PRESIDENT’S MESSAGE

Pain and Suicide: The Other Side of the Opioid Story

A former patient whom I’ll call Jack came to me for help after three back operations. He was on disability because of his pain. I treated him for about four years, struggling all the while to get his insurance to cover his therapies. I tried to get him to see a psychologist, but his insurance would not pay for the service. He was on what most physicians today would term a high dose of opioids and other medications. I wasn’t convinced that the higher dose was any more effective than a lower dose. He was mostly inactive and reported little improvement in pain or function while on his medication.

A device was implanted in his abdomen to deliver medication directly to his spinal canal where it could be more effective, allowing me to reduce or eliminate his oral dose of opioids. I began to reduce his opioids per our agreed plan, but as we began the taper he claimed his pain was too severe. He simply could not tolerate the pain. I insisted that we had to reduce his medication, that the medication being delivered to his spine should allow us to provide pain control equal to or better in effectiveness than the oral medications. He had never over used his medications. He had never showed any signs of drug abuse or addiction. But I was concerned that if he continued on such a high dose, something terrible could happen to him. I also worried that I might be held liable.

Jack never said much during his office visits. He was mostly silent and followed my instructions. But he did quietly express fear of the pain if I continued to reduce his pain medications. During the third clinic visit of this process, he said, “I can’t live like this, Doc.” I said, “It will get better,” hoping more than knowing my statement would be true. I counseled him that the pain may worsen for a while, but that—in time—this new regimen would be for the best. I heard his words but not his cry for help.

Three days later I got a call from his daughter. Jack had died from a self-inflicted gunshot wound. He left a note saying he couldn’t live with the pain anymore. He could not see a future. He had no hope. He had no life. He loved her but felt he was of no value to her or to anyone.

I had to ask myself if my concern for my freedom and licensure had led to this tragedy. This was a moral dilemma for me. I could have continued to prescribe a high dose of opioid, but if he had died, even from a natural cause, the medical examiner might have said the death was an unintentional overdose from opioids. Jack might have even intentionally overdosed and no one would know. Deaths from opioids have become red flags for investigations. By contrast, Jack’s death by suicide was not widely recognized by anyone beyond his family and me. I was tormented by the thought that he might have died because I was unable to help him escape extreme pain.

There is enormous pressure to limit the prescribing of opioids in noncancer pain patients today. The Centers for Disease Control and Prevention (CDC) reports an epidemic of overdose deaths from prescription medications [MMWR 2011], and the White House Office of National Drug Control Policy has announced a commitment to reducing deaths from prescription drugs through more aggressive law enforcement efforts [ONDCP 2011]. At the same time, our society has little comprehension of the nightmare experienced by people who live every day with chronic pain. To make matters worse, the U.S. healthcare delivery system is short on insurance coverage for the full range of interdisciplinary therapies that could make a difference. As a result, patients are caught in the crossfire between law enforcement efforts and physicians who have fewer, and less effective, tools available to treat patients whose pain approaches levels unimaginable by most people.

Against this backdrop, even before the Drug Enforcement Administration decided to review some of my patient records, I had been actively trying to reduce the amount of medication prescribed to many of my patients. Many patients opposed these efforts, claiming their medication reduced their pain and allowed them to be active. In most instances I believed the patient, but still felt the risk to the patient of overdose and risk to me of regulatory sanctions was too great to allow them to remain on higher doses of opioids. So I proceeded to counsel patients to lower doses whenever possible.

Nearly every day I would caution my patients that if they took more medication than prescribed, they could die. After a short pause, in a serious tone, slowly and intentionally, some patients would say something like, “It would be OK. I am not living a life now. There are worse things than death.” These types of responses always frightened me. But they also gave me insight as to why some patients may overdose—and die. Pain for some people is hell. Without hope, there may be no reason to live.

Policymakers, the news media and some advocacy groups have made it clear that the use of opioids is fraught with danger. In fact, opioids, like many medications, have serious risks. But we, as a society, have failed to recognize that the pain crisis is outsized in the United States and our
available solutions are inadequate, and that limiting the use of opioids is not enough. We fail to accept that pain can progress to be more of a disease than a symptom and, as a consequence, the many people who suffer from severe pain become desperate without relief and, consequently, lose all hope. The problem is exacerbated by the below-cost reimbursement for interventional procedures and denial of behavioral services or interdisciplinary care that could be effective alternatives to pharmacotherapy. Policy and medicine are at odds with each other and, as an unintended result, practitioners wind up abandoning patients with the worst pain due to the risk of treating them. To me this is a calamitous outcome but, for some reason, does not generate many speech sound bites, much ink or broadcast time.

Damned if you do. Damned if you don’t.

Physicians should not be derailed from trying to bring dignity to the lives of all people suffering from a life of dreadful pain. Admittedly, we need better therapies. But until there is the political will to invest more in developing safer therapies, we cannot abandon our moral obligation to bring the best compassionate care available to people in pain. Their lives may depend on it.

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References