

“First do no harm...”- Those words, from the Hippocratic oath, take on special meaning when discussing the topic of drug use and abuse. I speak to you today with almost 20 years of experience practicing medicine, the majority of those treating acute and chronic pain. I agreed to testify because I feel strongly that being on the “front line” of an issue offers a unique perspective to those interested in directing substantive public policy.

These proceedings are being followed by many that have been touched in one way or another by this issue. To those that have lost loved ones, I extend condolences – for you, my profession’s edict to “first do no harm” obviously failed. As painful as it may be, we must learn what we can from each and every failure, to best serve those with need in the future. Simply banning a drug that has demonstrated usefulness is not an option.

To those of you that have had bad experiences with a medication, be generous with all the facts so that my profession can learn how to do better the next time. Again, simply banning a drug that has demonstrated usefulness is not an option.

To the pharmaceutical companies that may have an interest in these proceedings, let me say that I am thankful for investments in research and development that result in “miracle drugs” that help my profession reach those that were previously unreachable. Keep your science pure so we will not lose faith in your work. Continue efforts to provide true continuing education to my colleagues and me, so that we can best serve our patients. Attempts to manipulate data and words for the sole purpose of creating demand and increasing sales will ultimately fail. Do not promote the mindset that there is a “pill for every ill”.

To the patients that suffer chronic pain, know that efforts continue to increase the quality of your lives. We understand now, more than ever before, about the neurophysiology of pain, the pain signal, pain generators and the pain process. This understanding has resulted in many more treatment options than have been previously available. The use of narcotic analgesics is just one tool that we have that may be useful.

In my practice lifetime I have seen the pendulum swing from one end of the spectrum to the other with respect to the use of narcotics to treat non-cancer pain. In the mid 1980’s I had to regularly defend this practice and now I’m having to recommend against it with almost the same regularity. “First do no harm...” Every patient deserves to be evaluated and treated as an individual in a way to be determined by his or her physician. Many things cannot be “cured”. Pain as a symptom is handled differently from pain as the disease state, which often, at best, is “managed”. True pain management is a dynamic process that demands continuous communication between a patient and the doctor. This is the only way the pain state can be evaluated, the only way better treatments can be attempted. The notion that a pain clinic is a place you visit to get drugs, and a pain management doctor is someone you need to convince you need narcotics is one that must be dispelled. Only continuous monitoring and interest in the patient will result in the highest quality care. I have many patients that were on narcotic pain medications for years, that have been able to totally discontinue these drugs without withdrawal, and without a decrease in the quality of their lives. These successes can only come about with the true practice of the science and art of medicine, which unfortunately today is coming under increasing attack from all sides.

To the pharmacists who fill prescriptions, I urge you to adhere to the highest level of your profession’s ethics, and don’t hesitate to question prescriptions that fall out of the norm. The system of checks and balances only works when active 100% of the time.

To my colleagues, you know that you are responsible for knowing the possible consequences, benefits, risks, and complications of any prescription you write. It is not acceptable or defensible to blame a drug company or their representatives if the facts do not add up, especially with respect to the complicated area of narcotics and opiate receptors. There is no substitute for the history and physical exam. The issue of diversion of legitimate prescriptions is an area in which we are not formally trained, but one in which we must always maintain a high level of suspicion when drugs with known street value are prescribed. The judicious use of urine or serum screening to document compliance of a regimen probably needs to be increased. Additionally, understanding the differences in abuse, addiction, tolerance and dependence is required for appropriate communications with patients, caregivers, as well as other colleagues and law enforcement officials.

With respect to public policy, I can only say that there is no way to legislate judgement. This is particularly true to the problem at hand. There are already laws that cover inappropriate obtaining, use, and possession of controlled substances. There are already laws that cover inappropriate practice of medicine and pharmacy. There are already laws that cover what a drug company can do or say. Additional laws in these areas will probably not result in any substantive change in the status quo. Additional funding in specific areas to enforce laws already on the books may help.

The database that has been discussed may have merit but the details about the construction, implementation, and ongoing costs have not been forthcoming. Anything that makes it more difficult for doctors to take care of patients is not acceptable. The availability of controlled substances via the internet is one frontier which probably deserves additional legislation.

Finally, the unfortunate truth is that there always have been, are, and always will be people with the genetic makeup that fosters drug abuse and the black market that feeds it. Any system that man creates will be circumvented by man. So let us be cognizant of the law of unintended consequences when we try to make things "better". Perhaps our greatest hope lies in the continued discoveries of the human genome project, that will let us understand more the complex areas of opiate receptors, and why people react in such varied ways to the same drug. Meanwhile, there is no better cure for the present situation, than a true understanding of existing science, and an ongoing dynamic doctor-patient relationship.

Respectfully submitted,

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