Curiouser and Curiouser

Thomas B. Strouse, MD, Associate Editor

Curiouser and curioser!” cried Alice (she was so much surprised, that for the moment she quite forgot how to speak good English).
— Lewis Carroll, Alice's Adventures in Wonderland

When it comes to science, we are living in strange times. Although much of the health, wealth, and power of our society derives from extraordinary achievements in physics, biochemistry, engineering, and medicine over the last 100 years, it seems curious indeed that political figures who trumpet America's material success are launching assaults on the nature of scientific endeavor—challenging the value of expertise, positing “alternative facts,” rejecting evidence-based findings in favor of bombastic claims and personal beliefs.

It is in this context of seeming open hostility toward scientific evidence that our society considers (some would say resumes) important deliberations about how to schedule, regulate, (de)criminalize, and otherwise govern whether its citizens will have legal access to a host of molecules—some plant-derived, some synthesized—for therapeutic uses. For we palliative care clinicians, the paramount uses in question relate to reducing intractable suffering—in particular, suffering for which our available treatments are often inadequate.

As an instructive example of the current disconnect between science and policy discourse in the public square, compare the scholarly 2017 monograph on the health effects of cannabis and cannabinoids produced by the National Academy of Sciences—which cites good clinical-trial evidence supporting the efficacy of cannabis and cannabinoids for pain management, (including for HIV- and chemotherapy-related peripheral neuropathies)—to an assertion by the future Attorney General’s recent rollback

Notes from the Editor
The excesses of those eras, mixed with the social upheaval and challenges to authority that accompanied them and terrified “the establishment”,5 provide a rich topsoil of images and impressions to support reactionary resistance to the emerging evidence.

Dr. Byock is no stranger to the politics and regulatory barriers that might lie ahead; he describes them plainly in the article. And even beyond those expectable barriers, we find ourselves in a “1984” world of political suppression of scientific and public policy discourse. A painful recent example: in an early 2018 editorial in the Annals of Internal Medicine, a group of Emory University public health experts called attention to an effort by the White House to ban specific words from the U.S. Center for Disease Control’s 2019 annual budget request.6 What those words mean—“vulnerable,” “diversity,” “transgender,” “fetus,” “evidence-based,” and “science-based”—is essential in all of medicine, and particularly in the field of palliative care. Is the idea that, if we do not use those words, vulnerability, diversity, transgender people, unborn fetuses, evidence, and science will just go away?

Palliative medicine physicians are accustomed to being outside the spotlight of high-tech modern medicine, and we routinely advocate for patients who do not get first-priority attention from our medical colleagues. If clinical trials continue to demonstrate new hope from psychedelics for some of our patients’ most intractable symptoms, we may find ourselves a bit blinded by an unfamiliar spotlight, and we may feel compelled to join an advocacy effort for the “right to try” these treatments. Common sense and good science are not likely to prevail on their own.

References

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