters, and through the American Academy of Family Practice. We will also seek to have our state AAFP chapters and national AAFP promote policies that prevent substance use, reduce usage and encourage treatment."

Dr. Wetterau reports that "we are trying to revitalize the Family Practice Committee. As part of this, we will hold a component session on family practice during ASAM's Med-Sci Conference, on Thursday night, April 29th, from 8:00 to 10:00 p.m. Any family physician is welcome to attend. We would like input from as many family physicians as possible at the component session."

Dr. Wetterau adds that although the Society for Teachers of Family Medicine and the Center for Substance Abuse Treatment have published excellent educational materials, many family physicians do not screen for alcohol or other drug problems, or know how to make an intervention. He wants the committee (and participants in the component session) to explore how this situation can be improved, perhaps by helping the state chapters and national organizations in family practice to reach out to their members.

1998 Review Course Exceeds Expectations

ASAM's 1998 Review Course in Addiction Medicine, held in Chicago in October, exceeded all previous courses — and the planners' expectations — in the number of registrants, the quality of the faculty, and the enthusiasm with which registrants participated.

The Review Course is designed to provide a broad overview of the core elements of addiction medicine and to foster multidisciplinary clinical discussions that illuminate the interdisciplinary nature of addictive diseases and addiction medicine.

The course welcomes physicians at all levels of knowledge, and more than 425 physicians from all over the U.S., Canada, Latin America and as far away as South Africa

▶ **RESEARCH NOTES** *continued on page 16*

Ruth Fox, 1895-1989

RUTH FOX MEMORIAL ENDOWMENT FUND

Dear Colleague:

We wish you and your family a very healthy and happy New Year, and hope that 1999 will be a peaceful and prosperous year.

We thank you, our donor, for your commitment and support, and look forward to your continued pledges, contributions, bequests, and other planned giving gifts, so that the Endowment can successfully reach its $3 million goal in 1999. For information, please contact Ms. Claire Osman at 1-800/257-6776.

Special thanks go to A. Kennison Roy III, M.D., long-time ASAM member and current Board member, for naming the Endowment Fund as beneficiary of a $50,000 insurance policy, in addition to his previous contributions. We are very grateful to Dr. Roy.

All donors receive an invitation to the Ruth Fox Memorial Endowment Reception, scheduled for Friday, April 30, 1999, during the Med-Sci Conference in New York City. It is an outstanding event, available *by invitation only* to Ruth Fox Fund donors.

A special program on "Estate Planning for Physicians" will be offered on Thursday, April 29, 1999, from 7:00 to 8:30 p.m. at the Conference. If you plan to attend, please check this session on the conference registration form. Everyone is welcome!

Max A. Schneider, M.D., FASAM, Chair, Endowment Fund
Jasper G. Chen See, M.D., Chair Emeritus, Endowment Fund
Claire Osman, Director of Development

As of December 15, 1998
Total Pledges: $2,353,683

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September 26 — December 15, 1998

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continued from page 14

Review Course faculty member Max Schneider, M.D., FASAM

eagerly participated in the three-day event. The textbook for the course was the new Second Edition of ASAM's *Principles of Addiction Medicine*, which many participants arranged to have signed by Dr. Allan W. Graham, editor of the text and a faculty member for the course.

Other faculty included Andrea G. Barthwell, M.D., FASAM; Lawrence S. Brown, Jr., M.D., M.P.H., FASAM; John N. Chappel, M.D., FASAM; Rosa Maria Crum, M.D., M.H.S.; Martin Doot, M.D., FASAM; Carlton K. Erickson, Ph.D.; Jeffrey Foote, Ph.D.; Eliot Gardner, Ph.D.; Anne Geller, M.D., FASAM; Harry W. Haverkos, M.D.; Donald Ian Macdonald, M.D., FASAM; Terry Rustin, M.D., FASAM; and Seddon R. Savage, M.D., FASAM.

Alex DeLuca, M.D., chaired the Review Course Committee, whose members also included Jimmy David, M.D., Michelle Rottenstein, M.D., Anatolio Munoz, M.D., and Brook Hersey. The committee was ably assisted on-site by Sandy Metcalfe and Linda Fernandez, of ASAM's Conference and Meetings Department, and Hermese Bryant, staff to the Illinois Society of Addiction Medicine, which served as local host for the event.

Reflecting on the success of the course, ASAM EVP James F. Callahan, D.P.A., praised the "excellent work" of Dr. DeLuca and his committee. ■

ASAM CONFERENCE CALENDAR

February 5-7
Florida State Chapter Conference
Orlando, FL
(Jointly sponsored by ASAM)
For information: 850/484-3560

February 7-8
Alabama State Chapter Conference
Birmingham, AL
(ASAM is a cooperating organization)
For information: 205/975-4882

February 16-21
Southern Coastal Conference
Jekyll Island, GA
(Jointly sponsored by ASAM)
For information: 912/638-5530

February 26-28
ASAM MRO Course
Chicago, IL
19 Category 1 CME credits
[The Medical Review Officer Certification Council offers the MRO Certification Exam immediately following the course.
For information, contact the MROCC at 847/671-1829.]

April 29
ASAM Forum on AIDS and Addictions
New York, NY
7 Category 1 CME credits

April 29
The Ruth Fox Course for Physicians
New York, NY
7 Category 1 CME credits

April 30-May 2
ASAM 30th Annual
Medical-Scientific Conference
New York, NY
19 Category 1 CME credits

July 15
Forensic Issues in Addiction Medicine
Washington, DC
7 Category 1 CME credits

July 16-18
ASAM MRO Course
Washington, DC
19 Category 1 CME credits
[The Medical Review Officer Certification Council offers the MRO Certification Exam immediately following the course.
For information, contact the MROCC at 847/671-1829.]

OTHER EVENTS OF NOTE

February 26-27
Washington Society of Addiction Medicine
Conference on Fundamentals
of Addiction Medicine
Seattle, WA
For information: 425/261-3690

May 21-23
Haight Ashbury Free Clinics
Conference on Critical Issues in Addiction
San Francisco, CA
For information: 415/565-1904

June 20-25
48th Annual Session of the
University of Utah
School on Alcoholism and
Other Drug Dependencies
Salt Lake City, UT
For information: 801/575-2181

June 26-July 1
Research Society on Alcoholism
22nd Annual Scientific Meeting
Santa Barbara, CA
For information: 512/454-0022

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