The Death of Pain Medicine

John F. Peppin, D.O., F.A.C.P.
Clinical Adjunct Professor, Marian University, College of Osteopathic Medicine, Indianapolis, IN
Consultant/Director, John F Peppin, DO, LLC, Hamden, CT.

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The Rise of Pain Medicine

- Pain poorly treated for Millennia
- Pain Medicine in the 1950s-1960s
  - Initially for "cancer pain"
  - Chronic "noncancer pain" COT developed out of this
- Initial focus:
  - Get physicians to take pain seriously
  - Get physicians to treat pain more aggressively
  - Get Physicians to use opioids more frequently
    - They worked in cancer pain

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Opioid Focus

- Initial desire to improve pain treatment
- Simplistic approach:
  - One medication, e.g., opioids, would fix the problem
  - A single approach in chronic pain, whether pharmaceutical, marijuana or interventional will fail.
- Financial incentives:
  - Pharmaceutical industry
  - CME companies
- Impression:
  - Chronic pain treatment = opioids
  - Learn about opioids = learn pain medicine
  - Anyone can treat chronic pain
    - Simplistic linear view

Complexity and Chronic Pain

"We must acknowledge, to ourselves and our nonhospice/palliative care colleague what providing optimal pain care is difficult … the trap … is to minimize how hard pain management truly is …"

(Weissman, 2004)

Complexity in Chronic Pain

- Complexity in Chronic Pain
  - Example of Linear Thinking
    - "Clinicians should conduct a focused history and physical examination". (ACP/APS, 2007)
    - Increase use of opioids, interventional approaches, marijuana, etc …
- There is no single answer for chronic pain.
  - The complexities belie any such attempt.

Complexity in Chronic Pain

1) Medical co-morbidities
2) Other concomitant symptoms
3) Psychiatric and psychological co-morbidities
4) Risk for medication abuse and diversion
5) Number of pain problems
6) Number of past surgeries
7) Tobacco usage
8) Head trauma history
9) Body Mass Index
10) Sleep disorders
11) Goal setting
12) Educational level and employment status
13) Current pharmacotherapy regimen
14) Coping skills and social support
15) Physical conditioning
16) Current pain intensity

(Peppin, et. al., 2015)

The Rise of Pain Medicine

- Greater than 30 Journals devoted to pain
- More than 20 professional organizations devoted to pain
- 8 Physician Board Certifications
- Multiple other certificates for other HCPs

Inadequate Preparation and Training

- Health Care Professionals receive nominal training.
  - Medical School
    - Very few hours in pain, end of life, substance use disorder, opioids
- "Available evidence indicates that pain management training is widely inadequate across all disciplines." (Fishman, 2013)

Research: NIH Funding

- Decade of Pain Control and Research 2000-2010, (Brennan, 2015)
  - "In terms of public policy, the achievement of a truly balanced approach envisaged by Congress at the commencement of the Decade proved elusive."
  - What is needed is a "more measured response"
- Declined "sharply" from 2003 to 2007 by average of 9% per year.
- Federal response to 2011 IOM report (IOM, 2011)
  - "Limited and disproportionally focused on reducing opioid use rather than increasing pain relief." (Kroenke, 2017)

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Research: NIH Funding

- April 6, 2018 NIH announced a funding increase of $500 million
  - Focus on opioid misuse, addiction, and pain research.
  - $1.1 billion for fiscal 2018; 500 million is < 0.5%.
- NIH Director Francis Collins, MD
  - the initiative, called Helping to End Addiction Long Term (HEAL) Focuses on ways to:
    - "Reduce over-prescription of opioids"
    - "Accelerate development of non-opioid pain therapies"
    - "Provide more flexible options for treating opioid addiction."
- FDA Commissioner Scott Gottlieb, added:
  - "the number of prescriptions being written is still too high,"
  - Adding that "in too many cases, addiction still starts with a prescriber's pen,

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The Media

- "The DEA's War on Pain Doctors" (Village Voice, 2003)
- "As narcotics prescriptions surged, so did deaths from opioid-analgesic overdoses … " (New Yorker, 2013)
- "Amid Opioid Crisis, Insurers Restrict Pricey, Less Addictive Painkillers". (NY Times, 2017)
- "A 'civil war' over painkillers rips apart the medical community — and leaves patients in fear." (Stat News, 2017)
- "America's Opioid Epidemic". (CBS News 2017)

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The Media

"The institution of journalism is not doing its job well now. It is irresponsible with its power. The damage has spread to the public life Americans all share. The damage can be corrected, but not until journalism comes to terms with what it has lost."
(Fallows, 1996)

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Uncoordinated Federal Approach

- DEA
- FBI
- US Marshals
- Inspector General of DHHS
- FDA
- NIDA
- CDC
- CMS
- OSHA
- ONDCP
  - Supposed to coordinate
- PDMP-States
  - A distinct Law Enforcement Focus

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Regulation and Legislation

- Kentucky
  - "Kentucky may tax Opioid Sales" (Kentucky.com, 2018)
  - A tax of 25 cents on each dose of an opioid sold into Kentucky
  - State Attorney General's Office would have the power to go after wholesalers or pharmacies if they passed on the tax to consumers.
  - Did not pass.
- Multiplicity of Professional, Federal and State "Guidelines" frequently inconsistent
  - No coordination

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Coroner Reports/DAWN data

- Oxycontin Deaths frequently Polypharmacy
  - "Majority of cases involved multiple drugs." (Cone, 2003)
  - ".. no single drug should be interpreted as the sole COD." (Cone, 2004)
- Data:
  - 2015 NH 253/351 opioid deaths Fentanyl a factor (Costantini, 2016):
  - When a prescription opioid is detected, it goes down as a "prescription opioid death". (Hannah, 2017)
- Do we have a prescription opioid problem or a polypharmacy problem?

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Failure of the Health Care System

"Historically, the health care system has failed to recognize chronic pain as a legitimate condition. However, it is clear that persistent pain is a complex illness that has many causes and affects every part of life, and in the process exacts enormous social costs."

(Mayday Fund, 2009)

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Death of Pain Medicine

- "Assaults" by media, regulatory and legislative bodies, etc …
- Pain Physicians focusing on interventions
  - Fewer and fewer go into the pain field who want to do coordination or care, medical management, do H&Ps, etc …
- Insurance Companies Failure
- Pain Medicine is at a crossroads
  - The future is bleak for pain patients.
  - Suicides increasing in chronic pain patients (Cheatle, 2014)

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The Future Needs of Pain Medicine

- ONDCP
  - Needs to coordinate Federal Responses, recommendations, Guidelines etc ..
  - Recognize the complexity of the Chronic Pain Experience.
  - Pain patients need to be the focus, rather than reducing opioid prescriptions
- Media
  - Needs to be engaged, confronted and responsible
- Professional organizations
  - Advocate for patients and for pain medicine
- Professional schools
  - Need to take pain, palliative care and substance use disorders seriously
- Legislation needs to be rational (unintended consequences)
  - Consider evidence based legislation

The Future Needs of Pain Medicine

- Stakeholders
  - Needs to be a regular meetings of serious and rational stakeholders.
    - Statements concerning legislation, consensus statements etc ..
- Research
  - Government needs to get serious about pain and addiction.
  - Monies need to be marked for serious research
  - Barriers need to be reduced.
- Pharmacy
  - Pharmaceutical industry needs to broaden it's perspective.
  - Pain is complex, no one treatment will "trump".
- Dialogue ... not pejorative wrangling

The Future Needs of Pain Medicine

"Imperfect treatments do not justify therapeutic nihilism. A broad menu of partially effective treatment options maximizes the chances of achieving at least partial amelioration of chronic pain."

(Kroenke, 2017)

Thank You. Questions?

The Death of Pain Medicine: ICOO 2018

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