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Addiction medicine and addiction psychiatry in America: The impact of physicians in recovery on the medical treatment of addiction

CHRISTOPHER R. FREED

Abstract

Two distinct medical disciplines treat addiction in the United States: Addiction medicine and addiction psychiatry. This article argues that physicians recovering from alcoholism or drug abuse played a key role in creating the field of addiction medicine, and that the development of addiction medicine inadvertently contributed to the formation of addiction psychiatry. Addiction medicine's undercurrent of recovery, specifically questions about the knowledge that recovering physicians call on to treat addiction, remains central to an ongoing professional conflict between addiction medicine and addiction psychiatry.

> Man at work has been praised as peaceful, and so have forests, but a detailed study of either will show that conflict can occur without being either swift or bloody.
>
> —WILLIAM J. GOODE (1960:902)

The term addiction medicine is often used by newspapers, magazines, and other media to refer to a broad body of medical and scientific knowledge on substance abuse in which nearly all physicians might have some expertise (e.g., Denizet-Lewis 2006; Katz 2005). Although widespread, this understanding is not accurate. In actuality, two distinct medical disciplines treat addiction in the United States: one is called addiction medicine and the other is called addiction psychiatry.

Addiction medicine was born in 1954 out of "the alcoholism movement" of the mid-twentieth century. The alcoholism movement was a new approach to alcohol addiction that was systematized in the 1940s and 1950s by Alcoholics Anonymous, the Research Council on Problems of Alcohol, the Yale Section of Alcohol Studies, and the National Council on Alcoholism (Johnson 1973; Levine 1978; Page 1988; Page 1997; Roizen 1991; Seeley 1962; White 1998; Wilkerson 1966). Addiction medicine grew rapidly between the 1960s and 1980s, largely due to the efforts of physicians from New York, California, and Georgia to "re-medicalize" addiction. As this article will show, during these formative years, many physicians working in addiction medicine were themselves recovering from alcoholism or drug abuse. They were among the ranks of thousands of former alcoholics and drug addicts who permanently reoriented their careers toward addiction treatment (White 2000a). Today, the field's leading organization, the American Society of Addiction Medicine (ASAM,

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pronounced A-SAM), has about 3,000 members. According to reliable estimates from prominent ASAM officers and former officials, approximately one-third of ASAM's membership is in recovery from addiction.[1]

Addiction psychiatry comes from very different roots. This discipline formally originated in 1985 when a small, influential group of psychiatrists founded their own organization of addiction specialists. The psychiatrists, believing that they could treat addiction far more effectively than addiction medicine physicians, especially those in recovery, were unnerved that "addictionologists" had displaced them at the forefront of treatment. In 1991, addiction psychiatrists successfully persuaded the American Board of Medical Specialties that they possessed a body of specialized knowledge on addiction. This won them subspecialty recognition from the American Board of Psychiatry and Neurology, giving addiction psychiatry substantial status and power over the field of addiction treatment. Addiction medicine, in contrast, holds no specialty or subspecialty status in organized medicine.

This article stems from a larger sociological and historical research project analyzing the development and current training and treatment practices of addiction medicine and addiction psychiatry. In the course of conducting pilot interviews for that research, the topic of physicians in recovery who provide addiction treatment surfaced, and did so in nearly 24 subsequent interviews without my initiating the subject. (See the appendix for a complete discussion of data collection and analysis.) Accordingly, this article argues that physicians in recovery have played a key role in creating the field of addiction medicine in America, and that the development of addiction medicine inadvertently contributed to the formation of addiction psychiatry. It suggests that questions about the type of knowledge which physicians in recovery call on to treat addiction are central to an ongoing professional conflict between addiction medicine and addiction psychiatry over what Goode (1960) labels the "right to responsibility" for the medical treatment of addiction.

The first reformed physicians to treat addiction

Physicians who were reformed drunkards first became prominent in the late nineteenth and early twentieth centuries (White 2000b). Starting in 1891, the Keeley Institutes, famous for their mysterious and likely phony Double Chloride of Gold remedy for alcohol and drug addicts, employed as many as 131 doctors with a history of addiction to alcohol, opium, morphine, or cocaine. Most of these physicians were hired between 1891 and 1894, and a majority took to their medical duties within one year of having been treated themselves—"many did so within a few weeks or months" (White 2000b:5).

These physicians ignited a controversy. Some doctors, chiefly superintendents of inebriate asylums like T. D. Crothers, did not approve of reformed drunkards as treatment providers. Crothers sought to professionalize addiction treatment, and cure institutes like Keeley's competed with inebriate asylums for patients, proceeds, and medical credibility (White

[1]That addiction medicine was born out of the alcoholism movement is apparent to the addiction medicine and addiction psychiatry fields, but not much beyond the medical and addiction treatment industry. Although there is a vast body of literature on addiction among physicians, as far as I have been able to determine there is very little scholarly work about physicians working in contemporary addiction medicine who are recovering from their own addiction. I have revealed this hitherto private knowledge because it is essential to understanding the development of both addiction medicine and addiction psychiatry.

2000b). Crothers (1897, in White 2000b) claimed that inebriate and addicted physicians like those cured and hired by Keeley were mostly incompetent, with physical and mental "deficits" that severely limited their medical abilities. He argued that the medical treatment of addiction could not be professionalized or profitable with this unreliable contingent of ex-drunkards in the discipline. As White (2000b) reports, "a debate raged in the 19th century between those who believed that recovering addicts brought special knowledge and sensitivities that could enhance their work in addiction treatment, and those who believed that the recovering addict brought vulnerabilities that outweighed any such assets" (p. 9).

By the 1920s, the debate over what role, if any, reformed physicians should have in addiction treatment was silenced by the Eighteenth Amendment and national alcohol prohibition. With beverage alcohol banned throughout the United States, prohibitionists argued that drunkards would disappear, making treatment unnecessary and obsolete. That hope was illusory and debate over the role of previously addicted physicians as providers of addiction treatment resumed after prohibition's repeal, especially in the second half of the twentieth century.

The addictionologists and the rise of addiction medicine[2]

Despite frequent bouts of beavy drunkenness, in 1953 G. Douglas Talbott finished his medical residency in cardiology and internal medicine at the University of California, San Francisco. Having damaged his health, family life, and professional reputation just as his career was starting, Talbott was sent to several psychiatric hospitals for treatment. Finally be was committed to Dayton State Hospital in Ohio where he was housed with the criminally insane and endured physical and emotional assaults (Talbott 1998). But as Talbott (1998) explained years later, something else happened there:

> I will never forget lying there bleeding, in severe pain, and even suffering through the humiliation of being urinated on. I kept thinking, God, where are you? Lying on the floor that night, I clearly remember making a vow to myself that if I ever got out of this place alive, I would dedicate my life to helping doctors and other health care professionals in this situation. I vowed I would find a way to help suffering doctors like myself and dreamed of one day creating a place where healers could be healed (p. xvii).

Talbott had experienced a "spiritual awakening" that was strikingly similar to the "bot flash" reported by Alcoholics Anonymous (AA) co-founder William Griffith Wilson and "the light" seen by Marty Mann, founder of the National Council on Alcoholism (see Alcoholics Anonymous World Services, Inc. [1957] 1971; Alcoholics Anonymous World Services, Inc. 2001). Talbott attributed his sobriety to his family and a Catholic priest who renewed his spiritual faith and convinced him to join AA. This priest also supported Talbott's decision to leave cardiology and internal medicine in order to learn more about alcoholism (Talbott 1998).

[2]All interview respondents are identified in the text by assigned code: AM = addiction medicine physician; AP = addiction psychiatrist: AM/AP = certification in addiction medicine and addiction psychiatry; AMO = former addiction medicine official; APO = former addiction psychiatry official; and ABPNO = American Board of Psychiatry and Neurology official. The number adjacent to each coded respondent designates the order in which he or she was interviewed.

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By the mid-1970s, Talbott's treatment program for impaired physicians, the Disabled Doctors' Plan, was up and running in Georgia. Based on AA, this program featured one month of inpatient care followed by another month of outpatient work and two months of addiction treatment apprenticeship under former disabled physicians (Sargent 1985; Talbott, Richardson, and Atkins 1977). A similar program at the Talbott Recovery Campus in Atlanta, Georgia also stressed the spiritual development of patients during and after treatment. In keeping with "step two" of AA's Twelve Steps of recovery, Talbott and his associates believed that "without surrender to [a spiritual] force, alcoholics and drug addicts continue to attempt recovery alone and thus feel in control, isolated, and sick. As a consequence, many of them experience relapse" (Angres, Talbott, and Bettinardi-Angres 1998:96).

Like Talbott himself, the graduates of Talbott's impaired physicians programs were inspired by their own recovery from addiction to reorient their careers to care for other alcoholics and drug addicts. "These people came out bonded into AA," said an addiction treatment expert familiar with this history. "And many of these people—surgeons, obstetricians, anesthesiologists … internists, family physicians—decided that they wanted to work in the field of addiction" (AM/AP-19). Years later Talbott (1988) himself wrote that "most [state-run treatment] programs were initiated by physicians who were in the recovery phase of their disease" (p. 216).

One serious problem faced by these physicians in recovery was that alcoholics and drug addicts were stigmatized as social deviants, even when they recovered or reformed. This stigma remained strong in the 1970s despite declarations by the American Medical Association (1956; 1967) that alcoholism was a treatable illness. Additionally, organized medicine, virtually system-wide, considered most or all addiction treatment a misappropriation of precious time and resources. Acute care hospitals, chronic care hospitals, and private practice groups were indifferent to addiction treatment and often unwilling to employ Talbott's former patients to provide it.

In response, in 1975, Talbott formed a loosely structured organization called the American Academy of Addictionology comprised mostly of his former patients. As one interview respondent further explained, "they called themselves 'addictionologists' and they began spreading out around the country founding treatment programs for professionals, but also for others as well" (AM/AP-19). According to one former Academy officer and physician in recovery, "in the very beginning, 90 percent of us [in the Academy] were recovering, so we had a passion built out of our own illness, and I don't think that there is any question that that was a very powerful factor in getting these people together" (AM-11). Just as significant was Talbott's desire to credential physicians in recovery as addiction treatment specialists and "to start a specialty" (AMO-1) in addictionology that would be recognized by the American Board of Medical Specialties.

In the mid-1980s, members of Talbott's Academy joined the American Medical Society on Alcoholism and Other Drug Dependencies, the forerunner to today's American Society of Addiction Medicine (ASAM). Yet Talbott's physicians were not the only doctors in recovery who were attracted to addiction medicine and ASAM during its formative years. In 1973, the

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American Medical Association's Council on Mental Health issued a report on alcoholism and drug dependence entitled "The Sick Physician" (American Medical Association Council on Mental Health 1973). This report gave birth to the "impaired physician movement," or what one observer described as "a necessary reaction to the conflicts inherent in the healing profession's attempt to heal its own" (Sargent 1985:295). Within this movement to help addicted physicians (and to protect organized medicine and patients from them), some doctors like Talbott "[were] of the mind that every physician who fell to alcohol and drug abuse needed to become an addiction [medicine specialist]" (AM-10). As such, former physician-addicts increasingly encountered one another at ASAM events. One recovering physician talked about a late 1980s review course for ASAM's certification exam where there was an AA meeting in the basement of the hotel hosting the event:

> There were probably 150 of us in that course…. So I showed up for [the AA meeting], being a recovering person myself, and almost everyone from upstairs was downstairs. Out of the 150 who were there [for the review course], I would say there were about 120 in that [AA] meeting, which was a real eye-opener. So the first five or ten years that I was doing this, most of the other doctors that I talked to were like me—they were just old drunks who sort of got into the business sideways (AM/AP-22s).

Since 1986, ASAM has administered its own certification exam "to identify those physicians [recovering or not] who, by testing, have shown a mastery of the body of knowledge … amassed in [the] field" (Schnoll, Durburg, Griffin, Gitlow, Hunter, Sack, Stimmel, deWit & Jara 1993:132). Another physician in recovery characterized the doctors who took the ASAM exam in the early years as "a crazy bunch of people" from disparate medical backgrounds:

> [There were] anesthesiologists galore … [and] a handful of people who were pathologists who didn't deal with 'live ones' at all. We even had a couple of forensic pathologists which I thought was great sport. Can you think of better people to be counseling you? But there they were. So it's been a grand hodge-podge (AM-6).

Estimates vary as to the proportion of recovering physicians in this alleged "hodge-podge," but it was probably high. Indeed, physicians in recovery were drawn to addiction medicine —and ASAM in particular—for many reasons. One of the most important reasons, in keeping with Talbott's aspirations for the field in general, was their hope for a medical credential.

Recovery, residency, and medical specialty status

Addiction can so thoroughly spoil a medical career that physicians who get sober need to "start up fresh in something" (AM-5). Younger physicians can begin residency training anew. But for some of them, and for most older doctors who recovered in their forties and fifties, starting or continuing residency training that was disrupted by addiction was difficult, costly, and time-consuming. Not completing a residency, however, came with serious professional consequences.

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To be a "board certified" medical specialist in any field, physicians must complete a residency training program approved by the Accreditation Council for Graduate Medical Education. After doing so, they are eligible to sit for their specialty field's board exam and are deemed board certified if they pass this exam. But what about physicians whose training was interrupted by addiction? As one former addiction medicine official noted, "they're not board-eligible, they're not anything, really, and they can't really call themselves specialist." In short, if these physicians determined that it was too late to finish a residency or to start another one, "the door is irrevocably shut on them ever having a specialty" (AMO-1).

Except perhaps, in addiction medicine, their new passion. But addiction medicine was not board recognized, nor is it today, meaning that it is not one of the 24 specialty boards under the aegis of the American Board of Medical Specialties, or a subspecialty under one of these 24 primary medical boards. Still, the hope appeared early in the minds of some addiction medicine physicians, those in recovery and those not, that their combination of experience, knowledge, and practice could provide the basis for establishing a new board specialty for their discipline. As the addiction medicine official just cited explained:

> So here we have this community of people within the recovering community who are becoming interested in the treatment of alcoholism and other drug dependencies. They do it for a long time …. They do a lot of continuing medical education. May be they even do some research …. They become very, very knowledgeable and very well-respected. Where are they going to get the kind of recognition that they want within medicine that comes with being boarded? They are going to get it with the new specialty in the field in which they happen to be very expert and knowledgeable. So there is that big important thread that pushes for this [board recognition] (AMO-1).

The hope of board specialty status for addiction medicine persists, but has never been fulfilled. The unmet expectation was that AS AM's certification exam, what Freidson (1986) calls a "private credential" (p. 69), could help addiction medicine achieve board recognition. An addiction psychiatrist described ASAM's certification exam as a "guild" exam—those who pass it are "able to call themselves addiction experts and consider themselves … primary care for addiction." The issue here, said this psychiatrist, is that ASAM's test-takers "came from specialties where the main understanding of the disease came from their personal experience of having had the disease" (AP-7).

The advent of addiction psychiatry

In the mid-1980s, a select group of psychiatrists who studied and treated addiction contended with their own set of professional status and legitimacy issues. Despite assertions that "addictive illness is the most common psychiatric disorder" (Galanter 1986:769), and in the face of surveys that found a moderate interest in addiction treatment among psychiatrists was not due to personal experience (Miller & Frances 1986), psychiatrists working in the addictions field felt stigmatized by their mainstream colleagues. As one prominent psychiatrist explained:

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> [We] felt marginalized … by the rest of psychiatry. We were sort of odd ducks. We didn't get a lot of training in [addiction]. Many psychiatrists thought it was not respectable. They had biased attitudes towards it. It didn't get a lot of play in the training programs …. Tbose of us who really got into it saw that this is a psychiatric disorder [and that] we ought to be leading the way in this. We have a lot to offer. So we felt marginalized within our own specialty (AP-8).

These feelings of professional powerlessness, bowever, derived from an added source:

> We were [also] feeling marginalized and threatened by tbose people who called themselves 'addictionologists.' They were by and large … doctors who were in recovery, many of whom had been treated by psychiatrists or in psychiatric hospitals and were very disparaging of their treatment …. [Psychiatrists and psychoanalysis] all failed them miserably. So they had their own agenda … vis-à-vis psychiatry (AP-8).

As a result, continued this psychiatrist, "outside [the] self-help enterprise, at the more professional levels, the doctors who were really interested in alcoholism and addiction, … the ones in the trenches mostly, were people in recovery, and they kind of shaped the notion of what alcoholism is" (AP-8). A physician in recovery agreed: "if you go back 25 years, who were those doctors who were taking care of addicts and alcoholics? They were doctors like me who were drunks and junkies who needed jobs and who went to work in treatment centers doing histories and physicals and trying to recover from their own impairments" (AM/AP-22).

In 1985, stirred by these "other" physicians who had come to "dominate the field excessively," and fueled by a growing contention that "substance use disorders are important aspects of psychiatry" (Miller & Frances 1986:196), leaders of the American Psychiatric Association's committees on alcoholism and drug abuse founded the American Academy of Psychiatrists in Alcoholism and Addictions (AAPAA). The influence of physicians in recovery on the medical treatment of addiction even figured into the naming of this organization. According to one of the group's founders:

> The reason why I wanted to have those letters ['AAPAA'] was … I wanted to [put] AA around P because the … vision was we're going to bring together AA and psychiatry, bring together the craft side of the field with the scientific side of the field, and have the medical leadership of psychiatry kind of leading it (AP-7).

The "craft side of the field" to which this psychiatrist referred included credentialed and non-credentialed counselors, social workers, nurses, and AA. But his suggestion is that AAPAA psychiatrists, its founders in particular, were also concerned—like T. D. Crothers about 100 years before them—with whether and to what extent physicians in recovery should provide addiction treatment.

Treatment specialists and leading members of AAPAA—which in 1996 became the American Academy of Addiction Psychiatry (AAAP)—reiterated this concern. One doctor talked about how addiction psychiatrists "became disillusioned with ASAM because they felt that politically ASAM was being dominated by the recovering community and by its

affiliation with the National Council on Alcoholism and kind of anti-academic." And, she added, "all of the founding bigshots of AAAP were academic psychiatrists" (AM/AP-17). A renowned addiction medicine physician with a personal history of drug abuse recalled that the founders of addiction psychiatry said, " 'we're forming because ASAM was formed and is threatening our domain.'. .. There's absolutely no question the recovering physician in addiction medicine was used as a rallying cry to form addiction psychiatry" (AM-15). A psychiatrist summarized that rallying cry like this:

> Sometimes they [recovering physicians] were anesthesiologists [and] sometimes they were GP's (General practitioners). After they got into trouble and … got into a recovery mode, they became addiction medicine specialists by passing the ASAM tests and getting active in ASAM …. At least a serious percentage of them, their knowledge base had to do with … personally having been addicted and then being in a recovery mode (AP-9).

Consequently, during the 1980s and 1990s, an antagonism developed between addiction medicine and addiction psychiatry, especially among the leadership and prominent members of each field's medical organization. "Psychiatrists felt that they were the ones who ought to provide all the treatment for addiction problems," said one ASAM-certified addiction psychiatrist. "And many ASAM members felt that they were the ones who should be providing the treatment" (AM/AP-19).[3] Another doctor certified in both disciplines described the founding of addiction psychiatry as a "watershed event," a response to Talbott and the tradition of recovery that he and his organization embodied:

> Basically you had all these recovering docs melded [into ASAM], and I think the New York academic psychiatrists that had been active in ASAM may have been reacting to that. So it [AAPAA, and then AAAP] was … [an] anti-non-academic and anti-recovery doctor movement …. I think your watershed event in history is … [that organization] forming itself (AM/AP-16).

Board subspecialty recognition for addiction psychiatry

In 1991, another critical event in the history of addiction medicine and addiction psychiatry further increased tensions between the two medical groups. That year addiction psychiatry became a board recognized subspecialty under the American Board of Psychiatry and Neurology. This recognition formally differentiated, or "stratified by differential prestige" (Freidson 1986:211), addiction psychiatrists from their non-boarded, but ASAM-certified, colleagues. Gusfield (1981) suggests that professional groups compete for "ownership" of social problems. In winning board recognition, addiction psychiatrists "owned" the medical treatment of addiction. This was precisely what they had set out to achieve.

In a 1991 position paper entitled "Substance Use Disorders: A Psychiatric Priority," the Group for the Advancement of Psychiatry (GAP) Committee on Alcoholism and the Addictions noted that the mental health profession had "reawakened" to the health

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[3]I do not mean to imply here that psychiatrists did not participate in ASAM. The organization currently reports that 27 percent of its members are board certified in psychiatry. Still, the early opposition to addiction medicine came from psychiatrists whose professional loyalties were to their discipline's burgeoning role in addiction treatment.

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consequences of drug addiction, but psychiatry itself had not responded in kind. The GAP committee's paper (1991) also stated that "within the treatment system, 'addictionologists' of all disciplines have supplanted psychiatrists on the front lines" (p. 1292). In October of 1991, the same month that the GAP statement was issued, the American Board of Psychiatry and Neurology launched the Committee on Certification of Added Qualifications in Addiction Psychiatry "to officially establish the field of addiction psychiatry as a definite area of subspecialization in psychiatry and to provide a means of identifying properly trained and experienced addiction psychiatrists" (American Board of Psychiatry and Neurology, Inc. 2005:18). Rosemary Stevens (1998) might say that addiction psychiatry had found its "place in the sun" (p. 343).

To acquire subspecialty recognition, representatives from AAAP presented to the American Board of Psychiatry and Neurology "a significant body of knowledge that was separate from and more in depth than a general psychiatrist would glean from their residency training in general psychiatry" (ABPNO-13). Research grants, scholarly publications, and AAAP's official organ, the *American Journal on Addictions,* which began circulation in 1992, evidenced this knowledge. Addiction psychiatrists could also point to postgraduate medical training in the addictions. By 1991, there were 48 addiction fellowships nationwide, mostly in departments of psychiatry and thus predominantly serving psychiatrists (Galanter & Burns 1993; Galanter & Frances 1992). Indeed, "psychiatry clearly played the key role in postgraduate training in the addiction field" (Galanter & Frances 1992:1068).

The scientific literature on comorbidity further boosted addiction psychiatry's argument for subspecialty status. At the root of this research was the Epidemiologic Catchment Area study which concluded that "mental disorders must be addressed as a central part of substance abuse prevention efforts …. For mental health professionals, it is also important to recognize the high rate of substance abuse disorders among those with severe mental disorders" (Regier, Farmer, Rae, Locke, Keith, Judd & Goodwin 1990:2517). A former president of AAAP confirmed the importance of the comorbidity data to his subspecialty's development:

> In the late 80s throughout the 90s [there] were excellent methodological studies accounting [for] the various DSM [Diagnostic and Statistical Manual of Mental Disorders] diagnoses in the population. This showed a high rate of alcohol and drug problems … [and also] that dual diagnosis and comorbidity was very, very common. So all of a sudden you're finding that maybe 40 percent of alcoholics and 70 percent of drug addicts have a co-occurring psychiatric disorder. This gives us a real big foot in the door in addiction treatment because a lot of these people have a psychiatric disorder (AP-8).

The comorbidity literature reinforced addiction psychiatry's "jurisdiction" (Abbott 1988) over the medical treatment of addiction. "Even if you accept the argument that we shouldn't call [addiction] a psychiatric disorder," said this same psychiatrist, "as it turns out, a very high percentage of these folks have a psychiatric disorder that's tied in with … their substance use disorder. So it made psychiatry's role a lot more obvious" (AP-8).

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Board subspecialty recognition and physicians in recovery

The effort of addiction psychiatrists to acquire board subspecialty status was stimulated by more than discernable bodies of knowledge, scientific journals, extant training programs, and the comorbidity literature. Addiction psychiatry's leadership insisted that addiction medicine and ASAM were permeated with physicians who were recovering alcoholics and addicts. These doctors usually lacked fellowship training in the addictions and some had not completed residency training in any medical specialty at all. As one respected addiction treatment physician said:

> These were people that were in the practice community, got into the field because of their own personal recoveries, [and] had never published a thing. And [addiction psychiatrists] viewed ASAM as being full of… non-intellectual, non-academic people. So they took some umbrage, if not offense, that so many people without academic legitimacy would be embraced [by organized medicine] (AM/AP-16).

One of addiction psychiatry's founders agreed. "The problem with ASAM was that they were trying to legitimize people who were being pulled into the field more because of their own recovery than having had a scientific training or background in the field" (AP-7). Another highly placed addiction psychiatrist was more direct. "People in ASAM call themselves 'addictionologists.' And that's people who are as far as I'm concerned undereducated. They may be very good at treating addictions … but those are people who don't have board certification and can't sit for board certification. So they'll give you a story, but that's probably the truth of the matter" (AP-14).

Although the work of addiction psychiatry's academic leadership to attain subspecialty recognition for addiction psychiatry was justified by tbeir discipline's clinical interests and scholarly achievements, it was also motivated by their desire to separate and distinguish themselves from ASAM's community of physicians in recovery. According to one ASAM-certified addiction psychiatrist, "I think they [addiction psychiatrists] wanted to move away from ASAM which they considered to be non-academic" (AM/AP-16). That the psychiatrists did so by acquiring board subspecialty recognition was "galling" (AMO-1), said a former addiction medicine official regarding what that field has yet to achieve. Ironically, then, it was addiction medicine's "undercurrent of recovery" (AMO-1), the product of Talbott's impaired physicians and other recovering doctors attracted to the field and to the prospect of acquiring a medical credential, that partially and inadvertently undermined addiction medicine's right to responsibility for addiction treatment.

The right to responsibility

According to Goode (1960), professions alike in aim, function, and knowledge quarrel over the "right to responsibility" for matters to which each lay claim. A similar process occurs inside professions, particularly medicine, where specialty development causes conflict between disciplines which share the same "turf" (see Gritzer & Arluke 1985; Halpern 1988; Jordan 1985; Rosen [1944] 1972). When serious competition develops, one field may eventually look beyond market forces to resolve the conflict; it may declare that its competitors are "charlatans, that is, not properly trained" (Goode 1960:904).

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The development of addiction medicine and addiction psychiatry, including each discipline's respective specialty status in organized medicine, is a striking example of such professional conflict. Psychiatrists with a scholarly and clinical interest in the addictions, marginalized by their primary specialty's indifference to the subject, were troubled by what "addictionologists" knew medically about addiction and how they applied this knowledge to treatment. That physicians in recovery rated AA more important to their sobriety than the professional treatment they received (Galanter, Talbott, Gallegos & Rubenstone 1990) supported this concern. Addiction psychiatrists questioned what recovering doctors in ASAM knew besides what they learned while getting sober and reading *Principles of Addiction Medicine* (Graham, Schultz, Mayo-Smith, Ries & Wilford <au 2003), ASAM's primary text and one of a handful of works which that organization advises candidates for its certification exam to review. As one ASAM-certified physician acknowledged, "how much medicine does a radiologist actually know? … What qualifications does this person have" (AM-24)?

By 1991, psychiatrists argued that they had a distinct body of specialized knowledge on addiction, as well as research grants, publications, and training fellowships, the medical legitimacy of which was enhanced by a scientific link between substance use and mental illness. Equipped with this intellectual armamentarium, addiction psychiatrists claimed that they could offer a service that their non-psychiatric addiction medicine counterparts, at least those in recovery—the "charlatans"—could not. Board subspecialty recognition for addiction psychiatry was a formal endorsement of this claim, what Freidson (1986) labels a "binding credential" (p. 63) that established addiction psychiatry's right to responsibility for the medical treatment of addiction. One psychiatrist contextualized recovery's impact on addiction medicine a bit differently, but the implication is the same:

> [Addiction] is one of the few illnesses where you get it first and then you specialize …. Is ASAM a bunch of drunks more worried about their own ability to get back into the workplace than anything else, or is it a bunch of doctors who have a fundamental understanding of this disease, sometimes based in personal experience? I prefer the latter. I think that this is a group of people, probably a good percentage of whom are in recovery, where that degree of personal knowledge adds something to the overall understanding of the group as a whole. But does that cause stigma for all the organization? Yes, it does (AP-21).

Indeed, addiction psychiatrists have charged that physicians in recovery, and hence addiction medicine and ASAM in general, make "a profession of their stigma" (Goffman [1963] 1986:27). But individual accomplishments in aggregate do not guarantee higher occupational status for the group, especially inside the medical profession where professional standing is a function of involvement with formal knowledge. As Abbott (1988) contends, "the more one's professional work employs that knowledge alone—the more it excludes extraneous factors—the more one enjoys high status" (p. 118). Since 1985, the year AAAP was founded, addiction psychiatrists have underscored their relationship with formal knowledge while calling attention to what they regarded as the "extraneous" factor—knowledge about addiction based on the personal experience of recovering from addiction—

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that diminishes the professional legitimacy and medical status of addiction medicine. This practice continues today.

Not all ASAM-certified addiction medicine physicians have been, or are, in recovery from alcoholism or drug abuse. It bears repeating that about one-third of ASAM's estimated 3,000 members are in recovery while about ten percent of AAAP's roughly 700 active members are recovering addicts. "Yet the stigma remains," said one addiction psychiatry leader who is convinced that recovery in ASAM, particularly the organization's emphasis on Twelve-Step treatment, is still "hugely, hugely pervasive." The problem with this approach, he alleged, is its lack of scientific evidence:

> You get a lot of people with a lot of attitude who sound like a bunch of jerks these days because what they're saying isn't evidenced based. It's belief based …. And a lot of those people can't think of the possibility of somebody recovering without Twelve-Step, without AA. And that's ridiculous …. It's like a religion. It's like 'there but through me you're not going to get to God.' Excuse me. I think that is presumptuous, arrogant, and plainly wrong …. Where the [treatment] synergies are, you use all the tools available (AP-14).

ASAM, of course, does not require that the physicians it certifies in addiction medicine endorse AA's Twelve-Step program of recovery, but this psychiatrist alleged that "there's a 'nudge-nudge-wink-wink.' There is a real arrogance that I have seen among [ASAM] people and they look askance at people who are not part of 'the club'" (AP-14).

An addiction psychiatrist who is both ASAM-certified and in recovery attributed comments like these to a "thinly veiled antagonism" that many psychiatrists still have toward recovery's role in addiction treatment. "These are the same folks who won't really seriously look at a question unless they can use the new language of evidence-based research. And there is a malignant side to that. There is an … intellectual arrogance in that that's just really sad. They don't know what they don't know" (AM/AP-22). This doctor meant that personal recovery does not need to be a prerequisite to treat addiction, but that it can be a valuable experience to call upon so long as recovering physicians are not blinded by it:

> Who we are is so inseparable from our transactions from others. This bears on … the philosophy of knowing, epistemology. Anyone who has really seriously looked at how therapy works has to be curious about epistemology … and the nature of the self …. My colleagues who have no interest in that, who dismiss that, are … just ignorant of those questions (AM/AP-22).

Addiction medicine and addiction psychiatry both claim unique knowledge about the medical treatment of addiction and both criticize their counterpart's ignorance. Still, "the key difference" between these disciplines, said a former addiction psychiatry official, "the one that causes the most fights and the most sitting on opposite sides of the issue, is the influence of the recovering community" (APO-23). Today, the leadership of both fields acknowledges a "maturation process" (AP-14) in ASAM that continues to elevate addiction medicine's medical "credibility" (AM/AP-16). However, a divide between addiction medicine and addiction psychiatry over the professional and medical implications of having

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experienced recovery from addiction has not diminished. Neither has American medicine's penchant for conflict within its professional ranks, especially with regard to addiction.

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Appendix

Data Collection and Analysis

Primary data for this article derive from 24 semi-structured interviews with addiction medicine physicians and addiction psychiatrists (seven of whom explicitly mentioned their own recovery from addiction), former officials from both medical fields, and from one current official with the American Board of Psychiatry and Neurology. The interview protocol was approved by the Committee for the Protection of Human Subjects at The Graduate Center, The City University of New York. It consisted of 15 open-ended questions on the professional background of interview respondents, the concept of addiction and addiction treatment, and the development, medical training, and medical specialty status of addiction medicine and addiction psychiatry. Interview data are supplemented with historical information embedded in the scientific literature on addiction psychiatry.

I identified interview respondents with a variant of purposive sampling called expert sampling (Trochim 2001). Expert sampling entails the recruitment of respondents who have experience and expertise in a particular subject matter. Each respondent was recruited based on one or more of the following criteria: 1) their role in the development of addiction medicine or addiction psychiatry; 2) their clinical or scholarly contribution to addiction treatment; and 3) their current or former administrative position in the American Society of Addiction Medicine or the American Academy of Addiction Psychiatry. These recruitment criteria emerged from a systematic review of the contemporary medical literature on addiction treatment, preliminary examinations of each discipline's administrative structure, and references from interview respondents.

I conducted interviews between November 2004 and May 2006. Each interview was tape-recorded and most lasted about 90 minutes. Twenty-one interviews were done by telephone to accommodate respondent work schedules and geographic distance, and three were conducted in person. Telephone interviews are a useful substitute for conventional face-to-face interviews (Sturges & Hanrahan 2004) where the professional identity of the researcher, and a respondent's perceptions of the interviewer in person, can affect data quality (Chew-Graham, May & Perry 2002; Richards & Emslie 2000).

After transcribing each interview, I identified and organized data on recovery using the ATLAS.ti qualitative data analysis program. I created the code "recovery" after numerous

close readings of each interview transcript to identify phrases, sentences, and paragraphs from all of the interviews that mentioned any personal experience with alcoholism or drug addiction from which a physician recovered. The following is an example of an interview excerpt coded "recovery:" "I do hold my status as a recovering individual as a very important part of my life. I'm one of those people who will say it's a way of life. And at the same time I should hasten to add I'm not an ideologue about it. I don't insist that everyone I see go to AA or do it the way I did it. But I am quick to share my own experience" (AM/AP-22). A total of 116 segments of interview text were coded "recovery." I analyzed this content in conjunction with other coded text referring to medical certification, medical specialization, professional competition, specialty recognition, medical training, and treatment approach. Altogether, data indicate that physicians in recovery are an often invisible but powerful "social fact" (Durkheim [1895] 1982) that profoundly affects how the medical treatment of addiction is organized and practiced.

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