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Ethical Dilemmas in the Postmodern Condition: When Patients and Their Physicians Confront the Controversy of Medical Treatment with Schedule II Controlled Substances

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INTRODUCTION TO THE PROBLEM

When prescribing medical treatments identified by federal law as schedule-II controlled substances,[1] contemporary physicians may confront challenges associated with concerns widely reported in media headlines and other reports.[2] Moreover, as physicians, we may often encounter patients presenting with chief complaints, medical histories, and exam findings that assemble as the qualitative data for a proper clinical diagnosis; commonly without laboratory, radiology, or other such quantitative data. When the medical decision includes treatment with a prescription listed as a schedule-II controlled substance, as physicians we may respond to circumstantial challenges differently, some may include of the following:

1. provide appropriate patient care according by our competency and our historic oath as healers; or
2. defer and refer those patients, regardless of adequate training and competency, to other physicians to evaluate and manage, as motivated to avoid entangling ourselves in apparent controversy and associated challenges.

As some may respond by the latter course, other physicians may withhold criticisms of colleagues, but rather seek to prevent harm and injustice. Hereinafter offers some review of the development of the postmodern condition, along with a few of its effects as challenge physicians' care for patients, notably those with conditions diagnosed from clinical

[1] *See* 21 U.S.C. § 812 (Schedules of controlled substances, including schedule-II.
[2] *See eg. infra* notes 17 - 23 and accompanying text.

assessments of qualitative data, and then, if appropriately managed, with Schedule II controlled substances. A review of the literature and historical context validates this framing of the problem, as the philosophical construct of the postmodern condition rejects absolutes in favor of relativism, resulting in an erosion of trust in the establishment, including the medical profession. After illuminating some of the challenges contemporary physicians face and examining the roots of these through the lens of postmodernist philosophy, I conclude by optimistically offering a few practical strategies for further consideration by clinical physicians.[3] Turning to an exploration of the historical roots of the contemporary problem, what follows is a summary review of the postmodern condition and the resulting uncertainty in medicine.

I. Background in historical context

It was the day certainty died: for medicine, physicians, and patients.[4] If so, then this end seemingly began with a 19th Century German poet, Friedrich Nietzsche (1844 – 1900), later magnified in popularity by the 20th Century French Philosopher, Jean-François Lyotard. The following clarifies the context of postmodern condition as a cause for what may seem a cataclysmic disruption for medicine, patients, and their physicians.

Deconstruction: Lyotard, Nietzsche, Homicidal Merchants, and a Mad-Man

Lyotard's postmodern condition may seem as if inspired from Nietzsche's poetry. In Nietzsche's famous parable,[5] he tells of a person identified only as a madman, one who lit a lamp in the dark of early dawn and set out on a quest to find God. To this person's dismay, he encountered a group of local merchants who boasted that they had murdered God.[6] Reasonably, a poet such as Nietzsche, may have projected himself as the disappointed madman as a type of auto-biographic parable for his own personal tragedies.[7] Nietzsche also wrote, "You have your way. I have my way. As far as the right way, the correct way, and the only way, it does not exist. There are no facts, only Interpretations."[8] Nietzsche disregards the possibility of an objective Truth.

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[3] *See* infra notes 42 - 55 and associated text.
[4] *See* Paul Hodgkin, *Medicine, Postmodernism & End of Certainty*, 313 BMJ 1568 (1996).
[5] *See* Charles Bambach, *Nietzsche's Madman Parable: A Cynical Reading*, 84 Amer. Catholic Philo. *Qtr.* 441 (2010).
[6] *Id.* Friedrich Nietzsche (1844 – 1900)
[7] *Id.*
[8] Friedrich Nietzsche (1844 – 1900).

Nearly a century later (1979) a French philosopher, published a pivotal book that seemed to claim the end of certainty in what he titled the *Postmodern Condition: A Report on Knowledge.*[9] In his book, Lyotard brazenly proclaimed that status of knowledge was changed in the postindustrial age.[10] Lyotard's book seemingly was an extension from Nietzsche's existentialist poetry. While postmodernism may elude a fixed definition, a seemingly general observation may describe it as the method of comprehending the external world through personal experiences; without reference to an objective, fixed meta-narrative as a reference point for 'truth,' essentially championing of epistemology at the expense of ontology.[11]

Feyerabend & Paradox

Ironically, postmodernism seems as if it is championing epistemology while rejecting ontological truth; shifting moral philosophy, medical ethics, journalism, education, and law. University of California Berkeley professor Paul Feyerabend underscored that irony of Nietzche's claim, summarizing crisply that "the only absolute truth was that there are no absolute truths."[12] Lyotard, however, seemingly missed that postmodernism itself is a meta-narrative, notwithstanding Lyotard's claim that the status of knowledge was altered so as to reject such overarching meta-narratives for the postmodern age. Moreover, the postmodern narrative also suffers the internal inconsistency of other familiar enigmas such as the following two impossible statements: (1) nothing can be asserted as true, and (2) I do not exist.[13]

THE POSTMODERN CONDITION: THE AGE OF UNCERTAINTY

In the postmodern condition, the once prevailing certainty that arose from the Enlightenment's optimism, moral liberalism, and predictable moral deontology was replaced with a less predictable, results-oriented consequentialism, or utilitarianism. Lyotard's Postmodern Condition opened the potential deconstruction of the rule of law, journalism, and eventually western medicine and then presented unprecedented challenges for patients and their physicians, especially those prescribed Schedule II

[9] *See gen.* 10 Jean-François Lyotard, *Postmodern Condition: A Report on Knowledge* (1984).
[10] *Id.*
[11] *See* Parker Martin, *Post-modern Organizations or Postmodern Organization Theory*, 13 J. Org. Stu., 1, 2 (1992). "To define postmodernity, postmodernism or postmodernization would appear to be a futile task. It is not one school and since many of its adherents refuse the language and logic of 'definition' in the first place, it is difficult to summarize it to their satisfaction."
[12] See George Couvalis, *Recent feyerabendiana*, 10 Metascience 39 (2001).
[13] *See* Adrian Bardon, *Aristotelian Prescription: Skepticism, Retortion, and Transcendental Arguments,* 46 Int. Philos Q. 3263 (2006).

controlled substances; some for unrelenting chronic pain, and also others for Attention Deficit Hyperactivity Disorder ("ADHD").

Critical Legal Studies & the Rule of Law

In 1983, a Harvard professor, Roberto Unger, inaugurated *Legal Realism* with his widely influential publication titled "*The Critical Legal Studies Movement*" (hereinafter "CLS").[14] In CLS, Unger argued that all law was merely a power play by elitists, casting the western construct for the rule of law as an unreachable myth.[15]

Journalism: Editorial Opinion, v. Objective News Reporting

Having observed the effect of the CLS movement on the construct of the rule of law, the impact of the postmodern condition for journalism may not be surprising. Relativism became the new context for journalism in the postmodern era. A so-called "new journalism" emerged wherein truth depended on opinion as seemingly untethered from objective facts.[16] Journalists were then freed to interpret and then communicate their own narratives according to their individual perceptions.[17] Readers then may dismiss as "fake-news" any report that disagrees with their preferences.[18]

Government & Nixon's War on Drugs

In the postmodern condition, distinctions between media: entertainment, journalism, marketing, and propaganda may blur together. All media appear to merge into merely different means to the same desired end; the active shaping of public opinions. For example, President Richard Nixon shaped his narrative as: a "*law and order*" president[19] fighting a "war-on-drugs."[20] Contemporary reports of this so-called war may shape public opinion on matters of policy for health and medicine. As physicians, perhaps more than a few of us have observed consequences of media's influence on medical care for our patients. Furthermore, this seemingly endless postmodern war and its effect on physicians was aptly detailed by a noted political science professor, Dr. Ronald M. Libby, in his

[14] *See* Roberto M. Unger, *The Critical Legal Studies Movement*, 96 Harvard L. Rev. 561 (1983).
[15] *See* Roberto M. Unger, *The Critical Legal Studies Movement*, 96 Harvard L. Rev. 561 (1983).
[16] *See* Susan Robinson, *Recapturing Journalistic Authority*, 7 Journalism 65 (2006).
[17] *See* Einar Thorsen, *Journalistic Objectivity Redefined? Wikinews and the Neutral Point of View,* 10 N. Media & Soc. 935 (2008).
[18] See Jones & Geoffrey Baym, A Dialogue on Satire News and the Crisis of Truth in Postmodern Political Television, 34 J. of Comm. Inq. 278 (2010).
[19] *See* John Powell & Eileen Hershenov, *Hostage to the Drug War: National Purse, Constitution & The Black Community,* 24 U.C. Davis L. Rev. 557, 561 (1990).
[20] *See* Thomas Johnson, *et al*., *Influence Dealers: A Path Analysis Model of Agenda Building During Richard Nixon's War on Drugs*. 73 Journal. Mass Com. Q. 181 (1996).

critical report on the narrative *Treating Doctors as Drug Dealers*.[21] Libby's report chronicled an outrage that doctors had been compared to Taliban terrorists.[22] As physicians, our experiences also may agree that the effect of the war-on-drugs narrative appears to affect most those diagnosed through physicians' clinical assessments using qualitative data. Common examples for practicing physicians may include patients reporting chronic pain (before receiving schedule-II opioid treatments) and also patients reporting concerns about focus and/or hyperactivity (before receiving schedule-II neuro-stimulants). One reason for such challenges may be that skeptics embraced a narrative that doctors are drug dealers. Thus doctors' mere qualitative data may seem too subjective to justify fully the recommend controlled substances[23] associated with the war-on-drugs. In hindsight, perhaps the war on drugs narrative conveniently functioned for Nixon as a diversion to draw public attention away from other concerns, such as poverty, unemployment, and the Post Traumatic Stress Disorder ("PTSD") of Vietnam veterans; all of which could more directly influence those suffering from drug abuse. As medical practice is regulated and documented, doctors are also easier targets for prosecution than drug traffickers and racketeers. In the postmodern condition, prosecuting doctors also could produce results to mollify an anxious public and demanding US Congress. Patients suffering with serious pain experienced negative consequences of the war on drugs as well, since some physicians would actively choose to avoid prescribing these medications for concerns of potential legal issues. The challenges for pain patients parallel those of patients seeking evaluation and management for ADHD. Both diagnoses have management guidelines that may include controlled substances, the former an opioid narcotic and the latter a neuro-stimulant.[24] A few journalists accepting the postmodern narrative war on drugs seem convinced that medical conditions treated with schedule-II controlled substances, when diagnosed by physicians from qualitative data, are suspect or even illegitimate.[25] The root cause of such conviction may stem from the success of the ongoing government postmodern narrative for the need for law and order. This may result that a few physicians will shy away from the evaluation and schedule-II medical treatments of those conditions associated with the war-on drugs.

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[21] *See* Ronald Libby, *Treating Doctors as Drug Dealers: The Drug Enforcement Administration's War on Prescription Painkillers*, 10 Indep. Rev. 511 (2006).

[22] *Id.* at 541.

[23] *See supra* note 1 and accompanying text (Schedule II).

[24] *See* Russell Barkley, *Behavioral Inhibition, Sustained Attention, & Executive Functions: Constructing a Unifying Theory of ADHD*, 121 Psych. Bul. 65 (1997).

[25] *See* Alan Schwarz, *Risky Rise of the Good-Grade Pill*. N.Y. Times (Jun. 9, 2012).

Credicide & Physicians' Growing Uncertainty

Writing for the British Medical Journal ("BMJ") a general practice adviser, Paul Hodgkin, warned that the postmodern narrative poses an "active killing" of all belief in moral frameworks; a risk that Hodgkin named "credicide" as the cause of general angst from widening uncertainty.[26] Moreover, he argued that credicide would not have reason to spare any particular dogma; not even medicine's Hippocratic Oath. Remarkably, the World Court in The Hague heard evidence of those accused of heinous crimes against humanity and the Court then fully embraced moral deontology in an effort that the world should never again suffer such evil. Then the World Court held as a matter of foundational international law that *human dignity*[27] was an essential universal ethical principal, and acknowledged the universal value of all human beings, the intrinsic worth of humanity as documented by the Nuremberg Code and more recently by the Universal Declaration on Bioethics and Human Rights.[28]

Relativism Collided with the Oath

Well beyond mere inconvenience for ADHD patients and their doctors, postmodern relativism crashed into medicine's supporting moral foundation.[29] Retrospectively; however, such destructive effects should have been foreseeable, because western medicine's moral and ethical foundations rested on a widely accepted meta-narrative for medical truth, the Oath of Hippocrates ("Oath"). For example, by the Oath, physicians have a sworn duty that they must not give a deadly drug to anybody who asks for it, nor make a suggestion to that effect.[30] Through that Oath, physicians were also sworn into the service of their patients'

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[26] *See* Paul Hodgkin, *Medicine, Postmodernism & End of Certainty*, 313 BMJ 1568 (1996).

[27] *See* Eyal Benvenisti, *Human Dignity in Combat: Duty to Spare Enemy Civilians,* 39 Israel L. Rev. 81 (2006).

[28] *See gen.* Roberto Andorno, *Human Dignity & Human Rights as a Common Ground for a Global Bioethics*, 34 J. Med. & Philo 223 (2009).

[29] M. Gregg Bloche, MD, *The Hippocratic Myth: Why Doctors are Under Pressure to Ration Care, Practice Politics & Compromise Their Promise to Heal* (2011).

[30] *See* Atul Gawande, MD, MPH, *When Law and Ethics Collide — Why Physicians Participate in Executions*, 354 N. Engl. J. Med. 1221, 1221 (2006). "The AMA passed a resolution against physician participation [in executions] as a violation of core medical ethics. It affirmed that ban in detail in its 1992 Code of Medical Ethics. Article 2.06 states, 'A physician, as a member of a profession dedicated to preserving life when there is hope of doing so, should not be a participant in a legally authorized execution' …. It states that unacceptable participation includes prescribing or administering medications as part of the execution procedure, monitoring vital signs, rendering technical advice, selecting injection sites, starting or supervising placement of intravenous lines, or simply being present as a physician ….The code of ethics of the Society of Correctional Physicians establishes an even stricter ban: 'The correctional health professional shall... not be involved in any aspect of execution of the death penalty.'"

needs and into the duty of protecting those patients from injustice and malfeasance.[31] Furthermore, physicians acknowledged a moral truth that they must only prescribe regimens for the good (beneficence) of their patients and not for any other reason.[32] Thus, the Oath denies physicians an ethical means to participate in the killing of any human being.[33] Surely, because physicians have an undeniable duty to heal and never hurt,[34] those duties of the Oath produced a social good because the public may value having confidence in a fair and dependable medical system with trustworthy physicians.[35] However, as observed, when the Postmodern Condition directly collided with medicine's Oath that social good may be at risk.[36]

Relativism and Human Dignity

As physicians we should be shaken that in the postmodern condition a few utilitarian acolytes seem unconvinced of the intrinsic worth of every human being as universal dignity and human right.[37] For example in 1993 a professor published his utilitarian argument with the following conclusion: "the fact that a being is a human is not relevant to the wrongness of killing it."[38] Moreover he supported his conclusion arguing that because infants lack rationality, autonomy and self-consciousness, then killing infants cannot be equated with killing normal human beings.[39] Such utilitarian logic may seem at odds with the reasoning of the World Court recognition of intrinsic human rights and dignity of the human species.[40]

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[31] *See* Richard Barton, *Sources of Medical Morals*, 193 JAMA 133 (1965).
[32] *Id.*
[33] *See* Atul Gawande, *When Law and Ethics Collide — Why Physicians Participate in Executions*, 354 N. Engl. J. Med. 1221, 1221 (2006). "The AMA passed a resolution against physician participation [in executions] as a violation of core medical ethics. It affirmed that 'a physician, as a member of a profession dedicated to preserving life when there is hope of doing so, should not be a participant in a legally authorized execution' …. It states that unacceptable participation includes prescribing or administering medications as part of the execution procedure, monitoring vital signs, rendering technical advice, selecting injection sites, starting or supervising placement of intravenous lines, or simply being present as a physician….The code of ethics of the Society of Correctional Physicians establishes an even stricter ban: 'The correctional health professional shall... not be involved in any aspect of execution of the death penalty.'"
[34] *See* C. Ronald MacKenzie, *What Would a Good Doctor Do? Reflections on the Ethics of Medicine,* 5 Hosp. Spec. Surgery J. 196 (2009).
[35] *See supra* Bloche note 30 at 270.
[36] *Id.*
[37] *See supra* notes 28 - 29 and accompanying text.
[38] Peter Singer, *Taking Life: Humans, Practical Ethics* 175-217 (2d ed. 1993).
[39] *Id.*
[40] *See supra* notes 28 - 30 and accompanying text.

Medicine's Reaction to the Uncertainty of the Postmodern Condition

A few years thereafter, the BMJ's Paul Hodgkin offered that as a result of the postmodern condition physicians must juggle conflicting interests with added uncertainty. For physicians prescribing medications chronic pain or ADHD treatments those conflicts seemingly grow alongside the uncertainty produced by the relativism of postmodern narratives.[41] Medicine's efforts to respond to postmodern uncertainty seemingly focused on creating objective diagnostic criteria, reproducible treatment algorithms, and measurable results through popularizing an "evidence-based medicine" movement.[42] Some physicians may experience added angst, when the seemingly subjective data must be employed with objectivity whenever medical management will include Schedule II controlled substances, such as with either chronic pain or ADHD. Physicians must trust in the apparently genuine, however subjective, reports by family, educators, and patients for the diagnosis of ADHD. In the postmodern era, physicians may have angst with the uncertainty of compulsively following the obligation to employ plainly subjective diagnostic criteria in a paradoxical effort to objectify and quantify the subjective data for detached clinical and legal regulations. This may reasonably cause physicians uncertainty and angst.

Skeptical Critics and Uncertainty for Physicians

When Hodgkin announced in the BMJ that the postmodern condition ended certainty for medicine, he also observed negative consequences for patients and their physicians. Reasonably, the skepticism of the postmodern condition has shifted the preceding established trust-building narratives of physicians, away from those of doctors fighting death and disease on behalf of their patients,[43] toward others that implicate doctors in the war-on-drugs. The shift may have been amplified when President Nixon focused public attention on medical treatment with controlled substances. As a result, physicians then confronted volumes of laws and regulations with numerous ambiguities. For example, federal and state regulations prohibit any 'refilling' of a schedule-II controlled substance.[44] Also in the same regulation, a narrow and doubtful exception appears as a false hope for physicians who may attempt provide more than a single 30 day prescription order for a schedule-II controlled substance.[45]

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[41] Leslie Paul Thiele, *The Agony of Politics: The Nietzschean Roots of Foucault's Thought*." 84 Am. Pol. Sci. Rev. 907-925, 907 (1990).
[42] Paul Hodgkin, Medicine, *Postmodernism & End of Certainty*, 313 BMJ 1568 (1996).
[43] *Id*.
[44] *See* 21 C.F.R. §1306.12 (2007).
[45] *Id*.

The Federal Regulation 'refilling' is prohibited

Regulators created some ambiguity because their regulations did not define '*refilling*' within the context of law enforcement.[46] This ambiguity results as the word 'refilling' is a common word used every day; when used by physicians or their staff refilling may mean different actions from the meaning for pharmacist and pharmacies. For example the word 'refill' in the patient's record may describe 'refill' alongside a patient's newly reported data since the last patient encounter; the interim medical history and also a few pertinent contemporary physical exam notes. Then the doctor may typically note a 'refill' to document the medical diagnosis with a confirmed medical decision to continue the patient's treatment plan. Possible ambiguity may arise when physicians and pharmacists have different context as each provide services for an existing patient with repeated medical encounters for continuing evaluations and management for the same chronic condition, such as Asthma, ADHD, Cancer Chronic Pain, or Diabetes. When a patient is a frequently encountered for the same condition, some of the documentation reasonably employs the plain context of the patient's existing medical record with the diagnosis and treatment plan decision. Potential ambiguity may occur if the recorded notes for such an evaluation read something such as follows: "today MD decided to '*refill*' the patient's current medication as treatment for this condition." However, more precisely the physician's decision was to write a new order for the same medication that before was prescribed. The concern may arise because '*refill*' can mean as in the prior example, when a physician decides to prescribe again the same medication, even in context when a contemporary medical decision was made to prescribe again that treatment also as before prescribed. For the pharmacist and pharmacy staff, a prescription may be 'filling' and also differently meaning later 'refilling.' The 'filling' in the pharmacy context indicates that by a physician's single order the pharmacist will fill that order with a one, single dispensing of a medication. In the pharmacist's context then "refill' indicates by reference to a previous filling of a physician's order for a medicine that was already before filled or dispensed at least once, and that order includes authorization by a physician for the pharmacy to refilled it, or to dispense it again. For purposes of clarifying a somewhat confusing concept, of 'filling' differentiated from 'refilling' (briefly the latter would be a physician's authorizing of two or more pharmacy dispensing from a single encounter). Here reasons how prudent clinical physicians

[46] *Id.*

seeking to may abide the basic federal rule that "refilling" of a schedule-II controlled substance is prohibited.[47]

A narrow and doubtful exception as a false hope for physicians

After the aforementioned basic federal rule (no refilling), the regulations offer a narrow and doubtful exception, that may prove a false hope that any physician who would provide patients with more than single 30 day prescription. The specific language of that narrow doubtful exception in the federal rule reads with that an individual practitioner may issue multiple prescriptions authorizing the patient to receive a total of up to a 90-day supply of a Schedule-II controlled substance only if the following are also met: (1) Issuing multiple prescriptions will not create an 'undue' risk of diversion or abuse.[48] However, the word "undue" is not specifically defined within the rule; and (2) The prescriber must also comply fully with all other applicable laws and requirements, including every additional requirement under state Laws. Finally, while the above two requirements may be difficult to guarantee, then further reading in the regulation one finds a somewhat unsettling disclaimer that reads "… nothing in the preceding paragraph shall be understood as requiring or even as 'encouraging' prescribers to issue multiple prescriptions' or to evaluate their patients with schedule-two controlled substances only once every 90 days." The Practical Application for Any Physician Prescribing Schedule-II Controlled Substance physicians seeking to comply fully with the labrynth of federal prescribing regulations will benefit from consulting their own legal counsel, familiar with their respective state jurisdictions. The above broad disclaimer should sufficiently discourage every prudent physician away from any effort provide any patient more than 30 days of medical treatment from each medical encounter. All the preceding coincides with the DEA focus on preventing diversion of schedule-II controlled substances.

Conclusions: Physicians and the Postmodern Condition

Conflicts, Dissonance and Professional Disillusion

Moreover, in the postmodern condition enforcement and regulatory powers that scrutinize, and challenge physicians may seem skeptical, adversarial, and unbridled from the rule-of–law.[49] As a result physicians may fret confronting and then defending themselves against such overwhelming power. Then, a few physicians may under-prescribe schedule-

[47] *Id*.
[48] *Id*.
[49] *See* Unger *supra* notes 15 - 16 and accompanying text.

II medications as a reasoned risk-management strategy. Although understandable in such circumstances, in so doing, a few doctors, however fretfully, set their own interests first, put themselves before their patients, and thus stray reluctantly from medicine's Hippocratic foundation. Of course, such may engender considerable dissonance for those well-intended and ethically aware physicians. The dissonance and uncertainty seems correlated with physicians' sense of professional disillusionment. Further consequences associated with the postmodern condition may continue to emerge in the context of physician wellbeing and mental health, as uncertainty in medicine continues to grow.[50] Worrisome reports estimate that 400 physicians kill themselves yearly as a sober measure of an expanding epidemic of US physician burnout.[51] Perhaps, illuminating some of the contributing reasons for the otherwise perplexing state of medicine for physicians and their patients may provide some answers for those engaged in treatment with Schedule II controlled substances.

A Few Solutions

As a final note for pediatricians and family practitioners providing care for ADHD patients with Schedule II controlled substances, we must acknowledge the law enforcement narrative. We should consider adopting useful strategies employed by our colleagues who treat patients with chronic pain, such as utilizing detailed informed consents and patient agreements as a prerequisite for receiving treatments of Schedule II controlled substances. Specifically any physician seeking to continue serving patients faithfully with Schedule II medical treatments should resist issuing multiple prescriptions from a single encounter. Given the aforementioned government focus on preventing diversion, physicians may consider the real medical benefits and apparent decreased risk of diversion when prescribing the 'long-acting' or 'extended release' ADHD therapeutics. Moreover, physicians discouraged by the postmodern condition may realize that the forces for discouragement are broad and pervasive. Seeking support for the resulting negative emotional consequences for physician wellbeing is understandable and should be commonplace.

[50] *See* Georgia Cooke, *A Survey of Resilience, Burnout, and Tolerance of Uncertainty in Australian General Practice Registrars,* 13 Biomed. Central Med. Edu. 2 (2013).
[51] Anna Pavlov, *On Physician Burnout: A Serious Problem!*, 10 So. Calif. Clinicians J. 9 (2016).