DRUGS: COMPLEXITIES, CONFLICTS AND CONTRADICTIONS

I am the son of a pharmacist. My father practiced as a registered pharmacist for 65 years, and my stepmother is still a practicing pharmacist, with more than 40 years of experience. I grew up in a home where pharmaceuticals were as common as spices and condiments. To this day, when I travel, I bring an arsenal of over-the-counter medicines to prevent and treat any malady that might try to invade my body.

BRIAN SMITH

"Better life through pharmaceuticals," I joke with my friends. They call me a traveling drug store.

My family has experienced both the healing benefits and harmful side effects prescription medications can bring, as well as the damage caused by illegal drug use, including arrests, treatment centers and recovery programs.

It is ironic to think that my family has earned its livelihood through pharmaceuticals, been saved and kept alive through drugs, but also has experienced deep heartache and chaos because of them. Drugs heal and harm.

There are a variety of perspectives to consider when thinking of drugs as agents of both healing and harm. To help outline some of the complexities, contradictions and conflicts regarding pharmaceuticals, here are three points of view: linguistic, clinical and theological.

LINGUISTIC

What is the difference between medicine and a drug? People used to refer to medicine as something you used to prevent, alleviate or cure a symptom, ailment or disease state. Medicine was useful and good, it was a tool for helping people in a positive way. By contrast, drugs, in popular culture, referred to something used or misused in a recreational way. Drugs and drug use carried the overtones of something illegal.

In recent years, however, the terms drugs and medicine have become almost interchangeable. In the dictionary, medicine means "a substance or preparation used in treating disease."[1] Drug is defined as "a substance used as a medication or in the preparation of medication."[2] The secondary definition of drug is: "something and often an illegal substance that causes addiction, habituation, or a marked change in consciousness."[3]

We know that legal prescription medications can cause addiction and habituation. So where lies the difference between drug and medicine?

I then turned to the U. S. Food and Drug Administration. According to the U.S. Food, Drug and Cosmetic Act, drugs are "articles intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease" and "articles (other than food) intended to affect the structure or any function of the body of man or other animals."[4]

Interestingly, the FDA doesn't have a formal definition of medicine at all. The agency seems to use the word drug instead of medicine, as if drug is a component of medicine and that the two terms can be used interchangeably.

The use and meaning of the words medicine and drug appear to have changed over time due to politics, society's sense of what constitutes legality and how the medical profession itself refers to these agents. So, although we may want to force medicines and drugs into separate categories, the terms continue to merge in the scientific and medical realms.

CLINICAL

The complexity and contradiction represented by pharmaceuticals is not lost among medical professionals I talk to. I asked a physician friend

about the irony that drugs can be something that heals and harms. He said that any time he prescribes a drug for a patient, he knows he is taking a risk.

"There is always the possibility of side effects or an adverse reaction to a drug when you prescribe. However, you weigh the probable benefits against the possible risks," he said. "All drugs, even those legally prescribed, have toxicity. You intend to do good — to cure or relieve symptoms — but you know there is a chance the drug you recommend may react differently in different patients and may harm the patient. So, you assess the impact of the drug you have prescribed and make sure it is doing more good than harm.

"If not, you stop the medication and try another course of action. You also must continue to monitor the effect of a drug on a patient even when there are no immediate side effects. Their situation may change, and the drug at any time may stop producing the desired benefits it once had; instead it may start to cause harm or become burdensome to the patient."

His response reminded me of the ethical principle of benefit versus burden. In the *Ethical and Religious Directives for Catholic Health Care Services*, Directive 56 states:

"A person has a moral obligation to use ordinary or proportionate means of preserving his or her life. Proportionate means are those that in the judgment of the patient offer a reasonable hope of benefit and do not entail an excessive burden or impose excessive expense on the family or the community."[5]

I thought of several ethical consultations I have been involved with over the years in which the benefits and burdens of life-assisting technology and medicine had to be reassessed in an ongoing manner to insure the benefits always were outweighing the burdens. As my physician friend told me, "you must continue to monitor."

Let's use a current patient population as an example for ongoing benefit and burden assessment: those who are prescribed pain medications. Many of those suffering opioid addiction began with prescribed pain medications that were intended for temporary use. However, what began as a short-term benefit became a burdensome addiction. Somewhere, the discussion of benefit versus burden got lost, and the overall well-being of the patient was sacrificed.

Another piece of the problem lies in what many now realize may have been a mistake — linking patient satisfaction to providers' reimbursement. Many physicians have told me that providers became reluctant to challenge some patients and wean them off pain killers, fearing the result would be lower patient satisfaction scores.

Patients also must recognize their own responsibility. We know there are those who inflate their self-reported pain score in order to remain on pain medications longer than they need to. Some patients may not tell the physician that they are becoming dependent on pain killers, that they are increasing dosage on their own or that they are buying black market pain killers on the side.

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The *ERDs* remind us that the healing relationship is based on entering a relationship "that requires, among other things, mutual respect, trust, honesty and appropriate confidentiality ... Neither the health care professional nor the patient acts independently of the other; both participate in the healing process."[6]

Physicians must know what is truly taking place in a patient's body, mind and spirit when assessing the benefits and burdens of whether to continue prescribing a certain medication, especially when those medications can cause the patient to become addicted.

THEOLOGICAL

The last perspective is one that some people would rather not face: In spite of the advances made in medicine, at some point in our life, we all will become sick. We all will experience pain. We all will die. This is part of the human condition. Yet many people will do anything they can to deny death, avoid people or situations that will remind them of sickness or human frailty or take an abundance of drugs to avoid feeling any kind of pain. So, the last perspective I want to share

is a theological reflection on what Christians call the paschal mystery, as well as how the Catholic tradition of redemptive suffering might offer new insights.

The opening paragraph to the Introduction to Part Five of the *ERDs*, "Issues in Care for the Seriously Ill and Dying," reminds us: "Christ's redemption and saving grace embrace the whole person, especially in his or her illness, suffering and death. The Catholic health care ministry faces the reality of death with the confidence of faith. In the face of death — for many, a time when hope seems lost — the Church witnesses to her belief that God has created each person for eternal life."[7]

When I was young, I remember being taught by my parents and the religious sisters who were my teachers to offer up my pain and sufferings for the temporal punishment due to my sins and for the remission of the temporal punishment of the poor souls in Purgatory. While it is true there have been people who have taken this Catholic tradition of "redemptive suffering" to an extreme form of self-mortification, there also is the other extreme, people who purposefully discard this tradition as if there can be no value or meaning found in the experience of suffering and death.

Redemptive suffering, in the truest sense, is the Christian belief that when we willingly join our pain, suffering and death to the suffering of Jesus on the cross, we participate in the redemption of the world. It is not because the suffering and death of Jesus is insufficient for our redemption. It is part of the mystery of God's plan for the Word being made flesh. When Jesus became human and embraced pain and suffering, God willed that even human pain, suffering and death — all the result of original sin — be transformed by God's redeeming love and mercy. It is God alone who redeems, but it is by God's will that we who share by faith in the mystery of the Incarnation also share in the ongoing process of redeeming the world and in the paschal mystery of new life coming from death.

I wonder at times if we have forgotten that the human condition involves pain and suffering. Do we sometimes place our hope and trust in the gods of science and medicine, forgetting that only God can save us from suffering and death? Have we lost sight of the fact that as co-creators with God, we are meant to use human reason, with creation and the laws of nature, to improve the human condition through science and medicine — but in no way are they to take the place of God's redeeming love and the ultimate destiny of humankind, eternal life?

The contribution Catholic health care can bring to this puzzle of drugs as both healer and harmer lies in our foundational beliefs: We share in the Incarnation. We manifest God's redemptive love and mercy when we are willing to enter into others' pain, suffering and death, precisely because Jesus did. We also believe the mystery of the Incarnation invites us to enter the paschal mystery. Through embracing the human condition, including suffering and death, we enter into the mystery of living and dying with Jesus, which means we also will share in his resurrection and eternal life.

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NOTES

1. *Merriam-Webster Dictionary online*, s.v. "medicine," https://www.merriam-webster.com/dictionary/medicine.
2. *Merriam-Webster Dictionary online*, s.v. "drug," https://www.merriam-webster.com/dictionary/drug.
3. *Merriam-Webster Dictionary online*, s.v. "drug."
4. Federal Food, Drug and Cosmetic Act, Title 21, Chapter 9, subchapter II, section 329 (g)(1). http://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title21-section321&num=0&edition=prelim.
5. United States Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, 5th ed. (Washington, D.C.: USCCB, 2009) no. 56.
6. *ERDs*, Part Three, "The Professional-Patient Relationship," Introduction.
7. *ERDs*, Part Five, "Issues in Care for the Seriously Ill and Dying," Introduction.

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