
The Opioid Epidemic: From Freud to Fentanyl

— Anna Lembke, MD
Associate Professor
Stanford University School of Medicine
alembke@stanford.edu —

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

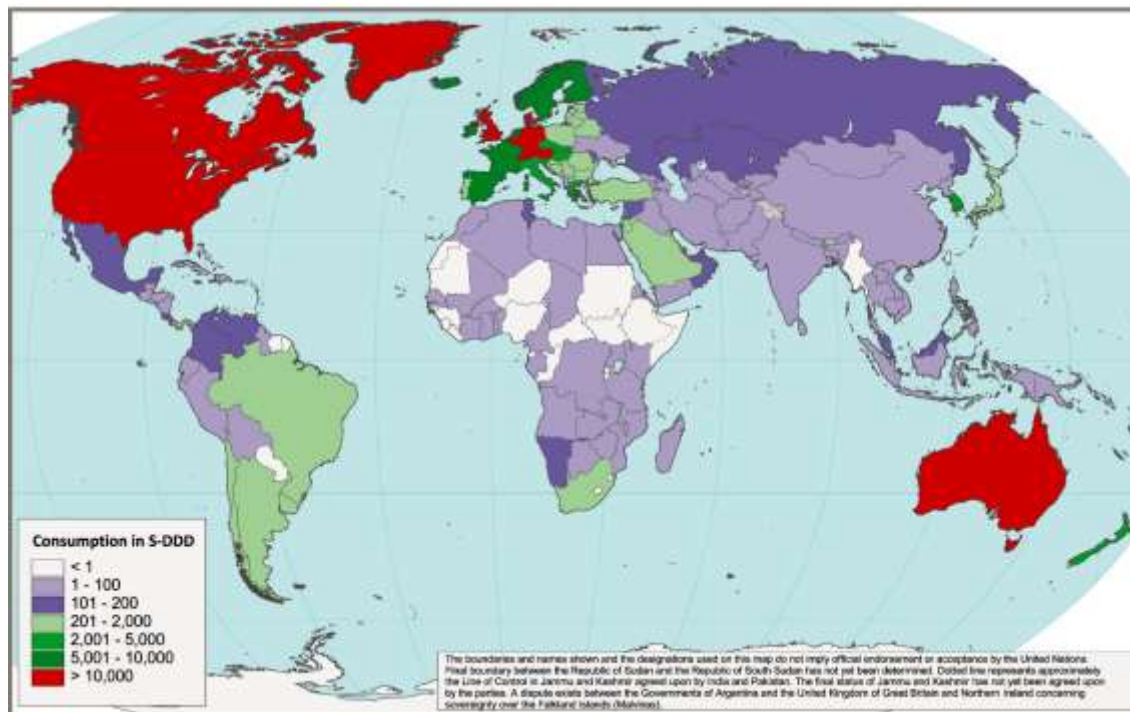
 [Supplemental content](#)

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.

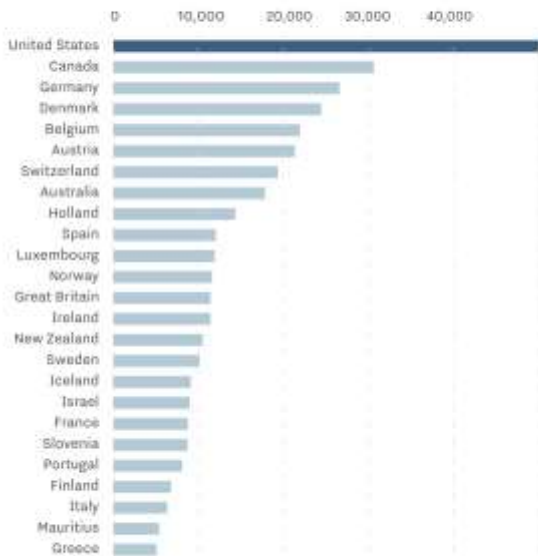
The U.S. and Canada prescribe and consume a disproportionate amount of the world's Rx opioids



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

Americans consume more opioids than any other country

Standard daily opioid dose for every 1 million people



Source: United Nations International Narcotics Control Board

Credit: Sarah Frostenson

Wax

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



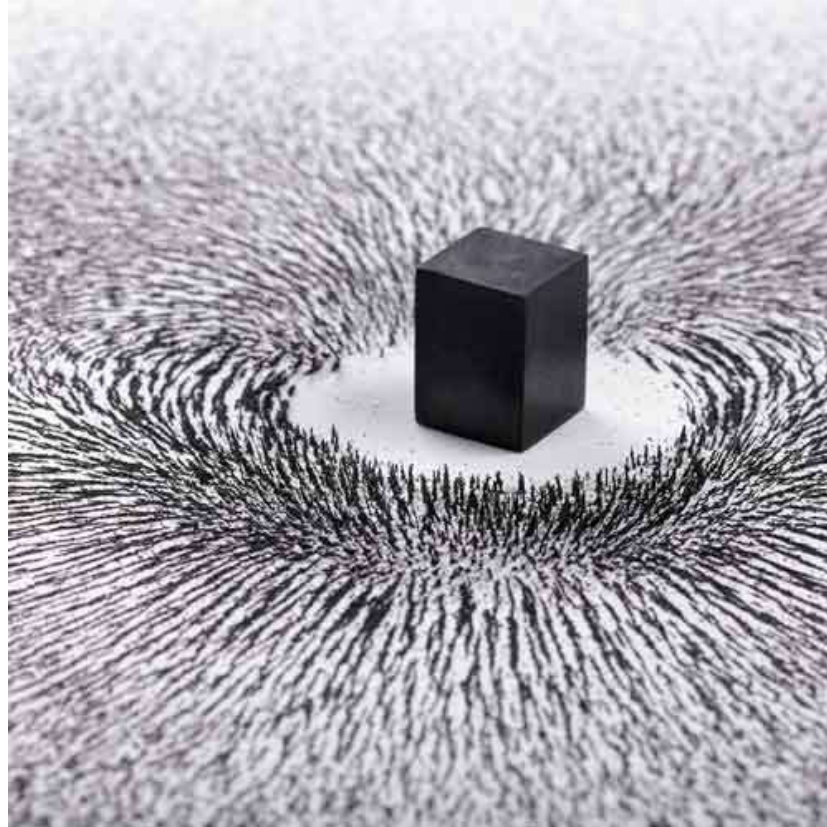
The Doctor-Shopper



The Bully



Invisible forces continue to drive overprescribing



#1 The Toyota-ization of medicine



The P-Paradigm



k0883516 www.fotosearch.com

- 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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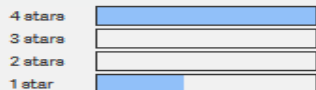
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Ratings



Ease of Appointment: ★★★★★

Promptness: ★★★★★

Courteous Staff: ★★★★★

Accurate Diagnosis: ★★★★★

Bedside Manner: ★★★★★

Spends Time with Me: ★★★★★

Follows Up After Visit: ★★★★★

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.

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1 Trick to
Fibromyalgia

KUBI Telemedicine
Robot

Archives of Internal Medicine 2012

ONLINE FIRST

The Cost of Satisfaction

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

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



Scan for Author
Audio Interview

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 3.0 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).

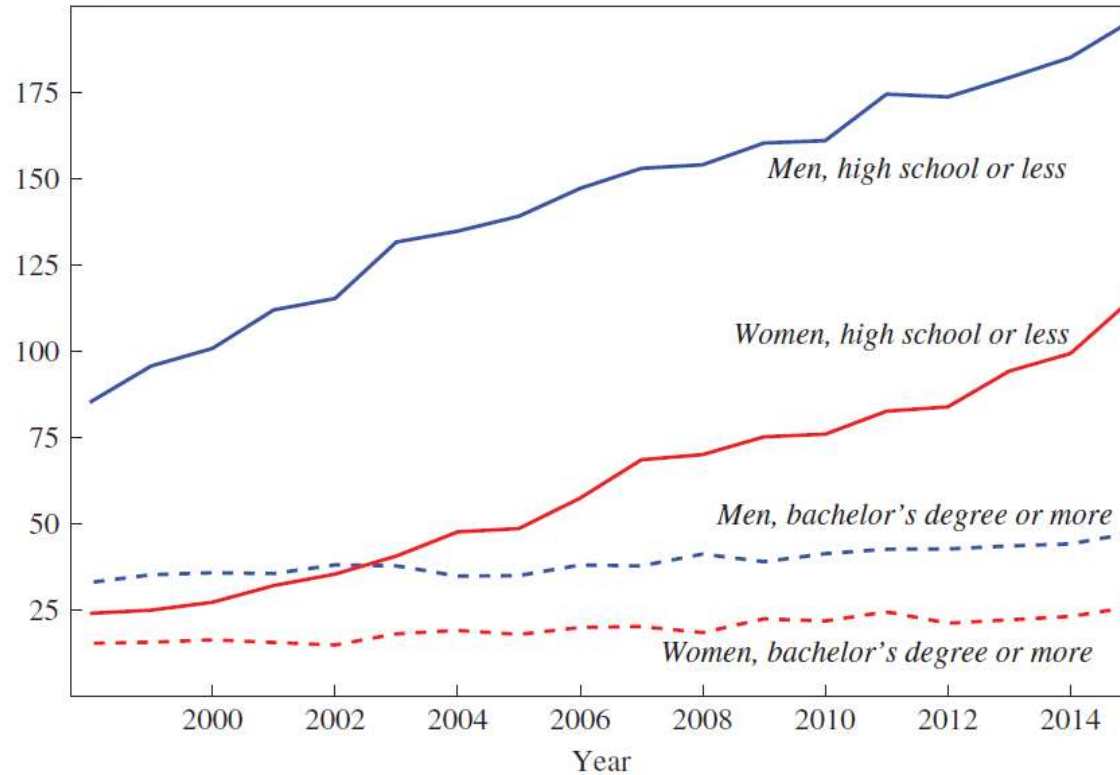
Conclusion: In a nationally representative sample, higher patient satisfaction was associated with less emergency department use but with greater inpatient use, higher overall health care and prescription drug expenditures, and increased mortality.

#2 Medicalization of poverty



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

Deaths per 100,000

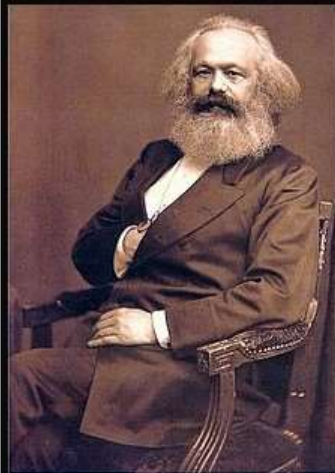


Sources: National Vital Statistics System; authors' calculations.

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)



Religion is the opium of the masses.

(Karl Marx)

#3 Cultural narratives



Pain is dangerous



Doctors have superhuman abilities to heal





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



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

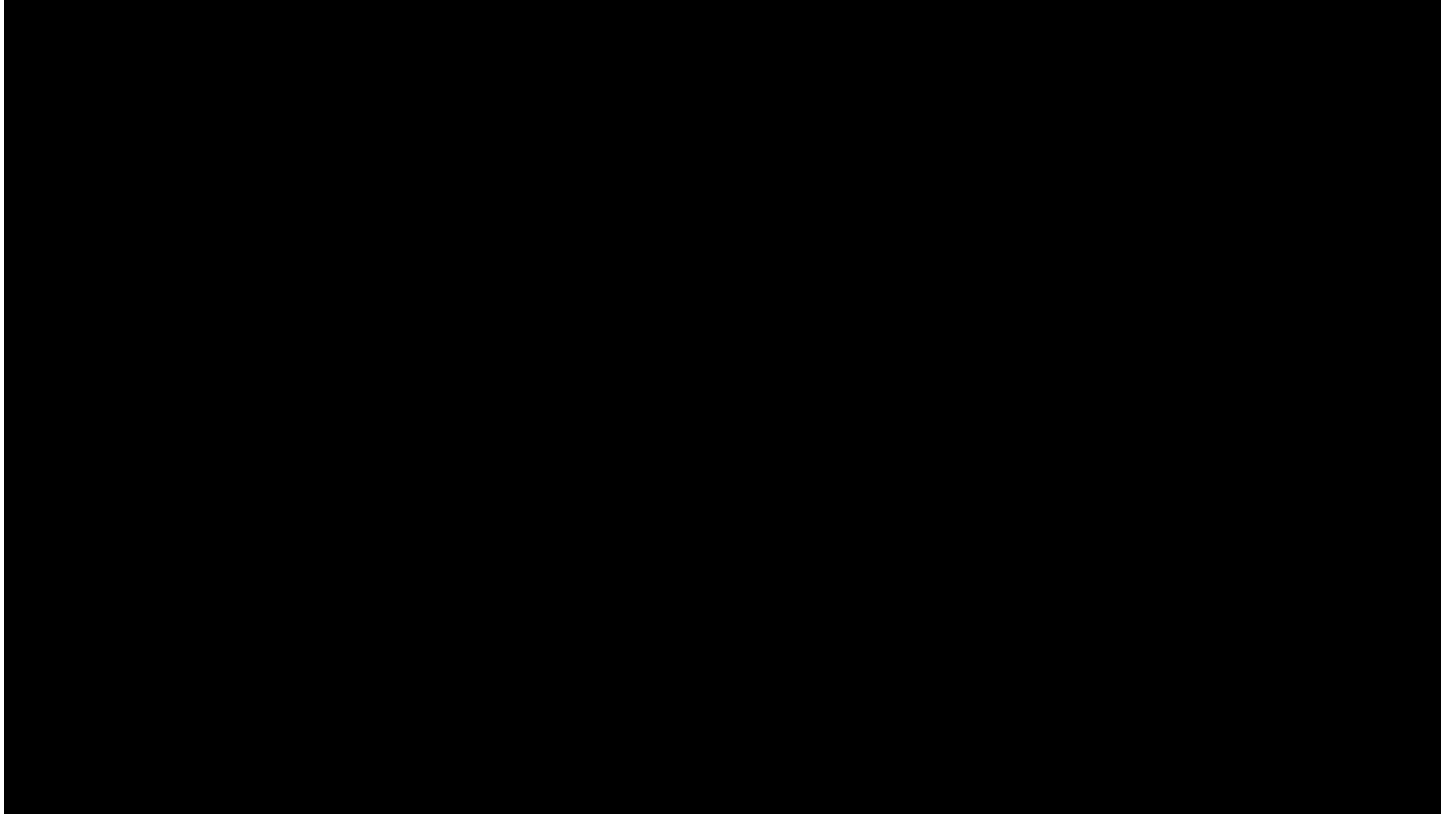


Heinz Kohut, *The Kohut Seminars*, 1987

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

CDC's *Guideline for Prescribing Opioids for Chronic Pain* intended to improve communication between providers and patients about the risks and benefits of opioid therapy for chronic pain, improve the safety and effectiveness of pain treatment, and reduce the risks associated with long-term opioid therapy, including opioid use disorder and overdose. The Guideline is not intended for patients who are in active cancer treatment, palliative care, or end-of-life care.

DETERMINING WHEN TO INITIATE OR CONTINUE OPIOIDS FOR CHRONIC PAIN

1 Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. Patients are not to be initiated on controlled substance therapy and nonopioid pharmacologic therapy, as appropriate.

2 Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how opioid therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.

3 Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.

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 the minimum that needed
- Do not prescribe CME/A opioids for acute pain
- Follow up and re-evaluate risk of harm, reduce dose or taper and discontinue if needed

- When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/acting (CME/A) opioids.
- When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should not routinely alter prescribing opioids at any dosage, should carefully reassess evidence of expected benefits and risks when considering increasing dosage to add another opioid or equivalent (CME/A), and should avoid increasing dosage to add CME/A or entirely justify a decrease in dose dosage to add CME/A.
- Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient, even if that seems high will opioids be needed.
- Clinicians should evaluate benefits and harms with patients within 1 to 2 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently if benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.

ASSESSING RISK AND ADDRESSING HARMS OF OPIOID USE

- Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including monitoring, offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorders, higher opioid dosages (>50 MME/day), or concurrent benzodiazepine use, are present.
- Clinicians should review the patient's history of controlled substance prescriptions using a state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or dosages combinations that put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months.
- When prescribing opioids for chronic pain, clinicians should use drug testing before starting opioid therapy and consider urine drug testing of least sensitivity to be prescribed medications as well as other controlled prescription drugs and illicit drugs.
- Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.
- Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or naltrexone) in combination with behavioral therapies for patients with opioid use disorder.

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



U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

CC0 Public Domain | www.cdc.gov/guidelines-prescribing-chronic-pain



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



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



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COURSE DETAILS

Original Release Date:

08/02/18

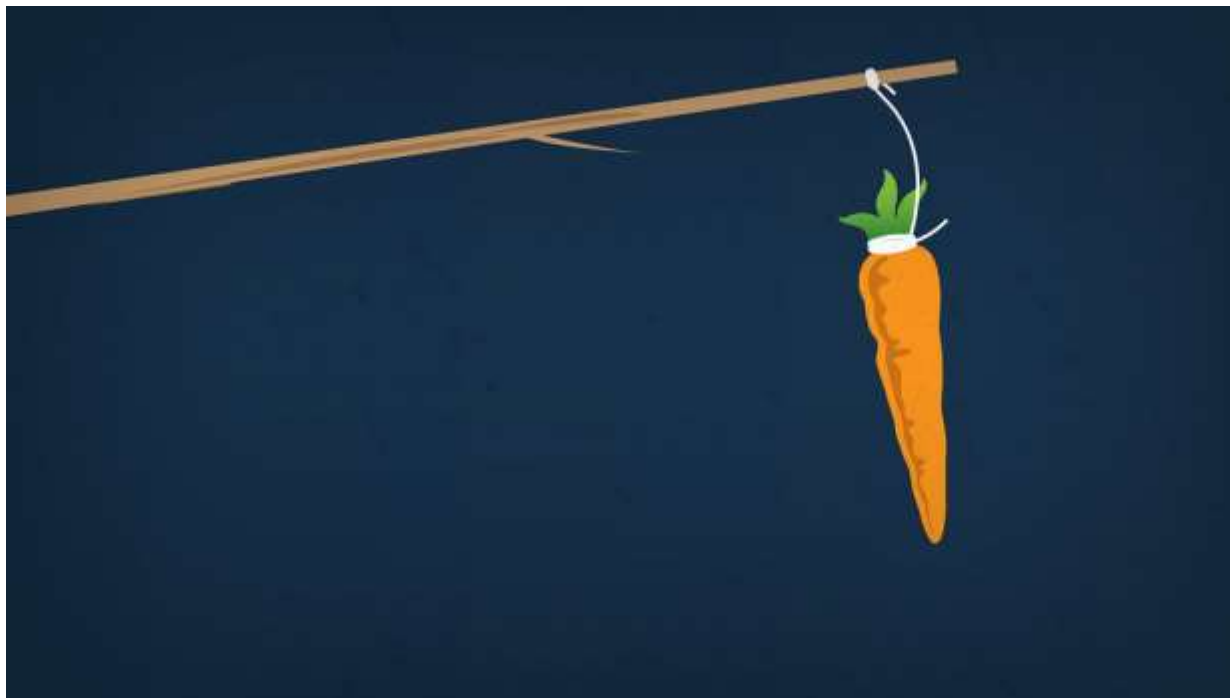
Expiration Date: 08/02/21

#3 Treatment

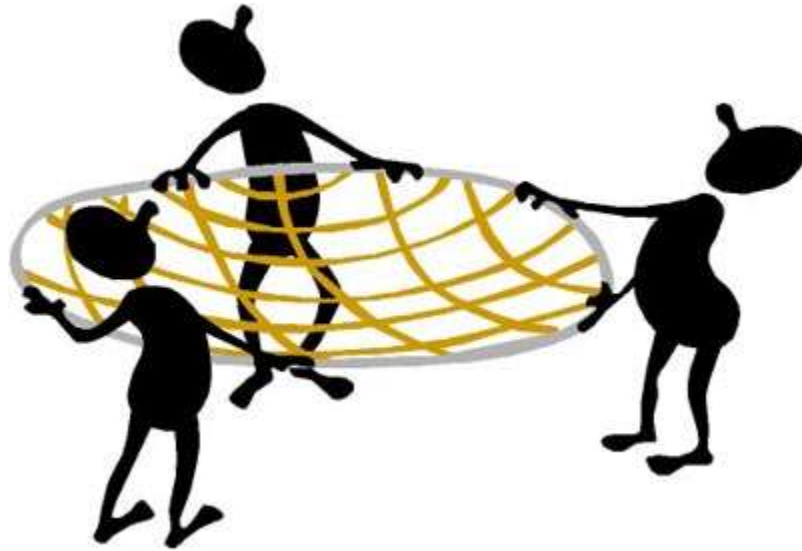


**Think of addiction
as a chronic
relapsing and
remitting disease
*(even if you don't
believe it is one)***

#4 Change the perverse incentives inside health care driving overprescribing



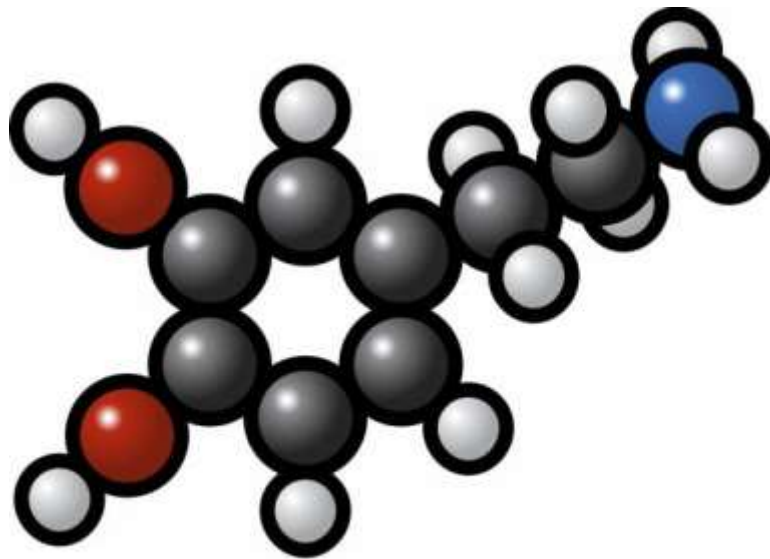
#5 Reform disability



#6 Limit influence of special interest groups



#7 Provide alternative sources of dopamine

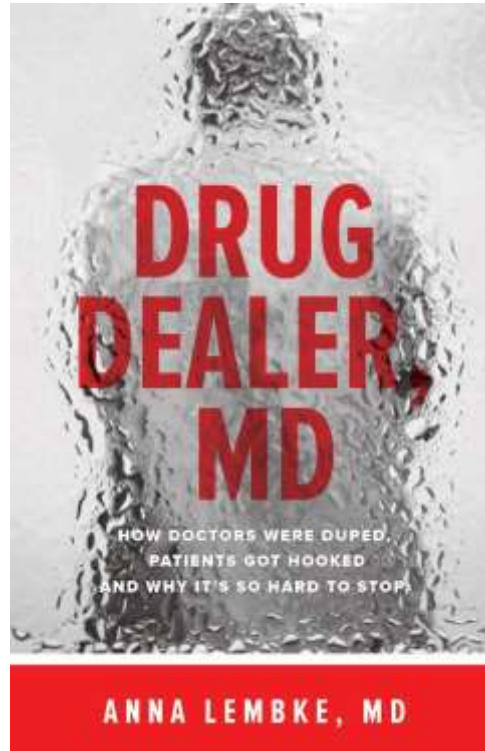


Dopamine $\text{C}_8\text{H}_{11}\text{NO}_2$

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!

