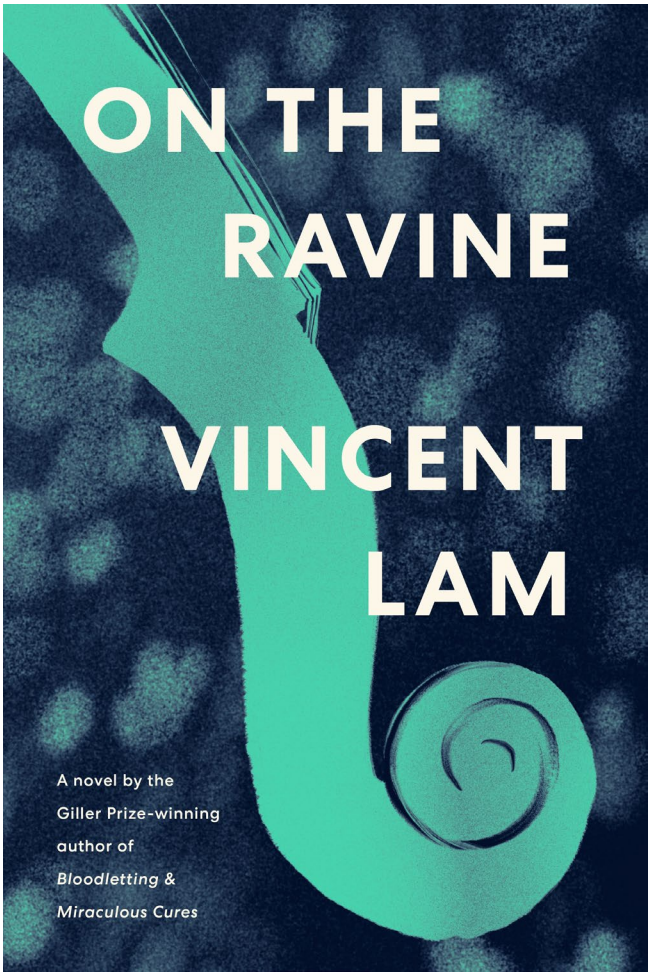
BOOK REVIEW

On the Opioid Crisis: An Interview with Vincent Lam

Neil Stuart and Anne Wojtak



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Vincent Lam

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Vincent Lam, the author of the best-selling novels *Bloodletting & Miraculous Cures* (Lam 2006) and *The Headmaster's Wager* (Lam 2012), recently spoke with the editors of *Healthcare Quarterly* (*HQ*), Neil Stuart and Anne Wojtak, about his new novel *On the Ravine* (Lam 2023). The novel explores the nuances of substance abuse and its impacts on patients and the people in their lives.

***HQ:* I picked up *On the Ravine* and was just swept away by it. It is a great book and really brings to life the tragic but very real story of drug use and treatment. Could you tell us about how you came to write the novel?**

Vincent: I have always been interested in medicine through the lens of a story. Like most doctors, I am also fascinated by physiology and pharmacology, yet the human story has always been the lens I gravitate toward.

When I began to do addiction medicine about 10 years ago, I immediately understood that there was something profoundly human about the stories that I was privileged to be a part of and that the forces that underlie addiction are fundamental human forces.

There are the forces of wanting to avoid pain and anxiety, the desire to repeat pleasurable experiences and the power of habits. There is often a tension between how we want to feel and the person we want to be. For all of us, this creates tension in many choices. It is the same in addiction. These are also the difficult choices that motivate characters in novels. I wanted to be able to explore these kinds of choices and dynamics in a novel.

***HQ:* Thinking about those kinds of choices people make, one of the characters that we were taken with was Fitzgerald. He seemed to embody the idea of promoting safer supply in order to save people from a poisoned, toxic drug supply as one solution to the drug crisis. How did you think about this and to what extent did you use Fitzgerald to question the idea of creating a safer supply?**

Vincent: I am uncomfortable with the terminology, "safer supply," which presumes that there has been some clear consensus that it is actually safer. I feel more comfortable with the term PSAD (Public Supply of Addictive Drugs), which I find more neutral.

I began working on this book almost nine years ago, which predated the advent of PSAD. Of course, I see the parallels between what happens with the character of Fitzgerald and the dynamics that play out in real-life PSAD. This should not be surprising, because the question Fitzgerald asks, "Does it work if we just make opioids freely available?" is both a very old question and the question at the core of PSAD. There are historical examples of opioids being freely available. The British exported opium to China as an organized commercial enterprise, and their refusal to stop this trade when it was harming the local population resulted in the Opium Wars. Until the early 20th century, laudanum was available in North America and Europe without a prescription, and the recognition of its harms led it to be regulated.

More recently, in North America, oxycodone was liberally prescribed for about a decade and was easily available in the illicit market. Many people who now contend with opioid use disorder and access illicit fentanyl started with prescribed opioids such as oxycodone, whether it was prescribed for them or someone else.

To speak directly to your question, I did not write a novel in order to comment upon PSAD. I wrote a novel to explore the inner worlds and difficult choices that face individuals who are experiencing opioid use disorder and those who are in a caring role. I wanted to write about people's passions and their humanity.

In the face of dire situations, such as the opioid crisis, it is legitimate for us to try experimental and unproven interventions such as PSAD.

***HQ:* As the author of *On the Ravine* and from your perspective as a clinician treating people with opioid addictions, is there an evidence-based case for PSAD? Also, if you were to take more of a prevention lens, is what we are doing with PSAD complicating our approach to fundamental prevention of addictions in the first place?**

Vincent: That is a question for a doctor, so I will answer as a doctor. I think PSAD is motivated by a mix of compassion, desperation and hopefulness, which are emotions that all of us in this field experience. The hope is that it would reduce opioid-related deaths. That is an incredibly important goal and that is what I strive for every single day in my work as an addiction physician. We are now seven years into the use of PSAD and it has been provided to thousands of Canadians but we do not have any clear, quantitative evidence that it reduces opioid-related deaths. In the face of dire situations, such as the opioid crisis, it is legitimate for us to try experimental and unproven interventions such as PSAD. We also have to be willing to critically evaluate those attempts. Certainly, there have been dedicated efforts to evaluate PSAD, and there is a growing body of literature around it. Nonetheless, at this moment, we do not know if it reduces opioid-related deaths, which is a central question.

So, since right now we are in a place where we do not know whether or not PSAD reduces opioid-related deaths, this creates some difficult choices. Advocates for PSAD would say that we have to expand or modify the programs in order to better show reductions in opioid-related deaths, so that is one approach. On the other hand, the longer people are given this intervention in greater numbers without showing a reduction in opioid-related deaths, the harder it seems to justify devoting attention and healthcare resources to this strategy.

We also need studies that actually compare PSAD to established interventions, such as methadone and buprenorphine, which are the standard of care. Typically in medicine, new interventions are compared with existing ones. Often, we do not adopt new interventions unless they show some kind of superiority – whether in terms of efficacy, safety or acceptability. It is fair to suggest that PSAD might have a role as a more acceptable option for some people who do not want opioid agonist therapy (OAT), if a benefit in terms of opioid-related deaths can be shown. Even then, it will be important

to know something about the relative benefits of each, so that when we are offering interventions to people, they can make an informed choice.

From a public health prevention point of view, we need to be worried about a repeat of the oxycodone experience, which was that a widespread increase in the availability of opioids led to an increase in the incidence of opioid use disorder in North America. Many people who are now dying from fentanyl overdoses first started using oxycodone or hydromorphone in the 2000s, so I do not think we can ignore the risk of widespread PSAD resulting in new entrants to opioid use. PSAD pills – typically hydromorphone – are diverted for reasons that may be understandable at an individual level, but this still means they reach people who are not the intended recipients. With the opioid use disorder in North America, we are grappling with a multi-decades-long tragedy, so how can we ignore its lessons?

HQ: **Readers will appreciate this very complex issue and that there is no single treatment that is going to solve our crisis. Can you also comment on the comprehensive treatment centres – i.e., the safe injection sites (SISs) and supervised injection sites, and how they fit into the picture for you?**

Vincent: They are very important. They provide life-saving care in the event of overdose. I absolutely applaud the important work that is done at those sites.

One thing that would be a great service to the clients of those sites is creating stronger pathways through those sites to access a range of other services. I can only speak to the Toronto context to observe that similar to so much of healthcare, too many services are siloed. So the SISs and safe consumption sites (SCSs), the detoxes, the outpatient clinics and the in-patient treatment programs, all operate separately. There needs to be more linkages and collaboration so that SISs and SCSs can streamline access to all the other services people might want when they are ready for them.

That is not something that those sites can be expected to do on their own. That requires system-level leadership, support and collaboration.

HQ: **One of the subplots in the novel is Chen's involvement in the drug trial business, and there was a comment in the book stating that part of the reason we got to the situation we are in, is by not asking the tough questions. Could you share your thoughts on what are some of the tough questions that we should be asking at this point in the crisis?**

Vincent: One tough question is how to address both physical and psychological pain in a realistic and functional way. What does that look like? I think it needs to be a compassionate approach to pain that does not presume or promise to eradicate it. I wish we could make all pain disappear, but instead what we have learned is that an ethos of reflexively trying to extinguish all pain with opioids has actually led many people to opioid use disorder and to a great deal of suffering.

We need to think about how our culture and caring systems can recognize that some degree of pain, both physical and psychological, is often a part of life. Some tough questions are: How can we be truly compassionate within that reality? How can we support people, first and foremost, to live meaningful lives? What does it look like to reduce pain and suffering as much as realistically possible while prioritizing function and without being wedded to this ultimately unachievable agenda of eradicating all physical and psychological pain?

Part of the question is how to publicly fund and ensure the availability of a range of nonphysician forms of care. Most behavioural and physical therapy, which is recognized to be very important in managing pain, is done by nonphysician providers. However, they are not universally publicly funded, so it can be quite difficult for many people to access their services if one does not have either sufficient money or a job with good benefits that pays for those kinds of services.

We train physicians to do a variety of things, but mostly to make diagnoses, do procedures and prescribe things. To a smaller degree, we train some physicians to do behavioural and physical therapy but that is less common. So, having universal funding for physicians – who are able to prescribe – and no such funding for nonphysicians, tilts our system toward prescriptions and away from other important forms of care that are crucial for a holistic approach to pain management.

Another thing that we need to think about, which is again a hard question, is how we can manage technology and scientific innovation in such a way that it remains in the service of humans in the long term. I can think of many examples in which we have engaged in technologies – such as the carbon-driving industrial revolution – that have helped us in the short term but are costing us a great deal in the long term.

Opioids, similarly, can be really helpful in the short term. No one wants surgery without good anaesthetic and acute pain control, which often involves opioids. Yet we are learning that if the use of opioids is not carefully managed for well-defined goals, opioids have the potential for creating immense negative human impact and societal costs. Those effects can have a very long tail, extending into decades as we are now seeing.

Another really hard question is how do we care for and respect one another when we disagree about certain things? This is a very tough question in our political sphere and in healthcare as well.

We want healthcare to be patient-centred and to consider the perspectives of patients and advocates, but we also have to

figure out how we are going to deliver care and work together when we do not necessarily agree on everything. How do we do this in an environment that has become more polarized and more vocal? In a sense, despite the current loudness of public debate on many issues, including PSAD, the environment ends up being constrictive for individuals. Some people feel they have to choose a *side* and support that side without deviation, and others choose to remain silent because of the frequent toxicity of public discussion. So, a tough but important question in healthcare, as with many spaces, is that despite the fact that we may disagree on some specific issues, how can we work together on the priorities that we agree on?

HQ: **That is a good segue into the next question, which is how to make care decisions, and care itself, better aligned with the values of patients and their families. What are your thoughts when it comes to the opioid addiction treatment and drug use disorders area – are we too stuck on imposing values on others?**

Vincent: Firstly, I observe that there is less of a difference in overall perspectives between those of patients and families and care providers than we might think from consuming popular media. More extreme viewpoints get amplified in the media because that generates more controversial content and clicks. It is less newsworthy if people agree on something. These forces exaggerate the perception of big divergences in perspective.

For example, from popular news coverage, one might think that the predominant goal among people who use drugs and people who are experiencing an opioid use disorder is to have PSAD. Yes, that is true for some people and families, but it is not the most common viewpoint I hear in my clinic. When I ask people what they want, most often people say that they want to stop using the substances that have come to dominate their lives, and they want to be doing other things in their lives. By far, that is the goal that I hear most often.

But we should certainly acknowledge that a diversity of views exists, and yes, some people do want ongoing access to the drugs that are part of their substance use disorder. I get that, but then it is tremendously important to distinguish between personal values and goals.

I think of values as a person's outlook on what matters to them, their sense of who they are in the world and how they want to behave in the world. Yes, there is a subset of people who use drugs who would say one of their core values is that they are someone who wants to use drugs to change how they feel. It is not for me to judge that as being good or bad – that is a personal value. But PSAD is not a value, it is a specific intervention wherein the hope is that it can achieve certain goals – allowing ongoing opioid use that results in its users feeling the way they want to feel while also reducing opioid-related deaths. It makes sense to ask whether or not the intervention actually does achieve those goals and whether or not it also causes harms.

If it does not achieve the goals, we have to be comfortable with both respecting peoples' values and telling people honestly if something like PSAD does not achieve the goals that they wish to achieve. If we are pretending otherwise, we are not being honest.

Again, more often when I ask about values, rather than talking about drug use, people say "I am a partner," "I am a parent," "I am a co-worker" or "I am part of a community." Their goal is to participate in those relationships. Then, my job is to figure out what medical treatments allow them to achieve the goal of participating in those relationships, and thankfully, the established medical treatments are often very good at supporting those goals.

HQ: **You mentioned that you have worked on this book for eight years. I am wondering if you have seen a shift in that time period in the conversation about how we approach drug use and treatment.**

Vincent: I have seen some shifts. There is more awareness and compassion in what I hear from healthcare professionals and people in the community. However, the impulse is still to ask what the quick, simple solutions are. People are disappointed to hear that the full scope of work we need to do is probably neither quick nor simple.

The issue has become politically partisan in a way that is unhelpful. PSAD, an experimental intervention, has come to dominate the conversation, although we do not know if it reduces opioid-related deaths. This is unfortunate because different political parties are spending more time arguing about PSAD and less time figuring out how to support the treatments for which we know there is good scientific evidence, which is OAT, and how to deliver those treatments to people who need them.

It also takes up space where we should be having a broader discussion on the broader economic and social support that we need. It is not just about providing good OAT. My most vulnerable patients are sleeping rough while winter is approaching. We have to provide safe spaces for people to get on their feet. We have to provide high-quality mental healthcare because many people who suffer from substance use disorders also suffer from concomitant mental health conditions. We have to provide high-quality primary care. We have to find pathways to reintegrate people who do not currently feel like they have a place in society.

We have a very prosperous society. It is also one in which it is very difficult for someone who has gone off the beaten

track to find their way back onto it. Without employment, it is very hard to find housing. Without housing, it is hard to find employment. If someone has a criminal record, it is hard to get a job. Without a way to earn a living, some people resort to crime. So, how can we make sure that everyone who has experienced a substance use disorder can still live in a dignified way? These important domains of social and economic policies are what I wish I would hear politicians talking more about.

It is also problematic that the discussions around one specific and narrow medical intervention, PSAD, have become so partisan, with specific positions associated with particular parties. That means that decisions may be influenced by ideology and political concerns. With changes in governments, we then run the risk of seeing very rapid shifts in policy. That is not how good healthcare decisions are made.

HQ: **There is so much tragedy in the human experience with addictions. It is too easy, especially for those of us who are not directly involved in the field, to have a sense that there is nothing but an awful downward trajectory awaiting everyone involved in these addictions. I was really struck by how *On the Ravine* seemed to defy this.**

There was sort of a dogged optimism that rang through the novel, particularly in the way that the novel came to its conclusion. I would be curious as to what are the things that make you optimistic when you look at the whole question of addictions and addictions treatment.

Vincent: As a doctor, I do see hope, and it is often a long road to see those hopes realized. That is such an important human journey, and so that is the journey I wanted to write about in *On the Ravine*.

You are right that in the media there is a portrayal of this inevitable downward trajectory. Part of this is a selection bias that arises because, historically, people were ashamed of substance use disorders. Therefore, those who have experienced it and now moved forward in their lives often do not want to talk about it. Hopefully, now because we are speaking more openly about mental health issues and substance use disorders, people will feel empowered to speak more publicly about their recoveries and their journeys through and beyond their substance use disorder.

The biggest thing that allows me to be hopeful is that so many of my patients are doing very well in their lives; have meaningful relationships; have satisfying employment; and are our neighbours, co-workers and perhaps members of our families.

It is true that the practice of addiction is tremendously demanding, because every day, I see people who are in a really, really tough place in their lives. I remain hopeful because those people want to steer their lives to a better place.

I also have the privilege of working with colleagues who are also trying deeply to help people around them. That shines through and gives me optimism. It is not always a smooth path, we do not always know exactly what to do and we do not always agree on what is best, but I think the instinct to help those around us is incredibly precious, and I am glad to take part in this work.

HQ: **Is there anything else that you wanted to say before we close off, bearing in mind that *HQ* readers are people from across the health sector who are involved in managing and making leadership decisions, around how healthcare is delivered?**

Vincent: A top priority must be to address challenges in access to care, particularly those faced by disadvantaged and marginalized Canadians. For far too many, a lack of access to appropriate care for common health problems means that issues that could be feasibly and appropriately addressed early become tremendously difficult chronic dilemmas. A lack of easy access to comprehensive pain management systems – which should include nonphysician services such as physiotherapy and workplace accommodations where necessary – means too many people just end up with a prescription. If that is a prescription for opioids, a percentage of those people go on to develop opioid use disorder.

Another key issue should be to support families with children. The large majority of people whom I care for can think back to experiences in childhood that set the stage for their substance use disorder. These experiences may or may not fulfil a legal definition of child abuse or neglect, but they were experiences that made them feel that they were not seen or recognized or valued, that they should not be feeling the emotions they were feeling and that somehow they were not "good enough."

There is clear evidence that adverse childhood experiences increase people's risks of developing mental health problems, substance use disorders and physical health problems. I am sure that the great majority of parents are doing their absolute best to be the best possible parents. But it is more difficult than ever to do that in an uncertain economy, with the evolving pressures of social media and in a society that seems to take the work of parents for granted, while they are doing the most important possible work – raising the citizens of this country. So I think we need to really invest in supporting families with adequate parental leave, with investment in newborn and infant

health, with high-quality affordable child care and with high-quality student-centred schools. Too often, opioid use disorder seems to step in when people feel that something is missing inside themselves, so we need to support people growing up to feel whole. HQ

References

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