**Charles Reznikoff**

**Narrator**

**Amy Sullivan**

**Interviewer**

**January 17, 2017**

**Minneapolis, Minnesota**

Charles Reznikoff -**CR**

Amy Sullivan -**AS**

**AS**: This is Amy Sullivan. I am with Dr. Charles Reznikoff at the Addiction Medicine Center at HCMC [Hennepin County Medical Center] in Minneapolis, Minnesota. It is January 17, 2017.

I am trying to get a whole picture of the people who are involved in what is going on right now with opioids in treatment and recovery and what has happened in the past. That said, I would like to be able to paint a picture of who are the kinds of people who are doing this and what their personal story is. Can you tell me a little about your family and growing up and how you got interested in medicine.

**CR**: I grew up in Madison, Wisconsin. Both of my parents were professors at the University of Wisconsin. My dad’s dad was a famous doctor in New York City -- he was a hematologist. My mom wanted to be a doctor but because of circumstances in her life that wasn’t available to her. I grew up in a very academic family. Both my parents were geneticists. I grew up talking about genetics and biology over the dinner table every day.

My mom was Catholic. I think she is now a recovering Catholic, you might say. I was brought up Catholic and my mom was very into service. Anyways, I grew up always told from a young age that I was going to be a doctor or a priest. It sounds terrible, but I think my mom meant the best by that. My dad was really mellow about that -- he never told me what he wanted me to be. But, my mom wanted me to be in some form of service. I think she would have accepted if I didn’t, but from a very early age I was told I was going to do one of those things. By the time I was twelve I knew I wasn’t going to be a priest. [laughs] I crossed that one off the list! That led me to be a doctor.

I think other relevant things in my family was that my sister was the smartest person I had ever met. She was my older sister and she is a mathematician. She was a very rigorous and demanding thinker. It sounds terrible to say this but she was verbally aggressive. I don’t mean that to be abusive. I mean that if you misspoke she would correct you and if you were illogical she would correct your logic. If you used poor grammar she would correct it. I still use poor grammar but the ability to deal with a critical verbal environment came from my sister. She also has a little bit of OCD [obsessive compulsive disorder] so I grew up with some mental health issues in the family.

My brother is one year older than me. He is adopted. He is currently a safety manager at a construction worksite. He is ten months older so we grew up almost as fraternal twins. My parents couldn’t conceive another child so they adopted my brother and then immediately conceived me. We grew up like fraternal twins. He has a much higher risk for addiction and anxiety. At age twelve, thirteen, fourteen I saw him smoking cigarettes and weed and drinking. He was getting in trouble. As soon as he could he was getting tattoos and taking all the risks. The way I think about it is whatever ‘dumb’ is I did ninety-five percent of it and he did one hundred and five percent of it.

Overall, childhood was excellent. I was very sheltered and protected. It was a safe and wonderful thing. I grew up in this amazing, academic, intellectually challenging circumstance. With my brother I got almost a twin-like experience when we were getting in trouble together. With my sister I got this older sister who was very rigorously demanding and intellectually challenging. My parents were these very smart intellects.

My elementary school was like lily-white. Very affluent, white kids. There was one person of color in my elementary school. My middle school was forty percent black just by coincidence of the districts of those different schools. My high school was back in the other district with the University brats in Madison, Wisconsin.

**AS**: Which high school was that?

**CR**: Madison West. It was a great school. I don’t know if it is anymore, but at the time it was.

I would say I was pursuing the doctor thing, but I hadn’t really thought deeply about it. It seemed like a good path, and it seemed like a good fit. It was being put in front of me. Then out of high school I got into a program called the Medical Scholars, which I don’t believe happens anymore. The University of Madison Medical School has one hundred and fifty medical students per year. Fifty of those spots -- one third of the medical school -- is reserved for Medical Scholars.

Medical Scholars get in coming out of high school. Basically you apply to a program out of high school at the University of Wisconsin. You have to be a Wisconsin resident, you have to go to University of Wisconsin for undergrad, and if you maintain a certain GPA [grade point average], which was very challenging, and do certain prerequisites, they grant you automatic admission into the medical school. What Wisconsin wanted was to capture what they thought were their bright students and keep them in Wisconsin or in Minnesota. Keep their applicants in the state. They did this as a lure.

I got into the Medical Scholarship program. My pediatrician was on the admittance committee. I don’t know if that’s nepotism or whatever you call it. [laughs] I have really just had incredible luck along the way. It is not like I earned everything I am. I’m not saying I’m incredibly successful, but I am a doctor so I have a lot of things going for me. When someone has all of that going for them I am just so aware of all the little turns of luck I had.

Within the University of Wisconsin’s forty thousand person campus, Medical Scholars is like a liberal arts school dedicated to biology and pre-med embedded within the undergrad. I had all the benefits of a big undergrad, yet none of the problems of being in a gigantic state school. It was an incredibly focused pre-med education program. You have to get a good GPA, and they would dictate fifty percent of your pre-med courses and you had to get basically all As in your pre-med courses. All of the rest of your course credits -- do whatever you want; do enriching your careers, take philosophy, take Spanish, take whatever.

The typical pre-med is stressing out about their GPA to get into the medical school spots. I was basically studying to learn. I had to get a good GPA to maintain my Medical Scholar standing, but I wasn’t trying to outcompete my colleagues. It was amazing. I met the GPA bar by like .01. It was literally a miracle. It was like a B plus in organic chemistry instead of a B that did it. It was literally that close.

**AS**: But you stayed with it. You continued to enjoy it.

**CR**: What is really does is it gives you a really enriched education. You can take philosophy and Spanish and history and all these courses that make you feel more like an enriched person. Meanwhile you work your butt off in your biology classes where you can take some risks in your other courses. The typical pre-med is so anxious about their GPA that they will take fluff so they will get good grades in the fluff to focus more on the bio-sciences. I could take more risks with my curriculum.

That has set this precedent for me with this kind of pay-it-forward thing where a lot of people enter medical school feeling like they competed their way in -- I feel like I entered medical school with this like, You’ve been given this, do something good with it. I had incredible fortune.

I didn’t feel like I was a doctor until human anatomy. The first week of medical school you start dissecting bodies. At that point I was like, Oh, wow, this is what being a doctor is and I loved it. Human anatomy was probably the most important class I ever took. It was incredible. I don’t feel like I knew what being a doctor was until medical school. In some ways that’s the story of an entitled person. Someone affluent who had the silver spoon. I didn’t have to stress out about my career until I was already in medical school. And then when I was in there I was like, Yeah, this works for me. I had it easy. I really did. I had a really good path.

**AS**: The important thing is that you realize that.

**CR**: Oh yeah. I am very lucky, compared to some of the things our patients and other people have to fight against in their young life.

**AS**: How did you get into addiction medicine? Did you have a personal connection?

**CR**: I think that almost everyone’s got someone in their family that is addicted. My sister had some mental health issues; my brother was alcoholic and later got into cocaine and opiates.

When I was in medical school there was a scandal in Madison, Wisconsin where some cop caught a news reporter using coke. The news reporter, rather than taking some felony cocaine charge, said I’ve got a good deal for you. He said, I know of at least a dozen firemen that are selling cocaine out of the fire station. I will give you those names if you give me a plea bargain. Of course because the cops and the fire stations usually have competitions, the cop was like, Yes. This guy names thirteen names of these firemen that were using and selling cocaine.

**AS**: Do you remember what year this was?

**CR**: 2000, 2001. It’s in all the newspapers. You would be able to find it. Among those names, he listed my brother who was a fireman at the time. My brother was certainly alcoholic and had certainly used cocaine. Eleven out of the thirteen people were selling cocaine out of the fire station. It was a huge deal and they got fired and went to jail. Two of the people that were listed didn’t have any evidence. My brother was one of them. So my brother was caught in this fire storm of the fire union versus the fire police chief. Someone had seen my brother do cocaine in a bar late at night. No doubt he did; no doubt. But lots of people use cocaine at 2:00 AM when they are twenty-three years old and they just got this new job and they have money.

All the seriousness of the accusations of the people selling the drugs -- no one ever linked my brother to that. I don’t link my brother to that. I don’t know. He was one of two people that were front page news in the newspaper for a year.

**AS**: Even though he was still part of it all.

**CR**: Ultimately he was exonerated. The charges were all dropped against him. It put him under such stress and scrutiny. He was an alcoholic. He was exonerated of all charges. He was allowed to keep his job. After six months of being on the front page my mother was tortured by it. You can imagine being his mom. In the end, he was wrongly accused of this. Two months later he got his third DUI [driving under the influence] and lost his driver’s license. After that he was fired as a fireman.

Joe has since gotten sober. After that he got sober from alcohol and hooked on pain pills. Then he got sober from pain pills and now he is married, in recovery, a safety manager at a construction site, and a union welder. I saw this whole process go down. We did an intervention for my brother.

**AS**: Were you in medical school? When did you start medical school?

**CR**: 1998. I graduated in 2002. It was 2000, 2001 when this was happening. That may have been subconscious and it may have directed some of my thoughts but I was not explicitly becoming an addiction doctor to treat my brother. I was actually really clear with him. I didn’t want to threaten him and be like, I’m doing this because of you. I was also not doing this to help you. I’m not doing this because of you, or to help you. I’m doing this because it is right for me. I’m doing this selfishly.

When I got into opioids and the pain world, Joe, my brother, had not come out as addicted to opioids. When he finally told me he was hooked on Percocet, I was already deep into this world. Going down the opioids path was good for me and it had nothing to do with my brother. Only later I found out he got hooked with opioids. Just like every other person in the county that is introduced to opioids.

That was a very influential, early thing that happened to me. I think also dealing with my sister’s mental health issues affected how I interact with patients and think about mental health. It’s easy, in this story to be like, Oh, he had an alcoholic brother. But I also had an OCD sister. Both these things had equal influence on how I think about and interact with patients.

I did an addiction rotation in medical school in that context -- while all of that was happening. I talked to the addiction doctor at the University of Wisconsin. His name was Rich Brown. There was a Randy Brown and a Rich Brown -- both of which work in addiction at Wisconsin. In this case I talked to Rich Brown, and he was cool.

**AS**: What do you mean you talked to him?

**CR**: I emailed him and I was like, I’m struggling with what I should do with my brother. Do you have any advice? He emailed me back and then I did an addiction rotation. I went to internal medicine residency at County Hospital -- here, HCMC. I didn’t know if I was going into addiction or not, I didn’t know what I was going to do. I was just enjoying residency. I did find that working with patients who had addiction wasn’t like Oh, an alcoholic. I don’t want to go into the room. Then when I come out of the room I feel gross and weird. A lot of doctors are aversive to working with addicts. Or they find working with addicts aversive, I should say. That’s a really common thing. Doctors are humans too. Some doctors are like, ‘I feel really weird dealing with the health consequences of obesity’ because they think obese people caused this by themselves by eating too much and gaining weight. ‘They have bad knees because they are obese. I feel morally compromised.’ Some doctors have that thought. Some doctors have the chainsmoker opioid user who has a heart attack.

For me, honestly, if there is anything, I don’t know if there is a bias, but patients I work with that have diabetes -- I will do it, but it’s not thrilling to me. I leave the room and I was like, I had to do that because it’s part of my job. Whereas other people love that. They go into that field. We all have our things. It just so happened I discovered during residency that when I’m in the room with a patient that’s addicted I’m not stressed out. I’m happy to be there, I feel like I’m delivering care, I can look them in the eyes and relate to them, they seem to relate to me back, and I didn’t question that. During residency I realized that was unique. Most people are avoiding those patients whereas I’m drawn to them. It’s probably because I saw it happening first hand with my brother. I know my brother is a good person, and I love my brother, so I know this person right here is someone’s sibling and I can look them in the eye and treat them as a sibling. I think that contributed.

The fable I tell about how I got into addiction medicine is when I was a first year resident, I saw this young, black, gang member named Anthony. He called himself Ant. He had a tattoo of the word ‘ant’ on his arm. He had congenital heart defect and he came in for his heart problem. When he was there he confided in me that he was a heroin user and I didn’t know what to do. I was an intern.

He went home and a couple of days later, as I was walking down the hallway a phone rang. A receptionist picked it up and said, Yeah, actually yes, he’s right here. Someone just called this phone and asked for you, Charlie. I just happened to be walking down the hallway. Crazy coincidence. I was surrounded by people that saw this happen. I picked up the phone and it was Ant and Ant was crying. He said, I just injected heroin and I don’t know what to do. There were people yelling in the background and he was crying and he said, I’m worried, I injected heroin and I don’t know what to do. I didn’t know what to tell him so I told him to go to the emergency room, which probably was not even the right answer. I didn’t even know what to tell him. All of these people were like, What happened and I told them that a patient that I saw three days ago randomly called this phone number and asked for me and confessed that he had just injected heroin.

In some ways that was my vocation calling. I was like, That’s my future calling. That was a true story.

The other, more real, practical reason I got into addiction medicine was that my senior year, then as a chief resident, in my chief year, I would always work out in the gym. Gavin Bart, who is an addiction researcher and is my current boss, would work out beside me. He would talk to me and he said, Look, if you want to take this job in the addiction department, we’ll account for fifty percent of your time with addiction work and the other fifty percent you can self determine.

Sounds eerily familiar, like the Medical Scholars program where it’s like here are fifty percent of your work you will have to work really hard for and we are going to account for and then we are going to give you freedom. Taking a job here pays thirty percent less than a community job, so it’s not like I’m going for the money.

**AS**: What do you mean a community job?

**CR**: Like if I went to a community hospital and just out of general interest I would have made at least thirty percent more money. He didn’t give me a financial pitch, he gave me a professional enrichment pitch. He just said that if I liked addiction to come do a fellowship and then come to the addiction division and you’ll be able to have a lot of freedom to self determine your job.

It was just such a great offer. Then when I assembled my dream job it’s this diverse patchwork of different things. Everything balances each other. There is a lot of addiction, but a lot of it is non-addiction. He let me develop myself professionally and he trusts me. I saw this opportunity to work within a professionally enriching setting with a good boss.

**AS**: When did you start with him?

**CR**: Residency was 2002 and then chief residency was 2005 to 2006 and then fellowship was 2006 to 2008. I have been here since January 1, 2008.

**AS**: When you say fifty percent with addiction medicine does that involve the clinic?

**CR**: Yes.

**AS**: Can you describe what you do?

**CR**: About half of the weekdays of the year I am responsible for being on-call for the methadone clinic, which could be super mellow or super busy. It allows me to be in my office to take phone calls, multitask, do academic projects. From 6:00 AM until 1:00 PM, six hundred patients might come through these doors to the methadone clinic and we need a doctor on call. It could go smoothly or it could go crazy. About half of the days when this clinic is open I am on-call and then the other half is another doctor. Methadone is a big component of my addiction work.

Every Wednesday afternoon, I do a tobacco clinic.

**AS**: This is one of the other things you do?

**CR**: This is one of the other components. Well, the tobacco clinic is within the addiction domain and is something I have chosen to do. I don’t know if that counts as my addiction part. What Dr. Bart needed me to do was be on-call for the methadone clinic. That’s what he needed. Outside of that ten percent of my time is dedicated to tobacco work.

Ten percent of my time I drive to Rice County and work in Rice County and I work at a Suboxone clinic. Ten percent in tobacco, ten percent teaching at the University of Minnesota. Twenty-five percent is general medicine hospitalist work. I work with medical students and medical residents taking care of patients with pneumonia and heart attacks and what not. The rest of it is on-call for methadone.

**AS**: That’s busy.

**CR**: It’s a lot of things. The methadone is so hit and miss that you can have a lot of side projects. So I have a lot of side projects, extra curricular projects.

**AS**: What happens when you are in here at the methadone clinic? What do you typically get called out of your office for?

**CR**: Someone appears oversedated, someone wants to change their methadone dose, someone has been continually been using drugs despite our best efforts and we need to do an intervention.

**AS**: When you say other drugs what do you mean?

**CR**: Could be opiates, could be cocaine, could be alcohol. Any combination of drug use plus being on the methadone dose and whether or not it’s wrong or they appear oversedated. Sometimes they have a question and they want to speak to a doctor. Or they are dissatisfied in some way.

Often the counselor has a question; the counselor feels like they are up against the wall or they have hit a roadblock and they need to brainstorm what is the next best step.

**AS**: Have you gotten to know a lot of patients? Do you have patients that have been here for years?

**CR**: Yes. I think the stereotype about addiction medicine is that it is this series of emergencies because an addict who is not in care is a series of emergencies. An addict who is seeking care isn’t going to the emergency room, isn’t going to the urgent care. They are hospitalized, and in jail, and in detox.

An addict who is in care isn’t like that at all. An addict who is seeking addiction medicine is in long-term medical management of care. Whether they are getting a medicine or they are at support groups. These addicts that get into care are these long-term patients working towards stability. You get these long-term, incredibly fulfilling relationships with people. There are people that I have seen sixty times within the last eight years -- literally sixty times. I have seen them and fifty plus of those times they are doing great and just checking in. Less than ten of those times they really need help for some reason. They are relapsing or they are worried about relapsing or they are being triggered in some way.

Taking care of an addict as an addiction doctor is not a series of crises. Seventy plus percent of the time you are managing people in stable recovery and you are just trying to keep them there. In that sense it is really fulfilling. At any given time, twenty to thirty percent are in crisis. Every day there is something new.

The vast majority of one’s patients are in long-term stable recovery. I think that is a misconception of addiction medicine: that you are dealing with people that don’t want to be there whose lives are blowing up, who are lying their pants off, and who are reprehensible characters. It’s not that at all. It’s people who have accepted that they have a disease, who are working to get back to a relatively normal life, and who are working hard. Most of them are in treatment. We help them get there and help them attempt to have a perfect life. It is really rewarding and that is a misconception of the job that I do.

**AS**: Speaking of that, I’d like you to talk a little about the stigma of methadone. In interviews that I have had and other conversations there is a stigma that you don’t want to be on methadone because you don’t want to come to a clinic like this. There are class and race assumptions that go along with methadone, not to mention in many of the support groups such as AA [alcoholics anonymous] and NA [narcotics anonymous], to be on a medicine is to go against.

**CR**: It is changing.

**AS**: It is changing, and I would like to see if you could talk about stigma and methadone and if you have seen a change and when that started?

**CR**: I think there are a couple of different reasons why the stigma for methadone is there. I will lay out what I think is the biggest one first. It is basically a misunderstanding about addiction. I am going to come back to that one once I find the words for it.

Number two: the easier one to explain. In a methadone clinic twenty years ago you would have a lot of black people. A huge number of African-Americans, a lot of poor people, and whatever the other oppressed group in your local community is. For us it might be Native Americans, poor people, black people, and if you happen to be caucasian you probably had a mental illness. The demographics of a methadone maintenance clinic -- the demographics of heroin twenty years ago -- was black, urban, felons. Because of that I think there’s some component of, I don’t want to go to that clinic with all those people I don’t identify with. If you’re an affluent, urban, caucasian person, the idea that going to a clinic that is highly black, urban, poor, with some mental health and felonies mixed in -- racism and classism took over. That was the first thing.

Now, I entered the field of addiction just as heroin was affecting white, suburban kids. You just roll your eyes: this is something that has been endemic in the North Minneapolis black neighborhood for decades and decades and decades. Now that it is affecting affluent, urban kids people are freaking out. I get it. But I roll my eyes at it.

I do think how democratic opioid addiction is will force the stigma to change. Opioid addiction is absolutely democratic. Opioids absolutely have no racial, gender, or age preference. This is absolutely a democratic addiction and it is fatal.

Now, a *New York Times* article about a Mexican drug cartel looked at a map of America and they said, Where are the regions already controlled by gangs? Don’t go there. We aren’t going to get into a gang war to sell heroin in North Minneapolis. But, Wayzata, and Eden Prairie, there are no gangs there and there is a lot of money there. There was a concerted effort of the Mexican drug cartel to look at a map of America, look at existing gang territory, and go to other regions.

That came on the tail end of the pharmaceutical opioid epidemic. Obviously the epidemic affected people who had insurance. The pharmaceutical thing disproportionately affected people that had some sort of insurance and didn’t hit the working class as much fifteen years ago. The pharmaceutical thing was more white. The Mexican drug cartel rode those coattails to those same communities that were getting the pharmaceuticals with their three dollar co-pay from their insurance.

It’s more complex than that, but opioid addiction has been democratized in the last five years and the only good thing about the new demographics of people: women, caucasians, suburban; these groups were less affected by heroin twenty years ago. It was more male, African American, and urban. Obviously it is negative when other groups get affected. The only positive thing about it is that I think it will dramatically affect the stigma going forward. When only urban black men are affected, when HIV [human immunodeficiency virus] only happened to gay, male, IV [intravenous] drug users, you can’t help but to think of it as a gay disease. When it starts happening to straight people you realize it can happen to everyone.

I think that is what is happening with opioids right now. People realize they had false ideas. That gets back to the methadone thing. The treatment was mistaken for the demographic thing twenty years ago.

That’s one. Two is that another thing that has bedeviled methadone maintenance, which is kind of a specific point, but relevant, is that methadone tablets for pain can very clearly cause death in pain patients. There have been many very important warning from the CDC [center for disease control] that methadone causes death when given for pain. Recently, there was a *Star Tribune* article on this where I was weirdly misquoted but then people say, Methadone for pain is so deadly, why are we giving something so deadly to the addict themselves? This is what I was trying to get at. People don’t understand that once you’re an opioid addict, methadone reduces death, prolongs life, improves pregnancy outcomes, reduces incarceration, reduces IV drug use, reduces Hepatitis C and HIV transmission. Once you are an opioid addict, the medicine helps stabilize the addict. Once you are an addict, you have an incredible high death rate. Methadone lowers the death rate in that person in a controlled setting.

If you are a pain patient -- not addicted, but in pain -- you should have a really low death rate and methadone raises it. If you are an addict you have a high death rate and methadone lowers it. The pain patient in theory shouldn’t be at risk of incarceration and all the other stuff. The point is that in saying that ‘methadone kills pain patients, so why are we giving it to drug addicts,’ they misunderstand that we are talking about two distinctly different groups of people and the addict is at incredible risk of death. They are totally different groups of people. It’s like saying insulin would harm someone without diabetes, so why are you giving insulin to someone with diabetes? It’s like methadone helps someone with addiction, so why would you give it to someone without addiction? The reason is because over and over since the fifties it has been proven to save lives.

I think that since all the stigma and talk is going to go away when you realize that young, caucasian, affluent kids that are dying, we need to have something to make these kids not die. That is a racist idea that we have let it go so long in the African American community. That is a sad thing. The good thing is that now that it is hitting other communities we are finally going to wake up.

The addicts themselves who enroll in a methadone clinic, if there is anything they don’t like it is the attendance requirement. The attendance requirement is funny because the addicts don’t like to attend because the first ninety days you have to go six days a week. The community is often surprised to hear how close we monitor people on methadone maintenance. We observe dosing six days a week for up to six hundred patients. There is a doctor on-call every day. This methadone clinic sees more people every year than the emergency room does. Up to three hundred patients a day come here and are observed. It is an incredibly tight monitoring program. We are giving them a powerful medicine, but it has been proven to save their life and it is in the context of very powerful monitoring.

Totally different from methadone for pain when they give you a bottle of pills for a month's worth and tell you almost nothing and we have almost no regulation on the doctor's prescribing those pills. It is a totally different context.

Part of the stigma that comes from patients is they call methadone ‘liquid handcuffs.’ It comes in a liquid form. They call it liquid handcuffs because they’re really kind of stuck here. They feel stuck here. This gets me back to trying to articulate what I was going to say at the very beginning. A lot of people think they are on methadone and then will be tapered off and then can be done. Then I’ll be cured. What methadone is not is a cure for addiction. I hope someday we have cures but we don’t. Before you enter the methadone clinic it means you have opioid addiction, which means you have high risk for death, HIV, incarceration, bad pregnancy outcomes, et cetera. When you enter our clinic, we can’t make that go away. We can only manage it with a drug.

A lot of people enter our clinic and think, Maybe I’m addicted to methadone now. You’re not addicted to methadone now. You are still addicted and there’s no getting around that. They feel like they are stuck on methadone. In some ways you’re stuck with opioid addiction and you need to find the best way to manage it and methadone is one tool. I think a lot of people express their frustration at opioid addiction directed at methadone. They’re frustrated with the fact that they have an incurable disease and there’s no way around it and it has incredible consequences for their life. It manifests as showing up to a methadone clinic six days a week and feeling beholden to that liquid methadone because if you don’t you’re in a lot of trouble and then you get angry at it.

I think doctors see that as well, for example, for dialysis patients. If you are a dialysis patient you show up for dialysis three times a week, do a three hour dialysis run, and it shifts fluids in and out of the body and pumps blood around and it feels really weird and uncomfortable. You become reliant, dependent on the dialysis machine. If you skip you die in two weeks. A dialysis patient with die without it in two weeks. They are both totally dependent on dialysis for life. Many, not all, come to resent dialysis and what it represents in their life. They can become angry at their dialysis unit, angry at the dialysis nurses and doctors. Not all are unhappy. They come and get it quietly. Many patients become resentful at this ball and chain. They mistake the dialysis for the kidney failure. They mistake the methadone for the heroin addiction. That’s a really common confusion. Long winded answer.

**AS**: Methadone has an image problem from all sectors. From society, from the patients themselves, and from the twelve-step recovery communities.

**CR**: I’m going to sound like what I’ve heard Obama saying. He keeps saying these things like there are these forces and demographics at play in America that will take us on a path, whether we have steps backwards or not, we are on this path and we can’t stop it. These things are changing. It’s a good change. I think the same thing about treatment of addiction. In some ways it’s bad news because addiction is so democratized now, but it will force us to change.

The twelve-step programs not liking methadone -- I’m not even worried about it. Just give it ten years. You can be in twelve-step programs, but you can only blame the dead person for their death so often before people will just reject it. You cannot blame the dead person for dying. It just sounds cruel. Unless you have another way to keep those people alive you’re ideology is going to need to change -- and it will change.

Just like it changed for anti-depressants and all things twelve-step programs went back on. I’m not against twelve-step programs. I think it’s a good thing. We have seen Hazelden Betty Ford begin to backtrack on the opioid thing. All the dinosaurs that don’t believe in the life saving care, they are going to come around because they have to.

**AS**: There is accountability now because you also have a whole new demographic of rich, affluent, white people who are not going accept that your program didn’t work because they paid for it.

**CR**: Exactly. I think a lot of those things are going to change. I’m not worried about twelve-step programs or Hazelden Betty Ford. They are changing and they have to change. I am happy that I spent those hours in the gym with Gavin Bart who coached me.

I will say one other thing. People in the government and people in the insurance companies don’t flinch for a second about methadone. They know that methadone keeps people out of prison and keeps people alive. There is no insurer in Minnesota that has done the actual math in methadone maintenance clinics that doesn’t pay for them. Every insurer pays for them. The typical clinic with collect fifty percent of their bills and the insurance companies will negotiate or people won’t pay or that treatment isn’t covered. We collect over ninety-five percent of our bills. The only people that aren’t paid for are people who are clearly abusing the system and still relapsing and they get their funding cut off rightfully so.

Every insurer is like, Oh, so you’re telling me for five thousand dollars this heroin addict gets six days a week plus urine screens, drug tests, nurses and doctors visits, monitoring, social work; wrap around services for a heroin addict, for five thousand dollars a year. You just need to save one emergency room visit and we’ve made a profit. We easily do that for every patient. Methadone is just one of the best bargains in healthcare, so almost every insurer is going to pay for it.

That tells you that the monied interests love it because it saves money. The government is very clear-eyed about medication assisted treatment; there is no stigma there. This just keeps you alive. The people who look at this with analytical eyes all really clearly understand the value of methadone and suboxone for the treatment of opioid addiction. The people that get their eyes clouded with their stigma, their ideology, their belief system, and aren’t just being analytical about it throw their ideology about it and get moralistic and they blame dead people for dying.

One more thing about the stigma of addiction is that [A. Thomas] McLellan published an article in JAMA [Journal of the American Medical Association] in 2001 in which he took four diseases and compared them: asthma, high blood pressure, diabetes, and alcoholism. He made a grid and you say, What is the genetic contribution to these diseases? It turns out that asthma, hypertension, diabetes, and alcoholism all have fifty to sixty percent genetics. Fifty to sixty percent of if I’m an alcoholic is due to my genetics.

Second, what is the curability of those diseases? None of those diseases is curable. What is the treatability of those diseases? All of those diseases have treatments, but not cures. What is the patient adherence to doctor’s recommendations? All of them have comparable patient adherence. Whether you tell a diabetic to not eat sugar or an asthmatic to not smoke a cigarette or a hypertensive to not use a salt shaker or an alcoholic not to drink alcohol. When you’re telling a person to change their lifestyle behavior, whether it is in the alcohol or the salt shaker, you get the same results. About thirty percent of patients just don’t follow doctor’s orders -- whether it is alcohol or salt or sugar or exercise or weight loss or whatever it is. Thirty percent don’t follow doctor’s orders and seventy percent try to. Many of those don’t succeed. Alcoholism is just like diabetes, hypertension, and asthma in its genetic risk, patient reaction to news, treatability, and curability. If you forget you’re stigma it looks like any other chronic disease.

The final line on the bottom of the comparison is access to treatment. All those other diseases are given access to treatments, but alcoholics are not. This was a really powerful, thoughtful argument made by McLellan saying basically in every way if you are analytical and put your stigma aside, alcoholism is every bit the same, chronic disease but for some reason they’re not given treatment. There are treatments available; they are no less good or worthy of patients than the hypertensive that continues to use salt. They have no more curable than a disease. I think that is something we’re still slowly wrapping our heads around.

**AS**: There is such a moral stigma and judgement against people. It’s been called a disease for a very long time, but we don’t see it as we see other diseases.

**CR**: Here is another thing I would point out. In 1975 if you had a heart attack they would put you on bed rest for six weeks and tell you that you are stressing yourself out, you’re an A-type personality, and because of your lifestyle you’ve given yourself a heart attack. In other words, your heart attack was blamed on your personality. Now, if you have a heart attack it’s bing-bang-boom: cholesterol, diabetes, hypertension, put a stent in, give them the common cocktail of medicines, and they are back at work in two or three days. Nobody cares what your personality is.

Ten years later in 1985 if you had an ulcer people would say, Your family has given you an ulcer, you’re worrying too much, you eat jalapenos. Crap like this. Now if you have an ulcer, no one cares what your lifestyle, personality, anxiety level, jalapeno, or coffee intake is. It’s, Do you take Ibuprofen or Advil? Do you have cancer? Do you have an infection called helicobacter pylori? Correct those things and you are back at work in a day and your ulcer will be healed in two weeks. No one cares about your stress level today if you have an ulcer.

This is human nature. There used to be this disease called consumption. There was a consumptive personality. That turned out to be tuberculosis. Or gout was the king’s disease. Gout has nothing to do with being a king. It has to do with that you eat foods that are high in oxalate, which kings happened to do because they had money back then and it was trendy.

**AS**: Or hysteria.

**CR**: Hysteria! There are lots of examples of this. When we don’t understand a disease fully, and more importantly when we don’t have tools to treat it, we don’t have analytics to measure it, we always describe these diseases to personality. It’s just human nature. When we can’t define it, when we can’t measure it, and when we can’t cure it.

**AS**: Does it surprise you that we are still there with addiction?

**CR**: No. Brain diseases are more complex. It’s just a more complex disease. Depression is probably about ten to fifteen years ahead of addiction in terms of stigmatizing it. The difference with depression was when Prozac came out. People say good and bad things about it: the Prozac revolution, the Prozac brain. What Prozac and all the similar antidepressants that followed -- Prozac is actually not as good as an antidepressant as those that preceded it. There were better antidepressants.

But, Prozac was so safe that any primary care doctor could give it out basically willy-nilly. It’s main advantage was safety, which allowed it to be used in any primary care clinic in the country. By putting a tool in the hands of every primary care doctor, suddenly a primary care doctor could ask their patient about their mood. Suddenly, if the patient had a bad mood the primary care doctor could do something right there to help them safely. Not perfectly effective, but moderately effective. By putting a tool in the hands of the average doctor, you basically began the process of destigmatizing the disease.

To have depression in 1980 was totally different than having depression today. Having depression in 1980 would have kept a politician out of office. Today we have a governor that has had depression.

**AS**: And we can talk about it and people know about it.

**CR**: We can talk about it. Great! I voted for him knowing that and I don’t regret it at all. I think it’s appropriate. When we start putting metrics and tools in hands -- not BS, but things that work and really make a difference for people’s lives -- we are going to see. You need metrics. If we need a blood test or if you can measure and quantify something with a blood test, or an x-ray and you have a tool to fix it and it goes to every primary care clinic in the country it changes everything. It is out of the shadows now. It is quantifiable, it’s visualizable, and it’s treatable.

Right now addiction is hard to quantify and treatment is still in this shadowy, ghetto corner of medicine. That’s why I think Suboxone should be in primary care clinics, not just to gain access, but to destigmatize.

**AS**: Can you talk about Suboxone a little bit? Is the clinic that you work in in Northfield [Minnesota]?

**CR**: We actually moved to Lonsdale for practical reasons; they actually have a great space. I know have a Suboxone clinic here in Minneapolis at HCMC. I’m not taking any patients at that now, but I have a Suboxone clinic in Lonsdale, Minnesota in a family practice setting. All the doctors that work in that clinic are family practice doctors.

Every other Monday I see patients in Lonsdale. Yesterday I saw twenty-three patients in five hours. It’s crazy. It’s incredibly rewarding. Yesterday literally two of my twenty-three patients were using heroin still. The rest were sober. I get drug screens, I check their prescription monitoring program, but more so I just know these patients. I meet with them regularly. One of them was given a cruise as the best salesman in their company. She was awarded a cruise to Hawaii. One of them just got offered a major promotion at work. These people are really thriving at work and are really happy. It’s incredibly rewarding work for me. Suboxone is like that thing I said about Prozac. Prozac isn’t a better antidepressant, but it’s safer, so therefore it could be given out more easily in a primary care facility.

**AS**: Can you talk about the difference between suboxone and methadone?

**CR**: Suboxone and methadone when compared head to head have similar effectiveness in keeping people alive, out of prison, stopping injections -- there’s more data on methadone because it’s been around longer -- but every time Suboxone and methadone have been compared they come out about equal. What that means is that on nothing, on abstinence based therapy, you could say twenty percent at best are abstinent still after a year. If you just try to do behavioral, talk therapy alone, the outcomes are approximately twenty percent a year, and some have been ten percent in the studies. Sometimes it’s five percent. To be fair to abstinence based treatment, twenty-five percent is the high end after a year.

Methadone or Suboxone changes that to seventy-five percent, eighty percent in some studies. You are taking a one year abstinence success rate at twenty percent and turning it into seventy percent. Still note that thirty percent of opiate addicts don’t respond to Suboxone or methadone. This is not a one hundred percent effective treatment. If you do Suboxone or methadone it is not one hundred percent. It is not. Seventy percent are going to respond to either methadone or Suboxone as opposed to twenty percent to behavioral treatment.

Methadone and Suboxone are comparable in those studies, but there are some differences and I’ll itemize them. Methadone is a full opioid. Both are very long acting and can be taken once a day and will last all day. If you stop taking them you won’t go into withdrawal for three days. In case of emergency or if something happens you have time to get to a clinic if you can’t get it today. They both have very long half lives, and can be taken once a day and last all day, and don’t cause withdrawal for the first three days.

They both block other opiates. If you try to use heroin you won’t feel the heroin. Therefore, it helps you extinguish your heroin habit. Almost all methadone and Suboxone patients, early on, test it; they try heroin on this drug and they realize they are wasting their money. Suboxone may be a little better at blocking heroin than methadone, but they both block heroin. They are both once a day drugs that last long and block opiates.

Neither of them get you high if you are tolerant. If you have never touched an opiate before and you take methadone -- yeah, you’re going to get really intoxicated. Even Suboxone you can get intoxicated on if you have never used an opioid before. But, if you are a heroin addict, you aren't going to get high on methadone if it is dosed appropriately. They are long acting, block other opiates, you should be wide awake, not nodding off, not intoxicated. In that sense, they are identical.

The difference comes in in that Suboxone has a ceiling effect in approximately forty percent opiate strength. Even if you really wanted to overdose someone on Suboxone you couldn’t because it has that ceiling effect. Suboxone in some ways is dummy-proof. You aren’t going to get oversedated on Suboxone. If you take Suboxone patients -- I was showing this to a medical student yesterday in the clinic -- if you took Suboxone patients and lined them up with patients who had never used opioids in their life and you took an expert and they had to pick who’s on Suboxone and who’s not, you can’t. I’m very attuned to this -- the size of someone’s pupils, their eyelids, the rate of their speech. I’m very attuned to opioid intoxication and I cannot pick a Suboxone patient out of a line-up. It’s got a lighter touch. You don’t have to worry so much about dosing Suboxone. If you don’t nothing terrible will happen.

Methadone does not have that ceiling effect. Methadone is a full opioid agonist. Because of that, if you want to be a responsible methadone prescriber you have to work really hard to set limits. There is a dose of methadone which is enough to keep the patient out of withdrawal, addiction managed, keep the patient comfortable, block other opioids, and yet not cause oversedation or, even worse, overdose. There is a dose of methadone that can do that. There is a sweet spot. There is also such thing as too much methadone. If you are going to work with methadone you have to work really hard to set limits on your patients. Some of these are patients that don’t like limits. Part of the job of being a methadone doctor is setting limits. If you can set those limits and keep them in that window where they are getting incredible therapeutic benefits without the oversedation, then methadone behaves exactly the same as Suboxone. Suboxone’s advantage is that ceiling effect and you don’t have to constantly say ‘no’ to people. That is the first major difference because you can overdose and die on methadone much more easily. There’re only a few cases of people dying of buprenorphine alone. You can mix buprenorphine with all sorts of other drugs and die, but buprenorphine alone doesn’t kill you. Methadone alone can kill people. Because it is more potentially lethal that is why it is more highly regulated. That is why we get these clinics and people coming in six days a week. Suboxone is less tightly regulated and can be done out of a primary care clinic. Primary care doctors can prescribe Suboxone and not see the patient six days a week.

**AS**: I’ve heard that there’s a limit on how many patients a doctor can take because of the DEA [Drug Enforcement Administration]. Has that changed?

**CR**: Yeah. First, there were thirty patients per doctor. Then, if you do that for a year you can apply for a hundred patients. Now the DEA has raised it to 275 patients per doctor. That far exceeds what any reasonable doctor needs.

**AS**: When did they do that?

**CR**: Within the last year -- less than six months ago. That far exceeds what any doctor would need. Right now that limit has been raised to almost too high of a level. The truth is that the average primary care doctor has 1500 patients, let’s say. Of those, twenty percent at least are on opioids. That’s three hundred patients on opioids. So the average primary care doctor has three hundred opioid patients and of those ten percent are addicted. The average primary care doctor actually has thirty patients that are addicted to the opioids they are prescribed.

The average primary care doctor has a couple dozen addicts in their midst, and they know those patients and they are desperate to do something for those patients. It is incredibly burdensome to their day, to their clinic, to their nurses. They call in all the time, they are running out of pills; they are addicts. Right now those patients are fumbling through with their primary care doctor on Percocet. When the primary care doctor creates a manmade addiction -- iatrogenic addiction -- they created it themselves as a side effect of a prescribed medicine. When that iatrogenic addiction occurs it would be really handy if the primary care doctor had a tool to treat that addiction. It would save everyone a ton of time and heartache. In that sense, the average care doctor only needs fifteen to thirty spots in suboxone. If they wanted to take on community Suboxone patients they would need more than thirty.

When I’m talking to a person and they ask if they should go on Suboxone or methadone, if you are a very complicated patient: mental illness, socially sick, homeless, legal issues, and you’ve relapsed multiple times and you would benefit from very close supervision, methadone is better. If you need a stronger agent because you have a super sky high tolerance, methadone is better.

If you basically have stuff together, if your life is together, you’ve got a job, you aren’t seriously mentally ill, you haven’t had multiple life-threatening overdoses and relapses, having a community Suboxone doctor for one month at a time and not get all that supervision; that may be better for you. You don’t have to come into the clinic six days a week because you basically have good mental health, good social stability, good structure because you can take medicines on your own. You just need to get out of this trap you are in in this opioid addiction. That’s the really basic part. The reality is what can you get in your community. Right now you just take what you can get.

**AS**: Right. In the ideal world where the primary doctor knows how to deal with Suboxone, but that’s not happening right now?

**CR**: That’s not happening right now. There’re not enough Suboxone spots. Only these major metropolitan areas have methadone clinics. If you are in the rural clinics you have to drive hours to a methadone clinic. It’s not safe. There is this weird patchwork of availability of these different drugs. If you can get anything they just jump at it and take it. It will save your life. In the future if there is greater availability, that’s what a methadone clinic is for: people who need this high degree of supervision.

**AS**: Is there any kind of campaign to get Suboxone out more?

**CR**: I don’t know. People talk about campaigns but I don’t know what that actually is or if it will actually affect change.

**AS**: The only other question I was going to ask was what an ordinary day for you is and what an extraordinary day for you is. You can limit it to one of your places.

**CR**: There is one other thing I want to say. Another variable in all of this is the research into addiction. There is incredible work being done right now in the NIH [National Institute of Health]. Nora Volkow is at the center of this but there are many great researchers involved in looking at where the addiction centers are and all the neurotransmitters involved.

There’s a lot of money involved in other pharmaceuticals and treatments. If you can treat addiction more effectively and safely it is a gold mine. There is a lot of interest in it, but it is complex science. I think it’s going to take ten to twenty years. As that science emerges I think it’s a really exciting time. There is a refocus on clinical science and basic science and the development of pharmaceuticals for addiction. It’s exciting. That is another way to destigmatize things. If you can define them in analytical terms it removes a lot of stigma. I’m hopeful that we are on the right path. I really am. I’m not doing any of this science, so I’m really glad someone is out there doing it! My boss is one of them, so I’m glad people are doing it.

A fulfilling day -- there are two versions of the same day. Either a busy Suboxone clinic or like on Monday I saw twenty-three Suboxone patients. Greater than eighty percent are doing well. One of them was a pregnant mom who was on pain pills and got pregnant and the doctor abruptly cut her off pain pills. She went into withdrawal and she got desperate and she went and used heroin. She called me and I was able to get her onto Suboxone which was life saving for her and her pregnancy -- it improves her pregnancy outcome.

Another one, similarly; I had two pregnant moms. I just had an incredible mix of patients at a crossroads in their lives. I had this pregnant mom who was at a crossroad in her life. Eight years in I’m confident -- I’ve made errors, I’ve had bad outcomes -- but I’m confident I can help this mom who is snorting heroin and get a good outcome. That is exciting and thrilling me to see my eighty plus patients who are living the good outcome and then have the ten to twenty percent that are trying to get there and I feel a real sense of hope and confidence that I can get these patients to cross the finish line to a good outcome. I want both these moms to have healthy deliveries.

A similar analogy here is I’ll have methadone clinic days where I’ll just line up the methadone patients and I’ll see maybe ten in the morning talking about dose and side-effects and their life. Some of those mornings it is so fulfilling and wonderful to me even though the majority of them have some problem we are working on, either with their dose or something else. To see these people that were really badly wounded and suffering and sick in a lot of ways, to hear them and their stories and to meet them and understand how they are really leading a meaningful life now. Whether it is Suboxone or methadone having those clinics where I can see these folks and sit down and get to know them. Friend isn’t the right word, but I’m friends with some of them and I really appreciate their presence in my life.

I had one guy give me a cup of coffee -- he’s a ceramicist -- and I drink out of it every morning. This heroin addict made me this beautiful mug and I drink out of it every morning! Those things are wonderful.

I think the worst thing for me is administrative paperwork called a prior authorization that is attached to Suboxone administration. It is January so I am getting nailed with them because it is the beginning of the year. The worst things is when red tape gets in the way of delivering care. Then I have to call my patients and be like, Sorry, there is going to be a three day delay until you can get your medicine. They start crying and yelling. They are angry, scared, tearful, and they’ll relapse. I’ll call them and say there is nothing you can do because your insurance requires this paperwork and they’ll blame me, the pharmacy; they’ll cry, they’ll beg, and I’ll say there is literally nothing I can do. It is all work put on me.

**AS**: It is red tape but also denying access to care.

**CR**: There has been lawsuits settled in other states about prior authorizations for Suboxone. The attorney general has put on notice the insurance companies in the state that she will be prosecuting. A similar thing for prior authorizations on Suboxone. She just put out a memo encouraging this to be a legislative priority. She is hoping that she won’t need to prosecute them because it will be legislative in this session. There’s hope, but it is absolutely the worst thing when an administrative detail prevents the care of a patient and then I feel their pain when I tell them it is going to be days before they get their medicine.

**AS**: Is the prior authorization because it is Suboxone or just red tape from the insurance company? It’s not DEA restrictions or anything?

**CR**: No. Insurance companies made a practical, financial decision that they used prior authorizations for anything that is costly or potentially abusable or when they think physicians aren’t educated about appropriate use for a medicine. When you talk to the people doing the prior authorizations, like me, they catch a lot of doctors prescribing the wrong thing. There is a benefit to it, but it hurts the well meaning.

**AS**: Thank you very much. I’m so appreciative.

**CR**: Thank you. It was fun