Long Read Review: Drug Dealer, MD: How Doctors were Duped, Patients got Hooked and Why it's So Hard to Stop by Anna Lembke

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In **Drug Dealer, MD: How Doctors were Duped, Patients got Hooked and Why it's So Hard to Stop**, **Anna Lembke** *sheds light on the rise of prescription drug addiction in the USA, fuelled in part by the actions of doctors and the structure of the US healthcare system. As the book illuminates the causes and drivers behind the increasing everyday reliance on prescribed opioids,* **Thomas Christie Williams** *ponders whether this situation could hit countries such as the UK in the coming future.*

***Drug Dealer, MD: How Doctors Were Duped, Patients got Hooked and Why it's So Hard to Stop*. Anna Lembke. Johns Hopkins University Press. 2016.**

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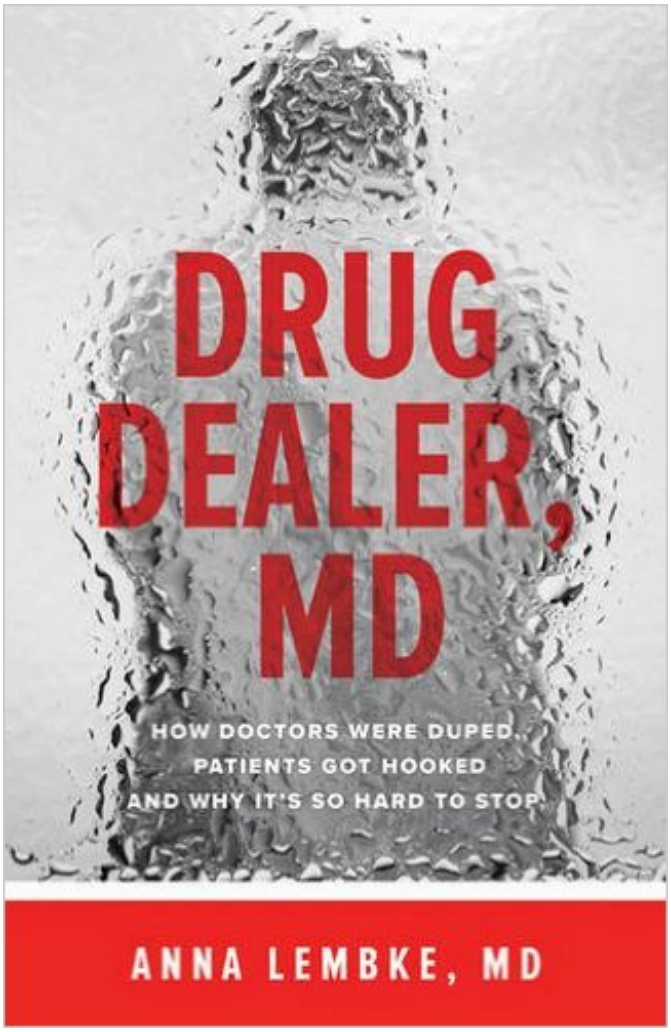


In the 1970s, Canadian psychologist Bruce Alexander and a group of colleagues at Simon Fraser University tested the widely believed hypothesis that drugs such as morphine are intrinsically addictive. They took two groups of rats and placed the first in the standard laboratory cages used at the time: small and cramped with little space to move and interact. The second they put in the 'Rat Park': a spacious enclosure filled with wood chips, platforms, running wheels and tin cans.

Alexander and his colleagues introduced two types of liquid for the rats to drink: water and morphine solution. The caged rats consumed significantly more morphine than their 'Rat Park' counterparts. Alexander and his colleagues concluded that there was something about the living conditions of the isolated rats that meant that they were more likely to drink the morphine; the 'Rat Park' rats tended to avoid it. Whilst these results have subsequently been disputed, it is an attractive allegory for drug consumption and addiction in humans.

Following this line of thought, it is not necessarily the substance that is the problem: many people consume alcohol and other drugs without becoming addicted. Instead, it is more to do with social context. Those hardest hit by addiction are predominantly from economically and socially marginalised groups. These include residents of the Edinburgh estates that, twenty years on from the release of *Trainspotting*, are contributing to the highest ever rates of death from drug overdoses in the United Kingdom (heroin and morphine remain the biggest killers). Amongst the indigenous inhabitants of the New World, alcohol plays a similar role, with this thought to be a key factor behind the

six- to eightfold higher death rates among indigenous Australians between the ages of 35 and 54 .

Consider taking the ‘Rat Park’ allegory one step further. Instead of the heroin and morphine being supplied by criminal gangs, imagine it is medical professionals providing drugs users with their hit. The people who should be treating those who are addicted are fuelling their habits, and in some cases instigating them. This is not a futuristic dystopia, but a view of the contemporary United States healthcare system presented by psychiatrist Anna Lembke in *Drug Dealer, MD: How Doctors were Duped, Patients got Hooked and Why it’s So Hard to Stop*. Lembke describes how patients will travel from clinic to clinic to obtain prescriptions for opioids such as Vicodin or Oxycontin. Describing one of her patient’s interactions with a physician, we hear how ‘Jim’s encounter with the drug dealer pretending to be a doctor was the moment he realized he had become a drug addict pretending to be a patient’ (117).

Image Credit: (woodleywonderworks CC BY 2.0)

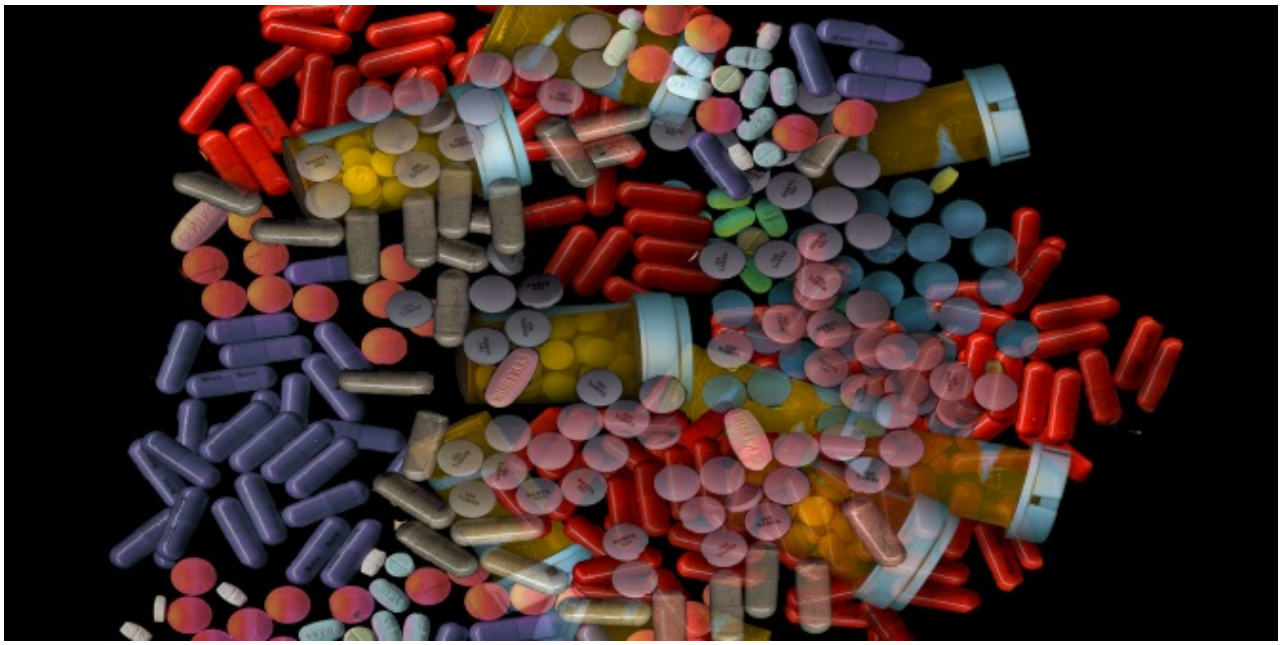
The US is currently in the throes of a prescription opioid epidemic. From 1999 to 2015, more than 183,000 people died from a prescription opiate overdose. In 2014, almost two million Americans abused or were dependent on prescription opioids, and 1000 people are treated daily in emergency departments for the same reason. And some are turning from prescribed medications to heroin, which is often cheaper and easier to access: studies of various US cities report that between 39 and 86 per cent of heroin users had previously used prescription opioids.

So how did this situation come about? Lembke outlines a combination of factors. First, the emergence of chronic (as opposed to acute) pain as an entity to be feared and aggressively treated, followed by the marketing of opioids by the pharmaceutical companies for both. This has been compounded by a fragmented, de-personalised, mainly private healthcare system that prioritises profit over patient care.

Lembke argues that pain has come to be seen by modern medicine as something to be avoided at all costs: ‘pain is considered an almost intolerable sensation for patients to endure […] The pressure to treat pain has become so overwhelming that doctors who leave pain untreated are not just demonstrating poor clinical skills; they are viewed as morally compromised’ (42). In tandem has come the idea that pain in itself can be a disease. Lembke makes the case that what she calls ‘chronic pain syndromes’ are a contemporary phenomenon, claiming that the idea people could experience physical pain in the absence of a disease process or physical injury would previously have been an alien concept to most medical professionals.

As a treatment for acute pain and a substance to abuse, opiates are nothing new. Opium is known to have been used for millennia, and its potential for addiction was recognised (and exploited) by British merchants, leading directly to the Opium Wars of the mid-nineteenth century. Morphine's more potent cousin, heroin (known medically as diamorphine), was first synthesised in 1874, and marketed by the German pharmaceutical company Bayer from 1898. Lembke describes the first US heroin epidemic at the turn of the twentieth century, which led Bayer to discontinue its production in 1913, and a second epidemic in the 1960s as US soldiers returned from Vietnam. In the US and Europe, these experiences led to caution amongst physicians in prescribing opiates for anything more than short-term use to patients experiencing the most severe pain.

Lembke links the start of a change in medical opinion to the rise of the hospice movement, which advocated aggressive comfort care at the end of life: this 'good faith effort to improve the lives of patients in pain […] gave way to an epidemic of opioid painkiller overprescribing' (57). It is important to note that in many parts of the world opiates retain their fearsome reputation: Mother Teresa famously courted controversy by refusing morphine to end of life patients in her Missionaries of Charity Hospices. Even now, an estimated 80 per cent of the world's population has no access to morphine, meaning millions with terminal diseases die in (preventable) pain. In a situation perhaps analogous to that of obesity and malnutrition, addiction and untreated pain have become two sides of the same coin.



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Back in the US, Lembke also documents how unscrupulous academics, often funded by pharmaceutical companies, used cherry-picked and flawed evidence to launch a questionable new paradigm in pain medicine: that opioid painkillers were effective in the treatment of chronic pain. She quotes Dr Russell Pourtnoy, one of the cheerleaders for more liberal use of opioids in the 1990s and early 2000s: 'because our primary goal was to de-stigmatise, we often left evidence behind' (62, also available on YouTube). By then there was a variety of semi-synthetic and synthetic opioids such as Vicodin and Oxycontin being marketed to doctors and patients. Manufacturers claimed that these had fewer side effects than morphine. Unsurprisingly, these new formulations were also more expensive: in 2015 the global prescription opioids market was valued at almost $34 billion dollars.

Another claim made by academics and pharmaceutical companies was that the use of opioids for chronic pain was unlikely to be addictive, a premise that Lemkbe is sceptical about. It is revealing that in 2007, Purdue, the manufacturer of Oxycontin, pleaded guilty to misbranding their product as less addictive than it truly was, paying $634 million dollars in fines to the US Department of Justice (71). Like Big Tobacco, pharmaceutical companies are

being forced further afield and appear to be aggressively marketing synthetic and semi-synthetic opioids in the developing world.

One of the paradoxes of the US prescription opioid epidemic is that, like many addictions, it is hitting hardest those who can least afford the substances on which they are dependent. In a predominantly private healthcare system, how can those who are the poorest and least educated (and proportionally most affected) pay for their medications? Here, Lembke draws on the work of economists David Autor and Mark Duggan. In *The Growth of the Social Security Disability Rolls: A Fiscal Crisis Unfolding*, they examine the factors underlying the near-doubling of the number of US adults on Social Security Disability Insurance (SSDI) since 1984. They argue that congressional reforms in the 1980s 'enabled workers with low mortality disorders such as back pain, arthritis and mental illness to more readily qualify for benefits', leading to an increase in people claiming SSDI for conditions such as chronic pain. To this Lembke adds the 1996 US Welfare Reform Bill, which she believes provided an incentive for states 'to move poor people to the disabled category to improve the state's welfare numbers' (93). Lembke believes that these have led to the creation of 'Professional Patients': people reliant on federally funded disability as their primary source of income (91). As for those unable to obtain opioids through medical channels, they are increasingly turning to heroin and other black market alternatives.

The final two chapters of *Drug Dealer MD* are devoted to ways to curb the current epidemic. The key complicating issue is the structure of the US healthcare system. It appears much easier to continue to prescribe opioids to an addicted patient with chronic pain, as insurance companies tend not to fund treatment for addictive disorders. Lembke describes the difficulty in persuading a patient's insurance company to fund Suboxone, her chosen treatment for a patient's opiate addiction: 'the whole process required three days […] Had I written a prescription for an opioid painkiller […] Jim could have picked it up in the same hour' (132).

Could this epidemic hit the UK? Certainly, many of the ingredients are already present. Between ten and fourteen per cent of Europeans are estimated to suffer from chronic widespread pain. Prescriptions of opioids for non-cancer pain in the UK rose sevenfold between 2000 and 2010. Since the 1980s, there has been a well-documented shift from unemployment to disability benefits, particularly in areas with a predominantly manufacturing workforce. What distinguishes the UK is a centralised health care system that, for now at least, does not have the financial incentives to drive opioid prescribing in a similar fashion to the US. And there is no evidence yet of rising rates of heroin use amongst young people. However, with the financial crisis currently engulfing the NHS and the likelihood that a post-Brexit trade deal with the United States will involve greater access to the UK healthcare market for US companies, this may well change.

Thomas Christie Williams is a Clinical Lecturer at the University of Edinburgh in the field of Evolutionary and Molecular Genetics. Prior to taking up this post, he was a Specialist Registrar in Neonatal Medicine. Thomas has a long-standing interest in how our evolutionary past is relevant to human health and disease today. Read more by Thomas Christie Williams.

Note: This review gives the views of the author, and not the position of the LSE Review of Books blog, or of the London School of Economics.