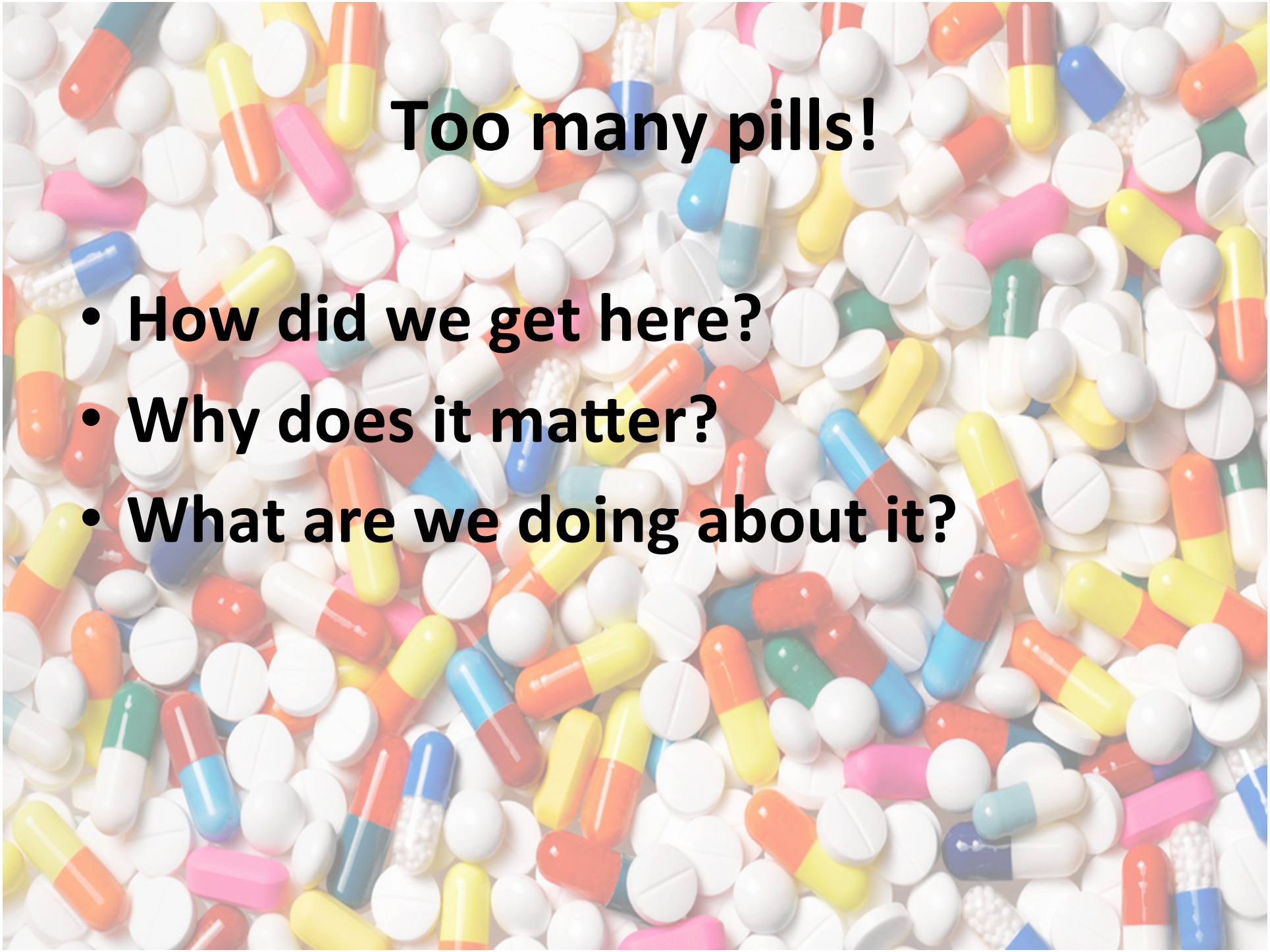
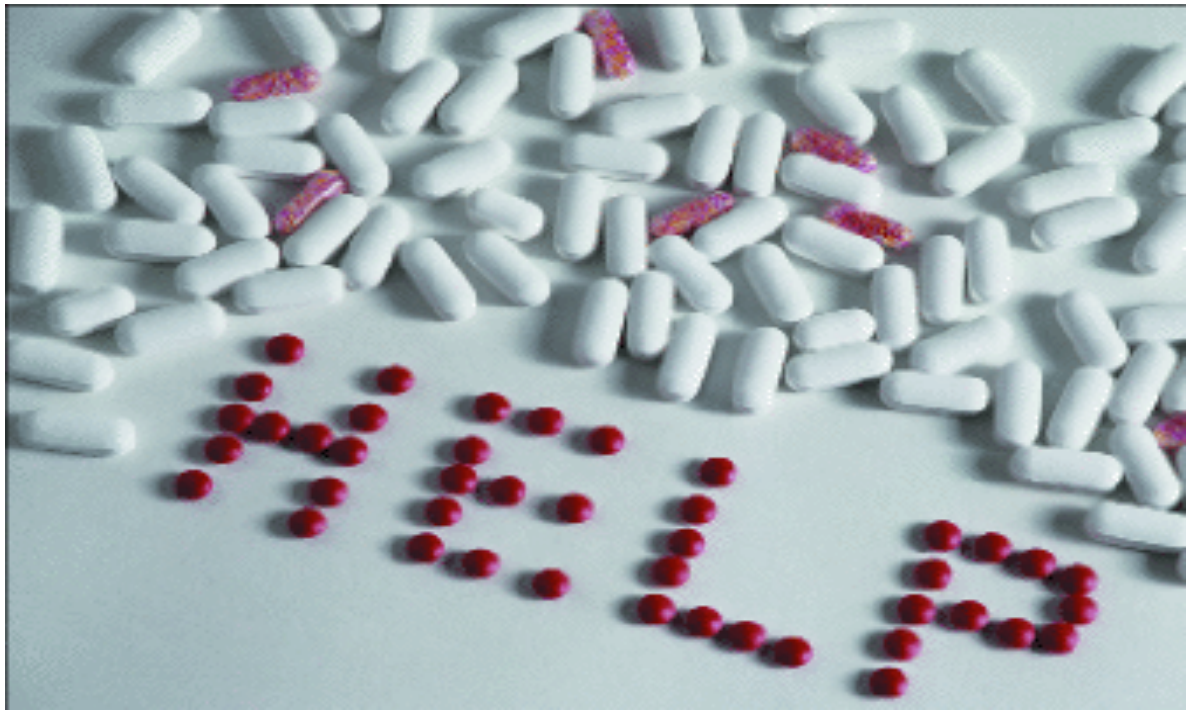
Jim Shames MD
Medical Director Jackson County Health and Human Services
AAFP, ABOM
shamesjg@jacksoncounty.org

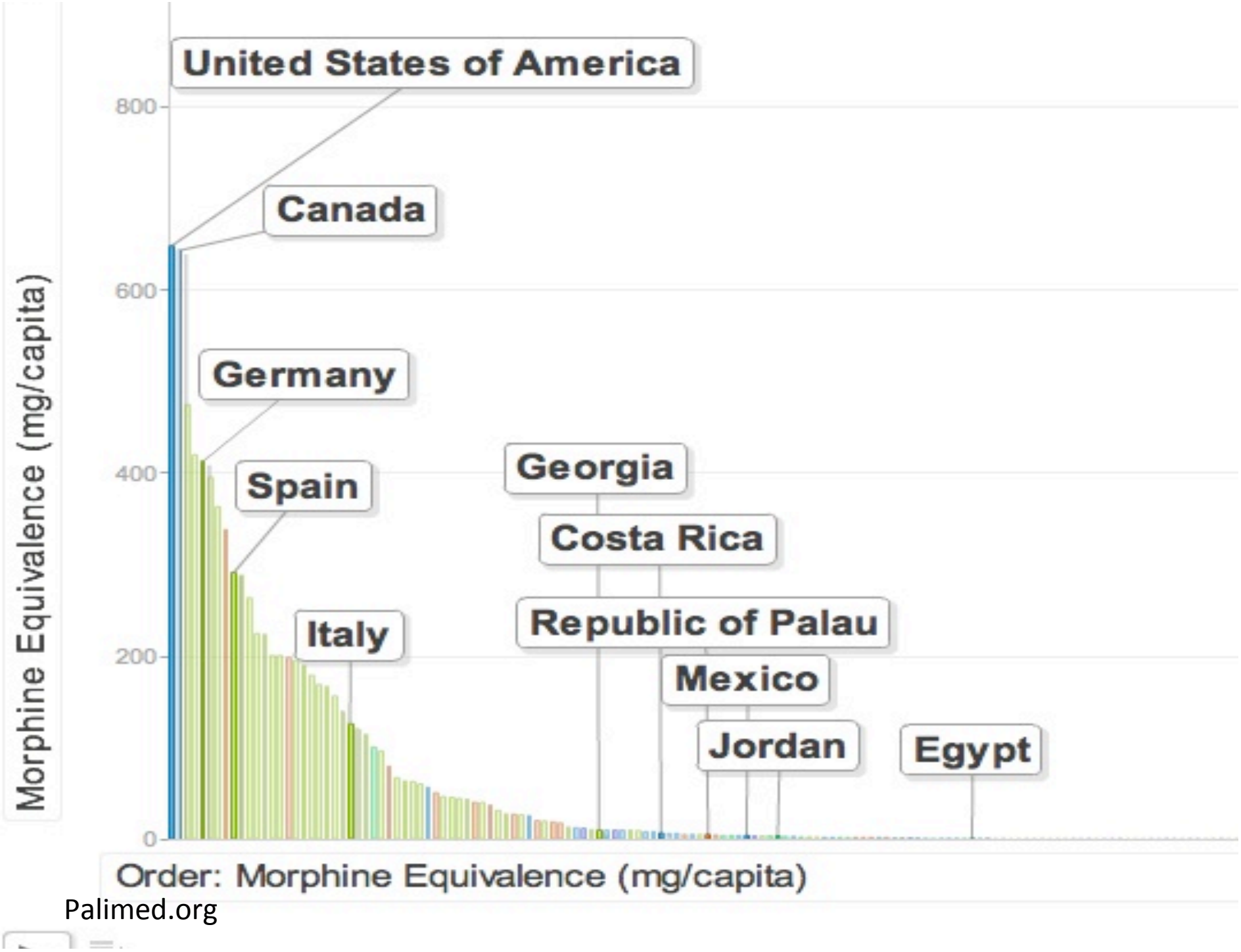
I no longer accept gifts, lunches, or anything “free” from pharmaceutical companies.


Too many pills!
• How did we get here?
• Why does it matter?
• What are we doing about it?

Opioid Consumption in US

- We are 4.6% of the world's population and consume 80% of the world supply of opioids.




United States of America
Canada
Germany
Spain
Italy
Georgia
Costa Rica
Republic of Palau
Mexico
Jordan
Egypt
800
600
400
200
0
Morphine Equivalence (mg/capita)
Order: Morphine Equivalence (mg/capita)

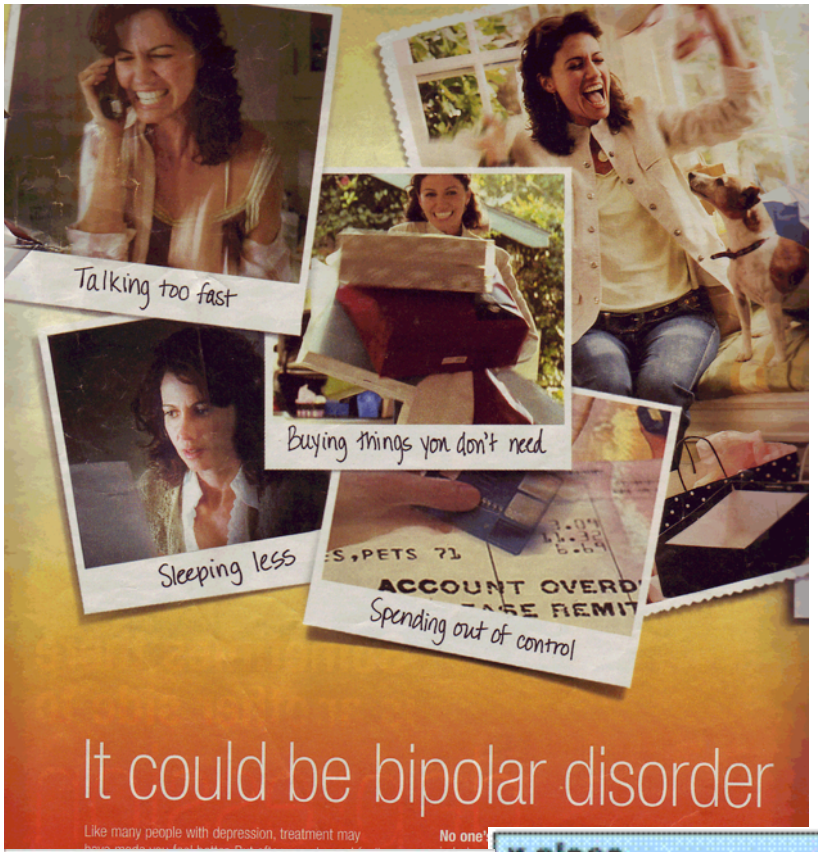
Palimed.org

How did we get here?

The Recent Past

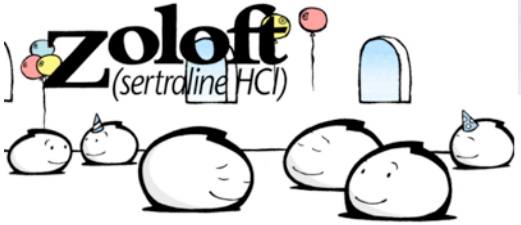
- 88% of medical board members surveyed in 1991 believed that extended opioid prescribing for chronic non cancer pain was ***unlawful*** and ***unacceptable*** medical practice. [1]

- 1. Gilson AM, Joranson DE. Controlled substances and pain management: changes in knowledge and attitudes of state medical regulators. J Pain Symptom Manage 2001;21(3):227–37.



You Could Have Adult ADHD.

A serious, treatable condition that affects many adults.



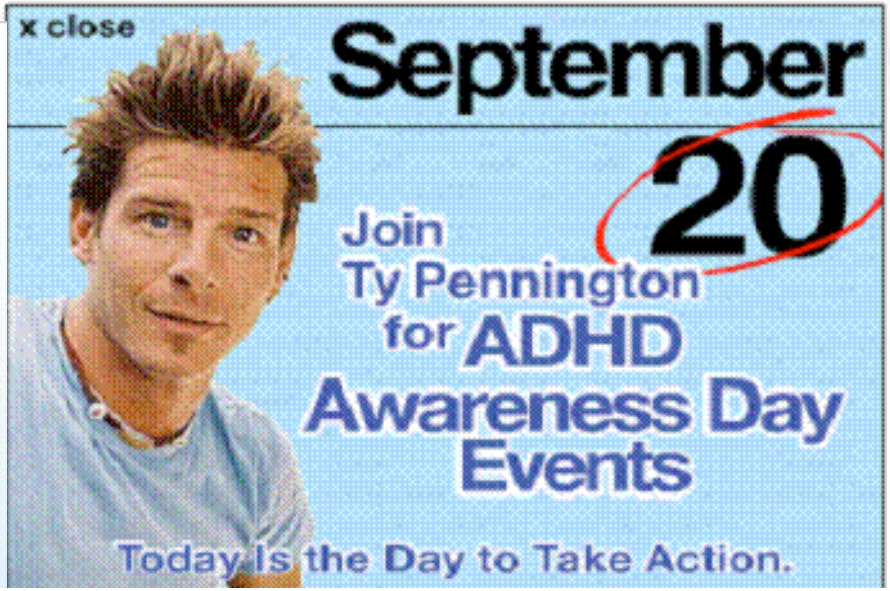
Could Zoloft be right for you?

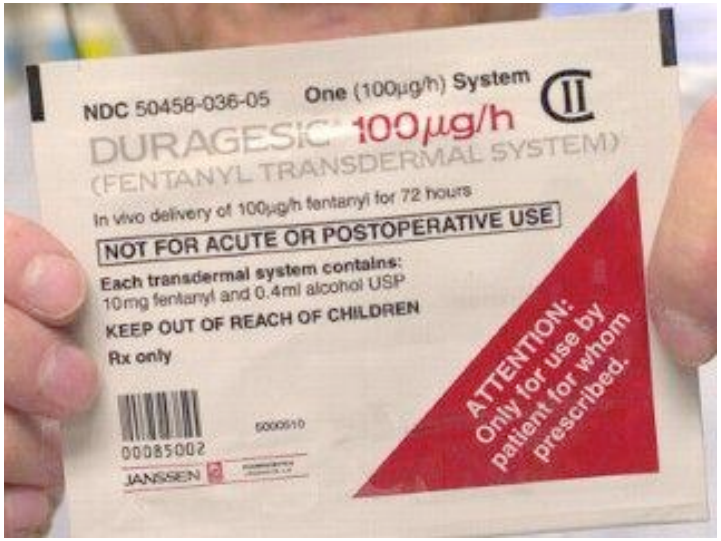
Take this self-quiz.

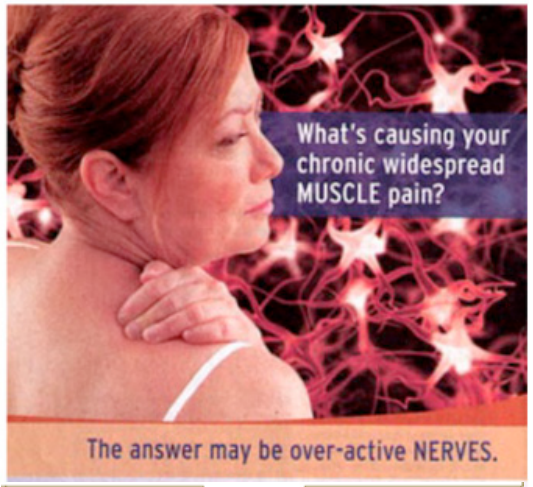
Have you experienced any of the following?
Check those that apply or might possibly apply:

Trouble concentrating?	○YES	○NO
Crying or thoughts of crying?	○YES	○NO
Feelings of sadness?	○YES	○NO
Low energy, fatigue?	○YES	○NO
High energy, restlessness?	○YES	○NO
Loss of interest in certain activities?	○YES	○NO
Unexplained pain or headaches?	○YES	○NO
Lack of motivation?	○YES	○NO
Stress?	○YES	○NO
Worry?	○YES	○NO
Lack of involvement with family or friends?	○YES	○NO
Over-dependence on family or friends?	○YES	○NO

If you took this quiz, Zoloft is probably right for you.
Ask your doctor about Zoloft.




NDC 50458-036-05
One (100µg/h) System
II
DURAGESIC 100µg/h
(FENTANYL TRANSDERMAL SYSTEM)
In vivo delivery of 100µg/h fentanyl for 72 hours
NOT FOR ACUTE OR POSTOPERATIVE USE
Each transdermal system contains:
10mg fentanyl and 0.4ml alcohol USP
KEEP OUT OF REACH OF CHILDREN
Rx only
00085002
JANSSEN
ATTENTION:
Only for use by
patient for whom
prescribed.


What's causing your
chronic widespread
MUSCLE pain?
The answer may be over-active NERVES.


OxyContin®
II
(OXYCODONE HCl CONTROLLED-RELEASE) TABLETS
10 mg
20 mg
40 mg
80 mg
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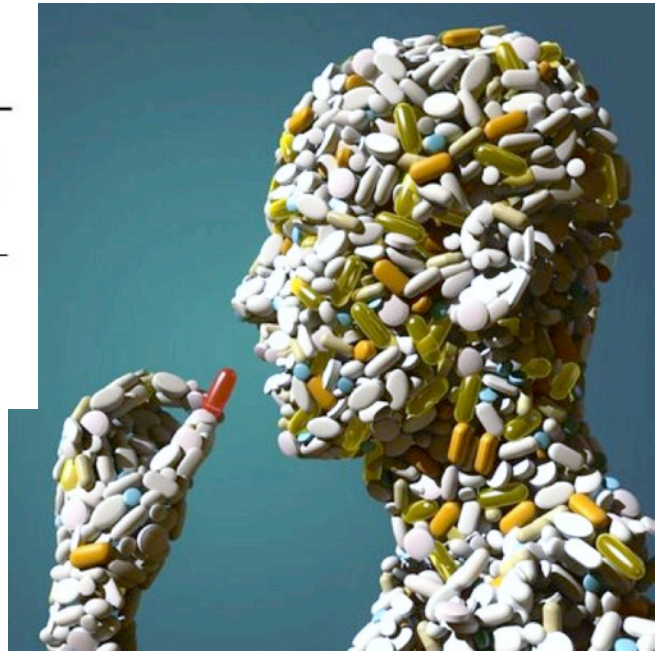
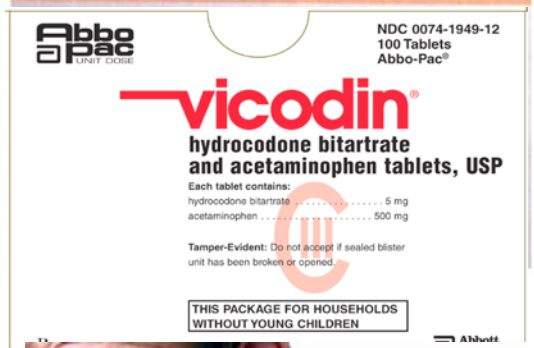
OC

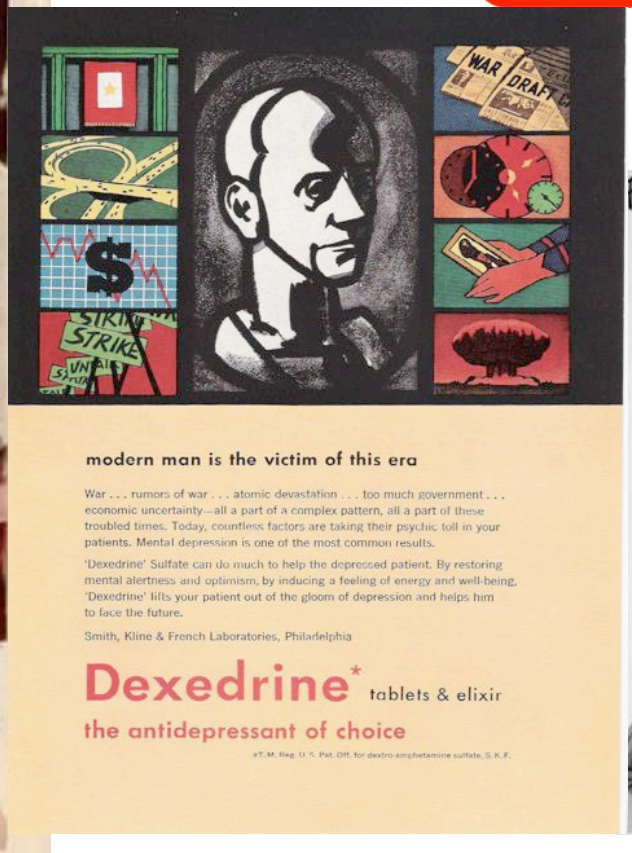



Abbo Pac
UNIT DOSE
NDC 0074-1949-12
100 Tablets
Abbo-Pac®
vicodin®
hydrocodone bitartrate
and acetaminophen tablets, USP
Each tablet contains:
hydrocodone bitartrate . . . . . 5 mg
acetaminophen . . . . . 500 mg
Tamper-Evident: Do not accept if sealed blister
unit has been broken or opened.
III
THIS PACKAGE FOR HOUSEHOLDS
WITHOUT YOUNG CHILDREN
Abbott


3.375"
NDC 59011-263-10
MS Contin®
II
(morphine sulfate
controlled-release) Tablets
100 mg
Rx Only
100 Tablets
for use in opioid-tolerant patients only
3 59011-263-10 3
Purdue Pharma L.P.

AS SEEN ON TV


According to repeated nationwide surveys,
More Doctors Smoke CAMELS than any other cigarette!
Doctors in every branch of medicine were asked, "What cigarette do you smoke?" The brand named most was Camel!
THE DOCTORS' CHOICE IS AMERICA'S CHOICE!
CAMEL
For 30 days, test Camels in your "T-Zone" (T for Throat, T for Taste).


WAR
DRAFT
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STRIKE
modern man is the victim of this era
War . . . rumors of war . . . atomic devastation . . . too much government . . . economic uncertainty—all a part of a complex pattern, all a part of these troubled times. Today, countless factors are taking their psychic toll in your patients. Mental depression is one of the most common results.
'Dexedrine' Sulfate can do much to help the depressed patient. By restoring mental alertness and optimism, by inducing a feeling of energy and well-being, 'Dexedrine' lifts your patient out of the gloom of depression and helps him to face the future.
Smith, Kline & French Laboratories, Philadelphia
Dexedrine* tablets & elixir
the antidepressant of choice


For a better start in life
start COLA earlier!
How soon is too soon?
Not soon enough. Laboratory tests over the last few years have proven that babies who start drinking soda during that early formative period have a much higher chance of gaining acceptance and "fitting in" during those awkward pre-teen and teen years. So, do yourself a favor. Do your child a favor. Start them on a strict regimen of sodas and other sugary carbonated beverages right now, for a lifetime of guaranteed happiness.
The Soda Pop Board of America
1515 W. Hart Ave. - Chicago , ILL.

We were told that we needed to be more "compassionate" in the treatment of chronic pain

Influential Medical Leaders promoting opioid use

Russell Portenoy

Scott Fishman

Influential Licensing agencies

OREGON BOARD OF MEDICAL EXAMINERS

BME REPORT

FALL 2003

www.bme.state.or.us

Inside:

License Applications Now Online: A Guide to the BME Website

2003 Legislative Review

Physical Therapy Referrals

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NEW LAW CLARIFIES PATIENTS' RIGHTS TO ACCESS MEDICAL RECORDS

By Mike Sherman
BME Complaint Resource Officer

Rarely does a day go by that the BME does not receive several telephone calls, from either patients or licensees, regarding a patient's right to copies of their medical records. It is clear from the type of questions received that there is misunderstanding in the medical community regarding patient rights and medical records.

To make matters more interesting, the 2003 Oregon Legislature passed House Bill (HB) 2305, making state patient-records laws comply with federal Health Insurance Portability and Accountability Act (HIPAA) regulations. This bill took effect upon passage and made some significant changes in state law regarding patient's access to medical records.

HB 2305 was meant to complement HIPAA, and needs to be read in conjunction with the federal regulations. I will attempt to summarize some of the more important changes the Oregon bill and HIPAA make. The BME is in the process of changing its administrative rule on the release of records to incorporate these changes.

The law gives patients the right to access their medical records personally, or to have them sent to an authorized person or organization. The law gives a very broad definition of information that the patient is entitled to obtain, and includes "information Ê that relates to the past, present, or future physical or mental health of an individual" in any form. The law also includes billing information as information the patient is entitled to obtain.

Unlike the previous law, HB 2305 does not exempt the release of records of another health care provider which may be contained in the record. The new law allows the health care provider to require a written release from the requesting patient in a format very similar to the one specified by the old law (ORS 192.525, which has been repealed).

As in the old law, current law does allow certain exemptions to the general requirement to release information. There is an exemption for release for information which would harm the health of the patient. Psychotherapy notes are exempt as is information compiled, in anticipation of, or for, litigation. If the medical record contains information obtained from someone **other than a healthcare provider** under a promise of confidentiality, then that information may be exempted if releasing the information would tend to identify the source.

HB 2305, like the previous law, allows charging a fee for reproducing records. However, the new law specifies the amount which may be charged. HB 2305 allows a fee of $25 for the first ten pages of written material and 25 cents a page for orders of more than 10 pages. When X-rays or other non-written materials are ordered, the actual cost of reproducing the items may be charged. Inability to pay is not grounds to withhold medical records. **Additionally, the law does not exempt the release of records when a patient's bill is not paid in full. Records should not be withheld for that reason.**

In summary, HB 2305 and HIPAA:

- Give patients broad access to their medical records in the possession of the licensee who receives the request.
- Patients may request all or part of the record.
- Patients may request that the information be sent to them or to another person.
- Licensees may require a written release and require the patient to specify which part of the record they wish to obtain.
- A fee, which is specified in the statute, may be charged.

Please keep in mind that this article is a summary, and is not intended to substitute for a detailed reading of the current law. If questions arise concerning medical records, feel free to contact the Board's Complaint Resource Officer at (503) 229-5770. ■

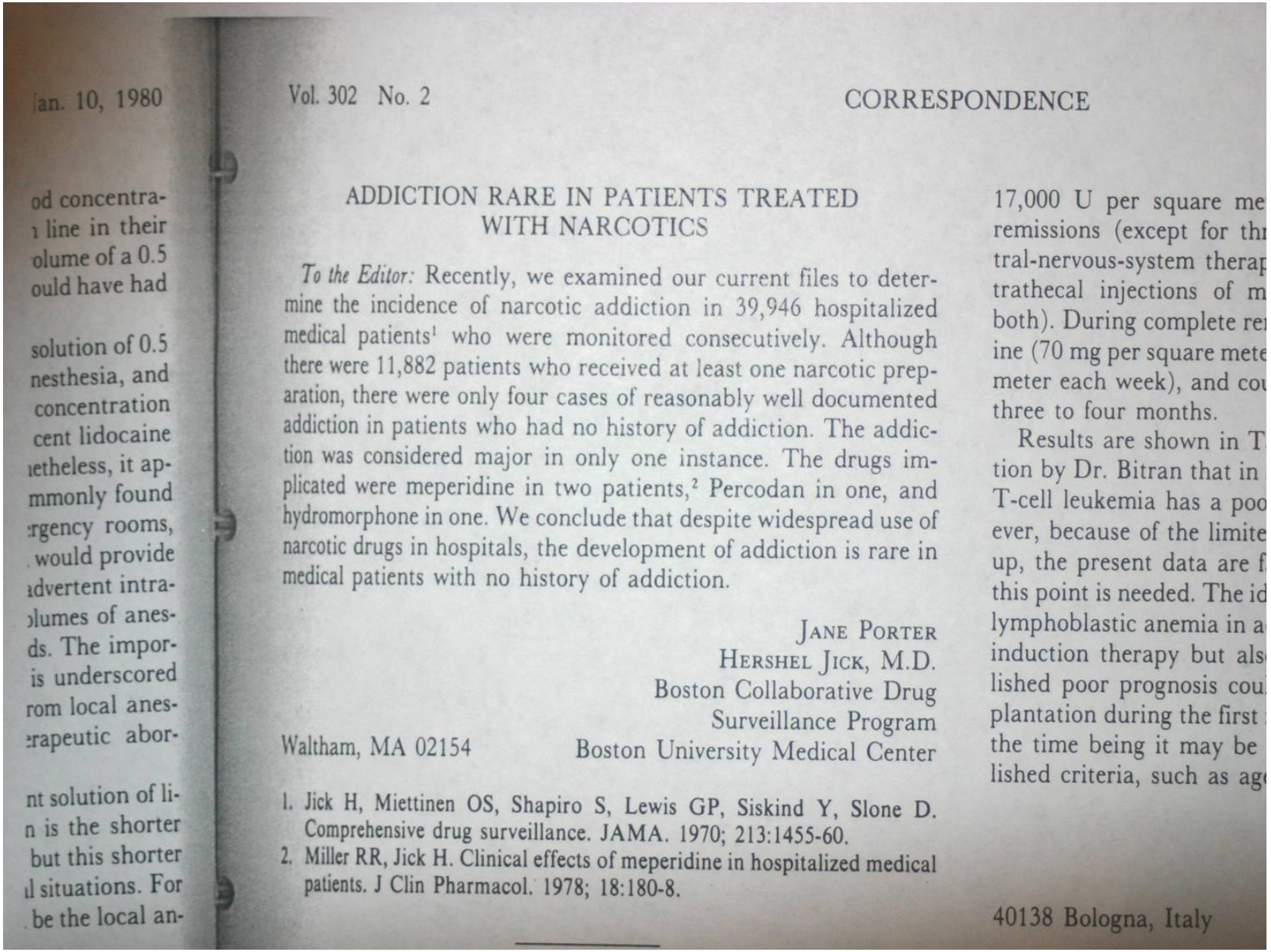
Joint Commission

on Accreditation of Healthcare Organizations

Pseudoscientific Evidence…

- "Only 4 documented cases of addiction among 11,882 patients treated with opioids."
- Cited over 690 times (Google scholar)
- PORTER, J., & JICK, H. (1980). Addiction rare in patients treated with narcotics. *New England Journal of Medicine.* 1980 Jan*; 302 (2):123.*

Pseudoscientific Evidence



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ADDICTION RARE IN PATIENTS TREATED WITH NARCOTICS

To the Editor: Recently, we examined our current files to determine the incidence of narcotic addiction in 39,946 hospitalized medical patients[1] who were monitored consecutively. Although there were 11,882 patients who received at least one narcotic preparation, there were only four cases of reasonably well documented addiction in patients who had no history of addiction. The addiction was considered major in only one instance. The drugs implicated were meperidine in two patients,[2] Percodan in one, and hydromorphone in one. We conclude that despite widespread use of narcotic drugs in hospitals, the development of addiction is rare in medical patients with no history of addiction.

JANE PORTER
HERSHEL JICK, M.D.
Boston Collaborative Drug Surveillance Program
Boston University Medical Center
Waltham, MA 02154

1. Jick H, Miettinen OS, Shapiro S, Lewis GP, Siskind Y, Slone D. Comprehensive drug surveillance. JAMA. 1970; 213:1455-60.
2. Miller RR, Jick H. Clinical effects of meperidine in hospitalized medical patients. J Clin Pharmacol. 1978; 18:180-8.

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40138 Bologna, Italy

Changes in medical practice

- Providers have less time with their patients
- They are more reliant on pharmaceuticals for their treatments
- Influenced by insurance formularies e.g. methadone
- So called best practices e.g. 5th vital sign

- Created Oxycontin in 1996
- Became the best selling opioid in 2001
- By 2010 it was making $3.1 Billion a year for the company
- The Sackler family is now one of the richest in the US

Senate Investigations 2007 and 2012 of Purdue Pharma

- Fined $600 million for misleading the public about the painkiller's risk of addiction 2007
- Investigating financial manipulation of the Joint Commission(JCAHO), Federation of State Medical Boards, and the American Pain Foundation.
- Dr. Scott Fishman (American Pain Foundation) and other pain experts are being investigated

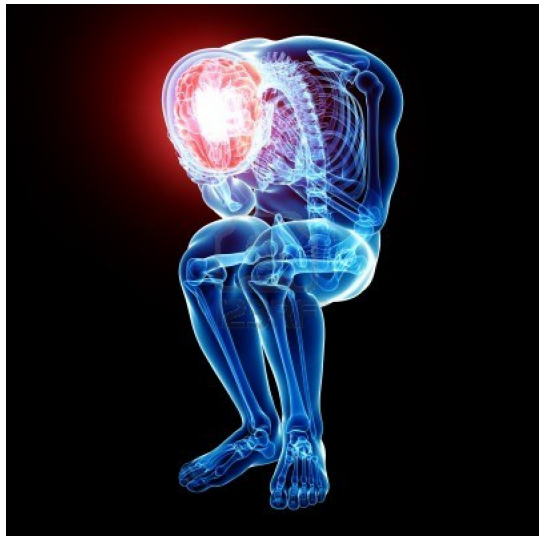
Why does it matter?

- We might be mistreating our patients
- We might be making things worse
- We might be contributing to an epidemic of opioid overdoses and long term morbidity
- We might get in trouble with our licensing board.

Our current paradigms for treating chronic pain are antiquated

We've been looking for pain in all the wrong places

Central Sensitization, Central Amplification, "Brain Pain"



- There is not good correlation between damage in the periphery (nociception) and the degree of perceived pain.
- We identify pain by the "source" of the pain: IBS, low back pain, tension headache, pelvic pain syndrome
- "Central" versus "peripheral" might make more sense
- Fibromyalgia Syndrome is the paradigm for this phenomenon

"Brain Pain"

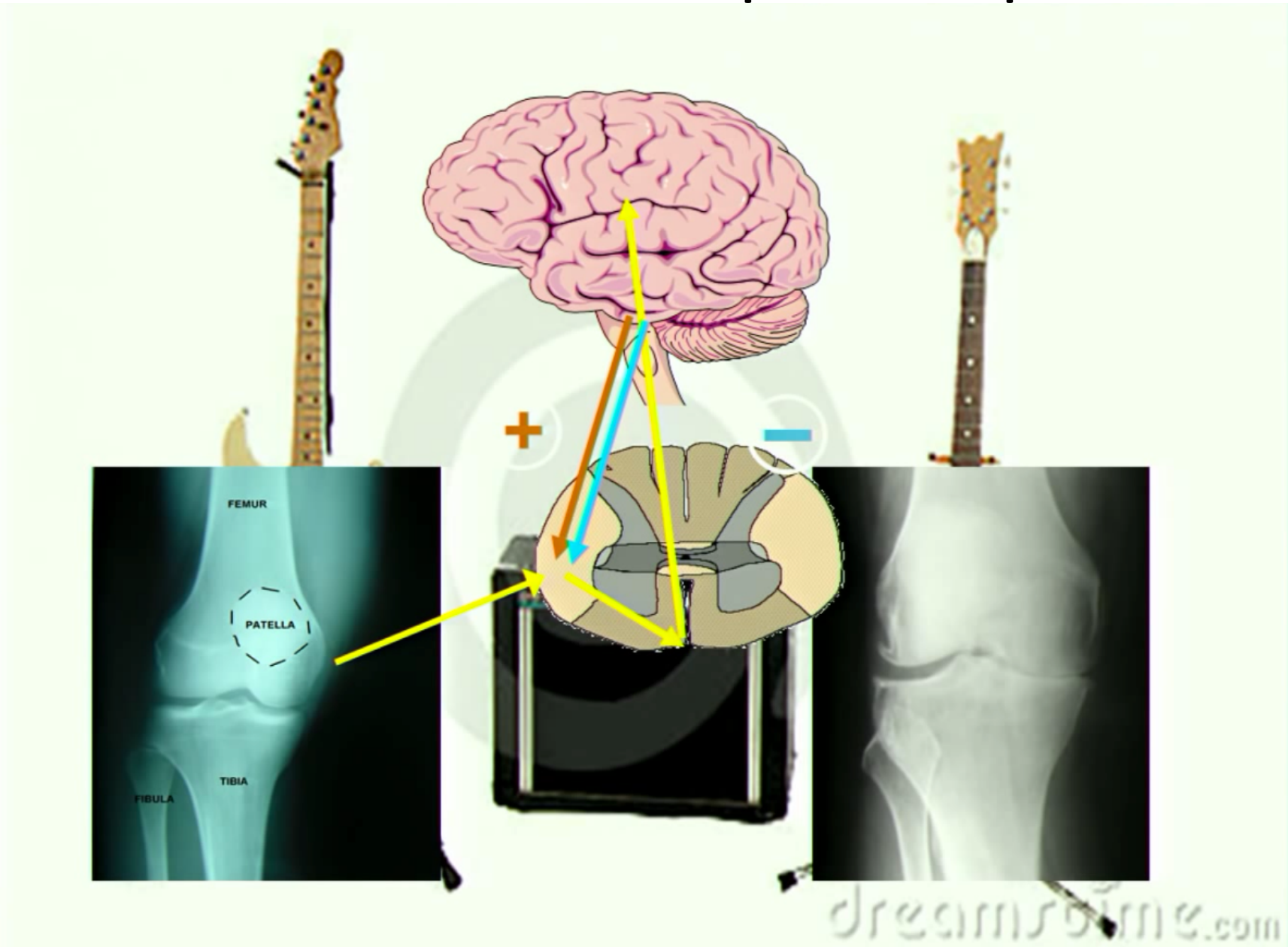
- Amplification of nerve impulses
  - Patients perceive pain at lower thresholds than controls
  - They produce high levels of endogenous endorphins. Therefore opioids are less effective.[3]
- Present in many chronic pain states[2]
- Evidence for a genetic component[1]

1. Best Pract Res Clin Rheumatol. 2015 Feb;29(1):20-8. doi: 10.1016/j.berh.2015.04.018. Epub 2015 May 1.**Update on the genetics of the fibromyalgia syndrome.** Ablin JN[1], Buskila D[2].

2.. Psychosom Med. 2014 Jan;76(1):2-11. doi: 10.1097/PSY.0000000000000010. Epub 2013 Dec 12. **Psychological trauma and functional somatic syndromes: a systematic review and meta-analysis.** Afari N[1], Ahumada SM, Wright LJ, Mostoufi S, Golnari G, Reis V, Cuneo JG.

3. mayo Clin Proc> 2011 Sep; 86(9): 907-911

“Brain Pain” = central pain amplification



Are we treating emotional pain when we think we are treating body pain?

- Childhood maltreatment, particularly sexual abuse, strongly predicts poor psychiatric and physical health outcomes in adulthood.[1]
- Individuals with PTSD are more likely to experience severe pain and to experience substance abuse[1,2]
- Severity of emotional childhood abuse is associated with decreased pain tolerance.[3,4]
- FMS is associated with childhood trauma across cultures[4]

1. Depression, risky behaviors, "over-utilization of J Clin Psychiatry. 2004;65 Suppl 12:10-5. **Relationships between childhood maltreatment, adult health and psychiatric outcomes, and medical utilization.** Arnow BA[1].

Psychiatry. 2015;78(3):277-87. doi: 10.1080/00332747.2015.1069659.

2. Relations Between Pain, PTSD Symptoms, and Substance Use in Veterans. Gros DF, Szafranski DD, Brady KT, Back SE.

3..Neuropsychiatr Dis Treat. 2015 Aug 19;11:2109-16. doi: 10.2147/NDT.S87703. eCollection 2015.

2.Childhood adversities and laboratory pain perception. Pieritz K[1], Rief W[1], Euteneuer F[1].

4. Clin Exp Rheumatol. 2015 Jan-Feb;33(1 Suppl 88):S86-92. Epub 2015 Mar 18. **Self-reported childhood maltreatment, lifelong traumatic events and mental disorders in fibromyalgia syndrome: a comparison of US and German outpatients.**Häuser W[1], Hoffmann EM[2], Wolfe F[3], Worthing AB[4], Stahl N[5], Rothenberg R[6], Walitt B[7].

Meta-Analysis of 23 studies: JAMA[1]

- There was a significant association between a history of sexual abuse and:
  - Functional GI disorders
  - nonspecific chronic pain
  - psychogenic seizures
  - chronic pelvic pain
  - Fibromyalgia, associated specifically with rape
- **CONCLUSION:** Evidence suggests a history of sexual abuse is associated with lifetime diagnosis of multiple somatic disorders.

1. JAMA. 2009 Aug 5;302(5):550-61. doi: 10.1001/jama.2009.1091. **Sexual abuse and lifetime diagnosis of somatic disorders: a systematic review and meta-analysis.** Paras ML[1], Murad MH, Chen LP, Goranson EN, Sattler AL, Colbenson KM, Elamin MB, Seime RJ, Prokop LJ, Zirakzadeh A.

CHRONIC PAIN TREATMENT
"COMPARATIVE EFFECTIVENESS"

Extrapolated averages of reduction in *Pain Intensity*

Opioids:	≤ 30%
Tricyclics/SNRIs:	30%
Anticonvulsants:	30%
Acupuncture:	≥ 10^{+}%
Cannabis:	10-30%
CBT/Mindfulness:	*≥ 30-50%*
Graded Exercise Therapy:	*variable*
Sleep restoration:	*≥ 40%*
Hypnosis, Manipulations, Yoga:	*"+ effect"*

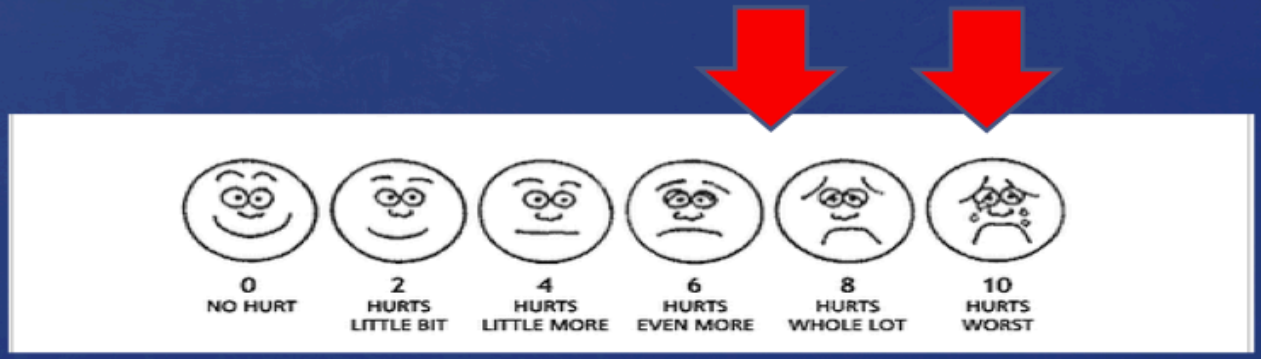
Turk, D. et al. Lancet 2011; Davies KA, et al. Rheum. 2008; Kroenke K. et al. Gen Hosp Psych. 2009; Morley S Pain 2011; Moore R, et al. Cochrane 2012; Elkins G, et al. Int J Clin Exp Hypnosis 2007.

UW Medicine
PAIN MEDICINE

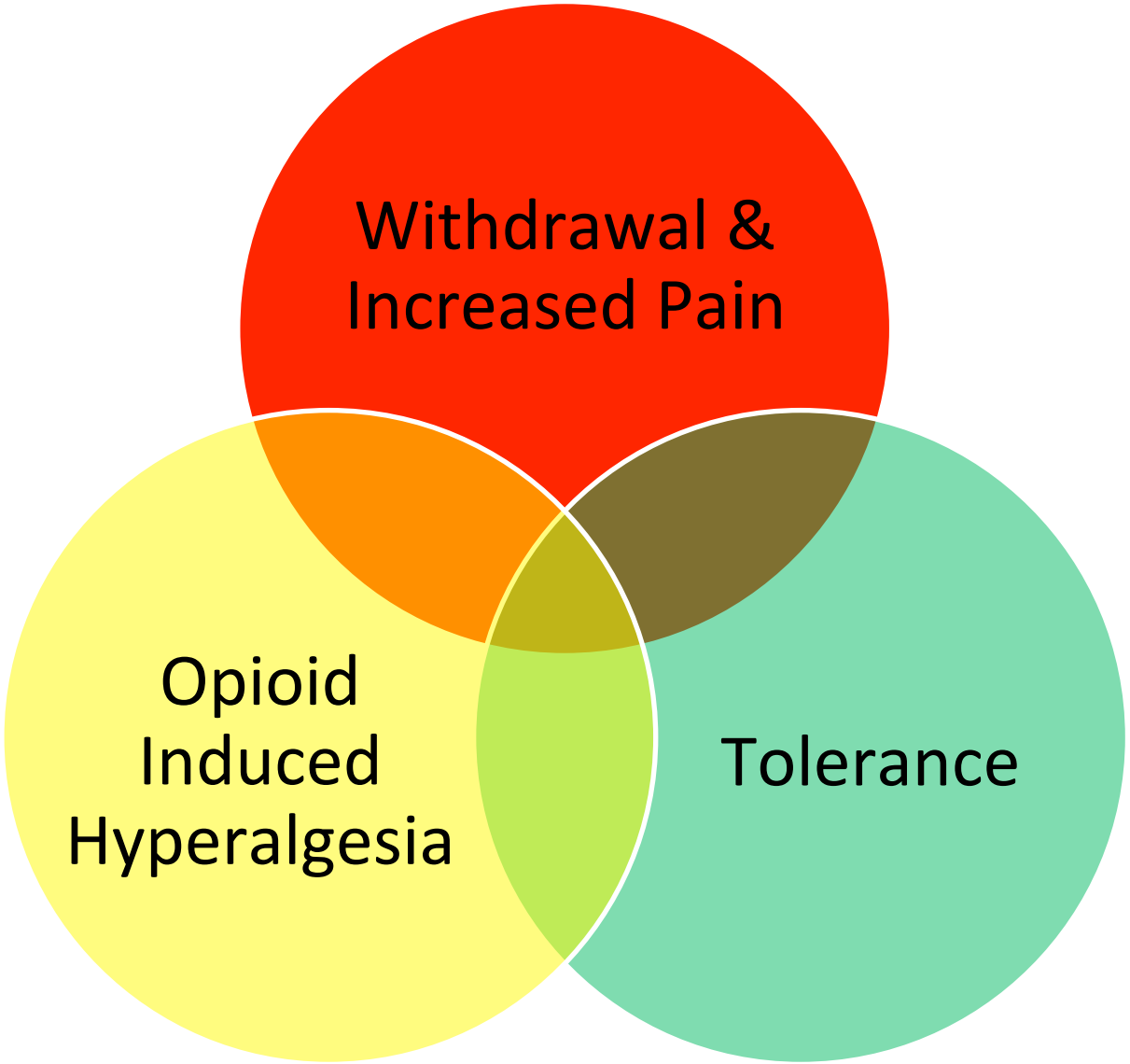
Expectation (75%) vs Reality (30%)

Patient Expectation

Medical Reality

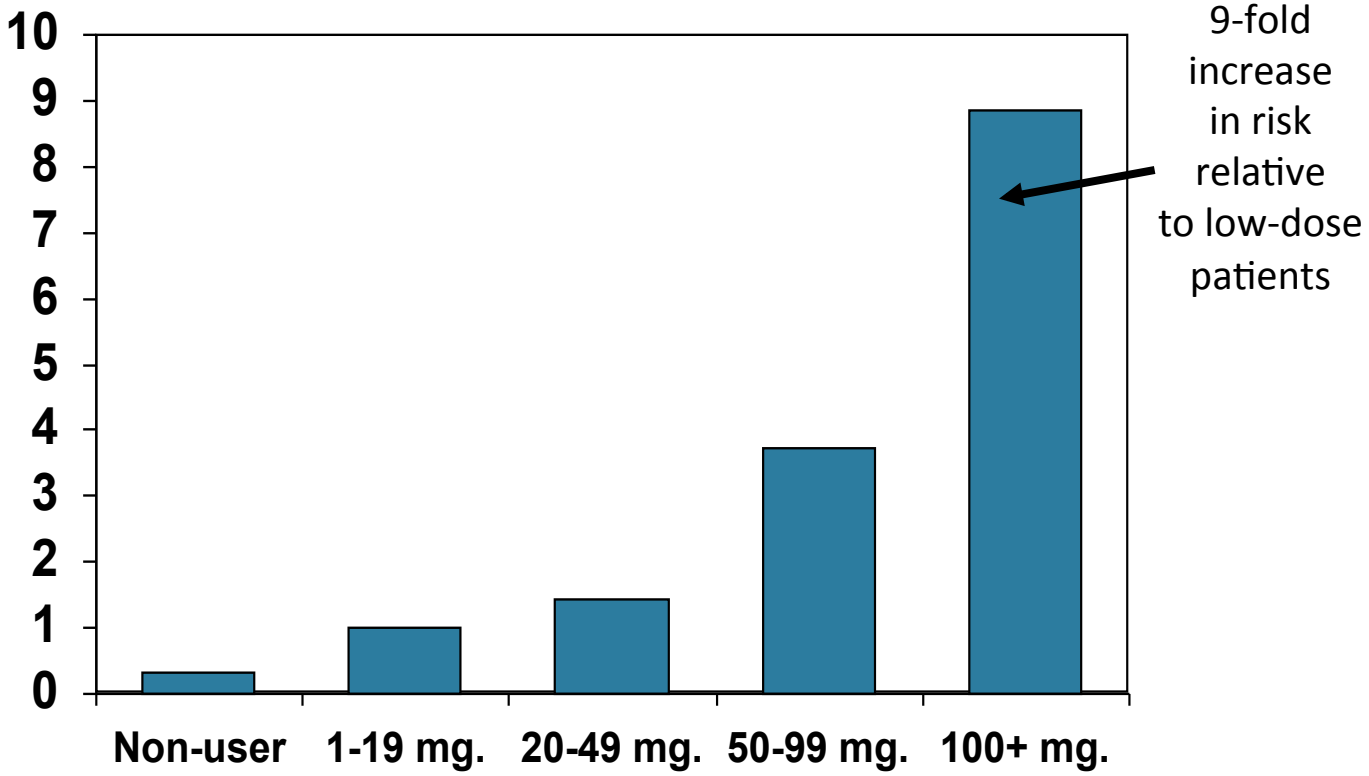


Dose Escalation with Opioid Use



As the dose increases, so does mortality

Mortality risk compared to Morphine Equivalent Dose (MED)[1]

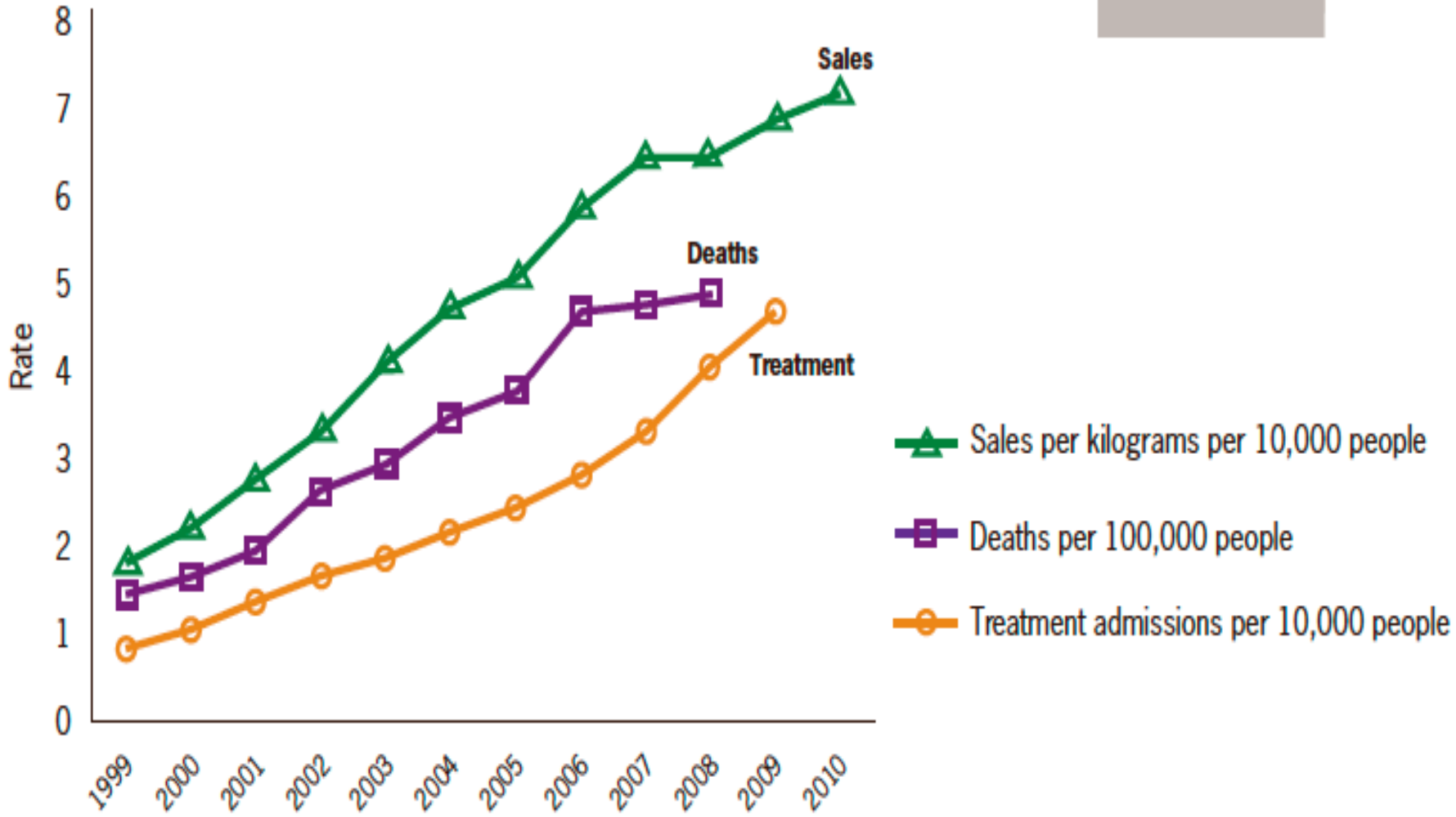


Combining Opioids plus Benzodiazepines increases the mortality 10 fold

1. Dunn et al., Annals Int Med, 2010

2. Pain Med. 2015 Sep 1. doi: 10.1111/pme.12907. [Epub ahead of print] **Cohort Study of the Impact of High-dose Opioid Analgesics on Overdose Mortality.** Dasgupta N et al.

Rates of prescription painkiller sales, deaths and substance abuse treatment admissions (1999-2010)



SOURCES: National Vital Statistics System, 1999-2008; Automation of Reports and Consolidated Orders System (ARCOS) of the Drug Enforcement Administration (DEA), 1999-2010; Treatment Episode Data Set, 1999-2009

Overdose deaths in US compared to motor vehicle accidents

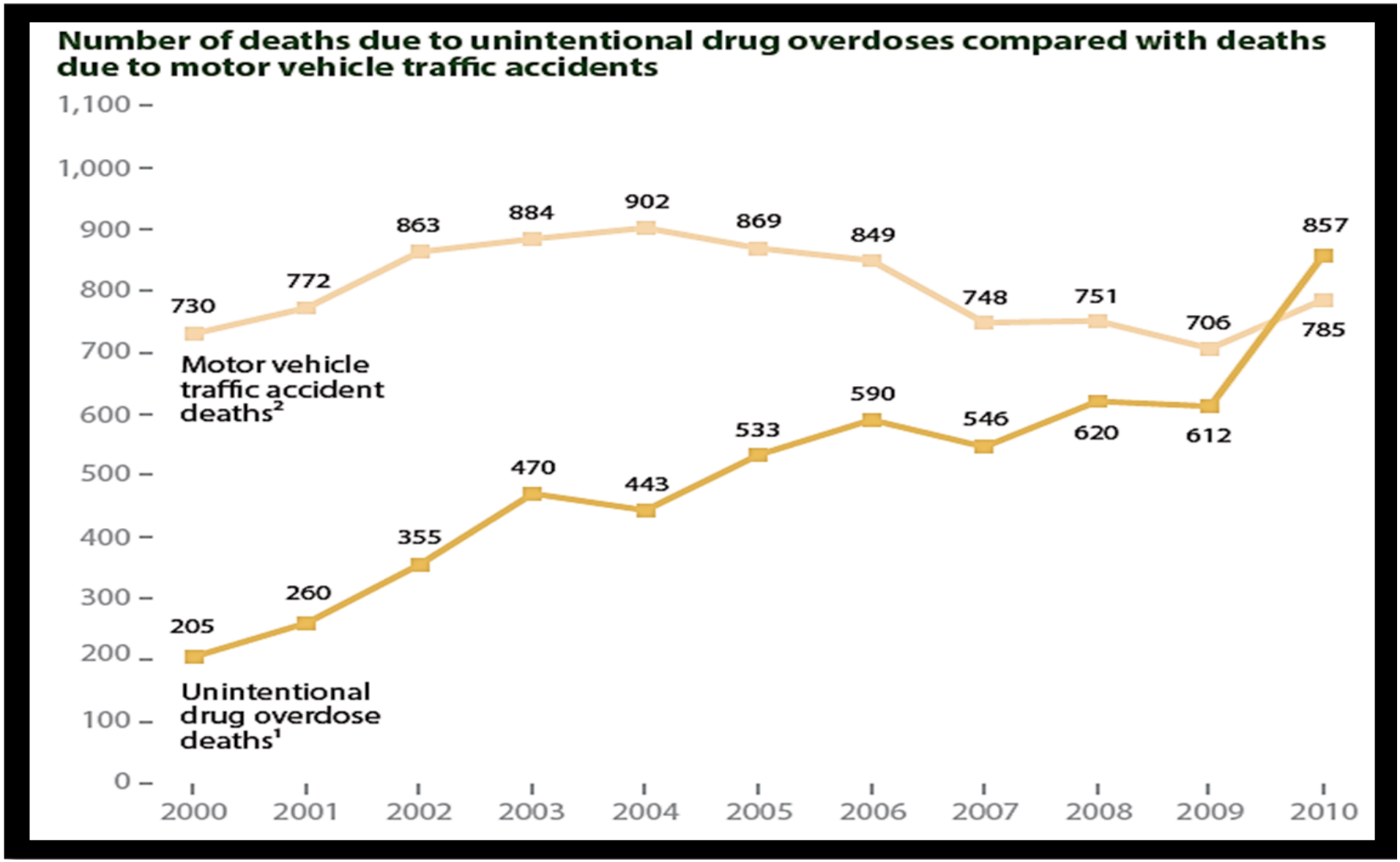
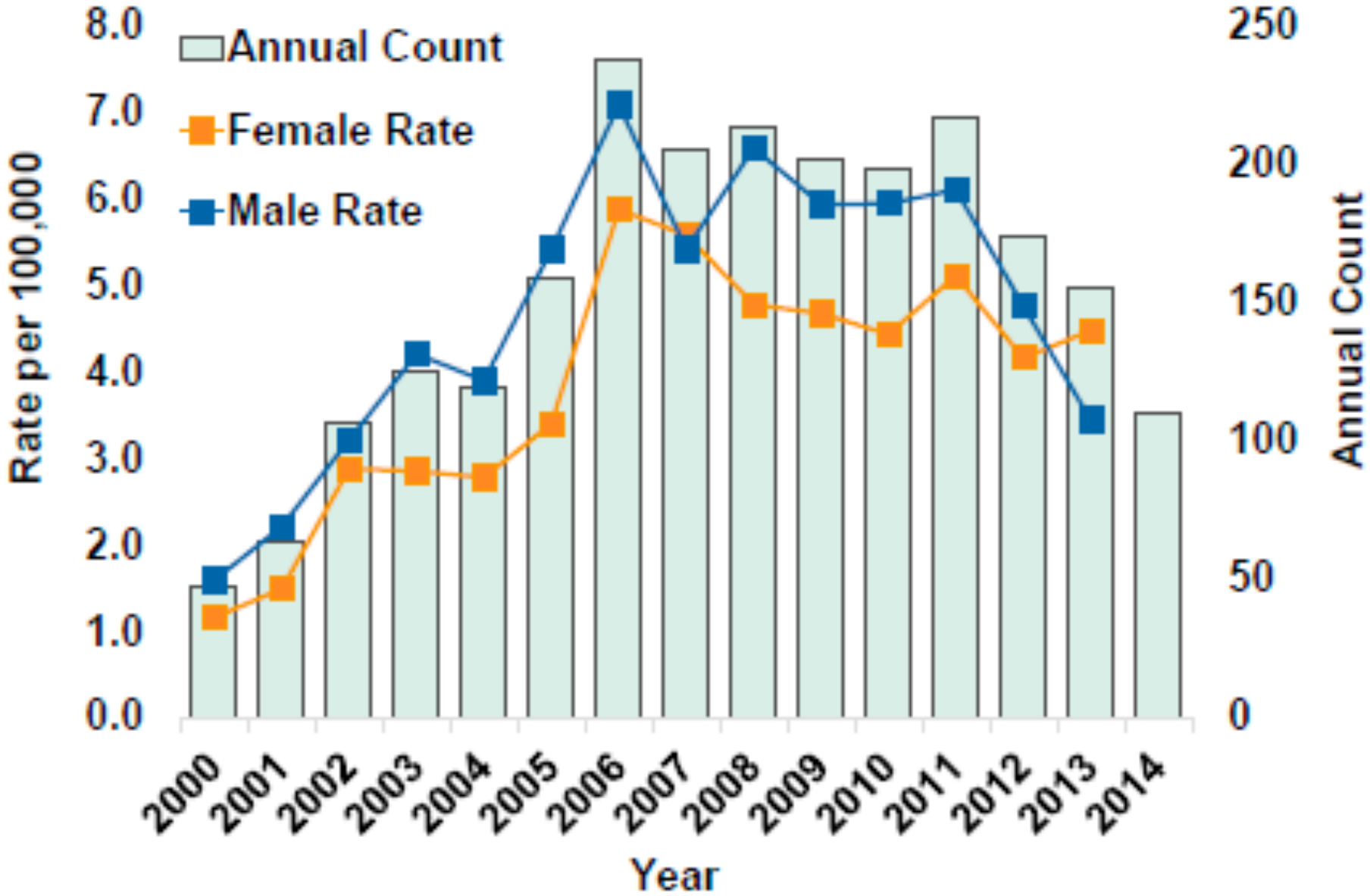


Figure 1. Unintentional and Undetermined Prescription Opioid Poisoning Deaths and Death Rates, Oregon, 2000–2013



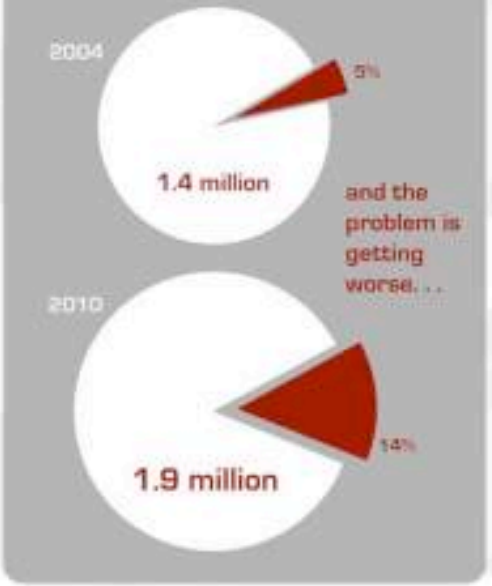
Abuse of Prescription Pain Medications Risks Heroin Use

In 2010 almost 1 in 20 adolescents and adults – 12 million people – used prescription pain medication when it was not prescribed for them or only for the feeling it caused[1]. While many believe these drugs are not dangerous because they can be prescribed by a doctor, abuse often leads to dependence. And eventually, for some, pain medication abuse leads to heroin.

1 IN 15

PEOPLE WHO TAKE NON MEDICAL PRESCRIPTION PAIN RELIEVERS WILL TRY HEROIN WITHIN 10 YEARS[2]

Number of People Who Abused or were Dependent on Pain Medications and Percentage of Them that Use Heroin[3]



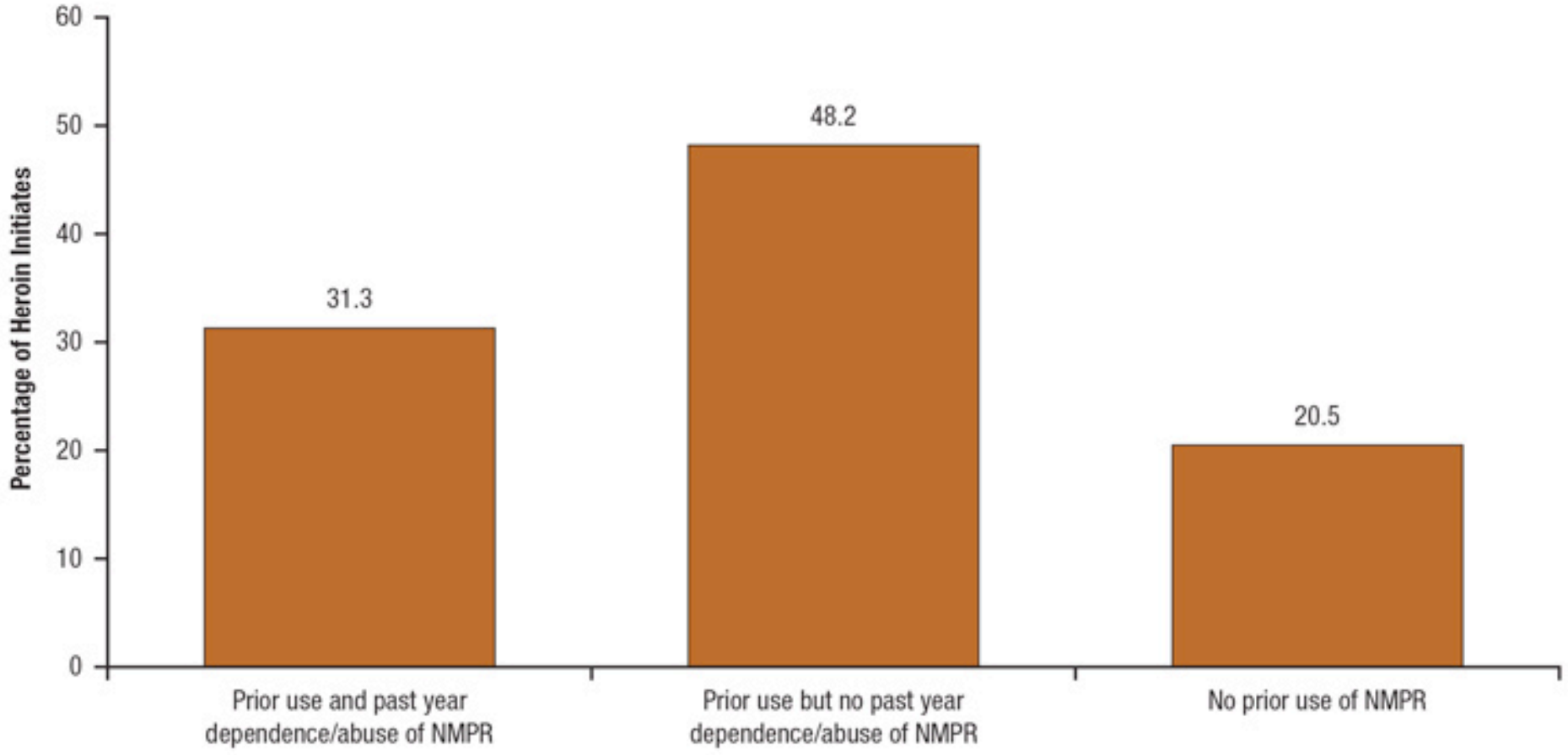
Heroin users are 3X as likely to be dependent

14% of non medical prescription pain reliever users are dependent

54% of heroin users are dependent[4]

Heroin Emergency Room Admissions Are Increasing[5]

4 out of 5 recent heroin users started with prescription opioids

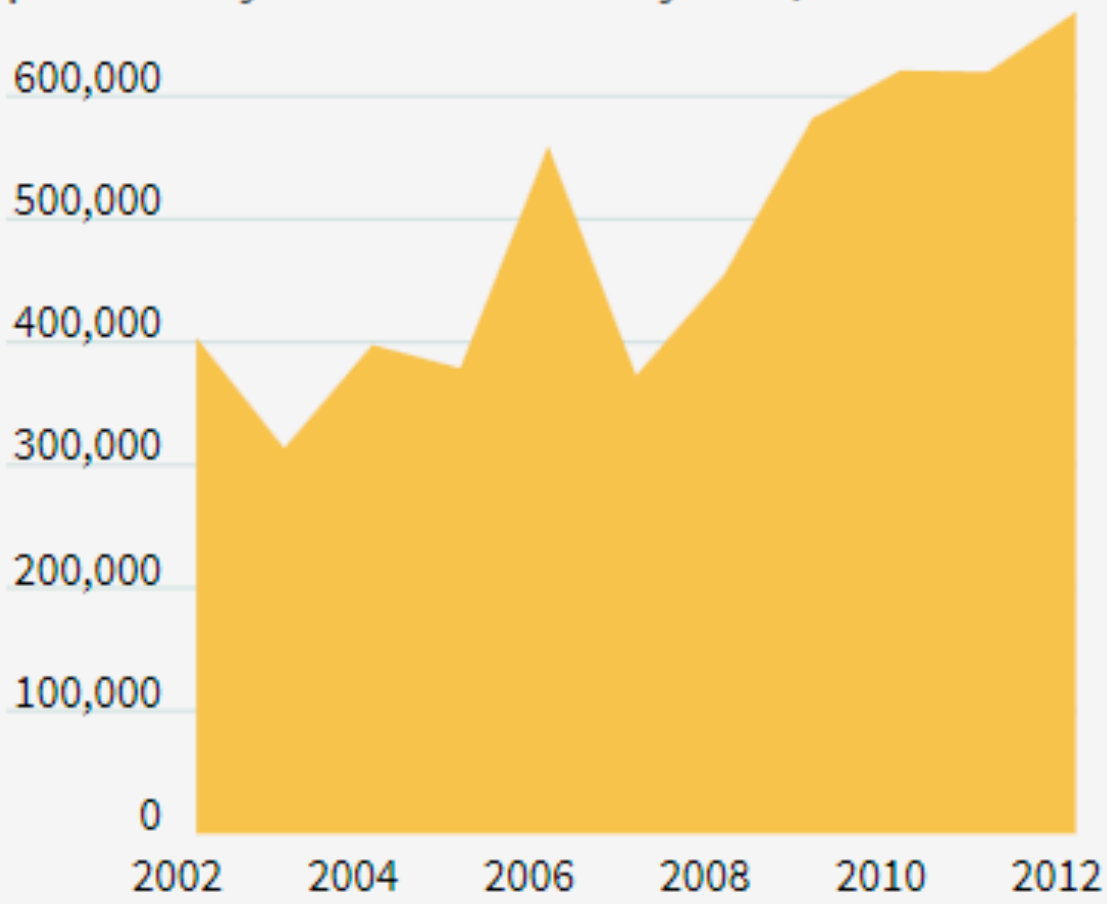


Note: Past year NMPR users are those who had initiated NMPR use prior to initiation of heroin use in the past 12 months. Past year NMPR users who initiated NMPR subsequent to initiation of heroin use in the past 12 months are not included. Dependence or abuse is based on definitions found in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV).

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2004, 2005-2010 (revised March 2012), and 2011.

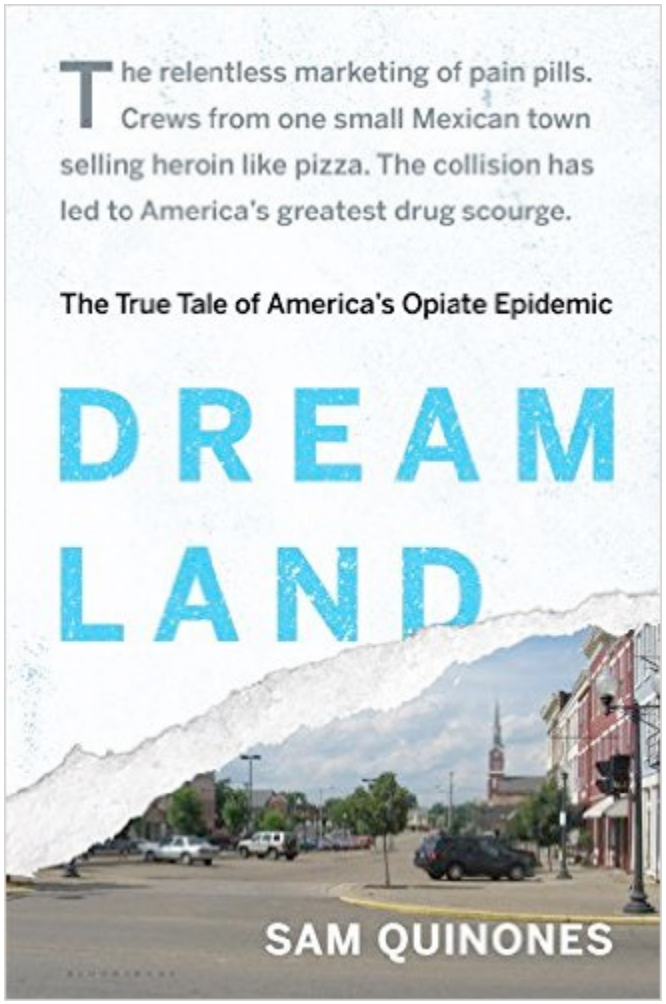
U.S. HEROIN USE BY YEAR

Between 2002 and 2012, the number of people who reported using heroin within the previous year increased by 265,000.



Source: Substance Abuse and Mental Health Services Administration

Community “book club”



October 21st 6-8 PM Carpenter Room, 3 Rivers Hospital

The paradigm shift

Thank You

- "When I was in medical school, one thing I was told, was completely wrong. The one thing I was told was, if you give opiates to a patient who's in pain, they will not get addicted. Completely wrong. Completely wrong. But a generation of doctors, a generation of us grew up being trained that these drugs aren't risky. In fact, they are risky."

- Dr. Thomas Frieden, Centers for Disease Control and Prevention.

Shifts are **Driven** by Change Agents

- Laura Heesacker, MSW, LCSW
- Behavioral Health Innovation Specialist
- Heesackerl@careoregon.org

- Jackson Care Connect October 14, 2015

Jackson Care Connect

Help!

"This is out of control… something needs to change!"

2007-FQHC Request for help

Problem

Chronic Opioid Therapy is **not** as **safe** or **effective** as we once believed.

+

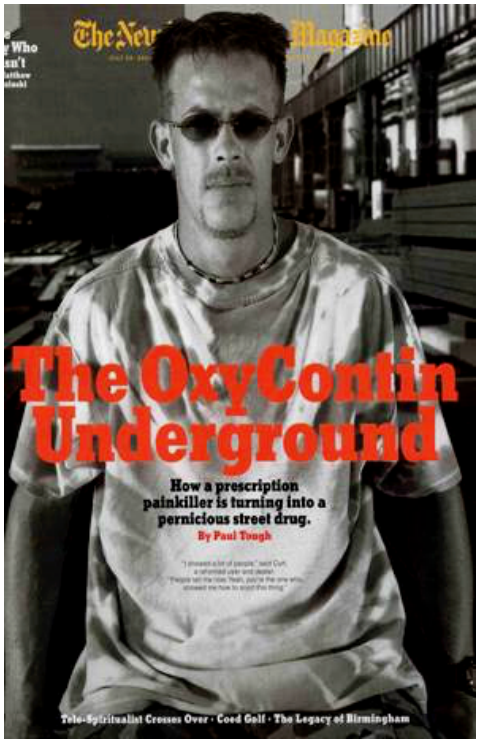
It is highly challenging to do something **different** for both providers and patients

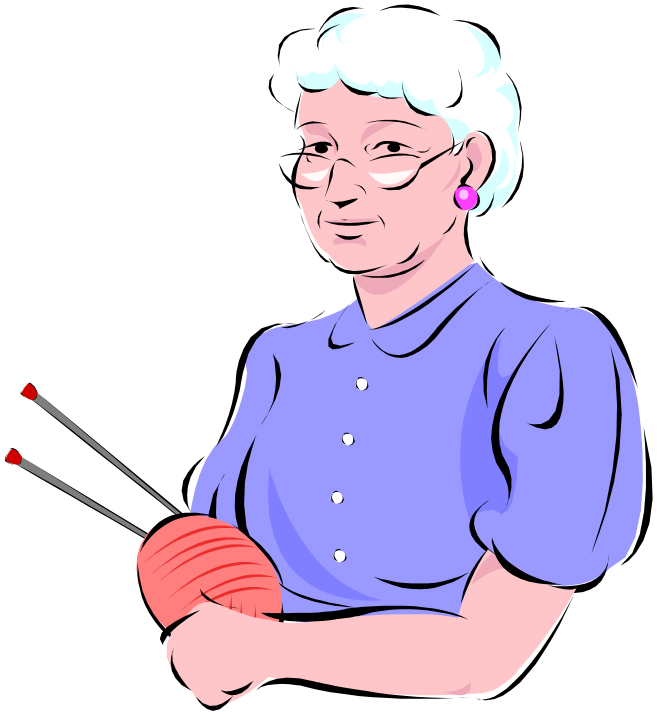
It’s a Parallel Process

- It’s hard to do something different!

Warning

It is tempting to build a program to manage the “opioid epidemic”





Fire the Molecule Not the Patient!

This is **not** a sting operation!

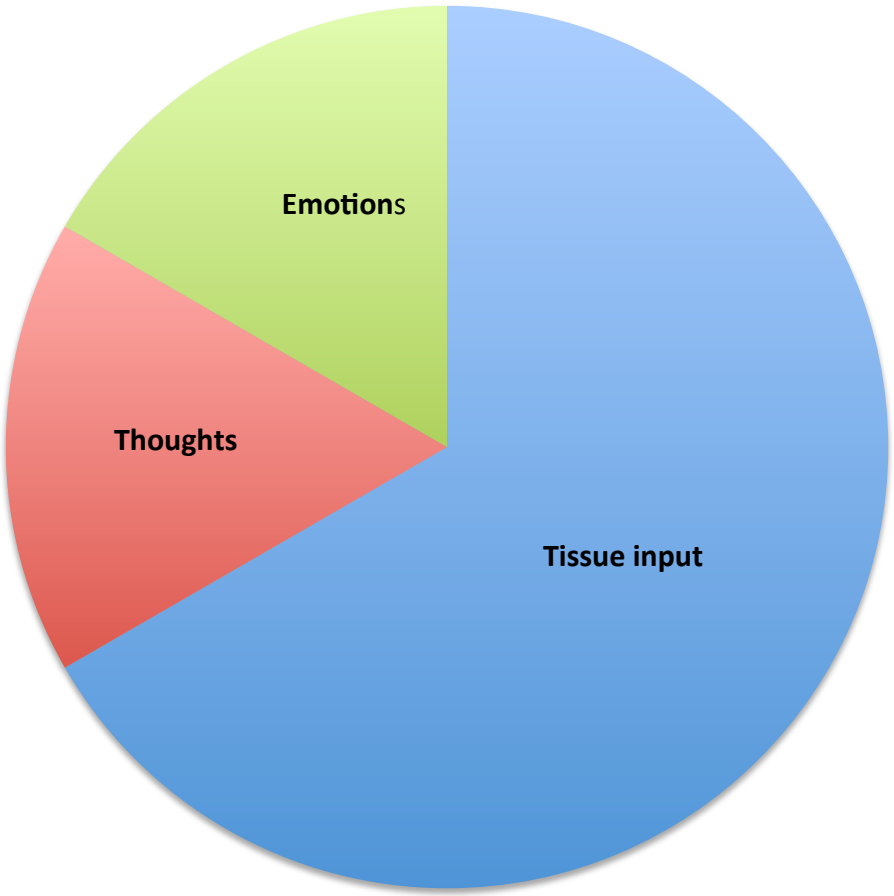
It **is** possible to make changes without firing patients

Considerations to help the "Shift Happen"

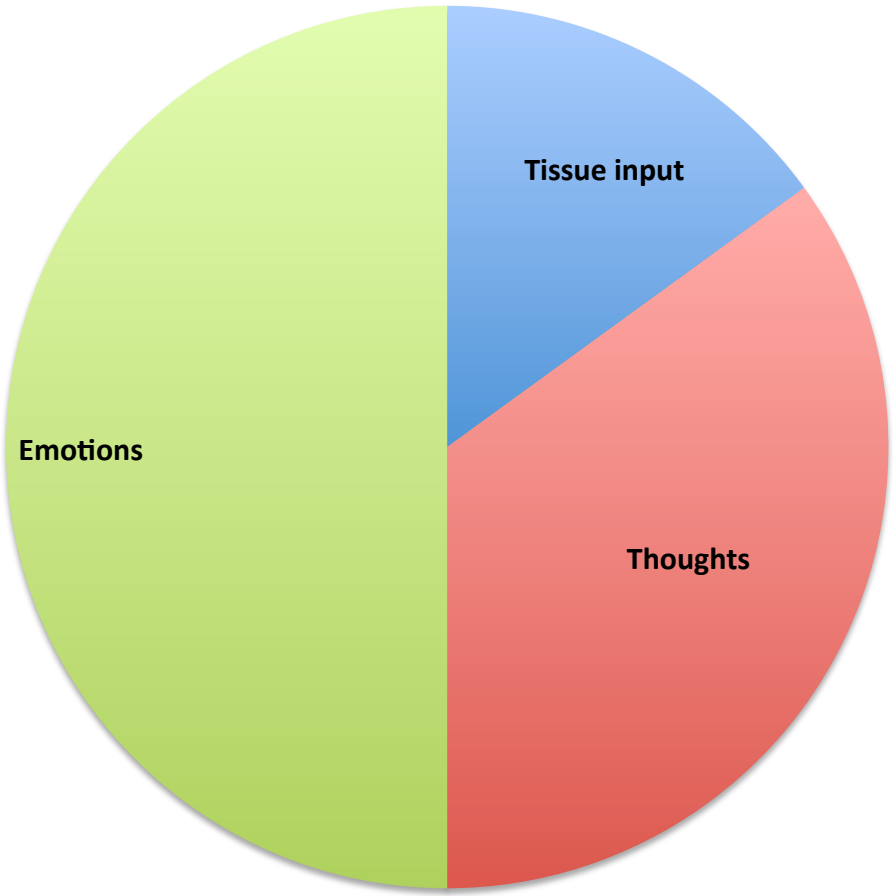
1. Understand the Shift from Acute to Chronic Pain
2. Redefine Chronic Pain
3. Be Grounded in Values
4. Blind Spots and Triggers
5. Reframe Resistance
6. Some are More Vulnerable to the Risk
7. What you Believe Matters!

#1-Acute to Chronic

Acute Pain



Chronic Pain



Most of us know that…

Emotions play a big part in **Living** with Complex Chronic Pain

It's a Parallel Process

- It's highly emotional!

But Guess What…

EMOTIONS play a big part in **Treating** Complex Chronic Pain

#2. Redefining Chronic Pain

A new way to think of **Chronic** Pain

Pain

+

the unwillingness to have it.

A Treatment Model

Improved willingness to have the experience of pain

+

More frequent engagement in valued activity over the longer term

Should =

Improved Mood and Functioning

Progress

Expectation (75%) vs Reality (30%)

Patient Expectation

Medical Reality

*Am J Emerg Med 2004, July 22(4) 286-8

We started asking…

How much relief are you expecting from your pain medications?

Rate from 0 – 100%

80-90%

How much relief are you actually experiencing from your pain medications?

Rate from 0 – 100%

30-40%

CHRONIC PAIN TREATMENT
"COMPARING" EFFECTIVENESS

Extrapolated averages of reduction in *Pain Intensity*

Opioids:	≤ 30%
Tricyclics/SNRIs:	30%
Anticonvulsants:	30%
Acupuncture:	≥ 10^{+}%
Cannabis:	?10-30%
CBT/Mindfulness:	*≥ 30-50%*
Graded Exercise Therapy:	*variable*
Sleep restoration:	*≥ 40%*
Hypnosis, Manipulations, Yoga:	*"+ effect"*

Turk, D. et al. Lancet 2011; Davies KA, et al. Rheum. 2008; Kroenke K. et al. Gen Hosp Psych. 2009; Morley S Pain 2011; Moore R, et al. Cochrane 2012; Elkins G, et al. Int J Clin Exp Hypnosis 2007.

UW Medicine
PAIN MEDICINE

It’s a Parallel Process

- Do you truly believe the science behind the shift?

#3. Be Grounded in Values

A Treatment Model

Improved willingness to have the experience of pain

+

More frequent engagement in valued activity over the longer term

Should =

Improved Mood and Functioning

Progress

We started asking…

(we were relentless!)

What is important and meaningful in your life?

What small step will you commit to today, to move closer to what is important and meaningful in your life?

It's a Parallel Process

- Getting Clear about Values helps providers/clinics/ communities too!

Shift from external to internal Values

External=value belongs to someone else (clinic, CCO, Medical Board)

Internal=value belongs to you:

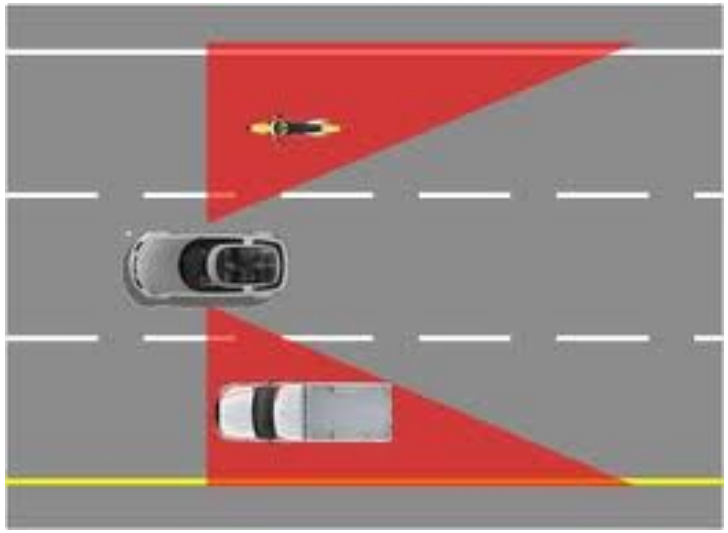
To Do No Harm

Practice Best Practice Compassionate Care

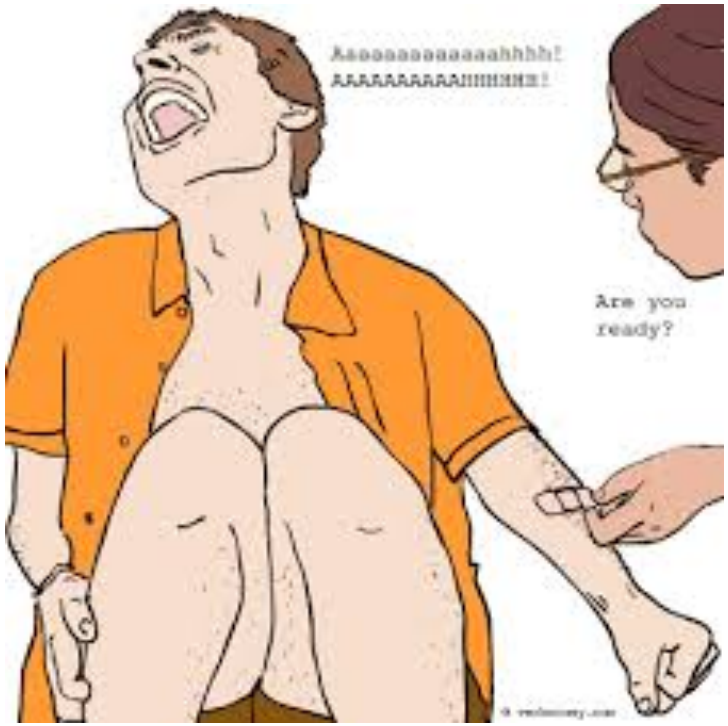
To Align with your Colleagues, State, etc.

The shift from the **Difficult** to the **Safety** Conversation

#4. Blind Spots and Triggers



This shift triggers our patients



Pain is Pain is Pain-
It's All Legitimate!

The Research:

- Childhood maltreatment, particularly sexual abuse, strongly predicts poor psychiatric and physical health outcomes in adulthood.[1]
- Individuals with PTSD are more likely to experience severe pain and to experience substance abuse[1,2]
- Severity of emotional childhood abuse is associated with decreased pain tolerance.[3,4]
- FMS is associated with childhood trauma across cultures[4]

Meta-Analysis of 23 studies: JAMA[1]

- There was a significant association between a history of sexual abuse and:
  - Functional GI disorders
  - nonspecific chronic pain
  - psychogenic seizures
  - chronic pelvic pain
  - Fibromyalgia, associated specifically with rape
- **CONCLUSION:** Evidence suggests a history of sexual abuse is associated with lifetime diagnosis of multiple somatic disorders.

Establishing a Foundation of Safety and Validation

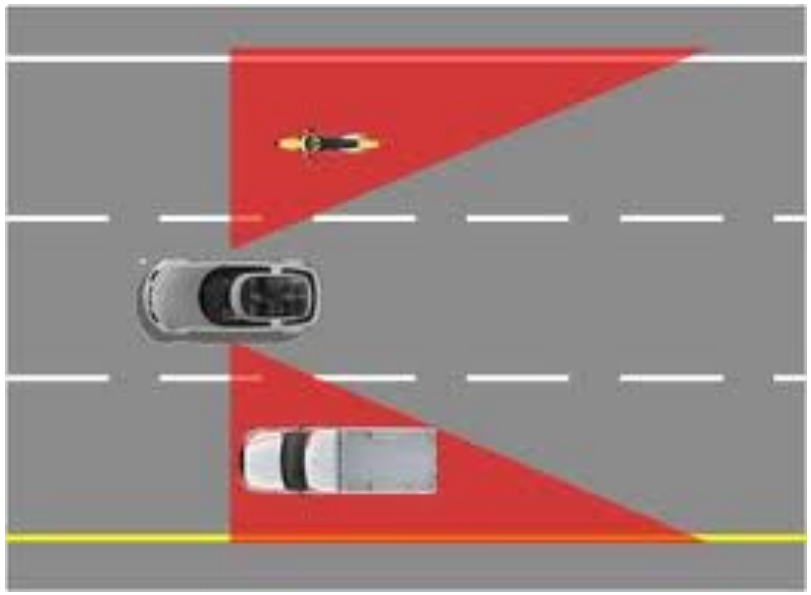
- “You are safe”
- “I will stay by your side as we make changes”
- “Which Rx do you want to tackle first?”
- “I am watching out for your safety”
- “Your safety is important to me”
- “I believe that you are in pain”

It’s a Parallel Process

- We all have blind spots and triggers!

Blind Spots

- Which patients trigger you? (If you don't know ask your staff!)
- With whom are you more lenient or ready to cut off or "fire" abruptly?
- Are you prescribing for SLS (Sad Life Syndrome)?



“Are you threatening me?”

Negotiations:

- First Line-“I won’t be able to work”
- Second Line-”You promised you wouldn’t (reduce, remove, etc.) my medications!”
- Desperate Threats-”I will have to get my medications from the streets, is that what you want?”

5. Reframe Resistance

What we know about Resistance?

- Resistance occurs when we mistakenly assume that a person is ready to change
- People usually have good reasons for avoiding change
- Change can feel fearful

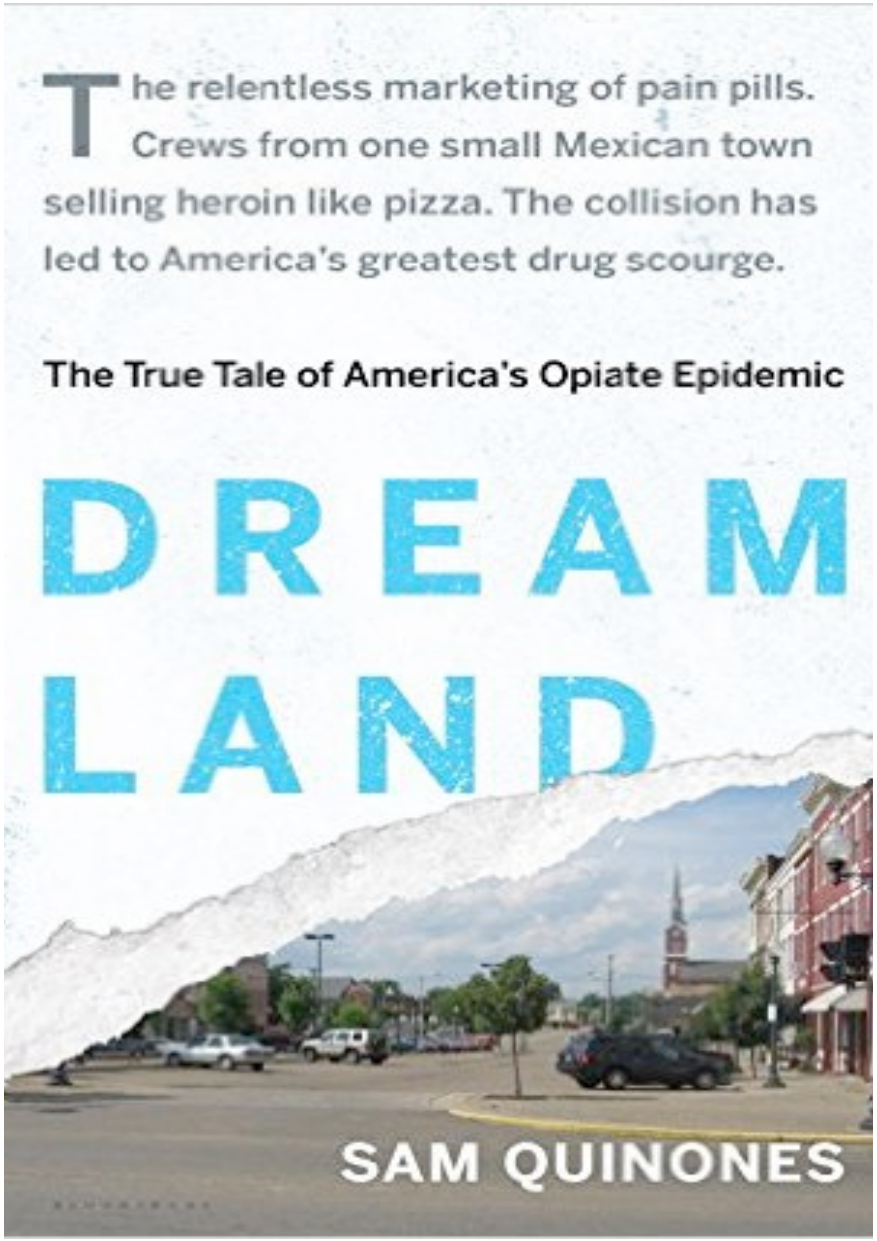
- Ambivalence and Fear can look like Resistance
- Ambivalence is feeling two different ways about the same thing
- “I want this change and I don’t want this change”

It’s a Parallel Process

- Ambivalence shows up in everyone!

You know you're really in trouble when you've had the wool pulled over your eyes AND the rug pulled out from under your feet!"

Linda Pondexter

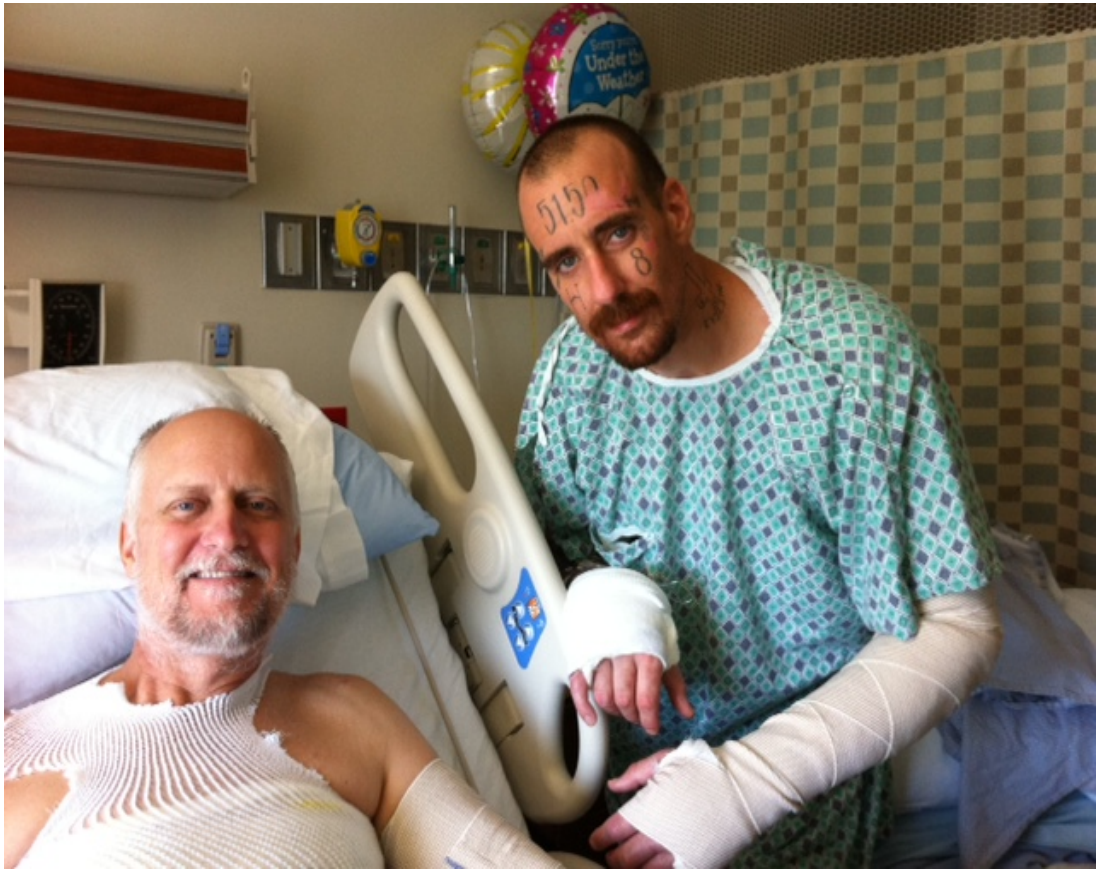


"Porter and Jick is amazing for the absence of information in it," Katz said. "{But} that paragraph gives <u>you relief from your inner conflict</u>. It's like drinking from the breast. All of the sudden the comfort washes over you"

Interview with Nathaniel Katz, Pain Specialist
Boston

#6. Some are more vulnerable to the risk

(The Risk Belongs to the Drug)



The Risk-Benefit Framework

NOT…

- **Is the patient good or bad?**
- **Does the patient deserve opioids?**
- **Should this patient be punished or rewarded?**
- **Should I trust the patient?**

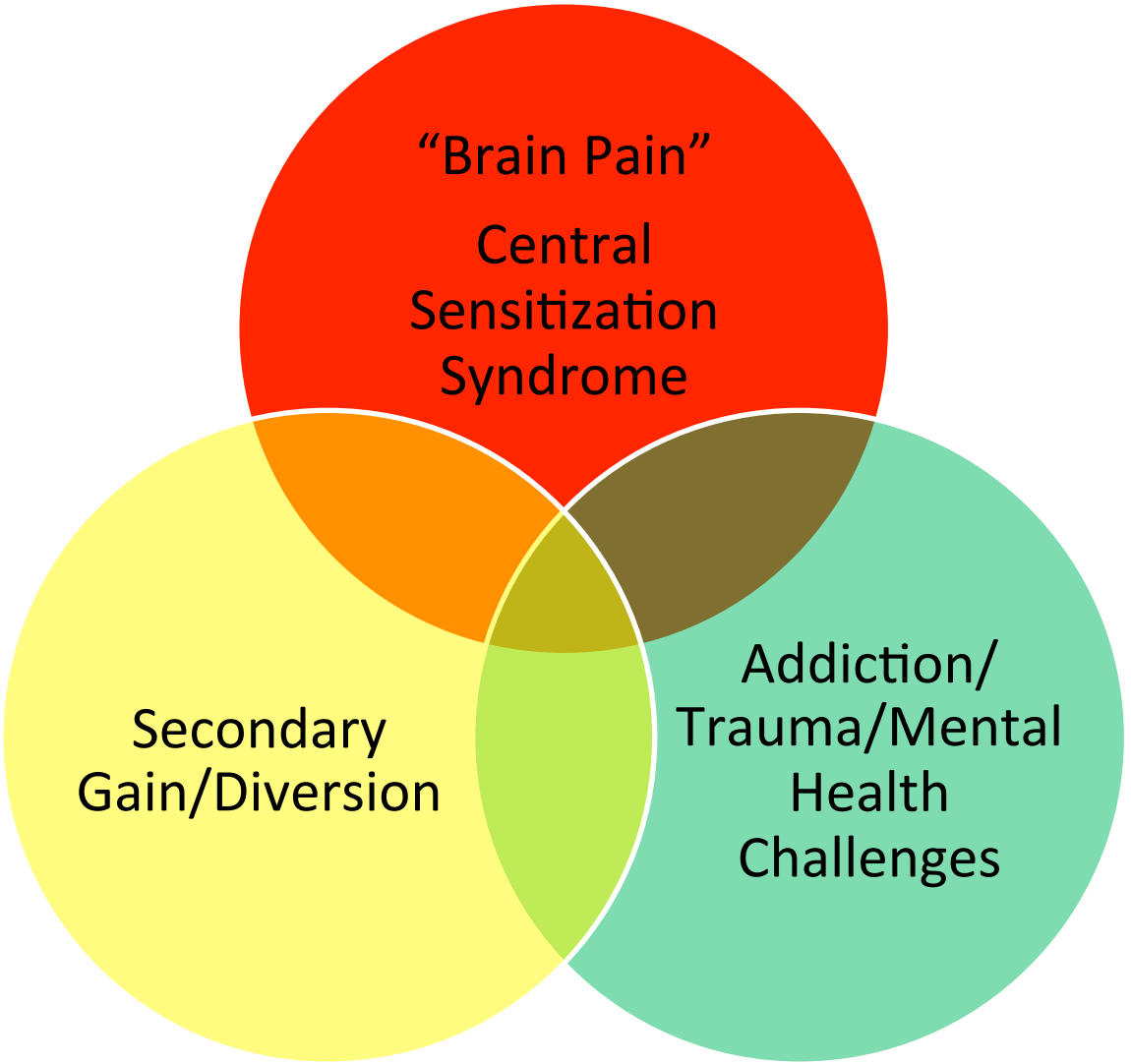
RATHER…

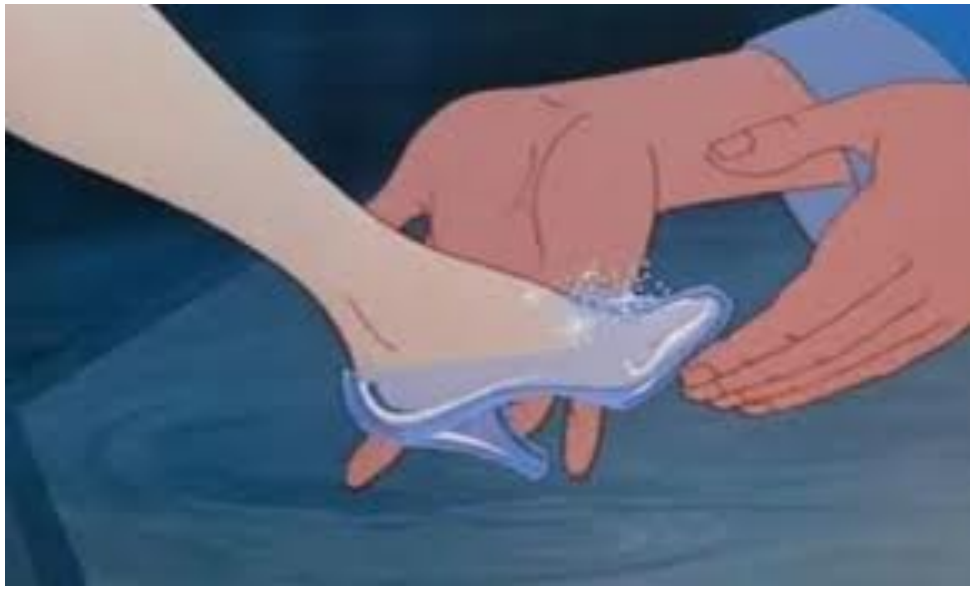
Do the benefits of opioid treatment outweigh the untoward effects and risks for this patient (or society)?

Judge the opioid *treatment* – NOT the patient

Nicolaidis C. Pain Med. 2011 Jun;12(6):890-7.

Buckets of Vulnerability



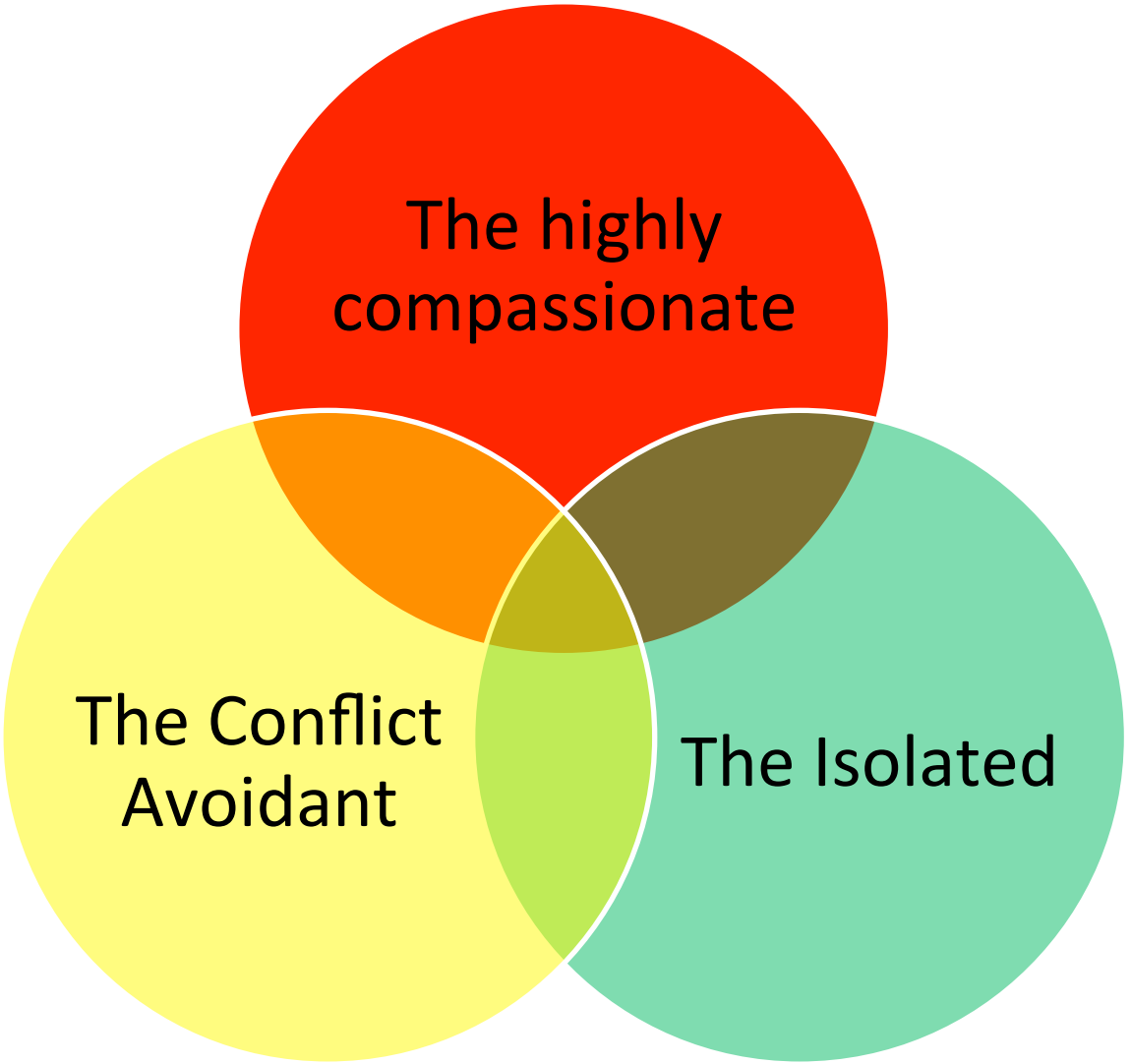


- Treatment needs to be about **Safety, best fit,** and **best practice guidelines**

It's a Parallel Process

- Patients aren't the only one who are vulnerable!

Buckets of Vulnerability



#7. What you Believe Matters!

When you change the way you look at things… the things you look at change.

The Late Dr. Wayne Dyer

It’s a Parallel Process

- We are all in this together, moving down this very bumpy road AND there is light…