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A Startling Injustice: Pain, Opioids, and Addiction

Jessica Gregg, MD, PhD

Like other residents and medical students in the late 1990s, I was taught to assess the "5th vital sign"—pain—and address it, usually with opioids. My colleagues and I were taught that the medical community had long ignored the treatment of pain and it was now time to redress that wrong. Our teachers, medical boards, and professional associations (and always in the background, the pharmaceutical companies) urged us to assess and treat pain aggressively (1).

Thus, with no training in pain management, and no training in addiction, I was soon prescribing large doses of opioids to treat pain in patients who were clearly not improving and who were marginally functional at best. They crowded the examination room with physical complaints and stories of unemployment, fractured households, and deepening depression. According to their Global Assessment of Functioning, they were drowning in dysfunction. According to my 15-minute clinical assessment, this meant I should raise their methadone dose.

Fast-forward 15 years. Since 1999, the United States has seen a 300% increase in sales of prescription opioids and a similar increase in deaths from overdosing on pain pills. More Americans now die of overdose of prescription pain pills than of heroin or cocaine. In some states, opioid-related deaths exceed deaths from motor vehicle accidents (2, 3). If they survive overdose, many individuals addicted to prescription pain killers will eventually turn to heroin, which is cheaper and often easier to obtain (4).

Through good intentions and bad medicine, the medical community helped create a deadly epidemic. Now, in an act of startling injustice, we are abandoning its victims.

Although unfair, our impulse to flee is understandable. Primary care medicine—where responsibility for these patients inevitably lands—is difficult enough. Primary care is the common pathway for all patient symptoms, somatic or otherwise, to be addressed in 15- to 20-minute visits, with hours of additional charting and paperwork afterward. Buried under this avalanche of expectations, primary care providers have no place in their practices for patients who may lie about their pain, steal prescriptions, or create angry scenes in the office when the physician finally refuses to prescribe more. Patients addicted to opioids are often demanding and unpleasant.

We need to take care of them anyway.

They are suffering from a disease—addiction—that we can and should treat. Scientific understanding of opioid addiction and its treatment is advancing rapidly. It is now clear that the risk for addiction is heritable and is worsened by social isolation and trauma (5). New tools help identify patients who are at the greatest risk for addiction and for whom the risk of prescribing opioids probably outweighs the benefits (6). An array of medications can help reduce addictive behaviors (7). This leap in scientific understanding is revolutionary. We have an emerging grasp on the cause of the disease, and we have new and effective ways to treat it.

Were this a discussion of cardiac disease, the advances in disease understanding and treatment would be big news. Residents would compete to show their familiarity with the research. Primary care physicians might send their patients to specialists to begin treatment, but they would also learn the risks and benefits of the various medications and assume ongoing, day-to-day care of the patient.

But this is not cardiac disease. Addiction is a highly stigmatized condition that the current medical system is ill-equipped to address and often chooses to ignore.

So, an individual addicted to opiates will struggle to find a provider who is willing to treat addiction or prescribe buprenorphine or extended-release naltrexone, both of which decrease the use of illicit opioids (5, 8, 9). That patient will probably not find a provider who understands which patients might be appropriate for a methadone clinic and its proven success in decreasing drug use, HIV risk behaviors, and criminality (10). Most primary care providers do not know who to call for help in figuring all of this out, and the medical systems where providers work offer little support (7).

This potent cocktail of overwhelmed physicians, lack of knowledge, uncertain resources, and difficult patients means that most patients suffering from addiction will not get care. Although effective treatments exist, patients and their families will be abandoned to their disease and its consequences. At best, this is a tragic oversight.

To be clear, I am not suggesting that people addicted to opioids are simply victims of bad medicine or dysfunctional systems and that all they lack is a little bit of support and some attention from their physicians. No, they have made bad choices and have sometimes done terrible things. When they are at their worst, I would be afraid of some of my patients if I encountered them on a dark street in the city. But when I meet them in my office, they are not on a dark street. They are mothers like me who love to talk about their children or are kids, not much older than my own, who giggle when I check their reflexes. They are patients, this is their disease, and they need medical attention.

Major shifts must occur for patients with addiction to receive that attention. First, systemic changes are critical if primary care is expected to shoulder the burden of care for yet another complicated, time-consuming condition. Changes would include more and better education about pain and addiction; primary care physicians with more time and tools to treat disease and coordinate care; and transformed systems of care providing better chronic disease management, patient-centered care, and team care (9).

Systemic changes alone will not be enough, however. Clinicians must also shift their attitudes about the treatment of addiction. Physicians must be willing to consider addiction, along with heart disease, diabetes, hypertension, and depression, as one of the many relapsing, remitting, frequently frustrating, and sometimes heartbreaking diseases that they—that *we*—treat. We cannot turn our backs on this epidemic or these patients. We helped create them.

From Hooper Detoxification and Stabilization Center, Portland, Oregon.

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Requests for Single Reprints: Jessica Gregg, MD, PhD, Hooper Detoxification and Stabilization Center, 1535 North Williams Avenue, Portland, OR 97232; e-mail, Jessica.Gregg@centralcityconcern.org.

Author contributions are available at www.annals.org.

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Drafting of the article: J. Gregg.
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