CSAM NEWS

Newsletter of the California Society of Addiction Medicine / Winter 1991, Vol. 18, No. 3

INSIDE

NEWS is published three times a year by the California Society of Addiction Medicine, a nonprofit professional organization in the state of California with offices at 3803 Broadway, Oakland, CA 94611; (415) 428-9091.

Subscription rate is $25 per year.

The California Society is a specialty society of physicians founded in 1973. Since 1989, it has been a State Chapter of the American Society of Addiction Medicine, Inc.

Use of Nicotine Medications for Smoking Cessation – Effective Tools but No Magic Bullet

David Sachs, MD

This article is an edited transcript of the presentation given by Doctor Sachs at the CSAM conference, "State of the Art in Addiction Medicine," November 21-23, 1991, in San Diego.

Cigarette smoking is driven by two interlinked forces: true physical dependency on nicotine and psychological dependency, which can be evoked by a mood or an event that serves as a trigger for the smoker making him/her want a cigarette. On the nicotine dependency side, we have now two approved agents to use as pharmacologic assists: nicotine polacrilex (Nicorette) and the transdermal nicotine patch.

Several other agents—including buspirone, clonidine, nicotine nasal solution, nicotine vapor inhaler, phenylpropanolamine, doxipin, adrenocorticotropic hormone (ACTH), d-fenfluramine and fluoxetine—have shown possible effectiveness, but I will focus on the medications which utilize nicotine itself as the medication, because we have many more studies with them.

♦ Nicotine Polacrilex

Nicotine polacrilex has been available in the United States since 1984 in a 2 mg dosage form only. The 4 mg dosage form which has been available in Europe for the past several years should be available on the U.S. market shortly after the first of the year. That is going to be an important advance.

The 2 mg nicotine polacrilex has been shown in randomized placebo-controlled, double blind trials to alleviate substantially, if not eliminate, many of the symptoms of nicotine withdrawal, including anxiety, irritability, frustration or anger, difficulty concentrating, increased appetite or weight gain, restlessness, and decreased heart rate (although that's never a concern to patients). The 4 mg dose, not the 2 mg dose, does relieve craving for cigarettes. In a study we recently completed, we found that the 2 mg dose did not, by itself, relieve craving for tobacco.

Incidentally, we have really exciting data from nicotine polacrilex

trials, as well as a nicotine patch trial, which show that nicotine is a very effective weight suppressant, particularly in women.

♦ Inhalers

There are two other nicotine replacement or nicotine withdrawal pharmaceuticals that are undergoing phase three pivotal trial testing now. I expect that New Drug Applications will be filed the first part of next year for the nicotine vapor inhaler and the nicotine nasal inhaler. The nicotine vapor inhaler delivers a relatively small amount of nicotine in literally molecular vapor form. This is a device in which nicotine is administered via nasal spray.

Each of these four delivery devices—gum, patch, vapor inhaler, nasal spray—has different nicotine absorption kinetic profiles and that, I think, is

Each of these four delivery devices—gum, patch, vapor inhaler, nasal spray—has different nicotine absorption kinetic profiles.

going to contribute to the importance of their clinical utility. Nicotine polacrilex is a sustained release medication which allows nicotine to be slowly absorbed across the buccal mucosa of the mouth into the systemic submucosal capillary bed. The transdermal nicotine patch is also a sustained release medication which slowly releases its nicotine across the epidermis into the subdermal capillary bed, again into the systemic side of the circulation. Those products, because of their slow release of nicotine into the systemic circulation, have no arterial pulse or bolus.

The nicotine nasal inhaler has been seen as simply providing nicotine through the nasal mucosa into the systemic side of the nasal capillary bed. However, some recent research seems to indicate that there may be some kind of direct vascular connection that enables the nicotine from the nasal inhaler to bypass the systemic circulation and get directly into the central nervous system. So, in fact, this device may come closer to administering the high arterial bolus that the smoker has become accustomed to when smoking a tobacco cigarette.

The vapor inhaler has the potential for delivering nicotine down to the alveolar capillary level; however, because the amount of nicotine delivered by the inhaler depends on the vapor pressure of nicotine at atmospheric pressure, this product provides a relatively dilute concentration. The vapor inhaler will, however, provide that respiratory tickle upon which many smokers are quite dependent, as shown in very elegant controlled trials done at UCLA.

If we looked at a study done 50-60 years ago using a sulfa drug to treat infectious diseases, we probably would have found that sulfa effectively treated perhaps 20% of infectious diseases. As we became more sophisticated, we would have seen that those patients best treated with this medication had urinary tract infections. If we stratified more specifically, we would have seen that sulfa was highly effective and cured 80-90% of urinary tract infections, but was ineffective against tuberculosis, pneumococcal pneumonia, gonorrhea, syphilis, etc. I think our job in the next five years in treating nicotine dependence is figuring out the important stratification variables so we can tailor tobacco dependency treatment, both the behavioral component as well as the pharmacological components.

♦ Low nicotine dependence vs. high nicotine dependence

There are two variables that I think are crucial: the level of nicotine dependence and gender. In a 1988 study, cigarette smokers completed a questionnaire to identify whether they were low nicotine dependence smokers or high nicotine dependence smokers. If they were low nicotine dependence smokers,

Two crucial variables: the level of nicotine dependence and gender.

they were randomly assigned to receive, in double blind fashion, either 2 mg nicotine polacrilex or placebo. At every time point except at 12 months, the 2 mg group had a success rate that was approximately two-fold better in non-smoking than the placebo group. At the end of two years, approximately 30% of those who received the 2 mg dose during treatment were not smoking compared with only 10% in the placebo group.

The high nicotine dependence smokers were randomly assigned to receive either 4 mg or 2 mg nicotine polacrilex. At virtually every time point, the high nicotine dependence smokers who received the 4 mg dose had a two to three-fold higher likelihood of remaining a nonsmoker

On fixed schedule dosing, patients are told to chew one piece of nicotine polacrilex per hour instead of being told to chew for relief of craving or nicotine withdrawal symptoms

than those who got the 2 mg dose. At the end of two years, about 35% of the 4 mg group versus about 8% in the 2 mg group had maintained smoking abstinence.

With low dependence smokers, defined as persons with a Fagerstrom tolerance scale of 0 to 6, if we do not give nicotine reduction therapy with a nicotine replacement pharmaceutical, we reduce their chances of quitting smoking by half. Looked at the other way, giving them even a 2 mg nicotine polacrilex dose will double their chances of reaching their goal of stopping smoking and remaining a nonsmoker.

If we give the high nicotine dependence smoker, defined as a person with a Fagerstrom tolerance scale of 7 or higher, only the 2 mg nicotine polacrilex, it is no better than the placebo is for the low dependence smoker. The high nicotine dependence smoker clearly needs the 4 mg dose.

In a study that we just completed at the Palo Alto Center, high nicotine dependence smokers who had a baseline cigarette smoking serum cotanine level of greater than 250 nanagrams per ml were randomly assigned in double blind fashion to get either placebo, nicotine polacrilex 2 mg, or the 4 mg dose. The 2 mg dose, even when used at 12 pieces per day, was shown to be no more effective than placebo. With the 4 mg dose, 65% stopped smoking on their target quit day and stayed nonsmokers for the next four weeks. This was significantly different from either the 2 mg or placebo dose.

As we looked further, we found that it was only the males on the fixed schedule who showed any treatment efficacy. On fixed schedule dosing, patients are told to chew one piece of nicotine polacrilex per hour instead of being told to chew for relief of craving or nicotine withdrawal symptoms. For females, there was no difference at all between either dose of the nicotine polacrilex or the placebo. So maybe, nicotine polacrilex is a drug of choice for males. What about women? We're going to get to that when we look at nicotine patch trial results.

♦ Nicotine transdermal patch

In a large study (N=220) that we recently completed, the point prevalence results at six weeks showed 75% with the active patch were nonsmokers versus 46% with the placebo patch. Forty-two percent of the active patch subjects sustained non-smoking for all six weeks (no cigarettes at all after quit day) versus 25% of the placebo patch subjects.

Subjects received the 30 centimeter square patch for the first three months, then were tapered from the nicotine replacement product with the 20 centimeter square patch for three weeks, the 10 centimeter square patch for the next three weeks, then no further patches. We have just completed collecting one year data, off patch. There is a highly significant treatment effect at every time point, and at 26 weeks from target quit date there is about 35% successful smoking cessation in the active patch condition versus 15% in the placebo patch condition.

When we look at the low nicotine dependence smokers, the success rate increases to 50% in the active versus 15% in the pla-

Information overload

Should I even bother to read the article?

Things are happening so fast in this field that we are continually faced with stacks of articles to read. One of the ways I deal with the information overload is to ask these three questions:

1) Does this article present sustained abstinence, or only point prevalence?

2) Does this article show one year abstinence – and, better, one year's sustained abstinence – or only end of treatment results?

3) Does this article include objective confirmation of the self-reported non-smoking status?

If any of the answers is no, I don't bother to read the article. It saves a lot of time, and I don't get my mind cluttered with invalid statistics.

David Sachs, MD

cebo group at week 26. For high dependence smokers, the success rate falls, but there is still a significant difference between the active and placebo conditions with 15% versus about 3%.

Of note also was that the active patch high dependence subjects relapsed during the 10 centimeter square tapering phase. They went from about 45% successful non-smoking status down to about 25%, which is about a 50% fall off. And when the high dependent subjects went off nicotine entirely another 50% fall off was noted. The bottom line conclusion here is that high nicotine dependent smokers need nicotine replacement therapy for a longer period of time and I also believe with a higher dose than low nicotine dependent smokers.

In contrast to the nicotine polacrilex, women did really well on the transdermal nicotine patch, and men didn't do so well. The survival curve for men on the transdermal nicotine patch is not statistically significantly different between the active and placebo conditions. One problem, however, is that there were only 90 male subjects. Our power is, therefore, only 0.45. Although we can't definitely conclude that the nicotine transdermal patch is ineffective in this population of males, the trend, nonetheless, is obvious. Clearly the transdermal patch is highly effective for women.

♦ Physician involvement

I want to conclude with this reminder: you get out of treatment what you put into it. If you the practitioner, or your patient, wants a quick fix, you can expect lousy results—a fraction of 1% at one year. On the other hand, if you the practitioner help the patient to realize that quitting takes sustained effort and if you remain involved using all the tools which are becoming available, you can optimize that patient's chances of reaching his or her goal. □

Editors' note:
The syllabus includes a reprint of "Advances in Smoking Cessation Treatment" by Doctor Sachs, a 30-page chapter with 185 references, from the Mosby Year Book, Current Pulmonology (1991). A copy of the chapter reprint is available from the California Society office; a charge of $5 is made to cover copying and postage costs.

Copies of the course syllabus with materials from all speakers are available for $25.

Copies of Doctor Sachs' presentation on audiotape are available from InfoMedix, 12800 Garden Grove Boulevard, Suite F, Garden Grove, CA 92643,
(714) 530-3454
(800) 367-9286
FAX (714) 537-3244.

Recommendations from CSAM's Collaborative Study of Addiction Treatment Outcome

The Steering Committee for this project has completed its study of existing data bases which collect patient information for the purpose of studying program effectiveness and patient outcome. A paper has been completed describing and comparing eight of the data bases, and making recommendations for the next steps of the project.

Recommendations

Chemical dependency treatment services should be monitored at the national, state and local levels in such a way that aggregate data pertaining to client characteristics, program settings and treatment outcomes can be made available to program administrators, health care planners and policy makers.

In addition to the use of assessment data for the purpose of individual program improvement, such data should be pooled from representative programs within the treatment system in order to provide a data base to guide treatment policy and health planning on the local, state and national levels.

A consortium of purchasers, payers, providers, and researchers should be formed to refine the policy questions that require further research in the area of patient treatment matching for chemical dependency services.

Simultaneously, funds should be secured to support a collaborative effort that would conduct secondary analyses on the data sets. □

A Book Review

Understanding the Alcoholic's Mind: The Nature of Craving and How to Control It.

Arnold M. Ludwig
New York: Oxford University Press, 1988.

I confess that initially I dismissed this book on the basis of its title. "How to" manuals on recovery from addiction usually strike me as worthless pop psychology. I mean, if it were simply a matter of knowing *what* to do, five hundred different writers wouldn't be vying for space on the bookstore shelves – one would suffice. As usual, one of my father's pithy sayings describes the situation neatly: "If there are a hundred ways of doing the same thing, no one knows what they're doing."

All that said, something about the book bothered me as it lay there on my desk unread. As it turned out, it was the author's name. Arnold Ludwig is no fly-by-night opportunist. He is the author of several important articles on such topics as altered states of consciousness, therapeutic insight, and conditioning. He has written for some major alcoholism texts and important journals. Unknown to me, he is also Professor of Psychiatry at the Kentucky College of Medicine, a member of the editorial board of the *American Journal of Psychiatry*, and a winner of the Hofheimer award. Still, it takes more than prestigious credentials to make a book worth reading. Fortunately, Ludwig provides plenty of substance in a highly literate form.

In an era when virtually all serious works on alcoholism or the addictions are multi-author tomes, *Understanding the Alcoholic's Mind* is a refreshing change of pace – perfect for reading on an inclement Saturday afternoon. Noting in his preface that "many books have been written about why people become alcoholics," Ludwig observes that "few of a clinical nature have been written about how alcoholics recover." Skillfully combining research findings (backed by an excellent, if lengthy, section of notes and references) with the more mundane clinical experiences that are the lot of every practitioner, he provides us some badly needed encouragement to go on doing what we do – despite the fact that no one can show scientifically that it does any good.

In the first chapter, Ludwig defines some of the paradoxes of addiction, treatment, and recovery: the acceptance of weakness as the foundation of strength (the first step of AA – "powerlessness"); the inability to refrain from drinking as evidence of unsuitability for treatment (patients are often discharged from programs for demonstrating the presumed symptom of their condition); the persistence of a disease long after symptoms are no longer present ("Once an alcoholic, always an alcoholic"). Although one might argue that many of these statements are over-simplifications, they are problematic for many professionals working in the field.

Ludwig maintains that the source of these paradoxes is in the disparate perspectives on addiction – the moral, psychological, social and spiritual. He believes that the answer to much of this confusion lies in the real-life cognitive and behavioral phenomena of addiction. The "common area" of all these viewpoints (including, perhaps most importantly, the alcoholic's) is, as he puts it, "in the mind." In subsequent chapters of the book he illustrates this point with poignant examples of patients' cognitive scripts ("The Dry Drunk") and automatized behavior ("On and Off the Wagon," "Resisting Temptation").

In the midst of these clinical vignettes – the stuff of our daily work – Ludwig offers some useful reflections on how we can help our patients develop the skills of recovery. For example, learning to cope with drug-use urges and the inner dialogue they generate is one of the essential tasks of recovery, yet in the heat of battle, cognitive resources may be insufficient to remember formulations discussed in the more leisurely therapy hour. When being driven to drink by intolerable feelings, repeating a phrase like "This too shall pass" or "One day at a time" may be all the alcoholic can do, and we clinicians should support his efforts. Ludwig provides a thoughtful rationale for doing so.

Perhaps it won't surprise anyone that Ludwig concludes his thoughts with an appreciation of the Serenity Prayer. Some may wince at this unashamed acknowledgment of the spiritual dimension of recovery, but for those of us in the clinical trenches, acutely aware of our inability to *make* our patients "get well," it's a welcome reminder that the alcoholic's mind is not so different from everyone else's.

Reviewed by Richard S. Sandor, MD

From the Incoming President

The High Ground

Kevin Olden, MD

This is a time of profound change in the nature of chemical dependencey treatment; it is entering the post-industrial age." For-profit, "industrial" treatment programs, no longer enjoying unrestrained reimbursement, are closing at an ever increasing pace. Reports of fraud and even, possibly, kidnapping of potential patients by hospital agents are being seen in the media. Such ethical lapses are painful to us all.

The members of CSAM have traditionally marched to a different drummer. The tales of our members standing up to unethical practices are legion. Providing ethical, scientifically based, quality care to chemically dependent patients has always been our first goal, and these days are no different.

There is a fairly new and growing movement to redefine complex psychiatric disorders such as sexual and eating disorders into "addictions" and look to 12 Step programs as appropriate treatment. The cry to declare these conditions addictions came first from non-physicians, and in some cases from non-professionals. Non-physicians enjoy the luxury of unrestrained speculation regarding treatment. As physicians, we are ethically bound to base our treatment decisions on what the studies have shown is best for the patient. These disorders are well-studied and reported; we cannot turn our backs on the data. We cannot ethically treat these disorders unless we are fully versed in the relevant psychological, psychosocial and psychobiological literature. These syndromes are clearly the purview of professionals other than addictionists.

Many patients with sexual and eating disorders may benefit from involvement in 12 Step programs. The mistake to be made here is that 12 Step treatment alone can provide the comprehensive treatment which these extraordinarily complex conditions require.

It is my goal to keep this organization focused on our highest intellectual and ethical principles. In that way, we will continue the tradition of leadership that the California Society has provided for the last eighteen years. □

From the Outgoing President

Hard Work Lies Ahead

P. Joseph Frawley, MD

Sir William Osler is quoted as stating that the secret to success was "one thing: hard work." The late John Houseman, as his professorial face looked into the camera, uttered in his authoritative tone, "Smith-Barney makes money the old-fashioned way. They earn it." No doubt others have said it even better. But when all the smoke of the current destruction of the addiction treatment system clears, the refrain will be the same. If we want to provide better care for chemically dependent patients, if we want the systems of care to work better, if we believe that physicians have a significant role to play, then we must work hard to bring it about.

The hard work lies in characterizing patients in meaningful prognostic ways, defining treatment in meaningful ways, and identifying short and long term outcome measures. The California Society has already agreed upon the long term outcome measures it recommends. We have also begun development of a data base project in conjunction with members of the research world and those who pay for care.

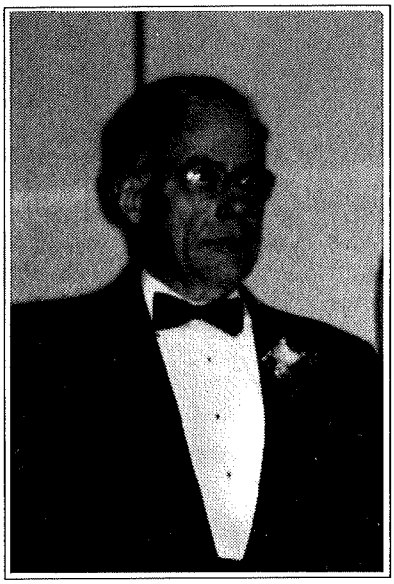
ASAM has developed Patient Placement Criteria to use in an assessment process to identify levels of care to match patient problems. NIAAA and NIDA are increasingly interested in tying research into treatment with clinical application. The success of these efforts both within our state organization, the national organization and at the federal level will depend upon how hard we work and the level at which we work.

ASAM and CSAM by 1994 will have the same membership within the state. This means that our hard work at the state level will contribute to a national effort as well. Joint membership will create a politically unified body with a more effective voice, but we have to have something solid to say; assertions of our beliefs will not hold much water. It will take work to test the assertions, not only on the part of those who serve on committees, but also on the part of each member. Each member must do his or her part to ensure that the Society's spokespersons are well connected to the realities of the problems we face and are willing to confront tough issues. The hard work will include developing relationships with leaders from the wide range of groups which are working to solve the same problems we face.

Respect for what addictionists do eroded during the period when patients were not referred to a physician but to a treatment program. If five years from now the role of the physician is better established and we have a better system of care for those with chemical dependency problems, it will not have happened of its own accord. Addictionists will have gained respect the old fashioned way: they will have earned it. □

ANNUAL MEETING November 1991 SAN DIEGO

1991 Vernelle Fox Award to Enoch Gordis



CSAM

The California Society of Addiction Medicine
presents the

Vernelle Fox Award

to

Enoch Gordis, MD

in grateful recognition of what his commitment to science is accomplishing for the field of alcoholism and addiction.

His voice as Director of the National Institute on Alcohol Abuse and Alcoholism has introduced a new level of excellence and rigor to the study of our field.

He speaks as a clinician and brings those who provide care for patients to the table where the research is designed.

He speaks as a scientist and brings the demands of science to the patient care activities of the clinicians.

He integrates, strengthens and energizes our field from his office in Rockville.

Presented November 22, 1991 ■ San Diego

The Role of Science in Addiction Medicine

The following is an excerpt from the address delivered by Doctor Gordis at the Awards Dinner.

Over the last few years, I have seen a regression in public sympathy for the alcoholic as a patient and for the concept of the disease of alcoholism. What are the sources of blame for this situation? There's no question that some of it is a consequence of the stigma associated with our patients who often are considered second class.

I believe some of this stigma and public attitude is our fault, because of our long-term blindness to the need for science, the need for rigorous evaluation of alcoholism treatments, and the need to view treatment as something other than an approach handed down directly by God to Bill Wilson.

Past reliance on dogma and anecdotal experience instead of science has contributed to the attitudes of the medical mainstream and the public. Ways of thinking which have long been standard in other branches of medicine are new to the field of addiction, and, in general, new to behavioral medicine, also. But addiction was even later than psychiatry in getting its act together and we are paying the

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price for that. We are paying the price for it in the attitudes of our colleagues and ultimately in the reimbursement process.

The history of our field shows that the treatments for alcoholism did not evolve in the mainstream of medicine. It is being medicalized now, but that's not how it evolved. Because of that history, our field still has some catching up to do.

There are two assumptions, held by practitioners of medicine in all fields, which unfortunately are not incorporated into the thinking of many who are providing treatment in the chemical dependency area. The first is that all treatment is provisional; there is no sacred treatment. It is the best we can do today, and God help us if we can't do better tomorrow. If we had somebody in our family sick with cancer or coronary artery disease, we would not want to be treated with the treatment of 30 years ago.

The second assumption is that the new advances will come from research. You can be a practicing gastroenterologist who's doing nothing but very profitable colonostomies and endoscopies all day long and who hasn't got the slightest interest in the lab, and yet you know that the next medicine for ulcers or ulcerative colitis or the next optical device that you're going to use in your practice is going to come from research. You don't even think about it; it is such a natural assumption.

Bill Wilson said, "What this field needs is a methadone for alcoholism."

For the field of addiction medicine to achieve the respect of our colleagues in medical schools and among our professional societies, we're going to have to have the same basic assumptions and expectations of science and evaluation that are typical elsewhere.

♦ New measurements

I want to highlight two areas where the needs of our field are critical now. The first is a better measurement of severity, and the second is a definition of the product of treatment.

In my view, the instruments we have now for assessing severity, like the MAST and others, are only rough indices; they rely on historical accidents to judge severity. For instance, if your marriage comes apart because of your drinking, and somebody else's doesn't, the difference might be in the severity of your alcoholism, but it also might be in the temperament of your spouse. Factors related to the spouse may be as important to deciding whether the drinker gets divorced as the severity of the alcoholism. Loss of job is another example. If you are a freelancer working at home, you are not as likely to be caught with problems resulting from your drinking as you would be if you are in a factory working under a supervisor.

My own feeling is that we need some index of severity that would measure the craving; that is, how much do you really want alcohol when you don't have it, and what are you willing to give up in order to get it. I hope that neuroscience will help us achieve that measurement because without it I think we are going to continue to be plagued with problems in the disposition of patients.

The other question for which we need an answer from research is what is the product of treatment? If a Martian were to come down to earth and look at somebody who has been in treatment in a residential unit for 20 days and then look at somebody else who has been in treatment for 35 days, how would this Martian know the difference? If a hip replacement patient stays in the hospital for an extended period in order to achieve an increase in independent mobility, it's very clear what the product of treatment is. But it is not clear what the product of treatment is if you are going to say that a patient needs 10 more days of inpatient care for alcoholism, because, as yet, we have no objective measures based on science to tell us what has been accomplished in those 10 days. Our judgment is still based solely on intuition.

♦ Stricter standards/double standard

Much as I believe that we must rely more on data and less on opinion, I don't think we should be held to stricter standards than other branches of medicine. The fact of the matter is, I think there is a double standard which operates here. For example, immense amounts of money are spent without batting an eyelash on the therapies for lung cancer,

whether it's chemotherapy or radiation or surgery, when we know that cancer of the lung is certainly brought on by smoking, which, like alcoholism, is an addiction. And that is only one area where the treatments are expensive and not terribly effective, but because of tradition and goodwill, reimbursement is not an issue.

While we have to bring science to our data and emphasize the importance of evaluating what we do in the treatment of alcoholism and addiction, I don't think it's fair that this field should be held to standards in excess of what other areas of medicine are held to. However, I think we'll be in a better position to make that point after we've done our homework and made treatment evaluation a habit.

♦ New pharmacologic treatments

The other area of our field which is dependent on science is the establishment of new pharmacologic treatments. There are two ways of getting new drugs. One is the accidental finding that a drug used for another purpose is also useful for chemical dependency—the serotonin uptake inhibitors, for example.

In the future, we should be able to view the three-dimensional molecular structure of receptors using computer-aided design, and formulate a drug to fit certain receptors.

The other way is the research which begins with first principles. You heard this morning from Doctor Paul Berger that maybe one day we'll be able to plug in antisense nucleotides which will essentially paralyze certain nucleic acid transcriptions, so certain proteins won't be formed, maybe a bad receptor of some sort. Maybe that's going to happen.

Another approach using first principles is to look at the three dimensional molecular structure of receptors using computer-aided design, and design a drug which will fit into this receptor. We don't have anything like that in progress now, but it certainly is coming down the way. These are the two main ways that drugs are going to be developed: to abolish craving, and to treat withdrawal more effectively.

♦ Conclusion

There is no question that science and the treatment field need each other—they always have and always will. We know that Bill Wilson, the founder of AA, recognized the relationship between the two. Doctor Vincent Dole, who with his wife Doctor Marie Nyswander was the author of methadone maintenance treatment for heroin addiction, was for many years a nonalcoholic trustee of Alcoholics Anonymous, and he knew Bill Wilson very well. Shortly before his death, Bill said to Vince, "What this field needs is a methadone for alcoholism." And we know Bill Wilson's viewpoint about the potential for such a discovery and its ultimate relationship to AA because he spoke about it in a lecture he gave to a New York Medical Society back in 1958.

> *We also realize that the discoveries of the psychiatrists and the biochemists have vast implications for us alcoholics. Indeed these discoveries are today far more than implications. Your president and other pioneers in and outside your society have been achieving notable results for a long time, many of their patients having made good recoveries without any AA at all. It should here be noted that some of the recovery methods employed outside AA are quite in contradiction to AA principles and practice. Nevertheless, we of AA ought to applaud the fact that certain of these efforts are meeting with increasing success: therefore, I would like to make a pledge to the whole medical fraternity that AA will always stand ready to cooperate, that AA will never trespass upon medicine, that our members who feel the call will increasingly help in those great enterprises of education, rehabilitation and research which are now going forward with such great promise.*

If Bill Wilson can say that, I guess we all can. □

Comments Requested

Nominations for Award Recipients

Each year the Annual Meeting of the California Society includes an Awards Ceremony at which recognition is given for accomplishments which further the most fundamental goals of the Society and the profession.

♦ Vernelle Fox Award

Acknowledgement is given to a physician for landmark achievements in clinical, research, education, prevention or legislative/administrative areas of the field of addiction medicine.

The Award was first given on March 12, 1982, to Vikki Fox with this declaration: "With this presentation, the California Society establishes the Vernelle Fox Award and designates you as the model against which all future recipients will be measured."

Doctor Fox was a Charter Member of the Society and its second president. She was a dynamic leader for this new organization which she saw as a vehicle to increase physician education and involvement in the clinical care of alcoholics — professional goals of her own. She was a determined teacher. The newsletter has published two articles taken from her lectures which are as timely today as they were when she delivered them in the 1970s. They are "Standards of Care for Acute Alcoholism" (Volume 15, Number 3, Winter, 1988) and "The Best Prime Therapist for an Alcoholic is an Interdisciplinary Team" (Volume 14, Number 2, Fall, 1987).

Previous recipients of the Vernelle Fox Award have been Peter Banys, Gill Ayotte, Josette Mondanaro, Jess Bromley, Max Schneider, David Smith, and Joseph Zuska.

♦ Community Service Award

A Community Service Award is also given to recognize leadership and achievements in a context broader than addiction medicine, such as advancing public policy or increasing public awareness about matters related to addiction, alcohol and other drug use. The Community Service Award is usually given to someone outside the health professions.

Previous recipients have been Betty Ford, Assemblyman Lloyd Connolly, and Mrs. C. W. Roddy of East Palo Alto who took a stand against drug dealers in an effort to keep her home and neighborhood free from the violence associated with drug use.

Nominations for future recipients are hereby solicited from all members so that the net can be cast more widely in the Society's effort to give recognition where it is merited. Send information to the California Society office; it will be forwarded to the Executive Council. □

Questionnaires to Hospital Well-Being Committees

A joint subcommittee with members from the California Medical Association Committee on the Well-Being of Physicians and the California Society of Addiction Medicine has been formed to collect data to assess the effectiveness of the mechanisms in place in California to respond to physicians. with problems arising from alcohol or other dru use, psychiatric disorders or physical illnesses.

The first project will be a questionnaire to be sent to hospital medical staffs. For over two years now, California's Title 22 regulations governing licensure of hospitals have required hospital medical staffs to provide for aid to impaired physicians. The information received from the questionnaires will give an indication of the effectiveness of the mechanisms in place for that purpose.

Members of the joint subcommittee are Daniel Lang, MD; Gary Levine, MD; Gary Nye, MD; Leland Whitson, MD; Michael Smith, MD; Chet Pelton, the Manager of the Diversion Program of the Medical Board of California, Gail Jara from the California Society, and Fern Leger of the California Medical Association. □

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 them as members. If you have comments to bring to the attention of the Executive Council, please contact Kevin Olden, MD, at (415) 361-1400, or write to him in care of the California Society office.

Robert Belknap, MD, is an internist in private practice in Mill Valley. He graduated from UCSF in 1970 and completed a residency in medicine there.

Darryl R. Brown, MD, is Medical Director of Starting Point in Costa Mesa, and has a private practice in internal medicine in Long Beach. Doctor Brown received his MD from Hahnemann University in 1986 and completed a residency in internal medicine at the University of California at Irvine in 1989.

Laurence A. Denny, MD, in private practice in Encinitas, is Board-certified in psychiatry and emergency medicine. He graduated from UCSF in 1968 and completed a residency in internal medicine at LAC-USC and Letterman Hospital in San Francisco. In 1974-1975, he was a Fellow in ICU Medicine at Massachusetts General Hospital, and a Fellow in pulmonary medicine at the University of California at San Diego. He completed a pyschiatry residency at UCSD in 1989.

Howard G. Kornfeld, MD, is an emergency physician at Novato Community Hospital, Letterman Army Medical Center, and San Ramon Regional Medical Center. He received his MD from Northwestern University in 1975. In 1988-89, Doctor Kornfeld was a Substance Abuse Fellow at the VA in San Francisco.

Germaine D. Strother, MD, is the medical liaison for the Chemical Dependency Recovery Program at Kaiser-Baldwin Park. She received her MD from Ohio State University. She completed a residency in family medicine at Case Western Reserve in 1984.

Other applicants include:
Alan Berkowitz, MD, Leucadia
John Buehler, MD, Kentfield
L. Arden Gifford, MD, El Paso, TX
Michael Horne, MD, Redwood City
Mark Souza, MD, Hercules □

NEWS ABOUT MEMBERS

Phillip Mac is now the Chair of the Santa Clara County Medical Society Committee on the Well-Being of Physicians.

Donald Gragg has retired. His position as Physician-in-Charge of the Chemical Dependency Recovery Program at Kaiser Los Angeles is filled by James Johnson, MD. Doctor Gragg continues as the Chair of the California Society's Committee on Education, but devotes most of his time to freelance hedonistic pursuits. You can reach him in Belize in February.

Joe Frawley has opened an office practice in general internal medicine in Santa Barbara. He continues as Medical Director and Vice President for Clinical Affairs of Schick Shadel Hospital.

Jess Bromley is now the Medical Director and part owner of Step One, a multifaceted outpatient chemical dependence treatment program in San Leandro, in the same medical office building as his private practice of internal medicine/addiction medicine.

Tim Cermak is now the Chair of the ASAM Committee on Family and Generational Issues.

Hope Ewing is now the Co-Chair, with Barbara Bennett, MD, from Children's Hospital in Oakland, of the ASAM Committee on Pregnancy and Neonatal Addiction.

Robert Peterson has been appointed to the California State Board of Nursing, Diversion Evaluation Committee. Also, he has been named to represent ASAM on the Diagnostic and Therapeutic Technology Assessment Project of the American Medical Association. □

1992 Review Course and California Society Annual Meeting

Ramada Renaissance Hotel

Long Beach

November 5-7, 1992

Steven Eickelberg, Richard Sandor and Karen Sees will serve on the planning committee chaired by Donald Gragg.

CONTINUING MEDICAL EDUCATION

Psychotherapeutic Interventions in Chemical Dependency

Sponsored by the Northern California Psychiatric Society and the California Society of Addiction Medicine
Good Samaritan Hospital, Main Auditorium, 2425 Samaritan Drive, San Jose
Saturday, February 8, 1992
Speakers include Timmen Cermak, MD; Robert Matano, PhD; Peter Banys, MD; Norman Reynolds, MD; Kathleen Unger, MD; Sam Naifeh, MD; Kevin Olden, MD
Credit: 6 hours
Fees: $70 for members of NCPS or CSAM; $90 for non-members
For information, contact NCPS, 1631 Ocean Avenue, San Francisco, CA 94112; 415/334-2418.

The Basics of Being an MRO
MRO: The Experts

Sponsored by the American Society of Addiction Medicine
Crystal Gateway Marriott, Arlington, VA
February 14 - 16, 1992
Speakers include David Smith, MD; Donald Ian Macdonald, MD; Robert DuPont, MD; H. Westley Clark, MD, JD
Credit: The Basics of Being an MRO–2.5 hours; MRO: Meet the Experts–14.5 hours
Fees: The Basics, $75; Meet the Experts, $350
For information, contact ASAM, 5225 Wisconsin Avenue, NW, Washington, DC 20015-2016; 202/244-8948.

12th Annual Betty Ford Center Conference

Annenberg Center for Health Sciences at Eisenhower Medical Center, Rancho Mirage
February 23-25, 1992
Speakers include Anne Geller, MD; Marty Jessup, RN; Mel Pohl, MD; Richard Sandor, MD
For information, call 800/321-3690.

Addiction Medicine and the Media: A Professional Challenge

How to Succeed with the Media

Sponsored by the California Society of Addiction Medicine
Clarion Hotel at the San Francisco Airport
Saturday, February 29, 1992
Fees: $60 for members of CSAM; $75 for non-members
For information, contact CSAM, 3803 Broadway, Oakland, CA 94611-5615; 510/428-9091.

ASAM's 23rd Annual Medical-Scientific Conference

Ramada Renaissance Techworld, Washington, DC
April 2-5, 1992
For information, contact ASAM, 5225 Wisconsin Avenue, NW, Washington, DC 20015-2016; 202/244-8948.

25th Anniversary Conference
Sponsored by Haight Ashbury Free Clinics

Treatment and Prevention in the Era of Smokeable Drugs, June 4-5

Speakers include David Smith, MD; Max Schneider, MD; Donald Wesson, MD; Herbert Kleber, MD; Andrew Mecca, DrPH; John Newmeyer, PhD; Darryl Inaba, PharmD; Reese Jones, MD

Prescription Drugs with Abuse Liability, June 6-7

Speakers include David Smith, MD; Sidney Schnoll, MD; Paula Horvatich, PhD; H. Westley Clark, MD, JD
For information, call Haight Ashbury Training; 415/565-1902.
