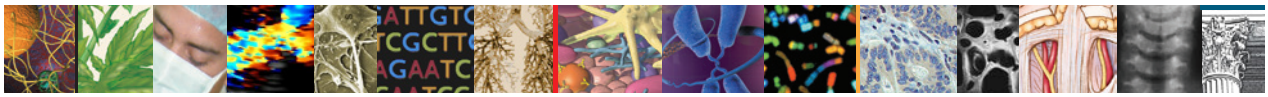

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Perspective

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The Other Victims of the Opioid Epidemic

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I'd seen Jerry in pain before, but never like this. He lay prostrate on the gurney in the emergency department, his hands clenched in silent prayer. I laid an apologetic hand on his shoulder and told him we would do what we could to help. Then I logged in to the bedside computer to order his pain medication.

When I clicked the "sign" button, a message appeared on the screen.

"*This patient has a documented history of substance misuse. Are you sure you want to order this medication?*" Two options appeared below the query: "*Yes, continue with this order*" and "*No, cancel this order.*"

It was true, of course. Jerry was the first to admit that he had used cocaine in the past, before his cancer diagnosis. In fact, it was one of the first things he told me when we met in the palliative medicine clinic, shortly after his escalating back and abdominal pain led to a diagnosis of widely metastatic cancer. During the same appointment, he told me how opposed he was to using any sort of controlled substance for his pain. Over the next few months, he submitted gamely to any nonopioid therapy I could offer, from nerve blocks to adjuvant analgesics to reiki and massage. Finally, when the pain became so bad that he couldn't travel for his chemotherapy infusions, he agreed to start an opioid.

Jerry knew that he was dying. He hoped that the chemotherapy would allow him a little more time with his young daughter and teenage son. But each infusion left him weaker and more debilitated, and his staging imaging did not offer good news. The tumor spread rapidly, threading its way through his liver, lungs, and spine. As his tumor burden increased, so did his pain, and he required increasing doses of opioids just to get out of bed. We both knew that time was short.

His progressive debility, combined with side effects of chemotherapy, meant that Jerry had to come in to the hospital a lot. He hated it. For Jerry, the hospital meant repeated questions about his past, looks of disbelief when he described his home opioid requirements, assumptions about why he was asking for so much medication, and long nights of undertreated pain. When he'd arrived at the hospital with vomiting the previous night, he'd been given doses of intravenous medications that were only a fraction of the dose of the oral equivalent he'd been taking at home. He'd spent the night in escalating pain, so that by morning he was reduced to the mute agony in which I found him.

I clicked "*Yes, continue with this order*" and went to find his nurse.

She was understandably apprehensive about the dose I had ordered; anyone would be. I agreed that the dose was high, described his home regimen, explained the need for equianalgesic dosing, and agreed to review the dose with our pharmacy staff, but nothing I said seemed to assuage her apprehension. Finally, she voiced her real concern.

"You know he's an addict," she said.

I let the silence grow. We were standing outside the open door to his room. I knew he could hear us. "I know he has used cocaine. His tumor is spreading. He has a reason to have pain, and we should try to control it."

She turned away and spoke loudly enough for both me and Jerry to hear. "This is how we make monsters."

When I turned back to Jerry's room, he and I locked eyes. He was weeping.

Jerry is not innocent, nor does he claim to be. His vilification, however, is the result of an all-or-nothing approach to pain management under which the pendulum has swung from one unsustainable end of the spectrum to the other in the past two decades.

Early in my training, the nursing station on our main hospital floor was home to a bucket of lapel pins that depicted a lion tamer in circus gear, encouraging us all to "Tame the Pain." The hospital's initiative mirrored national campaigns. The American Pain Society supported a campaign to consider pain the "5th Vital Sign" in 1995.[1] The Joint Commission's Standards on Pain Management were released in 2000, and although they never explicitly recommended opioid prescribing, they did include recognition of the right of patients to appropriate assessment and management of pain, as well as incorporation of pain management into health care organizations' performance measurement and improvement programs.[2] Multiple national organizations, as well as vendors of the Hospital Consumer Assessment of Healthcare Providers and Systems survey, fell in line.[3] Over time, for many clinicians, opioids became the treatment of choice, regardless of the cause of a patient's pain or the likelihood that it would respond to therapy.

An audio interview with Dr. Glod is available at NEJM.org

Now we have swung dangerously close to the other end of the pendulum's arc. The "opioid epidemic" has captured the attention of lawmakers, the media, and the public. We have placed the blame for the tragic losses of so many lives in so many communities on the drugs themselves rather than on the complex interplay of factors that has led to the current crisis. The role of opioid analgesics has been distorted to the point where the word "oxycodone" uttered in front of a patient in my palliative medicine clinic is met with raised eyebrows, and some patients choose a bed-bound existence as they near the end of life rather than risk the possibility of addiction. Many patients with a history of substance misuse who now only want to control their pain face additional challenges — they are subject to discontinuation of their opioid treatment even when they exhibit no behavior suggesting addiction.[4] Should the bar for these patients be higher, or should we focus on the uniform application of careful practice standards to everyone?

The opioid epidemic is a national crisis that should not be underestimated. But its solution will require careful thought, consideration, and most important, development of meaningful interventions to improve both pain management and substance-misuse prevention. These interventions should not come at a cost to the epidemic's other victims — hospice patients who are too afraid to take the medications they need to control their symptoms[5]; people whose history of substance abuse, no matter how remote, determines whether their pain will be treated; patients like Jerry, who, dying from cancer, his body containing more tumor than anything else, was told he is a monster.

He, too, is a victim of this epidemic.

Disclosure forms provided by the author are available at NEJM.org.

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