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EDITORIAL

Prescription drug overdose: between patients and their doctors

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Prescription drug overdoses, mainly involving prescription opioids, have reached epidemic proportions in the United States over the past 20 years.[1,2] Since 2003, prescription opioids have been involved in more drug-related overdose deaths than heroin and cocaine combined. Among patients who were prescribed opioids, an estimated 20% were prescribed high doses of opioids by either single or multiple physicians, and these patients appeared to account for the majority of prescription opioid-related overdoses.[1,3,4] The increase in prescription overdose deaths has coincided with a major increase in prescription opioid sales.[2] The prescribing practices of some physicians are often believed to have contributed in part to the increase in these overdose deaths. In a recently published perspective, Anna Lembke speculated on why doctors prescribe opioids to known prescription opioid abusers.[5] Her article raises a timely and troubling issue for all of us interested in this area of medicine. Lembke identifies the root of the problem to lie in the changing societal attitude towards pain and suffering, the ever-growing availability of opioid medications, the regulatory requirements promulgated, and the perceived shift in the role of the medical professional in this context. Central to her argument is that physicians must now practice according to a set of externally imposed expectations of patients, payers, and regulators, putting the prescriber in the position of being "damned if you do and damned if you don't". If Lembke is right, the physician now prescribes not according to what he or she wants to do, but according to what he or she must do. The result, at one extreme, is the patient acting as their own physician and, at the other extreme, self-deception on both ends. Things could hardly get worse. Lembke's proposed solutions are to make the threat of public and legal censure equal in not treating addiction as in not treating pain, and to compensate addiction treatment on a par with care for other illnesses (presumably including pain).[5]

Lembke's perspective can be read more meditatively and with some reflection. What has fundamentally changed in the care of pain and in addiction medicine over the past several decades is the relationship between patients and their caregivers. That relationship is the foundation of medical practice, without which medicine is nothing but voodoo and a bag of tricks. To fix the system of care, this is where we must begin; one has to go deep to slay the dragon, and it will not be easy.

From the very beginning, the doctor-patient relationship was a sacred one, and there was no bargain or demand, with only giving on both sides. The patient brings to this relationship a plea for relief, if it is possible, for understanding and sharing

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if relief is not possible. The patient comes with faith in the physician's knowledge and skill, exercises faith through trust in the physician's sincere desire to care for the patient, which in turn gives the patient hope: an anticipation that things will be better despite uncertainty. That is what the patient comes to the physician for. The physician brings to this relationship the healing power of knowledge and skill, yes, but also love, compassion, and self-discipline. The foundation of this patient-physician relationship is sincerity, "with no wax," in other words, authenticity, ie, "let there be no veil, no concealment, no barrier, nothing between us". That is how it was and how it should be.

Let us illustrate this in another way with a story. Many years ago, back in the 1970s when Daniel X Freedman was editor-in-chief of the *Archives of General Psychiatry,* Jim Klett and the author (WL) submitted a manuscript for consideration for publication in that journal, and received back a note that said "Walter, I will exercise the power of the editor-in-chief and accept the paper as is, if you and your coauthors change all the words 'client' to 'patient'; merchants have clients, doctors have patients". Freedman knew what he was talking about.

The relationship between the caregiver and the "client" is different. The relationship has been commercialized. The physician is now a care deliverer and the patient has become a client who is the care purchaser. Inherent in this relationship is gaming and negotiation, which involves concealment. What Lembke laments is that physicians now practice in an atmosphere of mutual concealment: "don't ask, don't tell." There is a veil, a barrier that now exists between the patient and the physician, and no amount of legal reform and political speech can fix it. It has to be removed by the parties involved. The current buzzword in evidence-based medicine is "transparency", but transparency is not sincerity, which is what we need. Sincerity requires personal responsibility, whereas transparency does not. If we cannot see each other because the glass between us is dirty, it is nobody's fault; we are not responsible for it. Let us not be transparent, let us be sincere.

Is there hope? Yes, we do believe in hope. These days we speak of individualized medicine, and that is where we can begin. We say every patient's treatment is an experiment of one, but that should not mean we are experimenting on that one patient. What we should do is regard it as an experiment on this one special physician-patient relationship in which we are engaged. We could do well if we begin with "let there be no concealment between me and thee".

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