clinics with more emphasis upon brief, early interventions than on treatment for chronic, severe patients.

Not surprisingly, few addicts receive treatment. A national survey of urban population aged 18 years and over showed that only 17% of respondents with substance use disorders reported having been treated during the 12 months prior to the study, usually by people in professions other than medicine and psychiatry [6].

The delay in treatment for people with substance use disorders is higher than for any other psychiatric diagnosis disorders, with less than 1% making contact the same year (0.9%), compared to 16% for any other mood disorder [7].

The possibility of modifying this situation depends upon our ability to modify popular perceptions, including the science of addiction in medical syllabi, and inform policy makers of the enormous cost-effectiveness of treatment in order to increase both the budget and facilities for addiction treatment. The high proportion of comorbidity of addictions with mental disorders highlights the need to integrate services, perhaps increasing the likelihood of attracting more psychiatrists to the field.

Both developed and developing counties must advance further in regarding addictions as a chronic disease and guarantee the right to treatment, as a result of which they might be able to attract more medical doctors to this field.

Declarations of interest

None.

Keywords Access to treatment, addictions, developing country, medical treatment, Mexico, psychiatry training, residents, shortage of doctors.

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FURTHER REFLECTIONS ON 'WHY SHOULD ADDICTION MEDICINE BE AN ATTRACTIVE FIELD FOR YOUNG PHYSICIANS?'

We appreciate the opportunity to respond to the commentaries regarding our recent paper: 'Why should addiction medicine be an attractive field for young physicians?'[1–4].

Dr Medina-Mora describes the situation in Mexico and throughout the developing world as similar to the problems and issues that we raised regarding the developed world [2]. In our view, this emphasizes the need for improved international collaboration to address these issues. Useful first steps might be a systematic international survey to evaluate more clearly the actual situation around the world and to collect suggestions for and examples of practical responses; and engagement with relevant international medical and scientific organizations, e.g. the International Society of Addiction Medicine and the World Federation of Societies of Biological Psychiatry.

Dr Wodak raises several specific issues [3]. He mentions the 'little evidence' behind many of our arguments and calls for 'systematic research'. We could not agree more. He questions whether the problem is 'a shortage of young medical recruits or a lack of suitable positions'. We believe these problems are not mutually exclusive, but rather mutually reinforcing. A lack of suitable positions discourages young physicians from considering or training for a career in addiction medicine. A shortage of suitable applicants may discourage hospitals, clinics and health-care systems from offering positions in addiction medicine. We agree with Dr Wodak that a health approach to addiction would improve the low status and stigmatization of the field and its patients. We believe that this is beginning to occur in the United States, where screening for tobacco and excessive alcohol use is being promoted as a public

health measure by all medical specialties, and is now reimbursed by both government and private health insurance. We disagree with Dr Wodak that 'psychiatric domination' of the addiction field deters young physicians from entering, and are not aware of any evidence to support his opinion. More probably, what is discouraging non-psychiatric physicians from entering the field is that, at least in the United States and the United Kingdom, only psychiatry has an officially recognized subspecialty in addiction. Finally, we believe that Dr Wodak has misinterpreted as 'absurdly simplistic' the notion that 'addiction is a brain disease'. This phrase was popularized by Dr Alan Leshner, a former director of the US National Institute on Drug Abuse (NIDA), precisely to counteract the view of addiction as a moral failing or personal weakness, and therefore outside the realm of medicine. The phrase never implied that there were not also psychological and social components to addiction. The brain is the organ of the mind, so that calling something a brain disease in no way denigrates the biopsychosocial model of disease.

Dr Crome provides an interesting recent history of developments in the addiction field in the United Kingdom [4]. We applaud the improvements that have occurred, but are not certain that all her recommendations would necessarily bear fruit. As mentioned in our paper, the United States has had a national research institute devoted to addiction research (NIDA) for more than three decades, which spent almost US$ 5 billion on research grants from 1996 to 2006. Despite this, the United States has the same problems in attracting young physicians to addiction medicine or psychiatry as do countries without such an addiction research infrastructure. We believe that reducing stigma, expanding insurance coverage and increasing insurance reimbursement rates for physicians are steps more likely to improve the situation than are increases in research funding and visibility.

Declarations of interest

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