



ASAMNews

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Newsletter of The American Society of Addiction Medicine

**SPECIAL
REPORT**

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The next regular issue of ASAM News, featuring complete coverage of the Annual Med-Sci Conference, will appear in June. Watch for it!

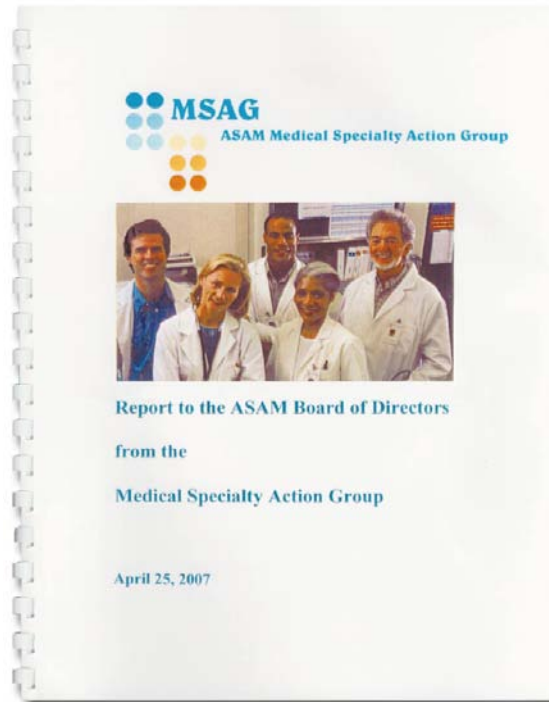
WWW.ASAM.ORG

ASAM Board Approves Plan to Seek Specialty Recognition of Addiction Medicine

Meeting in Miami during the Society's 38th Annual Medical-Scientific Conference, ASAM's Board of Directors approved a recommendation from the Medical Specialty Action Group (MSAG) that ASAM proceed with the steps necessary to achieve recognition of Addiction Medicine by the American Board of Medical Specialties (ABMS).

The MSAG, which has been co-chaired by ASAM President-Elect Michael M. Miller, M.D., FASAM, FAPA, and ASAM Chapters Council Chair Kevin Kunz, M.D., M.P.H., FASAM, was established by ASAM President Elizabeth Howell, M.D., FASAM, in April 2006, and charged with investigating all the considerations involved in applying to the American Board of Medical Specialties for recognition of Addiction Medicine. The MSAG made its initial presentation to the ASAM Board in October 2006, at which time the Board directed the Action Group to investigate and report back on the options of primary specialty status or subspecialty status. The MSAG held its inaugural meeting in December 2006 at the Hazelden Foundation, Center City, Minnesota, where roughly half of the 30 members were able to gather to plan the ensuing months' work.

Dr. Miller and Dr. Kunz report that the MSAG's recommendations and the ASAM Board's actions were prompted by members' growing concern that too few physicians are appropriately trained to diagnose and treat patients with alcohol, nicotine and other substance use disorders. Moreover, surveys show that most patients and their families are



uncertain as to how to identify a physician who can help them with such a disorder. Thus, the pursuit of ABMS recognition of Addiction Medicine serves not only ASAM members, but their patients, and also the public health.

Through a process of consultation with officials of certifying and accrediting bodies, leaders of new and long-standing medical specialty societies and Boards, and ASAM members, the Action Group analyzed the requirements for recognition of certifying boards, as well as for

accrediting training programs. Based on this information and extensive deliberations, the MSAG prepared a 60-page report to the ASAM Board that outlines the requirements for achieving recognition of Addiction Medicine, describes the specific steps ASAM must undertake if it decides to pursue formal recognition by ABMS, analyzes the costs and benefits of each of the available options, and makes recommendations for short- and long-term actions by the Society. The first step suggested by the MSAG was that an independent American Board of Addiction Medicine be established by the end of 2007. ASAM's Board of Directors voted to accept the full MSAG Report and approved the recommendations at its April 25th meeting in Miami.

This issue of **ASAM News** features a special report to the ASAM membership describing the MSAG's findings and recommendations, and outlining the proposed path toward specialty recognition for Addiction Medicine that has been approved by ASAM's Board.



ABMS Certificates Awarded, 1996-2005

To date, 24 specialties and 130 subspecialties (74 of them separate entities) have been recognized by the American Board of Medical Specialties, and more are coming on line all the time as medical science develops and as medical practice diversifies. The success stories of other specialties that have been accepted into membership by the ABMS provide a clearly delineated path for Addiction Medicine.

The following information is taken from the 2006 ABMS Certificate Statistics, compiled by the American Board of Medical Specialties.

SPECIALTY CERTIFICATES AWARDED

(total number awarded, 1996-2005)

Internal Medicine	73,070	Physical Med & Rehab	3,170
Family Medicine	33,074	Dermatology	3,080
Pediatrics	27,586	Otolaryngology	2,906
Psychiatry & Neurology	15,011	Urology	2,600
Radiology	12,439	Preventive Medicine	2,478
Anesthesiology	12,191	Plastic Surgery	2,082
Obstetrics & Gynecology	11,427	Thoracic Surgery	1,374
Surgery	10,904	Neurological Surgery	1,331
Emergency Medicine	10,407	Allergy & Immunology	1,171
Orthopedic Surgery	6,263	Nuclear Med	704
Pathology	5,277	Medical Genetics	895
Ophthalmology	4,696	Colon & Rectal Surgery	517

SUBSPECIALTY CERTIFICATES AWARDED

(average number per year, 1996-2005)

MORE THAN 400 PER YEAR

Cardiovascular Disease	Pulmonology
Interventional Cardiology	Critical Care

200-400 PER YEAR

Pain Medicine	Hematology
Endocrinology	Infectious Disease
GastroEnterology	Oncology
Geriatric Medicine	Nephrology

100-200 PER YEAR

Rheumatology	Geriatric Psychiatry
Cytopathology	Neuroradiology
Neonatal-Perinatal Medicine	Vascular & Interventional Radiology
Addiction Psychiatry*	Clinical Cardiac Electrophysiology
Child & Adolescent Psychiatry	Maternal-Fetal Medicine
Clinical Neurophysiology	Hand Surgery
Forensic Psychiatry	Sports Medicine

50-100 PER YEAR

Adolescent Medicine	Pediatric Hematology-Oncology
Pediatric Cardiology	Pediatric Emergency Medicine
Pediatric Critical Care Medicine	

LESS THAN 50 PER YEAR

(35 subspecialties)

* 1999-2006: - 40/year

American Society of Addiction Medicine

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ASAM is a specialty society of physicians concerned about alcoholism and other addictions and who care for persons affected by those illnesses.

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A Report to ASAM's Members from the MEDICAL SPECIALTY ACTION GROUP

Kevin Kunz, M.D., M.P.H., FASAM, and Michael M. Miller, M.D., FASAM, FAPA, Co-Chairs



Co-Chairs, Kevin Kunz, M.D., M.P.H., FASAM, and Michael M. Miller, M.D., FASAM, FAPA.

The leadership of the American Society of Addiction Medicine has a long-term commitment to achieving the formal recognition of Addiction Medicine by the American Board of Medical Specialties. In 2006, this commitment was codified in ASAM's Mission Statement and Strategic Plan. Concurrently, then-President Elizabeth F. Howell, M.D., FASAM, created the Medical Specialty Action Group (MSAG) to "develop a knowledge base and recommend actions to the ASAM Board regarding the recognition of Addiction Medicine as a Board-certified medical specialty by the American Board of Medical Specialties."

The MSAG was charged with gathering relevant information, analyzing the advantages and disadvantages of various options, making a recommendation as to which option ASAM ought to pursue, and explaining the rationale for and implications of the recommended course of action. The Group was asked to report on its work at the ASAM Board meeting in April 2007.

MSAG Structure and Work Schedule

A planning team consisting of the MSAG Co-Chairs, the ASAM Executive Vice President, the ASAM Credentialing Director, and the MSAG Consultant met in weekly conference calls, beginning in July 2006. To assure that the MSAG would have broad representation from the ASAM membership, the MSAG Steering Committee publicized the initiative widely and invited members to participate. To assure that the many medical specialties that comprise ASAM would be represented, the Steering Committee developed an *MSAG Structure and Guidelines for Selecting Members*. Through this process, 30 members agreed to serve on one of four MSAG groups: the Process and Structure Committee, the Training Committee, the Finance Committee, and the Steering Committee (see page 4).

The MSAG held its first face-to-face meeting December 1-2, 2006, at the Hazelden Foundation in Center City, Minnesota. There, the group began to explore the possibilities for a post-residency subspecialty of multiple primary specialties, as well as a primary specialty with a dedicated residency. Attendees acknowledged that each of these options had multiple pros and cons. The spirit that united the group was best expressed by James W. Smith, M.D., FASAM, who said, "We can pursue one option or another, but in the end, we should do whatever will save the most lives."

Following the Hazelden meeting, the Steering Committee was expanded to include the Chairs and Co-Chairs of the three MSAG Committees created December 2, and then met in conference calls weekly to discuss progress and review the work of the component MSAG Committees, which held their own weekly or biweekly meetings.

At the end of March 2007, the Steering Committee, along with several invited guests who had been key contributors to the MSAG Committee on which they served, held a face-to-face meeting in Philadelphia to agree on the recommendation it would make to the ASAM Board of Directors.

MSAG's Research and Results

Working through the four committees, the MSAG members extracted information, key documents and reference materials from Internet sources, existing medical specialty Boards, medical specialty societies, and related organizations. They studied the experience of recent and prospective applicants to the ABMS to learn how applicants have successfully navigated the process of attaining ABMS recognition. Through interviews with representatives of the American Board of Medical Specialties (ABMS) and the Accreditation Council on Graduate Medical Education (ACGME), as well as leaders of many ABMS member Boards, plus other key informants, the MSAG members compiled and collated the criteria and procedures for attaining ABMS member Board status as a specialty or subspecialty, and for creating and maintaining ACGME-accredited training programs.

The careful research conducted by the MSAG produced a unique historic and dynamic review of the evolution and current operation of ABMS specialties and subspecialties approved over the past 30 years.

That information is summarized in the report presented by the MSAG to ASAM's Board on April 24th and 25th, which also contained specific recommendations for future action. The Board voted to accept the MSAG report and approved the recommendations, setting Addiction Medicine on a path toward the achievement of recognition as a medical specialty.

The Action Group is committed to keeping ASAM's members and other interested parties fully informed of its progress. This special issue is a first step. There is also a page of information, with links to dozens of resource documents, under the "Certification" tab on ASAM's website (WWW.ASAM.ORG). Watch the website and future issues of **ASAM News** to follow ongoing developments.

Members of ASAM's Medical Specialty Action Group

ASAM's Medical Specialty Action Group (MSAG) was charged by the Society's Board of Directors with gathering relevant information, analyzing the advantages and disadvantages of various paths toward specialty recognition, and making a recommendation to the Board as to which option ASAM ought to pursue. To lead the initiative, the Board named Kevin Kunz, M.D., M.P.H., FASAM, and Michael M. Miller, M.D., FASAM, FAPA as co-chairs of the MSAG.

The MSAG met its charge through the work of the following committees, all of which contributed to the report that was accepted by the ASAM Board at its April 25th meeting in Miami.

Steering Committee

The Steering Committee was composed of the MSAG co-chairs, the chairs and co-chairs of each of the other committees, the ASAM Executive Vice President, the MSAG Consultants, and the ASAM Director of Credentialing. The role of the MSAG Steering Committee was to coordinate the work of the other MSAG committees, communicate progress to ASAM members and others, and prepare a report for review and action by the ASAM Board of Directors. Members of the Steering Committee are:

Kevin Kunz, M.D., M.P.H., FASAM, *Co-Chair*
Michael M. Miller, M.D., FASAM, FAPA, *Co-Chair*
James F. Callahan, D.P.A.
David R. Gastfriend, M.D.
Stuart Gitlow, M.D., M.P.H., M.B.A.
R. Jeffrey Goldsmith, M.D., FASAM
Michael M. Miller, M.D., FASAM, FAPA
Eileen McGrath, J.D.
Michael M. Miller, M.D., FASAM, FAPA
Christopher M. Weirs, M.P.A.
Bonnie B. Wilford, M.S.
Martha J. Wunsch, M.D., FAAP, FASAM

Special Advisors:

Brian Hurley, M.B.A. (Medical Student)
David C. Lewis, M.D. (Internal Medicine)
John A. Renner, Jr., M.D., DLFAPA (Psychiatry)
Norman Wetterau, M.D. (Family Medicine)

Process and Structure Committee

The role of the Process and Structure Committee was to gather data on the requirements, process, costs and other issues to be addressed by ASAM to attain recognition of Addiction Medicine by the American Board of Medical Specialties (ABMS). Much of this work was conducted through an extensive series of structured interviews with leaders of other medical specialty societies and medical specialty Boards. Members of the Process and Structure Committee are:

David R. Gastfriend, M.D., *Co-Chair*
Martha J. Wunsch, M.D., FAAP, FASAM, *Co-Chair*
James F. Callahan, D.P.A.
Robert L. DuPont, M.D., FASAM
David R. Fiellin, M.D.
Larry M. Gentilello, M.D., FACS
Kevin Kunz, M.D., M.P.H., FASAM
David C. Lewis, M.D.

Daniel J. McCullough, M.D.
Eileen McGrath, J.D.
Michael M. Miller, M.D., FASAM, FAPA
Seddon R. Savage, M.D., FASAM
Marvin D. Seppala, M.D.
Norman Wetterau, M.D.

Training Committee

The role of the Training Committee was to gather data on what Addiction Medicine needs to do to create training programs that meet the guidelines set forth by the Accreditation Council on Graduate Medical Education (ACGME); the content of the training to be offered; whether training programs currently exist that meet the ACGME's guidelines, and (with the MSAG Finance Committee) to determine what it will cost to create and sustain training programs in Addiction Medicine. Members of the Training Committee are:

R. Jeffrey Goldsmith, M.D., *Chair*
Mickey N. Ask, M.D., FASAM
Gavin B. Bart, M.D.
Jeffrey D. Baxter, M.D.
Jeffrey A. Berman, M.D., M.S., FASAM
Marc Galanter, M.D., FASAM
Mark S. Gold, M.D.
Denise E. Greene, M.D.
William F. Haning III, M.D., FASAM
Gary D. Helmbrecht, M.D.
Merrill S. Herman, M.D.
Mary G. McMasters, M.D.
John A. Renner, Jr., M.D., DLFAPA
Richard K. Ries, M.D.
Stephen J. Ryzewicz, M.D.
Richard Saitz, M.D., M.P.H., FASAM
Sidney H. Schnoll, M.D., Ph.D., FASAM
Barry Stimmel, M.D., FASAM
Joseph Westermeyer, M.D., Ph.D.

Finance Committee

The role of the Finance Committee was to gather data on the revenue and expenses involved in achieving ABMS and ACGME recognition of Addiction Medicine, including the income and expenses to ASAM, the costs to finance the MSAG until ABMS recognition is achieved, and the financial arrangements required to create and sustain both ABAM and the ACGME-approved Addiction Medicine training programs. Members of the Finance Committee are:

Stuart Gitlow, M.D., M.P.H., M.B.A., *Chair*
Thomas J. Brady, M.D.
Lawrence S. Brown, Jr., M.D., M.P.H., FASAM
Martin C. Doot, M.D., FASAM
Brian Hurley, M.B.A.
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Penelope P. Ziegler, M.D., FASAM

SPECIAL REPORT:

Actions of the Board of Directors of the American Society of Addiction Medicine on Recommendations Presented by the Medical Specialty Action Group

The American Society of Addiction Medicine is a national medical specialty society of more than 3,000 physicians. Its mission is to increase access to and improve the quality of addiction treatment; to educate physicians, other health care providers and the public; to support research and prevention; to promote the appropriate role of the physician in the care of patients with addictive disorders; and to establish Addiction Medicine as a primary specialty recognized by professional organizations, governments, physicians, purchasers and consumers of health care services, and the general public. ASAM was founded in 1954, and has had a seat in the American Medical Association House of Delegates since 1988.

The leadership of the ASAM is committed to the formal recognition and designation of specialty status for the field of Addiction Medicine by the American Board of Medical Specialties. This commitment was codified in ASAM's Mission Statement and Strategic Plan, most recently revised in 2006. Concurrently, ASAM President Elizabeth F. Howell, M.D., FASAM, created a Medical Specialty Action Group (MSAG) to "develop a knowledge base and recommend actions to the ASAM Board regarding the recognition of Addiction Medicine as a Board-certified medical specialty by the American Board of Medical Specialties."

In October 2006, the ASAM Board of Directors, based on its understanding at the time and after review of multiple options, directed the MSAG to gather data on two options for ABMS recognition, which it described as follows:

Option 1. Establish an independent American Board of Addiction Medicine (ABAM) now, to become an ABMS primary specialty Board, or

Option 2. Establish an independent ABAM now, create Addiction Medicine as a subspecialty of several ABMS-recognized specialties, and later seek to establish Addiction Medicine as an ABMS primary specialty Board.

The MSAG was charged with gathering relevant information, analyzing the advantages and disadvantages of each option, making a recommendation as to which option ASAM ought to pursue, and explaining the rationale for and implications of the recommended course of action. The MSAG was asked to report on its work to the ASAM Board of Directors during the Society's annual meeting in April 2007.

This charge was met through a presentation of the MSAG's report and recommendations to the ASAM Board on April 24, 2007, which were acted on by the Board the next day, when it voted to accept the report and approve the recommendations (see page 9). The following is a synopsis of the MSAG's report and the actions taken by the ASAM Board of Directors.

METHODS

To assure that the MSAG would have broad representation from the ASAM membership, the MSAG Steering Committee publicized the initiative widely and invited members to participate. To assure that the many medical specialties that comprise ASAM would be represented, the Steering Committee developed a document titled the *MSAG Structure and Guidelines for Selecting Members*.

Through this process, 30 members agreed to serve on one of four committees of the MSAG: the Process and Structure Committee, the Training Committee, the Finance Committee, and the Steering Committee. The Steering Committee was composed of the MSAG co-chairs, the chairs and co-chairs of each of the other committees, the ASAM Executive Vice President, the MSAG Consultants, and the ASAM Director of Credentialing.

The members extracted information, key documents and reference materials from Internet sources, existing Boards, medical specialty societies, and related organizations. Members of the MSAG studied the experience of recent and prospective applicants to the ABMS to learn how applicants have successfully navigated the process of attaining ABMS recognition.

Through interviews with representatives of the ABMS and the ACGME, as well as leaders of many ABMS member Boards and other key informants, the MSAG members compiled and collated the criteria and procedures for attaining ABMS member Board status as a specialty or subspecialty, and for creating and maintaining ACGME-accredited training programs. In addition, the MSAG's research resulted in a unique historic and dynamic review of the evolution and current operation of ABMS specialties and subspecialties approved over the past 30 years.

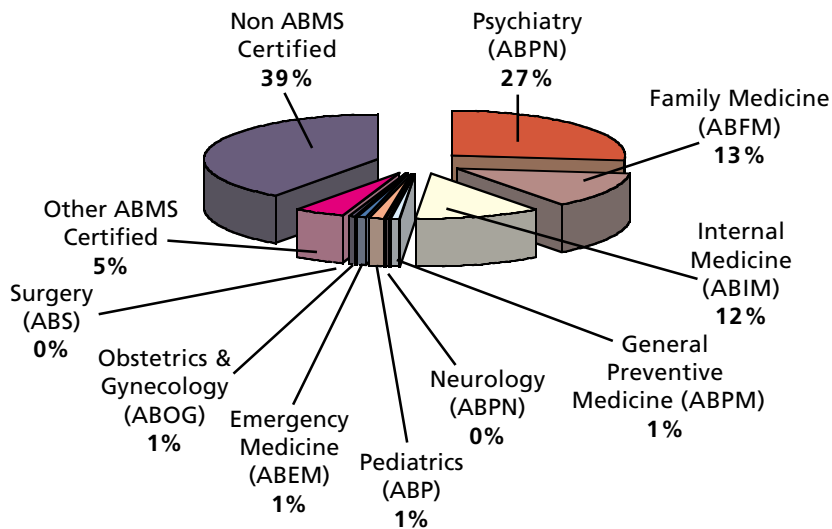
BACKGROUND TO THE REPORT

Addiction is a major public health problem in America. Addiction Medicine is a specialized area of medical practice that is recognized by the American Medical Association, by government agencies, health insurers, other private-sector organizations, most health care professionals, and many laypersons. However, Addiction Medicine is not yet a medical specialty recognized by the ABMS.

As the leader in this specialty, ASAM has developed educational programs and other processes to increase, to document, and to recognize the knowledge base in Addiction Medicine. Since 1986, ASAM has offered a process through which physicians who wish to demonstrate their expertise can become certified in Addiction Medicine. The heart of the certification process is an examination developed for ASAM by the National Board of Medical Examiners — an examination that is similar in scope and rigor to the examinations employed by many ABMS-recognized medical specialties and subspecialties.

Through the ASAM examination, 4162 physicians have been certified in Addiction Medicine. However, these physicians are not, and cannot describe themselves as, Board-certified because there is no specialty Board representing Addiction Medicine, either ABMS-recognized or self-designated.

Distribution of Current ASAM Members, by ABMS Board Specialty



In the absence of an ABMS-recognized specialty of Addiction Medicine, patients and their families, and even medical colleagues, do not always know how to find a physician who has expert knowledge and skills in the evaluation and management of addictive disorders. Hospital medical staffs and academic medical centers do not have official departments of Addiction Medicine. Managed care panels often do not include such specialists to care for members who have addictive disorders, do not reimburse for such care at rates comparable to those for other specialized care, and do not involve Addiction Medicine physicians in their utilization review panels.

This imbalance is even more striking when one considers recent Federal data showing that one in four hospital admissions in the U.S. is related to an alcohol, tobacco or drug use disorder, and that millions of Americans are affected by such disorders in a family member.

The members of the MSAG were motivated by a conviction that accreditation of Addiction Medicine training by ACGME and recognition of Addiction Medicine by ABMS would support the highest standards in training and certification for Addiction Medicine physicians, to the benefit of the patients and families who receive care from them.

ASAM-Certified Physicians, by ABMS Board Specialty

ASAM	ABMS	SPECIALTY
65	40	Addiction Psychiatry
5	3	Aerospace Medicine
1	1	Allergy & Immunology
1	0	Anatomic Pathology
62	49	Anesthesiology
5	2	Cardiovascular Disease
3	3	Chemical Pathology
29	23	Child and Adolescent Psychiatry
3	0	Clinical Pharmacology
2	2	Dermatology
4	3	Diagnostic Radiology
49	37	Emergency Medicine
2	2	Endocrinology, Diabetes and Metabolism
765	532	Family Medicine
8	0	Forensic Pathology
3	3	Forensic Psychiatry
10	6	Gastroenterology
15	14	General Practice
122	39	General Preventive Medicine
2	2	General Surgery
2	2	Geriatric Medicine (Family Practice)
4	4	Geriatric Psychiatry
1	1	Hematology (Pathology)
1	1	Hematology/Oncology
1	1	Infectious Disease
667	498	Internal Medicine
2	2	Internal Medicine/Pediatrics
1	1	Maternal & Fetal Medicine
2	2	Nephrology
12	7	Neurology
6	3	Neurological Surgery
1	1	Neuropsychiatry
1	1	Nuclear Medicine
27	23	Obstetrics & Gynecology
1	0	Occupational Medicine
3	2	Ophthalmology
7	6	Orthopedic Surgery
3	3	Otolaryngology
20	16	Pain Management
4	3	Pain Medicine
2	0	Palliative Medicine
3	0	Pediatric Anesthesiology (Anesthesiology)
65	56	Pediatrics
6	2	Physical Medicine & Rehabilitation
2	1	Plastic Surgery
1400	1066	Psychiatry
2	1	Psychoanalysis
1	1	Pulmonary Critical Care Medicine
1	1	Pulmonary Disease
2	2	Radiation Oncology
3	3	Radiology
1	1	Rheumatology
32	25	Surgical Critical Care (Surgery)
1	1	Thoracic Surgery
4	4	Urology
4,162	2,559	TOTAL

FINDINGS REGARDING SPECIALTY RECOGNITION

A number of recent developments suggest that the addiction field may be at a “tipping point” in history — a time at which many vectors are aligned to pave the way for a fully recognized medical specialty or subspecialty of Addiction Medicine. Certainly, the extraordinary level of cooperation and guidance the MSAG received from the leaders of other medical Boards and specialty societies, as well as from officials of the ABMS and ACGME, was most encouraging.

A Unique Body of Knowledge Must be Defined

An applicant to the ABMS or ACGME must be able to demonstrate that its body of knowledge and training programs are distinct from those of an already-approved ABMS Board. Specifically, the application must document that the new medical specialty meets the definition of “an area of medical practice which connotes special knowledge and ability resulting from specialized effort and training in the specialty field.” Given that the subspecialty of Addiction Psychiatry already exists within the ABMS structure, an application for Addiction Medicine must distinguish between the two fields. As an exploratory step, the MSAG Training Committee initiated the task of outlining three key documents that define Addiction Medicine (including those elements that distinguish it from Addiction Psychiatry): core content, core competencies, and scope of practice.

An Independent Board of Addiction Medicine is Necessary

The MSAG also investigated whether it is necessary to create an independently incorporated American Board of Addiction Medicine (ABAM) as an initial step in the process of seeking ABMS recognition for Addiction Medicine, either as an ABMS specialty Board or as a subspecialty of one or more ABMS-recognized specialty Boards. The MSAG members learned that this is indeed an essential step.

The ABMS Bylaws stipulate that “a medical specialty Board must be a separately incorporated, financially independent body...” Several sources confirmed that Addiction Medicine’s certifying Board must be separately incorporated as an independent Board, with no overlap between the governance of the specialty society (ASAM) and the certifying Board (ABAM).

Multiple sources also confirmed the ACGME requirement that an applicant seeking to accredit training programs must first apply to the ABMS for approval. Thus, a separately incorporated Board is necessary even to apply to the ACGME. (The ACGME does not require that such a Board actually *obtain* ABMS approval, but it does require that an application for approval be made to the ABMS before it will accept an application to the ACGME.)

Finally, the MSAG members learned that a Board is fundamentally different from a medical specialty society, and that the two organizations have distinct missions and governance processes. As one interviewee told us, “We’re a business. We have a business plan. Our business is to certify diplomates [and to assure they maintain their certification status].”

Training Programs are Key

Availability of ACGME-accredited training programs are the key element in approval of a new ABMS specialty Board or a new subspecialty. Indeed, the most difficult challenge to be met in achieving ABMS recognition of Addiction Medicine is to establish, financially support, and continually fill Addiction Medicine training programs.

Addiction Medicine training programs would first be accredited by ABAM, using criteria that reflect those of the ACGME. In a second phase, ABAM would apply to the ACGME to establish a new accreditation process for training in Addiction Medicine. Before applying to the ACGME for accreditation of training programs, an applicant Board must have applied to the Liaison Committee on Specialty Boards (LCSB) for recognition as a new examining Board or for subspecialty certification by one or more ABMS member Boards. (ASAM as an organization would officially support the application to the LCSB.)

Regardless of the decision by the LCSB, the applicant Board may then submit an application to the ACGME, which determines

the recognition of a new medical discipline and its associated review committee. Prior to the ACGME review, an *ad hoc* committee (including members nominated by the applicant organization) reviews each petition. The applicant must provide information similar to that required by the ABMS for recognition of a new examining Board or new subspecialty certificate. Following its review of the petition, the *ad hoc* committee makes one of three recommendations to the ACGME:

- 1. PRELIMINARY APPROVAL FOR DEVELOPMENT OF THE NEW SPECIALTY.** If this recommendation is accepted by the ACGME Board of Directors, the petitioners are authorized to develop Program Requirements appropriate to the new specialty. The *ad hoc* committee will recommend the structure and function of an appropriate Residency Review Committee with no more than three appointing organizations; or
- 2. REFER THE APPLICATION TO AN EXISTING RESIDENCY REVIEW COMMITTEE** to be considered for inclusion in the current specialty or for consideration as a new subspecialty of the existing general specialty; or
- 3. DENY THE APPLICATION.** In the case of a proposed subspecialty certificate, the ACGME requires documentation that there has been appropriate communication between the proposed Residency Review Committee and the relevant ABMS Board(s) concerning the proposed subspecialty area, and (1) that the Board(s) awards a certificate in the subspecialty and supports accreditation in that area; or (2) that the Board(s) does not intend to award a certificate at this time, but is not opposed to the Review Committee’s beginning to accredit training programs in the subspecialty; or (3) that the Board(s) opposes accreditation of training programs in the proposed subspecialty.

continued on page 8

FINDINGS *continued on page 8*

The cost of establishing training programs appears to vary widely because the process differs from one facility or program to the next. For example, some institutions reported direct costs of programs in the range of \$50,000 per trainee per year, while other institutions added indirect costs and faculty expenses, bringing the total to \$200,000 per trainee per year.

ABMS Recognition is Essential

In the course of the MSAG's research, the importance of ABMS Board recognition was underscored by many of the leaders consulted. None stated the argument more clearly than one Board executive, who at the end of the interview was asked, "Do you have further advice to give us?" He replied: "Yes. ABMS Board certification is what it is all about. It's not about CME and brochures. Your members' future and improved patient care lies in receiving ABMS certification. If this is not achieved, then you can predict that there will be no future for your specialty."

Specialty Versus Subspecialty Status

As described in the ABMS Bylaws, a *primary specialty board* is a separately incorporated, financially independent body, which determines its own requirements and policies for certification, elects its members in accordance with the procedures stipulated in its own bylaws, accepts its candidates for certification from persons who fulfill its stated requirements, administers examinations, and issues certificates to those who voluntarily take and pass such examinations.

A *conjoint Board* is an ABMS-recognized member Board that is "separately incorporated and has similar responsibility for determination of requirements for certification, accepting candidates for certification, administering examinations, and issuing certificates" as a primary specialty Board. A conjoint Board is established under the joint sponsorship of not less than two primary specialty Boards. Medical specialty organizations such as ASAM also may be included as sponsors.

Subspecialty certification is conferred by one or more ABMS member Boards to designate special competence in a component of a specialty. Subspecialty certification is conferred only on physicians who are certified in a primary medical specialty by one or more ABMS member Boards in an area of general certification.

The MSAG Steering Committee gave particular attention to:

- (1) scope of practice,*
- (2) training,*
- (3) funding,*
- (4) feasibility and*
- (5) flexibility.*

In evaluating the various options, the MSAG Steering Committee gave particular attention to: (1) scope of practice, (2) training, (3) funding, and (4) feasibility and (5) flexibility.

1. SCOPE OF PRACTICE. A major difference between a primary Board and a conjoint Board is that a primary Board's members are physicians from within a single specialty, whereas the members of a conjoint Board are drawn from multiple primary specialties. This is much more closely aligned with the composition of Addiction Medicine.

Like a subspecialty, a candidate for certification in Addiction Medicine by a conjoint Board already would be credentialed by a sponsoring primary Board. Thus, no other Board need be concerned that Addiction Medicine is drawing away its candidates or otherwise encroaching on its scope of practice.

2. TRAINING. An attractive feature of both a conjoint Board and a subspecialty is that, under the customary model, candidates for Board certification would be required to take only a one- or two-year Addiction Medicine fellowship after completing their residency training, rather than taking a full three- or four-year residency in Addiction Medicine, as would be the case with a primary specialty.

Another model of training under a conjoint Board might involve a one-year post-residency training program. For example, the American Board of Emergency Medicine currently offers a five-year program to be double-Boarded in Emergency Medicine and Internal Medicine or Emergency Medicine and Pediatrics (a

similar program with Family Medicine is in development).

3. FUNDING. Creation of either a subspecialty or a conjoint Board would sharply reduce or eliminate the problem of funding training, because Addiction Medicine would not have to support the development of entirely new residency programs. Instead, a much more modest expense could be incurred by adapting existing programs to include the essential competencies in Addiction Medicine.

4. FEASIBILITY. Establishment of either a subspecialty or a conjoint Board may be attractive to Psychiatry, Internal Medicine, Family Medicine, Pediatrics, and other ABMS primary Boards whose patients are significantly affected by addictive disorders because neither option requires them to accommodate a new specialty. Moreover, the addition of Addiction Medicine may be helpful in attracting candidates to fill currently vacant training slots.

5. FLEXIBILITY. Flexibility also is a desirable feature of a conjoint Board. For example, the experience of the American Board of Emergency Medicine demonstrates that ABMS acceptance of a conjoint Board does **not** preclude subsequent recognition as a primary specialty. (On the other hand, it appears that ABMS recognition of Addiction Medicine as a subspecialty would foreclose the possibility of later recognition as a primary specialty.)

After evaluating the multiple factors associated with each of these options, the MSAG members identified certain key differences. For example, if a decision is made to pursue recognition of Addiction Medicine as a specialty through either a primary or a conjoint Board, ABAM would remain in existence in perpetuity, and ASAM would continue as the membership organization of choice. On the other hand, if a decision is made to pursue subspecialty status, ABAM will be dissolved whenever its role is subsumed by an existing primary Board or Boards.

The original description of Option 2 by the ASAM Board of Directors was based on the assumption that, at some point after subspecialty status was attained, an application could be made for primary specialty status. That assumption appears to be incorrect.

A reservation related to the pursuit of a conjoint Board derives from the fact that, although requirements for conjoint Boards exist within the ABMS Bylaws and several conjoint Boards have been approved (with one currently active), no new conjoint Board has been approved for several decades.

CONCLUSIONS AND RECOMMENDATIONS

In weekly conference calls and in daily email exchanges, the MSAG Steering Committee discussed the reports and findings of the other three committees of the MSAG. However, Steering Committee members withheld any decisions or conclusions as to the best option until they could meet face-to-face in Philadelphia at the end of March 2007.

Conclusions

At its March meeting, the MSAG Steering Committee concluded that ABMS recognition of Addiction Medicine as a primary specialty is not attainable in the coming decades because it is not feasible to develop primary residencies in Addiction Medicine in sufficient numbers to produce a critical mass of diplomates for a primary Board. Without such training programs and trainees, a certification process could not be established.

The Steering Committee also determined that either a conjoint Board or subspecialty certification in Addiction Medicine do appear possible. Choosing between these two options clearly requires additional research and extensive consultation with the leaders of ABMS, ACGME, and other specialty Boards, many of whom have been extraordinarily helpful as the MSAG committees pursued their preliminary research.

Therefore, the MSAG Steering Committee, having been presented with Options 1 and 2 in October 2006, came to favor what it called "Option 3," which it defined as "Take action, while deferring a final decision."

Because the ABMS and ACGME requirements are similar (albeit not identical) for recognition of a specialty Board or subspecialty certification, the Steering Committee determined that it is possible to create an American Board of Addiction Medicine, which then would take the next steps in building the required infrastructure and preparing an application to ABMS and ACGME. This could be done while deferring the actual decision as to whether to pursue recognition of Addiction Medicine as a conjoint specialty or as a subspecialty. Option 3 thus would allow the process to move forward, even as it affords time for essential dialogue and consultations with the leaders of potential sponsoring Boards and other medical organizations.

Under Option 3, ASAM would create ABAM and give it the responsibility for physician credentialing through administration of the Certification/Recertification Examination. ABAM also would assume responsibility for creating a process to certify training programs and to continue a dialogue about specialty versus subspecialty recognition with a variety of stakeholders.

The very act of setting up ABAM would send a clear message to ASAM's members and the larger medical community that Addiction Medicine is moving forward. Other advantages of Option 3 are that it would allow time to fully vet the core content, core competencies, and scope of practice of Addiction Medicine, both within ASAM and with other Boards and specialty organizations. It also would afford sufficient time to develop guidelines for accreditation

"We can pursue one option or another, but in the end, we should do whatever will save the most lives."

***— James W. Smith, M.D., FASAM,
at the MSAG Inaugural Meeting,
December 1, 2006.***

of fellowship training (either by ASAM or ABAM) that are aligned with ACGME's accreditation guidelines, in preparation for full ACGME recognition of training in Addiction Medicine.

Recommendations

ASAM's Board of Directors had multiple priorities to consider. One is the future of Addiction Medicine; another is the future of ASAM. The mission of ASAM, as articulated in the Society's 2006 Strategic Plan, is "To improve the care and treatment of people with the disease of addiction and advance the practice of Addiction Medicine." The members of the MSAG are convinced that, once Addiction Medicine has achieved membership in ABMS, patients and their families will benefit greatly and the health status of Americans will be improved.

To empower the Society to take the steps necessary to the success of this initiative, the MSAG Steering Committee recommended and the ASAM Board approved Option 3, with benchmarks for essential activities.

By approving Option 3, ASAM's Board took definitive action to create an American Board of Addiction Medicine, while deferring a decision as to which path to take to achieve accreditation of training programs by the Accreditation Council on Graduate Medical Education and the recognition of Addiction Medicine by the American Board of Medical Specialties.

The path forward will not be easy. The obstacles are political and attitudinal, as well as structural and procedural. Specifically, success in attaining recognition as a conjoint Board or subspecialty will require a full understanding and careful response to the requirements of ACGME and ABMS, as well as the time and effort required to consult with existing specialty Boards and other medical specialty societies.

Next Steps Toward ABMS Recognition of Addiction Medicine

The MSAG Steering Committee understood that it was undertaking a task for which many ASAM members had worked for decades. The Committee also understood that achievement of ABMS certification is a long-term project that will be accomplished in three phases.

In *Phase I* (2003 – October 2006) the ASAM membership and the ASAM Board of Directors arrived at a consensus to seek specialty recognition. The consensus was expressed in the Board's decision to create and finance the MSAG.

In *Phase II* (October 2006 – April 2007), the MSAG developed the knowledge base and the Steering Committee prepared its report and recommendations to the ASAM Board.

The Board's approval of the MSAG report and recommendations launches *Phase III*: the establishment of the American Board of Addiction Medicine, leading over several years to the development of accredited training in Addiction Medicine, and ultimately leading to ABMS recognition of Addiction Medicine.

The specific steps recommended by the MSAG and approved by the ASAM Board of Directors include the following:

STEP 1.

ASAM will encourage and assist in the development of an American Board of Addiction Medicine (ABAM), with incorporation of ABAM targeted for the end of 2007.

STEP 2.

The ASAM President and Executive Vice President will communicate and engage in dialogue with officials of ABMS member specialty Boards and medical specialty societies regarding the ASAM Board's decision and plans. The dialogue will include leaders of the American Board of Medical Specialties, the Accreditation Council for Graduate Medical Education, the American Medical Association, and other parties with an interest in formal recognition of the specialty of Addiction Medicine by the ABMS.

The Board's approval of the MSAG report launches Phase III: the establishment of the American Board of Addiction Medicine

STEP 3.

The Medical Specialty Action Group will continue its work until ABAM has been created. The MSAG will be reconstituted to include ASAM members who are Board-certified in the specialties whose Boards and medical societies are prospective sponsors of ABAM. The reconstituted MSAG will be responsible for suggesting a governance and staff structure for ABAM, as well as the initial requirements for a mission statement, budget and operating plan.

STEP 4.

After ASAM's 2008 certification examination, the process of certifying individual physicians in Addiction Medicine will be transferred from ASAM to ABAM. This will require that the MSAG (a) determine the value of the intellectual property ASAM has invested in developing and refining its Credentialing Program over the past two decades, and (b) devise a process for transferring ownership of the ASAM Credentialing Program to the American Board of Addiction Medicine.

STEP 5.

While ABAM will begin certifying individual physicians in 2009, it will not be in a position to submit a credible application to the ABMS via the Liaison Committee on Specialty Boards until there exist a sufficient number of ACGME-accredited training programs in Addiction Medicine. The sequential steps to achieve that reality include:

- a. The reconstituted MSAG will initiate a plan to conduct and publish the results of a survey of existing fellowship programs in Addiction Medicine (this catalog will complement the existing

catalog of Addiction Psychiatry fellowships prepared by the Center for Medical Fellowships in Alcoholism and Drug Abuse at New York University).

- b. ABAM will confer with leaders of multiple medical specialty societies, including ASAM, to obtain their input to the documents defining the core content, core competencies, and scope of practice of Addiction Medicine.
- c. ABAM will develop an accreditation process for training programs in Addiction Medicine, modeled after the ACGME guidelines for accreditation of training programs.
- d. After several years of carefully evaluated activity, ABAM will apply to the ACGME for approval of its accreditation process for training programs in Addiction Medicine.

STEP 6.

With its certification of individual physicians established and the ACGME's accreditation of its training programs attained, ABAM will submit an application for recognition by the American Board of Medical Specialties (ABMS) as a conjoint Board of the ABMS, or for subspecialty certification of Addiction Medicine by multiple ABMS medical specialty Boards, whichever path best serves the interests of patients and the specialty of Addiction Medicine.

STEP 7.

In order to fund the MSAG's ongoing activities, the ASAM Board approved an initial budget and authorized the use of monies from the Society's reserve fund and other available sources.

STEP 8.

The ASAM Board directed that the MSAG submit a progress report at the October 2007 meeting, describing the group's further findings and achievements. The ASAM Board also determined that, after its anticipated incorporation in December 2007, the leaders of ABAM should be invited and encouraged to report regularly to the ASAM Board of Directors on ABAM's findings and achievements.

How You Can Help Win Specialty Recognition for Addiction Medicine

To help fund the initiative to achieve specialty status for Addiction Medicine, the ASAM Board of Directors voted at its April 25th meeting to create a voluntary membership group, **Supporters of Addiction Medicine**.

The Supporters group is committed to ASAM's two key initiatives: specialty recognition of Addiction Medicine, and parity for addiction treatment. The Board found that both initiatives are consistent with the Society's Mission "to improve the care and treatment of persons with the disease of addiction and to advance the practice of Addiction Medicine."

All contributions are tax-deductible. While contributions of any size are welcome, those who give \$100 or more will be recognized as members of the "Supporters" group.

Checks should be made payable to **ASAM**. (Please notate the check: "Supporters of ADM.")

SEND CHECKS TO:

Supporters of Addiction Medicine
American Society of Addiction Medicine
4601 No. Park Ave., Suite 101 Upper Arcade
Chevy Chase, MD 20815



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Joe Vitale, Director of Physician Recruitment
Office of Professional Staff Affairs
vitalej@ccf.org

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ASAM CONFERENCE CALENDAR

ASAM

May 31-June 2, 2007

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[18 Category 1 CME credits]

May 31-June 2, 2007

Medical Review Officer
Training Course
Marriott Metro Center Hotel
Washington, DC
[18 Category 1 CME credits]

October 25-27, 2007

ASAM Course on the
State of the Art
in Addiction Medicine
Hyatt Regency Capitol Hill
Washington, DC
[21 Category 1 CME Credits]

October 28, 2007

Buprenorphine and
Office-Based Treatment
of Opioid Addiction
Hyatt Regency Capitol Hill
Washington, DC
[8 Category 1 CME Credits]

April 9, 2008

Ruth Fox Course for
Physicians
Sheraton City Centre Hotel
Toronto, Ontario, Canada
[8 Category 1 CME credits]



April 9, 2008

Pain & Addiction:
Common Threads
Sheraton City Centre Hotel
Toronto, Ontario, Canada
[8 Category 1 CME credits]

April 10-13, 2008

39th Annual Medical-
Scientific Conference
Sheraton City Centre Hotel
Toronto, Ontario, Canada
[18 Category 1 CME credits]

April 13, 2008

Buprenorphine and
Office-Based Treatment
of Opioid Addiction
Sheraton City Centre Hotel
Toronto, Ontario, Canada
[8 Category 1 CME credits]

OTHER EVENTS OF NOTE

May 21-22, 2007

14th Annual Nicotine Dependence
Conference
Siebens Bldg., The Mayo Clinic
Rochester, Minnesota
[14 Category 1 CME Credits]
For more information, contact
Mayo Nicotine Dependence Program
at 507/266-1093 or
MULHOLLAND.MICHELLE@MAYO.EDU

June 21-24, 2007

7th International Conference on
Pain and Chemical Dependency
Sheraton New York Hotel
New York City
[20 Category 1 CME Credits]
For more information or to register,
visit www.IAPCD.COM

September 6-9, 2007

20th Annual Cape Cod Symposium
on Addictive Disorders
Four Points by Sheraton
West End Circle Resort
Hyannis, Massachusetts
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May 11, 2007

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May 12, 2007

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University School
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June 16, 2007

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Except where otherwise indicated, additional information is available on the ASAM website (www.asam.org) or from the ASAM Department of Meetings and Conferences at 4601 No. Park Ave., Suite 101, Chevy Chase, MD 20815-4520; phone 301/656-3920; fax 301/656-3815; email EMAIL@ASAM.ORG.

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