The Addicts on Main Street

Daniel M. Becker

In Denis Johnson's story "Work," from his *Jesus' Son* collection, two heroin addicts spend the day stripping copper wiring from an abandoned house. They make some money and get ready to spend it.

> We had money. We were grimy and tired. Usually we felt guilty and frightened, because there was something wrong with us, and we didn't know what it was; but today we had the feeling of men who worked.[1]

In his close to infinitely long novel *Infinite Jest,* David Foster Wallace also writes about addicts. At an Alcoholics Anonymous meeting an alcoholic describes the slow loss of meaning in his life:

> "[L]ost my damn job," he says. "I mean to say I still knew where it was and whatnot. I just went in as usual one day and there was some other fellow doing it," ...
> "lost my wife to drinking," he says. "I mean I still knew where she was and whatnot. I just went in one day and there was some other fellow doing it"...[2]

At the University of Virginia's general medicine clinic, where I serve as an attending (supervising physician) most of the patients are underinsured, underemployed, and undereducated. I overhead one of the residents talking about an addict:

> She always looks good. The hair, the makeup, the nails, the dress, the scarf, the shoes. She tells me "look good, feel good; feel good, do good." When she comes to clinic she does look good. She thanks me after every visit. When she "no shows" I expect a call from the police. I expect the worst.

The patient was running late.

I. The Unintended Consequences of Pain and Pain Management

There are more and more opioid addicts because there are more and more opioid prescriptions.[3] Why? In the late 1990s pain became the fifth vital sign when the World Health Organization, the U.S. Agency for Health Care Policy and Research, the Joint Commission for the Accreditation of Health Care Organizations, and

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the American Pain Society called for doctors to treat pain more aggressively.[4] And, with good intentions, that is what physicians did.[5] Those good intentions preceded good research that opioids for chronic pain are safe and effective. Those good intentions coincided with new and aggressively marketed opioid preparations that were both long acting and allegedly addiction-proof.[6] Purdue Pharmaceutical sales of Oxycontin now exceed $35 billion.[7] In 2007, Purdue Pharmaceutical was fined $634.5 million for concealing data that Oxycontin is addictive.[8] That is a big fine, but a drop in the bucket compared to $35 billion in sales — arguably, just the price of doing business.

Consider the price in lives. From 1999 to 2015, more than 183,000 people have died in the U.S. from overdoses related to prescription opioids.[9] More people die from overdosing than from car accidents.[10] Prescription opioid abusers are 40 times more likely to abuse heroin.[11] It makes economic sense. An Oxycontin tablet on the street goes for $40.00 — a similar dose of heroin would cost $10.00.[12] Drug dealers are savvy, addicts are desperate, and the overdose fatality statistics mirror market trends. From 2010 to 2015, fatal overdoses involving prescription opioids fell while fatal overdoses involving heroin increased from 8% of opioid deaths to 24%.[13]

But before the epidemic of overdose deaths — accidental or otherwise — before the epidemic of addiction to prescription medications, before the epidemic of heroin abuse among former prescription drug abusers, before organized medicine decried the undertreatment of pain, before this cascade of good intentions and bad outcomes and misguided policy and weak science, there was pain: physical pain, psychic pain, spiritual pain.

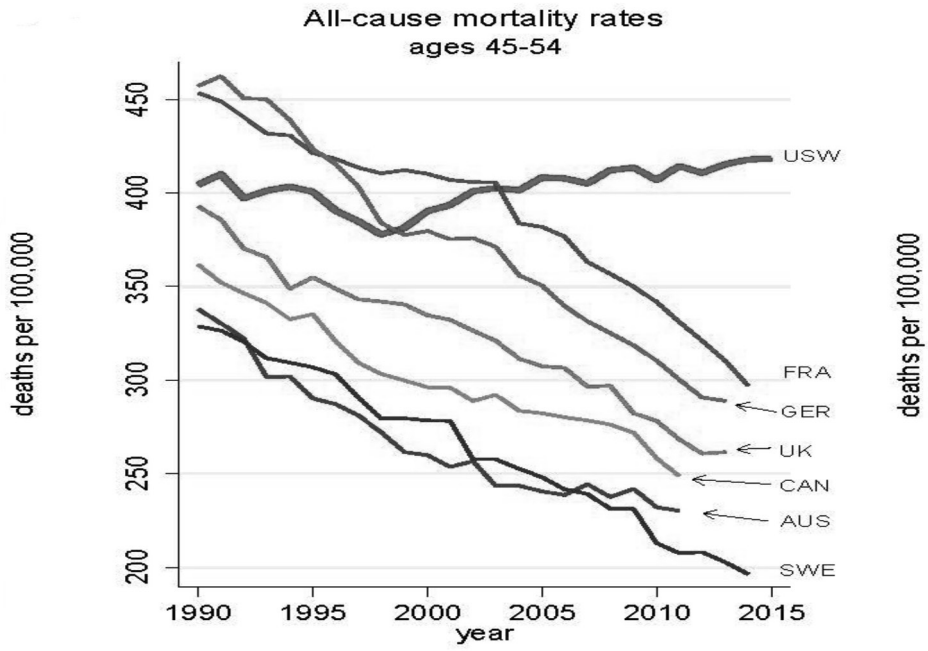
There was also economic pain. As the rich are getting richer, the poor are getting poorer, and jobs with living wages are harder and harder to find. Sometimes, it is hard to know where economic pain ends and physical pain begins. After a factory shift or at the end of a hot day on a construction site or after changing sheets and vacuuming carpets on three hotel floors, aches and pains are part of the job, especially if that kind of work is all you know. The next day you go back to work. If you do not have work to go to, you are left with the aches and pains and not much else.

II. Economics and the Deaths of Despair

Population scientists use a CDC database called Wonder to study "deaths of despair" and to link decreases in life expectancy for the white working class to lack of college education and the slow but steady loss of opportunity for the white working class.[14] The graphs below, compare mortality in U.S. non-Hispanic whites (USW) to mortality rates in other wealthy, industrialized countries.[15]

Figure 1

Mortality in U.S. non-Hispanic whites (USW) to mortality rates in other wealthy, industrialized countries



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Until the beginning of the 21st century, mortality rates for the middle-aged USW population — that is, the white working class — were falling.[16] However, since the turn of the century, mortality rates have increased.[17] This phenomenon is limited to the United States.[18] In other rich and largely white countries, middle-aged whites have better and better chances of living longer.[19] Importantly, education is an important predictor of mortality.[20] Mortality rates increased for the middle-aged USW population with only a high school degree or less, while mortality rates fell for those with college degrees.[21] The increased death rates are due to more and more "deaths of despair" — drug overdose, suicide, alcoholic liver disease — and a relatively slower decline in mortality from heart disease. Fewer Americans die of heart disease, unless they use long acting opioids, like Oxycontin.[22]

What accounts for more deaths of despair in the under-educated white population? The white working class and more generally the blue-collar workers (white or brown or black) are now less likely to be working.[23] The unemployed workers who once formed the backbone of America are often not working because they are in chronic pain. Poorer people are not only more likely to suffer from chronic pain, they are also more likely to suffer from widespread pain.[24] Among "prime age men," ages 25-54, not in the labor force, about half have a disabling and chronic health problem.[25] Forty-eight million Americans have chronic or recurring pain that is disabling and requires prescription medication; two thirds of those prescriptions are for opioids.[26] The epidemic of unemployed workers on opioids is both urban and rural and widely distributed across the country.[27]

The unemployed prime age men or women at our clinic might have chronic low back pain, neck pain, knee pain, or simply hurt all over.[28] They are disabled and on Medicaid or applying for disability and hoping for Medicaid. A few come to us straight from prison, where they did not learn how to get a job, keep a job, or stay well. A few have been disabled most of their working lives. A worksite back injury is career ending for a young man who depends on a strong back. Our unemployed and under-educated prime age or middle-aged patients can no longer work in construction or landscaping or housekeeping or manufacturing. Some are willing and able to work in fast food or at Wal-Mart. Many come from towns on rivers that used to run mills where most of the town worked. The manufacturing jobs in Virginia moved overseas a decade or two before the mortality data began to turn ugly. Office and white-collar jobs need office and computer skills. Not surprisingly, our chronic pain patients are semi-literate and computer illiterate. They are also likely to be depressed.

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To treat chronic somatic pain, we also treat chronic psychic pain. Pain specialists tell us that chronic opioids are not only ineffective for chronic pain but also might make the pain worse. There are better and safer options, both pharmaceutical and behavioral: antidepressants and mood stabilizers and repurposed epilepsy drugs help to down regulate centrally mediated chronic pain; cognitive behavioral therapy addresses unhealthy habits and attitudes; massage therapy

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relieves stress burdened muscles and tendons; acupuncture may improve energy and sense of wellbeing while relieving pain; mindfulness-based stress reduction lets people stop being their own worst enemy; and mind-body exercise disciplines such as tai chi improve function while reducing pain. Health insurance tells us the better and safer combo is not covered. Patients almost all tell us they cannot afford to pay out of pocket for the better and safer options.

III. More Expensive Options are Out of Reach for the Working Poor

Try telling a chronic pain patient that the Percocet might be making the pain worse, that it can perpetuate pain. Try telling a chronic pain patient that all pain, like all subjective experience, is in the head, that brains have a way of maladapting to chronic pain, that pain thermostats get stuck on high. It is never clear to patients why the doctor will not prescribe more opioids, why the doctor is tapering the opioids, why the new doctor will not continue the prescriptions from the previous doctor who is in jail for over-prescribing or the other doctor who moved to a community with fewer addicts on Main Street. A year after beginning the slow taper, when the patient is functioning at the same or maybe a higher level and living with less pain, the taper makes some sense, but so does staying on a little bit of Percocet, just in case.

I also see university faculty and staff in my practice. When their backs hurt, they switch from jogging or the elliptical to the stationary bike. When their knees hurt, they switch to swimming in the indoor pool. When stress builds and they cannot sleep, they take the mindfulness-based stress reduction course and learn how to manage restlessness at 3 AM. When stress at work bleeds into stress in the marriage, they get counseling. When family illness leads to a spiritual crisis, the minister, priest, rabbi, or imam comes to their home. Their kids go to good colleges. Our university health insurance actively encourages stress management and healthy behaviors. By "actively encourages" I mean financial incentives. I mean bribes. Who has the time to fill out health questionnaires or document workouts? For $500.00, most of us will find the time.

Most of our clinic patients do not belong to gyms. Their communities do not have indoor pools. They think I am joking when I mention yoga or tai chi. They think I am joking when I prescribe a dog. Walking the dog helps. Having a friend to walk with helps. Living in a neighborhood safe enough to walk in helps.

There appears to be a cumulative disadvantage for those without a college degree and without the family and community resources and traditions that support higher education. The common wisdom, the middle-class wisdom as expressed on middle-brow websites, sounds easy to apply: graduate, get a job, get married, have kids, and do those four things in that order.[29] Those who do not graduate are less likely to get a job and are less likely to get married, but not less likely to have kids who grow up in single parent homes or in homes with non-parental adult supervision. Not surprisingly, many of the prescription opioid addicts early in the opioid overdose epidemic were young, unemployed, uneducated, and tempted to sell some of their pills on the black market that fueled that epidemic.[30]

Unemployment rates parallel other markers for social dysfunction and isolation: divorce, broken homes with single parents, declines in religious and community affiliations, and jail time.[31] It does not take a population scientist and a CDC database to notice these trends. I have been practicing general medicine in university/public hospital teaching clinics for 37 years. Compared to when I started there are still lots of patients with diabetes, hypertension, heart failure, kidney failure, liver failure, obesity, and degenerative or "wear and tear" joint disease. But there are more patients with chronic pain and more conversations about pain medications. There are more difficult conversations that require hospital security. There are more disillusioned resident physicians turning away from primary care careers and towards subspecialties that do not treat patients with chronic pain. Who wants to take care of patients who may lie about their pain, steal prescriptions, create angry scenes in the office? Patients in pain and in need of more pain medications are often demanding and unpleasant. Addicts get painful cancers. Sickle cell patients, in pain their whole lives and unable to find relief while also trying everything — including heroin — exhaust their doctors and nurses. Who wants to treat the angry and untreatable? Who needs to take care of them?[32]

IV. Conclusion

How do we take care of them? For starters, we listen. That resident's patient did get to clinic that day. That patient was late because she was afraid to leave her house. She had to sneak out through the alley to avoid her dealer, waiting on the sidewalk with a free taste. I have never been afraid to leave my house. It is often difficult for doctors to understand what their patients are going through, but it is important that we start by listening.

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Note

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