By Genevieve M. Clavreul, RN, Ph.D.

# The Great Opioid Debate of 2012

*Balancing the need for pain management with the potential for abuse*

"We're going to have to take you off your pain meds and get you into detox."

Those words are something more and more patients are hearing from their pain management providers. Recent stories in the local and national news media have thrust opioid abuse and addiction into the public consciousness, making healthcare professionals increasingly gun-shy about pain medication.

## A National Epidemic

The public outcry is easy to understand. According to the FDA, almost 36,500 Americans died of drug poisoning in 2008 alone and more than 40 percent of those deaths involved opioids. The 2010 National Survey on Drug Use and Health conducted by the U.S. Department of Health and Human Services reported that more than 35 million Americans over the age of 12 have used opioid analgesics for non-medical purposes, up more than 16 percent from 2002. Particularly alarming is the rise in opioid abuse among teenagers, sometimes leading to serious addiction and even suicide.

Naturally, these statistics have put the issue on the radar of lawmakers and law enforcement officials across the country. In November 2011, the White House issued an 11-page document entitled "Epidemic: Responding to America's Prescription Drug Abuse Crisis," recommending steps for combating the issue. The FDA recently released its own recommendations and a few weeks ago, the Joint Commission issued a Sentinel Event Alert about the dangers of opioid use and abuse in hospital settings. Meanwhile, law enforcement has been going after suspected "pill mills" (which allegedly sell scripts for pain meds like oxycodone or Vicodin to anyone who wants them) and even charging doctors with second-degree murder in connection with opioid-related deaths.

**Opioids are a tool, and like all powerful tools, they have the potential to be misused — but so does a hammer or an electric drill.**

Illegal prescription drugs found during 2010 police raid (AP photo)

The next step will be state and federal legislation intended to quash this growing problem. The White House has already called for the passage of a Model Pain Clinic Regulation Law to regulate the practice of pain management facilities, and similar state measures are sure to follow.

## When Physicians are Overruled by Bureaucracy

From a public policy standpoint, the problem with issues like this is the unfortunate tendency of bureaucrats and policymakers to set rigid, uniform rules when what is needed is a more individualized, holistic response. Nurses and physicians are in the business of treating and caring for patients as unique individuals. When that standard of personalized care runs afoul of inflexible regulations and too-narrow

←The Ilazarov frame (photo courtesy Science Photo Library)

treatment protocols, the outcome can be less than desirable, especially for patients living with chronic pain or injury that needs to be ameliorated with the use of pain medications such as opioids.

Some of the suggestions that have been floated for combating opioid abuse and addiction are quite draconian, such as limiting all opioid prescriptions to no more than 100 mg per day for no more than 90 days. While such limits might be reasonable as a general guideline, such guidelines often become strict rules from which nurses and other healthcare providers are reluctant to stray out of fear of being reprimanded, reported to the state licensing board or even arrested.

Pain management for patients suffering chronic non-cancer pain (CNCP) — including conditions like fibromyalgia, arthritis, interstitial cystitis or reflex sympathetic dystrophy syndrome — is a complicated, multi-level problem. Unless the source of the pain can be removed, the appropriate use of opioids is often a must to maintain the patient's quality of life. For such patients, the risks of overuse or addiction must be weighed against the constant pain the patient would otherwise have to endure.

## Drinking to Numb the Pain

Years ago, while I was receiving care at the orthopedic clinic of a local county-run hospital, I witnessed a dramatic example of the dangers of overly stringent policies on pain medication.

A fellow patient was undergoing orthopedic care for multiple fractures sustained in a vehicular accident. When I first met him, he had already undergone numerous corrective procedures and had external fixators on one arm and one leg, as well as a cast over his upper torso — it hurt just to look at him. I saw and talked to him for many weeks, but he then disappeared for some time, leading me to assume he had been discharged.

When I saw him again a month later, he was still in the cast and external fixators and his fingers were now in wired suspension. I asked him what happened and he explained that after six weeks, his doctor had informed him that he could no longer receive Vicodin or other prescription pain medications. His pain was still so severe that he had resorted to self-medicating with alcohol. After imbibing a little more than he should have, he had ended up falling down a flight of stairs, adding to his already extensive list of broken bones.

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## Torture by Ilizarov

Although I was at the clinic as a patient, the nurse in me was haunted by the thought of this man being forced to drink himself into a stupor to manage the pain after being denied proper medication. Not long afterwards, I nearly faced a similar situation myself. Despite the fact that my leg was still in an Ilizarov frame — an extremely painful type of external fixator — the resident informed me at my six-week check-up that he could not write me another script for pain medication.

Luckily, my physician intervened and ordered the resident to issue me a script for Vicodin, but I had to wonder what would have happened had I not been a nurse, well-dressed and white; my fellow patient had suspected that the doctors had cut off his meds based on the assumption that as a Latino, he was more likely to sell his Vicodin than take it as directed. (I'm not implying that the protocol was racially motivated, but the fact that he even came to that conclusion suggests there was a problem.)

As both a nurse and a sufferer of chronic pain, I have serious doubts about the merits of any hard and fast limits on the selection of medication, dosage or length of prescriptions. However, I agree wholeheartedly that there is a need for greater education on opioid use for prescribers, pharmacists and patients alike. Of course, education alone will not stop deliberate opioid abuse, but not all misuse is intentional.

## Patients Tracking Use

One of the problems for patients in managing their pain medication is that when you're in severe, constant pain, it's very easy to lose track of when you took your last pill. I experienced that while undergoing treatment with the Ilizarov apparatus: Having six metal rods running through your femur to slowly and agonizingly rotate it back into position wreaks havoc on your sense of time! I believe the main reason I did not end up addicted to pain killers (a frequent problem for Ilizarov patients) was that I used a Post-It pad to record exactly when I took each Vicodin, helping me keep track of when I was due for another dose.

Doing this came naturally for me — as nurses, we're trained to record the time and dosage whenever we administer medication — but it might not occur to the average patient. I can't help wondering how much inadvertent overuse could be prevented if more providers educated their patients in simple techniques like this.

## Prescription Monitoring at the Pharmacy

Another promising approach that has already been implemented in several states is a Prescription Drug Monitoring Program (PDMP). This is a centralized database of prescription information that pharmacists can access whenever a patient tries to fill a script. The PDMP generates an alert if a patient's scripts for a particular medication exceed a certain threshold (dosage, total duration of use or both) or if the patient has recently filled a similar prescription at another pharmacy.

The system is an excellent way to detect potential over-prescription (whether intentional or unintentional) and it also addresses the practice of "prescription shopping," where a patient obtains scripts for the same drug from multiple physicians and fills each prescription at a different pharmacy.

One of the most effective PDMP models is the one currently being rolled out in Oklahoma. Oklahoma's PDMP works in real time (in other states, there may be a lag of hours, days or even weeks before the system is updated) and allows pharmacists to directly notify the state medical board if the system indicates that a physician may be over-prescribing medication.

Pharmacists can also flag patients whose prescription records suggest possible dependency for counseling and detox services; Oklahoma has opted for a treatment approach for first-time offenders, although more serious penalties are in store for repeat abusers or "pill mills." At present, Oklahoma's PDMP is voluntary and limited to certain pharmacies, but it will be adopted statewide in the near future. The Obama administration has recommended adopting such systems in all states, with the ultimate goal of creating a nationwide database.

## Do No Harm

Prescription drug overuse and addiction are serious problems, but in our scramble to solve those problems, we should not forget that opioids are a tool. Like any powerful tool, they have the potential to be misused, but so does a hammer or an electric drill.

It's one thing to take steps to help detect and thwart deliberate abuse of prescription drugs and promote education to help patients and providers use opioids appropriately. However, imposing arbitrary restrictions and inflexible limits will only hurt patients who are already in pain. I've seen the results of those types of policies firsthand and I can tell you the results aren't pretty. WN

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# ***Healthcare Reform*** *September Update*

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## *New Study Finds "Alarming" Number of U.S. Doctors Close to Burnout*

The massive influx of new patients that will result from the Affordable Care Act has barely begun, but a newly released study warns that our nation's doctors are already overextended.

Conducted in 2011 by the Mayo Clinic in Rochester, Minn., the study surveyed 7,288 physicians across the United States. A startling 45.8 percent of doctors surveyed reported suffering at least one of the symptoms of job-related burnout defined by the 22-question Maslach Burnout Inventory. The most common symptom: emotional exhaustion, reported by 37.9 percent physicians surveyed.

The Mayo Clinic's Tait D. Shanafelt, M.D., the study's lead author, characterizes these results as "alarming." He says the figures were substantially higher than the researchers anticipated based on past studies, suggesting that doctor burnout is becoming more prevalent.

The study also found that symptoms of burnout are much more common among doctors than among other working adults. Of the 3,442 non-physician workers surveyed, 27.8 percent exhibited signs of burnout and only 23.5 percent reported suffering emotional exhaustion.

## *New Name Coming for California State Healthcare Exchange*

California's state healthcare exchange, presently known as the California Health Benefit Exchange, is looking for a new name. Starting in October 2013, the exchange will be responsible for connecting uninsured Californians with state-funded and/or federally subsidized insurance plans under the Affordable Care Act. Before that happens, exchange officials want to rebrand, concerned that the program's existing name will be too confusing or too hard to remember for many consumers.

Some of the suggestions for a new name include CaliHealth, Eureka, Health Hub, Wellquest and Condor, but several of the exchange board members favor the name Avocado. California is a major producer of that fruit, which is believed to have a variety of health benefits. However, board members admit that they still need to do more consumer research. The official selection will be made before the end of the year. WN