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**Narrator**

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**Interviewer**

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Robert Levy -**RL**

Amy Sullivan -**AS**

**AS**: Tell me anything about your upbringing, your childhood, your parents, or your siblings.

**RL**: I am an only child. I was born in Manhattan, but I grew up in Brooklyn, New York. My parents were older when they had me. My mother had had several miscarriages before she had me and she desperately wanted to be pregnant. By the time she gave up, of course, was when she got pregnant with me.

My dad had three children from a previous marriage. His wife had died tragically when she was very young from a very aggressive form of breast cancer. They were much older -- it took my father some time to remarry and it took some time to have children. When I was born, the youngest of my half sisters was eighteen and the oldest had graduated from college already. They were all much older than me and really did not have a lot of impact on my upbringing.

I grew up alone as the child of two psychiatrists in New York -- both my parents are psychiatrists. My childhood was great. My parents both loved me a lot. They both have their own intricacies and quirks, but really, they were great parents. They gave me too much, but not way too much, let’s be honest. [laughs] I went to a private school growing up and I had great friends. It was a happy childhood.

My mom did get sick when I was fourteen years old. She had always had trouble walking. We always thought it was a bum knee but she ended up getting diagnosed with a mass, and then that progressed. By the time I was an early teen she had a lot of trouble walking and had a lot of pain from muscle spasms. As I got older, the disease continued to progress until the point when she became quadriplegic. She actually died in March of last year and eventually succumbed to her MS. [multiple sclerosis] My dad is still alive and well. He is eighty-five and lives in Los Angeles with his third wife now. They are doing great.

**AS**: Is she in her eighties?

**RL**: He married a younger woman, she is in her seventies. [laughs]

**AS**: Besides being raised by doctors, what motivated you to go into medicine?

**RL**: That’s a great question. I don’t have a single memory of ever thinking I want to be doctor, but I always wanted to be a doctor. When I was a little kid, my mom tells a story about telling some friend of mine to take two cookies and call me in the morning, or something like that. Always, as a little kid I wanted to be a doctor.

Both my parents, to a lesser extent my father, really my mother, persuaded me not to become a doctor. They were both psychiatrists that changed a lot and were some what disillusioned with the way modern medicine was dealing with psychiatry. They really did not want me to be a physician. I really always have wanted to be one. It was one of the great desires of my whole life. I have a very vivid memory of being in seventh grade taking biology class in school and thinking, This is the first step. I have to do well in biology so I can do well in high school so I can do well to get into college so I can do well to get into medical school. I remember thinking that.

**AS**: You’ve always wanted to be a doctor, but you’ve wanted it for so long you’ve forgotten what it was.

**RL**: There was no one moment. Ever since I can remember I wanted to be a doctor. If you ask me why it is because I’ve always liked talking to people, hearing their stories, and helping them. As germane as that sounds, which is what everyone says when they want to be a doctor, that’s why I wanted to be a doctor.

**AS**: Well, those are the types of people we want to be doctors. Can you talk a little bit about how you got into addiction medicine as a specialty, and if you want to precede that with your own experience with addiction?

**RL**: Sure. I am pulling this number out of thin air, but I would approximate that close to the majority or a large minority of addiction doctors have some sort of personal experience with addiction; either with family or friends or themselves. I am one of the ones that has that experience of addiction. That is why I talk about how great my childhood was because when people hear you have an addiction they assume your childhood was terrible. I can say that I was never really bullied. A little bit, but never badly. My parents never abused me. I had a great childhood. I also cannot blame my parents. My parents also got concerned. They said, How did we screw up? And I said, You know, not everything is about you guys!

**AS**: That’s hard to remember sometimes.

**RL**: It’s true though. I am an addict for my own reasons. I can believe the genetics, potentially, and it is a little sketchy because we don’t have a complete family history. In high school, my friends and I drank and experimented with marijuana. It was excessive sometimes, but we never got in trouble with the law, we never missed school, and we never cut class. It was pretty controlled. We were in New York City in the early nineties to mid-nineties and the laws around alcohol consumption were not very strict. If you had some sort of photo ID that you were over the age of twenty-one you didn’t have to be legit; they would sell you alcohol, and they didn’t particularly care. It was easy to get and we fooled around with it.

When I went to college I actually cut out a lot of drinking; I really didn’t drink much because I was always focused on my studies. I really wanted to be a doctor and so I was focusing on my studies. I did go through a period when I smoked marijuana pretty regularly for about a semester. I almost failed a class -- I got a B minus, not that I almost failed a class. That was the worst grade I ever got and I was like, No more marijuana. I stopped. I think I smoked once after that.

What did happen was during the last semester of my senior year, I fell and broke my ankle very badly. I was living with a group of guys and dating this girl at the time. It was a very bad fracture and I remember getting my first dose of morphine at the ER [emergency room]. All this anxiety and this tension and this stress in my life all evaporated. It was really miraculous.

**AS**: What was bad, the pain you were in?

**RL**: It wasn’t just the physical pain. It was bad but what was worse was the fear, the anxiety. I have always had anxiety, but the anxiety went away. Growing up I was always anxious too, but I dealt with it. It was an intramuscular injection of morphine. I remember that very, very clearly. And that, in addiction medicine, is called salience. We can talk about that, but that is a bad sign when someone remembers it very well like that, it is memory salience. I remembered it very clearly. All of that anxiety disappeared for a short amount of time, and it was really wonderful.

I was also in a lot of pain and the pain went away too, which was really nice. Anyone who has been in bad pain knows that. It didn’t go away completely, but it got much better. My ankle was dislocated and had multiple fractures so I had a lot of pain. What I remember was not as much the pain as the anxiety and being free from it. It was miraculous.

I was in Northfield, Minnesota and I was still living in New York at the time so I had to fly back to New York the next day. They relocated my dislocated ankle in the ER and gave me a splint and some crutches and told me to go see an orthopedic surgeon because I was going to need surgery to repair my ankle. This is over spring break. I remember flying home and I actually screwed up the prescription. I had a prescription for Vicodin and Ibuprofen. I meant to put the Vicodin in my carry-on bag and my Ibuprofen in my checked bag and I flipped them. I put the Ibuprofen in my carry-on bag and that was a very tough flight because I was in a lot of pain. When I got home I took a Vicodin and I remember thinking, Ah, that’s much better.

**AS**: What year was this?

**RL**: March 15, 2001 was when I had the fracture.

**AS**: You’re a senior in college, so you’re twenty-two?

**RL**: Twenty-two, yes. I was born in 1979. I was born February 5, 1979. After that traumatic experience I was at home and I actually didn’t take much pain medication after that. Then I had surgery, and my parents being doctors and knowing how terrible hospitals are elected to have outpatient surgery, and it was pretty extensive surgery. I trusted my parents when it came to medical procedures and I still do, my dad at least. I had an anesthetic block on my leg. When I woke up I remember there was no pain. It was fantastic. I didn’t take any medication, went home, and went to bed.

I woke up in the middle of the night feeling like they were still operating on that leg. What they did not tell me was when that block wears off all the pain relief goes away very quickly. You go from having total pain relief to having no pain relief. I was in some serious pain. I remember taking oxycodone and not getting much relief and not sleeping well. I was scared after that, of the pain. I took a lot of oxycodone during my recovery phase. At the same time, I didn’t notice any sort of euphoric effects, but I did notice I was more chatty and talkative when I was on it as opposed to when I was off it, but I didn’t think anything of that.

I went back to college after two weeks. When I went back to college, basically everyone was graduating. All my friends and the people I lived with were graduating. My girlfriend broke up with me, I wasn’t particularly fun to be around because I couldn’t do much. My friends were like, well, he’s kind of lame, and can’t do much, and frankly, yes, I was feeling sorry for myself. I was ostracized and I was feeling sorry for myself. I felt like I had, as I call it now, a lot of life pain for the first time. I had had bad things happen, like when my mom got sick there was a period of time when we were worried my mom was going to die. I had had life pain, but nothing prolonged for so long. I still have intermittent, pretty bad pain.

I was scared that the pain would come and get worse and come back to the pain it was after that first night I had been operated on. I would take some Percocet, and I noticed that when I took the Percocet the pain of my situation, which isn’t that bad, but hurt at the time, would also go away. The joke among medical professionals is that occasionally patients come in requesting Percocet for life pain. Most doctors say, Too bad, it doesn’t work. My point is that it does work. It actually works really well. Narcotics treat life pain for a short period of time very well. It treats all types of pain: existential pain, spiritual pain, physical pain, all pain because they work on the brain where pain is processed. I started taking it for my life pain, essentially.

Another important factor for me was that I was only taking two classes at the time. When I take narcotics I am one of the relatively rare people where it has what we call a paradoxical reaction. It did not make me sleepy. It almost made me feel like I had drank a bunch of coffee. It made me more alert. I started to do better in school, actually. I started taking them to help me do better in school. I was taking them pretty regularly. Also, because a lot of my parents’ friends were doctors and they knew I had this terrible pain and this terrible surgery, they would keep prescribing me narcotics. I took narcotics pretty regularly my last semester of college. I took the MCATs [medical college admission test], I remember I had taken a bunch of Vicodin for worried about being in pain during the MCATs and for thinking I would do better on the MCATs. Lord knows if I did or not, I did well enough to get into medical school.

**AS**: It was covering two different parts of your life: your fear of pain, and your desire to succeed.

**RL**: Yes, and the anxiety of taking the tests, right. My anxiety got much better, and that’s probably why I was doing better in school.

I took a year off because I had to rehab my ankle; I couldn’t go directly to medical school. I still had to learn how to walk again. The first half of that year I stayed in New York and mostly rehabbed my ankle and lived with my parents. I didn’t take that much pain medication because I wasn’t in pain. All of my high school friends were still around. They had gone off to college but they had come back and were all doing things. They had internships and stuff like that; all the things children of upper-middle class people do in New York. They were all around, I had a great physical therapist, and I had a trainer at the gym. I was getting into great physical shape and I was on a diet.

I was feeling pretty good, and I would only very rarely take a Percocet. Then it was more so because I had been too long on the elliptical, I couldn’t run yet, then did an intense physical therapy session, and then on the subway ride home it hurt pretty badly and I would take a Percocet. That was probably like once a week.

**AS**: You were able to stop whenever?

**RL**: The point is that I really never stopped. I still would take it weekly.

**AS**: But you could take it a whole week and you wouldn’t get sick? You wouldn’t get withdrawal symptoms?

**RL**: No. That fun didn’t come until later. [laughs]

**AS**: Is that possible for people? To keep using them intermittently and not experience any withdrawal symptoms?

**RL**: Yes. It is possible. Most people who get surgery and have intermittent severe pain can take narcotics intermittently and have no problem with them.

At that point, in my professional opinion, although it is always hard to be your own doctor, I was abusing narcotics but not addicted to them yet. Or, in the DSM-V [diagnostic and statistical manual of mental disorders, fifth edition], for those listening and judging me I would have opioid use disorder - mild at this point. That would be the diagnosis.

The second half of my year off I spent hanging out in Aspen [Colorado] with a buddy of mine who was a snowboard instructor. I did odds and end jobs, snowmaking, I worked at a gym for a while, and hung out. It was pretty lonely out there and I would take a Vicodin or two every couple of days because I was bored. I thought it would make things more interesting. Again, I always had plenty. My surgeon and other doctors would write prescriptions for huge amounts of it because I would tell them I take it rarely and I didn’t want to bother them and I was going to Colorado. They would give me one hundred and fifty of them just to make sure I had enough, but I did it from a couple of doctors so I was progressing at this point. They were all good friends of my family and things like that. “We don’t want Bob to suffer! It sounds reasonable” and stuff like that.

**AS**: You had some good, legitimate excuses.

**RL**: I went out to Colorado and started dating my girlfriend who would become my wife. I was also going to medical school interviews. I would take a Vicodin before all of my interviews because it would help with my anxiety and I wanted to do better at them. I would take it for that. We are talking once, twice, maybe three times a week.

Then there was a time when medical school interviews were over. I was accepted to a few and the one that I eventually went to. I had this period of time where I didn’t really have anything to do and I was hanging out in Colorado and I stopped taking them again for a couple of months.

The first year of medical school I almost never took them. Occasionally on the weekends to have a good time I would take them. The interesting thing was that living with my fiance at the time, the same person, and I never told her that I was doing this. I never told anybody; I was hiding this. I think I did at one point tell one of my high school friends. I was like, Hey, have you ever taken pills to have fun? He said, No, and I said, Do you want to try it? He said, Not particularly, so I thought, Okay, I get it. I was taking it once a month on Saturdays.

Second year comes around and my fiance starts at NYU [New York University] and is commuting. I was living on Long Island at the time and I would come home and be totally alone for a percentage of the night. I would start taking them after school to help with the anxiety of being alone, but in my mind it was to have a good time. I did that for a while too and the use escalated.

Third year was a very intense year and I cut way back. The other really interesting thing was that the medical licensing exams have various steps and you take your first step of that exam after the second year of med school. I got married between the second and third year. I remember taking a couple of Vicodin before my wedding, but I did not do it before taking step one. I can’t tell you why that is. I can tell when I was high and when I wasn’t now because my memory was different. My memory is much clearer when I wasn’t taking the drug. The wedding is a little fuzzy but I clearly remember taking step two. The MCATs were fuzzy, I have very little memory of taking the MCATs now. It is directly correlated to how much opioid I had taken. I remember the subway ride, I remember things around taking step one and I don’t remember taking drugs for that. I did okay on step one, but not as well as the other one I had taken. [laughs]

I get married, third year comes around, and I use it very rarely again. Part of me knows it’s not a great idea to take drugs then see patients in a clinical setting. The fourth year comes around and you have to start picking what sort of specialty you want to do. You have to start making life plans. My mom is getting sicker and my parents are starting to have marital discord. It was a stressful time and I found myself taking more, again, because of the stress. That was what I told myself. I find myself taking it after rotations.

Fourth year was the time, I don’t remember why, where you could argue that I go from mild to moderate opiate use disorder and from moderate to severe opioid use disorder because I started taking it every day. It was sometime in my fourth year right as I was making the decision about what to do. I distinctly remember sitting in a hotel room with my wife, I still have the paper, and doing a pro and con list of doing family medicine or anesthesia. I chose to do anesthesia, I took my anesthesia sub-bi and I was so nervous that I took a Vicodin everyday before the rotation because I could do better. At this point it is actually clear that I’m not doing better on it, but I still am under the impression that I am. My dose has gone up a little bit, I’m not taking the one Vicodin, I’m taking one or two or a Percocet. I would break them in half and eat half of one and now I’m eating a whole one and I’m doing it every day.

**AS**: Is one stronger than the other?

**RL**: Not really. People believe that hydrocodone is weaker than oxycodone but it’s really not, they are all the same. I go to taking it daily at some point at the end of my fourth year of med school. It’s strange to me because I was really using it infrequently the third year and my fourth year it really escalated quite quickly and I can’t place my hand on it. Hearing stories from other addicts, some people can and some people can’t place it. I am one of those people that just can’t. There isn’t just one moment.

What I do know is that I matched at a very good anesthesia program and my first year of anesthesia was a rotating schedule and you aren’t in the operating room much. You are doing a lot of other things: medicine, cardiology, the ICU [intensive care unit], pediatrics, emergency room, and a bunch of other rotations. It is called a transitional year, but I went to a program where everything is integrated together.

I reverted back to only using it occasionally again that year. I experienced withdrawal, but I didn’t know it at the time. The interesting thing too, I forgot about this, I had to take a drug test before my job. I knew I had prescriptions but I didn’t want to throw any of these doctors under the bus. They prescribed them over the phone or I would go pick them up at their house, this is not super legit, it is some kind of sketchy stuff. I stopped and I had withdrawal. I thought I had the flu and I was super sick, but I remember I thought it had to be a week before I peed in the cup. That isn’t true, you don’t need that much time, but I didn’t know. I peed in the cup, passed the test, and didn’t return to regular use right away.

Eventually, towards the end of that last year, I started using it to have fun on the weekends or for anxiety and it very quickly went back to daily. Also, when I was on-call I would get nervous and I thought I was a better doctor when I was on them and I would take them while I was on-call. I practiced medicine while I was under the influence of these opioids. I didn’t get caught, and the fortunate thing is that as a resident you always have supervision. I can’t comment because I really don’t know what my practice of medicine was really like, but I do know that someone was always watching over me. And I was never under any academic problems when I was under residency.

Second year of residency starts and I do a lot more anesthesia and I find anesthesia a lot less fulfilling than I thought I would. I have a lot of respect for people who do it but it was not my calling. I’m more of a people person, I wanted to listen to the stories and meet the people. Anesthesia is really cool in medical school because you get to do procedures and give out drugs and see things happen. Once you start to do that regularly it becomes, at least for me, routine and then boring. I would sit in the OR [operating room] bored all the time.

At the same time I am running out of pills. Most of my doctors, or suppliers, frankly, are in New York. I am not. I am far away from New York. I would go back to New York for vacations and hit these people up for more drugs and they would give them to me because I am so-and-so’s son.

**AS**: Now it has been a few years. It has been four or more years since your surgery.

**RL**: It has been five years.

**AS**: Five years and they are still willing with no questions asked?

**RL**: Yes. Well, I was starting to get questions. I don’t think ‘no questions’ is fair. I was starting to get questions. I was starting to get heat. Some people stopped. Some people started really questioning me and my supply was dwindling and my needs were increasing. I needed more and more and my supply was dwindling and I couldn’t go back as much. In the place I was living my doctor, I got the impression, was not going to be willing to prescribe for me. I never asked him, for whatever reason.

One day it happens I was basically out. Like most drug addicts, I was hyper careful about my supply and I was down to my emergency supply. I went to work and I went into withdrawal for the first time at the hospital and that was really terrible. Having to do rounds and have withdrawal is no fun. Then I had to go to work and do the anesthesia.

**AS**: When you were in withdrawal and doing your rounds you were sweating, shaking, and feeling sick?

**RL**: Sweating, shaking not so much, diarrhea, abdominal cramps, not looking healthy, having a runny nose, yawning, tearing. It is full on withdrawal.

**AS**: And you are managing to do your rounds?

**RL**: Yeah, I mean I am taking Ibuprofen. Every addict has their ways of dealing. I am doing what I can and managing as best I can. I know I wasn’t because my attending was kind of like, What is going on? Get your shit together. I got nervous. I remember the first time thinking, Well, fentanyl is a narcotic. It’s right there and I know how to use it. At the time I thought of it as borrowing, but it was really stealing. I stole fentanyl for the first time.

Like a good anesthesiologist I injected it because that’s how you use fentanyl as an anesthesiologist. The one thing I am grateful for is that I had a family friend who was in a position of leadership at a medical institution where they had an addicted anesthesiologist who contaminated a bunch of fentanyl with Hepatitis C. It gave a bunch of patients Hepatitis C and I knew that story, so the one thing I am grateful for was that I was very, very careful to never cross contaminate anything. At the same time I was dividing fentanyl for me and my patients, and really it’s all for your patients. I’m not trying to defend that.

I started using fentanyl and it is not long after that that things really started to fall apart. My appearance started to fall apart. My personal life started to fall apart. My wife was just saying, You’re always so distant. My friends were like, What is going on? Once you really start using intravenous fentanyl it is a big jump. The withdrawals are a million times worse. The cravings start and they are really bad. They had started before that but they got really bad.

I had a three month run. It was only three months before one of my attendings noticed that I had essentially -- anesthesia has actually done a really great job in trying to discover when anesthesiologists or nurse anesthetists start using, because they have the highest rate among medical practitioners. I was the poster child. I was taking more bathroom breaks, I was volunteering for call, I was wearing long sleeves -- I had to wear long sleeves because I had track marks at this point. I normally do not wear long sleeves and I was doing it all the time now at this point, and it wasn’t because I was cold!

**AS**: They have known things to watch for. People are aware of this?

**RL**: These are known things, yes. People are aware of it. At this program there was a person that was supposed to be watching it. He did the best he could, but these people have a lot of residents and I wasn’t working with him at the time.

At the time the person I was working with and I had a good relationship, frankly. She was someone I really respected and she knew more about my personal life. My parents had also divorced at this point. My dad had gone off to live with someone else and my mom had moved away to live closer to me and help care for me, so I had a lot of stress with that. My aunt had also died. There were a lot of things that had happened that had escalated it. I didn’t go into any of that and I’m sorry.

**AS**: That’s okay. This is all during this three month period?

**RL**: Preceding it. That leads to the build up. It sounds very sudden, but there actually is a boiling point of things in my life. I had no other way of dealing with my anxiety. Actually, I was seeing a therapist. I was always seeing a therapist. I was lying to him and or her, there were two I saw, about what I was using. I didn’t tell them I was taking pills all the time. I didn’t tell them I was taking fentanyl. I was just trying to deal with my anxiety.

**AS**: Did they ever suggest medication for your anxiety?

**RL**: I honestly cannot remember. They must have. At some point before all of this I had started on Zoloft. Someone started me on Zoloft but I don’t remember when. But, of course, it didn’t help because I was taking opiates. I knew anxiety was a problem so I took it. At this point most of my anxiety is of opioid withdrawal. When you take fentanyl you withdrawal all the time. And, of course, the only way to not withdrawal is to go into treatment or take more opiates.

Eventually I get intervened on on May 3, 2008.

**AS**: By colleagues?

**RL**: By my attending. She said, Can you come talk to me in my office? I knew something was up. I was on-call, and it was a Saturday. Salience; I remember this very well. I was really bad at that point. I had just finished my cardiac rotation which is where you have a lot of access to narcotics and I was going to outpatient where you have very little access to narcotics and I was hoarding a bunch at that call.

It was the first time, she later told me this, but it was the first time that a patient of mine was under anesthesia at that time and woke up and was in a lot of pain, which is the last sign that someone is using. Even though I had charted and gave him a bunch of narcotics he still woke up in a lot of pain. She said that that was when she knew. There were all the other signs, but that is when she knew. It had never happened before.

She called the program director and she agreed that that was what she should do. She did it alone but she didn’t do it alone. She did all the right things, she got everyone involved, and everyone knew. They had their protocol and they did it. She said, I think you use anesthetic drugs. I didn’t hide it, I started crying and telling her how I had desperately -- and I had -- tried to stop so many times in the past.

**AS**: But first you denied it?

**RL**: Yeah, of course. I sat down and she was like, Are you using anesthesia? And I was like, No, no, and she didn’t say anything. If anybody is listening to this or reading this that is a great way -- to just not say anything. It is really effective. She just didn’t say anything and I started to sob and sob.

It was true, I had tried to quit so many times. I knew I had a problem. A couple weeks before that I had started Googling ‘how do you stop injecting drugs?’ and I got all this stuff on detox and was like, okay, no. Seriously. I desperately tried to stop. I had tried tapering, substituting, I had stolen Naloxone and induced my own withdrawal. I tried a lot of things.

**AS**: So you were ready to be discovered?

**RL**: Super ready. I was ready before I stole the fentanyl. Maybe I didn’t do a great job through this whole story because it is kind of stream of consciousness but --

**AS**: It’s been fine. Yeah.

**RL**: I was really done pretty much when I entered med school. I had thought, I don’t want to do this anymore. Sorry, when I entered residency. I didn’t want to do it anymore and I still felt compelled to because the withdrawal and the anxiety. And I didn’t want to lie to these people; my friends, my family friends. I don’t want to fill these prescriptions under false pretenses. It was against every ethical and moral thing I stood for. And it still took me like fifteen months to come to the point where I was like, Okay, it’s time.

**AS**: When people say addiction hijacks someone’s brain and their core self, that would also be your experience?

**RL**: Absolutely.

**AS**: It is a matter of privilege and circumstance that you were allowed to do those things without being caught. Someone with lesser resources would be shoplifting or robbing people or accessing the street corner.

**RL**: Clearly, yes. Absolutely. I have never done heroin, but I describe myself as a heroin addict sometimes. When I am at AA [alcoholics anonymous] meetings I don’t say I’m a fentanyl addict -- well, actually these days people do know what that is, but before they did not. And to say that is to imply that there is something different between me and them, and there’s not. There is not. I want to make that very clear. For all intensive purposes I am a heroin addict, I just never did heroin. I did morphine, which is essentially the same thing. Fentanyl was the opioid I liked the most, but I took all of them if I had the access. I took morphine and pills. They are all the same.

In street and AA meetings I identify as a heroin addict and I did it intravenously. There were times when I came close to overdosing. I remember in the bathroom of the hospital a couple of times. There were ultra potent derivatives of fentanyl and remifentanil. Super potent fentanyl derivatives. It is super terrible, really terrible.

**AS**: Let’s go back to that day. She intervenes on you. What else does she say?

**RL**: She says I know you are using drugs. I break down. She says it’s okay, I’m going to drive you home. I have someone else to come in and cover for you. The other resident is going to deal with the pager. I had this pain pager that dealt with the acute pain. She said, I’m going to give someone else the pager, there are no cases right now. I am going to take you home in your car. I gave her the keys to my car. She made me change so I couldn’t bring drugs home from the hospital.

She drove me home and my wife was there, she told my wife what happened. She made my wife look after me. She called someone else and someone else picked her up. My wife was great and she looked after me. I remember waking up in the morning and having my eyes closed and thinking, Please, god, let me wake up in the call room. If I wake up in the call room this is all a dream. A terrible, terrible dream. I opened my eyes and for the first and only time in my life I supremely disappointed to find myself in my own bed. I was like, Shit. I knew it was coming so I went through withdrawals and it was terrible. I also had this sense of peace because I was like, Okay, now everyone knows. Excuse my language, but fuck it, everyone knows at this point. Whatever is going to happen, all the fear and anxiety about what is going to happen when I run out, I am going to find out.

The other thing I did that night, I forgot to mention, the night I was intervened on, the attending and my wife were like, Do you have any drugs in the house? For whatever reason I was completely honest. I showed them where all of them were and they threw away all of them. That doesn’t mean there were any in the house. I actually found a couple of pills in the house that I didn’t know where they were. They had fallen behind the dresser or something like that. So, I had no access from the first time, which was the day that I broke my ankle. From March 15, 2001 until May 3, 2008 I was always in reach of a narcotic. And that was the first day that I was not. It was scary.

At the same time it was liberating. That withdrawal, although it was really bad, in my mind was not nearly as bad as the other ones because I was never thinking about how I was going to get more, what I was going to do, how I was going to hide it. I was like fuck it, it’s out. I do remember distinctly thinking how I was never going to be happy again. I do remember that. The only thing that made me happy was drugs. I was going to have to learn how to live life with never being happy. It was about the closest I got to being suicidal. I was actually never suicidal, I just knew I was going to have to live without ever being happy again, which is not true.

**AS**: No, but it’s what you thought at the time.

**RL**: It is what I thought at the time. I remember distinctly thinking that I would never be happy again.

The chair of the department comes and talks to me on that Monday. He let me alone on that Sunday.

**AS**: At your home?

**RL**: At home. He told me he was going to put me on medical leave and have the addiction point person come talk to me, and he offered support. The addiction point person came and said, I want you to meet with this addiction doctor. I got you an appointment and it’s on Wednesday. It was Monday at this point. I was like, Okay. I continued withdrawal and spent a lot of time in bed, watching T.V. and drinking soup or whatever else I could get down.

By Wednesday it was getting better. This is the longest I have been without narcotics for like a year and some. It was getting better, still not super happy and some underlying anxiety. I talked to this guy and he was great. He did the whole intake. I was going through withdrawals and he was like, You know, it looks like you’re still in mild to moderate withdrawal. I thought it was the worst thing ever. He was right. He said, I’m not even going to give you any buprenorphine, I don’t think you need it at this point. You’re past the worst of it. He was right. I didn’t like that statement, but he was right.

He got me started in intensive outpatient therapy. According to ASAM [American Society of Addiction Medicine] criteria, it was technically partial hospitalization treatment and I had to go into that. It is the highest level that is not inpatient treatment or the lowest level that is inpatient treatment. It is kind of in that gray area. I would go everyday from eight until one Monday through Friday. Then we would have a group meeting on Sunday.

I did that and met with a bunch of other people in the community. They got me hooked up with doctors in recovery very early. I was interviewed on Monday and the meeting which was the AA meeting for doctors in that town was Monday night. They were like, You should go! And I was like, No, I’m not going to go. The addiction point person was super persistent and he called someone else who was a medical student in recovery and he said you should go to this meeting. Leah, my wife, told me she would drive me. So she drove me to this, what I now know is an Alano Club, but it was a clubhouse. I went into the wrong damn meeting. I did not go to the doctor’s meeting, I went to a different meeting. The Thursday meeting became my home group because it was a great meeting. I remember my first AA meeting. Everyone was telling my story.

**AS**: The wrong meeting became your home group.

**RL**: It was the wrong meeting. I was like, These people are doctors? Then as they were telling their stories I learned that they weren’t doctors. I’m at the wrong meeting. They all look great and a lot of them look very professional, but the dude sitting next to me was clearly a mechanic that had just come from work. He was working a shirt that said like Rusty’s Auto Repair with some grease and a little rag.

**AS**: Right. You know your people.

**RL**: I think he said something about a transmission and I was just like there is no way that guy is a doctor. [laughs] The point was that they were fantastic and that’s actually where my love of non-medical AA came from. It was my first meeting and these people’s stories were all the same. Yes, they didn’t work in hospitals, but this guy was fixing cars and he was intoxicated. The other guy was a salesman and he couldn’t sign his signature because he was shaking so bad from his alcoholism. This is the same as my story, just twenty times over. It was great. I felt at home. I felt at peace. I felt like, Oh my god these people all did it. Some were worse off than I was and they were doing okay. Maybe I could do this too.

I started IOP [intensive outpatient program], I eventually got hooked up with the Kaduceus group, they were very important, I’m not going to lie. There are certain things that are unique physicians and other healthcare providers and professionals. One of them was like, You have to tell the state. You have to tell the state what is going on because if you don’t they are going to find out anyway and it is worse if they find out and you don’t tell them. Lots of fun!

At the same time the hospital doesn’t officially agree. The department did everything by the book and so they alerted the hospital administration. They do their own official inquiry. I am new in AA and all of that. Yes, I was deposed.

**AS**: You had your own deposition.

**RL**: Kind of. In rigorous honesty I tell them everything, which my sponsor later was like, You know, that’s good when you are in the room, but maybe not with the opposing side’s lawyers. [laughs] Long story short is that they put me on FMLA [family and medical leave] and paid me salary and benefits for six months. When that ran out they ‘allowed’ me to quit. They were not going to take me back. I was hoping I could just switch and do family medicine there, and the family medicine program was all set to take me and the hospital was like no, you’re fired. I was like, Oh right, I did all that stuff.

Initially I was super pissed at the hospital but they did what they had to. I had admitted to them that I showed up intoxicated, stole from them, and practiced under the influence. They terminated me. Actually, they didn't terminate me. They said they would give me a week to resign and if you don’t we’ll terminate you. The distinction is important because in medicine on your credentials it asks if you have ever been terminated and I can honestly say, No, I’ve resigned, I was never terminated. I have enough things to say to on those credential application things. One of which is why did you ever have a break in your training, which I’ll talk about.

I alert the state and I’m five days away from graduating from this partial hospitalization. The state comes back and says, You’ve got to go to inpatient treatment and you’ve got to go to one of these places that deals with physicians. I said, But my addiction doctor said I have to do outpatient and my insurance is not going to cover this. They said, Medically you don’t have to. If you want to keep your medical license you have to.

I had a long and difficult conversation with my parents because it was expensive, I was in residence, and I had no coverage. Also, under the influence I had bought this really big house that was way too much house for me because I thought it was very important. We were never super broke because my parents were always able to help us out, but we were way over extended and I didn’t have thirty thousand dollars laying around. My mom footed the entire bill. I am really lucky.

I went to the Hazelden Center in Springbrook, Oregon which is where they housed all the physicians. I went there because over the phone they said it would be a twenty-eight day program. Every other place I went to said for physicians it is ninety days. I get there and on the third day they said, For physicians it is ninety days also. It is funny because the doc, the treating physician at the time, who is a wonderful guy, was used to people just blowing up. You could see him preparing himself. At that point I was like, Whatever, I don’t care. He was like, Really? I am in a very privileged position because my mom was paying for all of this. Instead of thirty thousand it was going to be forty-five thousand. I have to get the fifteen grand and she is going to pay for it, but she is going to pay for it so that doesn’t matter. Leah, my wife, is pissed that I’m not going to be home, but she said it’s better than using drugs. I was like, Whatever. Plus, it was a really beautiful time to be in Oregon. I went in early April. Even though I was only three days there I knew it was more intense. Nothing against the treatment center I had in my hometown, but this was clearly better treatment. I knew I didn’t want to go back; I didn’t want to use again. I thought if it takes more time it takes more time.

I had met some good friends. Some of them I’m still friends with. Some of them are physicians and some are not. I was where the physicians were housed but my best friend in treatment was younger than me, I think I was twenty-nine at the time and I think he was twenty-two or twenty-three. We became best friends. We are still friends. He ended up dying in a car accident sober, just tragically. He grew up in Alaska and he moved to Minnesota to be in aftercare and I ended up getting a job in Minnesota, so we were close to each other and hung out and saw each other. He was doing great. He was driving to work on an icy road and the car slipped off and flipped and he was killed. They did test him because his family wanted to know and he was sober when he died. It was just an accident. Bad things happen even when you’re in sobriety.

Anyway, I met some great people. I did my ninety days of treatment. You have to go back home and get plugged into AA and get a sponsor and stuff but I actually already had all that stuff. I had done that partial hospitalization program and almost completed it. I had already done aftercare through the same program and I already had a sponsor and I already knew all the AA meeting that I was going to. I had all this time during the IOP to go to AA meetings everyday.

I’m done with treatment, I go home, and I step back into all this. The state grants me back my medical license and I do get terminated from this hospital, so now I’m in this limbo. It is August or September and now the process to get another residency spot is passed. I can’t get my stuff together in time anyways. The one thing I really wish the hospital would have done would have been to just fire me in September, but they didn’t. They kept me in limbo and didn’t announce they were terminating me until the day before Christmas. I think administratively they just had to get all their ducks in a row and it took them that long, but at the time I thought they did it because they were being punitive. I don’t think that anymore.

**AS**: I thought you quit?

**RL**: Okay, they sent the letter saying you have to quit or we are going to fire you. So, yes. Technically I quit. They sent the letter saying you have to quit or we are going to terminate you the day before Christmas. In that time between September and December I met with the family medicine department and the medicine department. I had already made the decision in treatment that I was not going to go back to anesthesia. It was a bad idea because there was too much fentanyl lying around, and it wasn’t really my passion. Looking back I had that piece of paper and I should have done family medicine anyways because it was more in line with what my goals were. Again, nothing against anesthesia.

I met with the addiction point person in the department of anesthesia. We had a couple of conversations on the phone and then met in person when I got back. Everyone was okay with this and on board with this. Then I met with the department of family medicine and I was like, I’m going to start family medicine and I’ve been accepted and it is going to be great. They had a position for me, and they had actually just lost one of their residents for a drug related problem also. They said, Perfect you will fit right in. Then the hospital sends the letter and I had to inform them that I could not join them.

I was really devastated because I was unsure if I was ever going to be a doctor again. It is hard, there is all this stigma. Now I am an addict. I’m an intravenous drug using addict who resigned from their anesthesia job, has a gap in their training of at least six months and will be even longer because I can’t get a job. The earliest I can get a job as a resident now is in June of the following year, 2009. What am I going to do?

To make matters worse, my wife is a very tolerant and loving person, and she put up with a lot. At some point she was like, Look, I’m okay not making anesthesia money anymore. One of the main reasons I was an anesthesiologist was because you make a lot more money than family medicine. Not to say that my wife is monetarily driven, but of course it is part of it. She said, I’m fine with that, I’m fine with us moving, I’m fine with us selling this house, I’m fine with you being a drug addict, I’m fine with you going away, but if you are going to do all of this we are going to move closer to my family so we wanted to move to Minnesota.

I can’t do the match process which usually happens in residency. I had to scramble which means I had to find a program with an open spot that is not through the match process. And now we were limiting it to Minnesota. I was going to have to do pediatrics or something. Nothing against pediatrics but I didn’t want to do pediatrics. I was stuck with family medicine or I was willing to do internal medicine in Minnesota. I said, Leah, the odds of me getting a position are really small. She was like, I’m going to move to Minnesota. If you have to do residency somewhere else we will try to make it work but I’m moving to Minnesota. I was like, Well, shit. I’m moving to Minnesota, too.

Part of my disease -- my pathology, not my disease -- was that too much of my identity was tied up in being a doctor anyway. I thought this might be the universe’s way of telling me I shouldn’t be a doctor for a little while. I thought, If I can’t get a spot in Minnesota I will find something else to fill my time, but I’ll be in Minnesota.

I get the scramble list from a friend of mine in treatment actually because I hadn’t even signed up in time to get the scramble list. There are two open family medicine spots and one open internal medicine spot. I called the internal medicine spot place actually second and no one answered. The first place I called was the residency spot in North Memorial, the family medicine residency at the University of Minnesota. I didn’t get a voicemail, I got the program coordinator. I just blurted out my history to her. And she was like, Oh, okay. Can you fax over your stuff? [laughs] I said, Sure.

So I did, and then I got a phone call a half an hour later from the program director. I tell him my whole story and he goes, Okay. Then we did a little interview and he asked me about my interest in family medicine, he asked me about Minnesota, about treatment, what I thought of it, and if I viewed myself as an addict, which I did at the time. Then I got another phone call from the associate program director and another from the head of behavioral medicine at the program. Then I got an offer faxed to me and I took it.

**AS**: Did the behavioral medicine have anything to do with addiction medicine?

**RL**: No, it was just the behaviorist. Most family medicine programs have some sort of behavioral health component. Most of them have a behavioral health lead. I think it is required. North certainly does. They have a long history of integration with behavioral health in their primary care training. It was just part of the interview process for every applicant. It was pretty clear they didn’t know anything about addiction. But they knew enough that they thought, Well, this guy seems pretty smart, pretty motivated, and he says he’s sober.

**AS**: And they had an opening.

**RL**: They had an opening. One thing I did not know was that they had an opening in the first year position and in the second year position. Given my standing they could move me to the second year open position and take someone else they really wanted for the first year position, too. It worked out very well for them.

**AS**: You already had a year?

**RL**: According to the American Board of National Medicine I had something like twenty months of actual training. You also have to do twenty-four consecutive months at one training center so you had to do that. I had to do my second and third year here at North. So, I did. That’s how I wound up in Minnesota.

**AS**: How did you get into addiction medicine? When did you get into it?

**RL**: That’s a great question. It was 2009. One of the things I loved about my treatment and about my treatment provider at Hazelden was that he, and my addiction doctor at the other treatment place was great, but the addiction doc at Hazelden really loved addiction and loved teaching it to other physicians. It was part of his spiel.

When I first got intervened on, I initially thought that addicts are bad people. I’m sorry, I did think that. Through treatment I thought, Well, other addicts aren’t bad people, but I’m a bad person. That took a long time. Part of Dr. Williams’ approach was teaching us about the disease. He said, You’re not a bad person. I know you did some bad things, I’m not going to lie. But this is why. This is what is happening in your brain. I found that fascinating.

My parents are both psychiatrists. I knew I didn’t want to do psychiatry. I wanted to do something that was more medical and this seemed like a great intersection. I was just utterly fascinated about it and I started reading about it in treatment. I had a ton of time, it was actually great. There was a ton of structure, I actually didn’t have that much free time in treatment. But, with my free time I did a lot of reading on it. Also, I still loved medicine. I thought, I may not be able to be a doctor, but that doesn’t mean I can’t learn about it. I read about it, and I learned a fair amount even before I ever set foot in a family medicine residency.

I set foot in a family medicine residency, I started seeing patients, and I loved it. I loved it from the very start. I also remember being super grateful that I had a job. By the way, that persists. I still, to this day, am super grateful that I am a physician. It is a really wonderful way to fight burnout. People talk a lot about burnout physicians. I know how close I came to not being able to be a doctor and I am still to this day infinitely grateful that I was given that chance. And how privileged that position is, and it is.

I realized that no one knows the first thing about addiction. They will go, This guy is an alcoholic. He’s in bad pain we should just give him Percocet. I’m like, That’s a bad idea. They are like, Why? I go, What do you mean, why? They would say, He’s addicted to alcohol he’s not going to get addicted to Percocet. I’m like, That’s not how it goes. I was printing articles and showing them to my attendings. They were saying, Oh, that’s interesting I didn’t know that. What? How do you not know this.

**AS**: Because there is no training.

**RL**: Because there is no training on addiction, especially back even in 2009. There was none. And this is a very good and progressive group of doctors at North. They said, We need to learn more. Even as a second year resident, they started asking me to help develop a chronic pain program and develop screening tools and help us develop this because I already knew stuff. They forced me further to do more research and to do more stuff and I got super into it. I also was like, No one knows what they are doing. I was like, Why am I a second year and a third year resident telling attendings how to do this stuff? The answer was because I knew more than they did.

That’s okay, but that’s when I started to develop my passion. I was like, Look, addiction treatment belongs in primary care. Not all of it, there is a time and a place for an addiction specialist, but like diabetes, the vast majority of addiction treatment I feel should occur in primary care settings. Only when they are too complicated should they be referred to an addiction specialist. There is no way we are going to have enough addiction specialists to treat everyone who has an addiction. Just like we are never going to have enough renologists to treat everyone with renal problems. We are never going to have enough endocrinologists to treat everyone with diabetes. Family medicine has to do the bulk of this, but the bulk of the simple stuff.

Frankly, the majority of addiction cases are relatively straightforward. The ones that we hear about are very complicated and do belong probably to a specialist. I can tell you the mundane are mundane. “You’re just a normal alcoholic, man!” [laughs] That’s the most common visit I have. They tell you this whole story and it is my story, it is me again, and I’m like, You’re an alcoholic. They think it’s the end of the world, and I’m just like, No, you’re just one of the thousands of people I’ve treated. It’s not exciting to me. They are like expecting me to be really upset and I’m like, No, seriously, I do this all the time. This is super common.

I started and then I really wanted to work in integration of addiction medicine into primary care. I had a meeting with one of my mentors at North Memorial when I was a third year resident. I said, I want to do faculty, I want to do this. And he said, If you want to do this you need to do fellowship. You need the credentials. We would take you, but to make policy change and to take to systems and things like that. You need -- even though at the time it wasn’t Board of American Medical Association recognized -- you need a fellowship and the letters after your name.

At the time I was also going to a meeting of drug doctors and I’m not going to talk about it because it violates on the rules of AA too much, but there was a large meeting where a bunch of doctors in recovery meet regularly. I had become friends with a bunch of the doctors that meet regularly and one of the people there happened to work at the Hazelden location in Minnesota. They said, Look, we can create a fellowship for you and someone else. They had two people in line. They said, Why don’t you drop by when you are back in Minnesota? So I did and we met a couple of times. He was a friend of a friend and we became very friendly and he eventually became my mentor in addiction medicine and I did the fellowship. I continued to work with Hazelden part time and at the University of Minnesota [Minneapolis/St. Paul] part time.

In 2015 I left Hazelden to work at the University full time. Since then I have, through a lot of luck and hard work, I have been sober since May 3, 2008. I didn’t talk about this, but of course I had to be monitored by the state. They knew and I had a medical license from my hometown and I had a medical license from Minnesota so I told them and had to be monitored. For three and a half years everyday I would have to call and leave a random urine drug screen. Sometimes I would have to wake up very early before rotation or after I was on call I would have to drive to a collection point and leave urine. I had regular quarterly reports from work and from my sponsor. I needed to have meeting attendance, I had to see a psychiatrist, I had to do aftercare again. I don’t know why the state had me do that again because I had been sober for two years. They suddenly mandated that I had to do another aftercare program. I don’t understand that fully. But I was still at the stage where I was like, Okay, whatever. I did twenty-five two hour meetings with this group. It was great actually.

**AS**: You have remained open and cooperative in your own recovery because it’s humbling. Would you say you are a more humble person now? More grateful?

**RL**: Infinitely so. I had strengths growing up but humility was not one of them. I’m not sure you could call humility one of my strengths now, but I certainly have a lot more of it than I did. I wouldn’t call it one of my weaknesses anymore.

**AS**: But you aren’t using your authority as a physician to bulk at or refuse to go to these things. Or is it that you aren’t allowed to do that anyway?

**RL**: Good, good point. I wasn’t able to because the state could always take my medical licence away. That was always the threat. I was always compliant because I knew how good recovery was.

I had learned, frankly, when I was a patient at Hazelden, that I didn’t have all the answers. Sometimes you have to listen to other people. Still, to this day, I trust those people. That they know more about what is best for my disease than I do. When I start to take control of my disease is when I start to run into trouble. When my sponsor says, You need to go to a meeting, I go to a meeting. My new sponsor in Minnesota is not a physician. My first sponsor was. He doesn’t know anything about medicine. I prefer it that way. If he tells me I need to go to a meeting, I go to a meeting. If I say, I’m an addiction medicine doctor, what do you mean I need to go to a meeting? I just go to a meeting. I trust him.

**AS**: You say something or he hears something and he knows you need to go to a meeting?

**RL**: If I’m getting petty, or too anxious, or irritated while driving. That’s a big one for me. He’ll be like, How was the drive home? And I’ll tell him, Not great. He says, You’ve got to go to a meeting. And he’s almost always right. Sometimes he’s not but I still go to a meeting and it’s good. Yes, AA is very important to my recovery. I acknowledge that. I know that it’s not for everyone. I feel sorry for those people because it has been integral to my recovery and my social group.

I don’t hide my addiction either. I hid it long enough. I was always open with the people at the University and at North Memorial. I was very fortunate in that they did not judge me because I know stories of people that have been judged. Now that I have a track record of successful employment it is harder to stigmatize and not hire me for things. They have no basis to not hire me. I was successfully hired before. I know I am lucky.

I also teach residents now and I tell them in orientation about my own story as a part of wellness. I say, Look, there are fourteen people in this room between the staff and the residents. Statistically two of us are going to develop a problem with substance use disorder. Fortunately for you guys I have already taken one of the spots. That’s how I usually start. Only one of you now can take the other spot. I tell them my story and, like the person that was there for me at my other job, I say, I am always here for you guys.

It has come up. We have had residents in this program that have developed addiction and we have gotten them help. They have gotten their medical licenses and are successfully practicing. Not all those stories go that way, it just happens to be at this program I sponsored someone in medical school who did not graduate medical school. He relapsed and said he was done.

It is not always rosy, I’m not going to argue that. I have been very blessed and very fortunate in my life in many ways.

**AS**: How has the integration of addiction treatment in primary care been working for you here?

**RL**: That is a great question. It totally depends on what you define as success. If you set the bar at better than when I got here, it has succeeded very well. I go to a lot of opioid and addiction forums in the state and I hear what doctors that practice are doing and I maybe have an ego moment that I have a lot of pride that none of my residents are going to do any of those things. I will say that with certainty every year we graduate ten family medicine doctors and none of them will do these things. None of them are going to blindly going to prescribe benzos or narcotics to anyone with an opioid use disorder. They will at least have a conversation about risks and benefits and monitor them with drug screening. They will at least do that at a very minimum.

**AS**: That adds up to a lot of patients every year who those people will be seeing.

**RL**: Yes, it does. It is not because of me. It is because of what the faculty and I have built here. I guess it did start with me.

**AS**: What does it involve? What are they required to do as a part of it?

**RL**: That is a very long and complicated answer.

**AS**: How many hours of training do they get?

**RL**: That is a little like asking a family medicine doctor, How many hours on diabetes and hypertension do you have? The answer is like, I don’t know, it comes up when it comes up.

**AS**: Okay. What you’re doing is creating a space where this is considered part of your normal training. Patients will come to you and some of them --

**RL**: Right. And we do have formal didactics. I just had a formal didactics with the residents on congestive heart failure. We also have one on alcoholism and opioid use disorder and chronic pain.

**AS**: The fact is is that it is integrated into the program whereas there are many programs where it is not discussed at all.

**RL**: Right. When I discuss a case with the resident, when a twenty-six year old male comes in for a physical, which happens, they say, His blood pressure is fine, his cholesterol is okay, he needs more sleep, his single partner and sex stuff is okay. I will say, Have you asked him about his alcohol use? Initially it was ‘no’ but now he would say, I screened him for alcohol use and yes, he’s drinking too much and we talked about that. I asked if he has a family history of alcohol use, and actually, yes, he meets the criteria for alcoholism. We talked about that and we talked about next steps.

**AS**: So it is just integrated into it.

**RL**: It is integrated into it, yeah. You have patients that you know are alcoholics. When he comes back and his blood pressure is high and I tell him he needs to quit drinking and he comes back and he actually looks like he is in alcohol withdrawal and we talked about that. It changes the trajectory of the treating. It just becomes something that you are used to talking about doing, and it therefore becomes part of it.

**AS**: And not one of these uncomfortable, hidden things. The patient can still hide it, but if the doctor is willing to talk about it --

**RL**: I don’t want to say that it never happens because it does. Because these things are still difficult to talk about. The thing that it does mostly is in established patients in our clinics that have chronic pain, that are on narcotics, that we start to suspect have narcotic depends, residents will shy away from that conversation because it is a very difficult conversation. I am working on it. That is something a primary care doctor has to do. That is not something an addiction doctor has to do. Something that the person prescribing the opioids needs to do.

But, we look for it now. We didn’t even look for it. We have prescribed you a bunch of oxycodone, why is there all this morphine in your urine? We test it further and it comes back, Well, it looks like you did some heroin. I never did heroin, doc. No, you did. It’s in your urine. Okay, I’ve been doing heroin for three years. You’re like, Okay, now we need to have a separate conversation. It happens all the time.

**AS**: Right. What about best practices for the future of addiction medicine and for primary care doctors dealing with addiction?

**RL**: I would say that a lot of the recommendations are already out there. If you look at the American Academy of Family Physicians there are different classes of recommendations for screening. Class A is the highest. At least to my knowledge at this date and time, there is only one Class A recommendation for screening and that is for drug and alcohol use. Everything we do is Class B, which is still very good. You should still do it, there is still good evidence, but it’s not as good.

When you get screened for depression, cholesterol, high blood pressure, sexually transmitted diseases, Hepatitis C, or pap smears that’s actually all Class B. The only thing that is A is substance use disorder. Everyone does is with the same rigor that they do all the B stuff. When they think about why, it just becomes part of what they do. When they find a positive they know what the next steps are.

Part of the reason doctors don’t screen for addiction is because you will never convince a physician to screen for something where they say, Yeah, I got that. They have no idea how to treat it. They would just prefer to not ask the question. No one wants to feel like an idiot. If I asked you the question as a physician and they say, Yeah, I have that. What do I do, doc? And I’m like, I don’t know. You would never ask that question. I hope that they know at least enough to do it.

There is a whole system called ESPRIT out there that is supposed to teach primary care doctors how to do that. I would like to see that very tightly integrated with primary care. I would like to see a better understanding of medication assisted treatment; I would like to see more primary care doctors doing buprenorphine treatment and other things like Naloxone, Vivitrol, and Capral. Plus, better behavioral therapy and understanding of addiction as a chronic, relapsing disease of the entire family, and more help with the biologic, psychologic, housing, financial stressors that come with this disease like we do for a lot of other chronic diseases. We do this for diabetes. We really do, especially inner-city clinics. We just don’t with addiction. That’s all I’m asking is to pair it with these other diseases.

**AS**: Cancer, too. There are mothers of addicts that have written about having breast cancer and being so supported and cared for, so much follow through that their addict children never get.

**RL**: That’s what I would like to see. A good idea about where to refer one to treatment. An easier, immediate availability of treatment. That is a key piece that we really lack. Even with all the resources we have here in Minneapolis. If I see someone that really needs to go to treatment I cannot get them in. Many studies have shown that that is frankly very tragic because you will never get better results than immediately. Right now when you are ready you need to go directly to treatment.

**AS**: The waiting of ten days, two days --

**RL**: Yeah. Forget it. Even a day is too much. Sometimes even twelve hours is too much. If you have ever watched the show Intervention, which I am not going to comment on, the one thing they do really well is if you say yes, you are on a plane. You don’t get time to pack even. They pack you a bag. You are on that plane and that is the way they do it. That is actually the way to do it. No time to think about it, just do it. I would like to see that. I want to see a primary care doctor that says, This guy needs help right now, like you would if someone was having a heart attack. You would get them a bed at the hospital immediately. You are not going to wait two days on a heart attack.

There needs to be enough knowledge in the primary care system so that every doctor isn’t like, Oh, you drank too much alcohol? You need a good -- It’s not like everyone with chest pain needs to come to the hospital for cardiac care. There needs to be enough knowledge in the primary care setting to when the one needs to go, but these thousands of others just need to be seen again in a few days when we will talk more about your drinking.

**AS**: How far are we from that?

**RL**: Far. We are not there. Not even close.

**AS**: Besides someone like you happening upon this program, are there more people like you?

**RL**: It is starting. Medical schools -- yes. I am infinitely replaceable. There are lots of people like me.

**AS**: Are there people like this across the country?

**RL**: Absolutely. The American of Board of Medicine has many people like this. Some people way more than I am, even. There are people that are trying to develop whole health care systems like this. My former colleagues at Hazelden, everyone who is really committed to recovery is working on this problem.

**AS**: In primary care?

**RL**: In primary care. Particularly in primary care because they acknowledge that you need that basis. You need to have the same understanding of addiction that they do of heart disease. They need to know enough to know when this person needs help and this person needs something else.

**AS**: Right. When to refer you and stuff.

**RL**: There is not a ton of availability of people that can train other people. Time is tight and time is precious. What are you going to sub out for addiction care? Then you start getting into political issues. It’s not like medical students sit around not doing stuff for periods of weeks. Everyday is busy in medical school. You have to remove something if you are going to put something in. The issue is what are you going to remove? You’re not going to remove my thing. Everyone thinks their thing is the most important, including me! I’m addiction doctor and I think addiction is the most important.

If you have a heart disease, you do you need to know.

**AS**: Did we make room for HIV [human immunodeficiency virus]?

**RL**: Yes, but I would argue that the training for HIV in medical school is not sufficient.

**AS**: Still?

**RL**: Still.

**AS**: What about mental health?

**RL**: It is definitely not sufficient. I can make the argument that all training in medical school is not sufficient and that is why we do a residency. That is why you aren’t ready to practice once you graduate medical school.

We need to build a foundation. Is there enough of a foundation in HIV? Probably. Mental health? Probably not. We still have work to do.

**AS**: It seems to me there is so much that goes hand in hand with mental health and addiction.

**RL**: Right. Stigma, too. The thing that we do really well that have foundations are that I have taken all the CPR classes, pulmonary, and renal. That we have down. That we have a good basis in medical school. And that is really important as a doctor. I am not trying to minimize that. If one of those fails you are going to have big problems. You need to know that stuff.

**AS**: Of course. But you as a doctor are going to encounter people with addiction. Very severe and very mild. All of it.

**RL**: Especially once you start looking. Some people will go, Oh, addiction isn’t that common. Then once you start looking and a student comes to a residency and they go, Oh my god, once you start looking for it it’s everywhere. I’m like, Yeah, I know.

Most of it is this guy who drinks too much and has uncontrolled hypertension and diabetes because he drinks too much. That is the most common form of addiction that we see. Guy or woman. Addiction is blind to sex and race and everything. You can treat the hypertension and diabetes as much as you want but until you treat their addiction you’re not going to make any headway. That is the most common case I see.

**AS**: Two last things. What is an ordinary day like? And then kind of an extraordinary day?

**RL**: It is interesting because I have so many hats as faculty that I use in an ordinary day of practicing addiction medicine. At a normal clinic I will see anywhere from six patients in a half day to twenty patients in a half day. My clinic is integrated so not all of my patients are addiction patients. Even on a twenty person day it is still at most sixteen addiction patients and four will be hypertension and diabetes. Even though I have time set aside I still get general primary care, which is great. I like it that way.

Most of the preponderance of my patients that I see because of the way the clinic is set up are more severe. They are almost all opioid addicts. Most of the run of the mill alcoholics get treated by my colleagues because it is more straightforward. If they get more severe then I will see them. The ones in liver failure or the ones that are coming out of treatment and have bad neuropathy, I will see them.

We will have discussions ranging from how their life is falling apart now because they relapsed to how great things are because they are finally sober again and their kids are talking to them again. Little victories and little defeats. People getting better and people getting worse. People requesting medication that is not appropriate. People telling me this other doctor that wanted to give them medication that was inappropriate and they said no and are really proud of it or things like that. There is always some confrontation like, I looked in your urine and it’s in there. They say, No, I didn’t do it. There’s always some of that and some talk about what we are going to do moving forward and what the next step of treatment is.

Almost every day has some sort of discussion of someone that needs to step up treatment and needs to see me more frequently or they need to go to an even higher level of care, meaning inpatient treatment or more intensive outpatient treatment or something like that. I’ve mentioned that AA isn’t for everyone, and that’s true. I can’t get everyone to go to AA. We then discuss, for lack of a better term, what sort of spiritual recovery are you having? By that I mean what part of your recovery are you not focusing on yourself but you’re focusing on others. How is that integrated into your recovery? If the answer is no I have the whole spiel about, You need that to really have a happy life. If I had stayed focused on myself my entire life, my entire recover, I would have used again I’m pretty sure.

I have had some really bad things happen to me when I was in recovery. It is by pulling upon my resources of friends and family that really helps me through that. And by getting out of myself. Going and doing stuff that is not for me. Even when I am in a lot of turmoil it is important.

That’s a pretty typical day.

**AS**: And an extraordinary day? Whether that is good or bad.

**RL**: Addiction does make chaos. Even in an ordinary day there is a fair amount of chaos in it. I have patients show up hours early, hours late. I have double bookings, and then I have patients showing up twelve at a time within twenty minutes. I have to scramble. People in early recovery --

**AS**: But you work with them and you’re flexible?

**RL**: Oh, yeah. There are some patients that I set boundaries with. I am not going to say it for everybody, but yeah, for the vast majority of patients I will work with them. They are here to see me and I will see if it is physically possible, and it is for the vast majority. It can be stressful.

What makes an extraordinary day for me is a therapeutic breakthrough or a therapeutic collapse. The thing that makes an extraordinary day is when I have a patient of mine that has not been doing well and we have a really difficult conversation where I say, I think you need to go to inpatient treatment. Then they say, What about my kids? I say, You are going to lose them. I am going to have to report you to CPS [child protective services] or I already have reported you to CPS. You have to go.

When they come back from treatment and they are sober, which happens, the change in them is remarkable and will make my entire week or month. It is wonderful to see. Sometimes I don’t recognize them. Patients that cursed me and told me how much they hated me. They curse at me and yell at me and tell me some very, very hurtful things. [laughs] Seriously!

I just had this one patient three months ago tell me I was a terrible doctor and that she hates me and she can’t imagine that all my patients don’t hate me and she can’t imagine any reason why anyone doesn’t hate me. The only reason anyone is nice to me is because they are afraid of me. It was actually really hurtful and I had to destress and debrief with another colleague afterwards. It really hurt especially because I had treated her for a while and she was not doing well.

She came back to see me just a couple of days ago and she told me she needed to talk to me. I asked her why and she said it was because her case with CPS was ending and they were going to stop monitoring her. She was taking narcotics from a pain clinic and I told her it was a bad idea for her. They were monitoring her usage and she said, I know that as soon as they stopped monitoring me I was going to relapse, you were right. There is no way I’m going to stay sober. She asked me to help her not do that. The amount of courage it took her to do that really moved me.

**AS**: To come back to you.

**RL**: She never actually apologized, but coming back she didn’t have to apologize.

**AS**: The act of it.

**RL**: It was really an extraordinary day.

**AS**: And you understand how remarkable that is, really, only because you have been in her shoes. Would you say that is true?

**RL**: I think you can develop that working with addicts long enough. I would not say you need a personal experience. Maybe it is easier if you have had one. I am not one of those doctors that thinks that. I think you can just have someone who is intellectually curious about addiction, as good of an addiction doctor as me. Without any personal or family history with the stuff. You could still understand. But yes, it helps.

**AS**: It helps. The other thing I was thinking about was what if a doctor didn’t have an understanding of a patient’s addiction and they went off on them like that, they might be barred from coming back to the clinic or something.

**RL**: They would certainly be hesitant to see that patient again. They probably couldn’t see me again.

**AS**: Once you start to understand addiction and what people will say and do in the throws of it you can treat them differently and by treat, I mean both ways.

**RL**: Yes, you can.

**AS**: That goes back to what we were talking about about integrating it into primary care because you can lose so many people who need help with addiction and primary care if you don’t know how to deal with their responses.

**RL**: Yeah. The other thing is I have had patients that literally have threatened to stab me if I didn’t give them a drug. I have zero tolerance for that. They will be disbarred from the clinic and they cannot come back. There is one patient in particular who straight out showed me a knife and said, I’m going to stab you if you don’t give me benzos. I told him I would go get the prescription pad right away and so security came and escorted him out. That has happened. He was barred from coming back to the clinic. I’m sure he didn’t do well. I was prescribing him suboxone and he called and said he needed his suboxone. I said, Not from me you don’t. You threatened to stab me. I’m sorry, but you can’t come back here.

**AS**: Unbelievable.

**RL**: I don’t know what happened to him. That kind of stuff does happen. It has happened once since 2009. That’s a remarkable day.

**AS**: Is there anything else that you want to say?

**RL**: A lot of people have this misconception that addiction is exhausting and people must burn out. Most people have this impression that in addiction medicine everyone knows the nature of their disease. ER doctors that I have a tremendous amount of respect for look at me like I am crazy for doing this because every single addiction patient they see is in the ER. They aren’t in recovery.

Take me for example. I am a perfect example. I was working here at North and I am still klutzy. That has not gotten better with my recovery. I tripped and fell down the stairs and I very badly sprained one of my toes. I hobbled myself into the ER and said I needed an x-ray because I couldn’t walk. I got an x-ray and the whole visit was an hour. They told me to take Ibuprofen and go back to work. They gave me a little walking shoe to walk in that helped the pain a lot.

That ER doctor had no idea -- even though I know it is in my chart -- that I was an addict. He had no idea. None. I did not appear to be an addict. I did not request narcotics and I would have turned them down if he had offered them to me. There is nothing about that visit. I was in scrubs for christ’s sake. There was nothing about that visit that made it look like I was an addict. In his mind I wasn’t an addict.

Then the person coming in demanding drugs for vague symptoms and screams at you and calls you all sorts of names, because they are in the throws of craving or in withdrawal or they are desperate, that is every addict for him. His denominator for every addict is all those people that bother him. But I am not in that denominator because in his mind I’m not an addict.

That is a part of the problem with addiction. Once you recover from it no one knows unless you tell them. That is part of the reason I tell people. Because you would never know. I am a bigger person and so you might know that I struggle with some eating issues, and I do, but you would never know that I was an IV drug addict by looking at me. Because I used pharmaceutical grade fentanyl I don’t actually have track marks. I have a scar, but it is very hard to see.

**AS**: You’re point is that addiction medicine isn’t as terrible as some people think.

**RL**: Patients do not do that because by the time they come to see us they know that they have a problem and they are there to work with us to get better. They are not the patients in the ER screaming for meds. They are not that pain patient that every doctor hates to see.

By the way, on that note, that pain patient that you hate to see, you hate to see because he or she has an addiction problem. If you confront it then you have one painful visit and you can help them get over it. If you don’t help confront them, every time you see them it is a painful visit. Just get it over with, confront them, or discuss it with them. Just get it on the table and then it is done. That is the crux of recovery in a lot of ways. Just talk about it. Once it is out in the open they can yell at you and scream at you. It can be a tough visit. I do this a lot and my heartrate still goes up when I go into the room. Then we get to move on.

That’s all I’ve got.

**AS**: Thank you, that was really generous.