FELLOWSHIP PROGRAMS IN ADDICTION: 
THE IDEOLOGY OF FORMAL TRAINING

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ABSTRACT: In 1986, the American Society of Addiction Medicine administered the first national certification examination for physicians who practiced addiction medicine. Certified addiction medicine physicians, dissatisfied with how psychiatrists conceptualized and treated addiction, received no formal medical training in addiction medicine. However, certified addiction medicine physicians were eligible to enroll in fellowship training programs in addiction. Psychiatrists in addiction believed that certified addiction medicine physicians underestimated psychiatry’s central role in drug treatment, but the psychiatrists also acknowledged that they needed better training in addiction and relied on medical fellowship programs to obtain it. Fellowship training programs, however, served another purpose. Formal training is ideological: occupational groups utilize formal training programs to not only enhance their skills but also to be able to say that formal training for their discipline exists. This article suggests that leading psychiatrists in addiction developed national consensus standards for fellowship training programs in addiction to improve training and treatment skills but, more significantly, to ultimately privatize and institutionalize addiction training fellowships so that psychiatrists in addiction could acquire full professional and market control over the medical field of addiction, namely over certified addiction medicine physicians, their only medical competitors.

Keywords: Addiction, fellowship, ideology, medicine, professional and market control, psychiatry, training.

“What counts in the things said by men is not so much what they may have thought or the extent to which these things represent their thoughts, as that which systematizes them from the outset.” —Foucault ([1963] 1994, p. xix)

Introduction

In 1971, President Richard M. Nixon sent a Special Message to the U.S. Congress on Drug Abuse Prevention and Control in which he warned that a generation might be lost to “the tide of drug abuse which has swept America in the last decade” (see Zimring and Hawkins 1992, p. 46). Nixon’s remarks, four years after the American Medical Association (1967) first called alcoholism a disease, persuaded organized medicine to support America’s war on drugs. In 1972, the American Medical Association stated that “there are logical key roles which physicians can fill professionally … with respect to the prevention and treatment of drug abuse. Also, as responsible citizens of their communities, they can try to help bring order out of
Two fields of medicine accepted this task: addiction medicine and addiction psychiatry. Addiction medicine was born in 1954 when Dr. Ruth Fox founded an organization of physicians interested in alcohol addiction called the New York City Medical Society on Alcoholism (Freed 2007). The New York Society grew rapidly during the 1960s and 1970s as another group of doctors who treated substance abuse, the California Society for the Treatment of Alcoholism and Other Drug Dependencies, developed the first certification examination for physicians who practiced “addiction medicine.” In 1985, the New York and California Societies formed the American Society of Addiction Medicine (ASAM) which adopted the California Society’s certification examination and administered it nationally. ASAM-certified addiction medicine physicians came from several different medical specialty backgrounds. Approximately one-third of ASAM’s roughly 3,000 members were themselves recovering from addiction (Freed 2007). Collectively, ASAM-certified addiction medicine physicians were dissatisfied with how psychiatrists conceptualized and treated addiction as a symptom of a mental disorder and not as a primary disease. ASAM certification in addiction medicine required no formal medical training in addiction medicine, but ASAM physicians were eligible to enroll in medical fellowship programs (which follow residency training after physicians graduate from medical school) that offered formal training in addiction.

Addiction psychiatry originated in 1985 when a small group of psychiatrists from the American Psychiatric Association Committees on Alcoholism and Drug Abuse founded their own organization of addiction specialists that today, with about 1,000 members, is called the American Academy of Addiction Psychiatry (AAAP). The psychiatrists felt marginalized by mainstream mental health professionals who considered addiction treatment a futile medical pursuit. But more than this, AAAP psychiatrists felt marginalized by ASAM-certified addiction medicine physicians whom the psychiatrists believed underestimated psychiatry’s central role in drug treatment, especially in light of the scientific comorbidity literature that linked substance abuse and mental illness. AAAP psychiatrists nonetheless acknowledged that they needed better training in addiction and relied on medical fellowship programs to obtain it.

Fellowship training programs, however, served another purpose. In the medical profession, conflict between specialty disciplines that share the same “turf” is common (see, e.g., Gritz and Arluke 1985; Halpern 1988; Rosen [1944] 1972). To prevail, the leaders of specialty disciplines, particularly leaders of new medical specialties, utilize formal training programs to not only enhance their skills but also to be able to say that formal training for their discipline exists. As Freidson (1970, p. 80) argues, “the nature of an occupation’s training, therefore, can constitute part of an ideology, a deliberate rhetoric in a political process of lobbying, public relations, and other forms of persuasion to attain a desirable end—full control over its work.” In so far as occupational groups seek jurisdiction over their competitors (Abbott 1988), this article suggests that leading AAAP psychiatrists developed national consensus standards for fellowship training.
programs in addiction to improve training and treatment skills but, more significantly, to ultimately privatize and institutionalize addiction training fellowships so that psychiatrists in addiction could acquire full professional and market control over the medical field of addiction, namely over ASAM-certified addiction medicine physicians, their only medical competitors.

Data Collection and Analysis

Data for this article, part of a larger sociological and historical study about the professional competition between addiction medicine and addiction psychiatry (see Freed 2007; 2010), derive from historical documents supplemented by semi-structured interviews. Scholarly papers, conference reports, and government catalogs from the 1970s detail medical training initiatives in addiction. A piece about the California Society for the Treatment of Alcoholism and Other Drug Dependencies (Heilig 1993) traces the origin and development of the California Society and of the ASAM certification examination. In addition to biographies and organization newsletters that describe addiction training programs, the medical literature contains information about substance abuse training needs and strategies, certification and fellowship statistics for ASAM physicians and AAAP psychiatrists, and the certification examination requirements for the fields of addiction medicine and addiction psychiatry. An article published in the American Journal of Drug and Alcohol Abuse (Galanter et al. 1991) about national consensus standards for fellowship training programs in addiction is especially relevant to this analysis.

Thirteen semi-structured interviews with leading addiction medicine physicians, addiction psychiatrists, doctors certified in both medical fields, and former addiction medicine and American Board of Psychiatry and Neurology officials supplement the historical data. I selected interview respondents with a variant of purposive sampling called “expert sampling.” Expert sampling involves the recruitment of respondents with specialized knowledge about a specific field or subject matter (Trochim 2001). The interview respondents created the fields of addiction medicine or addiction psychiatry as well as each field’s respective training and certification procedures, occupy or recently held prominent positions in ASAM or AAAP, and influence how medical professionals and the American public understand addiction. The 90-minute interview consisted of 15 questions about professional distinctions between addiction medicine and addiction psychiatry, including distinctions with respect to formal training in addiction in each field. The consent form that all interview respondents signed, approved by the Committee for the Protection of Human Subjects at The Graduate Center, The City University of New York, did not guarantee confidentiality. I identify interview respondents in the article by code: AM = addiction medicine physician; AP = addiction psychiatrist; AM/AP = physician certified in addiction medicine and addiction psychiatry; AM/P = physician certified in addiction medicine and general psychiatry; AMO = former addiction medicine official; and ABPNO = former American Board of Psychiatry and Neurology official. The number adjacent to the respondents indicates the order in which I interviewed them.
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I analyzed the historical and interview data inductively using the grounded theory method (see Glaser and Strauss [1967] 2006). “Deriving a theory simply means identifying the interrelationship between concepts, and presenting a systematic view of the phenomena being examined, in order to explain ‘what is going on’” (Wiener 1981, p. 268). I reviewed the historical documents as I transcribed and imported each tape-recorded interview into Atlas.ti, a qualitative data analysis program that researchers across scholarly disciplines use (see, e.g., Barry 1998; Gibbs 2007). I then analyzed the historical and interview data to identify and code text about “medical education” and “training” in addiction, or the formal instruction in substance abuse that ASAM-certified addiction medicine physicians and addiction psychiatrists receive, including claims from both groups of doctors regarding the formal training in addiction that their counterparts have. In conjunction with reviews of how the fields of addiction medicine and addiction psychiatry originated and developed, specifically examinations of historical documents and coded interview text about “addiction recovery,” “addiction treatment,” “definitions of addiction,” “medical specialization,” “medical specialty recognition,” and “professional competition,” I reanalyzed the historical and interview data to identify additional information that corresponded to one comprehensive code, “medical training,” which represented the full range of data about formal medical training in addiction for ASAM-certified addiction medicine physicians and addiction psychiatrists.

Medical Training in Addiction: The Modern Era of Concern

The 1970s introduced “the modern era of concern” (Lewis et al. 1987, p. 2946) about medical training in addiction in the United States. In 1970, for instance, over 100 physicians and scientists met at the Conference on Professional Training on Alcoholism to discuss medical school instruction about alcohol addiction. According to one conference member, “if our universities and medical schools are instruments of society created to help people solve some of their important problems and to meet their needs, ... then the major problem of alcoholism certainly deserves a significant place in their programs” (Willard 1971, p. 17). In 1972, 30 medical professionals convened at the Macy Conference on Medical Education and Drug Abuse to help schools of medicine and public health develop and improve training programs in addiction (Josiah Macy, Jr. Foundation 1973). The Macy Conference called substance abuse a social problem of “epidemic proportions” for which organized medicine was “unprepared” (Josiah Macy, Jr. Foundation 1973, p. ix). Conference participants proposed a drug abuse curriculum for each year of medical school as well as postgraduate medical training in addiction at the residency and fellowship levels.

The Career Teachers Training Program in Alcohol and Drug Abuse implemented some of these conference initiatives. Started in 1971 by the National Institute on Alcohol Abuse and Alcoholism and the National Institute on Drug Abuse, America’s top addiction research centers, Career Teachers were medical school faculty with federal grants to develop and teach courses about addiction in their home institution. By 1978, 40 medical schools had Career Teachers who increased elective courses and required
teaching hours in drug abuse, mostly in departments of psychiatry (National Institute on Alcohol Abuse and Alcoholism and National Institute on Drug Abuse 1978; Pokorny and Solomon 1983). In 1982, when the Career Teachers Training Program ended, 59 faculty had worked in schools of medicine or public health nationwide (Samet et al. 2006). Despite this modest success, or perhaps because of it, health care professionals called on “specialty groups and medical school departments” (see Lewis et al. 1987, p. 2948) to offer more medical training and credentialing in addiction. This effort was already underway.

**ASAM Certification in Addiction Medicine**

In the early 1970s, police officers in Riverside County, California arrested two physicians for treating heroin addicts at a local hospital (Heilig 1993). Reminiscent of the early 1900s when federal agents under authority of the Harrison Narcotic Act arrested doctors who treated opiate addicts (see Musto 1999), California law prohibited physicians from treating addiction outside of a city or county jail or hospital, a state prison or hospital, or a facility approved by the Department of Mental Health or licensed by the Department of Alcohol and Drug Programs (Legislative Counsel of California N.d.).

The arrests prompted Dr. Jess W. Bromley, a member of the California Medical Association Committee on Dangerous Drugs who advocated medical care for addicts, to author and lobby for a legislative bill in California that would, as Bromley stated, “bring [the law] into conformance with reasonable clinical practice” (see Heilig 1993, p. 2). Bromley received help from the California Medical Association and grassroots support from the Haight Ashbury Free Clinics, a medical and drug treatment center in San Francisco’s Haight Ashbury district (Heilig 1993). In 1971, Bromley succeeded. The California State Legislature amended the law so that a physician “may treat an addict for addiction in any office or medical facility which, in the professional judgment of such physician, … is medically proper for the rehabilitation and treatment of such addict” (Legislative Counsel of California N.d.).

Bromley next requested authorization from the California Medical Association to form an official medical society devoted to addiction (Heilig 1993). After years of working under the threat of arrest, a network of professional support for physicians who treated substance abuse seemed long overdue. In 1973, Bromley and Gail B. Jara, an experienced bureaucrat inside organized medicine in California, founded the California Society for the Treatment of Alcoholism and Other Drug Dependencies—the California Society. “Our vision,” Bromley recalled, “was to begin in California and bring treatment of addiction into the [medical] mainstream” (see Heilig 1993, p. 3). The California Society addressed issues such as standards for drug treatment and reimbursement for care, but it prioritized physician credentialing in addiction (Heilig 1993). As one member of the California Society said, “the development of recognized expertise [in addiction] was reason enough to start this association” (Becker, in Heilig 1993, p. 5).

Former First Lady Betty Ford sparked the California Society’s work on physician credentialing. In the late 1970s, Ford’s recovery from alcohol and prescription drug
abuse brought high-profile attention to addiction treatment (Ashley 2003). Based on her personal experience, Ford believed that substance abuse should be treated in special hospitals and not in large general medical facilities. “An addiction treatment hospital? There were very few of those in the U.S. back in the early 80s and virtually none in the state of California. Yet [Ford] knew that addiction to alcohol and/or other drugs is serious business, and requires serious treatment, and that treatment works best in a hospital environment” (Schwarzlose 2008, p. 2). In 1981, then, with support from Leonard Firestone of the Firestone Tire and Rubber Company (himself a recovering alcoholic whom Ford convinced needed treatment) and other “movers and shakers” (AMO-1) in California including Bob and Dolores Hope, the California State Legislature, at the urging of former President Gerald R. Ford, passed legislation to build a licensed hospital, the Betty Ford Center, exclusively for addiction treatment (Ashley 2003; Schwarzlose 2008).

The California Department of Health Services, the state agency responsible for licensing hospitals, stipulated that only physicians with expert knowledge in substance abuse could direct addiction treatment hospitals. However, the Department of Health Services did not specify how to measure “expert” medical knowledge. “Here is your opportunity, California Society,” a former addiction medicine official recollected. “You are the specialty society in California…. If you say [the hospital directors] are knowledgeable, then the state of California will probably take your word for it because who else is going to say it?” (AMO-1)? Accordingly, the California Society developed a certification examination for not only directors of addiction hospitals but for all California physicians who practiced “addiction medicine.” The objective of the examination was “to identify a body of knowledge, mastery of which would assume that a physician had attained knowledge relevant to the diagnosis, management, and treatment of addictive disorders” (Schnoll et al. 1993, p. 125). In 1983, the California Society administered its certification examination to its members for the first time (Galanter and Bean-Bayog 1989).

In 1985, the California Society united with the New York City Medical Society on Alcoholism to form the American Society of Addiction Medicine (ASAM). The physicians who coordinated the merger agreed on the importance of having an instrument that measured medical expertise in addiction, especially for a growing national field. ASAM thus adopted the California Society’s certification examination in addiction medicine and, in 1986, administered a restructured version nationally “to identify those physicians who, by testing, have shown a mastery of the body of knowledge that has been amassed in this field” (Schnoll et al. 1993, p. 132). The five-hour examination consisted of 120 multiple choice questions about clinical and treatment components of addiction as well as four patient management problem questions “validated on expert and nonexpert physicians” (Galanter and Bean-Bayog 1989, p. 2). To take the examination, a physician needed to be licensed, actively involved in addiction treatment, and a “good standing” member of ASAM (Galanter and Bean-Bayog 1989, p. 1).
Nearly 900 physicians took the first ASAM certification examination in addiction medicine, 735 of whom passed (Galanter and Bean-Bayog 1989). These physicians, most residency-trained, practiced general medicine, family medicine, psychiatry, or internal medicine. Others were surgeons, pediatricians, obstetricians and gynecologists, and pathologists (Galanter and Bean-Bayog 1989). An ASAM physician explained why doctors from different medical specialty backgrounds took the addiction medicine certification examination. “For years … psychiatrists were the only ones who looked at addiction. You know the old saying: ‘scratch any alcoholic and you’ll find a schizophrenic, you’ll find a manic-depressive.’ That was an attitudinal thing that went along for years” (AM-11). In other words, psychiatrists traditionally defined addiction as a symptom of a mental disorder and not, as ASAM physicians did, as a primary disease (Freed 2010). In the late 1930s, for example, Karl Menninger (1938, p. 147) claimed that alcohol addiction is not a disease, but “a suicidal flight from disease, a disastrous attempt at the self-cure of an unseen inner conflict.” Consequently, “psychiatric treatment for addiction in the 50s, 60s, and 70s [was] an unmitigated disaster accompanied by a great deal of arrogance” (AM-5). In fact, “most addicts who saw psychiatrists were damaged by that experience” (AM/P-18). “[So] one of the reasons that many of us got certified back in the 1980s,” said one treatment expert, “was that we felt psychiatry had missed the boat [on addiction]. We found colleagues [in addiction medicine] who could really speak the language of treatment” (AM/AP-22).

Some of these colleagues were themselves recovering from addiction who too received poor care from psychiatrists (Freed 2007). One study confirmed that psychiatrists, who treated most alcoholic physicians, regarded alcohol addiction as a symptom of a mental problem and not as a biological disease (Bissell and Jones 1976). “Since it is virtually impossible to arrive at a reasonable treatment plan for a disease whose existence is not acknowledged,” the researchers concluded, “this behavior had frequently resulted in dangerous delays in obtaining appropriate treatment” (Bissell and Jones 1976, p. 1144). As one ASAM physician in recovery stated, “Freud himself could not have analyzed the drunk brain. It wouldn’t have worked” (AM-6).

Between 1986 and 1990, ASAM administered its certification examination to 2,537 physicians, of whom 2,145 passed (Schnoll et al. 1993). “The certification craze took off with a big bang,” said an ASAM physician who helped to design the addiction medicine examination, “but it wasn’t followed up with training. It wasn’t followed up with teachers who trained other people so that when they retired those people could take over” (AM-4). Indeed, without board specialty recognition for addiction medicine from the American Board of Medical Specialties, “the pre-eminent entity overseeing the certification of physician specialists in the United States” (American Board of Medical Specialties N.d.), the field of addiction medicine could not establish departments of addiction medicine in medical schools to sponsor formal training programs. Therefore, as one observer noted, ASAM physicians “[took] the exam and that’s it…. You’re working in addictions” (AP-20). However, ASAM-certified addiction medicine physicians were eligible to enroll in fellowship training programs in addiction (Galanter 1993; Galanter and Burns 1993). Psychiatrists in addiction sought to dominate these training fellowships.
Fellowship Training Programs in Addiction Psychiatry

In 1982, 4,657 psychiatrists in the American Psychiatric Association reported an interest in addiction, two-thirds of whom identified substance abuse as a psychiatric disorder and all of whom devoted at least some portion of their clinical practice to addiction (Miller and Frances 1986). Sheldon I. Miller and Richard Frances (1986, p. 196) of the American Psychiatric Association Committees on Alcoholism and Drug Abuse speculated that “psychiatrists are becoming aware that substance use disorders are important aspects of psychiatry, and they are becoming active in assuming their place in teaching, research, and treatment roles.”

Most mainstream mental health clinicians, however, stigmatized psychiatrists who specialized in addiction. “We were odd ducks,” one of these psychiatrists explained. “Many psychiatrists thought [addiction] was not respectable. They had biased attitudes towards it…. So we felt marginalized within our own specialty” (AP-8). But psychiatrists in addiction also felt marginalized by ASAM-certified addiction medicine physicians. In 1982, one-third of ASAM consisted of psychiatrists (Galanter et al. 1983), yet the various medical backgrounds of ASAM physicians, most of whom, to reiterate, endorsed addiction as a primary disease, including doctors in addiction recovery “[who] had been treated by psychiatrists … and were very disparaging of their treatment” (AP-8), overshadowed the distinct contribution that psychiatrists believed they could make to drug treatment.

The scientific comorbidity literature supported the psychiatrists’ conviction (see, e.g., Lewis et al. 1982; Powell et al. 1982; Rounsaville et al. 1982). One study, for instance, found that 93 per cent of narcotic addicts suffered from a mental problem such as depression (Khantzian and Treece 1985). Other research uncovered a strong correlation between alcoholism and antisocial personality disorder (Lewis et al. 1985). One psychiatrist characterized the comorbidity literature as “the ‘dawn’s early light’ that substance use disorders are a psychiatric condition” (AP-12). Another psychiatrist stated that “a very high percentage of [addicts] have a psychiatric disorder that’s tied in with their substance use disorder. So it made psychiatry’s role a lot more obvious.” In short, he continued, “those of us who got into [addiction] saw that it is a psychiatric disorder—we ought to be leading the way in this” (AP-8).

Accordingly, in 1985 a small group of psychiatrists from the American Psychiatric Association Committees on Alcoholism and Drug Abuse, led by Sheldon I. Miller and Richard Frances, formed today’s American Academy of Addiction Psychiatry (AAAP). AAAP addressed drug abuse prevention, treatment, and research (Galanter and Frances 1992), but the psychiatrists gave considerable attention to fellowship training programs in addiction. As one AAAP psychiatrist cautioned, “until mental health professionals learn to use the proper tools to initiate and sustain abstinence in alcoholic and drug-dependent patients, the field will be deficient in meeting one of its primary responsibilities” (Galanter 1986, p. 769).

In 1987, 27 fellowship training programs in addiction (one to two years in duration) operated nationwide. In 1989, 34 programs existed and by 1991 there were 48 addiction
fellowships. Residency-trained physicians from any medical specialty background could enroll in these training programs, including residency-trained physicians certified by ASAM to practice addiction medicine (Galanter 1993; Galanter and Burns 1993; Galanter et al. 1991).

In 1991, having determined that these programs needed more structure, the National Advisory Committee of the Center for Medical Fellowships in Alcoholism and Drug Abuse issued national consensus standards for fellowship training programs in addiction (see Galanter et al. 1991). The Center for Medical Fellowships in Alcoholism and Drug Abuse, directed by Marc Galanter, a psychiatrist and influential medical educator in substance abuse, was a national organization that promoted addiction fellowship programs. Notably, its National Advisory Committee consisted of 23 “leading figures in academic medical training in the addiction field” (Galanter et al. 1991, p. 2), including prominent AAAP psychiatrists such as Marc Galanter, Sheldon I. Miller, and Richard Frances. In fact, AAAP co-founded the Center for Medical Fellowships whose National Advisory Committee developed its consensus standards for fellowship training programs in addiction for AAAP (Galanter et al. 1991). Indeed, a close look at the training standards, which outlined skills in clinical assessment, pharmacology, treatment, and research (Galanter et al. 1991), reveals a threefold strategy to suit only psychiatrists.

First, the National Advisory Committee stated that its consensus standards applied to “existing approaches” (Galanter et al. 1991, p. 4) to addiction fellowship training—that is, for all medical school departments that offered addiction fellowships. However, the available training programs mainly served psychiatrists because medical school departments of psychiatry, in light of psychiatry’s longtime role in addiction treatment (see Josiah Macy, Jr. Foundation 1973), sponsored virtually all of the fellowships (Galanter 1993; Galanter and Burns 1993). Moreover, as the psychiatrists knew from the stigma they experienced from their contemporary mainstream colleagues, a majority of medical fields considered drug treatment “dirty medicine” (Josiah Macy, Jr. Foundation 1973, p. 2) and thus substance abuse training unnecessary. As one treatment expert acknowledged, “[most] doctors belonged to specialty groups that could not have cared less about addiction” (AM/AP-19). The field of addiction medicine might have adopted the National Advisory Committee’s fellowship training standards, but, to repeat, without board specialty recognition from the American Board of Medical Specialties, addiction medicine did not have medical school departments to house training fellowships. Consequently, only departments of psychiatry could implement the National Advisory Committee’s fellowship training standards.

Additionally, the National Advisory Committee urged medical school departments (i.e., psychiatry departments) that hosted fellowships to offer the “caliber of training” (Galanter et al. 1991, p. 5) that produces a medical subspecialty credential in addiction from the American Board of Medical Specialties. More specifically, fellowship training, followed by a medical subspecialty examination sponsored by a medical specialty board, should lead to board subspecialty recognition in addiction. In 1990, one year before the
National Advisory Committee published its consensus standards, as a rivalry grew between addiction medicine and addiction psychiatry over the “right to responsibility” (Goode 1960) for the medical treatment of addiction (Freed 2007), AAAP psychiatrists proposed creating an addiction psychiatry subspecialty under the American Board of Psychiatry and Neurology (Galanter and Frances 1992). And just months after the National Advisory Committee issued its training standards, the American Board of Psychiatry and Neurology recognized addiction psychiatry as a medical subspecialty (see Freed 2007). The Board made its decision based on the psychiatrists’ research about addiction, the scientific comorbidity literature, and, as a former Board official explained, “[our] judgment … that there were a number of [training] programs [in psychiatry departments] extant at that time that were graduating a sufficient number of [psychiatry] fellows” (ABPNO-13). In 1993, 475 psychiatrists passed the first subspecialty examination in addiction psychiatry (American Board of Psychiatry and Neurology 2006). Importantly, the American Board of Psychiatry and Neurology stipulated that only those clinicians it first certified in general psychiatry were eligible to take its subspecialty examination in addiction psychiatry (see Galanter and Frances 1992).

Lastly, the National Advisory Committee gave “special emphasis” (Galanter et al. 1991, p. 5) in its training standards to the fellowship requirements of the Accreditation Council for Graduate Medical Education, the organization in American medicine that evaluates and approves all graduate medical training programs. These requirements included exposure to a diverse patient cohort, knowledge of medical, social, and cultural issues related to addiction, and teaching and research opportunities (Galanter et al. 1991). In 1996, it appears that the National Advisory Committee’s “special emphasis” paid off because the Accreditation Council began accrediting addiction psychiatry fellowships. Accreditation “allowed for standardization and elaboration of [fellowship] programs within psychiatry, with mandatory affiliation with general psychiatry residences as well” (Galanter et al. 2002, p. 198). In other words, by its action the Accreditation Council ensured that the only accredited fellowship training programs in addiction would be housed in departments of psychiatry to train only psychiatrists. Equally noteworthy, in 1998, with 1,776 board certified addiction psychiatrists, the American Board of Psychiatry and Neurology ordered that henceforth all applicants for its subspecialty examination in addiction psychiatry must first complete an accredited addiction psychiatry fellowship (Galanter et al. 2002). This requirement solidified “the establishment of addiction psychiatry firmly as part of postgraduate medical training” (Galanter et al. 2002, pp. 197-198).

Discussion: The Ideology of Formal Training

The 1970s underscored the need for medical training and credentialing in addiction. The fields of addiction medicine and addiction psychiatry addressed this need. Former First Lady Betty Ford’s effort to see that addicts receive treatment in special hospitals led the California Society for the Treatment of Alcoholism and Other Drug Dependencies to develop the first certification examination for physicians who practiced “addiction medicine.” In 1986, ASAM adopted this examination and administered it nationally to
doctors from different medical specialty backgrounds, some in addiction recovery, who opposed the psychiatric approach to substance abuse. However, ASAM certification in addiction medicine required no formal medical training in addiction medicine. Without board specialty recognition from the American Board of Medical Specialties, the field of addiction medicine could not establish departments of addiction medicine in medical schools to sponsor formal training programs. As one ASAM physician said, “when we started we didn’t have any training programs. The only people who offered anything were in psychiatry” (AM-4).

A small group of psychiatrists specialized in addiction despite stigma from mainstream mental health professionals. These psychiatrists, members of the American Psychiatric Association Committees on Alcoholism and Drug Abuse, also felt marginalized by ASAM-certified addiction medicine physicians whom the psychiatrists argued overlooked the crucial role of psychiatry in drug treatment. The scientific comorbidity literature supported this argument. Accordingly, the psychiatrists formed AAAP and focused on fellowship training programs in addiction.

In the medical profession, leaders of new specialty disciplines use formal training programs to not only enhance their skills but also to be able to say that formal training for their discipline exists. As Freidson (1970) asserts, formal training is ideological: occupational groups utilize formal training programs to acquire full control over their work. Leading AAAP psychiatrists developed national consensus standards for fellowship training programs in addiction to improve training and treatment skills but, more significantly, to ultimately privatize and institutionalize addiction training fellowships so that psychiatrists in addiction could acquire full professional and market control over the medical field of addiction, namely over ASAM-certified addiction medicine physicians, the only other group of doctors both interested in addiction and eligible to enroll in fellowship training programs.

Consider once more the origin and threefold strategy of the National Advisory Committee’s fellowship training standards. To be sure, “a profession is bound up with the pursuit of jurisdiction and the besting of rival professions” (Abbott 1988, p. 30). AAAP co-founded the Center for Medical Fellowships whose National Advisory Committee, which included influential AAAP psychiatrists, developed its fellowship training standards for AAAP. Related, the National Advisory Committee claimed to design its training standards for all addiction fellowship programs. However, the psychiatrists knew that other medical specialties and their medical school departments ignored substance abuse. As Marc Galanter (1993, p. 1) acknowledged, “the large majority of addiction fellowship programs operate in medical school departments of psychiatry.” How could the field of addiction medicine, the only other medical discipline likely to want to implement addiction training standards, do so without medical schools departments and training fellowships? Training standards for addiction fellowships would thus primarily, if not exclusively, serve only the training needs of psychiatrists.

Next, “in order to achieve jurisdictional control, a professional segment initiating the subordination of [an] ancillary work force needs support from established segments”
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(Halpern 1992, p. 1006)—the form of persuasion that Freidson (1970, p. 80) calls “lobbying.” To help convince the American Board of Psychiatry and Neurology to recognize addiction psychiatry as a medical subspecialty, the National Advisory Committee promoted a “caliber of training” (Galanter et al. 1991, p. 5) in its fellowship standards commensurate with the fact that psychiatry departments hosted most training programs and that most training fellows were psychiatrists (Galanter 1993; Galanter and Burns 1993). To repeat a former Board official about one reason why the psychiatrists won subspecialty recognition, “there were a number of [training] programs [in psychiatry departments] extant at that time that … were graduating a sufficient number of [psychiatry] fellows” (ABPNO-13). The American Board of Psychiatry and Neurology then privatized fellowship training programs in addiction by stipulating that only the clinicians it certified in general psychiatry could take its subspecialty examination in addiction psychiatry. Why would non-psychiatric addiction medicine physicians participate in a training fellowship if they were ineligible for the medical subspecialty credential to which that training led?

Finally, the Accreditation Council for Graduate Medical Education codified the body of knowledge that addiction fellowships disseminated after the National Advisory Committee put “special emphasis” (Galanter et al. 1991, p. 5) in its training standards on the Accreditation Council’s fellowship requirements. Accreditation ensured that addiction fellowships would be affiliated only with medical school departments of psychiatry, and would train only psychiatrists, in that the Accreditation Council accredited addiction psychiatry fellowships. “By creating a shelter for full-time teaching and research in professional schools, which is one of the consequences of accreditation, professions … can maintain control over innovations to the body of knowledge they claim as their own by keeping it within the professional family” (Freidson 1986, p. 83). The American Board of Psychiatry and Neurology could then justifiably require, as it did, that all applicants for its addiction psychiatry subspecialty examination must first complete an accredited addiction psychiatry fellowship. Fellowship training therefore became an institutionalized step toward the medical subspecialty credential to which it led. Moreover, compulsory accredited fellowship training assured the survival of both the training fellowships and the field of addiction psychiatry. The psychiatrists could control encroachment from ASAM-certified addiction medicine physicians by arguing that anything less than accredited fellowship training leading to a board recognized medical subspecialty credential is insufficient to treat addiction.

The psychiatrists, it would seem, had reason to make this argument. Larson (1977, p. xvi) notes that occupational groups organize to “constitute and control a market for their expertise.” Furthermore, market “legitimacy” is based on “the achievement of socially recognized expertise, or, more simply, on a system of education and credentialing” (Larson 1977, p. xviii). In the late 1980s and 1990s, as the fields of addiction medicine and addiction psychiatry continued to contend for power over addiction treatment (Freed 2007), ASAM-certified addiction medicine physicians and AAAP psychiatrists, the only two groups of doctors interested in addiction and equally committed to drug treatment, competed for patients with private insurance coverage.
“Psychiatrists felt that they were the ones who ought to provide all the treatment for addiction problems,” said one treatment specialist. “And many ASAM members felt that they were the ones who should be providing the treatment” (AM/AP-19). However, it was “the managed-care driven emphasis on credentialing and setting standards for providers of addiction treatment” (Galanter et al. 2001, p. 430) that actually determined which group of physicians received reimbursement for care.

Specifically, as the National Advisory Committee issued its consensus standards for fellowship training programs in addiction through when the American Board of Psychiatry and Neurology institutionalized addiction psychiatry fellowships, managed care introduced and expanded the reach of managed behavioral health care “carve-outs” (see Galanter et al. 2001; Miller 1995). Behavioral health care carve-outs, which managed care organizations administer separately from standard health care plans to cut costs, “contract with mental health and substance abuse specialist groups or preferred provider networks. Typically, [carve-outs] employ specialist ‘gatekeepers’ to assess and monitor patient need for access to and utilization of treatment within the network” (Galanter et al. 2001, pp. 422-423). In other words, beginning in the late 1980s and throughout the 1990s, behavioral health care carve-outs handled most of the mental health needs of the privately insured (Galanter et al. 2001). In as much as fellowship training programs for psychiatrists in addiction helped to persuade the American Board of Psychiatry and Neurology to formally recognize addiction as a medical subspecialty of psychiatry, that is, as a behavioral health problem, and in as much as the Accreditation Council for Graduate Medical Education eventually codified the knowledge that addiction psychiatry fellowships disseminated, addiction psychiatrists possessed the medical and training credentials that an insurance system crowded by behavioral health care carve-outs (Hodgkin et al. 2000; Lewis 2001) favored. Addiction psychiatrists, therefore, could control the patient market for the medical treatment of addiction which today, according to one ASAM member, still “creates a lot of ill-will” (AM/AP-16) among certified addiction medicine physicians.

Conclusion

Formal training distinguishes the professional from the layman (Larson 1977) and addiction psychiatrists from ASAM-certified addiction medicine physicians. Leading AAAP psychiatrists regarded fellowship training programs as the surest means to preserve psychiatry’s basic monopoly over substance abuse training, the most effective method to disseminate the psychiatric approach to addiction, and the clearest route to ensure lasting professional and economic standing for future generations of addiction psychiatrists. Leading AAAP psychiatrists developed national consensus standards for fellowship training programs in addiction, training programs which the American Board of Psychiatry and Neurology privatized and institutionalized, so that psychiatrists in addiction could acquire full professional and market control over the medical field of addiction. Fellowship training programs in addiction are as ideological as they are practical, and maybe more so.
Notes

1. To be precise, in 1967 the New York City Medical Society on Alcoholism became the American Medical Society on Alcoholism which, in 1985, became the American Medical Society on Alcoholism and Other Drug Dependencies after the American Medical Society on Alcoholism, the California Society, and still another group of physicians who treated drug abuse called the American Academy of Addictionology united. In 1989, ASAM officially formed. For clarity, only ASAM is named in the article as the national organization for the field of addiction medicine regardless of the time period under discussion.

2. The American Board of Medical Specialties currently recognizes 24 different medical specialties, or “Member Boards.” An analysis of why the field of addiction medicine has still not achieved board specialty recognition from the American Board of Medical Specialties is outside the scope of this article, but two hypotheses based on the interview data deserve some attention. First, in the late 1980s the field of addiction medicine lacked the substantive medical and scientific depth that the American Board of Medical Specialties requires for board specialty recognition. Second, because certified addiction medicine physicians represent several different medical specialty backgrounds, the American Board of Medical Specialties has concluded that an addiction medicine subspecialty under one or more of these medical specialty boards would yield more clinical benefit. In 2006, ASAM renewed its efforts to achieve board specialty recognition for addiction medicine (see American Society of Addiction Medicine 2006). It also deserves note that in 1990 ASAM developed “Guidelines for Fellowship Training Programs in Addiction Medicine” (see Bromley 1993). However, without board specialty recognition for addiction medicine from the American Board of Medical Specialties and medical school departments, these guidelines would serve no formal training utility.

3. The National Advisory Committee also developed its consensus standards for fellowship training programs in addiction for the Association for Medical Education and Research in Substance Abuse (AMERSA), the organization that co-founded the Center for Medical Fellowships with AAAP. AMERSA, founded in 1976 by doctors in the Career Teachers Training Program in Alcohol and Drug Abuse and first led by Marc Galanter, is a multidisciplinary organization of physicians and other health care professionals that is an important voice for medical education about addiction. However, as an organization AMERSA lacked the institutional access and authority in medical schools to integrate the National Advisory Committee’s fellowship training standards and thus had no practical use for them (for more information about AMERSA, see Samet et al. 2006).

References


American Board of Psychiatry and Neurology (2006), Personal Communication (April 28).

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