The Practice of Medicine and Ongoing Issues with Opioid Addiction

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Austin Egbert:

Greetings, and welcome to Mind Matters News. We have a more sobering set of topics for this month's Bingecast, namely around the practice of medicine and ongoing issues with opioid addiction. This episode is divided into three parts. First, we talk with anesthesiologist, Dr. Richard Hurley, about opioid addiction from a medical perspective. We then interview an anonymous guest about their own experience with opioids. This section of today's episode contains detailed description of surgery and opioid addiction that some listeners may find disturbing. Listener discretion is advised. Finally, we return to our conversation with Dr. Hurley to discuss how computer algorithms have both improved and stifled the proper practice of medicine. Now here's your host, Robert J. Marks

Robert J. Marks:

Greetings. Welcome to Mind Matters News. I'm your affectionate host, Robert J. Marks. Today we're going to discuss opioid addiction. Opioids include Oxycontin, Percodan and fentanyl. All are highly addictive and all have been responsible for numerous deaths. They also have useful medical applications. So opioids like fentanyl are not themselves good or bad. It's like most everything, it's how it's used. Before we speak to our guests, here's a little bit of background about the brain chemistry of addiction from the perspective of neuroscience.

In the 1960s, neurosurgeon Benjamin Libet noticed there was a signal in the brain that occurred before you knew you were going to do something. In other words, if you had a sudden impulse to call your mom, there would be a signal in your brain prior to your impulse to call your mother that would say, "Call your mother." And then it would tell you that you were supposed to call your mother. On the surface, it looks like you don't have free will. Your brain generates signals about what you were to do before you knew you wanted to do it. But Libet noticed that humans do have the ability to say no to these impulses. We don't have to do what the brain signals tell us to do. Libet called this free won't. Not free will, but free won't, saying no to these impulses that came from the brain. There is some controversy about Libet's experiment, but one thing is certain: anyone who is recovering from an addiction practices free won't.

I remember when I was quitting smoking, my wife Monica kept telling me we were not going to have any kids as long as I smoked and I wanted to have kids. So as I was quitting smoking, my brain kept telling me, "Smoke a cigarette. Go ahead, Bob. You really want a cigarette." And I had to exercise a lot of free won't in quitting my addiction to tobacco. After a bunch of attempts, I finally quit. And when you quit an addiction, your brain rewires itself away from the addiction. But that path is always there, ready to be rebuilt. Recovering alcoholics are told they must not even take a sip of booze if they want to stay on the wagon. And ex-smokers reinforce their commitment with the mantra, which I was taught, "I am a puff away from a pack a day," so I wasn't even to touch a cigarette. I am a puff away from a pack a day. Now, opioids are highly addictive. Oxycontin is an opioid, Percodan is an opioid. Fentanyl off the street is an opioid that is killing people, but also has some useful medical uses.

To talk about addictions, we're really privileged to have as our guest today, Richard Hurley. Dr. Hurley is a medical doctor who is board certified in anesthesiology and pain medicine. Dr. Hurley, welcome.

Richard Hurley:

Thank you very much, Robert.

Robert J. Marks:

Let me start off a little bit off topic. You are board certified. We hear this term a lot. What does it mean to be board certified? Who's the board? What is their authority in certifying you? And what hoops do you have to jump through to be board certified?

Richard Hurley:

Well, there are several boards that you do, but I chose anesthesia because my initial training was in anesthesia. So I'm boarded in anesthesia and pain medicine through the American Board of Anesthesiology.

Robert J. Marks:

This is a national board, is that right?

Richard Hurley:

That's correct. And it's been available for more than 75 years.

Robert J. Marks:

Oh, I see. Is this put together by the AMA or a government agency?

Richard Hurley:

It is put together, but it's not put together by the AMA.

Robert J. Marks:

Okay. So it sounds like a federal sort of thing.

Richard Hurley:

That's correct.

Robert J. Marks:

You were sharing with me that you have to stay up on things and that you have to take, what is it, a test every few months?

Richard Hurley:

That's correct. It's called Maintenance of Certification, and it's called MOCA. Many of the subspecialties in anesthesia are required to participate in this on an annual basis. By the way, you're privileged to spend $210 a year for the excitement of taking this exam every three months. It's done online and you get instant feedback. And I actually initially was against it, but I'm not now. It's one way to study. It's another thing to keep up. It's also another way to realize that maybe you ought to be reading current articles in certain areas that you're not familiar with. And so there are also quality things that you have to do. You have to go to CME and take things on safety and also on quality improvement.

Robert J. Marks:

My goodness, if I was taking it on... I shouldn't say if I. If somebody who was dishonest was taking an online test, I would open two computers and I would have my second computer ready to Google a question to get the answer.

Richard Hurley:

Well, could you do that in 60 seconds? Because that's all the time you have.

Robert J. Marks:

Oh, is that what they do? They give you 60 seconds to do it?

Richard Hurley:

You get a question, you have four answers, and you must answer that within 60 seconds. And if you don't, you get cut off and you get a zero.

Robert J. Marks:

Oh my goodness. Okay.

Richard Hurley:

Yeah, it's happened to me several times.

Robert J. Marks:

Oh, you've been cut off with the 60 seconds?

Richard Hurley:

Yeah, but you just get cut off of that one question, not for the whole exam.

Robert J. Marks:

I see. Okay. Well, that's interesting. So I know now what board certified means, and you have to pass these tests every few months in order to stay board VI certified, right?

Richard Hurley:

That's correct.

Robert J. Marks:

Okay. Wow. That makes me feel better about going to board certified physicians. I know that they've been tested to make sure that they're up to date. Okay. Let's get back to the topic that we wanted to talk about and that is opioids. And I know you use opioids in your practice. Why are opioids so addictive?

Richard Hurley:

There are very few drugs that can actually give you a sense of euphoria or pleasure, but the compound in the molecular structure of the opioids stimulates certain areas of the brain. Now, the receptor that really does this is the Mu receptor. There are other receptors that are also involved, but the Mu receptor... and those receptors are throughout the brain.

Robert J. Marks:

Okay. Could we back up a second? what is a receptor in the brain? What does that mean?

Richard Hurley:

Okay, so these are little tiny receptors, almost like a key and a lock. And the molecule itself gets in there, it stimulates this little receptor, and there are little G proteins that are then stimulated and they'll go on to stimulate the receptor, then the nerve. And then those nerves actually go, if it's in the brain, they'll stimulate the lateral hypothalamus, the tegmental area in the mid-brain, and then it'll go to stimulate the areas of the Aucubin, which are actually basal ganglia. And all of these parts of the brain are heavily modified by dopamine. And dopamine seems to be the pleasure one. There's also a release of endorphins, which are endogenous morphine like compounds in the brain. And the two of them together in high amounts will produce euphoria. And then what's really interesting, this pleasure sensation that you get is then transmitted to the prefrontal cortex, which makes you remember it all, hence the reason why that memory is never erased. And that's why one puff is one pack. I remember Mark Twain said quitting smoking was the easiest thing he'd ever done, he did it a thousand times.

Robert J. Marks:

Yeah, that's me. Yep. I did it a thousand times too. Yep. So I have talked to some people, in fact a very, very close friend who was addicted to fentanyl. And it started with medical procedures and I guess the fentanyl comes in little lollipops and stuff like that. And he confided in me that he never took the opioids to get that high, that he just took the opioids so he could feel normal. So this feeling of euphoria comes maybe the first few times when you take this and then all of a sudden your body craves it, and just to feel normal, he had to take his fentanyl.

Richard Hurley:

That is very true. And we see that also in prescription drugs where I just don't feel normal unless I take it. But in prescription medications, especially short acting, what they do is they go through a sense of withdrawal every four to six hours as the drug wears off.

Robert J. Marks:

Oh gosh. Okay. Yeah. I also am familiar with the Johnny Depp trial, and he says that he went through a detox sort of situation and it was the most miserable thing he'd ever experienced in his life. My friend has done this also and he's had kidney stones, which really hurt. He says, "Yeah, it was worse than kidney stones," going through the detoxing and getting that addiction out of his body. We hear about the street drug fentanyl, which is an opioid killing so many people. What's happening here?

Richard Hurley:

It's interesting. It's a synthetic. The molecular formula of fentanyl is very similar to heroin. It's a unique analgesic, and that is it's extremely powerful. Given IV, it is a hundred times stronger than morphine and 50 times stronger than heroin. The problem with the drug is you get an intense high, no question about it, euphoric state. That euphoria though, like you mentioned, as you continue to use it, is not the same. But the therapeutic window of this drug is critical. In other words, if I give you an overdose of heroin or morphine, we've got about an hour to give you naloxone or Narcan to reverse that, it's an antidote, and then all of a sudden you'll start breathing again. With fentanyl, if you don't get to the patient with IV fentanyl, within minutes they'll be dead.

Robert J. Marks:

Oh my goodness. I was reading about the street fentanyl that's available in the authority for all facts, People Magazine. This was from the April 18th, 2022 edition. They had a paper in there. They had The Faces of Fentanyl, and they have like a hundred pictures of different people that have been killed through fentanyl. And I guess it's a big problem in the US. They said drug overdose deaths were up by nearly 30% last year. And in Milwaukee County, they say there has been a 234% increase in drug related deaths in the past 10 years. And it's cheap to make and up to, like you mentioned, was a hundred times stronger than morphine. The DEA has absconded 9.6 million of these pills in 2021. And 73% of the drug related deaths in the United States, 73% are due to fentanyl. And that is astonishing. And then they say, I think it's two milligrams is the amount of fentanyl that can kill an adult.

Richard Hurley:

200 micrograms or two tenths of a milligram is enough to kill anybody.

Robert J. Marks:

Wow.

Richard Hurley:

That's a very small amount. Now, you'll understand, when I was first using fentanyl was when I was an anesthesiologist.

Robert J. Marks:

Yeah, you used fentanyl in your practice, right?

Richard Hurley:

If you could see how much fentanyl I would give a patient who had open heart surgery, it would scare you to death. But as long as I take over their pulmonary aspects, in other words, as long as I intubate the patient, put them on a ventilator, keep their carbon dioxide levels 40 or less, I used to give six to 12 ampules, and each ampule has 250 micrograms. An ampule, it's a little glass ampule, and we would pop it and then we would aspirate that out into a syringe and inject it IV. And prior to thoracotomy, I would've given a patient six ampules. Now, if you were on the table and I was giving you two CCs or a hundred micrograms, you'd quit breathing within 45 to 60 seconds. So that's not a problem with me because I'm going to breathe for you. You know what I mean?

Robert J. Marks:

Oh, you have instrumentation there that takes over their breathing.

Richard Hurley:

Right. In other words, I'll put an intratracheal tube in there, I'll hook you up to a ventilator. I'll set the ventilator dose based on your tidal volumes and how often you breathe. I'll make sure your oxygen levels and CO2 levels are normal. And then we do the operation and you have no pain at all. In other words, they crack your chest and your heart rate and blood pressure doesn't change a bit.

Robert J. Marks:

Wow. Okay.

Richard Hurley:

So it's a very powerful drug, but certainly its utilization in anesthesia is just fantastic.

Robert J. Marks:

Now the obvious question, if you use the fentanyl in the anesthesia, do the patients have any withdrawal after they come out of their operation?

Richard Hurley:

That's a great question. And the reason I say that is because the drug has a half life of 30 minutes to an hour. That's all. It's gone. It is so rapidly metabolized and excreted primarily through the urine so that you'll have to actually give them postoperatively some pain medicine, either fentanyl, whatever. And the fentanyl can be given either in a bolus or you can set it up in a pump, and it'll deliver so many micrograms per hour.

Robert J. Marks:

I see. So even the people that take this drug recreationally only have a short period of being high. Is that right?

Richard Hurley:

That's right. IV, half life's about 30 to 60 minutes. Intramuscularly might last a little bit longer, but not much more than that, that's about it.

Robert J. Marks:

Isn't that interesting? I watched, there was a series called Dopesick. I believe it was on the Hulu channel streaming, and it's still available if people want to watch it. It was a Hulu special production. Michael Keaton started as a physician that got hooked on Oxycontin. And it went through the addiction that spread through Appalachian Southern Ohio a decade or so ago. And the Oxycontin, it comes in pills, fentanyl comes in lollipops. Has there been any pushback from the medical community about the prescription of these drugs? Can any physician write a prescription for Oxycontin or fentanyl?

Richard Hurley:

Okay, so if you write a prescription for Oxycontin, you may be familiar with the CDC guidelines for opioid prescription writing.

Robert J. Marks:

No, I'm not. What are they?

Richard Hurley:

Okay, so in 2016, the CDC came out with 12 guidelines for primary care physicians and what they should write. And let me just go through those real quickly so you'll understand what happened. Any physician can write a prescription for fentanyl, but by the way, that's usually done in a patch. Now, most of the orals, the buckles and the sublinguals and the sublingual sprays are predominantly for cancer pain, breakthrough cancer pain. But anybody can write that as long as they have a license to practice, like in Texas, and also have a license through the DEA.

Robert J. Marks:

But are those for people who are terminally ill and you're just trying to make them comfortable until death comes?

Richard Hurley:

The only patients that I use, the suckers, the sublinguals are for patients primarily who have head and neck cancer and they're not opioid naive at all. And the only way you could control their pain, for me, in this particular patient was the orals. Now, most patients who get fentanyl, like when we prescribe it, it's called a fentanyl patch, or the trade name was Duragesic. And they come in a patch that looks like a Band-aid, and the Band-aid is designed to deliver the drug through the skin into the circulation and then into the central nervous system. And they're labeled at 12 and a half micrograms per hour, 25 micrograms per hour, 50, 75, and so on. And that drug is so lipophilic, it penetrates the skin, fat, it gets into the circulation quickly, but it does take 11 hours to penetrate to get through. But once it's through, it's fine. And these patches, you change them every three days.

Robert J. Marks:

I see. So they're kind of slow release in a way.

Richard Hurley:

Right. That's correct. But people who abuse it will then take the patch and scrape it off and take the drug. If you look at it, if you scrape it off, it looks like a little gel and they'll put that under their tongue, the whole amount, a three day supply under there. And one of the things about this was, we used to see this, that drug was used a lot by nursing homes because the nurses would only have to give their pain medicines every three days. They didn't have to run in every two hours. And then they would take those patches off, they'd throw them into the dumpster and people would dive the dumpster to get those.

Robert J. Marks:

Oh, geez.

Richard Hurley:

Yeah. And by the way, the name of them was, they were called Chiclets.

Robert J. Marks:

Chiclets.

Richard Hurley:

Chiclets. Yeah, that's a Chiclet. And that's been on a sweaty arm for three days and now you're going to put it in your mouth. Oh my gosh.

Robert J. Marks:

You must really be hard up if you're going to put a sweaty thing in your mouth.

Richard Hurley:

You really are.

Robert J. Marks:

Oh gosh.

Richard Hurley:

Yeah. So the 12 guidelines, let me do this real quick. Opioids are not the first line anymore. You've got to try over the counters, you've got to try exercise, you've got to try interventional cognitive behavioral therapies. If you do decide to do them, you have to establish realistic goals for pain and for function, you have to discuss the risk and benefits. You must start out with short-acting pain medicines, not long-acting like Oxycontin. You got to use the lowest effective dose and they really want it under 15 morphine milliequivalents, and I can explain that later on, and certainly not to exceed 90. If you're going to treat acute pain, you can only treat it for three to 10 days. 10 days now in Texas. You can evaluate the benefits and harms frequently. So initially when I put them on there, you need to see them every one to two to four weeks, then you got to do mitigating strategies, you got to give them naloxone if they're going to get more than 50 morphine equivalents. You can't them take benzos, benzodiazepines at the same time and they can't drink alcohol.

Then you got to review the prescription drug information, and that's put out by the state now. And so I can look and I can pull up the patient's name and see if somebody else is prescribing them other medications. I have to do urine drug testing to see if they have illegal medications or alcohol in their urine. You avoid the use of opioids with benzos and with alcohol.

Robert J. Marks:

What are benzos?

Richard Hurley:

Benzos, or benzodiazepines would be like Valium, Ativan, lorazepam, ambien. And then you've got to have a way to offer medication assisted treatment either using suboxone or possibly methadone or cognitive behavioral therapy. So all of these things came out in 2016. And the opioid problems in the Appalachian, in 2000, their death rate was the same as the general population. It was amazing. They didn't have a big issue with it. But by 2017, the overdose death rate in the Appalachian was 72% higher than the general population. And one of the things they figured out was, interestingly enough, the prescription writing was 45% higher than the general population.

Robert J. Marks:

Wow.

Richard Hurley:

Yeah. So there was a lot of abuse going on. And some of that was due to marketing of Oxycontin and those kinds of things.

Robert J. Marks:

Yeah, that's what the Dopesick series was talking about, was the company kept on coming out with pills with higher and higher dosage. And they kept saying that if you had this slow release of the opioid over time, it wasn't addictive, which turned out to just be company hype. It didn't work. My friend who was addicted to opioid, I think probably this happened before all of these restrictions came in. In other words, he was given fentanyl whenever he said, "Ooh, I feel uncomfortable," and it was just an

overdose. He became addicted totally from prescriptions. And he wanted to and he was tempted to go to the street, but decided not to and suffered the consequences of doing that.

I also read today as a warning, this is People Magazine, and this is from the DEA, the Drug Enforcement Agency, it says, "Many fake pills made with fentanyl look like prescription drugs. And as many as," and this is what blew my mind, "two in five counterfeit pills may contain a fatal dose of fentanyl." Two in five according to this source. And I tell you, that's really scary. And I understand on the street, they also begin to do things like cut cocaine with some fentanyl. And so even though you don't buy this fentanyl and you buy some sort of other drugs, there's a good chance that it's cut with fentanyl in order to give it a bigger hit. So this is really serious. But it sounds like from the medical side that things are pretty well tuned right now and they seem to be working pretty well. Have the statistics gone down after the imposition of these criteria?

Richard Hurley:

Before the guidelines came out, prescription opioid writing was actually going down. Now, it has dropped precipitously since 2016, but have the overdose deaths gone up? The answer to that is yes, over a hundred thousand last year and 72% of those are fentanyl based. So what has happened is that those guidelines, if the CDC came out with a guideline for you at Baylor University, how long would you think it would take before that became the standard of care? And so not only did it become the standard of care among physicians, it also led to legislation about the states that they started to adopt, they made those recommendations into law. So the biggest problem we had then is that if I had a patient that needed more than 50 milligrams of morphine a day and I told them now I can't order it because of the recommendation of the CDC guidelines, where do you think they went? Straight to the street.

Robert J. Marks:

Did they?

Richard Hurley:

Yeah.

Robert J. Marks:

Have you had incidents of that where you...

Richard Hurley:

Absolutely. Well, yeah, incidents and you read them in the obituary.

Robert J. Marks:

Oh gosh, that's terrible.

Richard Hurley:

What has actually happened is that when we started cutting them back and they couldn't get the medication and fentanyl was so easy to get, that was it. And really something, if your thoughts of addiction and substance abuse disorder are so strong, I can't believe this, but actually the addict will actually go try to get the drug that killed the most people. Now that thinking is just-

Robert J. Marks:

What?

Richard Hurley:

Yeah. In other words, "I like what I've got, but if that dose killed that person, I bet you if I took just a little bit less than that, that would be the best high I'd ever have."

Robert J. Marks:

Oh my gosh.

Richard Hurley:

Isn't that something?

Robert J. Marks:

Oh my gosh. I tell you, addiction and the wiring of the brain to these dopamine hits is really dangerous. was going to ask if you had any advice for the addicted. You mentioned exercise, which I think is interesting. What happens when you exercise? How does that help you?

Richard Hurley:

Physical therapy is... What I always tell my patients, if you actually do something function-wise, walk a block, walk a flight of stairs, walk a mile, achieving a physical goal is actually pain relieving. And you may have noticed that yourself. I couldn't do 10 pushups and now I can do 11. In other words, if you set physical goals to patients and they actually do them, it actually is pain relieving. If you set a goal like, "I'm going to lose 10 pounds in the next three months," setting goals and actually accomplish them actually creates, again, the same kind of pleasure sensation. Now, granted it's not as powerful as the opioids, but those things are definitely helpful.

Robert J. Marks:

That's interesting. I have a friend, in fact, I'll even mention his name, he's Winston Ewert , he was one of my students who started to pack on some pounds. And I saw him a year later and he was skinny. And I said, "What happened?" He says, "I found out that if I charted my weight every day and the weight went down, I have this sense of pleasure." I don't know if he got a dopamine hit or whatever. But I think that nerds like Winston and me are really interested in graphs and things like that. So he put down a little point and he said, "That made me feel so good. I wanted to feel that good the next day." So that was another example of what happened. You also mentioned cognitive therapy.

Richard Hurley:

Right. Cognitive behavioral therapy.

Robert J. Marks:

Okay. Does this include groups like AA and that are similar to AA?

Richard Hurley:

Certainly. You could certainly say that's a part of the group. But basically what they try to do is they try to change your thought processes in terms of a situation. So you may have a situation, but is that situation causing your emotional change or is it the interpretation of that? So they help you to deal with your thought processes as you deal with whatever it is that the issue is, whether it's addiction or whatever. It changes the thoughts and feelings. I have patients that come into my office and I ask them, "Well, tell me about your pain." And they'll say, "Well, my back pain, I feel like somebody is cutting me in two with a knife." Obviously they may have had back surgery, but they weren't cut in two. If they were awake, how would they know that? In other words, many patients make it dramatic or catastrophize their pain beyond... "Doctor, you don't understand what I'm going through." And yet, 65% of all patients who were over 65 have at least three to four weeks of crippling back pain every year.

Robert J. Marks:

Wait, say that again. What percent?

Richard Hurley:

65% of all Americans after the age of 65 will have at least three weeks of significant lower back pain.

Robert J. Marks:

A year.

Richard Hurley:

A year. Every year. Yeah.

Robert J. Marks:

Wow. Interesting. Okay.

Richard Hurley:

Those numbers are well done. So what they try to do is to help them to, if a situation occurs and that's actually you think this is what's causing it, we're going to interpret that differently, we're going to develop constructive techniques. And one of the things that they do is get you to write it down like this guy did so that you can modify your dysfunctional thinking and you can modify these automatic thoughts like Libet was getting into that you mentioned at the beginning of the talk.

Robert J. Marks:

The free won't, yes. Yeah. I remember I used to be afraid of needles. I would hate to go in and give blood because I was just afraid of needles. My son is really afraid of needles and I've talked a lot to these... What do they call them, phlebotomist? Is that the person that takes the blood? I've talked to them and I ask who is most afraid of the needles going into the arm? And two of about the five phlebotomists that I've talked to said it's these big, burly guys with tattoos trying to announce to the world they're big tough guys, which I thought was a very interesting observation. Anyway, I used to be afraid of needles and then one day, and I think this touches on what you were talking about, one day I decided, look, it doesn't hurt that much. I'm more afraid of the needles than I am the pain. So I started to actually look at my arm when the needle went in and it wasn't that bad. It was just this change in perspective that took away that fear. And I think that's what you're talking about with this cognitive intervention that you're talking about.

Richard Hurley:

And I explained this to my patients in this way. If I came into the room, didn't introduce myself to you, and I slapped you in your face, your response might be one of horror and you might leave, or you might slap me back.

Robert J. Marks:

Yes.

Richard Hurley:

But if I came into the room with a suitcase and I opened it up and it was full of $100 bills and I said, "This is yours, tax free," and then I slapped you, your response would be totally different. You might say, "Why'd you do that?" But you wouldn't walk out, and you probably at the end of the visit you'd say, "Thank you for the million dollars." So it's the state of mind in which this happens that creates the emotional response like you had. You didn't have the emotional response to the needle, you set your thought processes that way. I don't have any problem with needles. My problem is flying on an airplane.

Robert J. Marks:

Oh, really?

Richard Hurley:

Oh yeah. And all of the problem it starts from the time I start packing in the morning, to the time I get to the terminal, to the time I check in, to the time I go through my bags, to take the shoes off. By the time I get there, I'm a basket case. And the way I get through it is watch an action movie on my phone.

Robert J. Marks:

Is that right? Okay. Emo Philips, he tells a joke about him being despondent and kind of depressed, and he went to a therapist to get cheered up and the therapist charged him $100 per hour. And then he realized that if he was walking down the street and he found $100 bill, that, that would really cheer him up. So he decided not to go to his therapist anymore than saving that $100 was going to be good enough for him. Dr. Hurley, any last thoughts?

Richard Hurley:

Well, I think we've covered a lot of different topics on that, but the opioid issues are still there. And I think for what I tell my patients is, you have to make up your mind what you're going to do at the very end. And the problem with opioid addiction is, it starts at such an early age. When we're young and we're young teenagers and stuff, we really don't have those firm graphs of the problems and we want to experiment and the peer pressure, as you know, is just terrible.

Robert J. Marks:

We think we're immortal when we're young.

Richard Hurley:

Right. And parents are nervous about talking to their young children about sex, and they're just for some reason they're nervous about talking about drugs. And teenagers they've got to just say no like Nancy Reagan said, they got to have that just imprinted in their brain from day one. Otherwise, it's a sad

situation. And it's bringing our death rates down. We used to live to be 82-years-old. It's dropping every year because of opioid deaths.

Robert J. Marks:

Really? And that's the prime reason that the death age is lower?

Richard Hurley:

Yeah. If you're supposed to live and to be 82 and you overdose at age 15, what do you think that does today?

Robert J. Marks:

Oh, that really screws up the average.

Richard Hurley:

Absolutely. It's massive changes, yeah.

Robert J. Marks:

On this People's magazine said that almost all of the opioid deaths from fentanyl were from young kids. I'm looking at the pictures here, 25, 35, 20, 32, age 19, 20. So these are all kids that think they're immortal and just want to experience part of life and like you said, is probably due a lot to peer pressure too.

Richard Hurley:

Yeah, absolutely.

Robert J. Marks:

In a previous podcast we chatted with Dr. Richard Hurley about opioid addiction. Addiction is documented by the science of neuropsychology. Donald Hebb, who passed in 1985 is considered the father of neuropsychology because of the way he first effectively merged the psychological world and the world of neuroscience. He is known for Hebb's Law. We study this in artificial intelligence and it's part of brain chemistry. Hebb's Law says that, well summarized in a very short statement. It's that neurons that fire together, wire together.

In terms of addiction, this roughly means that as you repeatedly perform an action that gives you pleasure and by pleasure, we can also include the idea of relief. So it gives you pleasure of relief. Anyway, an action that gives you pleasure, as this happens, the neurons between the action and the pleasure in your brain simultaneously fire. So the path between the neurons dedicated to the action and the neurons dedicated to the pleasure, they build up in strength so the path becomes stronger and stronger.

Triggers eventually push you towards performing the action to experience the pleasure. I think I mentioned in the previous podcast with Dr. Hurley that I used to smoke. I am old enough to remember when smoking was allowed on airplanes, like commercial airplanes. There were smoking and non-smoking sections. It was actually a big joke because after the plane took off, the whole cabin filled with smoke. But after the plane took off, it's okay to smoke. And there was this audible ding when the non-smoking light was turned off and all the smokers lit up. Both the smoking and non-smoking sections of the cabin were filled with tobacco smoke.

Today's smoking on commercial aircraft seems intolerable. So the good news is, I quit smoking and my neuropath between what the audible ding and having a cigarette began to lessen, but it never went away. Today when the fastened seatbelt lights goes off in an airplane, there's also a ding. It was like a ding when the no smoking light went off. And when this happens, I get an immediate urge to have a cigarette, even today, the urge is slight and the urge is mostly curious, I think. That's interesting. So it isn't a compelling urge, but I quickly and easily dismiss it and just go on about things. But this reminds me the little dinging that the neuropath talked about in Hebb's Law. It's still there. It's diminished, but it's still there.

The neuropsychological science of addiction is more complicated than this, but Hebb's law is one high level way to look at it. Now, opioids, of course, are more addictive than tobacco. Our guest today was addicted to opioids, specifically the highly potent synthetic opioid fentanyl. And we're not going to disclose his identity, but we'll simply called him, Stretch. Is that okay?

Stretch:

That's fine, yeah.

Robert J. Marks:

Okay. Well Stretch, welcome.

Stretch:

Thank you. Thanks for having me, Mr. Marks.

Robert J. Marks:

You're very welcome. Well, first of all, let's get legality out of the way. You never purchased fentanyl off the street. I think all of the drugs that you became addicted to were prescribed by physicians. Is this right?

Stretch:

Yeah.

Robert J. Marks:

And I do know that you suffered from a series of failed surgeries, so let's talk about these and could you kind of go through the surgeries and the pain that was associated with each one of the surgeries and then the corresponding opioid prescriptions you were given?

Stretch:

Sure. That's a long story. Essentially, I got diagnosed with inflammatory bowel disease. This was 1999, and it was after a long period of bleeding, basically bloody diarrhea, continuously and urgent. But it was always lots of blood. And before I ended up at the gastroenterologist, just for a note, my general practitioner kept diagnosing me with hemorrhoids for all this blood. In all reality, the failings of the medical community started with the late diagnosis of this disease I was having symptoms of for a long time before my general practitioner walked through the insurance approved steps to get me a proper diagnosis. And initially, the inflammation was seen with the barium enema, which is a horrible experience. You don't want to be behind or in front of a doctor who is standing behind a sheet of plexiglass to assess you. That's never a good situation.

Robert J. Marks:

Wait, you stood behind a... There was a plexiglass-

Stretch:

Yes, because I had received a barium enema for the imaging, and when he came in, he wanted to protect himself in case the barium let loose.

Robert J. Marks:

Oh, was there radio activity on the barium? Is that the guy-

Stretch:

Well, no, but yes. There was. But he was more concerned with the splashing onto him of the stuff that might come flying out of my bottom.

Robert J. Marks:

Oh my gosh. Okay.

Stretch:

So he stood behind a Roman shield that he carried with him, it was plexiglass that he could see through.

Robert J. Marks:

Did he carry it around a shield?

Stretch:

I swear to goodness, yes. He came out of the all office with the computers and grabbed the shield and walked up to me and...

Robert J. Marks:

Oh, that's terrible. That's a terrible experience. Okay, go ahead.

Stretch:

Okay. So anyhow, I finally saw a gastroenterologist. He did an endoscopy. Yes, there was evidence of ulcerative colitis, which is the swelling of only, well, it's the ulceration of only the rectum and large bowel. If you've heard of Crohn's disease, Crohn's disease is basically the same inflammatory bowel disease, but it affects the whole digestive tract where ulcerative colitis is strictly colon and rectum. So I went on medication, well that was difficult trying to hold an enema of medication when you go to bed every night.

So I was glad that my disease went into remission, which at the time I just thought, have never had having a life-threatening disease or a long-term disease. I didn't understand the significance of the medication and getting in on the remission at the time. So after the medication worked, I stopped taking the medication thinking, oh, goodie, that's over with. Well, it came back with the vengeance and the medication never worked again after that period.

So I ended up in the hospital, local hospital for a week. They couldn't bring the inflammation under control with prednisone. That was the place I received my first injection of opiates. First experience with

opiates ever was in that hospital about fourth day I was in there and after the nurse was, she was, let's say she instigated the shot. I think she understood I was pretty miserable and offered me one where nobody else had and of course I was kind of like, "I guess," and she's, "Okay, I'm going to get you one."

So she comes back with a shot and gives it to me and I just remember it seemed like forever later, just sitting on the edge of the bed in the same exact spot that I was after I set up after she gave me the injection. So it really just totally zoned me out. And it really was-

Robert J. Marks:

So zoned you out.

Stretch:

It zoned me out but it was an escape from the reality of the situation at the time, even though I didn't understand it as such, I just zoned out. So it kind of gave me a mental and a physical respite that I probably didn't even recognize that I was getting at the time. But it wasn't a sense of, I want that again, or, oh, I need to have that. I just noticed it was like, man, there was something strange happening with the passing of time over this period. I realized I was loopy. But the notion that all this time had passed and I couldn't recall being miserable or whatever during that period was interesting. So I ended up going to the Cleveland Clinic. My gastroenterologist that I had basically said, "You're going to the Cleveland Clinic.

Robert J. Marks:

Now the Cleveland Clinic has an incredible reputation.

Stretch:

Yes. At the time, they were one of the best, probably next to Mayo Clinic, the next best place to go in the country for bowel surgery, colorectal surgery. And there was a gentleman there started a program called Dr. Fazio, who had been there for years from Australia and had really developed a fine program there that they were proud of and that drew a lot of support. So off I went, transferred at night in an ambulette which... Don't pick the ambulette.

Robert J. Marks:

What's an ambulette?

Stretch:

The ambulette is a wheelchair delivery van that's made to deliver wheelchairs, not people.

Robert J. Marks:

I see.

Stretch:

So they put you in a wheelchair, in the wheelchair van, and you're surrounded by 50 wheelchairs, banging and clanking and banging and clanking for however long it takes to get you to the next hospital. So you've been in this nice calm environment. Next thing you know, you're in a 55 gallon drum with people banging on it with sticks for an hour. So it's really a traumatic experience. Don't do the ambulette unless you absolutely have to. Have a family member transfer you to the other hospital if you can.

Robert J. Marks:

Okay. So you went to the Cleveland Clinic and you had an operation?

Stretch:

I ended up, yes, having an emergency colectomy, and it was taken out of my hands. Surgeon said, "You got to do this, or it could rupture and you might die." This was their protocol. If it got so bad, that it looked like it could be at risk of the inflammation and the ulceration actually breaking through the boundary of the bowel into the abdominal cavity.

Robert J. Marks:

Oh geez. Okay.

Stretch:

And then that's the risk factor that can set off, I guess problems with septisin, other things that can be deadly. So that was their line that they didn't want my bowel to cross that line. So they chose to cut me wide open and take out the whole large intestine and no, I take that back. They left my rectum. And sew me back up with an end ileostomy, the end of my small bowel protruded through my abdomen, and they sewed it and used a regular ostomy appliance.

Robert J. Marks:

That sounds terrible.

Stretch:

That was the first surgery of a series of three that was intended to get me a functional ileal pouch, I've heard it referred to. And essentially it's a reservoir that they fashion out of your small intestine that serves as your rectum as a place for your stool storage.

Robert J. Marks:

Okay. Now when you did this, again, that was clearly a lot of pain.

Stretch:

Yeah.

Robert J. Marks:

And there were probably more F opioids, combined?

Stretch:

Yes. And interestingly, at the time, of course I had pain medicines for the surgery and after. My pain was bad, but it wasn't like excruciating. They gave me opiates until it was time to go home. They gave me a modest amount of opiates. I believe they actually had tapered me off the opiates before they let me leave the hospital.

Robert J. Marks:

You know Dr. Hurley, I was talking to him, he said that during surgery, he pumps enough fentanyl into a patient to kill them because if he didn't take over for the breathing, that they would just stop breathing. But they're in the operating room so the breathing apparatus takes over. So you went through an experience like that I suppose?

Stretch:

Yeah. Man, wake up in the recovery room and the nurse would assess your pain if I recall, a muffle groggy and they would minister more if you needed it, kind of assess based on your feedback.

Robert J. Marks:

Did they give you one of these little push buttons?

Stretch:

Eventually, from the recovery room by the time you got back into your hospital room I believe I had, even in that surgery, because that was in 2000. And some of the stuff, there has been differences, but I do believe I had a pump with a button. So that's your solution which is self initiated which is, you learn that it's self initiated but it won't give you any more medication than a doctor has told it, it can give you.

Robert J. Marks:

So there's a maximum that you can give yourself.

Stretch:

Yeah.

Robert J. Marks:

Okay.

Stretch:

Yeah. But the important thing there was, is when I checked out, they were very adamant to me about not using opiates unless I absolutely has to, Percocet at the time. Common, just everyday Percocet. Don't use this, if you don't need to. Just very direct. And I didn't feel like I needed to. And I heeded the warning. So I used ibuprofen, work fine.

Robert J. Marks:

Okay. Not an opiate.

Stretch:

For the most part, I used ibuprofen. After I was home, there were a couple nights where I chose to take some of the opiates and I hated the way it make me feel, bothered me. I couldn't sleep and things were irritating and it's just like, oh, I don't like the way this stuff makes me feel so I was deterrent from taking it.

Robert J. Marks:

Well I've heard it. It's really constipating too.

Stretch:

Well, that's an issue that eventually turns out to be a blessing and a curse for people that have had bowel surgeries, because where a normal person ends up constipated and has extremely difficult time, you know, overcoming that after having been on a lot of opiates, a person who has chronic loose bowels, the slowing of your digestive system is a very beneficial thing.

Robert J. Marks:

That's interesting because it solidifies.

Stretch:

It gives time to draw out some water, which you need. You need your fluids and you need nutrition from your food. And typically what's going on is it's just flying through your system. And for whatever reason, the calming effects of opiates is a calming effect on your bowels. And it's different from Imodium type bowel slowers, in that, the Imodium type bowel slowers they will cause cramping. They will make it extremely difficult to actually use the bathroom to evacuate your bowels if you need to. And it doesn't do anything for the pain.

So it prolongs the pain that you're in while you're trying to evacuate your bowels because it's slowed things down. It's made things rock hard and it's just not conducive to helping you. So the opiates do the opposite. The opiates help you out with all that stuff. It's calm, you don't typically get rocks formed in your system and when you need to evacuate, you can do so without a huge amount of pain and it works better. Of course, you're using opiates and there are bowel slowers that are opiates that are prescribed as bowel slowers.

Robert J. Marks:

Wow, for that-

Stretch:

For bowel slowing.

Robert J. Marks:

... for that specific purpose.

Stretch:

Yes. But for the same reason they're addictive.

Robert J. Marks:

So you had the surgery, you went home, you took some opioids.

Stretch:

Yes. Didn't like it and got through my recovery without them for the most part.

Robert J. Marks:

Okay. So would you say you were in any way addicted? Did you have any...

Stretch:

Interestingly, I didn't know it at the time, but after been on them in the hospital and come home, I was really having a hard time sleeping. I was fidgety and my arms would ache and it's like, "What is going on?"

Robert J. Marks:

Really?

Stretch:

After I ended up dependent and addicted, I understood what was happening at that time and I actually ended up calling. I was so disturbed I called one of the doctors at the Cleveland Clinic like, "What's going on?" From the withdrawal effects that I didn't understand that I was experiencing. I was experiencing them as just like a panic psychological kind of-

Robert J. Marks:

Really? So you did-

Stretch:

... like a psychological problem.

Robert J. Marks:

You did have withdrawal symptoms, but you really didn't identify them.

Stretch:

Yeah. I didn't even know that's what it was.

Robert J. Marks:

Okay. Let's go to the next stage. That surgery didn't work some way.

Stretch:

Well, like I said, this was part of one surgery of three that occurred. So July 2000, I had a colectomy. December of the same year I had another surgery where they opened me completely up again, went in and created what they call a J-pouch, the ileal pouch out of the small intestine and fashioned it to my rectal stump, planning to use my anus to evacuate this pouch.

Robert J. Marks:

Wow.

Stretch:

So it was a big surgery, and after that surgery-

Robert J. Marks:

So the previous surgery failed in some way?

Stretch:

Well, the failure is happening. See, when you're calling you're saying the previous surgery, the first surgery that failed is really a three surgery process.

Robert J. Marks:

Oh, I see. Okay.

Stretch:

So this is a second part of that surgery where it was very difficult. It was potentially not a long enough recovery between my first surgery and my second surgery. So it really wiped me out and I was sore and I felt like I'd been beat up really bad after that surgery. So I started using the opiates more just because I was a wreck basically. I think the surgery was very invasive.

Robert J. Marks:

And the doctors were happy to prescribe you the opiates for the pain.

Stretch:

Yes. Well, the modest amount of opiates.

Robert J. Marks:

Modest?

Stretch:

This is kind of like, I think I had 20 Percocet or something. And like I said, I was struggling and I used those and then I didn't have anymore and it took me a while to come around after that sort of weeks before I was... Just to give you an idea. After I got home from the hospital, it was two weeks before I could walk up a flight of stairs to get to the shower. I'd go sit down at the table and somebody would have to scoot me up to the table to eat. That's the kind of condition I was in.

Robert J. Marks:

Whoa. Okay.

Stretch:

So the second surgery was worse than that. And my perception was I didn't have enough pain medication. But I got through it. And then the third surgery...

Robert J. Marks:

Well, before that, did you consider yourself in any way addicted after the second surgery?

Stretch:

No. I considered myself under medicated.

Robert J. Marks:

Under medicated?

Stretch:

Yes. Because of the intensity of the recovery from that second surgery. So after the third surgery, which was not nearly as invasive as the first two. But at the time I didn't understand what the recovery was going to be like and actually it was very frightening because I was going to start using my anus and my bowels like I hadn't done for a year at that point. Well that was, April of 2001. So it was quite a year.

Robert J. Marks:

It was a new style of life for you.

Stretch:

Yeah. But the recovery as far as pain wasn't that, I say that, but a whole different problem arose. But as far as recovery from the abdominal surgery, I expected it to be worse. I asked for more pain medication, which they gave me based on my experience the second time around. But then I didn't end up needing them. That's the point I'm trying to make. I had a most of a bottle pain medication left over after the recovery of that surgery.

Robert J. Marks:

Okay. But I do know that eventually from your stories that you did get addicted.

Stretch:

Yeah. That J-pouch.

Robert J. Marks:

What happens with the addiction?

Stretch:

The J-pouch never worked properly and it leaked into my abdominal cavity. I'll just say, my J-pouch leaked stool, diarrhea into my abdominal cavity for seven years. I carried an abdominal infection and the pouch itself was always ulcerated and red and infected. And the gastroenterologist I had at Cleveland Clinic was a dedicated man trying to come up with solutions for these post pouch surgery problems. And they called it a pouchitis, which is basically just an affection and a pouch that they didn't understand.

So the point I'm trying to make is we diddled around trying to fix the pouch longer than we should have. It should have been excised long before it was. We didn't do that. They didn't do the imagery that would've been necessary to see the abdominal infection because they were looking in my pouch, not in my abdominal cavity. And over this period of time, starting with the third surgery directly after third surgery, I would have frequent, excruciatingly painful bowel movements. I mean, I consider myself a pretty tough guy. I would come out of the bowel movements, shaking, eye watering, my knees quivering, that's the type of pain it was that I would need to recover from.

Robert J. Marks:

And this wasn't from the constipation, this was regular...

Stretch:

This was pain. It was like trying to evacuate razor blades.

Robert J. Marks:

Oh geez.

Stretch:

Kind of thing. And it really did feel like somebody was jamming a knife up my rear end every time. But I would've to do this, I mean 14 times a day, 12, 14 times a day. And this went on for months and years, in different varying-

Robert J. Marks:

Years?

Stretch:

... amounts. Yes. Because I would get it under control a little bit and it would go wacky. I wore out, I became resistant to one antibiotic, Flagyl. I had another antibiotic, Cipro that I was using heavily, that if I became antibiotic resistant to that medication, there was only one more antibiotic that was available for me. And had I became resistant to that, then I would've been at severe risk of all the infections, the hospital infections, the C. diff and the whatever else.

Anyhow, the point is, we did great lengths to try to get that J-pouch working and I stuck it out the best I could and I used pain medication to do it. I was able to bridge off of the pain medication that I had, leftover from the third surgery start taking it, realized that it was going to enable me to live a better life, and that's when I basically chose I'm going to do this. I'm going to use these meds because I need to.

What I should have done was said, "Okay, let's cut this pouch out and do something different." But didn't have the wisdom to do that at the time. So I started medicating it with pain medication and my gastroenterologist chose... After I decided to utilize the medication, he didn't want to be involved in prescribing the medication long term, which I understand. They were starting to get a lot of heat from the FDA, which was of course induced by the evil pharmaceutical companies. But they came down on the doctors. So the doctors chose to direct all their patients for chronic pain to actual chronic pain med doctors at the Cleveland Clinic. So there was a pain management department.

Robert J. Marks:

Yeah. My understanding from Dr. Hurley I think it was 2018, that there was guidelines put up for the prescription of things like fentanyl and OxyContin.

Stretch:

Yeah.

Robert J. Marks:

... things like fentanyl and OxyContin.

Stretch:

Yeah. I don't know exactly what they were, but I know they really tightened up the ship as far as people's access to the medications.

Robert J. Marks:

Now, I think you mentioned to me that one of the ways that you took the medication was through lollipops. Is that right? Fentanyl?

Stretch:

Yeah. Yes. You may have heard the whole story about the company that developed those. I was prescribed those fentanyl lollipops after having been on large amounts of tablet prescription medication. And I had started taking OxyContin, which is Oxycodone in some continuous release form.

Robert J. Marks:

Right. Right.

Stretch:

Well, the continuous release mechanism doesn't work very well for a person that doesn't have a complete bowel system because it doesn't stay in your system long enough for all the medication to release from the pill. And the other thing that happens is the pill-

Robert J. Marks:

Oh, that's right. The OxyContin is slow release.

Stretch:

Yeah. So, you spit it out halfway through because you don't have any more bowel.

Robert J. Marks:

Oh, because it goes through your system. I see.

Stretch:

Yeah. Okay. And for some reason this is very, very, very difficult for doctors to understand. I don't understand why... I don't understand if they insist that they don't want to go there because they don't want to have to adjust their thinking. But people do not absorb medication in the same way. But they prescribe medication as though everybody receives the dosages into their body the same way. Doesn't happen.

Robert J. Marks:

Okay.

Stretch:

So they assume you are observing all the medication. There's no way for you to say, no I'm not. Well I found out a way. These pills would swell up, so I would have to force them through my anus to evacuate them.

Robert J. Marks:

Oh gosh.

Stretch:

And they would plop into the toilet and I fished one out, I dried it, I cut it in half, I took pictures and I took it to the doctor.

Robert J. Marks:

Oh, that's so terrible.

Stretch:

This is what you have to do with the educated men. You have to fish stuff out of the toilet to make illustrations for these people that think that they know what they're doing.

Robert J. Marks:

We think about this as gross in a way of talking about it. But when you're experiencing pain, you go through all sort sorts of situation.

Stretch:

You have to. And it's amazing how resilient humans are. It's amazing how adaptable we are. And I've experienced that, too. It's like you just find a new normal, but when you're under the stress of constant pain, your body knows that you need to make a change and it will basically force you to find some type of solution because your body won't tolerate the pain. It's basically a motivator, personal motivator, physical pain. You just can't ignore it.

Robert J. Marks:

So when did you know you were addicted?

Stretch:

Well, after I started taking it to just maintain, try to maintain some... And I was working and overtime and I was trying to travel. I mean this was crazy, but I knew based on the feeling when I didn't have it, that I was starting to become dependent on it because I would start to feel agitated and I knew that this was because I didn't have the medication in my system. Of course, there would be more pain, but on top of the pain there would be this just kind of mental, just aggravation, unhappiness.

Robert J. Marks:

When you get addicted to opioids such as fentanyl, you have to take it not to get that euphoria again, but to feel normal.

Stretch:

Yeah, absolutely. The withdrawal becomes the motivator. The withdrawal is what you are mostly concerned about. And that is not being sick because after you become dependent, the withdrawal is more disturbing and painful and agitating, whatever, that it's then the pain that you were trying to overcome with the medication ever was. And you may end up with the pain that you were trying to overcome with the medication on top of horrible withdrawal symptoms.

And then maybe on top of that you've got actual disease that's making you sick. So you've basically compounded your problem dramatically when you take on an addiction. If you've already got a physical health problem because you've created another one for yourself that's as bad or worse than the one that you had, from your point of view, from your wellbeing, quality of life point of view.

I believe the addiction was the hardest and most urgent thing I needed to take care of in the context of all that sickness. Of course, as urgent as it was, it took me a long, long time and two stints and rehab and then years with a Suboxone product, which is a synthetic opiate that's not supposed to be psychoactive. That basically eliminates your cravings for the actual opiates. It tricks your body into thinking you're on opiates without the withdrawal associated with not being on them, somehow.

And it is basically how I experienced it was like an easier letdown. The Suboxone was yes, addictive in its own right some way, but coming off of Suboxone was stepping down with less pain and discomfort than it would've been having tried to just come straight, or had it been previously coming off of opiates without the Suboxone.

Robert J. Marks:

You mentioned you went to something like, I don't know if it was called narcotic synonymous or something like that, but does support group. You've shared with me some of the incredible people that you met there.

Stretch:

Yeah, Alcoholic Anonymous Bond, Narcotics Anonymous, other addiction, Gambling Anonymous, and it's all about applying the principles of Alcoholics Anonymous to the other addictions. So it's the same thing, basically it's just the matter of the different people that are in the group. Alcoholic Anonymous is tailored towards alcoholics.

Robert J. Marks:

Sure.

Stretch:

Narcotics Anonymous is tailored towards people-

Robert J. Marks:

Do you remember any of the people that you met in these groups?

Stretch:

Oh, I met so many people. So many different people. And I've been in treatment from with anesthesiologists and dentists.

Robert J. Marks:

You had anesthesiologists in the group recovering from-

Stretch:

Yes. Dentists, nurses, chiropractors, business, wealthy businessmen, executives down to people that had been on death row. I'm serious. The whole-

Robert J. Marks:

Seriously?

Stretch:

-Gamut of humanity.

Robert J. Marks:

So you have an anesthesiologist with a death row inmate all at the-

Stretch:

Well not at the same time, but via the same system. Alcoholics Anonymous bring... Into those rooms came all these different types of people.

Robert J. Marks:

And this was probably a mix of people that got addicted both through prescription and through street drugs.

Stretch:

Oh absolutely. And yeah, it... Doctors self prescribing to manage either an injury that they think they can fix themselves or managing their anxiety and problems with their family, with medication nurses that have easy access to it and know how to game the emergency rooms and get a bunch of medication out of the system. That type of thing. No nurses' boyfriends who come in with the nurses who are addicted because they've had access to the drugs through their girlfriend who's a nurse. Anything, any... It's almost ama... And when I say that through these rooms, I, not specifically through the rooms of Alcoholics Anonymous, but also in the hospitals in the detox hospital. I'm reflecting on the whole gamut of people I've seen in both of these environments.

Robert J. Marks:

So I want to talk about your detox in a minute, but you did go through detox and it was kind of self imposed detox, right?

Stretch:

Oh, I tried many, many times.

Robert J. Marks:

Many times.

Stretch:

I tried cold turkey so many times and I would be so sick for a week or two just trying. Miserable, barely able to get out of bed, trying to do it myself. And I would dedicate all that time in misery for, however long it was. And I couldn't do it. I couldn't do it. The sickness would not go away. It would not go away.

So at some point you become desperate and you become suicidal. How do I get rid of this? I am miserable. I don't want to live like this. I can't live like this. The only solution a person sees is more of the drug. And really that's the problem. The only solution is more of the drug. That breeds the desperation that people go through to get it. They become very desperate to get money, resources to get the drug because they feel like they're going to die without it.

Robert J. Marks:

My goodness. But you did finally kick it?

Stretch:

I did. I kicked it by going to two different rehab programs, one in Columbus and I kicked it, but it was premature. I kicked it and I still needed it, from a medical standpoint. So I ended up eventually months later starting it again.

Robert J. Marks:

Well see, that's what I was going to ask you. If you go through detox and you still have the pain, I don't know, is it better to live with the addiction or live with the pain? It's a rough choice.

Stretch:

Yeah. You can't do the pain, it'll just destroy you. And actually there was another solution we tried, and this was through the pain management clinic at the Cleveland Clinic. The doctor was a doctor who had been involved in the early days of the neurostimulator development. So he'd been doing that for a long, long time. And he thought he could place a lead along my spine that would electrically scramble the pain signals coming from that area.

Robert J. Marks:

Oh my goodness. You had an operation on your spine?

Stretch:

I had two or three trials with that system that were temporary where the wires came out of my back.

Robert J. Marks:

Oh my goodness. That's terrible.

Stretch:

And it was amazing how it worked.

Robert J. Marks:

It worked?

Stretch:

It really was. It would work, but the problem was it had to be located just right along your spine. And I would have the trial and be in the car and by the time I would get home bouncing in the car, it would've shifted enough where it had stopped becoming effective.

Robert J. Marks:

Geez.

Stretch:

And it may start working somewhere else that you didn't want the electric stuff going.

Robert J. Marks:

And what happens when it works somewhere else? Do you go numb?

Stretch:

Well, you don't like the feeling of electricity boiling through your lower member. It's not comfortable. You could... And actually that happened during one of the surgeries. He was trying to place it and they're sending a charge through, and it electrifies my genital area essentially. And I start hollering out in the operating room, that's what's happening. And he and the other people that were in there are laughing out loud at me. But I mean, it is kind of a shocking experience.

Robert J. Marks:

Well, you want a doctor with a good sense of humor, I suppose. But no, that that's, yeah, that's very interesting.

Stretch:

I don't know how much money they spent on that, but it was a serious effort. I didn't keep track with the insurance or whatever, but in the end he decided okay, this... He basically had to apply for the coverage and they determined through these trials that... And this was work for this guy. We just got to get it implanted and sewn up in them. And then there's a remote used to control it.

Robert J. Marks:

Oh really?

Stretch:

Yeah.

Robert J. Marks:

So you have a little wireless remote?

Stretch:

Yeah.

Robert J. Marks:

Or is it plugged in to your back?

Stretch:

No, it was no wire when it was done. Okay. However, they did that.

Robert J. Marks:

Isn't that interesting?

Stretch:

So they did the implant and this was the surgery I was just describing where they were having a hard time locating it and in the end they stopped trying and I didn't exactly know what had gone on because I

wasn't completely under. But they'd sedated me for relaxation kind of thing. And he came to my bedside and he said, I have been doing this for, I don't know, 20 years or something. And he said, you are the second person that I could not get this lead located in.

Robert J. Marks:

Really?

Stretch:

And he said he suspected, and this makes sense because he suspected that it was the scar tissue that had developed from the other tests. And in my bowel troubles, there was lots of speculation about my body's, maybe excessive production of scar tissue causing some problems. So that kind of related to that, I don't know, there's no proof. But it was interesting that he suspected it could be scar tissue.

Robert J. Marks:

Now just to clarify this, these, well first of all, you were awake during the surgery for the spinal implant.

Stretch:

Yeah, and it wasn't painful. They had to sheet up, and my head was on the other side and I don't remember being in pain. It must have been a local anesthetic type thing.

Robert J. Marks:

Now was the purpose of it or the effect of it to reduce your pain from the operations or to counteract the opioid addiction?

Stretch:

Oh no. It was the pain that was a result of the dysfunctional J pouch.

Robert J. Marks:

I see.

Stretch:

That was a result of the surgery. That's what it was all about.

Robert J. Marks:

Wow.

Stretch:

But at the time, had I had that been a solution, I still would've had to withdraw from opiates because I was taking large amounts of opiates, at the time. So had that worked and in retrospect, I still would've had to have dealt with the opiate dependence problem.

Robert J. Marks:

Understood. So how long have you been free of opiates?

Stretch:

Seven years.

Robert J. Marks:

Seven years.

Stretch:

I think seven years.

Robert J. Marks:

Will you ever take pain medication again or opioids?

Stretch:

I've had to be in the hospital for bowel obstructions and I used what they gave me in the hospital and I came home with a very small amount and used it. Didn't have a problem.

Robert J. Marks:

Really?

Stretch:

Really.

Robert J. Marks:

So what was the problem the first time you overdid it?

Stretch:

Yeah, I think just way too much in my system. My body truly became dependent. It needed the drug to function properly. And the way to describe what the drug does to you, it changes to your brain chemistry. Your brain brain chemistry takes a very long time to readjust.

Robert J. Marks:

Well that's what I talked about in the monologue, in the introduction. This idea that neurons that fire together are wired together. So it takes a long time for that path to diminish and-

Stretch:

Absolutely.

Robert J. Marks:

-Go away.

Stretch:

I had another factor that was important. I did do the Alcoholics Anonymous thing through the Suboxone program, which is required. Suboxone was the medication they used to wean me off of opiates. And

that took five years. I was on that stuff and gradually tapered down on that dose of that stuff. So it was a very long deliberate process to get off of it. And basically after twice in rehab, I was still addicted, dependent. I had got to the point while I was in rehab, the second time at the Cleveland Clinic, that I could go a day and not be miserable. But, as soon as I went home, it was all... It was starting all over again. And that, I think that's a testament to the people, places and things you hear them say. You got to change your people places and things. And that's easy to do-

Robert J. Marks:

For addictions. Yeah.

Stretch:

-When you go to a hospital. But then they release you from the hospital and you're back to your same old people places and things. Which may be a daily routine of dealing with medical problems, which you don't get away from. The thing that saved me, I believe, I did have that pouch removed. That was taken away and it gave me another solution and another pouch that works a different way that actually is now problematic but isn't causing the pain that the other pouch caused. So I didn't feel it necessary to continue with the alcoholic narcotic anonymous system because my addiction was rooted in the medical aspect.

And I didn't have the same triggers that the people that were there taking say, heroin and-

Robert J. Marks:

Well that's interesting.

Stretch:

-Cocaine and other stuff. So I could kind of... If I didn't have the medical problem, there was no pressing need for me to want to take that medication. Now if it was laying around in front of my face, if it was down at the corner store like alcohol, I may have not been able to have kicked it. But it was too hard to get to, or and too risky to try to get. And I never wanted to take that step outside the relatively legality of... I say relative because, there was more scripts than I was supposed to have just on account of being in and out of the hospital so frequently. And they would write me scripts every time I left the hospital. So I ended up with an abundance of scripts that offered me more medication than I really should have been taking. So it wasn't done legitimately, but it wasn't done on the street, I guess, the support of my addiction.

Robert J. Marks:

Well let me ask you one final question. What advice would you give to I guess number one, people who are undergoing operations who will need med pain medication such as fentanyl, the lollipop, the patches. Did you use the patches?

Stretch:

I did.

Robert J. Marks:

-The fentanyl patches?

Stretch:

I did patches, pills and lollipops, at the same time.

Robert J. Marks:

Really? Oh gosh. So what advice would you give them or maybe some youngster who's considering going out and getting some fentanyl on the street?

Stretch:

Maybe you would be better off playing chicken with your friends in your fast cars or something than playing around with fentanyl. Maybe you'd want to try some skydiving without a parachute or do the cliff climbing thing without any ropes and stuff. It's, kind of, the same thing. Likely you're going to die if you don't have a good, real good understanding of the risk that you're taking. And nobody does because nobody looks at it from the addiction point of view-

Robert J. Marks:

They're looking for that high.

Stretch:

-Unless they're being advised. Yeah, right. You're taking it for, to alter your mind.

Robert J. Marks:

So what would you say to people that are undergoing operation that know that they have to use this pain relieving medication after they're done? I mean, you basically didn't have a choice.

Stretch:

Well, I did, just because of the circumstances. The first surgery, the doctor says, don't use it if you don't have to. And then I did use it a couple nights that were bad, but it was like I don't even taking it. So I stopped. I had no interest in using it. I had an alternative. I had ibuprofen, which interestingly down the road becomes a problem for people with bowel problems because you can't take lots of ibuprofen. It causes bleeding in your bowels. So as a bowel patient, you have no pain option choices other than acetaminophen, which doesn't work at Tylenol, or opiates. That's your choice.

Robert J. Marks:

Yeah. Well this has been great. Thank you. We've been talking to somebody anonymous. We're calling, Stretch. Thank you, stretch.

Stretch:

No problem.

Robert J. Marks:

This was a... Stretch is not his real name.

Stretch:

I hope I scared those kids enough to stay away from that stuff. It'll kill you. It really will. And you don't understand how it will kill you until it's too late and then you will be on your way to the grave. So, stay away.

Robert J. Marks:

So we can talk about the theory of brain chemistry and neuropsychology, but getting down to somebody who has experienced and walked through it is really eyeopening and really educational. So thank you very much. We really, really appreciate it.

Today we're going to discuss how algorithms can either sharpen or derail services. Specifically we're going to talk about the practice of medicine. Algorithms, if you're not familiar, are step-by-step procedures for accomplishing something. When you bake a cake, for example, you have the input to the algorithm, which is all the ingredients. And then you have a step-by-step procedure. Put the cake mix in the batter, add some milk, some eggs, possibly beta preheat the oven, cook for a certain amount of time, et cetera, et cetera, and you end up with a cake. So recipes are algorithms. In fact, I like to think that algorithms are indeed recipes. I think it probably goes both ways. Google driving instructions are algorithms, when I'm told to go to your place and I'm supposed to go two miles on the freeway, turn left at the 7-Eleven, go a couple blocks, turn right on Oriole Street and et cetera, et cetera.

So those are step-by-step procedures to get me from point A to point B. Now computers and AI are restricted to be algorithmic. In other words, computers can only do things which are algorithmic. Every computer follows a step-by-step procedure for doing something. If something is non algorithmic, it is not computable. And one of the things that we've shown at the Bradley Center is that creativity, nuance and insight are human characteristics that are non algorithmic. You cannot write a computer program to do them.

Creativity, nuance and insight. And if you remove creativity, nuance, and insight and other criteria from making decisions, you are really stifling the degree to which you can interact. We're going to talk about how algorithms stifle and also enhance the practice of medicine. Our guest today is Dr. Richard Hurley. Dr. Hurley is a medical doctor who is board certified in anesthesiology and pain medicine. Dr. Hurley, welcome back.

Richard Hurley:

Thank you, Robert.

Robert J. Marks:

One of the things that we were talking about offline is algorithms and medical procedures and the fact that a surgeon can come up with a new way of doing something and they can patent it. That's really astonishing. So if a surgeon that you works with uses a procedure that's patented by somebody else, does he have to pay the person that originated and owns that patent, for the right to use that procedure? Do you know?

Richard Hurley:

No, I don't... I'm not an expert in this, but of those physicians that I have known that have developed a technique or a device, they've usually partnered with companies that actually may produce or manufacture that. And the two of them together will get a patent either on that procedure or the type of procedure, or the device itself.

Robert J. Marks:

I have a personal story. I was trying to quit coffee, but every time I quit I started to get headaches and then I got a hold of some bad calamari and that bad calamari put me in bed for about three days. Just terrible. And just agonizing, agonizing pain and gastro discomfort. When I finally recovered, I thought I probably went through my headache withdrawal during my time when I was out with this food poisoning, from the bad calamari. And somebody told me about patentability and I thought I could have patented this for people that want to recover from addiction to coffee. But, of course, it would involve bad calamari. But I'm sure that there's ways that they can induce this sort of coma and distraction. And I think they use this in drug recovery sometimes, don't they?

Richard Hurley:

Yeah. It's really interesting for severe depression now for different types of pain states that are actually using infusion of ketamine, which is its sister drug is LSD, and ketamine is a dissociative agent that actually seems to help depression. It's not such a strong deal in terms of abuse or addiction, but it has really been successful in the treatment of depression.

Robert J. Marks:

Okay, so do they knock you out for that or they put you in-

Richard Hurley:

They don't have to give you an anesthetic dose. It's an infusion in which you are awake. You're not dissociated, but the there's and the infusion rights, you couldn't do anesthesia. You can actually use the drug for anesthesia. I used to use it all the time, but you got to use it a higher dose. It's not necessary than to use high doses in order to get this response that you're looking for.

Robert J. Marks:

I see. Okay. Well, speaking of procedures, you've mentioned to me about the onslaught of technology in your field and... Could you comment on that? One of the things you mentioned was a suture device for deep wounds.

Richard Hurley:

The spine surgery that I do is predominantly implanting spinal cord stimulators. And basically, it's two very sophisticated wires that are put into the epidural space. It's tunneled up into the mid-portion of the spine and when you turn it on, patients feel tingles in their lower back and legs. And for some patients that is excellent pain relief, but you don't even have to feel the stimulation or grit relief.

The biggest problem we had with this is that active patients and even non-active patients, if they fell or whatever, the leads would move. They would either fall down or to the right, or to the left, and so then you'd have to operate on them again and fix it. So I didn't have as much trouble as other people did, but I still some, what we call migration of the lead. And so there was a group of, I don't even know who they were, that developed a product called Fixate. And basically it's a device that allows you to suture a wire deep into a wound and you don't even have to get your fingers down into it. It just all designed with a way that it was done. And then when you pull up on it and tighten it up, it would cinch it down. And it's amazing, once a lot of people started using this, the lead migration went way down and re-operations went way down. So it's just a simple device that's available to anybody that wants to use it.

Robert J. Marks:

That's interesting. So are there other technological advances? I understand that robotics is now being used for a lot of operations and all of this is going to be algorithmic. You have to go in and the physician either uses as a tool or if it's unmanned, it does it on its own.

Richard Hurley:

Exactly right. Yeah. So the robotic, of course, I'm not as familiar as a lot of other people are, but we're using robotics in treatment of... Some guys are using it for knee replacement for any abdominal or pelvic surgery. And the list just keeps increasing daily. But the advantage is that you don't have to have large wounds. You can do everything through a small incision. And so recovery time is better. And overall the results have been just as good if not better.

Robert J. Marks:

Interesting. So what is the history of, I guess technology has always been a part of medicine, but in terms of AI and some of this high technology, that's a recent development, isn't it?

Richard Hurley:

That's true.

Robert J. Marks:

Okay. Let's talk about algorithms in other places. So we have algorithms in the practice of medicine, and I think that's one of the reasons that we have nurse practitioners today. When I was a boy, we didn't have nurse practitioners, you went to the doctor. But nurse practitioners kind of take care of, as I understand, the low level medical diagnosis that can be taken care of through algorithms. You come in, you got a fever, you got a temperature, and they probably say, you got flu and you should take such and such medication. And this is pretty proforma.

And that's what the nurse practitioners are supposed to do. And then if they're outside of their silo of expertise, they put you and they refer you to a specialist who can take care of you. I use a nurse practitioner and I really appreciate that she knows her limit of expertise and I can go to her for normal things. But if it goes outside of her silo of expertise, she can refer me to other specialists. So nurse practitioners are followers of algorithms in terms of what they do. One of the things that I wanted to talk about is the application of algorithms, not necessarily in the practice of medicine, but in the constraints which are put on to medicine by insurance companies and stuff. Could you talk to that?

Richard Hurley:

I can. By the way, a nurse practitioner who refers a patient because they're not sure, I agree with you. I think you appreciate that about her.

Robert J. Marks:

Yes.

Richard Hurley:

You should also appreciate that about your own physician as well. I refer patients when get out of my expertise. I don't treat somebody's diabetes. I don't treat their hypertension. I don't treat their stroke. I make sure that I get that patient into the right physician to take care of that.

Robert J. Marks:

Good.

Richard Hurley:

But if you look at algorithms, medical algorithms are... It's a visual roadmap to help guide you in your decision making, okay? That helps you plan for and evaluate your care. It's to help to remove the uncertainty, okay? It makes the decision making much more accurate and it's developed by physicians for either physicians or other healthcare providers. It's evidence based and it's data driven. Now, algorithms by health insurance companies, they use algorithms for prior authorizations to determine the medical necessity for hospital admissions, prescriptions, surgeries and procedures.

Robert J. Marks:

So this really constrains your practice, doesn't it?

Richard Hurley:

Yeah, because their prior authorization purportedly is to reduce healthcare costs, but they claim to save money by denying health services that are considered to be experimental or unnecessary, even if that care or drug or procedure is FDA approved or approved by the Centers for Medicare & Medicaid Services.

Robert J. Marks:

Is that right? I was talking to a friend, his first name is John, I forget his last name, but he has a startup of a new service for senior people that can monitor old people in their houses and just make sure that they're okay, they're moving around, and then there's a lot of data mining, which comes from that. How many times they go to the restroom, for example, how long they sleep. You can monitor all of this from their technology.

But he was saying that his big hurdle was to get approval by Medicare and Medicaid. He said, "This is the main hurdle that needs jumping and approving new medicine and procedures." He also said, and I want to check your viewpoint on this, that the insurance companies would usually become a part of it and agree to cover this cost if Medicare and Medicaid did that. But you're saying that's not necessarily true, is that right?

Richard Hurley:

The Center for Medicare & Medicaid, they can approve payment for anything that they think is... Now, they're not going to approve something that's not FDA approved, if it's a drug. If it's a procedure, then there are all kinds of things that they have to do to get that done. But even then, many procedures and devices have to be FDA approved, okay? But insurance companies, private insurance companies, just because Medicare does it, they're not obligated to do that, okay?

A lot of times they are actually behind the eight ball. They have other agendas. Or a perfect example is a new drug that comes out that may have a strong indication FDA approved. But before I can write a prescription for that, I've got to use all the old drugs that were never approved for that particular diagnosis or problem. But we knew that if you used them off label, the patients got better, and then if they fail those, then you could order this new drug that might cost a hundred times more than the old drugs, okay?

Robert J. Marks:

I see. Okay, so the drug companies come in and they probably want to have everything approved by insurance, and then the insurance company come in and they make all the rules. To what degree do the drug companies stifle your practice of medicine?

Richard Hurley:

Well, to give you an idea, and just recently in the last three years, we've seen a number of pharmaceutical companies produce drugs that are called CGRP inhibitors, which are known to be fantastic drugs for migraine. These drugs are given intramuscularly and they last about two months and it's been tremendous in terms of relief of patients who suffer from migraine. In order to get this approved, you got to have 15 migraine attacks per month before they'll approve that drug.

Robert J. Marks:

Really?

Richard Hurley:

Now, that number may have gone down, and I shouldn't probably give you an exact number.

Robert J. Marks:

But there is a threshold, that's the point.

Richard Hurley:

The threshold is so high and it's so hard and it takes a lot of time. A lot of times, the nurses or physicians have to go to their insurance companies to get this approved. I have the same problem I have with the things that I do, but that those issues are that way. So it is tough. Now, over time, those drugs will become cheaper and the insurance companies will use them and then they'll be fighting something else.

Robert J. Marks:

I see. So it seems to me that in the practice of medicine, we talked about algorithms and nuance and insight and things of that sort. It seems that with a physician, you have this nuance, you have this insight into patients and that you should have this flexibility to prescribe what you think is appropriate. Yet I kind of get the sense that insurance companies kind of stifle that creativity and your practice, if you will, in medicine. Do you agree?

Richard Hurley:

I do. I totally agree. So in other words, in pain medicine, I'm an interventional pain physician, so I do agree that we should approach the patient certainly from a conservative standpoint. You shouldn't go into the most expensive treatment modalities from day one. You got to get to know the patient. They got to have trust in you, all that stuff.

Robert J. Marks:

Of course.

Richard Hurley:

But ultimately, if I have a patient with mechanical back pain, they're in their fifties to sixties. They've got enlarged facet joints or the small joints in the lower back, and when they move a certain way, it pinches them and it causes them severe pain. They've been on an over-the-counter medications such as Tylenol or Ibuprofen or a naproxen. They've done some exercises at home. It didn't help. Maybe they've even had physical therapy or chiropractic manipulation, or maybe they've had acupuncture. They've had all kinds of conservative care.

Ultimately, I may decide that what I want to do is a procedure called medial branch blocks or facet nerve injections where we actually anesthetize the joint to see if their function and pain improves. Now, once I request that, I have to send all of my notes, all of my imaging, everything to the insurance company, and we might hear back from them in a week. So when a patient comes in and they expect care at that particular time, I can't even offer it to them because it has to be approved.

They ask 15 different questions that my nurse will fill out electronically, okay? But if she misses one, just one, or she doesn't dot the I or cross the T, it gets denied. The insurance companies have people who are not experts. They're not nurses. They're not even medical assistance. They are people who have been trained to read notes and then look for reasons to deny it.

Robert J. Marks:

Well, this is the whole point, right? They're following fixed rigid algorithms, which do not allow the flexibility that you need.

Richard Hurley:

Right. These companies that do this have just blossomed with managed Medicare, okay? So managed Medicare is essentially, everybody thinks managed Medicare is like standard Medicare. That's false. Standard Medicare, you have standard Medicare, but then you have to pay for your supplement, okay?

Robert J. Marks:

Yes.

Richard Hurley:

Which is 20% of the care. Well, that sometimes that costs more than the standard Medicare. Well, managed Medicare gets rid of all that. It's just one fee. So if an insurance company like Blue Cross Blue Shield or Aetna or whatever is going to be involved in that, they can make money if they deny services or postpone them. The algorithms that are set up are saying, "Well, the reason we have these algorithms are to get rid of unnecessary procedures." Okay? But it's really interesting of the number of case procedures that I want to do and then I go to appeal. Probably they don't reject more than maybe two or three initially, but within a month, 100% of them are approved over time.

Robert J. Marks:

Really?

Richard Hurley:

Yes.

Robert J. Marks:

Okay. So they're reasonable. But you really have to go to battle with them.

Richard Hurley:

That's right.

Robert J. Marks:

How much time do you spend battling the insurance companies?

Richard Hurley:

So not all insurance companies require prior authorizations, but all managed Medicare does. Almost all primary insurance does, but standard Medicare does not. So if you have standard Medicare with a supplement, there's no pre-authorization. So what I say and what you agree to is the type of care you're going to get. But people who sign up for managed Medicare are not aware that they're going to be plagued with pre-authorizations for that year that they have that insurance.

Robert J. Marks:

The funny thing is, I go in for procedures every once in a while and I'm given an estimate of what the insurance company will pay. Invariably, almost 100%, I get a bill for extra money. In other words, the medical doctor doesn't know how much the insurance company will pay. They guess. Or maybe they have a standard reimbursement that they quote me, but it never seems to be enough. On one occasion, I did get a check back that I paid too much, but that was a rarity. That seems to me to be frustrating and a very bad algorithm. If you can't decide Apriori beforehand what a procedure's going to cost.

Richard Hurley:

Absolutely, and you don't see that. In medicine, if there was no insurance and everybody paid cash, you'd have the prices written on the outside on the billboard.

Robert J. Marks:

I've heard that and wondering, so the insurance companies, the algorithms that they use, let me use the word brittle. You can't crack them, you can't go outside of them, and that certainly must be frustrating. On the other hand, we know that we need algorithms because there needs to be some sort of constraint in terms of containing cost. So Richard, how could it be fixed?

Richard Hurley:

So the thing that the State of Texas came up with in the last legislation was the Golden Rule. I don't know if you've heard of it or not.

Robert J. Marks:

No.

Richard Hurley:

But essentially what they got passed was if a physician had six months of care in which maybe they were a proceduralist, whatever it was, and all of virtually 90% of the requested authorizations were passed, then they would get a gold card which will allow them to then-

Robert J. Marks:

Oh.

Richard Hurley:

For the next six months, they can go ahead and schedule the procedure without getting authorization. Now, that's just coming about now. In other words, it was supposed to have happened by I think the beginning of the year, but interesting enough, insurance companies have trying to tackle on different rules. So it still hasn't been a decision, but that was something that the Texas legislature came up with was the Golden Rule.

In other words, if they look at you over your past six months and everything you did, even though you might have done some appeals, if your appeals were approved, then we will grant you a six month reprieve from pre-authorizations. It's one thing or another. I disagree, but I understand why pre-authorization's there because there are always dishonest providers who do things. They'll the schedule procedures that are not indicated, or they'll do too many of them, or they'll do it for the wrong reason.

Robert J. Marks:

Wow. Now, when you or your assistants or your nurse talks to the insurance companies, I guess one of the things that must be frustrating to you, and you mentioned this, is that you as a physician are arguing with somebody who is trying to follow a strict algorithm, but which has no medical experience.

Richard Hurley:

Correct.

Robert J. Marks:

They are still constrained of following their algorithm, yet you say that most of your controversies are concluded in a happy way. So how do they get around the algorithms? Are you given exemptions from the algorithm or what?

Richard Hurley:

Well, hopefully that's going to happen. In other words, maybe one day I'll have a gold card. I don't know.

Robert J. Marks:

Okay.

Richard Hurley:

I doubt that interventional pain physicians, because the problem with chronic pain is is that everybody's going to be a patient at some time or another. You will be. I will be. Now, how you cope with it is obviously different. Everybody copes with it differently. But authorizations for certain medications, like those CGRP inhibitors that I was telling you for migraine, well, those drugs cost $600 a month. You think about how many millions of patients who have that, and you just dump that on the system. Insurances would really struggle with that and I understand that as well.

Maybe it's the cost of drugs, maybe it's all that stuff. I don't think that's a real good answer. But to actually streamline this differently would be better. But the biggest problem I have is when I do a pre-authorization, it's rejected, and then I go to appeal and I go back and review my notes, and then I talk to the doctor there. The reason I win is because they didn't read all the notes. They didn't look at the MRI report. You know what I mean?

Robert J. Marks:

Yes.

Richard Hurley:

They just missed it. So I always ask them, "Why do you ask for us to send all the notes on the patient when you don't read them?" I mean, it doesn't make any sense.

Robert J. Marks:

Oh my gosh. The gold card, the more I think about it, the better idea it is. I like the idea vetting physicians to give them more flexibility in what they do. Another question I have, what is the difference between the different insurance companies? They all have this brittle sort of algorithmic criteria that they impose on the practice of medicine. Are there some which are better than other ones? You can mention names or not mention names. That's up to you.

Richard Hurley:

I'm not the expert in that, so I can't tell you. We have less problems with, if you have standard Medicare, if people can afford standard Medicare with a supplement when they get Medicare age, I just encourage them to go that route because even though you're healthy and even though you may not have used a lot of healthcare, you don't know what the future's going to bring. So even though you may be paying more, that's the way I would go. Managed healthcare changes, so what I mean by that is Blue Cross and Blue Shield may have this criteria to do medial branch blocks on a patient this year, but next year they're going to change it.

Robert J. Marks:

Really? So the rules keep changing.

Richard Hurley:

Oh, the rules change on the first of the year. They publish it. You might get to see it, you might not, and then all of a sudden you haven't met that criteria, so it gets denied.

Robert J. Marks:

How do you play the game without knowing the rules?

Richard Hurley:

Well, yeah, it's really funny. You get denials and then all of a sudden you find out what the new rule is and then you start adjusting your notes so that that fits their criteria. Those are kinds of things that we as physicians get really frustrated with. Those rules seem to be quite arbitrary and they're based on what they perceive as abuse.

Robert J. Marks:

Sure.

Richard Hurley:

Okay. All of a sudden this procedure's going way up and is there any reason for it? Well, there may not be, and it may be abuse, but you're penalizing everybody else and all the other patients that are involved by changing the rules and not letting us know.

Robert J. Marks:

There are a number of different companies that give health insurance, if you will. Is there a monopoly happening unsaid where the rules for all of these insurance companies are roughly the same? The reason I ask this is it seems that if there were true competition in the spirit of free enterprise, in the spirit of capitalism between the different healthcare insurance providers, that there would be a competition to give the best service, which would be a motivation to sharpen their algorithms to make them more user-friendly to the physician.

Richard Hurley:

When you're buying health insurance, I feel sorry for the layperson who doesn't know a lot about medicine and how healthcare is done because basically you would think, "Well, I'm probably not going to buy the cheapest, but I'm certainly not going to buy the most expensive, and so I'm going to try to hit one in the middle of the road." If you ask the layperson in the United States what a pre-authorization is for healthcare, many patients might know, but most people don't. They don't ask that when they go and get their plan. But an answer to your question, all of managed care providers use other companies to develop these algorithms to decide whether a procedure is medically necessary or if it's experimental, okay?

Robert J. Marks:

Really? So they farm it out then.

Richard Hurley:

One of the largest companies is a company called eviCore. They manage 100 million Medicare advantage patients. 100 million.

Robert J. Marks:

How do you spell that name, eviCore?

Richard Hurley:

eviCore, E-V-I-C-O-R-E.

Robert J. Marks:

eviCore, okay, thank you.

Richard Hurley:

So I usually have to talk to eviCore. By the way, I have the right under the State of Texas, I have the right to talk to a peer of my own. So in other words, if I call and my nurse sets up a appeal, she'll say, "Now, Dr. Hurley does want a pain physician board certified who he'll talk to." By law they have to get that. I don't know if they have to be board certified, but you have to have... In other words, I don't have to argue in front of an oncologist or a primary care, somebody-

Robert J. Marks:

Peer review, if you will.

Richard Hurley:

Right. It's a peer review. You have to have peer review in order to do that and that can't change. If it ever changes, It's time for me to retire.

Robert J. Marks:

Okay, okay. You mentioned previously, and I thought this was interesting, if we didn't have insurance, the price of every procedure, of every medicine would be printed on the bottle.

Richard Hurley:

Absolutely.

Robert J. Marks:

Do you think that the use of insurance would increase this price? So there's kind of an implicit price on everything according to what insurance provider you have. Do you think that this price is going to be higher or lower if we didn't have insurance?

Richard Hurley:

Anytime the federal government gets into anything, the price goes up.

Robert J. Marks:

Yes, okay.

Richard Hurley:

You know that as well as I do, okay? So they get into whatever it is they do, the price goes through the roof. That's because you're very inefficient if you run anything from Washington, D.C. as opposed to doing something local. The state can do things cheaper than the federal government can do, and the local governments can do things cheaper than that. A private institution like Baylor or whatever, in other words, there are ways to do things.

But if the federal government gets involved, whether it is in medicine, whether it's in construction, whether it's in military, whatever it is, the price goes through the roof. A perfect example that I had was I had some properties down in Belton during Katrina. People who were looking for places to live, they came up and we had a place for them. Well, I put up this family for that, and I'd been renting, my place had been renting for $800 a month before they came, and then we moved them in, and the government paid me 1,250.

Robert J. Marks:

Really? Oh my goodness. Okay.

Richard Hurley:

I mean, I didn't ask them. They said, "That's what we paid for a three bedroom, one bath house." Okay. All right. Well, I didn't argue. I just took it.

Robert J. Marks:

It strikes me that in order to improve insurance, I do like the idea of free enterprise. I'm a big believer in it. I do believe that the FDA has to stay in the mix. I mean, what was that drug that caused birth defects a number of decades ago?

Richard Hurley:

Well, it was a German drug for sleep is called thalidomide.

Robert J. Marks:

Yeah, thalidomide. It caused all of these birth defects. To our credit, the FDA didn't approve it. So all of those birth defects occurred in other countries that had the slippery slope that allowed it to be approved prematurely. So I like the idea of the FDA in terms of clearing stuff. But it seems to me that we really don't have free enterprise among the insurance companies from the small amount I know, and I do like the idea that the state has some control over it, your gold ticket, for example, was at the state level. I'm wondering if some of these different insurances were localized more and separated the divestiture of the Bell Systems Labs where they broke up the company that maybe we would get a better deal.

Richard Hurley:

Oh yeah. Well, the drugs that we use in the United States cost X dollars. The same drug in Canada costs 75% less because they have one payer and that's the Canadian Healthcare System. They buy all the drugs and they dispense them out.

Robert J. Marks:

Okay, so that's a vote for socialism.

Richard Hurley:

It is. It is. I'm not saying that, but what I'm saying is is that was there any reason why two years ago the price of insulin doubled and tripled and quadrupled? I mean, I don't know. I don't that information. But then if the federal government goes in and says, "Okay, you can sell insulin, but you can only sell it for $35 a vial, okay?" How many people are going to play with that? I don't know. I don't have the answers in terms of the cost and how to control it. All I know is everybody wants American healthcare and they'd come here in droves to get it.

Robert J. Marks:

It's still the best, yes.

Richard Hurley:

It's still the best and I think it always will be as long as we do it. It's not truly private, okay? There's a mixture of the federal government, state government, private enterprise, all that other stuff. So I like the drugs that I take and I like the facts that my pharmacists provide them, but how to handle the cost are not there. But algorithms that are involved in healthcare to help patients get better whether in surgery or on the floor are designed by physicians to help other physicians or providers to do things. The algorithms for insurance companies are done differently.

Robert J. Marks:

So, yeah. So that's another interesting question. This eviCore, do you know what degree that they employ physicians to set up these policies?

Richard Hurley:

I have no idea. But they must have hundreds if not thousands of physicians that work either part-time. But please don't give me that job. I don't want to have to answer the phone and listen to guys about appeals. I couldn't that.

Robert J. Marks:

Yeah. The interesting thing is probably all those medical doctors make these recommendations and it's eventually decided by a bunch of guys with MBAs.

Richard Hurley:

That may be true.

Robert J. Marks:

Yeah. That would be my hunch. Okay. Any final words, Richard?

Richard Hurley:

No. I'm glad we had a chance to at least talk about this. I doubt that the public is aware of the algorithms that are involved in pre-authorization of patients for procedures or medications. Frequently they blame the physician, "Okay, why are you not getting this done? Why am I having to wait?" They don't realize that the hangup is not at the office where you see your physician, but it's in computers and insurance companies that are actually want to say, and whether you can have that care or not. If that was something that everybody knew, then my suggestion for people who are buying health insurance is how much pre-authorization is this product going to have and I might run away from it.

Robert J. Marks:

I see. Okay. How would you find that out though?

Richard Hurley:

You can always ask.

Robert J. Marks:

Always ask.

Richard Hurley:

Always ask, always ask. It's a procedure, do I have to have pre-authorization to be admitted to the hospital? Do I have to have pre-authorization for this type of surgery? All those things. Okay. Do all that. Yeah.

Robert J. Marks:

Oh, wow. Very interesting. Richard, this has been a fascinating conversation. Fascinating chat. Thank you. Thank you very much.

Richard Hurley:

You're welcome.

Robert J. Marks:

Our guest today has been Dr. Richard Hurley. Dr. Hurley is a medical doctor who is board certified in anesthesiology and pain medicine. So until next time, be of good cheer.

Announcer:

This has been Mind Matters News with your host Robert J. Marks. Explore more at mindmatters.ai. That's mindmatters.ai. Mind Matters News is directed and edited by Austin Egbert. The opinions expressed on this program are solely those of the speakers.