CSAM NEWS

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RELAPSE TO DRINKING: DOES CIGARETTE SMOKING CONTRIBUTE?

Richard S. Sandor, MD

Clinicians have long recognized that large numbers of patients coming to chemical dependency treatment programs are also addicted to cigarette smoking. Even the pathologist at my hospital whose license plate frame reads, "Drinkin' and smokin'. . . keep me in business," puts them together. The legendary heavy smoking at AA meetings once led some wag to dub it "the church where you can smoke." Several otherwise popular addictionists have been criticized by some in AA for asserting that continued smoking indicated continuing chemical dependency.

These everyday observations are well supported by rigorous research. Among the most convincing data are those reported in George Vaillant's 1983 book, *The Natural History of Alcoholism.* In this 40-year prospective study, the rate of heavy smoking (50+ pack/years) among alcohol abstainers was 10%, whereas among moderate and heavy drinkers it was 12% and 22% respectively. For those meeting criteria for alcohol abuse, the rate was 33%. The course of alcoholism was also correlated with smoking history. Fifty-five percent of the subjects who met criteria for alcohol abuse (at some point in their lives) *and* whose alcoholism conformed to the model of a progressive illness (with an outcome of either deterioration or abstinence) had a history of heavy smoking. By contrast, only 26% of another group of subjects whose alcohol abuse followed a course characterized by return to social (really more accurately described as "controlled") drinking, smoked at least two packs of cigarettes a day.

In a parallel, prospective study following college students into adulthood, Vaillant found that "midlife drinking habits bore a much higher relation to college smoking habits than they did to college drinking habits."

Of course, the important question is what sort of correlation exists between drinking and smoking? Is it merely associative or is it also causal?

Conventional wisdom among treatment program professionals (clouded, I think, by some degree of self-protection) has held that patients should focus on the most serious problems first. I myself

INSIDE

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The California Society is a specialty society of physicians founded in 1979. Since 1989, it has been a State Chapter of the American Society of Addiction Medicine, Inc.

have counseled patients to take "one addiction at a time" and to wait for a year of sobriety before tackling the addiction to nicotine. Leaving conceptual and ethical issues aside, and taking the question from a strictly practical

Those who smoke relapse more often and sooner than do non-smokers.

perspective, we would have to conclude that, if continuing to smoke cigarettes after treatment for alcoholism has a causal relation with relapse to drinking, then this may have been poor advice. The following data, although preliminary, suggest just that.

As a part of its follow-up program, the Betty Ford Center in Rancho Mirage gives graduating patients 36 cards to fill out as follow-up questionnaires and return, one each month for three years. Table A presents data from cards returned from January 1, 1990 through February 13, 1991, and compares smokers with non-smokers.

Since the smoker and non-smoker groups in this study showed no other significant differences in demographics (age, race, gender, education), pre-treatment factors (employment and marital status, history of other drug use and previous treatment), or treatment variables (days in treatment, percent completing, or family participation), it may well be that smoking tobacco plays an independent and significant role in relapse.

The data and conclusions offered here are tentative and should by no means be considered definitive; nevertheless, they do suggest that among patients completing a chemical dependence rehabilitation program, those who smoke cigarettes relapse to their primary drug both more often and sooner than do non-smokers.

Some caveats are in order. First, the data are self-reported and come from a little less than two thirds of all of the patients. Second, while there are no differences in rate of returning cards and the other pre-treatment variables noted above, there may be other differences between smokers and non-smokers which reflect severity of the primary addiction for which patients sought treatment. Such differences could explain the smoker *versus* non-smoker relapse variation on the basis of association alone.

It should also be noted that no attempt was made to identify and match patients treated for smoking cessation (during treatment for the primary addiction) with a control group not so treated. This would be the critical study, because it is possible that attempting abstinence from all drugs at once, including nicotine, could lead to additional stress and *increased* relapse rates. On the other hand, there are both neurochemical and conditioning mechanisms which might contribute to a causal relation between smoking and relapse to alcohol or use of other drugs.

These questions are well worth more intensive study with carefully matched populations controlled for smoking cessation as part of comprehensive treatment. Only then will we know if chemical dependency treatment should aim towards simultaneous abstinence from all addictive drugs — regardless of their social acceptability or the acuity of the harm they cause. □

	Non-smokers	Smokers	*p*	All Patients
Subgroup population	402	533		937
Returned more than 1 card	58.5%	58.2%	NS	58.3%
At least 1 relapse	15.7%	21.0%	= .05	18.9%
More than 1 relapse	3.0%	6.8%	< .03	5.1%
Mean days to first relapse	119	91	*	101

Table A

*The standard deviation was not calculated from the raw data; however, even if the variance had been as much as 60 days, the differences between smokers and non-smokers would have been significant at $p < .05$.

DSM-IV in Progress

DSM-IV: SUBSTANCE ABUSE DISORDERS

Editors' Note:
Hospital and Community Psychiatry, Vol. 42, pp. 471-473, May 1991, © 1991, included several articles about the development of DSM-IV, which is scheduled for publication by the American Psychiatric Association in 1993. The following excerpt is reprinted with permission from the article on substance abuse disorders.

Marc Schuckit, MD, is the chair of the work group responsible for revisions to that section. Other members are John Helzer, MD, Thomas Crowley, MD, Peter Nathan, PhD, and George Woody, MD.

Address correspondence to the work group, c/o the APA, 1400 K Street, NW, Washington, DC 20005.

Criteria for substance dependence in the revised third edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-III)* focused on physiological dependence and required evidence of either "tolerance or withdrawal." The *DSM-III* definition of substance abuse included a "pattern of pathological use, impairment in social or occupational functioning due to substance use," and a minimum duration of disturbance of at least one month. In general, *DSM-III* assumed that individuals who met diagnostic criteria for substance dependence would also meet criteria for substance abuse and that in those instances only dependence should be coded.

In *DSM-III-R*, the definition of dependence was markedly influenced by the much broader concept of dependence theorized by Edwards and Gross ("Alcohol dependence : provisional description of a clinical syndrome," *British Medical Journal* 1:1058-1061, 1976). This change broadened the criteria to reflect a perception that substance dependence could be conceptualized as compulsive use, characterized by cognitive, behavioral, and physiological aspects. Some components of the *DSM-III* definition of abuse, such as impairment in social and occupational functioning and pathological use, were also included in the *DSM-III-R* definition of dependence. With this less restrictive definition of dependence, an individual could be diagnosed as a substance dependent without ever having exhibited tolerance or withdrawal. Substance abuse in *DSM-III-R* became a residual category, almost an afterthought, capturing individuals who exhibited a "maladaptive pattern of psychoactive substance use" that did not meet criteria for substance dependence.

Information gathered from data reanalyses and field trials will guide decisions made about criteria for DSM-IV.

Some have raised the concern that the *DSM-III-R* criteria for abuse and dependence have increased the heterogeneity of dependence, obscured traditional concepts of this disorder, and reduced the saliency of the concept of abuse. While reports published by members of the committee who developed *DSM-III-R* have been somewhat helpful, it has been difficult in the short time since *DSM-III-R* was published to identify data that establish the validity, reliability, or clinical coverage (the percentage of relevant patients that relate to the various categories) of these new and significantly different diagnostic criteria or their ability to predict the future clinical course.

Two different definitions for substance use dependence are being evaluated for *DSM-IV*. Both maintain a broad concept of dependence and attempt to define abuse more precisely. The first possible version is a partial return to *DSM-III* in that at least one of the three criteria for receiving a diagnosis of dependence must include evidence of tolerance or withdrawal symptoms. The second option involves more changes from *DSM-III-R*. In this version, individuals with substance use dependence would be subtyped according to whether or not they showed physical dependence.

Comparing proposed diagnostic criteria

To complement the sparse published data, the group turned to some additional sources of information. Funds made available by the John D. and Catherine T. MacArthur Foundation allowed the group to identify existing data sets gathered from the general population, such as the Epidemiologic Catchment Area studies, and from various substance-abusing groups including those involved with cocaine, heroin, and alcohol. In these data sets, information gathered through structured diagnostic interviews is being used to help assign diagnoses according to the criteria listed in *DSM-III*, *DSM-III-R*, and *ICD-10*, and in the two proposed *DSM-IV* definitions.

One data set comes from the Alcohol Research Center of the San Diego Veterans Affairs Medical Center and the University of California San Diego School of Medicine. Structured intake interviews were used to gather from the patient and at least one resource person information about the alcoholic's alcohol, drug, and mental health problems and alcohol-related life problems including occupational, legal, and interpersonal difficulties. In analyses of interviews from 460 consecutive men with primary alcoholism, differences in assigned diagnoses were seen across the four different diagnostic systems. More than 20 percent of the individuals were assigned a diag-

nosis of substance abuse using the *DSM-III* definition of abuse, and seven percent were assigned this diagnosis using the *DSM-III-R* criteria.

The validity of criteria describing abuse or dependence will be determined in part by how well those criteria predict the course of illness. Reanalysis of data sets made possible by the MacArthur Foundation funds will give the work group some idea of the prevalence of abuse and dependence in difference populations

About 1,500 individuals in six U.S. centers and five international sites will be interviewed using criteria sets from DSM-III, DSM-III-R, and ICD-10, and both sets of proposed criteria for DSM-IV.

and the validity of these diagnoses over time. Using outcome data gathered from the subjects themselves, other resource persons, blood tests, and medical records, work group members will continue to look at the four different diagnostic systems and how reliably different definitions of abuse and dependence predict, for example, in the San Diego sample, resumption of drinking, patterns of alcohol problems, alcohol withdrawal symptoms, drug use, patterns of depression and anxiety, and future diagnoses of abuse and dependence. Similar analyses of differences in prevalence and course of users of other drugs in diverse settings are being completed.

Information gathered from data reanalyses and field trials will guide decisions made about criteria for *DSM-IV*. The work group visualizes keeping the basic *DSM-III-R* criteria while improving the clarity of the wording and including more clinical examples. The group will determine if a review of available data supports a definition of abuse that represents a distinct and specific group of behaviours rather than a residual category. Data may support a definition of dependence that requires, in addition to the broadened concept presented in *DSM-III-R*, evidence of tolerance or physical symptoms when the drug is stopped.

Field trials

Recently funded field trials, a necessary step in evaluation of the proposed criteria for abuse and dependence, are now under way. The trials are supported by funds from a grant awarded to the task force on *DSM-IV* by the National Institute of Mental Health, the National Institute on Drug Abuse, and the National Institute on Alcohol Abuse and Alcoholism. In the substance-use field trials, about 1,500 individuals in six U.S. centers and five international sites will be interviewed using criteria sets from *DSM-III*, *DSM-III-R*, and *ICD-10*, and both sets of proposed criteria for *DSM-IV*. Populations will include adolescents, men and women, various nationalities and ethnic groups, samples from the general population, and individuals identified from their participation in treatment programs for abuse or dependence on alcohol, opiates, cocaine or amphetamines, cannabinols, or tobacco. Data from field trials will offer additional information on the reliability, coverage, and validity of the five sets of criteria and will inform decisions about which if any of the proposed modifications of *DSM-III-R* criteria for abuse and dependence will be made. The modified diagnostic schemes will then be shared with consultants and advisers and presented to the field at large.

Substance use and other psychiatric disorders

Similar approaches have been applied to enhance understanding of the relationship between psychiatric symptoms and intoxication and withdrawal from a variety of substances. Evaluations have focused most intensely on the substances for which data relating to psychiatric syndromes are most plentiful, including depressants (alcohol, benzodiazepines, and barbiturates) and stimulants (all forms of cocaine, amphetamine, and over-the-counter and prescription weight-reducing drugs). A comprehensive report circulated among the work group's advisers documents the high prevalence of symptoms of depressive, anxiety, and psychotic disorders observed in connection with use of these substances. Many of these syndromes improve markedly or actually disappear with continued abstinence.

The treatment and prognostic implications of anxiety, depressive, and psychotic syndromes observed only during intoxication or withdrawal often do not carry the same meaning as similar syndromes observed outside the context of alcohol and other drug use. The substance use disorders work group aims to establish guidelines for these phenomena that are based on the best data available and that apply in the most appropriate manner across different categories of drugs. To do so, the group is cooperating with members of other work groups, including the affective disorders, psychotic disorders, and anxiety disorders work groups, to develop both general and specific guidelines for *DSM-IV* relating to this complex topic. The group's review suggests that individuals should be drug free for between four and six weeks before they can be reliably diagnosed as having a psychiatric disorder. The group will recommend that language highlighting the importance of these distinctions be incorporated into *DSM-IV*.

New areas under consideration

A third major focus of the group has been to develop practical definitions of relapse and severity as they apply to use of different substances. The

definitions are being developed using literature reviews and data reanalyses sponsored by the MacArthur Foundation.

The work group is also considering the possibility of including in *DSM-IV* an expanded explanation and description of substance-induced organic or cognitive disorders. In one proposed format, clinicians would note the symptoms the individual is exhibiting, such as changes in mood, the drug or drugs that are the suspected cause of these symptoms, and the individual's status with regard to ingesting the drug or drugs, that is, whether the individual is intoxicated, in withdrawal, or has evidence of a residual effect that has persisted past the symptoms of withdrawal.

It is hoped that within the next year specific criteria as well as the reasons behind each of the group's decisions can be circulated among a wide audience for additional input.

Additional reports have focused on alcoholic dementias, appropriate wording for the *DSM-IV* section on solvents, and evidence for categories of nicotine and caffeine abuse. Other important topics include the potential relevance of noting familial alcoholism as defined by the family history of the disorder, the potential importance of abuse of anabolic steroids as a specific diagnostic subgroup, and the clinical relevance of noting long-term or protracted abstinence syndromes as they relate to stimulants, opiates, and depressants. In addition, the work group will consider the optimal definition for marijuana-related problems, the organization of disorders involving intoxication and withdrawal, inhalant abuse and dependence, use of psychostimulants including cocaine and amphetamines, and criteria for remission.

For many of these topics, the data suggest that no major changes would appear appropriate for *DSM-IV*. For other issues, some changes are being considered, and for yet others the work group hopes to highlight the potential research and clinical relevance of these topics in the future.

The substance use disorders work group continues to frame options for diagnostic criteria. The group has already established a philosophy, a structure, and a mode of operation that has allowed significant progress in addressing issues that are relevant to the next edition of the *Diagnostic and Statistical Manual of Mental* Disorders. It is hoped that within the next year specific criteria as well as the reasons behind each of the group's decisions can be circulated among a wide audience for additional input. □

AMA House of Delegates

Physician's Use of Alcohol When Providing Patient Care

In 1990, ASAM introduced Resolution 137 to the AMA House of Delegates which called upon the American Medical Association to study the "relationship between physicians' ingestion of alcohol and engaging in patient care." As a result, a report was issued for the meeting of the House held in June, 1991, focusing on "the acute effects of occasional alcohol use on professional performance when the physician is called upon to provide patient care." It specifically excludes the issue of physicians impaired by chronic use of alcohol.

The report reviews studies on the acute effects on psychomotor performance and on higher cognitive or intellectual function. Eleven references are listed.

When the House accepted this report, it created the following AMA policy:

The AMA urges that physicians engaging in professional practice have no significant body content of alcohol.

The AMA further urges that all physicians, over a period of several hours prior to being available or scheduled for patient care, refrain from ingesting an amount of alcohol that has the potential to cause impairment of performance or create a "hangover" effect.

Copies of the report—Report Y (A-91)—are available from the California Society office. □

REPORTING LAPSES OF CONSCIOUSNESS

Gary F. Levine, MD

A new law in California could go a long way to resolving a thorny issue for physicians practicing addiction medicine. SB2328, recently signed into law by Governor Wilson to take effect January 1, 1992, seeks to clarify which patients *must* be reported, by physicians, to the local health officer for subsequent reporting to the DMV because they are potential risks behind the wheel. It also allows physicians to report with immunity other patients who the physician believes "in good faith" *ought to* be reported because their driving might be periodically or consistently impaired.

SB2328 was passed in part because of concerns raised by a 1989 San Diego jury award of $3.2 million to a woman passenger left paraplegic as a result of an auto accident. The driver, an epileptic, had been reported to the DMV by her physician at the time of her initial diagnosis in 1981, but he failed to report her again when she had a breakthrough seizure in 1983. The recurrence was quickly controlled with an adjustment in medication. It was never established if a seizure contributed to the auto accident, yet the jury still found the physician to be 5% responsible because he had not alerted the DMV to her change in status. The driver had already settled for $50,000 so the doctor was left liable for the bulk of the award (the case was filed prior to tort reform).

The jury found the physician responsible because he had not alerted the DMV.

This case brought home to organized medicine the extent of the risk doctors were taking every day by not uniformly complying with current reporting regulations. A 1984 opinion of the State Attorney General held that a physician is *required* to report a patient when certain preconditions are met. The physician must know of a diagnosis of a reportable condition, that it has previously caused a lapse of consciousness or an episode of momentary confusion, and that it may do so in the future. The state law under which our colleague was held liable also requires physicians who diagnose serious alcohol abuse or alcoholism to report those patients to the DMV.

For the last several years, the language of Title 17 of the *California* Code of Regulations has said, "Persons subject to lapses of consciousness or episodes of marked confusion resulting from metabolic or neurological disorders, including but not limited to .... alcoholism or excessive use of alcohol sufficient to bring about blackouts (retrograde amnesia for activities while drinking) shall be reportable."

Several attorneys expressing opinions on this matter were consistent in concluding that physicians should definitely be reporting alcoholics and those other patients whose use of alcohol is sufficient to cause blackouts. Failure to do so places the doctor in violation of state law, and at risk for potential liability if his or her patient is found responsible for an alcohol-related auto accident.

Although the goal of keeping dangerous drivers off our streets is certainly laudatory, a large number of physicians are uncomfortable with being designated the state's agents responsible for identifying such individuals. And there are specific issues about this requirement as it pertains to alcoholics that trouble many physicians specializing in addiction medicine.

How do physicians operating in federally assisted treatment programs reconcile the direct conflict between this state reporting law, and federal law protecting patient confidentiality?

- The regulations do not consider the level of activity of the alcoholic's disease. Must a person in stable recovery over the past two years be reported? Does the previously heavy drinker who experienced a couple of blackouts a few years ago need to be reported?

- If physicians were to report every patient who fulfills the regulation's criteria, the DMV would be overwhelmed with virtually tens of thousands of reports. Is the DMV really set up to be able to deal appropriately with that kind of a load on its system?

Reporting Lapses of Consciousness *(continued)*

- How would confidentiality be maintained? The "leakiness" of the DMV and other state departments is notorious. Is it reasonable or just to enter the names of all individuals with any significant history of alcohol problems into a state-controlled computer? And how do physicians operating in federally-assisted treatment programs reconcile the direct conflict between this state reporting law, and federal law protecting patient confidentiality? Should they, as one attorney suggested, consider seeking court orders to allow them to report their patients to the DMV in the name of community safety?

- What kind of an effect would stricter reporting have on the physician's ability to obtain a reasonably accurate alcohol history from patients? A patient's fear of being reported to the DMV would certainly make such information more difficult to elicit. The state's attempts to achieve the reasonable goal of keeping impaired people from getting behind the wheel could very well result in an increase in the number of drivers who are undiagnosed and untreated alcohol abusers and alcoholics.

Because of these troubling considerations and the imprecise language of the regulations which have been in force for many years, SB2328 requires the Department of Health Services must revise the regulations. SB2328 requires the State Department of Health Services to solicit comments from a variety of sources, including organized medicine. Comments in preparation for writing a first draft of proposed revisions were requested earlier this year. The California Society has joined with the California Medical Association and the California Psychiatric Association in recommendations to narrow the focus on those patients who most would agree, should certainly be reported, and to allow for the professional judgment of individual physicians to determine which additional patients ought to be reported.

It is important to stress that these recommendations, even if adopted in the revised Title 17 Regulations, would not reduce a physician's exposure to potential liability if an unreported alcohol abusing or alcoholic patient was responsible for an alcohol-related auto accident. However, these changes would allow physicians to make their own, careful good faith decisions about which patients need to be reported.

What effect would stricter reporting have on the physician's ability to get a reasonably accurate history from patients?

Editors' Note: The Department of Health Services Epidemiology Section is preparing proposed revisions to Title 17 CCR, Section 2572. You can call James Howard, Chief of the Alzheimer's Disease Program, at (916) 327-4662, to request a copy of the notice of the public hearing, which is expected in the fall of 1991. See CSAM News, Spring 1991. □

Annual Meeting, Awards and Installation Ceremony

Friday evening, November 22, 1991 — Hilton Beach and Tennis Resort Hotel, San Diego

Installation of Kevin W. Olden, MD as the 9th President of the California Society

The Awards and Installation Ceremony will be followed by dinner and the keynote speaker for the State of the Art Conference, Enoch Gordis, MD, the Director of NIAAA, will speak on Science and Practice: The Indispensible Partnership.

There is no fee for attendance at the Awards and Installation Ceremony. Attendance at the dinner is part of the registration fee for the conference. For those not registered at the conference, dinner tickets are available for $30.

How Far Is It To The Truth?

Long ago and not so far away there were at least three organizations which had the truth. One organization had started in New York City and was one of the first to find the truth. Although it thought of itself as a local group, it soon became national in focus (as can happen for things starting in New York City). But, there was another group who arose in the south, Georgia to be specific, and many of its members had been moved by the truth and wanted to teach the truth. Many people across the land had heard them speak the truth, and so they gave themselves a national name. There was also a group of teachers, and, as we all know, teachers learn the truth in order to teach it to the rest of us; and they had a national name as well.

As happens in human affairs, the truth is so broad that many people can honestly seek it in many directions. While this is valid, it is very difficult for the common seekers of truth to know which direction to go in. Since the truth is everywhere, any direction may be as good as another; but, alas, people often have trouble seeing different sides of the truth. Unlike other times when those who lead the seekers of the truth end up going in different directions with followers in tow, this time, something different happened. The leaders of the three groups who had the truth agreed to combine their truths and thereby decrease the confusion of the truth seekers. They began a new national combined organization. This seemed to help most of the followers and leaders. A fourth group of truth seekers set out to identify those who had been imbued with the truth and to certify them. This began in California. At first truth seekers from all over the land flocked to California to become certified truth holders. Eventually, the new national combined organization began to certify truth holders.

Awakened

At this point some who were not of the new national combined organization were awakened and disturbed by this. They thought that they had had the truth all along, and were worried that people who sought the truth might not know that they were the source of the truth because they were not truth holders certified by the new national combined organization. While in the past it had not been important to be identified as having the truth, now to be without the truth was unacceptable. But for some truth seekers, to seek the truth through this new national combined organization would make it appear that the new national combined organization had the truth first or that the awakened seekers had not always had the truth themselves. That was uncomfortable for the awakened truth seekers. Moreover, the new combined organization could not have all the truth, for as we all know truth is eternal and unlimited and therefore there can be no first knower of all knowledge (except for one's higher power as one understands him/her).

Thus the awakened truth seekers gathered as much of the truth together as they thought possible and certified their own as being imbued with the truth. Some had now been doubly certified as having the truth and thus felt safe, in full knowledge that they had the complete truth. Others, however, still wondered if they had all the truth, because they thought, perhaps each organization could certify people for having only part of the truth since man is limited and tests can only be so long. So, they thought, perhaps one could not test for all the truth. This raised consternation in some of the followers of the seekers of the truth because they wanted all the truth and not to get it all was frustrating and for some embarrassing.

Meanwhile, there was another group of truth seekers who always make you swear to tell the whole truth and nothing but the truth before you can answer their questions. This group of truth seekers, whom we might call the Advocates for Truth, is particularly good at seeing one side of the truth at a time. This always worries the true truth seeker because he/she knows that the truth has no sides, or any other dimension. But supposing one were asked questions by the Advocate of Truth and one didn't know the whole truth. That was frightening especially if one had only been certified for part of the truth.

The Limits of the Truth

A council of truth seekers was held at a sacred site. The true seekers of truth thought about the limits of truth and decided that it was okay not to have the whole truth, because to state that one knows the whole truth would be a lie (and might confuse oneself with one's higher power). They said this to their followers and most of them were glad that they could now tell the difference between the truth and a lie. The followers of the true seekers of the truth also suggested that maybe the leaders of the seekers of the truth should get together once again to combine more of the truth together, and suggested that it was okay that they really didn't have the whole truth, but it would be less confusing to the followers. And after a little rest and a recitation of the Serenity Prayer, they started off to continue seeking the truth. □

P. Joseph Frawley, MD

A Book Review

Addicts Who Survived: An Oral History of Narcotics Use in America, 1923-1965.

David Courtwright, Herman Joseph, and Don Des Jarlais
Knoxville: The University of Tennessee Press, 1989.

I can't remember the last time a medical text kept me awake, reading into the wee hours of the morning — voluntarily, anyway. Now that even the memory of cramming for medical school exams has faded, a book has to be fairly compelling on its own merits to hold my interest late at night. *Addicts Who Survived* is just such a publication, perhaps because it is, as the subtitle indicates, an oral history. To the authors' great credit, the patients themselves are permitted to tell their own stories.

The kind of living details that statistical studies never reveal.

Without doubt, heroin addicts are among the most difficult of all chemically dependent patients to treat. Recovery rates, outside of methadone maintenance programs, are wretched. The manipulative, predatory antics of heroin addicts in inpatient treatment units make mere alcoholics look like candidates for sainthood. Sadly, most of us have forgotten that the repressive anti-narcotic policies of the "classic narcotic control" era have played a major role in shaping the behavior of the modern-day "junkie."

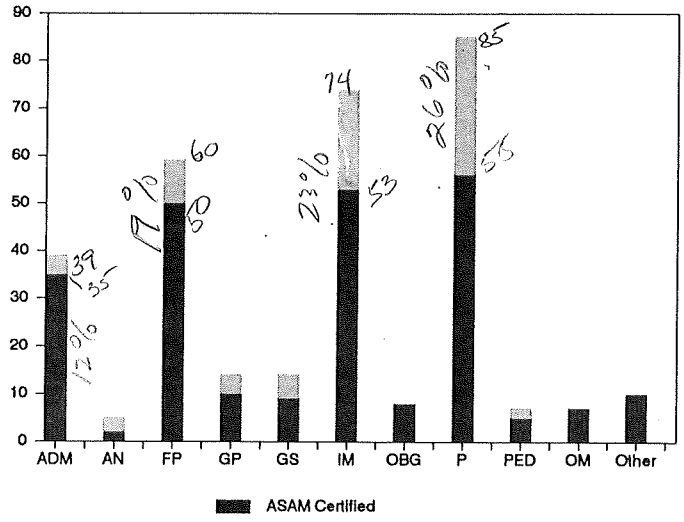
These firsthand accounts of what it was like to be an opiate addict from 1923 to 1965 are provided by elderly methadone maintenance patients who somehow avoided the premature deaths by violence and infection common to their fellows. Arranged by topic into chapters with titles like "Turned On," "Hooked," "Hustling," and "Busted," these narratives have been skillfully edited to provide the kind of living details that statistical studies never reveal. In their own words, the "laid-back" opium smokers of the 1910's describe how opium prohibition policies inadvertently fostered the black market's turn towards the more easily concealed heroin. As the illegal trade was taken over by increasingly vicious gangsters, heroin became more and more expensive, and the "sniffers" of the twenties turned to "mainlining" to get the same effect. As "dope" became weaker and weaker (stepped on for more middle-man profits), obtaining enough of it to ward off withdrawal became a full-time occupation.

There may very well be no public policy "final solutions" to our illicit drug use problems, but a book like *Addicts Who Survived* gives a unique and engrossing view of exactly how such policies affect the lives of real people. For specialists in addiction medicine who may have a hand in shaping future drug-control policies, it provides an invaluable perspective on how we came to be where we are.

Reviewed by Richard S. Sandor, MD

An Overview of the Membership of the California Society of Addiction Medicine

By specialty



Specialty abbreviations:
ADM–Addiction Medicine; AN–Anesthesiology; FP–Family Practice; GP–General Practice; GS–General Surgery and other surgical specialties; IM–Internal Medicine; OBG–Obstetrics and Gynecology; P–Psychiatry; PED–Pediatrics; OM–Occupational Medicine including Public Health and Preventive Medicine

Certified
71.5% are ASAM certified; 66% are Board certified in their primary specialty.

What percent of your time is devoted to working in the public sector?

% time in public sector	*Number*
100%	6% (7)
80-99%	4% (5)
50-79%	4% (5)
20-49%	6% (7)
20-49%	21% (24)
No response	57% (64)

Do you treat patients for diseases other than chemical dependence?*

Disease	*Number*
Gambling	21% (23)
Eating disorders	39% (44)
Sexual compulsion	21% (24)
Co-dependency	53% (59)

Survey Responses

Responses to the 1991 member survey totaled 112 or 35%, as of July 12th. On this page and the next are summaries from those 112 replies. The table showing the distribution of specialties represents all 323 members.

What percent of your practice is devoted to addiction medicine?

Percent of practice	*Number*
100%	23% (26)
80-99%	9% (10
50-79%	19% (21)
20-49%	27% (30
less than 20%	15% (17)
No response	7% (8)

What percent of your income is derived from your practice in addiction medicine?

Percent of income	*Number*
100%	22% (25)
80-99%	8% (9)
50-79%	17% (19)
20-49%	21% (24)
less than 20%	17% (19)
No response	14% (6)

Over the last four years, has the percentage of your income which is derived from your work in addiction medicine gone up, down, or has it remained the same?*

Income from ADM work	*Number*
Gone up	26% (29)
Remained the same	52% (58)
Gone down	18% (2)
No response	4% (5)

**Respondents marked as many ansers as were applicable; therefore, the total percent of responses for these two questions does not equal 100%.*

APPLICANTS FOR MEMBERSHIP

The names of applicants are published and sufficient time is allowed for comments from the members before the Executive Council acts to accept candidates for membership. If you have comments to bring to the attention of the Executive Council, please contact P. Joseph Frawley, MD, at (805) 687-2411, or write to him in care of the California Society office.

H. Westley Clark, MD, JD, MPH, is Chief of Associated Substance Abuse Programs at the Veterans Affairs Medical Center in San Francisco. He attended the University of Michigan School of Medicine from 1969-1973. Doctor Clark completed a three-year residency in psychiatry at the University of Michigan in 1976. From 1984-1986, he was a substance abuse fellow at the San Francisco VA.

Karen Lea Sees, DO, is Assistant Chief of the Substance Abuse Treatment Clinic at the San Francisco Veterans Affairs Medical Center. She graduates from West Virginia School of Osteopathic Medicine in 1983. In 1987, Doctor Sees completed a two-year substance abuse fellowship at the San Francisco VA. She is Assistant Physician, Department of Psychiatry and Langley Porter Psychiatric Institute, UCSF; and Clinical Instructor of Psychiatry at UCSF.

Other candidates for membership are:
Alan Berkowitz, MD, Leucadia
John Buehler, MD, Kentfield
Michael Horne, MD, Redwood City
Mark Souza, MD, Hercules □

NEWS ABOUT MEMBERS

Merritt Smith received his MPH on May 18, 1991, from the UC Berkeley School of Public Health.

Garrett O'Connor's REPAIR Treatment Systems now includes a 12-bed residential treatment center at Van Nuys Community Hospital.

Thomas Schneider has left his position as Medical Director of the Chemical Dependency Center at Hoag Memorial Hospital in Newport Beach and is now in Kentucky.

Richard Sandor received the Silver Apple for excellence in clinical teaching at the Sepulveda VA for the second year in a row. He also received NCADD Los Angeles Chapter's annual award for medical services. In honoring him, NCADD cited the articles Sandor has written which have contributed to more widespread understanding of some complex concepts related to addiction.

Joel Nathan is now a full-time physician in the Chemical Dependency Unit at Kaiser Permanente Medical Center in Carson.

Robert Daigle is the Associate Medical Director of O'Connor Recovery Center at O'Connor Hospital with David Breithaupt. He is also at Oak Creek Psychiatric Hospital in San Jose. □

SURVEY RESPONSES

What is the *one* most important thing the California Society can accomplish for its members in the next 12 months?

- activities to give me identity and collegial satisfaction as an addiction medicine practitioner
- increase its visibility to physicians so that more MDs will understand that there is a personal and educational resource available to them for treating patients or themselves
- establish credibility with county, state and federal agencies and with memberships other than our own
- further enhance the acceptance of addiction medicine as a bonafide specialty
- public relations campaign directed to the general public and to health care professionals and 3rd party payers. Other specialties have developed programs to convince the pubic that the treatment of hypertension, cancer, diabetes, etc., are important, can be successful and can make a meaningful difference in survival and well-being.
- educate the public about the loss of insurance coverage for chemical dependency treatment
- educate the public about the specialty of addiction medicine because people now frequently self-refer to specialists
- get managed care criteria for adequate treatment for chemical dependence established and promulgated
- establish standards of practice
- hold a scientific research meeting in Los Angeles
- campaign for better third party payment for the related diseases of addiction
- training for residents
- reestablish solid medical care, control and guidance in addiction treatment programs
- make CD units tobacco free □

CONTINUING MEDICAL EDUCATION

Fourth National Conference on Nicotine Dependence

Sponsored by the American Society of Addiction Medicine
North Raleigh Hilton & Towers, Raleigh, North Carolina
September 13-15, 1991
Speakers include Alan Blum, MD; Joseph Cruse, MD; Lowell Dale, MD; Jack Henningfield, PhD; Max Schneider, MD; John Slade, MD
Credit: 16 hours
Fees: $250 for ASAM members before September 1, 1991; $300 after September 1. $275 for non-member physicians. $195 for non-physicians. $50 for medical students.
For information, contact ASAM, 5225 Wisconsin Avenue, NW, Washington, DC 20015. (202) 244-8948.

State of the Art in Addiction Medicine

Sponsored by the American Society of Addiction Medicine
Orlando Airport Marriott Hotel, Orlando, Florida
October 24-26, 1991
Speakers include John Slade, MD; Terry Rustin, MD; John Morgan, MD; Anne Geller, MD; Lawrence Brown, MD; David Mee-Lee, MD; Larry Siegel, MD; Loretta Finnegan, MD; J. Ray Hays, PhD, MD
Credit: 20 hours
Fees: $350 for members of ASAM; $400 for non-member physicians; $350 for non-physicians and spouses; $250 for residents; $50 for medical students
For information, contact ASAM, 5225 Wisconsin Avenue, NW, Washington, DC 20015. (202) 244-8948.

Managed Care and Addiction Medicine: The Interface with Quality Assurance

Sponsored by the California Society of Addiction Medicine
San Diego Tennis & Beach Hotel, San Diego
November 21, 1991; 9:30 am - 11:45 am
Speakers include William Goldman, MD; Peter Sterman, PhD
Credit: 2 hours
Fees: $40 for members of CSAM; $50 for non-members
For information, contact CSAM, 3803 Broadway, Oakland, CA 94611; (415) 428-9091.

State of the Art in Addiction Medicine

Sponsored by the California Society of Addiction Medicine.
San Diego Tennis & Beach Hotel, San Diego
November 21-23, 1991
Speakers include Enoch Gordis, MD; Marc Schuckit, MD; Ernest Noble, MD; Jack Henningfield, PhD; Paul Berger, MD; Gerald Brown, MD
Credit: 19.5 hours
Fees: $350 for members of CSAM or ASAM; $400 for non-member physicians; $350 for non-physicians; $250 for fellows or residents; $50 for medical students. One-day registration also available.
For information, contact CSAM, 3803 Broadway, Oakland, CA 94611. (415) 428-9091.

Developing Reimbursable Treatment Systems Using Patient Placement Criteria

Sponsored by the American Society of Addiction Medicine
Sheraton Grand on Harbor Island, San Diego
January 22-25, 1992
For information, contact ASAM, 5225 Wisconsin Avenue, NW, Washington, DC 20015; (202) 244-8948.