

Turning Points in Establishing the Medical Specialty of Addiction Medicine
(October 24, 2006; with November 22 selections for Hazelden Presentation)

1. 1951: New York City Medical Committee on Alcoholism established. (Under NCA; Marty Mann, Ruth Fox collaboration).

2. 1954: New York City Medical Society on Alcoholism's (NYCMSA) first scientific meeting, September 16, 1954 at New York Academy of Medicine).

Objectives:

- a. To gain recognition of alcoholism as a treatable disease**
- b. To persuade general hospitals to admit patients under the diagnosis of alcoholism**

3. 1967 (September): The New York City Medical Society on Alcoholism becomes the American Medical Society on Alcoholism (AMSA).

4. 1971: NIAAA, and the NIMH's Division of Narcotics and Drug Abuse (precursor of NIDA) create the Career Teacher Program for medical school faculty development grants (63 schools); Medical Monographs published on Diagnosis, Treatment, Pharmacology, other; under contract with NIDA, a Task Force is created at the National Board of Medical Examiners (NBME) to develop examination modules, and questions for medical specialty board examinations.

NIAAA Clearinghouse publishes curriculum guides for medical school; AMERSA founded (1976).

5. 1972: California Society for the Treatment of Alcoholism and Other Drug Dependencies incorporated: (Housed at CMA headquarters), emphasizing:

- a. Education, and**
- b. Proficiency and competence of the Society's members**

6. 1975: American Academy of Addictionology: a medical specialty society to certify physicians (Doug Talbott, M.D., Georgia)

7. 1978: American Medical Society on Alcoholism (AMSA) Board appoints an *ad-hoc* committee to consider credentialing options. Nothing concrete resulted at that time.

8. 1982: California Society for the Treatment of Alcohol and Other Drug Dependencies begins a certification program.

9. 1982 (I-82): AMA resolution is passed (submitted by the CMA) that a new or existing organization unify and represent the field. The policy is to have a single national medical specialty society to represent addiction medicine.

10. 1983: Kroc Ranch "Unity" meetings:

- a. February: The people attending the conference were individuals, not official representatives of organizations. The outcome of the conference was agreement only on the**

proposition that a single medical specialty society should represent the field; but this was not a consensus.

b. October (Convened by AMA): the conference accepts AMSA's offer "to be the national society of physicians concerned with problems of psychoactive drug use." (A History of Addiction Medicine, p. 58).

11. 1983: The Kroc Ranch "Unity" conference attendees agree that AMSA should become the national specialty society and represent addiction medicine, and should study alternative models for credentialing, including the possible formation of an independent certifying body.

12. 1986: AMSA elects to adopt the California Society model, and offer certification as a society nationally. The California Society gave AMSA its certification examination. The decision not to establish an independent board was, in part, based on the assumption that establishing an independent board would place addiction medicine outside organized medicine and lessen its legitimacy and its chances for later ABMS board recognition.

13. 1988 (A-88): ASAM is approved and accepted into membership by the House of Delegates of the American Medical Association (AMA) as a national medical specialty society.

14. 1989 (fall): ASAM Board establishes the Specialty Status Task Force (A. Geller, M.D., Chair) to:

a. study and evaluate various avenues and options that may be available for the eventual establishment of an ABMS-recognized specialty or sub-specialty certification in addiction medicine.

b. include as part of that study and evaluation the possible creation of a certifying entity independent of ABMS and ASAM.

c. report its findings and conclusions and recommendations for future actions to the President of ASAM by November 1990.

15. 1989-1990: The Specialty Status Task Force members and staff visited the leaders of specialty societies, specialty Boards, and organizations such as the ABMS; requested comments from ASAM members through announcements in ASAM News, and held an open hearing at the 1990 Medical-Scientific Conference in Phoenix.

16. 1990 (A-90): The AMA House of Delegates acts to assign addiction medicine a code as a self-designated practice specialty in the AMA Physician Masterfile by approving a resolution inspired by ASAM and introduced by the California Medical Association. The code (ADM) is officially approved by the AMA Board of Trustees in July.

17. 1990: ASAM Board approves the *ASAM Guidelines for Fellowship Training Programs in Addiction Medicine* (amended 1992), developed by the ASAM Fellowship Committee.

18. 1990: the ASAM Board adopts the Special Status Task Force Recommendations, contained in the Task Force's November 11, 1990 report, that:

a. In the short term, 1990-1994, ASAM should:

o continue to offer certification, and

o consider methods of making ASAM certification available to physicians who are not members of ASAM, and

o stimulate education in addiction medicine within as many specialties as possible: through ASAM specialty caucuses, approach as many specialties as possible to stimulate training programs and educational approaches of all sorts, with a view to encouraging and fostering potential interest in the establishment of Certificates of Added Qualifications (CAQs) and/or Certificates of Special Qualifications (CSQs) in as many specialties as possible.

b. In the intermediate term, 1995-1998, ASAM should continue to offer certification and seek establishment of CAQs and/or CSQs in as many specialties as possible, trying to engage cooperation in the efforts necessary to arrive at mutually acceptable training standards and an exam, with the understanding that using the same training standards and exam may not be feasible but is worth initial efforts to achieve it. ASAM should move toward this objective with an inclusive approach, and not take any action that would appear to restrict or exclude any specialty or to force a method or approach on any specialty. ASAM certification would still be available to individuals who do not meet eligibility requirements for sitting for specialty board exams.

c. In the very long term, from 1998-onward, ASAM should seek a Conjoint Board under the auspices of the American Board of Medical Specialties (ABMS).

“The Task Force concluded that the quest for specialty status is a dynamic, developmental process, and that ASAM should start the process, and continually evaluate what develops.”

19. 1994, 1998, 2003: *Principles of Addiction Medicine* published, documenting the scientific and clinical foundations of the specialty.

20. 1996: *Content of Addiction Medicine* developed, to outline the multi-disciplinary content of the specialty of addiction medicine.

21. 1996 and 1999: The ASAM Board resolves that “ASAM will make the development of fellowships a priority near-term goal. A plan, including allocation of resources towards this goal, should be prepared for further consideration by the Board of Directors.”

22. 1999:

a. The American Board of Preventive Medicine (ABPM) seeks ASAM support to apply to the ABMS for a subspecialty in addiction medicine open to all diplomats of ABMS member boards.

b. The ASAM Task Force on Specialty Status is re-established (Dr. Galanter, Chair).

c. ASAM and ABPM representatives meet in Chicago to discuss ABMS application. On learning of the scope and practice of addiction medicine, and of the ASAM credentialing

program (criteria for sitting, and the examination), the ABPM representatives say, “as you describe addiction medicine, it is a specialty, not a subspecialty.”

23. 2000: the ASAM Board votes to support the ABPM request, while continuing to consider alternative options.

24. 2001:

a. The American College of Physicians/American Society of Internal Medicine express an interest in encouraging a subspecialty.

b. The American Academy of Family Physicians’ leadership reiterates the Academy’s opposition to new subspecialties, while wanting family physicians to be eligible to sit for any new subspecialty.

c. (April): The ASAM Board adopts a three-part resolution:

MOTION: Encourage and assist the American Board of Preventive Medicine in its efforts to gain ABMS approval of sub-specialization of addiction medicine under ABPM alone or in conjunction with other ABMS boards.

MOTION: Continue to offer the ASAM Certification Examination to those physicians who meet the criteria to be eligible to sit.

MOTION: Compile additional information to help the ASAM Board determine whether the Society should assist in the formation of an independent American Board of Addiction Medicine, in the event ABMS sub-specialization proves not to be feasible.

25. 2003: ASAM Member Survey (p.13): “It is clear that members should pursue one major initiative in the future: advancing the specialty by gaining ASAM’s ‘board certified’ status on addiction medicine.

26. 2006:

a. (April): Medical Specialty Action Group (MSAG) is created.

b. (July): The ASAM Board approves the ASAM Strategic Plan to “establish addiction medicine as a primary specialty” (Mission Statement), “a recognized ABMS medical specialty” (ASAM’s Goals: 2006-2010); and to “develop standards for appropriate content on addictive disorders for use in residency training programs, and compile and disseminate information on the Addiction Medicine content of residency training programs” (Goal 1).

c. (August): The ASAM MSAG Steering Committee holds its first meeting by teleconference.

d. (October) The MSAG Steering Committee makes a presentation to the ASAM Board; the Board approves ongoing work by the MSAG according to the proposed Work Plan, with an appropriation of funding for face to face meetings and travel for outreach meetings with key individuals/organizations, and a report back to the Board in April 2007.

e. (December 1-2) The MSAG holds its first face-to-face meeting at Hazelden in Minnesota, and with the selection of Chairs of three MSAG Committees (Outreach, Training, and Finance), the MSAG Steering Committee composition is completed.