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# Visions in addiction medicine — also for pneumonologists?

## Rozważania o medycynie uzależnień — również dla pneumonologów?

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### The special reason for your invitation to me

My invitation as a physician for addiction medicine from Germany certainly seems somewhat curious to you. I owe this great honour to Prof. Kowalski. He has, as a leading pneumologist, cooperated with my father for decades. I have always seen that this cooperation with Polish colleagues was a great pleasure for my father. He took it seriously, also, because he had to march to the East as a soldier under Hitler and he felt a special responsibility towards Poland for his whole life. He has transferred this sense of responsibility to me, also concerning Jews, Sinti and Roma, and generally all who have once suffered under German arrogance and today all, who are handicapped by any disadvantages. Concerning Poland, I have another special connection: We have Polish relatives. My father's mother was born in Lodz and her mother, my great-grandmother, had to pay for her confession; "I'm Polish" with her life when Hitler invaded Poland.

Prof. Kowalski said to me: "There are many lasting emotions between Poland and Germany that still have an influence on us till the present, due to our history. We can deeply understand that". He also said: "The cooperation between your father and us in Poland was like a counterpoint. It was so amicable, so cooperative. We worked together like good friends, working only towards one goal: to optimize the treatment of patients. This should not end. There should be some continuation. It would be a pity if this all would simply doze off".

Therefore, I'll attend your conference the beginning of September in Nikolaiken and I am very pleased. But what can we do? My position is not comparable to that of Prof. Kowalski's or my father's. I am a physician in private practice like around half of the German doctors.

I am also not a pneumologist. This profession was occupied by my famous father. I had to find another field for myself. I founded a practice as a family doctor in 1984. The first HIV patient came in 1985. There was only a very limited knowledge and no treatment available at that time. This quickly became a special challenge for me. Our practice, where I work now with two colleagues, has in the meantime, treated more than 2000 HIV and AIDS patients and is currently treating more than 700.

I owe a lot to this challenge. I could witness and partly contribute to the development of special medical history and I could learn some interesting human aspects. Respect for homosexuality and great pleasure in becoming acquainted very well with many gay men. Respect also for people, who are normally denunciated because of their sexual identity or their way of life. Respect for addicted people, respect for refugees from other countries, where there is no sufficient access to antiretrovirals, or where wars and corruption destroy all possibilities of a good life. Respect also for very ill or dying people, who have lost their dignity because of illness.

Do you see the analogy to good pneumology? And from our respect for human beings the special consternation looking at our unbelievable history, which happened because of our forefathers'

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disrespect for human dignity which lead entire nations into confrontation?

Thank you for inviting me! Today we cooperate to reach another goal. This goal is deeply connected with human dignity. And it is especially required always and everywhere where people violate it most.

## The dignity of addicts. Who of you is without addiction, let him first cast a stone

Addicts, especially, suffer from a deep violation of their dignity. They suffer from the insufficiency of the treatment offer and from related accusations. You may think now: this will be a one-sided view. Never fear, it will not.

My special experience with addicts developed because of my specialization in HIV. I was confronted with drug addicts regularly and all of a sudden it was clear: There can be no help without long term treatment with opioides. I became a cofounder and co-organizer of the German society for addiction medicine and I took an active part in the introduction of Methadone in Germany. This all led to a special treatment of alcohol addicts over the years.

What is the special suffering of an addict? He suffers from a special attraction to behaviour or to the use of substances, which harm his psychic or somatic health. It often takes years until one becomes aware of the fact and even longer to confess to being an addict and ill. Addicted behaviour and use of addictive substances are quickly connected with underhandedness causing mistrust. Underhandedness and mistrust become central attributes of addiction diseases. The addict cannot even trust himself. How often has he resolved or promised and always experienced again that the addiction was stronger!

Everybody has an addiction centre deep down in his character which sometimes signals: I'm not feeling well, I want, I need. The clearly overwhelming, rational part of our brain counters: It's forbidden, you shouldn't, I have these and those intentions. But the addiction centre signals: I couldn't care less, I want, I need, now. Most people have experience with such fights. They belong to life like the experience of not really to winning these fights often, especially not once and for all. They return and return for decades.

Therefore, concerning addicts, we have to reflect the word of Christ: "Who of you is whithout sin, let him first cast a stone". Who of you is without addiction…

Nevertheless, there is a central difference between craving and addiction and addiction disease. It's a disease, if anyone repeatedly and severely succumbs to the fight between craving and ratio, with appreciable psychic or somatic harm or disturbances.

Many people think: "The ratio of addicts is too small". But this is not our experience. Addicts are normally not more weak-minded than others. But in the addiction centre, there is a lack of a messenger substance that sufficiently satisfies the centre. This is comparable to thyroid hypofunction. For a normal function, there is always a lack of something, in this case of thyroid hormone. There are also many analogies to asthma and COPD. Imagine if you would say to a man with obstruction — you must only breathe the right way. We know as experts: he is not able to do it, with his will alone. He needs medical substances to reach a nearly normal state. Real healing is rare, but we can often realize an acceptable quality of life.

It is very similar with addicts: real healing is similarly rare. But an acceptable quality of life is possible for many, and most of them need medical substances for that. Educational and psychotherapeutic approaches can achieve a lot, of course. But in specialized practice for addiction medicine we see many patients, who have experienced much of this, and you get the impression: It has not really reached their addiction centre. The same applies for antidepressants and antipsychotics.

Most patients need medically prescribed substances with an addictive potential for their normalization, like the hypothyroid patient needs his thyroxine for a long time.

## Why the potential of maintenance therapies is not exhausted yet for a long time?

Medicine and society make many crucial mistakes providing maintenance substances. Addicts, their partners and relatives, and eventually all of society, have to pay a high price for it.

The main mistake is the fundamental **demonization** of these substances with addictive potential. We must examine things much more differentiatedly, really like usual in all good medicine, clearing advantages and disadvantages.

If we look exactly, we first see the adamantly chronic character of addiction diseases. Just remember our own addictions initially mentioned: how often have we resolved to eat less calories or sweets, better to cope with our workoholism, to banish the thought of specific sexual fantasies? We succeed, but don't we also have the experience, that this craving is demanding something from us for decades? Imagine how much more difficult this might be for a man with a real addiction disease, concerning a substance giving him a wonderful sense of well-being immediately! It is part of our natu-

re and of the character of addiction diseases that freedom in permanent abstinence rarely succeeds.

Real healing is the exception, chronicity normal. Why do we have so many difficulties to accept the quite obvious chronic character, like in COPD, asthma und hypothyroidism?

Mainly for two reasons:

— we still ostensibly connect the disease with the terms 'sin' and 'blame'; the reflections hitherto have sufficiently explained how wrong that is;

— we do not see enough examples of lives succeeding with a chronic addiction disease; heroine from the streets and addictedly consumed alcohol destroy all schemes of life, yes, sometimes the whole life; but from patients on Methadone also, people predominantly don't get convincing impressions.

That's the consequence of crucial mistakes, made in many Methadone- or similar treatments. Like in many other diseases, many patients need **individual medication**. Substances, which are terrible for one patient, are optimal for another and vice versa. The spectrum of available substances is by far not sufficient yet. Most opiate addicts are treated perfectly with Methadone but some suffer from side effects, some are better treated with other substances like Buprenorphine or Dihydrocodeine. Some hints and study results indicate that Diamorphine as a pharmacological substance has the best effect/side-effect profile. It's still more urgent for alcohol addicts to have a substance with addictive potential because of the special toxicity of alcohol, it's poor controllability and the strong psychological side effects. First study results and partly only reports of specialized centres indicate good effects with Baclofen, Clomethiazole, Dihydrocodeine, Buprenorphine, Methadone, Gammahydroxybutyrate and sporadically Amphetamins. Some Heroine addicts report that they have been alcohol addicted first but they stopped drinking when they changed to Heroine.

Most of this is not established yet. It might be shocking for unfamiliar readers. But in practice, we see crucial improvements in some of our patients. They reach a state very similar to healing. This success depends on a few other crucial aspects, besides the individual medication.

One is the **dosage.** Because of so much mistrust in Methadone and all substances with addictive potential and also because many patients experience the treatment as unhappy, in many cases the dosage is kept too low. Aim is, not to be so dependent and to be closer to escape. But instability, use of other addictive substances, mainly alcohol, is the common consequence, in many cases showing that the effect of the medically prescribed substances is insufficient. Some of these patients profit crucially from a clear increase of the dosage, which shows us subsequently that the dosage, to date, was too low. Patients don't seem to be "stoned" then. As treating physician, you get the impression that you have at last found the right dosage. They feel much better and it is much easier for them to surmount their harmful use of other substances.

The most crucial point for a really successful, happy life with a maintenance therapy is neither the fitting substance nor the right dosage. It is the right **attitude** in fitting **basic conditions**. Because of the fact that the substance alone is not a sufficient treatment, in several countries it is fixed, never without concomitant psychosocial care by official counselors. That's good in many aspects, but it doesn't meet the crucial point.

It is essential to surmount the vicious circle of underhandedness and mistrust as a crucial symptom of addiction. This succeeds only, if there is a well-founded, primary trust in the prescribed substances as well as in the users. Most substances are dangerous in case of abuse. They have a bad reputation, because of that. Death cases make headlines, patients on Methadone are described as common abusers and chronic users of additional addictive substances. Severe Clomethiazole-alcohol-mixintoxications and the image of Gamma-Hydroxybutyrate as k.o.-drops for sexual crimes induce understandable worries, new mistrust and the call for strict control.

But this avoids the disruption of the crucial, typical interaction of underhandedness and mistrust. Quite the contrary: mistrusting control remains as a central part of the disease. The self-image of the addicts remains restricted. Quality of life doesn't become acceptable. This will not be the case until there is enough trust based liberty. Thus a setting of addiction treatment, mainly oriented on safety and control, is like a horse bridled from the back (German saying) — a crucial problem in many current maintenance therapies, and perhaps the most important handicap preventing a normal development of addiction medicine like in other medical fields. It is a crucial part of human dignity to have free spaces of life, where control is missing. You know, the others trust you here and it is my personality that justifies it.

Crucially too, mistrusting, strictly controlling rules are also applied to physicians in many countries, discouraging most of them. Thus the number of involved physicians is clearly too low, leading to an absolutely insufficient infrastructure with a very negative impact on the quality of life as a year-long patient.

No! No real success without trust as a central term, real warrantable trust. Only, if all concerned people, especially the patients themselves, have a good feeling, a really good way succeeds. Therefore a wide base for a lot of trust is necessary. This is impossible without an attitude and basic conditions, which support and justify this trust.

### Physicians need:

— a good network;

— transparency, showing that they really work facing the patients, listening and looking at their experiences, fears, problems and their development under the treatment, committing subsets of substances, which are not highly perilous, but really committing it, right from the first day, with exact, written instructions, how to use it (which dosage at which time);

— the explicit foundation on trust and the discussion with the patient and active elimination of everything that inhibits trust.

Patients have the same responsibility to eliminate all barriers against real trust. Most of them appreciate this responsibility and don't disappoint us if we are open and fair-minded to them. This all can be presentable. This way, life can make sense and bring pleasure despite a chronic addiction disease.

Addition medicine could then develop in a normal standard, like pneumology. If practiced systematically and earnestly, it can help the patients similarly in a comprehensive manner. The analogies are evident.

After all, what I know up to now about Polish addiction medicine, the interaction of mistrust and trust is also evident in Poland. Mistrust is possibly greater, Methadone is provided much less than in Germany and many other EU-countries. But there is a great chance for new developments implementing much more trust and much more effective treatments of addicts. For that, I would like to give you my hands.

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