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Thinking Seriously About Alternatives to Drug Prohibition

Ethan Nadelmann, JD, PhD

Editor's Note: It seems that not a month goes by without the debate over drug control policy being raised again in one or another of the popular media—usually under the provocative title of "The ***Legalization*** *Debate." Too often the result is further polarization of the opponents and resigned confusion of the audience.*

No matter how one feels about the arguments for and against liberalization of drug control laws, no one can deny that current prohibition policies have at least some harmful, if unintended, effects. In the interest of keeping members informed about these questions, the California Society presented three speakers during our biennial "State of the Art Conference" this past November. Coincidentally, the day before, during the annual business meeting, the membership voted to ask the Executive Council to endorse and ask ASAM to endorse the "Hoover Resolution" which calls for creation of a Federal commission to recommend revisions of the drug laws to reduce the harm our current policies are causing. (The Resolution is described on page 13.)

Doctor Nadelmann is a leading advocate for re-examining drug control policies and has published important articles in both **Science** *and* **Daedalus.** *He is the founding chair of the Princeton Working Group on the Future of Drug Use and Alternatives to Drug Prohibition. We are pleased that he has taken the time to help us prepare this article from his talk and hope it will stimulate a healthy discussion among our members.—Richard S. Sandor, MD*

We do not have to choose between prohibition and legalization. It is not an either/or choice. We, as a people, a nation, must find an appropriate place along a very long spectrum that ranges from the most severe restrictions on one side to the most free market on the other. At one extreme, there are, for example, the highly punitive policies in Malaysia, Singapore, Iran and Communist China, where there are highly coercive drug treatment programs and imprisonment, and where possession of 7 oz of cannabis gets you the death penalty. At the other extreme, there is the free market. America's policy with respect to cigarettes from about the 1930s to the 1970s was virtually a free market—low tax, low regulation, and restrictions only on sales to children.

Another example of the free market was America's policy with respect to opiates, cocaine and cannabis a hundred years ago. All were entirely legal. During much of the 19th-century period, when these drugs were available in the United States, in Canada, and actually in much of the world, rates of opiate use, and, so far as we can tell, of cocaine use, were somewhat higher than they are today, but there were far fewer drug-related problems (Courtwright, 1982; Musto, 1987).

In between the two extremes, you have control strategies whose aim is harm reduction. For example, there is the Canadian cigarette control policy, one of the toughest in the world right now. With prices of $6.85 a pack and vigorous campaigns against cigarette smoking, Canada has had tremendous success in reducing smoking, especially among the young. This is a model that takes as its basic assumption the right of adults to consume a highly deadly substance—the right of adults to make that stupid decision to smoke cigarettes—but then says if you want to do that you've got to pay taxes, you've got to be restricted in where you use it, and you've got to be subject to our propaganda. Tough regulatory control systems can simultaneously acknowledge the rights of adults to consume and possess harmful drugs and then seek to minimize the harms that result.

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I'd like to see the United States stretch down this drug policy spectrum towards more of a legal regulatory system, with different control models that build on the best of the alcohol and tobacco regulatory systems, that rely on new technologies and new means of making information available to people and that try to empower consumers in their choice and use of drugs.

History provides data from which we can try to estimate the consequence of different policies. The United States began to impose the first restrictions with the 1906 Food and Drug Act, which said, "You can still sell all these opiates and cocaine, but you've got to label the bottles. You've got to tell us what's in those patent medicines." Today, most of us assume that if, all of a sudden, you were able to go to a local store and buy a bottle that said 4% cocaine, or 3% heroin, or 7% cannabis, sales would zoom extraordinarily. But in 1906 when they labeled the bottles, sales dropped. People were already sufficiently aware of the addictive potentials of cocaine and opiates and they didn't want to buy them.

We can never know for sure what the consequences of different legal regulatory regimes would be, but we can begin the process of identifying options and thinking scientifically—applying what history and epidemiology have already shown us—about the consequences of each option. For each option, we should estimate its ability to reduce both the harms done to individuals by their drug use and the harms done to our society by our current system of prohibition. I pursue these questions as a scholar, doing my best to do and find objective studies and to identify areas of agreement among different approaches. But I am also an activist, because I think it is very important as a citizen, and as a teacher, to take action—to make efforts to have those changes happen.

Alcohol Prohibition

Let me explain why we need to move down the road away from prohibition. Most of what we identify as the drug problem today is, in fact, the result of drug prohibition. The analogy to alcohol Prohibition is apt.

We know that alcohol Prohibition gave us Al Capone. We know it fueled organized crime, produced rising levels of violence and corruption, overflowing prisons and jails and courthouses. We know it corrupted law enforcement agencies, the judiciary and top political figures. And we know that thousands of people were blinded, poisoned, or killed by bootleg liquor. These are all consequences of alcohol Prohibition.

Nonetheless, alcohol Prohibition, at least in its first years, did reduce consumption and the ills associated with alcohol abuse, just as we assume today that drug prohibition does play a role in suppressing drug consumption. But the role of prohibitions in reducing alcohol and drug use has been overstated. From 1916 (three years before Prohibition) to 1922, alcohol consumption went down dramatically. Those years were the peak of the temperance movement and anti-alcohol propaganda. It was the period of World War I and self-sacrifice. There were boycotts of breweries because of anti-German sentiment. By the time the 18th Amendment entered into force in 1919, many elements had already come together to depress alcohol consumption to an unprecedented low level in the United States. But between 1922 and 1933 consumption steadily increased, despite intensified law enforcement efforts, and by 1933 there was probably more hard liquor being drunk than when Prohibition started. By the time it was repealed in 1933, alcohol Prohibition had fallen far, far short of the hopes of the temperance advocates (Morgan, 1991; Thornton, 1992; Miron & Zweibel, 1991; Nadelmann, 1989; Levine & Reinarman, 1991).

The analogy is apt. We assume that drug prohibition does play a role in suppressing consumption of illegal drugs — but there is no hope that prohibition will eradicate use. And, whatever benefits might result from persisting with our prohibitionist policy come at a very high cost to society. Neither the 14 years of alcohol Prohibition nor today's increasingly repressive drug prohibition are built on sensible public policy analysis and regard for public health and individual rights. From the first legislation and judicial decisions that imposed drug prohibition until today, our drug policies have been based principally upon rhetoric, not on science.

There's one other interesting lesson of alcohol Prohibition that people often overlook. During the same time the US was experimenting with Prohibition, European temperance movements were agitating for prohibition as well. But governments in Britain, the Netherlands and Australia, among others, rejected that option, choosing instead to tax the hell out of booze, limit the number of hours that bars and pubs could be open, impose very tough sanctions for public drunkenness, etc. The results were impressive. They reduced alcohol-related ills much more than the United States did. They sustained low levels of alcohol consumption for much longer than the United States did. And rather than subsidizing organized criminals to the tune of billions of dollars or guilders or pounds a year, they put that money into local treasuries (Room, 1988; Shadwell, 1923; Nadelmann, 1989). The lesson is clear. A regulatory strategy can prove more effective than a prohibition strategy not only in reducing crime and violence and the problems caused by adulterated drugs, but even in reducing drug abuse problems.

The Free Market Model

Let me speculate with you for a moment about the possible consequences for American society of having virtually no drug control policy whatsoever. Imagine, for instance, that Congress passed a law granting the freedom of drug consumption, and even production and distribution, and giving those freedoms the same legal protections as freedom of speech, press, religion, and assembly. And imagine that "supermarkets" sprang up all around the country in which drugs of every variety could be purchased at prices reflecting nothing more than retailers' costs plus reasonable profit margins and sales taxes.

The great advantage of the "supermarket model" is that it eliminates virtually all of the direct and indirect costs of drug prohibition. Its great disadvantage is its invitation to substantial increases in both the amount and the diversity of psychoactive drug consumption. What needs to be determined are the magnitude and nature of that increase and its consequences.

Antiprohibitionists typically assume that the vast majority of Americans do not need drug prohibition laws to prevent them from becoming drug abusers. By contrast, prohibitionists typically assume that most Americans, and at the very least a substantial minority, do in fact need such laws—that but for drug prohibition, tens of millions more Americans would surely become drug abusers. The "supermarket model" provides no immediate insights into which perspective is closer to the truth, but it does suggest two important approaches for analyzing the implications of a free market.

First, it is imperative that we broaden our horizons to examine not just potential changes in the consumption of drugs that are currently illicit but changes in the cumulative consumption of all psychoactive substances. Virtually all human beings consume

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psychoactive substances. Alcohol and caffeine are certainly the two most common in the United States today, followed by nicotine, marijuana, and a variety of the more popular prescription drugs used to alleviate feelings of depression and anxiety. With the notable exception of alcohol, which has retained its preeminent position throughout the history of American psychoactive drug consumption, all other drugs have witnessed substantial changes in their levels of consumption. Some of these changes have been a result of changes in drug laws. Others have reflected the emergence of new drugs, or new formulations of familiar drugs, as well as changes in medical prescription practices, new marketing techniques, changing fads and fashions in recreational drug usage, and broader changes in popular culture as well as particular subcultures.

There is reason to believe that a non-prohibitionist regime would result in less dangerous drugs driving out more dangerous ones (Aldrich, 1990). By most accounts, alcohol and tobacco represent two of the most dangerous drugs that have ever entered into common usage in human society. There is no reason to assume that their predominant position in the hierarchy of favored psychoactive substances will persist forever, and good reason to believe that the desirable functions they serve can be replaced by other substances that pose far fewer dangers to the health of consumers in both the short and long term.

Second, in evaluating the consequences of any model, we need to focus not on how many people will use drugs, or how many drugs will be consumed, but rather on the magnitude of the negative consequences that would result. These include the immediate effects on the health and behavior of the user; the debilitating effects of sustained misuse; and the deadly effects of sustained consumption. Each of these effects may also be of consequence for nonusers ranging from those who love or live with drug abusers to those who depend upon them in the workplace to those who encounter them on the roads. The evaluation of these consequences, and the assessment of which are more or less serious, inevitably involve ethical judgments. But it is important to recognize that public policy can seek to shift patterns of drug use and even abuse in safer directions by favoring drugs, sets, and settings that cause less harm to users and others. It is, in short, possible for the undesirable effects of drug use to decrease significantly even as the amount and diversity of drug consumption increase substantially.

Indeed, if we really seek to be truly objective in our assessments, what needs to be calculated are not just the cumulative negative consequences but the positive ones as well (Aldrich, 1990). Proponents of the public health

perspective as well as substantial segments of the American population are reluctant to speak of the positive benefits of psychoactive drug use except to the extent they conform with conventional notions of physical health and medical treatment. Alcohol's benefits, for instance, are defined primarily in terms of their potential to reduce heart disease, and those of prescription drugs entirely in terms of their capacity to alleviate pain, depression, anxiety, and feelings that disrupt normal functioning. Yet most people use drugs because they enjoy the effects and many perceive a variety of personal benefits that are rarely measured by physical, medical, or social scientist. The benefits of moderate consumption of alcohol as a social lubricant, and of caffeine in coffee and other beverages as a mild stimulant to increase alertness, are probably the most easily accepted and widely acknowledged non-medical benefits associated with nonprescribed psychoactive drug consumption, but it is also the case that millions of Americans justify their past use and/or explain their current use of marijuana, cocaine, hallucinogens, and a variety of other drugs in terms of the benefits that they have derived from their consumption of those substances. Such claims are easily belittled in a society that adopts the notion of "drug-free" as its motto, and are often dismissed by scientists who find such benefits particularly difficult to measure. Nonetheless, it seems inherently unreasonable to dismiss entirely the perceptions of consumers, especially when the negative consequences of their consumption are not apparent. We are fortunate in this respect, that the current popularity of Prozac and, to a lesser extent, MDMA (Ecstasy), is raising these issues anew in a fresh light (Kramer, 1993; Rothman, 1994; Wright, 1994; Beck & Rosenbaum, 1994)).

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What conclusions can be drawn from an analysis of the consumption of psychoactive drugs in this country?

- First, virtually all Americans consume psychoactive substances—and even the small minority who appear to abstain entirely, such as the Mormons, seem to compensate by consuming substances not traditionally viewed as psychoactive, such as sugar and caffeinated soft drinks.
- Second, a substantial majority of Americans consume these substances only in moderation, suffering little or no harm as a result.
- Third, the drugs that prove most addictive to most Americans are those, such as cigarettes and caffeinated beverages, that can be easily integrated into everyday life with minimal hassle or disruption.
- Fourth, virtually all drugs, even heroin, cocaine, and other drugs most associated with destructive patterns of consumption, are consumed in moderation by most of those who use them (Zinberg, 1984; Waldorf, Reinarman, & Murphy, 1991; Cohen, 1989).
- Fifth, a substantial majority of those who enter into destructive patterns of drug consumption eventually pass on to either abstinence or moderate patterns of consumption (Peele, 1989; Faupel, 1991).

When we focus on those who appear most susceptible to destructive patterns of drug consumption, further conclusions are apparent.

- While certain types of drugs are more difficult to use in moderation than others, the principal determinants of destructive drug use patterns involve not the pharmacology of the drug but the set and setting in which the drug is consumed (Zinberg, 1984). That is why alcohol consumption among conquered aboriginal groups and cocaine consumption among some inner-city populations have more in common with one another than either does with patterns of alcohol or cocaine consumption among less vulnerable sectors of the population. Indeed, no set and setting is more conducive to extensive and severe drug abuse than the combination of poverty and maladjustment to a mainstream society.
- Those who engage in destructive patterns of consumption with one drug are the most likely to repeat the pattern with other drugs; conversely, those who demonstrate an ability to consume alcohol and common prescription drugs responsibly, or who have succeeded in either stopping or dramatically curtailing their consumption of tobacco, are much less likely to engage in destructive patterns with other drugs.

Consider the results of recent polls on drug use in the United States, such as the National Household Survey on Drug Abuse and certain Gallup polls. Approximately one third of Americans over the age of 12 claim that they have not used alcohol in the past year, and close to half report that they have not consumed any alcohol in the past month (US Dept. of Justice, 1991; NIDA, 1990). Approximately 75% of all Americans over the age of 12 have smoked at least one cigarette; slightly less than 30% report that they smoked within the past month, of which half consume about a pack or more a day (NIDA, 1990). With respect to marijuana, about 33% of Americans have used it at least once, 11% in the past year, six percent in the past month,

and about one percent on a daily basis (NIDA, 1990).

Even if we assume that self-reports of alcohol and tobacco consumption tend to under-report actual consumption by 30-50%, we still must conclude that at least 70% of Americans are resistant to the sorts of temptations and risks posed by the easy availability of cigarettes, and that more than 90% either refrain from powerful intoxicating drugs altogether or else consume them responsibly and in moderation. This conclusion strongly suggests that a very substantial majority of Americans is immune to any far reaching liberalizations in drug availability for the simple reason that they do not really need drug laws to prevent them from entering into destructive relationships with drugs.

The important question is thus not whether people would change their patterns of drug consumption under a radically different drug control regime—since there is good reason to assume they would—but rather whether those patterns would be more (or less) destructive than their current patterns of drug consumption. For the vast majority of Americans the principal danger posed by a free market in drugs has little to do with drugs with high potential for harm to the user, like the concentrated "crack" form of cocaine, since so few Americans would be likely either to try them in the first place or, if they did try them, to continue to use them. Public opinion polls (1990 poll by Targeting Systems, Inc.; Trebach, 1993) consistently reveal that few Americans believe they would consume cocaine, heroin or even marijuana if those drugs were legally available (Johnston, O'Malley, Bachman, 1991).

The greatest danger of a free market in drugs, I suspect, is the possibility that a drug, assumed at first to be relatively safe, becomes popular among millions of Americans and then is revealed to be far more harmful than initially believed. This danger has proven commonplace in the annals of pharmaceutical innovation, medical prescription practice, and inebriation, from morphine and cocaine during the 19th century to cigarettes, barbiturates, amphetamine, tranquilizers, and many nonpsychoactive drugs, including steroids, during the twentieth. It is one that has continued to frustrate the regulatory efforts of the Food and Drug Administration in recent decades, and that promises to persist into the future regardless of whether the drug laws change substantially. But it is fair to assume that the dangers would be greater if far more products were to become legally available.

The most common fear of legalization, however, is usually of a different sort, and it must be taken seriously. It is that there are millions of Americans for whom the drug prohibition system represents the principal bulwark between an abstemious relationship with drugs and a destructive one. Under a free market regime, it is feared, many of those who currently abstain from, or consume in moderation, alcohol and other powerful intoxicants, would become drug abusers, and many of those who already have demonstrated either a potential for, or a pattern of, drug abuse would engage in even more destructive patterns of drug use. Underlying this fear are a variety of assumptions: that the only things which prevent many current users of illicit drugs from engaging in far more destructive patterns of drug use are the higher price and lower availability of those drugs under the current prohibition regime; that at least some of the illicit drugs are more seductive than those that are currently legal and/or available; that a free market regime would inevitably invite greater levels of drug experimentation, which in turn would lead to higher levels of use and abuse; that many people would be more likely to complement their current drug use with newly available drugs than to substitute those for their current preferences; and that the heightened societal tolerance for more varied psychoactive drug use that would likely accompany a free market regime would lend itself to higher levels of drug misuse.

We can assume that there is a relatively small, but indeterminate, proportion of Americans for whom the drug prohibition system provides not just the image but the reality of security. Figuring out the magnitude and composition of this vulnerable population is among the most important intellectual challenges here.

In trying to predict which drugs will prove most popular in the future, who will use them responsibly and who will do so destructively, it is important to keep in mind why people use drugs and why they use the drugs they do. To the extent that drug consumption patterns and preferences can really be described as a choice, it is fair to say that people choose those drugs that give them what they want. Most people can in fact be described as rational consumers even in their choice of psychoactive drugs. They use drugs because they seek or like their effects, whether those involve relief from pain, reduction of stress and anxiety, release from inhibitions, stimulation of the senses and the intellect, enhancement of physical or mental performance, or any of the many other psychoactive effects of drugs. Most people, moreover, tend to limit their consumption in order to minimize the negative consequences, whether those involve hangovers, heart disease or cancer. The evidence from a broad variety of cultures suggests that the single most important determinant of a drug's popularity is its capacity to be

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integrated into ordinary lives with minimal disruption.

One can supplement the notion of rational drug consumption, which focuses on the individual's preferences, with another notion also drawn from libertarian philosophy. It is that societies, like individuals, generate nonlegal social norms in the absence of governmental prohibitions and other restrictive laws. Although there is much evidence to support this notion, most Americans unfortunately demonstrate insufficient faith in the power of social norms to control drug use.

When we stretch as far as possible from the free market extreme of the drug policy continuum, but seek at the same time to retain the basic feature of accessibility without the permission of a government-sanctioned gatekeeper, what emerges is the "right of access" or "mail-order" model.

The "Right of Access" Model

What other options besides the "supermarket model" should we study? Direct access is the feature that distinguishes the legal status of alcohol, tobacco, caffeine, and aspirin from that of marijuana, cocaine, morphine, and Valium, and that accounts for the generally greater and easier availability of the legal drugs compared to the illegal or restricted drugs. "Legal" drugs are almost always available over-the-counter; illegal or restricted drugs are not. Government-sanctioned medical authorities and pharmacists, and sometimes additional barriers as well, stand between the illegal or restricted drug and the person who wishes to obtain it.

It is important to recognize that legal availability does not always connote easy availability, and conversely, that restricted legal status does not always make it that difficult to obtain. Legal drugs may, for instance, be so expensive—either because of high costs of production or high taxes—that they are for all intents and purposes unavailable to many potential consumers. And efforts by government to restrict severely the availability of a legal drug without depriving consumers entirely of the right to purchase it legally may prove successful in diminishing consumption. Recall the experience of Britain, Australia, and the Netherlands with non-prohibitionist alcohol control during the 1920s and 1930s.

Illegal or restricted drugs, by contrast, can occasionally prove to be highly available. Medical practitioners often write prescriptions for mild tranquilizers, sedatives, and other psychoactive drugs in response to their clients' complaints. Illegal drugs may prove more available than many legal drugs, such as alcohol, for which the hours of sale are often restricted by government. In many highly restricted environments, moreover, such as prisons, jails, and mental institutions, illegal drugs are often more available than alcohol because their smaller bulk makes them easier to smuggle past guards and other barriers.

Analysis suggests that it is possible to construct regulatory control regimes in which drugs may be made accessible, yet less available than is the case under prohibition regimes. When we stretch as far as possible from the free market extreme of the drug policy continuum, but seek at the same time to retain the basic feature of accessibility without the permission of a government-sanctioned gatekeeper, the model that emerges is one that might be called the "right of access" or "mail-order" model. It is based on the notion that adults should be entitled not merely to the right to possess small amounts of any drug for personal consumption but also to the right to obtain any drug from a reliable, legally regulated source responsible (and liable) for the quality of its products. Unlike the "supermarket model," the right of access model is one that can be superimposed on the current drug prohibition system.

If such a right of access were legally acknowledged by Congress or the Supreme Court—a prospect, I recognize, with scant political or jurisprudential potential in the foreseeable future—those desirous of minimizing the potential threat to public health might well advocate the notion of a mail order system. In order to ensure a right of access to all residents of the United States no matter where they might live, at least one mail order source would have to be available in the United States from which any adult could order a modest amount of any drug at a reasonable price reflecting production costs and taxes. Most states, cities, and other communities might well continue to prohibit the sale and public consumption of most drugs within their jurisdictions as they do now, but would be obliged to acknowledge the basic right of access by mail order as well as the basic right of possession and consumption. But the option of ordering one's drugs by mail would allow any adult to opt out, in effect, of the local control system insofar as private consumption was concerned.

The right of access model strikes at the heart of much of what is wrong with drug prohibition, in particular the creation of violent and powerful black market entrepreneurs, the harms that befall consumers from adulterants or unknown strength due to unregulated production of psychoactive drugs,[1] and the many infringements on individual freedoms. And it also provides a skeletal framework that can be filled out with harm reduction measures that we

[1]Just imagine if, every time you took an aspirin, you didn't know if it were 5 mgs or 500 mgs. You didn't know who had put what other ingredients into it. Every time you drank a glass of wine, you didn't know if it was ethyl alcohol or methyl alcohol, or if it was 5% or 80% alcohol.

associate with public health approaches to alcohol and tobacco control. It has the advantage of resembling actual models in other domains of public policy both today and in recent history, including the alcohol distribution system in Canada and Sweden during the early decades of this century as well as in pre- and post-Prohibition United States, and the modification of FDA policy (Johnson, 1990) in recent years to allow individuals to import by mail small amounts of drugs that are legally available outside the United States but have yet to be approved by the FDA for the treatment of AIDS or cancer.

This model is not, I must stress, a panacea, nor should it be misconstrued as a final proposal for an alternative drug control regime. It raises numerous questions such as how a mail-order system like this would be established and maintained, who would run it and profit from it, who would oversee it, who would have access to its mailing lists and other information about consumers, how consumer privacy would be protected, how minors would be prevented from taking advantage of it, how new drugs would be made available, and so on. Most of these questions strike me as susceptible to fairly precise answers, in good part because there are so many close analogies to a mail-order system. More difficult to assess are the same sorts of questions raised by the "supermarket model" and all other alternative models, in particular those that focus on assessing changes in psychoactive drug consumption—although I assume that they are easier to answer with respect to a mail-order model since such a system is more readily integrated with the current prohibition model than is the case with the "supermarket model."

One ostensible failing of the mail-order model is that it does not to eliminate the black market altogether. Just as some gun control laws rely on waiting periods between the time a person orders a firearm and the time he obtains possession, so a mail-order system imposes a sort of waiting period—presumably a minimum of one day. It is highly reasonable to assume that black markets would persist not only to supply minors—which is presently the case with most psychoactive substances, including alcohol and tobacco—but also to supply those who will not or cannot wait to obtain their drugs from the mail-order system, as well as those who want to obtain more at any one time than is allowed by law. This model might result in smaller scale illicit markets.

Local authorities could choose, in effect, either to suppress such black markets vigorously or to manage them through conventional vice control methods. But the scale of such markets would probably bear a closer resemblance to illicit prostitution rings in cities that sanction regulated prostitution than to contemporary illicit drug markets.

Few drug control regimes are static. Prohibitions, regulations, and decriminalizations tend to evolve as new drugs emerge, as drug use patterns shift, as other drug-related norms change, and as popular and elite perceptions of various drugs, drug consumers, and drug problems shift. In contemplating alternatives to the current drug prohibition regime, we need to distinguish among transition phases, longer term consequences and equilibria, keeping in mind that there is no drug control regime that will suffice forever.

Here it is worth pointing out the patent absurdity of the claim that drug legalization would devastate inner-city populations. Both legal and illegal drugs are already so widely available in inner cities that virtually any resident can obtain them far more quickly than in suburban neighborhoods. But a liberalization of drug availability could make more easily available drugs that are safer than those now sold in urban liquor stores, crack houses, and street markets. And, it would substantially reduce the negative consequences of prohibition—all of which are felt most severely in the urban ghettos.

More broadly, there is good reason to think that a regime of legal availability would substantially, even radically, transform the ways in which Americans relate to psychoactive drugs. There is also the question of how a liberalization of legal availability will affect both the doctor-patient relationship and the treatment of addiction. One might will imagine that pharmacological experts, certified perhaps by either government or professional agencies, would play an increasingly important role not so much as gatekeepers but as educators and consultants on the preferred uses of drugs for medicinal, psychotherapeutic, recreational, and other purposes. But even more importantly, nonlegal norms would undoubtedly emerge in the absence of current prohibitionist norms to shape the way people relate to drugs, the ways in which they use them, and the cautions they exercise. Here again, there is the question of determining which people are likely to prefer the least potent and least risky drugs and which are more likely to opt for the most potent, quickest acting, and so on. There is also the possibility that a world of widespread drug availability might be more likely to generate self-protective norms against all forms of drug taking. And it is fair to assume that far more people would assume greater responsibility for their relationship to drugs than is currently the case, since the gatekeeper role of doctors effectively transforms consumers into far more passive actors.

There is also the question of how a liberalization of legal availability will affect both the doctor-patient relationship and the treatment of addiction.

Educating the Consumer

This in turn leads to the question of how information about psychoactive drugs could be better distributed to a population so that it is readily available and intelligible to typical consumers. The challenges here are fourfold.

The first is to design effective means of distinguishing among categories of drugs so that consumers are properly informed of the risks and appropriate uses. The second is to design a system separate from the distribution systems whereby consumers can obtain necessary information on their own at little or no cost. The third challenge is to create honest drug education programs that tell children the truth about drugs without stimulating premature desires to try them (Weil and Rosen, 1983; Clements, Cohen, & Kay, 1990; Duncan & Gold, 1985; Engs, 1979). And the fourth is to design public health campaigns that effectively discourage drug misuse without resorting to lies, scare tactics, and the demonization of people who use drugs. The public service advertisements directed at discouraging tobacco consumption and drunken driving provide far better models in this respect than, for example, the "fried egg" ads which say, "This is your brain on drugs."

Most of what people know about drugs they have never used comes from the commercial media. It has repeatedly played a central role in transforming local fads and fashions into national and even international phenomena (Brecher, 1972). We can safely assume that it will play a crucial role in the distribution of information and the shaping of public perceptions about drugs, particularly those that are relatively unfamiliar to most Americans. One need only imagine what impact the news magazines' cover stories in late 1989 and early 1990 on the new antidepressant, fluoxetine (Prozac), would have had if Prozac were available over-the-counter or by mail; indeed, it would be interesting to know what impact those stories actually did have on potential consumers (Kramer 1993). How many people, for instance, visited doctors thereafter with the intention of obtaining prescriptions for Prozac, how many succeeded, and—even more difficult to say—how many benefitted or suffered as a consequence? Conversely, how many people who might benefit from Prozac have not yet tried it solely because they are unaccustomed to visiting a doctor to obtain assistance in alleviating depression? Certainly there is good reason to fear the media's impact on drug consumption preferences under a legal regime given the media's historic and persistent incapacity to provide accurate and balanced information about psychoactive drugs (Reinarman & Levine, 1989). On the other hand, the media occasionally have demonstrated their capacity to shape preferences in healthier and otherwise better directions. The media are certainly a loose cannon insofar as our efforts to evaluate the future direction of drug use are concerned. But there is good reason to devote at least some effort to considering how the media have shaped drug consumption patterns in the past.

Some believe that it is a fundamental drive within human nature to experiment with consciousness, and that use of psychoactive substances should therefore be a fundamental right and freedom. How optimistic or pessimistic are you about how human beings will deal with this sort of freedom?

The issue of advertising is a difficult one. In 1986, the Supreme Court ruled in *Posadas de Puerto Rico Associations vs. Tourism Company of Puerto Rico*[2] that strict restrictions on advertising casino gambling were constitutionally permissible. There seems to be little question that comparable restrictions on advertising psychoactive drugs would also be regarded as constitutional (Law, 1992; Hirsch, 1991). The difficult issues thus involve balancing the costs and benefits of both specific types of advertising as well as the advertising of psychoactive products generally. There is good reason to fear, and to curtail, the mass promotion of psychoactive drugs that present the sorts of harm associated with alcohol and cigarettes. There are also substantial incentives to avoid a revival of medical quackery and the mass marketing of patent medicines that once tricked millions of Americans into buying products that did them little good and occasionally much harm (Young, 1961). On the other hand, advertising can play a valuable role in informing people of new and beneficial products, in luring consumers to switch from more dangerous to less dangerous drugs, and in promoting competition that saves consumers money (Masson and Rubin, 1986). This is true of both psychoactive and nonpsychoactive drugs as well as those used for both recreational and more traditional therapeutic purposes. The solution to the advertising dilemma—to the extent we are willing to put aside First Amendment concerns—may well lie in a combination of restrictions on the promotion of more harmful products with vigorous educational campaigns to discourage their consumption.

Conclusion

Predicting human behavior remains, and shall always remain, an imprecise art. Social science can provide modest insights into the consequences of incremental changes in regulatory structures on human behavior. But when we try to envision the consequences of more far reaching changes in such structures, our confidence in social science insights falters. The variables are too numerous, the changes in individual and societal consciousness too unpredictable, and the tools too paltry to pretend that we can really know the future. Here, history offers a more powerful guide—with its potential to shed light on both the accretion of incremental changes and the suddenness of

[2] 478 US 328, 92L ed 266, 106 S Ct 2968, 1986.

revolutionary change. But even its lessons are limited by unanswerable questions regarding the potential of the future to evolve in unprecedented ways. Ultimately our predictions are bounded by theories of human behavior, and particularly of human and societal vulnerability and resilience, that have more to do with our visceral fears and confidences than any objective readings of the evidence.

When we switch from predicting the future to trying to plan it, our preferences are determined not only by our calculations of their consequences but also by our choices among competing ethical values. Such choices may be made explicitly or implicitly, as when we accept without question conventional ethical values. Our choices establish the parameters beyond which policy options will not be considered. They influence our calculations of the costs and benefits of various options. And they guide us in deciding who should benefit and who may be harmed by choosing one option over another. There are no objective standards by which to choose among ethical values. On can only appeal to conscience, principle, and empathy.

The challenges of evaluating radical alternatives to our current drug prohibition system are formidable. But so are the challenges of predicting the consequences of persisting with our current policies. In 1960, few Americans had ever heard of LSD, and the notion that 60 million Americans would smoke marijuana during the next three decades would have seemed bizarre to most Americans. In 1970, few Americans gave much thought to cocaine, and most would not have believed that 25 million Americans would try it during the next two decades. By the late 1970s, many Americans believed that marijuana would be sold legally within a few years. In 1980, no one had ever hear of "crack" cocaine; the notion of an AIDS epidemic among injecting drug users seemed inconceivable; and the prospect of a quarter-million Americans in jail or prison by 1990 for violating drug prohibition laws seemed preposterous. Clearly, retention of our drug prohibition system provides no guarantees about future patterns of drug use or the scale of future drug problems. New forms of legalization may present a wider array of possibilities, but the uncertainties are not dramatically greater than those of persisting with prohibition. I think that increased use is quite likely as we move down the spectrum towards a legal regulatory system. But I also believe that it's quite likely that the negative consequences of that use will diminish dramatically. We certainly have nothing to lose—and quite possibly much to gain—by thinking more seriously about alternatives to drug prohibition.

Questions from the Audience

Question: *Doctor Nadelmann, I want to thank you for a very interesting and provocative talk. I have a concern about cocaine, separate from other drugs. If you were to write the regulations for cocaine for this country, what would you write?*

EN: I would make available low potency coca products. I'd begin by carving out an exception to the 1961 Single Convention on Narcotic Drugs — the international convention which prohibits virtually all international trade in coca-based products. I would allow Bolivia and Peru to start exporting coca teas, coca tonics, the Vin Mariani type of wines that were popular in Europe and the Americas over a hundred years ago. There's some interesting arguments that these have beneficial health uses (Burchard, 1992; Weil, 1981). More in line with our discussion, however, is the preliminary evidence that they might be useful to people who are trying to get away from cocaine addiction (Siegel, 1989).

There's good reason to believe that cocaine in low doses may be no more addictive than coffee, with fewer negative health consequences than caffeine. Cocaine in low potency forms would be far less dangerous than current cocaine products. Once you make a lower potency product easily available, in a form that's not that difficult to use, you begin to deglamorize its use and you take all the steam out of the underground criminal side of things.

Question: *If our society allows free and open drug use, what assurance is there that people will use drugs safely and drug use will not get out of control?*

EN: First of all, we must agree on what is meant by "free and open drug use." I take it to mean minimal prohibition by the government. What might well happen is that, after an initial period in which people experiment with

I would make available low potency coca products.

the freedom to use drugs openly, social norms would develop. One of the powerful arguments of the libertarians is that in the absence of legal norms, alternative social norms emerge. We have powerful social norms around the use of alcohol, even today.

I also expect there would be a whole set of legal regulatory measures—an extension of the regulation which is already in place today. For example, we are now moving to the point where cigarette consumption is becoming a highly private activity. It's legal to use tobacco, it's legal to smoke cigarettes if you are an adult, but it's not so free and open anymore. That provides a good model.

There are at least two underlying philosophical questions in this debate. The first is how important you think individual autonomy, individual freedom is. The second centers on what you believe about human nature and its relationship to psychoactive drugs. Some believe that it is a fundamental drive within human nature to experiment with consciousness, and that use of psychoactive substances should therefore be a fundamental right and freedom. How optimistic or pessimistic are you about how human beings will deal with this sort of freedom? Your answers to those two questions are the fundamental influences on your thinking about drug policies.

Question: *To get back to treatment for a moment, I understand that some European countries are using drugs like heroin and cocaine in maintenance or treatment programs. Can you tell us about that?*

There are programs in Britain, Germany, the Netherlands, Australia and other countries which are based on the principle of harm reduction—"low threshold" programs which make methadone available to addicts with minimal conditions and hassles. Methadone buses travel around the city, an idea that has now been adopted in Baltimore and Boston. They say, "We don't need to see your urine; if you want methadone, have some contact with us; that's what's important right now. Let us show you how to inject cleanly so you don't hurt yourself." If we want to reach a larger number or a harder core population, we've got to open our minds to alternatives to our own current systems (Siegel, 1989).

In Switzerland, the federal government recently approved a study to prescribe drugs other than oral methadone—including injectable or smokeable heroin, injectable morphone, injectable methadone and smokeable cocaine—to 700 addicts. Participation in the study is limited to heroin users at least 20 years of age who have used heroin intensively for at least two years and dropped out of treatment programs at least twice—specifically those who have resisted other efforts to coerce or lure them away from the black market. The study, based on 14 projects in eight cities, will employ a variety of research designs, with some based on random assignment of addicts and drugs and others based on evaluation of individual needs and drug use patterns. The evaluation will examine the physiological effects of the prescribed drugs, compliance with program requirements, and the impact on drug consumption, physical health, quality of life, and criminality.

We don't see our researchers in the US sending proposals into NIDA for these kinds of approaches, and NIDA is certainly not encouraging anybody to develop them. Why not try those things? Why should certain approaches be off limits? I don't see any ethical reasons for putting them off limits.

Physicians are playing a role in the gun control movement right now. They have defined inner city violence as a public health problem and gun control as a public health strategy.

Has anyone ever heard Vincent Dole talk about what it was like to try to get a program started using oral methadone for maintenance in the '60s? I think it was probably easier then, no matter how hard it was, compared to trying to get some of the harm reduction initiatives forward in the United States today.

Question: *What can a group like ours, and individuals like ourselves, all of whom are working in the addiction medicine field, do in terms of having some influence on public policy?*

EN: This is an area in which policies are bubbling up from the city and local levels to the state, Federal and international. You can push for change at the local city and county levels. In Baltimore, Mayor Kurt Schmoke's Working Group on Drug Policy Reform issued its final report in November 1993 — one that might well provide a model for other cities around the United States. [Editor's note: Copies are available from the California Society office.] It proposes a range of harm reduction measures including expanded methadone availability and needle exchange. It advocates efforts to educate and involve the medical community in sensible and humane approaches to drug addiction. Many recommended approaches involve developing political support within the addiction medicine community and expanding treatment.

Also noteworthy is the Hoover Resolution, a simple call for creation of an independent commission. A resolution by the California Society in support would send an important message.

Question: *Would it not be better for our cause to come up with our own ideas as to what should be done, rather than ask the government to put together another political organization to discuss it, such as the Hoover Resolution does? I think that physicians need to come up with a plan that has medical substance to it, and use this as the background for what needs to be done. Do you have any comments on that?*

EN: I agree. I think groups such as this one should have positions on harm reduction measures—everything from needle exchange to opposition to the criminalization of users—and begin to push for change. In the 1990s, the issue is not about legalization or prohibition, it is about harm reduction. It is about the very good likelihood that this horrible connection between intravenous drug use and AIDS would not have emerged in a non-prohibitionist system. Harm reduction is inherently a public health concept. It should be very comfortable for physicians.

Harm reduction is inherently a public health concept. It should be very comfortable for physicians.

A recent *New York Times* article described the role physicians are playing in the gun control movement right now. They have defined inner city violence as a public health problem and gun control as a public health strategy. Politicians are starting to listen because physicians are an enormously powerful lobbying force in Washington DC. I don't know how powerful you feel as physicians, but certainly the *New York Times* thinks that you are extremely powerful.

There are several examples of where doctors have really laid it on the line by mobilizing their own groups and using their political power to fight for policies which benefit the public health. In some cases they've even gone so far as to practice forms of civil disobedience. The thing that really moved needle exchange along in Australia was when a highly respected doctor, Alex Wodak, MD, defied the authorities and started giving out needles. To the extent that one is doing what one really believes in, in a moral way, I think it opens people's eyes, and can lead to changes. □

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Commentary

US Prohibition Strategies: Are They Working?

-- Ethan Nadelmann, JD, PhD

Our war on drugs—our prohibition strategy—has several dimensions: 1) international control, 2) interdiction on the seas, the skies and the borders, 3) going after the high level drug traffickers, and 4) going after the low level drug dealers. Are they working? Let's look at each one of these in turn and see what you think.

Stop Production at the Source

We know that opium and marijuana grow virtually throughout the world and coca can be grown in a far wider area than is now being used to grow it. Stopping production is not feasible.

The push-down pop-up factor.

This approach is subject to the push-down pop-up factor. We pushed down on opium coming out of Turkey in the early 1970s and it popped up in Mexico. We pushed down there and it popped up in Southeast Asia; we pushed down there and it popped up in Southwest Asia. We've now pushed down so many places that the United States has become a multiple source heroin importing country. We're getting it from all around the world, including Colombia and Guatemala.

Marijuana production, pushed down in Jamaica, popped up in Belize; pushed down there, popped up in Colombia; pushed down there, popped up in Thailand; pushed down there and pops up in the United States. In fact, the countries think we pushed down on them because we wanted to provide trade protection for our local marijuana industries. You may know that the US now produces some of the finest marijuana around the world, and that we are emerging as a major exporter.

In 1993, the Attorney General of Colombia, Gustavo de Greiff, said, "In the end, the only solution for Colombia is legalization, with regulations to control the market." Why? Because he knows that most of Colombia's drug problem is the violence and corruption associated with illegal distribution and the increased demand for a crop which their cultures have incorporated—successfully—for generations.

I heard that somebody from the United States Drug Czar's office went to Bolivia and said to the coca growers, "Don't you realize what you are doing, growing these drugs which are poisoning and killing American youth?" And you know what came back at him: "Don't you talk to me of moral obligations, you delegate from the American Drug Czar's office. My moral obligation is to do the best I can for my family and my community, and if that means growing this coca, this opium, this cannabis, so be it. This stuff has been growing in my neck of the woods for hundreds, if not thousands, of years. My parents and my grandparents and great-grandparents used it without any problems. Don't tell us to stop using this stuff. You learn how to use it. Nobody ever said you had to whip up our coca leaves with other chemicals, and concentrate it to shove it up your nose. Don't think that my moral obligation is to keep your people from sticking a needle into your arm or shoving this stuff up your nose; that's not my moral obligation. And, norteamericanos, please forgive me, but is it correct that your tobacco farmers are being subsidized by your US government and that your trade representatives are flying around Asia and Eastern Europe pushing down trade barriers so you can export more of the most deadly product in the world?"

Interdiction at the Borders

If we can't stop production in other countries, perhaps AWACs can stop the shipments from crossing our borders. We have AWACs which were designed to look for Soviet missiles, but now are focused on drug trafficking airplanes—which as you know are distinctive and carry a sign, "This is a drug trafficking plane," on the side!

The experts estimate that roughly 10 tons of heroin and 200 tons of cocaine come into the United States each year. But you can't find one or even 500 tons of contraband among the billions and billions of tons of goods that come into the United States each year.

I shouldn't say border patrols have been entirely a failure; they have been somewhat successful against marijuana, because marijuana is bulky and smelly—easier to find. The success of stopping marijuana at the border had consequences. It became harder to get and the price went up. The traffickers and the dealers and the consumers switched over to cocaine in the early 1980s. But, it also had unintended consequences. A beautiful series of articles by an ethnographer in New York, Ansley Hamid, shows the transition in Jamaica from the ganja business to cocaine. Jamaica had the social controls to control ganja use but they did not have them for cocaine use. The results were devastating.

Big Drug Traffickers

If interdiction at the border's not going to work and international control's not going to work, what about going after the big drug traffickers? Get the biggest, baddest guys, and seize their assets. Does it make a difference to the availability of drugs or to the harm caused to individuals? No, not really.

"Nobody ever said you had to whip up our coca leaves with other chemicals, concentrate it and shove it up your nose."

Every time you get rid of number one there's a number two that's waiting to step in his shoes. You get number two and three's waiting to step into his shoes. And where do the police get the information to arrest number one? It's from number two because he wants to be number one. The police will all confirm this.

Low Level Traffickers
What about arresting all the street-level drug dealers? Actually, we've done that in a massive way. We incarcerate a number of Americans unprecedented in the history of Western civilization. It's the highest proportion of the American population to be incarcerated in American history, it's the highest proportion of any Western country being incarcerated ever: over 300 per 100,000. Compare that to England, France, Germany and other European countries where the figure averages between 60 and 70 per 100,000.

We now have 25 to 30% of the American prison population incarcerated for an act that our grandparents and great-grandparents could have done entirely legally.

Over 50% of the people in Federal prison are there for a drug law violation. We now have 25-30% of the American prison population incarcerated for engaging in an act—distribution, manufacturing, or possession —that our grandparents and great-grandparents could have done entirely legally.

Larceny, robbery, murder, rape are old crimes. But this one category—violation of the Controlled Substance Act— is a new crime for which we somehow think it is right to incarcerate about 400,000 Americans and put another 500,000 to one million into other forms of criminal justice supervision.

Every day we see the harmful results of prohibition in the forms of crime, violence, overdoses, spread of AIDS and other social ills. Every day we should be asking ourselves if this is what we want; asking ourselves if there is another way. □

The Hoover Resolution

Resolution for a Federal Commission on Drug Policy

WHEREAS, the overall situation regarding the use of drugs in our society and the crime and misery that accompanies it has continued to deteriorate for several decades; and

WHEREAS, our society has continued to attempt, at enormous financial cost and loss of civil liberties, to resolve drug problems through the criminal justice system, with the accompanying increases of prisons and numbers of inmates; and

WHEREAS, the huge untaxed revenues generated by the illicit drug trade are undermining legitimate governments world-wide; and

WHEREAS, the present system has spawned a cycle of hostility by the incarceration of disproportionate numbers of African-Americans, Hispanics, and other minority groups; and

WHEREAS, the number of people who have contracted AIDS, hepatitis, and other diseases from contaminated hypodermic needles is epidemic under our present system; and

WHEREAS, in our society's zeal to pursue our criminal approach, legitimate medical uses for the relief of pain and suffering of patients have been suppressed.

THEREFORE BE IT RESOLVED that our society must recognize drug use and abuse as the medical and social problems that they are and that they must be treated with medical and social solutions; and

FURTHER BE IT RESOLVED that an objective commission be immediately empowered by the President and by Congress to recommend revisions of the drug laws of these United States in order to reduce the harm our current policies are causing.

The California Society's Executive Council voted on March 5, 1994, to endorse this Resolution and to ask ASAM to endorse it.

Zolpidem: An Addiction Medicine Perspective

Donald R. Wesson, MD, Walter Ling, MD, and David E. Smith, MD

Zolpidem (Ambien) is a new imidazopyridine hypnotic marketed by Searle Pharmaceuticals. It is chemically unrelated to the benzodiazepines; however, it binds to the same GABA-BZ complex as benzodiazepines (Byrnes, Greenblatt and Miller, 1992), and its sedative effects are reversed by the benzodiazepine antagonist, flumazenil. Recent case reports from Europe show that zolpidem is subject to misuse and that it may produce a withdrawal syndrome.

Zolpidem is rapidly absorbed and has a short half-life ($T_{1/2}$ = 2.2 hours). Its sedative effects are additive with alcohol. Like triazolam, zolpidem decreases brain metabolism of glucose (Piercey, Hoffman, and Cooper, 1991).

Some investigators suggest that zolpidem does not produce tolerance or physical dependence (Perrault, Morel, et al., 1992). Mice were administered zolpidem or midazolam (both 30 mg/kg) by gastric intubation for 10 days. Animals treated with midazolam, but not zolpidem, showed tolerance to the drug's sedative effects and lowered seizure threshold after the drug was stopped. Further, the benzodiazepine antagonist, flumazenil, precipitated withdrawal in the midazolam treated animals, but not those treated with zolpidem.

Studies with baboons suggest that zolpidem is reinforcing and that it produces tolerance and physical dependence (Griffiths, Sannerud, et al., 1992). In a free-choice paradigm, baboons consistently self-administered zolpidem intravenously at higher rates than either the vehicle solution alone or triazolam. After two weeks of zolpidem self-administration, substitution of vehicle alone resulted in suppression of food pellet intake, which the investigators interpreted as zolpidem withdrawal. Baboons trained to discriminate either oral doses of phenobarbital (10 mg/kg) or lorazepam (1.8 mg/kg) from placebo responded to zolpidem as though it were an active drug more than 80% of the time. In another experiment, animals developed tolerance to zolpidem induced ataxia and sedation over seven days of drug administration. The investigators concluded that the rates of self-administration of zolpidem were similar to pentobarbital and higher than those maintained by 11 benzodiazepines that they had studied.

It is chemically unrelated to the benzodiazepines; however, it binds to the same GABA-BZ complex as benzodiazepines.

Case Reports

Zolpidem has been available in Europe for several years. Two recent case reports from Italy (Cavallaro, Regazzetti, Covelli and Smeraldi, 1993) of dosage escalation and possible withdrawal add concern that zolpidem might be subject to misuse here and that it has a withdrawal syndrome similar to other sedative-hypnotics.

A 60-year-old woman with a past history of triazolam misuse and a withdrawal seizure was admitted to a hospital following an apparent zolpidem overdose. On admission she was disoriented, dysarthric, and had an unsteady gait. Because of agitation, she was given promazine 60 mg in the hospital.The following morning she was oriented and cooperative. However, she was also tremulous and had muscle twitching and myoclonic jerks, and reported diplopia, abdominal pain and swallowing difficulties. She was amnesic for the psychotic episode. It was later discovered that for the previous two months she had been using up to 100 mg of zolpidem nightly. Eighteen hours after she took the last zolpidem, she had a seizure.The patient reported a history of waking up two to three hours after taking her nightly zolpidem. During the day, she reported having anxiety, tremors, sweating, nausea, difficulty swallowing, and abdominal pain. The patient attributed her symptoms to lack of sleep.

A 31-year-old woman with residual insomnia following a previous major depressive episode was being treated with zolpidem 20 mg daily. After several months, she began awakening about three hours after her dose, and she increased the nightly zolpidem dose to 40 or 50 mg. During the day she had sweating, tachycardia, tachypnea, tremors and severe anxiety, which she began to self-medicate with zolpidem. After her dose escalated to 70-80 mg daily, she began having myoclonic jerks and consulted her psychiatrist. She was treated with diazepam 4 mg daily and withdrawn from the zolpidem over one month. There was no mention in the case report of previous sedative-hypnotic misuse or abuse.

These case histories illustrate significant tolerance to zolpidem and the rapid production of withdrawal symptoms that might be expected from a potent, short-acting sedative-hypnotic. The package insert for Ambien is noncommittal on the subject of dependence and withdrawal. "The US clinical trial experience from zolpidem does not reveal any clear evidence for withdrawal syndrome. ...available data cannot provide a reliable estimate of the incidence, if any, of dependency, or the relationship of any dependency to dose and duration of treatment" (PDR 1994, p. 2191).

Efficacy trials of sedative-hypnotics do not typically reveal much about dependence and withdrawal because dosage is carefully controlled, and people with a history of alcohol or other sedative-hypnotic misuse or dependence

are usually excluded from participating. Only after the drug is marketed do patients with a history of drug abuse or misuse get relatively unlimited access to the drug.

Psychotic Reactions

A report from Belgium describes two cases of transient psychosis following the first dose of 10 mg of zolpidem (Ansseau, Pitchot, Hansenne, Moreno, 1992). Neither patient had a history of drug abuse or misuse, and neither was using alcohol at the time. Both patients experienced a transient psychosis with visual hallucinations beginning 20-30 minutes following 10 mg of zolpidem. Both patients have previously used benzodiazepines without difficulty and both were amnesic for the psychotic episode.

A report from Spain (Iruela, Ibañez-Rojo, Baca, 1993) describes a 20-year-old woman with severe anorexia who became terrified by visual hallucinations and illusions 20 minutes after a 10 mg dose of zolpidem. Unlike the patients previously described, she had full recall of the psychotic episode. A week later, she took a 5 mg dose of zolpidem and experienced a similar episode of reduced intensity. A week later, she took 2.5 mg and again experienced visual distortions.

Conclusion

Zolpidem has been on the market only a short time in the US. The European experience gives reason to be cautious about giving zolpidem to patients who are recovering from alcohol or drug dependence and to be on the lookout for cases of misuse or abuse. □

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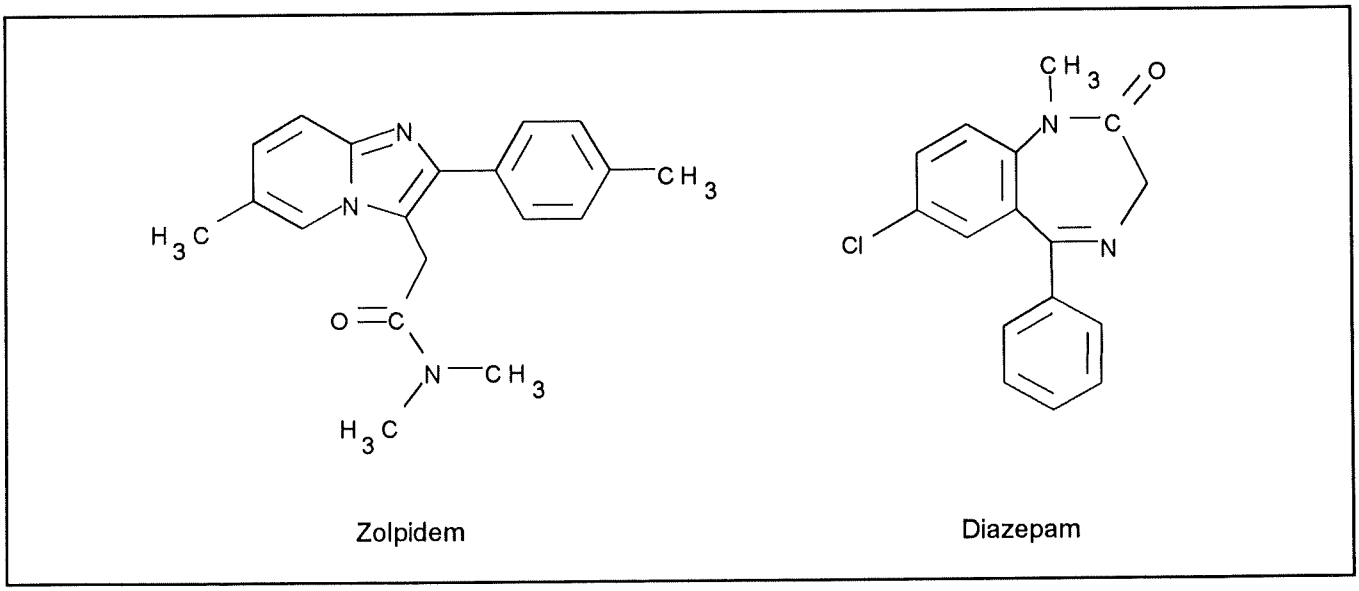

Zolpidem Diazepam

The Concept of Dependence: Historical Reflections

Jerome H. Jaffe, MD

Editor's Note: Alcohol Health & Research World *is a quarterly publication of the National Institute of Alcoholism Abuse and Alcoholism (NIAAA). This article appeared in the issue received in March—Vol 17, No 3, and is reprinted here as a helpful overview of the definitions given to the clinical entities seen in practice.*

The Old and New Testaments warn against drunkenness (although not against alcohol use per se) and link it with sinful behavior; Islam bans alcohol use entirely. Throughout history, the basic moral perspective has been that excessive use of alcohol is a willful act that leads to intoxication and other sinful behaviors. This perspective now competes with another view, which began to emerge in the 18th century, that excessive use of alcohol is a disease or disorder.

The present day view of alcoholism as a medical or mental disorder did not emerge fully developed, but has evolved progressively, and with considerable controversy, over the past 200 years. Benjamin Rush, a founder of American psychiatry, and Thomas Trotter, a British physician writing in the early 19th century, were among the first to advocate that excessive alcohol use is a disorder. "The habit of drunkenness," as Trotter put it, "is a disease of the will" (Edwards, 1992). Late 19th-century physicians viewed the habitual use of drugs (such as opiates, tobacco, and coffee) as a generic disorder stemming from biological vulnerability, either inherited or acquired. This early view of addiction as an illness was used to support advocacy for publicly funded treatment programs such as "inebriate asylums" and homes.

The Temperance Movement and the physicians who championed the disease concept of alcoholism agreed in viewing drunkenness as a serious problem. However, the physicians emphasized the need for treatment, whereas Temperance leaders saw alcohol itself as the cause of the problem and advocated control—and, eventually, prohibition—of its availability (Edwards 1992).

Prohibition, in the United States, dampened scientific interest in the nature of alcoholism, an interest that revived toward the mid-20th century with the rise of Alcoholics Anonymous, the publications of EM Jellinek, and the establishment of the Yale Center for Alcohol Studies (Edwards 1992). The early 1960s witnessed a growing acceptance of the notion that, in certain "vulnerable" people, alcohol use leads to physical addiction—a true disease.

The Disease Concept of Alcoholism

Central to this disease concept of alcoholism were the roles of tolerance and physical dependence, usually considered hallmarks of addiction. Tolerance indicates that increased doses of a drug[1] are required to produce effects previously attained at lower doses. Physical dependence refers to the occurrence of withdrawal symptoms, such as seizures, following cessation of a drinking bout.[2]

Although Jellinek (1960) recognized that alcohol *problems* could occur without alcohol *addiction*, the problem of addiction moved to the center of scientific focus. According to Room (1983), the reemergence of the disease concept of alcoholism was the result not of new scientific findings but of humanitarian efforts to shift the focus from blame and punishment of the alcoholic to treatment and concern.

Alcoholism was included in the first edition (1952) of the American Psychiatric Association's (APA) *Diagnostic and Statistical Manual of Mental Disorders* (DSM-I). The second edition of the manual (DSM-II, 1968) followed a precedent set by the World Health Organization's (WHO) *International Classification of Diseases, 8th Revision* (ICD-8), 1967), and included three subcategories of alcohol-related disorders: alcohol addiction, episodic excessive drinking, and habitual excessive drinking (Keller and Doria, 1991; Schuckit et al., 1991).

Both DSM-II (1968) and ICD-8 (1967) implied that alcohol use disorders were either secondary to an underlying personality problem or a response to extreme psychological distress.

The Diagnostic Criteria for Use in Psychiatric Research were published by Feighner and colleagues in 1972. Criteria for alcoholism included withdrawal symptoms, loss of control, severe medical consequences, and social problems. The National Council on Alcoholism (NCA), the same year, also outlined criteria for diagnosing alcoholism, emphasizing tolerance, physical dependence, and medical consequences. The NCA criteria considered alcoholism an inde-

[1] Throughout this article, the term "drug" is used to include alcohol.

[2] As a general term, "dependence" refers to addiction; thus, "alcohol dependence" is a synonym for "alcoholism."

pendent disorder, not merely a manifestation of an underlying personality problem (Keller and Doria 1991; Schuckit et al., 1991).

The relevance of the disease model of alcoholism as the primary focus for health programs was challenged by a 1977 WHO report. The report observed that not everyone who developed alcohol-related problems exhibited true alcohol dependence (Edwards et al., 1977). This observation provided support for policies aimed at reproducing overall alcohol consumption instead of just promoting abstinence among vulnerable individuals. The report described the alcohol dependence syndrome itself as a learned phenomenon, not "an all-or-none disease state, but...a condition which exists in degrees of severity" (Edwards 1992, p. 9).

The 1977 WHO report gave further momentum to the changing perspective on drug dependence. For more than a decade, at least one pharmacology textbook had put forth the views that addiction (dependence) existed along a continuum of severity, and that physical dependence was but one factor contributing to the development of compulsive drug use (Jaffee 1965). The desirability of specific criteria, the distinction between dependence and drug-related problems that do not involve dependence, and the notion of a continuum of dependence all formed the intellectual context in which the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III) was developed in 1980 (Schuckit et al., 1991).

Evolving Criteria for Dependence

The original drafts of DSM-III provisionally described a dependence syndrome for alcohol and other drugs that varied in degree of severity and in which tolerance and physical dependence were important, but not essential, criteria for diagnosis. Such was the inertia of the past that at the last moment, it was decided to make tolerance and physical dependence both necessary and sufficient to diagnose dependence. However, by distinguishing dependence from abuse, DSM-III began to recognize the conceptualization put forth in the WHO report of 1977 (Schuckit et al., 1991).

A 1981 WHO memorandum (Edwards et al., 1981) endorsed the concept of drug dependence as a syndrome that exists in degrees and that can be inferred from the way in which drug use takes priority over the user's previous life values. The memorandum, while recognizing the importance of tolerance and physical dependence, did not view these phenomena as always essential and required for diagnosis of drug dependence. The memorandum also endorsed again the so-called two-dimensional perspective that harmful or hazardous use can occur independently of dependence.

Both DSM-IV and ICD-10 recognize that not all drug-related problems reflect dependence syndromes.

DSM-III was revised in 1987 (DSM-III-R), based on DSM-III and the 1981 WHO memorandum. The revision presented nine criteria for a generic dependence syndrome, in which the presence of three criteria indicated some degree of dependence. Neither tolerance nor physical dependence was a required criterion. Meeting more than three criteria indicated a more severe degree of dependence. Drug abuse was a residual category to designate drug-related problems when dependence was not present (Schuckit et al., 1991).

The DSM-III-R criteria for dependence were controversial. Many years of emphasis on physical dependence and tolerance as evidence of a "true disease" left many clinicians believing that changing these criteria from their "necessary and required" status, as in DSM-III, was a mistake that greatly and erroneously broadened the category of dependence. Much of the focus of the developers of the fourth edition of the DSM (DSM-IV) was on how best to restore the primacy of physical dependence and tolerance in the diagnosis of drug and alcohol dependence.

The draft fourth edition of the DSM, recently approved by APA, presented seven criteria for alcohol and other drug dependence; three are required for a diagnosis. Tolerance and withdrawal are listed first but are not required. However, the clinician is required to specify whether either tolerance or withdrawal is present (American Psychiatric Association Task Force on DSM-IV, 1993).

The framers of the 10th revision of the ICD, however, did not waiver. ICD-10 continued the evolution begun in ICD-9 and adhered closely to the concepts of dependence outlined in the 1977 WHO report and 1981 WHO memorandum. The final draft of ICD-10 included a generic model of drug dependence with similar criteria for alcohol, tobacco, opioids, and other drugs that affect the brain. In other ways as well, the ICD-10 criteria for alcohol dependence and alcohol-related problems differ somewhat from those in DSM-IV. Like DSM-IV, ICD-10 presents several criteria (six) for determining the presence of the alcohol dependence syndrome; at least three of these must be present to judge that the syndrome is present to some degree (Grant and Towle, 1991).

ICD-10 does not include a diagnostic category of alcohol or other drug abuse but instead includes a category of harmful use—a pattern of use that causes damage to mental or physical health. In contrast to DSM-IV, which defines alcohol or other drug abuse as a pattern of use leading to social, legal, or family problems, ICD-10 states that "the fact that a pattern of

use of a particular substance is disapproved or may have led to socially negative consequences, such as arrest or marital arguments, is not itself evidence of harmful use" (WHO, 1992, p. 75).

DSM-IV has been criticized for using some of the same criteria for defining abuse as for defining dependence, thereby giving less clear-cut support to the two-dimensional perspective than does ICD-10 (Grant and Towle, 1991). Nevertheless, both DSM-IV and ICD-10 recognize that not all drug-related problems reflect dependence syndromes.

Despite the seeming consensus among health professionals, the moral perspective of alcoholism is still very much alive. In 1992, the Reverend JE Todd wrote an essay entitled "Drunkenness a Vice, Not a Disease" (Keller and Doria, 1991). Almost precisely the same thesis has been put forth more recently by Fingarette (1988) and Peele (1989). As late as the mid-1970s, sociologists had noted that the term "alcoholic" is commonly used in the United States as a synonym for "drunkard," rather than as a designation for someone with an illness or a disorder. In the mind of the average person, the concepts of alcoholism as a disease and the alcoholic as "morally weak" can apparently coexist quite comfortably. □

Jerome Jaffe, MD, is director of the Office of Scientific Analysis and Evaluation, Center for Substance Abuse Treatment (CSAT).

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Useful New Series from CSAT

The Center for Substance Abuse Treatment (CSAT) is publishing an excellent new series of manuals called Treatment Improvement Protocols (TIPs). Six manuals are available now; more are in preparation.

1. State Methadone Treatment Guidelines
2. Pregnant, Substance-Using Women
3. Screening and Assessment of Alcohol- and Other Drug-Abusing Adolescents
4. Guidelines for the Treatment of Alcohol- and Other Drug-Abusing Adolescents
5. Improving Treatment for Drug-Exposed Infants
6. Screening for Infectious Diseases Among Substance Abusers

A TIP, entitled *Detoxification from Alcohol and Other Drugs,* is in preparation. It covers acute abstinence syndromes, short-term (30 days) withdrawal as well as discontinuation of medications such as benzodiazepines, methadone and LAAM. Prolonged withdrawal is not covered here. Donald R. Wesson, Walter Ling and David E. Smith are members of the consensus panel. Doctor Wesson is the panel chair.

Each TIP is written by a consensus panel comprised of 10-15 non-Federal employees nominated by CSAT, state departments of alcohol and drugs, and the panel chairperson. The panelists try to achieve consensus about what constitutes best, reasonably attainable, clinical practice. They are assisted by a writer-editor working under contract to CSAT who hosts the meetings and prepares a draft manual for review by the panel members and approval by the chair.

Unlike the NIDA monographs, which are unedited collections of papers of value primarily to drug abuse researchers, TIPs are targeted to practicing clinicians, alcohol and drug abuse administrators, and drug abuse policy planners. Fortunately for us, most of the content is clinically focused and provides an excellent summary of current practices. Except for tables, graphics, and long quotes that were used from copyrighted sources, the content of the TIPs is in the public domain and can be reproduced or copied without permission (with, of course, appropriate attribution to the source).

The title, *State Methadone Treatment Guidelines,* is misleading. It is an excellent compendium of clinical practice and Federal law related to methadone maintenance. Every physician who works with methadone should obtain a copy.

TIPs are published in 8½ x 11" format and come in two versions: one, intended for clinicians, is three-hole punched, to put in a binder to which the clinician can add new or related information. The other is bound. The manuals are printed by the Government Printing Office; single copies are available without charge from the National Clearinghouse, PO Box 2345, Rockville, MD 20847-2345. Call 800-729-6686. □

— Richard S. Sandor, MD

From the Committee on Research

Clinical Research Projects

The best way to achieve credibility is to provide peer-reviewed, reproducible data on what works and what doesn't. Taking that as a theme, the CSAM Committee on Research is promoting small clinical studies, and encouraging members to design and conduct one in their own practice setting.

Here is an example. In our hospital we are currently studying the prevalence of hepatitis C virus (HCV) in patients undergoing ETOH rehabilitation. This infection, which is seen in over 20% of IV drug users, is parenterally transmitted. However, it is also seen in up to 20% of alcoholics without classic HCV risk factors. Since HCV has significant mortality from cirrhosis, and because it can sometimes be treated in its early stages, detection is of interest. Our study looks at the ability of the admitting

Simple studies asking basic questions can lead to significant advances in patient care.

physician to predict the likelihood of the presence of HCV based on drug history, social history, socioeconomic status, routine liver studies and physical examination. The question we are posing is: what is the sensitivity of clinicians in predicting HCV positivity? Physicians will be asked to complete a questionnaire on these variables and will be asked to predict each patient's "risk" for being HCV+. These predictions will then be compared to the results of HCV serologies. Serology results will be made known only after the rating forms are completed. We hope to discover 1) how well (or poorly) physicians can predict HCV in chemically dependent patients, and 2) the prevalence of HCV in a private treatment population. We expect this information to bring us closer to agreement on guidelines on criteria for ordering an HCV antibody serology.

Every member of this Society has the "resources" to do practical clinical studies. The major resource is our patients. Any patient population can be studied. The trick is to study what is common in the study population. Simple studies asking basic questions can lead to significant advances in patient care. The Committee on Research stands ready to help you design a study and present your data at the CSAM annual meeting in November 1994.

If our Society is to prosper and grow, we need to incorporate a research agenda. We look forward to hearing from you about yours. □

— Kevin W. Olden, MD

The Medical Board of California's Diversion Program

California's Diversion Program for MDs enters its 14th year with a renewed emphasis on CQI — continuous quality improvement — and a new (since mid-1992) level of participation for physicians who enter the Program when there is a complaint under investigation by the Board: "informal participation."

At the close of its 13th year, the Program reported that 439 physicians had completed it successfully, 130 had been terminated because they were not complying with the requirements of the Program, another two were put on MBC probation, three licenses were revoked, three licenses surrendered, and 10 had died of substance abuse-related causes.

Twenty five are currently in the application process and 231 are active participants.

Informal Participation

If there is a complaint about a physician in the Board's computer, the physician will not be allowed to sign a formal contract with Diversion; rather, with the approval of the Deputy Chief of Enforcement, the physician may participate in the Diversion Program "informally" — that is, without an agreement. All other aspects of particpation are the same. Both formal and informal participants have the same access to the services of the Diversion Program while investigation and/or prosecution continues. The physician is, however, not diverted in lieu of discipline. When the investigation is complete, a recommendation is made to the Deputy Chief either to prosecute or refer for formal diversion. (Copies of the materials distributed to the Liaison Committee for background on this issue are available from the California Society office.)

CQI

The call for quality improvement/quality assurance which arose from testimony before the Medical Board's Task Force on Diversion (see CSAM *NEWS*, Fall 1993, p. 18) got a positive reception at all levels of the MBC, although members of the CMA/CSAM/MBC Liaison Committee expressed serious doubts about the wisdom of imposing additional paperwork, more standards and new scrutiny on the Program; they said they feared it would have a serious negative impact on a program which they felt had been obviously successful in turning around the lives and careers of many physicians. "You might inadvertently kill it," said one member of the Liaison Committee at the meeting in December.

Nonetheless, the recommendations were modified into an implementation plan prepared by Chet Pelton and presented to the Board on February 4th. The quality improvement/quality assurance aspects of that plan rest in eight new policies and practices which are the response to the recommendations made by CSAM to the Liaison Committee in September.

1. Each physician applying to Diversion will have a comprehensive evaluation performed by a qualified physician. The DEC should make a diagnostic formulation at the first meeting with the physician.
2. The group facilitator should maintain a record for each physician in Diversion in accordance with the community standard and practice in counseling.
3. The case manager (formerly called the compliance officer) should have a current clinical record for each physician in Diversion.
4. The case consultant (a member of the DEC assigned to the physician in Diversion) should have a copy of the records with the current problem list, and should refer to it when discussing the physician over the phone with the Diversion staff.
5. Meetings of the Chairs of the DECs should be reinstituted for the purpose of standardizing the role played by the case consultants and the methods they use.
6. Each Group Facilitator will have a qualified clinical supervisor who has knowledge and experience in clinical supervision and chemical dependence. In addition, the Diversion Program staff will have a licensed therapist who has oversight of the facilitators.
7. The performance of case managers should be the subject of quality improvement activity. A list of indicators of quality (or measures) will be developed. The role and functions of the case manager should be carried out for the joint purposes of a) protecting the public and b) keeping the physician in Diversion and progressing toward treatment goals.
8. Follow-up studies should be conducted with all physicians who contact Diversion. □

— Gail B. Jara

Diversion Program for DOs

The Diversion Program of the Osteopathic Medical Board is entering its sixth year. It is operated by Occupational Health Services as part of a joint contract for diversion programs for seven healing arts boards: osteopathic physicians, dentists, pharmacists, registered nurses, vocational nurses, physical therapists, and physician's assistants.- The Program is open to any of the 1300 licensed DOs residing in California. Linda Bergman, Executive Director of the Osteopathic Medical Board, said that all information with the program is confidential, and not accessible for disciplinary purposes. The Program uses a 24-hour toll-free number: 800-522-9198.

There are currently eight participants and one three-member Diversion Evaluation Committee which meets quarterly. The three members are Karen Lea Sees, DO, Charley Maynard, DO, and Colleen Hunsaker, DO. □

Proposed Guidelines

Prescribing Controlled Substances for Pain

The Medical Board of California (MBC) is considering development of new guidelines for appropriate prescribing of controlled substances to replace, or update, the guidelines issued jointly with the California Medical Association in 1985.

On March 18th, the State held a Summit Meeting on Effective Pain Management to bring together interested agencies and organizations ("stakeholders") and experts in a day-long discussion of the issues. At that Summit, Karen Sees, DO, was invited to address the following issues/questions (quoted from the agenda):

> Several provisions of California Law appear to be outdated or unclear, especially in light of current understanding of pain management and addiction. Are references to "addict" and "habitual user" outdated and confusing? Is it appropriate to bar the prescribing of controlled substances to anyone in pain, including "addicts" and "habitual users"? Is the "clearly excessive" standard for prescribing or dispensing an impediment? Does it add anything not covered by other provisions of law?

H. Westley Clark, MD, JD, MPH, was invited to address these issues/questions:

> Health care professionals often do not prescribe appropriately for pain, in part due to a perception that they may be investigated and prosecuted for excessive prescribing. Are there regulatory policies or procedures that inhibit the delivery of effective pain management? Can they be revised without interfering with law enforcement and regulatory actions against diversion of drugs to the street and against drug abuse?

The Board's interest in new or revised guidelines for prescribing is an outgrowth of a focus on under-prescribing or under-treating pain, both acute and chronic or intractable pain. Also, the Board and the Federal and state enforcement agencies continue to study ways to control inappropriate prescribing by "script doctors" (the dated, duped, or dishonest physician). "New guidelines should keep enforcement from becoming an impediment to appropriate and compassionate treatment of pain patients. The Medical Board will work with DEA and the State Bureau of Narcotic Enforcement and the Board of Pharmacy to develop policy and guidelines [for enforcement] based on the physician's diagnosis and treatment program, rather than amounts of drugs prescribed," according to a statement being circulated by the Board for comment. (Copies of the statement are available from the California Society office.) "The Board hopes to replace practitioners' perception of inappropriate regulatory scrutiny with recognition of the Board's commitment to enhance the quality of life of patients by improving pain management while, at the same time, preventing the diversion and abuse of controlled substances." □

CSAM Activities

Physician Education Project about Perinatal Substance Use and Dependence

CSAM has begun a project to coordinate training and consultation services for California physicians about substance use, dependence and addiction in women of childbearing age, particularly pregnant women and new mothers. The objectives are:

- to increase the physician's sensitivity to chemical dependence,
- to teach a brief intervention and referral technique,
- to alert physicians to the unique opportunity for intervention during pregnancy, and
- to focus on appropriate management of the pregnant woman and the newborn, with consultation from specialists as needed.

The first activity is to define core curriculum and syllabus for a brief (60-90 minute) module for primary care physicians who see women of childbearing age, and to present it to physicians in a variety of settings. The project will identify knowledgeable physicians throughout the state who will be available for teaching and case consultation. We expect to leave in place a network of consultants who will continue to meet together as a journal club or special interest group and who will continue to be available for consultation. Interested physicians should contact the CSAM office.

The **Committee on Education** is exploring the design of a conference for psychologists, nurses, counselors and others who provide treatment for chemical dependence. Barry Rosen is preparing a report to the next meeting of the Committee on June 4. Interested members are invited to contact him at 415/367-5504.

CSAM will provide services, under contract, to other societies, organizations or individuals. The Executive Council has agreed to consider contracts for providing administrative services, writing and/or editing, project coordination, meeting planning, or other staff support. For more information, contact Gail Jara at the California Society office. □

President's Column

Realities in Post-Quake Los Angeles

For the second time in a row, it has rained on my efforts to arrange a day off to go trout fishing. I suppose I should be grateful for the water. Among other more important effects, it will keep the streams flowing longer into the summer, but for the moment I can't shake a deep feeling of disappointment. The mountain streams are so beautiful, the fish so willing, and it's so difficult to juggle my schedule and prevail upon a colleague to provide coverage . . . only to be washed out. In Southern California.

Perhaps it's all the more depressing because so much has been going wrong hereabouts lately. By now the Northridge quake of January 17 has become old news. Even with inconveniences of travel due to broken freeways, most people in Los Angeles have returned to life as usual, although some have suffered genuine devastation—loss of home or job, and, in some cases, both.

My hospital, Saint John's in Santa Monica, is putting on a brave post-quake face, but the entire north wing has been condemned and will be demolished soon. My office and the Chemical Dependence Center—the oldest hospital-based program in Los Angeles—were on the first floor of that wing.

The day of the quake, it was impossible for me to get to the hospital. Thanks to a gallant friend who did get there, all the patients were discharged and referred or transferred to other programs. The next day workmen began shoring up the walls with 10' x 12' timbers. We brought the day-hospital patients back for groups on the third day after the quake, but just as I was interviewing a prospective outpatient and his wife, the building began to shudder to yet another 4.x aftershock. By the morning of the fourth day, the decision was made to close the building altogether. We were given a few hours to gather our things and evacuate the entire building for good.

Meanwhile, the hospital's public relations folk came up with a catchy new spin-motto on the disaster: "Saint John's will never be the same. We'll be better." But 1700 employees have been laid off, and the number of beds will be reduced by two thirds in the new and improved hospital.

The Ross Mental Health Center, on the other side of a central fountain courtyard from the main hospital, escaped severe damage, and, after several weeks of uncertainty, it now appears that a new version of the CDC will re-open on its second floor. But as the hospital attorney told me, "We view this as an opportunity to re-examine everything." Chemical dependence treatment, already battered by managed care, wasn't a money-maker, and there's no doubt that the program will be scaled back significantly. (And along with it, the role of Medical Director.)

The program at Saint John's had a well-deserved reputation for integrity, a fine staff, and an active alumni association. When the quake hit, we had an inpatient census of 16 (out of 23 beds) and half a dozen day-hospital patients. There were also more than 20 outpatients, and thanks almost entirely to the efforts of that program's primary counselor,

"We view this as an opportunity to re-examine everything."

outpatient treatment was interrupted only briefly. The patients themselves volunteered to host group therapy meetings in their homes.

The shape of the new CDC hasn't yet been determined. What managers remain are boning up on such things as "critical pathways" and "patient-focused care." I am certain that whatever program emerges will be oriented primarily towards outpatient treatment—evening, day, intensive, modified, etc. Actual inpatient beds will be reserved for patients suffering from severe withdrawal syndromes and/or complicating co-morbid conditions (psychiatric and medical), and even then, all hospitalized cases will be intensely reviewed for earliest possible discharge.

I know it's true that every cloud has its silver lining—perhaps that's why I was so looking forward to going fishing. But just now, it seems that even in this there's no escaping one of life's fundamental lessons:

> The best-laid schemes o' mice an' men
> Gang aft agley.
> An' lea'e us nought but grief an' pain,
> For promis'd joy!
>
> Robert Burns, "To A Mouse" (1785)

— Richard S. Sandor, MD

NEWS ABOUT MEMBERS

James Ahern has moved from Lodi to Pioneer, California (in Amador County) and is working as a physician surveyor for JCAHO.

Peter Banys is serving as Interim Chief of Psychiatry at the San Francisco VA.

Charles Becker has left San Francisco General Hospital and UCSF, moved to Snowmass Village in Colorado and is a Professor of Clinical Medicine at the University of Colorado.

Laurie Buchfuhrer is serving as Medical Director for Woman to Woman, a program of the NCADD in the Los Angeles area.

Donald Dougherty was appointed to Diversion Evaluation Committee III in Southern California for the MBC Diversion Program for Physicians.

Linda Grissino Evans is the Medical Director of the Better Living Program, a perinatal substance abuse program, for San Bernardino County. She is also serving as a physician member of a Diversion Evaluation Committee in the Diversion Program for the Board of Registered Nursing.

Dan Ferrigno is serving as Medical Director of General Medical Services for CPC Sierra Vista Hospital as well as Medical Director for the partial hospitalization program of their Chemical Dependency Services.

Gary Jaeger has moved from St. Joseph Hospital in Eureka to become Chief of Addiction Medicine, and Chief of Service for the Chemical Dependency Recovery Program at Kaiser in Carson.

Calinica Semense is now working part-time in the Chemical Dependency Recovery Service at Kaiser in Carson.

Robert McFarlane is Medical Director at The Bethesda Recovery Center in San Diego.

Norman Reynolds is serving as the Medical Director for Westwood in Fremont.

Phyllis Schorr is now Medical Director of the Chemical Dependency Unit of Central Valley Recovery Resources in Ceres.

Karen Sees is now the Chief of the Substance Abuse Treatment Clinic at the San Francisco VA, and Assistant Clinical Professor of Psychiatry at UCSF.

Michael Turek is serving as a consultant to Blue Cross of California.

Theodore Williams is now the Medical Director of Starting Point of Orange County in Costa Mesa. □

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 Richard Sandor, MD, at (310) 392-4644, or write to him in care of the California Society office.

Mikki King Barker, DO, is an addiction medicine physician at the Chemical Dependency Recovery Program at Kaiser in Anaheim. She received her medical degree from the College of Osteopathic Medicine of the Pacific in 1987, and completed a residency in psychiatry at King Drew Medical Center in 1991.

Hale Dougherty, MD, has been Medical Director of the urgent care department of the Gallatin Medical Foundation in Downey since 1992. For 30 years before that he practiced family medicine in Orange County. He graduated from the School of Medicine at the University of Kansas in 1959.

Joan Kotun, MD, a board-certified psychiatrist, is Medical Director of the Martinez VA Substance Abuse Treatment Program and Assistant Professor of Psychiatry in Residence at UC Davis in Sacramento. Doctor Kotun graduated from Albany (NY) Medical College in 1981 and completed a residency in psychiatry in 1985 at the University of Michigan. With NIDA NRSA grant support she completed a post-doctoral fellowship in neuroscience. □

In Memorium

Richard Turner, MD, of Clayton, Georgia, died on February 26 of an acute myocardial infarction while attending a Medical Association of Georgia meeting in Atlanta. He was founder and director of Woodridge and Ridgecrest Hospitals. Doctor Turner was a member of the California Society since 1984.

CONTINUING MEDICAL EDUCATION

6th Annual Western States Regional Conference for Hospital Personnel

CMA Guidelines for Physicians' Well-being Committees

Wednesday, May 11, 1994, 8:30 am to 4:30 pm
Parkview Community Hospital, J. D. Lansing Center, Riverside
Sponsored by the Riverside County Medical Association, CSAM, CMA
Credit: 3.5 hours
Fees: $250 per hospital team of four; $50 for each additional team member. $100 for individuals; $25 for residents and students
Speakers include John Lanier, John Chappel, Kim Davenport, Esq, Donald Gragg, Chet Pelton, Max Schneider, Leland Whitson
For information, contact Nancy Barker at the Riverside County Medical Association, 909/686-3342.

Primary Care Intervention in Substance Abuse

Saturday, May 21, 1994, 8:30 am to 5:00 pm
Cancer Center Auditorium, UC Davis Medical Center, Sacramento
Sponsored by UCD School of Medicine and Medical Center Departments of Family Practice and Psychiatry/Office of Continuing Medical Education, and CSAM
Credit: 7 hours
Fees: $95 for physicians; $75 for non-physicians
Speakers include Nicholas Rosenlicht, William Brostoff, Robin Hansen, Donald Gragg, Edward Callahan, Joan Kotun, Peter Barglow, Ruth Lawrence, Elizabeth Tully
For information, contact UCD Office of Continuing Medical Education, 916/734-5390.

ASAM MRO Course

The Basics of Being an MRO / The Latest on the Science, Rules & Art of Medical Review

Friday, August 26 through Sunday August 28, 1994
Crystal Gateway Marriott, Arlington, Virginia
Sponsored by ASAM
Credit: 4 hours for "The Basics;" 14.5 hours for "The Latest"
Fees: $75 for ASAM members, $100 for non-members for "The Basics"; $450 for ASAM members, $525 for non-members for "The Latest"
Speakers include Ian Macdonald, Donna Smith, Robert Willette, Esq, Alan Jones, Joseph Autry, David E. Smith, Westley Clark, Barbara Johnson, Esq.
For information, contact ASAM, 5225 Wisconsin Avenue, NW, Washington, DC 20015; 202/244-8948.

1994 ASAM Review Course in Addiction Medicine

October 27 - 29, 1994
O'Hare Marriott Hotel near the airport, Chicago
Sponsored by ASAM
Speakers include Carlton Erickson, Edward Senay, John Chappel, Antonio Munoz, Janet Mitchell, Terry Rustin, Tom Payte, Ian Macdonald, Harry Haverkos, David Smith, David Benzer, Anne Geller, Allan Graham
For information, contact ASAM, 5225 Wisconsin Avenue, NW, Suite 409, Washington, DC 20015; 202/244-8948.

CSAM-ASAM Review Course in Addiction Medicine

November 3-5, 1994
Miyako Hotel, San Francisco
Sponsored by CSAM and ASAM
Speakers include Jerome Jaffe, Mel Pohl, Neal Benowitz, Westley Clark, Richard Sandor, David Smith, Steve Eickelberg, Kevin Olden, Carlton Erickson, Tim Cermak, Anne Geller, Barbara Bennett, Donald Gragg
For information, contact CSAM, 3803 Broadway, Oakland, CA 94611; 510/428-9091.
