THE NEW YORKER

CURRENCY

WHO IS RESPONSIBLE FOR THE PAIN-PILL EPIDEMIC?

By Celine Gounder November 8, 2013

How did doctors, who pledge to do no harm, let the use of prescription narcotics get so out of hand?

Photograph by Roberto Machado Noa / LightRocket via Getty

When I started working as a medical resident, in 2004, I heard from a patient I had inherited from a graduating resident. The patient had an appointment scheduled in a couple weeks. "But I need your help now," he said.

He was a former construction worker who had hurt himself on the job a couple of years earlier. He told me, "I also need some more OxyContin to tide me over until I can see

you." The hospital computer system told me that he had been taking twenty milligrams of OxyContin, three times a day, for at least the last couple of years. I had rarely seen such high doses of narcotics prescribed for such long periods of time. I'd seen narcotics prescribed in the hospital to patients who had been injured, or to those with pain from an operation or from cancer. But I didn't have much experience with narcotics for outpatients. I figured that if the previous resident—now a fully licensed doctor—was doing this, then it must be O.K.

What I didn't know was that my time in medical school had coincided with a boom in the prescribing of narcotics by outpatient doctors, driven partly by the pharmaceutical companies that sold those drugs. Between 1999 and 2010, sales of these "opioid analgesics"—medications like Vicodin, Percocet, and OxyContin—quadrupled.

By 2010, the United States, with about five per cent of the world's population, was consuming ninety-nine per cent of the world's hydrocodone (the narcotic in Vicodin), along with eighty per cent of the oxycodone (in Percocet and OxyContin), and sixty-five per cent of the hydromorphone (in Dilaudid).

As narcotics prescriptions surged, so did deaths from opioid-analgesic overdoses—from about four thousand to almost seventeen thousand. Studies have shown that patients who receive narcotics for chronic pain are less likely to recover function, and are less likely to go back to work. The potential side effects of prescription narcotics include constipation, sexual dysfunction, cognitive impairment, addiction, and overdosing. When patients receive narcotics for long periods, they can even become more sensitive to pain, a condition called hyperalgesia. (J. David Haddox, the vice-president of health policy at Purdue Pharma—the manufacturer of OxyContin—acknowledged "opioid analgesics have sometimes been associated with diminished pain relief in the face of increasing doses.")

And then there are the real-life Walter Whites. I once helped care for a patient with lung cancer who wasn't taking his narcotics, unbeknownst to his doctors. This patient's cancer had spread to his bones and other organs, which can be incredibly painful. But he was selling his prescription narcotics to help support his wife and himself. So when given these high-dose narcotics in the hospital, he overdosed—though not fatally, fortunately.

What's more, no medication reliably eliminates pain in all patients, and narcotics are no exception. And there isn't good evidence that the prescription of narcotics to treat chronic, non-cancer pain is effective over long periods: most studies of prescription narcotics last only twelve to sixteen weeks.

The use of prescription narcotics, and the problems associated with them, are so pervasive that, last month, the Food and Drug Administration recommended tightening regulations for how doctors prescribe some of the most commonly used narcotic painkillers.

How did doctors, who pledge to do no harm, let the use of prescription narcotics get so out of hand?

Not long ago, doctors in the U.S. prescribed narcotics mostly for short-term pain, like the kind that people experience after a surgery, or for pain related to cancer or to the end of life. Then came two small accounts in medical journals that helped lay the groundwork for an expanded role for prescription narcotics. The first, a hundred-word letter to the editor published in 1980 in the *New England Journal of Medicine*, reported that less than one per cent of patients at Boston University Medical Center who received narcotics while hospitalized became addicted. The second, a study published in 1986 in the journal *Pain*, concluded that, for non-cancer pain, narcotics "can be safely and effectively prescribed to selected patients with relatively little risk of producing the maladaptive behaviors which define opioid abuse." The authors advised caution, and said that the drugs should be used as an "alternative therapy." They also called for longer-term studies of patients on narcotics; we're still waiting for those to be performed.

At around the same time, the companies that manufactured these narcotics—including Purdue Pharma, Johnson & Johnson, and Endo Pharmaceuticals—began to aggressively market their products for long-term, non-cancer pain, including neck and back pain. They promoted their prescription narcotics to doctors through ads in highly regarded publications, and through continuing-education courses for medical professionals. They also funded non-profits such as the American Academy of Pain Management and the American Pain Society—the latter previously headed by Dr. Russell Portenoy, a co-author of the *Pain* study and a proselytizer for expanded

narcotics prescribing. The American Pain Society published guidelines that advocated for doctors to expand their use of prescription narcotics to relieve pain.

The Joint Commission, which accredits health facilities, issued pain-management standards in 2001 that instructed hospitals to measure pain—you may be familiar with the smiling-to-crying faces scale—and to prioritize its treatment. Elizabeth Zhani, a spokeswoman for the Joint Commission, told me that their standards "were based upon both the emerging and compelling science of that time, and upon the consensus of a broad array of professionals." Yet Purdue, according to a report issued by the U. S. Government Accountability Office, helped fund a "pain-management educational program" organized by the Joint Commission; a related agreement allowed Purdue to disseminate educational materials on pain management, and this, in the words of the report, "may have facilitated its access to hospitals to promote OxyContin."

In a policy drafted by several people with ties to narcotics makers, including Haddox, the Federation of State Medical Boards called on the boards to punish doctors for inadequately treating pain, according to the *Wall Street Journal*. The Federation also reportedly accepted money from pharmaceutical firms to produce and distribute narcotics-prescribing guidelines. In an e-mail, the Federation maintained: "[Our] most recent policy reflects the considerable body of research and experience accrued since our last series of formal policies related to opioid prescribing and addiction were adopted in 2004. Our latest guidelines, adopted this year, acknowledge that evidence for the risk associated with opioids has surged, while evidence for the benefits of opioids for long-term use has remained controversial and insufficient."

It took a while for authorities to notice what was going on, but once they did, there was a backlash. The Justice Department, the Food and Drug Administration, and the Senate Finance Committee have investigated these questionable marketing practices and financial relationships. Portenoy defended his relationships with pain-pill companies in an interview with the *Wall Street Journal* last year, saying that they "would benefit my educational mission, they benefit in my research mission, and to some extent they can benefit my own pocketbook, without producing in me any tendency to engage in undue influence or misinformation."

In 2007, Purdue Pharma and three of its top executives pleaded guilty to criminal charges that they had misled the F.D.A., clinicians, and patients about the risks of

OxyContin addiction and abuse by aggressively marketing the drug to providers and patients as a safe alternative to short-acting narcotics. (Doctors had been taught that because OxyContin was time-released, it wouldn't cause a high that would lead to addiction.)

Haddox wrote in an e-mail that "the abuse of prescription medicines has become a serious public-health problem." He added that Purdue works with health-care professionals, law-enforcement bodies, and communities to help curb the abuse. In 2010, Purdue reformulated OxyContin to make it more difficult to inject or snort.

William Foster, a spokesperson for the Janssen Pharmaceuticals subsidiary of Johnson & Johnson, said that the company believes it is "critical for physicians and patients to have multiple treatment options, including opioid analgesics, to help people who need relief from acute and chronic pain," while also recognizing "the potential for misuse of opioid analgesics." Both Purdue and Johnson & Johnson run educational programs on the responsible prescribing of opioid medications, and Janssen Pharmaceuticals has an online database where you can check whether a physician has accepted payment from the company since 2010.

Endo Pharmaceuticals didn't respond to requests for comment.

The rise in prescription narcotics may have been driven partly by the pharmaceutical industry, but many patients also welcomed—and encouraged—it. Many people believe deeply in the power of modern medicine to cure illness, and bristle at the notion that pain is a fact of life. The promise of a set of medicines that could cure pain was appealing to many patients—and, with a customer-is-always-right mentality having pervaded the doctor's office, patients were able to pressure physicians to satisfy their requests for the pain pills they'd begun hearing about.

The pain-pill epidemic has also forced doctors like me to consider our own role. Doctors have a duty to relieve suffering, and many of us became doctors to help people. But giving that help isn't straightforward, especially when it comes to chronic pain. Try explaining the downsides of narcotics to a patient while declining to give him the medication he wants. He might accuse you of not understanding because you're not the one in pain; he might question why you won't give him what another doctor prescribed; he might give you a bad rating on a doctor-grading Web site. He might

even accuse you of malpractice. None of this is rewarding for doctors: we're frustrated that we can't cure the pain, and that our patients end up upset with us.

Doctors have a hard time saying no, whether a patient is asking for a narcotic to relieve pain or an antibiotic for the common cold. We are predisposed to say yes, even if we know it isn't right. Some of us just don't want to take the extra time during a busy day to explain why that prescription for a narcotic isn't a good idea. Some of us also use the promise of prescription narcotics to persuade patients to keep their medical appointments, or to take their other medications.

It's important to take patients' pain seriously. Musculoskeletal disorders like back pain are among the top causes of disability in the U.S. But there are other ways to treat pain. Physical and chiropractic therapy, massage, and acupuncture aren't used enough, in part because they may be more expensive (at least until you take into account the unintended medical, legal, and social costs of overprescribing narcotics); patients also don't want to have to wait for a referral or repeated treatments to get pain relief. Perhaps the best way to address pain is a team approach, in which primary-care doctors, pain specialists, physical therapists, chiropractors, acupuncturists, massage therapists, mental-health providers and addiction specialists work together to find the best solution for a shared patient. Health insurers are part of the problem here: they reliably cover prescription narcotics, but not necessarily these other medical tools. (Foster told me that his company "believes it is critical for physicians and patients to have multiple treatment options, including opioid analgesics," to help patients with acute and chronic pain get better and go back to work.)

Under the F.D.A. proposal, slated to take effect as early as next year, doctors would no longer be allowed to write six-month prescriptions for products like Vicodin that combine hydrocodone with over-the-counter painkillers. Instead, doctors could prescribe only a ninety-day supply of hydrocodone without a return visit. Earlier this year, the F.D.A. also recommended that prescription narcotics be made more abuse-resistant; it is blocking the approval of generic OxyContin that doesn't use this technology. And it is requiring that extended-release and long-acting forms of prescription narcotics be labeled to indicate that these medications are for "around-the-clock" severe pain, and that alternative treatments should be considered first.

Those actions come as states and other local jurisdictions also crack down on the overprescribing of narcotics. Florida, for instance, passed a law making it illegal for anyone other than a doctor in good standing to run a pain clinic, and limiting how much narcotic medication can be dispensed at one time. And many states are also now requiring physicians to police their patients by looking them up in online registries to ensure that they aren't "doctor-shopping" to get narcotics from multiple sources.

I sometimes think of the patient who asked me for OxyContin early in my career; I continued to prescribe the drug. But I also referred him for physical therapy and helped him get bariatric surgery to lose the weight that was putting extra stress on his spine and joints. Unfortunately, even after he lost about a hundred pounds, he wasn't able to stop using narcotics or go back to work.

That wasn't the last time I faced difficult questions about whether and how to prescribe narcotics. Recently, I was tapering one patient's narcotics, then discontinued them completely after three urine tests came up negative for oxycodone but positive for cocaine—suggesting he was selling the former to buy the latter. He warned me that he would give me "one more chance." Since then, he has failed to show up for every appointment, and has lobbied to switch to another provider. I'm torn, because this patient has H.I.V. If he doesn't take his medications, his H.I.V. won't be controlled, and this will put his health at risk and make him more infectious to others. Again, the perpetual question: How do I do the least harm?

Due to an editing error, an earlier version of this article incorrectly stated that the American Academy of Pain Management published guidelines advocating for doctors to expand their use of prescription narcotics to relieve pain.

Celine Gounder is a physician, public-health specialist, and medical journalist. *Read more »*