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Opioids, Pain Management, and Addiction: Balancing Ethical Duties

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Almost two million Americans are now addicted to opioids. The *National Institute on Drug Abuse* notes that more than 100 people die each day in the U.S. from opioid overdoses. This unprecedented level of abuse — which involves not only heroin, but also prescription pain relievers such as OxyContin, Percocet, morphine, codeine, and fentanyl — has become a national crisis. Reportedly, about 80 percent of heroin addicts first misused prescription opioids. Yet for many patients, no pain-relieving options more effective than opioids exist. Figuring out how to use these powerful pharmacological agents in an appropriate and ethical manner is urgent and imperative.

At a minimum, a three-pronged approach is required. One prong involves working with medical professionals to limit the use and availability of these drugs by modifying prescribing practices. A second involves making patients more aware of the risks of addiction and increasing their involvement in monitoring their medications and managing decisions about their care. A third involves making effective addiction treatment and outreach programs accessible to those caught in the throes of chemical dependency.

With regard to reducing opioid availability, in recent years medical professionals have been seeking to establish guidelines for prescribing opiates that take into account the number of pills typically needed to get through a surgery or treatment. For example, recovery from more complex stomach surgeries might require 60 opioid pills, while an appendectomy or hernia might only require 15-20. Although prescription guidelines can be helpful, they clearly can't be fixed in stone, as individual patients will have varying pain management needs. Some nurses recall well the days when concerns about addiction could result in under-medicated patients watching the clock and writhing in pain until the time of the next dose. Unmanaged pain is a spiritual assault on the dignity of a person, and plays right into the hands of assisted suicide advocates.

Careful titration of pain medications, whether for surgery or chronic pain, also helps to avoid overmedicating patients and rendering them lethargic or semi-comatose; in terminal situations, patients still have the right to prepare for their death while fully conscious, and they should not generally be deprived of consciousness or alertness except to mitigate excruciating or otherwise uncontrollable pain.

In certain cases, of course, it may not matter if a person becomes addicted to pain medications. If a patient has only a few weeks of life remaining, and he or she is experiencing intractable pain such that high doses of

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opioids are the most effective approach, addiction during his or her final days and hours would not generally raise ethical concerns.

There are alternatives to the use of opioids that may be suitable for some patients. These include the use of less-addictive or non-addictive drugs such as acetaminophen, ibuprofen, naproxen, or anesthetics and blockers at the pain site. Cognitive behavioral therapy, stress management and relaxation techniques can help patients learn how to modify triggers that increase pain. Specialists sometimes remind us that bringing pain down to a tolerable level should be the goal, rather than trying to eliminate it entirely, which in many cases may not even be possible. Some patients may require assistance to come to accept even a limited amount of pain.

A San Diego-based pilot program to reduce the over-prescription of opioids included the novel step of notifying physicians when one of their patients had died from an overdose. The San Diego medical examiner would send health care professionals a letter in this format:

> "This is a courtesy communication to inform you that your patient [Name, Date of Birth] died on [Date]. Prescription drug overdose was either the primary cause or contributed to the death."

In follow up studies, physicians who received these letters were found to prescribe at significantly decreased levels, and they were also less likely to start new patients on opioids at all. Researchers speculated that, like everyone else, physicians tend to assess health and safety risks differently when bad outcomes spring readily to mind. At the same time, taking steps to restrict opioid availability can backfire, with devastating consequences for chronic pain patients who may now end up being refused opioid prescriptions they need and have relied on for years.

The proper use of pain medications, in the final analysis, requires a balanced approach, attending to objective indications from the patient, so clinicians can offer sufficient comfort and remediation of their pain. Patients must also take responsibility for their own pain management decisions, becoming informed about, and aware of, the challenges and risks. When the goal is to provide the lowest dose of opioids for the shortest amount of time, in direct response to the level and severity of the pain, patients are likely to have better treatment outcomes with diminished risks of addiction.

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