In the Course of Professional Practice

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Present methods of treating addiction to narcotics obviously are inadequate. Withdrawal of drugs can be accomplished in a hospital without much difficulty, but patients almost always return to narcotics after discharge. No one knows why. If treatment is to improve substantially, several steps must be taken. First, and of critical importance, physicians must review their own attitudes toward addiction. Drug abuse must be approached professionally as a medical problem rather than a moral issue, since moralizing cures nothing. Disturbances of behavior, however undesirable in social terms, must be treated as phenomena with discoverable causes. The physician’s task is to remove the cause if possible or, if not, to deal objectively with the symptoms.

Related to the present ambiguity of medical attitude is the need for more clearly defined goals of treatment. At present, physicians strive for two distinct goals which, if not inconsistent, are at least difficult to reach simultaneously. Elimination of drugs and rehabilitation are both desirable, but which has priority? If elimination of narcotic drugs is essential, what other addictive medications are allowable, and why are these preferred to narcotics? Are narcotics objectionable because they damage the body of the user, because they impair his social performance, or because they are morally bad?

Moral approach to addiction

The moral approach to the problem, which reflects popular sentiment, was uncompromisingly defined a few years ago in a U.S. Senate committee report: "... We believe the thought of permanently maintaining drug addiction with 'sustaining' doses of narcotic drugs to be utterly repugnant to the moral principles inherent in our laws and the character of our people." Presumably, these legislators would welcome a treatment that converted narcotics users into tranquilizer addicts. Something approaching this is, in fact, now occurring on a large scale. Conscientious police work has diminished the illegal supply of heroin in New York City, as compared with the quantities available a decade ago. If this effort could be coupled with an effective medical treatment, the narcotics problem would diminish rapidly; but with no cure for addiction, drug shortage simply forces the established addict to pay higher prices to the underworld. When the demands of the drug habit become unmanageably large, addicts accept withdrawal treatment and then return to drug usage at a lower dosage level. To potentiate the reduced amount of heroin, many addicts—perhaps now a majority—supplement their intake of narcotics with tranquilizers, barbiturates, amphetamine, and alcohol. This creates a more serious medical problem than addiction to heroin alone.

Unless immorality is a property of the heroin molecule, it is difficult to see any profit in this result. Lives wasted by addicts on reduced doses of heroin are as antisocial as lives wasted with no restriction of intake. Success in treatment of narcotics addiction must be measured by what people do, by their adjustment to the requirements of society, and by their capacity to enjoy the small pleasures of life and meet the larger responsibilities. Treatment must be directed to the patient and not be distorted by a narrow preoccupation with the chemical agents of addiction.

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Definition of narcotics

Another issue needing clarification is the term "narcotic." In its popular sense this word connotes a few well-known drugs (heroin, morphine, and meperidine hydrochloride) that are exten地说 abused and lead to abu-head behavior. On the other hand, to the pharmacist and the Bureau of Narcotics the term "narcotic drug" designates a large number of synthetic agents belonging to several different chemical classes, having in common only the property of relieving symptoms of abstinence after abrupt withdrawal of morphine. Apart from a cross tolerance with morphine, these drugs differ significantly in pharmacologic properties. They vary in addictive tendency, in euphoric effects, in duration of action, in most effective route of administration, in sedative action, in analgesic potency, in histamine-releasing action, in their actions on smooth muscle, in side-effects, and in therapeutic index. With a large number of untested "narcotic" drugs now available and a continuing discovery of new varieties, the statement, frequently made, that maintenance treatment of addiction has been tried and proved a failure seems preposterous.

Experience with morphine treatment

The only basis for discounting any further study of narcotic drugs in the management of addiction is the limited experience with distribution of morphine during the period 1919 to 1923. The dispensing clinics that operated during this period were organized hurriedly, staffed with well-intentioned but largely untrained people, kept no systematic records, attempted to treat large numbers of addicts, and gave out supplies of drug for self-administration. The results of these clinics defy analysis. Whether they failed because of administrative weakness or because morphine is not a suitable drug for the maintenance of addicts or, indeed, whether they really failed as completely as claimed by the critics—cannot be determined from the evidence available. To quote from a report of the Council on Mental Health, American Medical Association: Assessment of operations of the narcotic dis-pensaries between 1919 and 1923 is difficult because of the paucity of published material. Much of the small amount of data that is available is not sufficiently objective to be of great value in formulating any clear-cut opinion of the purpose of the clinics, the way in which they operated, or the results attained. ... On the whole the clinics seemed to have had no purpose other than the dispensing of drugs to addicts in order to prevent exploitation of the patients by drug peddlers and other unscrupulous purveyors of drugs. In some instances the clinics dispensed cocaine as well as opiates. ... It is, however, impossible to evaluate these claims of benefits from the clinics. There was a complete lack of any objective criteria of success or failure. ... Since ambulatory treatment of addiction (attempts to withdraw drugs without institutionalization of patient) was condemned by the A.M.A. in 1921, the policy of the Bureau of Narcotics has been to discourage and prohibit attempts at this form of treatment. ... One fact that seems to have been neglected or forgotten is that the medical profession played a major, and probably a decisive, role in closing the clinics.

On purely pharmacologic grounds, it is reasonable to question the wisdom of further attempts to maintain addicts with morphine. As does heroin, morphine has a relatively short and violent action; it causes profound narcosis, followed in a few hours by sickness and a need for more of the drug, with progressive tolerance that requires increases in the dose. Exclusion of morphine, however, does not rule out a trial of other narcotic drugs.

Because a single agent has failed, it does not follow that all narcotic chemicals are valueless. Such a conclusion is as illogical and defeatist as abandoning chemotherapy of cancer because a particular agent fails to cure leukemia. Yet the Senate Committee Report, if taken literally, does just that. Medical experts advising the legislators should have brought out the distinction between eliminating a particular drug with known defects and discarding a whole class of untested chemicals because of a pharmacologic designation.

Recommendations

Need for research. To avoid misunderstanding on this important issue, let it be emphasized that the plea here is not for unrestricted use of synthetic narcotics but rather for a systematic screening of these agents for possible utility in the treatment of addiction. Research on this topic is
both proper and urgently indicated. Controls on the use of these agents must be retained, not because narcotic chemicals have been discredited by prior work, but, on the contrary, because they are new drugs with as yet undetermined properties.

Programs of clinical testing should be planned with the understanding that narcotic chemicals will not in themselves eliminate the psychologic problems of the addict. Emotional difficulties in most cases precede the taking of drugs; for the immature, sensitive delinquent, addiction provides an escape from tensions and responsibilities. The narcotic acts as tranquilizer; the routine of addict life—hustling, injecting, associating with users, and being identified as an addict—absorbs his energies. Prescribing narcotic drugs without re-education and guidance almost surely will fail to return these patients to normal life.

Use of Drugs in Rehabilitation. Fortunately, chemotherapy and rehabilitation are not alternatives. In the treatment of addiction and other chronic diseases, medicines should be prescribed only as part of a larger program of rehabilitation. A narcotic drug should be considered for use in the treatment of addiction to facilitate the patient’s re-entry into society. It is now possible to stabilize the pharmacologic state of an addict by a long-acting synthetic agent; in proper dosage this removes the desperation of drug-seeking and the constant threat of abstinence symptoms, without producing euphoria or excessive sedation. In theory, although not yet proved by controlled experiments, a stabilized addict should be more open to new interests. This is not a radical approach. It differs from the standard treatment only by inversion of priority; rehabilitation rather than withdrawal of the drug is the first target. In both cases, of course, the ideal is social and pharmacologic cure, but if a choice must be made, rehabilitation should come first. In any event, the consistent failure of efforts to rehabilitate patients after withdrawal of drugs suggests that the addict during this phase of treatment needs pharmacologic support. This, incidentally, should not be described as “gratification” of an addiction, since a long-acting narcotic drug, if given in proper dosage, not only fails to produce euphoria but also markedly limits the euphoric action of heroin. The major problem in the use of such an agent is not addiction to it but persuading the patient to continue with a drug that diminishes the potency of heroin.

Role of Medical Profession. The measures so far considered, that is clarification of treatment goals and clinical testing of synthetic drugs, promise the most immediate results. Because of the urgency of the narcotics problem in large cities, the testing program should be pressed forward with vigor. This, however, is not enough. In anticipation of future developments the medical profession must improve the training of physicians, and medical institutions must stimulate basic research. Again, the first step is to consider the attitude of physicians.

Physicians today can be licensed to practice medicine without ever having seen an addict as a patient. Medical schools give little or no time to problems of drug abuse, and teaching hospitals shun addict patients. When confronted with the complex medical and social problems of a narcotics user, most physicians therefore react defensively. If possible, they avoid treating addicts even for an acute illness. Nevertheless, addicts are sick people and, as such, impose a responsibility on the medical profession. Individual physicians can specialize their work, accepting some conditions for treatment and referring others elsewhere, but the profession as a whole does not have the same right to limit its concern. Its responsibility goes to all sick people, including those whose behavior is pathologic.

The profession, moreover, cannot escape the responsibility by pleading legal impediments. There are tight restrictions on the prescription of narcotic drugs for addict patients, and many physicians object to the intrusion of law into what should be an area of medical decision. However, the legal restrictions do not justify neglect of the problem. Indeed, it seems reasonable to ask whether or not the converse may not be true: that neglect has made the restrictions necessary. With no experience in the treatment of addicts and burdened with prejudice and misconceptions, many physicians would find it difficult to accept a greater freedom in the prescription of narcotic drugs. Perhaps this is a pessimistic
view, but there must be some truth in it since the restrictive rules are, in the final analysis, imposed by the medical profession on itself. Contrary to general belief, the limitations on medical use of narcotics originated in medical committees not governmental agencies. The Federal code governing the use of narcotic drugs provides the following exception: "Nothing contained in this section, section 4735, or section 4774 shall apply ... to the dispensing or distribution of narcotic drugs to a patient by a physician, dentist, or veterinary surgeon, or practitioner registered under section 4722 in the course of professional practice only." The code does not define professional practice, nor should it. Medical treatment changes from year to year. Today, we reject purging and bleeding as treatments for tuberculosis, although these remedies were esteemed not very many years ago. Tomorrow, some of our accepted procedures may appear equally primitive. The concept of "professional practice" can be defined only in terms of the treatments employed by reputable physicians at a given time in history. Courts of law can be asked to evaluate the reputation and scientific authority of physicians giving professional opinion when an issue is in doubt, but medical controversies cannot be resolved scientifically by legal procedure. If they could, physicians should study law rather than medicine.

The medical profession therefore must establish its own standards of professional practice. With respect to treatment of addiction, successive committees of the American Medical Association have provided a definition, which was reaffirmed as recently as June, 1965, in a joint statement with the National Research Council. The latter report stated: "Continued administration of drugs for the maintenance of addiction is not a bona fide attempt at cure, nor is it ethical treatment except in the few unusual circumstances discussed later." The unusual circumstances are when "(a) withdrawal would be dangerous to life, or (b) continued drug administration is necessary for a chronic or terminal painful condition other than drug addiction itself and for which no other mode of treatment is possible." Thus, the medical profession, through its official spokesmen, remains on record as stating that withdrawal of narcotic drugs is the only acceptable treatment for the vast majority of addict patients.

This definition of ethical treatment clearly requires the Federal Bureau of Narcotics and other agencies charged with enforcement of narcotics laws to regard medical maintenance of addicts as unprofessional and therefore unlawful. If future medical research discloses a useful role for some narcotic drug in the therapy of addiction, and if a substantial number of medical authorities recognize this treatment as sound professional practice, the administrative ruling of the Federal Bureau of Narcotics prohibiting maintenance (section 151-392) would need clarification. Since no definitive research on this problem has yet been done, the prohibition of maintenance treatment remains firmly based on medical authority. A matter of great practical importance, emphasizing the need for basic research, is the poorly defined pharmacologic state of the addict after withdrawal. A few weeks after stopping drug usage, patients appear to be restored to normal reactivity; they no longer have an addict's drug tolerance or the physical dependence that requires repeated doses of narcotic drug to prevent abstinence symptoms. As far as can be judged from analyses of urinary excretion, essentially all of the drug has been eliminated from the body at this time, yet these patients are not entirely normal in function. Such patients show an ill-defined withdrawal syndrome which persists and in most cases leads them back to addiction. This phenomenon has been considered psychologic, since medical examination discloses no abnormalities, but the negative evidence is not conclusive. No medical or biochemical test, apart from analysis for the presence of the drug, is diagnostic of drug usage during active addiction or withdrawal; it is hardly to be expected that abnormalities not found in acute abstinence would become evident in the postaddiction state. For a satisfactory definition of this state we need to know more about the biochemical events involved in drug action, tolerance, and withdrawal. It is even possible that repeated exposure to large doses of narcotics, as does heavy dosing of susceptible tissues with hormones or radiation, may cause an irreversible change in some biochemical processes.

930 New York State Journal of Medicine / April 1, 1965
One final point relating to medical education: Physicians, for their own protection, need to learn more about the insidious beginnings of drug abuse. Addiction is an occupational hazard of medical practice, involving perhaps 2 per cent of the whole profession. As are other hazards, it is greatly magnified by ignorance. Almost all addicted physicians begin with the illusion that they can treat themselves with narcotics and control their own intake. This tragic mistake might be prevented in many cases by a better understanding of the hazard. Physicians now are trained to work with pathogenic bacteria and radiation; the era of psychoactive drugs is just beginning, and physicians will have to learn to deal wisely with these dangerous agents.

Summary

Medical treatment of narcotics addiction is unsatisfactory at present. It could be improved by the development of a more professional attitude toward the problem, free from moralizing, directing therapy toward rehabilitation as the primary goal rather than elimination of drug, and initiating systematic testing of narcotic agents as adjuncts in therapy. This can and should be done without delay.

Training of physicians, now inadequate, should be expanded to provide more experience in problems of drug abuse, both for their personal protection and for improvement of their professional skills. More basic research is needed to define the biochemical abnormalities of addicts before and after withdrawal of drugs.

References