White, W. L. (2012). A life of inquiry, service, and advocacy: An interview with David C. Lewis, MD. Posted at www.williamwhitepapers.com.

A Life of Inquiry, Service, and Advocacy: An Interview with David C. Lewis, MD Distinguished Professor of Alcohol and Addiction Studies Brown University

William L. White

Introduction

Dr. David Lewis' influence on the addiction field's training, clinical, professional practice, research, and policy issues has been ever-present for more than four decades. He has advised political and legislative leaders as well as advised and served on the boards of many of the field's national organizations. He has edited (e.g., *Substance Abuse*, *Brown University Digest of Addiction Theory and Application*) and served on the editorial boards of prominent scientific and trade journals within the field (e.g., *American Journal on Addictions*, *Journal of Addictive Diseases*, *Journal of Maintenance in the Addictions*), and has authored more than 400 addiction-related publications. His innumerable contributions to the field have been acknowledged by awards from the Association for Medical Education and Research in Substance Abuse (AMERSA), American Society of Addiction Medicine (ASAM), College for Behavioral Health Leadership (ACMHA), American Medical Association (AMA), and Harvard Medical School. In addition to being one of the most effective change agents in our field, his grace, charm, and friendship have blessed all of us who have worked with him. I have particularly fond memories of sitting with Ernie Kurtz at David's dining room table helping to catalogue the papers of Dan Anderson that had just been donated to Brown University while David provided us with liberal supplies of coffee and encouragement. Dr. David Lewis is one of the people I have most admired and who has most influenced how I have tried to conduct myself in the addictions field. Please join me in this engaging conversation with one of the field's true pioneers.

Addiction and Medical Education

Bill White: After graduating from Brown University, you completed your education at Harvard Medical School in 1961. What did you learn about addiction in your medical education at Harvard, and what were the prevailing attitudes of physicians toward the treatment of addiction at this time?

Dr. Lewis: There was nothing in the curriculum that I remember about addiction treatment, although there was quite a bit about the medical complications of alcoholism. There was little on addiction even though heroin addiction was a serious problem in those days. As for attitudes, nobody considered any of the addictive diseases part of mainstream medical practice. I have no notion about what mainstream medical attitudes were then because it was never discussed in any of our clinical sessions.

Bill White: Do you think a major accomplishment of the modern era has been the shift from focusing on the medical consequences of addiction to the rabid craving that sets the stage for these consequences?

Dr. Lewis: I think there's been an obvious shift to the realization that addictive disease is central to relapse and continued drug and alcohol use. The interest in the complications is still important, but we no longer believe that you treat the disease by treating the complications.

Bill White: You've been involved in the forefront of efforts to infuse addiction-related training into modern medical education. What are some of the most significant achievements you've witnessed in this area?

Dr. Lewis: The founding of the Association for Medical Education and Research in Substance Abuse (AMERSA), which is a multi-professional group that grew out of the federally funded Career Teachers Program, was very important because it influenced the faculty who taught in health professional schools. The fact that it wasn't a physician-only group was one of its greatest strengths. AMERSA also influenced the field's thinking about the kind of basic training all health professionals should have about substance use disorders. Specialist training was advanced by the American Society of Addiction Medicine with their certification exam and recently in forming the American Board of Addiction Medicine (ABAM), which then began to specifically target what should be in the curriculum for postgraduate training for addiction medicine.

Bill White: You played an important role in creating addiction medicine as a specialty. What drew you to addiction medicine before there was any such medical specialty?

Dr. Lewis: It was an accident in my career. I needed to write a paper in medical school for presentation at Harvard Medical School's Boylston Medical Society. You were elected to the Society by your classmates, and the only requirement was that you had to present a paper to your classmates. I had no topic, and then by chance, I was criticized for the way a marijuana patient was treated at the Mass. General Hospital emergency ward. Because of that criticism, I decided to look into the subject of addiction. At the time, there was a sign posted in Mass. General's emergency ward that threatened, "Drug Addicts shall be reported," listing cocaine, heroin, and marijuana.

So, I started to read about it, but there wasn't much in the library, and when I went to the advisor of the Boylston Society, he said it was a waste of time to write about addiction because you "can't do anything for those people." My anti-authoritarian nature led to my continued exploration of the subject. The resulting paper was eventually published in *The New England Journal of Medicine*, co-authored with Dr. Norman Zinberg, along with another paper we wrote together, documenting our encounters with 400 addicts in Boston's teaching hospitals.

People then thought I was an expert, so I kept getting asked about addiction, addiction history, and addiction medicine. That forced me to become an expert. There wasn't any formal training, but because my classmate's who heard the Boylston Society paper presented had internships and residencies all over Boston, they asked me to see virtually every addict in the teaching hospitals in Boston. I saw many people who were addicted to heroin and to alcohol especially at the Boston City Hospital. I simply built my knowledge patient by patient. There were very few physicians in Boston interested in addiction and most were psychiatrists. I quickly learned that addiction was not a symptom of another psychiatric disorder, which was a common view during this period. When you say I was focusing on addiction medicine from the beginning, I was forced to do it by my patient experience, not by formal training.

{I need to add here an explanation of how I went from writing a paper about addiction in medical school to being medical director of the Washingtonian Center for Addiction. My postgraduate training was in internal medicine: the first two years in Boston, then Cleveland and Dallas where I had a two-year fellowship in rheumatology. By the time I returned to Boston as Chief resident in Medicine at Beth Israel Hospital, I was an

arthritis specialist, but nobody wanted to hear about lupus or rheumatoid arthritis. Whenever I was asked to give the grand rounds, they wanted me to talk about heroin addiction or alcoholism. I was filling a vacuum in medical education, and it was the force of this vacuum that led me to the Washingtonian Center.}

Early Work in the Field

Bill White: How did your early work at the Beacon Hill free clinic influence your understanding of addiction?

Dr. Lewis: That was huge. In 1968, I was in my office at Beth Israel Hospital, where I had my first job as director of the medical outpatient department and emergency ward, when I got a call from a prominent lawyer in Boston. He said, "Where the hell are you?" I didn't have a clue what he was talking about. He said, "Come down and look at Boston Common. There are thousands of kids; there's drug taking of every variety and overdoses. It's a disaster." I went down there, and it was a disaster. So, I started a free clinic that was modeled a bit after the Haight-Ashbury free clinic in San Francisco.

I went out to San Francisco and had lunch with David Smith and asked his advice on setting up a free clinic. He said, "There is no advice; you just do it." So, I just did it with my colleagues in psychiatry, medicine, and pediatrics and lots of volunteers, including public health nurses from Boston City Hospital. We tried to provide care in the middle of all this drug-taking and Vietnam War protests on the Boston Common. It was really nuts and even more problematic because the police were there in attack mode.

Bill White: Did you have much contact with the local political system at this point?

Dr. Lewis: I had my first contact with the political system when I called the mayor of Boston at his summer place and asked him to do something about the police on Boston Common. We did actually succeed in getting the police to back off. That set the stage for setting up the free clinic at the King's Chapel parish house, which was a gorgeous building at the foot of Beacon Hill.

We saw about 10,000 kids in the first 2 years, all with volunteers. The equipment was "donated" from the surrounding hospitals. It was a very low cost operation, but extremely educational. I certainly learned that you can't

take care of individuals without knowing about their families, and you can't take care of addiction or drug problems without really knowing a lot about the community from which people come.

Bill White: From '72 to '79, you served as the medical director of the Washingtonian Center for Addictions in Boston. What was it like to work at such a historic institution?

Dr. Lewis: Like working in a history book. As I read more about the early history of treatment and recovery, I realized how successful the Washingtonian movement was. A lot of people took that pledge. The roots of the Washingtonian Center for Addictions in Boston can be traced to the 1857 opening of the Home for the Fallen in South Boston. I went through the archives and saw that Jack Kennedy had been a member of the board in its fancier days before I arrived. By the time I became the medical director, it had become a hospital for the down and out.

We divided the alcoholics and the drug addicts. Each side of the hospital had a different group, and we didn't mix them, so I had a chance to learn what the differences were. Of course now, there's so much overlap in drug and alcohol taking that you couldn't make that separation if you tried to. I recall many intrusions by the state police in those days, including interference with our efforts to start a small methadone maintenance clinic.

Norman Zinberg was the head of psychiatry—the individual who was my mentor in medical school and who had co-authored the papers for *The New England Journal of Medicine*. We worked together with a really terrific, sophisticated staff at the hospital in what was then a unique treatment resource in Boston. We treated thousands of addicted patients and rode the waves of drug trends at that time from heroin to barbiturates to PCP. We trained physicians and counselors and had what I think was the first addiction-focused social work training program in the United States.

What I learned in the free clinic was street learning, and what I learned in the Washingtonian Center was how to provide organized medical care for alcoholics and addicts, how to supervise clinical staff, and how to initiate treatment, which was connected to the community but was still medically oriented. That's where I learned about AA. I learned the hard way because a lot of the staff members and patients at the Washingtonian at that time somewhat opposed AA. We had a largely Roman Catholic clientele at the Washingtonian who had terrible things to say about their church experience and who saw AA as another church experience.

But I saw the successes of AA in our patients who participated, and so I got involved. I visited AA meetings and urged AA groups to meet at the hospital, which they had refused to do before but eventually did.

Our advisory board at the Washingtonian included figures well known in the history of alcoholism treatment like Seldon Bacon, who wasn't very helpful to me (a bit tough on doctors), and others, like Dr. Jack Norris, who were very supportive. Norris was particularly helpful in calming me down when I was feeling guilty that people weren't getting better as fast as I thought they should.

Bill White: You had a very unique position in the 1970s, from both a street level and also a clear awareness of what was unfolding nationally at the White House and with NIAAA and NIDA.

Dr. Lewis: Yes, it was a unique perspective. Our community was this frenzied scene on Beacon Hill and on Boston Commons and in the drop-in centers, but there was a much wider policy issue as to what would be done nationally. It was the beginning of planning for a national program, which had Jerry Jaffe going from Columbia to the White House to forge a national response to growing drug problems. My work as advisor to Mayor Kevin White of Boston as Chair of Boston's Coordinating Council on Drug Abuse was great training for the national policy work that would involve me in the years that followed. The Coordinating Council also was involved in state planning under Governor Michael Dukakis. Also during that period, nineteen mayors and their local addiction experts set up a national organization, the National Association for City Drug and Alcohol Coordination (NACDAC), in which Boston was quite active and I chaired. As federal policy programs developed further, I received several invitations to testify at Congressional hearings on such issues as amphetamine abuse and medical education. I met Senator Harold Hughes then and ended up working with some of his staff on the various pieces of legislation in the early '70s. So, for me, the '70s became a super learning curve and a time of growing policy involvement.

Brown University

Bill White: And then in 1976, you returned to Brown.

Dr. Lewis: That was another chancy thing. I attended a Brown University cocktail party at a research meeting in Atlantic City and met the head of

medicine and the vice president of Brown University. They tell me they have a donor named Donald Millar who's interested in urging Brown to do more in the field of alcoholism. And I said, "Well, I'm medical director of an addiction hospital. I'd like to know more about it." That's how it all started. They invited me to give a medical lecture at Brown. They got interested in the Washingtonian, and they sent a group of students there to do a project on addiction treatment.

One thing led to another, and I eventually ended up in the endowed chair that was established through Donald Millar's contribution. It was one of the first endowments in addiction medicine in the United States. I got very lucky with Donald Millar. When I first met him, he was at a dinner with the vice president of Brown. I was invited to that dinner, not as a candidate to get the endowed chair, but just to meet the potential donor. When he went on about his disappointment with treatment by his psychiatrist, I said, "Gee, that's too bad, but you know I'm an internal medicine doctor." He turned to me, grabbed my hand, and said "You're an internal medicine doctor. How wonderful!" I've always worked really well and closely with psychiatrists, but at that moment, I was all internal medicine.

Bill White: You published studies on the use of methadone and naltrexone in the treatment of heroin addiction. How did those early experiences influence your later views on the use of medication in addiction treatment?

Dr. Lewis: My positive experience with using medication in addiction treatment dates from when I started my private practice at the Beth Israel Hospital. I prescribed Antabuse for alcoholics and methadone for heroin addicts. Prescribing methadone was no problem then. I could write a prescription, and the pharmacist would fill it. This was before all the dysfunctional methadone regulations. I integrated my methadone maintenance patients, who were all heroin addicts, right into my primary care practice.

It was really an interesting scene because there was a waiting room for all the internal medicine private patients. Doctors were in various exam rooms, including the head of medicine, Howard Hiatt. Nobody knew that my patients were heroin addicts. I was taking care of primary care patients, many who just needed annual checkups, along with heroin addicts for whom I was prescribing methadone. Everything went smoothly. It was totally integrated into care.

It was only many years later when Howard Hiatt was on an NIH consensus panel—it was the first one on addiction they did at NIH, that I was one of the invited speakers. I told the story about my patients being integrated in the primary care clinic, and Dr. Hiatt came up to me afterwards, and he said, "I never knew." His cancer patients were sitting next to my heroin addicts, and he never knew. So, the whole idea of the integration of pharmacotherapy into addiction treatment was never a big deal for me, but I experienced the controversy. "You shouldn't do it. It's a crutch. It's wrong." I think the 12-Step programs were particularly vehement. They were telling our alcoholic patients to stop their anti-depressants when they went to AA.

I saw addiction as a disease from the very beginning of my work, and I knew that credibility within the mainstream health care system hinged on the development of better treatment—including medication-assisted treatment. I believed that medication-assisted treatment of addiction would lead to the same kind of clinical breakthroughs and reductions in social stigma that had occurred with cancer treatment. I saw methadone as the beginning of effective medications for addiction, and I did not see such treatment as incongruent with 12-Step recovery.

While it was hard for me to understand the resistance from the professional and the recovery community, I had memorable exposure to the opposition to the use of drugs for the treatment of a drug problem. Black Panthers from Chicago picketed the mayor's drug program because Boston had a methadone maintenance clinic. The state police started to film our methadone maintenance patients at the Washingtonian from a bread truck. I went to the head of the regional federal narcotics bureau and asked him to intercede, and he did. I got involved early on in trying to fight for the use of pharmacotherapy to treat addiction, and I still do. Now, we have a slew of outcome research showing that counseling (including 12-step) plus medication is more effective than either alone.

Bill White: You assembled a very impressive team at Brown whose members exerted a major influence on modern addiction treatment. What do you feel best about when you reflect back on your work to date at Brown?

Dr. Lewis: The Center for Alcohol and Addiction Studies was conceived as a research center with strong ties to health professional training public policy. We focused from the beginning on this science-community interaction, which received great support from then Brown University President Howard Swearer. From the very beginning, we were interested in

the relevancy of the kind of research we were doing and its applicability in clinical settings. I feel really good about our fidelity to that founding vision. We collaborated with many college departments at Brown, including anthropology, history, political science, and economics. I think that enriched the quality of our research and extended the range of our impact.

We advanced research training and medical education programs from the very beginning. We served as the national office for AMERSA for a decade. Our Addiction Technology Transfer Center was the first regional center including schools from all New England states. Last but not least, we developed a NIDA/NIAAA-funded post-doctoral training program that is now in its 27th year and is the centerpiece of the Center's training programs.

The History of Addiction Treatment and Recovery

Bill White: When did you first became infatuated with the history of addiction treatment and recovery in the United States?

Dr. Lewis: In medical school, I studied and wrote papers on the history of narcotics in the US, what happened with Harry Anslinger's Bureau of Narcotics, and how the war on drugs developed. I also became interested in temperance and AA history when I was at the Washingtonian because there was controversy around these issues in my day-to-day practice. I felt that I understood the war on drugs much better because I'd studied drug history as a medical student.

And then there is the story of how we started the archives at Brown. I received a call from Ernie Kurtz, whom I knew from both of us serving as faculty at the Rutgers Summer School of Alcohol Studies. Ernie tells me about collector and book dealer Charles Bishop's interest in divesting himself of 15,000 items about temperance and AA history all residing in his house in Wheeling, West Virginia. So, I said, "Sure. Why not?" I went over to the Brown library, and I told them about it. They were really unenthusiastic, particularly because Charlie's collection had a lot of "items." They're not interested in items; they're more interested in books and letters—mostly letters—and original documents. But the idea that they would be items, like sheet music scores, did not bring enthusiasm. I said, "Why don't we go down there and take a look anyway?"

So, two Brown librarians and I traveled to Charlie's home in West Virginia. And it was phenomenal! The whole house was filled with the most amazing stuff. There were photographs of Dr. Bob and Bill W. on the wall and a literal truckload of temperance material that Charlie had purchased

from the Anti-Saloon League. And of course, Charlie was such an engaging and interesting character that it was great fun for everyone. I'm an amateur photographer, so I took a slew of pictures that we were able to show when we got home.

So, the library sort of backed into it. They said, "We're not sure what we're gonna do with the items, but the John Hay Library would sure like the letters and books, but you need to raise the money for the purchase." That challenge seemed overwhelming but it turned out to be easy. Vartan Gregorian, who was the president of Brown at the time, was the head of the New York Public Library, and so he needed no convincing of the project's potential. I went to him for advice about where I could get money for this collection. He had somebody from the Development staff in there taking notes. And he's thinking, it should be a local leader from the business community—perhaps Chester Kirk. Chester Kirk was already a donor to our Center. So, Gregorian dictates a letter to Chester Kirk that I signed and sent. In the follow-up, Chester Kirk made a contribution of $250,000 that began this amazing journey that has now grown into multiple collections related to AA, alcoholism, and recovery. At one point, some of the local AA community had a meeting with me and the head librarian and suggested that we have an AA convention here where members could view our AA and related collections. The librarian turned to the leader of this local AA contingent saying, "How many people do you think there'll be," thinking about how they might accommodate a dozen or so visitors. And the guy said, "Well, probably about 7,000." I thought the librarian was going to faint on the spot at the very idea of 7,000 people coming to the John Hay Library. It was very amusing, but it also conveyed to me the potential import of these collections. And that was before we added the many collections since (see http://library.brown.edu/collections/kirk/related.php), including those of Dr Bob, Marty Mann/NCADD, Clarence Snyder, Ernie Kurtz, Rufus King, Rutgers Library Anti-Saloon League, and the papers of Dan Anderson that you and Ernie Kurtz assisted us in cataloging.

Bill White: One of the things you did as a follow-up was bring the field's historians together for the first time. A large number of us had never met face-to-face until those first meetings at Brown. In looking back, what do you think was most significant about those meetings?

Dr. Lewis: Well, I think we added credibility to historical studies within the addictions field and people liked the idea of having all these materials in one place accessible for scholarly research. We brought many historical threads

together. Here in one place, you've got women's studies with the Marty Mann collection. You've got temperance studies and a treasure trove of AA-related documents, including Dr Bob's archives. You've got all this continuity of lines of history that you've written about so eloquently. Bringing all this scholarly power together in one place for those early meetings was quite a milestone. It was a very congenial group, and the debates about historical interpretations were productive. They also gave good advice by proposing anonymity guidelines about revealing the names of AA members who were identified in the collection. Also out of those meetings and because the group wanted to continue their discussions, they developed a newsletter/journal called *Culture Alcohol & Society Quarterly* (CASQ) that we post on the Brown Library website (See http://library.brown.edu/collections/kirk/casq/)
.

.

Career Influences

Bill White: You've had the opportunity to work with some of the most influential people in the modern history of treatment. Who would you consider some of the real giants of this era?

Dr. Lewis: If I had to offer a list off the top of my head, it would include Vincent Dole and Marie Nyswander, whom I visited at Rockefeller University while I was a medical student and saw firsthand the caring approach they conveyed through their research and treatment.

There is Stanley Gitlow, who really set the tone of how the private practitioner could treat addiction. Recently, I was at the Recovery Luncheon that NCADD sponsored, and Judy Collins was telling me her story about getting sober and how Stan Gitlow was so central to saving her life. I think her story, the same way as Betty Ford's story, is important in its revelation of the importance of having physicians who know how to treat addiction in the context of private medical practice and the specialty practice of addiction medicine.

Then I would list George Vaillant because I knew him at Harvard and because I think his longitudinal studies of alcoholism were a major milestone in the history of addiction science and a milestone in the professional recognition of the value of 12-step programs.

Ed Senay would be on the list because of Chicago's multidisciplinary, multi-modality approach to treating heroin addiction. Ed and I became friends and wrote together on addiction treatment.

Tom McLellan and I worked together on some projects and became friends. Tom has this unique, self-deprecatory sense of humor, a fearless and fair approach to looking at new data that challenges prevailing wisdom, and he's a great listener.

Alan Marlatt's work in relapse prevention and the larger arena of harm reduction earns him a special place in this era. He brought a lot of rigorous science and common sense to discussions often lacking in both.

Thomas Bryant was for many years an articulate leader for the advancement of science-based drug policy and a first-rate leader in both the addiction and mental health fields. Tom and I had the privilege of working together at the Drug Abuse Council.

And there were other people memorable in my own development, including Ebby Hoff. Leadership at the Washingtonian Center (Gladys Price, Joe Mayer) told me that Ebby Hoff was the model practitioner for effective treatment of alcoholism and addiction. It's not just the medical. It's a health specialty, and he's a doctor who knows how to do it. And so I went to Virginia to meet Ebby Hoff. I go to his clinic, and the patients are lined up outside the door for status checks. Around a long table sits the clinical staff. Patients choose the staff member they want to see, and then all are seen by Dr. Hoff. Ebby chats with them, takes out a blood pressure cuff, and he takes their blood pressure. I walked away from that thing thinking, "What the heck is going on here?" And then I realized these status checks are what continuity of care is all about. This isn't initial treatment. These are people who are getting better; they're in early recovery. He lays on hands; he's a doctor. He's mostly a counselor, but he's a doctor, and so he takes their blood pressure. At Brown where I set up a clinic at Roger Williams Hospital, I modeled it after that clinic. It works!

There is Mark Keller. Mark was a good friend of Dwight Heath, the anthropologist and my colleague at Brown. Dwight would invite me over when Mark visited, and we had a great time. Mark was very pragmatic. He believed that words count and that you had to be very careful with how you used language. He was just very interesting and down-to-earth, extremely knowledgeable. He once turned to me—this must have been the '70s—and said, "Doctor, you know the story with addiction is not becoming addicted; it's not being able to quit." When I raised the question of psychological factors in addiction, he said, "Show me the psyche? You're a doctor. Tell me what a psyche is." We had these strange conversations. It was a privilege

for me to meet legendary characters like Mark Keller, editor of the then major scientific journal in our field, the *Journal of Studies on Alcohol*.

And Norman Zinberg was my mentor. He was the most non-judgmental yet effective psychiatrist I've ever met. I think his funeral at Harvard probably drew a thousand people. Half of them were Harvard faculty, and I have a feeling that more than half of them had asked his advice over the years. He was so approachable and a great leader in the field. He fought against the war on drugs. He was one of the first people to step out and help the AIDS community, and he served on the President's AIDS Commission. His book, *Drug, Set and Setting*, is a classic.

Reflections on Policy Involvement

Bill White: You have been invited on numerous occasions to offer congressional testimony on addiction-related issues, and you've worked on health reform. What have you learned through these experiences about how policy is formed?

Dr. Lewis: Well, it's not by science. I think what an academic has to bring to the policy arena is extremely limited. I think about 25-40% of policy is about science—40% on a good day. The political process is irrational enough and unpredictable enough that it operates under different rules. What may be controversial one day if you stick to it long enough may one day become policy. I drew my own conclusions. Sometimes, they didn't suit the political agenda or my professional colleagues.

Two things are required of the scientist trying to influence policy: brevity and persistence. When we set up a national organization of cities, we learned that everything we were advocating had to be able to be presented in a one-page position paper and that you had to be of service to the staff of the politicians even if you did not even meet the politician. I was lucky because I got to really work with some of the politicians, like Mayor Richard Hatcher of Gary, Indiana, who was a favorite. It's amazing when you find an elected politician who you can really work with directly. Mostly, that's not the case.

The hardest lesson for scientists to learn is that the currency of politics is not facts and science; it's money and votes. If you understand how the political system works, you can better serve as an expert consultant. I worked on the Hillary Clinton Task Force, and I was on the inside enough to see how bipartisanship can work. We got real agreement on the basic benefit package for drug and alcohol treatment with Bob Dole, John Chafee, and

Ted Kennedy. I wouldn't want to go through that process now. It is so partisan now, and that's unfortunate.

Bill White: I think you've published more editorials and commentaries than anyone in the modern history of addiction treatment. How did this advocacy writing begin and evolve over your career?

Dr. Lewis: When I became Editor of the *Brown University Digest of Addiction Theory and Application,* I thought I would start writing 500-600 word commentaries on the back page of each issue for a while and see how they went. I ended up writing more than 150 commentaries, each one on a different subject. You think each month, "What's going on that I'm interested in that others might be interested in?" I'd pick something scientific or pick a policy issue. I started with those one-page commentaries and turned them into letters to the editor and then longer op-ed pieces. After a while, they add up.

Bill White: You've spent a good part of your life studying American alcohol and drug control policies. What do you feel are the most important changes we need to make in those policies?

Dr. Lewis: I don't think prohibition works. I've been fighting the war on drugs ever since my days at the free clinic and seeing the "Addicts Shall Be Reported" sign in the emergency ward. The criminal law is not an effective way to control personal drug-taking behavior. The war on drugs has been a horrendous mistake. It undermines good medical care for people with addiction. Promoting stigma doesn't encourage seeking medical care.

It is socially counterproductive and discriminatory, imprisoning thousands of people of color. Alcohol prohibition was a mistake, and early anti-drug laws of the late 1800s at the state level and the 1914 Harrison Act were also mistakes. They drove medicine and science out of drug policy and out of the treatment of addiction. They continue to do so. Law is not the problem. We need strong regulation to prevent drug harms. The problem is using the criminal drug laws, particularly possession penalties (we had no possession penalties in alcohol prohibition).

Now, this is not the most popular view within medicine or in society, but I've held that view since the 1960s. I'm actually more conservative than a lot of my reform colleagues. I think that supply control is very important in terms of access and age of first use, but I do not believe that people should be punished with a criminal law for what they decide to put into their own

bodies. That is the position I have advocated for years through my role on the Board of Directors of the Drug Policy Alliance and its predecessor, the Drug Policy Foundation. I've received quite a bit of criticism for this point of view, but that's the breaks. That's the way I see it.

Bill White: In 1997, you designed and then served as Project Director of the Physician Leadership on National Drug Control Policy. Could you describe this project and some of its accomplishments?

Dr. Lewis: I tried to fill a vacuum. We didn't have the leadership of medicine speaking out about issues such as the need for more addiction treatment and fewer addicts in prisons. In order to get the leadership of medicine, we couldn't go directly after drug law reform. Several of the physician leaders did not want to even talk about harm reduction (even though I thought harm reduction is how doctors manage all chronic diseases). We recruited former surgeon generals, medical school deans, the leading medical editors, and heads of virtually every major medical society. It was a top level medical leadership group. We focused primarily on advocacy for the expansion of addiction treatment in our work with Congress and the administration. Some people credited us during the Bush administration of helping to get more money for treatment, and I think we probably deserve at least a piece of the credit for that and for turning public perceptions toward treatment and away from prison. We later expanded the group to include leadership of law and that helped us get our message across even more.

Addiction as a Chronic Disorder

Bill White: In 2000, you co-authored an article with Tom McLellan, Charles O'Brien, and Herb Kleber in the *Journal of the American Medical Association* on addiction as a chronic medical illness. How did this article come about, and how do you view its subsequent influence?

Dr. Lewis: One of the ways the Physician Leadership on National Drug Policy spread the word was by going public with the leading researchers in the field testifying before a panel from the medical leadership at the National Press Club. Tom McLellan was one of the people we invited. He and Charles O'Brien from the University of Pennsylvania had published research comparing the outcomes of addiction treatment to the outcomes of other chronic diseases. Tom presented this work to the PLNDP panel. The

Associated Press carried the story in 600 papers nationwide. After the hearing, Tom and I talked, and he decided to do further analysis of the data Tom did that, added a genetic analysis, called me back, and said, "Guess what? It's even better than I thought. As a matter of fact, addiction treatment outcomes fare as well if not better than treatments for asthma, hypertension, and diabetes." The subsequent *JAMA* paper we did obviously had an impact based just on the number of times that it's cited. As for its larger influence, you can judge that better as a historian.

Bill White: I believe it is one of the most important papers published on addiction of the last half-century. As you reflect back over the work you did with Tom and others, what conclusions have you come to about how we would treat addiction if we really believed it was a chronic disorder?

Dr. Lewis: I think that this distinction between acute and chronic disorders and the differing approaches to their treatment is critically important. People still think detox is a treatment for addiction, and they don't understand why many people treated for addiction do not get better following a single brief episode of treatment. So, the comparison with other chronic illnesses is very helpful in getting people to understand the need for sustained recovery management. And seeing addiction and its treatment in this way can decrease the related stigma because you are comparing them to other things people are familiar with. It would certainly redefine the idea of treatment failure and take the edge off the propensity to want to punish people who return to problematic use following treatment. We should also celebrate the potential for full recovery. Just because addiction is understood as a chronic disorder does not mean that recurrences of active addiction will be experienced by everyone following stabilization. It just means that there would be sustained attention and support for recovery over an extended period of time. That's what we do with all chronic diseases.

NCADD

Bill White: You joined the Board of Directors of the National Council on Alcoholism and Drug Dependence (NCADD) in 1995 and became Board Chair for two terms in 2004. How do you view NCADD's history and evolution as an advocacy organization?

Dr. Lewis: I seem to be drawn to historic organizations from my involvement at the Washingtonian Center for Addictions to my involvement

with NCADD that Marty Mann founded in 1944. The fact that it is the oldest recovery advocacy organization in the US doesn't necessarily solve our current challenges. NCADD has a wonderful history and has chapters widely spread across the country that have tried to extend Marty's legacy. All advocacy organizations have their ups and downs, and NCADD is now on an upward trend. At the time I was Board Chair, NCADD, Faces and Voices of Recovery, and the Johnson Institute were all about the same size. Faces and Voices is highly successful at constituency-building and policy advocacy within the political system. NCADD is highly successful in delivering referral and treatment services, and the Johnson Institute was very influential in defining recovery and working with clergy.

One of the things that I saw as a no-brainer that turned out to be a controversial no-brainer was to combine all these efforts into a single national advocacy and recovery organization. I managed to get representatives from two of the three boards (Johnson Institute and NCADD) to meet. And after that meeting, it seemed like an even better idea. I brought it to the entire NCADD board, and the whole thing sort of collapsed out of concern about what would happen with the NCADD brand and the local affiliate chapters. I was criticized for going ahead without full board involvement, so I took a lot of heat for it. The Johnson Institute subsequently went to Hazelden.

This idea has not gone away. I think it makes perfect sense that NCADD and Faces and Voices of Recovery, whether they merge or not, should operate as one recovery and advocacy operation. I don't know whether that will happen, but it should.

Handling Controversy

Bill White: You've taken on some of the most controversial issues in the field in your speeches and writings. What have you learned about how to influence and survive the personal and political push back that those stances have triggered?

Dr. Lewis: I think I'm helped by working in a university. I'm very interested in the ideas of the opposition. I do listen and try to find areas of common ground. I want to understand the reasons for opposition as well as I understand my own position, but I do not change my position to make somebody else happy. I try to incorporate the views of others in explaining why I've reached certain views, and I certainly don't take opposition to my ideas personally.

Bill White: You seem to have been able to maintain very respectful relationships across all the field's ideological divides. That's a rare quality.

Dr. Lewis: Teaching classes with a lot of student heterogeneity is good preparation for this. I've tried to engage students who come with widely varying ideas about these issues in some quite deep discussions, and it's important to recognize that students' feelings can be hurt in this academic arena. They pretend to be very tough, but they're not. You have to be a good listener, and you can't criticize someone in such a public forum. So that's been the training ground that I took into the political arena with mayors and governors and people from the White House. And most important of all, I have learned not to ever take disagreement personally. I just don't.

Status and Future of the Field

Bill White: How would you characterize the state of addiction treatment in the field in 2011?

Dr. Lewis: I think it's doing pretty well in spite of a lot of pressure, particularly economic pressure. The field has good diagnostic and patient placement criteria, which I think are major advances. We have a focus on families that you do not often see in mainstream medicine. Our treatment outcomes are not great, but they are comparable to other chronic diseases. However, when we talk about evidence-based treatment, we're not very good at operationalizing transfer of the scientific advances to clinical practice. Our resistance to pharmacotherapy in the treatment of addiction will hurt us and impede our ability to become part of mainstream medicine. Our counselors, compared to the mental health field, are not as rigorously trained as we wish. That's going to be a problem because our field is being somewhat ingested by the mental health field. We're going to have to live in that context both politically and clinically. We're going to have to figure out how to operate as one integrated delivery system. That is going to require major changes in training for all addiction professionals. We are making some advances now integrating substance use disorder screening and treatment into primary care, but we still have a long way to go. The formation of ABAM should bring clarity to the need for addiction medicine specialists. Parity and health care reform should also help.

Personal Legacy

Bill White: What have you most liked about working in this field for more than four decades?

Dr. Lewis: I obviously enjoy having worked in educational institutions like Harvard and Brown and setting up the Center for Alcohol and Addiction Studies. Undergraduate teaching has been the most fun for me. I taught a college course entitled "Addiction in the American Consciousness" for years at Brown. It was my vacation from a lot of medical education. Nothing beats working with colleagues and the friends that I've made over the course of my career. I've also enjoyed working to overcome the many policy challenges our field faces, which of course have changed, from decade to decade.

Bill White: Is there any advice you would offer for someone who is considering devoting their life to work in this field?

Dr. Lewis: I think it's a good time to enter the field because the treatments are going to continue to improve. I think the reforms of the health care system, no matter what form they take—state level, federal level, mandated, not mandated—are going to include attention to alcohol and drug disorders because of the growing realization of their close connection to so many other health conditions. The prognosis for every chronic illness is influenced by mental health and substance use disorders. That's where medicine is heading—a melding of what we've been teaching in public health all these years. We are moving toward the integrated care of whole individuals, families, and communities. I don't see anything interfering with that trend. There are going to be many, many more opportunities in the future for addiction treatment professionals.

Bill White: What do you hope will be the most important legacy you leave the field?

Dr. Lewis: It's very hard for me to judge. I think the progress that I've been able to help make on the educational front is good, and I think the addiction archives we have established at Brown will be a lasting legacy. I have never thought much about legacy. I have tried to do what I had to do and what I thought was right at the time. I don't think it was ever calculated to make a

"career contribution." There certainly was a lot of chance involved in it. I'm just happy I was able to advance some of the issues I really care about.

Bill White: Dr. Lewis, thank you for your willingness to participate in this interview, and thank you for all that you've done for the field and the people we serve.

Acknowledgement: Support for this interview series is provided by the Great Lakes Addiction Technology Transfer Center through a cooperative agreement with the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Treatment (CSAT). The opinions expressed herein are the views of the authors and do not necessarily reflect the official position of the sponsoring agencies.