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EDUCATION

Muffled Pain — Athletes, The Opioid Epidemic, and Painkiller Paranoia

TAGS: health insurance, medical education, alcohol consumption, heroin consumption, painkiller medication, Transnational Criminal Organizations, opioid epidemic, Marilia Coutinho, pain



EDITOR'S NOTE: Dr. Marilia Coutinho was born in Brazil, has lived on and off in the USA for many years with family as a student and professor, and has recently become a permanent legal resident under the Exceptional Ability provision. She has spent time in different countries and has been a health policy researcher for many years. She moved to Oklahoma last November, has lived in Florida for two years around the year 2000 and previously lived in Georgia and Virginia. She has served as an expert witness to Medical Boards in Brazil and has been a consultant to the Panamerican Health Organization, a World Health Organization chapter.

DISCLAIMER: This text contains negative judgment about certain aspects of health care and medical behavior in the USA. This is in no way a criticism of the country; most countries don't even have minimal health care for its citizens. It is because I love America and chose it as my home that I believe it is important to point out issues that can evolve into a crisis so that we may come up with solutions.

"Only great pain is the ultimate liberator of the spirit....I doubt that such pain makes us 'better'; but I know that it makes us more profound" (Leiter 2015, quoting Nietzsche)

Introduction

I am having a drink now. I don't like hard liquor, never have. I appreciate the smell of some. But now, I need it as medication, so I add lime juice and Splenda. I know, it's hideous. However, each drink produces analgesia comparable to 10 milligrams of morphine (Woodrow & Eltherington 1988, James et al 1978). Until the first synthetic painkillers started to be manufactured, alcohol and opium were the tools humanity had to deal with pain.

That's okay, then, right? These are traditional painkillers. No, it is not okay. This is happening at the core of the scientifically most developed country in the world, the United States of America, to a highly educated individual with a Ph.D. who has served as an expert to medical boards and to the World Health Organization. And, of course, I have health insurance. If this is happening to me, what is happening to the uneducated, poor, and uninsured individual who, like me, suffered an accident that caused extreme pain?

In this article, I will dissect the painkiller epidemic, the role of the decreasing quality of medical education, the government over-regulation of prescriptions, and the black market. With this, I hope to demonstrate we are looking at a disaster waiting to happen. A real, nearly uncontrollable health care crisis dominated by the most dangerous addictions (both to heroin and to alcohol) and orchestrated by the Transnational Criminal Organizations (TCO).

RECENT: All Together Now — Meet the Disciplines and Our Hosts

My purpose with this article is to use my involuntary position as a character in the story to explore the meaning of the opioid epidemic and its wider implications, and highlight issues that might help devise positive interventions.

I need to write this now, in pain and untreated. I need to write this while my mind is sharpened with suffering. I need to write this now, where my methodological tools can be best employed to analyze and interpret this situation from the inside and the outside and to make the gruesome prediction.

Finally, I need to write this now to show that athletes are at a special risk in this disaster in the making.

I am gazing into the abyss, once again. And when you gaze enough into the abyss, the abyss will gaze back into you. This abyss is called pain and health care. My eyes are wide open as we gaze into each other.

Some Context: The Eye Opener

As most seasoned and older athletes, I've experienced a lot of pain in my life. From sprains and major muscle, tendon, and ligament tears and surgeries, to rare conditions such as spondylodiscitis (a serious spinal infection).

As most athletes, my pain threshold is very high and my pain tolerance as well. For this reason, when I was being treated by the doctors that followed me for years and were friends, anytime I reported pain they were strict in bringing me to the clinic or hospital immediately. I don't like hospitals. In fact, I am afraid of hospitals because most of the time they mean I will have to engage in hostile argument under extreme pain. The truth is that most physicians are poorly trained. I'm well trained and pain is not really the best encouragement for patience. Because of this, I could have died from spondylodiscitis. Even when the low fever started to manifest and every day I spent a few hours screaming into a pillow, shivering, I didn't go to the hospital until I could no longer move and was passing out with pain. I was immediately hospitalized and 30 hours later the bacterial cyst broke open in sepsis. I don't remember much after that, only people coming in and out, handling me, five different teams of physicians, including the best pain management team in the continent.

Lesson 1: Opioids are not tiny demons packed in a pill. They are still the most effective tools to manage pain. They are addictive and each person reacts in a different manner. Management is always possible.

I was “out” for about 48 hours but hospitalized for more than 10 days. They allowed me to go home for Christmas.

I kicked the oxycodone (oxycontin) I was sent home with in 45 days, a far shorter period than was expected by the pain management group. They were amazed and happy. I was not even surprised: “Look guys, propensity for addiction is genetic, as you know. I am just lucky and I have the right genes.”

Lesson 2: Pain must be managed as soon as possible. It is not “just” a symptom. It is a complex biological phenomenon and failing to control it negatively influences the course of the injury or disease.

But that was in Brazil, where I was the hot shot medical expert, serving on medical boards and consulting for the World Health Organization. I provided information support to the best physicians and was deeply respected.

Then I moved to the USA.

That is a new reality. I don’t serve as expert witness in any medical board here. I can’t call the New York Times or the Washington Post if there is some scandalous act of malpractice. So, how do we get treatment here?

“You need to have a good relationship with your general practitioner” is what my friends said.

Lesson 3: Trust is important. Hold that thought.

I’m new in Oklahoma City and I don’t even have a general practitioner. I’m a healthy athlete. Unless there’s an accident, I really don’t need much medical attention.

And then an accident did happen.

I have some neurological “weirdness”, never positively diagnosed because it doesn’t manifest as an illness. I do have sleep problems I handle with some medication. We also know that I can manifest symptoms of what look like a dysrhythmic disorder (like epilepsy), but never an obvious convulsion. Rather visual distortions, photophobia, hyperacusis, dizziness, loss of balance, nausea and the sensation of “pressure” in the skull and eyes. It could be an atypical migraine, said one doctor. It could be epilepsy, said two neurologists. But not enough to justify long term pharmacological treatment; the symptoms only manifest under certain environmental stress situations, which are rare. Which ones, we don’t know. Stroboscopic or club-like lights are triggers. Loud noise is a trigger. I gave up going to shows of my favorite bands at fifteen, when I went to the first one and had seizure-like symptoms. But, like everybody, I don’t even remember I have a condition that doesn’t bother me the whole time. After all, it’s so rare, it only happens in rock concerts or night clubs, right? Wrong.

It was a Saturday and I was working. Someone turned the volume of the music up. I tried not to say anything. It would be a very annoying day, that’s all, right? Wrong. Big mistake. When I realized, I was already dizzy, nauseous, and felt like my skull was trying to squeeze my eyeballs out.

Lesson 4: Shit happens. Accidents are, by definition, a result of chance. But very frequently we can track them down to a bad decision. "This is not that bad" is not the best approach to health risks.

My boyfriend took me home and I wasn't walking on a straight line.

Excellent reasons to go to the emergency room, right? Or not. I knew I would have to wait many hours under bright bluish light to be seen by someone tired and probably undertrained who would, at best, prescribe me an anti-convulsant and CNS depressant.

At about 1:30 AM, when it was all dark, I got up to go to the bathroom and, not walking on a straight line, stumbled and fell over a bunch of odd objects on the floor: a computer, a monitor, a few boxes. A stabbing pain on my left shoulder paralyzed me. I was confused. It was dark and it took a while for my boyfriend to realize what was going on, turn on the light, and try to interpret the scene. He helped me up and I realized I couldn't raise my left arm. Something was wrong. The pain evolved into a different sort of stab and more areas were hurting. The pain was increasing.

The pain was now almost unbearable, but my fear of the hostile, bright and loud ER environment was worse. My boyfriend didn't even insist, knowing that in the Midwest states hospitals rarely provide pain medication in emergency care.

I screamed my pain into the pillows and at 6:30 AM, eventually the Valium and ethanol made me sleep out of exhaustion for three hours.

The following day, my kinesiologist saw me in his studio located inside the gym. He observed there was damage to some things in the rotator cuff and to the biceps tendon. I felt better but needed to leave as soon as possible. Too loud for me.

Without a referral, I chose a doctor based on Google parameters. This guy "looked" okay. He presented himself as a sports specialized orthopedist and his reviews were good. I got a consult for Thursday. Until then, I curled up, consumed NSAIDs plus alcohol, in the dosage calculated for minimal analgesia. I iced the area and used TENS. Except for the TENS, everything felt pretty medieval.

Thursday, I went to the office. They took x-rays and the doctor finally saw me. He looked at the x-rays and said (not asked), "You had previous surgeries on your shoulder." I replied, "No. Not even one. Not even a fracture. Would you like me to explain to you why you are confused with this image?" This was not looking good. A 69-year-old sports orthopedist who was unable to identify sports-specific bone adaptations to, well, sport.

He examined me and confirmed what the kinesiologist diagnosed Sunday. He did so by pressing the biceps tendon and it hurt.

He told me he would take a conservative approach (sounded good: no surgery) and give me a prescription dose of naproxen (sounded stupid) and a mild painkiller. I tried to list all the painkillers I had taken and which ones worked best. He refused all opioids and chose tramadol. I told him it hadn't been effective before but at this point all I wanted was to leave.

Lesson 5: Medical education is part of the equation in any health care crisis. Poor background leads to insecurity and insecurity leads to defensiveness, mistrust, and a stereotyped response.

When I got home the pain continued to increase. The night was horrible. The next day I asked my boyfriend to talk to the doctor and get a prescription for a real painkiller. He refused and scheduled a consultation for me for Tuesday. That makes sense: leave a patient in extreme pain suffering for four days and get a new consultation, so that he can

bill the insurance company again. I reported him to the State Board of Osteopathic Examiners. I also forwarded the report to the insurance company. I'm not naïve; I know this will result in nothing, but at least I did what I thought was right.

Lesson 6: Defensiveness and mistrust lead to a lack of empathy. Lack of empathy, on both sides, leads to conflict. Conflict fuels any crisis.

The Opioid Epidemic

Besides pure incompetence, what other reason would the doctor have to not prescribe me oxycodone, which actually works for this pain? And we should also ask: why would Midwestern emergency care units refuse pain treatment to patients under pain? The answer is the opioid epidemic or, rather, "the opioid paranoia."

Is there a true opioid epidemic? Sure there is. And these are the reasons:

1. Pain is a complex biological phenomenon. It is barely understood, new aspects of its manifestation are still being studied, and it involves many more physiological phenomena than previously believed (Recognition and Alleviation of Pain in Laboratory Animals 2009).
 2. Medical education and training are increasingly worse and unprepared doctors staff hospitals and clinics. The combination of a seriously complex and controversial health issue and poor medical education and training are part of the recipe for disaster.
 3. Epidemiological indicators show an increase in non-prescription consumption of prescription painkillers and a parallel rise in heroin and alcohol consumption (Sung et al 2005, WHO 2014, Kolodny 2015). The equation is obvious here: about 15 years ago, there was a rise in prescription of opioid painkillers to shorten hospitalization periods and other health costs. The unsupervised patients, still in pain, left to their own resources, not always recovered well. Also, opioids cause dependence and the patients were not followed through the process of managing the drugs and ceasing its use.
 4. A crowd of people in pain (and addiction) was left untreated and the war began: the government adopted stricter and stricter regulations as to opioid prescription. Doctors were warned that patients should be watched for "drug seeking behavior." Complaints began to not be taken seriously, resulting in tragedies (Kumar 2007). The war turned into greater and greater hostility and distrust between doctors and patients.
 5. Panic in the population. With no other resources, still in pain, unassisted, thousands of people fall into the hands of drug dealers for the painkillers the medical system is denying them. But that is expensive and soon these patients turn to heroin and alcohol (Unick et al 2013).
 6. Scammers still scam and social security numbers show an increase in disability claims, many of which are pain related.
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Lesson 7: Big time social crises rarely have ONE cause. Therefore, they can't have ONE solution. It is important to have a deep, interdisciplinary understanding of any crisis if we want to overcome it. Factors need to be identified and prioritized.

What happens to us, athletes, who inevitably will have our encounters with pain along our careers? Exactly the same thing. And since some of our injuries are serious and insurance companies want to keep their costs down, athletes are kicked out of hospitals with a prescription for "some" painkiller medication and then you are on your own. And data suggests that it goes to heroin (Wertheim 2015, Bieler 2016).

The widely recognized war on illicit drugs is now upgraded to a war on prescription drugs. That falls into the quote mistakenly attributed to Einstein according to which, "Insanity is doing the same thing over and over again expecting different results." Einstein didn't say

that and insanity is a bit more complicated than repetition. But let's agree that adopting again an expensive public policy that failed before (Rolles and McClure 2009), and failed dramatically, is idiotic to say the least.

I question "idiotic" policies. As a social scientist, I always look for hidden agendas. My question is if patients and doctors are losing in this war, who is winning?

The answer is the same as the one given to the question of who wins the war on illicit drugs: the Transnational Criminal Organizations (TCO). The drug dealer who sells you an oxy pill for some absurd price? He works for a gang, who actually is nothing but a TCO little branch. Some developing countries are in part controlled by TCOs. Private Security Contractors working for the government are frequently influenced by TCOs. Actually, there are scholars who question if the nation-state is not at risk with the increasing power of the TCOs (Shelley, 1995 — read more information on this connection here).

Blame the government if you want, or blame the insurance companies. Or blame medical education. Or blame addicts. But beyond all of that, there is something winning this war.

Lesson 8: The drug dealer or the bottle wouldn't have gained the patient if, back there, trust hadn't been lost. Patients and doctors don't trust each other, don't trust the government, and don't trust insurance companies. When there is no trust, it is easy to control everybody.

More and more, I gaze into the abyss and it gazes right back at me. Sometimes it feels I plunged into it. And this is what I learned from the abyss: the painkiller epidemic is just the tip of the iceberg of a much bigger health care crisis. It is written with blood on the walls and it is made of poor medical education, excessive and unreasonable government regulation, panic and paranoia concerning opioid over-prescription, lack of understanding about the mechanisms of pain, and the overpowering interests of the TCOs.

I'm looking at my phone, hesitant as to whether to schedule a consultation at the pain clinic or not. Will that mean another war, with another clinic, under pain? I am tired. I might as well have another drink. I might as well hit the wall until some other pain takes over and this nagging thing stops torturing me.

But still, I ask: how many more times will we all have to look into the abyss of medical incompetence with respect to pain and human suffering until we, as a society, finally lose parts of ourselves that we will never again recover?

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