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What Happens When You Are Arrested For Drunk Driving

This article is reprinted with permission from Motorland, published by the California State Automobile Association. It takes you step by step through what happens when a law enforcement officer stops you to determine if you are driving under the influence. *Beginning July 1, the officer can confiscate your driver's license on the spot.*

If you are stopped by a law enforcement officer who suspects you are too drunk to drive, you will be given a field sobriety test at the scene. This usually involves some simple motor-skill tests such as walking a straight line or standing on one foot for a time, while the officer observes your ability to reason, speak clearly and follow instructions. If you fail, you will be told that you are under arrest and asked to take a chemical test for your BAL or blood alcohol concentration. Effective January 1, 1990, it is illegal to drive a motor vehicle with a blood alcohol level of 0.08 percent or more. Another California

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WHAT IS ADDICTION? A MEDICAL PERSPECTIVE

Richard S. Sandor, MD

Jellinek's book, *The Disease Concept of Alcoholism*, is 30 years old this year, and while the idea that alcoholism is a disease is now widely accepted, it is not widely understood. Professor Herbert Fingarette's recent book, *Alcoholism: The Mythical Disease* and his success, at least in the popular media in attacking the disease concept of alcoholism are proof enough that the medical view of alcoholism is far from well established.

In view of the confusing irony of Fingarette, a philosopher, who argues what is genuinely a philosophical question as though it were a scientific one, it seems important to re-examine the foundations of the disease concept of alcoholism and other addictions.

Scientific data can no more prove that alcoholism is or isn't a disease than it can prove that the sky is blue. Either we all agree that the color of the sky is sufficiently like everything else we call "blue" to warrant using that word, or we agree to call it something else. By analogy, asserting that alcoholism is a disease requires us to abandon the simplistic "is it or isn't it" question in favor of showing in what ways it conforms to generally accepted ideas of what diseases are.

In proposing that alcoholism is a disease, do we mean, as Fingarette suggests we do, that drinking is a disease? No. Certainly, behavior may signify the presence of a disease. The behavior we denote by the word "seizure," for example, may indicate an infection, hemorrhage or tumor in the brain --to consider the seizure itself a disease is to confuse cause and effect. The common sense inherent in our use of the English language demands recognition of this difference--we don't speak of a person "high blood pressure-ing" or "pneumonia-ing." We speak of a disease as something a person has, not something he does.

No objective measure defines alcoholism consistently

The chief problem (which Fingarette exploits) in establishing the disease concept of alcoholism is that no objective measure of drinking defines alcoholism consistently. As a result, he and other critics of the disease concept feel justified in concluding that alcoholism does not exist and that it is a self-serving device of a misguided and greedy medical establishment. But if, as we believe, drinking is only a symptom of alcoholism, then it should not surprise anyone that measuring it brings no uniform picture of the disorder. In virtually all illnesses, especially early in the course, symptoms are remarkably variable. Just as fevers may be high or low, pain severe or mild, alcoholic drinking may be heavy or light, intermittent or continuous, boisterous or quiet--all depending on biological, social and psychological factors influencing that individual.

If by calling alcoholism a disease we mean that sometimes drinking is a sign of something else--that it is a result of something a person has--then we need to explain what that something is. Without a simple conception of what an addiction is, on par, for example, with what an infection is (i.e., hostile germs attacking human tissue), it is hard to fault those who dispute the disease concept of alcoholism.

The place to search for the disease concept

The difficulty we have had in establishing the disease concept of alcoholism is the same as for other mental illnesses, namely, that the gist of the condition is in the experiential world of the person who has it. It is forever subjective and cannot be quantified "objectively." Since the core of the illness is subjective, it follows that the place to search for our disease concept is in what alcoholics themselves say about what's going on inside them.

Doctor Silkworth, friend of the founders of Alcoholics Anonymous, called alcoholism an "allergy of the body," and although we may agree with the sense of what he was trying to say, advances in our understanding of allergy do not support his belief. Similarly, neither psychodynamic (Freudian) nor behavioral formulations of something underlying symptomatic drinking have proven terribly satisfactory.

My own conception of the disease of addiction is a result of having listened to the histories of well over 6,000 alcoholics and addicts. Somewhere around 2500, I discovered that the great American psychologist, Mark Twain, had distilled the essence of all these addiction stories down to this (speaking of his own tobacco addiction): "To cease smoking is the easiest thing I ever did; I ought to know because I've done it a thousand times."

The genius of Twain's remark lies in his articulation of the "all or nothing" quality central to the experience of having an addiction. Although addictive behavior is remarkably varied, in the end, most addicts discover that abstinence is the only way to achieve reliable "control" over the substance. Quitting, it turns out, isn't the major problem; people do it all the time. The big problem is not starting again.

This struggle for control (not whether or not it is achieved) is the core experience of having an addiction. As an addiction progresses, increasing

amounts of time and effort must be expended to maintain control. Most often, the end result is the loss of control. This is what the founders of Alcoholics Anonymous described as having become "powerless" over alcohol--not just for a night, but repeatedly and finally, inevitably. In the end, there is just no such thing as one.

The control conundrum

Now, non-alcoholics never experience this difficulty controlling their drinking. Whether they are stronger or better people (as they sometimes like to think) is a matter of opinion. The fact remains that normal drinking is unaccompanied by the struggle for control. The contrast between normal and alcoholic drinking leads to what I call the "control conundrum": how can an illness be characterized by the sense of losing control when health is experienced as not needing control? How can an alcoholic lose what a non-alcoholic doesn't have? This paradox is resolved by conceiving of an addiction as the *development* of something rather than as a *loss*. This "something" underlying addictive behavior may be termed an automatism.

Pictures being worth thousands of words, let me give an example of a relatively simple automatism--swimming. Once you "get it," you can't get rid of it; once a swimmer, always a swimmer. Stay out of the water for 20 years. Plan not to swim and then dive into the deep end of a pool. Whether you want to swim or not is utterly irrelevant. You will swim--you have lost control over swimming in the sense that it has become automatic. Whether or not you go into the water, yes, there you have choice, but once you're in over your head, you'll swim. In order to succeed in controlling an automatism, one must become abstinent. For swimming, that means staying out of the water; for an alcoholic, it means not drinking.

Complex automatisms

I do not mean to portray automatisms as necessarily harmful; on the contrary, our lives are filled with, and indeed, made possible by automaticity. Complex automatisms--bodily movement and speech, for example--free our attention for the experience of higher levels of responsiveness. Again, an example will be more instructive than description: DON'T READ THIS. In order to experience the meaning of the phrase (and the humor) you have sacrificed choice at the level of recognition--you cannot not read it.

Addictions are complex phenomena of the same type, involving the automatization of feelings (impulses), thoughts (obsessions), actions (behavior) and physiology (tolerance and withdrawal). This is the root of the all-or-nothing experience of addiction: Something inside has acquired a life of its own--a life that threatens the well-being of the whole.

If this conception of addictive disease fits the class of events called "illness," it shouldn't have to be forced into place. It should fit the way other, well accepted ailments fit. Does it?

In every disease, there is an agent of harm, a hostile germ, a defective protein, a mutant gene, that disrupts the harmonious balance of physiological and psychological functions. Alcohol, cocaine, heroin, nicotine, and others certainly fit that definitions. They are neurotoxins, nerve poisons.

Exposure to an agent of harm does not invariably lead to illness

Mere exposure to an agent of harm, however, does not invariably lead to illness. We are protected from many potentially harmful germs, for example, by the mechanisms of immunity. In the case of alcoholism and other addictions, a variety of factors combine to protect us against the development of an automatism in response to exposure to certain neurotoxins. As with other diseases, the failure of resistance leads to illness.

Just as the failure of resistance to a germ is a consequence of many factors--biological (heredity and acquired), social, and psychological--so too, the development of an addiction is shaped by heredity, biochemical effects of the toxin, social conditions (availability, cultural expectations), and co-existing psychopathology. The scientific literature provides ample evidence of the contributions of many different factors to the development of alcoholism and other addictions.

What about recovery and treatment? The argument has been made that because many people recover from addictions without professional help, these problems should not be called diseases. The word "disease," it is said, should be reserved for conditions which require medical treatment. But this is an absurdly narrow view. Firstly, we recover from all manner of illnesses (mild and serious) without professional help. But secondly, and more importantly, an enormous proportion of modern health care is a result of the consequence of drug and alcohol use (cirrhosis, trauma, emphysema, AIDS, etc.). To treat only the results of addictions without concern for the underlying disorder would be unconscionable.

The danger

Is there a danger in the disease model of alcoholism? Yes, and in this, valid criticism of the medical perspective must be acknowledged. Addictions are chronic conditions in which the capacity for and exercise of choice play the major role in recovery. Like other patients who have lost control of a part of themselves, the alcoholic must not only want to recover, he must be willing and able to work for it. Treatment programs, professional and non-professional alike, can do no more than create conditions in which this work can be accomplished. If the medical model of addiction gives people the message that they can not become more responsible for the decisions they make, then it will have done them great harm. No one is responsible for having an illness; nevertheless, to some degree, everyone is responsible for what they do about it.

From the medical perspective, addictions are simply at one end of the spectrum of illnesses. At the near end (injuries, for example) whether you suffer or not is more or less irrelevant to the outcome. In the addictive disorders, on the other hand, recovery requires the willingness to endure suffering. After a lifetime of changing his state of consciousness at the drop of a hat, the alcoholic must become willing to experience "life on life's terms " not because it's morally better, but because it's the only effective alternative to a path which leads to starting again.

The danger of the medical perspective is in the negation, intended or otherwise, of the awakening of the human spirit that is a fundamental aspect of recovery from addiction. However one conceives a Higher Power (the group, humanity, nature, God), without a sense of something greater than myself to which I am responsible, there is no reason to endure the pain of recovery. Despite the intoxicating success of modern medical technology, the statement of the brilliant French surgeon, Ambroise Par), is still true: "I merely dress the wound. God heals it." There's something in that lesson for all of us. □

Recovery requires the willingness to endure suffering

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Comments Requested

THE SCOPE AND AUTHORITY OF MEDICAL PRACTITIONERS IN ADDICTION MEDICINE

A study group has been named and charged by the Executive Council to explore the scope of the field of addiction medicine, to define the questions of role, task and authority which face us, and to provide us with an explication of the issues which need our attention and deliberation. The initial focus will be on the diagnosis and treatment of sexual disorders.

Five members of the Executive Council have been appointed to the Study Group: Kevin Olden as Chair, Peter Banys, William Brostoff, Margaret Gregory and Garrett O'Connor.

Comments are requested. We are most interested to learn how these questions and issues manifest themselves in the different settings and situations in which our members practice. Please send your notes to my attention, in care of the California Society office, 3803 Broadway, Oakland, CA 94611.

P. Joseph Frawley, MD, President

ETHICS AND THE PRACTICE OF ADDICTION MEDICINE

Lawrence J. Nelson, PhD, JD

This article is prepared from the presentation made at the conference "Legal Aspects of Addiction Medicine" in May, 1989, by Lawrence Nelson, a biomedical ethicist. Doctor Nelson received his PhD in ethics from St. Louis University, and his JD from Yale Law School. He is a consultant in bioethics with offices in Berkeley. He is a Clinical Lecturer in ethics at the UCSF Medical School.

As you can tell from the introduction, I consider myself to be both an ethicist and an attorney. Now I realize that for most of you that's an inherent contradiction in terms, but that is my background and I spend a lot of my work thinking about both. Today, however, I'd like to focus on ethics rather than the law, because the law takes us only so far.

The law is the floor for regulating human behavior, not the ceiling. I sincerely hope that the law alone does not represent our highest moral aspirations. To illustrate its shortcomings, let us consider this hypothetical case. If I fell over right now with a myocardial infarction, all of you in the audience could say, "Hey, we can take a 25 minute break. Let's go outside and get a breath of fresh air." Let us say that everyone walks out of here. No one tries to provide CPR to me, although I'm sure many of you know how. No one goes to a telephone and dials 911. None of you does anything. I die. My wife then gets a list of the registrants of this conference and sues every single one of you for not coming to my aid. What's the result of that law suit? You win; she loses. She would lose under the laws of our state and in fact, all around the country with the exception of Vermont and Minnesota, where if you didn't come to my aid they might fine you $100. If you are not in one of those two states, you have no legal obligation. It is not against the law for you not to come to my aid because you are strangers to me. You don't have any duty to help me. But I sincerely hope some of you might feel an ethical obligation to come to my aid.

Ethical principles go only so far

When I talk to you about ethics there's no way I can give you solutions to the ethical problems you face. I can only highlight the general principles which cover all professional health care practices, namely, beneficence, doing good for patients; autonomy, respecting the patient's right to make his or her own decisions about life and health care; justice, treating all persons fairly; and respect for the professional integrity of the health care providers, whether physicians, nurses, counselors, or social workers. Those four principles have been articulated frequently in the bioethics literature, but principles alone cannot tell you how to act. Ethical principles need to be applied in concrete cases, and you as a group of professionals need to reflect on how they apply to the hard cases you've come across.

One of the most severe ethical conflicts you may face is that between beneficence and autonomy, because addiction by itself impairs or completely takes away patients' autonomy, so they may literally have no idea what's really good for them. How far do you go in encouraging, persuading, coercing your patients to stay in treatment or follow your regimen? We would have to look at a particular case to see just how far can you go ethically.

The best model for thinking about decision making in health care matters--including questions surrounding treatment for substance abuse-- is that of shared decision making. The professional, the patient and the patient's family work together to identify a proper course of treatment. Again, the need to involve the family presents some unique problems in your field. I suggest that you try to define those problems and see how the ethical principles of autonomy and shared decision making would operate in specific cases. The decision maker should not be just the physician, not just the patient, and, to be sure, not just some third party payer. Rather, together you and your patient try to find the course of action that will best benefit the patient and respect his or her values.

I urge you to begin discussions about how you will apply these principles of beneficence and autonomy in your practice. Do it in a case context and do it in a way that will make those principles alive and workable for you.

The pressures of economics

I fear that the changes in the economic system and the reimbursement system in health care in our country are warping the professional ethic that we've been working under since Hippocrates that requires the provider of health care services to help the patient, to alleviate pain, to prevent and ameliorate dysfunction, to preserve life, and to preserve and enhance a patient's autonomy, that is, the ability of a

patient to make his own decisions and live his own life as he sees fit. Today we are witnessing a tragic trend where those concepts are being overshadowed by economic concerns. I hope that professional groups like yours can get together to address this trend head-on and create a statement of how your code of ethics applies in your professional practice. This is important because I think professional ethical standards can make a difference. Since the AMA came out with its statement on forgoing life sustaining treatment for patients in a vegetative state, including the withholding of nutrition and hydration, the courts have taken this statement seriously, and they have used it to support their rulings.

The war on drugs

I also think the war on drugs has become a war on drug abusers. It makes headlines for politicians and it makes it seem as if something is being done. Recently in Illinois and Florida, we have seen pregnant women prosecuted for taking drugs during pregnancy. A woman in Florida was prosecuted for "delivering drugs to a minor" by means of the umbilical cord to her newborn child. She was prosecuted under a law meant for drug pushers, not addicted pregnant women. She faces 30 years in jail. A prosecutor in Butte County, California, threatened to use positive toxicology screens on a newborn to prosecute the mother for misdemeanor drug use. The two possible punishments for misdemeanor drug use in California are 1) for first offenders with a clean record, a diversion program, including drug rehab, if such is available; or 2) an automatic minimum 90 day jail sentence. I think that as a matter of social policy, it's very questionable whether we should be separating newborns from their mothers--whether or not the mothers are drug users--for a minimum of three months right after birth. I urge you to get involved in the formation of public policy. Professional groups like yourselves should talk directly to legislators. You need to get your message across to them about what you think is sound public policy with respect to substance abuse treatment.

Make yourselves heard

Perhaps some of you have heard how the Oregon Department of Health Care Services convened various groups of people to try to figure out what basic health care services the indigent population in Oregon should receive. They were told to prioritize different health services, including very specific procedures and tests. They ranked the procedures from 10, the most important, to 1, the least important. Drug abuse treatment was way, way down the scale. When they were asked why, the group who worked on it said, "There's no evidence that it's efficacious. Given the competing demands on our dollar we simply cannot put dollars into something that doesn't seem to work." Well, insofar as you think that's not true, I think you need to make yourselves heard. Insofar as you suspect it is true but you'd like it not to be true, then you need to do the research to show public policy makers that you can make a difference, because obviously substance abuse is a terrific blight on our country right now.

Again, I remind you not to look exclusively to the law. I urge you not to be preoccupied with risk management. I urge you to focus on what physicians and nurses and all those involved with the healing profession have been focused on for many, many years, and that is the good of the patients, respecting them as persons, but also at the same time respecting your own values, as individuals and as professionals.

There are some ethical norms inherent in just being a physician, being a nurse, being a social worker, being a counselor. And it's important for us to articulate them and stand by them. I think ultimately that's the best way to serve patients. □

California Society Work Group on Ethics

In response to suggestions that the Society should explore the principles of ethical practice as they apply to the role of the addictionist and should draft a code of ethics, a work group is forming to begin to study the issues.

Kevin Olden of San Francisco will spearhead the effort to gather information from interested members. Those who wish to be involved in the project should write to him in care of the California Society at 3803 Broadway, Oakland, CA 94611. □

Extinction, Evolution, Adaptation

REAL SURVIVAL PROBLEMS FOR THE ROLE OF THE PHYSICIAN

P. Joseph Frawley, MD

The treatment of chemical dependency is evolving and being shaped, like any organism, by the environment in which it finds itself and the competition for resources. Many of us have expressed the feeling that inpatient treatment is like the ancient dinosaur which suddenly died out, unable to adapt to whatever the changing environment was. Others see the sacrificing of inpatient levels of care as more analogous to the drowning of porpoises in the relentless effort to net tuna.

The point of these analogies is that many physicians who love to work in this field are finding it difficult to do so because of the changing environment. In this evolutionary process we often find ourselves being told by others how to practice and what to prescribe. The National Association of Addiction Treatment Programs finds itself wavering, with a significant number of its members going out of business, while, at the same time, there are too many addicts for the treatment slots available in the public sector. While ASAM is moving ahead promoting chemical dependency as a specialty, those of us nearer the grass roots are concerned with where the patients for the private sector treatment programs will come from. There is a feeling of creeping irrelevance about what ASAM is doing in the face of real survival problems for the role of the physician.

Yet this sense of doom is paradoxical since the problem of chemical dependency is not disappearing from our communities. We are not in the same situation as the polio specialists or those who cared for tubercular patients in sanitariums when vaccines and good curative medications altered the prevalence and the course of these illnesses. If the illness is still there but physicians are finding it difficult to support themselves taking care of those with the illness, we must look to the following questions. Is our survival threatened because of overdependence on one source of patients -- like the giant panda of China who can eat only bamboo? Or is our survival threatened because our services are not as efficient to use as the services of other professionals or non-professionals? Is our cost benefit ratio too low? Will we lose out for survival like some water-inefficient mammal faced with a drought? I do not share the doom and gloom for the future of the physician in chemical dependency, although there is no doubt that there will have to be adaptations to the changing times. There is no doubt in my mind about the need for the physician, because addiction spans bio-psycho-behavioral-social-spiritual dimensions. No other group is trained for that. Nor licensed. The more important question for us is: are we continuing to train ourselves and to enhance our expertise in each of these dimensions as they relate to chemical dependency?

This sense of doom is paradoxical since the problem of chemical dependency is not disappearing from our communities.

This is what we must do to be cost effective:

1. Learn from our patients, and be willing to learn from those who refer patients to us.

2. Demand that what we and others do is measured, that the outcomes are monitored and that we have access to that information to help guide what we do.

3. Change or maintain what we do based upon what we have learned.

4. Share what we have learned with each other and the other professionals who care for patients in order to enhance the progress of the care of this disease and the expertise of the professions.

5. Teach our patients and those who refer us patients about how best to care for this illness and its many manifestations.

Some have felt that the place of the physician was secure as long as care was provided in a hospital. Hospital rules and the need for the physical exam within 24 hours codified our place. California State law required the physician to sign the treatment plan, again ensuring our survival. But in Washington State it is the addiction counselor who must sign the treatment plan, by state law. Which is right? My feeling is that it depends on how treatment is being delivered. If the treatment program for which the patient gives informed consent addresses only social-behavioral issues, it is possible that a counselor can understand and deal with these adequately. If the treatment plan includes bio-psycho-behavioral-social-spiritual components, then the physician will be needed, but the physician must have the training to treat the chemical dependency in each of these dimensions, and treatment must address each of these areas effectively. This is our challenge.

If the treatment plan includes bio-psycho-behavioral-social-spiritual components, then the physician will be needed.

Undoubtedly, certain types of care are best provided in a hospital and certain types of patients are best cared for in a hospital. But in all areas of medicine certain types of care are being moved outside the hospital or handled on a "come and go" basis. No doubt we will have to adapt as we learn what aspects of chemical dependency treatment can and cannot be done in different settings. But inpatient and outpatient only refer to settings. What is more important is the care or treatment provided. The setting is chosen to support the treatment each patient requires. Patients and people who purchase care want the best match possible for each patient. They expect us to help them make these choices. We must be vigorous in our promotion of appropriate care in the appropriate setting for each patient whether we provide the care or others do.

We must be vigorous in our promotion of appropriate care in the appropriate setting for each patient whether we provide the care or others do.

Some physicians, myself included, have become very dependent upon one source of patients. We may have given up a private practice to devote ourselves full time to this endeavor. We may wholeheartedly believe in what we are doing, but we must remember that this is a single lifeline and may be all too easily severed.

Over the next year the California Society is going to seek out members who are adapting to the changes and ask them to share what they are doing and how.

Treatment for chemical dependency grew up outside of the medical system in a variety of settings. Even today, many of the providers do not even talk with one another. Government regulations have mandated methods of care for narcotic addicts. Program philosophies or protocols may mandate a type of treatment or a length of stay or a level of physician involvement or lack thereof. The crisis in health care can be an opportunity for us to regain control of our specialty.

While ASAM pursues recognition for specialty status in addiction medicine, it is we at the state level who are evolving with the specialty. What it becomes depends on what we make of it.

So, we return to the question of extinction versus adaptation. Perhaps some may see the physician who specializes in chemical dependency treatment as an endangered species. I do not. I believe the evolutionary changes provide us with an opportunity to regain control of our profession and the care of our patients. There are no "Save the Physicians" groups, except perhaps for the patients we help in the course of practicing our profession. They are our best advocates. □

NIDA Funds Two California Treatment Research Units

With funds allocated by Congress for AIDS research, the National Institute on Drug Abuse has funded seven Treatment Research Units (TRUs) to conduct research that will improve treatment of intravenous drug users and thereby reduce the spread of HIV infection. The sites are funded for five years. Two of the TRUs are in California: one in San Francisco and one in Los Angeles.

The principal investigator for the Los Angeles TRU is Walter Ling, MD. The Pizarro Treatment Center, an outpatient treatment program located near downtown Los Angeles, will be the primary research site. Several studies are scheduled to begin early this summer. One will compare the relative efficacy of buprenorphine to two dosages of methadone for long-term treatment of opioid dependence. Another study will compare buprenorphine with clonidine for detoxification.

The Los Angeles TRU will also participate in a collaborative study of gepirone (a congener of Buspirone) in treatment of cocaine users. The gepirone study, which will involve an initial inpatient treatment, will be performed at UCLA's Neuropsychiatric Institute in Westwood, and Merritt Peralta Institute, in Oakland, California.

The Los Angeles TRU is administered by Friends Medical Sciences Research Center, Inc., in Baltimore, Maryland.

The principal investigator for the San Francisco TRU is James Sorenson, PhD, a psychologist at the University of California, San Francisco. Projects under his direction include a study of 180 day methadone detoxification, which will be conducted at the San Francisco Veterans Administration Medical Center, and several pilot studies which will be conduced at San Francisco Community Clinics, Bayview-Hunter's Point or San Francisco General Hospital. They include a diverse group of studies including acupuncture, AIDs treatment and prevention, and antidepressant medications in treatment of addiction.

California Society members are involved at both sites. In addition to Walter Ling, Donald R. Wesson is involved with both the Los Angeles and the San Francisco TRU. Steven Batki, Peter Banys, H. Westley Clark, Karen Sees, and Donald J. Tusel are investigators at the San Francisco TRU. □

Collaborative Study of Addiction Treatment Outcome

Fund raising is underway for the project called the Collaborative Study of Addiction Treatment Outcome which will bring together treatment providers, payers and researchers in a cooperative venture to agree on a database of patient information which will be useful to each group in assessing outcome.

Partial funding, in the amount of $10,000, has been contributed by Blue Cross of California. Matching funding is being sought in contributions from individuals to the Medical Education and Research Foundation.

The Project Steering Committee for Phase One will include researchers as well as clinicians; Thomas Babor, PhD, of the University of Connecticut has agreed to serve.

Phase One will include a pilot study of the existing databases in addiction treatment, such as CATOR, to see if they can provide the information which the clinicians and researchers find useful. The results of the pilot study will be reported at a consensus conference where researchers, clinicians, third party payers and regulators will be asked to agree on the information which should be available from patient databases for a chronic disease such as addiction. Databases from the field of heart disease and arthritis will be studied as models.

Fund raising will continue. The consensus conference is planned for early 1991. □

AMA CODE FOR ADDICTION MEDICINE

The following Resolution will be considered by the American Medical Association House of Delegates in June. If it passes, physicians can report their specialty as "addiction medicine" on the annual member profile questionnaire , and AMA will begin to collect data on the numbers and characteristics of physicians who practice addiction medicine.

WHEREAS, chemical dependency/addiction has been declared by this House to be the most important public health problem in the United States;

WHEREAS, the diagnosis and treatment of alcoholism and other drug addiction as disease has been recognized by the AMA and other reputable medical organizations as a legitimate form of medical practice;

WHEREAS, an increasing number of physicians are responding to the addiction problem by devoting an appreciable amount of practice time to diagnosis and treatment of addictive disease;

WHEREAS, these physicians represent a range of specialties including addiction medicine;

WHEREAS, codes are provided by the AMA so that physicians can self designate one or more areas in which they spend a significant number of practice hours,

WHEREAS, identification in the AMA Masterfile of physicians who treat addictive disease would serve the needs of both patients and referring physicians; now, therefore, be it

RESOLVED: That Addiction Medicine be added to the self-designated specialty areas which are assigned a code in the AMA Physicians Masterfile. □

Status Report

PERINATAL STUDY GROUP

In the San Francisco Bay Area, an Ad Hoc Study Group has been meeting regularly every six to eight weeks since January. Participants include physicians working in County Health programs in Alameda, Contra Costa, San Francisco and Santa Clara. Among them are Hope Ewing, Kenneth Saffier, Timmen Cermak, Maureen Lonegan, Merritt Smith, Anthony Puentes, and Barbara Bennett.

The group is sharing information about both clinical and policy issues related to drug affected pregnancies, addicted pregnant women and drug exposed babies, and preparing suggestions for activities of the Society.

Status Report

REGIONAL MEETINGS

On May 31st, at a regional meeting for CSAM/ASAM members and other intereseted physicians, David Smith led a stirring discussion of the physician's role in addiction medicine. His perspective ranges from the days when his malpractice insurance was cancelled in 1969 because he was treating addicts, to 1990 when he served as guest editor of a Special Issue of *The Western Journal of Medicine* devoted entirely to addiction medicine.

People came early and stayed late to participate in the wide ranging discussion of neurophysiology ("the decade of the brain"), the use of medications, and drug testing. They rated the evening as "excellent" and set the next meeting for September 27th.

NB: Any CSAM/ASAM member can organize an educational meeting or study group meeting of any size. Contact the California Society (415-428-9091) office for assistance.

Update

DIVERSION PROGRAM FOR PHYSICIANS

A sixth Diversion Evaluation Committee (DEC) has been formed to provide a special focus on mental health problems (including sexual disorders) of the physicians accepted into the Medical Board of California's Diversion Program for Physicians. The Medical Board of California (MCB) is the new name for the Board of Medical Quality Assurance (BMQA) effective January 1, 1990.

Members of the new sixth DEC are John Milner, MD, Chair; Lyman Boynton, MD; Cassandra Delacoeur; Margaret Gregory, MD; William Hazle, MD. □

DRUNK DRIVING (*Continued from p. 1*)

law provides that even with a BAL of less than 0.08 percent, you can be arrested and charged with a DUI offense if a law enforcement official has good reason to believe that you are "under the influence." If you refuse to take the test, your license will be automatically suspended for six months.

You will probably be restrained in handcuffs. The officer will take you in a squad car to a testing facility and you will be given a choice of a blood, urine or breath test. Most people choose the breath test, which is easiest to administer, and the results are available immediately.

Beginning July 1, 1990

Beginning July 1, 1990, the arresting officer will also confiscate your driver's license and you will face an administrative suspension of at least four months. (DMV will charge a fee of up to $100 to re-issue the driving privilege.)

About your car: if you were driving alone, and your car cannot be parked safely nearby, the police may order your car towed away. Later you will have to pay the towing and storage fees. These are expensive and vary from company to company.

If the test results show that your blood alcohol level is .08 percent or more, you may be formally charged with driving while intoxicated, advised of your legal rights, fingerprinted, photographed and booked.

Then you will be placed in the drunk tank, or a cell, until your lawyer or someone else arrives to bail you out. It could take several hours. Eventually, you will have your day in court.

If you are found guilty of a misdemeanor first offense on a DUI charge, you may be sentenced to 96 hours to 6 months in a county jail. You will also have to pay a fine ranging from $390 to $1000 plus penalty assessments, which vary with the jurisdiction. Your license will be suspended for six months. First offenders in some jurisdictions might receive probation. This requires spending 48 hours in jail or in community service, a $390 to $1000 fine, and proof of insurance. You may be required to attend an alcohol/drug treatment program and pay tuition for it. Your driving may be restricted for 90 days.

Note: the new "administrative suspension" which takes effect in July is separate from driver's license suspension resulting from a DUI criminal conviction. The suspensions may overlap, or they may occur at different times--first at the time of arrest, and later after court procedures. Also, even if the DUI charge is dismissed, the driver may still be subject to the administrative suspension.

The law is even tougher on young drivers. In 1989, a new law by Senator William Campbell, R-Hacienda Heights, took effect. It requires a one-year suspension of a driver's license for anyone 16 to 21 years old convicted of DUI, or any other alcohol or drug-related offense such as possession, sale, or use. If the driver is younger than 16, and doesn't yet have a driver's license, the same law requires a one-year delay in issuing a license to the convicted driver.

It doesn't stop there. Your insurance rates will probably rise dramatically. So will your employer's insurance, if you must drive in the course of your work. If it is your second conviction in seven years for driving while intoxicated, you will have to serve a mandatory sentence of at least 90 days in jail, and pay a fine of $390 or more. You may have your driver's license suspended for 18 months. Some drivers succeed in having the DUI charge plea-bargained down to a "reckless driving" charge. However, it must be noted as an alcohol-related offense and will be counted as a prior DUI conviction if you should be arrested for another alcohol-related crime. This will mean increased penalties.

If you hare convicted of causing the death or injury of another person while driving under the influence of alcohol, you may have to serve a jail sentence of 90 days to one year, and pay a fine of up to $1,000.

With each succeeding DUI conviction, the severity of the penalties increases. With a fourth conviction, a felony, you may go to state prison. □

NEWS ABOUT MEMBERS

Doug Ziedonis has moved from UCLA to Yale where he is an Associate Clinical Professor of Psychiatry at the Substance Abuse Treatment Unit.

Ray Deutsch is now Chairman of the Department of Medicine at Fresno Community Hospital.

Jess Bromley announced the closing of the inpatient unit Step One at Physicians Community Hospital in San Leandro. The Step One outpatient program continues.

Peter Banys, in addition to his role at the San Francisco Veteran's Administration Medical Center, now has a part-time private practice of psychiatry in San Francisco.

Donald Dougherty is now the Medical Director of the McDonald Center at Scripps Memorial Hospital. Ronald Mineo left that position in Fall, 1989.

Jay Miller is on the planning committee for ASAM's 4th National Conference on Nicotine Addiction to be held in San Diego in September.

Judith Dischel is now a full-time staff member of the Chemical Dependency Recovery Program at Kaiser Fontana.

Edward Kaufman is the President of the American Academy of Psychiatrists in Alcoholism and the Addictions (aaPaa).

Margaret Gregory is now Physician-in-Charge of the Kaiser-Bellflower Chemical Dependence Recovery Program. She has been appointed to the sixth DEC. See Diversion Update, page 11.

Lloyd Hyndman and **William Brostoff** have been appointed to Diversion Evaluation Committees (DEC) of the California Diversion Program for Physicians.

Max A. Schneider will receive the 2nd Annual Sidney Cohen Award given by UCLA. □

APPLICANTS FOR MEMBERSHIP

The names of applicants are published twice and sufficient time is allowed for comments from the members before the Executive Council acts on the applications. The first time the name appears, a biographical sketch prepared from information on the applicaiton form is included. If you have comments to bring to the attention of the Executive Council, please contact William Hazle, MD, at 408/358-3715, or write to him in care of the California Society office.

Robert D. Daigle, MD has been Medical Director of the Chemical Dependency Service at Monte Villa Hospital in Morgan Hill since June, 1989. He graduated from Medical School at LSUMC in New Orleans and completed a two year residency in Family Practice at the Earl K. Long Hospital in Baton Rouge. He was certified by the American Board of Family Practice in 1981, and recertified in 1988. He was a Substance Abuse Fellow at the San Francisco VA in 1987-1988.

Daniel J. Glatt, Millbrae, is a third-year medical student at New York Medical College. He is the co-chair of the Members-in-Training Committee of the American Society of Addiction Medicine, and student representative on the committee on alcoholism of the Medical Society of New York state.

Said I. Jacob, MD, MPH has been Medical Director of the Chemical Dependency Program at Charter Oak Psychiatric Hospital in Covina since March of this year. He graduated from medical school in Cairo and received a Master of Public Health from Tulane University in 1982. He completed a residency in psychiatry at Louisiana State University Medical Center in June, 1988.

Other candidates are:
Peter M. Braunstein, MD, Berkeley
Ramzi Z. Kiriakos, MD, FRCP, Los Angeles
Alexander (Steve) Orr, MD, Claremont
Glenhall E. Taylor, III, MD, Hillsborough
Phillip L. Wagner, MD, Eureka
James G. White, MD, Modesto
□

YOU CAN WRITE FOR

Professional Therapy Never Includes Sex!

An 11-page brochure prepared by the Medical Board of California in response to a Bill passed in 1989 requiring psychotherapists to provide a copy of such information to any patient who has been the victim of sexual exploitation by another psychotherapist. Copies ($5.00 for 25 copies) are available from Office of Procurement, Publications Section, P. O. Box 1015, North Highlands, CA 95660.

It's Never OK: A Handbook for Victims and Victim Advocates on Sexual Exploitation by Counselors and Therapists

Published by the Minnesota Public Education Work Group of the Task Force on Sexual Exploitation by Counselors and Therapists.
The 36-page handbook is free and the manual (Stock No. 14-16) is $19.95 (plus $1.50 for shipping and handling). Order from Minnesota's Bookstore, 117 University Avenue, St. Paul, MN 55155. Checks should be made payable to "State of Minnesota."

DOC News and Views...a Journal of Medical Activism

Published by Doctors Ought to Care, a coalition of health professionals, founded by Alan Blum, MD, which uses its own brand of guerilla tactics to educate and involve the public in counteracting the promotion and advertising of tobacco products. For information, write to Doctors Ought to Care, 1423 Harper Street, Augusta, GA 30912.

How to Help Your Patients Stop Smoking

Published by the National Cancer Institute, this manual for physicians provides a step-by-step office based approach. This information is based on methods proven in clinical trials. It outlines how to incorporate a smoking cessation program into a busy office practice. Contact Tobacco-Free California, 221 Main Street, P.O. Box 7690, San Francisco, CA 94120-7690. Or call (415) 882-5124. □

1990 REVIEW COURSE

San Francisco Airport Marriott Hotel

November 8-10

Thursday, November 8
Registration opens at 9:00 a.m. The course begins at 1:00 p.m.
Pharmacology, **Donald Catlin, MD**
Opiates, **Steven Batki, MD**
Marijuana and Psychedelics, **Lyman Boynton, MD**
Test Taking and Practice, **Julie Nyquist, PhD**
Evening Self-Help Group Meetings

Friday, November 9
Morning Self-Help Groups are part of the Course.
Cocaine and Amphetamines, **Richard Sandor, MD**
Sedatives and Hypnotics, **David E. Smith, MD**
Urine Drug Screens, **Dennis Ritz, JD, MS**
Alcohol, **Donald Gragg, MD**
Assessment and Diagnosis, **William Hazle, MD**
Medical Complications of Alcoholism, **Lawrence Tierney, MD**
Nicotine, **Neil Benowitz, MD**
Keynote Lecture: Denial, **Margaret Bean-Bayog, MD**
Evening Self-Help Group Meetings

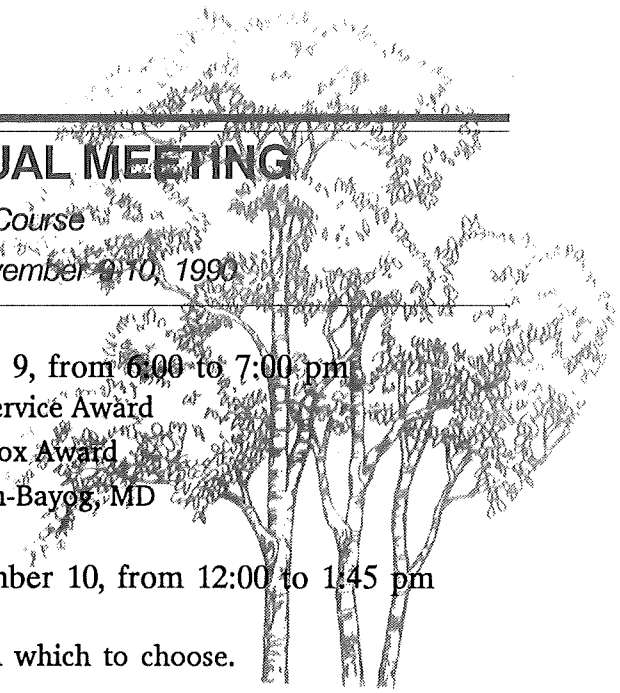
Saturday, November 10
Morning Self-Help Groups are the part of the Course.
HIV and Chemical Dependence, **Melvin Pohl, MD**
Models of Treatment and Recovery, **Peter Banys, MD**
Psychiatric Concomitants, **Sanford Reder, MD**
Pregnancy and the Newborn, **Loretta Finnegan, MD**
Family and Relationship Issues, **David Wellisch, PhD**

The California Society Annual Meeting will be held on Friday and Saturday, November 9 and 10, in conjunction with the 1990 Review Course. It will offer workshops on clinical topics, legal aspects and public policy issues. At any one time, registrants can choose to attend one of the two workshops (see page 15) or the Review Course presentation or activity.

CALIFORNIA SOCIETY ANNUAL MEETING

in conjunction with the Review Course

at the San Francisco Airport Marriott Hotel, November 9,10, 1990



Awards Ceremony, Friday evening, November 9, from 6:00 to 7:00 pm
Presentation of the Community Service Award
Presentation of the Vernelle Fox Award
Dinner Presentation by Margaret Bean-Bayog, MD

Business Meeting of the Members, Saturday, November 10, from 12:00 to 1:45 pm

Conference -- a series of workshop from which to choose.

Legal Aspects

Friday, November 9

Fundamental Legal Concepts in the Practice of Addiction Medicine, **H. Westley Clark, MD, JD, PhD**

The Role and Authority of the EAP and the Managed Care Professional
William Goldman, MD and **Wayne Bolio, JD**

The Role and Authority of the MRO
Steven Goodman, MD

Diversion Programs for Health Professionals: Issues on the Borderline between Voluntary and Involuntary Treatment, **LeClair Bissell, MD**

Clinical Aspects

Friday, November 9

Ethical Conflicts in the Practice of Addiction Medicine, **Kevin Olden, MD**

Treatment of Nicotine Dependence
Karen Sees, DO

Treatment for Adolescents
Gary Levine, MD, and **Arthur Bolter, MD**

Treatment for Third World Populations
Merritt Smith, MD

Treatment for Gays and Lesbians
Melvin Pohl, MD

Public Policy

Saturday, November 10

An Historial Overview, **Richard Sandor, MD**

Decriminalization of Drug Use: Both Sides of the Debate, **LeClair Bissell, MD**

Changing the Alcohol Environment

Public Sector Strategies, **Elizabeth Stanley**

Saturday, November 10

Treatment for Pregnant Addicts and Drug Exposed Newborns
Sidney Schnoll, MD, PhD

Relapse Prevention, **Peter Sterman, PhD**

Co-Dependency in the Healer
Garrett O'Connor, MD

Panel Discussion: Interface between Public Policy and Clinical Care.

CONTINUING MEDICAL EDUCATION

41st Annual IDAA Convention
Boca Raton Resort and Club, Boca Raton, Florida
August 1-5, 1990
Fees : IDAA members, $300; Spouse/Guest, $200; Resident/Student, $175
For information: William T. Haeck, MD, IDAA 1990 Convention, 100 Sample Road, Suite 300, Pompany Beach, FL 33064; (305) 785-7003.

ASAM's 3rd National Conference on Nicotine Dependence
San Diego Hilton Hotel
September 6-9, 1990
Sponsored by the American Society of Addiction Medicine
Credit: 16 hours
For information: Hermese Bryant, 6429 West North Avenue, Suite 102, Oak Park IL 60302; (708) 848-6050.

aaPaa's First Annual Symposium
Loews Santa Monica Beach Hotel
November 29-December 2, 1990
Speakers include Edward Kaufman, Thomas Kosten, Sheldon Zimberg, Marc Galanter, Peter Roy-Byrne, Floyd Bloom, David Smith, George Woody
Sponsored by the American Academy of Psychiatrists in Alcoholism & Addictions
For information contact aaPaa Central Office, P.O. Box 376, Greenbelt, MD 20768; (301) 220-0951.

1990 Review Courses
Chicago: October 11-13, O'Hare Marriott Hotel
New York: October 25-27, Roosevelt Hotel
San Francisco, November 8-10, Airport Marriott
Atlanta: November 15-17, Marriott Marquis Hotel
For more information contact ASAM, 12 West 21st Street, New York, NY 10010; (212) 206-6770.

Medical Director

CPC Sierra Gateway Hospital, a free standing psychiatric hospital in the Fresno/Clovis area providing acute adolescent and adult psychiatric care, is seeking a program medical director for the addiction medicine unit. The Director will supervise the medical and clinical services of the addictions program and work closely with other members of the medical staff admitting to this service. Interested physicians should be specialists in the field of addiction medicine, be certified by the American Society of Addiction Medicine (ASAM) or Board-certified in Psychiatry, and have experience working in a hospital-based addictions medicine program.

For more information about this opening, contact Tom Smith, Administrator, CPC Sierra Gateway Hospital, 650 West Alluvial, Clovis, CA 93612. 209-299-1100.

Assistant Medical Director

Medical Director of a hospital-based 25-bed inpatient unit, day-care service and separate evening outpatient program including co-dependence and ACA treatment looking for a partner to share the administrative and clincial tasks. For information call or write: Barry Rosen, MD, Sequoia Hospital ADRC, Whipple & Alameda, Redwood City, CA 94062; (415) 367-5503.