**There Is No Crisis**

**How the Government Used Opioids as Scapegoat, Diversion for Several of the Nation’s True Dysfunctions**

**From the author of**

**Games without Frontiers:**

**Manufacturing Moral Panic for Profit in Middle America**

**6 July 2021 (V7)**

**M Giarmo, Ph.D.**

**Jacqueline Goldberg**

**Carrie Judy**

Social psychologist uses the best available data, logic, and history to expose the Federal engineering of the “Opioid Crisis" and the systematic McCarthyesque expatriation of chronic pain patients, the doctors who dare treat them, and venerable cornerstones of a compassionate care system that once served as the hallmark of a civilization.

This is a living open source document that will respond to new developments and grow to accommodate contributions from the patient and physician community.

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| **Here we prepare to introduce the false but prevailing narrative about an “Opioid Crisis" (i.e., The Great Myth). We discuss its origins, its logic, and the social psychological principles leveraged to compel its support among incurious, slavishly compliant, and critically cataleptic professionals who either profit from it or who cannot afford to rock the boat.**  **We are in a state of war in the U.S. In the one corner are those in the “more prescriptions, more deaths" camp who believe today’s heroin addicts are yesterday’s patients. They aim to starve the Opioid Flu by eliminating exposure, and while there is a special emphasis on protecting our most vulnerable youth, proponents of this view are willing to prevent a doctor from prescribing a GMP painkiller – even for patients unconscious and under the surgical knife. In the other corner are those in the “more restrictions, more deaths" camp who believe that the crisis is really a heroin crisis and that it is an iatrogenic, self-inflicted, self-fulfilling prophecy of sorts brought about when patients, abandoned by their doctors under pressure from the DEA armed with the PDMP, are driven to unreliable Street drugs or to suicide.** | |
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***"Physicians should be judicious, but there should be some flexibility," Harris said. Ultimately, she concluded, the decision to prescribe or not to prescribe ... and how much to prescribe ... should be left to the physician based on the individual needs of each patient ... At the end of the say, physicians are prescribing opioids to treat pain.***”

* Cindy Sanders (Birmingham News) of Patrice A. Harris, MD, MHA, Chair of the AMA Opioid Task Force and immediate past of the AMA Board of Trustees (September 22, 2017)

**“It’s a remarkable juxtaposition. When it comes to what we put in our wallets and bank accounts ... we are proponents of deregulation. When it comes to what we put in our bodies ... we need a police state. Of course when you consider how lucrative the drug war has been and for whom, you realize all the new regulations that restrict or criminalize access to pseudoephedrine – painkillers – marijuana -- are for many in the right positions not restrictions at all but rather streams of revenue and economic opportunity. Remember that the new prohibition on painkillers is only harmful to the people who truly need them. For those in power, these restrictions are forms of recreational abuse.”**

* Matthew Giarmo, PhD, Senior Government Analyst and Social Psychologist

**EXECUTIVE SUMMARY**

**Before Americans were confronted by a genuine epidemic in COVID-19, they were subjected to a parade of headlines about another matter.  The Government calls it an epidemic, crisis, and emergency and forced its citizens to surrender their Constitutional right to pain relief – its once routine, non-contentious access to pain medication – even the pain experienced after surgery and the pain experienced in one's final days on earth – so that this “epidemic” can be brought under control.  The epidemic in question is the “Opioid Crisis.”**

Americans have always needed a bogeyman to inspire and structure our governance and our economy.  Over the past century we have summoned our will and scripted our morality to neutralize threats from all comers. Witches. Immigrants. Drunks. Nazis. Hippies. Terror cells. Satanic cults. Americans who harbor sympathies toward communists.  Americans who harbor the *names* of those who harbor sympathies toward communists. Unlike practical fears of realistic threats, there has always been an otherworldly or psychoactive quality added to the groups listed above -- not unlike the difference between a rational fear of the D.C. sniper or that lion that escaped from the zoo on the one hand and an irrational phobia for thunder, non-venomous spiders, and injections on the other.  There is something excessive about the anxiety.  Clinical even.  As if the anxiety has been dipped in a cauldron of subconscious material consisting of repressed memories, fantasies, and primordial myths. The fear persists long after the realistic threat has been contained.  The fear inspires a response so extreme that it causes collateral damage and prompts people to say that the cure may be worse than the disease.

Unlike the other run-of-the-mill, garden variety bogeymen, drug dealers do not appear to be confined to a particular era.  Fighting substance abuse has been profitable for decades, but the Opioid Crisis allowed us to expand our pantheon of demons beyond the creatures of the night to health care providers, insurers, pharmacists, distributors, and even patients under treatment for conditions that give rise to severe or intractable pain ... not to mention the friends and family who want to share more than just a roof with these patients.  The Opioid Crisis has driven many wedges into once sanguine relationships between doctors and patients, doctors and pharmacists, doctors and other doctors, and the grieving survivors of dead heroin addicts and the living caregivers of relatives debilitated by a pain that went undertreated as soon as their doctors discontinued their pain medication under pressure from the DEA.

The fight hardly seems fair.  In the one corner, you have a community of patients whose ties and whose strength is weakened by pain.  In the other, you have these agents granted almost unlimited moral and legal authority -- career-driven agents who performance is measured by how well they restrict access to pain medication, who are separated into two groups – one that burns the midnight oil and the superior group that burns the candle at both ends – agents who were comfortably hired into lifetime Federal jobs and who are so hardy they may have never endured a health condition of any kind in their lives.  They are accustomed to drawing their semiautomatic Rock River Arms LAR-15 upon heavily armed counterparts in international drug cartels, but these days they are just as happy to storm your granny's chiropodist for overprescribing.  You know, low hanging fruit and all that.  Whatever brings them closer to that 30% annual reduction in dispensed morphine units their political leaders promised in their State of the Union address.

Social media platforms have born witness to acrimonious disputes between the spouse of a migraine sufferer and the mother who stormed the office of their District representative to demand a prohibition on all Percocet following the untimely death of her son to a speedball.

In case you haven't noticed, America is at war.  A civil war is being fought over a system of compassionate care that has for decades been the hallmark of American superiority and the cornerstone of civilization.  I am talking about how we manage pain.    
  
There are many types of pain.  End-of-life pain.  Surgical pain.  Acute pain caused by ailments we expect to resolve within a matter of days.  And then there is a pain that lingers over the course of weeks, months, and in some cases years.  A pain so severe and so disabling that it impairs our ability to carry out the daily activities we took most for granted.  Impairs our ability to fulfill responsibilities in our home, school, and work environments.  Forces those around us to take care of us or to assume a greater share of the responsibility.  A pain so severe that it changes who we are to ourselves and to those for whom we care the most.  A pain that, where untreated, can even alter our biochemistry in ways that put our health at risk.   
  
Some pain shows up in blood tests as elevated cortisol.  Or in imaging as tumors, broken bones, or kidney stones.  But there is also pain whose sources cannot be made visible or verified with medical technology.  This neurological pain is often the worst pain of all.  Some of the conditions giving rise to this pain have widely accepted causes such as RSD, while others are more controversial (e.g., fibromyalgia).    
  
If you ask me whether I think pain is pain, the answer is as simple as it is clear ... yes and no.  Pain is pain in the sense that its effects are non-negotiable.  Pain holds us hostage and ransoms our lives until it gets the attention it demands.  Pain does not care whether we call it chronic or acute.  But those of us in pain sure care whether you withhold treatment; pending scientific evidence that chronic pain responds as well to treatment as acute pain or whether we might develop a fondness for the treatment others think is perverse.   
  
If you could relieve enough of the pain by swallowing a pill ... if a pill could make us feel whole again by allowing us to be who we are and to do the things we need to do for ourselves and for others ... you would embrace it, right?  
  
How often do you hear someone  say, "if only there was a pill for ... " or "there is no pill for ... ".  And yet for the thing that causes us the most grief and disability, there is such a pill and there has been for over a century.  It’s affordable ... inexpensive even. But there are a growing number of people being recruited into supporting a movement to restrict access to these medications, going so far in some cases as to reduce or altogether rescind what doctors have been giving their chronic pain patients for years.  They allege that the previously hidden dangers of these pills have been brought to light after ethically questionable and aggressive marketing practices by one of the pharmaceutical houses that manufactures these pills; and furthermore, caused doctors to prescribe at excessive rates resulting in increased rates of addiction, accidental overdose, and death.  Now these people want to ensure that these pills, for which no equal and effective substitute is available, are eliminated entirely from the health care system.  Isn’t that just like us as Americans? Everything has to be a win-win. Or in this case a win-win-win-win. Cheap, non-toxic, and effective are not good enough. You have to have a low potential for abuse.

Truth be told, measures have been implemented to target all the major risk sources and prescriptions are down 60% since 2015. That’s not a typo. Go ahead and take another look. *Sixty* percent.

1.  The alleged perpetrator of the aggressive marketing has been stopped, penalized, and shamed nationally as an industry tutorial.   
  
2.  Dentists are no longer trading 60 Percocets for the wisdom teeth of our most vulnerable youth.  Out of a paranoid concern for their licenses, most dentists will not prescribe anything stronger than ibuprofen or Tylenol with codeine.   
  
3.  The so-called "pill mill doctors" have hit the pause button on the automated dispersal of monthly scripts.  Prescribers must now schedule periodic follow-ups with the patient for status updates, risk assessment, and good faith efforts to document and address the root of the pain through nonpharmacologic and pharmacologic-nonpharmaceutical alternatives.    
  
4.  The DEA continues to leverage new technologies and authorities to curtail diversion of legal narcotics to unintended recipients outside the doctor-patient relationship and to monitor for the use of multiple doctors or multiple pharmacy chains to acquire more product than medically necessary.   
  
Any measures beyond those listed above encroach upon and disrupt the system of compassionate care by which people in real pain find real relief.  But there are those in positions of influence or authority who not only desire encroachment and disruption, but total annihilation.  They have used various propaganda techniques to compose a narrative centered on 8 myths and misconceptions:   
  
1.  Prescription painkillers are "heroin pills" and abuse of these prescribed products is a gateway to the abuse of other drugs, including Street drugs   
  
2.  Prescription painkiller abuse is responsible for at least a great many of society's crimes and underperforming institutions   
  
3.  The rate of dependency and accidental overdose is so great as to warrant a declaration of emergency that unlocks the full force of the Federal authority to manage the opioid pipeline and suspend the privacy, liberty, and protections afforded patients and doctors  
  
4.  Despite a lack of commonly known toxicities in opioids, researchers are beginning to identify their role in carcinogenesis  
  
5.  Reasonably safe and effective substitutes are available as well as combination therapies outside the pharmacologic modality   
  
6.  Prescription painkillers are not as effective at relieving pain as common over-the-counter NSAIDs, and are pursued only for a "high" enjoyed recreationally or as an off-label treatment for everyday stress or for clinical levels of anxiety and depression   
  
7.  Senior officials in elected, appointed, or career government positions have your best interests at heart when designing new legislative and regulatory mechanisms to restrict access to narcotic pain relievers   
  
8.  The pain being reported is not real or not sufficient to warrant narcotic intervention   
  
The effect of the PR campaign outlined above is one of turning your personal pain into a political game.    
With the politicization, you stopped owning your pain.  Suddenly our scientists and lawmakers are disputing the organic basis of your pain. They’re using educated speculation to suggest that not even you, the sufferer, has the sound mind to comment in some trustworthy fashion on how much of what you believe to be physical pain is inflated and perpetuated by emotional factors.  In other words, to some immeasurable extent, your pain is another pain entirely.  Anxiety. Stress. Depression. Resentment. Disappointment. Shame. Guilt. Or perhaps the pain is a psychosomatic symptom in the Freudian tradition, a condition in which a pain with no physiological basis at all manifests as a diversion from -- or symbol of -- repressed trauma.  As PTSD. And of the pain so stubbornly reported by those whose pills were discontinued, one key public figure says that it is withdrawal pain and only withdrawal pain.   
  
The campaign is designed to undermine your right to the pills and your need for the pills.  And it is designed to ensure that in cases where rights and needs are recognized, the pills are not considered a safe and effective remedy and one for which we can say that the risks outweigh the benefits.   
  
There's just one problem.  That is, other than the crisis of untreated pain.  Other than that *self-fulfilling* epidemic of accidental overdoses *caused by the Fed* when patients abandoned by their doctors *under pressure from the DEA* turn to Street drugs and suicide.  I'm talking about a crisis in the quality of the data used to establish that a Crisis even exists.  I'm talking about a crisis of science. A crisis in which science is suspended or subverted. A crisis that occurs when we suppress or neglect the errors, variations, and biases at the root of our conclusions. A propaganda machine.  A War Machine.   
  
The so-called Crisis has opened up revenue streams.  Rehabilitation centers and State governments rake in tax revenue and legal settlements from opioid manufacturers.  Local police departments are awarded Federal funds based solely on the number of drug arrests made the prior year.  Local and Federal authorities share the value of all property – cash and contraband – seized in accordance with the Justice Department’s Civil Asset Forfeiture law.  Not to be left out of the gold rush, entrepreneurs reach out to HHS to argue that no one should be authorized to receive an opioid prescription who does not also receive one of their shiny new “pill lockers" reimbursable of course by the Medicare-led health insurance industry.  Unscrupulous documentary filmmakers with no real scientific motives plaster Amazon Prime with free propaganda referring to prescription pain relievers as “heroin pills" and the manufacture and marketing of Oxycontin as the “crime of the century.”  In the tradition of such pop culture vanity icons as “Bill Nye the Science Guy," a regular on news networks like CNN despite not having an advanced degree, is the architect of the CDC 2016 Opioid Prescribing Guidelines. Andrew Kolodny failed to disclose as a conflict of interest his services as an expert witness for lawsuits against the pharmaceutical industry, a service for which he is entrusted at the hourly rate of $750 and for which he has earned $500,000 to date.  Our Government has given him complete control over the lives of millions of chronic pain patients despite the fact that his medical subspecialty is psychiatry and in the business of rehabilitation as executive of Phoenix House. Not only does he benefit financially from the declaration of emergency around prescription painkillers, but the fact that the mere 4% of those prescribed painkillers who actually develop a substance use disorder make up 100% of his daily operations has to skew his perspective via what social and cognitive psychologists call “the representativeness heuristic.”  Could it be the opioid crisis may just be a logical fallacy based on a perceptual illusion?  It begs the question: is drug policy causing more harm than drugs?

When red flags related to the integrity and reliability of data failed to elicit the requisite attention, suspicions were raised in professionals who do not have a stake in the prevailing Government-run narrative.  They realized that certain steps in the initial validation of the Crisis were never taken.  That certain assumptions were made in the absence of data that could have been acquired.  And so in one form or another they asked: “Let’s take this from the top.  What are the facts here?  Does the Opioid Crisis really exist?  Did it ever exist?”   
  
The answer may surprise you.   
  
The case against opioid based pain medication is grounded in the notion of danger.  In order to properly and responsibly evaluate this argument, it is important to identify what is meant by danger and what kind of dangers are posed by these substances.  Is it that the rate of use is remarkably high among our most developmentally and emotionally vulnerable populations (i.e., teen use)?  Is it that these drugs are difficult to discontinue of one’s own volition (i.e., dependency)?  Is it that long term exposure due to persistent pain or to addiction is unsafe for vital organs (i.e., toxicity)?  Or is it that in search of a euphoria, an unacceptable number of citizens suffer lethal respiratory depression from doses exceeding recommendation or from interactions with other drugs (i.e., accidental overdose)?  
    
This is where the American Government would say, “ask no questions, hear no lies.”  But I am here.  I am asking.  I am also answering.  I ask and answer as a trained social psychologist with a knack for analyzing social trends, institutional cultures, and collective behavior.  I ask and answer as a trained consumer and producer of knowledge, a dissector and critic of research, a data analyst, psychometrician, and philosopher of science.  I ask as a data detective once entrusted to illuminate the most stubborn of cold cases, having done more in one project to advance our understanding of an age old mystery – why we dream – than all the research spanning the 130 year history of academic Psychology.  And finally I ask and answer as a close friend or family to those who have lived with chronic pain for 5 – 15 years.  For a combined 23 years I attended the medical appointments of two wives – both women with disabilities – who live in pain and whose pain ripples outward to affect the lives of those who love, care for, or depend on them.  These people know one devil – pain – and a legion of demons led by the likes of Andrew Kolodny, Jane Ballantyne, Gary Mendell, Jeff Sessions, and other meddlers with God complexes whose scientific acumen, scholarly motive, and mental health are patently questionable.  
    
In the face of all kinds of individual differences – individual differences in (a) the underlying medical conditions producing a chief complaint of pain, (b) the history of treatment (i.e., tolerance), and (c) congenital enzyme-mediated sensitivity to pain and to pain medication, the Government pushes indiscriminate, across-the-board solutions and protocols, including one-size-fits-all limits on what physicians can prescribe in monthly morphine units.  And toward that end, the Government has unleashed Richard Nixon's DEA to help meet the arbitrary political objective of a 30% annual reduction in dispensed medication.  They don’t care which patients it comes from – or if they have to get there by shutting down physician practices altogether.  Like Nixon in 1968 the DEA makes sure the network television cameras are present when the armed agents kick down the doors to your grandmother’s chiropodist.  It certainly feels like Nixon is here in spirit.  His White House Counsel disclosed that he declared a war on drugs as a means to neutralize political adversaries, and he ensured a nation watched as the evening news programs captured the arrest of those who organized riots for Black equal rights (heroin) and those who organized demonstrations against the Vietnam War (marijuana).  And Nixon’s legacy of surveillance and segregation endures in the use of the Prescription Drug Monitoring Database to spy on doctor-patient encounters and in the use of the NARXScore to stigmatize for all to see those prescribed higher doses or quantities of morphine.   
  
Patients are human beings and individuals.  Their humanity and individuality pose obstacles to the Government mission to expand its theater of operations beyond Supply to Demand, where they treat pharmaceutical houses as international cartels, doctors as dealers, and patients as junkies.  In addition to laying waste to such democratic values as HIPAA-protected privacy, the Hippocratic Oath, the Constitutional right to pursue freedom from pain, due process for persecuted physicians, and the entire system of compassionate care on which civilizations are judged and for which opioids remain a cornerstone, the Government has practically criminalized what has been embraced within the medical community as individualized or patient-centered care.    
  
All those aforementioned sources of variation – of individual differences – describe just one of 4 consumer populations -- populations that vary as a joint function of the authorized status of user and product: (1) patients legally prescribed GMP manufactured painkillers with reliable ingredients and serving sizes they can trust; (2) recreational users who are able to acquire GMP manufactured painkillers by diversion; (3) patients abandoned by their doctors who resort to illicitly manufactured or counterfeit drugs on the black market; and (4) recreational users who acquire illicitly manufactured or counterfeit drugs on the black market.  In the face of this variability, the Government responds with one solution.  One protocol.  One ... hammer under God without liberty or justice AT ALL.  You want to slavishly comply with something?  Bend over – backwards – forwards – uncritically and unconditionally for someone?  If not the self-evident truth that is the suffering and the dignity of 50 million individuals then what?  The CDC?  The DEA?  Andrew Kolodny?  How about the fact that there is no grounds in science or nature to dictate how much opioid is too much?  That’s right.  As long as the starting dose is the smallest effective dose and as long as that dose is gradually and responsibly increased over months or years of periodic follow-ups in which unresolved pain is assessed and balanced against any side effects, that dose or quantity cannot reach a level that can be deemed excessive.  Sure, ninety 15 mg oxycodone tablets a month might seem like a lot of morphine to someone who is being treated for his first acute injury with ten 5 mg tablets or to Andrew Kolodny who has probably never experienced a day of pain in his life.  This whole idea that the Government and the likes of Kolodny will save people from themselves and from industry, specifically from a conspiracy of doctors and manufacturers to profit off excessive prescriptions – that patients exposed to painkillers have been set on a path to an accidental heroin overdose – that exposed patients have forfeited their objectivity and sovereignty to the brain-altering power of the drug – that NSAIDs are just as effective for pain as opioids – and that patients separated from their opioids and administered NSAIDs and other nonpharmacologic and nonnarcotic pharmaceutical alternatives, such as acupuncture, cognitive behavioral therapy, yoga, and unnecessary surgery through which patients will be given acetaminophen only. The idea that these patients will “thank them later" is the height of moral and intellectual corruption.  
    
This fundamental disregard of individual differences does not mean the Government will not invent its own variables where and when convenient.  We will examine the assignment of patients across 10 levels of risk for accidental overdose through a scoring system shamelessly named the “NARX Score.”  The score is used to put a quasi-scientific face on what had been a patently reckless and arbitrary practice of separating patients from their prescriptions.  But is the science underlying this scoring system above reproach?  We examine the NARXCheck data and methodology.    
  
Yes, the answer may surprise you.   
  
In unprecedented secrecy, the CDC drafted a document that became impetus and justification for new legislation, policy, and enforcement.  The 2016 Opioid Prescribing Guidelines was widely embraced at all levels of Government.  But there’s a problem.  Despite language explicitly limiting the scope of the guidance to first time users suffering acute injury or illness, the Guidelines were cited as grounds for separating some of our most troubled patients from medication they had been prescribed for years -- as grounds to destroy more careers than Joe McCarthy -- as an incalculable number of physicians were raided, prosecuted, and deprived of their licenses.  This is aggression on a scale Americans have never tolerated.  After an initial round of pill mill doctors and dentists trading 60 Percocet for the wisdom teeth of our most vulnerable youth, Federal officers hatched a scheme for attacking physicians who treated chronic patients in good faith.  They attacked pharmacies that failed to vigorously question what they considered questionable scripts – and pharmacies that filled scripts for patients further from their home for the taste of the DOJ.  But ... [let’s hear it now] ... there’s a problem.    
  
There is no basis in science or nature for determining how much medicine is too much; not for people who started at the lowest effective doses and increased gradually and responsibly over the years with regular checkups and special consideration for side effects and unresolved pain due to tolerance.  The FDA, which wanted no part of the CDC Guidelines, thought as much.

Decades of utilization have vindicated opioids as cheap, uniquely effective, and less toxic to vital organs than OTC NSAIDs.  Data compiled independently by NIH and SAMHSA even revealed reassuring rates of dependency.  So anti-opioid propagandists re-focused the spotlight on accidental overdose even as a highly suspicious statistic about dependency starts showing up in every new drug control bill – one which sells us that 4 of 5 heroin addicts were once prescribed painkillers.  Interesting statistic.  But here’s the problem.  So were 4 of every 5 Americans who never touched an illicit drug.  This is roughly the proportion of us who were given Percocet or codeine when we had our wisdom teeth removed.  But those pushing this statistic also want you to fall prey to a common fallacy by assuming the converse of the logical statement is true: that 4 of every 5 Americans prescribed painkillers turn to heroin.  80%.  Now that would be cause for alarm.

The source of the extraordinary statistic is SAMHSA (2013). This wisdom teeth theory is not something I wing and sling with casual aplomb. Besides all the sense it makes, how do I know that this dental procedure – as traditional and American as apple pie – is driving these numbers? If we consult the seminal 2013 SAMHSA survey, we see that 52.7% of the heroin initiates surveyed were between the ages of 18 and 25, which is contemporaneous with the procedure. We also note that even though 79.5% reported prior use of prescription painkillers, the use occurred within the past year for only 31.3% of these respondents. For the remainder, abuse or dependency occurred well over a year ago. With time scales like these, how can we speak of addiction and causality so compellingly? If I use some Percocet and can then wait over a year before using heroin, I wouldn’t consider that risky, impulsive behavior. Would you?

Now I realize that the term used by the SAMHSA article is *nonmedical* use, suggesting that the survey respondents were not legally prescribed the painkillers they acknowledged using prior to taking up heroin. And yet as a social science researcher and trained psychometrician myself, I remain skeptical. I doubt the surveyors would have went to the necessary lengths to ensure the respondents lawfully observed this distinction. There is an impulse among respondents seated with pencil in hand in front of this official questionnaire to ensure their most relevant experiences are not excluded especially when the questions are written in such a way as to support the impulse:

*“NSDUH defines nonmedical use of prescription drugs as use of drugs that were not prescribed for the respondent or used only for the experience they caused.”*

The addition of that second condition – “ ... or only for the experience they caused" – turns the item into something far more convoluted and inviting and one that authorizes the respondent to include the post-dental experience despite the legal prescription.

So I still feel that 4 of 5, or 79.5% statistic, includes an incalculable number of uses immediately following a dental procedure that is as much a rite of passage as their high school graduation or prom. It’s too important an alternative explanation to dismiss, especially when we consider that nearly all of us go through this experience at this time in our lives and nearly every public health official participating in a committee chartered to address a pre-ordained threat feels compelled to cite that SAMHSA statistic – but oddly enough not the one SAMHSA uses to keep our alarmist reaction in check ...

*“However, the vast majority of NMPR users have not progressed to heroin use. Only 3.6% of NMPR initiates had initiated heroin use within the 5 year period following first NMPR use.”*



The graphic above shows how viral friendly data can become. It’s a slide from a grade school level presentation created by The Oregon Coalition for Responsible Use of Meds, and the Office of National Drug Control Policy is cited as the source. We use extended time scales to link use of prescription painkillers to use of heroin and no matter how alarming that statistic appears, it is drowned in another statistic that tells a different story but that is seldom “allowed out of the house.” Truth be told: dependency is not the common outcome.

Those wondering how you could have alarming overdose data in the absence of alarming dependency data took notice when rumors of error, suspicious variation, and bias surfaced about both the source data and the analysis.  Among the critics is the CDC itself, which acknowledged inflating overdose fatalities by over 45% when it miscounted deaths involving illicitly manufactured substances as deaths due to prescribed products.    
  
The comedy of errors is matched only by the sobering seriousness of the consequences and by the stubbornness to adjust messaging and strategy to reflect the new facts.  So how do we make sense of the mind-boggling boondoggle that is the Opioid Crisis with its DEA Prescription Drug Division, with the Prescription Drug Monitoring Database, with the cattle like branding of patients with NARXScores, and with the incalculable number of threats, raids, prosecutions, and revocations of licensure?  As countermeasures go, these are fairly extreme reactions.  This may be just another instance in which the U.S. Government responds to a tragic incident – exacerbated by hypothetical worst case scenarios – by building a massive wartime detection and surveillance program.  The events of 9/11 produced the  Patriot Act, which served as an impetus and justification for an unprecedented program of surveillance and mining of telecom metadata by the NSA, which as Edward Snowden revealed was not limited in its design to test hypotheses about individuals with criminal histories (i.e., confirmatory data analysis) but rather to collect, record, and link the radio, digital, and analogue communication of every citizen for automated retroactive search by unique identifiers (e.g., email address, IP address, password) and, in cases where a citizen is flagged, the system is instructed to send all future activity pertaining to that citizen to an agent's attention.  Does this sound like anything to you?  It should.  Because this is how the Prescription Drug Monitoring Database (PDMP) operates.  And much like the NSA RKeyScore system, Federal officials justify the loss of privacy to the PDMP – and to the NARXScore -- with patriotic hymns about national health security and the public interest.  We even give police officers training and access to the PDMP ostensibly so they can identify "high traffic areas" -- but I would be shocked if they weren't using it to confirm whether individuals caught in possession actually had valid prescriptions.  Giving law enforcement access to private health information feels as invasive as leaving a teenage daughter's ground floor window open for the cool overnight low in summer.  I would also be shocked if the system wasn't used to establish grounds for suspicion of drug use because you all know what that means ... civil asset forfeiture.  Help yourselves there, boys.   
  
This is all fodder for analysis by social scientists specializing in collective behavior and specifically in a phenomenon known as mass hysteria, for which there are historical parallels and precedents most Americans are too young or too ashamed to remember.  Long before “heroin pills" and Al Qaeda, there were witches and the accusation, prosecution, and execution of 20 innocent citizens in late 17th century Massachusetts.  Then we tried to ban the sale, manufacture, and transportation of alcoholic beverages.  With visions of Hollywood filmmakers, university professors, and DOD cafeteria workers promoting the Soviet agenda, Senator McCarthy and something called the Committee on un-American Activities used a blacklist to permanently preclude employment for those of us accused of harboring Communist sympathies or of harboring the name of a Communist sympathizer.  Not to be undone, for a number of months in 1983, a group of concerned parents aided by unskeptical news broadcasters managed to convince us thousands of children across the nation, beginning with those at the McMartin School, were being subjected to an epidemic of satanic ritual abuse by daycare workers.  (I guess there’s nothing we can’t be sold).   
  
As utterly preposterous as these events are to us now, it was quite a number of years before we came to our collective senses to realize what was happening wasn’t noble, necessary, and patriotic ... or real.  As absurd as some of these events were, they were no more absurd than what our Government wants us to think or do about our painkillers.  In the final analysis, it is just as plausible that our Government leaders see in opioids the perfect scapegoat and diversion from a continuous series of more genuine crises plaguing all our systems and institutions over the past 25 years.  It is just as plausible our Government leaders would have you reverse the direction of causality so as to blame opioid abuse and addiction for disruptions to workforce participation and development, affordable housing, and our fundamental capacity to save -- after rent -- for a rainy day, retirement, and repayment of our student loans.  Isn’t it more likely that opioid use ... scratch that ... substance use, our inclination to manipulate our moods to escape or enhance through all kinds of drugs including methamphetamines (up 500%), cocaine (up 190%), and heroin and illicitly manufactured fentanyl (up 30%) is a symptom; one of many symptoms of fundamental breakdowns in our public institutions?  Even the abuse of over-the-counter medication like Immodium, Benadryl, Delsym, and Tylenol is increasing.  Nearly 17,000 of us succumb to complications of OTC med use each year – more than prescription painkillers.    
  
So now that you know the truth, you’re asking how we can snap out of our national delusion.  The answer is that it’s not easy.  It’s more likely a matter of having to survive what we cannot stop.  Of having to let a mental illness on a national scale unfold, play out, run its course.  We will have to suffer some awful consequences before we can ask ourselves whether it was all necessary and how it could have all been avoided.  No one is immune from the neurosis.  After all the regulations devised over the years by different Governmental and regulatory entities conspire to delay, complicate, and even jeopardize the fulfillment of a legal script at a pharmacy, you still find within the voting public and body politic, some who would say “why hasn’t anything been done?”  It’s the modern day equivalent of “will someone *please* think of the children?!” Quick aside here ... I remember an amendment proposed by a Representative Weldon (R-PA) to a Defense Authorization Act for the year 1998. He demanded the Act require that President Clinton confirm the veracity of a statement he had made on at least 130 occasions in speeches across the country – that statement being that “there are no longer Russian missiles pointed at America's children.” It seemed to me then as it seems to me now and as it once seemed to this Representative, that a statement like that is one that is impossible to verify; and one that a Russian General later confirmed could be true one moment and false the next given that that it takes only 10 seconds to retarget any ICBM. Yet the President made the statement knowing that a large swath of the American voting public want so desperately to believe it that they would not question it. At some point an astute politician realizes it is in his best interests to stop appealing to the rational faculties of however many Americans there are at any given time – and start appealing to the sensibilities of large chunks of voters harboring theories about how the world is run, despite being flawed. These politicians know that drugs have a role to play in many of these worldviews and they are never credited as a positive force. As someone campaigning for high office, you know you can line up quite an array of voters behind you with a public condemnation of drug abuse.

Nothing spreads diseased ideas more than a U.S. election cycle.  Those campaigning for high office seek to outdo rivals and predecessors on this issue, upping the ante by proclaiming that the other guy “hasn’t done enough” to a thunderous round of applause.  No sentence for pharmaceutical executives was too harsh for the Vice Presidential candidates who in their lone debate curried fantasies of lynching Sacklers in the Town Square.  No limit on the manufacture, prescription, and stocking of Percocet is too arbitrary or political.  No settlement figure for those who manufacture Oxycontin is too high.  Whether you’re an elected official, Federal bureaucrat, entrepreneur, rehabilitation program executive, or daytime talk show host, you should know better than any of us that we as a nation have become more addicted to an Opioid Crisis than we ever were to opioids.    
  
For years after the Guidelines , a Pearl Harbor-caliber attack that decimated most of the nation's compassionate care capability in which a community of chronic pain patients began lobbying for clinical minority status and mobilizing in defense of their civil rights.  Once they provided access to a more scrupulous base of factual information, the question of how a criminally engineered epidemic – a “crime of the century" -- could have been allowed to happen – began to share the stage with some very different questions like “how did we reach the point of declaring a crisis around opioids?”; “how did a complex biopsychosocial phenomenon like substance abuse get assigned to the CDC Injury Prevention and Control Center?”; “how did the CDC get away with staffing an advisory group with members of a fringe anti-opioid lobby?”; “how could the Department of Justice lead let alone allow the Government to violate sacred principles of American democracy, including HIPAA protected privacy laws, the Hippocratic Oath, the Constitutional right to pain relief, and due process for physicians treating in good faith?”; “why is the DEA continuing to cite the CDC Guidelines as justification for destroying our nation’s system of compassionate care long after the CDC held a press conference to announce its Guidelines were misapplied to chronic and palliative care?”; “why hasn’t the American Medical Association defended its physician members and its mission-to-treat and why hasn’t it brought the Federal crackdown to an end through a public campaign or through threats of work stoppage?” and “in light of the fact a great many patients abandoned by their physicians under pressure from the CDC and DOJ end up resorting to Street drugs or suicide, why is it taboo to suggest that the Fed has blood on its hands?”

One theory is based on the way the AMA executive offices are staffed. The President is elected to a single one year term. It’s an honorary position. An award more than an office. He or she is a temp. A perpetual lame duck. How could I expect the AMA President to mobilize his forces against Poncho Villa style guerrilla warriors from a fringe group like PROP propelled by an extremist ideology? I recall in 2005 that the politically and technologically savvy American Psychological Association (APA) used an Internet based action alert system to mobilized its 50,000 strong membership to automatically sign and send letters to members of Congress demanding prescription privileges for clinical psychologists with no medical training. Before the flatfooted AMA even knew what hit them, the APA had won privileges in 3 states. I see the AMA has not learned much from the experience.

The Report that follows will be subject to detailed examination about the facts introduced above.  The analysis will expose a lack of logical discipline and scholarly motives in the commission, selection, and celebration of substandard research, data, and analyses for the purpose of stoking public paranoia in an “Opioid Crisis.”  Yes, there is a risk inherent in almost everything we do.  When we operate a motor vehicle.  When we hire a new employee.  When we consume an alcoholic beverage.  Or when we resolve to defend the sovereignty of the South Vietnamese.  But those who sign a pain management contract with their designated provider – be it a neurologist, physiatrist, or whatever – are making it known that they are willing to accept a manageable risk in exchange for some quality of life.  That is a decision and a sovereignty of which their Government has robbed them:   
  
... the same Government that savagely relishes comparisons of the number of opioid fatalities over 20 years to the number of American soldiers lost over 9 years of active duty in Vietnam ...   
  
... the same Government that once drafted these kids into a war on foreign soil in which they had no stake ...   
  
... the same Government that currently denies prescription painkillers to soldiers who sacrificed on the battlefield in Iraq or Afghanistan ...   
  
... the same Government that once condemned to 50 years in prison a 25 year old Vietnam War vet and purple heart recipient for attempting to sell less than an ounce of marijuana to an undercover agent ...   
  
... the same Government that would never criminalize the sale, operation, or transport of Ford Fusions or raid auto plants in Detroit despite comparable deaths by motor vehicle accidents ...   
  
... and yet the same Government that engineered the comparability by inflating the number of accidental opioid overdoses by artificial means.   
  
By the time you have finished reviewing the best available data, logic, and experience – personal and historical -- I feel confident you will believe as I do that there are maybe two things about 21st century America in which you can trust: one is the temerity to destroy the one thing we can most rely on ... the other is that there is nothing more reliable and compassionate about this country than opioid based pain medication.

**BLAME GAMES: VINDICATING PAINKILLERS, CHRONIC PAIN PATIENTS, & THE DOCTORS WHO DARE TREAT THEM**

*“Doctors and public health practitioners are increasingly questioning the role of opioids in the treatment of long term, chronic non cancer pain while recent legal initiatives have also targeted prescribing for acute conditions, based on the concern that excess prescribing in the acute setting can lead to abuse among those patients or that leftover pills might be diverted”* (Kilby, 2016).

**AMERICANS BEING AMERICANS: OPIOIDS IN A CULTURE OF ASSET BUBBLES**

In the 1990s, research from the 80s suggesting opioid-based pain medication was not as addictive as previously thought gave rise to the view within physician communities and medical boards that pain was being undertreated, spurring an expansive application of opioid analgesics beyond acute and palliative care pain to chronic pain. Given that Americans who suffer pain from a chronic condition number in the millions, and given the symptoms requiring management are expected to persist over the course of months, this paradigm shift alone is responsible for putting some 259 million bottles of Percocet and Vicodin into circulation in 2012. You can see why bean counters like Andrew Kolodny immediately go to work attacking the evidence base for treating chronic pain with prescription painkillers. If you could end something the CDC calls the “Opioid Epidemic” by flipping a switch, you'd do it too – unless you suffer a chronic pain condition yourself. Or someone you love. Or someone you depend on. You get the picture. And that picture – the one I am drawing as you read and I type – is one that strikes a recurring theme in modern U.S. culture. I am talking about a bubble -- an asset bubble.

We love bubbles. We can’t get enough of them. We loved the stock market bubble in the 90s. And we loved us some real estate bubble in the 00s. This is how we do business. This is the model by which policymakers, corporations, and investors collaborate to determine the course of free markets in the U.S. Each of these bubbles was fanned by a controversial act of acquisitiveness. I remember how none of my dot.com co-workers did much of any work between 9 and 5. Too many of these companies had nothing to produce beyond a rolodex full of venture capitalists. We were fundraisers and day traders, and I will never forget the sight of those cube farms jam packed with colleagues monitoring the value of their stocks while a random subset of us kicked a soccer ball around a cavernous room adjacent. On Fridays this room was turned into a banquet hall for a catered 3- hour lunch. Once an enormous swath of us lost our jobs in the NASDAQ Crash of 2000, we realized it was unlikely we would ever find wealth or even job security in the workforce but we could always achieve it through the acquisition and sale of our homes. There was actually a time when we as a nation believed every American could own a home. Homes were investments that would eventually pay for 2.3 sets of Invisalign for our children as well as their bachelor’s degrees, a daughter’s wedding, a prom or two, and our retirement. No matter what we paid for our home, there was no stopping us from turning a ridiculous asking price into a fortune. What made the real estate bubble so salacious, was the repeal of Depression Era regulations that protected us from what ultimately happened. It was called the Glass-Steagall Banking Act, and it represented the best wisdom the Depression had to offer. So naturally Bill Clinton and the Republican controlled Congress would toss it all aside. That’s not a political statement. Reagan and Bush the Son would have done the same. There was money to be made off subprime loans and the bundling of bad debt. Traders employed by energy firm Enron made $500 million for themselves and their employer when they manipulated the price of energy stocks by arranging the shutdown of electricity plants they purchased in California. That in the process they made air conditioning unavailable and unaffordable to customers during a number of summer heat waves was not overlooked. The head of the Federal agency responsible for oversight might have intervened had he not been recommended for the post by the CEO of Enron.

So when we talk about opioids we tend to zero in on the distinctly American struggle with demons that tell us to there is nothing we cannot sell or sacrifice for an immediate and short-term “high.” But opioids fit into other aspects of our culture as well, most notably the opportunity for pharmaceutical houses and law enforcement to position themselves in a system that generates a whole lot of money.

The groundwork had been laid in the 80s research and in the authorization of opioid therapy for chronic pain. But the real bubble moment characterized by the suspension of common sense and ethics came when Purdue Pharma relied on financial perks and an untested assumption about the reduced dependency risk for encoated, extended release formulations to aggressively market Oxycontin to physicians.

Richard Sackler is no Jeffrey Skilling, and Purdue Pharma is no Enron. Untested but rational pharmaceutical assumptions and perks aside, the whole health insurance industry did not want addiction potential assessed along with all the other adverse events – not even in the Stage IV “don’t-hold-up-FDA-approval" post-marketing phase – but the whole health insurance industry did want these pills. Physicians wanted them too. The pills were cheaper, less time-intensive, and less invasive than steroid injections or spinal surgery, and psst ... come closer ... they were more effective. Yes, the patients, the customers, the ones that complete those CAPHS satisfaction surveys on which the Federal government bases the rates at which it will reimburse individual hospitals—*they* want it. I don’t care what some surveillance camera or hidden tape recorder caught Richard Sackler saying in a private moment in which he rallied the troops or in which he showed pride in his achievement or passion for his work. I am going to pardon his bellicosity inasmuch as these seem to be the rules of business to which all of America is addicted and, as Captain Benjamin Willard (Martin Sheen) said of fulfilling his orders to terminate psychotic Colonel Kurtz (Marlon Brando) in Apocalypse Now (1979), “even the Jungle wanted it.” I remember when I signed all those promissory notes for Stafford loans as a 22-year-old kid in the early 90s. Everyone – and I mean everyone – from my parents to college presidents to the President of the United States – looked me in the proverbial eye and said a man with no college degrees ... he is going nowhere -- but a man with an advanced degree ... well, the world is his oyster. Since my PhD in 1997 I have spent more years than not in unemployment. Granted, the Software and Internet Revolutions in the mid 90s dropped the world’s arsenal of nuclear bombs on intellectual capital and that changed The Game entirely. Maybe we should have targeted Big Tech after Big Tobacco -- but my point is that things change and Americans have the most remarkable knack for developing amnesia for events that transpired before The Change. Now of my PhD and my student loan debt, I can hear a chorus of Americans gleefully chanting everything from “you made your bed" and “should have been an engineer" to “pay your debts," “no one put a gun to your head,” and my personal favorite, “your PhD is just another achievement.” (It certainly is not as valuable as that Six Sigma black belt I could have had for 2 weeks and $2,000 from some “university" that only exists in cyberspace). Suffice it to say I have a hard time holding this first family of pharmaceuticals responsible for the “Opioid Crisis.” Having said that, I also have a hard time blaming the “Opioid Crisis" for everything that went wrong with this country since the turn of the millennium. I will have more to say on this later in my Report, but I don’t happen to believe there is -- or ever was -- an “Opioid Crisis.” I believe there is a much wider substance use problem and that this is the consequence rather than the cause of all the true socioeconomic disturbances. It is a symptom. One of many symptoms.

But even if we did weather a perfect storm that led to an overly liberal prescribing policy, any restrictions imposed today have already addressed those causes and -- once that mess is cleaned up -- will at best return us to that period in the 90s when we wrestled with questions of untreated pain. I am staring into my crystal ball, and I see that once that pendulum is pushed back toward a culture of prescriptive austerity, cries of pain and authoritarian excess will drive us back in the other direction once again. And once U.S. lawmakers are done reaping the benefits in votes for processing some of us through rehab while telling the rest of us to “just say no,” they will be receptive to a whole new ground-swelling grassroots movement to show tens of millions of voters in pain some compassion. And they won’t even sweat the hypocrisy. They won’t even realize they're waffling. Psst – I won’t tell them if you don’t. So I wouldn’t sweat the Americans being Americans thing.

Pardon my confusion. But it appears we live in a nation that embraces deregulation as an ideology of economic health and opportunity. This is the spirit that laid the groundwork for some vigorous recoveries from recession. But like anything else this ideology can be abused and exploited to the point where it causes irreparable harm. I refer you here to Enron. To the corporate raiders from whom Oliver Stone created Gordon Gekko. To the wild disparities in wealth between upper and lower classes. To the real estate bubble that would have destroyed our economy if not for Government intervention. Despite all that transpired, we still embrace freedom from regulations in every corner of life except one: the substances we put in our bodies. In this regard we are willing to live in a police state and goosestep behind a DEA that shakes us down over our pseudoephedrine, our painkillers, and our marijuana. It’s a remarkable juxtaposition. Money ... no restrictions. Substances ... Iron curtain. Of course when you consider how lucrative the drug war has been and for whom, you realize all the new regulations that restrict or criminalize access are for many in the right positions not restrictions at all but rather streams of revenue and economic opportunity. Remember that the new prohibition on painkillers is only harmful to the people who truly need them.

If we could quantify the loss in lives and dollars due to activities designed to grow our net worth, we may have a meaningful baseline against which to assess the practical significance of losses due to substance abuse and other enterprises. The acquisition of wealth has many forms, and these include activities that impact our wallets, bank accounts, stocks, pensions, insurance, and credit. Many of these activities are legal even though they have the potential to disrupt our revenue and decrease our overall net worth. Market forces -- including new technologies, changes to the predominant modes of screening and evaluating job candidates, competitive pressures, and employer bias -- can diminish our employability and earning potential. These forces may remain legal despite their disproportionately adverse impact on certain populations – or where illegal, undetectable or unenforceable. For the sake of pragmatism, I will focus on acquisitions of wealth that are illegal, which is to say, on financial crime. This is a sufficiently vast universe, the full accounting of which rivals the challenge of identifying all objects in space that pose the threat of Earth impact. Even the task of listing types of financial crime, which are named after the financial instrument at the center of the crime, has proven challenging.

There’s Bank fraud, Bribery, Cheque fraud, Computer Crime (e.g., phishing, ransomware), Credit card fraud, Corporate fraud, Elder abuse, Embezzlement, Forgery and counterfeiting, Health care fraud, Identity theft, Insurance fraud, Market manipulation, Medical fraud, Money laundering, Mortgage fraud, Payment (point of sale) fraud, Scams or confidence tricks, Securities fraud (e.g., insider trading), Sedition, Tax evasion, and Theft.

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| CRIME | SUBTYPES | ANNUAL OR 2020 |
| Embezzlement | Forging checks; cashing customer checks; faking vendor payments; overfilling customers; padding expense account; “penny shaving" /“coin clipping” / “salami slicing"; double dipping; using company credit card for personal use; voiding transactions at the cash register; siphoning off cash deposits; raiding the petty cash box / safe; setting up fake charity or pocketing cash from fundraisers; stealing office supplies, equipment, raw materials, products, or returned merchandise; burglarizing customer premises; claiming a company laptop was lost; falsifying overtime; setting up fake employees; failing to remit payroll tax money; collecting kickbacks from vendors; selling trade secrets; corporate espionage; business identity theft; setting up a business using company resources; legal arbitrage trading. | $50 billion |
| Identity fraud |  | $56 billion |
| Tax evasion |  | $1 trillion |
| Scam phone calls / Telemarketing fraud |  | $19.7 billion |
| Cybercrime | Cyber Extortion (e.g., ransomware); theft of financial or card payment data; cryptojacking; cyberespionage ($400 billion); denial-of-service attacks; using computer networks to spread malware, illegal information; | $1 trillion |
| Shoplifting |  | $61.7 billion |
| Insurance fraud |  | $40 billion |
| Securities fraud | Ponzi and pyramid schemes; “pump-n-dump” scheme; advanced fee schemes; high yield investment fraud; foreign currency fraud; broker embezzlement; hedge fund related fraud; late day trading; microcap fraud ($1 – 3 billion); short selling; mutual fund fraud | $10 - $40 billion |
| Health care fraud and abuse | Overbilling; billing for items and services that are (a) not medically necessary, (b) not rendered, (c) not properly documented, (d) misrepresented at type or level of service, (e) misrepresenting individual rendering service; (f) up-coding, (g) unbundling, (h) over-charging, (i) kickback schemes; (j) failure to charge Medicare or Medicaid customers at same discounted rates others are offered for prescriptions | $70 - $234 billion |
| Mortgage fraud | Identity theft; income/asset falsification; appraisal fraud; air loans. Predatory lending; foreclosure rescue; and mortgage reduction scams all contributed to the Great Recession of 2007. | $2.5 billion |
| Credit card fraud |  | $11 billion |
| Counterfeiting | Counterfeit goods ($29 - $41 billion); counterfeit bills ($70 million in circulation); software piracy ($18 billion); theft of trade secrets ($180 - $540 billion) | $600 billion |
| Elder abuse | Senior's signature is forged or identity misappropriated; senior is coerced or influenced to sign over deeds or wills or caused to execute legal documents they do not understand; abuser fraudulently obtains power of attorney or guardianship; money or property is used without the senior’s permission or taken from them; money is borrowed from the senior and never repaid; fraudulent investment or insurance schemes; fraudulent contracts or warranties that cover nothing; unauthorised charges imposed by Internet service providers; worthless “sweepstakes" into which the senior must pay in order to collect winnings; fake pharmaceutical or diet/health products; predatory or unnecessary lending (e.g., reverse mortgages); tech support and IRS impersonation scams; charitable giving scams that may include pressure to rewrite wills; 419 scams; lottery scams; work from home schemes; hybrid financial exploitation (HFE) in which financial abuse co-occurs with physical abuse or neglect; | $40-50 billion |
| Market manipulation | False order techniques: (1) Deflate the value of a security by placing hundreds of small orders at a significantly lower price than the one at which it has been trading, inducing investors to sell by giving them the impression there is something wrong with the company – pushing the price even lower; (2) placing simultaneous buy and sell orders through different brokers do the increased volume of activity creates an impression of interest in the stock. False order technique combined with false information spread on online channels and message boards (**churning**). (3) agreements, often written, among a group of traders to delegate authority to a single manager to trade in a specific stock for a work period of time and then to share in the resulting profits or losses (**pooling**); (4) stock promoters convince company affiliates to release shares into a free trading status as “payment” for services for promoting the security. Instead of putting out legitimate information about the company the promoter sends bogus emails (i.e., “pump") to millions of unsophisticated investors in an attempt to drive the price of the stock and volume to higher points. After both are achieved, the promoter then sells their shares (“Dump") and the stock price falls, taking all the duped investors' money with it (**pump and dump**). (5) a group of traders create activity or rumors in order to drive the price of a security up (**runs**); (6) using specialized high bandwidth hardware to quickly enter and withdraw large quantities of orders in an attempt to flood the market, thereby gaining an advantage over slower market participants (**quote stuffing**); (7) a trader trades in one market for the purpose of manipulating the price of an asset in another market, capitalising off the price-moving effects thus generated instead of with the bona fide intent of profiting off the trade itself (**cross-market manipulation**); (8) when financial instruments are settled based on benchmarks set by the trading of physical commodities, the manipulator takes a large long (short) financial position that will benefit from the benchmark settling at a higher (lower) price, then trades in the physical commodity markets at such a large volume as to influence the benchmark price in the direction that will benefit their financial position (**cross-product manipulation**); (9) feigning interest in trading futures, stocks, and other products in the financial market creating an illusion of pessimism in the futures market when many offers are being cancelled or withdrawn, or false optimism or demand when many offers are being placed in bad faith. Bidding or offering with the intent to cancel before the orders are filled. The flurry of activity around the buy or sell orders is intended to attract other high frequency traders to induce a particular market reaction and allow the timing of buying and selling based on the manipulation (**spoofing**); (10) the principals who publish a price or indicator conspire to set it falsely and benefit their own interests (**price-fixing**); (11) an attempt to manipulate the price of a security at the end if a trading day to ensure that it closes higher than it should, usually achieved by putting in manipulative trades close to closing (**high-closing**); (12) creating a monopoly by buying sufficiently large amounts of an asset, usually a commodity, to control the price (**cornering the market**) |  |

If we could take all the estimated $3.1 trillion lost annually to fraud and redistribute that nationally, we would relieve a critical mass of anxiety among Americans pushed to the brink of financial disaster. That sum is already greater than the $2.2 trillion Cares Act passed in the Spring of 2020.

$3 trillion lost annually. Since we started taking an interest in the so-called Opioid Crisis (1999), that's $3 trillion a year for 20 years or a $60 trillion crater in the economy. Methinks that focusing more on fraud than drug abuse might go a long way to restoring the kind of nation where there is less urgency connected to the manipulation of our moods through foreign substances. Once we give half to the Government in taxes and half of what’s left to the 1% to hoard away, there might still be enough to create a job with dignity and a decent wage for every adult who wants one. So maybe that’s overstating things. What if we were able to restore what we lost over 25 years of chicanery, shenanigans, and tomfoolery.

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| 9/11 and terror wars | $6.4 trillion |
| Stock market plunge preceding Great Recession | $19 trillion |
| H1N1 | $6.2 billion |
| COVID-19 | $4.8 trillion |
| TOTAL | $30.8 trillion |

That’s another $30 trillion. Did our economy really lose $90 trillion over the past 20 years? I just feel like someone should have said something ... that’s all. Someone should have told me. And all the prospective employers who demand an explanation for all the gaps in my resume since 2007. I'm supposed to know why recruiters stopped phoning me with offers of Government contract work. I'm supposed to know why employers failed to choose me over the 300 – 1800 identified by LinkedIn, Indeed, or CareerBuilder as other applicants for a job. Why so many? I suppose I'm expected to know that too. I do have a theory. The dust still has not settled from the Great Recession. 8.7 million jobs vanished. Those of us unfortunate to lose our jobs at the nadir of this economic downturn were forced to pursue or accept positions beneath our station. And that means we never stopped looking for a better role. We also went without a raise or promotion in years despite over that period having to do the work of 3. This likely explains why 1 in 3 working Americans is engaged in an active job search. And why I am competing with hundreds of people who already have jobs. They’re unhappy in the jobs they’re in.

All this more than adequately explains my difficulties finding work. Even as a PhD. Still, sympathy is hard to come by. The few who are happy in their jobs – namely those who have the power to hire and fire – do not favor any explanations that confer nobility on the disenfranchised. It detracts too much from the glory and the unassailable logic of their own success. They live in a world in which people get what they deserve and where the cream rises to the top. So my status has to make as much sense to them as their own. Psychologists call this the *just world hypothesis*. We need to justify and support a world in which PhDs file bankruptcies after prolonged periods of unemployment. “They have no skills.” “They made the wrong choices.” “They are overeducated.”

Unfortunately we cannot directly compare the costs of financial crimes with those of accidental opioid overdoses because the former is measured in lost capital and the latter in mortality. I think we can safely assume that financial gain is a common motive for murder. But can we safely assume these deaths outnumber deaths caused by accidental overdose? Probably not. There were 20,000 murders in 2020, up 25% from 16,000 in 2019. While deaths due to homicide were greater in 2020 than deaths due to accidental opioid overdose there is no national database on motive that can point to something that should occupy us more than opioids. I suspect my counterparts in PROP World Headquarters are putting their own speculative minds to work wondering how many killed while under the influence of oxycodone.

Still, based on the combination of costs measured in lives and dollars, one would think that money should displace drugs as public enemy number one. But I don’t see a single bill urging Congress to declare war on capitalism. The Joint Chiefs have not called an emergency session to discuss a raid on the Treasury or an air strike on Wall Street. And GW Bush is not about to assume a position behind the podium in an elder statesman or emeritus role to announce that “America is addicted to money.” Money is the primary weapon against undesirable individuals and groups. If you want to know who we dislike, just look at their access to opportunities to earn a living. How did we handle suspected Communist sympathizers in the 1960s? We made sure they never worked again. Their families too. I think if we could undertake the appropriate study, we would discover that race is not the only source of economic disparity. Introverts. Intellectuals. Short men. Unemployed job seekers over 39 years of age who failed to secure a permanent home – and management position -- in an organization. Persons who dispense high level employment-related analysis – or passive aggressive innuendos -- on social media. Those of us with gaps on our resumes. Those of us who call on our nation to rein in its singular focus on software and programming skills. Those of us who used a “Like" to express support for a social media comment that expressed support for universal basic income. Those of us who have not participated in the boycott of Woody Allen films, or who had ever been spotted splitting a cab with Jeffrey Edelstein.

If we could add up all these adverse events – all the people affected by these crimes – not to mention all the legal carnage – I bet they would dwarf deaths attributable to smoking, obesity, and medical error in the same way each of those causes alone dwarfs deaths due to overdoses on any combination of drugs. We are so desensitized to the corrupting influence of money – we accept it so reflexively if not a priori as synonymous with our culture – that we even speak of liberty and opportunity in monetary terms. We monetize everything. When we choose a college major, we often hear, “what can you do with that?” Even academic communities like our university psychology departments – which are known to be full of Communists and Communist sympathizers – will favor for any tenure-track appointment or admission to PhD program training – the candidate whose research is being funded by a grant. Now the impact of this bias on the soul of a field like Psychology has been completely destructive when you consider all the careers that have been discouraged or prematurely terminated because they were staked to some lifelong passion to advance our understanding of an age old mystery that challenges us intellectually rather than financially. Mysteries like we dream. The role of dream experiences in waking life. The role of dreams in the personality system. The role of dreaming as a bridge between mind and body. Unfortunately dream research at the early stages, much like radio waves, has no immediate or near term commercial applications and for that reason these Psych departments are staffed by professors who are designing safer cockpits on grants from the FAA.

Public cigarette smoking is disgusting and a threat to health via second hand smoke, but don’t think for a minute that this alone was the basis for all the new regulations. It was that some entity – the Congressional Budget Office or some private think tank like the Brookings Institution – reported on the costs of this – “filthy habit" – to the taxpayer by way of the health care industry. Job seekers are encouraged to quantify for their resumes their impact on the bottom lines of former employers. If you can “say it in numbers,” that’s – uh – that’s -- good – but if you can put it in dollar figures, well that makes a whole lot more sense.

**OUR PURITAN DNA: CULTURAL UNDERPINNINGS FOR LINK BETWEEN SUBSTANCE USE, SIN**   
  
Once drugs were firmly tied to evil such that drug use serves as a litmus test separating the good from the bad, the sacred from the profane, strong from the weak, and blessed from the damned, all hope for integrating drugs and drug consumers into mainstream American culture was forever lost.  Even as referenda added to 2020 Presidential ballots suggest an openness to legalize or decriminalize recreational marijuana, the public feels compelled to fill the void with a new evil in, of all things, prescription painkillers. Like two countries exchanging political prisoners, we must trade one drug for another. The reason that universal decriminalisation has proven a bridge too far may lie in the simple fact that at the heart of Western thought is this core belief that if you allow individuals too much freedom, you get anarchy. With the force of a law of thermodynamics, this principle dictates that we cannot make peace with one demon without declaring war on another.  I am reminded of my time seeking a PhD in Psychology – Social-Personality Psychology – from faculty that for reasons that struck me as arbitrary and unfathomable – persecuted me for remaining committed despite their protestation to my goal of making dreams the subject of my master's thesis, my dissertation, and my life's work as a university scholar. Witnesses to my struggle invoked the name of a 20th century philosopher unfamiliar to me at the time. I was gifted a massive novel authored by this philosopher and I was quietly heralded as a heroic figure from her stories. That book was Atlas Shrugged and the philosopher, Ayn Rand. Her thesis was that humans were self-contained creatures who could easily subsist on the happiness derived from allowing oneself to be guided by one’s innate and personalized calling rather than the arbitrary and outwardly imposed edicts of political and religious systems. The way in which this philosophy could be so badly mangled and misconstrued by the masses who had not read her works suggests the influence of this Western core belief that we need systems like politics and religion to manage and control the self-interest of individuals. When Rand used the term like happiness and rational self-interest, Americans heard “hedonism,” and they imagined their fellow countrymen diving into piles of cocaine stored in their front yards. But having claimed Aristotle as her sole influence, Rand was referring to a form of happiness he called eudamonia. This happiness is much more foreign —less intuitive – to Americans whose DNA consists of genes for materialism, pragmatism, and puritanism. The closest term we have to eudamonia comes from the human potential movement of the 1960s – self-actualization –and it refers to the happiness we feel when we are fulfilling our destiny doing what we were born to do and what is worth doing. The distinction between hedonism and eudamonism is similar to the one between careers and callings – vacations and vocations. I had always been perplexed and annoyed by my fellow American's casual disinterest in their ignorance about dreams – their lack of curiosity. They didn’t care that they themselves or that no one else could explain the function of dreams in the human psyche or personality system. For professors required by their titles to have something to say on the subject, dreams were a petty and they were a nuisance, but they were not a petty nuisance. Their limited intellects and methodological formulae were taxed by the chaotic streams of imagery with sparse references to the events of the prior day. For these academics, for whom saying “I don’t know" never comes easy, dreams represent the kind of anarchy their politics and religion is designed to eliminate. And that perhaps explains why I, as a proud and self-proclaimed student of dreams, could feel like a political dissident inside the halls of these psychology departments. I was treated as if I were under the influence of, or addicted to, an illicit substance that filled me with a combination of peace and stimulation that was foreign to them. They observed my eudamonism and saw hedonism. When forced to explain their views or defend their actions, they never looked comfortable. They would produce a verbal salad of virtues that vaguely referred to what it means to fit into the academic community and culture of science. But nothing that made sense of what they did to me over the course of those 4 years. That was brutal. Vicious. Ayn Rand had her admirers – most of whom would contribute so much innovation to the Information and Biotechnology industries that these industries ultimately contributed to a revolution in society. But she was also viewed as a villain by those who made no effort to distinguish between her alternative to middle class morality and the call for self-indulgence for which the Church of Satan had lobbied. Sometimes I lament over the opportunities we have lost as a nation simply because we could not make the impartial gesture to clarify our terms and identify what we all share in common rather than needing to invest in irreconcilable differences.

**PREDATORY REGULATING**  
  
In the 1990s we catch our first glimpse of an organized effort to promote and manage a stable global economy through a  philosophical movement.  The California Ideology combined the radical individualism and objectivist epistemology of Ayn Rand with a connectionism applied to vast networks of computers. Proponents of this ideology, the most prominent of which founded Silicon Valley I.T. companies, believed that computer networks would usher in a revolutionary democracy in which the markets, freed from their moorings in political control, supplant a history of boom-and-bust cycles with an enduring and global stability.  The active ingredient in this utopian recipe is the computer network, which offers the following:   
  
(1) God-like omniscience through which to surveil and detect.  A visibility over all transactions. Transparency.  
(2) Predictive analytics.  Mathematical models would enable us to identify risky loans and investments.  The risk can then be managed and minimized by hedging and balancing, making it possible to offer loans to recipients who would have never been previously considered.  As an economic engine, consumer spending can drive an economy or even resuscitate an economy on life support, as it had when Federal Reserve Chairman Alan Greenspan, a member of Ayn Rand's inner circle, took the unprecedented step of cutting interest rates to near zero following 9/11 and, one week later, the revelation of Enron and an epidemic of scandalous accounting practices designed to fake profits by hiding debts.   
(3) Collectivism.  Research has demonstrated that persons linked together in a network could adjust their behavior to manage optimal performance when given feedback on the combined outcome of the actions of all participating individuals.    
  
Greenspan served every Administration between Gerald Ford and GW Bush but may have had no influence more consequential than that during the Clinton Presidency when days into Clinton's first term, he convinced the POTUS that the most effective way to transform America so far in debt is to reduce interest rates with cuts to government spending, which would stimulate the markets and set them on a path of self-determination rather than one managed by political edicts.  Greenspan convinced Clinton to abandon campaign promises of social reforms that would have required taxpayer subsidies during an unprecedented budget deficit.  This economic philosophy in which power was transferred from political and religious leaders to individuals participating in a free market would produce some dramatic results on the world stage over the ensuing 16 years.  This strategy was an economic application of a philosophy that maintained that a network of individuals acting authentically in pursuit of personal happiness rather than altruistically in deference to political and religious edicts would make for a sustainable society.  Transcendental properties, such as those homeostatic mechanisms characteristic of connectionist networks, self-regulating systems like the human body and psychoanalytic models of the psyche analogous to the body, the emergent properties invoked by Gestalt psychologists to describe perception, and principles of stochastic resonance used by physicists to describe the manifestation of a thing's hidden inherent design or configuration under random perturbation, would insinuate themselves under these conditions.  The most notable proponent of this philosophy, Ayn Rand, believed that these outcomes would be more productive and salubrious than those that have been observed when individuals live in accordance with political and religious edicts that require them to sacrifice happiness for the sake of others (i.e., altruism).  Greenspan abandoned his allegiance to the philosophy of logical positivism after having been initiated into the inner circle of Ayn Rand by INSERT.  I believe that in the Congressional hearings that served as a forensic pathological examination of our near economic collapse in 2007, when Greenspan replied affirmatively to the question about whether his model was flawed, I believe the model to which he referred was Ayn Randian objectivism.  The philosophy led the Administration -- working in conjunction with a Republican-controlled Congress -- to suspend key regulations inspired by the Depression (i.e., Glass-Steagul) that would have prohibited financial industry personalities from concocting designer products known as "derivatives" that elevated the risk and complexity of buying and selling debt.  It is difficult to ascertain whether these events constitute a repudiation and refutation of objectivism when the destructive events were caused in large part by the pursuit of a very specific form of happiness grounded in the acquisition of wealth.  It's unclear whether this can even be equated with hedonism given we cannot assume these financial industry professionals would have squandered their profits on fast cars and escorts furnished by Debra Jean Palfrey.  But the damage was done in the name of freeing people to spend and invest and persuading world leaders to remove restrictions to the free flow of capital into and through their countries.  This was a critical provision in an effort to negotiate for the preservation of a short-lived Asian prosperity engineered as part of an in vivo economic experiment carried out by the U.S. in the 90s.     
  
We experimented with the nations of Southeast Asia, encouraging these runs of short-term speculation in property.  When the investments proved excessive, producing hundreds of thousands of offices and apartments that went unsold, developers defaulted on their loans, and a panic spread that sent Western investors fleeing.  The U.S. brokered a plan for the IMF to lend billions to stabilize the countries but only on the conditions that the governments radically Westernize their policies and that the Western investors get bailed out first.  This meant acknowledging with signature that they were responsible for the collapse, that they agree to ease all restrictions on the free flow of capital in and through their countries, and that they eliminate corruption and nepotism in government.  Within months of receiving the loans, the exchange rate of the currencies in all these Asian countries dropped precipitously -- as much as 80% in Indonesia -- leaving the common taxpayers with rioting, looting, 15-20% unemployment, and billions in debt to the IMF.  To add insult to injury, the terms of those IMF loans prohibited the governments from taking the actions that would have provided relief to its impoverished citizens.    
  
This is analogous to what happened in the US drug policy, where patients were told that if you wanted to continue to enjoy access to the medicines you had taken for granted for months or years -- medicines we facilitated through non-restrictive policies -- you would need to sign a pain management contract accepting pages of facts as part of consensus knowledge and pages of instructions as to how to live your lives.  You must also submit to monthly urine screens or random pill counts so we know you're taking rather than selling your meds.  And you must navigate a potential gauntlet of regulations that could delay or even jeopardize fulfillment of scripts at the pharmacy, not the least of which are DEA limits on what a pharmacy can stock at any given point, forcing the patient to drive up his or her NARXScore by attempting fulfillment at another location.    
  
And so patients complied.  They endured not only the very modest risk but an even greater indignity and inconvenience.  But the overdoses persisted, driven by physicians chastened by headlines about DEA raids often made personal by an admonishing or overly inquisitive phone call.  The abandoned patients were turning to the Street in greater numbers for relief, thinking they would hook up with diverted product but occasionally being given counterfeit product instead -- knockoffs laced with the sedative Xylazine or worse, with an opioid hundreds of times more potent than morphine.  Fentanyl.   
  
In the cases of both financial crime and drug use, the adverse events could ultimately be traced to a faith in the unlimited power and objectivity of computers to detect, monitor, and mathematically predict and balance risk.  In the collapse of the Asian economies in 1998, in the epidemic of corporate accounting scandals in which companies faked profits by hiding debts, and in the indiscriminate lending of subprime loans and commodidization of debt, the politicians abrogated control to Wall Street.  Time after time, over and over again, through boom and bust, we buy into the financiers when they say "it will be different this time" -- a statement we now know they make because through every bust -- no matter how bad -- they are bailed out -- whether by the IMF or the US Government -- even though their short term speculations caused the bubbles and even though it is the taxpayer who will ultimately pay for the losses.  By contrast, in a display of profound distrust for not only individuals but for individual patients and doctors, politicians seized control -- more control than they were logically entitled to given that they were now appearing to assume the role of physicians.  The politicians were not aversed to looking the other way while they expected shares to rise, which they did -- until they didn't at which time millions were put at risk for the kind of hardship that just might drive a person to drugs.  They trusted people to invest.  But when it came to prescription drugs themselves, that trust ended.  They treated both addiction and overdose as inevitable despite the fact the rates of both were nearly as low as Greenspan's interest rates. In the world of investing, we could have freedom without anarchy -- and the Fed egged us on with low interest rates to higher rates of borrowing, investing, and spending.  But when a handful of mentally ill doctors and dentists sounded alarms over 5 - 7% of patients who become dependent, the Fed steps in with stories of how epidemic addiction and overdoses on opioids are causing that stubbornly stagnant rate of workforce participation, low productivity, absenteeism, and embezzlement.  On the back of buses, the ad space tells us that "in Fairfax County you are more likely to die of an opioid overdose than a car accident."  I see someone is taking full advantage of a pandemic that turned our usually bustling streets into ghost towns.  Even before the pandemic, these roads were driven by a citizenry comprised so disproportionately of Federal workers and pedigreed professionals -- usually stuck in gridlock or at controlled intersections on route to a WMATA parking structure -- that insurance companies favor them with premium rates.  The consortium of Art Institutes, where first year enrolees are given their very first task of coming up with their own clever response to the Absolut \_\_\_\_\_\_\_ prompt, might have just as well been assigned the task of designing an opioid scare ad for the back of the 117 to Herndon.

Incidentally, isn’t 5 – 7% the range in which our nation’s rate of unemployment spends most of its time? Correct me if I'm wrong, but neither our senior Government officials nor our media have ever used this level of unemployment as an impetus for any kind of intervention. The New Deal was not propelled by 5 – 7%.

Given where the real losses are, we should be encouraging our citizens not to gamble the community away on speculation.  But we are addicted to these financial booms and we are powerless to stop them.  Americans realize that they can no longer generate the kind of wealth that will keep them safe during a rainy season, but they can buy and sell houses or get really lucky on a stock tip.  "I got this portfolio."    
  
We never maintained anything but a negative position toward drugs and those who consume them.  The question is when exactly -- and why -- did GMP manufactured products -- prescribed by  physicians trained in the medical disorder -- and knowledgeable of the patient -- acquire the same reputation as heroin.   
  
 The negativity might fluctuate between condemnation at its most prejudicial to a remote, disengaged contempt at its most polite.  But we have allowed the most heinous crimes and oppression to be committed in the name of money, usually under the auspices of noble and philosophical pursuits such as "market democracy" and "global economic stability."  And a quick aside here, it's worth noting that when their interests are at stake, they have shown a reliable propensity for meddling in the affairs of other nations. No nation is too far as the Asian Miracle shows.  The cover story they tell the Public is that they global economic stability is the rising tide that raises all boats and a form of immunity against a kind of economic downturn that spreads like a virus from country to country.  So they justify their intervention by saying it's good for South Korea. And for Thailand.  And Indonesia.  And the rest of the world.  But you still can't help but shred your scalp at all we did to mess with this foreign country.  We were demanding policy changes and enforcement actions from Indonesia and when we didn't get them we considered plans to overthrow the President.  We passed judgements to steel our resolve for such an extreme measure.  He allowed corruption within his ranks to go unchallenged.  He allowed nepotism.  These actions we considered taking were formulated not by Bill Clinton, who was both preoccupied and neutraluzed by Monica Lewinsky, nor by the State Department -- and not by the White House Council on Economic INSERT -- which claims to have been muzzled by the one unlikely agency and one man in whom these authorities were entrusted at this time: the Treasury Department and Robert Robinson.  Now by Rubin's own admission, these decisions fell well outside the scope of Treasury, but at the same time, he pointed out that the risks that needed management concerned the stability and health of the global economy.  The whole thing is so absurd.  And we have a history of meddling in foreign affairs, most notably in our war on drugs.  I see videos or photos of US agents and military in places like Colombia attempting to nip \*our\* nation's drug problem in the bud, and I marvel at just how far we are willing to go to impose our biases, agendas, and ideologies.  The World Health Organization (WHO) has recently adopted opioid prescribing guidelines modeled after our own austerity, going so far as to restrict painkillers to everyone but children in their final hours of life.  This is precisely the kind of centralized, indiscriminate, one-size-fits-all across-the-board political and religious control that Ayn Rand and Alan Greenspan opposed as inimical both to happiness and to sustainable economic prosperity. [Wink]   
  
At the core of Western civilization is a belief that if you give people free reign to pursue or accept what they desired, they would dive flared nostrils first into silos full of of cocaine and powdered opium stored in their yards.  But that assumption confounds primary and subordinate reinforcer as well as underlying / root cause with symptoms.  If doctors are willing to expound on the belief that pain is a symptom and that painkillers therefore only mask the symptoms and in so doing divert us from the root cause, then why can they not accept that substances that alter mood and energy appeal to those of us who have suffered emotionally, psychologically, and socially from a gauntlet of socioeconomic crises and technological disruption that alienated us from sources of personal fulfillment, identity/ reputation, and financial security / stability?  In other words, if given the freedom, if the obstacles were removed from their path, people might choose to spend their days painting, writing screenplays, learning how to fly, or simply working in the field in which they were trained.   
  
It has never been fully clear to me why people are not free to live the life they planned and trained to live.  Free markets are only part of the problem. I always assumed I could earn a living pursuing my curiosity as a research professor, but it seems the universities are saturated and eerning a tenure track position would -- in addition to a great deal of luck -- require I make a number of sacrifices including but not limited to the object of my curiosity.  There are competitive pressures.  Employer bias.    
  
But for the economic and financial stewards of this country, the preferred ideology was to free people by giving the markets the freedom to evolve of their own accord.  When it comes to money, investment, and development, any kind of political or religious control is deemed odious and we -- the Ayn Randian heroes like the architect of The Fountainhead -- should refuse to compromise the visions that make us happy.  And yet we cannot entertain the thought of granting the people the freedom to determine what medicine they need to free themselves of pain or, more broadly, to structure, channel, and adjust the various flows of energy and mood that make up our day-to-day lives.  How is it that we arrived at the position that some freedoms but not others need to be brought under political and religious control even as the unregulated freedoms routinely relegate millions to poverty and misery.  The computers failed to manage the risks that within a span of 10 years caused chaos, recession, and the collapse or near-collapse of economies.  And yet what our Government leaders are asking us to remember of this period are the increases in drug related mortality.  It's a juxtaposition so stark and so strange -- so incongruous and ironic -- that it makes me wonder whether it's a strategic decision or subconscious defense mechanism to divert our attention from crimes and addictions that are so much more frightening because they are endemic to our economy and fundamental to our way of life.  It almost feels like the Government is presenting drugs as a scapegoat for financial crimes that significantly reduced our opportunity, net worth, earning potential, credit risk, job security, financial stability, and resiliency.  Sixty-two percent of us are forced to take jobs in fields other than the chosen field in which we were educated at great expense.  We are told that due to vagrancies in the software market, our skills become outdated every 2 years despite our education, experience, acumen, and prior achievement.  That due to Internet mediated job searches, employers receive an average 300 to 1800 responses per ad, and that the "computers" are instructed vis-a-vis the mathematical models programmed into the applicant tracking software to discard applications from job seekers who have been out of work more than 3 months.  That due to the involvement of "computers," only 27% of applications ever see human eyes and those that do are given a cursory glance lasting no more than 6 seconds in which to seize and sustain the reader.  Does this sound like a rational and effective means to build a workforce?  Or a growing class of long term unemployed?    
  
In the domain of substance use, the PDMP is hailed as an achievement of A.I.  And yet all it seems to do is to deprive pain sufferers of risks they are more than willing to assume in exchange for some relief, some capacity to function, and some quality of life.  The PDMP and the NARXScore exists to assault the people who most need medication by declaring their risk unmanageable and referring them and their prescribers to the political control of agencies -- one at the State level and the other Federal -- with the word "enforcement" in its title.  These same people might have received subprime loans and bailouts when they wanted to manage the risk of "homeownership."  But that prescription for Vicodin ... [wags finger].    
  
In the end, the people who survived and flourished were those in positions of power and wealth who used policy to consolidate their power and capital to increase their wealth.  This was certainly true of Western investors in the Asian Miracle of the mid 90s.  It was true of banks that not only accepted bailouts after setting off the Great Recession with their predatory lending and their sale of mortgage backed securities and collateralized debt obligations but also demanded annual million dollar bonuses in exchange for fixing what they broke.  And while it's certainly true that individuals and organizations profit off the sale of drugs, this is a market of consumers who look to the immediacy of the product.  Rather than hoard them to sell later, there is a tremendous need to use the drug to bring relief to physical and other forms of pain that comes from living in a world of constructs, derivatives, intermediaries, and regulations that distance us from our authentic natures and immediate needs.  Take for example the idea that in medicine the individual patient -- what some call "anecdote" to diminish his or her standing as evidence -- should take precedence over any statistics (any measures of variability or central tendency).  If the assessments suggest a diagnosis and can lend credibility to our subjective claims of pain, why should one not receive pain medication?  Because analysis of data points furnished by thousands of research participants suggests a great many of these people -- but only 5 - 7% of them -- develop a use disorder?   Sorry.  That's not sufficient grounds for restricting access to painkillers.  But lawmakers and regulators in charge of a large population imbue authority to conclusions emerging from the analysis of data from large samples -- they could care less about the immediate facts and needs linked to an individual patient even though all medication decisions -- to prescribe or not to prescribe -- come from and are made for the individual.  There is a disconnect here between the scientist, policy maker, and public health administrator on the one side and the doctor and patient on the other.    
  
And yet upon the drug market we impose new waves of regulations in which a few in authority profit off the denial of millions.  The team that created the NARX Scores must have made out like bandits, as did those who built the PDMPs, as did Federal bureaucrats whose agencies were at risk of being defunded after the legalization of once evil marijuana, as did those who set up rehabilitation programs, as did the politicians who need to rehab a tarnished reputation.

The prejudice against opioids has become so ingrained and axiomatic as to have acquired the properties of a reflex arc, and some scientists who pride themselves on objectivity have seized on the opportunity to champion the largely untested cannabis as an across-the-board alternative to morphine. “Opioid-sparing” is the term you'll hear from them. Even Government leaders have precipitously moved toward hard wiring this wistful thinking into policy action, as if completely unaware of the years of new research ahead of them. Hundreds of micro-studies. Comprehensive meta-analyses to tie these all together into an understanding of the relative safety and efficacy of marijuana across the broad spectrum of medical diagnoses.  And then of course there are the practical matters of how readily and effectively cannabis products integrate into existing infrastructure that includes manufacturing and third party reimbursement. I have reviewed much of the cannabis research available to date, and I would be willing to wager my liver and both kidneys that cannabis will never replace opioids. The interest I have in cannabis is purely social, namely in how the evil characteristics of this once demonic drug could be transferred to opioids.

Hypothetically, an unpopular lawmaker can rehab his public image by limiting access to the product of a pharmaceutical house that has manufactured life saving drugs if that product in question is an opioid.  The stain of evil spreads like an infection such that any entity that can be linked to the opioid supply chain will suffer a crisis of confidence.  In this matter the media has exhibited a lack of skepticism and intellectual discrimination similar to that reserved for the ridiculous allegations of widespread satanic ritual abuse by daycare workers in the 1980s (i.e., McMartin School trial).  All anti-opioid bills are embraced as a form of therapy for the grieving survivors whose tears inspire posthumous reforms that could lend meaning to both the living and the dead.  And the bills are perceived as opportunities for well-meaning representatives to heal a cynical and deeply divided electorate by reaching across the aisle to break rare bipartisan bread in the fight against a common enemy.    
  
Reminiscent of the temperance movement that drove the criminalization of alcohol in the 1930s, groups affiliated with religious denominations link opioid use to moral weakness and character defect.  The once overtly religious rationales for condemning drug users have for the contemporary objection to opioids -- to include pain medication prescribed by physicians and manufactured according to GLM practices -- been replaced by a secular regulatory rhetoric to suggest its origins in the Government rather than the Church.  But this only thinly disguises what at its heart remains a moral sensibility with puritanical roots.  In my historical analysis I simply cannot find any cause to suggest that the evolution of our social consciousness -- that continuity -- has been broken.  This remains a case of shaming a sinner, and it should prompt us to search -- to critically examine -- our own souls as to why other people's drug use makes us so unhappy.  Our objection has a psychogenic quality that exceeds the nuts-and-bolts and the causes and effects that would otherwise ground it in pragmatism:   
  
1. obsessiveness: the authors of a Seattle Times article use as evidence of opioid overprescribing that traces of opioids have been found in the mussels of Puget Sound, not allowing their lecture to be sidelined in anyway after acknowledging that trace elements of antidepressants and heart medication were also found in the mussels -- nor allowing their argument to be tabled altogether by the unacknowledged probability of finding the entire pharmacoeia in these mussels.   
  
2. single-mindedness / rigidity: the inability to participate in a two-way dialogue and respond to facts as they are presented.  When someone asks you to respond to the rates of dependency compiled by NIH or SAMHSA, you switch the topic to accidental overdose   
  
3. dichotomous thinking: when presented with the plight of the chronic pain patient, we can embrace a one-size-fits-all limit on morphine units per month because we dismiss all the individual differences in diagnosis, treatment history (tolerance), and sensitivity to pain and to pain medication that make the truth murky and complicated. We are in effect subtracting the grey area and viewing the issue through a lens of black and white.   
  
4. hypersensitivity: when a patient presents to the ER with synptoms of benzodiazepine withdrawal because her doctor discontinued treatment cold turkey under pressure from the DEA, the attending ER doctor, upon noting the extended release transdermal fentanyl patch, angrily demands the name and specialty of the prescriber so he could meddle in her migraine treatment   
  
5. moralism / militarization: in the vernacular of a social psychologist, we subject those involved with opioids to both the fundamental attribution error and to other global, internal, and lasting attributions. In layman's terms, those who use opioids are bad seeds.  We do not afford them the courtesy of viewing them as the product of complex environmental and historical influences, bypassing such extenuating circumstances and attributing their opioid lifestyle to an innate disposition or character.   
  
the response to the problem of drugs early on and subsequently opioids in particular violates the maxim that the cure should not be the worse than the disease -- that drug policy should not cause more harm than drugs -- that we shouldn't have more people vested in or "addicted" to the Opioid Crisis than to opioids. This kind of overkill usually does not occur in the absence of demonization -- moralization of an issue.   
  
6. exaggeration:  the reference to prescription painkillers such as Percocet and Vicodin as "heroin pills," in disregard for obvious differences in route of administration, GMP status, purity and reliability, and consequence of use (heroin renders users unconscious and unavailable)   
  
7. inflation: we play connect the dots with the intention of assigning opioids a role if not the role in precipitating, maintaining, or exacerbating one or more of society's dysfunctions (e.g., workforce participation)   
  
We are trained from an early age to think of life as a zero sum game. Money itself reminds us constantly of this. Money can't be in two places at the same time. You have it until you decide to spend it on something you need. The Uncle who gives you 50 cents is 50 cents poorer. It's 50 cents he can't give your brother.  As a nation, if we increase spending, we're told we need to raise taxes.  There's a ledger.  One column for revenue.  One for expenses.    
  
American culture ties money & morality in many ways.  Money is regarded as a reward -- as something earned -- for actions that contribute to the public good.  That keep the country going.  It's also how we levy and quantify penalties for poor conduct (e.g., fines; reduced credit).  In Calvinist theology, a person's worldly riches -- wealth -- was a sign of his or her preordained salvation such that rich people were expected to find Heaven and the impoverished eternal damnation.   
  
We bring jobs under this same umbrella because jobs are primarily the vehicles for the transfer of money in the form of salary.  Like money, jobs cannot be in two places at once.  Three hundred people might want the job.  But the job can only go to one person. It's no coincidence that we refer to jobs as "earning a living."  With the exception of money gained by inheritance, gambling (e.g., lottery winnings), and marriage, our standard of living -- and quality of life -- is earned through the work we do for an organization that services a public need.   
  
We as Americans tend to think there can be no happiness unless we are meeting our basic physiological needs -- the fulfilment of which to one degree or another requires money.  Everything can be monetized.  With the possible exception of the air we breathe, everything comes at a price.  We may not pay directly for sleep but we pay to put over our heads the roof that guarantees a sleep free of disturbance from neighbors, noise, and weather.  Even our relationships require money.  Courtship can get quite expensive. Dinners.  Gifts.  Whatever we need to show the other party how much we value them, and this is done by making a show of sacrifice -- by spending on the other person or on experiences we share with that person.  We also appear to value the other person by investing in ourselves, which is to say, by putting ourselves in the style that our desired partner would like to be seen with.  Even while dating, our partners view us as extensions of themselves. Inasmuch as the courtship is public -- visible or known to others -- we reflect not only on their judgment but on their aesthetic sensibilities (i.e., "taste").  We're expected to invest in a style or image.  Clothing.  Cars.  Cosmetics.  Even mani-pedis.  And it's rare to find someone willing to take our name and parade us around as their lifelong partner -- their pea in a pod -- their soul mate -- who does not respect what we do for a living.  If our job does not make us the kind of money that allows us to keep up with the Joneses, it better have the reputation of grooming others to make money (e.g., teacher) or at least ensure their safety or safeguard their well being (e.g., nurse, pilot, fire fighter).   
  
The prospect of losing our ability to make ends meet -- to address our most basic needs -- would plunge us into the dismal end of the emotional spectrum.  Stress.  Anxiety.  Depression.  Resentment.  Shame & humiliation.  Loneliness.  This very strong association between poverty and misery -- poverty and substandard living -- drives us to forge an equally strong association between their opposites.  Drives us to associate happiness with wealth.  Now it's one thing to assume happiness from wealth.  We understand in principle wealth does not guarantee happiness but I think the vast majority assumes they could be happier if wealth were to put certain options and possibilities within their reach.  But when we assume wealth from happiness, things get a lot more problematic for our culture.  The problem comes into play when we view happiness as a sign -- an indicator or measure -- of our capacity to earn a living (or facilitate the transfer of money).   
  
If we're not earning a living, paying our share, or helping others to achieve ends facilitated by money, we are not expected to be happy.  To take this one step further, we do not deserve to be happy.  Any happiness we do express is viewed with morbid suspicion or skepticism as undeserved happiness or happiness obtained illicitly.  Some people whose efforts to survive the zero sum game are thwarted -- who end up without a chair when the music stops -- might seek happiness through other means such as through drugs or God for bid through a Bohemian lifestyle in which we indulge our higher callings or vocations that do not require capital and that might have conflicted with the expectations of an employer or eligible bachelorette.  It comes as no surprise that people who have chosen this path -- or who have been denied access to all the coveted paths -- might be treated as cheaters, losers, or given a label befitting their status as outsider, infidel,  expatriate, Commie, or hippie.   
  
Americans take more interest in the happiness of their neighbors than seems natural.  As if they have a personal stake.  I suppose we all feel better when those who do not fare as well as we do not act like sore losers by refusing to play the Game or by calling the validity of said Game into question.    
  
We give our neighbors -- our fellow Americans -- a choice: be happy for the right reasons or be unhappy.  We don't mind if we're surrounded by unhappiness.  The unhappiness of others can help solidify our position as one of the winners in the zero sum game of life.  We need a certain proportion of the community to be unhappy for us to feel good about ourselves when we win.  This is part of the social contract we signed when we agreed to make the acquisition of wealth a priority over all other considerations including authenticity and self-actualization.  As Americans we're pressured into a substantial sacrifice if we are granted authorization to participate in our society.   
  
I would go as far as to say that to a much greater degree than preceding generations, particularly those that enjoyed the post World War II prosperity (1946-2000), we stopped living in a society and started living in an economy.  Relationship columnists now opine that it is passé and even self-flagellating to ignore the debts and subprime credit one might inherit from a potential romantic partner.  Love no longer conquers all.  A diverse and thriving portfolio does.  Corporations no longer employ -- no longer carry a payroll -- that reflects a view of employment as a civic investment in the community.  In fact, corporations have elevated lean principles -- maximizing profits by minimizing overhead -- to a science or high art.  Their stocks rise whenever they lay off 40% of their workforce because investors love when they "trim the fat."  And databases and analytics are utilized as much as tools of detection and surveillance when measuring an employee's real-time contribution to the bottom line a when they are used to gauge his or her risk of overdosing accidentally on their prescription medication.   
  
Those of us who appear to have rejected the social contract a priori -- or those of us who failed to find our niche despite having fulfilled our end of the contract -- tend to forgive ourselves for resorting to any means necessary to grab some happiness in this world.  And for that we are punished most severely.  Stigmatized.   Demonized.  Treated as enemies of the State and every constituent institution.   
  
We may come to resent those whose wealth and success entitles them to a happiness greater than our own.  But the one thing we cannot tolerate are people who find a way to be happy in spite of failure.  Joe hasn't worked in 6 months.  He better not be happier than me.   
  
The reason why we treat substance use as so grotesque is that it provides an equalizer to those who would dare spoil the rules of nature.  It goes without saying that if we were truly happy in our jobs and salaries, we would not begrudge the happiness of our social inferiors.  "I gave up a lot for this job.  This salary.  This place in the world.  I am happy, damn it."   
  
It is in this spirit that the Drug War is set up as a tactical diversion and scapegoat from our nation's most daunting challenges.  Our nation’s Nixon-led drive to neutralize the influence of African Americans (heroin) and left-wing anti-war demonstrators (marijuana) is just one early historical example.  It's bad enough those hippies and Commie professors actually presume they have a right to protest a war they are not fighting in.  But the idea that the protestors might be having a good time -- flying high and happy on all that marijuana ... that's an excess -- an illicit gain -- and will not be tolerated.  It's bad enough all those African Americans are burning buildings and rioting because they feel disenfranchised.  But the idea that these actions might be made more tolerable, and potentially fueled by, heroin.

**THE GATEWAY THEORY**

The urgency in the Crisis is warranted by the number of deaths attributed to opioids but it is also buttressed by evidence linking prescription painkillers in as many ways as possible to the seamy underbelly of a world where derelicts and all types of damned Americans troll for heroin. Some have called attention to chemical similarities at the formulation level to argue that the Percocet you are given by your family doctor has a blood bond with the heroin some drug dealer who moonlights as a pimp injected into the diseased women he kidnapped as runaways. As someone who has been treated for a chronic pain condition for the better part of your life, the Federal government wants to be a fly on the wall when you are told you have an older brother your father sired out of wedlock with a homeless grifter he met under an Atlantic City pier. Now that you think your prescriptions are more dirty and dangerous than you did just minutes earlier, the Fed hopes you will walk away – or grumble softly when they raid your doctor’s offices.

Then there are the arguments that today’s heroin addicts were yesterday’s patients. Data on rates of dependency from NIH and SAMHSA do not support this interpretation but non-salacious “nothing-to-see-here" data does not make the WSJ let alone Reader’s Digest so for years our news feeds and proposed State legislation was filled with references to a terribly-misleading-kernel-of-truth type claim that 4 of 5 heroin addicts reported having once been prescribed a painkiller. The kernel of truth in this deceptive statement is that heroin addicts were once prescribed painkillers. The problem is that so have 4 of 5 of us who have never touched heroin. Four of 5 is roughly the percentage of the American population that would have been given a Percocet prescription in exchange for 2 or more of our wisdom teeth. There is additional survey data that establishes an elevated risk of substance abuse and experimentation for those of us prescribed painkillers at a vulnerable period of brain development but if the statistic is so crucial, then adverse outcomes like overdose deaths would be far more prevalent given 80% of us are exposed to opioids during a routine rite-of-passage, coming-of-age dental procedure. Truth is that while prescription painkillers present the second greatest risk of misuse among substances, the acute misuse does not translate into full blown chronic use disorders. We can find an explanation in an alternative interpretation of the Gateway Theory.

In the 70s and 80s, the Gateway Theory of Substance Abuse was coined to bring attention to the War on Drugs and to single out specific drugs like marijuana as dangerous. But the outcome data does not jibe with the idea that use of one specific substance will alter neuropathways in a way that lead individuals to abuse another specific substance. Granted, there is evidence that reward centers in the brains of rats and other animal models showed significant changes following the experimental introduction of addictive substances into their food, but the finding does not preclude the possibility that (a) using nearly any drug early on is associated with a higher potential to abuse other drugs later on and (b) the bridge to new addictive substances is mediated by the development of a mental health disorder. This means that much of the heroin use we see today may have been preceded by substances other than your prescription pain relievers and exacerbated by one or more of the many psychosocial stressors that have been amply supplied by our society over the past 25 years. We call this theory the Common Liability Model, and it appears to jibe with the far more fluid, flexible, and dynamic world we know today than the fixed relationships in the *1-initiating-drug – 1-terminus-drug* of the Gateway Theory.

Heroin had always been one of the most lethal drugs and figures prominently in any wider substance abuse spike, but it did not escape the notice of the Federal detection and surveillance capability – CDC, FDA, SAMHSA -- that prescription painkillers had been rising in tandem over the past 10 years. It was at this time opioids became eponymous with drug in much the same way we use “Xerox” for “photocopy” or “Google" for “search.” Suddenly opioid abuse was the only abuse. And those who knew it were made to think opioids were involved in nearly all overdose deaths and were involved in sensitizing addictive personalities to nearly all other drugs. More importantly we were in the process of investigating a developing story about manufacturers and prescribers that put the origins of abuse squarely in your doctor's office and specifically in how liberally your doctor has been prescribing opioid analgesics for pain relief. Suddenly we believed we had the problem diagnosed at its roots. From miles away one could see the scaffolding in front of the palatial imitation Myth we knew was being built to last – a myth we would have to address for decades to come.

**DEBUNKING THE GRAND MYTH**

We are in a state of war in the U.S. In the one corner are those in the “more prescriptions, more deaths" camp who believe today’s heroin addicts are yesterday’s patients. They aim to starve the Opioid Flu by eliminating exposure, and while there is a special emphasis on protecting our most vulnerable youth, proponents of this view are willing to prevent a doctor from prescribing a GMP painkiller – even for patients unconscious and under the surgical knife. In the other corner are those in the “more restrictions, more deaths" camp who believe that the crisis is really a heroin crisis and that it is an iatrogenic, self-inflicted, self-fulfilling prophecy of sorts brought about when patients, abandoned by their doctors under pressure from the DEA armed with the PDMP, are driven to unreliable Street drugs or to suicide (Singer, 2021).

We doubled the volume of opioids prescribed. Yes, we did.  Between 2002 and 2014 (FDA, 2018).  But over those same 13 years, we see no increase in the number of surveyed individuals reporting having used pain relievers for non-medical purposes over the past month and we see no increase in  the number qualifying for a use disorder at some point during the past year (SAMHSA, 2015).   
  
Then we *reduced* the volume of opioids prescribed.  Yes, we did. One analysis (Truong et al., 2021) identified 2012 as the corner-turning year the trend flipped from steady increase in opioid consumption to steady decline.  This is also the year total injury related mortalities began steadily increasing (Truong et al). The number of opioid prescriptions dropped 42% between 2012 and 2019, at which point overdose deaths promptly reached a new peak at 71,327. Between 2008 and 2017 per capita high dose opioid prescriptions (90 MME or greater) fell by 58% (Hoots et al., 2018).  Between 2010 and 2017, total volume of opioids dispensed fell by 29% (FDA, 2018) -- ***as opioid related deaths rose 226%*** (CDC).   
  
However you want to parse it, doubling prescriptions does not increase misuse and reducing opioid prescriptions does not reduce opioid fatalities.    
  
*"Opioid related morphine equivalent doses did not show a consistent or statistically significant relationship with injury-related mortality, including with any subgroups of unintentional deaths, suicides, or homicides ... In every state examined there was no consistent relationship between the amount of prescription opioid delivered and total injury-related mortality or any subgroups, suggesting there is not a direct association between prescription opioids and injury-related mortality.  Data from the CDC show that states with high prescribing rates do not necessarily have high rates of fatal opioid overdoses, even when the analysis is limited to deaths involving pain pills"* (Truong et al., 2021).  
  
The data presents us with quite a paradox.  Fortunately, there is data to resolve it.  The data implicates supply-side interventions in the fact that over the frequently aforementioned timeframe legally manufactured opioids like oxycodone and hydrocodone became more difficult to obtain through doctor (prescription) or dealer (diversion).  As the number of people entering addiction treatment who said heroin was the first opioid they tried increased between 2005 (8.7%) and 2015 (33.3%), the number who named one of the most commonly prescribed opioids -- oxycodone or hydrocodone -- as their initial experience *decreased* over this period from 42.4% and 42.3% to 24.1% and 27.8% respectively.  By 2015, more people were using heroin (33.3%) than hydrocodone (27.8%) as their starting drug (Cicero, Ellis, & Kasper, 2017).  So how do we explain escalating opioid overdoses over this period? Easily. By the limited tolerance of opioid novices. By increasing numbers of Americans seeking a first time psychoactive experience through a Street drug with no reliable "serving size" and "list of ingredients."   
  
This street drug was surreptitiously adulterated by substances to increase potency while reducing cost.  Across dealers and occasions, heroin varies in purity.  The user will have no warning or instructions about adjusting dose from one dealer to another -- one batch to another.  No awareness that his heroin was cut with fentanyl -- also illicitly manufactured – a cannabinoid known as K2 -- or with the powerful tranquillizer xylazine, which was used to cut 70% of heroin confiscated in Philadelphia in 2019.  Since most opioid overdose fatalities are polysubstance deaths, it makes sense that an invariably impure product like heroin would account for as many of the deaths as it does.   
  
A number of independent analyses depicts a startling rise in the number of fatalities involving fentanyl and fentanyl analogs  manufactured in Asia or Mexico and smuggled into the United States via private mail or courier.    
  
1. From 14% in 2010 to 60% in 2019 (Hedegaard,  Minino, & Warner, 2018)  
2. From 28% in 2010 to 75% in 2017 (CDC, 2018)   
  
Over that period deaths from prescription analgesics like oxycodone and hydrocodone fell from 52% to 30%.  And here is where the accounting gets bogged down in ideological trenches, as some agencies front estimated rates of prescription painkiller fatalities by the percentage of deaths in which a prescription painkiller was at least one of many substances in a cocktail.  By this criterion, I have seen estimates range from 30% to 71%.  This is far and away the preferred method of all Federal beancounters.  As I have commented elsewhere, there is a bias on the part of our Government to lump stats across categories to produce the most effective policy driver.  But there are curious, scientific-minded individuals such as myself who would like to isolate the relative contributions of the different products.  And with the help of one other like-minded spirit out there, I was able to see that once we subtracted prescription painkiller deaths that also involved heroin or fentanyl, the rate drops from 30% to 18% and then below 10% when we eliminate the 68% of deaths involving benzodiazepines, barbituates, cocaine, or ethanol (Singer et al., 2019).

**Only recently has evidence become available linking in the strongest of terms the increase in opioid overdose fatalities to forced tapering policies. A retrospective cohort study revealed that among 113,000 patients treated for non-cancer, non-palliative pain with long term (> 12 months) high dose (mean daily dose > 50 milligram morphine equivalents) opioid therapy, the incidence of overdose among patients subjected to involuntary tapering (9.3 overdose events per 100 person years) was 68% higher than among patients not subjected to tapering (5.5 overdoses), and the incidence of mental health crisis was also 128% higher among the force-tapered (7.6 events per 100 person years) than among those not subject to tapering (3.3 events), including increases with tapering for depression (346%), anxiety (79%), and suicide (430%). (Agnoli et al., 2021)**.

The CDC clings to its claim of 115 opioid fatalities a day in the U.S.  But the vast majority of these involve drugs that are not prescribed for pain: heroin, illicitly manufactured fentanyl, and methadone.  These are not drugs prescribed for pain.  When we remove these substances, 115 becomes 46.   
  
We also know that ~ 70% of these decedents took the painkiller with another substance.  Possibly alcohol.  Actually, it's usually alcohol.  But it might also be a sedative like Ambien or a benzodiazepine like Xanax.  Or cold medicine with an antihistamine.  Or an illicit Street drug like crystal meth or cocaine.   
  
At this depth of understanding you are less likely to blame opioids and more likely to blame polysubstance use.  That 46 is looking a whole lot more like 15.  l to research, polysubstance experimentation, predominantly during the teen years, also explains how most heroin addicts got started (NIDA, 2020).  With this in mind, other factors related to one's status as a vulnerable youth come into play.  Psychological research offers some corroboration for the stereotype of the insecurely / ambivalently attached (Schindler, 2019) victim of early childhood trauma (Khoury, Tang, Bradley, Cubells, & Ressler, 2010) stuck in that neutral gear known as identity diffusion (Jones, 2011).   
  
Now you are ready to know that an estimated 25-45% of those 15 people took opioids as a means to suicide.  You know this -- \*I\* know this -- because the former President of the American Psychiatric Association knows this.  Her guestimate comes from an extensive review of the literature.  Oquendo is her name.  She referred to suicide as a “silent contributor to opioid overdose deaths.” (Oquendo & Volkow, 2018). Fifteen (15) suddenly becomes 11 – 12.

And how do we account for diversion in this analysis?  The National Survey of Drug Use and Health have repeatedly found that over 75% of nonmedical prescription opioid users obtain these drugs not from a prescriber but from friends, relatives, or dealers (SAMHSA, 2015).  Of 27,000 Oxycontin surveyed addicts who entered rehab between 2001 and 2004, 78% said the drug was never prescribed to them, 86% said they took it to get a "high" or a "buzz", and 78% had a prior history of treatment for a substance use disorder (Carise, Dugosh, McLellan et al, 2007).  This would take us down to 4 - 5.   
  
Some dose recklessly out of frustration with intractable pain.  So now you're thinking -- why not blame the pain itself?  That sounds reasonable, right?  Not necessarily.  Not if you need to expand the opioid enemies list beyond Government to include the business community.  Aliprantis & Schweitzer (2018) do just that when they argue that increased opioid use leads to declines in labor market participation, providing a statistically significant correlation coefficient as evidence states with the highest prescribing rates have the lowest rates of workforce participation.  But there’s a problem with this copiously cited piece of scientific research.  The authors overlook an important confound.  How could it not occur to them that prescriptions for painkillers are also correlated with -- drumroll please -- pain -- and that the pain itself might explain the low rates of participation.  I'm sure the distinction is lost on all those CEOs who have been griping about not being able to find the skilled workers to fill their job openings.  Now they have something to blame.   
  
But we’re not playing the blame game.  And we're wondering what our number -- at last count 5 -- looks like now.   
  
In knocking down the CDC mortality for opioid overdose from 115 per day to ~ 5 per day, I am not denying that opioids are found in the blood of the deceased.  I am merely searching for a number – the only number -- that should have any bearing on policy that impacts valid prescribing for patients with chronic pain conditions.   
  
Now you're thinking we shouldn't blame opioids for the rise in overdoses since 2000.  That's the year the CDC wants us to use for comparison.  “More people have died of an opioid overdose since 2000 than ... “.  Well if you are asking why so many have died since 2000 you have likely answered your own question.  By the time you have finished reading this Report, you should understand that the cause of the increase in opioid fatalities since 2000 is neither manufacturers nor doctors but life in 21st century America.  Ever since we took Sting's advice and turned the clock to zero “honey," we've looked to substances to relieve a broader socioeconomic brand of pain ... depression ... anxiety ... stress ... resentment ... disappointment ... while others look to substances for something to blame for everything that went wrong with American during this time.

We can blame polysubstance use. Psychosocial stressors like displacement from jobs and relationships. Economic hardship.  Diffusion of identity.  Defamation of character.  Depression.

And we can blame pain ...

And we can blame the cure, which is to say we can blame all the actions we have taken to monitor, measure, and manage substance abuse since we declared it “crisis,” “emergency,” “epidemic,” and “public enemy number one.”   
  
"The data suggest the overdose crisis is an unintended consequence of drug prohibition with PDMPs (Fink et al, 2018) and abuse-deterrent formulations (Singer, 2018) as contributing factors.  Prohibition provides powerful economic incentives for illicit manufacturers, transporters, and dealers to supply banned substances" (Singer, Sullum, & Schatman, 2019).

New Jersey governor Chris Christie really twisted the arm of friend Donald Trump, on whose Commission he served while Trump was President, to persuade him to issue a declaration of emergency around opioids. Most presidents are not liberal with their use of emergency declarations – not like they are with pardons or executive orders. But this was the Opioid and Drug Abuse Commission afterall, and as of late these Presidential commissions find it a declaration by the President a culmination or coronation of sorts of all their hard work -- the notable exception being the commission that recommended to Richard Nixon that marijuana did not pose a health risk and that no one should be arrested for smoking it in the privacy of his or her living room. But then Nixon set aside the recommendation of his own commission. He viewed the commission in the same fashion Christie did: as a necessary political step in the validation of a war. I find it useful to view the activities of the commission in the broader context of Chris Christie’s political career. His national political ambitions were well known at the time – as were his reputation shortfalls at home. He even had his fair share of embarrassing run-ins with constituents in public places. If anyone needed a softball lobbed his way, it was Governor Christie. That softball was drugs. So many former U.S. leaders – including every President since Nixon – had teed up drugs as the national bogeyman. If you can’t score some political points by wagging a finger at substance abuse, your problems are more serious than you realized. And his friend President Trump set him up to head his Presidential Opioid and Drug Abuse Commission.

**PRESCRIPTION DRUG MONITORING: THE HEISENBERG PRINCIPLE AT WORK**

***"State Prescription Drug Monitoring programs were sold to pharmacists and physicians based on a promise that they were solely for the purpose of protecting patients from overdoses and preventing ‘doctor shopping’ by dishonest, drug-seeking patients.  Inherent in these programs was the promise they would not be used for the purpose of charging or prosecuting pharmacists or physicians, in criminal proceedings or administrative proceedings, based on their contents.  Most of the state laws that authorized the creation of PDMPs specifically forbid their use in such cases. This was required in order to get physicians and state medical societies to sign off on them ... Yet here we are.  We see this over and over again. The Federal government and Federal agencies obtaining copies of these reports from the state and using them as direct evidence against physicians, pharmacists, nurse practitioners, and pharmacies despite the prohibition of the state statutes ... The doctor or pharmacist is required by law to report the prescriptions to the PDMP, but then the Federal agency turns it around and uses it as evidence against the individual who reported it"*** (Indest III, 2020).

So what role did prescription drug monitoring databases (PMDPs) play in the Crisis?

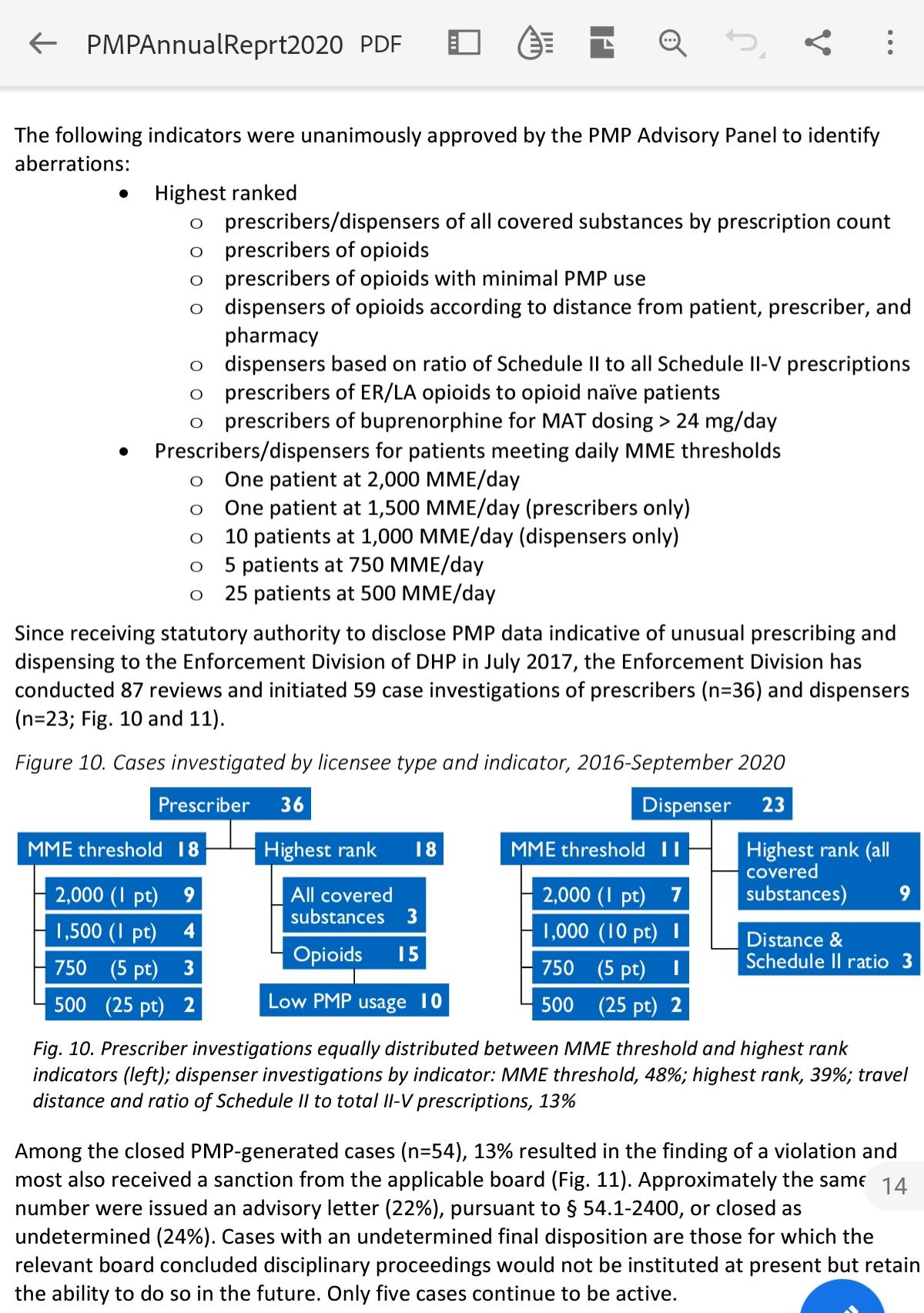
In 1927 German physicist Werner Heisenberg stated that the more precisely the position of some particle is determined, the less precisely its momentum can be predicted from initial conditions and vice versa. He called this his *uncertainty principle*. As a corollary, Heisenberg also noted that the system you are attempting to measure is altered by the very act of observing and measuring, because you are introducing elements of the classical universe into the quantum world. He called this the *observer effect.* Now Heisenberg was concerned only with the subatomic universe and any resemblance to the detection and surveillance of prescription painkillers is purely coincidental, but in Heisenberg’s challenges are some important lessons for social scientists and policy analysts grappling with the costs and benefits of medication. Heisenberg’s work ran into a fundamental oppositionality – or duality – inherent in nature. His work also uncovered a process by which scientists and policymakers bring about the very truth they claim through their science and their policy. The PDMP was designed to monitor prescriptions in order to flag for corrective action cases of illicit activity that put the lives of patients at risk. But as it turns out the effect of this detection and surveillance network was far more pervasive than originally intended.

Once PMDPs were installed by states and physicians encouraged and then required to utilize them for the purposes of ensuring patients were not receiving Schedule II or III medication from multiple sources, prescriptions declined dramatically across the board. Initial opioid scripts – most for acute pain -- were less frequent; morphine units were reduced for existing high volume users with chronic pain; and more initial prescriptions (80%) ended after one prescription. Analyses of ***Truven medical claims dataset*** -- which encompasses 175 million Americans with employer-sponsored health insurance -- and ***DEA ARCOS controlled substance monitoring dataset*** -- which in theory contains a complete accounting of all opioids that are distributed – converge on a remarkably similar trend in dispensation of Schedule II pain relievers: a decline of 10% (average 6.3 MME down from 60.8 MME per patient per quarter) and 11% (average 11.35 MME down from 102.3 MME) respectively lasting 3 – 4 years and accompanied by a 12.5% decline in overdose deaths (912 lives per year across the U.S.)(Kilby, 2016).

The death rate for chronic / heavy opioid users is 205 per 100,000 users (Kaplovitch et al, 2015). As successful as the PDMP policy has been in reducing prescriptions and deaths associated with accidental overdoses among medical users of prescribed pain relievers, it has also contributed to alarming increases in (1) untreated pain and (2) deaths due to overdoses on heroin.  While the heroin deaths offset the gains for the first 1 - 2 years, Kilby argues the reduction in deaths is strengthened after year 4 when considering the two categories together.  However, Kilby did not include in her analysis the number of abandoned patients who might have turned to Street drugs other than heroin.  Heroin overdoses increase 7% in the first year after a PMDP is implemented.  Over the recent period that heroin overdoses increased nationally by 30%, deaths linked to methamphetamines and other stimulants (500%) and cocaine (190%) have also risen, as well as deaths linked to products available over the counter (e.g., dextramorphan [Delsym], loperamide [Imodium AD], acetaminophen [Tylenol], and diphenhydramine [Benadryl]).  Kilby is right to suggest that over the long term overdoses across all categories of opioids and opioid users will bottom out -- in part because fewer new addicts are entering the pipeline -- but also because the new regulatory structure of which PDMP is a centerpiece will have killed off all those who have been exposed to prescription painkillers.

So how do PMDPs do it? Well for one they force doctors to take responsibility not only for every drug they prescribe but also for every drug -- prescribed by other physicians in the patient’s care network -- with which their prescription might interact. Doctors have to assume that responsibility because it is plain as day to everyone who can access the system – health care providers – pharmacists – law enforcement officers and judicial system professionals – that they have seen these other medications and, should they add a new medication to the patient’s regimen – the system will create a record for some prosecutor to use as evidence against them. And Government agents and attorneys are not waiting for patients to succumb to an overdose before they spring into action against a doctor. They are warning, raiding, arresting, and prosecuting physicians simply for prescribing more morphine equivalent than that recommended by the CDC -- for issuing prescriptions to patients with high NARX scores – or whose patients exhibit a higher-than-average NARX score than other physicians within the same region or specialty. The Government has created a culture that encourages physicians to think not only “they can see what I do" but also “they are watching.” Doctors tell their patients: “they are watching me – and they are watching you.” You don’t think this has a chilling effect on prescribing? You don’t think this drives a wedge between doctors and their patients?

So the bottom line is that these monitoring systems do more than just observe ... they have a hand in creating the very phenomena they observe by the act of observing. Some of the effects – the reduction in scripts and overdoses on prescription medication – were intended. Others – increases in heroin overdoses, untreated pain, medical expenses arising from less effective alternatives, and missed days of work – were NOT. One thing is certain – in all these accounts the Fed has a hand. The Fed can no longer claim to be an observer and bean counter. The numbers reflect the influence of Federal and State intervention. The image below was captured from the 2020 PMP Annual Report authored by the PMP Advisory Panel and the Virginia Department of Medical Professions. The PMP Advisory Panel sought and was granted statutory approval to refer for enforcement physicians and patients connected to numbers

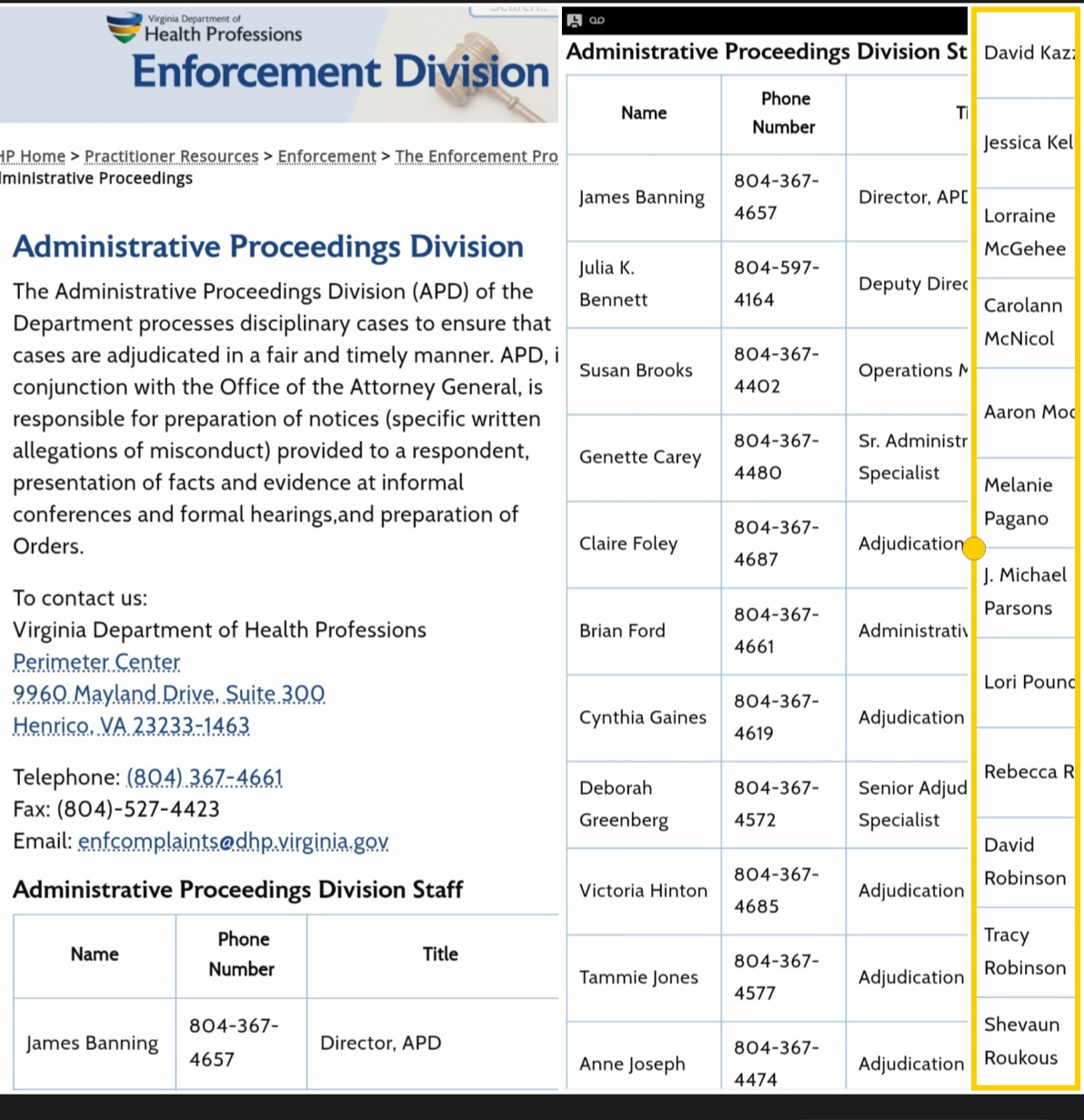
that exceed certain thresholds. If that isn’t “government in your bedroom,” I don’t know what is.

Scary stuff.

In the 1979 horror film *When A Stranger Calls*, the climax hits you like a ton of bricks when the police detective phones babysitter (Carol Kane) to inform her those menacing calls she has been receiving all night are coming from – brace yourself -- insider the house. This is unfortunately the reality for many chronic pain patients whose doctors, who once received menacing calls from the DEA, are now beginning to receive calls threatening suspension from enforcement entities created within the State to follow up on the latest State-run PDMP report. The implications are frightening because it means that at a time the CDC may be poised to revise its Guideline in a direction favorable to chronic pain patients, the source of the restrictions are being duplicated or transferred from the Fed (CDC / DEA) to a State-based tentacle of a multi-headed Hydra. This means that chronic pain patients can no longer pin their hopes to the unified resistance to one clearly identifiable common source at the national level. Who for example is helping me with my medication problems if my medication is being restricted by some group hidden in the bureaucracy of Virginia State government? The advocacy groups are still focusing their efforts on the Fed and, even once it becomes clear that the evil has been outsourced to franchises in every state, how will the advocacy adjust to reproduce these efforts on 35-50 different battlegrounds?

Groups like PROP, FedUp, and Shatterproof are already prepared to support the opposition once it is transferred to the states. PROP and other groups favoring a culture of austerity have been stoic through the alarming rise in heroin deaths. For groups such as these, it’s all part of a strategy akin to herd immunity. If their crackdown on pain relievers was part of some compassionate plan to save current and future heroin addicts, they would speak more about how to support patients at the time they are informed by their doctors or pharmacists that their medication has been discontinued, or at the time their doctors are raided by the DEA. But for these agents provocateur, it’s all about grounding the teenage daughter and enlisting the aid of cops to harass and intimidate the daughter’s boyfriend.

As if doctors and patients do not have enough to fear in the Fed (DEA), ***this*** ... is what they will face from the State if all that routine automated number-crunching places them over the proverbial line.



PROP spokesperson Andrew Kolodny has remarked often that pain patients are just pawns to Big Pharma, but it is PROP that has done nothing but show irritation and scorn toward patients. By virtue of their reliance on pharmaceutical products, patients present to PROP as proxies for Big Pharma. Patients who insist on their regular analgesic medication get in PROP's way – and in the middle of some war that is not really a war inasmuch as pharmaceutical companies do not concern themselves with the quixotic jabs of a small sect operating on the fringes of the academic and professional community. Unfortunately Tom Frieden's CDC gave these minnows the authority of whales when he invited them into his ocean. Now PROP associates enjoy grants, speaking engagements, and attention from journalists who have bought into the sensational conspiracy of pharmaceutical behemoths and doctors to connect addictive substances to addictive personalities. For me, as a social psychologist, it’s all so reminiscent of a period in the 1980s when journalists -- including those broadcasting the nightly news for the three major networks – failed to critically examine a moral panic out of Southern California and reports that thousands of children nationwide – beginning with those at the McMartin Preschool in Manhattan Beach -- were subjected to satanic ritual abuse by daycare workers.

Had we not been so near sighted – had we taken a step back and hit the +1 on our Google Earth view of Ground Zero, we would have seen an overall upward trend in drug use since the late 1970s. In our temperocentricity, we anointed the mid 90s surge as if it were the Big Bang, or at least the assassination of Archduke Ferdinand. The shot heard round the world. Substance abuse was not invented in 1999 much in the same way World War 2 really did not begin in the late 1930s. But the short view enabled us to invent a new bogeyman in opioids. The Myth included an Origin Story about a pharmaceutical house named Purdue and a product called Oxycontin. As the fable unfolds, financial incentives from Purdue Pharma helped physicians find the courage to believe untested claims that an extended release formulation minimizes risks of dependence. Once the prescriptions were discontinued, the patients were so hooked that they turned to the Street and specifically to heroin. With a three prong public health strategy in mind, public health officials believe the problem of rising opioid overdoses will eventually resolve through prescription drug monitoring and restrictions, interdiction, and rehabilitation. Until then, opioids remain the “crime of the century” and source of all socioeconomic ills.

These unprecedented restrictions scrutinized, discouraged, and penalized prescriptions for pain relievers that had been widely regarded for decades as the most affordable and effective -- and the least toxic – resource for pain overall and, for some conditions, the *only* resource. Did we finally solve the evil at the root of the world’s woes? Had we unmasked Lex Luther? Or were we creating new problems by destroying one of the few things that really worked and that we never had to question. Is it not Lex Luther but Richard Jewell we have in custody?

I understand doctors do accept certain perks from pharmaceutical houses. But they also receive money from third parties on behalf of insurance carriers: end of year bonuses proportionate with how well they adhered to formulary and other best practices. More importantly this money changes hands far more often over drugs other than analgesics. And speaking of opioids, I know doctors whose end of year bonuses would have been higher for denying my request for Tussionex suspension – which includes hydrocodone – in favor of what they referred to as the “preferred drug” or “what the computer recommended,” which is either an abuse-deterrent Hycodan that makes you sick if you exceed the recommended dose or a suspension headlined by a very weak codeine combined with guaifenesen or with a promethazine guaranteed to knock you out and leave you with a dehydrated hangover. So it cuts both ways. But yes by all means let’s exclude all the irrelevant practices so we could pretend there is an arrangement between doctors and manufacturers only and an arrangement that pertains to analgesic products only and that serves only to *encourage* prescribing. Not just prescribing. *Over*-prescribing.

I am reminded of all those photos that become Internet sensations where we feel absolutely certain we are looking at some dwelling on Mars or a demon hovering over a hospice bed. But in actuality it’s a perceptual illusion called a *pareidolia*. Our brains evolved certain time and labor-saving algorithms so we could estimate relative size and distance of objects automatically on the fly. There are unique constellations of cues that conspire to trigger these algorithms in ways that cause us to misinterpret our environment and see something that either isn’t there or that is much larger than it is. Similar to these algorithms that are hard-wired into our physiology, we have also evolved *mental* short cuts – rules of thumb and quick references -- called *heuristics* that streamline judgements about probability and representativeness but can also lead to misinterpretation or bias, as when a rehabilitation professional for whom addicts comprise 100% of his day determines that the rate of dependency among persons prescribed prescription painkillers is closer to 100% than the actual 1 – 6% established by unbiased epidemiological studies.

**MAKING A MURDERER: THE ILLUSIONS, HEURISTICS, & COMPLIANCE TACTICS THAT MADE US BELIEVE IN AN “OPIOID CRISIS"**

The most well known of these rehabilitation professionals -- and Guidelines architects -- is anti-opioid evangelist Andrew Kolodny. His appointment continues and further exacerbates a trend that started with the assignment of prescription painkillers to the CDC Injury Control and Prevention Center and their assignment of opioid prescribing guidelines to a Core Expert Group predominantly staffed by members of Physicians for Responsible Opioid Prescribing (PROP). Kolodny is not a trained pain specialist but a psychiatrist and former executive officer for Phoenix House, a chain of rehabilitation facilities. Dealing with the 4% who develop an OUD is what he does. It's ALL he does. Abuse, addiction, and overdose is 100% of his book of business. One hundred percent of his daily schedule. Have you ever heard someone intercede in a debate about the unemployment report by stating that if you're working unemployment is 0% and if you're not, it's 100%? Same principle. It's natural for a cloistered specialist like Kolodny to treat the rate of dependency among those prescribed painkillers as if it were closer to 100% than the 4 - 8% cited by NIH and SAMHSA. Kolodny, who ironically has a penchant for charging his opponents with arguing from anecdotal evidence, falls prey to a fallacy produced by a cognitive bias known to research psychologists as the *representativeness heuristic*. It's the cognitive equivalent of some of those perceptual illusions professors love to show their Psych 101 classes. The Moon Illusion. Muller-Lyer. There are quite a few of them. And these illusions illustrate how our minds might be tricked -- led by the arrangement of physical cues in our environment relative to our vantage point -- into a misinterpretation of what it is that is actually there compared to what we claim to see. I submit that perceptual illusion is one of the driving forces behind the Guidelines.

**THE ILLUSION OF SIGNIFICANCE**

Take another popular illusion known as The Ames Room. If you could see the room from above, it would be obvious that it is shaped like a trapezoid. Imagine for a moment that you put this room on the market but you want prospective homebuyers to see a sensible rectangle rather than a trapezoid. So to compensate for the fact the left half of the wall is so much further from the viewing location than the right half, you build windows of different size so the more distant left half window is proportionately larger than the nearer right half window. And of course you restrict the homebuyer so he could only view the room from one angle.

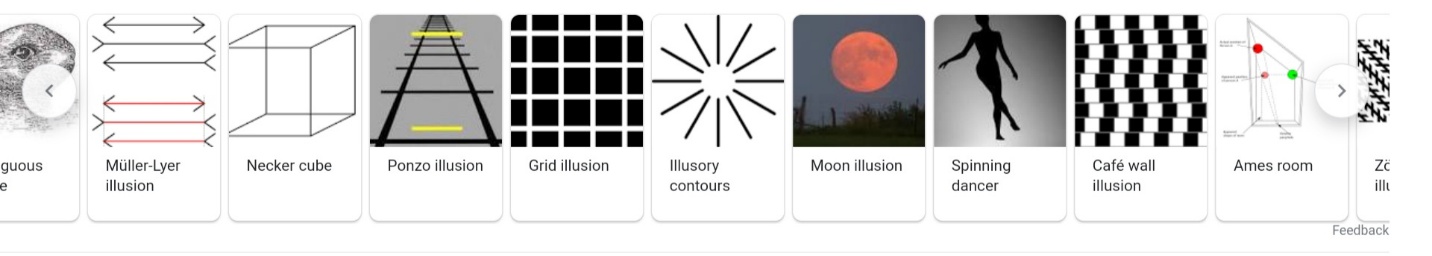


Those who elevate opioid risks to the level of supreme evil worthy of terms like “crisis,” “epidemic,” and “emergency declaration” manipulate cues to trick our rational minds into perspectives that do not jibe with the natural order. Inappropriate comparisons are one such tactic. Like hiding a discrepancy between the distance of left and right windows, they decided to invoke a comparison between number of fatalities in which opioids were involved and number of casualties during the Vietnam War. The problem is that while the conflict with Vietnam had persisted for 20 years – which is the period over which opioid fatalities were counted – the period of active military combat overseas was only 9 years. So to suggest that it’s a level comparison is not, well, on the level. Then there was research embraced by CNN and by lawmakers that cast doubt on the one thing about opioids we thought was beyond question. I mean, as much as we might be debating the potential for abuse and the actual costs of those risks in lives lost and productivity unrealized, we treated this as the price of a wildly effective medication. Now here comes some research that presents experimental evidence that opioids are no more effective than NSAIDs. The problem is that the experiment was carried in an Ames Room. The principal investigators compared the minimum dose of Percocet (5 mg) with a cocktail of two NSAIDs administered at maximum doses (i.e., 800 mg ibuprofen and 1000 mg acetaminophen). Those doses exceed manufacturer recommendations and become toxic to vital organs after a few days. By contrast, pain sufferers who have been taking 15 mg oxycodone – the opioid ingredient in Percocet – for over a decade have sustained no loss of function to the liver, kidneys, or stomach from the opioid alone. We have had to move a lot of goal posts, so to speak, to present opioids in their current light.

There are the ambiguous or reversible illusions that exploit the brain's inability to see two images at once.



Take the statement that 4 of 5 heroin addicts were once prescribed an opioid. This is the opiophobe’s most cherished datum. Forget for a moment that the significance of this statistic dissolves in the realization that – thanks to the ritual extraction of wisdom teeth late in adolescence -- 4 of 5 persons who have *never touched heroin* have *also* been prescribed an opioid. What makes that statement so alarming to so many is that when they hear or read it , their minds are transposing the two constituent propositions so that they also think they heard or read that 4 of 5 persons prescribed painkillers will eventually become a heroin addict. That is simply not true. Far from the 80% (4 of 5) suggested by transposing the initial statement, research by SAMHSA and NIH place the actual rate of post-exposure dependency somewhere between less than 1% and 12% based on the type of condition treated with the opioid and the duration of treatment. Critics of opioids induce you to see their image and then they restrict your access to information and your thinking so that their image is the only one you see. For example, they argue that a rate of dependency of 4-6% is very high in that it translates into quite a number of people. But they don’t want you to think about the 94-96% (100 – 4-6) for whom the opioids offer relief without consequence. Many of these people suffer chronic conditions, so their lives and the lives of those who depend on them would deteriorate indefinitely if we were to grant the wishes of those who want to eliminate opioids from the pharmacopoeia. So remember that the original and transposed versions of the aforementioned statement are not two sides of the same coin. They are not intrinsically tied by logical necessity. They are completely independent propositions. One is true (with a major caveat). The other is false.



There are many perceptual illusions. I suspect that for a great many of these physiological responses there is an analogous strategy by which propagandists exploit cognitive vulnerabilities in their intended audiences to wrest support for their point of view.

Propagandists also have another trick up their sleeve. They can exploit the principle that any non-zero difference between groups becomes statistically significant with a sufficiently large sample size. That means the difference between 36% and 31% -- which none of us would ever consider *practically* significant – and which is also not *statistically* significant when we have 50 volunteers in each of our groups – may become statistically significant – when we put 300 volunteers in each group – and becomes statistically significant for sure – and wildly so – with 3000 in each group. In the modern era of hospital databases and national registries, such numbers are not just feasible ... they’re inevitable. Suddenly researchers can lay claims to bold conclusions – and they are under no obligation to report the raw data – for example the fact they are evaluating the difference between 36 and 31% -- so that their readers could question the conclusions or draw their own conclusions.

The Government’s propaganda strategy begins by putting the issue of overdose fatalities in the hands of the trusted CDC, a beacon of science whose objectivity has never been questioned or tainted.

The CDC itself is a highly specialized branch of HHS. I even doubt whether the U.S. Department of Health and Human Services (HHS) is appropriate for the problem of widespread substance use. Substance use is a complex biopsychosocial problem requiring multidisciplinary coordination among biological and social sciences. Unfortunately there is no *human* in Health & Human Services. By assigning this problem to HHS -- and even further down the hierarchy to the CDC -- we ensure that a biological model is applied to a biopsychosocial phenomenon. It's tantamount to shoving an octagonal peg through a square hole. There is going to be distortion. The CDC thinks if they make the hole big enough, it won’t matter what shape the peg is. But all this ends up accomplishing is wholesale neglect of critical influences and knowledge bases including but not limited to the broad spectrum of crises and disruption that left millions of Americans to manage 20 years of existential terror. But I'm sure [NOTE SARCASM] this has nothing to do with the rise in substance use since 2000.

But we don't stop with the CDC. We assign the problem to its Injury Prevention and Control Center. This is tantamount to handing a labor crisis to the Bureau of Labor Statistics within the Department of Labor. Tantamount to helping Wade Boggs reverse a declining batting average by having him consult with the division of Topps that prints up his baseball cards. As a former hospital employee, I bemoaned the fact there were one systems analyst for every database but usually only one data analyst or statistician. The only time anyone in a hospital pays any attention to data is when such attention is compelled by the economic threats posed by new legislation. In 2015, MACRA legislation shifted the basis for reimbursing hospital physicians from volume to value, with value intended to refer not to clinical outcomes strangely enough but to patient satisfaction. Also in 2015, DSRIP in New York and other state initiatives spurred by rising Medicaid expenses forced health care facilities to put a cost and clinical value on every asset so as to identify the most costly sources of overutilization. But if there was anything I learned from these programs it is that in the absence of scientific and clinical objectives, regulatory drivers lead to the actuarial treatment of data as well as to efforts that promote I.T. solutions for analytic challenges. This is exactly the mindset – the mentality – we see unfolding in the Government’s efforts to bring the Opioid Crisis under control.

By assigning the problem to the Injury Prevention and Control Center, we ensure a purely actuarial strategy. The Center deals in Letterman-esque top 10 lists. Causes of death statistically ranked. The Center sees the problem purely as a number that is too-high-and-rising and concludes that the way to address the problem is to reverse the trend and make the number lower on future assessment. That's as scholarly and scrupulous an analysis as you get here. No investigative research. No analytical acumen. No thought as to what actually transpires in the minds or lives reflected in the statistic. There are people here. Stressed people. Depressed people. People for whom substances offer an opportunity to reassert or salvage some measure of control over a world that is continually changing. Some of these people are mature professionals who struggle to learn new software or programming languages to avoid being aged out of the workforce every 2 years. Others count among their concerns the threat of untreated or under-treated pain. And when their doctors doubt how long they can continue to treat them given arbitrary political objectives to reduce the national number of dispensed morphine units by 30% annually, these people become quite agitated at the prospect of having to forfeit their capacity to function and quality of life.

This statistical reduction strategy is reinforced by the inclusion of PROP within the ranks of the Guidelines Core Expert Group. Now in the "minds" of PROP consultants hired by the Center, each person who is encompassed by the problematic statistic represents a nail -- and the solution that presents itself as obvious is tantamount to a hammer. From the very outset, a conceivably broad and intellectually stimulating challenge is translated into an imperative to reduce a high number of overdose fatalities by reducing the number of prescriptions and number of milligrams prescribed. Once assigned to the CDC and to PROP, we forfeit any opportunity to expand and enrich our understanding of the real problem beyond *number* of *addictions* / *accidental* *overdoses*. Number addictions / overdoses is the question and the answer is *make number go lower*. For this, there is no need for intellectual discrimination, strategic planning, or analytical acumen. Not when you have the absolute authority of a Justice Department that possesses unlimited powers of surveillance, intimidation, and prosecution.

Our system of compassionate care -- our willingness and capacity to take away the suffering -- is a hallmark of our nation's superiority. But by alerting us to the fact our nation consumes 80% of the world's painkillers, PROP executive Kolodny managed to recast pain relievers as ICBMs and make us wish we were more like the developing nations. He managed to recast our physicians from elite class to embarrassments when he suggests so many physicians know so little about the medicines they prescribe and that many more are engaged in some quid pro quo to prescribe in exchange for kickbacks from manufacturers. This is a stunning exploitation of a very real problem. And it’s exploitative and effective as an attack because there is a kernel of truth to the claim that clinical decisions are influenced by non-medical considerations. ***But Kolodny wants us to believe this problem applies only to a potentially addictive class of pharmaceuticals, which would paint doctors in the worst possible light by making them key figures in an organized drug ring. He doesn’t want you to know that the pressures – the incentives – extend well beyond pharmaceutical company perks to insurer reimbursement systems and to hospital satisfaction surveys – the latter of which were driven by Congressional MACRA legislation in 2015 to determine the rate at which hospitals are reimbursed for services by Medicare.*** This was an effort to persuade doctors to accept more risk and to shift from volume to value as a model for reimbursement. Personally I never understood how the term *value* was equated with customer satisfaction, but the state of affairs could easily be understood once you realize which of the questions on the CMS-endorsed CAHPS patient surveys is correlated most with the total patient satisfaction score ... “how much pain are you in?” On the one hand you are distressed by how easily these reimbursement rates can be gamed by making patients as comfortable as they could be the best way you know how; but on the other hand, you are compelled to wonder what in the name of Sam Hill -- and Jack Kevorkian – is wrong with that. Kolodny also doesn’t want you to know that these institutional pressures to favor certain treatment options over others apply to just about every asset category in the hospital. They apply to all pharmaceutical options for treating all disorders – including those that do not involve pain as a symptom – as well as to procedural options. Physicians operate in an environment in which they are accountable for decisions on both cost and clinical benefit. The very idea that PROP would isolate pharmaceutical company perks for opioid prescriptions tells me they are in the myth making business. This screams “special interest of fringe / extremist group.” The world is full of them. It’s why we have a traffic safety group that is threatening Fairfax County police over a 70% reduction in traffic citations for the 2020 calendar year. 2020 also happens to be the year of the worst pandemic since 1918. The year we lost 570,000 American lives. That will reduce the number of vehicles on the road. The year officers were instructed not to ticket for expired registrations, inspections, or Virginia property tax decals because residents are having a hard time just putting food on the table and should not be expected to risk infection by venturing out to a petri dish of a DMV. In these special interest groups like this traffic safety group and like PROP there is an inherent psychological imbalance and a system of reinforcement – not unlike the one PROP sees compromising physicians – and PROP physicians are equally if not arguably more susceptible to view the business in front of them completely devoid of context and natural priority.

Let’s talk about priorities -- Constitutional and constitutional. HIPAA laws. Hippocratic oaths. A private relationship between doctor and patient. These are untouchable ... unless opioids are involved. Then the system dispenses even with due process for physicians whose offices are stormed by armed agents of the DEA.

But this is how we’ve been taught to deal with demons. And a demon is what we claim to see hovering over the corpse of every mother -- every son -- every sister -- every daughter – who ever succumbed to an overdose of heroin. I am trying very hard to explain how we could see something when all the data – data I intend to share with you in the next section – tells me it isn’t there. Sure, there are a number of reasons why we’d *want* to see it. Some of us are getting paid to fight it. Some of us need someone to blame for it -- so we could put the tragic death of a loved one behind us and, well, heal. Some of us have a reputation in need of repair, and fighting a demon will unite the public behind us.

But not all of us have a stake in the demonization. We're just ... wrong in our thinking about it. And the only thing I could do is try to account for the discrepancy – the gap – the delta – between what the truth is and what we believe is true. As a social psychologist, it is in my nature to question all the usual suspects – all the quirks of human perception and reasoning that we fall back on when we lecture the laity – the much-maligned “man in the street” – on how their brains or minds are always playing tricks on them. If you ever took a survey course in Psychology, you've seen Clever Hans. You’ve spent a class on all the perceptual illusions. Freud's defense mechanisms. Cognitive heuristics and Gestalt principles. And that’s just what we do *to ourselves.* When we bring our fellow citizens into the mix, a broad spectrum of social influences – manifestations of a Group Mind -- participate in the deception. Some confluence of the following vulnerabilities are being exploited by those selling us ***The Great Opioid Myth***:

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| **Social Psych Principles Evidenced in Construction of Great Opioid Myth** | | | |
| *Balance Theory* | Fritz Heider | | 1958 |
| The feelings we harbor toward “object P" are influenced if not wholly determined by whether it is liked or disliked by “object A" and by how much we like or dislike object A. The value someone or something holds for us at any time is a function of how much we value the persons or things associated with it. | | What this theory tells us is that barring a conscious override, a targeted objective assessment is not in our nature.  It’s no secret Nixon conservatives did not feel love for college intellectuals and anti-war demonstrators. It just so happens that these two groups liked marijuana. One of the self-evident truths of the 1960s was that Nixon demonized marijuana and made it the focal point of a campaign to restore law & order not because marijuana posed a threat to public health or safety but because it came to represent his adversaries and that, by restricting it, he was making life harder on those he hated.  60s Conservatives reserved a similar tactic for African Americans with a fondness for opium. Drug warriors view as cheaters anyone who would use substances to achieve a sense of well-being they did not earn rightfully through hard work. That euphoria is ill gotten. So all the Fed had to do in these modern times was portray heroin addicts as yesterday’s chronic pain patients and – voila – Percocet, the company that manufactures Percocet, the doctors who prescribe Percocet, and the patients who consume it to numb their pain become de facto moral degenerates and social contract holdouts looking for an easy way out. | |
| *Obedience* | Stanley Milgram | | 1963 |
| 50% of research volunteers were willing to deliver what they believed were painful electric shocks of increasing intensity to a confederate who provided incorrectly responses. Despite their own distress and that staged by the confederate located in another room, the volunteers continued to deliver the shocks simply because they were instructed to do so by an authority figure. | | When the Centers for Disease Control claims to have a national database full of numbers that tell us the nation is struggling with opioids in a way it had not struggled before, we take notice. Oddly enough conservatives had no trouble spurning the CDC over mask mandates because they violated their Constitutional rights. Will these same conservatives support chronic pain patients when they seek to overturn CDC Prescribing Guidelines cited as grounds for separating them from their pain medication. Conservatives have thrown just enough support behind the 2nd Amendment to keep guns legal and available for purchase despite an epidemic of school shootings that claimed the lives of our most innocent and vulnerable youth. Yet they have no problem yanking that Vicodin away from granny citing the tenuous link between prescription painkillers and future heroin use. They do not question the Gateway Theory but the links between carbon emissions and climate change, cigarette smoking and cancer, and semiautomatic weapons and dead schoolchildren they deny (“guns don’t kill, people kill"). | |
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| Labeling Theory | Philip Zimbardo | | 1971 |
| College students assigned roles of prisoners and guards in a simulated prison environment identified so extensively with their roles that the experiment had to be terminated after only 6 days due to mistreatment. | | We may never know Just what our current CDC and DEA employees once might have thought privately about substance use and pain management; because upon being given a title, uniform, and paycheck to police substances as potential threats to our communities, ideologies were born and identities forged. | |
| Conformity | Solomon Asch | | 1951 |
| Thirty-seven percent of research volunteers were willing to ignore reality and provide an incorrect answer in order to conform to the patently incorrect response given by a group of 7 confederates | | The CDC used a press conference to announce their Guidelines, which had been used as impetus and justification for new policy and for law enforcement initiatives, were misapplied to the chronic pain community. They also announced that a self-study revealed an error that inflated the estimated rate of accidental overdoses by 47%. But these admissions never served to undo any of the damage or alter the course of messaging or policy. The corrected data failed to yield a corrected narrative. It’s as if too many of us became to accustomed, invested, or addicted to the status quo to allow contradictory info to sink in. | |
| Cognitive Dissonance | Festinger & Carlsmith | | 1957 |
| In order to relieve stress caused by inconsistency, a person will use rationalization and confirmation bias to bring an inconsistent attitude and action into greater alignment. | | If you ever have ever wondered why the issue of pain management has become so disquieting, cognitive dissonance is the reason. You may hear silence or you may hear rage but no one speaks of the need for surgically nuanced solutions to a murky and complicated issue. We humans on average do not tolerate ambiguity or complexity well. We need a clear and impactful solution – preferably a punishment -- for a clear source – that we deem a culprit. Some brains you just can’t tax without short-circuiting them, stunning them into paralysis, or shutting them down completely. | |
| Fundamental Attribution Error | Jones & Harris | | 1967 |
| Even though we attribute our own attitudes and behavior to situational factors in our environment, we assume the attitudes and behavior of others are due to stable causes inside them, i.e., a personality or disposition. | | This fundamental attribution error, otherwise known as the actor-observer effect, has well established relevance for the Opioid Crisis, as we would invoke all sorts of circumstances to explain why we need a glass of wine with dinner but those pesky Anderson brothers smoke marijuana because they are bad seeds. | |
| Aversive racism | Gaertner & Dovidio | | 1986 |
| What would you do if a stranger, claiming he used his last quarter to dial you by mistake, asked you to phone a garage on his behalf? Those who identified as conservative refused to help in 92% of the cases in which the caller was African American but only in 65% of the cases in which the caller was white, whereas those identifying as liberal refused African Americans at a smaller rate of 75% and equally refused whites at a rate of 85%. As overtly more prejudiced as conservatives appeared, liberals hung up prematurely (before the caller could request assistance) on 19% of African Americans and only 3% of whites, while conservatives did not discriminate (8% and 5% for African Americans and whites respectively) | | For social psychologists, the findings suggest a whole new form of racism – quite possibly a subconscious racism -- that thrives in ambiguous situations where norms are ill-defined. This aversive prejudice may offer insight into how chronic pain patients as a social minority are being disempowered and denied medication. The circumstances cited by the Federal government as grounds for radical public health intervention consist of ostensibly high numbers of accidental overdoses involving a broad array of substances including prescription pills, diverted GMP pills, and illicitly manufactured counterfeits. But what is cited as the principal driver is deaths. And with the principal stakeholders to include senior Government leaders and the grieving survivors of decreased addicts stridently promoting a tenuous link between heroin overdose and a history of opioid prescriptions, no one is going to begrudge a lawmaker, doctor, pharmacist, or Federal agent for initiating an action that separates pain patients from their medicine.  Sure there is no shortage of conservatives who will look a roomful of pain patients in the eyes and tell them “take an aspirin and call me in the morning” (i.e., Jeff Sessions). But there are also those who speak of civil rights, compassion for minorities, and persons with disabilities when in front of a microphone even as they pretend not to hear those who beg them not to submit that bill that would force pharmacists to fill only 50% of the quantity on the script (i.e., Elizabeth Warren). | |
| Misattribution Theory | Dutton & Aron | | 1974 |
| In one experiment men were more likely to avail themselves of the phone number for an information hotline when the number belonged to an attractive woman and when they were given no time to rest after crossing a scary 450-foot suspension bridge on foot before being prodded to use it. | | Research psychologists believe people could be induced or manipulated into re-directing what they are feeling to whatever is presented to them, much in the way the men in this study were induced to mislabel their fear and enervation as sexual arousal. Americans have been through a lot since 2000, not coincidentally the year marked as the Opioid Crisis official birthday. No doubt many Americans have relied on substances to deal with the stress, although the Great Opioid Myth would have you believe that drug abuse is the cause of all these stressors. And to achieve that end of prodding stressed Americans to label the stress as righteous indignation over a national drug problem, the Fed floods us with TV and radio ads as well as newspaper and Internet headlines. | |
| Groupthink | Janis / Thompson, Peterson, & Brodt | | 1984 / 1996 |
| As members of a group, we resort to extraordinary measures to preserve group norms or harmony within the group -- measures that promote the perception of the group as invulnerable, invincible, and formally unassailable to criticism -- measures that discourage alternative points of view. | | There is in my opinion a feeling among those who have a role to play in the crackdown on opioids that they have no natural adversaries on Capitol Hill. They must believe that they are fighting on the side of the angels in a war not unlike World War 2. I believe this bolsters a sense of unity within each agency and a sense of camaraderie between agencies. When you operate this way you are not trying to build a case that is impervious to criticism, because you don’t feel that anything you do or believe is subject to critical examination. In recent years the community of chronic pain patients have mobilized, but the limited strength of a group forced to endure untreated pain is hardly formidable opposition. And you can see in the tenor of those responding to the community – if and when they feel kind enough to respond at all – a condescending parental like dismissal of children when they ask for candy before dinner. | |

The Grand Myth is built on a biased view of the world facilitated by heuristics and algorithms. We accord more weight to certain facts than others throughout a process of selective attention, selective memory, selective valuation, and selective connecting of dots. This selectivity narrows the logical progression of ideas and the accretion of relevant factoids around a central thesis or cause. While Oxycontin might have contributed to the wider abuse problem for a time, the problem was mostly confined to nonmedical users who never had a valid script -- and the problem has been addressed and contained a number of years ago. These individuals violated terms of use when they crushed the tablets to release an immediate and short-term euphoria. The incident should not be used as impetus for policies that discourage prescribing and restrict access to real patients.

Lex Luther or Richard Jewell? It’s an important question because ...

*..."Surgeons have been encouraged to use intravenous acetaminophen (Tylenol) to treat postoperative pain rather than risk 'hooking' their patients on opioids. We cited research that shows intravenous acetaminophen is ineffective for controlling postoperative pain"* (Singer & Bloom, 2021).   
  
Over a 48 hour period, acetaminophen did not statistically or practically reduce duration of postoperative hypoxemia (0.7 minutes per hour below 90%) over patients undergoing abdominal surgery compared with a placebo group (1.1 minutes) nor did the patients receiving intravenous acetaminophen report significantly less pain (M = 4.2, SD = 1.8) versus control (M = 4.4, SD = 1.8), less nausea and vomiting, less fatigue, or less respiratory function (Turan et al., 2021).

Chronic pain patients should not suffer now or 10 years from now for the hidden contract of sin between a manufacturer following the American business model and those who posed as consumers for their product.

If we take a less biased, less alarmist view, we see the mid 90s surge is a predictable extension or reasonable extrapolation of a trend that began 15 years earlier when millions rebelled against Nixon's War on Drugs.  As I will discuss later in this Report, we need to think of the current dispute over opioids as an extension of Nixon's campaign much in the same way the Second World War (1938 - 1945) only makes sense when viewed as an extension of the War to End All Wars (1914 - 1918).  The Drug War was created during the most turbulent period in U.S. history and only served to add to the turbulence.  And as fatigued as the nation was with a 20 year war with North Vietnam, the Drug War would prove even more enduring.

**FAILING TO MEET THE BURDEN OF PROOF: WHERE'S THE DANGER?**

On the scores of dependency, toxicity, teen use, and overdose, the Government fails to offer compelling evidence of an opioid threat.

**RATE OF DEPENDENCY: LOW**

But in refusing to address the predisposing, precipitating, and maintaining factors underlying substance use, senior leaders are committing the same error of which they accuse those seeking relief from pain through painkillers: the error of treating or masking symptoms. You know it is misguided for our Government to hold manufacturers, doctors, and patients accountable for overdoses on illicit Street drugs. It is not entirely clear who went public with the sneakily deceptive stat that 4 in 5 heroin addicts were once prescribed a painkiller, because truth be told so were 4 in 5 of us who never touched an illicit drug. This is roughly the percentage of the general population given Percocet or Tylenol with codeine in exchange for our wisdom teeth. The actual rate of dependency is somewhat lower than 80%. According to NIH, it's < 4% for chronic pain patients and < 1% for acute pain patients. A large scale survey of ~ 11,000 surgical patients in the 1980s found only 4 cases of dependency. The most unfriendly data comes from SAMHSA at 8 - 12% but then SAMHSA goes on to stipulate that of this group only 4 - 6% will eventually resort to heroin. In the 1980s of ~ 11,000 patients screened in the months following surgery, only 4 showed signs of dependency.

According to 2019 data, neither prescription pain reliever disorder (1.4M) or heroin disorder (438K) ranked among the greatest threats to the population aged 12 and over, falling well short of use disorders involving alcohol (14.5M), illicit drug (8.3M), and marijuana (4.8M) while being comparable to use disorders involving cocaine (1M) and methamphetamines (1M). Other use disorders include prescription tranquilizer or sedative (681K) and prescription stimulants (558K). (Substance Abuse and Mental Health Services Administration, 2020).  It is also noteworthy that while most of the use disorders remained stable or increased over the past few years, use disorders related to prescription pain relievers have declined across every age demographic since 2015, from 0.6% (152,000) to 0.3% (or 87,000) among teens aged 12 to 17; from 1.2% (or 427,000) to 0.6% (or 196,000) among adults aged 18 to 25; and from 0.7% (or 1.5 million) in to 0.5% (or 1.1 million) among adults aged 26 or older for prescription pain reliever use disorder.   
  
Complicating the issue are variations in how adverse outcomes of drug use are defined.  SAMHSA itself distinguishes between rates of drug *misuse* and rates of *use disorders*. The latter presupposes a misuse-related impairment such as disability, health problems, or the inability to carry out responsibilities at school, work, or home. Even though the rates of misuse for prescription painkillers declined remarkably among those 12 or older from 4.7% (or 12.5 million) in 2015 to 3.5% (or 9.7 million) in 2019, prescription pain relievers remain the second most commonly misused substance (9.7M) but fall well within the middle of the pack when the various drugs are ranked based on rates of use disorders.  This is an important distinction because it suggests that the consequences of misuse may not be all that great.  As we will examine more closely in another section, the worst imaginable consequence of misuse in accidental overdose is not all that common, as the overdose fatalities are skewed heavily toward illicitly manufactured formulations like heroin and fentanyl.  The reason why the jump from misuse to use disorder may not be all that common is hidden in the data SAMHSA compiled on the reasons for misuse.  Among those who misused prescription pain relievers in the past year, the most common reason cited for misuse was to "relieve physical pain" (65.7%).  Not to "feel good or get high" (11.3%), "relieve tension" (10%), or "because one is hooked" (1.9%), which are among the most socially and politically condemned reasons for misuse and the impetus for excessive policy action and regulatory overreach.  Now if you're like me, you were quick to seize on the major reason for misuse.  Your reaction -- and mine -- was just as quickly anticipated by the authors of the SAMHSA Report.  They waste no time launching into an explanation that when patients take it upon their own authority to increase the dose beyond the physician or manufacturer recommendation, even if it is to relieve pain, they are by definition committing misuse for the purposes of the Report.  So what do we have here?  What we have here is a situation in which the 11.6% rate of misuse among the pain relievers most commonly misused (i.e., hydrocodone) is grossly exaggerated on a technicality.  At some point after attempting the recommended dose, a patient discovers that some pain remains and thus makes with respect to dosing what amounts to an executive decision for which they probably could have negotiated support from the prescribing physician had an appointment been conveniently available.  We all know how conservative prescribers are with the starting doses for these pain relievers.  Dose for first time users regardless of diagnosis is 5 mg for hydrocodone or oxycodone products and 2 mg for hydromorphone.  Having suffered kidney stones myself, I can tell you that these doses are insufficient and that 10 mg for hydrocodone or oxycodone are safe when a large portion of the pain remains unresolved.  By the time the insufficiency is recognized by the patient, the urgency and severity of the pain makes the idea of a follow up consultation impractical or from a clinical standpoint untimely.   
  
More remarkable is what the SAMHSA authors felt compelled to provide as context.  It's easy in all the talk of misuse and disorders to get lost in those bad news statistics to the point where crisis and epidemic is the presumed diagnosis for the general population.  The CDC Center for Injury Prevention and Control, which managed the task of developing the 2016 Opioid Prescribing Guidelines, suffered this pitfall.  That may have been an inevitable consequence or logical necessity of that office charter / mission -- an occupational hazard of sorts -- like handing a piece of steel to a blacksmith and expecting him not to hammer the hell out of it.  To the credit of SAMHSA, their report writers make it clear that "most past year users of prescription pain relievers did not misuse them (p. 27)."  Okay, so "most" is a bit of an understatement considering that "most" could mean 51% when in actuality, in the case of the most widely misused product, hydrocodone, "most" is -- 100 minus 11.6 -- 88.4%.

**TOXICITY LOW**

We also know opioids are far less toxic to vital organs than OTC acetaminophen to the liver and than ibuprofen to the kidneys and stomach. I read of one cop, believing opioids were a sign of moral weakness and character defect, who refused painkillers for injuries sustained in the line of duty, only to succumb to kidney failure as a complication of excessive NSAIDs. I read of a research project CNN.com took public for leading the charge into the heart of the opioid's one indisputable and sovereign stronghold: its perceived efficacy. Critics of opioids could credibly exaggerate their addictiveness and lethality but they knew opioids could never be sanctioned the way we sanctioned alcohol during Prohibition for the simple reason that they worked -- and they were too often the only thing that did. So CNN.com throws a Ball, if you will, for a study claiming to have evidence that opioids are no more effective than NSAIDs you can purchase over the counter. Study architects specifically compared the minimum dose of Percocet, which for some ailments might fall below the least effective dose, with a combination of ibuprofen and acetaminophen at their maximum doses of 800 mg and 1,000 mg respectively. This is what we scientists call an "inappropriate control (group)" -- inappropriate in that the maximum doses, which exceeded the manufacturer's recommendations, were clinically unsustainable, carrying heightened risk of toxicity after only 8 consecutive days of use. Let’s examine what authorities are attempting to pawn off as safe alternatives to opioids.

*Acetaminophen*

Acetaminophen toxicity can result not only from acute overdose but from an insidious under-the-radar form of chronic overuse that may account for the fact acetaminophen toxicity, after a steady decade-long increase, has become the most common cause of acute liver failure, the second most common cause of liver failure requiring transplantation, and one of the most common causes of intentional and unintentional poisonings, accounting for 56,000 emergency department visits, 26,000 hospitalizations, and over 450 deaths annually (Dimitropolous & Ambizas, 2014).  Over a period in which the Government was campaigning hard to steer the nation away from opioids, "non-addictive" OTC alternatives like acetaminophen became increasingly available in various concentrations and formulations in products in which it was combined with other OTC and prescription medications.  In the U.S. 40% of the adult population reported using OTC acetaminophen monthly and 23% reported using either OTC or prescription acetaminophen weekly (Dimitropolous & Ambizas, 2014).   
  
Physicians and emergency departments routinely send patients home with acetaminophen even though it is indicated for only mild-to-moderate pain (or fever), unwittingly encouraging patients to consume doses above recommended limits.  Where a 5 mg Percocet with 325 mg acetaminophen may have safely sufficed, patients might consume a greater-than-1,000-mg-single-dose of Tylenol or greater than 4,000 mg in a day.   
  
The good news about acetaminophen is that 70% whose toxicity has progressed to the point of liver damage are steered through survival and recovery with timely intervention, with 1 - 2% ultimately succumbing to severe untreated acetaminophen hypertoxicity 4 - 18 days after ingestion.  The course of the disorder is unpleasant, beginning with nausea, vomiting, diaphoresis, anorexia, and lethargy (12 - 24 hours) before a false sense of recovery precedes abdominal pain and right upper quadrant tenderness (24 - 48 hours) followed by the re-emergence of nausea and vomiting accompanied by jaundice, malaise, confusion, somnolence, hypoglycemia, and bleeding and coagulation abnormalities (3 - 5 days). Fatal cases may include coma, hepatic necrosis, renal insufficiency due to tubular necrosis, multiorgan systems failure, cerebral edema, and sepsis (Dimitropolous & Ambizas, 2014).   
  
As with prescription drugs, how an individual responds to acetaminophen is complicated by the presence of other drugs affecting the availability of metabolic enzymes (e.g., alcohol, carbamazepine, primidone, rifampin, efavirenz, and St. John's Wort).     
  
Over a period of 16 years the FDA affixed to acetaminophen products warnings related to the consumption of more than 3 alcoholic beverages per day (1998), liver toxicity (2002), the potential risk for severe liver injury and hypersensitivity reactions including rare but serious anaphylaxis (2011) and potentially fatal skin reactions such as Stevens-Johnson Syndrome, toxic epidermal necrolysis, and acute generalized exanthematous pustulosis (2013).  The FDA limited the amount of acetaminophen in prescription combination products to 325 mg per tablet or capsule (2014).  Manufacturers voluntarily withdrew products containing concentrated infant drops.

*Toradol / Ketorolac*

The more I read about Ketorolac the more obvious it becomes that it has a standing within the medical community that is very similar to that of opioids.  Effective?  Check.  But so many concerns.  Actually, that's not entirely true.  The only real concern with opioids is the potential for dependency and misuse.  And some people struggle with constipation and something called gastroparesis.  Chronic use of opioids slows down digestion.  But the dependency is enough of a concern that doctors are willing to consider -- with a full smile -- a treatment (Ketorolac) they would have scowled at had it been requested by another patient who was not prescribed -- or not a good candidate for -- opioids.  Ketorolac is embraced only by those who've deemed them the lesser evil in a game of trade offs with opioids.    
  
Ketorolac can be used as an adjuvant to reduce the need for opioids and has been effective in treating pain associated with migraines, musculoskeletal injury, sickle cell crisis, and cancer that metastasized to bone (Mahmoodi & Kim, 2020).  Emergency room physicians love Ketorolac.  So do NFL club doctors who administer the popular injection to players before each game and in some cases before every practice as a prophylactic measure in anticipation of pain.  The injections were so effective that players it enabled players to play through pain and in some cases so that they would never even consciously apprehend that they had sustained an injury.  In 2011, 12 NFL players sued the league over these injections, claiming they made it more difficult to diagnose concussions and claiming the NFL failed to disclose side effects that lingered for years into retirement.  The plaintiffs described for the Court an indiscriminate cattle-call-like administration to entire rosters.  This is the kind of chronic use that elevates the incidence of heart and kidney failure.  European and Italian studies linked ketorolac to the highest risk of heart failure and chronic kidney disease respectively when compared to other NSAIDs.  After just 5 days of use, Ketorolac -- especially at higher doses and at advanced ages -- has been linked to stomach and intestinal perforations, toxic epidermal necrolysis, hepatotoxicity, GI bleeding due to thrombocytopenia, cardiovascular thrombic events, myocardial infarctions, and hemorrhagic stroke -- a veritable who's who of worst case scenarios (no offense to meningitis and aortic dissection)(Gleber et al., 2020).

*Ibuprofen*

Among all analgesic overdoses, 29% had used ibuprofen exclusively or in combination with other analgesics, making ibuprofen the most common NSAID involved in an overdose (Ershad, Ameer, & Vearrier, 2021).     
  
Having said that, you will not see many deaths from accidental overdoses.  The deaths involving ibuprofen are somewhat sneakier in that ibuprofen poses a hidden threat to persons with pre-existing conditions that make them uniquely vulnerable to the inhibition and depletion of two chemicals produced by the COX enzyme: prostaglandins and thromboxane.  These conditions may already be known to the person as a medical diagnosis but there are also cases in which the hyperactive response to ibuprofen will lead doctors to that discovery.  In most instances the adverse reactions require a supratherapeutic dose of ibuprofen but there are documented cases of persons suffering from doses within recommended range.  What makes ibuprofen so unique is the absence of a consensus or cross-cutting maximum recommended dose.  There is pain for which doctors will recommend as much as 600 - 800 mg, and there is pain, or mere inflammation, for which doctors will cap the dose at 200 mg.   
  
The risk posed by ibuprofen is the risk of the unexpected reaction to an underlying condition that might not have been diagnosed or that may simply describe a temporary physiological state (e.g., acute hypertension or dehydration). Ibuprofen has been known to   
  
1.  cause gastrointestinal blood loss occurring in up to 17% of patients who receive 1600 mg per day and in 25% of patients who receive 2400 mg per day, the susceptibility to which rises in patients with a history of gastrointestinal events or who abuse alcohol (Ershad, Ameer, & Vearrier, 2021)   
  
2. inhibit antihypertensive effects in patients treated for high blood pressure   
  
3.  induce fatal hepatitis in patients with chronic hepatitis C   
  
4.  be linked to several cases of aseptic meningitis in patients with connective tissue disease (e.g., systemic lupus erythematosus)   
  
5.   cause hypersensitivity reactions (e.g., pruritis, bronchospasm, urticarial rashes, angioedema, and anaphylaxis) in patients who have asthma, nasal polyps, or bronchospastic reactions to aspirin   
  
6.  inhibit platelet aggregation and cause bleeding in patients on anticoagulants and antiplatelets   
  
Ibuprofen has also been implicated in children with acute bile duct vanishing syndrome (Alam, Ferrell, & Bass, 1996) and in reducing male fertility (Kristensen et al., 2018).   
  
The organs most vulnerable to ibuprofen are the kidneys and gastrointestinal tract.  By preventing the conversion of arachidonic acid to various prostaglandins instrumental in sensitizing nerve fibers, ibuprofen inhibits pain but also interferes with gastric mucosal integrity and renal blood flow.  While reversible with supportive care and IV fluids, renal impairment -- manifested in urinary retention, renal insufficiency, acute renal failure, nephrotic syndrome, and acute tubular necrosis -- is a special area of concern in that it's often triggered by mere therapeutic doses.  By contrast, supratherapeutic doses are usually implicated in dyspepsia, GI hemorrhage, viscus organ rupture, perforation of the duodenum, ulcer, and pancreatitis.    
  
The other issue with ibuprofen is that while side effects are customarily mild, they affect a quarter of users.  People who take ibuprofen to relieve discomfort may not be so keen on a little nausea, vomiting, dyspepsia, diahrrea, flatulence, and abdominal pain.

*Opioids By Contrast*

Opioids by contrast have been consumed at high doses for months or even years with no damage to vital organs. In fact, contrary to the work of the CDC, there is no grounds in science or nature to suggest a limit on dose for chronic pain patients. As long as the patient begins at the lowest effective dose and then titrates up gradually and responsibly over time, with special consideration for side effects and unresolved pain, the sky is the limit. In the face of criticism from the American Medical Association and patient advocacy groups over its arbitrary 90 MME

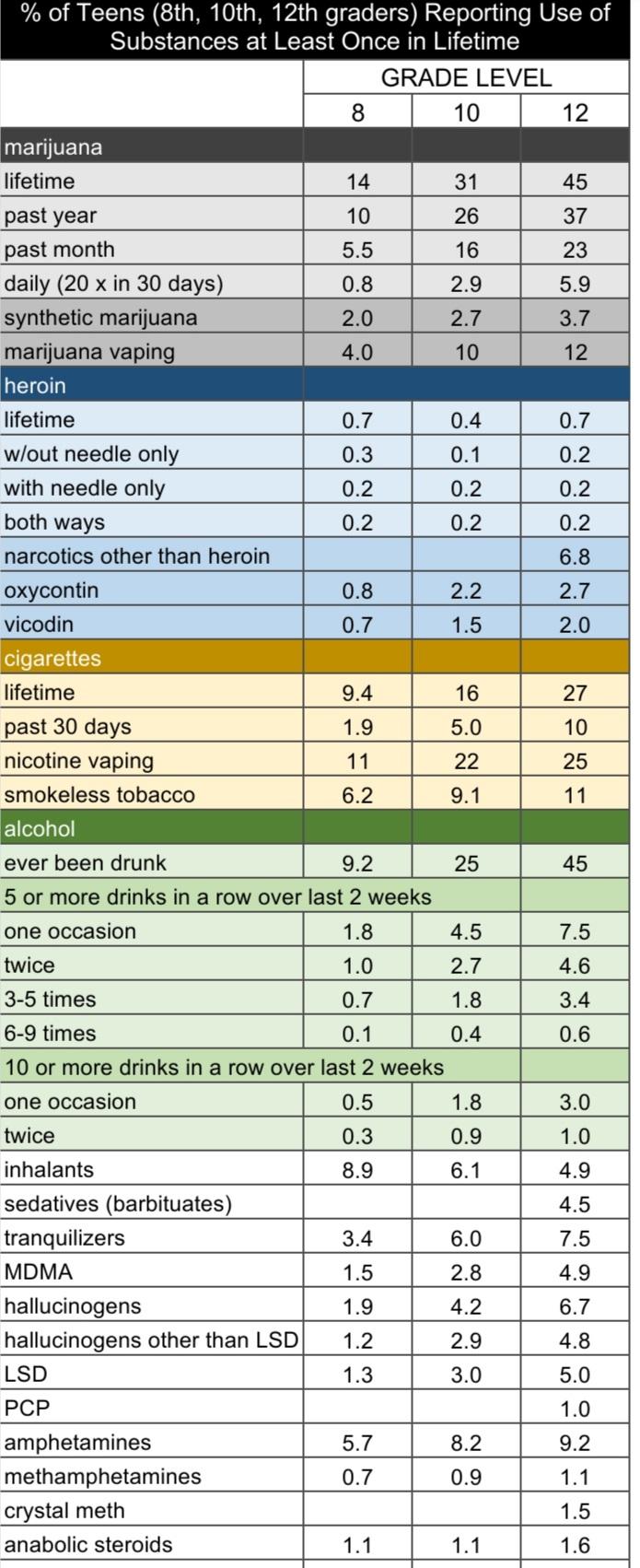
limit, the CDC held a press conference claiming that its Guidelines, which were intended for opioid-naive patients suffering acute ailments, had been misappropriated for chronic and palliative pain and that the standard of care is best described as individualized or patient-centered care. The CDC finally acknowledges that no one-size-fits-all solution holds water in the face of individual differences in diagnosis, treatment history (tolerance), and sensitivity to pain and to pain medication genetically moderated by -- among other things -- levels of the CYP2D6 enzyme (Smith, 2009).

They like to say that of the 71,000 drug overdose deaths in 2019, over 70% involved an opioid (**CDC**). But the converse of this is that of all the opioid fatalities, over 75% involve at least one other substance taken concurrently. I find it interesting that no one is reporting the percentage of decedents as active chronic pain patients, former chronic pain patients separated from their prescriptions precipitously or rightly, or recreational users utilizing diverted or illicitly manufactured drugs. Incidentally when I read that opioid fatalities increased 4% from 2018 (20.7 to 21.6 per 100,000), I know the desired and expected reaction is whoa when in actuality it's closer to yawn. Now I'm accustomed to reading and editing Federal reports that never see the light of day outside the Beltway or -- the Mall -- so I know Feds feel compelled to call everything an increase or decrease even when 95% of the changes cited in these reports are of the 1-2% variety. Somehow these end up being policy drivers.

**TEEN USE RATES (2017)**

For the War on Opioids, senior leaders recently revived a strategic angle that proved effective when used by a grassroots parents movement in the late 70s to stave off the once-irrepressible momentum and progress of a national campaign to decriminalize marijuana at the State level. That angle is our children and, more specifically, all the questions concerning the effect of drugs on developing brains. The new and improved strategy cites a 2015 University of Michigan study to stoke fears that “good children" -- defined as less susceptible teens who report disapproving of regular marijuana use – are subjected to an overall 33 percent increased risk of opioid misuse between the ages 19-25 when first exposed to opioids by the end of high school.

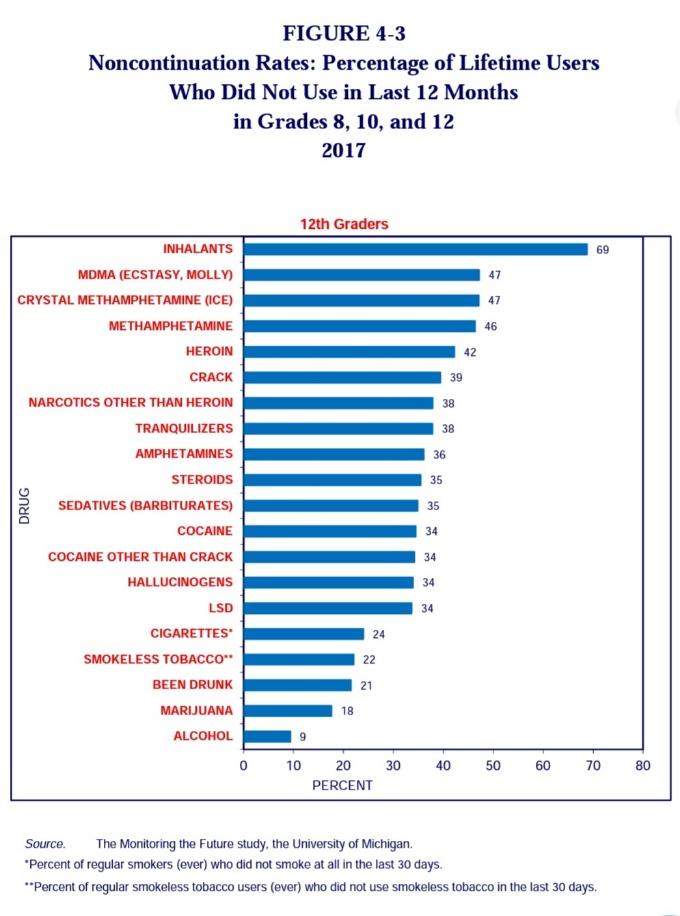
With that in mind, we should review the current status of opioid use among teens relative to other substances.



The table above lists the rates of lifetime prevalence -- defined as the proportion of teens who used a substance at least once – for a broad spectrum of drugs. The prevalence of non heroin opioid use among 12th graders at 6.8% is considerably lower than that for marijuana (45%), cigarettes (27%), nicotine vaping (25%), smokeless tobacco (11%), amphetamines (9.2%), tranquilizers (7.5%), and a 5-drink bender (7.5%). Comparable use was observed for hallucinogens (6.7%). The prevalence rate for Oxycontin and Vicodin -- at 2.7% and 2% respectively – was also lower than that for LSD (5%), MDMA (4.9%), inhalants (4.9%), and sedatives (4.5%). Medically supervised treatment of our vulnerable youth for ADHD by stimulant (e.g., Ritalin) and non-stimulant (e.g., Strattera) agents do not draw the same scrutiny and interference as medically supervised treatment for pain despite a lifetime prevalence rate of 13%.

Even more interesting than use rates are the non-continuation rates defined as the proportion of those who ever tried a drug that did not use it in the 12 months before the survey. This statistic is used as a measure of addictiveness.

As illustrated in the graph below, 38% of 12th graders who tried narcotics other than heroin did not use it within the past 12 months.



A single exposure to many of the substances widely regarded as posing an unacceptably high risk for accidental overdose (e.g., heroin, methamphetamines, crack) did not compel the user to an encore performance within the following year. Regardless of whether this statistic reflects access rather than addictiveness, it takes the sting out of the suppositions driving alarmist policy actions. The substances associated with the greatest probability of near term repeated use are those that do not pose the greatest risk of a single lethal event (e.g., alcohol, tobacco, marijuana).

But perhaps the most reassuring fact was that summarized as follows by the survey architects: ***"It is important to recognize that substantial proportions of students who try the various illicit drugs do not continue use." ( p. 41)***

More recent data from 2019 is even more reassuring. According to the data, neither opioid use disorder (1.6M), prescription pain reliever disorder (1.4M), or heroin disorder (438K) ranked among the greatest threats to the population aged 12 and over, falling well short of use disorders involving alcohol (14.5M), illicit drug (8.3M), and marijuana (4.8M) while being comparable to use disorders involving cocaine (1M) and methamphetamines (1M). Other use disorders include prescription tranquilizer or sedative (681K) and prescription stimulants (558K). (Substance Abuse and Mental Health Services Administration, 2020).  It is also noteworthy that while most of the use disorders remained stable or increased over the past few years, use disorders related to opioids and prescription pain relievers have declined across every age demographic since 2015, from 0.6% (152,000) to 0.3% (or 87,000) among teens aged 12 to 17; from 1.2% (or 427,000) to 0.6% (or 196,000) among adults aged 18 to 25; and from 0.7% (or 1.5 million) in to 0.5% (or 1.1 million) among adults aged 26 or older for prescription pain reliever use disorder.

I have no problem going the extra mile to protect our most vulnerable youth. But shielding our nation’s children is not grounds for separating adults living with chronic pain from their medication. For one thing, I am mystified by the fact no one has suggested separate policies for adults and minors. It’s not as though the legal age for purchasing alcohol and tobacco products are arcane precedents that have to be dredged from beneath layers of dust in old parchment buried beneath the annex of a local Philadelphia library. Secondly, the overwhelming source of exposure to opioids in our youth is through dental extraction of wisdom teeth. This is not a chronic pain situation but one that falls between the acute and post-surgical categories. Oddly enough large scale surveys place the rate of dependency at less than 1% for patients prescribed opioids for acute or post surgical pain. Now if you want to argue that this rate is higher within that particular age demographic, I will stipulate, and the group of oral surgeons who are pioneering an opioid-limiting pain control regimen estimate dependency between 5 and 7%. That still does not sound any alarms in my opinion, but I get it – it’s our children and there may be an organic basis for an increased risk of misuse down the road. But oral surgeons have already taken steps to address these risks. They covered a lot of ground already simply by reducing the quantities of pills prescribed from 50-60 to somewhere between 10 and 18. I think surveys will show that most dentists are reluctant to prescribe opioids at all, electing instead to recommend high dose ibuprofen and acetaminophen. But oral surgeons have also launched what is likely to become a standard practice of intraoperative injections of bupivacaine intended to numb the area of localized pain for 3 days, which would reduce the need for postoperative pain relief. Having said that, the technique is not all that straightforward. Citing reports of failed attempts by peers, the pioneering surgeons acknowledge that extraordinary technical precision is required to sufficiently neutralize the right pockets. Secondly, with a treatment window of 3 days, bupivacaine has never been recommended as an option for millions with chronic pain conditions. So let’s celebrate the gains made by shielding 6% of our most vulnerable youth from the risk of addiction posed by their wisdom teeth, and that may reduce – by 6% -- the number of adverse outcomes a few years downstream. But let us not confuse this population of youth with the many adults – and for that matter children as well – diagnosed with chronic medical conditions and enduring a severe pain that is not expected to resolve in 24-72 hours.

**ACCIDENTAL OVERDOSE: WITHIN LIMITS / ACCEPTABLE LOSS**

We laid waste to concerns about dependency. And we put to bed the myths and misconceptions concerning toxicity. But before we can claim victory and demand the Government restore access to pain medication without prejudice, we must also dispense with the allegation that our nation is drowning in accidental opioid overdoses. At a high level, it would appear that the mortality data lends weight to all the ridiculous talk of a “pandemic within a pandemic.” Unlike the data on dependency and toxicity, the data on death by accidental overdose is far more murky and complicated, and anti-opioid zealots have been able to harness the ambiguity – which I am beginning to think was engineered by design – to support their most alarmist interpretations. Fortunately you have me – a trained researcher, analyst, psychometrician, and social psychologist – as your guide as we dive deep into the numbers.

**THE CDC WONDER DATA: LET’S GO TO THE SOURCE**

If I was interested in knowing whether there was an opioid crisis, I would compare the rate of opioid poisoning with the rate of alcohol poisoning. All these numbers mean nothing intrinsically. Their meaning is derived from comparisons. Some might argue this year's opioid poisoning rate is high because it is higher than the rate for the preceding year. Some might argue it's higher than the number of souls lost during some other well-known tragedy like the Vietnam War. I for one prefer the commensurability and congruence afforded through comparing opioids with another substance -- particularly one that had once survived public prosecution. As a nation we came to terms with alcohol and decided to accept a manageable risk in exchange for the culinary aesthetics and sanguine impact on our mood. For many of us, inasmuch as alcohol had a part to play in some of our most interesting stories, alcohol is an indelible part of our culture. There was a time we couldn't so easily put into words the significance and function of alcohol. So we let ourselves lose it. And that's how we convinced ourselves we couldn't live without it. We are just now experiencing what it means to lose access to our pain medication. And for an unspecified number of us, losing opioids translates into misery. Into loss of livelihood, lifestyle, and in some cases life itself. One cannot undertake an examination of the overdose data without feeling the need to disentangle the deaths caused by opioids from the deaths caused by a denial of opioids.

The anti-drug warriors need opioids to kill a significantly greater number of people than alcohol. And the Guideline authors know it. Meanwhile, members of the chronic pain community need to reinterpret these deaths as the final outcome in a series of cause-effect relationships that begins with a doctor discontinuing treatment to placate DEA officers or pharmacists. It should be evident to readers at this point that we don’t have the information we need to support one interpretation over another. So while I embark on some high-level descriptions of trends and comparisons – this year with that year – this state with that state – you should know that ultimately the data is meaningless as a springboard for health policy action.

One of the things that jumped out at me was the variation across states. When the rate under discussion was rate of prescribing, Guideline authors thought enough of the cross-state variation to suggest physicians don't know enough about these drugs. I'm going to hold them to that. What do you think the cross-state variation suggests when the rate under discussion is rate of opioid \*poisoning\*? The authors might tell you that it means chronic pain patients do not know anymore how to pop opioids as physicians know how to prescribe them. But I think their interpretations of variability are facile and show that they don't know enough about variability both as an abstract mathematical concept and as a social construct that offers a window into our society. I think the variation reflects the impact of a Federal hand. Medical examiners have opioids on the brain when they adjudicate these deaths. Maybe it's just a politically charged culture that increased vigilance. Maybe in some jurisdictions they were given marching orders. Maybe a combination of the two. Who's to say some of these decedents weren't slain once the Fed pushed them into Street drugs by threatening to suspend their doctors' licenses for exceeding limits laid down in the CDC Guidelines?  
  
**ANALYTICS PLAN FOR CDC WONDER DATA**

An accurate diagnosis requires a complete view from all angles. Toward this end, I will separate the statistics for (i) average % increase and (ii) decrease from (iii) a metric for instability based on the addition of these two percentages (i + ii) and (iv) a metric for dominant trend based on a relative proportion (ratio) of increase & decrease. But before I examine the accidental opioid overdose data on its own, I would like to compare the opioid data with the alcohol data. Whether we call it a baseline or reference group, alcohol offers an instructive comparison. Having accepted alcohol as an irrepressible staple of our culture, Americans have tolerated its occasionally destructive impact on health, safety, relationships, and employment. This is important knowing that most substances do not interact well with alcohol, a substance that can be purchased from supermarkets and consumed with regularity.   
  
*Variation 1: Alcohol v. Opioid*  
One argument against an opioid crisis draws from the extraordinary variation among states and over the years. It's difficult to defend the idea of One Problem One Solution when there isn't a common concept of operations on the ground -- what government and military personnel call CONOPS. I believe that even among those of us who accept the existence of an "Opioid Crisis," we are not talking about the same thing.  
  
There are a number of ways to describe this variation. While there are some states for which alcohol claimed more souls consistently across the 1999-2019 timeframe (i.e., AK, CA, CO, ID, IA, MN, MT, NE, NM, ND, OR, SD, & WY), there are other states for which opioids just as consistently claimed more souls (i.e., CT, IL, PA). There are states for which opioids overtook alcohol 1-4 years into the timeframe (KY, LA, MO, NC, OH, TX, TN, VA, & WV). Oklahoma and Nevada could have made that list if not for the fact that alcohol reversed the trend again by claiming more lives in the very last year (2019). But there were also many other states where opioids overtook alcohol eventually, which is to say much further into the timeframe (GA, IN, MA, & MS [2005]; AL, DE, MI, & RI [2006]; AR [2008]; MD [2015], AZ [2017]). A few states show more fluctuations, which is to say there are more than 2 lead changes over the surveillance period (ME, NH, & KS).   
  
But the one pattern that was never observed was one in which opioids claimed more lives early before giving way to alcohol. This is most likely what stands out among those laying claim to an opioid crisis. Still, there can be no claim to a single unitary crisis. To a crisis on a national scale. There are just too many states -- 13 of 50 (26%) -- for which alcohol consistently claimed more lives through the 20 year duration of surveillance. One of these states, Oregon, comes down harder on opioids than any other state.  
  
Now occasionally you come across a mid course deviation that strikes you as suspicious. Massachusetts climbs steadily from 43 opioid poisonings in 1999 to 99 in 2004 before jumping to over 600 the following year. Each year between 2012 and 2016, Massachusetts records cases that represent dramatic increases over the prior year (725, 935, 1190, 1606, & 2100). It smells like someone's knitting a flag up there. And it makes you wonder to what extent a similar force might be influencing data in other states.  
  
*Average % Year-to-Year Change as Measure of Volatility*   
  
A lower % would indicate only small change from prior year (i.e., relative stability). I was interested not only in comparing relative stability across states but also in comparing the relative stability of opioids and alcohol. The ratio of the opioid to alcohol year-to-year changes was then calculated. The average ratio was 1.81 with a standard deviation of 0.69, ranging from lows for HI (0.91), MO (1.14), NV (1.15), MT (1.15), & WA (1.18) where opioids and alcohol exhibited relatively comparable levels of stability to highs for CA (4.35), NY (3.04), OH (2.94), & MD (2.75), where overdose fatalities involving opioìds fluctuated much more wildly (i.e., rose at a much more frenetic pace) than those involving alcohol over the years. Hawaii is the only state for which opioid overdose fatalities are more stable than alcohol overdose fatalities.  
  
The average volatility was 14% with a standard deviation of 6% for rates of opioid poisoning and 9% with a standard deviation of 3% for rates of alcohol poisoning. Opioid fatalities rose at a faster pace and fluctuated more dramatically than alcohol fatalities.  
  
The highest rates of volatility are opioid poisoning rates attached to DC (40%), WV (30%), NJ (25%), & VT (25%). By contrast, the most stable rates for opioid poisoning belonged to WA (7%), TX (8%), & NV / GA (9%).  
  
The relative proportion of opioid and alcohol fatalities was also established for each year for any given state and then averaged. States linked to a disproportionately greater number of opioid fatalities include PA (72%), KY (67%), LA & WV (65%), CT (64%), OH (63%), NJ (62%), & IL (61%). States linked to a disproportionately greater number of alcohol poisonings include MT & MD (70%), NE (69%), WY (68%), OR (67%), IA (66%), AK (64%), ID (63%), & MN (62%).  
  
Another way to characterize change would be to determine the extent to which poisoning cases increased over 20 years by recasting the 2019 rate as a percentage increase over the 1999 rate. This average factor increase in cases of opioid poisoning across 47 states is 7.57 with a standard deviation of 7.26. This is not a standard normal distribution or what they call a bell shaped curve. This is a positively skewed distribution, meaning there are a few states with some extraordinarily high factor increases that are driving up the mean and the standard deviation, most notably MA (47.51), WV (21.94), UT (19.09), MD (15.72), & IN (14.00). Given a comparatively steady trend for alcohol poisoning (1.08, 1.15, 1.28, 0.37, and 1.58 respectively), the numbers suggest a crisis. But are they real? And which reality are they reflecting?  
  
As I mentioned earlier I happen to believe this is a combination of 3 things: (1) waves of socio-economic vicissitudes causing psychosocial instability and a wider substance use problem of which opioids are only one component; (2) the iatrogenic thrusting of chronic pain patients to Street drugs after they were abandoned en masse by physicians threatened by drug enforcement authorities; and (3) increased attention by medical examiners to opioids within this emotionally and politically charged culture of obsession and vigilance.  
  
Alcohol poisonings increase but at a somewhat slower and more variable pace (M = 1.23, SD = 0.61). More specifically, by 2019 the rate of opioid poisonings boasts 6.15 times the increase over 1999 than the rate for alcohol. Only for New Mexico was the 2019 alcohol poisoning rate a more pronounced increase (1.49) over the rate in 1999 than the 2019 opioid poisoning rate (1.47). The fact alcohol increases at all is important in that it lends credence to the first of my three speculative causes for the rise in opioid fatalities. There is clearly an underlying stress that provides a common impetus to all crutches. If you are as inclined as I to treat the rise in alcohol poisoning as a baseline of sorts, then we are obliged to account for the source of the additional boost given to opioid use (i.e., 7.57 v. 1.23). This is where the Guidelines authors step in to tell you it's the overprescribing of addictive substances to addictive personalities -- possibly for a profit and exacerbated by a lack of pharmacology knowledge among physicians. While I believe this explanation had a limited utility for a limited period, I believe those issues have been more than amply defused by policy and enforcement initiatives. The days of dentists trading 60 Percocet for the wisdom teeth of our vulnerable youth are over -- at least systemically. As are the days of pill mill doctors who do not check in periodically to monitor patients, do not make a go at finding a cure, and fail to do diligence with respect to nonpharmacologic and pharmacologic-nonnarcotic alternatives. Guideline authors themselves have commented that it is meaningful to distinguish between three waves within the opioid crisis: the first driven by prescription opioids, the second by heroin, and the third by illicitly manufactured fentanyl. It boggles my mind that they can't take the small additional step to conclude that the second and third waves were brought about when the Fed cracked down on the presumptive cause of the first wave. But I suppose to do so would be to risk being perceived as foisting upon the community of chronic pain patients a strategy similar to that of herd immunity for coronavirus. How do we explain why many of the anti-opioid zealots -- whose paid contributions to the Opioid Prescribing Guidelines were hidden from the public by the CD-- are doubling down on their abstinence message and staying the course as accidental overdoses rise in the face of a severe decline in prescriptions? Herd immunity. The zealots believe the bottom will fall out of the overdose rate once and for all once any and all Americans exposed to prescription painkillers die off. This is happening as patients abandoned by their doctors under pressure from the DEA or from pharmacists similarly pressured resort to the Street or to suicide for relief. The Fed is waking up to the fact it has blood on its hands. The CDC has undertaken an internal review to assess the consequences of its Guidelines. What was found might surprise you. Namely that the CDC uncovered an error in which illicitly manufactured fentanyl had been coded as having a prescribed source. Yeah, oops. The CDC corrected the error by eliminating from the analysis all overdoses involving an ICD-10-coded source of T40.4. The correction dropped the rate of accidental overdose on prescription overdoses – you know, the kind given to granny for her bum hip – 48%. But it still left the CDC unable to determine for over 17,000 overdoses in year 2016 where the substance came from (i.e., Street or doctor). I began to have serious doubts as to whether there ever was an opioid crisis now that the overdose numbers were beginning to scale back in the direction of dependency rates. The error also conjured memories of my days as a contractor supporting HHS, where the staff seemed to suffer from a severe lack of data literacy. Analytics was just never part of the Federal skill set. I would not be surprised at all if the task of analyzing the mortality data was not assigned to a couple of program analysts.

The question then becomes "why would we have an overdose problem in the absence of a dependency problem?" Two thoughts. One concerns data congruence and commensurability. The dependency figures are expressed as percentages. While they are a low enough, the corresponding numbers might be high by virtue of the fact some 50 million people are treated for pain and somewhere between 11 and 23 million are treated with opioids. Four percent of 23 million is still a lot of people. Defenders of opioids, compassionate care, and the chronic pain community rely on the percentages while detractors use the numbers. The other fact of note here is that 30% of death certificates are completed ahead of the tox screens, the death certificate data does not specify type of opioid, and toxicology tests are not equipped to identify the illicitly manufactured fentanyl that is found on the scene, in the possession of the deceased, and in the heroin. This is important in that it calls attention to the fact it may be meaningful to distinguish between four populations that vary as a joint function of the authorized status of user and product: (1) patients legally prescribed GMP manufactured painkillers with reliable ingredients and serving sizes they can trust; (2) recreational users who are able to acquire GMP manufactured painkillers by diversion; (3) patients abandoned by their doctors who resort to illicitly manufactured or counterfeit drugs on the black market; and (4) recreational users who acquire illicitly manufactured or counterfeit drugs on the black market. The dependency rates come exclusively from a survey of Group 1 while the overdose data is heavily skewed by Groups 3 and 4.

*The Executive Summary Table*  
I started with a table of number of unintentional opioid poisonings with states as rows and years as columns. I converted these numbers into percentage increases or decreases over the prior year. I chose this approach because I believed that there is more meaningful information in data that is relational and that % change expresses a relationship between years and also offers a common yardstick with which to compare states that exhibit radically different size numbers simply due to differences in the size of their populations. In addition, I find data that express magnitude and direction of change to be kinetic.  
  
Between 2011 and 2019 there are only 3 instances in which the # of opioid poisonings reaches a better than 40% increase over the prior year, only one of which reaches the 50% increase. This is a period of remarkable stasis. A plateau. But between 2000 and 2010, there are 31 instances. But 2007 and 2008 are not crisis years either, with each having only 1 instance of a greater than 40% increase. There are two periods that stand out for heightened activity: (1) the 3 years between 2000 and 2002 and (2) the 2-year-period spanning 2009 and 2010.  
  
Vermont fluctuates, often following a rise with a drop and a drop with a rise -- failing to establish any trend for very long. But much like the analogy that is often used to describe the stock market over the years, Vermont's rate of opioid poisoning is tantamount to working a yo yo while walking uphill. Eventually the state deals in higher numbers despite all the vacillating.  
  
Oklahoma exhibits similar volatility and drops so often in the latter half of the surveillance period that by 2019 its opioid poisoning rate descends to pre-2007 levels. Is this a state that got a handle on its opioid crisis and, if so, was control regained without driving chronic pain patients into the Street?  
  
The first fact one notes when examining the Executive Summary Table is that by a 3-to-1 margin there are more increases than decreases in opioid poisonings. Over a 20 year period, the average state presents 15 increases and 5 decreases. Statistically speaking, states presenting a higher than average number of yearly increases over the 20 year surveillance period include TN (19), CO (18), IN (18), & PA (18), whereas states presenting a higher than average number of decreases over the same period include OK (10), DC (8), & VT (8). But the relative proportion of increases and decreases over a 20 year period does not offer a complete or even adequate depiction of the public health status of a state. The size of the change is also important. It is conceivable that a state might gain more ground in two years of decreases than was lost in 18 years over which poisonings increased.  
  
For each state, the % increases were averaged for those years an increase was reported. Similarly, the % decreases were averaged for the years a decrease was reported. Thus for each state there is an average % increase and an average % decrease. Across all 47 qualifying states, the average % increase is 15% with a standard deviation of 5%. So when identifying the states with the highest average increases, I restricted myself to those whose average increases were at least one standard deviation above the national average (i.e., at least 20%). These states include DC (29%), VT (26%), MD (26%), WV (24%), NH (21%), OK (20%), NJ (20%), and MA (20%). Across all 47 qualifying states, the average % decrease is 13% with a standard deviation of 11%. States with the highest average decreases include WV (57%), DC (55%), NJ (33%), and OH (29%).  
  
Now I'm sure you noticed that 3 states appear on both lists of highest average increases and decreases. Thus it would be on the basis of incomplete data for someone to depict DC, WV, or NJ as either a runaway train or a model of recovery. Perhaps it would be more accurate to depict these states as hot spots for instability. Maybe these states respond aggressively to reverse trends or maybe their measurement protocols are sensitive to real changes.   
  
Another way to assess volatility / instability is by adding the % increases and % decreases together. The lower numbers identify states with stable conditions, which is to say the absence of abrupt spikes or declines from one year to next. Across all 47 qualifying states, the average level of instability is 28% with a standard deviation of 15%. The most unstable states include DC (84%), WV (80%), NJ (54%), VT (49%), and OH (46%). Only TX (13%) exhibited a level of instability one or more standard deviations below the national average. Other relatively stable states include WA (15%), AZ (15%), GA (15%), & TN (15%). Tennessee's appearance on the list of stable states despite exhibiting 19 increases over the 20 year period tells us that the increases in number of opioid poisonings from year to year are very small. Certainly, there is enough data here to satisfy those on both sides of the debate. Opioid opponents can point to 19 years of increases in 20 while opioid advocates can refer to the negligible size of the trends.  
  
Also important is the relative proportion in the average size of the increases to the average size of the decreases. For each state, I averaged all the % increases and all the % decreases and then looked for states with a greater than 2.0 ratio of one to another, which is to say, states for which the average increase was at least double the average decrease or vice-versa. Take for example the District of Colombia, which registered the highest overall instability rating at 84%. But when we break the 84% down, we see that while the average % increase portion of this total is high (55%), it is not sufficiently high to double the average % decreases (29%)(ratio = 1.86), particularly when you consider it is not significantly higher than the average state (M = 1.72, SD = 0.71). While DC is noteworthy for its overall volatility, it's unclear whether it should be cited as evidence for a dominant course / direction.  
  
While I feel my 2-to-1 threshold approximates a standard for practical significance, I will note those states that meet a higher statistical standard, for which I require a ratio that is at least one standard deviation above (2.44) the national average.  
  
There were no shortage of states exhibiting an unfavorable trend toward increased opioid poisonings: MO (13% v. 3%, 3.98), MI (15% v. 4%, 3.94), MS (13% v. 4%, 3.44), TN (11% v. 4%, 3.03), OK (20% v. 7%, 2.72), MA (20% v. 8%, 2.50) meet the higher statistical standard while WI (13% v. 6%, 2.21), KY (15% v. 7%, 2.09), NC (13% v. 6%, 2.02), and GA (10% v. 5%, 2.01) meet my 2-to-1 standard. Only one state exhibited a significantly favorable trend toward decreased opioid poisonings -- also the only state in the group to present a high overall instability: WV (24% v. 57%, 2.42).  
  
*Year to Year*  
  
Even more interesting than the analysis illuminating the variation between states is the one shedding light on the variation between years.  
  
An average 35 states report an increase in opioid poisonings over the 20 year surveillance period compared to an average 15 states that report a decrease. With respect to number of states, 2006 and 2015 were the most problematic years in which poisonings were reported by 44 and 43 states respectively of the 47 that provided a complete set of data. Years 2017, 2013, and 2011 did not fare much better with 39 states reporting increases, and 38 states reported increases in 2003, 2004, and 2005. That being said, 3 years bucked the trend, with 25 states reporting increases in 2018 and 26 in 2010. The most exceptional year of all, 2012, featured more states reporting decreases (25) than increases (21). Strange how the trends seemed to reverse itself from year to year between 2010 and 2013.  
  
The average year to year increase was 14% (SD = 4%). The five years posting statistically high increases over average were 2000, 2001, 2002, 2003, and 2018. 2012 and 2019 were among the smallest increases. The years linked to the highest number of states reporting decreases were not the years linked to the highest average % decreases. In 2012, 26 states reported an average 8% decrease (against a 10% increase for the other states); in 2018, 25 states reported an average 12% decrease (against an 8% increase for the other states); and in 2012, 21 states reported an average 14% decrease (against a 17% increase). The decreases reported by the unusually high number of states reporting decreases were just not that remarkable.  
  
*Inverse Relationship between Prevalence & Severity*  
  
Despite the fact 33 states reported increases in 2009 compared to only 14 states reporting decreases, the reported decreases across the 14 states (M = 43%) were nearly 4 times greater (3.98) than the increases reported by the 33 states (M = 11%). A smaller but similar effect was observed for 2004 when the decreases reported by 9 states (M = 26%) doubled up the value of the increases (M = 13%) reported by more than 4 times the number of states (38).  
  
The upshot of all this is we cannot presume a relationship between prevalence and severity. In fact, there appears to be a negative correlation between the two. What you never see is a year in which high increases in opioid poisonings are reported by a high number of states or in which a substantial decrease in poisonings is reported by a substantial number of states. The fact 44 states might have reported an increase in poisonings in any given year or that over a 10 year period no less than 38 of 47 states reported an increase does not logically necessitate that the number of poisonings in or across any states is worthy of a crisis designation -- or even notable. In fact the widespread increase in poisonings among 33 states in 2009 concealed the only true -- substantial -- change that year -- a \*reduction\* among 14 states.  
  
It's worth noting that whether the question is a year or a state, when an increase in opioid poisoning appears to register with a degree of statistical significance, it's due to a very low rate of decrease for opioid poisonings (e.g., 13% v 3%; 18% v 5%) rather than for a high rate of increase. But when a \*decrease\* in opioid poisoning registers with a degree of statistical significance, it's due to a high rate of decrease for opioid poisonings (e.g., 57% v 24%). For the year or the state about which we are claiming the decrease is noteworthy (57%), the increase of 24% is -- strangely enough -- higher for that state or year than for those years or states in which the increases were deemed statistically significant (e.g., 13%) when or where the average decreases were very low (3%). In other words, the decisive piece of information on which everything turns is the % decrease, which is far more variable than the relatively steady % increase. Truth be told -- just looked it up -- while the average % increase and the average % decrease is the same across the 20 year surveillance period (14%), the standard deviation for the % decrease (9%) is more than double that for the % increase (4%).  
  
**CRISIS NARRATIVE LIVES OFF UNDERREPORTING OF FATALITY RATE DECLINES**

The takeaway here is that the deceptively most important piece of information in an analysis of accidental overdose data is the one that's most underreported: when, and to what extent, overdoses decline. Overdose junkies -- and I refer here to those of us who are more addicted to the Opioid Crisis than we are to opioids -- zero in on any index or measure showing a rise in fatalities. Because that is the data they need to supply as evidence for their worldview -- evidence on which their careers, promotions, mortgage payments, reputations, jurisdictions, and legacies has a material stake. But such data should be tempered by the years or the states for which declines in fatalities -- and some of these declines are substantial -- are observed.  
  
But to summarize, when we examine the ratio of the average increase for states reporting an increase to an average decrease for states reporting a decrease, we see that the years connected to a relative reduction in opioid poisonings nationwide include 2009 (3.98) and 2004 (2.04), and the years connected to a relative spike in opioid poisonings nationwide include 2016 (3.43), 2014 (2.40), and 2011 (2.31). I suspect this is the most meaningful statement even though other years might have been identified based on other metrics like number of states reporting increases or % increase in number of cases against prior year or against some landmark year -- perhaps year 2000, the year opioid poisonings were at a low, or the year we lost the greatest number of soldiers in Vietnam.

**LIES, DAMN LIES, AND STATISTICS**   
  
According to the CDC website, "In 2015, more than 15,000 people died from overdoses involving prescription opioids."  The Chris Christie-led Commission on Combatting Drug Addiction and the Opioid Crisis released a preliminary report calling on President Donald Trump to declare the issue a national emergency.  Isn't that just what you would expect of a Commission of that name?  The only more glaring example of preordination beyond that fait accompli is the appointment of Christie to lead it.  Christie is not only the most beleaguered of elected officials for whom a ready made demon like drug abuse offers a rare golden opportunity to repair a tarnished reputation, but he swore to avenge a friend who was snatched from this Earth after swallowing a handful of Percocet with a half bottle of vodka.  And just for the record, 17,000 souls are lost every year to a form of farm pollution in which methane and ammonia particulates hidden in fertilizer and animal feces get absorbed into the lungs.    
  
"America is enduring a death toll equal to September 11th every three weeks." - Chris Christie   
  
Not to be outdone, there are researchers who claim to have linked opioid use to cancer, using multiple regression models to assess how well increases in the number of opioid fatalities line up with increases in pancreatic cancers.  And don't cha know it -- a state’s opioid death rate at 4 years prior significantly predicted initial incidence of pancreatic cancer and had a significant effect on the estimated annual change in the rate of pancreatic cancer.  Isn't that a kick in the pants?  And just when you thought we couldn't be more cruel to our chronic pain patients.  Maybe they needed something other than pain, addiction, and the ubiquitous threat of losing their medication to worry about.  Reminds me of all the studies revealing that many of us prescribed opioids for chronic pain are also prescribed antidepressants and benzodiazepines for psychiatric conditions (Melville, 2012).  The idea here is to help defuse those arguing for the necessity of pain relievers by calling them mentally unstable or uniquely unable to tolerate pain.  Right?  They may not have any more pain than you and I.  They just lack the mental toughness to deal with the pain they have.  They are depressives and worriers.  Here's an idea.  Let's give them something more to worry about by taking away their medication.   
  
Before we write off a pain sufferer's most cherished resource and best friend as a carcinogenic, let us consider the following about the research study.   
  
1. Opioid death rate was used as a surrogate for overall opioid use.  Under these circumstances it is impossible to disentangle GMP synthetic opioids prescribed to patients in pain from illicit opioids of unknown and variable purity.  The principal investigators appear to find lumping these users together desirable but I would want to know whether toxic impurities and impact of variable doses on vital organs may have played some role in carcinogenesis.  Even as the number of overdoses rise from one year to the next, the relative contribution to the death rate of these two product classes might change from year to year or state to state.   
  
2.  Dagnabit.  What do you bet if I included any two or three from a million different change agents in the regression model that we might find that hundreds of the oddest things fit that pancreatic cancer trend line?  The principal investigators included only three other substances in the model and found relationships with 2 of them (i.e., alcohol and obesity).    
  
3.  The study results are particularly sensitive to the quality of the source data.  For one thing the database records the year any given pancreatic cancer is diagnosed.  You think we could get a little more precision here?  Secondly, the database records the year in which someone succumbs to an overdose and we use overdose as a proxy for use -- a use that has no known duration.  That means we cannot know how long someone must be using before carcinogenesis is established.  Thirdly, the flaws in medical death certificate reporting are legendary.  Apparently in 30% of cases cause of death is established and documented well before the toxicology results become available.  The absence of uniform guidelines and training for coroners and medical examiners is also considered a source of variation.  It is also highly likely that the increases we see in opioid fatalities is the result of our own Federal handling of the substance ever since we declared it an issue -- and that includes filling the heads of our medical examiners with the opioid hypothesis while they hover over every corpse.  Once the name of an opioid makes it into one (or all) of those 20 fields for contributing factors, even if only on suspicion or pending the outcome of a toxicology screen that will likely not arrive before the certificate is signed, then that decedent becomes part of the statistical argument whether he actually died of morphine toxicity -- or from traumatic injuries after being hit by the Crosstown bus.    
  
4a. The principal investigators are correlating fluctuations in very large groups of people grouped in a national database.  Comparing trends at state and national levels fails to examine -- and yields no insight into -- what is happening with any one of the tens of thousands of individuals who unwittingly donated their data points – their coordinates in two dimensional space – to this research.    
  
"We acknowledge that our study is subject to ecological limitations; association between opioid usage and pancreatic cancer rates in our study is observed at group (states and national) levels and may not be directly extrapolatable to the individual level ... In the absence of longitudinal dataset that reliably register long-term outcomes in opioid users, our observation needs to be further tested in future cohorts where individual-level data on opioid consumption and long-term outcome is available" (Barlass, Deshmukh, Beck, & Bishehsari, 2021).    
  
This is tantamount to saying that they have no way of knowing whether any one in the database developed pancreatic cancer due to opioids.  It's a perfect illustration of what I call actuarial science.  We cannot speak of opioids as causes so we speak of them as risk factors.    
  
4b.  Research findings based on software-enabled analysis of thousands of data points furnished by national databases elevates the risk of an error that is nearly as bad as any public health crisis.  The error of which I speak and on which I will soon elaborate is so misleading and so common that it fills our periodicals and newspapers with a cancer of misconceptions.  It cannot be known in any given case whether this error could be attributed to ignorance or to gamesmanship.  We never had to worry about this error prior to the proliferation of databases and number crunching software, when an ambitious researcher like myself worked hard to find a meager 75 strangers to sit down and fill out a questionnaire.  We never had to worry whether the analyses we use to determine that the differences that emerge in the data we collected are so large as to be significant statistically were in actuality an artifact of how many people we were able to include in our study.  You see, in the age of hospital databases and national registries, the researcher does not need to approach strangers about listening to a sales pitch, filing out consent forms, and then doing whatever was necessary to provide a sample of data.  All that data is already stored.  The work is done.  Tens of thousands of data points are there for the taking.  But this raises a little known pitfall about crunching large data sets.  And the principle reads as follows:  any non-zero difference, no matter how small, becomes statistically significant with a sufficiently large sample size.  When I was working with correlation coefficients on a thesis back in 1992, I noticed that some of the associations approached significance despite being as small as 0.09.  And I was working with a sample of 400.    
  
As researchers we fall into this pattern of laziness where we find desirable this odd combination of a single data point from as many volunteers as the Lord will provide.  Our software can easily crunch that single but long data column and usually with the added seal of statistical significance.  In my opinion, the most illuminating but demanding research involves collecting a broad spectrum of information about each in a relatively small group of volunteers who are not stored in some database.    
  
As researchers, we fall into a pattern of laziness where we collect only as much data as we need to answer a binary yes / no question about a single hypothesis and we do not explore the data we do collect beyond that immediate goal.  More often than not, no more than a single statistical analysis is needed to answer the question, which involves comparing two groups -- usually a group that is administered a treatment with a control group or with a pretreatment baseline.  Two outputs from our analysis will determine whether the difference is sufficiently large to discount the role of chance: (a) the product of the analysis itself which, depending on the analysis we choose might be an analysis of variance (F) (i.e., ratio of variation between sample means to the variation within samples), correlation coefficient (r) (i.e., measure of the strength or straight-line relationship between two variables), odds ratio (OR) (i.e., the odds that an outcome will occur given a particular exposure compared to the odds that an outcome will occur in the absence of that exposure), or the beta coefficient in regression (β) (i.e., degree of change in the outcome variable for every unit of change in the predictor variable).  The second output is a p value that corresponds to the value of the above statistic that signifies the probability of obtaining that value based on chance alone.   
  
In the age before databases, we never had to worry that what we were being told by our computer was not accurate.  When we had a statistically significant outcome, it might be marked by an asterisk or by bold face, but the test statistic would always be followed by a p  < 0.05 or smaller (p < 0.01; p < 0.001).  When we have a non-significant result, the p -- which refers to the probability of obtaining the same result by chance alone over repeated administrations of the research -- would be followed either by an "=" and then some number greater than 0.05 (the conventional threshold for rejecting the null hypothesis) -- p = 0.23 for example -- or followed by an "ns" (non-significant).    
  
But we need to second guess our computer output in an age where our low p value might be an artifact of a large sample size, in which case the statistical significance is both misleading and meaningless.    
  
Analysts need to be more sensitive to the distinction between statistical significance and practical significance.  This is a clear case where statistical significance receives all the attention because study authors are required to report it and because papers reporting that statistical significance has not been attained do not get published.  There is no such requirement for practical significance.    
  
A growing number of researchers who are aware of the issue will privately agree that something should be done about it.  But in all the decades that hypothesis testing has been standard practice, there has been no consciousness raising movement or campaign.   
  
The difference between statistical and practical significance analytically is one between relying solely on the p value or on effect size to determine whether the critical difference (i.e., between groups or from baseline) is large enough to declare significant (i.e., to "reject the null hypothesis").  Where small p values may be artifacts of large sample sizes, the researcher should refrain from rejecting a null hypothesis based on the sign of the coefficient (positive or negative) and the p-value alone and help readers understand the meaning of the observed results within the study context by reporting the magnitude of the effect and the sensitivity of their dependent variable to changes in the independent variable" (Lin, Lucas, & Shmueli, 2013).   
  
We think of errors as being technical.  So in the absence of procedural or computational mistakes, we presume the conclusions as reported are sound.  But we are overlooking a far more virulent problem in conceptual errors.  The monomaniacal focus on p values and statistical significance, especially when they might be artificially inflated by large sample sizes, is one of the two most common errors in the social and behavioral sciences.     
  
*"About half of the recent papers with large samples rely almost exclusively on low p-values and the sign of the coefficient"* (Lin, Lucas, & Shmueli, 2013).   
  
*"In reviewing the literature, we found only a few mentions of the large sample issue and its effect on p-values; we also saw little recognition that the authors’ low p-values might be an artifact of their large sample sizes."* (Mithas and Lucas 2010).  
     
I have personally crossed paths with published research that lays claim to wildly significant differences among groups but when you examine these differences you are shocked by how small they really are (e.g., 36% compared to 31%).  The takeaways here are that (1) science demands more than what we deem adequate for practical decision making and (2) science can be manipulated by those with an agenda and manipulated in ways that cannot be detected because researchers are not required to report raw data or are not forthcoming about their criteria for including or excluding participants.   
  
There is no point here in reviewing the half dozen different ways false reporting of significance can be avoided when the majority of academics and research professionals are not even prepared to admit there is a problem. Much of this ignorance stems dually from the way they are rewarded and the way they are taught.  I devote a section of this Report to the uneven and variable training of the medical examiners from whom the CDC obtains its data.  But that criticism applies doubly to data analysts.   
  
I have enrolled in enough stats courses to appreciate the challenge of teaching one. Statistics. Introduction to Statistics.  Statistics II.  Statistics for the Behavioral Sciences.  Tests & Measurements.  Multivariate Statistics.  Statistics for Advanced Experimental Design.  Quantitative Psychology.  Drawing Inferences.  Exploratory Data Analysis.  Survey Research Methods.  Some were undergraduate courses and some graduate level courses.  Some were designed for those majoring in the field.  Some designed for those majoring in \*my\* field.  Some for a more general audience.  Some of these courses were intended to educate consumers of research while more intensive courses are designed for those aspiring to produce new knowledge.  When I look back, most of the courses were electives, and some were required only because a new school would not transfer credit for a core course taken elsewhere.  So when I look back on the list, I could have gotten through from start line to PhD having taken only 3 of these 10 classes.  If you ask me what I think it will take for me to feel like an expert, I will respond by saying, "a good teacher.  A good textbook."  While I believe they are within the realm of possibility, I have not personally seen them and I wonder whether there is one out there.    
  
Bottom line: I am awestruck by just how variably we data professionals are educated, and by how much the students are entrusted to put it all together for themselves.    
  
a.  There's the theory.  Even Statistics has a theoretical component: abstract mathematical concepts that form the foundation for a comprehensive understanding of how numbers behave.  Those who receive this education stand the best chance of being able to reason autonomously from a holistic and integrative understanding of how all the techniques fit together.    
  
b.  Some instructors will dissect formulae and require students to understand the purpose of each component expression.  This also teaches students how the various analytic techniques are related to one another.  What are we doing exactly when we partition variance?   
  
c.  Some instructors will prepare you to select the most appropriate analytic technique from among those available given the research objective and design and given the properties of the data collected.  This approach helps students understand the role of data in the broader context of the research project.   
  
d.  Some instructors require you to know how to explore, describe, and visualize your raw data as a prerequisite for further analysis.  Many instructors teach that there is a lot of information in the raw data that often goes unnoticed because the analyst proceeds immediately to testing the hypothesis.   
  
Every academic and professional community has its own preferred analytic techniques.  The medical community, which receives probably the most basic exposure to statistics, loves odds ratios, confidence intervals, and Chi-squares.  The behavioral sciences love the analysis-of-variance, t test, and Pearson product moment correlation.  Students seeking PhDs in any social science will have the option of diving more deeply into multivariate techniques and psychometrics, especially those who pursue careers that involve constructing and evaluating question-and-answer instruments to assess personality type and traits, cognitive functioning and aptitude (e.g., intelligence test), or to screen for clinical disorders (e.g,, anxiety, depression, ADHD).    
  
**DATA ILLITERACY: THE REAL EPIDEMIC**   
  
This variability in the quality and focus of statistical training is rather unsettling when you consider how much faith is placed in the reports we read of published research.  I am not trying to frighten you into thinking the organized body of knowledge, which is indisputably filled with contradictory conclusions, is ridden by as many errors as a NYC apartment is by cockroaches.  The error in which analysts fail to anticipate, prevent, detect, or adjust for situations in which statistically significant findings are artifacts of  large, database-enabled samples is so common that I am willing to go "all CDC" on it and label it a hidden "epidemic."  Having said that, errors are not nearly as common as unexplored alternative explanations hidden in unidentified third variables.  The most common source of misconceptions arising from statistically driven research occurs when we conclude that X is the cause of Y due to a covariation between X and Y.  This was the mistake made when researchers concluded that opioids are responsible for stubbornly low workforce participation and other adverse events in the workplace.  The basis for this conclusion: states with the lowest workforce participation rates exhibited the highest rates of opioid prescribing.  Sounds convincing right?  The data is analyzed with unquestionable accuracy.  And what they found was exactly what they expected and possibly even wanted to find.  It's logical and easily remedied by a policy action they were poised to recommend and implement.  But not so fast there, professor.  We have a third variable "Z" hiding behind Y.  And it's hiding behind Y because it is even more correlated with Y than Z.  I'm talking about the relationship between prescriptions for pain medication and ... pain.  Yep, did anyone even consider it might be the pain and not the pain medication that accounted for low workforce participation?  No, you say?  Why not?    
  
Because \*they\* have read some of the same fantastic tales told to reporters by employers who operate production lines in the Midwest.  I recall one such tale that took place in Ohio. The employer painted a picture of a town so overrun by heroin that businesses could not find workers and those that could watched their workers disappear for breaks during which they would leave heaping piles of used needles behind Facilities Management.    
  
Now I understand how this works.  The most sensational stories, which are written up for maximum clarity and impact by career-driven reporters, are the ones that get published, reprinted, and shopped to legislators.  But the employees in this and many other stories like it are on heroin, which is a completely different animal.  The adverse event studies published by manufacturers jibe with what I amassed anecdotally over 7 of my own experiences with prescription painkillers and with what I observed from 5 family members over years of continuous opioid therapy.  Prescription painkillers do not impair judgement, reflexes, or coordination.  They do not degrade consciousness or cause changes in mental status.  They are neither intoxicating, dulling, or sedating.  That is, not unless they are dosed inappropriately, with some other drug, or whilst the doser is sleep deprived.  Quite the contrary, prescription painkillers are known to promote optimism, charity, civility, talkativeness, energy, and productivity.    
  
The bottom line is that due a blend of bias, mathematical illiteracy, and the ignorance we acknowledge and the ignorance we hide behind presumption, we are flawed consumers and producers of knowledge.  If this is what passes for the system through which research findings are created and filtered to the policy makers and the press, I have little faith that we'll get pointed in the right direction.    
  
**HE BLINDED ME WITH SCIENCE: HOW AKLOD, PROP GAMED THE CDC**   
  
Physicians for Responsible Opioid Prescribing (PROP) and other likeminded public interest groups point out the absence of randomized controlled studies of the efficacy of opioid therapy beyond one year of treatment, leading them to recommend that efforts to curtail adverse events – to lower those stubborn overdose figures -- target the pain management system. PROP executive Andrew Kolodny (hereafter “AKLOD") muddies the waters further when his style of writing – his clever suspension of nuance and detail in which he excels when it suits him -- makes the *lack of evidence* (from lack of studies) sound like *evidence* *against*.

I must compliment these scientists for being models of science. Despite setting a commendably high bar – one year – none of these critics attempted any such research themselves, possibly because none of them had any foreknowledge that such research would ever be needed. Throughout all those years opioids were an unquestioned practice, that information was not needed and has not been needed until, according to their own press, an aggressive pharmaceutical company convinced doctors to help them flood the market with Oxycontin. And if in fact we could restore order by simply neutralizing the questionable practices and the effects of said questionable practices, why would we need to put on trial the role of opioid therapy in chronic pain management?

That being said, PROP is accurate when it points out that randomized controlled study of efficacy does not extend as far out as 12 months. The range for studies of opioid therapy is 3 to 16 weeks (Kilby, 2016). Why 52 weeks has acquired household notoriety as the unsatisfied gold standard has not been fleshed out. Why not 26 weeks? How is 6 months not sufficient? Why not 4 months? If we have solid data on patients who have been prescribed opioids for 16 weeks, why not use that? Or is the reason that we have solid data on patients who have been prescribed opioids for 16 weeks? I should think that conclusions drawn about pain tracked for 16 weeks – while not ideal – would be quite valuable. I wonder whether you can read similar comments from oceanographers: “... ocean floor ecosystems limited to a depth of 2 miles, with virtually no excursions into the Mariana Trench.” If we are going to be standard bearers and require 1 year -- why not *seven* years? There is no shortage of patients who have been prescribed opioids over a period as extensive as that.

The only study that examined opioids for more than 3 months was the SPACE Trial (Krebs, 2018), notorious within the chronic pain patient community as the work on which the CDC Core Expert (Opioid) Group relied heavily for evidence that opioids are no more effective than OTC NSAIDs in treatment of chronic pain. The only problem with the study is its use of an inappropriate control group and its inclusion of participants whose only medical conditions (osteoarthritis) was one for which opioids are not typically prescribed. Specifically, participants assigned to the non-opioid group were administered the opioid tramadol. Much like Vicodin, Tramadol had for years acquired a reputation for being a less potent opioid. So less potent that Vicodin had been designated as a Schedule 3 product rather than a Schedule 2. This was rectified by order of Congress in 2014. Clearly the study author Erin Krebs, widely known for her longstanding opposition to opioids, was engaged in some deception when she attempted to pass off Tramadol as an NSAID rather than administering ibuprofen or acetaminophen. On the other hand, it’s quite plausible that Krebs had very good reasons for not administering those NSAIDs for 3 months. But they’re reasons she never would have wanted to disclose: ibuprofen and acetaminophen become toxic to vital organs after a couple weeks. To divulge this would be to acknowledge the reasonableness and necessity of opioids and the fact there are no alternatives to opioids for long term treatment of chronic pain. In any case, pain relief was reported by more non-opioid (54%) than opioid (41%) group participants, which played right into the hands of kindred anti-opioid zealot Roger Chou, who led the CDC Core Expert Group.

I am not sure which came first – the a priori determination based on scholarly criteria that one year represents an important threshold or milestone – or a PROP literature review to identify the point to which research did not extend and then retrospectively draw a line that would prove challenging. If 1 year is the standard and we have no studies that have as yet aspired to this meet this standard, then that puts us 1 year away from the evidence PROP fears.

Opioid therapy beyond year one just hasn't been evaluated as often or as directly as one would wish for a few reasons:

1. The distinction between acute and chronic is a relatively modern articulation. Certainly the importance of such a distinction has never been underscored.
2. There has never been an alternative that could be used safely at effective doses beyond a few weeks. In other words, what else is there?
3. While acute pain is treated as a single unitary construct (i.e., as all one pain regardless of the medical condition at its source), chronic pain is treated as a family of related but distinguishable discomfort, with greater cause to distinguish the longer the pain persists. This is where PROP might demand dozens of specific micro-studies that establish efficacy separately for RSD, fibromyalgia, ankylosing spondylitis, and migraine headaches. The act of raising questions about the lack of research dampens enthusiasm for such research. When the questions are raised by PROP, you better believe it’s designed to. This is not a call for research. This is a call to surrender opioid therapy in the face of an impractical standard.

Opioid sceptics also point out that these empirical studies are dogged by *endogenous selection,* or self-selection bias. This bias, which refers to the fact most research participants are established patients who have chosen opioid therapy, complicates inferences of causation by introducing an indeterminate number and type of hidden third variables. All those policy makers urging restricted access to opioid pain medications like to refer us to a strong correlation indicating states with low rates of workforce participation happen to be the states with high rates of opioid prescribing. But in suggesting opioid medication causes absence from work or cause people to drop out of the workforce, they would be overlooking a plausible alternative explanation: pain itself. Pain medication is prescribed to people in pain. And since pain relievers do not impair judgement, coordination, reflexes, or consciousness, it’s far more likely that the pain – or comorbid health conditions -- is the agent of disruption. For reasons related to ethics and ecological validity, pain and pain medication are not subject to random selection, random assignment, and manipulation. Research participants are selected because they are already in pain and already being treated for pain with opioids.

As much as some of us would like to settle this once and for all in the gladiatorial arena – with the grieving survivors of dead heroin addicts joined by puritans, soccer moms, and temperance groups on one side – and those who turn to the nation’s medical and pharmaceutical resources to help them cope with severe intractable pain on the other – we rely on scientific research to settle these scores. But science is not an entirely objective and independent arbiter. And those on opposite ends of policy issues are continually debating the merits and limitations of published research.

One rate limiting factor that ensures the debate will persist indefinitely is the absence of a “clear consensus on the definition of problematic opioid use and abuse among prescribed patients” which “hampers efforts to estimate how many addicts are created via legitimate medical use” (Kilby, 2016). On the other hand, we cannot quantify how many patients transact in underground markets to assess the causal effect of policy restrictions. The capability to answer each of these questions is vital to either side of the dispute.

Efforts to pin down the rate of problematic opioid use produced estimates ranging from less than 1% to 81% (Vowles et al 2015). Critics of opioids seize on a rate of misuse north of 25%, but deeper dives into the criteria for misuse prompt many to feel the estimate is inflated. For example, misuse includes patients who make executive decisions to increase dose beyond that recommended by the physician. Surveys suggest that the reason cited by the vast majority who misuse their medication in this manner do so not to get high (11.3%) or relieve tension (10%) but to relieve unresolved pain (65.7%)(Substance Abuse and Mental Health Services Administration, 2020). So what does constitute misuse by medical patients? Does any deviation from recommended dose, frequency, or purpose constitute misuse? Should we discriminate between those who titrate up by milligrams using a pill splitter and those who pop another whole pill? Should we differentiate novices from experienced patients who have been prescribed the medication for months or years?

"*For the uninitiated, Andrew Kolodny is a self-appointed opioid regulator. His organization, Physicians for Responsible Opioid Prescribing (PROP), was largely responsible for a disastrous policy implemented by the CDC which ultimately made doctors afraid of prescribing opioids to chronic pain patients who needed them"* (Berezow, 2019).   
  
The claim by that no evidence exists for the effectiveness of opioids in the treatment of chronic pain is a politically motivated calculation. He may be acting like a scientist in deferring to a strict scientific standard but in so doing he strangely reveals a lack of maturity concerning the role of science in social systems broadly and in the public health enterprise specifically. He is suggesting that until his (scientific) demands are met, that medication that has survived a decades' long trial by ordeal -- trial by public use -- be suspended. We're talking here about pharmaceutical resources that have secured a near-century old reputation in patient communities, where those who have used painkillers continue to refer to them as painkillers and where the question “do painkillers kill pain?" is heard about as often as “is water wet?” or “is sugar sweet?” Sugar presents a fortuitous analogy. In response to similar public concerns over the addictiveness of sugar, the food industry has pursued all sorts of alternatives with similar results: products that either fall short on the critical score of sweetness or that end up being linked to even worse health outcomes. Do we feel we advanced the cause of civilization years after introducing margarine or alcohol free beer? And in our efforts to isolate and subtract the addictive properties of prescription painkillers, are we not similarly undermining the Gestalt? The soul or essential nature of the thing? If and when that day comes when we can tweak the pharmacodynamic properties of Percocet so it avoids the receptors that promote a sense of well-being, I will continue to lobby for their necessity for populations that require supportive care for terminal illness or end-of-life because somatic pain is not the only obstacle standing between the person and wholeness. And for many patients opioids address a host of negative symptoms that include malaise, fatigue, stress, anxiety, depression, disappointment, and resentment. Mitigating these symptoms far better than any antidepressant or anxiolytic agent – save those that knock you into a drunken stupor or sleep – opioids lay the groundwork for productive cognitions. I can only speak for myself here, but once I know my end is near, I will be quite active in planning my last months so I can go out on my terms – as myself – make peace or say my peace in bidding goodbye to specific individuals who impacted my life – and checking off a bucket list of to-dos that include producing autobiographical essays or other works I would want to leave behind and for which I want to be known. In all these endeavours, mood and energy are as crucial as hue and brightness are to a painter's last work of art.

In the aforementioned survey of those prescribed painkillers, the most common reason given for misuse was “to relieve pain” (65%). When pain persists over months, patients might find themselves making executive decisions in favor of increasing the dose beyond the one recommended by the prescriber. This act can be interpreted in one of two ways: (a) that opioid therapy becomes ineffective for chronic pain or (b) that opioid therapy remains the only effective therapy for chronic pain with modest, monitored, and manageable titration every few months. Yes, I would personally like to see research confirm what I have observed for so many patients I have known over the years: that as certain as dose increases will be necessary to sustain effective pain relief, these increases do not have to mean elevated health risks -- and the increases level off at a rate similar to that observed by ophthalmologists for vision loss.

But AKLOD is not content with the absence of evidence for chronic pain beyond one year. His war machine is opening a second theater of operations to question the validity of evidence cited by the FDA to authorize use in acute pain cases. Here AKLOD slams the FDA for allowing a separate regulatory pathway for opioids by authorizing manufacturers to test the efficacy of their products through a diminished standard known as enriched enrolment randomized withdrawal (EERW), a process by which only participants who reported in a pilot phase that they tolerated the drug and found it effective were enrolled in the trial and assigned to treatment and control groups.  While this criticism does have merit, it also ignores the fact that for a great many people these products are effective and well tolerated.  Do pain relievers work equally well for all conditions?  No.  And it's quite possible the special regulatory pathway is designed to prevent a situation where all that variability precludes satisfaction of an overly demanding statistical threshold.  It's quite possible that when you lump into a single group pain patients representing dozens of diagnoses, treatment histories, and genetic enzyme-mediated sensitivity to pain and to pain medication, that you will end up with a test statistic that falls just short of what is needed to say "the difference between treatment and control has reached a level where we can be reasonably sure it would not occur by chance alone in 95% of replications."  That's a high standard.  It's also the going rate for proof in science.  You could easily end up in a situation where your finding would not occur by chance alone in only 90% of replications, so you revoke the status of opioids as reasonable and necessary for treatment of chronic pain and in the process deny 70% of the patients who had been prescribed an opioid access to something they swear is their only recourse.  Now we could design separate experimental protocols for each of 10, 20, or 30 different diagnoses, but that's time and money.  And AKLOD would love nothing more than to put everyone's treatment on hold pending favorable outcomes for all these plodding experiments.  The other reason to authorize the separate pathway is that the product in question is not exactly novel or next generation.  Opioids have endured a trial by ordeal for decades.  Their practical significance has already been established.  Dependency aside, which has only recently emerged as an adverse outcome of interest, opioids have been given to millions of patients dating back 60-70 years. And they are known not to be toxic.    
  
So are we content to deny these individuals the resources they might find absolutely essential to quality of life?  Unlike many innovative formulations, opioids -- morphine -- have vindicated themselves over decades of real world use -- a trial by ordeal that is as ingrained in our popular culture -- as known to the populace -- as milk.  And while I agree with PROP that human beings had to do without prescription synthetic opioids for 50,000 years of our civilization, such a statement overlooks more natural precursors and variants adapted from the poppy plant.  Morphine was likely in use before there was a Food and Drug Administration or for that matter before there was a United States.  It is quite presumptuous,  impractical, and elitist for us to assign legal designations for everything we can ingest based on scientific, professional, and institutional requirements. But that's what AKLOD wants.  He is working toward a world in which the FDA revokes authorization for use of prescription pain relievers for chronic pain pending new research that meets his strict scientific standards.  AKLOD is an apostle of science because it serves his political agenda well.  Science is afterall the most difficult mistress to please.  AKLOD has found in science the parent most likely to say "no" to the child.    
  
Now this may come as a surprise to a psychiatrist like AKLOD, but Science has within the culture a certain standing as an important tool and principle – vital to the system – but never the sole or even the supreme criterion. We still don’t know how a CNS stimulant like Ritalin calms and focuses children, but that doesn’t stop us from prescribing it for just that purpose in those with ADHD. In children! This is just one of many examples of medications for which reliable treatment outcomes are observed in the absence of a scientific understanding of the mechanisms of action. Would AKLOD have us cease and desist treatment until the Science catches up and keeps pace?

Science is a tool. A means to an end. And as long as it is conceivably achievable and does not %$\*! up a good thing, an end in itself. A standard. A vision of excellence. But there is a reason training institutions distinguish between scientific and practitioner models. Doctors make clinical decisions all the time based on a body of scientific knowledge that will always remain a work in progress.  We will probably never reach a point of scientific maturity where we can say we know more than we don't.  Where we can cite a scientific study to back up every treatment call.  We work toward certain ideals -- a vision of excellence -- but we also know we have to be pragmatic and redefine the task at hand as one of making the best possible decisions with limited information for the purpose of improving the welfare of the individual in front of us.  AKLOD the psychiatrist profoundly disappoints when he seems to overlook the ubiquity of individual differences in medicine.  His criticisms suggest that he seeks a situation in which all persons respond predictably in the same uniform manner physiologically and psychologically to any dose of any drug.  He also ignores pre-existing variations in the somatic conditions that produce the pain and in the genetically determined enzyme profiles that determine sensitivity to pain and pain medication.  To meet his standard, manufacturers would need their products to vindicate themselves in separate clinical trials for every diagnosis.    
  
Now AKLOD thinks he's being clever in suggesting that what is true for acute pain may not be true for chronic pain due to tolerance. But we all know tolerance can be thwarted and the pain relieving benefits restored simply by increasing the dose -- even slightly.  I know many people who have been dealing with pain for over 10 years. Some started on 5 mg oxycodone and now take 12 mg hydromorphone, which is the equivalent of 30 mg oxycodone. Throughout the 10 year period of treatment, relief was always achieved. The patient is and always has been happy to have this resource and it is often the only modality -- or maybe one of two modalities -- that has restored quality of life and capacity to function and, ***as dependent as these people are on the pain medication, they are that much less dependent on family and co-workers to assume responsibility for chores. That much less dependent on sleep to escape the pain and remove them from life.  Opioid based pain medication gives as much if not more independence than it takes***.   
  
Now AKLOD would dismiss these statements as anecdotal, but life is not lived in a laboratory.  It is for this reason that patients denied their prescription medication will experiment with herbs like kratom, combinations of OTC drugs that become insidiously toxic to vital organs in a matter of weeks, or seek counterfeit or diverted opioids on the black market, where there is even greater risk and uncertainty.  In order to neutralize mounting popularity for the argument that an increase in overdoses due to illicit fentanyl were caused by separating patients from their prescription medication, AKLOD marries up trend lines in the CDC WONDER Data to establish that illicit fentanyl was being consumed even before prescription painkiller deaths subsided.  But there are problems with his argument.  First, public confidence in the death certificate data that sources the CDC WONDER database has diminished, owing to the kind of rampant error, variation, and bias that has been documented by NIH and that make comparisons across states and across years untenable. Secondly, he overlooks a plausible scenario in which patients might begin exploring the Street even as they continue to access their preferred drugs by prescription.  A great many of the 71% who lost medication had a great deal of advanced notice -- if not from the prescribing physician than from what they read in the newspapers or on social media -- that a change was imminent and that the eventual change was not a complete revocation but rather a reduction.  So they may have turned to the Street to supplement a 25 - 50% loss in monthly morphine units.  But I don't expect a nuanced vision from AKLOD who demands simplicity from a world that is so much more murky and complicated.

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| **For the life of me, I cannot figure out why we put this man [Kolodny] on a pedestal. He's a house of cards. He was a friend of CDC Director Tom Frieden. His friendship is rumored to have facilitated his placement on the Prescribing Guidelines Work Group. Then due his work on this group – all of which took place behind closed doors – he became a popular choice for expert witness in these trials against opioid manufacturers, for which he earned $500,000 at a rate of $750 per hour. Now due to his role as expert witness -- during which he became a household name within the industry – the Anthony Fauci of Opioids – he will easily secure external sources of funding for research and a fast track to publication. But once you identify his load bearing premises, you realize his argument is riddled with fallacies, heuristics, and conspiracies. He's risen on emotion, authority, and association. The substance isn’t there.** |

There are methods we can use other than published experimental research to address urgent public health questions.  You cannot let people like AKLOD shame you into thinking that other approaches fall prohibitively short on ethical grounds.  The scientific standard is unfair in more ways than one.  There is a reason disciplines distinguish between scientist and practitioner when they classify models of training.  We all agree doctors should treat patients individually on a case by case basis and in so doing each patient is treated as a variation of a rule -- a principle -- established in science.  In some cases, the variation is so great that you could even speak of exceptions to the rule.  These rules are expected to change under various conditions. Science is not so comprehensive as to have a research project that addressed every potential principle under every conceivable condition. It is in an environment complicated by conditional rules, patient variation, and the unfinished business of science that doctors make clinical decisions.  Rather than rely on published experimental research in all cases, clinical decisions may also be guided or informed by an analysis of archival data available in hospital databases, by various data sources available from the individual patient (e.g., symptoms, histories, labs & scans) to whom the decisions are being applied, and by the knowledge the individual clinician gained over a professional history of having treated related but distinguishable patients.  AKLOD is demanding that the doctor and the patient -- and for that matter the wisdom culled from the aggregate body of physicians and/or patients -- be removed from the process of clinical decision making.  He demands a one-size-fits-all rule established once-and-for-all by the scientific community. The CDC Guidelines reflect this absurdity.  Additionally, he wants the FDA to take a broad spectrum of valued and venerable resources off the table entirely and before science could provide any substitutes that approximate the effectiveness of opioids while significantly reducing the risk of dependency.  He has goaded a growing number of hospitals into using their surgical patients as guinea pigs by experimenting with opioid-free surgeries and pinning hopes on acetaminophen or a numbing agent known as Exparel.  This drug is expensive, adding $250 to the cost of wisdom teeth extractions and is with the exception of Aetna not covered by insurance.  The successes reported by one dental practice overly concerned with reducing a 5 - 7% rate of dependency appear contingent on a set of procedures so exacting -- technical precision, multiple injection times and sites, and concurrent therapies -- as to strain replicability.  And the dentists were quick to seize on colleagues who struggled to replicate their outcomes. And then there is a growing body of unfavorable outcomes.

In a civil complaint against publisher American Society of Anesthesiologists and 12 study collaborators, Pacira Biosciences Inc. alleges significant harm to its brand, including loss of customer contracts and removal of product from hospital formularies, stemming from three studies published in the February 2021 issue of Anesthesiology that present false and misleading statements against their pain medication drug Exparel.  The move unfolds against the backdrop of a dispute on the direction of public health policy regarding the role of opioids in pain management and the need to explore alternative treatments (e.g., Exparel). As the War escalates, both those sympathetic and those antagonistic to opioids rely on Science and on the Courts to inflict wounds and secure mission critical territory.  In addition to alleging that criticism of Exparel was the central theme of an entire issue, Pacira points to an accompanying webinar and even raises, in the absence of evidence, the specter of direct opioid industry involvement in the commissioning of the unflattering research.    
  
Pacira scientists report having replicated the offending meta-analyses using the protocols of the original authors but correcting for their significant errors, and report that the corrected outcomes reveal an average reduction in pain of 1.77 points favorable for patients treated with Exparel over those who were not.  While I am inclined to agree with Pacira's criticisms of the original meta-analyses, I do not think the corrected outcomes constitute a winning case for Exparel as an opioid alternative.  While Andrew Kolodny would demand that the pain management community cease and desist opioid therapy and wait for Science, he seems amenable to how hospitals have used Exparel as an impetus to abandon established anesthesiology practices with immediate suspension of opioids both during surgery and for 3 days postoperatively -- a move that essentially makes guinea pigs of those undergoing invasive procedures.  As regulatory pathways go, I would call this one less stringent.  What sayeth thee now, Andrew?   
  
Assuming Pacira's corrections are sound, the 1.77 difference in pain levels at best strains practical significance.  1.77 is an average with a 95% confidence interval of 0.71 to 2.86, which in and of itself is not substantial when you consider that the control group providing the basis for comparison is the absence of Exparel rather than opioid analgesics.  When you consider that the authors acknowledged significant heterogeneity, you realize that the outcomes are distributed in such a way that many of these poor guinea pigs receiving Exparel are experiencing a reduction in pain of 0.71 points or less.  I don't know any patients scheduled for surgery who would prefer to roll the dice on where they fall on the 0.71 - 2.86 spectrum -- and some will experience less pain relief than that -- when they could feel reasonably assured that the traditional equal opportunity pain reliever -- an opioid -- will render pain a non-issue.    
  
Even as they acknowledged the alleged flaws in the original research may have been due to a simple lack of expertise in the highly specialized field of meta analysis, Pacira wanted to put in the heads of the Court the specter of interference by opioid manufacturers.  Like Kolodny himself, Pacira executives want us to believe dissenting facts and views are provided by corporate shills.  Such an allegation appears unbecoming of professionals in the absence of direct evidence.  Even where evidence has been established, this does not automatically constitute malfeasance or some breach of professional ethics. Even without business at stake, academic research is inherently adversarial and science has always been used as both the arena and weapon for competing ideas.  The motives of any researcher are highly variable and fair game for speculation.  I wish I could say all scientists are driven exclusively by scholarly motives but the fact of the matter is that there is much that rides on a significant scientific finding: publication, reputation, jobs, tenure, a sense of validation for one's personal worldview, and in the case of someone like Kolodny,  Federal grants and paid gigs as an expert witness.  To allege a pay-for-outcome arrangement with an opioid manufacturer shows a lack of insight into the complex motivation of one's peers.    
  
Among  these motivations is the simple fact that contrary to how it is perceived by the scientifically illiterate naive public, science is not one monolithic set of procedures.  Across the academic disciplines in which a researcher may have been trained, there is tremendous variability in how research is designed and data analyzed.  There is no equivalent of a United Nations to unify all activities under a common set of rules or best practices.  Even within a field it is commonplace for  academics -- even those researching the same issue -- to question one another's choice of method or analysis.

*"Patients who received interscalene brachial plexus block plus soft tissue infiltration with Exparel when undergoing primary shoulder arthroplasty used significantly more narcotics postoperatively and had no significant reduction in pain scores in the early postoperative period compared with patients who received interscalene brachial plexus block alone ... There is no value in adding liposomal bupivacaine injection during surgery"* (Namdari et al., 2018).   
  
If you want to know if opioid based pain medication is effective, you only need to gauge demand and utilization.  If a pain sufferer continues to use it or want it then it must be effective.  AKLOD can get cute by claiming that the benefits are not true pain relieving benefits but euphoria -- that these patients are high but in pain -- happy in spite of hurting -- and he might even claim that these patients might not even be able to achieve euphoria but continue to take the medication anyway because the addictive properties of the drugs compel it even in the absence of any appreciable benefit whatsoever.  But I see patients who are able to function on the drug and unable to function without it.  Functional capacity assessment questionnaires like those used by attorneys handling appeals for those whose claims for medical disability benefits were turned down on initial application would be an appropriate procedure moving forward. These questionnaires are completed by physicians familiar with the physical limitations of patients saddled by these neurological or musculoskeletal conditions. I would hang with that as a working standard for determining whether patients should be authorized to receive opioid medication.

I do not believe AKLOD would be so pragmatic however. And since a growing number of doctors and patients are made to feel dependent on his personal approval where pain relievers are concerned, I would want to plumb the depths of his grisly psyche for the motives behind his crusade. AKLOD has suggested that the sudden inability to function is attributable to withdrawal and not to the revocation of any pain relieving properties.  Not only does he discount all those patients -- who are in ample supply thanks to his Guidelines -- who have been deprived of their medication for so long that they exhausted the window of withdrawal, but he also seems to have forgotten that there is a pain rooted in a medical condition that has nothing to do with withdrawal.  In so doing he also strays too far from pragmatism -- from the realm of practical considerations -- and into a scientific exercise that presents a prohibitive challenge so great he might as well be demanding that we solve the mind-body problem or the problem of gravity.  How does he propose designing an experiment that is capable of disentangling all his alternative explanations so we can actually verify that painkillers improve functionality by relieving pain?  The subjective reports of the pain patients participating in the experiment would not be reliable or trustworthy by AKLOD standards.  AKLOD has placed the true arbiters -- the required mechanisms of action -- beyond the reach of mere introspection.  And that means he will settle for nothing less than biochemistry.  Here he hopes to capitalize on a misalignment between timelines for public policy and tectonic / glacial science.  He demands scientific guidance for urgent policy action.  And that rigs the game so that there can be only one public policy on opioids.   
  
*Other Rate-Limiting Factors*   
  
The distinction between acute and chronic is a false dichotomy. We can talk about then and now but it's always now. The pain is always acute in the sense that it is always present. The pain chronic pain patients endure is the same pain they endured when the pain was acute.  And you would use the same formulation every time.  The reason why there is so little evidence for the efficacy of opioids in treating chronic pain is that we were not always this keenly alert to these distinctions and semantics and those that were might have assumed that the only difference between efficacy at the acute and chronic levels is a dose elevated by tolerance.  We began requiring a special evidence for chronic pain once we became obsessed with dependency, the risk for which increases with the persistence of the pain over a period that eventually outlasts the acute designation.   
  
If the opioid was effective over the first week, it will be effective 6 months later.  The pain might worsen if the underlying condition deteriorates.  But assuming a stable condition, the only thing that might change is how much of the opioid you need to attain the same relief (due to tolerance).  Now if AKLOD wants to argue that pain is not pain -- that it is not a single unitary construct -- that it varies as a function of etiology -- of diagnosis -- then how could he possibly support a one-size-fits-all limit on milligrams dosed or dispensed?   
  
But for the same patient whose pain is produced by the same condition, the pain is the same.   
  
AKLOD shows his true colors when he dismisses such testimony as the secretion of brain cells under the influence of the drug.  When you hear AKLOD speak, it's clear he does not treat members of the chronic pain community as mature, intelligent adults.  He treats chronic pain patients as people who cannot be trusted to provide objective and accurate accounts of what is going on in their own lives because it is the drug that is talking.  He has used the phrase “pawns of the opioid industry" to describe pain patients, depicting them as hapless victims and contested turf. He treats them like pod people or Helsinki syndrome cases -- hostages who were brainwashed in captivity and who have come to identify with their captors.  Addictive personalities invaded and exploited by addictive substances must relinquish sovereignty to outside authorities who know best, namely him.  On what is happening in the minds and bodies of patients, he knows better than they do.  And that's when he is being kind to these patients.  When he's in a foul mood, he's suggesting that these people are engaged in a dishonest scheme to get "high."  The suggestion here is that opioids somehow maintain their euphoric effects months after they have lost their painkilling properties.   
  
*”A conversation that is not worth having is one in which facts are replaced by destructive myths, such as the erroneous beliefs that the opioid crisis is the fault of irresponsible doctors, greedy pharmaceutical companies, or addicted pain patients. Yet “advocates” like Andrew Kolodny are doing just that and getting filthy rich in the process”* (Berezow, 2019).

**NARX STRATIFICATION: AN OBJECT LESSON IN INTERNMENT**

During World War II, senior German officials kidnapped 11 million citizens deemed undesirable – gypsies, Jews, criminals, and homosexuals – and shipped them in boxcars to their deaths at one of several work camps. They were deemed undesirable because they posed problems for the nation economically but mostly because they did not fit a preconceived image of what was considered the ideal or model Teuton. The second world war was an extension of the first and that war was spurred by tensions between races and religious ideology.

On a smaller but still significant scale, the same chemicals that sparked 30 years of world war are at play in the Opioid Crisis. Once heroin addiction was scapegoated as the source of all the nation's ills – and the public made to feel that there wasn’t a citizen alive who was not adversely affected in some way by an issue caused by drug abuse – alliances formed around common enemies. While patients linked to prescription painkillers were not responsible for heroin overdoses, the public began to believe that the problem of drug abuse and addiction could disappear if this pharmaceutical-needy minority was neutralized in some way. Oh and somewhere along the way, the public was convinced that these patients were in fact responsible for heroin overdoses and by extension everything that ailed our nation.

Now this is pure speculation on my part, but it stands to reason that once American citizens began complaining about Soviet style violations of their most sacrosanct entitlements (i.e., HIPAA and the Hippocratic Oath; the relationship between doctor and patient and the physician's discretionary authority to formulate treatment plans in accordance with his wits; the patient’s Constitutional right to pursue a life free of pain), the DEA decided it needed to appear less arbitrary in pursuing its political objectives. Heretofore senior U.S. leaders and stakeholders across the mission space rallied around a 30% annual reduction in prescribed morphine units, a quota set by the Executive Branch. From the cowboy style in which the DEA pursued this objective, it was apparent that no one cared where the reductions came from. Whether it was quantities or doses. Whether scripts were reduced or rescinded. Whether they were taken from patients in the least or most amount of pain. Whether they were stopped by the usual prescriber or later by the pharmacist.

The DEA must have decided that it needed more of a rhyme or reason to its interventions – a method to the madness. Enter the NARXCheck. Suddenly doctors are informing patients that after a phone call from the DEA or the pharmacist – it’s suddenly clear they need to work on bringing down their “NARX Score.” It was at this time millions of chronic pain patients around the country learned of a 3 digit Scarlett number that would be following them around for life like a credit score.

The name of this number is the NarxScore. I cannot think of a more prejudicial and pejorative label than the one that borrows from the word "narcotic." So let's talk about the N word, shall we? Afterall, I have no doubt it conjures in your mind as well as mine memories of identifying patches Jews, homosexuals, and other expatriated groups were forced to wear in World War II era Germany by another ambitious police force. It's hard to satirize meddling-to-malicious actors wearing shiny boots and demanding we goosestep in line to what they decree as maximum limits on painkillers. History is replete with examples of imperial agents who enter our lives as strangers, taking from us what we know we need to meet a certain standard for living, all the while telling us that it is in our best interests that they do so and that we will thank them later.

On a scale from 000 to 999 the multivariate composite index measures the patient’s risk of accidental overdose based on a proprietary algorithm. The principals act as if the score is determined exclusively by the milligrams of narcotics, sedatives, and stimulants that act on the central nervous system but in actuality this is only 50% of the score. The other 50% is determined by what the architects call “red flags,” which include the number of prescribing physicians and the number of participating pharmacies. When a composite blends together so many unrelated variables, the enterprise resembles less science and more an exercise in reading tea leaves or in insurance underwriting. And it is yet another example of how the influence of regulatory drivers contaminate the science with actuarial motives.

The assignment of Americans treated for chronic pain to various camps is based on the data that could be found in the PDMP. Dependence on the PDMP, the data repository for which Federal authorities fought hard and in which they invested millions, is skewing our perception of reality. If you want to know whether accidental opioid overdoses have reached a level worthy of an emergency declaration ... if you want to measure it and track its movement over time ... if you want to surgically delimit the scope of the problem, the NARXScore is not how you do it. If it's immediate and underlying causes you're seeking -- predisposing, precipitating, and maintaining factors -- you have to step outside the PDMP.   
I am reminded of the hospital cancer registry where certified tumor registrars create profiles of cancer patients called abstracts and at designated intervals deliver to the American College of Surgeons and to the State incidence and prevalence data in fulfillment of requirements for accreditation. This research enterprise has a purely regulatory (rather than scientific or clinical) driver, and the data maintained is purely actuarial. And yet occasionally a medical oncologist will wander into the registry with a question no CTR could answer with the data stored in its data repository (ERS).

It's unfortunate that anyone would exploit PDMP data for any purpose whatsoever let alone one that aspires to manage the monthly morphine allowances granted to patients in severe pain by their doctors. The data in this system is personal. And while deidentified and aggregate data is used to construct and validate the NARXCheck stratification system, it cannot be overlooked that the purpose of this system is the assignment of risk levels to individual patients based on their personal data and with the aim to evaluate, adjudicate, and if necessary modify their treatment. This is an unapologetic, shameless encroachment into the relationship between doctor and patient to violate the right of the patient to assume a manageable level of risk in exchange for some quality of life.

As a social scientist and trained psychometrician, I count chronic pain patients among his inner circle of friends and family. Their lives were threatened by highly uncomfortable medical conditions but not ruined. No. At least not until federal law officers, legislators, and pharmacists -- the Central or Axis Powers -- decided how much medication is too much -- and threatened family doctors. One of my close associates disclosed a NARXScore of 888. While the score has only been around about 2 years, the patient has survived without incident the same scripts that currently earned him his 888. Isn’t that interesting? I mean, he's visual proof of that. Ten years. I tell you what – let’s come back to that.

Anyway, he wonders what his score might have been if determined exclusively by morphine units. He cannot help but wonder just to what extent his score is elevated meaninglessly by the fact he has had to utilize a number of Walgreens pharmacies due to issues of stock. Opioids cannot be split or transferred so back when hard copy scripts were issued, the patient hopped from one Walgreens to another to determine which of the 8 pharmacies in a 13 mile radius could fill it immediately. Research lumps this behavior in with the criminal pharmacy shopping, most notoriously perpetrated by celebrities or members of the affluent class, who fill scripts from different doctors at different pharmacy chains. These tactics preceded the PDMP. Now that pharmacists and physicians are required to look up the patient in the PDMP before writing and filling any scripts, no one can use a little hard work to slip through loopholes. The combination of surveillance database systems, network interoperability, and analytics have put us all under the same blinding floodlight. If there is a lesson to be learned from this sociologically, it’s that senior Government leaders can no longer tell the electorate any plan is too big or too ambitious to implement. If we can put a man on the moon or spy on a patient’s medical appointments, we can do anything.

From these three variables the architects of the NARXScore create quite a hotdog of a composite index intended to disperse chronic pain patients along a distribution artfully gerrymandered for maximum variability. Not unlike how Princeton-based Educational Testing Service (ETS) constructed a nationally standardized examination of high school vocabulary, reading comprehension, and math called The Scholastic Aptitude Test (SAT) to help university admissions departments choose between thousands of applicants with excellent GPAs. You remember the SAT? Did you know that the difference between a score of 760 and a score of 670 is just 1 correct answer? ETS is candid about the limitations of their tests, understanding that the most predictive of its GRE scales -- Verbal -- accounts for only 16% of the variance in how well students perform in a graduate program. But admissions committees, whose members are not among the most esteemed denizens intellectually of the campus, cling to cherished illusions about these standardized tests. And why not? It makes their jobs a whole lot easier. Lends their work a modicum of prestige -- a sheen of rigor. It's all cosmetic of course.   
  
Rather than randomly selecting 16000 patients from the PDMP, our NARXScore architects started with 1600 decedents and then randomly selected 100 matching cohorts for each decedent. (The seminal paper does not specify that the 1600 for which records were "isolated" were randomly selected. That's suspicious). In so doing the architects ensured that they were stocking the pond with 100 times more living than dead fish. But why fix these numbers? One possible reason is to avoid an outcome in which we bystanders to this politicometric boondoggle cannot help but notice how uncommon these accidental overdoses really are. Fix it beforehand so we don't see it happen naturally.  
  
Now I realize their purpose is to assess whether it is valid to distinguish between their 10 risk stratification levels by looking to see how the deaths are distributed among them. At each level the number living is divided by the number deceased to create odds ratios. All the odds ratios are statistically significant and they are only significant because they are all being compared with a reference group / baseline (000 - 099) that receives little to no medication for presumably conditions lacking in pain or mortality risk. If you look closely enough you will notice the string of wildly significant p values throughout the matrix is dictated by one cell -- the 000 - 099 living cell -- and the disproportionately large number -- 71,000 -- that it holds. This cell alone accounts for 42% of the sample. I think it's an unfair baseline and that what we're seeing here are floor/ ceiling effects. Due to the constraints of these effects and due to the non-random predetermination of the sample's ratio of living to dead, the odds ratios offer no insight into the risk of accidental overdose for those prescribed morphine. Now admittedly that is not the study's purpose. But it should be. A more scientifically motivated researcher would have known it was possible given what is in the PDMP to correlate variables like minimum, maximum, average, or % increase morphine units with days survival. But no one to my knowledge has exploited that opportunity. We don't want to know people use years of opioid therapy to push past the challenge of survivability and carve out sustainably happy and high functioning lives. My gut instincts tell me based on the choices made by the NARXScore architects that while there is in fact tragic stories to tell, they won't be told in or through the PMDP. That the preponderance of overdoses occur after treatment is discontinued, which is increasingly due to the precipitous and prejudicial contamination of medical judgment by cultural forces, thrusting patients into Street drugs, suicide, or highly precarious methadone.   
  
The choice of 000-099 for baseline comparison belies the modus operandi of the entire health care system. When we provide health care to anyone who shows up in an ER, our treatment is indicated or governed by the illness or disease rather than some ideal or optimum portrait. And we don't withhold treatment on the grounds healthy people don't need it.   
  
I would have used as a baseline the 100 you get from dividing the total number of living across all levels from the total number of dead. This is the preset rate for everyone in the sample. When you use that, you see that groups 000-099 (0.11) and 100-199 (0.89) outperform the group as a whole. The risk linked to the sample on the whole is 90 times greater than that of 000-099. This for me explains why 000-099 is such a bad baseline. Through 499, the increased risk is negligible:  
  
200 - 299 1.13  
300 - 399 1.11  
400 - 499 1.82  
  
Even though the risk does rise as high as 11.31 times as great for 800-899 and 18.76 times as great for 900-999, it's clear that this is far less severe than the 100 times depicted in the original analysis. We should also bear in mind that the risk applies to a considerably smaller group of patients, with the 800-899 and 900-999 groups accounting for 19.8 and 1.1% of the sample respectively.  
  
Of the 1600 decedents in the study, only 3 scored in the 900-999 range, a fact which is just as meaningful to me as the odds ratio linked to this group. There were 16 living patients in this range. The 16 of the 19 who lived in spite of the > 900 "Scarlet Number" must have been doing something right. Something that minimized risk. But the seminal researchers are not interested or inclined to include such habits as possible predictors in building their composite index. Only the red flags are included. A purely red flag approach will paint the medication utilizer in the most negative light and affirm nothing. Why is it that data collected for research spurred by \*regulatory\* (rather than clinical or purely scientific) drivers tends to be so actuarial? Duly diligent or scholarly research objectively aimed at penetrating etiology will include variables that go beyond the demographic into the clinical or behavioral.

So the kneejerk response to an excessive number of accidental opioid overdoses is a forced reduction in the number of opioids – quantity and dose of opioids – available to the population. Cut off the supply lines. Obviously it’s more difficult and more dangerous to cut off the supply of illicitly manufactured product to the Street than it is to cut off the supply of Vicodin from your grandmother's chiropodist. When we deal with the supply of regulated products through the legal pathways – a manufacturer like Purdue Pharma to a distributor like McKesson to a retail pharmacy chain like Walgreens – ordered by a physician like a neurologist and paid for by an insurance carrier like BCBS – we are dealing with product that can be monitored and measured down to the very last pill. We are dealing with known or knowable quantities. And that makes the pharmaceutical supply chain an attractive target for Federal regulators because around such a supply chain they can develop measurable goals through a system of detection and surveillance they call the Prescription Drug Monitoring Database. And they can develop a set of rules through algorithms like the NARXScore. Like the limits on MME units set by the CDC Opioid Prescribing Guidelines of 2016. Like the most current rankings of physicians within any given region or specialty based on average or total MME prescribed to an average patient NARXScore. And these algorithms tell the doctors and the DEA which patients should not receive any new prescriptions without giving something up. Or which doctors should not accept any new pain patients until they can drop one off the books. It's a closed system – a closed and controlled morphine economy. The DEA can estimate how much morphine is in the system at any time and can decide to impose on manufacturers new limits on how much new product they can roll off the assembly line – or how much of any product any given Walgreens can keep in its safe. Pharmacists have confided that severe DEA restrictions can pose challenges to filling certain scripts. A customer presents a new script for 10 ounces of Tussionex cough syrup. If the DEA allows a maximum of 12 ounces in the store at any given time, then it’s unlikely the pharmacy will be able to service a customer who in the next week presents a script for 90 ml. Restrictive limits on pharmacy stock will inevitably result in behavior that authorities violently characterize as “pharmacy shopping.” The proprietary algorithm that determines the NARXScore composite index includes *number of pharmacies* as a red flag. How can we know such things and not diagnose our public health and judicial systems with psychosis? The granularity with which the Government demands access to -- and control of – the lives of its individual citizens and the licenses of its physicians – it’s unhealthy. Given the absence of an exit strategy and the absence of stratified codes like NORAD’s Defcon system for nuclear readiness or DHS’s colors for levels of risk, we have to assume our Government expects us to live in a permanent state of emergency when it comes to our controlled prescription drugs.

The real danger in the NARXScore is that is forces physicians to take responsibility for the medications prescribed by other doctors across the patient’s care network – and to envision a nightmarish scenario in which they are interrogated on the witness stand: **“How can you continue to prescribe Xanax to a patient with an 800 NARX Score. You must have seen that she is also taking hydromorphone and Ambien.”**

Like many of the entrepreneurial products and services offered by actors seeking fame or fortune from the Government’s Opioid Trough, NARX Check owns “stock” – so to speak – in the Opioid Crisis. And we add this company to the list of those beautiful feral beasts that emerge from the wilderness and lope their way to a Federal watering hole. There is a K Street consulting firm with the word Democracy in its title that analyses Google keyword searches on opioid related terms before targeting the searchers with customized ads for the nearest rehabilitation center. There are two researchers in North Carolina who hope their method of screening raw sewage from individual households for opioids can become the basis for a business relationship with public health or police departments. As we speak there are at least a few people I have met who are hoping their first-of-its-kind “pill locker” will become CMS mandatory acquisition for everyone prescribed pain medication such that you cannot fill a script for an opioid without first filling a script for “Pill Safe.’

You will hear the agents of the DEA and members of the PMP Advisory Panel threaten to suspend physician licenses if the physician does not accede to involuntary reductions in the patient’s prescriptions. It happened yesterday to someone about whom I care deeply. Her physician told her “I have been taking all sorts of heat for this.” He made it sound as if representatives of various enforcement agencies had expressed that they needed him to reduce her monthly allowance of three different medications. These communications may have been issued with ascending levels of urgency, beginning perhaps with the kind of innuendo that left the provider muttering under his breath upon hanging up the phone, “did he just suggest I make changes to my patient’s treatment plan?” Then, having seen her name appear in the PDMP’s monthly exception list – however that’s done – one DEA agent notices a previous warning from the other agent went unheard – a more direct message is issued in a follow-up phone call – something to the effect of “we ‘re going to need you to reduce her monthly Dilaudid and start tapering her off Xanax.” Then when the physician failed to respond to that message with the kind of definitive and expeditious action favorable to the agency, comrade doctor was – how you say in Russian – oh yes – [Russian accent] given an offer he could not refuse [end accent]. The physician had to this point avoided putting stress on his patient but could shield her no longer. He had to bring her up to speed on his communications with these jackasses and suggest a plan for some slow reduction. The patient asked him whether the DEA had a problem with x. Then she asked about y. And finally z. To which her physician responded, “they have a problem with all of them.” Having been in the room at this time, I had wanted to ask the doctor whether he was comfortable telling them to “fuck off" – because – you know – what happens in his medical office and in her bathroom is none of their God damn business and we construe their actions and the impact on my aunt and our family as a form of violence. The message I want relayed back to these ... “people" ... is that what originates from a black deed will blossom in a foul manner. I did not need to remind her doctor that over the years he has had to reduce her monthly allowance on 3 separate occasions. He let me know in rather colorful terms he was aware this was not the first such instance of meddling. Apparently the doctor received not received any credit or concession whatsoever for having complied with those earlier demands. The caller at hand cared only about this *latest* demand. Then I realized – holy fuck -- the J. Edgar Hoover is tapering my aunt off her Xanax and painkillers. The caller told the physician “comply or we suspend your license for one year.” He heard this from the DEA. He heard it from the Virginia Medical Board. Naturally, the pretext for all this was an abundance of concern over the risk to the patient, who is depicted as a ticking time bomb despite the fact she has been prescribed these medications for over 10 years -- despite the fact her prescriptions were arbitrarily reduced on 3 occasions already – and despite the fact she has never overdosed. And let’s not forget about the fact the patient understands and accepts this risk. No matter what that stupid 3 digit number might oh-so-creatively connote – it’s a manageable risk. She has been managing it. She’s in control. She has never had to run for the Narcan the Feds demand she keep on her shelf. The law requires she has one at all times. And since it would save her life in the event of an accidental overdose, improving the risk forecast from manageable to minimal, why do they behave like they had just kicked down the door to her apartment to find her in the grasp of an armed lunatic yelling “I swear I'll kill her"? Because they penalize her for having that Narcan in her home and on her shelf when they calculate her NARXScore.

But make no mistake. Neither the Feds nor the PMP Advisory Panel care about my aunt. The only difference between caustic indifference at the State and Federal level is that the bureaucrats are toiling anonymously. I mean, who has heard of the PMP Advisory Panel? The question is – is this anonymity inadvertent or is it intentional? Are we supposed to know about them en masse? Or is that like announcing to the German people in the 1930s – hey you know about our Schutzstaffel – now get a load of our Sicherheitsdienst. For now these new State enforcement arms will have to remain sequestered with the fluorescent tubes, radon, and asbestos and the rest of the toxic anachronisms from bygone eras of unfathomable ignorance. My point is they don’t care about her even as they pretend their curfews and bans are just a form of tough love. But she’s just a commodity to them. The more often they get to cut into her allowance, the more they benefit professionally. Allow me to paint you a picture. A Federal bureaucrat named Carl Pendergast -- a GS-9 with the DEA Prescription Drug Division – now he wants to be a GS-11. Carl meets with his supervisor, Ken Hallorhan -- annually to discuss what he should put in his individual development plan, or IDP. Carl feels he needs to be ambitious. He wears that yellow letter DEA jacket with bonne amie and bravado. He doesn’t really appreciate the fact that for all intents and purposes has a job for life. After all, there are rare circumstances under which Feds can be displaced – and more common forms of mental illness endemic to the Federal community whereby straight-laced drones with square haircuts, suspenders, and short sleeved business shirts labor under the irrational fear they are close to losing their job. So these neurotics subject everyone around them to their unfounded self-imposed personal stresses from which springs these annoying habits that combine self-protection and self-promotion. When these guys phone a prescribing physician to insist he reduce my aunt's Oxycontin to the point she can no longer tolerate visits from grandchildren, prepare family meals, or – well – ***eat***, they do it not to keep her from “taking one too many” but because they like the sound of the proverbial bell they get to ring when another cold call convinced a complete stranger to purchase an encyclopaedia over the phone. Metaphors notwithstanding, Carl Pendergast profits when my aunt's doctor “agrees” to cut her painkillers by a third. Now I seriously doubt even a great delusional rationalizer like Carl believes that he has actually reclaimed the life of my aunt from the jaws of an inevitable overdose. He would have you think of the Big Picture – epidemiologically as a donation to the Cause. The cause of fighting heroin overdoses, which is a war that stretches beyond my aunt’s inflamed frame and beyond the walls of her home to her nation's coastlines and borders and beyond the next dose into the future – specifically January 1, 2022 when today’s beneficiaries of scripts for Oxycontin are drowning in a bathtub from the Fentanyl the Chinese cartel pounded into the tablet of counterfeit Vicodin. But also when some law crudely fashioned from the campaign promise of a President – which one it doesn’t matter – is set to expire ... the one that grinds every gear of the Federal machine to ensure a 30% annual reduction in morphine units dispensed to the public. In this Big Picture, all individuals are just interchangeable and anonymous bricks in a wall. None of what makes you special or relevant clinically matters. You are here to donate and exchange your pills for the subsistence and glory of the President & Congress, the Federal agencies doing their bidding (i.e., HHS/CDC; DOJ/DEA), and Carl Pendergast. Yes, let’s not forget Carl. He too has to pay the mortgage – even with the favorable interest rates offered by D.C.-area banks to (lifetime) Federal employees. Did Carl meet the expectations and objectives codified in his IDP? There is much at stake. Promotions. Raises. Grade and step increases. And funding for an agency that has grown extravagant to a public eyeing 50 plus years of the only unwinnable war to last longer than Vietnam. Eyeing mounting support for the legalization of marijuana. The DEA needs to put a new face on evil. It needs an “Opioid Crisis.” Carl needs an “Opioid Crisis.”

**AMERICAN RAILROAD: A KANGAROO COURT FOR A CULTURAL ACHIEVEMENT, CORNERSTONE OF COMPASSIONATE CARE SYSTEM, & STAPLE OF CIVILIZATION**

Opium has been used medicinally and recreationally by civilizations for at least thousands of years and may have been in use for as long as man walked the earth. Opium is a natural condition of the planet and modern opioid pain medication only serves to mimic the body's own pain relieving chemicals and mechanisms. Endorphins in the human body and opium in the planet's flora are part of the natural order. Our ability to exploit these chemicals pharmacologically are triumphs of civilization that structure our otherwise unreliable and precarious relationship with Nature's raw materials.

Okay – show of hands ... how many of you female chronic pain sufferers of childbearing age would have planned or continued a pregnancy had your doctors told you there were no medications available to treat pain in pregnancy? Fortunately, you've learned there is an effective way to treat your pain that poses no known risk to fetal development. Effective way – thy name is Percocet. Or Vicodin. Yes, your newborn may spend some time in the neonatal intensive care unit weaning off methadone. Because your child will be born dependent on whichever opioid you took, some candy stripers, soccer moms, and reporters might be inclined to treat him or her as one would a crack baby. You have to forgive these mental midgets as the lenses fell out of their big picture glasses some time ago. They have somehow managed to overlook that your child owes its very existence to opioids. It’s yet another sign of a miracle drug.

We owe a debt of gratitude to opioids. The research methodology we uphold today as the essence of medical science -- and the rapid production of new medicines we celebrate as progress -- were established in pursuit of our first painkiller (Freeman, 2014). Modern chemistry was discovered along with the pain pill. When Friedrich Serturner isolated the active ingredient in poppy resin in 1815 -- an alkaloid he named morphine -- he refocused the mission as one of replacing the naive use of unreliable herbs with an extracted and measured dose of their key ingredient. When Bayer research chemist Arthur Eichengrun applied his method of molecular modification to chemicals -- acetanilide, phenacetin, and salicylic acid -- in an industrial waste product (coal tar) – he led us to the significance of the acetyl group and ultimately the discovery of aspirin in 1899. These same methods, when applied by his team to morphine, produced heroin which Bayer had made available to the public over the counter in 1898.

This was a period of trial and error, tinkering, bold risks, happy accidents, and deductive reasoning from chemical theory. These discoveries would have been highly unlikely today largely because the modern scientist as a professional is trained and required to base his or her decisions on certain preconditions. Decisions are links in a chain of events and must have probable cause such as a recent experimental finding or hypothesis extracted from a review of the research literature. “I had a hunch,” “for the hell of it,” or “because it had never been tried before" are not grounds for a project or program of research. I remember having a hell of a time justifying my proposed dissertation research to my doctoral committee. I had come up with an original method for visualising the dynamic interplay of changes between dream experiences and waking life and I nearly didn’t get approval to implement it because I couldn’t answer such basic questions as “where did this come from?” and “where had it been used before?” Scientific innovation suffers from some of the same problems as employer screening and evaluation of talent in job candidates. Many bright applicants with all the big ideas and strategies are deemed ineligible from the outset simply because they never held the same position before for another organization. We demand a form of provenance before we consider or pursue an approach outside what we consider our best practices, protocols, or industry standards. The upshot of all this is that we force everything into a template such that every research paper and the project it describes is the same Mad Libs story but with new words to fill in the blanks.

Friedrich Serturner defied conventional wisdom when he naively searched for alkaloids in poppy resin believed to contain nothing other than acids. Thanks to his semi-blind poking and prodding, we now understand alkaloids – caffeine, nicotine, morphine, codeine, and quinine among them – to be the active ingredients in pain relievers. Serturner nearly died defying convention when he administered novel experimental agents to himself and his assistants.

The problem is that we feel in order to discover formulae we need to conduct our affairs formulaically. All our research projects and proposals are summarized using the same format and stylistic elements to describe variations on common practices. We do this so our peers could read and evaluate our research in their sleep regardless of the phenomenon under study. When we review research we are processing the methods applied and not the subject matter. It’s tantamount to being editors who review manuscripts for syntax rather than for semantics. If we were quizzed afterwards on what we had just read, we can talk about grammar – “this author makes appropriate use of semicolons and commas for his compound-complex sentences and relies heavily on parallel structure and metaphor” – but we may not be able to answer a single question about the topic discussed (e.g., “how old did the author contend these dinosaurs are?”). It is perhaps for this reason that we don’t immediately understand how many of our cherished pharmaceutical products work. Our Government demands demonstrations of safety and effectiveness in experimental settings but does not require for approval that we understand the mechanisms of action – that we understand how or why these products work. In so many cases, most notably anti-inflammatories like aspirin and opioids like oxycodone, that this understanding comes decades later.

As Americans we are notorious for wanting everything to be a win-win. We don’t settle for tradeoffs. When the cost of epipens were unreasonably hiked we struggled to deal with the issue so that a remarkably fast and effective lifesaver could be made affordable again. We crafted a system of laws so that patents on brand name drugs could expire and allow more affordable generic substitutes to be obtained.

As they were sharing with us – a patient and her educated caregiver husband – some information that in effect shed some light on a question we had about the inner workings of the health care system at the crossroads of medicine and pharmacy – we can see it dawn on them that maybe these were realities that were not meant to be common knowledge – that the public was never meant to know. That there are in fact things the government regulators regard as for office use only or proprietary and confidential. A couple physicians even went as far as to say “I don’t know if I should be telling you this” and “keep this under your hat” before disclosing that generics by law must be 80% as effective as the brand products, which means that by law they can only be 80% as effective as the brand products. The disclosure was one doctor’s way of taking responsibility or alleviating guilt for an unexpected setback in the course of treatment – a kind of ‘I'm sorry the topiramate is no longer working for your migraines. This may not be a tolerance issue. Allow me to let you in on a little trade secret about the generic we were forced to switch you to.’ I tried to rope some pharmacists into commenting on this, hitting a wall of hesitation in some cases and in others it was clear the pharmacist may not have even been aware of this factoid. I mean one should bear in mind that this is not something anyone would find in a medical or pharmaceutical textbook. This is not considered part of the organized body of knowledge about biochemistry and is not needed to dispense with one’s regular duties in nurturing a patient back to health. If you ask yourself ‘what does this information belong to?’ one realizes there’s an unpublished, even unwritten book on regulatory science or health delivery systems that places the human body in the broader context of clinical practice and – even broader – Government. Beyond the scientific and clinical challenges of maintaining the health of a patient are regulatory, economic, and even political realities affecting the affordability, availability, and development of pharmaceuticals, procedures, equipment, technology, training, etcetera. And one pharmacist actually did extend my knowledge in this area when to my statement that “the generics only have to be 80% as effective ... ” he added “ ... 90% of the time.” One of the dirty little secrets about medicine is that while some – and perhaps most -- drugs work just as well in generic form, certain brand name drugs began to develop a reputation within patient and physician communities for lack of equivalence (e.g., topiramate for Topamax). I have friends who were quite exuberant when Pataday eye drops appeared on the customer side of the pharmacy shelves, but they quickly discovered that not only was this not the medication they recognized, they were no longer able to get the old stuff by prescription. Finding a drug that is safe, effective, and affordable should not be taken lightly. And where we need such a drug the most – such as in the management of pain – and I'm talking about the kind of pain that brings tears to one’s eyes – and the eyes of loved ones – we have it. We actually – thankfully – mercifully – have it. In fact we have more than one. We have quite a number of such medical countermeasures. And guess what? They are all just as effective in generic form. But they’re all opioids. It's all some variation on the formula for morphine. Oxycodone. Hydrocodone. Hydromorphone. Codeine. They’re called opioids.

As an advocate and educated caregiver I had been on the proverbial sidelines for over 23 years now. I count among those whose experiences were so informative two wives who live in pain, a mother who struggled with pain for two years before she succumbed to cancer that spread to her lungs, a cousin who decided he could no longer live with the injury sustained in his masonry work, and a mother-in-law who lives with debilitating degenerative disorders that affect both knees and both hips. And while I endured the horrors of acute pain – that kidney stone I ultimately passed on November 4, 1991 was at 6 mm the largest one can pass without surgical intervention – the extraction of one of my molars was complicated by the fact my roots are uncommonly shaped like hooks – and breaking a rib is no small ordeal for any allergy sufferer prone to what under normal circumstances is a forgettable sneeze – while I endured the horrors of pain – I could always find solace in the fact the pain would be fleeting in the grand scheme that is my life. But over the course if this life I met and in some cases married persons who suffered the certain knowledge pain would be a part of their lives for as long as they lived or suffered the uncertainty of not knowing if and when the pain would ever be resolved. That knowledge or known lack of knowledge adds a psychological dimension to the physical pain. It opened my eyes. I remember a time when my eyes were not open. And it’s in this vein that I reach out to that part of the public and body politic that is pain illiterate and therefore prone to manipulation by those who would complicate, stigmatize, or jeopardize access to palliative resources for the sake of some other agenda. I crossed paths with those who have an axe to grind with the pharmaceutical industry. In some cases it’s unclear – as it is with one of the principal architects of the CDC Opioid Prescribing Guidelines – whether this is a practical matter of retribution, an opportunity to build a fortune and reputation on exploiting or exaggerating questionable industry practices, or full on delusional disorders or cases of what legendary Swiss psychiatrist C.G. Jung would call “archetypal possession” or “possession by a complex." In the case of possession, an idea or a feeling becomes so formative and all-consuming that it warps one's capacity for reason much in the way the gravitational strength of a black hole warps space, time, and every known law of physics responsible for the life we recognize. There are ways to determine whether the CDC put a madman in charge of all public health policy that pertains to the management of pain. There are ways to determine whether the Federal government gave such a man – and a few others like him – with authority over the lives of millions of Americans who are now suddenly – thanks to the meddling of this man – forced to live as if pain was the sole or supreme criterion. But the people and the agencies that vested this authority lack the will, the psychological sophistication, and the incentive to do such diligence.

On safety, efficacy, and cost-effectiveness grounds, I not only find no cause for alarm but I also find cause for celebration. These morphine-based painkillers are a cultural achievement and the pride of a civilization. I acknowledge there is always room for innovation and I can relate to those who view these medications, which have been around for quite some time now, as the Old Testament of sorts awaiting a new book. As misguided as the “Crisis” may be, it has spurred insights into the importance of individual differences in genetics, history, and experience with pain. These are criterial or influential with respect to the individualized care of a patient as well as to one's philosophy and politics where pain management is concerned. There are those in Government and law enforcement – there are even those grieving the loss of a loved one to an accidental heroin overdose – who refuse to acknowledge or account for these individual differences because to do so logically necessitates moderation in policy to include exemptions, exceptions, stipulations, conditions, qualifications, etcetera that water down an otherwise absolute message. And with public acceptance or public tolerance of that absolute message comes the privilege of absolute authority and control. There are people out there who feel they may never get this chance again to regulate and punish those built up in their minds as adversaries in the pharmaceutical and medical industries. These people finally feel like they have their foot squarely on the throats of Big Pharma executives and philistine doctors – and they want to take advantage. Once again, I must be clear that the motivations for the antagonism are unclear and that like pain and pain management itself we are entering a domain that is made murky and complicated by individual differences. Some of the motivations can be reduced to class envy. Some motives are predicated on association with some other object of derision. History is replete with instances in which drugs were contemptibly deployed by recognized institutions for purposes of experimentation or exploitation. Some motives involve an uncommon knowledge of industry loopholes and weaknesses that could benefit from reforms. I feel I have personally witnessed the moment when a little knowledge opened up someone's eyes and nostrils and set them on a war path worthy of Archangels Gabriel and Michael. It’s one thing to pursue targeted reforms and to raise awareness for the betterment of an industry but it’s quite another to aspire to punish an industry to the point of rendering it ineffective for the purposes for which it was created.

*“We are going to bury the competition in a flurry of prescriptions.”*

I believe this is the statement attributed to Robert Sackler that has infuriated so many and filled with glee so many others hoping to bring an end once and for all to the manufacture of morphine products.

The advanced development and manufacture of pharmaceuticals is and never has been a utility. It is a business. Viewed in this context – in the context of competitive pressures, government regulations, laws of supply and demand – it almost feels violent to draw inferences about intent to harm or defraud from a comment such as this made in a back room in a moment of bellicosity from someone who thought to leverage his passion for the mission and pride in his achievements to “rally the troops.” This is the reason Pittsburgh Steelers head coach Mike Tomlin famously prohibited players like Antonio Brown from sharing on Instagram video of his private locker room comments about the New England Patriots (e.g., “those assholes"), their opponent for next week’s AFC Championship Game. When New England Quarterback Tom Brady turned over access to his email account to the NFL league office to cooperate in good faith with an investigation into an alleged ball deflation scheme, he did not expect the NFL to leak to the media emails disclosing unflattering comments about friend and rival Peyton Manning. If you want to throw all of society into chaos and grind all operations to a halt, just install hidden microphones in all board rooms and offices. I realize that most of think this kind of access to information – testimony from a disgruntled employee or witness compelled by subpoena – is the most effective means to uncover and characterize the “reality.” But I can think of circumstances under which information obtained in that manner might only serve to cloud the truth. I can only imagine what the Sacklers are feeling in the way of betrayal from the U.S. Government, from some of the institutions to which they contributed, and from the public – not to mention the producers of the unfortunately titled Netflix documentary “Crime of the Century.” Whatever the Sacklers knew and when they knew it does not mitigate the fact 79% of those who abused Oxycontin never held a valid script and would have had to violate instructions for use when they crushed the coated tablets to maximize immediate access to any euphoria. Nothing that occurred constitutes grounds for depriving the compassionate care system of its most valuable resource. Oxycontin gave me two additional years with my mother. At one point when her cancer reached her lungs and bones she was so overwhelmed with discomfort, malaise, and depression that she was no longer herself – no longer the person we knew. She couldn’t be mother to her three adult sons, grandmother to my 6-year-old boy, wife to my stepfather, and dynamo for the Wayne, NJ chapter of Elks. She didn’t have the energy to do what she loved most – prepare meals. She couldn’t even enjoy food. Some combination of the cancer and chemotherapy laid waste to her appetite and left her with some absurd aversion to smells and some anomaly that messed with the taste of food. Only after I intervened did her doctors think to add Oxycontin and onandestron to her list of regular medications. And my mother ... was reborn. Of course she had to live with the stress of knowing her oncologist might have to discontinue her Oxycontin – you know – “because of the culture.” I think he always knew at some level that I might have had to kill him if he ever made good on that threat. There are some things you just don’t mess with – at least not for the reasons you're messing with them.

The charges of deceptive practices in the marketing of morphine products like Oxycontin might hold water. Much of the evidence was put under judicial seal when the $600 million settlement was reached. I am inclined to think that at the outset executives proceeded with informed optimism that an extended release formulation would produce reduced rates of dependency. The rates are already low enough, so I am having trouble understanding how Oxycontin is being held accountable for an epidemic that does not exist. And it also remains unclear how many of the dependency or overdose cases resulted from illicit access (i.e., diversion) and from use that violated instructions. Executives are having their feet held to the flames for not taking any action upon becoming aware of the way their product was abused. But just what would we expect them to do? Pull their product? Search engine and social media giants have been aware of how their products are abused. Search engine vandalism. Defamation. Cyber-stalking. Violations of privacy. We even believe as a nation that Facebook user data and ad space was gamed in a way that might have turned the outcome of a Presidential election. But any effort to compel these cool companies to take responsibility for preventing, mitigating, or taking some other corrective action immediately spawned Congressional legislation (i.e., Telecommunications Decency Act of 1996) that granted them immunity from all manner of liability.

As for the improprieties and indiscretions concerning these pain medications, I do see them as an opportunity to learn more about the reforms that could improve the industry. For one thing, dependency is not among the adverse events studied in either the safety phase of clinical trials or the post-marketing phase. I don’t see why our posture has to be so punitive and prohibitive. The Sackler statement is not on par with the kind of revelations about impact boosting in cigarettes that Jeffrey Weygand used to suggest Brown & Williamson and the entire tobacco industry engaged in a scheme to defraud the public for profit. And I can find a hundred more statements from pharmaceutical industry opponents that suggest the Anti-Tobacco Playbook is being used in an effort to restrict manufacturing and marketing of painkillers. But unlike tobacco, prescription painkillers serve a valuable public health function.

In short, we took a really good thing -- one of the few things that actually work in this declining nation -- blamed it for all the terrible things that have happened over the past 25 years -- and bombed like it were Baghdad. One study of the effects of reduced opioid availability found elevated levels of unresolved (i.e., self-reported) pain in hospitals, increased days of work missed due to short term disability sustained in worker’s compensation cases, and increased number of instances in which patients turn to alternative treatments – among them elective surgeries that had more often than not proven relatively ineffective despite the expense and invasiveness. The study authors conclude that -- when added to the increased heroin use as a substitute for less available prescription products – $12.1 billion in increased medical spending and lost wages from the adverse outcomes of reduced opioid availability more than offset $7.3 billion in reduced addiction and lives saved from opioid and heroin overdose. In a nutshell, as a cure, Prescription Drug Monitoring databases may be one step forward – one and a half steps back.

CMS reduced reimbursement for interventional pain procedures like nerve ablations and endoscopic radio-frequency treatments for GERD citing evidence for a common scenario in which patients feel driven to repeat the procedures at regular intervals and at great expense simply because they do not offer a decisive solution beyond near-to-mid term relief.

The workforce development, secondary mortgage, healthcare financing, credit, and political systems may not work the way they used to -- or at all -- and clearly our capacity to respond as a nation to a pandemic leaves little to be desired -- but those of us who suffered a painful or fatal diagnosis had a silver lining in the worst of the storm -- a compassionate care system that was the envy of the world. While these drugs were not the cause of the nation’s dysfunctions, they did offer a crutch to many of us who suffered economic hardships or exclusions on top of the hardships of un- or under-treated pain. But to even suggest that plays right into the hands of those who wish to exploit the link between opioid use and use of psychiatrist medications. “See? These pill poppers and stoners are emotionally unstable. Why would we want to give these dangerous drugs to emotionally unstable people?” Sure. That'll solve the problem. Identify those whose clinical anxiety and depression make it more difficult for them to manage pain – and then take their painkillers. Of course, those who take this prejudicial view believe that these head cases see pain where it doesn’t exist. We as a nation have come around to condemning every man of sexual harassment or assault on an unsubstantiated word – to the point where the allegations of Dylan Farrow, which for 20 years were accorded the status you'd expect of allegations that were dismissed after two exhaustive investigations – are suddenly treated as irrefutable and used as impetus and justification for career-cancelling campaign. But when a chronic pain patient with a verifiable history of assessments and interventions shows up in your ER complaining of pain, they are treated as morbidly seeking addicts. We tell patients their slightly diminished kidney function – indicated by abnormal levels of creatinine and other chemicals in a blood panel – is due to all the Advil or Motrin they’ve been using to treat their pain. And then we hand them a script for prescription strength ibuprofen that is twice what they had been dosing (600 – 800 mg).

The measures we have taken to deny or repress pain are extraordinary. Opioid-free surgeries involving only acetaminophen. Opioid sparing diets and cookbooks. Recommendations for acupuncture, yoga, and cognitive behavioral therapy as substitutes for pills. I am astounded that we should characterize painkillers as much as we do as dangerous drugs when there are so many records of botched executions involving lethal injections of midazolam and ... hydromorphone.

In a nation in which we no longer trust our cops, our clergy (sexual abuse scandal), our Government officials (approval rating vacillating between 9 and 19% for over 20 years), and the financial industry leaders that impact our economy, we are now depicting physicians as uneducated about the drugs they give us for pain and as willing participants in a scheme to prescribe in exchange for kickbacks. The dissemination of falsehoods about painkillers, pain sufferers, and the doctors who dare treat them, a national campaign aided by indiscriminating media, conjures memories of mass hysteria throughout U.S. history, most notably the Salem Witch Trials, the McMartin School fiasco of the 1980s, Joe McCarthy's response to the Red Scare in the 1960s, and that ridiculous competitive integrity scandal known as "DeflateGate." For years at one time or another the nation stressed under the misapprehension that thousands of children suffered satanic ritual abuse at the hands of daycare workers, that hundreds of Communists protected by Communist sympathizers reluctant to name names had infiltrated Hollywood and the Pentagon, and that a 3 time Super Bowl champion quarterback couldn't throw a regulation football. These cases of mass hysteria were all resolved once a critical mass of common sense restored our rational faculties, but not before irreparable harm came to the lives or livelihoods of a great many people. McCarthyism was an example of something that just outlived its usefulness long enough to go too far. Ethel and Julius Rosenberg and David Greenglass were identified and neutralized but McCarthyism persisted to terrorize DOD cafeteria workers and Hollywood writers, threatening with lifetime career bans anyone accused of harboring Communist sympathies or harboring the names of associates who harbored Communist sympathies. The manner in which the House Committee on un-American Activities conducted an investigation to root out the undesirables destroyed careers, relationships within families and circles of friends, and caused some suicides. Similarly, there are tactics used by legislators and bureaucrats in the HHS/CDC and DOJ/DEA that remind me of the very worst of Joe McCarthy:  
  
1. weaponization of the Prescription Drug Monitoring Database as a detection-and-surveillance tool to spy on doctor-patient encounters and contest scripts soon after they were written, putting us at odds with our most sacred tenets of medical practice (Hippocratic Oath) and privacy (HIPAA). There was a time when I might have thought the PDMP was developed to confidentially collect aggregate data, but it was used instead to flag and fight patient treatment plans.  
  
2. The PDMP is also used to instill in anyone involved with opioids a paranoia around the data stored there, data that is routinely exploited as material evidence in the trial of any physician prosecuted for overprescribing. Thus it could be said that one of the purposes of the PDMP is to discourage -- to have a chilling effect on -- prescribing. Over 70% of chronic pain patients report that their monthly medication has been reduced or rescinded.  
  
3. The PDMP is also intended to drive a wedge among stakeholders in the health care system, introducing tension into relationships between doctors and their patients, doctors and pharmacists, and patients and pharmacists.

4. There was certainly nothing wrong with shutting down pill mills and educating rogue doctors who traded far too many pills for the wisdom teeth of vulnerable youth. I also find valuable guidelines that stipulate regular appointments; pain management contracts; documentation; a plan to start opioids at the lowest effective dose and titrate up gradually and responsibly with an eye for side effects and residual pain; and a good faith effort to order assessments, set a cure as a goal, and include in the treatment some nonpharmacologic and pharmacologic-nonnarcotic interventions. But the crackdown should have stopped with the execution of this three-pronged strategy. The 30% annual reduction in scripts, an arbitrary political goal designed to win votes and placate the grieving survivors of dead heroin addicts, could only encourage bad behavior on the part of DEA agents who harass physicians indiscriminately because they do not care where the reduction comes from.

**GOVERMENT'S IDEA OF HERD IMMUNITY AS APPLIED TO OPIOID CRISIS: IILLUSTRATIVE CASES OF EXTREME HARM TO PATIENTS**

I maintain the view that there is no opioid crisis. Even as prescriptions were slashed 42% since 2011, overdose rates continued to rise: 30% for heroin and illicitly manufactured fentanyl and even more so for non-opioid substances like cocaine (190%) and methamphetamines and other stimulants (500%)(IQVDA, 2019). I think it can be argued that the rising overdose rates reflect a misguided Prohibition-style crackdown that forced abandoned patients into Street drugs or suicide. Extremist groups like Physicians for Responsible Opioid Prescribing (PROP) take issue with that interpretation but offer no better one. Their staple, the Gateway Theory, is an even more tenuous assumption that the appeal of street drugs like heroin was caused by exposure to prescription painkillers. The PROP strategy to stay the course appears to suggest that overdose fatalities will drop dramatically once everyone exposed to prescription painkillers has been killed off. I suppose that's their idea of herd immunity applied to the substance abuse "epidemic."   
  
If you think chronic pain patients are not being demonized and abused, consider the following.

EXHIBIT A. 47-year-old Virginia woman forced into Medicaid by her husband's unemployment

Scripts she was routinely able to acquire and fill within a matter of 2 hours now faced strident documentation requirements clearly designed to deter prescribing. The doctor and his front office staff had difficulties satisfying the requirements, and the documents were often returned by Medicaid with notes about missing or incomplete information. For 21 consecutive days (except Sundays), patient’s spouse phoned the physician's office, pharmacist, and Medicaid daily for status updates. A detailed 21-day log was reconstructed from cell phone records (see Appendix A). Just when Medicaid appeared to approve the physician documentation, the representative noticed that the 21 days exceeded the deadline and the physician's office manager was instructed to destroy the documentation and request a new form. The office manager could be heard screaming into the phone about the plight of a poor pain sufferer who had to go without her meds for 3 weeks. Authorization for the fill was finally granted. I recommend browsing through Appendix A for proof of torture. Tell me the State of Virginia should not be charged by HumanRightsWatch for crimes against humanity.   
  
EXHIBIT B. There are about a dozen rules unique to Schedule 2 opioids that jeopardize the timely fulfillment of a legal script at a pharmacy. Opioids can not be split. This means that if you present a script authorising you to receive 60 10 mg Percocet tablets and the pharmacy only has 45 in stock, you are given the option of delaying processing of your script until the next shipment arrives – or accepting the 45 now. But if you elect to take the 45, you are required to forfeit the balance. If the script had been for any other substance, you would have been able to claim the 15 at a future date. Complicating matters further, pharmacists likely for reasons of store security refuse to disclose the day the next shipment is due to arrive. And they are prohibited from special ordering the opioid specifically for any one of their patient-customers nor could they reserve a quantity of new arrivals for that patient-customer. This means another patient could claim some or all of what you have been waiting for. Some pharmacists will not even answer questions pertaining to the current inventory of opioids over the phone. Some patients would have to drive from one store to another in search of one that could process the script with what they had on the shelves. This is not ideal for any customer let alone those who might otherwise confine themselves to bed due to severe pain. This state of affairs was reinforced not only by the regulation prohibiting the splitting of opioid scripts but also by the one prohibiting opioid scripts from being transferred. As uncomfortable as it was to carry a hard copy script across town in search of an adequately stocked store, the customer was at least in some control. But things were about to get a whole lot worse. When some states developed electronic doctor-to-pharmacy script submission capabilities, it was done not in the interests of facilitation or expedition. Quite the opposite. Doctors found the process so onerous that they reported feeling the new system discouraged prescribing. And while unnecessary, some states adopted electronic submission as law of the land, meaning doctors were prohibited from handing their patients paper prescriptions. Most importantly, the electronic script was tied to one target pharmacy. So while the Vienna, VA Walgreens could see the script in its Walgreens system, it was not authorized to process the script earmarked for the Reston, VA store just 5 miles away. The only way to hasten access to the tablets if Herndon was out of stock would be to leave a message for the prescriber to log into the system, cancel the original script, log out, log in again, and submit a new script to Vienna. But lest you think this is a serviceable workaround, doctors and pharmacies alike are under enormous pressure from the Government to require patients to sign contracts that not only identify one physician as the source of all pain medication, but to identify one pharmacy as well. Not one pharmacy chain. One store. Customers in recent months have been advised by a pharmacist or pharmacy tech if their system alerted them to a store closer to the residence listed on their driver’s license. The one delay the electronic scripts did reduce was the one incurred by pharmacists who felt compelled to authenticate every paper script (i.e., to treat every paper script hand delivered by a customer-patient as potential fraud). But electronic scripts did not end the harassing phone calls to physician offices; they merely altered the purpose of the call. Physicians are now asked to defend their clinical decisions, answering such questions as “did you know your patient is also prescribed [INSERT DRUG NAME HERE]?” or “were you aware of the potential interaction with [INSERT DRUG NAME HERE]?” And some pharmacists are not as subtle or indirect about expressing differences of opinion.

**A PHARMACIST MESSES WITH THE WRONG PATIENT**

In 2017, after an exhaustive investigation, Susan was designated medically disabled by the Social Security Administration due to chronic intractable migraines and laryngopharangeal reflux disorder (LPR) complicated by other conditions (Type 1 diabetes, back degeneration, and psychiatric disorders). This designation was upheld on review in 2019.   
  
For well over 10 years these conditions have been treated with hydromorphone, an extended release hydrocodone-chlortrimeton suspension (brand name Tussionex), & alprazolam.  The Tussionex is prescribed for an LPR-induced cough that exacerbates Susan's migraine & back pain. Starting doses & quantities in 2009 were very low, and scrupulously and gradually escalated over many years due to tolerance & w/ special consideration for side effects (none) & residual / unresolved pain.  Prescriber exercised due diligence and best practices by (1) maintaining regular appointments to reassess need and risk, (2) obtaining letters from other specialists in her care network establishing that the medications are reasonable, necessary, and uniquely efficacious, (3) ordering or performing the necessary diagnostics in search of root causes and potential cures, (4) exhausting all other nonpharmacologic and pharmacologic-nonnarcotic avenues for treatment, and (5) prescribing the opioid antagonist nasal spray Narcan to safeguard against the worst consequences of accidental overdose. Susan has never needed the Narcan, which she proves by returning all expired medication still in its sealed packaging.   
  
Every month for the past 3 years, the Herndon Walgreens has filled the scripts for these same medications & over this time, w/ one exception, there have been no changes to dose or quantity.    
  
Wednesday, April 7, 2021. Susan phones Walgreens to process a refill of her alprazolam. Initially, she has no idea that the voice on the other end of the line is not that of a pharmacy tech but of head pharmacist Hussad Hawi. And his tone and rapid and pressured speech signify irritation and disdain. Hawi conveys that his system flagged Susan's profile and, as he reviews her list of monthly medications, he aggressively questions her about problems posed by each one. He has issues with dose, quantities, and interactions. In his mind, everything is wrong. Susan is a ticking time bomb. Her spouse recalls that Hawi began interrogating him about the script that was due for processing but this is the first time he has a bird's eye view of the entire list. For this, we have a new procedure and technology to thank: Walgreens periodic drug utilization review. Just what gave rise to the new protocol remains unclear. Is this an internally generated initiative from inside Walgreens? Or does this fulfill some external regulatory requirement?

Despite Susan’s best efforts to convince Hawi not to engage her prescribing physician, Hawi does just that. He immediately phones Susan’s neurologist, which would impress you if only you knew how the pharmacists normally operate in this hectic environment. If there’s something you need, it gets kicked down through the hours of the day. If they tell you they will have something ready by 11 am, you can be reasonably certain that when you arrive at 11:30 to pick it up, they will not even pretend to remember ever talking to you. They’re the most heavily trafficked Walgreens store I have ever seen. Lines at the drive through window. In the store. On the phone. All by the minute the pharmacy raises its metal shutters at three or four minutes after 9 a.m. The employee only area behind the counter resembles a M.A.S.H. unit on the front lines. And yet within seconds of finishing his call with Susan, Hawi had her physician – a ridiculously busy neurologist in his own right – on the phone. And from the accounts of both men, it was not a pretty conversation.

Hawi advised the doctor that his pharmacy will no longer service his patient. Hawi would later tell Susan’s spouse that the action was taken out of concern for his license.  Her doctor fought for her, citing letters from an ENT & psychiatrist as additional support for the prescriptions, but Hawi was unmoved. Hawi deemed the alprazolam dangerous enough to his license to discontinue it but not dangerous enough to offer Susan one last partial fill to sustain her while she made other plans. This is important, as Hawi indicated he was aware that cold turkey discontinuation of a benzodiazepine like alprazolam puts a patient at seriously high risk for fatal arrhythmia & seizure. Hawi offered as a compromise that he would not object if Susan persuaded the pharmacist who replaced him at 3 pm to do a one week fill. That pharmacist, Jenny, was more than happy to do it, indicating she would have overruled Hawi on all grounds if she had the authority. Jenny had never had any problems with Susan’s regimen, nor did the 1head pharmacist (Debra) of the nearby Reston, VA Walgreens to which Susan will have her doctor submit all new scripts going forward. So as dangerous to his license as Hawi deemed this partial fill, he was more than happy to transfer that perceived risk to a colleague.   
  
Hawi was condemning in his disposition, and Susan felt he shamed her for needing these medications. The FDA did issue a black box warning on simultaneous consumption of alprazolam & an opioid in 2016, but pragmatically, this caution is seldom used to force patients to choose between treating their anxiety and treating their pain.   
  
Hawi also argued that the neurologist should cease and desist prescribing the hydrocodone-chlortrimeton syrup on the grounds it is not a "neurological drug."  Why should the pharmacist insinuate himself this deeply in the workings of Susan’s care network? The syrup contains hydrocodone, which is an analgesic as well as an anti-tussive, and is prescribed by neurologists.  So why should adding an antihistamine (chlortrimeton) remove it from her doctor's expertise and jurisdiction?  Susan's care network -- and the terms of her pain management contract -- favor that any product comprising or containing a scheduled painkiller be routed through a single prescriber.  Here Susan feels Hawi oversteps his bounds in attempting to dictate how a physician should discharge the clinical, administrative, and regulatory aspects of his job.   
  
Feeling the communication from Hawi created a documented warning of sorts, the neurologist, who had never been prohibitively concerned with the patient's 800 NARXScore, suddenly surrendered the Tussionex script in the interests of “bringing it down.” Angered by the change to her treatment plan, Susan and her spouse filed grievances with the Virginia State Board of Medical Professions, with the Department of Justice Office of Civil Rights (as an ADA case), and with Walgreens corporate offices. If it's a war the Feds want, a war they shall have. Susan’s spouse was keen on revealing to each intended target where other complaints were being filed. Less than three weeks later, on April 24, Jordan Steves, Regional Director of Pharmacy for Walgreens, surprised Susan by revealing that Hussad Hawi was no longer a Walgreens employee. Steves echoed the sentiments of other pharmacists in the organization that Hawi’s conduct violated company standards for customer service and professionalism. It was the first real expression of support for a chronic pain patient since the Connecticut Department of Health encouraged a resident to file a formal complaint of abandonment against a primary care practice for withholding alprazolam after a DEA raid of their offices three days prior.

At that time Susan contemplated that as prejudicially as Hawi had acted, he believed he was doing the Government’s bidding and insulating himself against a potential DEA judgment. This is a nation of very convoluted covenants and contradictory expectations. One in which physicians and pharmacists alike must feel that they are damned if they do, dammed if they don’t. As fierce a pressure as they face from Federal regulators, they face an equal and opposite pressure from the patients, educated caregivers, and advocacy groups.

In the end, Walgreens terminated Hawi's employment for patient endangerment and poor customer service. As frustrating as his conduct was, I am capable of connecting with him about the liability and the culture of fear. I am sure he felt caught between his customers and a DEA operating on a mandate that would bring a blushing smile to the corpse of Elliot Ness. Hawi thought he was protecting his license by indulging what he perceived as the more imminent threat. But once Susan's spouse applied equal pressure from the opposite end – as the educated caregiver of a customer-patient egged on by his smug statement “there’s nothing you can say" – he lost his job. Is this what our Government had in mind?

The incident report from Susan's spouse was retweeted dozens of times among hundreds of patients within the chronic pain community. In addition to the State and the Office of Civil Rights, the report was also shared with the Walgreens Social Care Unit that had turf to defend in social media space and with a number of Walgreens executives who accepted the spouse's invitations to connect on LinkedIn. The spouse also filed through the official Walgreens complaint web page and shared the incident on every consumer review web site. Had none of these avenues produced a response, there were plans to impact Walgreens social and financial base through more targeted grassroots actions around the local store. And there were plans to reach out to members of State and Federal government. But many of these strategies were pre-empted by a timely and effective response from the store manager (Joel) and from the Social Care Unit (T.J.), both of whom expressed sympathy and vowed to escalate the incident up the organizational chain.

The action taken by Walgreens however did not automatically restore conditions to what they were prior to the unpleasantness of April 7. The patient still had to convince the doctor that he was free and clear to resume the Tussionex therapy he surrendered to Hawi as a show of good faith to protect his own license in the unlikely but not impossible event that something happen to Susan soon after Hawi's warning. Toward this end, Jordan Steves agreed to reach out to the doctor but he confined his comments to reassurances that Walgreens shared his goal of providing effective care for a satisfied customer. And Steves promised an atmosphere of collegiality and collaboration. But for legal reasons Steves did not feel he could broach the subject of Hawi’s termination, a development he left for Susan to share. And Steves did not feel comfortable discussing what he called “clinical data,” by which he meant the facts pertaining to the decision to surrender Tussionex. At this time, the doctor has chosen not to reply to Susan's emails requesting reinstatement of the Tussionex. This is a matter that will have to wait for their next scheduled appointment. Susan and spouse have stated that if a satisfactory resolution cannot be reached such that this change to her treatment becomes permanent, they intend to make the pressure on Hawi's career equally permanent beyond the loss of his role at Walgreens. The sooner our senior Government leaders realize that efforts to tamper with treatment plans are met as declarations of war, the sooner we can prevent outcomes as adverse as this pharmacist's job loss. The sooner we will all realize that there will be blood.

The one pharmacy regulation I find Selma grade prejudicial is a Walgreens policy -- observed to my knowledge only by the Centreville, VA store -- that requires anyone dropping off an opioid script to vacate the store for a period no less than 1 hour while it is being processed. Mulling over the implications of that policy might induce a panic attack. But is this any worse than the way chronic pain patients are treated at CVS, which recently launched a PR campaign around the announcement that it stood shoulder-to-shoulder with the Government in the fight against the “Opioid Crisis.” CVS will not fill new scripts for pill quantities exceeding a 72 hour supply. The problem with policies like these is that they are created with the knowledge physicians do not have the availability to schedule acute pain patients to follow up appointments just so they could extend access to painkillers by a few days or weeks. CVS is not a pharmacy anyone with a serious medical condition should ever use. Once pain becomes a symptom and chief complaint – and this is reportedly the case with 11 – 23 million Americans – the patient needs to switch to a pharmacy that aspires to be more than a pharmacy for the well. Patients diagnosed with conditions that involve pain are patients that are also treated for comorbidities. They may also be diabetics. They might be prescribed medication to help them cope with anxiety and depression related to their pain or to complications of pain. But many CVS pharmacies will not stock oxycodone tablets at doses greater than 10 mg or hydrocodone tablets at doses greater than 7.5 mg. And if you need something greater, they will not special order it for you. It is hard for me to imagine that loyal CVS customers would continue to patronize CVS for their non-controlled medications but seek another pharmacy for their opioids. I would hope and suspect that CVS would lose their high utilizer customers entirely.

EXHIBIT C. 45-year-old Sam relocates to Connecticut with the challenge of replacing his multidisciplinary team of specialists treating him for multiple health conditions that include chronic and significant pain, compromised immunity, and psychiatric symptoms. Due to lack of resources within the mental health delivery system, Sam's primary care physician (i.e., Westport Family Health) assumes responsibility for continuity of care for anxiety, prescribing alprazolam and Ambien. After a year of receiving refills for these medications, Sam is summoned to the offices of his primary care physician, where he is dismayed to learn the practice will not issue any further refills. When prompted for an explanation, the physician cited recent State legislation leading to an unspecified “incident” about which the physician refused to clarify but it was clear it impacted the practice. That incident turned out to be a DEA raid on the medical practice – an all-day affair during which scheduled patients were turned away at the door by an armed officer and patients attempting to reach the office by phone were redirected to an answering service.  
Subsequent to the negligence and abandonment, Sam is admitted to the ER on two separate occasions with severe symptoms of benzodiazepine withdrawal.  Over the course of his stay, Sam hears from two ER physicians and three different internists that abrupt discontinuation of these substances is dangerous and potentially life threatening.  In addition to self-destructive behaviors resulting from delusions and hallucinations, the patient may also suffer fatal seizures and arrhythmias.  Also during his stay, Sam is informed by a hospital psychiatrist that the head of Westport Family Health, Dr. Martin Singer, was arrested – “led out in handcuffs and tears" -- for over-prescribing controlled substances in violation of a law that went into effect in January.  When an opportunity presented itself to discuss the raid with an actual eyewitness, Sam learned of substantial hyperbole in the account offered by the hospital psychiatrist who was not present. Singer was neither handcuffed nor in tears. He was placed on paid administrative leave and expected to return. Like one of the ER physicians, the psychiatrist made Sam feel he was a bad seed for ever having used alprazolam.  The two ER physicians overstepped both their jurisdiction and the scope of the urgent problem at hand (i.e., benzodiazepine withdrawal) when they instructed Sam to distance himself from the painkillers he was prescribed by his neurologist and had been prescribed for the better part of 7 years. One of these ER physicians, a Dr. Jeffrey Weintraub, was adamant about needing to engage the prescribing physician personally, and demanded Sam disclose his identity. “Who did this? Who gave you these?” to which Sam replied “piss off.” Upon Sam's second visit to the ER, he arrived with full-blown hallucinations and delusions and had uncharacteristically neglected to check his blood sugar in 2 days (Patient is a Type I diabetic). It was at this time that Sam finally received appropriate care for benzodiazepine withdrawal, which involved inpatient re-exposure to benzodiazepines (i.e., Librium) and a titration in dose over a 3-day course.  In a letter dated March 21, 2017, Director of Patient Relations & Advocacy Kristin Winbigler reported that the unnamed “Vice Chairman of Emergency Medicine and Chairman of Medicine” both deny any “problems or issues with the care received on the visit of March 10” and that it was “never anyone’s intention to be rude.” Not everyone agrees.  Among them -- a Section Chief within the Practitioner Licensing & Investigations division of the Connecticut Department of Public Health.  He received a copy of what he later described as an “interesting letter” in a follow-up phone call to its author (Sam’s father). Believing sufficient grounds exist to move forward with an investigation, Section Chief invites Sam to file an official complaint.  Like Sam, the Section Chief believes that there are two sides to the debate about controlled substances, that steps need to be taken to restore balance to the discussion, and that Western Connecticut Health Group – parent organization to both Westport Family Health and Norwalk Hospital -- may have violated Sam's rights in withholding his medication and coding the ER visit in the discharge summary as “sedative abuse.” Sam was involuntarily subjected to a 4-day inpatient benzodiazepine detoxification at the expense of Connecticut Medicaid. This transpired over a period Sam was scheduled to vacate his apartment and relocate to the state he called home before his spouse's new job took him to Connecticut. Once released and relocated, Sam decided that he enjoyed a higher quality of life on the alprazolam and resumed the alprazolam under the care of his former physician. For more detail, see Appendix B.

EXHIBIT D. Dmitry marries a chronic pain sufferer. Dmitry likes to point out that he has become acquainted with other men who have married into pain. He will tell you they're not in contact all that often, but when they are, they compare notes on what has evolved into a common enemy: the U.S. Department of Justice. None of them enjoys watching his wife suffer. It's stressful. None enjoys having to assume a greater share of the household chores while the wife is laid up. Laid up, I say. Not laid. Oh no. Dmitry will tell you their sex lives are also diminished by the disabilities. And their wives tend to be more irritable and irrational when they're in pain. The men walk on eggshells. They planted more than a few flags on some eggshells. They also don't enjoy having to explain to their children why their mothers are unavailable or unbearable. And the impact of the wives' pain has not gone unnoticed by their employers.  
  
So naturally these husbands are inclined to prefer a well-stocked armamentarium -- a full medicine cabinet -- for their spouses. Let's be pragmatic about this. When they married, Dmitry and friends never expected that they would find themselves in the middle of a war zone. *“It's one thing to fight the pain itself. But when you have to defend your spouse from hordes of finger wagging strangers who presume to know more about you than you know about yourself. They know nothing about your medical conditions or history and yet they still somehow know what's best for you.”*  
  
There are those who think they know more than their wives what's better for them. "You'll thank me later," is their preferred refrain. Then there are those who believe that it is OTHERS -- the broader community of vulnerable youth -- whose lives are threatened when our wives continue to avail themselves of the only medication that offers any relief. Their wives are treated as co-conspirators in an epidemic of involuntary manslaughter for which doctors and drug makers are master architects. It's with this attitude that Dmitry's wife contended on the morning of June 2, 2018 when a deputy patrolling the mountain roads of rural Nelson County, Virginia uncovered a prescription bottle in a search of her car.  
  
"She was having a hypoglycemic episode," insisted Dmitry. *"My wife has Type 1 diabetes. These episodes -- they're rare. She has her sugars under control the vast majority of the time. She knows how to use that pump of hers. Maybe this is the third severe low she's suffered in the 12 years I've known her. But I know one when I see one. It does not look all that much like a drug intoxication. And so when she phoned from the road and told me what she was feeling, I knew what we were dealing with. But it's no simple matter to tell your diabetic wife to pull over and grab something to eat. She already knows what the right thing to do is. But she's not all that rational. And she doesn't trust her husband like she usually does. That's the low blood sugar talking. I knew that I only had a few minutes before she stopped thinking of me as her husband of 12 years and started thinking of me as a CIA agent. So I had to work within her warped logic -- trick her if you will -- to get her to put into the McDonald's drive thru for a strawberry milkshake."*3  
  
Dmitry was helpless. His wife had two hours earlier left on a 3 hour drive to her 25th college reunion. It was an event she had eagerly anticipated for months. And this departure from her routine was the catalyst for a medical 911.  
  
*"Sophie has not been behind the wheel very often. Now that she's married she takes full advantage of my offers to drive her to all her doctor's appointments and run all the errands. Being in pain as often as she is, it's more convenient to keep her in bed where she can rest and make use of sedative medication. Her antihistamines and anti-nausea medication can be quite sedating so she knows not to drive with these in her system. And she knew not to take any sedatives before she left for her reunion. I offered to drive her but this weekend was all about reclaiming her youth and her independence.*"  
  
Dmitry was acutely aware that his wife occasionally veered on to the shoulder. He could hear the strafing of rumble strips over the phone. She was looking for a safe place to pull over. But the winding narrow roads made her feel vulnerable. She had also lost the only road familiar to her -- route 29. She was lost. Dmitry toyed with the idea of reaching out to law enforcement for assistance, but quickly abandoned the idea when he realized that for anyone who relies on medication, cops are more liability than asset. Dmitry knew a cop would gleefully mistake her hypoglycemia for drug abuse. A cop would be more interested in the drugs collar than her safety.  
  
Dmitry soon lost contact with his wife altogether. It would be 5 hours before he would hear from her again. The last words he remembers: "there's a cop behind me. I'm being pulled over."  
  
It's now 9 pm. His wife phones him with a chilling tale of police brutality. His 5-foot-2-inch dandy of a wife with Wilma Flintstone hair and unblemished alabaster skin was bloodied by her handcuffs and hauled barefoot into a jail littered with feces.  
  
"I told them the handcuffs were too tight. So he tightened them."  
  
She was referring to Deputy Richard Clarkson. When she was pulled over, the officer noticed a yellow paint transfer 1 inch wide along with some leaves plastered by moisture on her front fender.  
  
He kept yelling at me. "Who did you hit!?"  
  
Dmitry admitted causing the paint transfer himself when he grazed a column in the narrow confines of his residential parking garage.  
  
Sophie was conciliatory and cooperative -- largely because she was scared. For the first time in years, she was alone in the world. And she was in unfamiliar territory. Deputy Clarkson was joined by Officer Brooks.  
  
*"They took to my car like a pack of hyenas after I gave them permission to search. The first thing they found was my insulin pump. The other officer began to ask me questions. ‘Are you diabetic? When did you last test?’ But when Deputy Clarkson found my box of Narcan, he short-circuited that whole line of questioning -- the one that put my health and safety first -- and launched into a drugs interrogation. The first thing he did was dismiss the other officer. ‘I got this. You can go.’ Something along those lines. Now I'm alone with this idiot.”*  
  
Sophie attempted to explain to the deputy that traveling with Narcan is a sign of responsibility and conscientiousness. If her explanation resonated in the slightest, he was not letting on. Then he found the prescription bottle of hydromorphone and pill box. You would think he found a bag of heroin. She denied taking any pills on or within hours of her drive. He insisted she take a blood test. She complied.  
  
But she knew that the hydromorphone she took 12 hours earlier would show up on the blood test along with a number of other substances consumed within the past 24-36 hours.  
  
*"My concern,"* said Dmitry, *"was that they would attribute her cognitive dysfunction and drowsiness to anything and everything that showed up in her blood even though they could not establish that any of these medications were taken in the timeframe necessary to actually impact her driving. And they'd love nothing more than an opioid collar. Here we have in her diabetes an alternative explanation that is plausible and verifiable. And they couldn't care less."*  
  
Sophie was charged with DUI-D.  
  
*"This was one of those rural jurisdictions where it was clear the arresting officer, prosecutor, toxicologist, defense attorney, and judge knew one another very well. You have to worry under those circumstances that perhaps their first priority is getting along with one another and that that takes precedence over her and over the facts. We asked the prosecutor to knock this charge down to reckless or improper driving. After all, the only thing they had her on was doing 15 mph in a 40 mph zone while she was looking for a safe stretch of shoulder to pull over. But the prosecutor made it quite clear they were going to save the children of their community from Pablo Escobar. It was clear we were dealing with a first rate [REDACTED] who cared more about a conviction rate and an anti-drug campaign than both the truth or health of my wife. That's just pure evil. The cop handled all the pills in her pill box and she had to identify every one for him. There must have been 20 different pills there -- some over the counter stuff like Sudafed, Mucinex, Advil, Tylenol, and Colace -- and some prescription drugs for about 4 different medical conditions."*  
  
Sophie was told she caught a break when her case was assigned to a substitute judge. The judge took into account that Sophie was officially classified by the Social Security Administration as medically disabled based on a confluence of 4 conditions, including chronic intractable migraines for which she is prescribed the hydromorphone.  
  
*"The prosecution made some mistakes. At one point the prosecutor insisted that Tussionex cough syrup does not contain hydrocodone -- which is an odd position for someone attempting to secure a DUI conviction. In an odd twist of fate favorable to the defense, Tussionex had recently been prescribed to the judge himself. After that gaffe, it proved difficult for the prosecution to appear knowledgeable on the subject of drugs. The prosecution also obsessed over the level of pseudoephedrine in her bloodstream -- again an odd focus when building a case for DUI. Sudafed does not cause drowsiness."*  
  
It was the tenuous association of pseudoephedrine to methamphetamines -- Sudafed is now controlled because it was once used as an ingredient in the production of crystal meth -- that drove this prosecutor to invoke its presence in her bloodstream in the hopes of sullying her by the most indirect means imaginable.  
  
*"You know what ELSE doesn't cause drowsiness?"* posed Dmitry.  
  
Hydromorphone. It's a myth and misconception people are all too happy to spread -- that opioids are linked to every adverse event and side effect in the book. The intoxication of alcohol. The recklessness of PCP. The drowsiness of over the counter antihistamines. The obtuseness of dextramorphan. And the hallucinogenic properties of mushrooms. Except for the illicit Street drug heroin, opioids cause none of these. And yet people are routinely prosecuted -- with extreme prejudice -- for crossing a double line or bending a fender after an opioid turns up in their blood test. The Stage IV post marketing data reveals that 31% of those who used hydromorphone in clinical trials reported either drowsiness or changes in mental status. More importantly, of the people who make up this 31%, 98% either dosed inappropriately or with another substance. Yes, opioids like hydromorphone are classified as CNS depressants. But ask anyone you know who has taken an opioid and he or she will tell you a tale of restlessness, talkativeness, and an unbridled enthusiasm and impetus to productivity. These are known in the medical literature as "paradoxical effects." Similarly, we all probably know someone whose hyperactive child is tranquilized by Ritalin -- a CNS stimulant.  
  
*"This guy was shamelessly throwing everything at the wall in the hopes something would stick. The judge wasn't buying any of it."*  
  
The judge was moved far more by the 1,000 pages of medical documentation from her application for Social Security Medical Disability. He clearly saw a troubled woman. A medically beleaguered woman. He knocked the DUI down to reckless driving and reduced the fine for reckless driving from $2500 to $1250.  
  
In the end, no one was happy. The judgement drew a menacing condemnation from the prosecutor. *"The State of Virginia is most unhappy with you, Your Honor."* Dmitry saw a sadist in the prosecutor.  
  
Still, the medically disabled defendant -- unfit to work and married to a man who has been unemployed himself 6 months -- was set back $1250 after an unpleasant 3 hour return trip to the site of her most traumatic memory. And her auto insurance rates were about to skyrocket. All because she suffered one of the more severe symptoms of her diabetes.  
  
*"For the record, she missed her reunion."*  
  
Dmitry believes the reunion is to blame for the rare episode of hypoglycemia.  
  
*"The closer she got to the date, the more second guessing she did with her normal meal choices. She wanted to look her best for friends she hadn't seen in years. And in the last hours, she was so busy packing and primping that she not only forgot to eat, she forgot to test her sugars. Still ... she didn't deserve what happened to her."*

**NEVER AGAIN ... UNTIL NOW: CORRECTIVE ACTIONS WERE REASONABLE & EFFECTIVE UNTIL THEY WENT TOO FAR**

Many Americans do not recall that our response to the Red Scare at the outset of The Cold War (i.e., McCarthyism) was for a brief time necessary, noble, and patriotic. Before FBI raids on Tupperware parties delivered accusations of harboring Communist sympathies or harboring associates who harbor Communist sympathies – before private citizens, DOD cafeteria workers, and Hollywood writers were required to name names to avoid a career-ending Blacklist destroying lives, livelihoods, and relationships – we nabbed domestic spies David Greenglass and Julius & Ethel Rosenberg. The reason most Americans do not remember the successes is that they were overshadowed by the harm done to innocent Americans who either never held views sympathetic to Communism or who held the kind of non-threatening sympathies to which they are entitled as free thinking Americans under the Constitution. At one point after years of slavish compliance and paralyzing intimidation we came to our collective senses, came off the sidelines, and called out the real evil in our midst. Joe McCarthy was censured by Congress for undue pressure, the House on un-American Activities was decommissioned, and we all said “never again.”

Until now. Until a campaign of misinformation and classical conditioning attached the same pejorative connotations once enjoyed by “Communist" to “opioid." Until the DEA expanded its theater of operations, opening up a second front to combat Demand as aggressively as Supply, treating pharmaceutical houses like international cartels, doctors as dealers, and patients as junkies. Until we were told in countless TV ads for Federally funded rehabilitation programs that the chronic pain patients of today are the heroin addicts of tomorrow. Until they learned that overdoses spiked even higher after prescriptions declined 30% -- and decided to stay the course and double down because they know that overdose statistics will have to fall eventually and dramatically once patients abandoned by their doctors are forced into Street drugs and suicide. It’s their idea of herd immunity applied to the substance abuse crisis.

The tactical combination of propaganda, clandestine surveillance, and intimidation we loved so much during the Red Scare is alive and well again.

One day Americans will come to their collective senses to hold the Fed accountable for all the blood on its hands – for the careers destroyed in DEA raids on medical practices – for all the innocent patients who took their own lives or took fatal doses of counterfeit pills laced with fentanyl – for the physicians, physician wives and staff, patients, pharmacists, and insurance carrier representatives pitted against each other in tense disputes rooted in liability risk and new paperwork requirements. And when the blood splatter hits the wall, we would have long forgotten that some good actually came early from the first round of corrective actions:

1. Require prescriptions for Narcan accompany prescriptions for morphine-based painkillers
2. Require that persons suffering pain from acute conditions who have never been exposed to pain medicine before be limited to a one week supply of the lowest effective dose
3. For chronic pain patients, require quarterly appointments with prescribers for regular follow-up and risk assessment, require that the history include good faith diagnostic efforts to penetrate etiology and good faith palliative effort to pursue nonpharmacologic and pharmacologic-nonnarcotic treatments.
4. Require chronic pain patients sign a pain management contract initiating specific clauses identifying the physician as the one and only prescriber of pain medicine, stipulating that patient is willing to assume a manageable risk in exchange for some quality of life, and promoting awareness of potential interactions from simultaneous dosing and of the potential overdoses spawned from tolerance when patients titrate up by whole pills rather than by milligrams

Now that these practices have been implemented ... now that pill mill doctors (defined as those physicians who do not abide by the aforementioned practices) and rogue dentists have been identified and subject to corrective action, there is no need of further action. The actions taken beyond those listed above constitute harassment, discrimination, and violation of a patient's civil rights as a clinical minority and person with a disability. Much of this regulatory overreach and harassment occurs at the pharmacy, through opioid-specific rules stipulating that an opioid order can not be split, transferred, special ordered, or reserved for the customer, who cannot even be informed by phone of a delivery. Some pharmacies will not even answer stock questions over the phone, requiring sick or pain-addled customers to drive from one pharmacy to another. Some states require electronic scripts, not to facilitate or streamline, but to create more work for prescribers and to limit the patient to one pharmacy of choice. If that pharmacy is not the store closest to the patient’s listed residence, the pharmacist is alerted by his computer system to advise the patient of a closer pharmacy, as when the Herndon, VA Walgreens 3.2 miles from my home that I had been comfortable using for the past 3 years, attempted to re-route me to a new Walgreens (formerly a Rite Aid) that opened up 1.9 miles from my home. Back when doctors were allowed to hand out hard copy scripts at the end of an appointment, that patient could take the script to any store within the chain that had the full quantity in stock. (Remember, opioid scripts cannot be split). Now in the event the pharmacy is out of stock, the patient is forced to wait days for a delivery that cannot be special ordered or reserved for him, or he could burden his doctor to cancel the script in the system and issue a new one to a new preferred location. And of course, the electronic scripts have not eliminated doubts of authenticity. Pharmacists are still encouraged to phone doctors with such questions as “are you sure this is what you want to do? Are you aware patient is also taking ...”. At this point doctors averse to phone calls or liability might reverse course and give the pharmacist the option of refusal.

And yet in the face of this spate of regulations threatening delays and complications, there are still idiots out there – senior Congressional leaders among them – who feel compelled to ask “why aren’t we doing anything?!”

Painkillers are blamed for a lot of deaths. But the painkillers themselves are not the problem. There seldom is a problem when a patient has at his or her disposal the medication needed. The problems arise once the medication is taken from the patient precipitously or for reasons unrelated to a physician’s medical judgment. Then of course the naive public and parties antagonistic to drugs point to the adverse outcomes and say, “see, I told you these drugs were dangerous.”

CDC officials will lump all opioids together when they need a figure that compares favorably with the number of souls lost to alcohol, car accidents, or the Vietnam War. And yet even the most manipulated data can achieve no more than comparable status. But if accidental opioid overdoses owe their significance to motor vehicle accidents, for example, why are we not criminalizing the operation, ownership, sale, and distribution of Honda Civics? We are not imposing limits on the number of sedans on our nation’s highways. The Attorney General is not suing General Motors, nor are the Joint Chiefs sending strike teams into Detroit by parachute. Why not? Why, you already know the answer to that. Speed limits and safety belts save enough lives without having to mess with how people get to work or to the supermarket. It is in this vein that we should recognize as sufficient progress the measures taken to prevent overdose fatalities. The ramifications of taking people’s painkillers are not as obvious but they are there nonetheless. After my mother's breast cancer metastasized to her lungs but before she was prescribed Oxycontin and oxycodone, she was overwhelmed by a combination of discomfort, malaise, and depression. She could not be the dynamo of the Wayne, NJ Elks. She could no longer be wife to my stepfather. And she could no longer be a grandmother to my 5-year-old boy. My poor kid couldn’t understand what had become of his grandma. That more than anything else brought tears to my eyes. But when the opioid therapy started, she returned to form. She was her old self again. There are people who think of painkillers as lies possibly due to morbid seeking orientation of the stereotypical addict. But I have always associated painkillers with truth inasmuch as they enable patients to be themselves – the people they are underneath the pain, the stress, and the depression. The bottom line? ... we may need our cars but there is something even more fundamental to our lives. So fundamental that it cannot be labelled. Fundamental in that it \*is\* our lives. Seventy-one percent of chronic pain patients surveyed have already reported that their pain medication has either been reduced or rescinded. Awful is this state of affairs and yet it can still be far worse. And far worse is in the offing if many in authority – including those re-assigned to revisit the CDC Prescribing Guidelines they originally wrote (e.g., Roger Chou) – are scheming. I don’t think you want to know a world without pain medication.

Why would Republicans argue mass shootings are used as an excuse to take guns from law-abiding citizens – and not argue that heroin overdoses are used as an excuse to take legally prescribed painkillers from responsible pain patients?

**AN UNDERLYING CAUSE FOR SUBSTANCE USE**

Critics of opioids like to point out that pills only mask pain and that the pain is only a symptom of an underlying disorder. But these same critics are also using band-aids and playing whack-a-mole with symptoms when they fail or refuse to see recreational opioid use as an effect – one of many effects – of more foundational disturbances to our economy, our social order, and ultimately our individual psychology. While our finger-wagging leaders in business and government attempt to shame us for our vices, weaknesses, and poor decisions, I might be inclined to blame them for failing to address continuous waves of socioeconomic crises and disruption over the past 25 years. I hold them accountable for a lack of foresight, risk assessment, and response to the virulence, malevolence, malfeasance, and prejudice. To automation, transformation, immigration, and globalization. For millions of Americans who suffered through the NASDAQ Crash of 2000, the Software Revolution, two terror wars, the Great Recession, the Gig Economy, and the 5 year Budget Impasse, COVID is not the first or only emergency. In fact, COVID was not even the first pandemic (i.e., SARS, Zika, H1N1). Our crises in student loan delinquency, retirement planning, affordable housing, health care financing, and workforce development could be traced to revolutions in Software and Internet that subordinated the value of college degrees and intellectual capital to software proficiency and shifted the advantage from unemployed job seekers -- who faxed, snail mailed, or hand-delivered typewritten resumes in response to ads in the classified section of the newspaper and comprised 60 of 80 applications to an employer -- to working Americans now just keystrokes and mouseclicks away from candidacy and, in a stunning reversal, comprise 600 of 800 applications to an employer.   
  
The 4 decades following the World Wars, including the 1960s, were an era of stability during which our parents and grandparents enjoyed remarkable job security and a stable of friends from prom to pallbearer. With no college degrees and a father's salary of $13K, my parents were awarded a $39,900 mortgage on a brand new 4-bedrooom Colonial in metro New York. Their firstborn son and his first wife held 3 doctorates between them and yet struggled to find and keep jobs and knew they would never own a home.   
  
We have entered an era in which politicians seeking high office enjoyed advantages for having less experience inside the Beltway. Clinton unseated the most experienced public servant in GHW Bush, the incumbent who helped the U.S. overcome the USSR, led the U.S. to a victory over Iraq in 4 days, served as VP, CIA Director, WW2 fighter pilot, and Congressman. Bush's son would defeat Clinton's heir apparent, a lifelong Senator and VP, with the lightest resume in U.S. Presidential history: 4 years as governor of Texas. Barack Obama, whose resume was even lighter than that of GW Bush, would be the first African American elected to the Presidency. Donald Trump would become our first anti-establishment President, winning on a populist platform similar to that of kindred businessman Ross Perot, who surprised everyone by taking close to 20% of the vote as a third party candidate in 1992. And Trump prevailed over an experienced candidate in Hillary Clinton, who had been First Lady, U.S. Senator from New York, and Secretary of State. Ours is a restless nation steeped in discontent and continually questioning whether we need to chart a new course. This applies both to our search for a leader outside the Establishment and our search for a job that doesn’t make us unhappy. Someone one asked me how I would reconcile the low unemployment figures with the fact the average job opening draws somewhere between 300 and 1800 responses. To this I respond by pointing out that the vast majority of applications come from people who already have jobs but who are unhappy with their jobs. Allow me to paint you a picture. These are people who may have had to pursue or accept a job beneath their station in the years after the Great Recession. They have not seen a raise or promotion in 4 years despite doing the work of 3. The fallout dust from the Great Recession still had not settled when the COVID pandemic hit. Throughout this period and into where the foreseeable future meets the horizon, one in 3 working Americans is engaged in an active job search. That works to drown out applications from those who haven’t seen a paycheck for a very long time. It prolongs their unemployment and makes the gaps in their resume even more visible to prospective employers who just have to ask them why they haven’t been working and what they have been doing with themselves. Now as a seasoned unemployed job seeker I get asked this question often and I can honestly tell you there is no good answer or, more accurately, no answer inquiring employers consider acceptable. As a social psychologist, I can also point out that extended unemployment is toxic to one's self-esteem, reputation, resume, resources, and relationships. I have known unemployed job seekers who have had to liquidate assets, file Chapter 7, or bankrupt relatives from whom they needed money for rent. Not many members of my own extended family remember that I had been gainfully employed as a senior management analyst with Health & Human Services for 4 years when my son was born. I was laid off just a few months after his birth – a casualty of the politically divisive climate in which President Obama and a Republican controlled Congress could not agree on a budget for an historically unprecedented 5 years. So to hear that members of my family had made my son the subject of some really nefarious gossip – by which I mean blood relatives rallied around a comment to the effect of “Matt didn’t have to have him" – as if my son was the unfortunate product of self-indulgence and irresponsible financial planning – well suffice it to say I haven’t spoken with family in years. My family also blamed me for the death of my mother. You see, it was my financial stress that burdened her to the point where her immune system laid down its defences and allowed a once dormant breast cancer to suddenly reappear in her lungs. And all the money she had to gift me to keep a roof over her grandson's head was that much less my brothers could receive as inheritance. To add insult to injury, my mother did not possess a PhD like the son she found herself having to support into his 40s. She never even went to college. The money she gifted her son came from two places: her pension as a retired high school secretary and the legal settlement she negotiated with an oncologist who badly butchered her during the resection of her primary tumor. Unfortunately, as much anger as I carry around, no one would allow me to blame anyone but myself for my failure to find work. And I cannot help but hold a grudge for all the people who intervened unnecessarily in the 11th hour to sink my application for jobs for which I at one point was considered the sole or leading candidate. I remember all their names. And I remember that if just one of these malevolent clowns refrained from harm, I might have avoided all the adverse outcomes to me and to many people who either depended on me – whose fortunes were tied to mine – or who exhausted or invested resources to prevent me from bottoming out. Perhaps someday I will find riches from taking my tales public as a novel. For now, allow the unlikely fall of a PhD to serve as a graphic illustration of an era where substances are used to manipulate moods for the purpose of enhancement or escape. But I also know I am not the only casualty of the Times. And yet despite all the civil unrest -- all the geopolitical, socioeconomic, and technological instability -- we're still trying to decide whether to blame doctors or pharmaceutical houses for the one crisis that isn't real ... or more accurately the one crisis that fails to accurately or adequately characterize the source and symptoms of what ails us.

**HOW AND WHY THE U.S. GOVERNMENT BOTCHED ITS INVESTIGATION INTO OVERDOSES, OPIOIDS**

*Illustrating Breakdowns in Logic and Discipline in the First Five Sentences of the Guidelines*

I submit this literature review as evidence for undisciplined reasoning and referencing by Guidelines authors. In a document with such profound influence on health care policy, you want to see objectivity, logic, and a conscientious review of the research literature. I intended a full review of the Guidelines but found all the evidence I needed after just the first five sentences.

As I walk you through my commentary on the Guidelines, I might strike you as a bit of a stalker. But please understand that I don't take anything for granted. And neither should you. You see, if you read this CDC document too casually -- without a critical eye -- you will fall victim to some tactics designed to mislead. But if you pay sufficient attention, it will be clear to you that the authors are trying very hard to sell you something -- and that the product is one they had on hand before a single scrap of research had been reviewed -- a single statistic calculated. The 2016 CDC Opioid Prescribing Guidelines (hereafter "The Guidelines") is not a response to a vision that came slowly into focus as a critical mass of information fell into place in the due course of research and detective work. Far from it. As my commentary will make clear, the narrative -- the desired public service message -- that came first. And then data that fit the narrative was headhunted and used to fill in the blanks.  
  
My walkthrough will also make clear that both the writing and the underlying logic lacks discipline. Eventually you will see how this lack of rigor and fidelity applies to their analysis of the organized body of knowledge on the subject of pain management. The body of knowledge happens to be disorganized -- which is not their fault and which can be said for most biopsychosocial phenomena. But it's the way they go about imposing order on this domain that most dramatically exposes a political agenda.  
  
Guidelines authors open with "Opioids are commonly prescribed for pain." This is their first thought.   
What an entrance! No one could accuse them of burying the lead. But they can be accused of undermining it ... in sentence number 2: "An estimated 20% of patients presenting to physician offices with noncancer pain symptoms or pain-related diagnoses (including acute and chronic pain) receive an opioid prescription." Twenty percent. In what universe is 20% common? Now if 20% of all patients received an opioid prescription, yeah, I would agree 20% would seem excessive. But lo and behold it's 20% of patients presenting with acute or chronic pain. Twenty percent of patients in pain receive a painkiller. You'll forgive me if I'm not knocked out. In fact, 20% strikes me as conservative. I am left to wonder how many of these poor pain-addled patients walk away with no adequate means to address their chief complaint. Bear in mind that psychometricians expert in assessing patient satisfaction through the Medicare-approved CAPHS survey will tell you that the question that correlates most highly with the overall patient satisfaction score is the first one: "are you in pain?"   
  
Bias is also evident in the third sentence: "In 2012 health care providers wrote 259 million prescriptions for opioid pain medication, enough for every adult to have a bottle of pills." This statement feels labored. You sense that before writing commenced -- before words were put to paper -- that there was an outline with a placeholder where this sentence is now that read "INSERT STATISTIC HERE that incites feeling the streets are flowing with painkillers and that doctors are practically handing out free samples to go along with a Census form and a mailing from Publisher's Clearinghouse." It just feels more like a preconceived / boilerplate strategem than an inspired response to real data. And when you think about it, 259 million bottles is not all that unreasonable when you consider the number of people in pain and that for every chronic pain patient there would be one bottle per month. And while the preceding sentence excludes cancer ("noncancer pain symptoms"), readers need to avoid being misled into thinking cancer patients are not represented in the staggering 259 million figure. Because they are. And if we look at the CDC's own statistics, there were 1,529,078 new cancer diagnoses in 2012 alone. You have to imagine that this is just a fraction of the number of cancer patients overall. The American Cancer Society estimates the current prevalence of cancer at 8,781,580. If each of these individuals received a bottle of pills each month for a full year, that's 105,378,960 bottles right there. That means that a full 41% of the statistic the CDC presents in the spirit of shock and awe is accounted for by cancer alone. And since cancer patients are not really part of this debate -- as they are exempted by the palliative care provision -- we're really only fretting over 154 million prescriptions. But such a figure wouldn't interest the authors. You can't shock readers unless you can say there's "enough for every adult to have a bottle of pills." And once cancer patients are excluded, you can't make that statement.  
  
So the CDC authors want to call attention to how much drug is received by people who don't have cancer, but then they need to include cancer patients in order to arrive at a number like 259 million and the great "one bottle per every adult" line. They will avail themselves of this tactic again when they cite that the number of citizens lost to an opioid overdose since the turn of the century exceeds the total number lost during the Vietnam War. Put a pin in that one. We'll expose the flaws in that comparison in due course.  
  
"Opioid prescriptions per capita increased 7.3% between 2007 and 2012, with opioid prescribing rates increasing more for family practice, general practice, and internal medicine compared to other specialties."  
  
This is not actually the interpretation the authors of the study (Levy, Paulozzi, Mack, & Jones, 2015) would have framed as the one that best fits the data. I do not have access to the full article, which sits behind a paywall, but the synopsis is clear enough. "The greatest percentage increase in opioid prescribing rates between 2007 - 2012 occurred among physical medicine / rehabilitation specialists (12.0%)." While the authors did mention that "primary care specialities did account for nearly half the dispensed opioid prescriptions," this could not have been more practically significant than the rate of prescribing for pain medicine (48.6%).  
  
The timeframe in which the data is collected is also remarkable. I mean, much has been made of the link between opioid dependency and emotional lability, and the 2007 - 2010 window coincides with the greatest economic downturn since the Great Depression. I find it particularly odd that Government specialists tend to ignore psychosocial and socioeconomic contributions to the crisis du jour. These factors were ignored when Deloitte Consulting executed a report on long term unemployment funded by the Rockefeller Foundation and commissioned by President Obama's Council on Economic Affairs in 2015. These factors were ignored when CMS reported on the impact of increased utilization of the health care system on budgets. And we pretend the psychosocial universe does not exist as we seek to reduce our citizen's reliance on a broad array of substances to a fraud in which opioid manufacturers conspire with doctors to profit from peddling addictive substances to addictive personalities and vulnerable youth (i.e., wisdom teeth extractions). As far as HHS and DOJ are concerned, it's all finance and physiology. The Guideline authors neglected to mention the finding that the rates of opioid prescribing did in fact drop for emergency medicine (- 8.9%) and dentistry (- 5.7%), which suggests the influence of opioid-antagonistic policies targeted at that time to recreational drug seekers and vulnerable youth who received a generous helping of percocet in exchange for their wisdom teeth. The Guideline authors also neglected to mention that opioid prescribing leveled off after 2010. Incidentally it was in reviewing this source that I learned of the IMS Health National Prescription Audit. Isn't it nice that there is an agency that performs this service for us? How would our Regulatory Culture -- cynics might say "police state" -- thrive without databases and analytics. "In 2012 U.S. pharmacies and long term care facilities dispensed 4.2 billion prescriptions, 6.8% of which were opioids" -- apparently. I can't decide whether I should think of that 6.8% figure as high. More interestingly, neither could Levy. No effort was made in text or tone to lead me one way or the other.  
  
"Rates of opioid prescribing vary greatly across states in ways that cannot be explained by the underlying health status of the population, highlighting the lack of consensus among clinicians in how to use opioid medication."  
  
So if we take the past two sentences together, Guideline authors suggest that physicians are prescribing opioids in greater numbers despite not knowing when it is appropriate. Guideline authors are lubing us up for quite an apocalyptic state of affairs. I'm surprised they were able to refrain from stating something to the effect that this is tantamount to selling more firearms to people who have never been trained to use one. They make doctors out to look like clueless newbies in over their heads. And I imagine that they succeed among readers who confuse a "lack of consensus" within the medical community with ignorance and who buy into the supposition that the unexplained cross-state variability is evidence for a lack of consensus. This is a strange leap. Two strange leaps actually. In fact, the whole sentence is just plain weird.  
  
Just because the Guideline authors and the authors of the article they reviewed (Paulozzi, Mack, & Hockenberry, 2014) could not explain this cross-state variability does not mean doctors don't know when to prescribe painkillers to treat pain. It might just refer to the intellectual limitations of the aforementioned authors. And after reviewing the article, it became clear to me that the intellect of these study authors is truly rate limiting. Here is their study conclusion in their own words: "Factors accounting for the regional variation are unknown. Such wide variations are unlikely to be attributable to underlying differences in the health status of the population. High rates indicate the need to identify prescribing practices that might not appropriately balance pain relief and patient safety."   
  
So according to these authors, doctors do not know how to appropriately balance pain relief and patient safety -- are you following? -- doctors are unsafe in their prescribing habits -- simply because more prescriptions were written per 100 residents in some states than others and because short acting opiate pain relievers and benzodiazepines were prescribed at higher rates in the South census region while long acting / extended release opiates and high dose opiates were highest in the Northeast. Now allow me to explain why this variability they parlayed into serious public health policy implications is so utterly meaningless. For one thing, the metric used to express these differences is number prescriptions per 100 residents. If this had been an experiment, the study authors would have had to adhere to strict standards to ensure the groups compared were meaningful and interpretable. This means resorting to practices to ensure the experimental and control groups are as similar as possible outside the manipulation under study and that the variation within each group is minimized. This would normally be attained through randomization of sampling / assignment and the double blind procedure. But this is not an experiment. In fact this is not a research project of any kind. It's a database survey. A brain dead actuarial exercise.  
  
What is being compared among states is the number of prescriptions per 100 residents. If the 100 persons in question were 100 visitors to a family practice presenting with a chief complaint of pain, then the difference between 96 for one state and 72 for another might mean something. And by the way, attempting to dress up the data by standardizing the state numbers does not make it meaningful. It just contributes cosmetically to the optics of scientific rigor and sophistication. Now Paulozzi et al get around to making sense of the variation across states. This is when things really get amusing. Once they've used all the power of their brain to surmise that the variations across states are "unlikely to be attributable to the underlying health status of the population" -- and this conclusion is not informed by any research or data by the way -- they arrive at what they think is the only remaining explanation. It must be the doctors. THEY'RE the one and only source of variation. THEY'RE different. Contrary to what Paulozzi et al would have you believe -- and et al here includes the authors of the Guidelines who are slavishly complicit with these lazy and wistful interpretations -- the data does not necessarily say anything about differences in prescribers. In their prescribing habits or philosophies. I am sure it is as obvious to you as it is to me that the variability among states are equally if not more likely to reflect differences in the RESIDENTS of the states. Any number of factors related to personality, economics and insurance, or geography could influence when persons in any state decide it's time to visit a doctor.  
  
How these authors could be so unprepared for this outcome is mind-bogglingly atypical of anyone with a human forebrain. And yet this study is used by Guidelines authors to cast doubt on the clinical capabilities of prescribers and to pronounce as the study authors do that "state policymakers might reduce the harms associated with abuse of prescription drugs by implementing changes that would make the prescribing of these drugs more cautious."   
  
**OPIOID CRISIS BOONDOGGLE INEVITABLE RESULT OF INAPPROPRIATE AGENCY ASSIGNMENT**  
We have a Government that put the CDC Injury Prevention and Control Center in the lead here. This is an agency responsible for detecting, quantifying, and ranking causes of death as threats to the physical integrity of living Americans. Similarly in 2001 in response to 9/11 and the anthrax attacks, we created a Department of Homeland Security that issues to HHS material threat determinations -- or calls to action -- for what it deems plausible and high consequence threats of biological, chemical, radiological-nuclear, or emerging disease origin. But what is lacking is an agency that deals with a broader class of crises and disruption capable of destabilizing a person economically, professionally, and socially.   
  
The widespread use of substances to manipulate moods is a symptom -- likely one of many symptoms. When our nation's leaders are unwilling or unable to solve existential threats to our lives or livelihoods -- or when our leaders or other members of the community unwittingly cause or exacerbate these threats themselves by finding new and creative ways of standing between us and what we need -- we tend to self-medicate as a means of escaping or enhancing our ability to address the threats. Since the turn of the century, we have endured a continuous series of crises and disruption that impacted our mortality, security, identity, vocation, community, and faith. For many of us, the impact left crater-size gaps on our resumes and ultimately damaged our resources and our relationships with those who depend on us or those from whom we have had to borrow for food or rent. You want to know the cause of the spike in overdoses since 2000, I give you life in 21st century America.

If our leaders could have attended to these matters ... workforce participation & development, long term unemployment stemming from employer biases, the impact of Big Tech and the Software Revolution on the value of traditional degrees and intellectual capital, affordable housing, and even partisan divisions within its own ranks resulting in a 5 year budget impasse and failure to deliver timely and adequate economic COVID relief ... then people wouldn't need to turn to drugs to stave off anxiety or depression or to steal a little happiness in a world that appears increasingly obstructionist and discompassionate.  
  
The understanding generated by such an agency cataloging these tectonic events would inspire, inform, and justify public health actions beyond the narrowly conceived definition of health as biochemical stasis, harmony, or integrity. This is why the CDC has failed in its characterization, estimation, and remediation of the so-called opioid crisis. It is an agency largely staffed by virologists who force everything into a model of person-to-person transmission.   
  
If one could describe the CDC-stamped "Opioid Crisis" as a glass house of cards with clay feet built on a foundation of sand -- pardon the mixed metaphor -- then perhaps this is an appropriate time to call out the elephant in every room.  
  
"Death certificates are the foundation of drug overdose mortality surveillance. Variation in systematic approaches and jurisdictional office policy in drug overdose death certification can lead to bias in mortality rate calculations." (Slavova, Delcher, & Costich, 2019).  
  
I am sensitive to the limitations of the medicolegal death investigation (MDI) system. At one time I spearheaded an effort to integrate data "siloed" or "stovepiped" across hospital information systems. From the moment I first stepped foot in a hospital, I was impressed by the potential windfall of integration for basic research, business intelligence, and clinical decision making. Having the support of the executive officers only opened so many doors. In the end, I still had to grapple with a barrier to integration so complex and so foundational that it placed the entire project in jeopardy. I'm speaking of pathology data. What can we say about pathology data? The data describes what was learned from biopsies, body scans, and other specialized diagnostics aimed at confirming, denying, and clarifying the underlying or ultimate causes of the patient's condition -- causes that come with associated prognoses and risk factors. So pathology data is important. What else could I say about it? It's surprise surprise -- only occasionally digital. It consists almost entirely of text. Critical values are often embedded in the text, and other critical information resides in the use of certain terms or keywords such as those that indicate whether cells are "columnar," "cuboidal," or "pseudostratified." What I found most frustrating was the lack of standardized guidelines to prod pathologists into using the same style, format, and terminology to free-verse the same outcomes. It is certainly possible for pathology data to look a lot like lab data from a CBC, with a set of single numbers and letters capable of providing an at-a-glance profile of a tumor. I can only imagine how much more advanced our understanding of disease might have been had pathologists followed such guidelines. In its current form, it is very difficult to execute any research that makes use of pathology data.  
  
So you can imagine just how much I must think our understanding of the "opioid crisis" is limited or distorted by similar barriers in medicolegal surveillance. I don't even feel comfortable referring to an "opioid crisis" knowing its very existence is based on statistics sourced mainly from pathological examinations.  
  
1. LIMITS OF ICD-10 CODING. Death certificate data relies on ICD-10 codes. But the codes do not allow MDI officers (medical examiners and coroners) to identify specific opioids. Presented with a limited range of options lacking sensitivity and elegance, MDI officers lose any inspiration they might have had to name any drug at all. Approximately 1 of every 5 U.S. overdose death certificates do not identify any specific drugs. This certainly dampened my enthusiasm for the cause-of-death natural language text search tool developed by the NCHS and the FDA, but it hasn't curbed my enthusiasm for questioning the validity of insights claimed by other users of the search tool braving a missing data rate of 20%. The rate for missing data is higher than opioid prescribing rates. If you really think about it, we base policy actions -- and many of us are quite emotional about these policy actions -- on rates or changes as small as 2 - 3 per 100,000 people or 4 - 6 per 100 prescriptions. We are essentially reacting to small fluctuations in small numbers. Alarm bells go off when the outcome rates (e.g., rates of dependency or mortality) are dwarfed by the rates at which data is missing, variable, or sourced through components of a process that vary considerably. But that's just me.  
  
I would love to cite with some certainty the transition from oxycodone to heroin -- with increased involvement of fentanyl -- as a leading cause of overdose deaths between the years 2010 and 2014 (Warner, Trinidad, Bastian, Minino, & Hedegaard, 2016). Those who make and enforce new policy certainly seem to ignore the fact that illicitly manufactured drugs have superseded prescription medication as the driving factors behind overdose mortality.  
  
2. Missing data is problematic. But so are the "reallocation strategies" and methods of statistical adjustment used to account for the underreported involvement of specific drugs in overdose deaths, which revised upward the U.S. opioid-involved drug poisoning mortality rate from 10.3 per 100,000 to 12.5 per 100,000 in 2015 (Ruhm, 2017). Buchanich, Balmert, Williams, & Burke (2018) have found many eager to buy into their assumption that the proportion of unspecified drug unintentional overdose deaths that might be attributed to opioids would be the same as the proportion of opioid-related overdose deaths among all unintentional overdose deaths with specified drugs. This assumption gave us an additional 70,000 deaths between 1999 and 2015 to blame on opioids. The goal ... two actually... to be able to state that opioids have claimed more souls than car crashes and than the Vietnam War. Even within the NIH, these assumptions are regarded as "reasonable but difficult to verify" (McGivern, Shulman, Carney, Shapiro, & Bundock, 2017). We assume that the prevalence of unspecified drugs is a lack of diligence due to inadequate resources or ethics even while we fail to understand why certain toxicology protocols and certain ME/C jurisdictional types are associated with more complete, consistent, and accurate drug information. Truth is ... we don't know when and why unspecified is used.  
  
3. Systemic Underreporting of Heroin / Fentanyl Fosters Attack on Prescription Drug Users  
  
One possibility is that unspecified lives where there is a lack of technology or training needed to overcome the challenge of rapid metabolism. Heroin specific analytes often go undetected due to the rapid metabolism of heroin to definitive metabolite 6-acetylmorphine (6-AM) and the rapid metabolism of 6-AM to morphine. Since codeine is often present in heroin as an impurity, heroin-related overdose rates could be adjusted by accounting for a morphine-to-codeine concentration ratio greater than 1 in toxicological analysis (Ellis, McGwin, Davis, & Dye, 2016). To make matters worse, we are not consistently and uniformly scanning for fentanyl precursors (e.g., 4-ANPP) and metabolites of fentanyl analogs. Until we do more to distinguish between codeine, heroin, and morphine deaths, myths and misconceptions about the opioid crisis will persist in the faces of undiagnosed illicitly manufactured drugs.  
  
4. Detection & Surveillance System Unable to Tease Out Relative Contributions in Multi-Drug Toxicity Cases  
  
In multi-drug intoxications it usually is not possible to tease out an individual drug's role and it is not uncommon for the MDI officer to deal with this by including all the drugs with concentrations greater than trace amounts in the cause of death statement.  
  
5. Despite the fact accurate certification requires that drugs that did not contribute to cause of death should not be recorded on death certificates -- and despite the fact the U.S. has no nationally accepted best practices, standards, or guidelines for post-mortem toxicology testing -- the recording on death certificates of opioids in non-contributory roles is done with a regularity that would make one think it is the closest thing we have to a guideline.  
  
So why would I believe something like this might happen? That is, beside the obvious fact that we stupidly tie paychecks, jobs, votes, public approval ratings, legacies, and funding streams to the notion that a crisis does indeed exist. But don't take my word for it. Look at South Carolina, where the rate of opioid poisoning appeared to double from 4.7 per 100,000 in 2013 to 9.3 per 100,000 in 2014 due to an impressive increase in drug poisoning death certificates that just so happened to list specific contributing drugs. You see, in 2013, only 57% of the death certificates listed any specific drug names in the contributing fields, whereas in 2014 that figure rises to 94%. A procedural change -- and voila -- a crisis is born. I am giving the anti-opioid crusaders, self-aggrandizing careerists, and mercantile imperialists among us the benefit of the doubt here. I am assuming that this was a procedural change ordered in the interests of improving the fidelity of the surveillance system. A cynic might be disposed to wonder whether this was done to pad the stats. If it was, then the opioids received the honorable mentions in the contributing fields merely for appearing in the blood of the decedents and not because the coroner or medical examiner really believed they played a role in the death. The distinction between "drug-caused" and "drug-detected" deaths urged by SAMHSA is not the rule of thumb.

**ADDRESSING LESS THAN SCHOLARLY MOTIVES, CONFLICTS OF INTEREST, AND NEUROSES AT THE ROOT OF THE OPIOID CRACKDOWN**

***"If you're the National Football League and you really want to know whether future first ballot Hall of Fame QB Tom Brady was engaged in a scheme to deflate 12 gameballs below the legal limit of 12.5 pounds per square inch, you don't hand the question off to Ted Wells along with a suitcase of 5 million dollars. Similarly, no truly curious, scientific-minded person assigns questions about the costs and benefits of opioid therapy to the CDC Center for Injury Control & Prevention and, in turn, to a team of consultants staffed by members of an extremist group who call themselves Physicians for Responsible Opioid Prescribing."***

Federal regulators, law officers, and even emergency room physicians are trained to view any reported need for prescription painkillers with a measure of distrust somewhere between modest skepticism and morbid suspicion. These professionals would tell you it’s all part of the job. Even physicians contributing to the 2016 Opioid Prescribing Guidelines have made statements to the effect chronic pain patients do not pursue painkillers for relief from pain but to get stoned or to avoid the depression and malaise that accompanies withdrawal. These so-called experts, who do not possess advanced degrees related to the physiology or clinical management of pain, advise legislators that those who live in pain forfeit authority over their own condition once they expose themselves to painkillers. From their point of view, painkillers possess a seductive and intoxicating hold over the user so that their motivations and rational faculties become corrupted. They become every bit the addict as any junkie wandering the Southern California beaches.

For years these “this is your brain on drugs" warriors have cornered the market on the use of motivational psychology to discredit their opponents. So we ask if those calling for a prohibition on opioid-based pain medicine are immune from a speculative analysis focused on their own motivations? Do they not have conflicts of interest, prejudices, or weaknesses of their own?

As a social-personality psychologist, I have given considerable thought to this matter and determined that those who invested substantial time, resources, and emotion to opposing opioids can be broken down into four groups based on motivation.

*Bereavement Cases: They Lost a Loved One*  
  
The grieving survivors of dead heroin addicts need an Opioid Crisis. They demanded one when they stormed the offices of their District Representatives seeking to recast their dead sons or daughters as victims of industry and posthumous agents of reform. There is no greater therapy than enlisting the aid of a Government leader in crafting legislation through which their deceased loves can continue to live and influence the world. It's the kind of thing that brings meaning to the lives of the surviving family as well as to the otherwise senseless and gruesome deaths of their loved ones. Those who persist in their nuisance activism beyond the one year anniversary of the tragic overdose can be diagnosed with Bereavement Disorder under the Diagnostic and Statistical Manual of Mental Disorders (DSM). It must be difficult for a Government official to turn away such sorrow and righteous indignation.

*Self-Aggrandizing Careerists*  
And often they don’t. They see in the grieving survivors of these deceased constituents a rare upside-only opportunity to score votes and repair a tarnished public image. In drugs they see a reason to reach across the aisle for a rare opportunity to calm a cynical and divided electorate with bipartisan action. And so it is beside an easel bearing an enlarged head shot of the deceased that the Congressman takes to the podium to announce a new bill designed to make pain medication more difficult to obtain.

But elected officials are not the only ones motivated by their careers. These are many other self-aggrandizing careerists consumed with their survival and that of the organizational units in which they are nested. With voter referenda showing a growing public disinterest in the Drug War and showing increasing support for the legalization of marijuana, the DEA must feel an urgent need to put a new face on evil. Rebrand or risk defunding. Why not? In the wake of police brutality, there has been a lot of talk of defunding local police departments. And with analysts like myself suggesting that the DEA's role in the abrupt discontinuation of opioid medication for millions of pain patients amounts to a form of brutality, well, you get the picture.  
  
A change in funding or mandate could bring destabilizing changes to one's role, division, agency, organization, or industry. Take the current pandemic as an example. If not for COVID-19, Fauci does not become a household name. No one listens to Fauci when he steps in front of a microphone. No one invites Fauci to throw out the first pitch at a Nationals home opener. Similarly, if opioids had not been (falsely) deemed the root of 80,000 overdose fatalities -- if the word opioid was not treated as eponymous with substance like Xerox with photocopy -- Andrew Kolodny is not charging $750 an hour to testify against pharmaceutical houses. He is not procuring a home with the $500,000 he earned from his expert witness testimony. Chronic pain patients who were abandoned by their doctors might call this blood money. Go figure.

There are rooms full of Federal bureaucrats on Constitution and Independence Avenues deep in urgent reflection intended to produce the next big idea on drug control. They work for CDC, FDA, and NIH, and they know that meeting the objectives laid down in their annual individual development plans (IDPs) is the only means to an outstanding performance evaluation, step increase, and raise. Someone’s always bucking for promotion or worried about keeping their job – and the only ideas that will help promote or defend their careers are the ones that introduce new regulations and restrictions. Ideas that would ease restrictions and liberate health care users and professionals are never considered ideas. The only ideas are the ones that create the need for more documentation, communication, assessment, management, and technology.

*Mercantile Imperialists*  
Then there are those who materially benefit from the declaration of emergency around opioids. Funding streams were set up to create jobs, research and rehabilitation programs, and to stimulate entrepreneurial ventures. I've crossed paths with three different entrepreneurs leveraging LinkedIn to promote their first-of-its-kind, one-of-a-kind pill locker. It's their plan for curtailing accidental overdoses by delivering only the pre-programmed dose at a pre-programmed hour. Each also unveiled a stratagem for putting his product in the home of every person prescribed an opioid. Each is reaching out to the appropriate lawmakers and bureaucrats in the hopes CMS can be compelled to require physicians to prescribe these pill lockers as a precondition for an opioid prescription. Hell it worked for naloxone.  
  
Two enterprising researchers found a way to tap outgoing sewer lines in residential neighborhoods so they can perform opioid drug screens on households. The plan is to use the confidentially aggregate statistics to shock lawmakers into envisioning a use for the technology by law enforcers. As surveillance and detection systems go, it's creepy. It's invasive. It's grotesque. But like the Prescription Drug Monitoring Database, it's legal. But most importantly, it's lucrative -- at least for the two enterprising researchers.

The regulatory and compliance monitoring industry also saw 49er gold. Katherine Keyes, Vice President of Operations for Affiliated Monitors, offered a slanted perspective on the Opioid Crisis when pitching the value of placing an independent integrity monitor on site in physician practices across the country to curtail overprescribing and save physician licenses from precipitous all-or-nothing suspension. Affiliated Monitors was founded in 2004 to provide independent integrity monitoring and ethics compliance assessments nationally and internationally across all industries with its knowledge of effective ethics programs and cultures. At the dawn of the “Opioid Crisis,” the company saw an opportunity to apply another level of oversight into a burgeoning bureaucracy crowded with cogs. In his Compliance Network podcast, host Tom Fox introduced Keyes in a 5-part series on the value of independent monitoring in the health care sector, during which Keyes presented what I imagine is the naive viewpoint rampant in the public domain, particularly among those with no connection to pain management. Keyes thinks that overprescribing is linked to doctors who feel they are "in over their heads,” who "let things get away from them," and who report "relief" at the idea of having an independent monitor keep them honest, helping them to say "no" when one of their patients reveals to his or her circle of drug-seeking friends that the doctor has a reputation as a "soft touch” (Fox, 2020). This characterization portrays as the norm a run-on doctors for happy pills by kids with no real need to manage pain. The narrative depicts a “mosquitoes in summer” situation that compels everyone to call for bigger and finer mesh netting around the back yard. It depicts a state of affairs similar to the one used to describe the run on the Southern border by illegal immigrants. This alarmist view is one advocates for the community of chronic pain patients report seeing too often in public health professionals. Perhaps if there is a pestilence in need of monitoring and controlling, it is the expansion of services offered by the regulatory and compliance industry.

At least four board members for the fringe group Physicians for Responsible Opioid Prescribing (PROP) have earned as much as $725 an hour as plaintiff witnesses for law firms involved in litigation against opioid manufacturers (Johnson & Johnson; Purdue Pharma) and distributors (McKesson; Cardinal Health). The law firms will make billions in contingency fees off a settlement that will send $26 billion to states, counties, and municipalities. These lawyers, many of whom are political donors, help politicians with campaign contributions before retiring to work on mass tort claims. Chronic pain patients who have suffered from the demonization of their lifesaving medication seem resigned to the fact they were caught in the path of a wealth redistribution dynamic endemic to the American economic system. Even more disturbing is that the CDC helped PROP contributors to the Guidelines hide their conflicts of interest from the public.

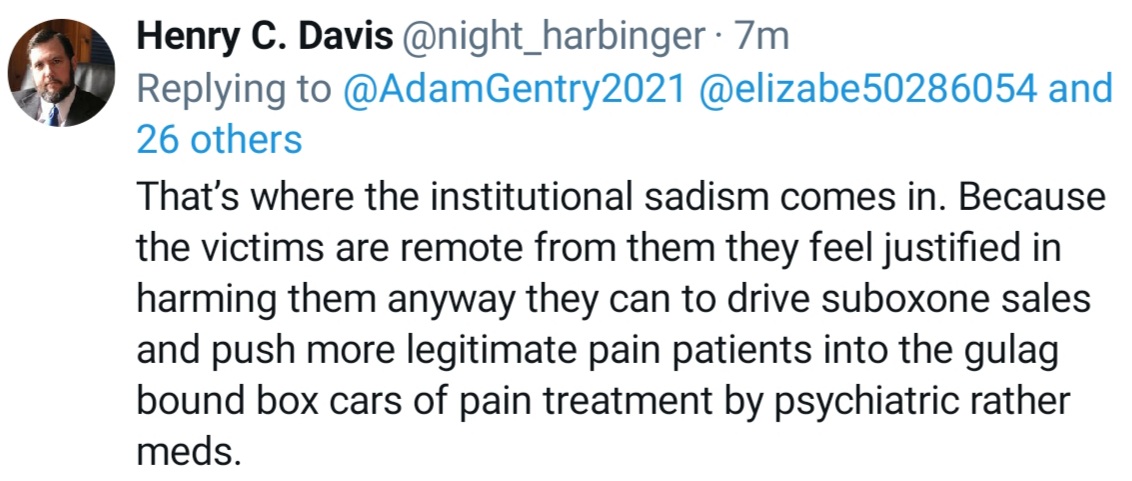
The State of New York was seeing treasure chests when it decided to tax opioids. $30 million to be exact, which it earmarked for recovery and rehabilitation programs. In taxing opioids, legislators unwittingly prompted pharmacies to put a stop on all opioid shipments. If you’re New York, you think you just stumbled into one solution to the Opioid Crisis, but you also deprived yourself of the tax revenue you need to fund rehabilitation and recovery programs. You also replaced the Opioid Crisis with a crisis of untreated pain. And you’re about to test the theory that those abruptly cut off from their medication will find substitutes on the black market.

In a June 17, 2018 article in the Seattle Times, associate professor Heather Tick and PROP member Jane Ballantyne announced that detectable traces of oxycodone were found in a population of mussels in the waters of Puget Sound. The discovery was cited as evidence of opioid overprescribing and as a springboard to introduce opioid-sparing culinary recipes for pain. Not much was made of the fact the mussels also contained traces of hormones, antidepressants, and heart medications. The fact I could find the whole pharmacopoeia in there didn’t seem to interest the pair. Selective attention bends facts to an agenda like gravity bends all the matter in the vicinity to a black hole, destroying space, time, and the known laws of physics in the process.

What would become of the DEA's Prescription Drug Division if Rx opioids were downgraded from crisis and epidemic to "minor nuisance"? Hundreds of Federal bureaucrats working for HHS and DOJ have tied their annual performance evaluations -- promotions and step increases -- to how well they fulfilled opioid-related objectives written into their individual development plans (IDPs) earlier in the year. Someone within the Federal bureaucracy was bucking for promotion when he or she proposed that the DEA seek authorization for expanded access to the data stored in the Prescription Drug Monitoring Database. Makes you wonder what's in there. My daddy's DEA was concerned with the bathroom break schedule of armed sentries guarding the Escobar drug lab. My DEA is more concerned with whether the spouse is picking up from the pharmacy, if she routinely shows up 2 days early every month as allowed under the grace period, and whether the pharmacy techs have noticed whether she seems particularly happy to be there.  
  
And this brings us to our next group.  
  
*Sanctimonious Crusaders*  
  
And finally you have the sanctimonious crusaders -- the ideologues -- for which the fight against opioids is practically a religious war. Their motivations are not entirely clear. We might look to terror management theory (Greenberg, Pyszczynski, & Solomon, 1986) for one practical framework. Perhaps it's as simple as this: perhaps some of us need those who lose at the Game of Life to be truly unhappy. Why? Maybe some of us need to feel superior. We cannot relish our own fortune or success if others less successful or unsuccessful could possibly be just as happy. Happier. Others may need to believe failure will spur our nation's losers to greater effort. Drugs throw the whole equation out of whack. With the ability to manipulate our mood or mental state to artificially induce an illicit happiness, we are reducing the chasm between life's winners and losers. We are cheating. Now there is something disturbing about this tidy view of the world order. Perhaps it's because this marriage of morality and accounting aggressively monitors the balance in the books like your average IRS agent. You can see why such a moralist would have no problem with the Prescription Drug Monitoring Database ... and why they would have so much trouble with prescription painkillers. Painkillers -- and drugs that kill other unpleasant states like anxiety and depression -- are the Great Equalizer. They level the playing field. Not unlike the way guns level the playing field by giving the short and scrawny men of the world a means of keeping a young Arnold Schwarzenegger from kicking their weight in California coastline into their faces and making off with their girlfriends.  
  
Until now, the anti-opioid warriors had cornered the market on motivational psychology, attributing what they call a morbid seeking orientation to addictive substances and personalities. They were so adept at controlling the language that with mere conjuring of the word addict, they could neutralize the credibility of those reporting that opioids are the only resource that has helped them maintain their capacity to function and their quality of life. That their painkillers are the only thing keeping them from being bedridden and forcing family to assume greater responsibility for household chores or family income. And yet the anti-opioid campaigner will listen to this with blank stares and then respond by saying things like "these people are addicted and they don't know it" or "that's the drug talking. Their brains are so rewired by the drugs that these people cannot be trusted to provide objective accounts of their own lives."  
  
But now we turn the tables when we probe the motives of anti-drug warriors and subject them to some of their own deconstruction, biological reductionism, relativization, and psychoanalysis. Who is going to trust Kolodny once he has been recast as the modern day equivalent of Joe McCarthy, Jonathan Corwin, Clark Stanley, Ted Wells, and Ronan Farrow?

Of special interest to the chronic pain patient community is the motivation behind PROP members. I invited participants on social media to critically examine their mental health and propose various explanations for what seems excessive investment in the absence of personal stake. To stimulate discussion, I proposed that Government experts like Andrew Kolodny and Jane Ballantyne suffer from Munchausens Syndrome by Proxy. The prototypical case of this disorder is the mother who derives satisfaction from the attention and authority that comes from being needed. Toward this end, she is always mixing into her child’s meals poisons that induce flu like symptoms. Many of these children will eventually die when the toxicity of the clandestine additives overcome vital organs. Similarly, I believe Kolodny and Ballantyne will do or say whatever it takes to retain access to the mainstream media and policy mechanisms they were denied when they were just another 5-and-dime lobby operating on the fringes of the medical community. As authors of the 2016 CDC Opioid Prescribing Guidelines, PROP members not only enjoy a spotlight and microphone but seem to occupy a status over the medical community they fault for causing the crisis through overprescribing. The American Medical Association is forced to defer to their authority on matters of Federal policy on prescription practices and pain management. In the meantime, the American citizens for whom they assume a posture of caring are suffering —and many are dying. Some from overdosing on OTC alternatives like ibuprofen and acetaminophen that are toxic to vital organs when used long term. Some from seeking out heroin or counterfeit pills on the black market. Some from suicide. PROP's recommendations to the CDC – their contributions to the Guidelines – are widely cited as factors that maintain and exacerbate the Opioid Crisis. All the while these PROP executives project an image of national protector standing between chronic pain patients and deadly opioid poison. They rationalise that mere exposure to painkillers by prescription will set patients on a date with overdose destiny at the hands of heroin. While they lecture patients on the appropriate and responsible methods of managing pain, millions of patients suffer an unnamed crisis of untreated pain and suffer the risks associated with losing access to their familiar, effective, and non-toxic opioids. PROP stokes fears of overdose but the overdoses that are showing up on the stats sheets are not typically accidental overdoses resulting from taking the prescribed levels or taking liberties with the prescribed levels. They are the kind of overdoses that occur when people use what they find on the black market, pills consumers believe to be diverted when in actuality they are counterfeit – replicas of the real thing whose real “serving size” and ingredients can never be known and vary across procurements. When confronted with this all-important distinction, PROP will tell you that prescription painkillers remain deadly inspiration for the morbid pursuit of these variants. In another words, you are safe only when you don’t know what you’re missing – when you remain completely virginal when it comes to a drug induced high. Since we don’t know how any given opioid naive subject will respond to an encounter, no such encounter should ever occur for anyone anywhere under any circumstances – even when put under for a major surgical procedure. Throughout it all, PROP clings to a Government-subsidized reputation as a heroic barrier to pharmaceutical companies and the unscrupulous doctors with whom they negotiated a scheme involving kickbacks for prescriptions. We pay a heavy price for PROPs new lifestyle. We no longer trust our doctors are informed or honest about the meds they give us. We want to bleed dry pharmaceutical companies that not only provide what qualifies as the cornerstone of a compassionate care system but that also provide what we need to survive hypertension, heart disease, and a host of other ailments manageable with medicine. Rather than allowing our traditional opioid medicine to take away our pain and induce a state of optimum human functioning (e.g., optimism, charity, energy) free of anxiety, depression, and other unproductive moods (e.g., disappointment, resentment), we would rather pay out of pocket to blow out our livers and kidneys on what we find over the counter. Also like those with Munchausens, PROP members like to mischaracterize or misrepresent the condition of their victims. While Munchausen cases like to promote the perception their children are sick, PROP likes to promote the perception of Americans as opioid-addicted. “You're addicted and you don’t even know it" and “you'll thank me later" are common phrases used by PROP.

That being said, support for my Munchhausens diagnosis was curtailed by alternative theories of a Gordon Gekko grade greed, a religious zealotry, or psychopathy / sadism.



Mr. Davis astutely identified what social psychologists have deemed necessary preconditions for mass murder. In Nazi Germany, those who carry out death sentences on homosexuals, criminals, gypsies, and Jews relied on practices that induced a state of remoteness or detachment from the victims. The use of uniforms for soldiers and prisoner-appropriate attire was instrumental in stripping victims of both their humanity and individuality. References to a “pain patient genocide” by patients on social media were not assuaged by their assignment to classes based on something called a NARX Score. I can only imagine what Appriss Health might have enjoyed in the way of compensation for this contribution to the surveillance and warehousing of pain patients. As for my Munchausens theory, Davis and others were dismissive, in large part because they felt I was dismissing or at least failing to appreciate the scale – the scope and severity – of the consequences. Consequences as severe as these warrant an attribution of malevolent intent or inherent evil.

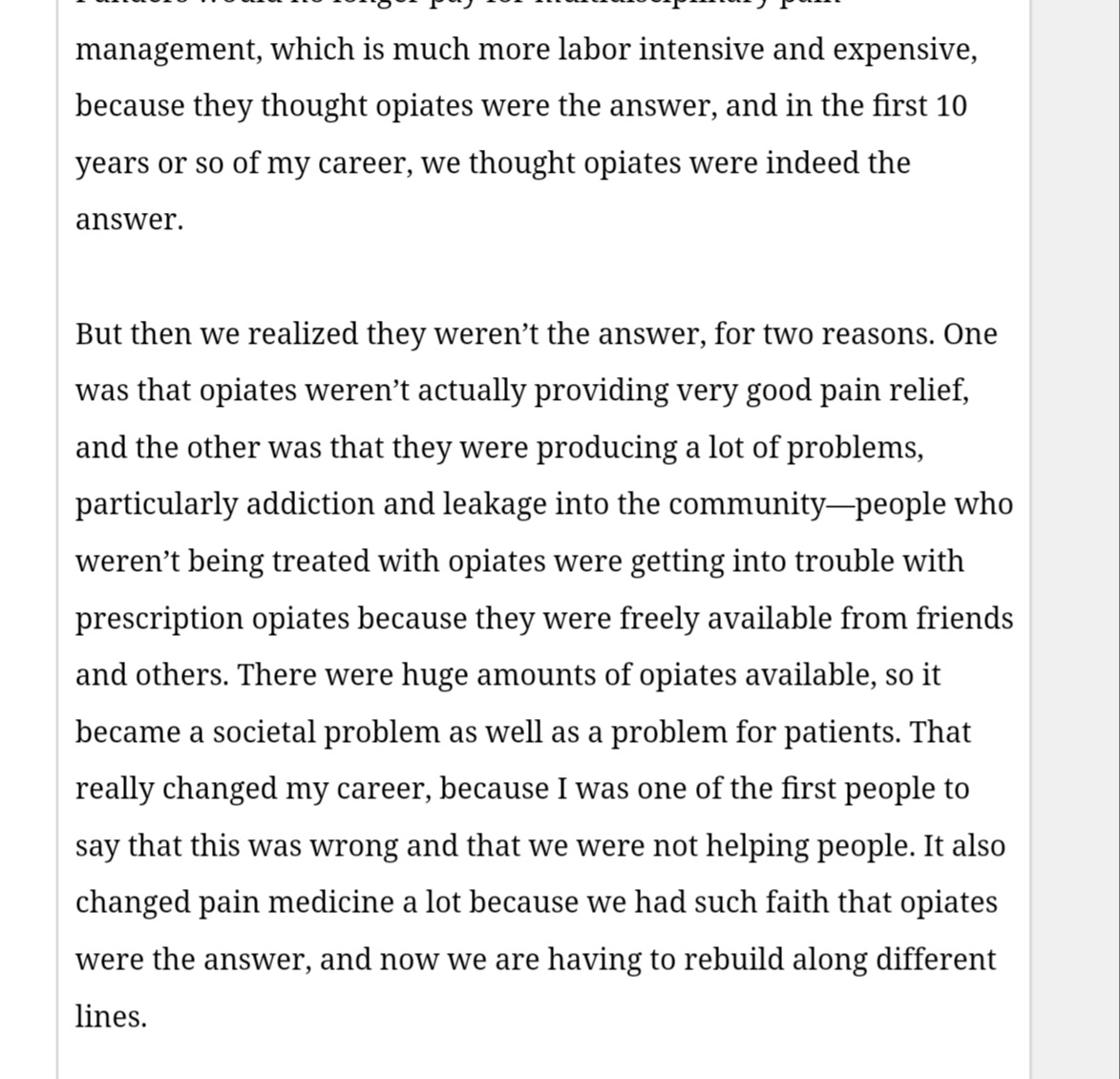
*“I don't think the PROP quacks are mothering anyone. The PROP quacks have settled into a highly profitable position of respect and authority and they'll keep running this grift as long as they can. They were more like Stalin with his torture and genocide of the Ukrainians than a little woman who slowly kills her 2 kids to get a contact high from the sympathy and sadness of those around her”* (Henry Davis).

*“I'm of the opinion they are institutional sadists, nothing so soft as Munchausen by Proxy. They manipulated Government and society to torture people they would never see and cared less than nothing about the harm they caused and did it for money and power.”* (Robert Curtis).

In an interview with Nick Fallon, PhD, a research fellow at the University of Liverpool, at the 17th IASP World Congress on Pain (September, 2018), Jane Ballantyne, advocate for PROP and FedUp, answers the question “How did you get interested in pain?” Here I hoped to gain valuable insight into the reason Ballantyne has so fiercely obstructed the livelihoods of those who need their pain medication. Instead I found something no one could fault for being inspired or even self-motivated:

*“ had a strange passageway to pain.  I was an anesthetist in Oxford, and my consultant asked why patients were gave epidural diamorphine to scratched their noses; in those days in the UK we used diamorphine for epidurals. So I did a big research project looking at the reasons why opioids, particularly neuraxial opioids that are put into the cerebrospinal fluid and therefore access the brain, might cause itch. And it turns out -- and I didn't realize it at the time -- that itch is very closely related to pain. When I went to Boston to do a traveling fellowship, I was told I better hook up with the pain people because I had done all this research on opiate-related itch. That's what started the whole thing, but this was pain research in the lab. I chose to stay in the U.S. and later I was persuaded to study clinical pain.”*

So it’s an entirely different kind of itch that is responsible for her participation in the anti-opioid crusade. I feel obliged to ask her who persuaded her to join the campaign to demonize opioids.



I don’t know how the anti-opioid crusaders came to believe, if indeed they do or ever did believe, that opioids are not providing real pain relief especially when millions of Americans will tell them otherwise. Of course crusaders like Ballantyne think these patients are lying to maintain access to a substance that promotes more euphoria than pain relief but even if that were true, you’re talking about a state in which patients with no means at all to relieve pain find something that makes them not mind as much about the pain they have to live with. But I still have no doubt that opioids provide full relief for at least a substantial minority and substantial partial relief for millions more. This is the modus operandi of crusaders like Ballantyne and Kolodny, who impose an all-or-nothing ultimatum on opioids. Be the total answer for everyone or be eliminated. This is certainly the standard on reward (benefit) she imposes given her assessment of the risk. Given that some of these pills are being diverted into the hands of unintended recipients, they better work perfectly in those for whom they were intended.

“Once they've been doing it for a long time, they are at high risk for becoming addicted.” For one of the dumbest statements I have ever heard, it’s a common one that flies under the stupidity radar. We are so desensitized to all the talk of “addiction,” that we don’t even process statements like this one for meaning. Any medication that has been and continues without a foreseeable end to be a part of someone’s life is likely or logically one that contributes to the quality of that life. That confers a valuables benefit or fills a need. So Ballantyne’s statement here, translated, amounts to “if the medication helps the patient, he or she runs the risk of wanting to continue using it.” The assumption here is that the day will come when the medical condition responsible for the pain will disappear and the person will continue to need the pain medicine or else will suffer withdrawal. But this shortchanges research that shows addiction is rarely observed in patients who took the pain medicine when and only when in pain. The physiological mechanisms at the root of addiction are fairly well known and addiction appears to require consumption of the medication in excess of the pain or beyond the duration of pain. The statement also assumes that the pain will end. Many chronic pain conditions have no known causes, mechanisms of action, or cure; and so many of these conditions are endured for the balance of the lifespan. I am always astounded to hear a nurse say something to the effect of “well you have to come off this stuff sometime.” Oh really? Why? When do you suppose that will be? Why does it have to be now?

The other fear is that we may never know if the condition producing the pain has resolved itself because the drug has trained the brain to produce the illusion of pain as a means to keeping itself in the person's life. The anti-drug warriors have come to think of the addictive substance as something that has attained an independent life and mind of its own. It outsmarts you. Takes control of you. Does whatever it takes to ensure its own survival. In this sense it reminds me of all the machines we ever created that have become mainstays of our culture. And we're perfectly happy being slaves to social media, our Internet phones, desktop computers, microwaves, coffee makers, hair dryers, and toasters. Truth is they make our lives easier and more happy. Until they’re taken from us. Then we realize we don’t know how to live without them. And that’s really no different than the argument about opioids. Opioids make our lives easier and happier ... until someone takes them away.

You can say the consumer is in some sort of functional harmony with the medication. The medication plays a role in the person’s biochemical and experiential ecosystem. And if that consumable were a Chinese herb we might think that way, but instead we rely on terms like dependency that implies an abrogation of part of one’s personhood or a wilful concession to a morally inferior lifestyle. We do not apply the same concept of addiction – not seriously anyway – to all the other enduring patterns or elements of our lifestyle. We even spent decades debating whether the term addictive can be applied to the nicotine in our cigarettes. But what about the gasoline we put in our cars? Are we as our 43rd President announced in an address to the nation “addicted to oil”? We slavishly and grudgingly acquiesce to the notion that we are addicted to sugar but the proposition is so infrequently raised in comparison to the number of occasions on which we consume a high carb or sweet food. By contrast, we are trained or encouraged to feel we are guilty of some kind of crime every time we pop a Vicodin. There is something very unhealthy about this level of obsessiveness, sensitivity, and judgement.

If there is one thing we should know, it’s that the truth is often a secondary consideration. Research on decision making by committees within academic and corporate communities has demonstrated that the accuracy of information can be subordinated to the preservation of group harmony and norms (Thompson. Peterson, & Brodt, 1996). No professor wanted to cross his or her peers to ask that the Committee reveal the evidence for my ouster from my PhD program. Three of my detractors, the only professors aware that a months long investigation into my allegedly fraudulent management of records of student participation in faculty experiments had been completed, were absent from the meeting for the first time in each of their 20 year careers. As long as the investigation remained active, I was treated poorly by professors who were motivated to assume the worst about me by their profound disinterest in my area of research: dreams. The tide turned on a miracle of sorts, when a low ranking assistant professor of all people sent the Department Secretary into a file cabinet to retrieve documents showing that not only did the investigation fail to unearth any evidence against me, but that the discovery prompting the allegations – a student who came forward to confess he had not completed all the required experiments – turned out to be misleading. The student was under the misapprehension students were required to complete 4 experiments when in fact they were only required to complete 3. Despite the full exoneration and the subsequent revelation one of my detractors had hoped to honor an ill advised promise to an unfunded first year protégé that funding would shake free, I continued to be treated poorly by some professors who maintained friendships with my detractors and who lived by the maxim that in a dispute between professor and student, the professor is always right. It’s a testament to a more fundamental reality. What matters is not what's true. It’s not what one believes is true. It's what one wants to believe is true.

We learned this lesson twice from Ted Wells, a research consultant hired to provide scientific evidence against second hand smoke for the tobacco industry. Wells was also paid $5 million by NFL Commissioner Roger Goodell to deliver a scientific basis for the presupposition that Tom Brady was "more likely than not generally aware of an inappropriate scheme to deflate footballs." Independent scientists operating out of university labs across the U.S. have since identified some 20 fallacies or acts of fraud in the analysis performed by Wells firm Exponent. But that did not stop a large swath of the television viewing public from buying into the NFL / Exponent narrative simply by tying together headlines and soundbites delivering misleading, incomplete, and in some cases inaccurate information. For a number of months between the start of the investigation and Brady's historic comeback from a 25 point deficit in Super Bowl 51, seasoned columnists questioned whether the future first ballot Hall of Famer could even throw a regulation football. Sixty-two percent of those surveyed believed Brady was guilty, which ironically is favorable when you consider NFL football is part religion and part entertainment and that some 95% of NFL fans – short for fanatic—supporting teams other than the New England Patriots worship at a different altar.

Money. Power. Revenge. Holy roads. We have thus far covered quite a lot of territory while addressing the suspect motives of those who favor restrictions on prescription pain medication. We want to know what makes drugs so special that some prosecutors have complained they do not have the resources to settle murder and rape cases due to the disproportionate allocation to substance possession and use. When the statistics are padded to elevate overdoses as a cause of death on par with motor vehicle accidents, we don’t question why we feel mandatory speed limits and safety belts are sufficient rather than criminalize the sale, transport, and operation of Ford Tauruses. Then there are deaths caused by medical errors. Talk about your preventable deaths. Talk about your iatrogenic deaths. Medical errors may account for as many as 251,000 deaths per year. Two hundred and fifty one thousand. Our highest estimate of death by accidental overdose involving an opioid – and I have already demonstrated how these estimates are wildly inflated – is 80,000. Deaths by medical error are more than 3 times that – and no one ever talks about it. Why? Well, how do you put a face of evil on something that (a) has an incalculable number of forms – I mean, there are thousands of ways to make mistakes when caring for a patient. The term medical error occurs when a provider fails to choose the appropriate method of care, improperly executes the appropriate method of care, or misleads a CT scan. These are errors or delays in diagnosis, errors in communicating or administering the correct dose of the proper medication, infection, and defective medical devices. The legibility of handwritten prescriptions alone is indirectly responsible for 7,000 deaths annually. The other reason network television news and entertainment have not seized on the issue probably has something to do with the word “error” in the title. Error. Mistake. Accident. These are the very opposite of intentionality. You need a devious mind or a devious plan before you can claim evil. A review of other systems for classifying preventable death include many other non-sexy causes (Danaei et al., 2009):

|  |  |
| --- | --- |
| **PREVENTABLE CAUSE OF DEATH** |  |
| Smoking | 467,000 |
| Untreated high blood pressure | 395,000 |
| Medical errors | 251,000 |
| Obesity | 216,000 |
| Inadequate levels of physical activity | 191,000 |
| High blood sugar | 190,000 |
| High LDL cholesterol | 113,000 |
| High dietary salt | 102,000 |
| High dietary trans fatty acids | 82,000 |
| ALL DRUG OVERDOSES COMBINED | 70,980 |
| Poisoning | 65,773 |
| Alcohol use | 64,000 |
| Low intake of fruits and vegetables | 58,000 |
| Overdose involving ANY OPIOID (2019) | 49,860 |
| Intentional self-harm | 47,511 |
| Falls | 39,443 |
| Motor vehicle | 37,585 |
| Influenza | 36,400 |
| Fertilizer pollution | 17,000 |
| Homicide | 16,425 |
| Psychostimulants (including methamphetamine) | 16,167 |
| Cocaine (2019) | 15,883 |
| Prescription pain medication (2019) | 14,139 |
| Heroin (2019) | 14,019 |
| Benzodiazepine (2019) | 9,711 |
| Suffocation | 7,076 |
| Antidepressants (2019) | 5,175 |
| Drowning | 3,692 |
| Fire/burn | 2,758 |

One would think that with all the attention that anti-opioid zealots have demanded over the years – and continue to demand – lamenting that their spotlight had been stolen by COVID and marketing their new “hidden pandemic” or “pandemic within a pandemic” mantra – that we would have seen more deaths than those in the table above for 2019. Truth is that opioids need to be lumped with other drug classes into an “all drug overdoses combined" category before they can pass alcohol use. Prescription painkillers need to be lumped with heroin, fentanyl, and methadone before the “Overdose Involving Any Opioid" can pass suicide and motor vehicle deaths. The statistical gerrymandering that keeps these people relevant and preserves their proverbial seat at the table is the one in which they claim an opioid is “involved" in 71,000 deaths. But the other side of polysubstance involvement is that relatively few people succumb to an accidental overdose when the only drug they are consuming is a prescription painkiller. In other words, the medical users concerned only with relieving their pain are not likely to die from an overdose of Percocet. So then why are we using policy to restrict access for this population? The problem has never been more obvious. If we are talking about Street product, the message remains “don’t do drugs.” Otherwise, the new messaging should be “*don’t mix drugs*.” Having said that – where the message is simple and easily understood doesn’t mean it will be followed. But if you restrict access to the prescription medication you are only going to drive the user to find a replacement.

**SUDAFED (SUE-THE-FED)**

In 2005 Congress passed the Combat Methamphetamine Epidemic Act, which prohibited the over-the-counter sale of any cold medicine containing pseudoephedrine as a nasal decongestant. Manufacturers were forced to make changes to their formulary and their product lines, and allergy sufferers and sufferers of other conditions that include nasal congestion as a symptom were forced to adjust to restrictions. The new restriction meant those who relied on Sudafed as a daily treatment would have to stand in line at the pharmacy every 3-4 days. The law also prohibited customers from purchasing Sudafed at the pharmacy drive-thru-window once that became an innovation years later. And the legislation imposed a per month, per day, and per transaction limit on the number of grams of pseudoephedrine an individual could purchase, prompting some patients to arrange for family or friends to purchase Sudafed for them. Pharmacists are aware purchases are commonly made for others, and the practice is widely accepted as a necessary way around an inconvenient restriction.

During COVID-19, one family member who was diagnosed with immunosuppression was advised to avoid the DMV to renew her license. Since the law required the Sudafed customer to present a valid unexpired license, I had to purchase Sudafed for the entire family on my license. Before it expired, the law did not allow me to present my family member's license in her absence. Unless she was present – and presented a valid license – she could not procure Sudafed. The PDMP records that I regularly purchase Sudafed to the monthly maximum allowed – an inaccurate representation of who is consuming the substance.

The driving force behind the new legislation was to prevent those operating drug labs out of their homes from using the pseudoephedrine to manufacture crystal meth. As usual, the Government failed to consider – or failed to care about – the collateral consequences to medical users. Since Sudafed is a capital expense in our family, I had hoped a family member could have a doctor prescribe it so that it would be reimbursed by insurance. That’s when I discovered that doctors developed cold feet for Sudafed. “That’s a controlled substance,” is what I often heard. Since I was on my last nerve with the cumulative effect of all these restrictions, I would just as often reply by saying, “Look you idiot – it’s not controlled in the same way oxycodone is controlled. It’s not controlled because it represents a risk to the health of the consumer. It’s non-addictive and an unlikely candidate for accidental overdose. It’s also non-toxic to vital organs – even for chronic users. It’s availability is limited and it’s sale documented to restrict its use as an ingredient in the manufacture of crystal meth.”

These meth manufacturers continue to dictate health policy long after they replaced pseudoephedrine with window cleaner. Some meth makers, taking a cue from the popular A&E series Breaking Bad, have even aspired to produce a pure form of crystal meth with no adulterants at all. Meanwhile, the Government collaborated with the manufacturers of Sudafed to create a new formula – phenylephrine -- for over-the-counter sale. It is impossible to make crystal meth from phenylephrine but just as impossible to alleviate congestion. Now that we have witnessed a full blown resurgence of crystal meth in 2016, we can honestly say that the Government’s Act made crystal meth better – and people’s colds worse.

The Government has neglected to adjust its response to reflect changing conditions on the ground. I guess to do so would be to acknowledge that one is losing a war one failed to recognize as unwinnable at the outset and failing to recognize that there are millions of cold and allergy sufferers who need pseudoephedrine more than recreational users of crystal meth. This means the Government wasted the People's time —and dime – disturbing the lives of innocent patients.

If only I could have back the cumulative time spent waiting in line at the pharmacy just for Sudafed. You can imagine what kind of mood I was put in on those occasions I discovered the pharmacy was out of stock, or on those occasions I discovered the pharmacy could not sell me Sudafed because the system advised that I had reached my limit: “try again tomorrow.” I'm afraid to read the 2005 legislation because I'm afraid someone might find a chalk outline outside the homes of a sponsor or two.

**STAYING “IN THE FORMULA": NO, PRESCRIPTION PAIN RELIEVERS ARE NOT HEROIN PILLS**

And where opioids are concerned, pain patients have to worry about a Federal campaign to paint them with the same broad brush reserved for heroin addicts. Pain patients have to worry that one of the Guidelines principal architects refers to prescription painkillers as “heroin pills.” That a large swath of the public who never had to live with pain -- or watch a loved one live with pain – will never challenge the Guidelines because they worry more that their 5-year-old daughter might get invited 10 years down the road to a "pill party" supplied by friends who'd just had some wisdom teeth removed.

Let’s take a moment to consider just how irresponsible is it to compare heroin with prescription painkillers like Percocet or Vicodin.

1. Heroin renders its users unconscious and unavailable. With injection as the route of administration, bioavailability is orders of magnitude higher than it is when a pill is subjected to the digestive system..
2. Heroin is an illicitly manufactured substance that does not abide by a uniform code of best practices. Unlike a tablet of Percocet, heroin does not come with a “serving suggestion" and “list of ingredients.”
3. Across dealers and occasions, heroin varies in purity. The user will have no awareness that his heroin was cut with fentanyl -- also illicitly manufactured – a cannabinoid known as K2 -- or with the powerful tranquilliser xylazine, which was used to cut 70% of heroin confiscated in Philadelphia in 2019. Since most opioid overdose fatalities are polysubstance deaths, it makes sense that heroin would account for as many of the deaths as it does. Heroin is almost invariably impure.
4. By contrast many patients report that their prescription painkillers confer energy. Some reference becoming talkative. Others speak of an impulse to work off excess energy through work. The conventional wisdom that links prescription painkillers to sedation – my doctor once told me “now this (Vicodin) is going to make you very dizzy” – is likely based on rumor. Myth and misconception. The post-marketing adverse event studies carried out by the manufacturers of hydromorphone report that 31% of respondents linked the medicine to drowsiness or change in mental status. A minority, yes, I thought, but it still struck me as high. Then I read the next sentence, which indicated among those who constitute this 31%, 98% dosed inappropriately or with another substance.

As a social psychologist I marvel at what must have been an exhibition of groupthink put on by the Core Expert Group hired by the CDC to draft prescribing guidelines for opioids. Evidence for the destructiveness of opioids -- that opioids fail every risk-reward / cost-benefit measure -- that opioids cause far more harm than good -- comes from a working group stacked with consultants who spent most of their lives preaching against opioids. The working group did not include a single physician who specializes in the management of pain. Not one neurologist. Not an anesthesiologist. Not a physiatrist. Staffed in secrecy, the identities of group members were eventually leaked. They met behind closed doors and meeting summaries obtained under the Freedom of Information Act are almost entirely redacted. All we have is a standard operating procedure the group used to assign ratings of quality to empirical research projects. Whether the scope of the research included for examination is comprehensive is highly questionable. One window into the day-to-day operations of the working group is claimed by watchdogs reviewing the research cited by one prominent member, Andrew Kolodny. These watchdogs submit as evidence of bias a double standard with which Kolodny rates the quality of research favorable and unfavorable to opioids. It is their contention that Kolodny holds research favorable to opioids to a considerably higher standard.  
  
And yet here is the CDC unveiling what amounted to one-size-fits-all caps on prescribing -- applied indiscriminately across all patients regardless of diagnosis, treatment history (tolerance), and individual differences in sensitivity to pain and to pain medication. And on an even more absurd note, the Guidelines were intended for use with acute pain cases. It says as much on the very first page of the Guidelines. So why were they being adopted by Federal and State regulators to limit the treatment of chronic pain? How did it come to pass the DEA would cite the CDC Guidelines as the impetus and justification for raiding the offices of 4,000 physicians for excessive prescribing? Given all the sources of variability cited above (e.g., treatment history), there is no basis in nature or science for determining a priori how much opioid is too much for any given chronic pain patient.  
  
This farce elicited remarks similar to those uttered as the McCarthy Hearings delivered lifetime banishments to persons accused of being, harboring, or refusing to name a Communist: how could our most trusted institutions allow this to happen? How are these institutions failing us? But it makes more sense when you realize that the physicians hired by the CDC to develop Opioid Prescribing Guidelines represented a homogeneous subset of the medical profession with ties to the fringe group, PROP (Physicians for Responsible Opioid Prescribing). And it makes more sense when you realize the division of the CDC responsible for addressing the rise in overdoses and for staffing the team that would craft the Guidelines was the CDC Injury Prevention and Control Center (hereafter "Center"). Yep. This is a simple case of one small faction of the CDC hiring from within one small faction of the medical community. The CDC faction was biased by charter. PROP was biased by shared extremist ideology. You can see how objectivity was in serious jeopardy from the outset. You've heard the expression, "when all you have is a hammer, everything looks like a nail." Well, what course would you expect the investigation to take when you hand it to officials whose role is to prevent & reduce adverse outcomes? The question of whether opioids cause harm was answered before it was ever asked, bypassing the need for any fact-finding commission. It was answered the moment it landed on the desk of Center director. And as a division of the CDC, two other conclusions about opioids were preordained: (1) The injury in question would be treated as a biological contagion capable of being transmitted (i.e., "epidemic") and (2) with infection being an unmitigated and unmediated function of simple proximity and exposure. If you're in pain and you enter a medical facility, you will be prescribed painkillers. This fact alone was lamented by hotel magnate Gary Mandell, who lost a son to a heroin overdose. Mendell composed a letter to JHACO demanding hospital physicians refrain from asking patients to rate their level of pain -- a practice he believed led to overvaluation of pain and overprescribing of pain medication. "Pain is not a vital sign." And from the moment the painkiller is consumed, you will be placed on a path to addiction. Once access to prescription painkillers is discontinued, a morbid search for a deadly Street equivalent is deigned inevitable. It's in the programming of the CDC Injury Prevention and Control Center analyst -- in his mindset -- to see this hard determinism that is a philosophical staple of the physical but not the social sciences. It's as simple and certain as diffusion and osmosis. Why not make opioid addiction a fifth law of thermodynamics? I'll tell you why. Because both NIH and SAMHSA estimate that the rate of dependency among those prescribed opioids is somewhere between 4 and 8%. But it's PROP among others who have managed to sell legislators and journalists on the rather sensational statistic that 4 in 5 heroin addicts -- that's 80% -- were once prescribed an opioid. How do we reconcile 8% with 80%? Easily. The fact 4 in 5 heroin addicts were once prescribed an opioid is not all that compelling. The statistic does not tell you when these addicts were exposed to painkillers? After all, roughly 80% of all Americans -- admittedly at an age at which they are particularly vulnerable -- were given Percocet in exchange for 2 - 4 wisdom teeth. So upon hearing that 4 in 5 heroin addicts were once prescribed an opioid, one could respond "so were 4 in 5 of us who never went anywhere near heroin." Odd how the more empirical data from NIH and SAMHSA get far less press. It's almost as if the data had been placed under judicial seal.  
  
And the PROP-aligned members of the medical community hired to craft the Guidelines will view their role as one of prophylaxis. They were led to believe -- or they want to believe -- that they were hired to stem a public emergency. Put out a fire. Defuse a bomb. Or more to the point I am making now, control and prevent an injury. They were not about to nuance their response with concerns over how they might impede or complicate a system of compassionate care by which civilizations are measured.  
  
There are cyclical phenomena which occur with some regularity throughout our history. For example, sociologists like to point out there is a religious revival every 30 years in the U.S. Tracking the trend that exhibited obvious examples in the 1920s, 1950s, and 1980s, people could not see that the one taking place in the 2010s was led not by religious institutions and personalities but by secular government. This took the form of a moral crackdown on drug abuse and an almost religious demonization of opioids. But the moral sensibility extends to the sexual assault or exploitation of women in the workplace -- spawning the #metoo and #timesup movements -- with notable examples of overkill and in some cases severe penalties and presumptions of guilt even for those who are suspected in the absence of evidence or in the face of contradictory evidence. I rely on Woody Allen's case to help support my point because one can track the fluctuations in perception over the 30 years the accusation has been known to the public. His culpability is viewed differently by the public now -- during my proposed 2010s revival era -- than it was during the two preceding decades that fell between revivals. Had the alleged incident occurred more squarely in the 80s, it might have received a response similar to allegations of satanic ritual child molestation against a prominent California daycare facility in 1983. Remember that? That ranked alongside the Salem Witch Trials as a Wonders-of-the-World-caliber hysteric. A single accusation from a woman widely doubted within the District Attorney's office as psychotic still managed to set in motion a chain of events that led to 300 indictments leveled at 7 employees of the McMartin School as well as to paranoia that spread like an epidemic across the State and eventually the nation. The hysteria was aggravated by three missteps: (1) after police released alleged assailant Raymond Buckey for lack of evidence, they released a letter to 200 families instructing them to question their children about sodomy, oral sex, and fondling, promoting some emotionally involved parents to compare notes after engaging in leading and suggestive questioning of their children; (2) unskeptical, sensationalist treatment of the allegations by nightly news broadcasters that appeared to get caught up in the paranoia; and (3) interviews of 400 preschoolers by psychotherapists employed by a child abuse prevention center (Children's Institute International) to confirm or deny the abuse hypothesis using hand puppets. When children initially answered "no" to the question "have you ever played any naked games?", the therapists, rather than accepting the responses, repeated or rephrased the question. For those who have a hard time knowing what to make of what appear to be sincere allegations from Dylan Farrow in the absence of evidence, it might be useful to read up on a phenomenon that was all the rage at the time: false memory syndrome. University of Washington research psychologist Elizabeth Loftus found notoriety demonstrating under controlled experimental conditions how a form of regressive hypnosis popular among psychotherapists at the time for retrieving or clarifying repressed abuse – particularly one involving the use of sodium amytol – could create memories of events that never occurred. The convictions of many bemused and beleaguered fathers were overturned based on Loftus's work, and the 1995 American Psychological Association convention played host to spirited debates between clinicians and scientists on the subject of recovering memories in a therapeutic setting. Season 3 Episode 1 of Law & Order SVU titled “Repression" drove the point home that contrary to the strength of some emotionally held beliefs and to the number of people whose support is recruited, the truth is not always what it seems. This principle applies equally to the notion of an Opioid Crisis, a phenomenon in which the Fed invested millions and in which officials in pertinent roles appear to have raised the data needed to meet a burden of proof. What many do not know – and have every career incentive to turn to avoid knowing – is that in a spirit similar to that of “making a murderer,” a system was set up to engineer an Opioid Crisis through various devices, mechanisms, stratagems, and maneuvers that include but are not limited to positive reinforcement (i.e., reward), selective attention, fulfillment of prophecy, illusory correlation, double standards, prejudicial language, cognitive heuristics, inappropriate controls for scientific research, favorable criteria for inclusion / exclusion of research participants, media saturation, yellow journalism, abuse of authority to create uncontested appearance of impropriety, and deliberate misrepresentation of reviewed research or legislation.   
  
We pawn off these investigations on agencies whose missions are prominently displayed in their names -- Child Abuse Prevention Center – Physicians for Responsible Opioid Prescribing – Injury Control and Prevention Center – Committee on un-American Activities -- and then we wonder how we end up 10 years down the road looking back with embarrassment on mass hysteria, regulatory overreach, and extremism.

**HISTORICAL PARALLELS, PRECEDENTS: IF IT HAPPENED BEFORE ... THE DRUG WAR**

This Report would not be complete without an effort to view the putative "Opioid Crisis" in the wider history   Much in the same way we are driven to greater heights of understanding when we view the Second World War (1938-1945) as an extension of the War to End All Wars (1914-1918), I believe there is much to gain in our understanding of the "Opioid Crisis" from identifying precedents, blueprints, and parallels in histories attached to mass hysterias including but not limited to the 50-year-old War on Drugs.   
  
While Nixon campaigned as a law and order candidate, upon election he realized he needed a conduit through which the Fed could influence conditions locally.  Today's elaborate system of vertical influence between Federal authorities and local jurisdictions was not all that well articulated in the late 1960s.    
The drug issue provided the impetus and justification for that bridge.   
  
Nixon realized that by declaring war on drugs as public enemy number one, he could use arrests on heroin charges to disrupt his enemies in the black community and arrests on marijuana charges to disrupt his enemies in anti-war left. By arresting their leaders and vilifying them on the evening news, he could delegitimize their meetings and their missions. On March 10, 1973 Nixon announces from the Oval Office his plans for a comprehensive revision of the criminal code to include tougher penalties on drugs.   
  
We have enough testimony from former Nixon White House staffers, most notably White House Counsel and Domestic Policy Advisor John Erlichman, to feel reasonably certain that Nixon used drugs as a political stratagem and that this was consistent with the 37th President conducted business when he felt he was in over his head.  Nixon used distraction and misattribution to manipulate the public perception of challenges he did not know how to resolve.

Nixon took office during a tumultuous period of race riots and anti-war demonstrations, but rather than face these issues head on, he used a press conference to proclaim drugs public enemy number one.  This is no small trivia.  Nixon's bait-and-switch strategy would serve as the prototype for how contemporary U.S. leaders manufactured an "opioid epidemic" to turn a 25-year tsunami of crises and disruption into a mere roomful of politically innocuous 800 pound gorillas.   
  
The strategy is so effective that I feel I actually need to devote a few paragraphs to remind my fellow Americans just what hit them since the dawn of the new millennium.  But before I do that, let's dispense with the history.   
  
Nixon couldn't deal with race relations.  Does this look like a man prepared, let alone the least bit interested, in appealing to the hearts and souls of African Americans?  When the blacks rioted for their long-overdue equality, he panicked.    
  
Nixon couldn't deal with the Vietnam War.  His strategy, known as "peace with honor," was fraught with political landmines.  Even though his generals believed this was a winnable war, the Will to win outright, gauged by the willingness to destroy the North Vietnamese population and occupy its territory, always seemed a bridge too far.    
  
(1) America's involvement in the war, known originally as a "conflict," was not compelled by a threat to U.S. interests but to the democratic principle of South Vietnamese sovereignty.  (2) The decision to enter the war was made 8 years and 2 Presidential administrations ago, with Nixon feeling reasonably certain he'd  been elected to make the war go away.  He found himself divided between fulfilling a promise to abandon the unpopular war and sparing American honor and dignity.  Nixon was unprepared for the rapidly escalating price of withdrawal in national humiliation before Cold War adversaries China and Soviet Union but also in his own personal humiliation at home.  The withdrawal would appear as nothing short of abandoning the South Vietnamese for which young Americans were drafted kicking and screaming into a fight that would see them die halfway across the globe or see them spat on by their own countrymen upon return.   
  
When intellectuals and the youth of America demonstrated in protest, Nixon panicked.    
  
He kicked off his press conference by stating that drugs were public enemy number one.  He was like Monty Hall, revealing his choice of demon to the American people like so many cans of squid that had been hidden by curtain number 3.  Nixon needed to put a new face on evil, the face of something he could control. Nixon had the misfortune of having two longstanding national crises reach a boiling point on his watch.  Neither racial harmony nor total victory in Vietnam were within his power to resolve.  So he staged the birth of a new evil he could defeat -- and use -- to manipulate perceptions of the ones he couldn't.    
  
Nixon was desperate for us to acknowledge that it was neither the Vietnamese nor racial tensions that were our greatest threats to peace and security -- but drug abuse.  And those leading the race and anti war demonstrations might vehemently disagree -- but Nixon would respond by inviting you to believe that they are abusing drugs.  If you don't believe him, watch tomorrow's edition of the evening news.  As his new DEA cop unit and cameras will attest, leaders of the civil rights movement will soon be arrested for possession of heroin -- anti war demonstrators for marijuana.   
  
We also know Nixon's position on remote surveillance.  We know he ordered illegal wiretaps of hundreds of White House staffers suspected of leaking to the New York Times plans for an illegal bombing of the Khmer communists in neutral Cambodia.  And we know he was involved in the illegal wiretapping of Democratic National Committee leaders, kicking off the archetypal scandal connecting Watergate to DeflateGate.  Even more enduring than the pop culture suffix "-gate" is the tradition of unwanted detection and surveillance.  As it turns out, American citizens as patients -- as patrons of the health care delivery system -- are not all that fond of being monitored for drug prescriptions when they meet with their doctors (i.e., PDMP).  We tolerate the intrusion better today but only because we have accepted that drug addiction is the single greatest threat facing our country, that it is the work of the Devil, and that the Drug Enforcement Administration has our best interests at heart.  We may not realize why we accept these things, and I wonder how much this acceptance might be shaken if we knew we accepted these things because these things were proclaimed repeatedly and vehemently by Nixon.   
  
Why shouldn't we bow uncritically and unconditionally to -- bend over backwards and forwards for -- a legacy we rejected.  The legacy of "Tricky Dick."   
  
Nixon told us drugs were inherently evil in 1968 and we bought it.  Support for the drug war did in fact erode during -- and for a number of years after -- Nixon suffered a loss of political capital to allegations of his involvement in the Watergate break in.  For a few years it appeared that the drug war may not survive the ruination of its principal architect.  A reactionary campaign to legalize marijuana led by the attorney-run lobby N.O.R.M.A.L was in the process of securing the support of the states for Presidential Marijuana Commission recommendations the President had himself rejected, namely that after $20 million in research no medical consequence for marijuana use could be discerned and no citizen should be penalized for marijuana use in his own home.  To this maxim President Carter and his drug czar Peter Bourne added in August, 1977, that people should not suffer more from drug policy than from drugs -- that the cure should not be worse than the disease. We were well on our way to a rational management of substance use predicated not on the notion of how we stop it but how we live with it.  It is conceivable our nation could harmoniously co-exist with substance users -- substance users with substances -- with a combination of education and more smartly targeted restrictions.  Our high schools allocate so much of its phys ed curriculum to prevention of venereal diseases and unwanted pregnancies but I could design a single lecture that would reduce accidental overdoses of prescription medication by 75%.  Most accidental overdoses on prescription drugs are facilitated by a handful of misconceptions and logical fallacies.  The vast majority of those prescribed painkillers do not misuse them or become physically dependent.  Most of those who do misuse prescription painkillers or who become physically  dependent do not develop addictions or what we call use disorders, which is to say they are not impaired in a way that affects their health, functional capacity, or ability to fulfill responsibilities in the home, work, or school environment.  At the risk of appearing to contradict gospel, not every user has a problem.  Some problems arise when persons use recreationally or in the absence of a medical necessity like physical pain.  But even more of the problems arise when the patient is denied access to the substance.  There are millions of chronic pain patients for whom access may never become a problem for the balance of the lifespan.    
  
These nonalarmist perspectives drove the movement to normalize substance use as a staple of our culture not unlike alcohol and tobacco.     
  
We were on our way ...   
  
... That is, until grassroots parents groups questioned the effect of marijuana on the developing brains of children. And there were three facts they thought none of us should ignore: the average age of first drug experimentation was 12, the drug of choice among teens was marijuana, and XX% of teens was smoking it at least once a week.  Marijuana use among high school seniors rose through the 60s to a peak in the latter half of the 1970s, when 51% reported using within the last 12 months and 37% within the past 30 days (Schulenberg, Johnston, O'Malley, Jachman, Miech, & Patrick, 2017).  Over 1 in 7 8th graders (14%) reported using marijuana at some point in their lifetime.  By this time the Presidencies of Ford and Carter, which if anyone could possibly imagine were led by moderate pro-legalization drug czars, had given way to a right shift in the nation's political sensibilities, the election of Ronald Reagan, and the appointment of a pediatrician to the top drugs job.  The maxims "just say no" and "this is your brain on drugs" were second only to "where's the beef?"  The public reinvested in Doctor Nixonstein's Monster DEA, having probably never realized its origins as a nifty political dodge, and doubled down on mandatory minimum sentences with civil asset forfeiture laws.   
  
To the violations of our most sacred democratic ideals -- HIPAA-backed privacy, the Hippocratic Oath, the Constitutional right to pursue a pain-free life, and due process for physicians raided for over-prescribing -- we can add the violation -- through civil asset forfeiture -- of the basic principle of innocent until proven guilty. Civil asset forfeiture presumes guilt and places the impossible burden on owners to prove on an article by article basis that their own property was not procured with proceeds from drug sales.  As the War on drugs intensified, Congress expanded the range of property originally subject to forfeiture under The Comprehensive Drug Abuse Prevention and Control Act of 1970 to include cash, bank accounts, cars, jewelry, boats, airplanes, businesses, and land.  The Crime Control Act of 1984 authorized a sharing of seized assets between Federal and local agencies.  The Reagan Administration embraced this crime fighting strategy as a means to a world in which the prison in which the criminal serves time, the police vehicles used to arrest him, and the sting operation used to catch him could be financed by forfeitures.   
  
The law as written seemed to recognize that the acquisition of funds proceed smoothly and expeditiously when it's not held up by such burden of proof as the actual presence of illegal drugs -- when suspicion alone is necessary and sufficient grounds for seizure.  All fear-based mass hysterias accord suspicion a key role, as evidenced throughout the hearings of Senator McCarthy and the trials of Salem.  Curiously enough, seizures did not necessitate or precipitate criminal arrests or charges of any kind, even when drugs were found.  In a staggering 80% of civil asset forfeitures, criminal charges are never filed against property owners.  It's as if the penalty of having your privacy and property so utterly invaded was considered a trial, conviction, and sentencing unto itself.  Or law enforcement's form of apologizing.  The all-too-obvious appeal of the forfeiture laws is that we're converting the value of seized property into tangible resources law enforcement can use at its discretion to fight the financially disadvantaged drug traffickers.   
  
The Justice Department's civil forfeiture program inspired questionable free-for-all-cash-grab paramilitary units to target drivers for profit.  Former California highway patrolman Joe David, who had proven techniques for finding cash and contraband hidden in cars and trucks, facilitated a cottage industry of highway interdictors through a training program and private intelligence network.  As a detection and surveillance tool, the Black Asphalt Electronic Messaging and Notification system was embraced just as warmly by the DEA as its Prescription Drug Monitoring Database.  The extraordinary vertical communication between local officers and Federal authorities (DEA) infused the DOJ's Civil Asset Forfeiture program with $427 million in seizures over 5 years.  But suddenly there was a problem.  It’s one thing when no drugs are found but another entirely when no cash is found either and sensitive information about the suspected motorists to include social security numbers and identifying tatooes are being shared across a network, as was the case with the vast majority of citizens targeted.  This matters apparently.  I say apparently because I am through making sense of what passes for sensible in the War on Drugs.  I guess what they say is true:  "all is fair in love and war."   
  
While Joe David struck all the right notes when publicly asked to describe or defend his operations, a book published under an assumed name by his chief marketing officer boldly incites invasive and dangerous enterprises by appeals to base motives, encouraging police to use cash seizures to bolster municipal coffers.  David hosts an annual competition to honor police who seize the most cash and contraband for which local patrol officers are instructed to post selfies next to stacks of currency and drugs. His group's contractual arrangement with the Caddo County (OK) District Attorney's office, which entitled them to keep 25% of the $1 million they ultimately seized, would ultimately be dissolved and condemned by a District Court Judge.  Never having been sworn in as Oklahoma officers left the self-styled Eliot Ness posse vulnerable to accusations of impersonating police officers.   
  
There was mounting sentiment within the public concerning the perversion of the drug war by extraneous (i.e., monetary) incentives, further evidenced by the disproportionate allocation of resources to drugs over homicide, rape, and burglary.  Incidentally, this graph published by the Washington Post reveals that the loss of public net worth to civil asset forfeitures surpassed burglaries. Justice Department records indicate that forfeitures increased from $27 million in 1985 to $556 million in 1993 to $2.4 billion in 2012 (Stillman, 2013). Debate about civil forfeiture procedures happened in the late 90s but when public scrutiny died down legislators quietly relaxed -- without much public debate -- the reforms at the behest of police groups and prosecutors.  Much like the State-led trend toward legalization in the late 70s was abruptly repelled, a State-driven move to curb the powers of police to seize assets was reversed by the Justice Department in 2017 in an effort to raise funds for Federal and local agencies (Ingraham, 2017, WP).   
  
The deincentivization and behavioral extinction by civil asset forfeiture law of efforts to legalize drugs was a Ronald Reagan masterpiece blending Skinnerian conditioning with spiritual fortification.  The involvement of God Himself blinded us to our inner Gringo.  And in the event the demonization of drugs grows trite on an evolving audience, there's a moral imperative we can all fall back on.  Safeguarding ... sacrificing ...  "for the children."  Another Reagan triumph.   
  
Temperance groups decades earlier at least briefly won their battle with alcohol with the Volstead Act of 1919, but the parents groups of the 1980s achieved something more lasting with marijuana and for that matter all other controlled substances: a fundamental lack of will to develop different sets of rules for adults and minors.  No one even trial ballooned the option of legalizing marijuana for adults over 18 or 21.  The nation decided that the only way to modify the behavior of their most vulnerable population was through a single unified message to people of all ages: all drugs, marijuana included, are dangerous and all those who would sell or use them ... evil.  Any gains progressive groups had made between the years of 1975 and 1980 calling for a cease fire in the War on Drugs and preaching temperance with rationally nuanced and surgically discriminating messages ... were overturned -- mocked and jeered as corrupt and contemptible weaknesses by audiences on afternoon talk shows.    
  
*Drug War Gets Personal*  
No one seemed to care that the search, arrest, and sentencing policies conceived and implemented by the likes of those with military sensibilities such as General Barry McCaffery -- Director of Office of National Drug Control Policy (ONDCP) under Bill Clinton -- and those with Southern evangelical religious sensibilities such as former Senator and U.S. Attorney General Jeff Sessions risks relegating to the American counterculture minds more promising and productive than the aforementioned figureheads above.  In an April 5, 2016 speech to the International Narcotics Caucus Sessions demonstrated with one statement -- "good people don't smoke marijuana" -- that it is possible for Government to regress over 30 years with respect to psychological sophistication and general intelligence.  You would have thought that we would have learned from all that U.S. history that paranoia and fanaticism accomplish nothing beyond mass excommunication.  The first DEA agents had orders to surveil, infiltrate, and raid subversive enclaves that would become known to the world as "friendship groups" -- maybe you've seen one -- private gatherings of teens or young adults who might share a mood enhancing substance as innocuous as a $5 joint.  Imagine Richard Nixon or any POTUS crashing your rec room with armored cars and armed officers.  That's how it all started, and now with DEA agents using the PDMP database to crash your neurologist's appointment, I'd say we've come full circle.  Richard Nixon ... meet Donald Trump.  Trump appointed Sessions to Attorney General, and in that capacity he had this to say about those of us who were required to surrender access to prescription painkillers: "take an aspirin and call me in the morning."  This level of ignorance, inflexibility, and hostility is better suited to the psych ward than to positions of authority in Government.  Someone like that can't be bargained with or reasoned with.  He doesn’t feel pity -- or remorse -- or fear.  And he absolutely will not stop -- ever -- until every last milligram of medical morphine is made to vanish.    
  
Now the Drug War has suddenly become personal, brought into the bedrooms and bloodstream of millions of Americans who suffer chronic pain.  I certainly felt that way when I helplessly watched the new head pharmacist at Walgreens decide that none of my wife's medications would be filled at his store and, even more egregiously, he phoned the prescribing physician in an effort to ensure they couldn't be filled anywhere else.  Not only did I have to watch the woman I love suffer, but I had to assume a greater share of the household chores, one of which involved tending to a child with a developmental disability.  This was complicated when at the age of 51, I developed my first chronic pain issue of my own: a paraformis syndrome exacerbated by irritation of the nearby sciatic nerve.  I couldn’t roll over in bed.  Getting in and out of bed or on and off a toilet was a medley of burning and stinging sensations that ranked 9 - 10 on the 10 point pain scale.  After significant campaigning, my Kaiser physician gifted me a script for the maximum number of hydrocodone tablets allowable: 10 pills. Less than a 3 day supply for a condition expected to last 4 - 6 weeks.  He was only willing to give me the script -- on which he wrote "final script" -- because I pointed out that 2 weeks of ibuprofen elevated my creatinine to levels suggesting severe toxicity to my kidneys.  Opioids are non-toxic.  But I suppose it's more prudent to kill a patient than allow him to get addicted to hydrocodone.    
  
I got angry.  I had to take it out on someone so I took that pharmacist's job.  I filed grievances with State and Federal agencies and alerted Corporate to my social media campaign.  The pharmacist had made it clear his only concern was protecting his license from the DEA.  But he couldn’t protect his job from the likes of me.   
  
In the anti-drug crusade we were stigmatizing people -- making them ineligible for employment opportunities simply by giving them criminal records -- not only limiting what they could become -- they could never ascend to any of the roles Jeff Sessions occupied -- but also thwarting their efforts to earn so much as a living wage.  In just one year 200,000 Americans were given permanent criminal records after having been arrested for possession or use of marijuana.  In the Nixon Era War on Drugs, the first generation of DEA drug warriors were given the objective of arresting for offenses as negligible or questionable as possessing a joint or keeping the company of joint smoking friends.  There was an arbitrary political objective measured by number of arrests and number of front page arrest headlines. Toward that end, the DEA did not care who was arrested, and many were arrested and almost immediately released just to learn in interrogation and negotiation who else they could arrest.  Much as in the heyday of Joe McCarthy, Federal officers frightened citizens into naming names and informing on friends -- all to help bolster those statistics and those headlines.    
  
Most of those arrested are young men and women in their formative collegiate careers who found themselves permanently precluded from employment and who could earn a living only by turning to the Street from which the arrests were allegedly intended to save them.  With no other place to go, these antagonized and disillusioned young men and women were backed into an anti-establishment counterculture.  How would you like to survive Vietnam only to be killed by your own Government's Drug War?  That's precisely what happened when a jury was forced by mandatory minimum laws to sentence to 50 years one Don Crowe, to whom the Government just a year earlier awarded a purple heart for his sacrifice during the Vietnam War.  Now there's a country, huh?  Draft a fella into an unpopular and unnecessary guerilla war -- a war in which he's injured -- and then send him to jail for the rest of his life for attempting to sell to an undercover agent less than an ounce of some plant known to have pain-relieving properties.   
  
*Self-Fulfilling & Self-Perpetuating*  
Throughout the history of the drug war, we have developed quite a knack for creating two things.  The first is self-fulfilling prophecies, which refers to the practice of creating the very problems we aimed or claimed to destroy.  We do this largely by design because a Drug War is lucrative not only for drug makers and dealers but for local and Federal agencies.  And not just monetarily.  By this point with an infrastructure in place we see that jobs, careers, promotions, identities, legacies, values & emotions are tied to the drug war.  The drug war has structured and systemized the activities of daily living and the concept of operations for so many Americans that one can argue the drug war itself is as much a habit as any drug.  Americans may be more addicted to the Opioid Crisis than we ever were to opioids.  Now that's the very definition of cutting off your nose to spite your face.  Or is it?  Is it a really a matter of protesting the continued use and trafficking of drugs publicly while privately or subconsciously embracing its role in the economy and in our moral education?  But this system will not work -- we cannot continue to profit off arrests and seizures unless we perpetuate the crimes themselves.  And we do this through several mechanisms.  One is that by giving criminal records to thousands of young Americans in the prime of their collegiate careers -- as we did in the Nixon Era -- we give them no place else to go to earn a living but back to the Street where they ascend to the ranks of dealers and manufacturers.  Another is through a practice known as "clearing corners" by which the incarceration of 4 drug kingpins creates 400 local dealers each of whom aspires to be the next Tony Montana.  This has no other possible outcome than to raise the number of arrests.  Raise the statistics.  Raise headlines.  Raise currency.  Real financial currency.  Political currency.   
  
And we have a knack for creating a self-perpetuating, increasingly expansive sense of crisis which inevitably led to a speech from the Oval Office in which G.H.W. Bush identified drugs as the nation's most urgent problem and challenged the nation to build more prisons and court houses and train more prosecutors.  At some point you have to ask "is substance abuse actually getting worse or do the statistics merely reflect a perpetual increase in arrests facilitated by an increase in the laws under which we can arrest them and an increase in funding for police narcotics activities ... activities incentivized by civil asset forfeiture laws and by the practice of tying the size of Federal grants for municipalities to the number of drug arrests the previous year?"  The Drug War is an economy in its own right -- a portfolio of investments conservative in the sense that you know their value is always going to rise but aggressive in the sense you can willfully effect yields of any size at any time inasmuch as the yields are limited only by the work ethic, entrepreneurial spirit, and most importantly the acquisitiveness of the investor.    
  
Fast forward to the Opioid Crisis under Presidents Obama and Trump, and we see the Nixon Era Playbook at Work.  The DEA had orders to help fulfill an arbitrary political objective of a 30% annual reduction in morphine units dispensed.  Not caring where the reductions came from (ring a bell?), the DEA grabbed the lowest hanging fruit: medical prescriptions.  How lazy and dirty is this strategy of pivoting from Supply to Demand?  My daddy's DEA was consumed with invading foreign countries to meddle in the activities of international cartels at the point of production in Mexico or Colombia. I never paused to consider all these years how imperious it was of us Americans to make our nation’s politics, policies, and problems the problems of countries around the world -- to the point where we are demanding assistance and cooperation from foreign governments we blame for what happens within our own borders -- dispatching our Federal agents and military to countries where marijuana, cocaine, and opium are farmed and harvested from the planet's natural flora. And in the process putting foreign government leaders and their loved ones in harm's way by projecting them into the middle of a war that is largely our war.  But we have since taken the fight closer to home -- opening a new theater of operations that treats as enemy combatants the American consumer of prescription drugs.  Patients, doctors, pharmacies, and pharmaceutical houses.  This is not my daddy's DEA.  My DEA, which requested and naturally received expanded access to data in the Prescription Drug Monitoring Database, is now just as concerned with who picks up my wife's scripts at the pharmacy, whether they are regularly picked up two days prior to the 30 day fill date as allowed under the grace period, and whether the person picking up the scripts appears particularly eager to do so.  The DEA knows it will meet with far less resistance from unarmed physicians too busy seeing paying customers all day and too concerned with protecting a license to prescribe that was awarded them by the DEA in the first place.  And the DEA knows it will meet far less resistance from senior citizens chronically weakened by pain.  I admit I was at first more trusting than I should have been when I read that this PDMP was in development.  Sure, the Feds had to sue 47 states to install it but I figure the judges were of a mind that this boondoggle would be used to confidentially collect aggregate data for, ya know, research purposes.  Then I had my Death Star moment when I read of its very first exploits and cried out in the presence of my big hairy dog, "that thing is operational."  If these intimidating DEA phone calls scared doctors into reducing pills to patients living with modest back pain or if these phone calls scared doctors into rescinding scripts altogether to patients with severe RSD, no one -- other than the patients that is -- cared.  The DEA could have been selling Grollier's Encyclopedias by phone.  A sale was a sale.  When the DEA needed to set the example -- having exhausted the pill mill doctors and rogue dentists -- they peered into their database -- applied some analytics -- and picked out some doctors whose patients received the highest average morphine units per month by region or specialty -- and then raided their offices and homes armed with shotguns and network TV camera crews.  Numbers.  Milligrams.  Arrests.  Headlines.  Nixon is smiling.  And where possible, pharmacists were deputized, maybe not to narc on doctors and patients, but certainly to throw up an added roadblock: forcing doctors to defend their scripts or refusing to fill them outright.  McCarthy cracks half a smile.  Actually who needs pharmacists to narc anymore.  The NARXScore will narc.  One look at someone's 800 -- mmm, love the thousand point scale -- will scarecrow any doctor ... and any patient armed only with an 8 on a 10 point pain scale.    
  
We have self-fulfilling prophecies today.  The doctor, under pressure from the DEA, takes away your xanax cold turkey.  If you're lucky, your spouse hauls youv4 days later as disoriented and delusional dead weight into an ER where the doctors disgnose you with "benzodiazepine ABUSE" (not withdrawal) and then in their most smug tone tell you "see, these drugs are dangerous."  But my favorite is how we make the opioid-related deaths increase when we take away their medication, forcing them into the Street, to high risk methadone, or to suicide.  I can hear it now: "see, these drugs are dangerous."    
  
In this rude and ridiculous ruse of a response, anti-drug warriors  demonstrate time and time again a bait-and-switch style penchant for reversing the direction of cause and effect.  Let's recap:   
  
*Reversing Cause & Effect*    
1.  They create the conditions that give rise to the uncomfortable withdrawal or dangerous overdoses, first by separating patients from their medication and then by blaming the patient’s condition on the patient and the drug.   
  
2.  They point out that states with the lowest workforce participation rates are those with the highest opioid prescribing, thereby laying the groundwork to link our most fundamental economic shortcomings to opioid use and addiction.  But they commit a glaring fallacy in this argument when they fail to acknowledge that the pain itself, which is also correlated with  prescriptions for pain medication, might be the ultimate cause of low workforce participation.  They also fail to acknowledge the fact that the modern struggle to find work, leading to a growing class of discouraged professionals who drop out of the workforce, might inspire someone to drug use.   
  
3.  They argue that the pain experienced after pain medication is involuntarily discontinued is withdrawal pain and only withdrawal pain.  Regular patrons of this argument -- such as Andrew Kolodny, co-author of the CDC Opioid Prescribing Guidelines -- deny real pain -- somatic sources of pain -- as shamelessly as those denying climate change or the health effects of second hand smoke.    
  
4.  Some even go so far as to claim that the ultimate cause of pain is the painkiller itself.  They are attempting to recast as prevalent -- even epidemic -- a phenomenon as rare as opioid-induced hyperplasia, a complication emerging from the chronic use of high doses of opioids to treat some neuropathic disorders.  How rare is it?  Not a single case was found among one hundred ninety-seven patients exposed to an average dose of 180 mg of morphine for an average 56 months (minimum 1 year)(Schneider & Kirsch, 2010).  And yet many insurance companies have declined to pay for opioid pain medications, citing opioid-induced hyperalgesia (Schneider, 20XX).   
  
5. As alluded to earlier, drugs are blamed for all kinds of social, economic, and personal troubles when in actuality, drug use is more likely an outcome or symptom -- one of many outcomes and one of many symptoms -- of underlying disruptions.  I will have more to say on this later.    
  
The Drug War gave us lot of cool weapons. Legal technologies like mandatory minimum sentences, civil asset forfeitures, and three strikes.  Makes you wonder why drug use has become a crime at all let alone a crime more evil than burglary, rape, or murder.  We managed to tie drugs more firmly to the concept of sin on the one hand and to economics on the other.  Yes, murder and rape are grotesque and have the most deep and lasting consequences on their victims, and it is perhaps for these reasons that we do not allow ourselves to dwell on them.  Murder and rape are also highly specialized crimes committed by murderers and rapists, while we think of drug users as those all-purpose evil doers who commit all kinds of crimes, including murder and rape, as well as every other ignominy and iniquity that involves deception and greed.  Aside from those who commit random serial murderer or rape, we tend to attribute murder and rape to specific situational factors, which is to say the acts are the culmination of a history of events that reside outside the character or disposition of the murderer or rapist.  In films, murder is often portrayed as something that happens during strife or in the heat of battle between two parties working at cross purposes.  As portrayed in countless works of literature and cinema, murder is not perpetrated solely by the inherently evil, but by a range of characters including the morally compromised, the unfairly disadvantaged, and even good people in self-defense or in the line of duty.  And rape is depicted in film or in the news of current events as something that is steeped in misunderstanding or confusion, often involving parties in the throes of shifting, uncertain, or complicated feelings.  By contrast, politicians will not allow themselves or anyone else to contextualize, humanize, relativize, psychoanalyze, or complicate drug related activities.    
  
Drug users become the target of what social and cognitive psychologists call "global, internal, and enduring attributions."  Until we overcome the deeply ingrained prejudices that surround drugs, drug use, and drug users, our judicial system and health care system will be guided by Medieval policies grounded in ignorance and fear.

**DRUG WAR AND THE ENTERTAINMENT INDUSTRY**

The War on Drugs always made for great entertainment. For many TV producers, it also presented an opportunity to deliver a message into millions of living rooms. Americans are well aware of Government-sponsored TV ads such as the iconic “this is your brain on drugs" commercial ubiquitous through the 1980s. But I would be willing to wager that the vast majority of U.S. adults are aware that in the second half of President Clinton’s second term, the Federal Government took control of network television content to ensure it was consonant with White House anti-drug messaging (Forbes, 2000).

In 1997 Congress created a financial incentive for TV programmers to push anti-drug messages in their plots.  Under the influence of President Clinton's drug czar Barry McCaffrey, TV network programs like *ER*, *Chicago Hope*, *The Drew Carey Show*, *Beverly Hills 90210*, and *7th Heaven* “filled episodes with anti-drug messages to cash ìn on a complex Government advertising subsidy.”  When the networks balked at a Congressional plan to pay the networks $1 billion for $2 billion worth of anti-drug public message advertisements, McCaffrey offered to reduce the required ad time in exchange for anti-drug plot tie-ins.  Suddenly, the television scripts were being approved and altered by the Office of National Drug Control Policy (ONDCP).  Since the Government was able to broker this back door arrangement with the networks without attracting attention from program writers or journalists, one must accept that it is an open question whether the Fed has enjoyed similar periods of influence since Clinton or enjoys such influence today.

Even before this direct, heavy-handed propaganda, government and law enforcement had from the very beginning enjoyed a friendly relationship with the entertainment industry.

Referring to the "Thin Blue Line narrative" and "copaganda," TV producer David Simon and author Piper Kerman ("Orange Is the New Black") respectively see typical police dramas as modern day Westerns written from the perspective of -- and to drum up empathy for -- law enforcement, depicting cops as the last line of defense against lawless dealers and addicts:   
  
"*TVs early police procedurals set the pattern: a whitewashed vision supporting the status quo focused on middle class sensibilities. Exhibit A: 1950s and 60s era series like Dragnet, which lionized straight-laced detectives lecturing young people that a hit of marijuana would inevitably lead to an out-of-control heroin habit.*" (Deggans, 2021).   
  
When Harvard-trained doctor turned TV producer Neal Baer arranged for popular and amiable ER doctor John Carter (Noah Wylie) to develop an addiction to painkillers, he was attempting to humanize addicts with a bold new message that addiction is not a special case of evil, character weakness, or willpower, but rather a brain disease.  Unfortunately this depiction gave rise to the view that regardless of your mind, personality, or circumstances, the laws of biochemistry ensure that mere exposure to painkillers will inevitably lead to addiction.  This presented even stronger obstacles for those seeking treatment for chronic pain.     
  
NPR media critic Eric Deggans is keen to point out how these series show that the campaign of aggressive arrest and imprisonment we call the Drug War is not effective, but he exchanges the politics of drugs for the politics of race when he attributes its failure to the "disproportional punishment given to people of color and the poor."  He roped me in with his accurate and amusing review so you can imagine the sound of all that air leaving my sails when he delivered a closing argument about race in the criminal justice system.    
  
During the “Opioid Crisis,” we have punished thousands of doctors as well as patients from all walks of life, all while the number crunchers are whispering in our ears rates of staggering increase in heroin overdoses and suicides. In a world in which we have failed to wrap our minds around all the sources of human variability -- choosing to reduce the diversity of the United States to the color of our skin -- we exchange one myth for another.

The one program that serves as a cure for the common depiction is *House* (2004-2012), where producers gave its white anti-hero character 4 characteristics: life-saving diagnostic acumen, a chronically debilitating pain condition, an antagonistic personality[[1]](#footnote-1), and a dependency on Vicodin.  For the first 5 seasons, the scripts advance the position that none of the four characteristics is responsible for any of the others[[2]](#footnote-2) and that contrary to the most well-meaning but lazy presumptions of colleagues, his drug use helps more than hinders, allowing him to do his job and in that role to save lives no other doctor could.  Dr. House can be the one and only solution to medical mysteries only in that Vicodin is the one and only solution to his severe intractable pain.  Arguably the most quintessential moment of the series occurs at the end of Season 1, Episode 11 (“Detox").  After winning a $100 wager from his Dean of Medicine, for which he was required to go one week without Vicodin, House confesses learning he is in fact "an addict."  But just as his colleague begins to sketch the broad strokes of a rehabilitation plan, House completes the thought: " ... I said I was an addict. I didn't say I had a problem."    
  
The series does appear to turn on itself in the final episodes of Season 5 when the escalating dose of Vicodin is the presumed cause of an hallucinatory psychosis in which he imagines pivotal developments in his personal relationship with his boss and carries on an unwelcome week long conversation with a deceased colleague.  For a few months the world’s leading diagnostician vanishes into the drug rehab system where his release from a psychiatric facility and his reinstatement as a healer is contingent on satisfying the arbitrary treatment goals of a mental health professional.

The problem as I see it with national discourse, with messaging designed to speak to hundreds of millions, is that it omits differences / variability at the level of the individual such that groups become the fundamental units in our analyses as well as the language for our discussion. In order to help you understand what I mean by this, I would like you to consider how university professors hire new colleagues to replace retiring faculty and how they select from among the 70 – 700 applicants to their PhD programs. With all their fetishistic rhapsodizing over multiculturalism, you hear them prattle endlessly about the importance of diverse backgrounds, and then they make some combination of race, ethnicity, and gender a proxy for those diverse ideas and experiences. Now anyone who ever knew me considered me a dynamo of creative thinking and innovative ideas. I have been producing these ideas since I was a precocious prepubescent indulging my superhuman curiosity about why we dream – and using my own dream diary as the basis for original theories and research methodologies. But when the time had come to claim my slot in a PhD program, I was turned down by 39 of 40 universities over a 2 year period at a cost of $2,300. It appeared for awhile that my career in research psychology was about to end before it ever got started. Was it my GPA? Not really. I graduated magnum sum laude with a 3.76 from Trenton State College. Was it my GRE scores? Not really. I scored in the 98th percentile on the Verbal Scale, which accounts for the most variation in graduate school performance (16%) among the scales. I also placed in the 92nd percentile on the GRE Subject scale (i.e., Psychology). After extensive research into how my application was processed and perceived at a number of these universities, it was clear that I had been dismissed largely because I declared as my preferred focus of research a phenomenon that extremely few professors pursued themselves or considered a viable subject of inquiry for an academic community (Psychology) desperate to be regarded as one of the rank-and-file sciences. Even though the research I designed to probe my novel theories on this age-old mage-old was by necessity original, psychology professors do not do original. They prefer to treat every phenomenon as an interchangeable commodity that can be expressed in numbers and input as data into the same formulaic designs and analyses (e.g., 2 x 2 ANOVA). This is how they envision building an organized body of knowledge brick by brick. Original research designs and unpopular research topics do not fit into their idea of a scientific community. So when they speak of diversity, they are referring to race, ethnicity, and gender. An African American is unique inasmuch as his or her minority race is not well represented in the public ideology. You can say the psychology professor’s view of diversity is skin deep. And so when they choose a new assistant professor or a few new graduate students to serve as research / teaching assistants and lifelong protégés, they are remaking their community into a racially and ethnically diverse group *of* *likeminded* *drones*. I cannot make this too clear. They do not welcome new ideas or personalities. When you read the ads in some old Personals columns or some profiles on Internet dating sites, you are confronted with a thicket / gauntlet of very specific requirements. Must be close to his family. Must like dining in exotic restaurants. Must have a fondness for Bach and balmy climates. No sculpted beards. No hair on toes. No one under 5’10”. Must be a non-smoker. And absolutely no drama. As a man like myself, you really do get the sense she is looking for herself but as a handsome man. The same principle applies to the psych prof's search for new colleagues. They like their new recruits to be themselves but as an African American or Aleutian woman. I struggled because I did not come across as anyone’s clone and, well, because I was a white male.

As an individual, I fell between the cracks. None of this academic or political talk about equity, equality, opportunity, or discrimination marginalized me and made me feel like an afterthought in my own country and profession. Most importantly, none of this structured boilerplate discussion ever put its fingers on any pulse – because that would require individuals. Individuals have always been, are, and will always be the vehicles of life. But we’re a country of 400 million. We think we're too big for individuals so we cram everyone into demographic groups, pretend these groups are communities, and imagine what these communities would say to each other if they could talk. We think this is the only way to be fair and relevant to the greatest number of us when, in actuality, we do no one any favors when we’ve milked dry during every campaign cycle -- or every instance of tragedy – every act of police brutality or every school shooting – old points and counterpoints set to new faces and music. Because these debates, false dichotomies, and turgid categorical imperatives miss the facts and the realities needed to usher in We cannot usher in a new era of inclusiveness by excluding individuals. We could ensure every race and ethnicity is represented equally or proportionately across all job categories

I contend that the variation among “members” within any one of these groups is significantly greater than the differences between groups. Once we realize that we take the first step toward treating people as individuals rather than as instantiations of demographic categories. For as long as we recycle the same tired arguments about racism and sexism, we continue to overlook a treasure trove of real insights about justice, vocations, employment, identity, citizenship, spirituality, progress / innovation, and relationships. I doubt we even know what discrimination is at its core. I suspect heightism and ageism are just as common as racism even though no one even wants to include these in the conversation. We think that we are being clever and pragmatic – and that we are representing our organization against risk – when we categorically dismiss job candidates who express themselves in certain ways in interviews – but has it ever occurred to us we might be discriminating against introverts? We discriminate against persons with disabilities, persons with subpar credit, and analysts who value intellectual capital above software and the frenzied acquisition of technical micro-certificates. Employers truly do try to cram a country of 200 or so million individual personalities into a single suit. Are employers adding insult to injury when after all that they ask, “does it come in blue?”

**HISTORICAL PARALLELS, PRECEDENTS: IF IT HAPPENED BEFORE ... MASS HYSTERIA**

As I watched an incredible series of events unfold in what can be accurately described as the War on Prescription Pain Medication, I was torn between two competing impulses: one to refer to the extraordinary actions taken by the Government as “unprecedented” and another to call out a striking resemblance to a number of other crackdowns across American history. As a social psychologist I have been exposed to collective behavior and can set aside my skepticism for what we are capable of when we divert power and authority from the individual to a Group Mind (i.e., institutions, networks). One phenomenon almost exclusively diagnosed months or years after the fact is mass hysteria.

Symptoms of mass hysteria would include the following:

* At the core of the movement is a fear stoked by a tragic incident or hypothetical worst case scenario (i.e., adverse event or AE).
* The AE is attributed to a single cause that effectively puts a face on evil
* The factual basis for the attribution is questionable or contradicted, or any effort to investigate is resisted or controlled by an entity with a stake in the attribution
* As rewards are doled out in support of the attribution, decisions pertaining to the allocation of jobs, promotions, funding, and media attention are skewed toward the preservation of the attribution-based narrative
* There is a ready-made reason in place for discrediting or disqualifying those seeking to question or re-direct responsibility elsewhere
* There is a loss of flexibility and rational discrimination. The objective pursuit of accurate information is subverted to the pursuit of whatever it takes to simplify a murky and complicated issue and secure a political consensus.
* Imperfections and uncontrolled variations in source data collection (e.g., death certificates) are roundly ignored or exploited.
* Interventions to control variation are skewed toward increasing sensitivity to desired outcome. This double standard also is at work in the meta-analytic evaluation of past research where decisions are made to include, exclude, and assign weight to previous outcomes
* Also overlooked is how thesis-consistent increases in AEs are iatrogenic artifacts of a culture in which the medical examiners are either instructed to attend to the cause or are disposed to do so in a climate in which the cause is emotionally and politically charged.
* Anticipating publication and media attention, researchers use inappropriate controls to stack the deck in favor of a thesis-consistent outcome, and the research is disseminated in viral fashion where headlines omit the flaws (owing to lack of scientific literacy or scholarly motive on the part of journalists)
* Regulatory and legislative drivers – conduits to some catharsis -- are used to snuff out the cause without the usual consideration for collateral damage or unintended consequences
* If the legislation, policy, or regulation includes stipulations, qualifiers, conditions, exceptions, or exemptions that limit unintended consequences, they are ignored deliberately or else overlooked simply due to the fact no one reads or provides an adequate summary of the law. There exists this duality comprised of the law itself as written but never read – and then this other organism entirely which is the interpretation of the law kicked around the grapevine and based mostly on assumptions triggered by the very fact of the law and by the creative act of announcing it in media. Upon its introduction, the law gives rise to a doppelganger that is not a true doppelganger.

Based on these criteria, I identified a handful of events that qualify as potential manifestations of hysteria. Rather than identify them by the descriptions and pop culture phrases by which they are most known today, I would like to introduce them by presenting the challenges that set them in motion.

1. Against the backdrop of continual fighting with the Wabanaki Indians, colonial girls suffer involuntary convulsions as well as dreams and visions in which another villager forces them to write their name in a Satanic registry
2. A temperance movement run primarily by women who were completely dependent on their spouses for sustenance and support were impacted by the drinking habits of their husbands, who consumed on average 3 times the alcohol consumed today.
3. Americans fear that Joseph Stalin’s USSR, positioned by the Bolshevik Revolution and victory over Nazi Germany – and governed by philosophies antithetical to democracy (i.e., dictatorship) and capitalism (i.e., Communism) – may be secretly destroying America from the inside by placing moles in the Pentagon and by using propaganda spread by its own citizens to win converts.
4. Citing her son's painful bowel movements and difficulty sitting down, Judy Johnson files a complaint with local police alleging sexual abuse by her estranged ex-husband and daycare worker Raymond Buckey of the McMartin School in Manhattan Beach, CA.
5. Defensive back Marlon Jackson intercepts a throw from 3-time champion Tom Brady during the conference finals set to determine whether the Indianapolis Colts would upset the dynastic Patriots to advance to Super Bowl 49. Citing the lightness of the ball, Jackson and the Colts allege that the Patriots have reaped the competitive advantages of a ball deflation scheme masterminded by their quarterback.

Each of the above incidents had at its center a mystery that brought out the worst of us regarding the rallying of the masses around a delusion, myth, and misconception.

1. The falsehoods fostered around the mysterious symptoms of these three girls. To this day, the nature and cause of these convulsions are open questions although science offers one plausible explanation in ergot fungus contamination of the local rye crop, which survives the temperature at which their bread was baked.
2. The 19th and early 20th Century American men were unable to understand or moderate the impulse to drink. Campaigns linking alcohol consumption to sin and leveraging the power of the Protestant Church to urge moderation and encourage drinkers to help one another resist temptation proved ineffectual.
3. Stalin’s state of mind and ambitions for a post World War Europe were impenetrable questions and sources of mistrust. Precedents were set when Stalin forged a pact of convenience with Hitler to divide Poland but after repelling the invasion from a treacherous Hitler, it was unclear whether Russia's version of a dictator harbored the same dreams of world domination.
4. Having also accused McMartin employees of sex with animals, Judy Johnson is dismissed as psychotic within the Office of the District Attorney, which instructs police to release Raymond Buckey due to lack of evidence. However, in a bizarre twist, police also release to some 200 parents a letter urging them to question their children about sodomy and oral sex. Concerned parents gossiped among one another after subjecting their children to highly emotional and suggestive lines of inquiry.
5. The NFL league office was slow to correct an Inaccurate report from ESPN Ian Mortenson that 12 of the 13 Patriots gameballs were a full 2 lbs of pressure under the legal limit compared to only 3 Colts game balls. Public perception congealed around the QB's guilt as Commissioner Roger Goodell commissioned research consulting firm Exponent at the rate of $5 million to investigate. Brady surrendered access to his emails to the league as part of the investigation.

Questionable practices spurred by the misconception played a role in the indictment of innocent individuals who felt they were being scapegoated or sacrificed for a cause.

1. A Court was established in which locals were encouraged to provide as spectral evidence the names of those who appeared in their dreams and visions. When a respected citizen was acquitted, convulsions from the three girls on the floor of the Courtroom persuaded judges to reconsider before rendering another verdict. The only plea more likely than guilty to result in a perception of guilt was a protestation of innocence. The one man who attempted to avoid any statement altogether, 80-year-old Giles Corey, was interrogated for a week while rocks were placed on his chest until he succumbed to suffocation. In all, 20 men and women were convicted and hanged as witches and another 3 died in prison. The State was late to intervene, suspending the Witch Trials only after the initial 20 had been allowed to play out.
2. The Anti-Saloon League (ASL) demonstrated a willingness to ally with any and all entities that shared a common interest in an amendment banning the manufacture, sale, and transportation of alcohol. The alliance included Republicans, Democrats, Populists, suffragists, KKK Klansmen, the NAACP, and industrialists Henry Ford, John Rockefeller, and Andrew Carnegie. The campaign was bolstered by another new amendment that made the Fed less dependent on income tax from the sale of alcohol. American involvement in WWI helped Americans connect beer with Germans, discouraging every last politician from opposing the 18th Amendment, which sailed through both houses of Congress and was ratified by the States within 13 months.
3. Early efforts by the House Committee on un-American Activities helped unearth and convict David Greenglass and Julius and Ethel Rosenberg as Soviet spies and traitors to the U.S. But when a low ranking Senate Republican from Wisconsin was assigned to speak at a women’s conference in West Virginia, a second wind was breathed into the Committee when Joe McCarthy announced there were 205 Communist sympathizers working in the State Department. McCarthy persuaded Americans to suspend academic freedom by arguing that professors doing Moscow's bidding were not engaged in free thinking at all, after which nothing stood in the way of his “fifth column" investigation of prominent people in the film industry. McCarthy treated Communist sympathy like a biological contagion, a simple matter of proximity and exposure to views ordinary Americans cannot be trusted to resist. Many ordinary citizens employed as DOD cafeteria workers and Hollywood writers were intimidated into naming the Communist sympathizers within their own circle of friends and associates to avoid prosecution themselves. More influential than prosecution was the threat of being blacklisted, which for many meant a lifetime ban from employment in their chosen profession.
4. With parents fit to be tied and enabled by an unskeptical media eager for an 11 o'clock news break, independent agencies were recruited to investigate what had become allegations of satanic ritual and sexual abuse of children by a nation of daycare workers. The Children’s Institute International, a domestic abuse prevention program, led by Kai McFadden, used puppets to question over 300 preschoolers. But an independent review of the interview transcripts would reveal years later that rather than accept answers denying a “naked game,” psychotherapists would repeat or rephrase the question until the children realized they were supposed to provide a different response. While most of the investigative findings were kept under wraps, McFadden was calling press conferences and confirming parents' worst fears -- until the FBI calmed the nation by calling attention to the total absence of physical evidence – bodily fluids and animal carcasses – at the scenes. Nearly all the charges were dropped, and the case against Raymond Buckey twice resulted in an acquittal.
5. Citing the ideal gas law, independent labs housed in universities across the country demonstrated that the loss of air pressure in the footballs could be explained on the basis of temperature conditions in the locker room and on the field. Two different gauges were used to measure the balls. And it was revealed that not only was the loss in pressure not as steep as initially reported in Patriots balls, but 3 of the 4 Colts balls were also under inflated. The case against Brady relied heavily on a 90 second excursion of a ball custodian into a urinal-less bathroom, a vague reference to a “deflator” in a 7 month old text message, and the fact Tom Brady destroyed his cell phone. But Brady destroyed his phone after having been informed by league sources that they had everything they needed from him and after the league office leaked some of the more personal of the emails Brady provided in an initial discovery phase. Brady would not only lead his Patriots to an upset of the reigning champion Seahawks with what at the time was the largest 4th quarter comeback in Super Bowl history, but he would lead an even greater 4th quarter comeback against the Falcons two years later. All in all, to the 3 championships we were being asked to re-evaluate based on an alleged competitive integrity violation, Brady added 4 more over a 7 year period in which ball pressure was now routinely monitored. But you will still find those who attempt to rekindle notions of Brady's guilt on Internet comment boards. It’s unclear whether they believe their own press or whether they are hiding behind anonymous fronts to stoke these opinions in kindred fans of franchises not named New England. And that’s the real point here. With football being half religion and half entertainment with a strong fantasy component, 95% of fans worship at another altar. Only one team has a successful season and for 6 years of 18, that team was New England. In an era in which new rules were intended to promote parity, the Brady led Patriots forged the most enduring dynasty in Super Bowl history. League owners were looking for their $44 million Commissioner to reclaim parity by any means necessary. And despite the lack of evidence for a ball deflation scheme, Exponent, led by Ted Wells, found a new math with which to deliver the conclusion their customer paid for: “It is more likely than not Tom Brady was at least generally aware of a scheme to deflate footballs.” Brady ultimately did serve a 4 game suspension reinstated on appeal but not because the judges determined there was sufficient evidence for a scheme but because the Commissioner had the right to impose an arbitrary decision and penalty under the terms of the Collective Bargaining Agreement negotiated between the league and the player’s association in 2011.

**OPIOID CRISIS AS MASS HYSTERIA: DOES THE SHOE FIT?**

Now I ask that you consider these indisputable facts about the Opioid Crisis and whether the response of our Government and the public at large fits in with the five precedents of mass hysteria listed above.

The torch mobs responsible for the negativity surrounding opioids consist of the grieving survivors of dead heroin addicts who storm the offices of their District Representatives in search of therapy. And there is no greater therapy than recasting their loved ones, many of whom died senselessly, recklessly, and grotesquely, as victims of industry and as posthumous agents of reform. Nothing brings more meaning to the deaths of their children and to the balance of their own lives than to point out the face of Satan in these pills. Under the pretext of genuine caring, the Representatives agree to help, knowing opioids offer the perfect opportunity to rehabilitate a tarnished image, offer hope and healing to a divided electorate, and win votes. Chris Christie lost a friend to opioids, his friend having washed down a handful of Percocet with a half bottle of vodka. When politicians looked into the statistics, they were disappointed to find low rates of dependency estimated by NIH and SAMHSA. So they ignored the percentages and hoped to create a perceptual illusion of sorts by juxtaposing raw tallies of overdose deaths with groups that offered favorable comparisons. How terrible must opioids be if they claimed as many souls as the Vietnam War, alcohol, or motor vehicle accidents. But the Vietnam War lasted only 6 years compared to the 16 required for a favorable opioid comparison. After safety belts and speed limits, we stop short of criminalizing the sale, manufacture, and transportation of Honda Civics. And as for alcohol, those numbers remain relatively stable while opioids made a number of suspicious leaps due most likely to iatrogenic factors / artifacts: (1) chronic pain patients abandoned by their doctors under pressure from the DEA turn to Street drugs or suicide to deal with their under-treated pain; (2) medical examiners were either instructed to lend weight to opioids when listing causes of death on the certificates or else evolved a sensitivity simply from living in a climate where opioids became emotionally and politically charged. Ask yourself how overdose data could be so high when dependency data is so low. The NIH published a report calling out all the weaknesses in death certificate data, including the fact 30% of these certificates are completed before the toxicology results are known and the fact states and years vary so wildly. And yet even as empirical data is ignored or overlooked in the media, one strange stat goes viral: that 4 of 5 heroin addicts were once prescribed painkillers. This suggestion that 80% of those prescribed painkillers develop a use disorder supplanted contrasting data from NIH and SAMHSA. There were no voices of reason in high places to point out that 4 of 5 people who never touched an illicit Street drug were also prescribed a painkiller at some point in their lives, because at some point in their lives roughly 80% of us filled a script for Percocet or Tylenol with codeine after having our wisdom teeth removed. For some reason, no one was wiling to oppose or moderate organized efforts to purge the nation of its compassionate armaments. Another preferred statistic in the opiophobe's press kit is that 80% of the world's painkillers are consumed within U.S. borders. The stat conjures comparisons to another symbol of American extravagance and excess – the ICBM. No one countered with the argument that the prescription painkiller is a cultural achievement enforcing minimum standards of compassion. A cornerstone of civilization. Triumph of pragmatism. Evidence of American superiority. In a stunning reversal, opioids were used to open a second theater of operations – a second front in the War on Drugs expanded from Supply to Demand. This enabled the Fed, and particularly the Department of Justice, to depict pharmaceutical houses as international cartels, doctors as dealers, and patients as junkies. The DEA turned on its own citizens like an agency scorned, upset with the insinuation it was mired in the only unwinnable war to drag on longer than Vietnam. The DEA would not be painted this way by a public that continually undermined it with a consumer's appetite for mood-altering and performance-enhancing substances. In a final irony that is too often understated, the United States government went to war against its own people. Against recreational drug users. Against chronic pain patients. Against the doctors who treated them and the pharmaceutical manufacturers and retailers who supplied them. Just ask Walmart, which pre-emptively sued the Fed in the knowledge the Fed was preparing to sue them for failing to more vigorously vet legal scripts from physicians. In another bizarre subplot, the Government appeared to repress the inconvenient truth that there can be no universal limit on morphine units that fits all people – not with individual differences in medical diagnoses, treatment history, and sensitivity to pain and to pain medication. One liver enzyme alone accounts for genetic differences in what a patient needs and can handle. The Federal government, including the CDC, went about its business as if it were oblivious to the fundamental notion of tolerance. It seems an irrepressible sociological axiom that when confronted with murkiness and complication, one oversimplifies. Perhaps this is the reason our nation turned to minds like those belonging to Andrew Kolodny, who sought cult of personality status in managing the issue into submission.

Widely regarded as the Father of the CDC Opioid Prescribing Guidelines, Kolodny can often be heard on webinars and news programs reducing Percocet to “heroin pills" and reducing critics of the Guidelines to mere “shills” for the pharmaceutical industry bent on “distorting the facts.” And yet the media hosts never ask him how he would know a shill nor do they ask him to clarify his comments on distortion. Kolodny is trained as a psychiatrist and has been an executive for a chain of rehabilitation clinics (Phoenix House), where he obviously falls victim to a cognitive bias known within psychological circles as the representativeness heuristic. Even though rates of dependency are low, they come through his doors. They are what he does. They are all he does. They are 100% of his book of business, so naturally he carries on as if the proportion of patients prescribed painkillers who develop use disorders is closer to 100% than the 4 – 8% reported by NIH and SAMHSA. Naturally he is a card carrying member of the fringe group Physicians for Responsible Opioid Prescribing (PROP), a political lobby harboring extremist and alarmist views. But what is entirely unnatural is that the CDC, after delegating this matter to its Injury Prevention and Control Center, would stuff its advisory group with PROP members. Could it we owe this fateful and absurd turn of history to a friendship between Kolodny and CDC Director Tom Frieden? Because it’s tantamount to staffing an exploratory gun control committee with NRA executives. For Kolodny, this one fortuitous appointment set in motion a chain of honorary assignments that includes the mother of all conflicts of interest: at a rate of $750 an hour, Kolodny earned half a million from providing the most ridiculous expert witness testimony. In the heat of a moment in which a reporter stuck a microphone in his face as they watched a group of activists picket his employer on behalf of a community of chronic pain patients harmed by his Guidelines, Kolodny let slip that he didn’t believe in real pain. Yeah, I know, sounds incredible right? I believe his words were that the only pain experienced by those whose painkillers were discontinued was withdrawal pain. He blames every adverse event on the companies manufacturing opioids despite the fact chronic pain patients will tell you that opioid based medicine is the only resource that gives them any capacity to function and quality of life. Despite the fact that some of these patients have gone so long without their medication that they can’t still be inside the withdrawal window. Despite the fact that the suffering only really began after the medication was taken from them, at which point sanctimonious crusaders and self-aggrandizing careerists like Kolodny step in and say in their saucy irreverence “see, I told you these drugs were dangerous” before recommending their time in an emergency room be diagnosed as “opioid abuse.” Knowing how people hang on his every word, one must think Kolodny is an expert in pain. Nah. He’s just a psychiatrist. He's like the Bill Nye of the pain management world. You know Bill, right? He weighs in with his expertise on science on everything from UFOs to allegations Tom Brady deflated footballs, and yet he possesses no advanced degrees or certificates in a scientific field. Please forgive me if my memory bares false witness to Kolodny or Nye sitting in the center of the Hollywood Squares beside such entertainment icons as Rip Taylor and Charles Nelson Reilly. I realize I'm indulging an impulse to light heartedness, but how else could I do justice to such absurdity? Woody Allen once said of an op-ed piece in the New York Times critical of neo-Nazis, “it’s hard to satirize a guy wearing shiny boots.” I too feel that any barbs of mine will bounce right off a person whose capacity to rationally process new data or alternative points of view is disabled by repressed fear sublimating as narcissism.

“He can’t be bargained with. He can’t be reasoned with. He doesn’t feel pity – or remorse – or fear. And he absolutely will not stop – ever – until opioids are dead ... or outlawed everywhere except for prepubescent children in the final hours of a DNR order.” – said of Andrew Kolodny

Come now. I defy you to listen to this man speak and not think of that scene from The Terminator. Kolodny is the machine built to infiltrate our system of compassionate care. His authority is yet another symptom of this mass hysteria.

What also signifies a mass hysteria is the absence of an independent and objective class. You have a metal-on-metal clash between (a) those who believe nothing short of the total annihilation of opioids will save us from a public health crisis and crime of the century in which doctors receive kickbacks from manufacturers in exchange for prescriptions and (b) those who will defend the civil and privacy rights of patients and the medical authority and due process of those trained and willing to treat them from imperialists locked in a mutual support of personal, professional, and moral agendas. Even years into this cold civil war, high courts have not yet been called upon to weigh in.

So, you still think what happened in Salem, MA in 1692 – what *didn’t* happen in all those daycare centers -- or in the Capitol Rotunda in 1960 -- can’t happen today? You still think mass hysteria is a tale told by kooks, fantasists, and unemployed sociologists to explain childhood pranks? Obviously my work here is unfinished.

**STRIKING SIMILARITIES IN OUR RESPONSES TO “OPIOID CRISIS,” RED SCARE**

The solid center in the denominator under crusaders bent on destroying both Communists and opioids is (1) the need to sell you on the notion you and the country around you is and has been in the throes of a War and (2) that this is a war we have been losing and will continue to lose without some extraordinary intervention. This forces you to line up behind the crusader and do so urgently. The War in question is the War on Drugs.  
  
But the similarities do not end there. This article will attempt to identify the ones that tell us two things: history repeats itself and, when it does, we often make the same mistake twice. The similarity in which I am most interested is the one that has not yet come to pass. You see, there was a time when we as a nation embraced McCarthy. That we found his call to attention and action necessary, noble, and even patriotic. Those that did not embrace him remained complicit, compliant, or downright silent out of fear for what dissent could mean for their jobs, their freedom, and that of those closest to them. Four years later we came to our collective senses and censured the Wisconsin Senator for, well, okay, so I don't know for what -- something to do with undue pressure. Will Andrew Kolodny and his friends in PROP and the CDC have their day of wreckoning? And who will lead us out of our mass hysteria? Our mob mentality? Who will free us from bandage to this Group Mind? It wasn't Barack Obama. Nor was it Donald Trump. And it's not Joe Biden. The personality that served most as catalyst to help us turn the corner on McCarthy did not belong to a President or to a Senator but to a journalist: Edward R. Murrow. Murrow had access to the minds of every American. In the modern era of fractured and saturated media, there is no such pipeline.  
  
McCarthy treated Communism much like a biological contagion -- a virus. Our susceptibility to Communism was regarded as something no more complex than proximity and exposure. He did not trust us to rely on our own devices to resist indoctrination. This sentiment echoed within Senate chambers, most notably in the testimony of FBI Director J Edgar Hoover:  
  
"There is no doubt as to where a real Communist loyalty rests. Their allegiance is to Russia -- not the United States. Communism in reality is not a political party. It is a way of life -- an evil and malignant way of life -- it reveals a condition akin to disease that spreads like an epidemic and like an epidemic a quarantine is necessary to keep it from infecting this nation."  
  
Similarly, Kolodny convinced someone in Government -- who I cannot seem to ascertain -- to refer the problem of rising overdose fatalities to the Centers for Disease Control (CDC), where substance use could be treated as a biological contagion. Prescription opioids were singled out as a force so seductive that none of us could resist the threat of addiction. I could almost hear the likes and lot of Kolodny goosestepping into Congress and grandstanding with a statement to the effect that "prescription painkillers -- opioids -- are not a medication but a way of life -- an addiction -- an evil and malignant way of life and that a quarantine is necessary to keep it from infecting this nation."  
  
Much like our indoctrination to Communism, addiction was regarded as a simple and highly predictable matter of exposure and proximity to opioids. And Kolodny makes no distinction between dependency and addiction. Those who come to rely on Rx opioids -- to which millions owe their capacity to function and their quality of life -- live in harmony with the medication and live in harmony with their lives due to the medication. And yet the Kolodnys of the world would abruptly, involuntarily, and contemptuously deprive these people of their medication to spare them and countless others -- including future generations of pain sufferers -- from what they deem certain death by heroin overdose. It's a level of metaphysical presumptuousness that belies nature, science, and medicine -- not to mention the most basic civility.  
  
The threat McCarthy describes in Communism is one of "enslavement" by a "brutalitarian force." He notes that the USSR has been going about this in almost a business like manner and under the radar for 106 years. Now what does this sound like? It sounds like how anti-opioid crusaders describe the Drug War, which they extend beyond the network connecting some armed pony-tailed Colombians with night runners and local dealers on mopeds or minivans. You see, much like McCarthy broadened our view of the Cold War so the Red Scare was no longer confined to the Red Square (Soviet spies and moles are hiding in Hollywood studios and State department cafeterias), Kolodny would have you believe the principal actors behind the epidemic of overdose fatalities are pharmaceutical houses, physician offices, and pharmacies. Addiction is described much like McCarthy describes the modus operandi of Communists as brutal enslavement.  
  
Much like anti-communist crusaders had to contend with certain freedoms, rights, and traditions endemic to America, like academic freedom or freedom of speech, the anti-opioid crusader has to somehow navigate a gauntlet of inalienable rights such as the right to privacy, the right to expect that your doctor will treat according to his wits, the right to live free of pain, and the right to choose the treatment you know will take away that pain.  
  
This is how McCarthy neutralized our freedoms:  
  
"... Now I realise the minute anyone tries to get a Comunist out of a college or out of university there will be raised the pony crier that you're interfering with academic freedom. I would like to emphasise there is no academic freedom where a communist is concerned. He is not a free agent. He has no freedom of thought -- no freedom of expression -- he's taking his orders from Moscow or he will no longer be a member of the Communist Party. I don't care how much of a screwball or a crackpot any professor or teacher might be as long as he or she is a free agent but once you have this United States from the Atlantic to the Pacific covered with a network -- a network of professors and teachers who are getting their orders from Moscow -- from an organization that wants to destroy this nation -- that wants to corrupt the minds of youth -- then Mr. Jenkins we are rapidly losing the battle."  
  
Well, much like McCarthy denies the freedom of the academic by alleging that the academic is acting on orders from Moscow (and therefore is not a free agent), the Kolodnys of the world allege that the freedom involved in selecting opioids as the treatment is not real freedom but an act of addiction in which the patient is doing the drug's bidding. It's his or her brain under the influence of the drug and those who stand to profit off his or her use of the drug -- that's the behind the scenes Moscow that Kolodny thinks he's exposing here. Remember, Kolodny even went as far as to deny genuine sources of pain. In an unscripted response to a reporter covering the protests at Brandeis University -- where Kolodny is employed and carries out research -- Kolodny said that any pain experienced by those whose painkillers have been abruptly discontinued is withdrawal pain and only withdrawal pain -- dismissing out of hand pain for which sources can be found on diagnostic imaging and dismissing pain that persists well after the window of withdrawal has closed.  
  
And much as McCarthy contends that Communists have infiltrated the government and Hollywood, Kolodny would similarly point out how the seductive opioid has infiltrated the FDA, American business and industry, and the American Medical Association, whose letter to the CDC denying the opioid crisis and describing the Guidelines as harmful to patients drew a demagogue's reaction from the organization -- PROP -- in which Kolodny until recently served as an executive officer.  
  
In the fall of 1947 the House un-American Activities Committee questioned prominent people from the film industry to investigate their possible connections to the Communist Party. Since Hollywood had developed such a wide audience, it became an obvious target for investigations of the so-called "fifth column." The fifth column was a common term used in the 40s and 50s to refer to subversive organizations working within a country to further an outside enemy's aims. Fast forward 60 years and the modern day War on Drugs. When the war on foreign cartels supplying the drugs began to draw analogies to the Vietnam War, the DEA shifted its focus from supply to demand and found a fifth column of sorts in the American consumer. The DEA was not about to entertain complaints from the public for 40 years without vindictively calling out the public's role as instigator and co-conspirator. After all, no one would supply the drugs to people that didn't desire the drugs. But it was only a matter of time before millions of citizens seeking treatment for chronic pain conditions would find themselves in the DEA's cross-hairs. The fifth column was expanded to encompass patients, prescribers, and manufacturers.   
  
Much like House on un-American Activities (HUAC) perceived an agenda within Hollywood to spread ideology favorable to communism, subpoenaing, censoring, and imprisoning members of Hollywood and ensuring they would never work again, today's anti-opioid crusaders, acting through the DEA, are surveiling, raiding, and prosecuting doctors they believe are supporting opioids by prescription. They have deprived thousands of doctors of their licenses to prescribe and shut down their practices. If you are a doctor or a patient, you take to social media at great risk and with the fear you will be flagged by the Government as an opioid sympathizer and placed under surveillance through the Prescription Drug Monitoring Database. The DEA's Prescription Drug Division functions like a modern day HUAC. One day you receive a script. A few days later your doctor is getting a threatening phone call from a Government official protesting the script and perhaps dictating an alternative approach to treatment. You may walk into the doctor's office and your doctor or another member of the practice might throw a print out at you listing all the opioids you have received over the years and, noting the variety of prescribers and pharmacies, proclaim that "THIS ... " is a "red flag." Patients suddenly perceived as a risk to their doctor's licenses -- a liability -- are abandoned and secret shopper research has shown that such patients will be turned away by other doctors. The end result for many people who were flagged as a suspected Communist sympathizer or who simply refused to co-operate with the Government investigation by providing the name of a Communist sympathizer, was suicide. They were shamed in a way that undermined their perceived status within the public not only as patriots but as fellow Americans. The denigration of their reputations and resumes compromised their capacity to earn a living for themselves and for their families, placing their most personal relationships at risk.  
  
Suicide is also the fate of many chronic pain patients abandoned by the medical system. On top of the pain they must endure, their most personal relationships are complicated when they can no longer work through pain and disability to support their family. Other members of the household also assume a greater share of the responsibility for household chores. They are now officially burdens. The pain also changes them. They are unable to be the personalities we have come to know and love. On top of all that, we demand that they accept the label "addict" even though their painkillers did nothing but benefit them, their families, and society at large. If they do not commit suicide, they are often driven into emergency rooms with withdrawal symptoms or to the Street -- and their use of illicit substances with no or misleading labels with respect to ingredients and serving sizes kills them or transforms them into the junkies the Government claimed they always were. Either way, the Government can point to the patients whose legal opioids were taken and say "see, we told you these pills were a problem." Of course, the medications are only a problem after they are taken away. The Government fulfills its own prophecy.  
  
Crusaders against Communism and painkillers alike love to charge that their opponents are in denial despite exhibiting denial themselves through tautological or irrefutable arguments. If you refused to name yourself or someone else as a Communist, well then you were a Communist quod erat demonstrandum. Similarly, if you are prescribed opioids you are, in the words of one ER physician to a friend of mine, "addicted and you don't know it." My friend entered the ER with symptoms that had nothing to do with his opioid therapy. His PCP abruptly discontinued his Xanax on order from the DEA, which had raided his practice earlier in the week. But when my friend showed up in the ER with predictable symptoms he was not only diagnosed with "benzodiazepine abuse" (he was not abusing his Xanax), but the ER attending subjected him to interrogation over his opioids prescriptions and attempted to have these monthly scripts discontinued. ("You'll thank me later"). When my cousin's wife was stopped by a deputy for driving 15 mph in a 40 mph zone due in part to a hypoglycemic episode (she was a documented Type 1 diabetic) and in part because she lost her way and found herself on unfamiliar winding narrow mountain roads, she was subjected to a blood test. When the blood test revealed her painkillers, there was no arguing with the deputy that the painkillers were taken over 12 hours before she got behind the wheel. As far as he was concerned, he had himself a drug collar. The prosecutor pushed for a DUI-D conviction and when the Judge ruled the State of Virginia failed to meet its burden -- he strongly suspected hypoglycemia -- the prosecutor brazenly remarked "the State is most unhappy with you, Judge." Other drivers are not so fortunate. Drivers are routinely convicted of DUI-D when opioids are found in their car or bloodstream even though it is impossible to prove they were consumed in a medically relevant time frame to affect the driver's state of mind. In addition, the presumed side effects attributed to opioids are myths and misconceptions. They do not cause drowsiness, a change in mental status, psychomotor retardation, intoxication, delirium, or a blunting of cognition. Not unless they are dosed inappropriately or with another substance. And yet we treat opioids as a conspiratorial blend of alcohol, dextramorphan, marijuana, and cold medicine. Or as heroin light. But as much as some like to point out that heroin and prescription painkillers both target the same receptors and are both classified as central nervous system depressants, there are important distinctions. Heroin is not sold in standard units. Therefore there can never be a label with a serving size and list of ingredients. These units vary from dealer to dealer and possibly even across interactions with the same dealer. Secondly, you never know the purity of the heroin you're purchasing. Heroin may be cut with a variety of other substances. Would you like to venture a guess? It's not acetaminophen. One in 3 heroin overdoses in Philadelphia in 2019 involved the adulterant xylazine, an animal tranquilizer. Heroin is also routinely cut with fentanyl, a form of morphine so potent that a few sand grains would kill even some experienced users. Heroin is designed to knock you out. Render you unconscious after a few seconds of euphoria. Prescription painkillers by contrast and when dosed appropriately increase energy and make the consumer talkative, restless, and even productive. Many people report being unable to sleep after taking a prescription painkiller. Other side effects include the capacity to alleviate depression, anxiety, stress, and resentment better than any anti-depressant, leading to thoughts and acts of altruism, civility, and optimism. It almost sounds to me like many of society's ills can be cured with painkiller prescriptions. But that's not going to translate into the kind of soundbite an attorney general could ride to re-election. Politicians run on fear -- not hope. It's all about making you afraid of it.  
  
Now the intense focus on communists in the government did in fact turn up 3 government employees spying for the Soviets, Alger Hiss in 1948 and Julius and Ethel Rosenberg in 1953. That is, before overextending its bounds and outliving its usefulness. McCarthy afterall claimed there were hundreds but failed to produce a list. He made the statement there are 205 Communists in the State Department alone. No one asked whether they actually exist, who they are, or how McCarthy knows what other people don't.  
  
Similarly, there are some positive developments that could be credited to the anti-opioid crusade. We closed pill mills. We required opioid users to fill an inexpensive script for Narcan. It fostered a mindset in which doctors committed to meeting regularly with patients, educating them on risk, attempting alternatives for managing pain, and seeking a cure where possible for the pain-producing conditions. But the campaign didn't stop there. It went too far. It goes too far still.  
  
Even after raiding the medical practices of what the DEA would call the worst 4,000 offenders, they continue to invent new guidelines to serve as impetus and justification for raiding more doctors. Only these are no longer rogue dentists offering 60 percocet for the wisdom teeth of our most vulnerable youth. These are no longer doctors who auto-pilot scripts without periodically checking in with patients or making an earnest effort to address their symptoms or their underlying causes with a broader and due-er diligence. These are simply the doctors flagged by the Prescription Drug Monitoring Database as prescribing more units of morphine than anyone else in his or her region or specialty or whose patient pool boasts the highest average NarxScore.  
  
NarxScore. This is a fairly new metric representing an attempt to measure a patient's risk of overdose as a function of his or her current prescriptions. (This ridiculous number ranging from 0 to 1000 does not account for duration of use, tolerance, pain severity, or genetic sensitivity to pain or to pain medication). The number follows patients around like the pink triangle patch hemmed to the garments of Jews and homosexuals living in World War II Germany. The fact doctors are required to look it up before each new patient encounter and the fact hospitals are being given awards for plugging it into the EMR system would bring a blushing smile to the corpse of Heinrich Himmler. New regulations complicate and delay the patient at the point of fulfilling legal scripts at the pharmacy, with some pharmacists challenging physicians out of pride or fear. Some employers have demanded that their contracted health insurance carrier deny employee claims for opioid based medication. And states like New York, which taxed opioids to raise millions for rehabilitation programs, are finding that the pharmacies are no longer accepting deliveries of opioids, leaving chronic pain patients in the state with no access.  
  
Campaigns like these don't know how to stop. No exit strategy is possible when people's jobs, paychecks, legacies, and funding streams are tied to a declaration of emergency. To a widespread public perception of threat. It is beyond this point of inflexion when we can say that America is more addicted to the Opioid Crisis than it is to opioids.  
  
Joe McCarthy prolonged and intensified public interest in government programs to root out Communists in universities, Hollywood studios, and Federal agencies when he made the claim in his high octane "Enemies from Within" speech to the Ohio County Republican Women's Club in 1948 that there were 205 Communists in the State department. Similarly, after Andrew Kolodny earned $500,000 from expert witness testimony against opioid manufacturers, he skewered the AMA for sending a letter to the CDC claiming that the crisis was over and that the Guidelines were proving harmful to patients. Kolodny also refers to the fact overdoses and suicides have increased dramatically over the period that opioid prescriptions have declined 60% as an example of illusory correlation -- as an illustrative case of the naive among us falling into the trap of confusing correlation for causation. He is quick to dismiss any information inconsistent with his view as "anecdotal," which might resonate with those of us who are unaware that he cannot lay claim to evidence of higher quality.  
  
And much like HUAC was criticised for holding two-thirds of its meetings behind closed doors, the group hired by the CDC as architects of its Opioid Prescribing Guidelines held all its meetings behind closed doors. When meeting transcripts were requested under the Freedom of Information Act, what was turned over were hundreds of pages with over 80% of the text redacted.

A serial documentary titled Unsolved History (20XX) attempted to penetrate unanswered questions about the Salem Witch Trials with special attention to the factors that caused and maintained the delusions. How could this have happened and could this happen again?

*“Some girls came down with a mysterious ailment, perhaps brought on by eating rye bread contaminated by a hallucinogenic fungus (ergot alkaloids) ... Then natural Puritan fear of the Devil was amplified by the constant threat of attack by Wabanake Indians, forces directly linked to Satan in the colonists minds. We have seen how easy it would be for isolated villagers to whip themselves up into a frenzy and see witchcraft everywhere. Magistrates twisted the girls' testimony to serve their hardliners religious agenda. And the Governor seeking to enhance his power sat back and watched this mayhem play out.”*

Let’s examine this phased account of the phenomenon one phase at a time.

*“Some girls came down with a mysterious ailment, perhaps brought on by eating rye bread contaminated by a hallucinogenic fungus (ergot alkaloids).*”

This phase is meant to identify and characterize a precipitating event (trigger) or initial manifestation. The ailment to which the statement refers is a convulsive fit resembling an epileptic seizure. The convulsions manifested in three teenage girls who also reported dreams or visions in which a demon appeared in the guise of a local woman demanding they sign their names to a Satanic book / registry. These dreams or visions were the focal point of testimony offered by the girls in the act of naming the defendant a witch. This spectral evidence was outlawed by the State of Massachusetts soon after the Trials ended in 1692. If indeed the convulsions can be traced to a biochemical event in a highly toxic fungus that would have been rampant given ideal climate conditions (i.e., cold winter following a moist hot summer) and that survived baking temperatures in recent experimental testing, misattribution research within the field of Social Psychology offers ample evidence that the unexplained physiological arousal would have compelled cognitive labels based on social cues or unconscious projections. Defendants were named because they had the misfortune to appear in the dreams and the arousal was labelled as a form of demonic possession. Why the non-llife-threatening convulsions required a culprit, why a culprit required a trial that was devoid of due process and that carried a sentence of death bemused generations of historians, many of whom settled on the constant war between the colonists and the Wabanake Indians who were considered minions of the Devil. Governor Fipps, who eventually suspended the trials on Constitutional grounds, could have done so in a timeframe that would have spared lives but he fabricated a story about spending the summer on the front lines, thereby allowing the trials to play out so he could curry favor with local officials. The hearings held by the House Committee on un-American Activities should have been allowed to wind down into decommission status after the conviction and execution of the Rosenbergs. A little known Senator from Wisconsin named Joe McCarthy should never have been permitted to expand the campaign of accusations into the lives of innocent citizens. But this one man seized the opportunity to rise to national prominence and rise within the ranks of his party by simply using an assigned speech at a women's conference in West Virginia as a platform from which to announce that there were some 205 suspected Communists working in the State department.

Coincidentally, the accusations of satanic ritual abuse by daycare workers, which was kicked off by allegations against Raymond Buckey of the Manhattan Beach-based McMartin School in 1983, also can be traced to anomalous physical behavior in a child, who exhibited difficulty sitting down, and was also maintained by one person's political aspiration and agenda. Actually the case should have ended when the police department deemed the mother of the child psychotic and released the accused for lack of evidence. But the department also released to each family with a child enrolled at McMartin a letter advising parents to question their children on the subjects of sodomy, oral sex, and fondling, promoting some emotionally involved parents to compare notes after engaging in leading and suggestive questioning of their children. At that point authorities were compelled to engage a child abuse prevention center (Children's Institute International) to investigate the abuse hypothesis. Lead investigator Kai McFadden interviewed 400 preschoolers using hand puppets, but allowed her preconceived notions and quite possibly foregone conclusions to contaminate data collection. An analysis of the transcripts revealed that when children initially answered "no" to the question "have you ever played any naked games?", the therapists, rather than accepting the responses, repeated or rephrased the question until they received the answer they desired or expected. Given the attention the case had already garnered on a nightly basis, a conclusion of “no findings" would have thrust McFadden and her institute out of the spotlight and out of a lifesaving role in a sensational crime. A self-aggrandizing McFadden needed to maintain the common concept of operations for ends similar to those served by Governor Fipps and Joe McCarthy.

In each phenomena the theater of the absurd was foisted on the public. Aided by unskeptical, sensationalist treatment of the allegations by nightly news broadcasters that appeared to get caught up in the paranoia, the public actually believed for a number of months that thousands of children across the country were subjected to satanic ritual and sexual abuse by daycare center employees. The lives of a great many DOD cafeteria workers and Hollywood writers whose names were coerced from friends or associates were destroyed in the interests of protecting American freedom from Soviet propaganda.

The significance of each of the above incidents is that as they unfolded we were in the throes of a mass delusion that would give way months or years later to this disillusioned sense of “what were we thinking? How could have we allowed such a thing to happen?”

**STRIKING SIMILARITIES IN RESPONSE TO CRYPTIC SALEM-ERA SYMPTOMS, HEROIN OVERDOSES**

In the qualifying statement “but the Devil made me do it,” three young girls eventually apologize for testimony used to condemn 20 innocent townsfolk to 3 agonizing minutes of lethal asphyxiation. In a few cases, when the more popular or respected defendants were acquitted, the three girls would drop to the floor and writhe in an exhibition that invariably prompted the judges to reconsider. These murders strike many of us contemporaries as something that could never happen today, largely because we do not share the religious ideology of the early Puritan settlers. We do not include Satan an immediate presence and ubiquitous threat. We also do not convict anyone today based purely on spectral evidence. That being said, we have retained in secular-humanistic terms the same need to rid the times of some demon.

Could this happen again?

In the modern version, the anomalous manifestation that launched the “Opioid Crisis” would have been the physical condition of the heroin addict in the throes of an overdose. Police unions and politicians alike referred to the grisly nature of the deaths as impetus for sustained attention. “Have you ever held someone dying of a heroin overdose?” became a mantra. The police union even issued a public indictment of a Saturday Night Live skit about a fictitious product called “Heroin A.M.” This was a pathos-driven declaration of emergency rooted in image – in what we were asked to imagine of a dying addict and in their enlarged poster boarded headshots, raised in their pre-opioid innocence on easel for the bill signing ceremony. The Crisis was tempered in the hidden contract between the grieving survivors led down a spiralling path to Bereavement Disorder and the lawmakers who saw in opioid addiction a rare opportunity to salvage a tarnished reputation and inspire the public with an equally rare feat of bipartisanship. Some of these grieving parents saw in the participation of senior Government officials an opportunity to give meaning to their lives and to the senseless, reckless deaths of their children by recasting them as victims of industry and as posthumous agents of reform. There is no greater therapy. Some of these parents like billionaire hotelier Gary Mendell, have money for the cause. In a letter to the Joint Commission (JHACO), Gary pleads for the top accrediting body to suspend the practice whereby attending physicians ask emergency room patients whether they are in pain and, if so, to rate the pain on a scale. Arguing that “pain is not a vital sign,” he thinks those routine questions could lead to the overvaluation of pain and consequently the overprescribing of pain medication. Forget for a moment that hospitalists tell us that responses to the question “How much pain do you have?” correlates more highly than any other item with the patient’s overall patient satisfaction score. Even though surveys tell us less than 1 in 5 Americans know someone struggling with an opioid use disorder, an inordinate number of these senior Government leaders (e.g., Bill Clinton) are grieving over the loss of close personal friends to opioid addiction. Friend of former embattled New Jersey Governor Chris Christie inspired much-needed, long overdue reform when he washed down a handful of Percocet with a half bottle of vodka.

So in our contemporary instantiation, as in previous cases, we can observe a precipitating physical violation and the maintaining influence of political authority and aspiration.

*“Then natural Puritan fear of the Devil was amplified by the constant threat of attack by Wabanake Indians, forces directly linked to Satan in the colonists minds.”*

The fear of opioids was amplified by the constant threat of drug dealers and the specter of a 50 year Drug War. Children walking obliviously into parties where pills were served by teenage peers who had just had their wisdom teeth removed. The War was occasionally conjured by headlines reporting the death of a high profile actor or musician to opioids or cocktails in which opioids were a part, most notably or recently River Phoenix, Elvis Presley, Delores Riordan, Prince, Heath Ledger, and Philip Seymour Hoffman, or more broadly to other classes of drugs such as Amy Winehouse, John Belushi. When confronted with the perception of an unwinnable trench War – and threatened by public leanings toward the legalization of marijuana or decriminalisation of possession of small quantities of any substance – the DEA steels its resolve by taking aim on a new culprit, American citizen without whose demand for the drugs there would be no incentive for criminal organisation to supply. A new front on the Drugs War is opened as DEA agents find ways to attack Demand by recasting pharmaceutical houses as international cartels, doctors as dealers, and patients as junkies. Here we may have a case where agencies of Federal bureaucrats attempt to preserve their power base and their familiar activities against existential threats of defunding, reorganization, defamation, or worse. The DEA needed to feed a new face of evil to an increasingly skeptical, cynical, and secularized public.

*“We have seen how easy it would be for isolated villagers to whip themselves up into a frenzy and see witchcraft everywhere.”*

The CDC conveniently infused the campaign with numbers it subsequently acknowledged had been inflated by errors in analysis or by untested assumptions about the definitiveness of data sources. By assigning the subject to its Injury Control and Prevention Unit, the CDC turned a matter for exploration into a foregone conclusion in need of immediate corrective action. Guidelines were drafted with input from a Core Expert Group staffed predominantly by members of an ideological fringe group that calls itself Physicians for Responsible Opioid Prescribing (PROP). Experts in pain management were excluded from the Group and information about the Core Expert Group and its day-to-day operations were withheld from the public and declared immune from FOIA requests. Knowing they were operating in secrecy and that their recommendations would provide impetus and justification for agencies with broad or unlimited enforcement authority – even over doctors – emboldened them. The fact they were already well acquainted with one another and knew they held common views of opioids also would have steeled and steered them toward more ambitious feats of intervention and disruption.

The media helped them whip the public into a frenzy by promulgating misleading statistics including a story about mussels in Puget Sound and 4 in 5 heroin addicts, while ignoring the calming and credible data unearthed by NIH and SAMHSA. For a few years now the public has been fed a bizarre narrative that depicts doctors as pharmacology-illiterate and prescribing excessively in exchange for kickbacks from manufacturers. The Fed sued 47 states to install a Prescription Drug Monitoring Database that would be used not to confidentially collect aggregate data but as a surveillance and detection tool to spy on doctor-patient encounters and flag scripts deemed excessive on the basis of the limit laid down in the Guidelines or on the basis of how the physicians compares with peers. Armed with a network television crew, DEA agents staged raids on physician offices as a strategy to dampen prescribing rates in peers. Doctors were also discouraged or disincentivized by onerous documentation requirements and harassing phone calls from pharmacists to verify or second guess scripts. The NARXScore was invented to provide a quasi-scientific legitimacy to what had been perceived heretofore as reckless posse-style invasions. It was only a matter of time before pharmacy and hospital EMR systems were interoperable with the PDMP and the NARXScore. The DUI charge was expanded to include a DUI-D charge so cops and prosecutors that smell a drugs collar could bring the full force of the Court down on anyone whose tox screen revealed opioids. Convictions were inevitable even though no one could prove the defendant wrong when claiming the drugs were consumed 12 – 48 hours prior to getting behind the wheel. Employers demanded that the carriers contracted to provide health benefits to employees adopt a policy of denying claims for pain medication. Biased or scientifically illiterate columnists published articles blaming opioid use disorders for every societal problem, such as when citing in state comparisons the correlation between higher rates of prescribing and lower rates of workforce participation, overlooking – or ignoring – the obvious covariate: the pain itself for which pain medication is prescribed. Overlooking – or ignoring – the obvious possibility that they had reversed the true direction of cause and effect when announcing that opioids caused society's longstanding issues of workforce participation, affordable housing, household debt, etcetera.

*“Magistrates twisted the girls' testimony to serve their hardliners religious agenda.”*

It’s hard to imagine senior Government officials in religious observance, but in the argument to save the world from opioids there is tell tale religious fervor and leaps of faith. ER physicians nowadays hurl unqualified axioms that cannot be nuanced or refuted (e.g., “Gotta get off the benzos"; “you have to come off the pain meds sometime"; and “you'll thank me later”).

“And the Governor seeking to enhance his power sat back and watched this mayhem play out”  
In 17th century Salem, this political game put 150 men and women in jail, 23 of which paid with their lives.  In 21st century America, the political game put an incalculable hundreds of doctors in courtrooms, many of whom had paid with their practices well before a favorable judgment.  And the Game separated 71% of chronic pain patients from at least some part of their treatment, an unspecified number of which would turn to the Street or to suicide for relief.

**INVASION OF THE ACTUARIAL SCIENTISTS:  DURING  A 30-YEAR CYCLE OF RELIGIOUS REVIVAL IN THE U.S., A SECULAR REGULATORY MOVEMENT IS BORN, SUBJECTING THE INDIVIDUAL CITIZEN TO A GROUP MIND**  
Have you seen any one of the four films based on Jack Finney's 1954 serialized science fiction novel Body Snatchers?  A species of extraterrestrial plants replicates human bodies so that even the closest friends and family at least briefly fail to recognize the clone.  The impersonation is perfect physically.  Those aliens know how to imitate humans at a level we might say is skin deep.  But the clones are incapable of human feelings.  They lack the things that make us who we are as both human beings and as individuals.  Sure, they know how to represent and serve the community of pod people but they are incapable of attachments to other individuals.  Value-judgments.  Independent and creative thinking.  The premise for the novel and the films resonated so profoundly that one wonders whether it captured a shared but (collectively) unconscious apprehension of where we as a society were headed.  A similar premise could be found in John Carpenter's The Thing (1982), James Cameron's The Terminator (1984), and an incalculable number of works about vampires, satanic cults, and zombies.  These works conspire to warn us that a desensitization to humanity and to the idea of the individual is the vehicle of life are contagious.  This is the real epidemic here -- a social contagion -- and it is arguably to medicate or restore what is lost during this phase of our cultural evolution -- this dehumanization, deindividuation, and degradation -- that we rely on substances.  I realize that if the SAMHSA surveys are to be believed that this may not be true for the 65% who cited "to relieve pain" as the reason for misusing prescription pain relievers.  But as a trained social psychologist, psychometrician, depth psychologist, and dream researcher allow me to be the first to acknowledge the limitations of surveys and, well, generally all paper-and-pencil instruments. Not all our motives are known to us, accessible via introspection, desirable to admit privately let alone publicly, or represented among the options provided on a multiple choice exam.  Is their a broader pain or prophecy indulged when we turn to substances?  That I suspect is a hypothesis that has yet to be explored through research.    
  
But one of the dehumanizing and deindividuating trends I believe to have been anticipated by forward-leaning literature and cinema is the imitation of real science by a pale actuarial substitute that is driven by regulatory objectives to identify, assess, and manage risk or to establish and monitor compliance with best practices.     
  
By contrast, real science guided by pure scholarly motives -- science that is not used as a tool to advance or defend some political agenda, personal bias, or preconceived conclusion -- proceeds with open eyes toward a naked truth.  We do science for all the possible realities we can imagine as well as for the incalculable number of realities we can't imagine.  Actuarial science is performed in the name of a risk or regulation.  That risk or regulation is the impetus to collect and analyze the data and it is the language through which the conclusions will be expressed.  Even when we are not researching some risk or regulation, I regret that our research practices have come to resemble those that make up actuarial science.  Without a sufficient fund of knowledge we precipitously foreclose on a binary and highly circumscribed hypothesis that is more often than not derivative of prior projects in a way that affords us some reasonable certainty as to the statistically significant outcome we require for peer support and publication on a timetable conducive to a CV-driven career.    
  
That last sentence was a mouthful but if you could understand it you will understand how easily social trends, political goals, and professional / institutional requirements can pollute a scientific body of knowledge.  I wish I can be 19 again and think of science as this sanitized tool performed in a vacuum by an objective class of research professionals whose supreme if not sole aim is the pursuit of truth.  But I learned early and often that science is a social enterprise like any other culturally embedded / nested in institutions such as a career, a profession, and the university department or client-facing consultancy firm that employs us.  Scientists have to satisfy, among other things, requirements for membership in an academic community.  They have to publish.  Think about that for a moment.  What do you need to publish at least once a year?  You need what we call a positive finding, which refers more technically to a statistically significant outcome.  Have you ever wondered how in the name of Sam Hill every assistant professor manages over the 4-7 year period that he or she is pursuing tenure -- and for that matter 30 years after that -- to meet only with positive findings he or she could submit for publication?  Bear in mind that these trade periodicals do not publish non-significant findings.  So all these tenure-track professors do nothing but compare groups whose average differences are so great that by chance alone a difference this great would be  observed in no more than 5 of the 100 times the experiment were repeated.  All these professors have to have known in advance that their research would produce such a wild outcome.  Are they that smart?  Well in all fairness they have read all the relevant research on the topic.  Call it legalized insider trading. They acquire a great deal of insider information before they bet on a research project to help their career.  Still I think most professors stack in the deck in their favor by designing research so that it is more derivative or imitative of past research.  They vary a variable.  Up a dosage.  Replicate a project but with an added variable so that even if the new variable proves uninteresting, they can fall back on the more commemorative elements of the research design.  This must be why replication is so roundly celebrated within academic communities as vital to science.  Still, you don't see a lot of bold or exploratory research being performed or research that explores the more mysterious phenomena within an academic field.  Well, maybe you do in Physics, and any periodical or for that matter newspaper will publish the outcome -- any outcome -- of any Stephen Hawking study -- "so to conclude, a black hole is not -- I repeat -- NOT curved like the armpits of a 70-year-old woman" -- but this I promise you is for obvious reasons the exception.   
  
In order to publish at least once a year -- at least twice a year if you're building a competitive CV -- you help.  You need to divide the labor among co-authors.  If I learned one thing from my stint at University, it's that credit cannot be divided or diluted but labor can.  If you discover the role of an enzyme in cancer pathogenesis, you are celebrated the same whether you are listed as the sole author, primary author, or fifth in a 6-deep list of authors.  And that is likely the case because no one knows anything about the nature or magnitude of your contributions to the work.  The CV doesn't tell that story.  You may have formulated the hypothesis after a review of the literature, conceived the whole idea of a research project, and assembled the research team.  Or you might have developed the analytic strategy which may be a simple matter of selecting from a menu of paradigm-preapproved statistics like the odds ratio or the 2 x 2 ANOVA or which may involve something intuitively groundbreaking.  You may have been asked to write the 5 or 6 paragraphs that will summarize the methodology.  You may have done nothing more than attend a weekly meeting and messenger materials to and from the library.  The more established and dare I say famous you are within a certain field it's more likely you had no role at all beyond lending your name to the effort so it stood a better chance of getting green lighted for publication.  All I know is that there is very few solo research projects in science.  That must also be the reason the phrase "science is a community" is so roundly appreciated in these academic departments.  It must also be why everyone runs up and down those halls joining all these research teams so as to become the 6th author on as many 4 page publications as possible.  Everyone is helping each other build a curriculum vita.  I recall how impressive this one CV was.  It belonged to the man hired to replace me at Mount Sinai.  Sure, I had joined the organization and wasn't planning on going anywhere -- but when John James Crowley (AKA John James Crony) let the department head (AKA former 20 year co-author and friend) know he was available, how could anyone pass him up?  His CV was 41 pages long.  Forty pages of research publications spanning a 20 year career.  His CV was distributed among the hospital employees while my future with the hospital was still just writing on the wall, so I took the opportunity to subject it to some data analysis of my own.  Let's see ... he averaged roughly 15 publications a year which spurred me to dig deeper.  I mean, just how good could this research be or perhaps more to the point, just how much could he have contributed to each project over this time?  He averaged 9 co-authors and a rank of 5 in the official citations' list of co-authors.  And as I suggested earlier, we have no details on his role in any of these projects beyond his eminently forgetful doctoral dissertation.  But what we do when we hire and when we evaluate for tenure, speaking invitations, teaching assignments, or for the right to emcee the faculty dinner is we count the number of pages in that CV.  I believe we used to put it on a bathroom scale but that just prompted professors to invest in a heavier card stock.  How often do you think anyone on that decision making committee reads even one of the dozens of publications listed in that CV?  There are many ways to conceal or compensate for mediocrity in the academic ranks.  Many ways to hide a mediocre mind.  Research and publishing as a herd activity is one of them.  It's a form of herd immunity in which great minds and great ideas are prohibited from spreading within the academic community.  And it's the main reason university libraries are filled with thousands of periodicals whose supreme purpose is to sit on a shelf and collect dust.    
  
If you think of all the salaries we invest in academics to perform research and to baby sit and mass certify our children, that's wasted opportunity on a scale that defies comprehension almost as well as the thought of counting the sandgrains on all the world's beaches.  And the opportunity is unfulfilled because it is influenced if not driven disproportionately by goals like getting my research published twice a year, building my CV, fitting in with my peers, paying the mortgage, and being awarded research grants.  As innocuous as you might think this is, it severely restricts the range of phenomena and research hypotheses considered acceptable or popular.  If your research does not lend itself to the kind of routine paradigmatic methods and reporting styles that result in a paper your peers -- and this includes those who have no interest or familiarity with the phenomenon under study -- could read in their sleep ... if it does not support a worldview with which your peers identify or feel comfortable ... if it cannot be linked to the kind of immediate or near term commercial applications that could earn the research proposal the kind of external sources of funding for which your department would be awarded matching State funds ... your career faces an uphill battle.  That's all the more pressure on your likeability because absent the three criteria above, original research leading to mere groundbreaking discoveries and game changing insights as they concern a phenomenon that is not trendy or monetizable is, how should we say, "academic."  This is what happened within the field of Psychology to the age old mystery of dreaming and the careers of those who started down the path of dream research.  They either sold out by taking to heart the recommendations of faculty to abandon the phenomenon -- or they simply disappeared.  Over generations of training -- where students are selected for admission to PhD programs and socialized into academic culture -- these non-scholarly influences on scientific research not only introduce contaminants into the body of knowledge but also have a homogenizing effect on university faculties.  A principle akin to natural selection ensures that these politically liberal communities who rhapsodize about policies affirming diversity replace their outgoing members with a racially and ethnically diverse group of likeminded drones.  Infusing the ranks with all shades of skin is not the problem.  The problem is finding a PhD candidate who isn't harassed for wanting to devote his doctoral dissertation to the study of dreaming.    
  
This is what I mean by an actuarial universe.  It's a frame of mind in which science is not measured by discovery and appreciated for the quality of the original thought produced to meet the challenge but rather by its readability, slavish compliance with established ways of thinking and doing business, peer involvement, commercial applications, and funding opportunities.  In a list of contributors to what passes for a scientific community, these are your true "co-authors."   
  
And it's for this reason that I reserve judgement on any finding that comes out of a widely cited, disseminated, or celebrated research or report.  Before I invest any faith in that conclusion, I need to read the original source in full and with the uncomfortable knowledge that not everything I need to know to determine the research wasn't gamed for a hidden or suspiciously obvious agenda that is personal, professional, and/or political in nature.    
  
But research and analysis designed to support a pre-existing "diagnosis and treatment plan" sets in motion an actuarial view of society that subverts a disciplined exploration of cause effect relationships to a more casual and correlational approach. And it provides both fertile ground and fodder for the misconceptions, particularly those illusory correlations that can be dismissed or subsumed in favor of some alternative explanation hiding behind what we like to call "third," "moderating," or "confounding" variables.    
  
I see lots of them in research related to the role of opioids in both pain management and substance abuse.    
  
*Actuarial Culture as Maintaining Factor in Long Term Unemployment, Exclusion*  
How can I effectively convey what I mean here by "actuarial"?  Perhaps by use of illustration.  Under normal circumstances an employer would evaluate job candidates based on evidence for core capabilities deemed vital to meeting position objectives: a history of remarkable successes performing tasks similar to the ones the candidates would be expected to perform if they were hired.  A history of academic excellence in fulfilling course requirements on route to an advanced degree.  An ability to communicate in an interview setting concrete and conceivably achievable plans for addressing the challenges faced by the organization.    
  
In an actuarial universe, the employer would ignore search recommendations based on the above criteria, rescinding offers to top candidates in deference instead to what was found in a credit or toxicology report.  Or based on what is missing such as gaps in the resume, lack of an active security clearance or official project management micro-certificate (I.e., PMP), or difficulty finding previous supervisors willing to provide references.  While the factors above should not be discounted entirely, they are indirectly or obliquely related to job performance and should not be embraced as time- or labor-saving proxies.  What might appear as a red flag initially might just as easily have an alternative explanation.  Employers embrace predictors and risk factors like credit on the basis of population-level correlations suggesting that given x, y is slightly more likely than z.  This is how a number of adverse outcomes including but not limited to absences from work, debts, embezzlement, crime, poor health, and premature mortality are violently inferred from subprime credit.  Some very qualified -- even gifted -- persons belonging to a category or subpopulation associated with a slightly elevated risk above average ... are vulnerable to exclusion.  It's a categorical (i.e.,  all-or-nothing; 0% or 100%) response to a tendency measured probabilistically (e.g., up 3%).  Employers identify a series of predictors that include but are not limited to credit, toxicology, social media participation, resume gaps, even age -- and in an actuarial analysis these predictors stand in as proxies for all the detailed knowledge employers could obtain from a candidate if only they would ask.  But decision making based on population statistics has been the model now for some time, and drug use is a big part of that calculus.  The entire actuarial enterprise has been refined to the point where candidates are no longer just asked whether they were ever terminated from a job but whether they resigned in lieu of termination.  Where candidates are no longer simply asked to explain the most recent lapse in employment but every gap greater than one month going back 10 years (e.g., Stanford University Hospital).  Where candidates are not just screened for heroin, marijuana, cocaine, or crystal meth, but for a prescription percocet or xanax he might have been gifted by a spouse for an inconveniently timed migraine.  Employers have even shown a disaffection for candidates who receive controlled substances by prescription because, after all, chronic pain can predict only bad things.  And addiction -- even dependency authorized and facilitated by the health care system ... even worse things.    
  
As a bemused and frustrated job seekers it's important to remember that it's  nothing personal.  Sure in the middle of all these Visio-depicted predictive factors is a faintly outlined text box labeled "character," and the violent inferences drawn about character would not dignify the candidate.  He not only has risk factors, he \*is\* a risk, and more than that, he's a person of at best suspect character.   
  
I am convinced that the greatest organized crime family is the U.S. Department of Justice. But how do you fight an enemy that has the power to create or enforce laws custom-designed to neutralize you?  They own the criminal justice system.  They define what is just and unjust.  Legal and illegal.  We have seen the DOJ at work in the raiding of friendship groups in their rec rooms, in mandatory minimum sentences, civil asset forfeitures, and the three strikes law.  We have seen them at work in raiding doctor's offices and taking pain medicine from our most vulnerable citizens.  We saw them breaking and entering the home of Jean Seberg, planting listening devices, killing her dog, and breaking up her marriage by posting fliers announcing her sexual affair with an African American activist.  We saw them destroy the reputation of Richard Jewell.  We recently noted that at the behest of President Trump DOJ officials secretly gathered the phone records of Washington Post reporters.  We have seen them destroy the good work they have done by drowning it in foul deeds that have us rethinking the Elliot Nesses of the World for the new Capones.

**APPENDICES A, B, & C:**

**BENIGN ATROCITIES**

**I call them benign atrocities. These American citizens were deprived of life, liberty, and pursuit of happiness when they were forcibly separated from the only medication that for months or years relieved their pain to an extent that allowed to function, fulfill responsibilities, and be whoever they are to themselves and those closest to them. The privacy protected by HIPAA that surrounded their relationships with doctors was violated by a Department of Justice officer who surveilled and analyzed their prescriptions before finally contacting physicians to advise that their treatment decisions may cost them their practice, their license, and even their freedom.**

**Some live in excruciating pain. Some took their own lives. Some succumbed to illicitly manufactured drugs sold on the Street. Some in clinics to an equally unpredictable substance called methadone.**

**And they were stereotyped and demonized. Health care and law enforcement professionals are told their statements could not be trusted – not even those about who they are and what they need – because, you see, the brains of these addictive personalities were altered by addictive pain relievers. Their motivation and their rational faculties cannot be trusted. They have become third wheels in every conversation about them.**

**Atrocities, every single one of them. But no one who is not an immediate family member understands, cares, or cares to understand ...**

**... hence benign.**

**APPENDIX A:**

**21 DAYS IN THE LIFE OF A 47-YEAR OLD WOMAN WAITING FOR VIRGINIA MEDICAID TO FILL HER SCRIPT**

The script was written June 15.  This was the date of a hastily arranged appointment during which the neurologist planned to address Teresa's thwarted efforts to fill a script for a long-acting transdermal patch (LTP) prescribed during an appointment four weeks earlier.  The patch would have reduced Teresa’s reliance on short-acting pain pills, especially when used in conjunction with the botulinum toxin injection that is non-narcotic and that she has been receiving on a quarterly basis for over 7 years.  But unlike most insurance plans, including Medicaid in Connecticut, Virginia Medicaid only covers the $200 physician fee to inject the Botox.  It does not cover the thousand-dollar botulinum toxin itself.  Teresa is encouraged by Medicaid to obtain the substance herself.  But how many Medicaid patients do you know have the discretionary funds for such an expenditure?  Like most of what I have learned about the safety net in Virginia, this is a ploy.  Had Teresa borrowed the money for the substance, she would have received a phone call from the State’s Department of Family Services inquiring into the funding source.  There is no answer that would have prevented the State from assessing the money as income and revoking her State assistance (I.e., Food Stamps and TAN-F).  I’ll have more to say on Virginia’s conniving ways later in this report.  
  
June 15.  The neurologist operates on a saturated schedule.  He sees 2-4 patients per hour beginning at 7 AM and finishes around 10 PM.  He only has time to see his patients 4 times a year.  So when he created on two days notice what in essence is an emergency early morning appointment – and by early I mean before 7 am -- Teresa seized on the opportunity.  During the prior appointment one month earlier, the neurologist had written a number of scripts, two for products that carry the pejorative label “narcotic”: the LTP and the short-acting pills (SAPs).  But this plan was hatched on the assumption the non-narcotic botulinum toxin would be covered (it’s not) and that Teresa would fill the script for the LTP in a medically relevant time frame (she couldn’t).  In fact, as of this appointment, the LTP remains unfilled for reasons that will be clarified shortly, slowly, and painfully.  So the neurologist provided Teresa with a script for more SAPs.  After all, of all the scripts he and two other physicians had written for her, his SAP script was the only one that had not triggered a preauthorization requirement from Medicaid. Not yet at least. Teresa had run through the SAPs sooner than usual while treating some unusually awful migraines. You know what else was unusual? ... Teresa did not have botulinum toxin or LTP in her system.  
  
But when Teresa took the script to the pharmacy, she was informed that Medicaid required a preauthorization.  Apparently, the SAP quantity (#60) which is larger than that of the original script (#30), exceeded the 10-day supply threshold and triggered the requirement for additional paperwork.  Teresa's spouse, Logan, downloaded the form off the Medicaid web site, and the questions were such that the neurologist, in order to feel comfortable telling the State he exhausted all non-narcotic options and ordered all the proper diagnostic tests, would have to revisit Teresa’s history.  That's 9 years of history for those of you scoring at home. He began treating Teresa in 2009 but she relocated to another state for 2 years and recently returned to his care.  His extensive history with Teresa began with an MRI and matriculated through a series of prophylactic pharmaceuticals such as triptans (Immitrex, Relpax), NSAIDs (diclofenac transdermal patch), anticonvulsants (i.e., Keppra, Zonegram), anti-inflammatory agents (i.e., Cambia, ketorolac), anti-CGRP agents (i.e., Ajove, Ubrelvy, Aimovig, Emgality), and even a barbiturate (i.e., Fioricet) -- most of which were ineffective and one of which (Topamax) was effective at the outset but which lost its efficacy over the course of a few months.  And then there was the Botox, which was by far the most effective treatment, but which is not covered by her current insurance.  Teresa had already been prescribed anti-depressant SNRIs by another specialist which also mitigate against migraine pain.  The neurologist recommended a recently FDA approved device called Cefaly, but this was not covered by insurance plans.   
  
The narcotic “rescue” drugs were not immediately introduced at the outset of Teresa’s treatment regimen.  They were worked into her plan gradually and expanded when dictated by tolerance.  
  
If the new regulations are designed to steer physicians away from SAPs, you wouldn’t know it.  The neurologist and patient believed the current circumstances warranted a larger quantity of SAPs, but this triggered a series of requirements that led everyone down one large rabbit hole.  And as this chronicle will bear out, the more entities are involved and the more entities are required to collaborate, the longer the delays and the greater the inconvenience.  
  
The CVS pharmacy had already made mistakes on this day.  Teresa’s psychiatrist phoned in two scripts but the pharmacy only made a record of one.  The psychiatrist was so irked by the pharmacy that she called to berate the manager.  But the pharmacy had been dealing with a high volume of customers.  This is not an environment in which you would like to introduce new regulatory requirements.  This CVS had made mistakes with the SAP script.  Two days were lost at the outset when the neurologist’s office claimed not to have received the preauthorization request the pharmacy claims to have faxed.  For 2 days Teresa assumed the neurologist’s office was making inroads towards jumping a bureaucratic hoop, when in actuality it had not even started.  
  
The neurologist’s office also does a high volume business.  The office manager gets in the trenches with her staff to answer calls from patients inquiring into the status of these preauthorizations.  Whenever Logan phones the office on behalf of his wife Teresa, he most often receives the message that he is somewhere between 4th and 8th in line to speak with a representative, and the average wait time calculated from his cell phone records is 18 minutes and 37 seconds.  Patients are told that they may have to wait 24 hours for the office to turn around a preauthorization request.  So we're talking about a care system that does not have the slack or surge capacity to ramp up its response when needed.   
  
Two days later Logan phoned the CVS but learned the script was still being held up.  So he phoned the neurologist’s office and learned that Medicaid responded to the preauthorization form with a request for a urine screen.  What? ... Why?  No one could tell him.  In the appointment with the neurologist, it became clear the doctor did not know why Medicaid required the drug screen.  He surmised that the State wanted some assurance that Teresa was taking rather than selling the drug.  As an allergy sufferer, Teresa is already treated like a crystal meth maker when she stands in line at the pharmacy to produce her driver's license and assure the Federal database she had not reached her monthly limit on Sudafed. Now Virginia Medicaid is treating like a dealer. Still – the urine screen makes no sense. There is no drug screen outcome -- outside the presence of an illicit drug -- that would be actionable.  Low and high levels of the prescribed drugs could be explained by fluctuations in pain levels or -- in the present situation -- by difficulties filling a valid script at the pharmacy. When her urine screen comes back clean – and it will – that’s on Medicaid. There is also the possibility the State wants the urine screen to expand its data base. The PDMP already spreads her legs like a prostitute to a Naval fleet on furlough during the war. Now that the PDMP provides the wide screen picture, the urine tests could offer more to put on display. Still -- I would caution anyone attempting to interpret this data.  
  
So now the Patient reached the point where she had to identify the nearest Quest Diagnostics and then phone the neurologist’s office so the staff knew where to send the order.  Once the order was sent, Quest Diagnostics was phoned for the next available appointment.  Fortunately, there was an opening the next day -- but again -- this is another day Teresa is without her medication.   
  
The following day Teresa makes the trip to Quest Diagnostics and leaves a specimen.  She is told to allow 4-5 days for the results to be made available to her neurologist.  This seemed excessive to Logan, who had two drug screens performed by this same Quest for pre-employment purposes two years earlier and the results were accessible within 36 hours.  Not so this time.  After two days Logan began phoning the neurologist office and when Teresa grew impatient, he phoned again, which compelled the office staff to phone Quest directly for the results.  But Quest claimed the urine sample was “unsuitable.”  Neither Teresa nor Logan had any idea what this meant, and the Quest technician was not prepared to clarify.  Teresa’s initial supposition was that the sample was diluted but in actuality the reason Quest could not process the sample had nothing to do with the properties of the sample itself.  The neurologist’s office neglected to provide Quest with a code for the urine screen, meaning Quest did not know what to look for in the urine.  This was something you would think should be easily rectified.  Right?  But after a heated exchange with Quest, the technician made it clear to Logan she couldn’t tell the neurologist what to look for.  Only the neurologist knew what to look for.  But the office staff at the neurologist’s office informed Logan they didn’t know what to look for either.  After all, the request came from Medicaid and the neurologist didn’t even know why Medicaid wanted the test in the first place.   
  
So out of frustration the neurologist put what he suspected Medicaid wanted on a script for Teresa to take to Quest.  He identified the specific SAP and also added “Opiates.”  He figured this would cover it.  He also took the rather extraordinary step of giving Teresa his cell phone number and instructed her to text him if there are problems.  
  
Quest informed Teresa she would need to make a new appointment and leave another specimen. Quest doesn’t save specimens.  So Teresa makes the appointment.  Teresa shows up for the appointment.  But Teresa is turned away when the technician points out the substances listed on the script do not constitute or contain any proper numerical code for the processing.  Teresa asks the technician to text this to the neurologist but the technician indicates that the location does not support wireless communications and so Teresa resorts to having the technician dial the cell phone number from her landline, something for which the neurologist will subsequently berate her: “I told you to text me.”  The State of Virginia and the enforcers at the DEA would be more than pleased to learn they have already driven a wedge into what had been an amiable 9 year relationship between doctor and patient.  Eventually the Quest technician would direct the neurologist to identify the proper code and Teresa returned to Quest to leave a sample.  The sample was left in the AM on a Thursday and the results were not made available to the neurologist office until Wednesday -- and only after Logan phoned the neurologist’s office and directed their staff to call Quest for the results.   
  
Now all Teresa needed was for the neurologist’s office to fax the results to Medicaid.  But naturally Teresa had to wait for the neurologist to review the results, and the staff informed her that the only time he had available to review paperwork and other correspondence was the weekend.  But the prospect of burning another 4 days -- Thursday through Sunday -- concerned the Patient, and so Logan phoned the office again lobbying to speak with the office manager.  The office staff was more than happy to transfer him, but this became a predictable dump directly into a voicemail.  The office manager did not return the message at the end of the day.   
  
June 22.  The next day.  Logan reached out to the office again but this was a particularly bad day.  Eight calls would be placed this day from his cell phone and all 8 would fail to connect him.  At the 20 minute mark, he was re-directed to a voicemail, which was full.  He even entertained the morbid suspicion that either the office was screening his calls or that the offices were in the process of being raided by the authorities.  Don’t laugh.  This actually happened during a day’s worth of unproductive phone calls to a PCP in Connecticut.  So in order to ascertain what was happening, Logan called the office from three phones simultaneously: his own cell, his wife’s cell, and his mother-in-law’s hard line.  Logan actually thought he might get through this time because at the 5 minute mark he received the message he was first in line from his own cell phone. (Second in line from his wife’s cell).  And yet somehow he would continue to wait out the next 15 minutes -- the Muzak punctuated at regular intervals with a message reminding him “you are now first in line” -- but at the 20 minute mark both cell phones were re-directed to the full voicemail.  Fortunately, the landline did not cut off at 20 minutes and at the 24 minute mark, he was delighted to hear someone pick up.  He couldn’t believe his ears.   
  
Naturally at this point he expressed an interest in speaking with the office manager but he would not allow the staff to transfer him to her extension.  Logan indicated he was willing to hold as long as needed for him (or her) to become available.  At that point another staff member (but not the office manager) picked up the phone and asked Logan point blank what they wanted them to do for the patient.  Logan told them he needed the results of the drug test passed along to Medicaid preferably before the weekend.  
  
STAFF: “What do you need me to tell them (Medicaid)?”  
  
LOGAN: “They just need the results.”  
  
STAFF: “What about the results do you need us to tell them?”  
  
LOGAN: “I don’t know.  Medicaid asked for this.  Only they know what they need.  Just send it to them.”  
  
STAFF: “It’s with the doctor right now.  I’ll have to get it back from the doctor.”  
  
LOGAN: “I don’t think he’d mind.  Not even he knows why he’s looking at it.”  
  
STAFF: “Okay.”  
  
LOGAN: “I called Medicaid and apparently you can just call them with the results.”  
  
STAFF: “Do we have their number?”  
  
LOGAN: “I assume so.  You’re contracted with Medicaid.”  
  
STAFF: “Do you have their number?”  
  
LOGAN: “Their provider line?”  
  
STAFF: “Yes.”  
  
LOGAN: “Actually I do.  800-932-6648.”  
  
In a future conversation, the office manager would later voice her displeasure with the wait time for a Medicaid provider line representative.  You wait when you call the pharmacy.  You wait when you call the neurologist’s office.  The neurologist’s office waits when they call the payor.  That about covers it.  
  
Now Logan reports he is phoning the pharmacy every five hours on the assumption that the neurologist phoned the results of the drug screen into Medicaid.  But after 4 calls spanning 20 hours he calls the neurologist’s office and a frustrated staff member informs him they did their proverbial duty for Rome -- they “sent it in.”  So all there is left to call is Medicaid’s preauthorization line for Medicaid members (800-932-3923).  A Medicaid representative informs Logan the submission from the neurologist could not be found in the queue but the queue is substantial and that another source would have to be consulted to get visibility on any faxes sent within the past few hours.  The Medicaid rep gave Logan the impression this was a two-stage process, like the one through which the pharmacy transmits information to the doctor’s office.  It goes into a computer and then it has to be printed.  So there is a list of material on the computer, and then there is a list of printed material.  Unlike Medicaid preauthorization in Connecticut, which takes 2 hours, Medicaid “recipients” in Virginia are advised to allow as many as 2 days for a preauthorization processing.  I will venture a guess that the process didn’t always take this long -- let’s say -- prior to May 8. That’s the day the new regulations went into effect.  
  
Logan allows some more time to pass before he calls the pharmacy and again he’s told the script is being held up.  By now he suspects even the pharmacy is growing weary of him.  At 12:27 PM he phones the neurologist’s office and he’s informed that the neurologist kept the drug test overnight for review but that it had in fact been sent to Medicaid earlier this morning.  Okay.  Good.  
  
Spouse phoned Medicaid and by now they have located the drug test in the queue.  The representative informs him it’s just a matter of time (hours) before it is processed and available for the pharmacy to fill.  It’s June 26th.  2:27 P.M.   
  
At 4:19 PM Logan called the pharmacy.  This is a particularly bad day to call the pharmacy.  After waiting 3 minutes to get someone on the phone, he is placed on hold for 17 minutes and 5 seconds at which point he decides to hang up and call back.  He learns that there’s still no breakthrough.   
  
At 8:36 PM he calls the pharmacy again.  Again, after waiting a couple minutes to get a technician on the line, he is placed on hold -- this time for 19 minutes and 18 seconds.  Again he learns there’s been no change.  But he recalls Medicaid did assure him that their preauthorization is a 24/7 operation.  So progress can technically be made over the evening hours -- even as Teresa sleeps off her migraine.   
  
June 27.  10:16 AM.  A phone call is placed to the pharmacy.  This one from beginning to end only consumes a merciful 8 minutes and 36 seconds.  Unmercifully, there’s been no change.  So at 10:25 AM Logan places a call to Medicaid.  Today’s version of the truth is different from what a Medicaid representative told him the previous day.  While Medicaid did receive the results of the drug test, the “preauthorization package” is incomplete.  The neurologist’s office neglected to include something called an MME Form.  So the submission was rejected and returned to the doctor’s office.  Logan reports that his reaction at this point is “Ah shit!”  At 10:29 A.M. he phoned the neurologist’s office to alert them to this fact.  Logan recalls that the tone of the staff member was far different than usual.  Over the past few days the staff had grown unmistakably brusque.  Abrupt.  Curt.  Choose your term.  But now -- the staff member sounded almost apologetic.  In fact they were prepared for his call.  They had been expecting his call.  And before he can even finish his sentence, they were telling him that they’ve seen it (i.e. Medicaid’s response) and they “were on it.”  In fact they were “working on it as we speak.”  
  
Oh and by the way, in addition to the MME Medicaid needs another drug test -- at least that’s what the neurologist’s office thought.  
  
LOGAN:  “Another drug screen?  She just left a sample three days ago. Two samples actually.”  
  
STAFF: “That was for the Fentanyl patch.  This one’s for the hydromorphone.”  
  
So Patient made another appointment and left another sample.  Despite the fact the physician’s office neglected to send in the code for a second time, the technician was able to look up the code from the previous visit.  Logan believed that the technician felt this was something she shouldn’t be doing but Logan also sensed she was in no mood to call the physician’s office.  Being the suspicious type (what reason does he have to believe in these institutions?), Logan phoned Medicaid to confirm what he already suspected: Medicaid never needed a special urine screen for the hydromorphone.  All they need is one urine screen on record per month.  Yes, that’s invasive and inconvenient.  But they don’t need one per script.  It’s only because they didn’t have one on file yet -- because it was taking so long to get that data to them -- that they instructed the neurologist’s office that one was needed.

So back to this MME.  Logan had no idea what an MME was so he downloaded one off the Net.  It’s only a two-pager (but then again so is an IRS 1040) and the first few items required only the names and addresses for the patient and the physician.  But the following questions concerned him quite a bit.  Medicaid expected the physician to go on record declaring that he had exhausted all non-narcotic treatment options including NSAIDs, SSRIs, and anticonvulsants.  The neurologist did in fact do his diligence with Teresa but he has been seeing her for years.  Is he going to remember what he did and when?  Teresa was starting to worry that if he didn’t remember it all, the MME would give him pause and he would need to take his time -- possibly even a weekend -- examining her chart.  The MME also seemed to require a signed Drug Agreement identifying him as the sole source of all narcotic medications.  While they had a verbal agreement in place at the time he re-assumed control of her prescriptions from a physiatrist to which he referred her in 2010, at no point did he seek her signature.  And something was just about to happen -- a development outside the scope of their relationship -- that would have a direct and lasting impact on both of them …  
  
… The neurologist would receive word that a colleague who practiced just down the road and who had privileges at the same hospital, would be arrested by detectives from -- of all things -- the Prince William-Manassas-Manassas Park Narcotics Task Force.  With help from the Virginia Attorney General’s Office and the FBI to boot.  There’s a Narcotics Task Force just for Manassas Park?  What the [REDACTED]?  Is there one operating in my neighborhood?  Is there an agent hiding in the bushes behind my yard?  
  
Well as has been the case this century, pessimism -- and anxiety -- is prophecy -- and sure enough -- the Teresa’s fears were realized.   
  
At 4:25 PM -- it’s June 27th for those of you scoring at home -- and Logan calls Medicaid.  He led off that conversation by telling the Medicaid rep that the physician’s office assured him they were working on that MME “as we spoke,” and they really seemed committed at this point to tying up these loose ends.  So why shouldn’t you have received it?  
  
“We didn’t receive it.”  
  
4:29 PM.  Spouse called the physician’s office.  Once again they assured him they sent it in.   
  
Fast forward to the next morning.  June 28th.  10:37 AM.  The neurologist’s office informs Teresa she needs to review and sign a Drug Agreement.  The thing is three pages long.  It requires her to acknowledge roughly 30 different articles covering everything from knowing what to do if she suspects overdosing to not splitting or crushing the tablets to not selling it and to making every reasonable effort to ensure no one else is accessing it.  In haste Teresa stopped one sentence short of reading through the large paragraph of instructions, which instructed her to initial each article.  Instead, she places a checkmark beside each, signs, scans, and emails it to the office’s preauthorization specialist, Charlene.  When Logan called a couple hours later to follow up he learned Teresa had not followed the instructions and so the agreement was reprinted and initialed per instructions before signature.  Logan cracks wise about it not having to be notarized.  But he shouldn’t jest.  He is well aware that at this point he shouldn’t be giving anyone any ideas.  
  
Okay. So Logan is thinking “now they have everything, right?  They must.  What else can there be?”  
  
Let’s come back to that one.  In fact, Teresa and Logan have to put the whole matter in its entirety aside to deal with another catastrophe.  While re-confirming with Medicaid that Botulinum toxin is not covered -- because in all seriousness they just can’t believe it -- Logan is informed that their Medicaid is due to expire this Friday.   
  
“I beg your pardon?”  
  
The Medicaid representative could not elaborate but she urged Teresa and Logan to phone their Medicaid case worker.  But this did not make any sense to them.  They had just applied two months earlier.  They waited 45 business days for their Medicaid application to be approved; because you know, the State of Virginia tells you it takes 45 days from application to benefits.  Teresa waited long enough to take her scripts to the pharmacy, knowing the pharmacy couldn’t fill them until she had been assigned a Medicaid ID number.  The ID cards didn’t come – Teresa learned weeks later that the initial welcome packet from Medicaid was marked undeliverable and returned by the Post Office for reasons no one can fathom at the time. So Logan phoned the case worker and learned that when a mailing is returned undeliverable, it triggered the State’s fraud detection monitoring. The case worker had already been aware that Teresa had been having problems with the mail.  The mail carrier is under investigation after numerous complaints of mail being placed in the wrong boxes.  But there have been a number of items Teresa had expected in the mail that never arrived over a two-month period.  And while she did receive some documents from the State concerning the state assistance, one or more items have been returned to the State and for this reason their Medicaid is being discontinued in 3 days.  An investigation subsequently placed the responsibility squarely on a subcontractor – a non-employee -- hired by the Post Office to deliver mail on Saturdays.

Fortunately, the case worker was able to reinstate them immediately but the case worker did tell them that if it were to happen again, they might have to reapply, and that means waiting out another 45 day hiatus.  In fact, had it been another 3 days before they learned about the scheduled disenrollment, it would have been too late to avoid having to re-apply.  Nice.

In the absence of physical ID cards, Teresa was able to receive her Medicaid ID number over the phone and once she had that in place, Logan took the number to the pharmacy.  Then it was the pharmacist’s turn to fuck everything up. She claimed that she could not process any orders until Teresa identified the specific Managed Care Organization (MCO) her Medicaid ID was attached to. Only after Logan visited the Department of Family Services bearing the question – *“What the [REDACTED] is this pharmacist talking about?”* -- did he learn an MCO is assigned 90 days into Medicaid coverage and that the pharmacist did not need that information to process scripts.

At least now Teresa was able to establish a profile with the pharmacy and all that stood in her way were these preauthorization requirements. It’s been 16 days since the hydromorphone script was issued, and the parties were still working the requirement.

**We now return you to the regularly scheduled hazing already in progress**.

It’s June 29th.  10 A.M.  Logan phones the neurologist’s office because as of 4:25 PM the previous day, Medicaid still had not received the MME required to complete the preauthorization.  
  
STAFF: “He took it back.”  
  
LOGAN: “The doctor?  The doctor took it back?  I thought it was all ready to go.”  
  
STAFF:  “It is.  It is.  He just wants more time to review it.”  
  
Now Logan is thinking, “when is the world’s busiest neurologist who works from 7 AM to 10 PM and who sees 2-4 patients an hour going to find time to review this?  Is he planning on taking this REDACTED home with him over the weekend?”  
  
By 4:09 PM Medicaid had not yet received the MME, so at 9:54 AM on the 30th -- a Friday -- Logan calls the neurologist’s office.  This time he wants to speak with the office manager -- and he won’t take “no” for an answer.   
  
Logan ended up having what he described as a lovely conversation with the office manager.  While she seemed to want him off the phone at the get-go, the more she heard him talk, the more interested she became in a two-way dialogue that touched on a wide variety of topics related to the central issue.  More than just receptive to suggestions for streamlining the process of navigating the State’s land mines, she invited him to email his thoughts on the matter.  She confirmed what he suspected for some time -- his wife is their first patient to bring the new regulations to their doorstep.  She may be their only Medicaid recipient but according to the office manager, in two days the regulations will go into effect for two other carriers accepted by the physician: Aetna and Cigna.  In order to survive in the new hostile environment, the neurologist has decided that at some point in the near future he will process urine screens in his office.  And the office manager confirmed that the new regulations -- and the arrest of not one but two local neurologists -- has everyone very nervous.  She did tell me she would make every effort to fax the completed package to Medicaid by COB so that Teresa would not be without her medication over the weekend.  And not just any weekend.  The long holiday weekend.  The one where the holiday falls on a Tuesday.  Teresa and Logan do not yet know whether the neurologist’s office is closed on Monday or Tuesday -- or Monday and Tuesday.

It’s 6:12 PM.  Logan is inclined to think the neurologist plans to review the MME, along with Teresa’s chart, over the weekend.  He was quite pleasantly surprised to learn from Medicaid that the office was able to get the materials to them.  In fact according to Medicaid’s records, the office had the materials faxed over by 12:15 PM (just 30 minutes after Logan finished speaking with the Office Manager).  There’s just one problem.  In all this paperwork, the doctor neglected to include the strength of the hydromorphone.   
  
“I see where this is going,” Logan pleaded at which point he informed the Medicaid rep of the strength.  Logan also reminded the rep that the strength is listed on the original script and all he needs to do is refer back to the original script.  It is also on the earlier script for the same drug but with a different quantity.  In other words, the doctor’s intentions with regard to strength are clearly indicated on a number of other documents.  
  
REP:  “Sorry -- it has to be in the paperwork.”  
  
“Go [REDACTED] yourself!” exhorted Logan.  Or more accurately, this is what Logan imagined saying but decided to reserve it for the real antagonists and architects of the mass hysteria linked to opioids: the legislators and the regulators.  
  
Sensing frustration, the Medicaid representative argued that the doctor was the one screwing everything up, but Logan wasn’t buying any of it.  Doctors are busy.  They don’t have time to deal in disruptions of this scale.  The offices were never set up to deal with this kind of Soviet-style bureaucracy.  
  
Recalling that Teresa possessed the physician’s cell phone number, Logan made one last ditch effort.  He suggested Teresa text him.   
  
LOGAN: “Start off by apologizing.  Sorry.  I don’t mean to do this and I promise I’ll lose your number but I’m in a bind.  I’m not sure if you’ve left the office, but this is my Medicaid number and date of birth, and this is their provider line number.  They are claiming you forgot to put the strength of the hydromorphone in the preauthorization and they are unwilling to refer back to the original script or take my word for it.  Medicaid said you could phone it in.”  
  
Hours later Logan would phone Medicaid one last time to see whether the physician had taken the text to heart, because he did not reply to it.  Logan would never know whether the doctor attempted to phone it in or not, but it wouldn’t have mattered anyway.  According to the next Medicaid representative, the previous rep was mistaken if he told Logan it could be called in.  According to the one rep, Medicaid needed the documentation faxed in its entirety.   
  
Teresa suspected there would be precious little time to resolve the matter on Monday due to the holiday on Tuesday.  She anticipated many employees would want to take off Monday, so she expected physician offices would be operating with skeleton crews.  Never in her wildest dreams did she imagine that the physician’s offices would be closed until Wednesday.  But that’s exactly what happened.  Her heart sunk when her husband phoned the offices first thing Monday morning -- after waiting out Saturday and Sunday -- only to learn she would have to wait out Monday and Tuesday as well.  When Medicaid rejected the preauthorization package on Friday, it was essentially relegating Teresa to limbo for four more days.  The whole affair has exacerbated Teresa’s migraine pain, which she may end up taking into the 4th -- if not the emergency room.  How do you expect a migraine sufferer to take her 5-year-old son to a fireworks display?  She had 2½ weeks to get this resolved and did everything within her power to do so.  Naturally she needed assistance from her husband -- because how can you expect a migraine sufferer to get through hours of -- hours of -- well, you know what I’m talking about.  You the reader – yes, I'm talking to you – you probably couldn’t finish the 8 page chronology of events without contracting a headache yourself.   
  
Happy 4th everyone.  
  
Naturally, on the 5th (9:16 AM to be exact) Logan expected that when the physician’s office noticed the package had been returned, it would have been a cause for some alarm and that when he phoned the office, he would have been greeted with a “yeah we noticed that and we’re already all over that.”

That didn’t happen.  Logan asked the office to fax in the request.  Logan also recalled that he had in his possession the email address for the staffer – Charlene -- whose primary job function is the processing and faxing of prior authorizations.  Logan had it because Charlene once emailed him a copy of the Drug Agreement.  So Logan decided to back up his phone call with an email to her.  
  
At 1:08 PM Logan phoned Medicaid to confirm receipt.  Medicaid informed him they could not see a fax from that office among their faxes but that they had only processed faxes received before 11:30 AM, so if the fax came in after 11:30 AM, it might not have appeared on their radar.  As distrusting as Logan has learned to become since the beginning of this fiasco / ordeal, at 1:11 PM he phoned the physician’s office hoping he could be given the time the fax was sent but for some reason, he can’t get through.  After waiting 8 minutes and 24 seconds, someone picked up but as he launched into his customary “hi this is [NAME REDACTED] calling on behalf of … ”, the line was disconnected.  He called again at 1:20 PM and waited for 7 minutes and 53 seconds, and once again, just as he revealed his name, the connection was abruptly lost.  At this point he’s suspicious because this has happened before, and because he recalled that the office manager did once mention “yeah, we all know who you are when your number pops up on our screen.” So at 1:28 PM Logan put his mobile away and called from his mother-in-law’s hard line.  This time when someone picked up, he was resolved to launch immediately into a question without identifying himself first.  It worked.  Someone picked up and stayed on the line with him, ultimately confirming that the fax to Medicaid was probably sent after 11:30 AM. At 3:42 PM, he phoned Medicaid, but still, there’s nothing on Medicaid’s radar screen, and the Medicaid representative asked him for the number identifying the fax line from which the physician’s office sent the preauthorization.  Apparently, this is how Medicaid searches the nether reaches of its queue.  Logan provided the Medicaid rep with the main fax number listed on the physician’s practice web site as well as a second number he found in an online search that is linked to one of their other physicians.  Still, the Medicaid representative could not find either number in the queue and speculated that perhaps the office was using another fax number he has not yet identified.  The rep mentioned that as of that moment there are 50 faxes in the queue.  Maybe the physician’s fax is among them.  So at 3:46 PM Logan called the physician’s office.  He was concerned he had called too late because the phones close at 4PM, but someone did pick up at the 18-minute-mark.  The office representative didn’t have any explanation to rebut Medicaid’s claims that nothing had been received.  He asked the office representative for their second fax number -- the one that is not listed on the practice web site.  The office representative seemed quite certain that all faxes were being sent from that main fax number, but she eventually did provide him with a second fax number he had not yet identified.  At 7:32 Logan phoned Medicaid.  Nothing yet.  He did learn something on this call however.  He learned not to put much stock in anything the Medicaid representative has to say, because eventually he will encounter another Medicaid representative who will tell him that what he heard from the other rep was flat out wrong.  “I get this a lot.”  This time the Medicaid rep told him that it can take up to 24 hours for something to appear in the queue and since the physician’s office claimed to have sent the fax after 11:30 AM, that he should wait until tomorrow this time to confirm.  “We have over 120 faxes in the queue,” he said.  E gads!  
  
July 6.  Spouse knows it’s not quite 11:30 AM, but he has commitments – job search responsibilities and errands to run, so he phones Medicaid at 10:05 AM.  Nothing yet.  This rep disputed the 24 hour theory, claiming that if the fax had been sent from either of the two numbers identified, she would be able to find it.  When Spouse explained how long Teresa had been waiting and how much effort had been put into tracking this -- and pushing this along -- the rep launched into a scathing criticism of the physician’s office.  And Spouse personally agrees that the office had made many mistakes, but only because they were never set up to deal with the new regulations dropped on their doorstep.  This doctor had already maxed out on patient load and taxed himself and his office just within tolerable limits before all the new requirements took effect.  The Medicaid rep also dropped another juicy morsel of information.  “We used to be able to take requests by phone but the State now requires that all communications take place by fax.”  Add this to the long list of constraints and parameters – old and new – that are placing an enormous strain on all stakeholders in pain management.  With regard to pharmacies, we already know opioids prescriptions cannot be refilled over the phone, split, or transferred and the opioids themselves cannot be maintained in stock over a certain limit or reserved -- and the patient cannot be alerted when the ordered shipment arrives.  Now we know they cannot enter into a telephone conversation between Medicaid and prescriber.  So I don’t want to hear any whining to the effect of “why isn’t anyone doing anything about this (opioid crisis)?”   
  
So at 10:20 Logan phoned the physician’s office – again from his mother-in-law’s landline.  The woman who answered the phone stopped him mid-sentence to tell him who he was talking to – “it’s Charlene” -- and to tell him she had just faxed the corrected preauthorization to Medicaid.  She also informed him that she had been out of the office yesterday and had not received his email until this morning.  Naturally, his first question to her was “then who would have faxed the preauthorization to Medicaid?” – because the office claimed that it had been done yesterday despite Medicaid’s repeated claims to the contrary.  She did not seem to have a definitive answer, leaving him to wonder whether the fax was transmitted but incorrectly or whether it was never sent at all.  If it’s the latter, it would mean all the time Logan spent on the phone that long-awaited day after the holiday qualifies as a “wild goose chase” (or at least a “snipe hunt”).  
  
Then at 1:44 PM, something happened that had never happened before, which is to say it moved the process forward without Logan having to intervene and push things along with a phone call.  The office manager from the physician’s office phoned Logan.  Yes, she actually phoned him.  One can only imagine what the circumstances might have been to compel such extraordinary service.  Her tone initially spooked him.  Before she could complete a sentence and deliver the first meaningful unit of thought, he was taken by her pressured speech and agitation, which he immediately recognized as righteous indignation. “But was she upset with *me*?” he wondered.  “Or *with me*?” She explained that now that they had finally got every i dotted and t crossed, Medicaid rejected the amended preauthorization package and instructed her to start over from scratch!   
  
LOGAN: “You’ve got to be kidding me.  What rationale did they give you?”  
  
MANAGER: “They didn’t give me a rationale.  I don’t know why they’re requiring us to redo all this.”  
  
Logan's initial thought was that the physician’s office ran afoul of some obscure rule indicating you only have so much time once you submit a script or a preauthorization to complete the process and once that time expired, you had to begin again.  Logan shared that thought with the office manager, and she seemed to think it might hold water but she had bigger news.  She told him she got angry and became very assertive -- if not aggressive -- with the Medicaid rep.  She made it clear that it was cruel and arbitrary that Medicaid would make them start over after making them jump through so many hoops and after giving her the impression that the preauthorization would be approved once they provided the one small piece of information (i.e., medication strength) omitted from the previous submission.  The manager was also adamant in impressing upon the Medicaid representative that “this poor woman (Patient) has been without her pain medication for 3 weeks!”   
  
Then a miracle, which by definition is anything not scripted or dictated by regulation, happened.  Somehow the Medicaid representative relented.  Acquiesced under the sheer force of the manager’s logic and will.   
  
MANAGER:  “You have the authorization for 60 days.  You can pick it up from the pharmacy.”  
  
And by some other miracle, the pharmacy, which did not have 60 pills on hand 3 weeks ago, had 60 pills on this day, bringing to an end one woman’s epic 21-day struggle to fill a script she had grown accustomed to filling in less than 2 hours. She shouldn’t have had to struggle. In fact, she’s the last person who should be asked to assume such a burden.  After all, she’s a documented pain sufferer who’s been in the care of a Washingtonian Top Doc (neurologist) for over 8 years. bHer pain is so severe that her neurologist believes she will be awarded her medical disability status on the basis of her migraines alone.  If the case is resolved in her favor, she will be automatically re-enrolled in the health insurance plan in which she had been a member before her disability forced her to resign her Federal position.  But due to an extraordinary spike in medical disability applications, her evaluation has been delayed.  Her state lacks the staff to deal with the volume of applications and has had to commandeer reinforcements from a border state.  By the time her case is resolved, it would have been 2 1/2 years since her application was filed.  This is a recurring theme in 21st Century America, where her spouse has struggled to comprehend his chronic unemployment despite an advanced degree and 15 years experience.  His unemployment is the reason the couple has had to enroll in Virginia Medicaid, where they have become guinea pigs for the testing of new regulations governing the prescription of opioids.  These regulations have since been adopted by Cigna and Aetna and are expected to serve as a model for a wider group of third party payors in the near future.   
  
In addition to the obvious delays and to the added burden placed on the patient and her physicians, there is another unintended (or intended) consequence of the legislation: antagonism. The legislation pits various entities with a stake in the system against one another, as evidenced by the hostility the office manager ultimately directed toward a Medicaid representative … as evidenced when someone in the physician’s office began hanging up on the spouse the moment he identified himself … as evidenced by the Quest Diagnostics technician who grew frustrated with the office’s repeated failure to provide a code for the urine screening … as evidenced by the doctor’s office, the pharmacy, and Medicaid when each denied receiving -- or when each insisted sending -- the requisite notification or paperwork … as evidenced by Medicaid, when one of its representatives told the spouse that her doctor’s office was screwing everything up and placing the burden on the Patient.   
  
The Virginia legislators were receiving guidance from medical experts. So how did so many physicians on the Advisory Panel convened by the Virginia Department of Health Professions fail to imagine the chaos their regulations would cause?  How could so many physicians fail to grasp that they were about to place undue stress upon the medical demographic that were most physically vulnerable to it -- pain sufferers.  I tell you what -- let’s come back to that one.  There are some new research findings making the media rounds revealing the majority of painkiller prescriptions are given to persons with documented mood or anxiety disorders.  Mm.  Let’s give these people more reason to wallow and worry, shall we?  More reason to turn to painkillers.  The regulations play right into the hands of that dynamic that maintains or increases the appetite for them.  Good going. Actually the finding is intended to depict pain sufferers as crazy people in whose hands pills are dangerous and whose pain may very well be the product of a defective mind. Hypochondriasis. Hysteria. Everything from overactive imagination to a tendency to over-interpret or dramatize pain sensations.  
  
As for the medical experts, I have no doubt the legislation was guided and informed by working groups comprised largely of physicians (I suspect) were monitored by representatives of the DEA or Virginia Attorney General who would poke a physician with a stick if he or she makes the wrong kind of recommendation --  
  
-- which raises an interesting point.  The legislation is sourced by the State’s top cop, the Attorney General.  This is a police action, not a medical emergency.  The Virginia Medical Board, which advised on the legislation, does not include physicians who would make the best experts on pain prescriptions.  Aside from an anesthesiologist, who deals with the one kind of pain you don’t consciously apprehend, there is really no one qualified to address this issue.  There are more OB/GYNs and pediatricians on the Board than neurologists and physiatrists.  In fact, I couldn’t find a neurologist or physiatrist on the Board.

**APPENDIX B:**

**HOW A VISIT FROM THE DEA NEARLY KILLED CONNECTICUT WOMAN SEEKING REFILL OF XANAX**

Perry had been receiving excellent care from Westport Family Health since relocating from Virginia in September, 2015.  Perry had multiple medical conditions and applied for medical disability with the Social Security Administration.  He has been in the care of various specialists for disorders that include chronic intractable migraines and moderate sleep apnea (i.e., neurologist / 5 years), adult onset Type I diabetes of autoimmune origin (e.g., endocrinologist / 7 years), Bipolar Disorder and Anxiety Disorder NOS (i.e., psychiatrist / 13 years), and severe GERD (i.e., gastroenterologist / 3 years).  Perry’s Type I diabetes has also reduced his immunity and made him more susceptible to – and more likely to require more time to recover from -- infection than the average person.  His 5-year-old son started introducing viruses into the household on a monthly basis, exposing Perry to illnesses that would more often than not evolve into a chronic or severe bronchitis requiring treatment from his primary care physician or an ENT.   
  
When Perry relocated, he found daunting the task of replacing a multidisciplinary system of coordinated physicians.  He immediately noticed that the culture of the State as it relates to many of his prescriptions would put up a significant obstacle.  When the patient’s spouse suffered a job loss, the family had to enroll in the Connecticut Husky program (i.e., Medicaid), which further limited his options.  The two domains of care most affected by the relocation and the Medicaid include neurology and psychiatry.  Perry was limited to the choice of 1 local neurologist, who reduced his monthly allocation of prescription painkillers by 80%.  But what would prove to be more limiting is the simple fact that a psychiatrist who (a) accepts Medicaid, (b) is local, (c) answers or returns phone calls, and (d) accepts new patients simply DID NOT EXIST.  And it is this fact that would not only put Perry and other health care providers in harm’s way, but would ultimately do harm.  
  
Prior to the job loss, Perry had been leaning on his Virginia psychiatrist for his prescriptions.  But Medicaid does not cover prescriptions from out-of-state doctors, and so the patient turned to his primary care physician, Dr. Adler-Klein of Westport Family Health.  It’s important to note Dr. Adler-Klein’s mindset as it relates to the prescriptions in question, which include the anti-depressant Pristiq and the mood stabilizer Lamictal, but which also include two products that just so happen to carry controlled substance designations.  The substances in question are those that address Perry’s debilitating anxiety: -- alprazolam (i.e., Xanax) and the sleep aid zolpidem (i.e., Ambien).  Adler-Klein initially balked at what is considered a high dose for the Xanax (i.e., 1 mg up to 4 x daily) but agreed to assume responsibility for her patient’ continuity of care, with the understanding that the patient was working toward finding an appropriate specialist (i.e. psychiatrist) and with the understanding that it is dangerous to discontinue these medications cold turkey. Ultimately, Adler-Klein’s involvement in this aspect of Perry's care persisted for over a year due to difficulties and other circumstances that thwarted his efforts to continue his alprazolam therapy.  One of these challenges was introduced by a Norwalk Hospital psychiatrist by the name of Richard Maiburger.  Despite having a clear calendar himself, Perry waited a month for his first appointment with Maiburger and another month after that for the first follow-up.  From the very beginning Maiburger stated he was not a good option for Perry due to his lack of availability and due to the fact he was transitioning into retirement.  Maiburger did not feel the initial intake session was sufficient to support a diagnosis and consequently he was unwilling to prescribe anything at that time.  But if Maiburger wanted to discourage Perry from pursuing a therapeutic relationship, all he needed to do was to let Perry know that he harbored certain prejudices toward psychotropic medication. As a prescriber, his was a minimalist philosophy. Maiburger was well aware of Perry's prescription history and he was also aware that Perry and his reluctant interim prescriber Adler-Klein urgently hoped to find the appropriate professional to assume responsibility long-term, and yet he waited months to announce the foregone conclusion concerning his role in Perry's current medication plan. In so doing, Maiburger unwittingly set up Adler-Klein’s date with the DEA and undermined Perry’s relationship with all of Westport Family Health.

Maiburger is hostile toward alprazolam.  Alprazolam, otherwise known by the trade name Xanax, acquired some notoriety after the FDA issued a black-box warning about the risk of respiratory depression in patients who use this benzodiazepine concurrently with an opioid. Initially, the defamation of Xanax was predicated on its link to opioids in a patient population with dual pain and psychiatric disorders. But eventually, perhaps inevitably, Xanax shed its Tonto status as more providers with anti-opioid biases came to see in it some of the same risks for which opioids are known, namely its potential for addiction and abuse. The notoriety spread to other substances in the benzodiazepine class such as clonazepam (Klonopin), diazepam (Valium), and lorazepam (Ativan).

Perry was open to tapering the alprazolam down from 4 to 2 mg daily, but that’s as far as he was willing to go. But Maiburger was not interested in meeting his patient halfway. A search of online consumer forums turned up a patient with the complaint that “Dr. Maiburger is interested in one thing and one thing only – taking away my anxiety medication.” It looked as though Adler-Klein would have to continue to stop gap the alprazolam for Perry.

No one could have anticipated what would happen next.  
  
THE REFILL REQUEST THAT TURNED INTO A BIZARRE ODYSSEY  
  
9:30 A.M.  Perry places a call to the offices of Westport Family Health for a refill of alprazolam only to discover his call had been diverted to the answering service.  As subsequent calls were diverted throughout the day, the answering service representative initially attributed the problem to the practice’s “phone system” but later made increasingly extensive references to a morning meeting of practice physicians that ran overtime.  For the entire Wednesday, the practice was unavailable by phone.  An attempt to reach the on-call doctor after hours put Perry in touch with practice physician, Dr. Malik.  Dr. Malik stated he would have been willing to issue Perry the refill but because the controlled substance required an office technology for secure submission to pharmacies and because he was out of the office, Perry would have to wait until the following day.   
  
The next day Perry reached Adler-Klein’s physician assistant, Patricia.  Patricia stated the doctor would be unable to issue any further refills of any medications (i.e., antidepressant Pristiq, sleep aid Ambien, allergy drug Pataday, and anti-anxiety drug alprazolam) until Perry came in for an appointment and put his signature on some sort of “agreement.”  The condition seemed odd considering Perry had been seen by Adler-Klein just two weeks earlier for a persistent cold and cough and at no time during that appointment did Adler-Klein raise any issues with the status quo.

Despite the fact the refills were now contingent on coming into the office for an appointment, no near-term appointments were available, which is to say, the practice did not have an opening for at least two weeks, and this clearly fell outside the medically relevant timeframe for a refill.  The lack of availability also struck Perry as highly unusual.  Perry explained to Patricia that either the practice should find a way to fit him in or else phone in a refill to cover the gap to the next-available appointment.  The request appeared to strain and perturb the practice.  
  
Adler-Klein eventually phoned in the refill -- just enough to get him to the next appointment, but a couple hours before the appointment, the practice phoned to cancel.  So Perry rescheduled the appointment but issued a new request for another refill to bridge the gap.  A few minutes later Patricia phoned Perry with the only available appointment in the near future.  The problem was that Perry had only 25 minutes to get there on time.  This put Perry in a bind. He knows that if he accepts the appointment, he is solely responsible for failing to make it on time, which means a fee and a loss of leverage in what appears to be a developing imbroglio of some kind. But Perry also knows that he needs an appointment – that an appointments are scarce – and that he cannot appear to turn down an offer of appointment after lobbying vigorously for one.

Once on the premises, Perry was stopped short of the offices by -- what's this? -- a security guard.  The guard was there to limit access only to patients with scheduled appointments. He could not find Perry’s hastily scheduled appointment among those listed on his sheet -- a minor complication that was quickly resolved.  
  
Once in the examination room, the door was cracked ajar and an unfamiliar face inserted itself.  On an outstretched hand was a few sheets of paper, and the gentleman instructed Perry to review them.  The gentleman promptly departed without ever having introduced himself.  Perry’s recognized the gentleman as Dr. George Iannini, the member of the practice with whom Perry had never had an appointment.  Where was Dr. Adler-Klein?  
  
HARASSMENT OF THE PATIENT  
  
***“We will not be refilling any more of your anti-anxiety or sleep medication on this day or any other day.”***   
  
 -- George Iannini.  
  
Dr. Iannini did not bury the lead.  The first words out of his mouth were “we will not be refilling any more of your anti-anxiety or sleep medication on this day or any other day.”  No words were minced and no punches pulled in the course of the explanation.  
  
***“You’re a red flag.”***  
  
 -- George Iannini.  
  
Iannini referred to Perry as a “red flag,” referencing the sheets he had given him: a list of all the controlled substances he had been prescribed multiplied by the number of prescribing physicians and all the pharmacies that ever processed a script.  Iannini referred to these numbers and insinuated that they painted a picture of doctor shopping.  He then stated that a list like this puts his practice -- and him as well -- at risk, using the word “liability” to characterize the threat to him personally as a physician and to his practice.  
  
The list had been intended to pre-empt any and all objections to the practice’s new policies on Perry’s medications.  The list was intended to shame and suppress -- to have a chilling effect.  But a list like this is not only poor evidence -- easily brushed aside on cross-examination -- but it’s solid evidence that a physician has abandoned his or her role as a physician altogether.  This conduct is more consistent with that of a DEA officer than a doctor.  And when Iannini handed Perry those printouts, he thought he was handing out photo evidence of a reckless driver’s license plate as it appeared in the middle of some intersection during a red light.  Let’s start with the charge of “multiple pharmacies.”  
  
1.    Perry lives across the street from a CVS.  It is a small CVS that closes early, refuses to carry or order Tussionex cough syrup (which was discontinued in the Connecticut CVS system when hydrocodone was reclassified as a Schedule II substance in 2014), and limits the doses of pain pills it stocks on its shelves to 10mg for oxycodone / Percocet and 7.5 mg for hydrocodone / Vicodin.  Given these limitations, this CVS was not going to meet Perry’s pain management needs. Perry is prescribed oxycodone at the 15 mg dose.  But this does not mean Perry cannot use this conveniently located CVS for other non-narcotic medications.

2.    The Tussionex – a hydrocodone-chlortrimeton suspension -- is carried by all the local Walgreens, which is to say about 6 different Walgreens within 6-7 miles of Perry's home.  That being said, any given Walgreens on any given day is just as likely not to have the Tussionex in stock.  A Walgreens pharmacist cited Federal restrictions on how much the pharmacy is allowed to have in its store at any given time as an explanation, and even went so far as to characterize the regulation as “restrictive.”  This prompts Perry to phone one or more of these Walgreens locations until one is found that has the product in stock.  The Tussionex alone is sufficient to account for the appearance on this “list” of several different Walgreens pharmacies.   
  
3.    These pharmacies, the CVS on West Avenue and 4 Walgreens pharmacies, account for over 95% of Perry’s scripts during his time in Connecticut. Two other local CVSs were patronized on one occasion each due to their locations on a path along which a variety of errands were being run that day by Perry’s wife. There was also an occasion on which Perry’s wife filled one of his scripts at the Norwalk Hospital pharmacy while he was in an appointment with Dr. Maiburger.

Now let’s address the implied charge of doctor shopping.  The list is misleading on several grounds.  Perry’s multidisciplinary care team is continually evolving.  A snapshot of such a dynamic would fail to tell the story of how responsibilities for certain medications were transferred between physicians.  But even a snapshot is less slanderous than Iannini's printout, because the printout is cumulative and conveys the false impression of a “snapshot,” i.e. the false impression that Perry is -- or was at any time -- taking all these pharmaceuticals AT THE SAME TIME.   
  
1.    At no time was Perry receiving concurrent scripts for oxycodone and hydromorphone.  Perry initially received a monthly allocation of 15 15 mg tablets -- which averages out to 1 every other day.  After a few months, Perry raised the concern about tolerance and requested an alternate formulation within the opiate family.  Hydromorphone was selected.  Knowing that a 4 mg tablet of hydromorphone is equivalent to 10.67 mg of oxycodone and knowing that Perry received a monthly allocation of 225 mg (15 x 15) of oxycodone, the neurologist calculated that 21 tablets of 4 mg hydromorphone would be roughly equivalent.  To be frank, there is nothing medically or legally wrong with receiving both hydromorphone and oxycodone concurrently if they come from one physician and if they are equivalent in MME units to the regimen they are replacing. (The physician should be permitted to increase the MME units gradually if tolerance requires it). The matter should only draw attention if more than one physician were prescribing the opiates concurrently for the same condition. And it’s not illegal to switch physicians so conceivably it would be kosher for more than one neurologist to appear on Iannini's list. When Perry relocated to Connecticut, he came with a number of scripts from his Virginia neurologist to sustain him for the balance of the quarter.  Perry filled three of the scripts in the first 3 months after arriving in Connecticut and the rest of them could not be filled once he transitioned to Medicaid.  Perry ended up having to discard 4-5 scripts representing over 90 10mg Percocet, 60 15mg oxycodone, and 30 8 mg Dilaudid.  
  
2.    Perry’s neurologist also assumed responsibility for the cough syrup once it came to the attention of his ENT that Fentanyl had been added to the list of medications. The cough syrup is an extended release blend of an antihistamine and the opiate painkiller hydrocodone, which was reclassified as a Schedule II drug relatively recently in U.S. history (i.e., 2014).  Perry leaned on this cough syrup throughout the year.  Nothing exacerbates migraines quite like coughing, and most of the upper respiratory infections he contracted from his 5-year-old son developed into cases of chronic or severe bronchitis.  (And one developed into mild pneumonia).  From which physician Perry requested the cough syrup depended on appointment proximity or availability.  On some occasions, he received the cough syrup from his PCP (i.e., Westport Family Health).  On others, it came from the ENT.  Once the extended release transdermal Fentanyl patch was incorporated, responsibility for all the scripts containing Schedule II painkillers were run through a single point of care in the neurologist.  But the number of physicians has no relevance here.  The architects of the NARXScore seem to think based on a research project they reviewed that number of prescribers is a risk factor, a contributing factor in accidental overdoses. And there were a number of prescribers in Perry’s case, where it’s influence on his overall score is clearly an unfair misapplication. This is not a doctor shopper.

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| --- |
| **TANGENT ALERT: EVERYTHING ELSE ASIDE** |
| **The question of who should assume responsibility for prescribing a controlled substance was never murkier than this. The guy who prescribes our pain meds wants to be the only source of pain meds. He’s the jealous type. When a PCP prescribed a cough suspension during a bad cold, that guy knew about it and his front office staff phoned the patient will all sorts of questions to determine whether the suspension betrayed the pain management contract. But when the patient had the guy assume responsibility for the suspension long term – as it turned out that cough was a symptom of a chronic condition called LPR – the guy did so only grudgingly. As he expected, he took a lot of flack from the DEA and a few pharmacists for being a neurologist and prescribing a non-neurological drug. So which is it? That non-neurological drug contains a Schedule II painkiller in hydrocodone and for that reason, many ENTs will not prescribe it at all let alone long term despite the fact it is an ENT drug. Or is it in this case? LPR is a relatively new diagnosis that is just beginning to receive a lot of attention and while it affects the pharynx and larynx – it originates from conditions in the stomach. Some argue this puts Tussionex squarely within the realm of the gastroenterologist. In short, the neurologist can’t figure out whether or not the DEA thinks he should want the responsibility while the other appropriate specialists play hot potato with it to avoid a Federal microscope. The system as a whole has made it quite clear it would breathe a whole lot easier if Perry could stop wanting this medication.** |

Dr. Iannini also made a casual -- or arguably lazy -- reference to Perry having frequented emergency rooms in search of controlled substances.  This would not have been supported by the List, because it never happened.  When Perry began to question Iannini’s quick, off-hand reference (i.e., “when did I go to the emergency room?”), the doctor backed down.  Perhaps the doctor confused him with his 2 o’clock.  
  
Dr. Iannini was also concerned with the fact Perry is being prescribed a 25 microgram Fentanyl transdermal patch for migraine pain.  The fact Perry can even tolerate the Fentanyl at all – trace quantities of which have claimed the lives of those unaware their heroin had been cut with the world’s most potent opioid -- is proof positive that the pain he claims is both real and severe.  And he has endured this pain for over 8 years, over which time he acquired a tolerance for oxycodone and hydromorphone.  But due to all the headlines – the lives cut short – from high profile Americans like Prince and Phillip Seymour Hoffman to anonymous members of vulnerable populations – like the 14-year-old African American boy whose purchase of a single Norco tablet proved deadly – and the 10-year-old boy who came into contact with the substance at the side of a pool at an apartment complex in Florida -- fentanyl has become an emotionally charged term.  A profanity of sorts.  The new “F" word. When the patch was introduced into Perry’s regimen by his neurologist as an extended release option to balance out the short-acting pills, other physicians took notice.  The patient’s ENT refused to prescribe any more hydrocodone-based cough syrup (i.e., Tussionex) out of fear for Perry’s safety, his own liability, and more generally, the unknown.  A pharmacist refused to fill orders for any other painkillers until the prescribing physicians phoned to demonstrate an awareness of the fentanyl.  Based on the fentanyl alone, Perry had been characterized as a “red flag.”   
  
***“You’re a red flag in the system due to the Fentanyl.”***  
   - Dr. Ahsan Malik, PCP  
  
Perry pushed back, and his counterarguments began to take the sting out of Iannini’s concerns.  Iannini had just finished explaining how Perry’s medication history put him and his practice at risk.  He described Perry as a “liability.”  
  
Then, reminiscent of the shift in explanation from the “phone system” to a “morning meeting gone long,” Iannini folded tent and offered a new explanation for their refusal to issue refills.  At this time, Iannini stated that “this has nothing to do with you,” but with something that happened to the practice in connection to a State bill that went into effect in January.  Iannini refused to clarify his remarks when pressed for more information, stating only that he would “not go into detail.”  Days later, when Perry inevitably showed up in the Norwalk Hospital ER with symptoms of benzodiazepine withdrawal, he was informed by the hospital psychiatrist that Dr. Martin Singer, head of Westport Family Health, was arrested and led out in handcuffs, having taken responsibility for a practice that prescribed too many controlled substances.  
  
Iannini attempted to hand Perry a list of local area psychiatrists that had been prepared by Adler-Klein.  Perry adamantly informed Iannini that any list he handed him that day would prove ineffective because he has been though the lists provided by the Husky Web-based provider directory as well as lists provided by Husky nurses.  Iannini scoffed at first and then appeared to acquiesce, telling Perry he would give him a script for a 7-day supply of alprazolam-- adding that he was breaking the rules in doing so.  Then he disappeared for a prolonged period and returned with nothing in hand.  I don’t know who he consulted with, but he apologized and said he could not do it.  
  
The morning of Friday, March 15, Perry took his last milligram of alprazolam.  Thirty-six hours later, he checked himself into the emergency room of Norwalk Hospital complaining of body aches, disorientation, and a host of somatic symptoms that included the feeling that his skin was crawling.  
  
JEFFREY WEINTRAUB, NORWALK HOSPITAL, & THE WESTERN CONNECTICUT HEALTH GROUP  
  
The Western Connecticut Health Group, parent corporation for both Westport Family Health and Norwalk Hospital, committed patient abandonment and negligence not once but twice.  After being abandoned by Westport Family Health, Perry ended up in the ER of another Western Connecticut Health Group facility: Norwalk Hospital, conveniently located across the street from his home.  This is the facility that employs Dr. Richard Maiberger, the aging eunuch who is running out the clock on his career and who exists solely to separate people with anxiety diagnoses from their anxiety medication.  But the pomp and pretense does not end there, as evidenced by some rather presumptuous and adversarial remarks from the treating ER physician, Dr. Jeffrey Weintraub.   
  
Before meeting Weintraub, the nurse practitioner disclosed the limits of what they could do for Perry. “We could give you acetaminophen and Motrin here and a script for Wellbutrin.”  (Wellbutrin is not an anti-anxiety medication).  At this time no one informed Perry he would be visited by a doctor and no one even asked him to put on a gown.  So at that moment Perry opted to turn down the offer of Tylenol and Motrin and, well, just go home.  Perry's wife had advised him not to take any of his own medication before the ER visit so as to avoid limiting what the ER cold do for him.  But now that the best this ER had to offer consisted of two medications he could pull off the shelf at CVS -- or even the hospital gift shop -- he took one of his own 4 mg hydromorphone tablets.  This seemed to embarrass the nurse.  Perry answered the usual questions about other street drugs and even submitted to a fully chaperoned urine sample despite the fact he did not request anything more than what was necessary to survive these rather frightening symptoms of alprazolam withdrawal.  And his vitals exhibited pulse and pressure significantly higher than any one of the two dozen or so normal baseline readings over the past couple years.   
  
Enter Weintraub. He informed Perry that coming off 4x daily alprazolam after 11 years is “dangerous and potentially deadly.”  This was just about the only useful thing he said all day.  He laid out a plan that included IV Compazine and Benadryl to treat the spasms while they monitored his vitals and decided whether they should keep him overnight for observation.  Weintraub also claimed to have had a discussion with Adler-Klein.    
  
Perry explained that the medication had been revoked without warning -- and without an opportunity to taper off responsibly.  Weintraub’s response: “I saw your chart.  You had 11 years to taper off.”  When Perry mentioned that the original plan was to have his primary care physician fill his alprazolam until he could find someone else to prescribe it, the nurse practitioner rather callously remarked “no one’s going to prescribe that for you.”  Then when Perry disclosed that he was wearing a fentanyl patch, a curmudgeonly Weintraub responded by asking “now what is THAT for?”  When Perry responded “migraines,” Weintraub insisted that fentanyl is the worst possible treatment for migraines because it would cause rebound headaches.  When Perry, with spouse as witness, attempted to explain that the time and frequency of migraines does not suggest rebound, Weintraub doubled down and insisted that at no time are opiates appropriate treatment for migraine.  He then insisted on the name and field of the prescribing physician.  When Perry explained that two neurologists and a physiatrist (i.e., pain management specialist) had used opiates as rescue drugs in a complex pharmacological treatment plan, Weintraub insisted that there are rescue drugs available that are non-addictive.

A caustic Weintraub then proceeded to add that “you need to be more educated as patients,” implying that Perry should not have allowed himself to have been led astray by three prominent members of their medical professions.  Adding “you need to cleanse,” Weintraub then urged Perry to discontinue all opiate-based medications once he has completed his presumed successful withdrawal off alprazolam and zolpidem (i.e., Ambien).  “This is an opportunity,” he said.  “You’re addicted and you don’t know it.”  That argument is as irrefutable as Freud’s Unconscious itself, and even more irrelevant.  
  
ER physicians traffic in acute pain and in crises situations that require acute and intensive management.  Perry wouldn’t expect someone like Weintraub to understand chronic pain.  The doctor’s off-hand remarks on how narcotics in all instances cause rebound headaches is crass and cavalier.  
  
Weintraub is not alone.  The psychiatrist on rounds also made a similar remark.  “Then I want you off the opiates,” she said.  The psychiatrist issued this proclamation in passing.  Her knowledge of Perry was confined to an introduction lasting less than 2 minutes.  She had also not reviewed Perry’s history. She did not access the records of her Virginia psychiatrist. The psychiatrist didn’t even enter into any kind of discussion with the patient.  But this did not stop her from decreeing that Perry is not bipolar.  And to prove it, the psychiatrist rattled off from memory a list of symptoms from the Diagnostic and Statistical Manual of Mental Disorders (DSM).  But how does the psychiatrist KNOW Perry does not have these symptoms?  Perry takes medication that would suppress manic symptoms.  If she had looked into the history, she would have been privy to accounts of manic episodes that included reckless driving, reckless spending, and sleepless nights over which Perry might awaken his significant other for a 3AM jaunt to the Kripsy Kreme.  Even though Bipolar Disorder is an epidemiologic minority, so it is highly unlikely a person chosen at random will be bipolar, these people do in fact exist.  And Perry is one of them.  But why is he even visited by the psychiatrist? And why is she pretending to know him better than physicians who treated her for years that? Perry is at this point confused by this bizarre hospital, where strangers materialize out of thin air to question everything every other doctor ever established about him.

WATCHING THE DETECTIVES, DIAGNOSING THE DIAGNOSTICIANS

This may be an appropriate time to comment on the mental health and the fitness of some medical professionals. You may have anticipated this move based on the way I have described the behavior of Weintraub and other physicians who swore to do no harm – and who act as though they have the very best of intentions in wanting to save the patient from himself and from less astute colleagues – when in actuality, they are making a mess of the patient’s life. The basis for my concern can be clarified as follows:

* The physician operate under a suspicion for which there is no factual basis beyond the use of a substance that has been prescribed by a trained professional like him- or herself for medical purposes
* The physician avoids personal information from or about the patient, restricting communication to a handful of platitudes based on principles that lay claim to some universality
* The physician may even engage in hyperbole or Gestalt closure type presumptions to make a point, as when the psychiatrist spoke gratuitously about the head of a family medicine practice having been “led out in handcuffs.” Upon further investigation, this turned out to be untrue. Dr. Singer was placed on paid administrative leave while the DEA examined the records of his physicians and subsequently resumed his role. At no point were handcuffs used or an arrest made. This is the same psychiatrist who attempted to un-diagnose a patient in a vacuum. The psychiatrist may have been motivated to do so, thinking the sudden absence of the diagnosis would eliminate the clinical basis for all psychotropic medication. And this leads me to my next concern.
* The hospital that employs these suspect physicians issues awards based on efforts to curtail opioid use. This is an odd practice inasmuch as it is predicated on the assumption that the substance in question has no valid applications. One group was honored for its opioid rehabilitation and recovery program. Even the I.T. department was honored for plugging the PDMP into the EMR system so all the staff could more easily spy the patients’ NARXScores and history with opioids.

Back in the Golden Age of psychiatry, Swiss psychiatrist CG Jung spoke of patients being influenced by unconscious structures known as “complexes.”  At the heart of the complex is an emotionally-tinged memory -- in many cases a traumatic event.  The more traumatic the memory, the more of a gravitational-style force it exerts over other psychological content, drawing associations such as other memories, feelings, images, and thoughts into orbit in a process he called agglutination similar to the process of accretion coined by astrophysicists to describe the formation of planets around the Sun or satellites around Jupiter.  Jung fingered complexes as the source of hypersensitivity, obsessiveness, and black-and-white thinking blind to all manner of nuances and variations.  Complexes are also referred to as splinter personalities and they are given control over dream characters and alternate identities in dissociative identity disorder.

Clearly what we have here in Connecticut is a collective controlled substance complex with the tragic deaths due to accidental drug overdoses at the core.  As a social psychologist, I am concerned with the health of the State as it pertains to the capacity of its officials to assess and adjudicate the matter of controlled substances, pain management, and health in a manner that is complete, balanced, and objective.  But from what I’m seeing, judgments of stakeholders in the legislative and health care mission space exhibit biases and rigidity and a willingness to sacrifice or subvert all other priorities and considerations to the management of controlled substances.  If the system is aware that certain diagnoses (e.g., Bipolar Disorder / Anxiety Disorder NOS) provide the impetus and justification for controlled substance prescriptions (e.g., Xanax), then you may see the diagnosticians skewing their judgments away from those diagnoses.  This is how clinical decision making and the practice of medicine -- and in fact the production of knowledge itself (i.e., science) -- can be shaped or “constructed” by the socio-political realities of the institutions in which they’re embedded.   
  
Additionally, psychological disorders spread much like biological contagions -- from person-to-person contact.  The primary care physicians adopted a posture of reticence toward refills of a cough syrup that contained hydrocodone out of fear of how Medicaid -- a State agency -- might respond.  The ENT ceased and desisted all Tussionex prescriptions when it learned Perry had been prescribed fentanyl, but the ENT was coaxed into consulting Perry’s database record by a pharmacist who phoned with complaints about the quantity and frequency in the script.  The neurologist learned that the ENT red flagged the fentanyl, which fortunately he continues to prescribe, although Norwalk Hospital physicians have put all over Perry’s record their recommendations for tapering off all opiate-based medications.  One can only hope that the neurologist will not see this and -- if he does -- that he does not respond with fear and paranoia.  The hospital discharge papers even contained text attributing Perry’s low white cell count to “persistent opiate dependence,” which is misleading because Perry has never registered a low white cell count over the months he has received fentanyl nor over the 8 years he has been prescribed short acting pills. I understand that providers hostile toward opioids may be desperate to link opioid use to certain toxicities -- as none are known at this time – but this is dastardly. This is no doubt another illustration of the “Controlled Substances Complex” (CSC) at work.  Perry never would have been hospitalized if it were not for the actions taken by the DEA against his PCP on charges of violating new laws governing the prescription of controlled substances.  
  
Unfortunately, two people on opposite sides of this issue can never have a rational conversation.  Proponents of the crackdown view advocates for the chronic pain patient community as addicts whose logic and perception have been warped by the psychosis of dependence (i.e., “it’s the drug talking” / “this is your brain on drugs”).  Opponents of the crackdown view proponents as agenda-crazed crusaders consumed with fears of losing their licenses and bent on promoting visions of both an ideal society and a standard of health.  
  
At some point a D.C. area psychiatrist, having diagnosed Perry with Bipolar Disorder and Anxiety Disorder NOS, determined that alprazolam was necessary to address the organic seat of the dysfunction in the anxiolytic pathways of the brain.  Talk therapy can provide compassionate support and strategies for bolstering the cognitive structures needed to modulate and mitigate emotions (i.e., the proverbial "software"). But talk alone is ineffective in the absence of pharmacological agents targeting the organic seat of the dysfunction (i.e., the "hardware") in those with genuine biochemical issues.  The keystone physicians of Norwalk Hospital looked past the questions concerning the necessity and reasonableness of alprazolam.  Out of hand, without due diligence, driven by prejudices and ideologies culled by the current political climate, and without recourse to science or due clinical process, these physicians have decided no patient should be, or should ever have been, prescribed alprazolam or any other drug with a controlled substance designation, for these drugs are inherently evil and cause nothing but problems for society at large.  There was no sound reasoning, nor scholarly motive, behind the decision to discontinue alprazolam and urge Perry off his painkillers.   
  
***“You need to cleanse.”***  
  
 - Dr. Jeffrey Weintraub  
  
“You need to cleanse.”  Sounds like more of an invective off the lips of Slobodan Milosevic than a coherent and well-articulated position.  I can’t tell you how often I’ve heard the word “narcotic” used as a pejorative incantation -- what anthropologists call an “apotropaism” of sorts -- intended to magically incite fear.  Fear of the drug.  Fear of being punished or shamed for requesting the drug.  “You need to cleanse” is a similar device.  It conjures in my mind images of previous social movements.  The Nazi internment of Jewish residents.  The Civil War that tore Yugoslavia asunder.  McCarthyism.  The Salem Witch Trials.  Similar to the victims of the collective behavior at the root of these social trends, an effort is made to strip the patient of his humanity and individuality so he, and others like him, can be treated like uniformed soldiers of an enemy force.  Not only was no effort made to determine whether there is or ever was a basis for a Xanax prescription that is organic and endogenous, but the physicians ignored the roles of other physicians in the prescribing of these meds, placing the locus of responsibility squarely on the shoulders of the patient so that he could be designated as an addict and admonished to attend the hospital’s award-winning therapy group.

If you think this is all hyperbole, try to have a reasonable discussion about painkillers with one of these physicians.  Their word salad is a steady diet of “Nope.  Nope.  Wrong.  Wrong.  I’m going to have to stop you there.”  Recently, on one episode of Forensic Files, a toxicologist stated during an interview that “we run these toxicology tests and find out which people are good and who is a bad person.”  E gads!  
  
Weintraub’s responses had a tone-deafness to them, a pre-programmed and disproportionate quality similar to that of reflexes and instincts.  It did not matter what was served up to him.  From his point of view, no one has any business being on that drug at any point and at any dose.  But those of us who have lived with pain for months, years, or most of our lives -- and who have been consumers of opioids for extended periods – have access to a font of experiential knowledge that for all intents and purposes makes the Weintraubs of the world naive by comparison. Perry did not walk out of an initial consultation with his Virginia neurologist with scripts for oxycodone and hydromorphone.  Perry made a go of a number of nonpharmacologic and pharmacologic non-narcotic alternatives before he was ever prescribed an opioid. Antidepression medication. Anticonvulsants. Antiinflammatories. Antihypertensives. And even the cutting edge anti-CGRP meds. Funny thing about those anti-CGRP agents. In clinical trials they reduce migraine days by 50% in 70% of participants. But in the homes of migraines patients treated by Perry’s neurologist, I doubt the rate of efficacy approaches 25%. That’s not to say I would call out these meds as shams and lobby for their discontinuation. I would still want them available for the 25% whose lives they changed for the better. That’s 25% we no longer have to worry about. But that’s not the way our leaders tend to think. The typical reaction to a drug like that is to proclaim it a horrible failure. If it's removed from the market – the 25% who found relief in it now rejoin the balance of sufferers in the hope a product could be developed that neutralizes the overwhelming preponderance of migraine pain. For some reason we believe we need to have one solution. We don’t respect individual differences. Individual differences among migraine sufferers. Differences among what are a family of related but distinguishable maladies. I mean, who’s to say all head pain is one pain.

Contrary to what Weintraub tells Perry, there is no silver bullet among the non-addictive rescue products out there.

Now back to the matter at hand – alprazolam. Yes, I admit that I went off on a bit of a tangent there, but then so did Weintraub. Perry entered the ER with complaints – presenting symptoms – that everyone agreed resulted from coming off this benzodiazepine cold turkey. Weintraub went off the reservation – he exceeded the scope of the problem at hand – when he made it about the opioids.

And despite being diagnosed with benzodiazepine withdrawal that day, Perry was not actually treated for benzodiazepine withdrawal.  On that day, Perry received 2 hours of IV Compazine and Benadryl and then told he would likely end up back in the ER.  Why?  I guess Weintraub, in his blind hatred for controlled substances, could not bring himself to do what was necessary, which is to re-expose Perry to a benzodiazepine and titrate him down.  
  
STORMY MONDAY: TWO DAYS LATER  
  
By Monday morning Perry had slipped into a full-blown psychosis.  His wife Colleen recounts that Perry built an elaborate system of delusional thought around the thesis that the apartment had become infested with germs.  Perry complained about seeing these germs everywhere.  “The whole bathroom has been compromised,” he would say.  Colleen returned from the supermarket to find piles of water-logged towels and trash bags filled with health and beauty products from the bathroom.  Even the shower curtain had been stuffed in the trash.  When asked about the mess, Perry had concocted this convoluted story that placed responsibility for the contamination with his sister’s baby-sitter.  Perry would later complain of being unable to breathe through the heavy smell of thick but invisible smoke.  Colleen feared that perhaps the delusion both expressed and concealed genuine physiological events and advised Perry that the time had come to return to the ER.  But she was acutely aware that the memory of the previous visit was still fresh in Perry’s mind -- an encounter in which the ER staff seemed more intent on adjusting attitudes and assaulting dignity than working the real problem of withdrawal. Colleen knew her husband was not keen on returning but she had not anticipated that he would refuse. The problem had just been compounded by Perry's detachment from reality – a complete lack of insight into his deteriorating mental state.  Colleen even offered to drive Perry to another hospital's emergency department-- Stamford Hospital – where his neurologist has an office and where he recently underwent a biopsy. Still, Perry remained steadfast in his refusal. Colleen had come to terms days earlier with the fact that if her husband did not seek treatment, he would probably die. Now she was coming to grips with a husband who would not go voluntarily. At 3:12 PM, she phones 911.  
  
Little did Colleen know that when she referenced a controlled substance in her call to 911, she unwittingly triggered a State law requiring that two police officers show at the scene in advance of emergency medical services. The first police officer met Colleen on the street before entering the apartment and would only enter once back-up arrived.  Though their conduct professional, one of the officers had to be disabused of the assumption that this was a case of drug abuse.  The second officer joined Colleen in calming the first by explaining to him that Perry had a legal prescription for a psychiatric medication and had used the medication as prescribed by his physician. At no time was the medication misused in any way, and the problem at hand emerged only after only that medication was discontinued without warning and without an allowance for titration or for time to find another provider.  Perry is an innocent victim despite how various authorities operating within the borders of Connecticut conspire to depict him.  
  
Colleen prepared the officers by claiming the man they were about to meet was not himself and not willing to enter the hospital of his own volition.  Then the officers dropped a bombshell. They informed her they cannot force anyone into medical care. During the frantic exchange that followed, the officers did amend their statement by adding one vital detail: they could not coerce a hospital visit *unless the person in question poses a threat to himself or others*. The delusions and strange behavior in and of themselves were characterized as “insufficient grounds” even after Colleen explained that they have a 5 year old son and that her husband intended to spray his oral cavity with cleaning fluid.

So naturally Colleen was distressed to find her husband behaving just as evasively and uncooperatively with police and paramedics. Perry adopted a defensive posture and refused to answer questions. This had all the earmarks of a situation that could only end badly.

Just as paramedics and police prepared to leave, desperation yielded revelation. Colleen informed police that Perry is a Type I diabetic and that his condition rendered him unwilling or unable to manage his insulin. The stalemate appeared that it might be broken after all when the cop asked Perry when he last checked his sugars. Perry conceded that he had not been monitoring his blood glucose levels – and added a “because it no longer matters.” Knowing any further elaboration would strike all present as psychotic, Colleen asked her husband why. It was at that point that paramedics were given the green light to obtain an involuntary reading.  The 269 told everyone present everything they needed to know.  Perry was going to the emergency room.

Still – it did not sit well with Colleen. She recalls the heart-breaking scene of having to witness Perry carted off against his will -- having to listen to her delusional husband blame her for the whole affair.  Perry ranted against Colleen for what he believed was her diabolical plan to use him to expose the incompetence of Dr. Weintraub to authorities.  “This is all a joke,” he ranted.  According to Perry, Colleen used a gadget received from his brother-in-law to produce the asphyxiating smoke, which no one could including him could see but the smell of which permeated everything.  The bedroom.  The bathroom.  Even the halls and elevator.  Perry described the initial output of smoke as having the appearance and operation of a “flying saucer.”   
  
RETURN TO NORWALK HOSPITAL  
  
This time around Colleen observed a much more curious and conscientious ER, led by physician Jason Fischel, who outlined a plan to titrate Perry down upon re-exposure to a benzodiazepine called Librium.  Once Perry was admitted into the inpatient unit, Colleen received a phone call from a Dr. Brown, who also requested the full back story and even asked her spouse why Westport Family Health would discontinue treatment so irresponsibly.  All three physicians advised her of the serious risks posed by untreated withdrawal including but not limited to arrhythmia and seizure.

The whole process kept Perry in the hospital for 4 days, throwing their lives into disarray by causing them to miss an important to-do on their calendar: they were scheduled to move out of their apartment and out of Connecticut altogether.

The more Perry reads about benzodiazepine withdrawal, the more he believes that while Norwalk Hospital finally acted properly in re-exposing him and titrating him down, the 3-4 day treatment window is far from ideal.  Benzodiazepine withdrawal may take months for those on higher doses. Having reached a dose of 4 mg daily and having been accustomed to that dose for over 5 years, Perry may have needed to spend two weeks at 3.5 mg per day, two weeks at 3 mg per day, two weeks at 2.5 mg per day and so on and upon reaching 1 mg, may have needed to spend each subsequent week titrating down by 0.25 mg. My titration schedule:

|  |  |
| --- | --- |
| WEEK | DOSE (mg / day) |
| 1 | 3.5 |
| 2 | 3.5 |
| 3 | 3.0 |
| 4 | 3.0 |
| 5 | 2.5 |
| 6 | 2.5 |
| 7 | 2.0 |
| 8 | 2.0 |
| 9 | 1.5 |
| 10 | 1.5 |
| 11 | 1.0 |
| 12 | 1.0 |
| 13 | 0.75 |
| 14 | 0.50 |
| 15 | 0.25 |
| 15 | 0.125 |
| 16 | 0.125 |

As you can see, the process could take 4 months for someone at a 4 mg daily dose. I also recommend this diligence for someone who had been relying on alprazolam for over 10 years. The schedule is not set in stone. It needs to adjust to the person. It is quite possible the patient may have to spend more time at a dose level, titrate at finer increments, or settle indefinitely at a certain dose.

While the ideal situation is one in which the patient does not need alprazolam at all; if the patient does in fact need it, the ideal situation becomes one in which he or she never has to come off it. I often hear from medical professionals a statement to the effect of “well, you have to come off it *sometime*” to which I respond “oh yeah ... why?” If the patient’s life is better with alprazolam in it – and if it is not toxic to organ systems – where’s the harm in keeping the patient on it until the day he or she dies?

I also like to respond to the “well, you have to come off it *sometime*” platitude with “why does *sometime* have to be *now*?” What’s the rush?

Perry relayed his concerns about Jeffrey Weintraub to Director of Patient Relations & Advocacy, Kristin Winbigler who referred the matter to an unnamed "Vice Chairman of Emergency Medicine" and "Chairman of Medicine." Perry was not surprised to learn that these officials ultimately denied that anything inappropriate occurred during his encounter with Weintraub. In a letter dated March 21, Ms. Winbigler reported that the unnamed “Vice Chairman of Emergency Medicine and Chairman of Medicine” both deny any “problems or issues with the care received on the visit of March 10” and that it was “never anyone’s intention to be rude.”

Not everyone agrees.

Colleen mailed a summary of the encounter to every member of the State's Public Health Committee and to the Department of Public Health. A Section Chief for the Department of Public Health found the Report so compelling that he reached out to Colleen in the hopes she might encourage her husband to file a formal charge of abandonment against Western Connecticut Health Network. Like Perry, the Section Chief believes that there are two sides to the debate about controlled substances, that steps need to be taken to restore balance to the discussion, and that Western Connecticut Health Group may have violated Perry’s rights in denying him his medication. The Section Chief also believes that the recent legislation cited by Westport Family Health physicians does not constitute a valid basis for abruptly and completely withdrawing the alprazolam therapy they’ve provided for over a year.  The Section Chief also recommended that Patient forward a copy of the letter to the Department of Consumer Protection.  Assemblyman Bob Duff, representing the district in which the Patient resides, does not have a seat on the Public Health Committee -- and while he mentioned the prospects of repealing legislation passed as recently as 2017 are unlikely -- he took an interest in Perry’s “sad” predicament and offered to review the legislation in reference to his situation.

Despite the dismissal from the unnamed Vice Chairman of Emergency Medicine and Chairman of Medicine for Norwalk Hospital, Patient believes his case is solid.  There was wrongdoing.  Perry would like to hear out of that arrogant mouth of his / hers [reference to Vice Chairman] that Dr. Weintraub acted improperly in instructing Perry to discontinue his painkiller therapy when he has no knowledge of Perry as a person, no knowledge of his history, and no knowledge of the specialty (i.e., neurology) he presumes.  Painkillers were not even the subject of Perry’s visit.  As for the real subject of his visit, Weintraub’s phobia and prejudices kept him from re-exposing and titrating Perry.  Perry should not have had to return to the ER a few days later in a mentally compromised state that nearly prevented him from getting the care he needed to avert a fatal incident.  ER physicians should be prohibited from sermonizing on subjects outside both their expertise and the scope of the visit.   
  
Perry also did not appreciate that his discharge papers identified that his visit to the ER had been coded as “sedative abuse.”  Abuse.  He landed in the ER not because he acted improperly in connection with any illegal substances, but because the executives who run Western Connecticut Health Network, the parent company of both Westport Family Health and Norwalk Hospital, instructed physicians in the network to abruptly and completely withdraw a medication from a patient who had been receiving prescriptions for it for over 11 years.  Norwalk Hospital was coding the consequences of its own precipitous and negligent actions.

For three reasons, Perry declined to pursue a formal complaint. First, it was made clear to him that for the duration of the investigation and subsequent proceedings that Perry would forfeit his right to privacy. More importantly, Perry did not want to put Dr. Adler-Klein at any kind of risk. Adler-Klein assumed responsibility for prescribing alprazolam when no one else would, and her practice drew some unwelcome attention from the DEA in no small part because of that decision. Finally, Perry was in the process of leaving Connecticut for good where he restored his therapeutic relationship with his former physicians. This meant that Perry was able to resume the alprazolam and higher dose opioid therapies that were taken from him by Connecticut physicians operating under a new state law that went into effect in January of 2017.

That bears repeating. You see, the State went to great expense to involuntarily wean Perry off alprazolam on Medicaid’s dime. Once Perry got a taste of his new normal, it was with a clear head that he ultimately decided that the alprazolam had indeed made a difference and that life was better on than off it. That outcome was a far cry from the one so glibly predicted by Weintraub when he told Perry “you'll thank me later.”

Perry didn’t ask to be kidnapped. His keepers attempted to brainwash him by telling him alprazolam is a problem. So they forced him off cold turkey.  Then when Perry developed withdrawal symptoms, they pointed to the symptoms and said, “I told you so. See?  A problem!”  Numbskulls. Alprazolam was a solution -- not a problem.  It had been a solution for many years. It becomes a problem only when some crusaders who think they know better force the consumer to come off like they forced Perry off. But Perry will tell you he never felt as right without it.  Not even months later.  So when he had access to his old doctors he went back on.  And even though it was Perry’s decision to resume alprazolam, the Western Connecticut Health Network would have been culpable had Perry miscalculated his dose upon restarting the drug. You see, that’s a risk you run when you stop and start again. Now Perry was astute enough to know he could not just pick up where he left off by taking a 1 mg tablet 4 times a day. He knows he would have overdosed. But figuring that new starting dose proved challenging. Does he take a 1 mg tablet twice a day? Is a 1 mg tablet too high a dose? Should he split the pill? Should he split it twice? It’s a dilly of a pickle – and it’s ultimately the DEA, Connecticut State legislators, a state full of psychiatrists, and the PCPs at Westport Family Health that would have had blood on their hands had Perry died.

It also bears noting that I personally reviewed the text of that new Connecticut law and it was a lot friendlier than I expected given that it was in the name of this law that so many doctors took a hard line with Perry and restricted access to his most valuable medications. The law was quite clear in making not only palliative care but chronic conditions the subject of exemptions, exclusions, qualifications, and stipulations. Either the medical professionals decided life would be simpler for them if they treated all patients and all conditions the same – or they didn’t read the legislation. I am inclined to think they were too busy to read the law. I am inclined to think the vast majority of those who cited the law as impetus and justification never read it. And this raises yet another interesting point about these laws. There is this inherent duality to them. On the one hand is the law as written. On the other is the law as a product of interpretation and rumor. Someone hears that a law was passed and they imagine what is in it and that conjecture based in the fact of the law – rather than its content -- is disseminated and reproduced much like the handcuffs put on Martin Singer’s wrists. Much like the CDC Opioid Prescribing Guidelines developed its own doppelganger.

**Appendix C:**

**Kaiser Permanente Serves Up Cold Turkey**

***"They [Kaiser Permanente] are trying to take a woman who has been a chronic pain sufferer for over 10 years and clean her up of all her opiate therapy and Xanax at the same time -- while denying her access to the only antidepressant that has ever really worked for her. In the middle of all this she gets a URI with a terrible cough -- a cough which worsens her head and back pain -- and they can't even give her the only remedy that works for her because the extended release cough syrup contains hydrocodone. It's galling. Initially, she thought her assigned PCP, a Dr. Mojdan Afshari, didn't want any responsibility for managing pain, but she later learned that the PCP's real motive is to deprive her of pain management altogether. And she continues to sabotage her even after the patient switched to a new PCP. And Kaiser allows it."***  
  
Kaiser Permanente and the End of Compassionate Care  
  
I don’t want to bury the lead, so here it is.  When Kaiser Permanente accepts new patients into its house of managed care, it asks them to leave their preferred medications at the door like a pair of shoes.  Wait – correct that – Uncle Kaiser’s not asking.  The fact Kaiser has moved 90% of the pharmacopeia into the non-formulary column plays no small part in the New Cruelty but also at play is Kaiser’s Wilhelmian War on controlled substances.  If the legislature or the DEA has an issue with it – or if the FDA ever issued a black box warning about it – you’re not going to get it.  Yes, your Kaiser PCP carries the banner in the modern military parade that is the war on the opioid epidemic.  So no painkillers.  But that’s not where the Prohibition style crackdown ends.  It will also embrace a benzodiazepine or two so say goodbye to your Xanax and Ambien.  And what’s with their crackdown on prednisone, the 4-day course of oral steroids doctors give you for inclement or intractable illnesses?  I guess if it feels good …  
  
I had the opportunity to chat one woman up in a Kaiser waiting room in Ashburn, VA who had been taking all of these drugs for years.  Except prednisone, which she received only when she was ill – along with that cough syrup that contains hydrocodone.  I’ve had that too.  In fact she’d been taking these drugs for 10 years as a chronic pain sufferer and psychiatric patient who recently received a medical disability designation by the Social Security Administration.  And as a Type 1 diabetic, she is more susceptible to catch illnesses than you and I and her young son brings home plenty from school.  She’s also less likely than you and I to shake a cold and many of hers evolve into bronchitis.  Hence the need for the extended release hydrocodone cough syrup otherwise known as Tussionex.  Without it, her coughing would tear her apart by exacerbating her migraine and back pain.   
  
HER NAME IS CHERYL  
  
Unfortunately for this chronic pain sufferer, spousal unemployment cost her access to a network of PPO physicians she's known for over a decade.  When Federal BCBS ended – arguably the best health insurance there is -- she fell to Medicaid. The Medicaid served her well enough.  Sure, new Virginia regulations bombarded her physicians with requests for preauthorizations. The work required to complete these forms -- which required evidence that that diagnostic methods were employed and non-narcotic avenues exhausted -- strained staff resources to capacity ... or exceeded them. Minor errors or omissions in documentation, errors in transmittal, and review and approval time delayed the fulfillment of one painkiller script 21 days for another VA Medicaid member (see Appendix A).  Cheryl submitted scripts for 15 different products to Medicaid for reimbursement -- and all but one of them required preauthorization. At least in Virginia. Connecticut Medicaid was not as bureaucratic nor as heavy-handed in pushing physicians and patients into a preferred or "formulary" drug. And the Connecticut Medicaid patient did not pay a dime in co-pays. Cheryl reports that there were days when as a Medicaid member she just did not have the $3 to her name. With Virginia Medicaid, she didn't think it could get any worse; that is, until at the 90 day mark -- without notice -- the State outsourced her -- as it does all Medicaid members -- to one of its managed care organizations. One day Cheryl opened a letter to learn that the next day she belonged to something called Kaiser Permanente.  Here she would learn what it means not to get her medication at all.  
  
IN THE MOUTH OF THE RABBIT HOLE

The first two visits with her KP-assigned PCP were Hyde and Jekyll.  Initially, Dr. Mojgan Afshari responded with shock and awe upon learning her new patient had been prescribed an extended-release fentanyl transdermal patch, short-acting opioid pills for breakthrough pain, the sleep aid Ambien, and the anti-anxiety medication Xanax.  Cheryl reports that her medications -- which she thinks of more as assets or resources -- have allowed her to reclaim her quality of life. When the FDA issued a black box warning on the concurrent use of an opiate and a benzodiazepine like Xanax, Cheryl thought nothing of it. She'd been prescribed these two medications for over a decade. All her resources have co-existed harmoniously and without incident in her system over this period.  But Cheryl walked away from the initial appointment believing that the PCP would not be party to these scripts.   
  
The Kaiser psychiatrist, Dr. Shweta Verma, insisted Cheryl begin tapering off the Xanax.  No Kaiser member was permitted to use this substance. The hydroxyzine Verma prescribed in its stead proved ineffective. Cheryl likened it to a combination of promethazine and the buspirone (Buspar) she was authorized to take while pregnant.  It was laughable to think 4 mg a day Xanax could be replaced by something so lightweight.  It also did not help that the psychiatrist refused to allow Cheryl to continue her use of a next-generation anti-depressant called Trintellix.  The drug was just too novel and too expensive for KP's tastes. I suppose for every Nordstrom there is a Nordstrom Rack. Kaiser Permanente was shaping up to be the Nordstrom Rack of the health insurance market. To make matters worse, representatives of Kaiser's Pain Management division informed Cheryl that they do not prescribe medications.  They only give injections. Cheryl also consulted with Kaiser Neurology. Outside of Kaiser, it was the neurologists who provided the Social Security Administration with the pivotal testimony concerning the impact of her migraine and back pain on her physical and cognitive functioning. And it was the neurologists who prescribed Cheryl her game-changing pharmaceutical countermeasures.  They were the equalizers. Not so the Kaiser neurologists. No, the Kaiser neurologists informed her from the get-go that they do not prescribe painkillers. They did however extol the virtues of Vitamin B-2.  
  
It was at this point that Cheryl realized she would be denied both compassionate care (relief of uncomfortable symptoms) and continuity of care.  While I am no doctor, I know that physicians are violating one of their own tenets.  If you are going to make changes to a new patient's treatment regimen -- particularly if it's a longstanding treatment regimen -- you need to make the changes slowly and to one medication at a time.  You also need a good reason.  A clinical reason.  "There's an epidemic," "the computer told me this is non-formulary," or "the DEA is cracking down on this," are not good reasons.  There are more risks associated with changing a person's medications than with allowing them to keep what they maintain works for them.  Kaiser thought it could save some money by switching her from her preferred $900 Dexilant to a generic $9 protein pump inhibitor.  Cheryl ended up in the ER with an allergic reaction.   
  
So Cheryl sent letters to her Congressional representative, the State Managed Care Office, and her County case worker lobbying to have her basic Medicaid benefits restored, but she was informed her chronic pain history and disability status were not among the 13 exceptions / exclusions in the Virginia legislation that would have authorized this.  She was stuck was Kaiser.  However, a case manager was assigned to mediate her concerns with her Kaiser PCP.  During the very next appointment, Dr. Afshari's demeanor was remarkably reformed -- more pleasant and accommodating -- and Afshari was now in a position to fill Cheryl’s fentanyl and short-acting pain pills.  But before the scripts can be written, Cheryl would have to sign a pain management contract.   
  
Cheryl is no stranger to these contracts.  They have evolved quite significantly over the years from the one-pager assuring the prescriber he or she would be the sole source of opiate-based pain medication … to three page documents warning of the inherent risks of opioid use, abuse, discontinuation, and that the patient would be held responsible for theft by third parties.  But the Kaiser contract contained a clause she'd never seen before.  The contract prohibited her from obtaining scripts for other controlled substances, specifically Xanax, for the duration of her opioid therapy.  This bears repeating.  In order for her to receive the pain medication she's received for 10 years, she would have to taper off her Xanax completely.  She was required to choose between her pain and her anxiety.  But what choice did she really have? She signed.  
  
CRUTCH-KICKING KAISER RAISES THE STAKES

Cheryl worked with a KP psychiatrist on a plan to titrate off her Xanax.  Benzodiazepines like alprazolam are orders of magnitude more problematic than even painkillers to withdraw from.  While abruptly discontinuing high doses of round-the-clock opiates can result in 3-4 days of unearthly hell (i.e., nausea, vomiting, rapid heart rate, existential depression, diahrrea), the withdrawal is generally regarded within the medical community as non-life-threatening.  "You may think you're going to die, but you’re not" is practically a mantra.  But titrating down from even the smallest doses of alprazolam has been known to produce tactile hallucinations, delusions, and existential anxiety in the early phases followed by potentially fatal seizures and arrhythmia if untreated.    
  
Cheryl's Kaiser PCP, Dr. Afshari, actually did prescribe her next month's supply of pain medication -- and even agreed to prescribe the extended release cough syrup when the patient developed bronchitis following a URI. So after a long drawn out battle complete with letters to the Congressional representative, it would have appeared that Cheryl had won her continuity of care. But this all came crashing down when Cheryl began running out of Xanax. She was tapering off as she was ordered, but she needed more to finish the job and psychiatrist Verma would not prescribe more. She may have been coming off more slowly than her KP physicians would have liked, but then Cheryl believed that Kaiser underestimated the time required to separate from alprazolam. Kaiser wanted a steeper curve than Cheryl was capable of. Kaiser wanted her to go from 5 mg daily to 0 in a month. For someone who had been prescribed alprazolam for over 15 years, that hardly seemed reasonable – or safe. It occurred to Cheryl that none of her KP physicians have probably ever witnessed withdrawal from alprazolam let alone experienced it themselves.  But she went through a very brief period of withdrawal when she working transitioning from one health plan to another, and the post-traumatic stress she suffered from even this less extreme adjustment has made her cautious. So Cheryl rummaged through some old papers in her wallet – receipts, business cards, and – eureka – she found a script for alprazolam that had been written by the neurologist she had seen for 8 years before circumstances diverted her into Virginia Medicaid and then Kaiser. She paid out of pocket to fill this script from a non-KP physician. It did not take long for the PDMP to flag it and alert KP. By doing so, Cheryl violated that clause in her pain management contract. And Afshari responded by acting like some combination of a cuckold and a mugging victim. **Afshari informed Cheryl that for as long as she remained with Kaiser she would never receive another patch, pill, or teaspoon of syrup again**.  
  
There was nothing Cheryl could say to end the blockade. She'd been grounded -- permanently. None of the explanations -- not her traumatic experience with alprazolam withdrawal -- not her long legacy of alprazolam -- not her dire life circumstances -- would mitigate the transgression in the eyes of her Kaiser PCP.  Cheryl filed a complaint in the hopes of working out the problem in mediation -- but the PCPs physician supervisor slammed the door and threw his full support behind the PCP.  Cheryl has never been without pain medication in the past 10 years.  The news is so jarring, that she is seriously tempted to return to her alprazolam -- or pay out of pocket to see her old doctors.  **She is bracing herself for withdrawal from the most powerful opioid on the market -- 100 times more potent than heroin by all accounts -- fentanyl. She might just need all the alprazolam in the world to deal with that**.

Fentanyl.  It's the drug making a lot of headlines lately.  It killed a 10-year-old boy who came into contact with it at a Florida pool.  No one knows how.  But it was found in his system.  And it was found at the pool.  He must have never known what hit him.  It sent a police officer to the ER after he came into contact with fentanyl as a white powder, having mistaken it for cocaine.  And fentanyl accounts for the majority of deaths broadly attributed to the opioid epidemic.  Most heroin addicts die not from the heroin itself but due to the fact their batch was surreptitiously tainted with fentanyl.  
  
And yet the Kaiser patient advocate Tina Brown informed Cheryl that Afshari and Afshari's supervisor both went on the record in maintaining that quitting fentanyl cold turkey -- and quitting alprazolam cold turkey -- is not harmful.   
  
In their minds it's so dangerous to be using these drugs and yet they don't believe there are any issues or complications in coming off.  How can that be? I guess none of this should surprise me. I cannot believe how many of the Kaiser doctors Cheryl has seen have never even heard of the medication she has been prescribed by non-Kaiser doctors. Neither the KP ENT nor the KP Allergist has heard of Zyflo. Neither has heard of Dexilant [the next-generation Nexium]. Neither had her PCP, who replaced the $900 protein pump inhibitor with a primitive $9 generic progenitor [equivalent] that ended up with Cheryl calling the paramedics because she had an allergic reaction to it. The psychiatrist never heard of Trintellix [anti-depressant]. No one has heard of the Flector (i.e., diclofenac transdermal) patches. And their only knowledge of fentanyl comes from what they read in the newspapers. It speaks to how cloistered these doctors are inside the walls of Kaiser's roach motel.   
  
Cheryl reports liking her patient advocate. That being said, it's a toothless, showpiece role within Kaiser. Cheryl's PCP encouraged her to file a complaint against her knowing quite well how it would all end. Cheryl talks to Tina. Tina talks to Afshari and Afshari's supervisor. The supervisor throws his support to Afshari with a statement like, "I don't see any evidence of wrongdoing." And there's no recourse beyond that. Tina admitted she has no medical background, so how could she formulate any opinions that the doctors would feel compelled to consider with an open mind.  And yet even Tina would make a casual, off-hand, drive-by remark that Cheryl considered glib -- cavalier -- crass: "you have to get off these painkillers some time.  You can't be on them forever."  
  
One of these days Cheryl should respond with two words -- 'Why not?' -- and watch them squirm.  There are people who live with chronic pain.  Why is it a sin -- a shame -- a crime -- to use these drugs?  Why are we even calling them “drugs.” Why not call them “pain medication”? “Resources”?  The first thing the pain patient community should do is reclaim the high ground in the war of weaponized language. Those who want to annihilate opioid based pain medication use words like “addiction” and “dependency.”  If you use opioids at all, you have a “use disorder.” The implication is that it’s unhealthy or immoral to need something. But how does this differ from millions who can’t function without their morning coffee? Or those diabetics who need insulin? Pain sufferers will describe their relationship with their oxycodone as one of harmonious coexistence. Their dependency is functional, or no less functional than the paranoia they developed around those who have made it their mission to take these resources away.

Cheryl believes it marks the end of compassionate care in America.  Managed care organization physicians like those who work for Kaiser are so hell bent on not doing anything wrong, they forget what it means to do right.  Even after repeated overtures, patients are unable to get courses of prednisone to treat harsh or intractable illnesses. The rule seems to be if it makes the patient feels good, it’s probably why the patient has requested it, and that’s grounds for refusal.  Cheryl requested Tussionex suspension to break a cycle of coughing that had been causing her headaches, insomnia, and irritability. She believed the coughing was begetting more coughing through irritation of the throat.  Her new Kaiser PCP would have none of it.  He initially called it a “band-aid.”  Then this …  
  
*"I apologize for the delayed response but I have been swamped. I'm sorry you're still not feeling up to par. I was not aware that you were diagnosed with reactive airway disease before. Therefore it may be the reason why this cough is still persisting. I suggest we start you on Qvar and see if it will take care of your cough. I would also suggest you see our pulmonologist to see if he would recommend pulmonary function tests.  I will send it in for you at our pharmacy. Like I mentioned when I saw you, I want to get to the root of the problem and I want to try to avoid patching things."*  
  
Cheryl told him that she could not afford to feel miserable and be laid up right now.  She had two phone interviews to prepare for -- and execute -- and she was caring for a sick husband and 6-year-old son with ADHD.  Neither him nor the Kaiser physician she switched from could seem to understand that while it is important to address the root of the discomfort -- and it took two visits before anyone even decided to take that approach -- it was still important to address the symptoms.  D.L. called it a "band-aid."  But the two approaches are not mutually exclusive.  In fact, they're complementary. And while it takes time for the cure to take effect -- why not make the patient comfortable?  Functional? Also, if Cheryl was right about the role of the short-term cough as a maintaining factor in the long-term cough, then the Tussionex becomes therapeutic.  
  
Initially, Cheryl’s first Kaiser PCP agreed to her request for the syrup and sent her over to the Kaiser pharmacy to pick it up.  When Cheryl arrived, she could see them loading the bottle into the bag, but something didn't look right.  The substance in the bottle appeared clear rather than milky and the quantity was off.  It didn't look like the 70 ml she agreed to.  So Cheryl had the pharmacist pull it back out of the bag for closer examination.  This was not Tussionex.  It was Hycodan.  Cheryl took a few minutes to research the substance on the Web and it appears this is what they give patients at risk for abusing cough suspension – such a person being someone who was ever prescribed it before and requested it in the future. Hycodan contains an anticholinergic substance called homatropine that works against the hydrocodone so that the user would become sick if they took more than the 5 ml.  Perhaps the doctor thought Cheryl was scheming to swallow the whole bottle.  That would explain why she changed the script from 70 ml of Tussionex to 30 ml of Hycodan.  Cheryl confronted her in her office about the change, and her response was priceless:  
  
DOCTOR:  "Did you know Tussionex contains hydrocodone?"  
  
CHERYL:  "Yes, so does Hycodan by the way."  
  
DOCTOR:  "I know.  The Tussionex is non-formulary.  This is what the computer told me to give you."  
  
Cheryl got the impression her doctor didn't know anything about Tussionex, Hycodan, or homatropine.  
  
CHERYL (paraphrase):  "I asked for the Tussionex because it is extended release and addresses all my symptoms.  One teaspoon would serve me for 8-12 hours.  There's an antihistamine in there called chlortrimeton that peaks at 6.8 hours and doesn't knock me out the way promethazine or over-the-counter antihistamines -- like the kind you find in NyQuil -- do.  But what you gave me [Hycodan] is straight hydrocodone.  Short-acting hydrocodone.  I would be re-dosing every 4-6 hours.  But you lowered the quantity to 30 ml.  So this is only 6 doses that would cover a day-and-a-half.  Could you put in an override and send the Tussionex over?"  
  
DOCTOR:  "I'm sorry.  I'm not comfortable.  There’s an epidemic."  
  
CHERYL:  "Hmm. What? Epidemic?"  
  
DOCTOR:  "The opioid epidemic.  I usually just have my patients take Robitussen."  
  
This would not be the only doctor to specifically cite the epidemic as a reason to deny Cheryl 4 days of relief from a cough and cold.  Another Kaiser PCP also casually alluded to the "epidemic" in the early phases of discussing symptom relief.  Cheryl’s first appointment with him started out well enough.  He asked her if what he'd given her the last time worked.  He was referring to the Tussionex.  But then he disappeared for 15 minutes and when he returned, he would only discuss NeilMed Sinus Rinse and Flonase.  
  
The "epidemic."  The "computer."  These are the criteria for clinical decision making.  Not Cheryl’s presenting symptoms, which they observed and documented.  Not her reported level of discomfort, which is consistent with what they observed in her ears, nose, and throat.   
  
Eventually, after repeated overtures through the Kaiser messaging system, the doctor relented and appeared to offer Cheryl the Tussionex, but it was not unconditional.  
  
*"Ms. Cheryl [REDACTED]"  
  
"I can certainly understand that it is preventing you from sleeping so here is what I will do: 1) I will give you a prescription for Tussionex which you will only use at night to help you get some rest. This will be a 7 day supply and is a one time exception because as previously mentioned, this is not a definitive therapy. In addition, the evidence is clear that there is no difference in symptom relief between this and Dextramorphan. Because it contains a controlled substance and you have been prescribed this medication now 3 times in the past 3 months, I will not be able to prescribe it to you again this year."*  
  
Actually, that is incorrect.  CheryI was prescribed the Tussionex twice in a 6 month period and the quantities were small.  A total of 140 ml for the 2017 calendar year.  Cheryl drained the Hycodan after one dose because it made her sick.  Apparently – and as her research has shown -- even some patients who take Hycodan as prescribed can be made to feel sick.  Nausea.  Headache.  Dizziness. Just what I needed. Furthermore, Dextramorphan knocks some users on their proverbial ass. One of the qualities Cheryl cherished in the Tussionex was that it did not make her feel drugged or knock her out. There is a dysmorphic or unpleasant feeling certain antihistamines instill. The antihistamine in NyQuil. The promethazine paired with codeine.

Nevertheless at this point in the email Cheryl is elated, because she thinks relief is on the way, but just like the two previous instances, it would turn out to be a tease.  
  
*"2) Before you fill the Tussionex, a urine drug screen will be required and needs to be clear. This is not my rule but nationwide and especially since you have had this medication multiple times.*"  
  
But before receiving this email, a resigned Cheryl resorted to popping the one 5 mg oxycodone she had been holding on to for a rainy day.  It was the remnant of a script she received for a dental extraction in 2015. After it showed up in her drug screen, she informed the doctor how that happened and while she was resigned to walking away, the doctor took time out of his busy schedule to research her drug history in the PDMP. He felt he needed to confirm – he just had to know – if she was being truthful about the dental work.

The doctor has since surgically deleted his response from the messaging system, but what he sent was an angry note explaining how he reviewed the PDMP to see what Cheryl received in Ohio and did not see evidence of any opiate scripts from 2016.  Essentially, he was calling her a liar.  But more remarkably, Cheryl learned just how much privacy has been lost to patients.  Your doctor can access a database that sees what controlled substances you were prescribed in another state, under another insurance carrier, going back an unspecified number of years.  When Cheryl clarified exactly when she received the script and from which practice, he actually took the time to verify her statement and ultimately find the script.  Quite an endeavor for a physician who told her he was "swamped."  
  
But this was not the only time Cheryl would be asked to donate some urine. The purpose of this other screen – requested by Afshari – was never made clear. Cheryl could not imagine what her doctor hoped to resolve with the screen. The doctor should expect to find some benzodiazepine and opioids in her system.  Afshari was dead set against giving Cheryl any more pain medication, so what does Cheryl win if the screen does not show whatever it is they don’t want to see?  Cheryl alleges that Afshari is using the screen to compile a dossier on her. It’s bad enough their doctors disregard your privacy and dig into your bloodstream and history searching for evidence of abuse. Incidentally, Afshari did call in an order for Narcan – the opiate antagonist nasal spray. She wouldn't give her any pain medication, cough syrup, prednisone, or promethazine, but she'll give her the Narcan she didn't ask for. Cheryl already had some from her brief stint on basic Medicaid.    
  
Other aspects of Afshari's behavior are particularly egregious. One -- it is not OK to tell your sick patient you are calling in scripts for her to pick up at the only Kaiser pharmacy open on the weekend, and then not call those scripts in. Cheryl made the trip to Reston only to later discover the scripts were never called in and that others that had been called in -- were cancelled by the physician. It is not OK to send your patient off to take a mandatory drug test and refuse to tell the patient why. Afshari has to know that it will turn up positive for the alprazolam and opiates she had prescribed previously. Cheryl can't think of any possible result that will benefit her, the patient. What does she get if Afshari sees or does not see what she wants to see (or NOT see)? Or is this a fishing expedition made in the hopes of finding something that will allow her to build a case against her patient? Much is made of "recreational drug use" but what about "recreational drug SCREENING"? Concerning the scripts that were never called in as intended, Afshari's assistant insisted the doctor would phone Cheryl on her lunch break, but after the entire day passed without a call, Cheryl was shocked to find in her online KP.org appointment minder that Afshari, without consulting Cheryl, scheduled a phone appointment for October 30. That's not only a week away but a day before Afshari knows Cheryl's Kaiser membership expires. Convenient.  
  
Cheryl reports having filed a complaint against Afshari through KP's Membership Services division, but the attempt at mediation ended rather abruptly when the physician head for Reston, VA threw her support unequivocally behind her subordinate. The patient representative Tina Brown informed Cheryl that the physicians are absolutely certain no wrongdoing has been committed. While I disagree, whether a wrong has been committed is kind of beside the point. The patient's interests are not being served. The patient is also being harassed and stressed unnecessarily. This is a violation of the Hippocratic Oath. But hey -- as long as KP feels they are legally on solid ground with Federal and State regulatory agencies -- I guess all is well.  
  
The second hand information conveyed to Cheryl by Kaiser's patient advocate Tina Brown paints a disturbing picture. Afshari was forcing her patient to choose between 3 days of short-acting painkillers (i.e., hydromorphone) and 4 days of cough syrup that also contains a painkilling agent. But Cheryl was being set up. Tested.

Cheryl pushed for the cough syrup. Because Afshari felt strongly that Cheryl did not need the prescription strength syrup -- "Just get yourself some NyQuil” -- that by choosing the cough syrup, Cheryl was to Afshari’s perverse way of revealing herself as a drug addict by exhibiting a morbid drug seeking orientation. This is not speculation. This was the patient representative’s summation of Afshari’s reasoning. When Cheryl decided she wanted the syrup, Afshari decided to cancel all of Cheryl's scripts. Not only did Afshari cancel the hydromorphone she intended to authorize (had Cheryl opted for it), but she refused to fill the chosen cough syrup and she also cancelled the prednisone. She even cancelled the promethazine, which is the one agent Cheryl would have needed to make the cold turkey withdrawal off fentanyl more tolerable. (The anti-emetic and sedative promethazine paired with 800 mg ibuprofen is standard treatment for opiate withdrawal). Make no mistake -- this was punitive -- an act of pure cruelty with no basis in medicine. Not only did Afshari decide not to follow through with her intentions to issue these scripts, but she decided not to inform Cheryl of the change, so that her patient -- cold and all -- opiate withdrawal and all -- made a fruitless trek to the only KP pharmacy open on weekends.

Cheryl still doesn’t understand what she supposedly did wrong. Yes, she felt like she had to make a choice. She shouldn't have had to feel that way, because there's nothing she requested that had not been prescribed on numerous occasions by a number of different physicians previously -- and once by Afshari herself. Perhaps this is retaliation for the complaint Cheryl filed against Afshari when she cited the violation of the contract as grounds to deny her ALL her pain medication. Cheryl wouldn't even have called it a complaint but rather an appeal, an effort to have Afshari reconsider her decision under a broader context of information. But in Afshari’s mind Cheryl made the wrong choice -- a choice that somehow betokened dark motives. But seriously, if you're Cheryl and accustomed to receiving a 30-60 day supply of hydromorphone tablets and then you're told to choose between a 3-day supply of these tablets and a product that would neutralize her most pressing symptom -- a cough that maintains and exacerbates head pain – Cheryl’s choice makes perfect sense. The syrup contains an anti-tussive that is also a painkiller. Afshari also seems to overlook a couple other important facts. First, a cough is not a trivial thing for someone who suffers chronic intractable migraines and back pain. What do you think happens when someone like Cheryl coughs? It makes her pain worse. It prolongs her pain. It keeps her in a pain cycle. A teaspoon of that stuff breaks the cycle for about 8 hours. As someone who's had to sneeze with a broken rib, I think I know what Cheryl means. But to anyone who does not have insight into Cheryl’s thought processes, Cheryl’s choice should have in the very least resembled *Sophie's* choice. One simply cannot reverse engineer Afshari’s syllogism to arrive at logical proof of drug abuse and addiction.

This is where we need to implicate the Kaiser system in this mess. All Cheryl’s prescriptions for all of Cheryl’s chronic conditions are managed through the one PCP. Outside this Gulag, Cheryl maintains visits with a number of specialists in a coordinated care network. She sees a top Washington neurologist. She sees an endocrinologist. She sees an ENT. She sees a gastroenterologist. How can Afshari be expected to possess anything approximating the knowledge of these specialists? Now Kaiser will occasionally refer to a specialist but Kaiser’s neurology and pain management functions are truly pale imitations. When the neurologist greets you with “I am not your pain guy" – (TRANSLATION: “I do not prescribe painkillers") – and then recommends a B vitamin for pain – you know you’re in trouble. The pain management division – a gated community of sorts requiring more referrals than West Point -- also does not prescribe painkillers. They only administer injections. Kaiser was thrilled to disclose to qualified patients that they had recently hired a Tsar of Pain Operations and Cheryl and her PCP spent a month exhausting the necessary channels to arrange for an appointment – with no word they had been successful.

Cheryl reports that one point she pushed for a non-narcotic alternative to Tussionex called BromFed DM, but that Afshari responded with a kind of cataleptic fit in which she repeated the word "no" over and over again without coming up for air. Patient advocate Tina Brown recalls Afshari's comments on the matter. According to Ms. Brown, Afshari complained that Cheryl "kept asking for all these different cough medicines. But she doesn't need a cough medicine."  Really? Cough was the primary presenting symptom and ultimate impetus for the appointment.  
  
As for the drug screen, the patient advocate disclosed that Afshari was searching for evidence that her patient might have been "shooting up." This is a rude and groundless abuse of her sick patient's time. Afshari had no probable cause. And while Cheryl was in the lab, she missed her chance to pick up a script at the pharmacy, which was closing not only for the day, but for the weekend. What makes the matter all the more incendiary is that Cheryl now knows why Afshari remanded her to drug screen. Evidence of illicit drug use would have allowed Afshari to wipe her hands of her patient once and for all. She would have no more responsibilities for a chronic patient sufferer with multiple conditions she not only considers high-maintenance clinically, but also problematic with respect to liability. **As Cheryl suspected, the drug screen was never intended to advance the cause of the patient but only the physician**.  
  
As for the bizarre appointment that showed up on Cheryl's calendar for the 30th of October, Afshari insists it was Cheryl who made the appointment. Cheryl did not.  
  
Cheryl attempted to reach someone with some oversight over the Ashburn, Virginia physicians, but no such person exists. Afshari's supervisor, Dr. Nguyen, has already reviewed Cheryl's complaint and constitutionally supports his subordinate.  
  
"He's not going to be any help," surmised patient advocate Tina Brown.  
  
Neither Tina Brown nor Cheryl's KP case manager, Linda Hendricks, could identify an administrative practice manager. Both were asked who would step in when liability became an issue, and both surmised that perhaps such a person could be found at the regional office in Rockville, MD.

There is something else worth noting here. Kaiser physicians like to hide behind what they call "national or nationwide laws."  Just like there is no nationwide law prohibiting concomitant use of alprazolam and opioid painkillers, so there is no nationwide law requiring Cheryl to submit to a drug test after receiving x number of scripts (for minuscule doses).  There is a brand new Virginia State law, but I have it on word from Medicaid representatives that this does not apply to acute illness designations like a cough.  It applies to chronic pain sufferers who will be expected to receive opiates on an ongoing basis.  And these patients are required to submit to a drug screen on a monthly basis.  I find the drug screen requirement for chronic pain sufferers odd, because you wonder what result could possibly invalidate their medication privileges.  One neurologist I talked to was at a loss, but surmised that the State is looking for heroin.  Another surmised that the State would want to identify negative test results in patients receiving scripts because that might signify that the patient is engaged in the illicit sale and distribution of their narcotic pain medication.  But that neurologist was admittedly guessing as well.  Isn't it interesting that physicians not only misunderstand the laws as they roll off the Virginia Assembly line, but they're also groping for explanations for the laws they get right?  
  
The legislation is sourced by the State’s top cop, the Attorney General. This is a police action, not a medical emergency. The Virginia Board of Medical Professions, which advised on the legislation, does not include physicians who would make the best experts on pain prescriptions.  Aside from an anesthesiologist, who deals with a kind of pain you never really feel (because you’re unconscious), there is no one qualified to address this issue.  There are more OB/GYNs and pediatricians on the Board than neurologists and physiatrists.  In fact, I couldn’t find a neurologist or physiatrist on the Board.  
  
I suppose this is a good time to mention that I support physicians (non-KP physicians) and understand that they are the ones caught in the middle.  I certainly wouldn't want to be a physician in this day and age.  One of the neurologists I talked to says his attitude changed dramatically after the shocking arrest of an associate in town who'd apparently been monitored by the Virginia State Attorney's Office and the local FBI for 2 years.  "I do all the necessary diagnostic testing.  I explore prophylactic and non-narcotic rescue drugs, but every time I write a script for painkillers, it pops into my head.  'They're coming for me.  I know they're coming for me.'"  The neurologist also mentions he continues to tell his patients he's on their side.  "We're on the same team," I tell them. If Kaiser physicians believe they're representative of the broader medical community, they are sorely mistaken.  
  
Not all doctors are teammates.  More interesting, physicians vary widely in their treatment philosophies.  As a patient, Cheryl is aware of this.  Most physicians, however, are not.  Most physicians are stunned by the decisions made by their predecessors.  Afshari was shocked and awed by what she considered irresponsible fentanyl patch prescription on the part of Cheryl’s Connecticut neurologist, Dr. E.K.  E.K. considered the fentanyl patch – which is extended release and always in her system -- a responsible means of reducing her reliance on all the short-acting pills she was accustomed to getting from her previous Virginia neurologist, Dr. R.C.  "That's bad prescribing," E.K. said of R.C.  "You need a balance."  R.C. would in turn have considered Afshari's approach nothing short of negligence and abandonment. Clearly there is nowhere near a consensus approach in the medical community.  The aforementioned three doctors represent three points along a continuum that encompasses an ample quantity of short-acting painkillers, a combination extended-release patch and small quantity of short-acting pills for breakthrough pain, and no exposure to painkillers at all.  Lawmakers may be discovering this and attempting to use regulations to achieve a measure of uniformity, which centers on browbeating doctors into non-opioid alternatives under threat of losing their licenses.

At the behest of the patient advocate, Cheryl would eventually dump Afshari for a new PCP. She really had no choice. The Kaiser pulmonologist -- one Dr. Phong Nguyen -- actually saw eye-to-eye with Cheryl on a limited 3-day course of Tussionex. He concurred that the maintaining factor in her cough was coughing itself. It was causing her irritation. There was some value in breaking the cycle so that stopping the cough in the short-term might actually stop the coughing longer term. So much for the notion Tussionex is "just a band-aid." But Nguyen also made an uncharacteristically important contribution to Cheryl's medical history. He diagnosed her weeks of coughing as a case of asthma. Cheryl has asthma. And as he laid out his reasoning, Cheryl kept thinking about how her PCP Afshari continued to minimize her cough and insist she didn't need to treat it (probably because she thought Cheryl was drug seeking). Nguyen prescribed two medications to inhale by way of a nebulizer and with this prescription came some hope that perhaps Cheryl will find a more lasting relief from her bronchial issues. But since it would take time for this treatment to take effect, Nguyen agreed that the hydrocodone cough syrup was reasonable and necessary. Yes, it would seem Nguyen had done it all. Except ... he could not authorize the Tussionex script. That would have to be authorized by the one woman hell bent on denying her patient ... Queen Afshari. You see, while it is universal that only one doctor should be a source for all the patient's opiate scripts, it is uniquely Kaiser (or unique to the MCOs) that this responsibility fall to the PCP. Since when does a general practitioner override a specialist? So Cheryl anticipated the futility and gave Nguyen a brief history of her relationship with Afshari. Nguyen offered to reach out to her directly and make a case for the Tussionex. Cheryl had no way of knowing after that if he was successful in reaching her. But the script remained unfulfilled and Afshari never addressed the question with her patient. The last email Cheryl received from Afshari ended with the statement: "sorry this relationship didn't work out" -- leaving Cheryl with the question as to whether she even had a PCP. So at the advice of the patient advocate, Cheryl switched to Osman. Frying pan ... meet fire.  
  
Osman was one of only two local physicians accepting new patients. Cheryl was able to wrangle a same-day appointment with her for the purpose of explaining she had two outstanding issues that needed to be addressed: (1) a Tussionex script that required approval and (2) a referral to Kaiser's only chronic pain specialist who could prescribe medication. Afshari was supposed to have approved this referral over a week ago but she kept sabotaging the process -- first by claiming she made the referral, which the chronic pain specialist's office refuted -- and then by insisting that it's the specialist's job to contact Cheryl. Cheryl replied to this by asking Afshari whether the chronic pain specialist can read minds at a distance. Again, it's downright perverse that the PCP would have so much control over her patients' fates.  
  
Osman was quite the curmudgeon. She claimed to have reviewed Cheryl's chart prior to her appointment. I guess when you don't have any patients, you can do this. Cheryl had made the appointment only three hours earlier. So Osman must have seen the pain medications and God knows what else the wicked witch of the Mid-Atlantic Region put in her progress notes. Because this relationship was poisoned before it began. A morbidly suspicious Osman's very first question was not "so what could I do for you?" or "what are you experiencing?" but "why are you switching PCPs?" Just a few words into Cheryl's response, she interrupted Cheryl to tell her she "couldn't prescribe her pain medication." But it didn't end there. Osman refused to authorize the Tussionex until she spoke with not only the pulmonologist but also with Cheryl's former PCP, Afshari. She briefly left the room only to return claiming to have reached Dr. Nguyen. But Cheryl knew this to be a lie because she learned an hour earlier that Dr. Nguyen was out of the office and out of reach today and tomorrow. Osman then claimed that after reviewing Nguyen's notes in the system that "Dr. Nguyen really does not want you to have this."  In other words, she was accusing by way of innuendo that Cheryl somehow talked Nguyen into doing something he really didn't want to do. Cheryl coughed so hard her bladder leaked, drenching the paper beneath her. She called Osman's attention to it. Osman couldn't care less. At this point Cheryl could not accept that she wasted her time securing a verbal commitment from a pulmonologist for a product she knows could provide her with the relief she's been seeking for weeks of coughing only to be sabotaged by general practitioners sharing a prejudice and a perverted suspicion about their patient's real motive. Osman may not have been prepared for what happened after that. To put it mildly, Cheryl was "disenchanted" with her new PCP. Osman may not have understood this. Osman may have mis-filed it under "drug seeking behavior." But when you take away all a patient's medications and then deny her treatment for her chief complaint, what do you expect?  
  
THE BOTTOM LINE  
  
If you have multiple chronic conditions, Kaiser Permanente may just kill you. Given their prejudices and penchant for serving a regulatory role within the government, Kaiser Permanente is not prepared to manage care for certain populations -- and the only responsible course of action would be to recuse themselves altogether. I would not wish on Kaiser Permanente anyone who has diabetes, psychiatric disorders, or significant pain. I even feel for people who turn to Kaiser with a common cold.

**ABOUT THE EDITOR**

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Matthew’s interest in the so-called “Opioid Crisis” is due in part to having witnessed its effect on many family and friends who live with chronic pain. Matthew is in a unique position to exploit his extensive knowledge of group psychology / collective behavior, scientific research production, and Federal governance for the purpose of exposing an entirely different kind of addiction than the one being sold to the American people.

Matthew Giarmo completed his PhD in Social Personality Psychology from Kansas State University in December, 1997 after defending a dissertation that arguably did more to advance our understanding of an age-old mystery than all the research spanning the 130-year history of academic Psychology. Since childhood Matthew has been driven by an innate curiosity to understand the role of dreams in the personality system. Toward this end he read the complete works of Swiss psychiatrist CG Jung by age 16, maintained a 15 year database of his dreams, and designed original methodologies to empirically explore the relationship between dreaming and waking experience. Unfortunately the academic community never shared his interest, and as more psychology departments permanently slashed their personality divisions during the recession of 1990, Matthew decided to carve his niche in the workforce as a data analyst rather than commit to a futile pursuit of a tenure-track assistant professorship. On fixed term contracts during some of the most unstable periods in the history of our economy, he jumped from one sinking dot.com to another and then one Federal agency to another -- never finding a home with the right organization. He joined DOD/DHA, HHS/ASPR, and DOL/ETA for which he supported Federal missions related to health care and national health security. Ironically his best work was performed independently or speculatively as an entrepreneur, free lancer, or job candidate. During these periods he discovered that the only worthwhile contributions are made outside the trappings of an academic, professional, or Federal community. To his independent status he attributes his (i) ground-breaking health information technology for cancer centers; (ii) innovative operational research strategies to raise patient satisfaction; (iii) analytics strategies to extract actionable insights from clinical research and hospital databases; (iv) innovative practice that integrates psychotherapy into the broader health delivery system, and (v) model for a next-generation university articulated with industry.

Matthew’s interests include the social construction and contamination of science and the impact of the Software Revolution on the workforce, intellectual capital, unemployment, and higher education.

Matthew Giarmo can be contacted at [matthewgiarmo@yahoo.com](mailto:matthewgiarmo@yahoo.com)

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1. Greg House doesn't visit patients, refuses to observe courtesy and congeniality, and assumes everyone, including patients, are lying to him. [↑](#footnote-ref-1)
2. The script made it quite clear House was House (an ass) before his life-altering injury. [↑](#footnote-ref-2)