Introduction: Opioid Analgesia: A Patient Perspective

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KEYWORDS

• Opioid analgesia • Prescription Opioid • Patient perspective • Physician perspective • Physician as patient • Pain medication • Opioid crisis

KEY POINTS

- Many individuals believe that physicians can be difficult when they become patients, as having "just enough" knowledge or attempting to direct one's personal medical care presents problems particularly when dealing with a dynamic issue such as analgesia.
- Physicians are used to being advocates for their patients, and when they are the patients themselves, there is a certain degree of transition that changes one's perspective and affects how complex medical issues are addressed.
- There has been an evolution in management of pain concerns in recent decades with growing recognition of the toll of the opioid epidemic on our society.

There is certainly anecdotal evidence supporting the long-held adage that "physicians make the worst patients." Domeyer-Klenske and Rosenbaum identified several different approaches physicians take when treating a colleague, ranging from ignoring the physician-patient's medical background or negotiating care around this background knowledge to allowing physician-patients to drive management.[1] With these considerations in mind, transitioning from being the physician to being the patient does change one's perspective and can provide invaluable strategies for dealing with complex medical issues. A significant portion of medical training involves development of a physician's ability to serve as an advocate for our patients, and these skills are often harnessed excessively when physicians advocate for themselves and/or family members.[2]

When the physician becomes the patient, this can potentially raise problematic issues, such as when physicians try to direct their own care or when the objectivity of the treating physician becomes obscured. The American Medical Association's

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code of ethics explicitly states that “physicians should not treat themselves or members of their immediate families…professional objectivity may be compromised.”[3] This represents a particularly dynamic issue when topics such as analgesia come up, as there has been an evolution in familiarity and management of pain concerns in recent decades, with the pendulum swinging from pain as an underrecognized “fifth vital sign” up through widespread recognition of the contemporary opioid epidemic.

As anybody familiar with political discourse nowadays can attest, the opioid “epidemic” has reached critical mass and captured public awareness in recent years. This crisis was initiated around the turn of the century by a variety of organizations trying to shed light on the “underrecognition” of pain control in our health care system. For example, in 2000 JCAHO released standards that maximized awareness of “the right to pain relief.” Around this time began a concomitant increase in direct to consumer marketing of painkillers.[4] Consequently, these trends continued, with current economic costs of *prescription opioid misuse* amounting to nearly $80 Billion annually.[5,6] Nearly 50,000 people died from opioid overdoses in the United States in 2017, whereas 1.7 million Americans qualified as having a substance use disorder due to the misuse of prescription opioids.[7] With increasing recognition of these considerations, addressing this crisis from both a supply and demand standpoint has involved a multipronged public health approach, including strategies for reducing access to prescription opioids, minimizing overprescription, diversion, and misuse and doing a better job of educating patients and physicians about the appropriate use of these drugs and available alternatives.[8]

Over the past year, I have had the opportunity to experience our health care system as well as aspects of various analgesia strategies from a patient perspective rather than that of the physician, and this has provided some compelling insights. There is little in the literature or lay press describing physician experiences with opioid analgesia; my hope is stepping back and briefly sharing some of these personal experiences may provide a practical perspective.

After attributing many months of cough, fatigue, and night sweats to other causes, I was diagnosed with lymphoma and started on chemotherapy about 6 weeks after finishing my fellowship and starting practice as an attending. I was doing well on my chemotherapy regimen until experiencing drug-induced pancreatitis, an adverse event specific to one of the induction chemotherapy agents. This pancreatitis itself was initially “mild.” Nonetheless, lingering and worsening symptoms along with the development of pseudocysts dragged these sequelae out over many more episodes of pancreatitis lasting months and gave me the unfortunate but eye-opening experience of both acute and chronic analgesic strategies in action. During my first emergency department visit for severe abdominal pain, before seeing a physician an order was written for me to receive 6 mg of intravenous (IV) morphine. For an opioid naïve patient who had never even had any pain medications in their life, having this medication “pushed” very quickly without an explanation of what exactly I was getting was quite an experience; the intentions behind it were good and it ultimately worked very well from an analgesic standpoint, but nothing quite prepares someone for the accompanying “head rush,” sensation of passing out, and generalized discomfort that precedes the analgesic effects. Over the remainder of this initial hospitalization along with subsequent ones for lingering and worsening symptoms, I ended up going through a multitude of different phases relating to analgesia, including the following: trying to avoid any pain medicine use at all, trying to minimize intravenous pain medication use, attempting to be comfortable without concern for how much I thought I was using, and in-depth discussions for the most appropriate outpatient regimens to facilitate

the use of nonopioid alternatives. Nonetheless, unless one has personally experienced the ebbs and flows of high-dose narcotic usage in both acute and chronic situations, it is impossible to describe the uncertainties and perceptions encountered. During these episodes it was remarkable to learn how my perceptions of narcotic usage (of which I felt I was using a huge amount) diverged with my treatment team's perceptions. In addition to the medical aspects of opioid usage and related health events, there are certainly the psychosocial impacts associated with considering these medications, such as a fear of dependence as well as concerns regarding how continued use could affect one's ability to lead a regular life (ie, working, driving) when not in the hospital. For example, I had worked toward a goal for so long, finally finished residency and fellowship, and 6 weeks into my job as an attending physician when I was starting to see more patients and perform more surgeries, I faced a diagnosis that had a potential to upend all of this. Having an unpredictable schedule, canceling patients frequently, and realizing you have suddenly missed 3 months of work after missing virtually no time the first few weeks of chemotherapy certainly all contribute as a psychosocial stressor. Going through 15 hospitalizations, multiple unexpected surgeries, and countless rounds of chemotherapy all have psychosocial effects, something that can affect analgesic strategies and patient management in general. This stresses the value of adding sections in the present issue such as *Pain Psychology*: *Practical Approaches for Otolaryngologists*, as the physical aspects of pain may not be the only consideration you are managing.

Although the current issue of *Otolaryngologic Clinics of North America* focuses more on perioperative analgesia, there are several lessons I took away from my personal experiences that I think can be kept in mind and invaluable for anyone managing someone's pain, some of which may be obvious and some of which are not:

- "Evidence-based" practices sometimes go out the window when you are in acute and severe pain, at least from a patient consent and decision-making perspective. This is where it is important for your treating physician to be familiar with evidence-based medicine and quality improvement practices, because in an acute pain crisis, you as a physician are not necessarily having an exhaustive discussion of risks, alternatives, and benefits or discussing outpatient regimens that are appropriate.
- If you find yourself in the situation of being the patient, try not to be your own doctor. This may seem self-evident even beyond us harping on this earlier, but it is actually not too difficult to find yourself placed in this situation. There were multiple times physicians who evaluated me either in the emergency department or elsewhere during these hospitalizations would ask "What do you want to do?" or "How would you like to proceed?" For some of these specific situations, just background knowledge and common sense dictated that they would not have provided these open-ended choices to nonphysicians. Although having the opportunity to participate in decision-making is something that is an important part of the physician patient relationship, being asked these open-ended questions on topics in which patients would normally not be asked for this much input was a bit disconcerting, particularly as this was brought up several times in relation to what should be my pain regimen.
- In situations during my care in which trainees were involved, I could not help but wonder how much formal opioid prescribing education these residents had in their training; I had just been a trainee and realize myself there is a dearth of

formalized opioid prescribing education opportunities. For example, I had just underwent a surgical resection of an infected pancreatic pseudocyst, with my preoperative pain requirements being considerable (2 mg Dilaudid every 2–4 hours); the on-call surgical resident felt they were being proactive in “getting me out of bed” by completely cutting off IV pain medications and replacing with IV Dilaudid with PO oxycodone *after* surgery. This is clearly due to a lack of education and understanding, not a lack of empathy: the resident had no knowledge of opioid conversion ratios and was not aware of the importance of my prior interdisciplinary regimen that the pain team had come up with. This is not to say it is the individual’s fault; this ignorance of opioid prescribing education is a systemic issue.

- The urgent and unmet clinical need for stronger education in this regard among trainees has become an issue with a larger overlying societal impact, and recent studies have demonstrated a lack of dedicated training encompassing the appropriate analgesic prescription among surgical trainees.[9] Our hope is that this issue of *Otolaryngologic Clinics* represents an important first step toward addressing this concern.
- Appropriate evidence-based pain management ideally represents an interdisciplinary endeavor, meaning collaboration between physicians and health care providers in several different specialties represents an optimal approach. This point of emphasis cannot be stressed enough, as the present issue is an interdisciplinary venture between otolaryngologists, pain medicine physicians, anesthesiologists, and pain psychologists.
- An abundance of retrospective studies, multiinstitutional trials, and evidence-based systematic reviews and meta-analyses exist regarding pain prescribing practices in surgeries and situations relevant to Otolaryngologists. Many of these have been published over the past 5 years, as there has been increasing recognition of the toll the opioid epidemic has on our society, as well as increased appreciation of how opioids started in the inpatient setting and continued in the outpatient setting (or simply started outpatient after surgery) play a critical role in the misuse and diversion of these medications. These studies cannot be highlighted and emphasized enough, and practical take-home points will be stressed throughout this issue regarding these resources.

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