Chronic Pain & the Opioid Epidemic
Moral, Ethical and Professional Duties and Obligations of Clinicians

Richard Payne, M.D.
Esther Colliflower

Disclosures

Activity | My Role | Comment
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Vitas Hospice | Paid Consultant | I teach Vitas pain and palliative medicine topics to Vitas employees and their referral base. Vitas is a “for-profit” hospice.
Cunniff-Dixon Foundation | Member, Board of Trustees | Family Foundation focusing on identifying physician excellence in palliative medicine and various educational programs.
Patrician Medical Company | Medical Director | Start up pharmaceutical and medical device company, focusing on palliative care products. No opioid products.

Pain-Nuanced and Conflicting Perceptions

• “Pain and death are part of life. To reject them is to reject life itself.”
  • Havelock Ellis
• “It is easier to find men who will volunteer to die, than to find those who are willing to endure pain with patience.”
  • Julius Caesar
• “The art of life is avoiding pain; and he is the best pilot, who steers clearest of the rocks and shoals with which it is best.”
  • Thomas Jefferson
“Effective pain management is a moral imperative, a professional responsibility and the duty of those in the healing professions.”

Relieving Pain in America
Institute of Medicine, 2011

“The duty to relieve pain and suffering is central to the physician’s role as healer and is an obligation physicians have to their patients.”

---Code of Medical Ethics, American Medical Association

“Physicians have the responsibility to relieve pain and suffering and to promote the dignity and autonomy of dying patients... this includes providing effective palliative treatment even though it may foreseeably hasten death”

---Code of Medical Ethics, American Medical Association
Defining Pain

“An unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage.”

H. Merskey, IASP. Task Force on Taxonomy, Pain 1979;6:250

“Chronic pain, defined as pain experienced on most days or every day in the previous 3 months. High impact chronic pain incorporates disability and pain duration to identify a more severely impacted portion of the chronic pain population.”

Pritchett MH et al. The Journal of Pain, 2018

Total Pain

100 m Americans experience pain
2011 report, total

4.8% adult population, 12.6 million Americans

Cecily Saunders—Total Pain Concept

“...I give a description of various symptoms and ills and then went on to say, ‘My husband and son were marvelous but they were at work and they would have had to stay off and lose their money. I could have cried for the pills and injections although I knew I shouldn’t. Everything seemed to be against me and nobody seemed to understand.’ And then she paused before she said, ‘But it’s so wonderful to begin to feel safe again.’ Without any further questioning she had talked of her mental as well as physical distress, of her social problems and of her spiritual need for security.”

Saunders, C. (1964) Care of patients suffering from terminal illness at St Joseph’s Hospice, Hackney, London.

Mrs. Hinson at St Joseph’s Hospice
Moaning and groaning on 2000 mg/morphine hour, intravenously—the literal embodiment of "total pain".

Pain & Suffering
The Death of Ivan Ilyich

"After supper his friends went home, leaving Ivan Ilyich alone with the knowledge that his life had been poisoned and was poisoning the lives of others, and that far from diminishing, that poison was penetrating deeper and deeper into his entire being"  
--p. 71

“They gave him opium and began morphine injections, but this brought no relief.”  
--p. 83
CHRONIC PAIN AS A "DISEASE:
Brain Gray Matter Decrease in Chronic Pain Is the
Consequence and Not the Cause of Pain
Rea Rodriguez-Riecche, et al.
The Journal of Neuroscience, November 4, 2009 • 29(44):13746–13750

A. Significant decrease in gray matter comparing patients with chronic hip OA vs. unaffected controls

B. Gray matter decrease in 10 pain free patients 16-18 weeks after total hip replacement vs. scans
TWO PUBLIC HEALTH CRISIS

Chronic Pain ↔ Opioid "Epidemic"

P A

P A
Did doctors and dentists cause the opioid epidemic?

https://www.youtube.com/watch?v=o64fRIgX8Sk.

Opioid Epidemic - Who is to Blame?

Big Pharma & the Opioid Epidemic: Profiting from Pain
Evolution of the Opioid Crisis

1. Over prescription of opioid medications led to misuse
2. Addiction to prescription opioids led to heroin
3. Emergence of fentanyl(s), with higher potency and greater profitability in the black market than heroin.

Two milligrams of fentanyl, a potentially lethal dose

Are opioids effective in managing chronic pain?
Opioids vs. Placebo in Chronic Pain: Pain Relief Outcomes
-- modest benefit
-- variable quality of trials
-- relatively short trial duration

Opioids vs. Placebo in Improving Function in Chronic Pain
-- very modest benefit
-- small number of trials

Opioids vs. NSAIDS & Tricyclics: Pain Relief
-- no difference
-- small # of trials
-- opioids & NSAIDs can have significant adverse effects
Opioids vs. NSAIDs & Tricyclics

Functional Outcomes
- no difference
- small # of trials
- opioids & NSAIDs can have significant adverse effects

We were not surprised that palliative care could change survival, because better pain management did.

Pain relief strongly associated with longer survival of 552 days, p = 0.04. Smith T, Stoma R et al. J Clin Oncol 2002; Annals Oncol 2003
Multidisciplinary biopsychosocial rehabilitation for chronic low back pain: Cochrane systematic review and meta-analysis

Swaroop K Kapur senior research fellow M A K Kapur research fellow A. Al-Saboury research assistant A. Al-Saboury research assistant F. J. M. Smits-Engelsman professor of rehabilitation medicine W. A. Van Den Oever professor of rehabilitation medicine N. W. van Tintelen professor of health technology assessment

Abstract
Multidisciplinary rehabilitation for chronic low back pain is effective for reducing disability and improving function. While multidisciplinary rehabilitation with specific aims is effective, the quality of evidence is low. This review concludes that multidisciplinary rehabilitation is effective for reducing disability and improving function. Multidisciplinary rehabilitation with specific aims is effective, but the quality of evidence is low. This review concludes that multidisciplinary rehabilitation with specific aims is effective for reducing disability and improving function.
Pain and the opioid “epidemic”
TWO PUBLIC HEALTH CRISIS

Chronic Pain ↔ Opioid “Epidemic”

What Do We See in a Patient in Pain?

“I don’t see a block of marble; I see a figure emerging from the block of marble.”
—Michelangelo (paraphrased)

Is every patient a potential substance abuser?
What is the incidence of iatrogenic addiction?
A Patient Story

• 80 y/o AA male with chronic knee and back pain
• Stable marriage x 50 years; many grandchildren & great-grandchildren
• On chronic opioids for years with downward dose trajectory
• Occasional passive suicide ideation
• Pain clinic referrals—falsely labeled an “addict” and offered several ineffective nerve blocks and other procedures
• Now has spinal cord stimulator and takes 3-4 hydrocodone/day
  • Goes to senior rehab facility several times a week; does all self care; travels for pleasure; sees OEX as “great”
• Pain “doctor” advises that he must stop hydrocodone—uses CDC guidelines as rationale
• Crises—function declines; confrontations—outcome unclear

What’s a doctor (clinician) to do?

• Practice professionally and ethically
  • Critique the evidence
  • Behave as clinicians, not as technicians
  • Act with the patient’s interest in mind
  • Don’t be intimidated!
• Advocate for access to comprehensive care models
• Advocate for research
CDC “Guideline for Prescribing for Opioids for Chronic Pain”

Uncommon NOT unprecedented
Low evidence/strong recommendations
IPRECC involvement
“Voluntary”
Keystone to coordinate federal campaign

CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016
Recommendations and Reports / March 18, 2016 / 65(1);1-49

“This guideline provides recommendations for primary care clinicians who are prescribing opioids for chronic pain outside of active cancer treatment, palliative care, and end-of-life care."

Many (un) intended consequences of policy being reported.

- Use opioids as part of a complete therapeutic strategy
- Start opioids as a "trial"-set expectations; weigh risk-benefits
- Start with IR (not ER) opioids
- Start with low dose and titrate slowly
- Avoid > 90 MME/day——get pain consult
- Re-assess 1-4 weeks after start; q 3 months thereafter
- Document: 4 A’s
  - Analgesia; Adverse effects; Aberrant behaviors; ADLs
- Monitor therapy
  - Urine drug tests
  - Opioid “contracts”/treatment agreements
  - Prescription monitoring programs
Medicare is cracking down on opioids. Doctors fear pain patients will suffer.

SPECIAL REPORT
A 'civil war' over painkillers rips apart the medical community — and leaves patients in fear
By BOB TADESCHI @bobtedeschi JANUARY 17, 2017

Caring for pain patients in the midst of mounting opioid regulation
Aug 24, 2017

What Do We See In Our Patient’s in Pain?
What values do we profess?

“I don’t see a block of marble; I see a figure emerging from the block of marble.”
— Michelangelo

Is every patient a potential substance abuser?

The Media and Pain
Media and Pain

• Provide historical perspective
• Strive for balance—recognize dual chronic public health crises
  • People living with chronic pain usually a “throw-away-line” in policy conversations about the opioid epidemic. “Of course, it would never be intended that policy would negatively impact those who live with chronic pain and have legitimate need for medication.”
• Explicitly consider unintended consequences
• Embrace the “expertise” patients and their families bring when addressing any public health issue
• Challenge statements asserted as “facts.”
  • Physical dependence vs. tolerance vs. addiction behavior

“Among the remedies which it has pleased almighty God to give to man to relieve his sufferings, none is so universal and so efficacious as opium.”

- Sir Thomas Sydenham (1680)

William Osler and G.O.M.

I have recently taken advantage of an unpleasant experience in my own person to observe the phenomena of these paroxysms in a ureter struggling with a calculus... And then abruptly, of working out of the steady pain, come the paroxysms, like a twisting tearing hurricane, with its well-known radiation, followed by the vasovagal features, the palor, cold extremities, feeble pulse, nausea, vomiting, and in two attacks, a final, not altogether unpleasant period, when unconsciousness and the pain seemed wrestling for a victory reeled only with the help of God’s own medicine—morphia.

Based on 1979 conference at M.D. Anderson Cancer Center, Houston, TX

-Much discussion on the “criminalization” of cancer pain patients and their doctors.

-Intense advocacy for liberalization of opioids

Media and Pain

https://www.youtube.com/watch?v=Cq_5KEMckYk=19b
Opioid Wars - Unintended Consequences

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