The Opioid Epidemic: From Freud to Fentanyl

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Disclosures

I have no conflicts to disclose.

Learning objectives

- Recognize that opioid overprescribing continues.
- Identify the psychodynamic, neurobiological, and sociocultural factors driving over-prescribing and over-consumption of prescription opioids.
- List ideas for what health care providers can do to target and substantially reduce this public health crisis.

September 2017

- 28 year old male with chronic pain
  - 40 mg Opana BID
  - 30 mg Dilaudid qD
  - 60 mg Oxycodone qD
  - 20 mg Valium qD
  - 65 mg Phenobarb qD
  - 30 mg Temazepam qD
  - 8 mg Xanax qD
- MED= 470

Big Pharma co-opts Big Medicine

Myths of opioids

- Myth #1: Opioids work for chronic pain
- Myth #2: No dose is too high
- Myth #3: Less than 1% get addicted if Rx'd by a doctor

SPACE Randomized Clinical Trial

Research

JAMA | Original Investigation

Effect of Opioid vs Nonopioid Medications on Pain-Related Function in Patients With Chronic Back Pain or Hip or Knee Osteoarthritis Pain

The SPACE Randomized Clinical Trial

Erin E. Krebs, MD, MPH; Amy Gravely, MA; Sean Nugent, BA; Agnes C. Jensen, MPH; Beth DeRonne, PharmD; Elizabeth S. Goldsmith, MD, MS; Kurt Kroenke, MD; Matthew J. Bair; Siamak Noorbaloochi, PhD

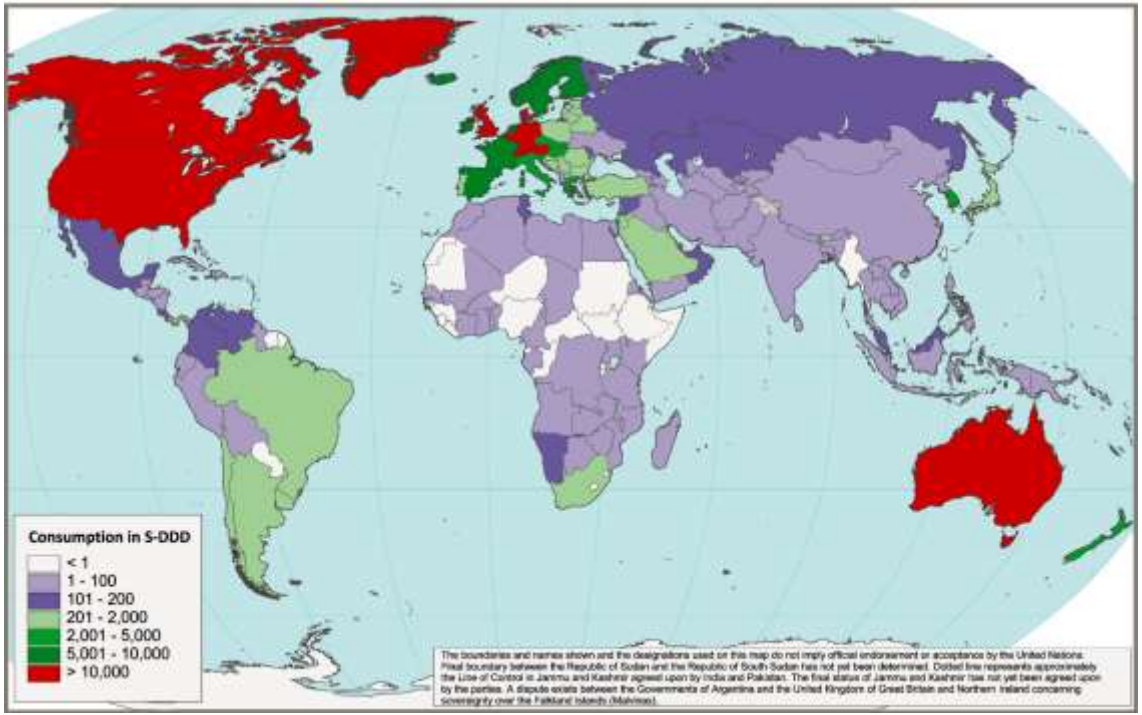
Supplemental content

IMPORTANCE Limited evidence is available regarding long-term outcomes of opioids compared with nonopioid medications for chronic pain.

OBJECTIVE To compare opioid vs nonopioid medications over 12 months on pain-related function, pain intensity, and adverse effects.

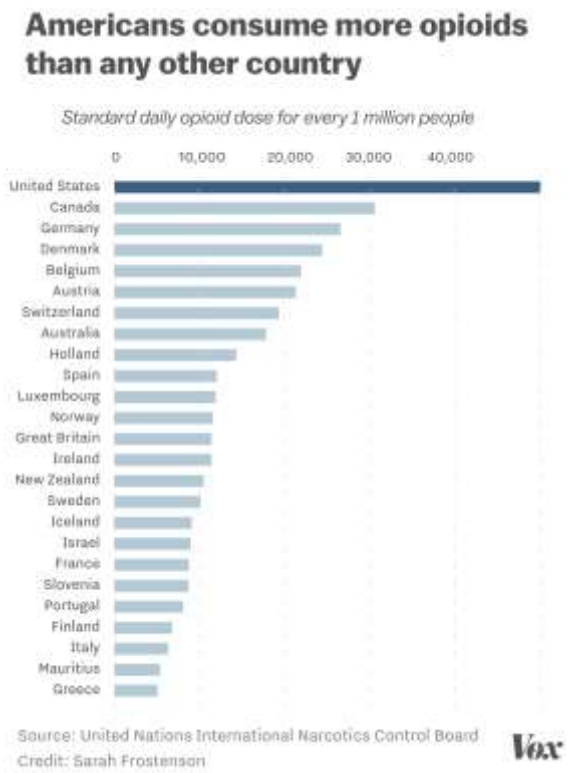
DESIGN, SETTING, AND PARTICIPANTS Pragmatic, 12-month, randomized trial with masked outcome assessment. Patients were recruited from Veterans Affairs primary care clinics from June 2013 through December 2015; follow-up was completed December 2016. Eligible patients had moderate to severe chronic back pain or hip or knee osteoarthritis pain despite analgesic use. Of 265 patients enrolled, 25 withdrew prior to randomization and 240 were randomized.

The U.S. and Canada prescribe and consume a disproportionate amount of the world's Rx opioids



https://www.incb.org/incb/en/narcotic-drugs/Availability/availability.html

U.S. outstrips other rich nations in opioid Rx'ing



A deeper look

The canary in the coal mine…

Opioids the solution …?

What motivates the compassionate doctor?

A pleaser

Responding to a ‘higher calling’

Socialized to empathize and believe patients

Put yourself in
THEIR
shoes

Motivated by mutually affectionate relationships

What motivates the drug-seeking patient?

Neuroadaptation

The Senator

The Sycophant

The Exhibitionist

The Dynamic Duo

The City Mouse and the Country Mouse

The Loser

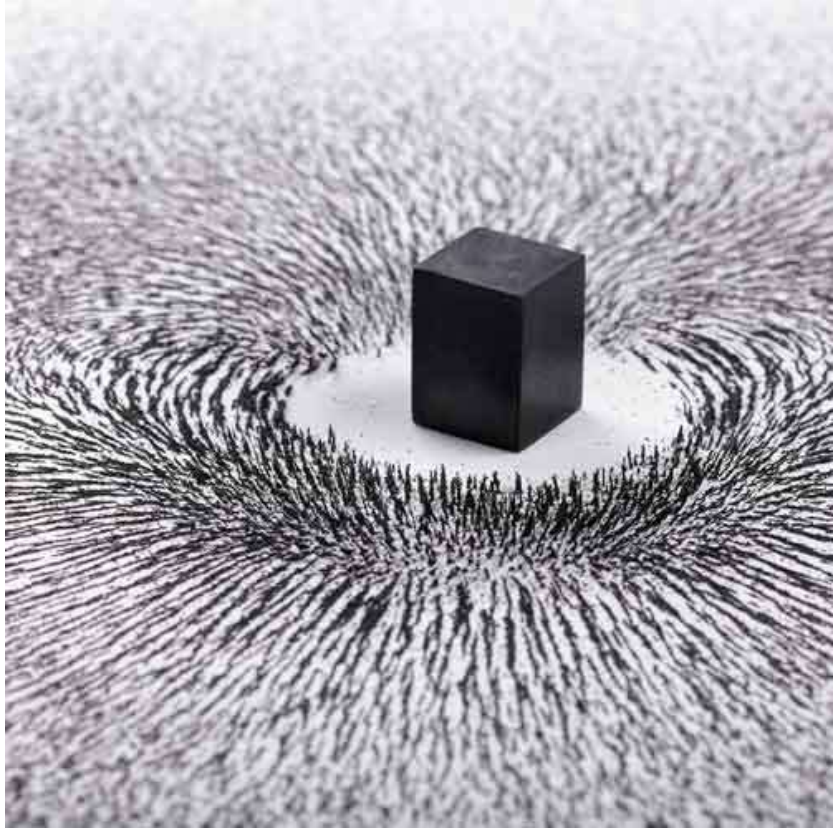
The Weekender

The Twin

The Doctor-Shopper

The Bully

Invisible forces continue to drive overprescribing



#1 The Toyota-ization of medicine

The P-Paradigm

- Palliate Pain
- Prescribe Pills
- Perform Procedures
- Protect Privacy
- Please Patients

Lembke, A., *Why Doctors Prescribe Opioids to Known Opioid Abusers,* NEJM, 2012

Dr. Anna Lembke MD

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Ratings

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3 stars	
2 stars	
1 star	

Ease of Appointment:	★★★★	Bedside Manner:	★★★★
Promptness:	★★★★	Spends Time with Me:	★★★★
Courteous Staff:	★★★★	Follows Up After Visit:	★★★★
Accurate Diagnosis:	★★★★	Average Wait:	5 minutes

Most recent

★★★★ | **Care that worsens your condition** | show details
by Corey on Jun 25th, 2013
Really wish I had seen this site's reviews before making an appointment with this physician. She provides the kind of care that will make you wish you had never sought help in the first place. Wrong diagnosis, wrong medication. In some cases this can be terrible. Seek help from someone else.

Archives of Internal Medicine 2012

ONLINE FIRST

The Cost of Satisfaction

A National Study of Patient Satisfaction, Health Care Utilization, Expenditures, and Mortality

Scan for Author Audio Interview

Joshua J. Fenton, MD, MPH; Anthony F. Jerant, MD; Klea D. Bertakis, MD, MPH; Peter Franks, MD

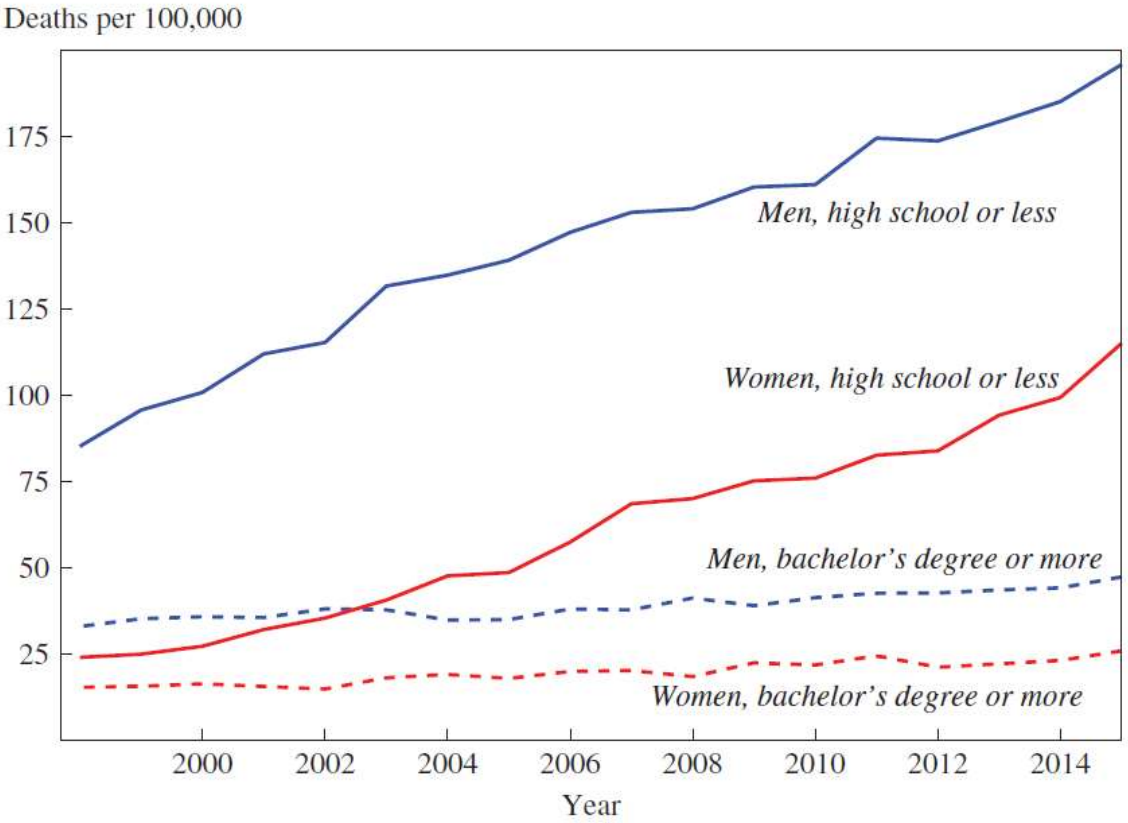
Background: Patient satisfaction is a widely used health care quality metric. However, the relationship between patient satisfaction and health care utilization, expenditures, and outcomes remains ill defined.

Methods: We conducted a prospective cohort study of adult respondents (N = 51 946) to the 2000 through 2007 national Medical Expenditure Panel Survey, including 2 years of panel data for each patient and mortality follow-up data through December 31, 2006, for the 2000 through 2005 subsample (n = 36 428). Year 1 patient satisfaction was assessed using 5 items from the Consumer Assessment of Health Plans Survey. We estimated the adjusted associations between year 1 patient satisfaction and year 2 health care utilization (any emergency department visits and any inpatient admissions), year 2 health care expenditures (total and for prescription drugs), and mortality during a mean follow-up duration of 3.9 years. ease burden, health status, and year 1 utilization and expenditures, respondents in the highest patient satisfaction quartile (relative to the lowest patient satisfaction quartile) had lower odds of any emergency department visit (adjusted odds ratio [aOR], 0.92; 95% CI, 0.84-1.00), higher odds of any inpatient admission (aOR, 1.12; 95% CI, 1.02-1.23), 8.8% (95% CI, 1.6%-16.6%) greater total expenditures, 9.1% (95% CI, 2.3%-16.4%) greater prescription drug expenditures, and higher mortality (adjusted hazard ratio, 1.26; 95% CI, 1.05-1.53).

Conclusion: In a nationally representative sample, higher patient satisfaction was associated with less emergency department use but with greater inpatient use, higher overall health care and prescription drug expenditures, and increased mortality.

#2 Medicalization of poverty

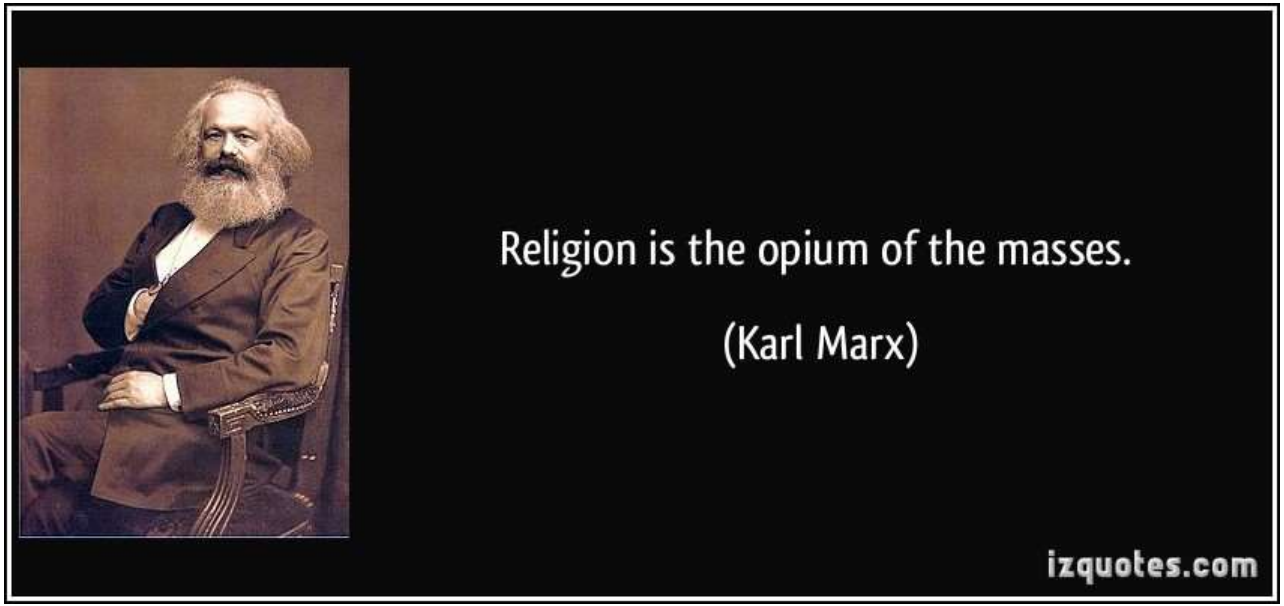
Figure 11. Deaths of Despair for White Non-Hispanics Age 50–54, by Level of Education, 1998–2015[a]



Sources: National Vital Statistics System; authors' calculations.
a. Deaths of despair refer to deaths by drugs, alcohol, or suicide.

Case and Deaton (2017) Brookings Papers on Economic Activity

Karl Marx (1818-1883)



#3 Cultural narratives

Pain is dangerous

Doctors have superhuman abilities to heal

Victimhood is a right to be compensated

Doctors (and patients) caught between a prescription and a hard place


scared
chest
tense
panic
trembling
headache
ANXIETY
stress
fear
sweating
feelings
worry
emotional
tension
angst
jumpy

Defense mechanisms to the rescue!

How defense mechanisms work

Anxiety →

Defense Mechanisms →

DECREASED ANXIETY

Denial

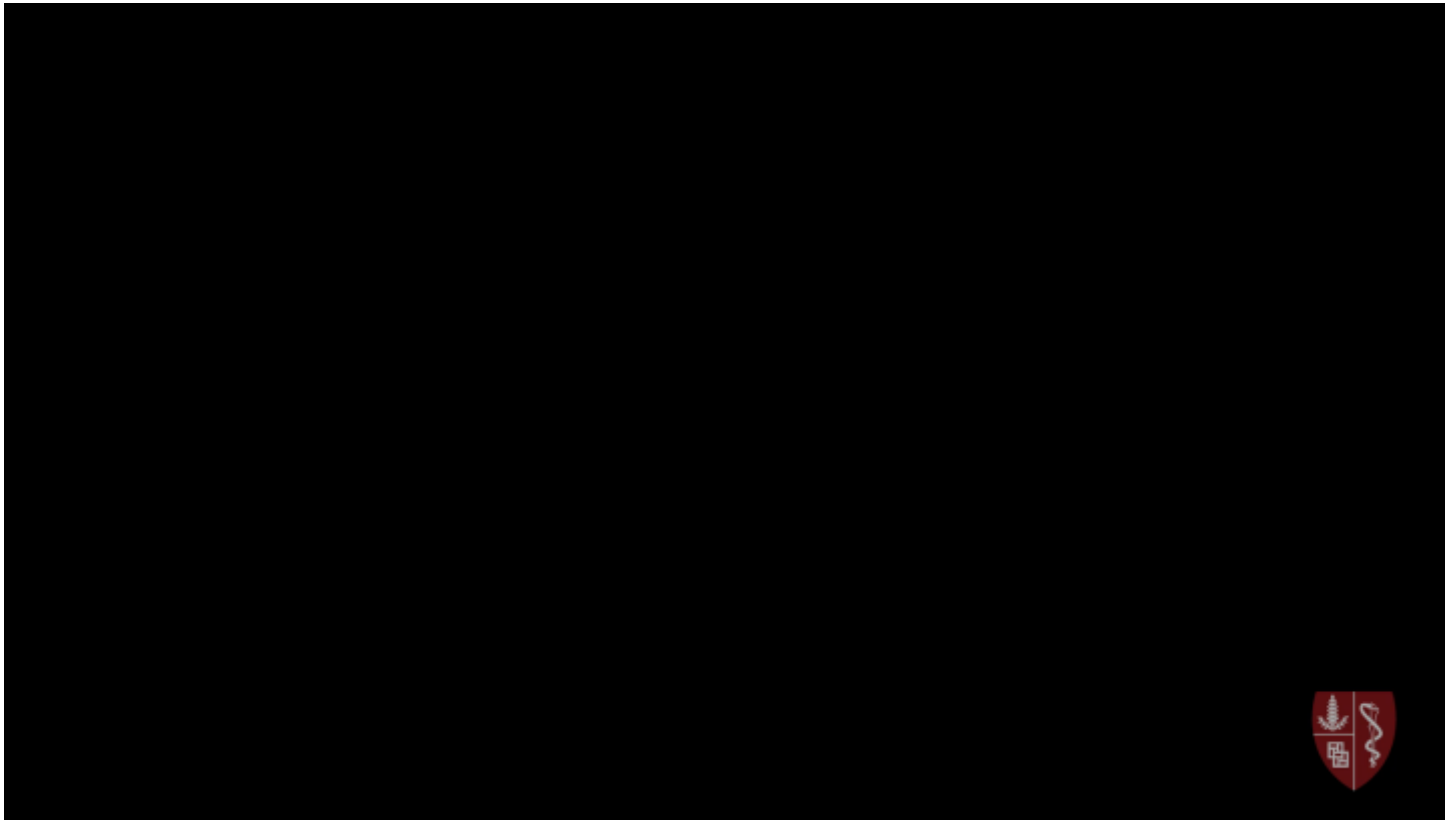
Projection

Splitting

Passive aggression

What happens when the compassionate doctor and the drug-seeking patient get a room?

Doctor meets patient Take 1



In other words …

A Kerfuffle that perpetuates the problem …

What happens when primitive defenses no longer work?

- For example when the Prescription Drug Monitoring Database shows undeniable doctor-shopping

- Doctor is fully unmasked as a de facto drug dealer

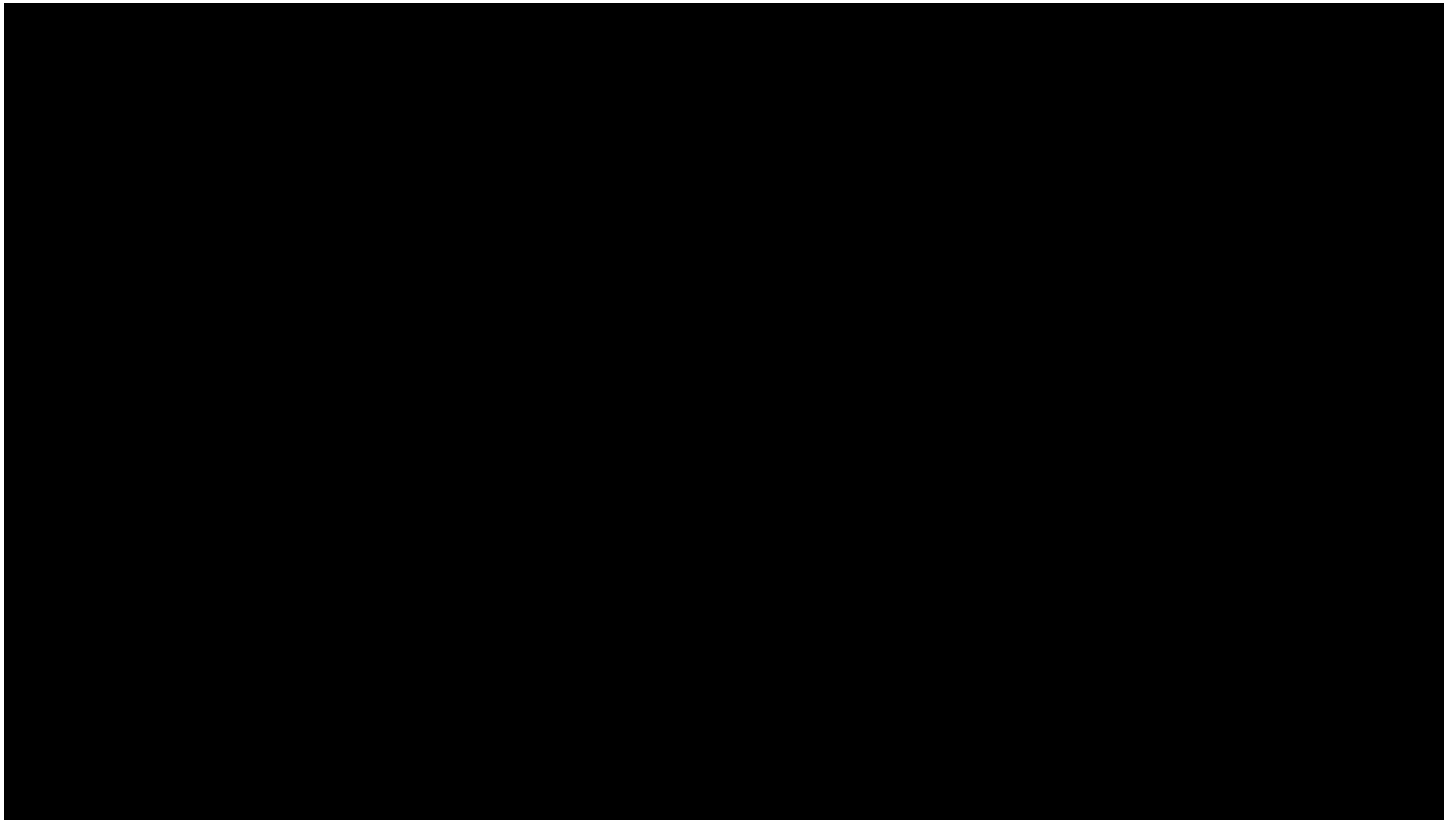
A narcissistic injury

Healthy narcissism

Heinz Kohut, *The Kohut Seminars*, 1987

Narcissistic rage and retaliation

Doctor meets patient Take 2

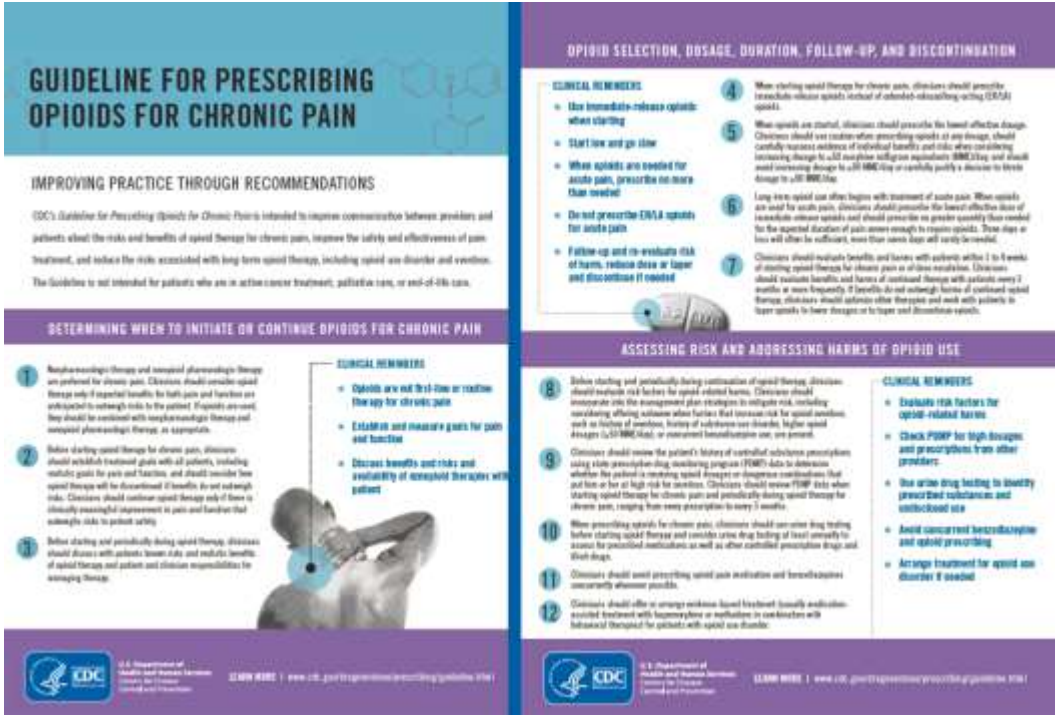


How can we do better?

Enabling

Retaliation

#1 Primary prevention
Limit new opioid starts



GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN

IMPROVING PRACTICE THROUGH RECOMMENDATIONS

DETERMINING WHEN TO INITIATE OR CONTINUE OPIOIDS FOR CHRONIC PAIN

CLINICAL REMINDERS

- Opioids are not first-line or routine therapy for chronic pain
- Establish and measure goals for pain and function
- Discuss benefits and risks and availability of nonopioid therapies with patient

OPIOID SELECTION, DOSAGE, DURATION, FOLLOW-UP, AND DISCONTINUATION

CLINICAL REMINDERS

- Use immediate-release opioids when starting
- Start low and go slow
- When opioids are needed for acute pain, prescribe no more than needed
- Do not prescribe ER/LA opioids for acute pain
- Follow-up and re-evaluate risk of harms, reduce dose or taper and discontinue if needed

ASSESSING RISK AND ADDRESSING HARMS OF OPIOID USE

CLINICAL REMINDERS

- Evaluate risk factors for opioid-related harms
- Check PDMP for high dosages and prescriptions from other providers
- Use urine drug testing to identify prescribed substances and undisclosed use
- Avoid concurrent benzodiazepine and opioid prescribing
- Arrange treatment for opioid use disorder if needed

#2 Secondary Prevention:
Taper high-risk patients down or off of opioids

http://stan.md/taper-off-opioids

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HOW TO TAPER PATIENTS OFF OF CHRONIC OPIOID THERAPY

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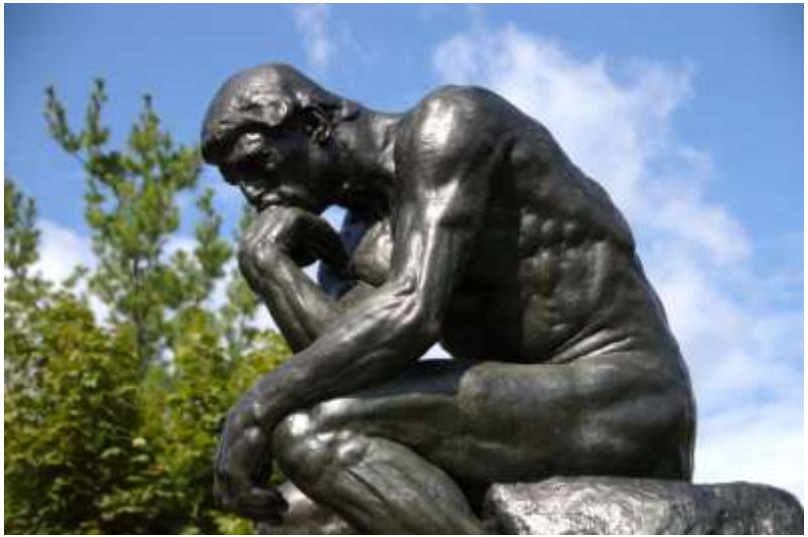
COURSE DETAILS

Original Release Date: 08/02/18

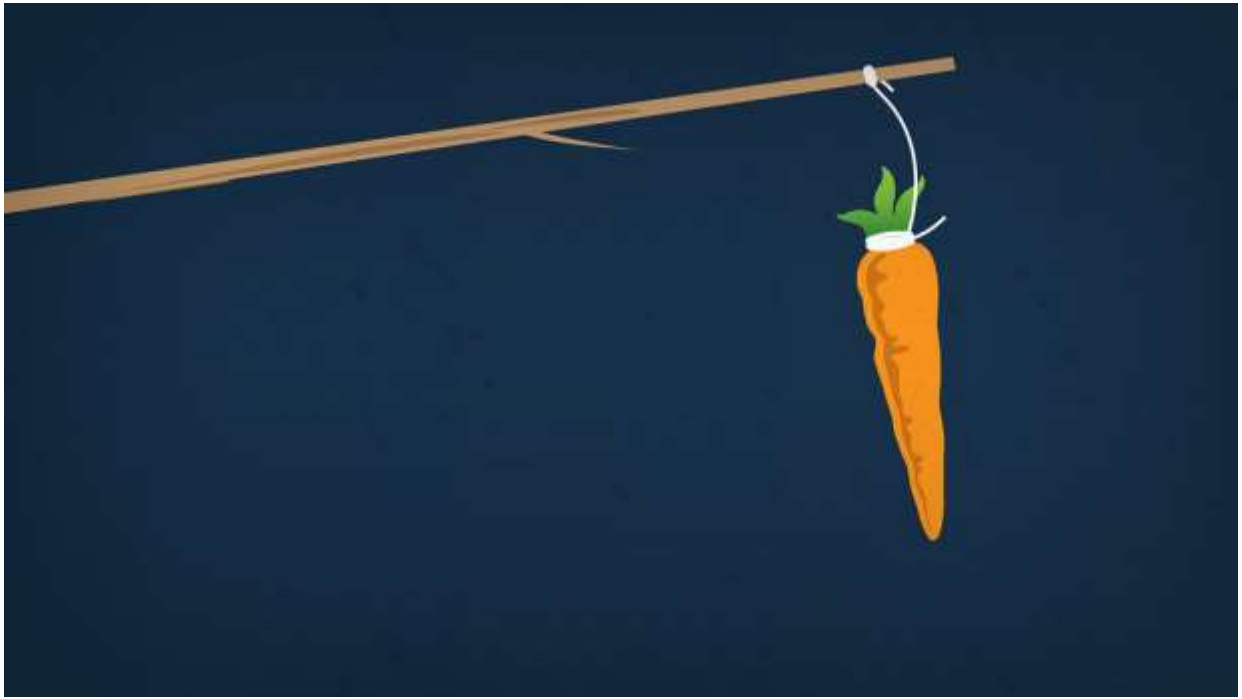
Expiration Date: 08/02/21

#3 Treatment

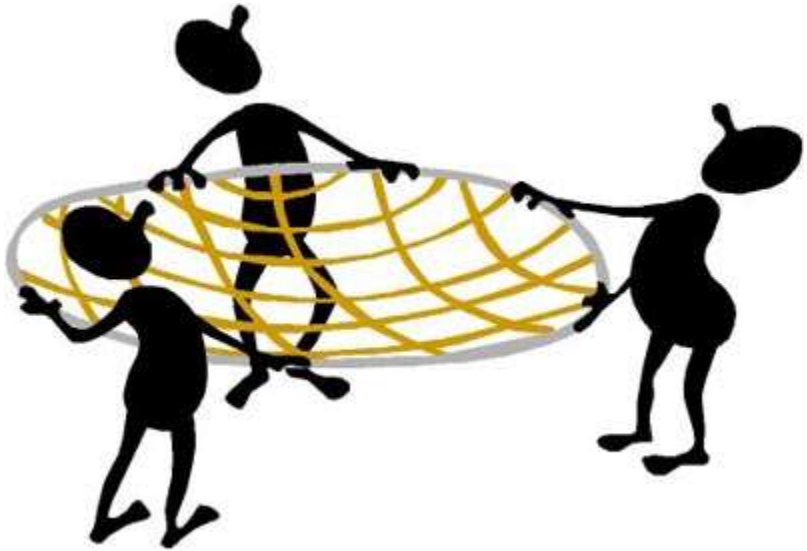


Think of addiction as a chronic relapsing and remitting disease *(even if you don't believe it is one)*

#4 Change the perverse incentives inside health care driving overprescribing

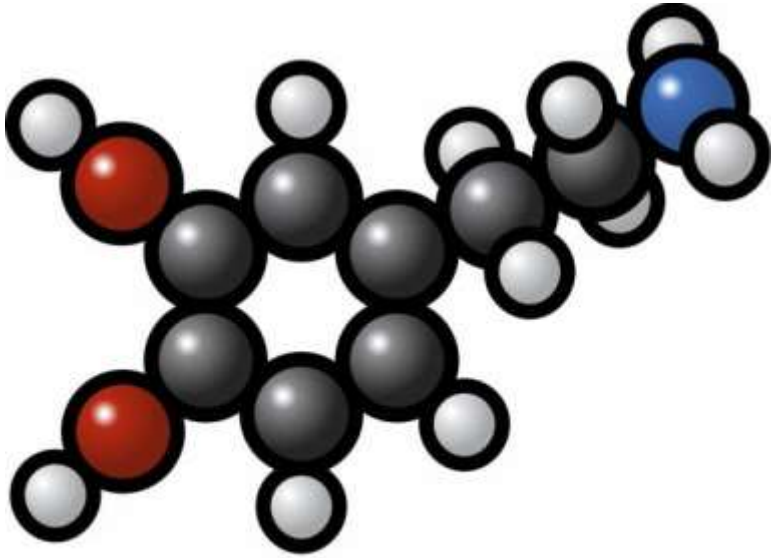


#5 Reform disability



#6 Limit influence of special interest groups

#7 Provide alternative sources of dopamine

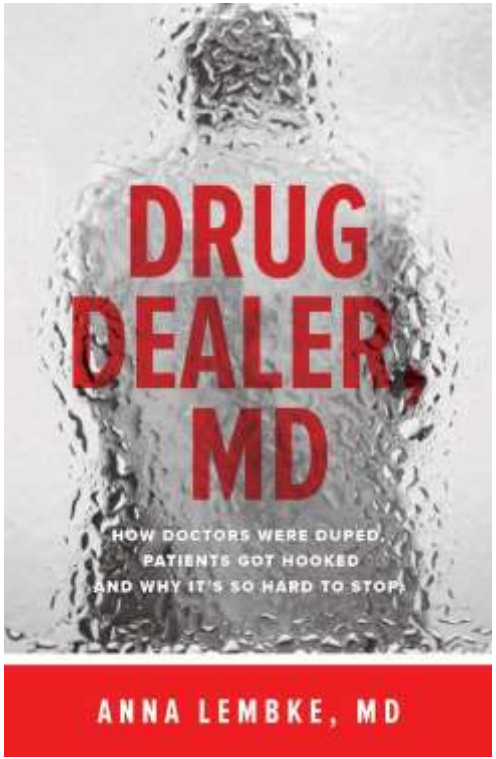


Dopamine $C_8H_{11}NO_2$

Reinhold Niebuhr (1892-1971)

“Ultimately evil is done not so much by evil people, but by good people who do not know themselves and who do not probe deeply.”

Additional References



Videos available free online

- Stanford University Online CME Courses https://med.stanford.edu/cme/learning-opportunities/online.html

- Youtube: Compassionate Doctor Meets Drug Seeking Patient: https://www.youtube.com/watch?v=SIJiMLxorkc

- Youtube: Drug Seeking Patient and Physician Interaction - Narcissistic Injury: https://www.youtube.com/watch?v=X9efr-5WAPc

Thanks for listening!