Opinion

Medphobia – a grand coalition of politicians, addictionologists and pharmacists

Abstract

The dysfunctional management of controlled medications reflects the abandonment of the Hippocratic Oath as the major mode of medical practice. Wanton prescribing and "pill-mills" are at one extreme while abandonment of medication dependent chronic atypical polysyndromic patients is the other extreme. The self-righteous grandiosity of politicians, addictionologists and pharmacists imposing dogma, because of incomplete understanding of the full range of patient needs, has created this bi-polarity of causes and effects. A return to the Art and Science of Hippocratic Medicine is needed.

Keywords: controlled medications, art of medicine, pill-mills, therapeutic dependency, politicians, addictionologists, pharmacists

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Opinion

The current epidemic of benzodiazepine and pain medication rejection is patently unbelievable to those of us taking care of patients who have their lives back because of controlled medications properly prescribed and properly taken. The attack on these medications, understandable because there are too many who fit the pattern of addiction and abuse, is anti-therapeutic and anti-medical when most, or even all, use of these medications is condemned. It is *medphobia*.

Patients' chemistries are as different as their faces, and it is totally un-Hippocratic to dogmatize (and "legalize") in the Art and Science of Medicine. The automatic prejudging and negative stereotyping, of all patients and prescribers involved in benzodiazepine and pain medication usage, seem to be particularly evident for many politicians, addictionologists and pharmacists. It appears that all patients are put on a Procrustean bed of "care" proving nothing except an arbitrary mandate that "no medication is always best," and the capricious confidence to reject any sort of therapeutic dependency or off-label dosing. Regardless, "cure" for most patients is not "the stopping of controlled meds." Properly used and prescribed, these medications work well to relieve suffering and help more patients than they hurt. "Dependency" is not the same as addiction for any medicine in the Physicians Desk Reference. Ignoring contradictory findings, suppressing positive outcomes, and willfully remaining blind to some suffering syndromes is clearly unethical, unscientific and unprofessional. Patient care and treatment are not homogenous. Creating a blanket mandate to deny medication-dependent patients their treatment—whether for diabetes, hypertension, seizures, panic attacks, pain syndromes, depression, and bipolar disorder, etc..—is, at best, a lack of knowledge and, at worst if legislated, a negative impact on peoples' lives. To work hard to find a medication or combination of medications that give relief, and then be prevented from providing care because of bureaucratic documentation requirements is to make the patient less important than the chart. "Perfection" in documentation is NOT the same as perfection in medical care.

My own belief is that each patient's chemistry is as different as their faces, and if their faces are not identical, their chemistry is not identical either—a fact which overrides any dogmatism in medicine. Indeed, the complexity of neurotransmitters and brain chemistry, especially for psychiatric patients, make it unlikely that one medication (one molecular structure) will correct the problems in hundreds of neurotransmitters, millions of nerve cells and billions of synapses. Psychiatric and pain treatments with medications require a "therapeutic trial and error" approach consistent with the longstanding Hippocratic tradition of LISTEN TO YOUR PATIENT…instead of only to yourself or to some beaucratism written by someone who hasn't seen patients for years if ever! Medphobia prevents listening to patients, because "know-it-all" critics have loud police-state powers as they act out the "gotcha" obsession so characteristic of investigators everywhere. More and more, it appears that government Bureaucracy Boards (formerly "medical" or other designations) rarely have direct contact with the patients and physicians about whom they are making judgments—in fact, these Boards seem not to *care* about the patients or physicians; they just want to act out their abuse of power, malicious prosecutions, fabricating investigations, and false accusations. Truth and justice are rendered impotent by medphobia.

Politicians

Medphobia is the result of a series of unforeseen consequences due to bureaucratic intrusion into medical practice. The current flood of controlled medications was preceeded by a government supported "help pain patients" promotion called "The Decade of Pain 2000 - 2010" or "Pain Decade 2000-2010 from the U.S. Congress and White House. Pain patients and their families had organized for needed pain med relief because the pain med centers had become (and still are for the most part) injection sites rather than pain med prescribing, understandable considering the fee differential. Practitioners received exhortations to learn how to evaluate and treat patients with pain meds. Each patient had to have a pain evaluation notation in the hospital record each day on each nursing shift. Pain scales were passed out everywhere. Seeing all this, I thought I could help by studying a few pain meds to, perhaps, help some of my patients who I knew were suffering as "pin cushions" at local pain centers. Up until then, propoxyphene was the only pain med I prescribed. I never solicited or took pure pain patients, just those psychiatric patients who also had pain problems. Anyway, about four years after the pain med promotion, there is a predictable consequence of a pain med epidemic, naturally followed by a predictable consequence of "medphobia." (The Law of Unforeseen Consequences regularly follows unlimited government bureaucratic control efforts.)

It is helpful to know that there are three types of patients: those cured and not needing further care; those uncured going elsewhere; and those remaining reasonably well with continued care required. After over 40 years of practice and not taking any new patients for several years, the third type of patient accumulates. These patients have been seen for years and are fairly stable with occasional, inconsistent adjustments needed. They almost all are on benzodiazepines, stimulant medicines, pain medicines, anti-depressants, anti-psychotics, or combinations of several or all. Such patients claim to be doing well in spite of continued problems which are bewildering, often overwhelming and tragic and just seem never to go away. They document that the medications and brief evaluation and management visits help them get through the previous month and will likely sustain them, with an occasional phone call, until the next appointment. For many, their brief appointments are usually the only really positive thing that happens to them each month and it is truly a therapeutic encounter of the Art of Medicine far beyond their receipt of any prescriptions and far beyond the ability of any law to define in fact.

One of my patients, now 50 years old, was seen by me as a resident initially when she was 9 years old. She was called "minimal brain damage" in those days. I put her on low dose imipramine because that was all we had and it helped greatly. Later we shifted to an amphetamine preparation when it came out. She continued it through high school, some college. She disappeared for a while only to return when she was 30 feeling she needed to go back on the medications to cope with her problems. The imipramine and amphetamine were restarted with an occasional Valium used. I have seen her monthly almost for 20 years. She occasionally has a party or occasionally a severe emotional crashing, but all that is temporary with good recovery and return to her baseline functioning because of readjusting her medications. Denying the success of this woman's treatment and rejecting the need for maintenance dependency lacks common sense and morality. No, she is not perfect. She has dealt for decades with a life that you would not likely trade for a winning lottery number. Her family has given me supportive testimonials over the years also, and she is grateful, eager and pleased to return each month. Further, she thinks the anti-benzodiazepine and anti-medication articles which I handed out were "medphobic" – a phrase that I quickly realized deserved promulgation.

Politicians seemed not to understand that the innate uncertainties and unpredictable results of medical practice do not lend themselves to legislative impostions without unforeseen consequences including medphobia which hurts patients and prevents good care. This may be because those consultants, used by politicians to help write laws, are not in full practice with the full range of patients and their disorders; and science changes every five years anyway. Legislative and political dogma are not possible for the full range of patients, disorders and treatment potentials in the practice of medicine.

Addictionologists

My just quoted patient was responding to a handout for all my patients: Audio Digest Psychiatry Volume 41, Issue 9, "Benzodiazepine Dependence" of 5/7/12 and a summarizing article entitled *Cognitive Effects of Long Term Benzodiazepine Use* BTP 2002; 25:41-43. I asked for feedback on a sheet which summarized many alleged negative claims about benzodiazepines, i.e., benzodiazepines should be used for only about four months; that they produce anxiety and depression themselves when used for long periods of time; that 90% can taper off and 85% will have less anxiety and depression when they do so; and that all users have negative mental testing in every way compared to non-users. In addition, I clarified the difference between addiction and dependency – basically "addiction" is understood as the need to increase doses to get some sort of a "high" with increasing loss of functioning rather than improvement overall, while "dependency" is the continuous normalization of functioning by proper taking of medications.

In such regards, the Audio Digest Psychiatry article, "Benzodiazepine Dependence" is a mistake because the article is not about therapeutic "dependence," but is a blanket condemnation of all benzodiazepine use. A young man who read it wrote:

I am shocked to hear these claims. I have been off and on benzos for many years. Life is 100% better when I am on my medication especially for long periods of time. I can work hard laying floors. I can take care of and enjoy my family. Your body needs to be used to it for it to work right and be a positive for someone.

One bright business man called me the next day, quoting the article: "Patients who abstain from BZDs for three years had significant lower levels of anxiety and depression compared with patients continuing BZDs." He howled at the illogic and was bewildered that such a statement could make it into print. As a diabetic, he said that when his sugar levels were low for long intervals, he did not need insulin; and when his sugar levels were high, he did take his insulin. He felt the same way about his anxiety and depression medications—if the symptoms are gone, he does not take the meds, perhaps for as long as "three years." And when he is feeling worse, he will be on his meds. Duh! He wanted to know how the writer of the article got through medical school, much less became Physician Director of the Betty Ford Center.

The failure to distinguish between addiction and dependency is medphobia. This seems to be a common problem for addictionologists especially because their patient sample is far from what most physicians deal with in the trenches of medical practice. Most patients will not fit into addictionologists' usual samples because, to reiterate, internal chemistries are as different as exterior faces, and especially neuropharmacologic responses will not be identical.

Completely overlooked in medphobia has been the negative impact of abstinence and the detrimental effect of an imposed medication-free state. Looking back, I believe that all of my patients were dead within twelve months after going elsewhere and not receiving some comparable stabilizing medications. This gives grandiose fantasies which I reject, but the experience is real.

A 45 year old man died after 4 months of sobriety. Five years before, he was referred to me by a pain center for anxiety, panic attacks and depression. After 18 months of treatment, he asked if I would prescribe a pain med which once had worked best. He had stopped going to the pain clinic for about 6 months because he felt like a "pin cushion" and the pain injections did not work well any more, and "they would not give meds." So for several years, I added Vicodin as part of my sessions at no extra cost, and he claimed good relief. It should be noted that this patient was always worried because of his drug abuse background as a youth. So we monitored the appropriateness of doses and with his family kept him, his relationships with his wife and kids and his business on track. The testimonials from his family were all positive. But occasionally he had a party and this time he ends up in the emergency room with a few friends. He gets admitted for detoxification which was brief, but he was convinced to stay for rehabilitation for several weeks and then he went for a month and learned all the sloganeering about medications. Now, happily free in the NeverNeverLand of no drugs or medicines, he returns home, leaves me a few, brief, obnoxious phone calls on my voice mail about how good he was doing and how glad he was to be off medications, implying that it should have been done many years before. I left a brief voice message to him of congratulations and positive support, hoping he would continue to do well and apologized for not doing it sooner, as I thought he was doing rather well considering all. Three months later I received a call from his wife that he was dead. Now I will take my five years of controlled medication prescribing to his four months of sobriety any day. His "cure" of pretentious sobriety was worse than the "disease" of eking out a functional life on medications with infrequent mild relapses. It should be obvious that my medications did not "cure him" but they enabled him to function with his children, family and business for years. His sobriety did not cure him either. In fact, it killed him. Some people, as chemical beings, need medications.

My personal experience is of over 40 years treating many atypical and chronic psychiatric patients with attention deficit, depression, anxiety, psychosis, and pain (the latter for only about 6 years after the pain med promotion). Most of my patients claim to have their lives back. Which is why it is so disconcerting to observe a medphobic, defamatory campaign from colleagues who unprofessionally instigate a negative stereotype of any and all patients using controlled medications and of the prescribing physicians. Most patients are helped with proper therapy and reasonable monitoring of their medications. Family involvement is usually helpful, and "testimonials" should be obtained from family members on a periodic basis. Medphobia is a disorder detrimental to the profession, to physicians and to patients and it seems to be especially present in addictionologists who generalize too much.

Pharmacists

One cannot discuss "medphobia" without considering pharmacists. Pharmacists are in the business of dispensing medications. They can count well but that is about all except for some experienced pharmacists familiar with a few physicians' practices. Like food delivery people should not dictate to restaurant head chefs, pharmacists should generally not be telling doctors what to do, other than side-effect or interaction reminders. Yet many states have given pharmacists unjustified and inappropriate responsibility for monitoring medical care beyond dispensing an appropriately prescribed medication. No doubt, pharmacists can count well, but this too contributes to a pervasive medphobia, because they have limited knowledge of what the numbers mean.

To be fair, while some fears on the part of pharmacists for dispensing medicines stem from insurance companies and their often fraudulent attempts to delay or prevent payment for medications, most of any pharmacist's medphobia is related to reliance on the Physician Desk Reference (PDR). Pharmacists usually have limited knowledge, if any at all, of the hundreds of pages not included in the PDR of medical information that exists for each medicine in its indices. Thus pharmacists are especially ignorant about *non-acute or maintenance* treatments because the PDR does not generally contain such. I suspect that pharmacist are, at the very least, subliminally aware of their uncertainty, which exacerbates the medphobia. It should. Basically, most pharmacists do not realize that the PDR contains nothing more than the acute-care study data on accepted medications, on the basis of which the Food and Drug Administration allowed the medication to be listed in the PDR. The PDR omits almost all subsequent data.

In personal correspondence about the atypical use of medications, the Food and Drug Administration has stated that, "*The FDA considers off-label use to be the practice of medicine.*" Thus, the PDR is not used to practice medicine. Pharmacists, confined to the PDR, are certainly not privy to, or trained to use, medication data on efficacy in treatment for atypical or chronic patients especially in maintenance care. Pharmacists cannot be "Guardians of Medical Care" no matter claims or even laws declaring such. I have written the Ohio Pharmacy Board for almost ten years complaining about pharmacists mistreating and abusing patients about their medications because of lack of knowledge about non-PDR prescribing of medications.

My 50 year old well-to-do business man was seen for several years for anxiety, mood swings, and long standing ADD. Fairly stable on antidepressants, lithium, occasional Adderall and lorazepam, he asked me to take over his pain meds for convenience and less cost. I did so. He stablized on Oxycontin 40 mg, 7 tabs a day (4 in AM and 3 each PM) after about 6 months of trials. That went on for several years. I had testimonials from his wife. Suddenly he had a big business opportunity requiring 2 months in Australia. So, at his request, I give him a prescription for 630 pills (210 a month for 3 months, without any extra fee for my doing so). The numbers were terrible and I doubted he could get this from a pharmacist, but he said he had alerted the pharmacist and was assured such would be all right (Actually, the pharmacist dispensed the meds 210 each month and she mailed them to him). This was early in my pain med prescribing and word of the current "epidemic" was not even considered nor offered by anyone in those days of pain med promotion. I gave him a cover letter verifying medical need (My advice to him: "They will arrest you as a drug dealer without this letter, so keep a copy of it with your meds and with your passport."). Upon return, he lost a prescription and I became wary. I logged onto Ohio Pharmacy Board's just implemented monitoring program and found he lied to me. I terminated him immediately in total disgust in 2008. This was my first realization that pain meds could be a problem and that more scrutiny was needed. Six months later, I found that he had forged some prescriptions… and then died. I have the misguided guilt that I could have rescued him had I kept seeing him and monitored more closely. Occasionally patients go bad. And they generally get worse without treatment. The number of pills can be reasonable one time and later unreasonable—just knowing the number is not enough. Somehow, abandoning these patients assures their deaths. This patient was the "worst case" against me by the Pharmacy Board and used to manipulate the Medical Board, the Prosecutor and the Judge against me.

The Art of Medicine cannot allow physicians to be heavy handed investigators nor force physicians to follow prejudging rules. And physicians have the right to a "good faith" belief in reasonable stories from troubled suffering people. But, as is commonly heard in medical education presentations, "If you are not being fooled once in a while, you are not busy." On the other hand, fortunately, "the ones going bad will reveal themselves sooner or later," and then dealt with appropriately. Most patients are not bad dudes, perhaps unless seen by addictionologists who have never seen a patient on meds whom they liked. That some patients are "bad" simply contributes to medphobia, especially for pharmacists who in their cubbyholes of knowledge and a 30 second look at their customers, do not know the patients' stories, disorders, stresses or thought processes. They solely have numbers about which they think anything different from the PDR is either a mistake or crime. They take it upon themselves to profile whether a customer "looks right" (whatever that means), and whether or not a given physician, whose practice and patients they do not understand, passes their muster. How self-righteous and wrong.

Many states have given Pharmacy Boards power to monitor medications in an effort to control the alleged epidemic of substance abuse of prescribed meds. This is somewhat helpful, but it is worth stating again that about six years ago, the government supported a "pain med *promotion*" effort – which had unforeseen consequences requiring replacement by a "pain med epidemic prevention" promotion, and again overlooking the unforeseen consequence of medphobia (One just wonders about government involvement in anything sometimes).

My personal experience with Pharmacy Boards is that they do not realize that "public criticism" is an automatic part of the job description for anyone in public service, which includes them. I have been reporting medphobic pharmacists who were abusing and mistreating their customers for years, and believe me, Pharmacy Boards do not like whistleblowers (incident after incident available from me at Sam@DocNigro.com).

I wanted to know about pharmacy education. So I wrote the Accreditation Council For Pharmacy Education asking for the required curriculum for pharmacy schools, but, amazingly and disturbingly, they never bothered to answer. I did find on the internet that pharmacy technicians have a high school education and two years of pharmacy while full pharmacists have a high school education and four year pharmacy training degree. Apparently the content of the curricula for the 2 and 4 year pharmacy degrees is secret. This contrasts dramatically to a physician's education of high school, plus four years of college, plus four years of medical school, plus four years of specialization, plus years of medical practice. It is not surprising that pharmacists do not understand medical care very well, ergo misunderstanding patient treatment, especially outside the PDR. Without a code of ethics, a code of professional responsibility, and a list of customer rights, pharmacists easily become arbitrary and capricious as they act out their ignorant grandiose desire to think they can do more than count out properly prescribed medications. Medphobia is understandable, but pharmacists have no right to take it out on patients or physicians. My "List of Pharmacy Customer Rights" is available from Sam@DocNigro.com. After almost a decade of complaining, I believe I have noticed an improvement in pharmacists' treatment of patients as a result of these complaints and I commend the Ohio Pharmacy Board for such, but pharmacists are still not qualified to monitor medical care and some still go off on their customers. Pharmacists will never be part of "medical care" if they treat their customers anti-therapeutically because of medphobia. Pharmacists will always have "customers" not "patients."

Summary and Recommendations

The Grand Coalition of politicians, addictionologists and pharmacists responsible for medphobia is identified and reviewed. Maintenance therapy for chronic and atypical patients is totally misunderstood and denied.

Recommendation 1: Physicians should be allowed to practice in the Hippocratic Tradition of open free Art and Science of Medicine. Laws should be basically unnecessary. The machinery of medical care is individualistic and isolated self-rule. In addition, each patient is an "exception to" and not "the rule." The Oath of Hippocrates should not be replaced by an "Oath to the Bureaucracy."

Recommendation 2: Those who criticize care should be required to take over the care. In the old days of Hippocrates, it was unethical to criticize a specific patient in another practitioner's care without the willingness to assume full responsibility for the patient. In such regards, I believe those who criticize benzodiazepine and pain medication dependence should be required to assume total care of the patients for whom they claim to know better. They can then prove better care as determined by the patient instead of some distant reviewer who probably has no practice. Those who "know better" should be required to prove long term cure and satisfaction rather than just four months of sobriety after quarantine based detoxification, for example. I know they have done it for their samples, and most of us with other samples congratulate them and wish them well. We also wish they did not have medphobia about the different looking patient samples of other physicians.

Recommendation 3: Pharmacists should remain pharmacists and provide medications appropriately prescribed in a way that is not injurious to their customers. Their inflated authority needs subordination to those really responsible for patient care. Their customers are sick and need special support for their medications. There should be a legally mandated procedure of clarification and helping for customer and physician whenever pharmacists have any concerns about any prescription.

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None.

Conflicts of interest

The authors declare that there is no conflict of interest.

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