

## *Too Much of a Good Thing*

Biotechnological achievements have allowed us to combat pain, distressing emotional states and some mental disabilities, but it seems to me that we now have too much of a good thing. Nationally, and in Oregon (the state where I have been practicing for the past seven years) the rates of recreational opioid and stimulant use among minors have been increasing. The rate of unintentional drug poisoning deaths involving prescription opioids has more than doubled from 1999 to 2007.<sup>1</sup> The publication presenting this data, almost in the same breath mentions and references an article stating that 15% of the adult population is affected with chronic pain conditions and can benefit from the treatment with opioids.

On a national level MMWR (Morbidity and Mortality Weekly Reports) reports more than doubling of ED (Emergency Department) visits for non-medical use of opioids during 2004—2008.<sup>2</sup> The same article indicates a 542% increase in New Abuse of Prescription Opioids Among teenagers from 1992 to 2003. Internationally, National Health Policy review quotes staggering figures of US consuming 80% of world's supply of pharmaceutical opioids.<sup>3</sup>

For most persons (patients and doctors alike) it now seems inconceivable that one can go through a kidney stone attack, back pain exacerbation, a root canal or even a dental filling without taking an opioid. Since I've added addiction medicine to my family medicine practice, I see a clear trend in recreational drug use among young people. While those who are now over 30 years of age started with alcohol and marijuana, the younger generation reports high school use of "vikes" and "oxys." More and more Ritalin and Adderall are passed around among high school and college students. Valiums, Ativan, Xanax and the like are the usual additions to many parties.

It is my impression that unwittingly, US health care system has become a channel for a back door legalization of opioids, methamphetamines and benzodiazepine tranquilizers through the processes of chronic pain management, adult ADD management and chronic anxiety management respectively. It troubles me that health care workers, whether they realize it or not, have a hand in a growing problem with addiction in the US, with its accompanying morbidity, mortality, and crime related deaths. Many federally subsidized clinics and pain clinics have turned into virtual distribution centers for controlled substances. Soon before I left my last employed position at a federally subsidized clinic, I recall a message from the pharmacist of the internal clinic pharmacy to providers, about the shortage of oxycodone. It made me wonder if the mass prescribing of the opioids is an ultimate expression of consumerism, misplaced faith in biotechnology, or a way of pacifying the "underserved."

It is ironic that in the current system, any doctor is allowed to prescribe unlimited amounts of opioids to an unrestricted number of patients, while to treat addiction to these same opioids, the doctor needs to be specially certified, is limited to treating no more than one hundred patients, and undergoes oversight and at times scrutiny by the DEA. This design gives a huge number of patients access to getting on opioids but only a fraction of those will have access to treatment should they want to stop taking them.

I stopped prescribing the above mentioned medication on chronic bases and now agree to take on a patient only if they agree to a taper up-front and express a clear interest in getting off of these meds. Thus I explicitly have to choose not to follow the accepted guidelines and become a kind of outcast. Patients have been so much conditioned to expect "pain relief" that in my earlier days of practice, I was threatened with a law suit for undertreatment of chronic pain.

I also find it ironic that the state of Oregon requires all prescribing physicians licensed by the state board to complete seven hours of additional training in pain management. Though, I am sure, the intention of

such requirement was not to promote the prescribing of opioids, it does add to the legitimacy of the chronic pain management practice.

The pain societies, and related to them pharmaceuticals sponsored chronic pain patient advocacy groups, make matters even more difficult, fostering the spirit of demanding pain relief as a social and political right.

Guideline makers in this domain also meet a formidable challenge. The scientific method that we generally accept for determining the validity of a treatment may not be suitable in the study of chronic pain management medications and other addictive, mind altering drugs. First, in this domain true blinding is impossible thus eliminating blinded studies and leaving us mostly with self-reported surveys. Second, and more importantly, there cannot be an objective observer. The illusion of object-subject separation is most apparent when it comes to mind-altering addictive substances. Asking the patient who is actively taking opioids whether or not opioids are helpful is akin to asking actively using heroin addict whether heroin is good for him. The observer (in this case the patient) has an enormous bias to always provide information in favor of the “treatment.”

A radical departure from the traditional methods of study may be needed. We may need to look at the big picture, at what is happening in the US and radically revise our guidelines, or allow others outside medical field, possibly informed non-pain medicine dependent patient groups, create a new policy and new set of guidelines.

The current thrust of the health care system to expand “health literacy” is really an ideological tool designed to recruit more and longer term health consumers, people who believe that in order to be healthy they need to surrender their autonomy to health authorities that will tell them about the tests and treatments they “need” in order to be well, consuming more gives an illusion of improving one’s chances for survival and so, more and more “patients” are demanding more health services as a new political right.

There are at least four types of harms that arise out of the current, at the same time the most hidden and the most practiced religious belief—the belief in biotechnology as an answer to human needs.

First and smallest, is the well recognized harm from the medical errors. Errors related to polypharmacy with fatal or harmful drug-drug interactions, are an example of this. This is somewhat quantified and the technological system-based solutions are constantly being developed and perfected. The nature of these solutions is that while they solve some problems, they invariably engender new ones. An example would be Electronic Health Record, which while fixing some problems (misreading medication name from bad hand writing) creates new ones (from clicking on a wrong medication from a drop down list of meds that the computer offers as one is typing medication name), while raising health care costs.

Second, a bit more elusive but still well recognized idea of the “acceptable risk.” As long as benefits outweigh risks, it is OK to use interventions that lead to harm. It is unrecognized that this idea opposes Hippocratic oath. Our notion of benefit is notoriously prone to error; post-menopausal hormone replacement therapy, dobutamin holidays for congestive heart failure, and thousands of cancers created by medical radiation (over 30,000 additional cancers annually estimated to be caused by CT scans alone, in the US), are but few examples.

Third, is the indirect harm that results from ideologically driven redistribution of finite resources to finance expensive technological “solutions” at the price of neglecting more basic and more fundamentally needed services like basic education, universal access to basic health care, and social

programs for employment and childcare. Seduced by the “miracles of science” we legislate spending on the promises of a future utopia at the expense of human lives today. This is analogous to the human sacrifice requiring idol worship spoken about in the bible.

Finally, fourth, is an ideological harm in which the modern doctor, completely unaware of being a drone of the system, acts as a wizard who systematically and methodically puts his patients under the spell, the spell that engenders mass psychosis of profound dependency, loss of autonomy, and fear. This psychosis is defined in the usual medical sense of having a persistent bizarre delusion. Only when you get many people to agree with you about any delusional idea, the delusion stops being bizarre, and eventually stops being perceived as a delusion, becoming a new reality. This is analogous to the communist psychosis of the early Soviet Union, and a fascist psychosis of the World War II Germany. A modern “spell” is a suggestion inserting and reinforcing the belief in the false deity of biotechnology and connected with it industrial production growth—a modern expression of greed. The doctors possessed by this idea genuinely believe that they are the saviors on the earth. Once a line from appreciating a helpful technique or technology to the belief in the high tech solutions to fundamental issues of human existence is crossed, the doctor turns from an educator into a wizard, with his set of magic instruments, rituals and a secret language for casting spells.

Chronic pain management is one ultimate expression of this belief in technology and the prime example of the contemporary false religion. To overcome its harmful effects it must be completely de-legitimized as a practice. If it remains legitimate, efforts at curtailing its harmful effects will remain ineffective as the idea of making “better pain management guidelines” implies that pain management is a “legitimate health care product.” If the medical profession remains passive, political action may be another alternative. Instead of passive acceptance of practice guidelines from the hands of so-called expert authorities, the people of the US should be involved in making political decisions about legalization of pharmaceutical opioids, methamphetamines and benzodiazepines. I feel we have crossed the line from “too much of a good thing” and surreptitious legalization of addictive substances for mass distribution. We, health professionals, clearly have our hand in this, and must accept responsibility not only for the “clinically acceptable risks” of accidental or intentional misuse, but also for the suffering, deaths and prescription drug related crime that is flooding this country.

Francisco Goya’s print *Los Caprichos #43 “El sueño de la razón produce monstruos”* shows a person asleep surrounded by monsters. Too much of a good thing is an expression of such unrestrained dreams of reason (intellectual avarice), dreams based on religious faith in biotechnological science as the ultimate answer to the questions of human suffering, a dream with a devouring ambition to fix all disability, impairment and ultimately death. For me as a health practitioner, the next step is developing the art of backing off and not intervening but letting the person be, while contributing to their confidence in their own capacity to deal autonomously with health and illness, with pain, disability and death.

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