Dr. Carl Erik Fisher:
Modern medicine basically abdicated its role in helping people with addiction. To this day, we still have these unnaturally and unhelpfully segregated treatment systems where, for example, people with addiction are treated separately from even other mental health conditions, because of a lot of historical stigma, we've done a really bad job at meeting people with substance use problems where they are.

Ellen Kelsay:
That's Dr. Carl Erik Fisher, an addiction psychiatrist who came to this area of specialty after facing his own addiction crisis. A clinician, bioethics scholar, and teacher, he's an assistant professor of clinical psychiatry at Columbia University, where he studies and teaches law, ethics, and policy, relating to psychiatry and neuroscience, especially issues related to substance use disorders and other addictive behaviors. *The Urge, Our History of Addiction* is his new book which offers an intellectual and cultural history of addiction, interwoven with his own experiences as a clinician and someone in recovery himself.

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I'm Ellen Kelsey, and this is a Business Group on Health podcast, conversations with experts on the most important health and well-being issues facing employers. My guest is Dr. Carl Erik Fisher, and today we discuss why he says that calling addiction a disease is misleading and how we should be thinking about it and treating it, instead. Dr. Fisher, welcome. We're thrilled to have you today.

Dr. Carl Erik Fisher:
Thanks so much for having me. It's good to be here.

Ellen Kelsay:
Of course. I found your book, *The Urge, Our History of Addiction*, to be fascinating on so many levels, certainly both in terms of exploring the history of addiction, as well as from your own personal perspective, as someone with lived experience. I'm curious, why did you decide to write the book?

Dr. Carl Erik Fisher:
Well, it was the book that I wanted myself in early recovery. Once I was a bit stable, I felt like I wanted to go deeper into this notion of what is addiction, what actually happened to me, what actually happened to my family. I began to notice that in not just philosophy, which is in some ways my home discipline within medicine and bioethics, but also even in general psychology people kept on making these references back to historical concepts arising out of Aristotle's philosophy, or drug epidemics that had gone back centuries. So, I had this sense that there was more to the history that I wanted to explore how different societies and different humans had understood the phenomenon of addiction over time. I started looking over the history of addiction and I just found that the book didn't exist. There's so much good scholarship about particular time periods or particular angles, but I didn't find one broad, overarching synthetic history of addiction. And the deeper I got into it, the more I recognized that there was this sort of personal component that one's own biases and cultural background and legacies of understanding are inescapable. That's part of the reason why I wanted to introduce my personal story.

Ellen Kelsay:
I found the historical perspective so interesting, and you did write that humans have struggled to define, treat, and control addictive behavior for most of recorded history. And in your book, you even talked to dates of recorded incidences of a 1000 BC, so certainly well before the advent of modern science and medicine. Is there anything as you did your historical research, that you found especially compelling? Any particular time in history or any themes that emerged?

Dr. Carl Erik Fisher:
Well, there's so much that was surprising to me because I do think in medicine we have an amnesia for the history of medicine. That's a shame because history is, in a way, the memory bank of human experience. One thing that comes to mind is drug epidemics. Of course, we're talking in the midst of a terrible historic overdose crisis. One of the biggest shocks to me was finding that drug epidemics are nothing new, that we've been having drug epidemics for at least 500 years. There's been historical amnesia over and over again, as societies in Europe and North America and elsewhere have struggled with waves of drug problems. That's a shame because those epidemics have real lessons. They show us how it's never the result of just one villain or one single cause, but drug epidemics always arise at the intersection of multiple intersecting causes that exist across so many levels. We need to keep all those forces in mind and avoid the sort of constant pull toward knee jerk, single solutions.

Ellen Kelsay:
I was going to ask you about that. I found this one quote about that addiction is often explained in terms of a dichotomy of free choice versus total compulsion. Which, as you write in the book, has set up an interesting conflict of perspective and approaches throughout history. Things ranging from those who believe that addictive behaviors are a choice, those people then justify punitive behaviors, and have for centuries implemented punitive measures, and then the opposite view, kind of on the other end, is that addictive behaviors are involuntary and uncontrollable compulsions, and therefore, that people who have addiction deserve compassion and treatment, not punishment. Yet you say neither maybe fully true on its own, but rather that addiction exists on a spectrum. What do you mean by addiction existing on a spectrum? Can you elaborate there?

Dr. Carl Erik Fisher:
Yes, definitely. Thanks for picking up on that, because it really is an important theme in the book. This binary, this stark binary between choice and compulsion is actually a relatively recent phenomenon. One of the things I loved about the history is that thinkers going back centuries recognize this massive gray area between choice and compulsion, and that most people struggle with self-control. Whether we're talking about St. Augustine, one of the earliest Christian theologians, or the historical Buddha, or ancient philosophies of Greece, particularly Aristotle, there have been so many rich contributions to understanding the ways that all of us struggle with self-control, all of us struggle with a divided mind. Once we recognize that huge open space, that sort of spectrum, I think that frees us up in a really useful way to break down the sort of false division of addiction as if it's a completely unique and separate aspect of human experience. I think, to the contrary, that addiction exists in all of us. It's just that these extreme cases of addiction, including the one that I myself encountered and myself and in my family, even while those extreme cases are still deserving of sometimes specialized care or just deep care and compassion, they're not different in some sort of kind, it's just a difference in degree.

Ellen Kelsay:
We're going to get to treatment in a minute, but I think the point you just raised is so important when it comes to treatment, because there is no one-size-fits-all, and there are different reasons for why people may have some challenges with addiction, and therefore having treatments also exist on a continuum and a spectrum is important as well, but let's pen that for a second. I want to first maybe get back to the term addiction and calling an addiction a disease you argue can be misleading. What do you mean by that? Why is addiction a disease, a misleading term to use?

Dr. Carl Erik Fisher:
One of the most important reasons is that calling addiction a disease is a double-edged sword. I want to say that because I want to acknowledge and emphasize that calling addiction a disease has been useful. It has helped at various points throughout history. It helped to advocate for hospital-based treatment of people with addiction. It helped to advocate for funding, or even just helped in terms of public understanding to move us toward more personal care and compassion. But the harms are also really apparent there too, that the notion of disease can be dehumanizing and fatalistic, that it can promote stigma and social distance. We have some

psychology research supporting that notion. Then even more bluntly, the notion of disease has been used as a weapon to say that people are somehow broken or doomed to use. In the end, I think the word disease is confusing. We have to stop putting a relatively facile label on the phenomenon and use it to look deeper. My ultimate point is that we can use the word disease as a cue to look at all of the different causes and conditions that go into addiction and just ask ourselves, what do we really mean?

Ellen Kelsay:
I know, based on a lot of research, that there are many causes for addiction. Back to this free will and compulsion versus some deep rooted biological pre-destination to become somebody who struggles with addiction, there's a range of what might lead to someone eventually struggling with addiction. If you could kind of sum what causes addiction or what are the range of things that could lead somebody to develop addictive behaviors over time.

Dr. Carl Erik Fisher:
Yes, those are important to consider. Before I jump into it though, I just want to be clear that I think when we talk about causes, sometimes people think about addiction as if it's a unitary phenomenon, meaning that all people with addiction are alike in the same way. That idea, which is pretty roundly disproven by this point, has long been bound up in ideas about causes that all the causes are somehow pointing in the same direction. I just want to distinguish those points, because it's really important to acknowledge not only the diversity of causes, but also, and certainly not unrelatedly, the diversity of manifestations of the addictive phenomenon that people with addiction might be alike in very similar ways. You could say this to use like jargon, the phenotype, or like the outward expression of addiction is similar, but people can be brought to addiction in a variety of different ways.

For example, some people appear to have really powerful genetic loading that may drive them toward addiction. Other people, and again relatedly, but maybe also because of early childhood experiences, some people are temperamentally prone to impulsivity. Trauma is a hot topic right now in addiction. I think we've suffered for a long while under the neglective trauma or just the failure to fully integrate trauma-based therapies. That's not a unitary sort of phenomenon either. To reduce all of addiction to trauma, I think is misleading as well. Then, of course, a major theme of the book is to broaden up our scope beyond the individual and to look at economic and social factors that go into addiction. Loneliness and despair and a lack of access to meaningful work, or certainly during the COVID pandemic, lack of access to meaningful pursuits or just basic social connections can also be a powerful driver. All of those different causes and conditions interact in a complicated matrix. I think that's part of the challenge, and it mirrors a broader challenge in all of medicine, that we have to recognize the personalized character of addiction and not slap people into a one-size-fits-all, let alone treatment, one-size-fits-all mode of understanding, because really when we appreciate those individual human factors, that'll help naturally guide us toward what people need most.

Ellen Kelsay:
That's so important, but so complicated, right? For somebody who's struggling with addiction to find the right resources, the right therapies, the right clinicians, the right counselors to help unravel that quagmire of very unique, personal characteristics that have led to their particular struggle with addiction. That leads me to the treatment and the evolving concepts of addiction have also led to kind of evolving concepts around treatment and treatment methodologies. How would you say that treatment paradigms have changed or are continuing to change?

Dr. Carl Erik Fisher:
Well, they've changed tremendously just in my own lifetime, say measured from like the 1980s. And then they've changed tremendously since, I would say, maybe around the 1940s or 1950s when modern medicine became reinterested in the phenomenon of addiction. But I say that because we still have a very, very long way to go. Earlier than that medicine suffered this massive break where addiction was really walled off from the rest of even other forms of mental suffering. We're still trying to ameliorate that break where modern medicine basically abdicated its role in helping people with addiction. To this day, we still have these

unnaturally and unhelpfully segregated treatment systems where, for example, people with addiction are treated separately from even other mental health conditions. Also, we have alcohol-related disorders treated totally separately from other sort of drug disorders, as if alcohol wasn't a drug, as if it didn't cause massive harm.

There's been tremendous efforts, especially in the context of the opioid crisis, at integrating care, at providing care, not only integrated with mental health care, but also with general medical care, that's a really crucial macro-level change going on. We still have much further to go. If we get more micro, one other really crucial development, I think goes along with that notion of personalized care that different people need different modalities, different people need different attempts or may have different motivations or different moments in their life. Maybe there's just a simple sort of evolutionary development in the way that people find a therapist or counselor that works for them. We've done, traditionally because of a lot of historical stigma, because a lot of the developments described in the book, we've done a really a bad job at meeting people with substance use problems where they are, and especially because of ways that the treatment system has been wrapped up in the criminal legal system, there's been a tendency, not only toward a one-size-fits-all model, but a very paternalistic and top-down approach where we essentially tell clients, this is your model for recovery, it's our way or the highway, if you relapse, you get kicked out of a treatment program. This just doesn't work. It just doesn't work. In respecting the many different varieties of recovery and working with clients to try to meet them where they are and supporting them in their path to recovery, I think is a crucial, crucial step. In a way it is almost prior to some of the more specific, say policy questions, about like what is the specific modality or how do we measure quality indicators and mental health care, and so forth and so on.

Ellen Kelsay:
That's tough. As you write in the book, you were one of the more fortunate ones. You were in an environment and you were placed in a facility with a lot of care, a lot of support. When you were in recovery, returning back to a job that was still there for you. A lot of people are failed by the system, to your point, whether it be for social, political, economic, or legal reasons, they don't get the care. All the things that you just mentioned aren't even availed to them, in many instances, or one is availed to them and it's the wrong thing, and then they're back on the streets, they're back homeless, or they're back in a prison. For the slim population that actually does seek help, there's a greater majority who are not getting the help they need. Do you see any glimmers of hope that that may be changing as we look to the future?

Dr. Carl Erik Fisher:
Yes, absolutely. I do recognize I had tremendous, tremendous privilege and opportunity in the way that I was treated. A big part of that, like you mentioned, is because I was in a physician health program. Some of your listeners probably are familiar with this notion that physicians, also lawyers, also airline pilots in some jurisdictions, get access to a specialized type of program that works really, really well. It really is tremendously helpful for attaining rates of recovery for the time period that people are enrolled in those program. The key question is why, why should it work any better? Is it just that people are getting a better treatment? It's not true, actually. When I was sent to treatment, it was sort of a specialized rehab for doctors, but it was actually contained within a pretty standard rehab facility. In fact, like I described in the book, the rehab itself suffered from a lot of those problems that you and I have just been discussing about one-size-fits-all models and all the rest. If anything, the benefit of the rehab was being in contact with other clinicians in recovery and getting over my own denial in more of a community and mutual help sense.

I think the thing that these physician health programs do well is that they orient our model of care away from an acute care model of addiction, toward a more longitudinal approach, what some people are calling a recovery-oriented system of care. For too long, our model has been about giving somebody who has an extreme substance use problem, 28 days of treatment in an in-patient setting, and then basically saying, go back to your home environment without any structural changes, and find a mutual help meeting, and try not to use again. That's shown time and time again, that it is just not sufficient. It will not work for the vast majority of folks. In fact, may even increase the risk of fatal overdose for people with opioid use problems. That's one of the elements. It's just one of the elements that, I think, was so helpful for me was that shift that

so few people get toward more of a life-course model or more of a long-term model of how do substance use disorders actually act in the real world.

Ellen Kelsay:
I'm talking with Dr. Carl Erik Fisher. This is the Business Group on Health podcast. We'll be back after this short break.

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Ellen Kelsay:
You mentioned our audience earlier, and you know most of our audience here at the Business Group are large employers, and of course their employees. They work very hard to give those employees support and programs that they need to manage a whole myriad of health issues and wellness concerns. As you think about our audience and these employers and their workforce, how should they think differently, or what might they want to consider moving forward, as things that they could do as employers to better support their employees or family members who do struggle and experience addiction?

Dr. Carl Erik Fisher:
Yes, this comes to mind immediately in my practice in New York, where I still do see patients in just regular private practice. I know from experience that in a lot of employee/employer relationships, there's not a lot of early intervention, and then it reaches a crisis point where somebody essentially gets an intervention or a kind of difficult choice of going away for treatment or not. I don't think that's because employers or the health systems are, in any way, malicious or deliberately letting people down. I think it's just an outgrowth of this sort of acute care model that we've inherited. It's also, like I discussed in the book, in a way is a legacy of some of the really harsh, confrontational practices that grew out of the 1970s, 1980s. Just one thing that I think would be helpful when you're thinking about employees and employers, is this topic, I sort of gestured to before, which we could call a stepped-care model, which is where you meet people where they are, with an eye toward improving their lives without necessarily insisting on abstinence as the initial goal.

There are many examples of that. One example is if somebody is having an alcohol use problem, abstinence might be a good long-term outcome for them. It certainly is a good model for me. I think my own abstinence-oriented approach to recovery saved my life and I plan to stick with it. We just have to face facts that a lot of people don't want to be abstinent or that they might be able to comply with the abstinence for a short period of time when they're being intensively monitored, say getting urine tests. Then the real question is how are they doing in their lives? What are their substance use problems expressing? What is the deeper sort of problem or pain that's manifesting through their substance use problem? If we instead shift and ask people, what do you need right now to improve your functioning, and giving people sometimes, and carefully when it's appropriate, the opportunity, for say a moderation-based approach, that can give us a lot of data and do a lot of good work toward establishing adherence. I see it all the time in my practice where somebody tries moderation, I might even give them the recommendation that moderation is not a good choice for you. Here are the risks and here is how we can mitigate those risks, but then once they themselves have had the opportunity to go out and give that a try, and hopefully we've minimized any sort of disruptions or problems in their life, they can come back in more wholeheartedly and with more of a sense of motivation to say, okay, I see your point, and now I'm willing to step it up in the next step of this step-care model.

Ellen Kelsay:
That's really helpful framing. Thank you. I thought it was so interesting in your book, how you did talk about that abstinence may not be the answer for everybody, and for everybody there isn't necessarily the “cure” and it is the spectrum of solutions and things that, to your phrasing, you use kind of the stepped-care model. Different things might work for different people at different times, and so to try different things and meet them where they are and when they're ready is so important to their ultimate success of helping their mental framing and their willingness to take, perhaps, baby steps that they need to take in the beginning to the ultimate end goal of hopefully a life in recovery.

Dr. Carl Erik Fisher:
Yes, two things about that actually. One is that I think we should be very careful to make the distinction between general substance use disorders and addiction. That's part of the whole point of the book and I spent hundreds of pages unpacking this, but there are a lot of different definitions and understandings of addiction, but it generally refers to a position of extreme powerlessness where somebody has really felt like that they are at the boundaries of control. Not every person with a substance use problem necessarily qualifies for addiction. When we conflate those two, that's one of the main drivers of this one-size-fits-all approach that doesn't serve everyone. The other consideration about that is that in the case of addiction, I don't think there's a cure. I don't think we'll see one through medical science or otherwise. In fact, throughout history we've seen how people have caused incalculable harm over and over again, trying to stamp out addiction, trying to cure it or conquer it, or otherwise control it. Usually that causes much more harm than good. Even when somebody has what we might consider an extreme case or a paradigmatic case of addiction, I think even then acceptance is the answer, that we have to accept that it's a part of human life and work with it. That's the thing that allows us to work with the full variety of interventions, medical and otherwise, that can help people.

Ellen Kelsay:
I think the point you made in your book is it's not an us versus them. We all exist on this continuum. To your point, knowing that it's a part of the human condition and learning how to manage and hopefully meet people where they are and where they're wanting to be in terms of their continuum solutions, is so important. I think the point you made really artfully in your book is, I think, people have long thought that it's an us and them situation. Again, this kind of binary thinking around addiction. To the point you also just made is, it is not just substance use. It is also things like gambling and people addicted to technology or many other types of addiction. But yes, of course, for this conversation, we were talking about substance use and alcohol. I agree with the point that there are many other forms of addiction and that definition holds true across all of them.

Dr. Carl Erik Fisher:
Yes, definitely. That's so important to me, the notion that addiction exists in all of us. It's a really key point of the book that addiction is really just where our normal human vulnerabilities are on display. This ties back to this false binary between choice or compulsion. Everybody struggles with self-control. That's, in fact, what those early thinkers like Aristotle and Augustine and so forth were wrestling with, was not the question of how do some people out on the extremes seem to have a total breakdown, but how is it that everyone seems to have some struggle with will, or choice, the misdirected will. This is the original form of sin, actually not to take us into a too religious of a direction, but that's what philosophy was. It wasn't about will as a sort of game or philosophical puzzle. It was the essential human question of why is it that people do the thing that is harmful, even when they know it's the case and even when they make resolutions to not do it. If it's not substances, then people will invariably have that problem with love or with money or with status or with power or with something else. I think waking up to that reality of addiction, which is in the end, that's the way that the idea and the word addiction was originally understood. If we wake up to that broader understanding of addiction as a universal phenomenon, that's actually a beautiful doorway to more compassion for the situation.

Ellen Kelsay:
Absolutely. That was so enlightening and I really appreciate you elaborating for the rest of our audience on that point as well. Let's talk about, again, kind of continuing with treatment. You did write that the medical system is coming up woefully short in its treatment of addiction. You cited a number of shortcomings. To

mention a few, you talk about there are barriers to medications for opioid use disorder, there's of course, stigma, and then there are racial and ethnic disparities and access to treatment. Can you elaborate on each of those?

Dr. Carl Erik Fisher:
Sure thing. Yes, let's take medications first because that's almost a laboratory for some of those other problems, and racial disparities and outright racism and oppression is very apparent through current medication disparities. We know that in the case of opioid use disorder, that the commonly prescribed medications like buprenorphine or methadone , or for some people long-acting naltrexone, drastically reduces the risk of overdose. Yet, we have tremendous access problems in this country. Some of those access problems are because of funding. Some of those are because of unnecessary and burdensome requirements at the level of government regulation. Again, your audience is more familiar maybe than some others, so probably a lot of folks know that there are special credentialing processes required for things like buprenorphine, certainly methadone, but even buprenorphine. I can prescribe morphine on my first day as a medical intern in a hospital, but in order to do buprenorphine, you have to go through this whole process of getting a special certificate. That's not a rational system. Just like a lot of our systems of drug regulation are not rational. If you go back to the Controlled Substances Act or even sort of like the 1920s legislation around the regulation of certain drugs, it's never really been a rational response to actual drug harms. It's more of a sort of reactive reflection of the prevailing social and cultural norms. I say all of that to say that when we're talking about addressing the current on the ground reality with medication disparities, it's not just a matter of the technocratic tweak that there there's this long history of social and cultural stigma and inertia against medications for opioid use disorder and generally for the treatment of addiction. Many treatment programs today still outright do not allow them, or even if they do allow those medications, they won't start people on them. Even when they do, there's sometimes this sort of Calvinistic push toward tapering people off of those medications as if it's real sobriety or it's being truly clean to be off medications. The fact of the matter is the jury is still out. I've got colleagues at Columbia University right now who are actively studying this, but we have very, very little data about what is the appropriate duration of say, for example, out-patient office-based buprenorphine treatment for opioid use disorder. We have this tremendous problem with the drug supply being poisoned with fentanyl and a drastically increasing risk of overdose. I worry about all of my patients who have opioid use disorder, or even if they're using cocaine, because fentanyl is everywhere now. I think we just need enormous, enormous caution in dealing with the risk of overdose, and yet we have this barrier around medication access. Then you also ask about racial disparities and that gets to one of the biggest themes of the book, which is that we've had these two tiers of understanding and responding to and treating drug problems for so long in this country, and really everywhere, like going back to the early modern historical period back after Columbus' first expedition, there were differential responses to tobacco. Tobacco was hailed as a sort of mystical medicine for the aristocracy, but then once it got associated with commoners, then it was treated as savage and brutal and as a so-called plague. We have that sort of two-tiered system, certainly today in the United States where the opioid problems are commonly framed as a white problem, even though in black and brown communities, opioid use problems have consistently been an issue since the 1950s heroin epidemic, the 1970s heroin epidemic, and then coincident with the crack cocaine in the 80s and 90s, and so forth.

One of the ways that those two themes connect, of medications and racism and oppression, is that whenever we undercut treatment for one group of folks, we are invariably undercutting treatment for everyone. That there's no such thing as an actual two-tiered system, because whatever failures are inherent in, say the system for the oppressed or the marginalized class, they will definitely bleed through at least in the form of public understanding and stigma, if not structurally in the way that we go about building and maintaining our treatment programs. It all comes back to the notion of interconnectedness that, in the case of addiction, if we try to treat it as if we can treat different classes or different supposed groups of problematic substance users differently, then it invariably comes back to bite all of us.

Ellen Kelsay:
So true it does. What about stigma? You wrote also that there's a lot of physician stigma, so expand there.

Dr. Carl Erik Fisher:
Yes, so sticking with medications just briefly, I just talked about those onerous barriers to prescribing medication, and if we could just wave a magic wand and make it so that every physician, nurse practitioners and other allied health providers can prescribe these medications too, if every provider could just go ahead and start prescribing buprenorphine, we would still have massive, massive barriers to access and care because we have studies where, and I described this a bit in the book, that individual health care providers don't necessarily like treating people with addiction. They say I'd rather not have patients like that in my clinic. And also, we have the structural stigma that you and I were talking about before, where even when we have beautiful, well-meaning clinicians, like I experienced in my mentorship at Columbia University psychiatry program, the whole system might be set up to exclude certain classes of patients, Just briefly, I had this experience that I described in the book where once I was doing my out-patient training in that program, I saw a guy coming in for alcohol use problems who was no where near as severe as I was when I was at my worst, and yet we couldn't provide care for him. My supervisor said he is not the appropriate patient, let's send him down the street to the substance use disorders clinic. I like telling that story because my supervisor in that case was a fantastic clinician and really seasoned and not at all skittish about treating people with challenging mental problems. She was just manifesting a sort of broader structural stigma that says these addiction patients are not the right kind of patients, they belong somewhere else, that they're so fundamentally different that they need to be treated elsewhere. That's stigma too, and in a way is sort of more insidious and difficult to combat form of stigma than the more obvious and stereotypical individual stigma.

Ellen Kelsay:
I always like to end on a positive note. While we just talked a lot about the shortcomings and where the medical system is coming up short, what gives you hope? Where do you see bright spots on the horizon?

Dr. Carl Erik Fisher:
I definitely see hope, even though during COVID, we are experiencing massive, massive problems with substance use disorders, not just overdose deaths, which are skyrocketing, but also alcohol use disorders and others. Even that being said, I do think that we're in a very special period in history where, because of a huge meeting of different causes and conditions, people are open to a different conception of addiction. We've had moments like this in the past. There have been brief windows of time back in the 19th Century after the American Civil War, and then in a way in the 1960s in the United States, there was a more capacious and open-minded and pragmatic, and multi-leveled understanding of addiction where people essentially played nicely with each other, and law enforcement and mutual help groups and different clinicians and researchers were able to come together and form more holistic and integrative approaches to the problem of addiction. We've gone through these cycles, and I describe more how societies tend to reach for these one-size-fits-all knee-jerk responses, like a prohibition is crack down or as if science will save us, but in these windows where we can bring these different responses together and form an actual, flexible, pragmatic, and multi-leveled response to the problem of addiction, there's tremendous, tremendous promise there. We've seen in history when people in societies are able to execute on this promise that they save a lot of lives. I think that we have the capacity to do that today. I certainly still believe so, even though not just in addiction, but in general health care, we face massive challenges. I just think that the kind of grassroots change in consciousness around what we believe addiction to be is at a particularly right moment today.

Ellen Kelsay:
Wow, with that, Carl, thank you so much for joining us. Your book should become required reading for all in medical school, all who are running treatment facilities, all who are clinicians supporting those with addiction concerns, and certainly those of us in the field of health and well-being. It certainly is enlightening. I found it to be fascinating, as I said on so many levels, the historical look back was really enlightening, and then also your personal story takes true courage, but also brings to light a lot of the true issues and opportunities. Thank you, again, for joining us. It wonderful to speak with you.

Dr. Carl Erik Fisher:
It's been a real pleasure. Thanks so much for having me.

Ellen Kelsay:
I've been speaking with Dr. Carl Erik Fisher, the author of the book, *The Urge, Our History of Addiction,* available now.

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