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The Birth of Addiction Medicine

The recent recognition of addiction medicine as a medical specialty obscures the fact that American physicians have been involved in the treatment of severe and persistent alcohol- and other drug-related problems for more than two centuries.

THE BIRTH OF ADDICTION MEDICINE

The roots of addiction medicine began not in a young America but in the ancient civilizations of Africa and Europe. The earliest American medical responses to alcoholism emerged within the systems of medicine practiced by Native-American tribes. In colonial America, there was pervasive consumption of alcoholic beverages but no recognition of excessive drinking as a distinct medical problem. This changed in response to increased alcohol consumption between 1780 and 1830, a shift in preference from fermented to distilled alcohol, and the emergence of socially disruptive binge drinking. Signaling alarm was Dr. Benjamin Rush (1746–1813), whose 1784 pamphlet, *Inquiry into the Effects of Ardent Spirits on the Human Mind and Body*, stands as the first American medical treatise on alcoholism. Rush was the first prominent physician to claim that many confirmed drunkards could be restored to full health and responsible citizenship through proper medical treatment and to call for the creation of a special facility to care for the drunkard.

Between 1774 and 1829, physicians proposed that chronic drunkenness was a diseased state characterized by biologic predisposition, drug toxicity, pharmacologic tolerance, disease progression, morbid appetite (craving), loss of volitional control of alcohol/drug intake, and the pathophysiologic consequences of sustained alcohol and opiate ingestion. Treatment methods of this era included purging, blistering, bleeding, and the use of highly toxic medicines. Concern grew among physicians about addiction to drugs other than alcohol, prompted by the isolation of morphine from opium and cocaine from coca, the introduction of the hypodermic syringe, and the widespread distribution of opiate- and cocaine-based medicines by a rapidly growing patent drug industry.

Early Professionalization and Medical Advancements (1830–1900)

In 1828, Dr. Eli Todd, superintendent of the Hartford Retreat for the Insane, called for the creation of a physician-directed inebriate asylum. Under his influence, the Connecticut State Medical Society passed a resolution supporting this idea in 1830. A year later, Dr. Samuel Woodward, superintendent at the Hospital for the Insane at Worcester, Massachusetts, wrote a series of influential essays echoing the Connecticut recommendations. In 1849, Magnus Huss published *Chronic Alcoholism*, the landmark addiction medicine text of the mid-19th century.

A multibranch treatment field emerged in the mid-19th century that included inebriate

homes and medically-directed inebriate asylums, the first of which was the New York State Inebriate Asylum chartered in 1857 and opened in 1864, under the leadership of Dr. Joseph Turner. There were also privately franchised, for-profit addiction cure institutions (e.g., Keeley Institutes) and bottled patent medicine addiction cures (most containing alcohol, opium, morphine, or cocaine). By the late 1870s, large urban hospitals, such as Bellevue Hospital in New York City, also opened inebriate wards.

In 1870, Dr. Joseph Parrish led the creation of the American Association for the Cure of Inebriety (AACI), which brought together the heads of America's most prominent inebriate homes and asylums. The AACI by-laws posited that: *1. Intemperance is a disease. 2. It is curable in the same sense that other diseases are. 3. Its primary cause is a constitutional susceptibility to the alcoholic impression. 4. This constitutional tendency may be either inherited or acquired.* The AACI held regular meetings and published the first specialized medical journal on addiction—the *Journal of Inebriety* which was edited by Dr. T. D. Crothers from 1876–1914.

Demedicalization and the Collapse of Addiction Treatment (1900–1935)

Between 1900 and 1920, addiction treatment institutions closed in great numbers in the wake of a weakened infrastructure of the field, rising therapeutic pessimism, economic depression, and a major shift in national policy. The country turned its gaze to state and national prohibition laws as the solution to alcohol and other drug-related problems.

As inebriate homes and asylums and the private addiction cure institutes closed in tandem with the spread of local and state prohibition laws, persons suffering from alcohol and other drug dependencies were relegated to the “foul wards” of large city hospitals, the back wards of aging state psychiatric asylums, and the local psychopathic hospital, all of which did everything possible to discourage their admission. Those who were wealthy sought discrete detoxification in newly opened private hospitals or sanatoria established for this purpose. There were also brief efforts to integrate medicine, religion, and psychology in the treatment of alcoholism, most notably within the Emmanuel Clinics in New England. For all but the most affluent, the management of the alcoholic shifted from a strategy of treatment to a strategy of control and punishment via inebriate penal colonies. The large public hospitals also bore much of the responsibility for the medical care of the chronic alcoholic.

Addiction medicine organizations struggled in this shifting cultural climate. The AMTA and the American Association for the Study and Cure of Inebriety merged in 1904 to create the American Medical Society for the Study of Alcohol and Other Narcotics. The last issue of the *Journal of Inebriety* was published in 1914, and the American Association for the Study and Cure of Inebriety collapsed in the early 1920s after passage of the Volstead Act and the subsequent sharp decline in demand for treatment.

The medical treatment of narcotic addicts was dramatically altered by passage of the Harrison Anti-Narcotic Act of 1914. This federal act designated physicians and pharmacists as the gatekeepers for the distribution of opiates and cocaine. Although this law was not presented as a prohibition law, a series of Supreme Court interpretations of the Harrison Act (particularly the 1919 *Webb vs. the United States* case) declared that for a physician to maintain an addict on his or her customary dose is not in “good faith” medical practice under the Harrison Act and therefore an indictable offense. Physicians in 44 communities operated morphine maintenance clinics between 1919 and 1924 that were eventually closed under threat of federal indictment.

The influence of psychiatry on the characterization and treatment of addiction increased

in tandem with the decline of a specialized field of addiction medicine. Karl Abraham's 1908 essay, *The Psychological Relations between Sexuality and Alcoholism*, marked the shift from seeing alcoholism as a primary medical disorder to seeing the condition as a symptom of underlying psychiatric disturbance. In the mid-1920s, Public Health Service psychiatrist, Dr. Lawrence Kolb, published a series of articles portraying addiction as a product of defects in personality—a characterization that reflected the growing portrayal of addicts as psychopathic and constitutionally inferior. The first American Standard Classified Nomenclature of Disease (1933) included the diagnoses of “alcohol addiction,” “alcoholism without psychosis,” and “drug addiction” and classified these conditions as personality disorders.

Few institutional resources existed for the treatment of alcoholism and narcotic addiction during the 1920s and early 1930s, but the growing visibility of these problems began to generate new proposals for their management. The opening of the California Narcotics Hospital at Spadra in 1928 marked the beginning of state support for addiction treatment. Physicians working within the federal prison system raised concern about growing population of incarcerated addicts and advocated more specialized addiction treatment. In the community, medical treatments for narcotic addiction in the first three decades of the 20th century continued to focus on managing the mechanics of narcotic withdrawal. The first decades of the 20th century were marked by a profound therapeutic pessimism regarding treatment of alcoholism and narcotic addiction. Biological views of addiction fell out of favor and were replaced by psychiatric and criminal models that placed the source of addiction within the addict's character and argued for the control and sequestration of the addict.

The Rebirth of Addiction Treatment (1935–1970)

Addiction medicine was revived within the context of two larger movements. The “modern alcoholism movement” was ignited by the founding of Alcoholics Anonymous (1935), a new scientific approach to alcohol problems in post-Repeal America led by the Research Council on Problems of Alcohol (1937) and the Yale Center of Alcohol Studies (1943) and by a national recovery advocacy effort led by the National Committee for Education on Alcoholism (1944). Two goals of this movement were to encourage local hospitals to detoxify alcoholics and to encourage local communities to establish post-hospitalization alcoholism rehabilitation centers. This movement spawned new institutional resources for the treatment of alcoholism from the mid-1940s through the 1960s, including “AA wards” in local hospitals, model outpatient alcoholism clinics developed in Connecticut and Georgia, and a model community-based residential model pioneered by three alcoholism programs in Minnesota: Pioneer House (1948), Hazelden (1949), and Willmar State Hospital (1950). Dr. Nelson Bradley, who led the developments at Willmar, later adapted the Minnesota Model for delivery within a community hospital. That adapted model was franchised throughout the United States in the 1980s via Parkside Medical Services and was replicated by innumerable hospital-based treatment programs.

The spread of these models nationally was aided by efforts to legitimize the work of physicians in the treatment of alcoholism. Early milestones in this movement included landmark resolutions on alcoholism passed by the AMA (1952, 1956, 1967) and the American Hospital Association (1944, 1951, 1957) that paved the way for hospital-based treatment of alcoholism. The former were championed by Dr. Marvin Block, chairman of the AMA's first Committee on Alcoholism. Mid-century alcoholism treatments included nutritional therapies, brief experiments

with chemical and electroconvulsive therapies, psychosurgery and new drug therapies, including the use of disulfiram (Antabuse), stimulants, sedatives, tranquilizers, and LSD.

A mid-20th-century reform movement advocating medical rather than penal treatment of the opiate addict also helped spawn the rebirth of addiction medicine. This began with the founding of state-sponsored addiction treatment hospitals (e.g., Spadra Hospital in California) and led to the creation of two U.S. Public Health Hospitals within the Bureau of Prisons—one in Lexington, Kentucky (1935), the other in Fort Worth, Texas (1938). Many of the pioneers of modern addiction medicine and addiction research—Drs. Marie Nyswander, Jerry Jaffe, George Vaillant, Patrick Hughes—received their initial training at these facilities. The documentation of relapse rates after community reentry from Lexington and Fort Worth confirmed the need for community-based treatment. Three replicable models of treatment emerged: ex-addict directed therapeutic communities, methadone maintenance pioneered by Drs. Vincent Dole and Marie Nyswander, and outpatient drug-free counseling.

State and federal funding for alcoholism and addiction treatment slowly increased from the late 1940s through the 1960s and was followed by landmark legislation in the early 1970s that created the National Institute on Alcohol Abuse and Alcoholism (NIAAA) and the National Institute on Drug Abuse (NIDA)—the beginning of the federal, state, and local community partnership that has been the foundation of modern addiction treatment. The growing sophistication of addiction science was aided by the College of Problems of Drug Dependence, and the Research Society on Alcoholism.

Addiction Medicine Comes of Age (1970–2013)

The reemergence of addiction as a clinical specialty of medical practice has been significantly advanced by two professional associations: the American Society of Addiction Medicine (ASAM) and the American Academy of Addiction Psychiatry (AAAP).

The ASAM can trace its roots to the establishment of the creation of a New York City Medical Committee on Alcoholism in 1951 by the National Council on Alcoholism, the 1954 founding of the New York State Medical Society on Alcoholism under the leadership of Dr. Ruth Fox, and the movement of this group in 1967 to establish itself as a national organization—the American Medical Society on Alcoholism (AMSA). AMSA was later evolved into the American Medical Society on Alcoholism and Other Drug Dependencies and then into the ASAM.

ASAM's achievements include 1) gaining ASAM membership in the American Medical Association House of Delegates, as a national medical specialty society (achieved in June 1988), 2) advocating the AMA's addition of addiction medicine to its list of designated specialties (achieved in June 1990), 3) offering a certification and recertification process for addiction medicine specialists based on the early work of the California Society of Addiction Medicine, 4) hosting its Annual Medical-Scientific Conference, and 5) publishing its widely utilized ASAM Patient Placement Criteria, *Principles of Addiction Medicine* and the *Journal of Addiction Medicine*.

The AAAP (formerly the American Academy of Psychiatrists in Alcoholism and the Addictions) was established in 1985 with the goal of elevating the quality of clinical practice in addiction psychiatry. The AAAP's contributions include successfully advocating that the American Board of Psychiatry and Neurology grant addiction psychiatry subspecialty status (1991), administering an addiction psychiatry certification and recertification process, hosting an annual conference on addiction psychiatry, publishing the *American Journal on Addictions*, and

promoting fellowships in addiction psychiatry.

Several additional initiatives have advanced addiction-related medical education. The NIAAA and the NIDA created the Career Teacher Program (1971–1981) that developed addiction-related curricula for the training of physicians in 59 U.S. medical schools. In 1976, Career Teachers and others involved in addiction-related medical education and research established the Association of Medical Education and Research in Substance Abuse (AMERSA). AMERSA draws its members primarily from American medical school faculty, hosts an annual meeting, and publishes the journal *Substance Abuse*. In 1980, the Consortium for Medical Fellowships in Alcoholism and Drug Abuse was established to promote addiction-focused research and teaching specialists.

The American Board of Addiction Medicine (ABAM), and The ABAM Foundation (2008 - 2012)

The American Board of Addiction Medicine (ABAM), and The ABAM Foundation were incorporated in 2007, with ASAM's "encouragement and assistance," to certify physicians in addiction medicine, and develop and accredit addiction medicine residencies, thus expanding the pool of physicians who can provide specialty care to patients with addiction problems. The goals for achieving this are to gain certification of physicians who practice addiction medicine by one or more member boards of the American Board of Medical Specialties (ABMS), and gain accreditation of addiction medicine residencies by the Accreditation Council for Graduate Medical Education (ACGME). This will make ABMS board certification in addiction medicine available to physicians of all specialties, complementing the certification of psychiatrists in addiction psychiatry approved by the ABMS in 1991, and offered through the American Board of Psychiatry and Neurology since 1993.

Certification: ASAM transferred the Examination to ABAM in 2009, and the *ABAM Credentials Committee* renewed the eligibility criteria to have them comply with ABMS's licensure and other requirements. The 5 ½-hour written examination is developed and continuously updated by a collaboration of the National Board of Medical Examiners (NBME) and the *ABAM Examination Committee*. There are 3,148 physicians certified in addiction medicine by ABAM: 2,060 of the ASAM certified physicians were granted ABAM certification, having met ABAM grandfathering requirements, and 1,088 were certified by the 2010 and 2012 ABAM Examinations. An additional 1,985 physicians hold a time-unlimited certificate from ASAM. The American Board of Psychiatry and Neurology has issued 2,206 certificates in the subspecialty of addiction psychiatry.

Maintenance of Certification (MOC): To assure that ABAM diplomates are current with the developments in the field of addiction medicine, the *ABAM Maintenance of Certification (MOC) Committee* launched the MOC Program in 2009. All diplomates must enroll in Part I to annually validate their licenses, and diplomates with a time-limited certificate are required to enroll in Parts II (Life-long Learning), III (recertification examination every 10 years), and IV (Practice Performance Assessment). Diplomates with time-unlimited certificates are invited to voluntarily participate in the four-part MOC Program.

Defining the field: In July 2010 The ABAM Foundation identified the core documents that define addiction medicine and its training programs. The documents included *Addiction Medicine Scope of Practice: Version 4* (September 13, 2012); *Addiction Medicine Core Content: Version 2* (March 11, 2010); *Core Competencies for Addiction Medicine: Version 2* (March 6, 2012); *Compendium of Educational Objectives for Addiction Medicine Residency Training*

(March 25, 2011); *Program Requirements for Graduate Medical Education in Addiction Medicine* (September 13, 2012), and the *Program Accreditation Application Form (PAAF)* (2013 cycle).

Accredited addiction medicine residencies: The *ABAM Foundation Training and Accreditation Committee* fostered the development of the nation's first addiction medicine residency programs. The first seven addiction medicine residents graduated in 2012. Nineteen (19) programs are accredited as of December, 2013.

Key Points

- Addiction medicine rose in the United States in the mid-19th century, collapsed in the opening decades of the 20th century, but reemerged and became increasingly professionalized in the late 20th and early 21st centuries.
- Early pioneers of addiction medicine in American during the 19th century include Drs. Benjamin Rush, Eli Todd, Samuel Woodward, Joseph Turner, Joseph Parrish and T.D. Crothers.
- Ninetenth century addiction treatment spanned private specialty medical practices, inebriate homes, inebriate asylums, private for-profit addiction cure institutes and bottled home cures for addiction.
- Following the collapse of addiction treatment in the early twentieth century, addiction treatment was reborn as a professional field in the mid-twentieth century as a product of both alcohol and drug policy reform movements.
- The progressive professionalization of addiction medicine in the modern era has been led by the American Society of Addiction Medicine, the American Academy of Psychiatrists in Alcoholism and Addictions, and the American Board of Addiction Medicine Foundation.

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