Moderation, Hope and Compassion: A Physician's Prescription for Responding to the Opioid Epidemic

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The following editorial was written by Dr. Mark Albanese, a psychiatrist, educator, and scientist who advocates for evidence-based care of opioid dependence and other expressions of addiction. This editorial is part of our Special Series on Opioid Dependence and Recovery.

Unless you have Rip Van Winkled through the past few years, you know that opioids have become a problem for our country. There has been a lot of shouting and hand-waving about who is to blame. An especially popular explanation is physicians who have been overzealous in prescribing opioid pain medications. This is ironic for me, since I am old enough to remember a time in healthcare when physicians were "guilty" of not adequately treating pain. It was thought to be such a problem that pain was declared to be "the fifth vital sign," and the healthcare facility that did not continuously monitor and address the pain of their patients did so at their own risk – including loss of accreditation and funding. I have somewhat jokingly said that you cannot get beyond the lobby of an American hospital without somebody asking you to complete a pain Likert scale ("1 being the least amount, and 10 being the worst you have ever had."), complete with facial diagrams.

I do not mean to make light of pain, but this brief historical interlude underscores what I think is a major issue for medicine and society in general. We don't do moderation very well. Drive through any city in the United States and it seems like there is a gym on every other block, and around the corner or across the street a fast-food joint in contradictory juxtaposition. The message on one hand seems to be that you are not serious about working out if you don't start your day with a couple of hours on the treadmill, and on the other hand it appears that you have a God-given right to comfort yourself whenever you want with whatever

artery-choking delicacy you see fit. The true path for most of us, of course, is probably somewhere in between. A half hour of moderate (there's that dreadfully unsexy word again!) exercise 4 or 5 times a week is probably what the doctor ordered. And an occasional cheeseburger is not the end of the world.

Yet, the societal message seems to mock the idea of moderation. This message hits the people I treat – patients who have an addictive disorder – especially hard, since they do all-or-none better than most and the stakes for them are very high. Some of my patients in early recovery would like to be running marathons (so would I, but it is probably never going to happen!), but struggle with the motivation to walk around the neighborhood after dinner. They have a tough time going from no exercise to just some exercise on their way to achieving that admirable marathon goal.

We are at risk of experiencing this same disregard for moderation when it comes to the issue of pain and using opioids to treat that pain. Now that both federal and state governments have opioids in their crosshairs, I get concerned that the proverbial pendulum is about to swing back to where it was when I was in medical school, such that pain is not adequately treated. Witness a recent Boston Globe headline: "Strict opioid laws hit chronic pain sufferers hard." The reality is that the job of healthcare providers is not to eradicate pain but to relieve it in order to restore maximal function. Sometimes that will mean using opioids. This does not mean that opioid prescribing practices should not change. Let's just be guided by the evidence when making those changes. Let's avoid hysteria and reflexive measures. And let's avoid extreme approaches, like deciding that "I will never prescribe opioids!" Rather, let's work on better defining both those clinical situations where opioids should be used and those times when they are counter-productive.

And the story is not just about opioids. Much of the pain confronting medical providers is bound up with psychosocial factors like comorbid psychiatric conditions including trauma and depression. And these are compounded by a predisposition to addiction. Merely turning off the opioid spigot will not relieve the suffering of these complex patients. We need a comprehensive, integrated approach to pain, addiction and psychological suffering. Let's make an investment in this kind of comprehensive care – in addition to implementing measures such as limiting the length of initial opioid prescriptions, mandating physician utilization of prescription databases, and sanctioning physicians who fail to

comply with the new guidelines.

I would propose, in addition, that there are at least two other factors that are helpful in this time of crisis. One is hope. I don't think that anybody would disagree that too many people—a disproportionate number of them with most of their life ahead of them–have overdosed and died. While opioid use disorder is indeed a potentially lethal disease, the reality is that most people with the disorder do not overdose. Many people make a choice for treatment and recovery. We are fortunate to have medications proven over decades of use to help stabilize people with opioid disorders, allowing them to engage in the recovery process. Although these medications are underutilized, every day I meet people who decide that there are relationships more important to them than their relationship to oxycodone or heroin. I am reminded of the young man who tearfully (in truth, we were both crying!) told me that he could not put his grandmother through more pain—she had lost her daughter (his mother), and more recently her granddaughter (his sister) to heroin overdoses. His death would kill her, thus he came to me to be enrolled in methadone treatment.

The other ingredient that we need to add to the mix is generous amounts of compassion. At the core of addiction is profound shame. It does not take much for the shame to revive and self-esteem to spiral downward. We all have the ability to make this happen, consciously and unconsciously, with both our words and nonverbal messages. I think that the process is more painful when it involves a healthcare provider. Maybe that's because we are supposed to be non-judgmental and brimming with compassion. So, an addicted person is left thinking that "if I cannot get compassion from a caregiver, there must be something unforgivable about me." Today, a patient about 9 years in recovery told me that she has switched pharmacies because "I got tired of the pharmacist at the other pharmacy rolling her eyes and treating me like a criminal whenever I dropped off my Suboxone script." The pharmacist at the new pharmacy "smiles at me and asks me how I'm doing." Another of my patients, in recovery about 5 years, at my urging, finally got himself to the GI specialist for a work-up of his appetite change and significant weight loss. He no sooner sat down than the physician told him that if he was looking for opioids he should know up front that he had come to the wrong place. The patient fled that office and presented to his next appointment with me beside himself. He somewhat rhetorically asked me: "Can't he see in the record that I'm on Suboxone??!! Can't he see that I've lost 60 pounds??!! Why would I come to a hospital where they can see my history to seek pain meds??!! I

could get those anytime, but I'm trying to do the right thing!"

A lot of factors have gone into getting us into this opioid mess, so it is no wonder that it will take a multi-faceted approach to get us out. Finger pointing, blaming and tripping over ourselves in a headlong rush to implement unproven interventions in an attempt to prove how seriously we are taking the problem is not as helpful as keeping our heads and both utilizing evidence-based approaches and further developing new approaches to the complex suffering of those with pain. And in the process, let's remember our humanity, which is defined by hope and our compassion toward the most marginalized in our society.