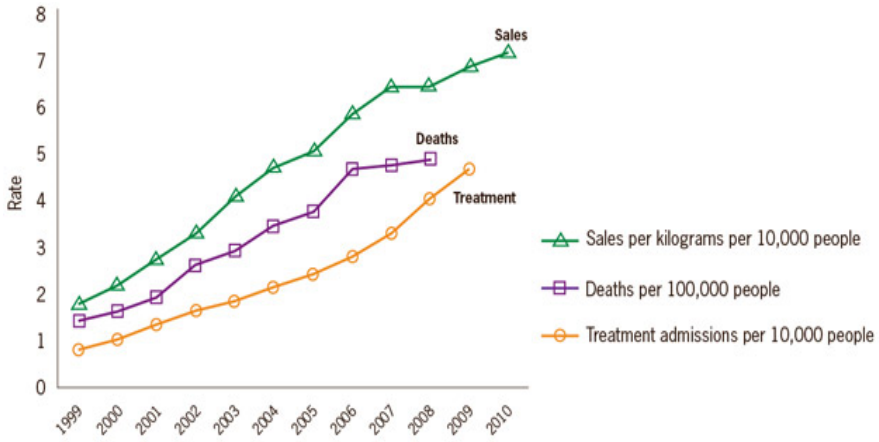
Massachusetts Medical Society
ANNUAL MEETING

THE ETHICS FORUM

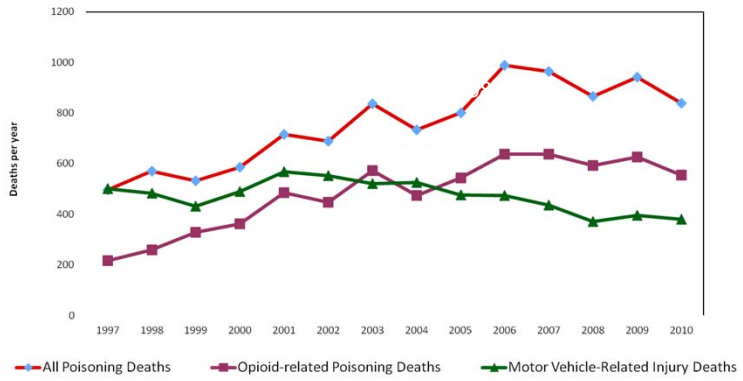
Ethics and Pain Management

Prescription opioid sales, deaths and treatment: 1999-2010



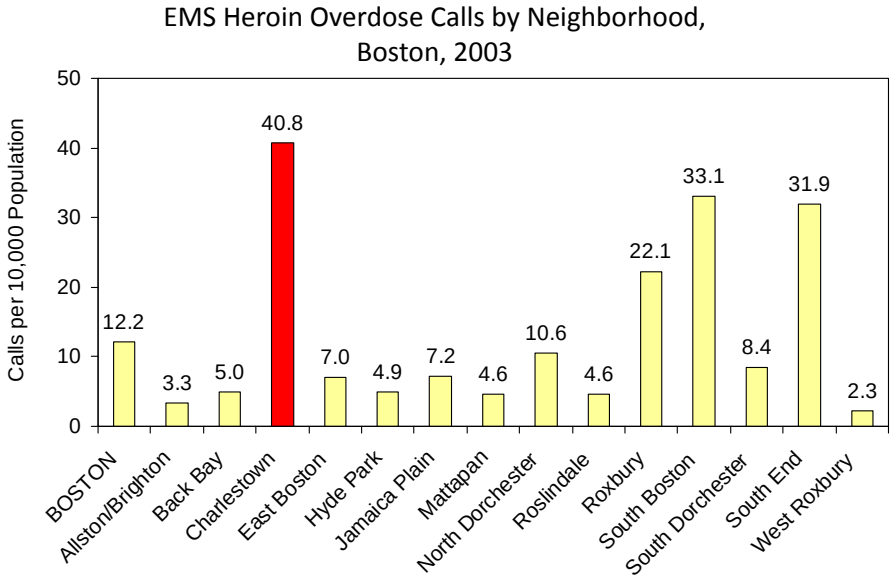
National Vital Statistics System, 1999-2008; Automation of Reports and Consolidated Orders System (ARCOS) of the Drug Enforcement Administration (DEA), 1999-2010; Treatment Episode Data Set, 1999-2009

Opioid Overdose Deaths in Massachusetts



- An estimated 978 people died of opioid-related overdoses in Massachusetts in 2013 — a 46 % increase

The source of the data is: Registry of Vital Records and Statistics, MA Department of Public Health



Heroin's Toll
Heroin Surges as Kentucky Cracks Down on Pain Pills

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March 12, 2015

Abuse-Deterrent OxyContin Shifted Patterns of Use, Introduced Heroin as Alternative

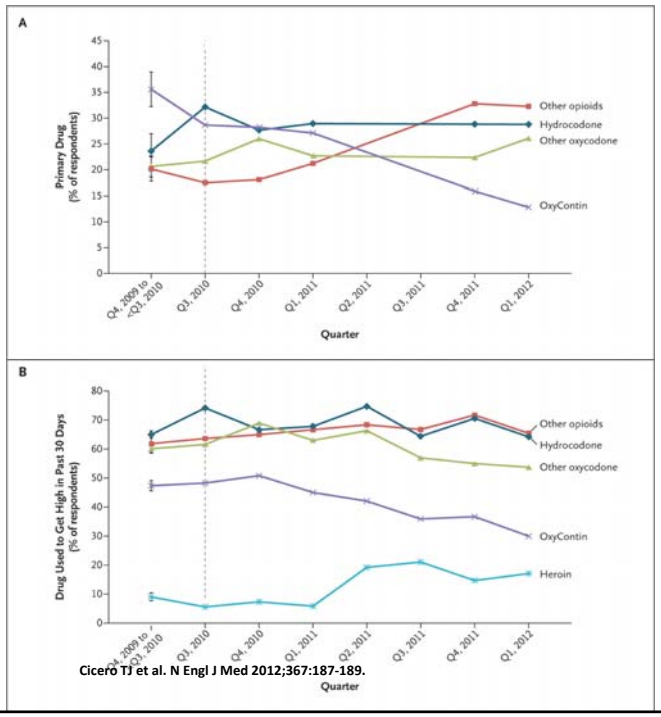
By Joe Elia

Edited by Susan Sadoughi, MD, and Richard Saitz, MD, MPH, FACP, FASAM

OxyContin abuse changed but didn't end with the advent of an abuse-deterrent formulation in 2010, according to a *JAMA Psychiatry* study.

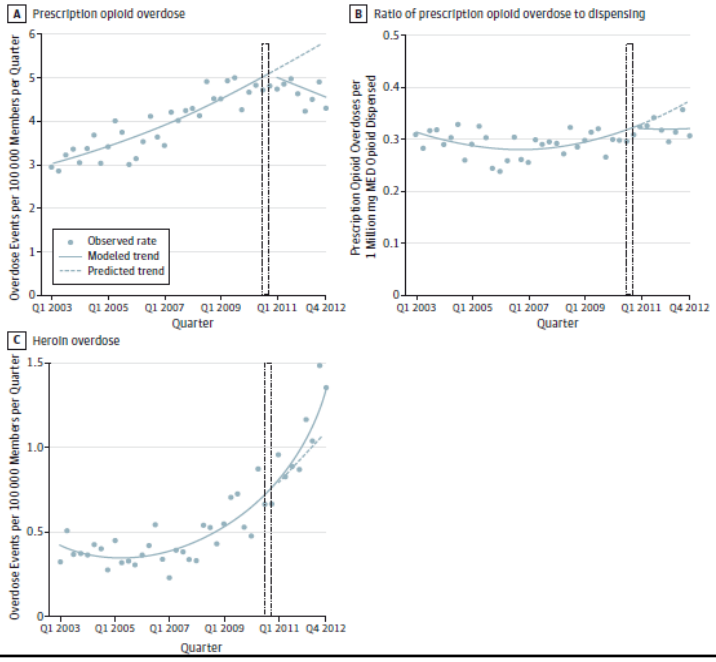
Researchers used data from an ongoing national survey of patients entering treatment centers before and after abuse-deterrent pills were introduced. They found that past-month abuse of OxyContin had occurred in roughly half the sample before the abuse-deterrent formulation, dropping to about 25% afterwards, where it has remained.

Continuing abusers of OxyContin switched in the following ways: about 45% changed from injecting or inhaling to swallowing; a third were able to defeat the deterrent safeguards and continued to inject or inhale; and about a quarter continued their previous pattern of swallowing the drug. Only about 3% stopped using opioids completely.



Cicero TJ et al. N Engl J Med 2012;367:187-189.

Figure 2. Standardized Overdose Rates and Segmented Regression Results Before and After Opioid Market Changes



Ethics Issues

- Beneficence vs. Non-maleficence
- Obligation to individual patient vs. society
- Role of physician and profession

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CASE STUDIES

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John is a 53-year-old mechanic who recently moved to MA. He had been relatively healthy since quitting drinking at 48. Due to his prior alcohol abuse, however, he had developed chronic pancreatitis, which caused him debilitating abdominal pain. He had modified his diet and had been taking pancreatic enzyme supplements faithfully, but needed long-acting daily morphine to carry on his normal work activities at the post office. To continue his care in MA, John went to a primary care clinic, where he was seen by Dr. Smith. Dr. Smith had 20 years of experience in prescribing opioid medications and required all his patients to sign opioid treatment contracts, which explicitly state the risks and benefits of treatment, prohibited behaviors, and criteria for termination of treatment. Dr. Smith approached John to discuss the terms by which he could continue to receive his prescriptions for long-acting morphine. As Dr. Smith explained the contract, John got increasingly upset. Finally he said, "Stop. Why are you treating me like a criminal when I have a legitimate medical condition?"

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Dr. Li is an ED physician in Boston. One afternoon, he sees a young woman named Doris who has come to the ER because of extreme abdominal and knee pain over the past 12 hours. Doris says that she is in great distress and rates her pain at a 10 out of 10. She says that the pain resembles that of her previous sickle cell crises and that only Vicodin helped. She points to her abdomen and both of her knees as the sites of pain and refuses to allow Dr. Li to touch them. Dr. Li observes no overt swelling or redness. Looking at her chart, Dr. Li sees a long list of emergency department visits and admissions over the past 2 years. Doris, 25, has a diagnosis of sickle cell disease. On most ER visits, the peripheral blood smear reports were inconclusive for vaso-occlusive crisis. Notes from her hematologist comment that she is habitually noncompliant and that they have considered consulting psychiatry to help address her persistent chronic pain.

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WM is a 38 yo patient of mine with a past medical history of heroin addiction and hepatitis C. He has a h/o incarceration for bank robbery. He is currently clean and sober and regularly attends AA meetings. He presented to the MGH ED after a fall off of a ladder at work twisting his ankle. The ankle was red and swollen, there was no fracture seen on xray. The ED attending made the diagnosis of cellulitis and admitted him to ED Obs for IV vancomycin. Because of his h/o heroin use, the ED physician refused to prescribe opioid medications for his pain. In frustration, the patient signed out AMA 6 hours later. He limped into my office the following day. He appeared to be in severe pain, the ankle was warm, red and diffusely swollen. The patient said to me, "Am I an effing animal"? Because I used to use heroin, does that mean I have to suffer?