Who Are We?

April 18, 2019

by D. Joy Riley MD, MA (Ethics)

"We started it," Dr. Atul Gawande told Vox interviewer Sarah Kliff in 2017when he was asked about the opioid epidemic. Dr. Gawande, a surgeon and author, was referring to the role healthcare professionals played in producing the staggering number of opioid overdose deaths in the United States. In 2017, there were 70,237 overdose deaths in the U.S. Opioids (those obtained through prescriptions, including methadone; fentanyl and other synthetic opioids; and heroin) contributed a total of 47,600 overdose deaths to that total.

While we await the final count of U.S. overdose deaths in 2018, there appears to have been a decrease. Yet, that is not true for each individual state. For a state-by-state analysis of the change in all-drug overdoses from 2017 to 2018, click here.

Overdose deaths in the U.S. now total nearly 2,000 per month, according to physicians Dr. Joshua M. Sharfstein and Dr. Yngvild Olsen in "Making Amends for the Opioid Epidemic" on The JAMA Forum. They note that though the number of opioid prescriptions has dropped by "more than one-fourth" since peaking in 2012, much harm remains. The authors point out that the U.S. has more than two million persons with opioid use disorder. What should be done?

They propose that "the Accreditation Council on Graduate Medical Education (ACGME) require all residents in clinical specialties to take a course on the appropriate use of buprenorphine and other medications approved by the U.S. Food and Drug Administration for the treatment of opioid addiction"—free of charge. Another possible way to combat the problem is to empower the Drug Enforcement Administration (DEA) to require mandatory training as "part of the registration process to prescribe controlled substances." (See also Medication for Opioid Use Disorder Save Lives from the National Academies of Sciences, Engineering, and Medicine.)

Drs. Sharfstein and Olsen agree with Dr. Gawande's assertion that, "We started it." They would like the medical profession to be able to say, "We ended it," as well. However, the etiology of the opioid crisis involves more than just healthcare professionals.

According to Patricia H. Berry, PhD, and June L. Dahl, PhD, of the University of Wisconsin Medical School's Department of Pharmacology, "In August 1997, the Robert Wood Johnson Foundation provided support for a 3-year project whose overall goal is to make pain assessment and treatment an integral part of the nation's health care system. An important part of this project was to integrate pain assessment and management into the standards that JCAHO uses to accredit health care facilities."

JCAHO integrated "pain assessment and management" into its 2000-2001 standards. That included "all patient care organizations accredited by JCAHO – ambulatory care, behavioral health, healthcare networks, home care, hospitals, long-term care, and long-term care pharmacies." These standards went into effect on January 1, 2001. Drs. Berry and Dahl saw this as a time of hope. In *Pain Management Nursing*, they wrote, "The newly approved Joint Commission on Accreditation of Healthcare Organization (JCAHO) pain assessment and management standards present a rare and important opportunity for widespread and sustainable improvement in how pain is managed in the United States."

(Note: A recent publication of the Joint Commission details the commission's side of the story.)

The web of interactions between various opioid makers, academics (like the University of Wisconsin Pain group), regulatory bodies and physicians is extensive. An example is the collaborative project funded by Purdue Pharma, LP, "to identify pain management performance measures focusing on arthritis, back pain, and cancer." JCAHO, the American Medical Association and the National Committee for Quality Assurance (NCQA) were all beneficiaries of Purdue's largesse for that two-year project. Another regulatory agency in this web is the Federation of State Medical Boards (FSMB). Reporter John Fauber, writing in 2012 for the *Milwaukee Journal Sentinel/MedPage Today*, described the FSMB by saying that it "often develops guidelines that serve as the basis for model policies with the stated goal of improving medical practice — but after its guideline for the use of opioids to treat chronic pain patients was adopted as a model policy, it asked Purdue Pharmaceuticals for $100,000 to help pay for printing and distribution that policy to 700,000 practicing doctors."

The "we" who are responsible for the current opioid crisis seems a remarkably large and varied population. While all the finger-pointing, hand-wringing and lawsuits are proceeding, perhaps it is time to revisit some definitions. We as a nation have expended much time, effort and money to treat pain. But have we spent enough time considering pain? In *The Problem of Pain*, C.S. Lewis describes "A" pain and "B" pain. "A" pain is that kind of pain that is a "sensation, probably conveyed by specialised nerve fibres, and recognizable by the patient as that kind of sensation whether he dislikes it or not…." On the other hand, "B" pain is "any experience, whether physical or mental, which the patient dislikes." All pains that are A can become B type pains "if they are raised above a certain very low level of intensity." But B pain is not synonymous with A pain. Lewis is very clear: "Pain in the B sense, in fact, is synonymous with 'suffering', 'anguish', 'tribulation', 'adversity', or 'trouble', and it is about it that the problem of pain arises."

We must begin to separate out exactly what we are trying to treat. As a culture, we have tried throwing opioids at "pain," precipitating a crisis of addiction and death. For those in the former category who are still alive, the advice by many is for the medical establishment to try administering more medications, such as methadone or buprenorphine. There is not much print space given to concomitant behavioral therapies. Yet listening—truly listening, perhaps with naloxone in our pockets—is going to be needed for healthcare professionals and others to separate "A" pain from "B" pain. We owe it to our patients, especially if we even hope to be able to say about the opioid crisis, "We ended it."

Blog Search

Search

Recent Posts

Administration Moves to Bind Human Tissue Research to Ethical ConsiderationsJuly 3, 2019

Believing GodJuly 2, 2019

Christian Doctor's Digest – July 2019 July 1, 2019

Scapegoating the Church for LGBT Suicide and Stigma June 27, 2019

Preaching to Myself June 26, 2019

Recent Comments

Paul Chandler, PA-C on Getting It

Steven Willing on Scapegoating the Church for LGBT Suicide and Stigma

Dale Volquartsen on Scapegoating the Church for LGBT Suicide and Stigma

John Mulder, MD, MS, FAAHPM, HMDC on In Favor of Organ Donation?

Dr. David Thompson on Scapegoating the Church for LGBT Suicide and Stigma

Categories

Select Category

Archives

Select Month

About D. Joy Riley MD, MA (Ethics)

Executive Director of the Tennessee Center for Bioethics & Culture.

View all posts by D. Joy Riley MD, MA (Ethics) →