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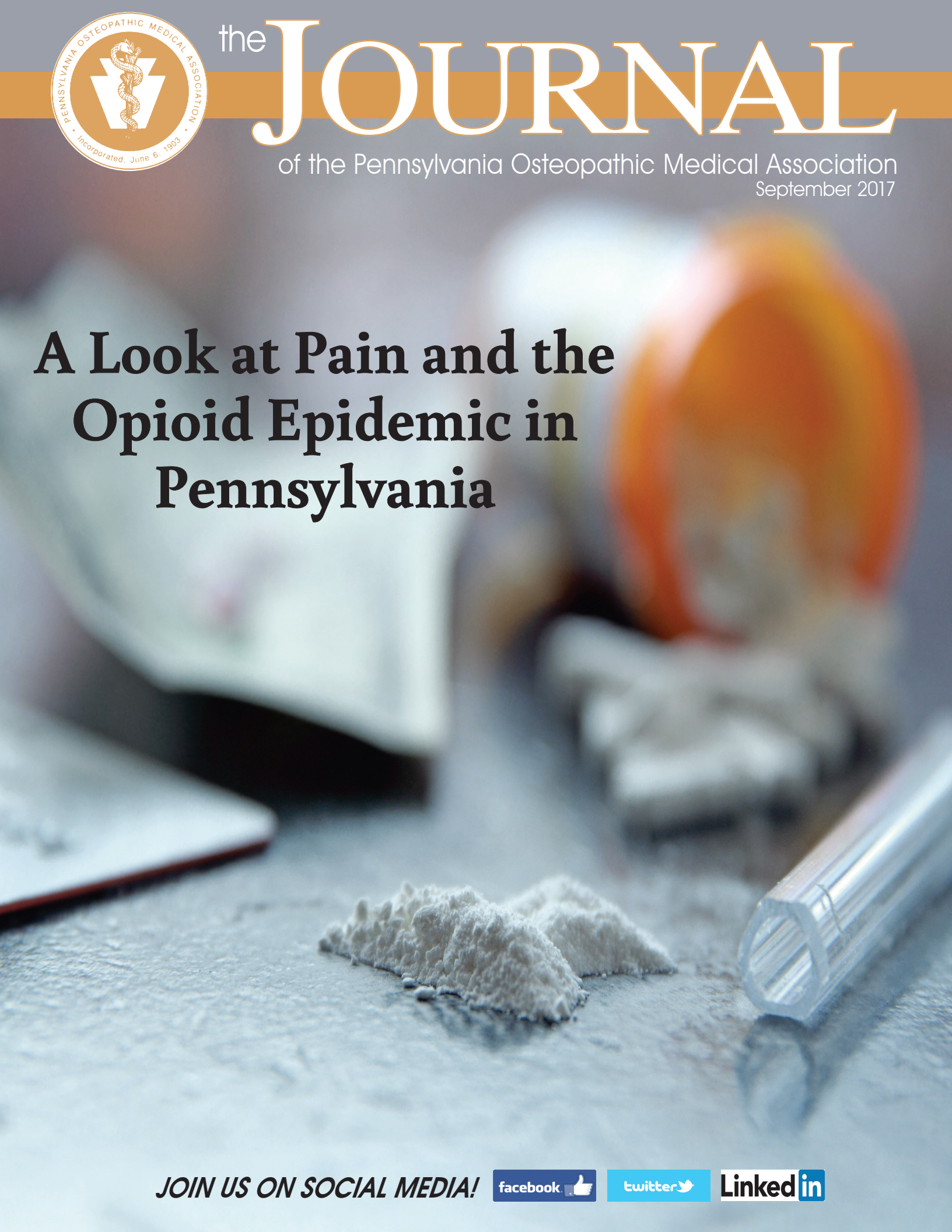
September 2017

A Look at Pain and the Opioid Epidemic in Pennsylvania



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FROM THE EDITOR'S DESK

Mark B. Abraham, DO, JD

Mark B. Abraham, DO, JD
Editor-in-Chief

As we continue the health care debate in the United States, one particular conversation continues to stand out and grow. Whatever it is, a(n) problem, issue, concern, crisis, epidemic, (insert your own word based upon your level of concern and view of severity), it is not going away. As such, this issue of the Journal is dedicated to discussing the opioid epidemic.

You will read the perspectives from the Deans of PCOM and LECOM and how they are addressing the issue as their physicians not only treat patients in their health settings, but also train the next generation of physicians. Our students, the future of medicine, have voiced their thoughts about about treating patients with empathy and dignity, acknowledging that treatment is possible and we as physicians are part of the solution. A palliative medicine physician shares her thoughts on the treatment of pain and how to best help patients suffering from chronic pain in the current opioid-sensitive environment. As you may expect, there are many references in her piece highlighting the benefits of osteopathic manipulative medicine.

We also have a guest submission from The Honorable Josh Shapiro, Attorney General of the Commonwealth of Pennsylvania. Attorney General Shapiro, whose father is an osteopathic pediatrician in Montgomery County, shares his thoughts on how to address the issue from multiple angles, including through involving our governmental leaders, whether prosecutors, legislators or executive leaders.

The opioid epidemic is so wide reaching that unfortunately, most of us know a colleague, have a friend, former classmate or possibly family member who has been affected by the opioid problem. Even though so many people are touched by this issue, the conversation is still lacking. When I taught the medical jurisprudence course at UMDNJ-SOM (now Rowan University-SOM) in Stratford, New Jersey, my students learned from DEA Diversion agents, lawyers from the New Jersey State Attorney General's Office, and a physician who had a substance abuse problem and ultimately spent a short time in prison as a result. That physician did beat the problem and is now practicing successfully. When that physician spoke to the class, the students put away laptops and such devices. There were no side conversations. They were all paying close attention. None were asked to do so. They realized the importance of what was being taught to them by that doctor at that very moment. Did his story mean there would always be a happy ending? Of course not. But, it was the start of the conversation for them. Finding a way to open the dialogue is a key component to continuing to raise awareness and hopefully, ultimately, put an end to the issue.

Looking forward, our December/Winter issue will focus on the future of medicine and the role professional organizations, especially POMA, will play in helping physicians and patients navigate the ever-changing world of medicine and health care. Just as we have a submission this time from the Attorney General and a palliative care physician, I hope that we will have other submissions from our members. I invite you to submit an article. If you know someone, perhaps a lawmaker, person in public policy, public health or even an executive in a health-related organization, encourage the person to write a piece. Ones appropriate for submission will ultimately be published. And while I cannot guarantee every manuscript will be printed in a specific edition, it is always better to have more from which to choose than less.

Similarly, even though this issue is about opioids, it is the **beginning** of the discussion and not the end. I hope that you will read this issue and that we will then hear from you. Share your thoughts and comments whether it concerns your views, thoughts on opioids and the current environment, or just your opinion of the Journal. I welcome the "Letter to the Editor."

I hope you have all enjoyed your summer.

Collegially,
Mark B. Abraham, DO, JD

OUT OF MY MIND

Samuel J. Garloff, DO

Samuel J. Garloff, DO

"The further a society drifts from the truth, the more it will hate those who speak it."
— George Orwell

The joy plant. Over 5,000 years ago, the Sumerians in lower Mesopotamia cultivated opium. It was known as Hul Gil, aka, the joy plant.

In 1840, Mrs. Charlotte N. Winslow, a midwife, prepared a tonic to market to children and infants to help relieve the pain of teething and allow them to sleep. It consisted of morphine sulfate, sodium carbonate, spirits foeniculi (alcohol) and aqua ammonia. It was sold as Mrs. Winslow's Soothing Syrup, it became known as "baby killer." In spite of condemnation by the AMA, it remained on the market until 1930.

John Stith Pemberton was a Confederate Lieutenant Colonel in the Civil War. He was injured during the Battle of Columbus, receiving a saber wound to the chest. As a result he, and thousands of other civil war veterans, became addicted to morphine. He found relief with a medicinal drink called Vin Mariani made in France. This French wine contained coca leaf. He then developed Pemberton's French Wine Coca, made with kola nut, damiana, coca leaves and wine. It became an instant success. It was advertised to help patients withdraw from morphine, invigorate their neurologic systems, etc.

Unfortunately, in 1886 the city of Atlanta enacted prohibition. As a result he could no longer market his French Wine Coca. He then created a temperance drink which we now call Coca-Cola. It consisted of coca leaves, kola nuts, carbonated water and a sweetened syrup, which is still proprietary. It was marketed as "delicious, exhilarating, refreshing and invigorating" as well as having "the valuable tonic and nerve stimulant properties of the coca plant and kola nuts". To this day, expended coca leaves are imported into the United States by a firm in New Jersey. Coca-Cola is then able to purchase the leaves, which are now cocaine-free, to add to their syrup. Once this process is complete these leaves are destroyed under presence of federal officials. This beverage company and its importer are the only companies allowed to bring this leaf to the United States. They asked for, and received, a legal exception to policy to be allowed to do so.

About 100 years ago, misuse of opioids and opiates was so common that the Harrison Narcotics Tax Act was enacted. The act was approved on December 17, 1914. It involved "a special tax on all persons who produce, import, manufacture, compound, deal in, dispense, sell, distribute, or giveaway opium or coca leaves, their salts, derivatives, or preparations and for other purposes."

Secondary to the Boggs Act of 1951-2 and the Narcotic Control Act of 1956, mandatory sentences for drug-related offenses, including marijuana, were set. A first marijuana possession offense carried a minimum sentence of 2 to 10 years with a fine up to $20,000.

Obviously the use of these narcotic preparations never stopped. They are incredibly effective for pain management. In fact, the Joint Commission issued standards for pain management control of hospitalized patients. In a *JAMA* article from July 26, 2000, the Joint Commission stated "the pain management paradigm is about to shift." Other hospital accreditation programs immediately followed the example of the Joint Commission and wrote changes to their pain management standards.

There are many who say as a result of the accreditation standards, drug abuse exploded in this country. There is little doubt that since these standards started, drug abuse has grown. Is this cause and effect or coincidental? The joint commission and other accrediting bodies say that this is due to misinterpretation of their guidelines. I for one will be happy to see the day when smiley faces disappear from every emergency room and patient chart.

There is an additional component that is often overlooked by all involved. It is not simply that misuse of opioid-like substances but, the concurrent and additional misuse of benzodiazepines leading to an escalation in preventable deaths. It is time for pain management clinics to become truly that, a clinic where a patient with pain can be seen and be given safe and satisfactory alternatives to prescription drugs. Obviously we see the future. Will we as physicians be brave enough to shape it?

"If this is the best of all possible worlds, what are the others like?"
— Candide

LECOM DEAN'S CORNER

Lake Erie College of Osteopathic Medicine

Silvia M. Ferretti, DO
LECOM Provost,
Vice President and
Dean of Academic Affairs

We possess the power to prevent thousands of deaths from opioid overdoses. So why haven't we done so?

With almost a 200 percent increase in opioid overdoses since 2000, it is abundantly clear that the treatment system as it stands is not working, and Americans, from all walks of life are dying as a result. Many of those who have found themselves becoming opioid dependent have become so after suffering an injury or enduring chronic pain. As a result, drug overdoses now outpace car crashes as the leading cause of accidental death in the United States.

Regrettably, America is in the midst of an epidemic of prescription and illicit opioid overdose deaths. In 2015 alone, more than 30,000 people perished as the result of the overuse or the improper use of such medications. Each day, more than 40 Americans die from prescription opioid overdoses. The amount of opioids prescribed and sold in the United States has quadrupled since 1999 with opioid-related deaths numbering more than 168,000, yet there has not been an overall change in the amount of pain that Americans report. While prescription opioids indeed can serve well as an appropriate part of pain management and new federal guidelines seek to improve the safety of prescribing and reducing harm associated with opioids, there is another option to treat pain: Osteopathic Manipulative Treatment.

LECOM advocates for opioid recovery methods that actually can break down barriers to treatment, so that people who want help can receive treatment that works.

Endeavoring to stem perhaps one of the worst public health drug crises in decades, the federal government Centers for Disease Control (CDC) recently published the first national standards (guidelines) for prescription painkillers, recommending that physicians try pain relievers, such as ibuprofen, before prescribing the highly addictive pills; and if doctors do prescribe such opioids, that they give most patients only a limited supply.

While all of the discussion regarding opioid limits and new guidelines may be fruitful, the most fruitful option would be never to have relied upon such medications in the first place. Enter Osteopathic Medicine!

The Lake Erie College of Osteopathic Medicine (LECOM) Integrative Medicine physicians manage pain without opioids using osteopathic treatment, acupuncture, and other non-medication treatments, including advanced aqua healing. Many of these therapies are derived from osteopathic principles.

Undoubtedly, chronic pain is common, multidimensional, and highly individualized; and its treatment can be challenging for health care providers as well as for patients. OMT is a comprehensive system of evaluation and treatment that is designed to achieve and to maintain health by restoring the normal body functions. It is important that the full range of therapies be brought to bear upon the treatment of chronic pain if the field of medicine is going to improve overall success rates. Integrative Medicine, such as that practiced by physicians throughout the LECOM system, offers a broad, healing-oriented approach to medicine that emphasizes a patient-doctor partnership; one which takes into account the whole person, including all aspects of the patient's lifestyle. It embodies the ability of the practitioner to offer therapeutic options consistent with the patient's belief system that are predominantly non-surgical and non-medication focused. Integrative options reveal high-quality research, patient safety, effectiveness — and they offer reduced adverse effects in clinical practice.

Indeed, the time-honored and effective osteopathic principles of whole-body health care offer a comprehensive approach to patient wellness. These principles account for the wholeness of the patient — complete in mind, body and spirit. Understanding this aspect of health care allows physicians to think broadly and use techniques and treatments that extend beyond the curative default position of prescribing pills. The use of that which many allopathic doctors may term alternative medicine has offered superlative results for many patients.

Perhaps, the rest of the world is just now learning that which osteopathic physicians have known from the start: that whole-person treatment entails using a wide array of effective treatment options that best facilitate the end result — a healthy and pain-free patient.

Fraternally,
Silvia M. Ferretti, DO

PCOM DEAN'S CORNER

Philadelphia College of Osteopathic Medicine

Kenneth J. Veit, DO
PCOM Provost, Senior Vice President for Academic Affairs and Dean

The illegal use and misuse of opioids continues to be a public health crisis. According to the National Institute on Drug Abuse, since 2012, heroin overdose deaths have increased five-fold, and prescription opioid deaths have increased three-fold.

As medical educators training the next generation of physicians, we must be vigilant about how we educate our students to treat patients who may be struggling with opioid addiction. While opioids can be useful in pain management, it is critical our students know the safest, most effective ways to prescribe those medications.

The PCOM curriculum is imbued with courses on safe prescribing methods, and, is right on target with the Centers for Disease Control and Prevention's (CDC) Guidelines for Prescribing Opioids for Chronic Pain. Those guidelines include opioid selection; initiation or continuation of opioids for chronic pain; opioid selection, dosing, duration, follow-up and discontinuation. Additionally, and of utmost importance, is addressing risk and harms of opioid use.

For example, in the clinical and basic neuroscience courses, our students learn not only about the structure and function of the human brain, but also psychiatric and behavioral medicine. This includes substance abuse disorders; pain and pain management techniques, with a focus on the emotional toll of chronic pain and it's relation to addiction. The course also includes lessons on pharmacological treatments and precautions, including those related to opioids, among other therapeutics.

However, in the larger, national conversation about opioid use and the addiction crisis, there is a segment of the population that has been overlooked — the pregnant woman addicted to opioids. According to a study conducted by Massachusetts General Hospital Center for Women's Health, the prevalence of women admitted to hospitals nationwide for obstetric delivery and also identified as abusing or being dependent on opioids increased more than 127 percent between 2008-2012.

The authors of that study found several complications, including maternal cardiac arrest, intrauterine growth restriction, placental abruption, preterm labor and stillbirth, were more common in women using opioids during pregnancy.

Pregnant women should not be overlooked when discussing opioid use. To that end, in the 2016-2017 academic year, Joanne Kakaty-Monzo, DO, chair of Ob/Gyn at PCOM, added the topic of opioid use in pregnancy to the curriculum of the Reproductive Genitourinary and Obstetrics, Gynecologic Medicine course.

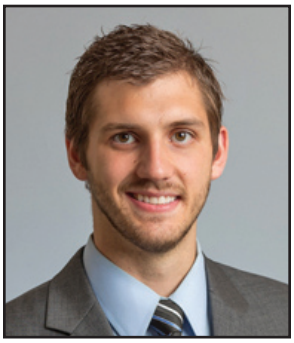
During that course, students learn about all aspects of the opioid crisis. Those topics include the neurobiology of addiction, signs and symptoms of substance abuse in pregnant women, and recommendations on how to communicate with their patients on the risks of substance abuse disorder to both mother and baby. Students also learn treatments that can help wean those patients off substances, which include opioids.

When we talk about combating the opioid crisis, it is imperative that we consider all segments of the population. For our future doctors, arming them with the knowledge that addiction can strike anyone, anywhere, at any time, will prepare them to be effective and conscientious health care providers.

Fraternally,
Kenneth J. Veit, D.O.

A STUDENT'S VOICE — LECOM

Jordan M. Spencer, OMS-IV



Jordan M. Spencer
LECOM OMS-IV

A Student's Musings on Addiction

Over the last few years, the opioid epidemic has become a buzzword within the medical community. Bills have been passed and legislation has been made, worried organizations and medical facilities have created policies to limit the distribution, more effective communication between pharmacies has been established. And in all this commotion, I fear that in many respects the epidemic has become nothing more than a buzzword, or an all-to-often said phrase that has begun to fall on deaf ears. One of those fads in the medical world that will come and go. I urge you to not let this be the case.

While this is a multi-faceted issue and there are many to whom we can point our fingers, I do not believe placing blame on any one group will accomplish anything. It will only raise up defenses and cause contention between hospitals, legislators, families and so forth. However, that being said, as physicians I believe it is important for us to recognize the role that we play, not only in the issue at hand, but in the solution.

I come from a rather interesting background as a student to speak on this issue. I grew up in the state of New Hampshire, which was the number one state per capita for alcohol and heroin abuse while I lived there. When the high school 30 minutes way was given a survey regarding drug usage, they were comparable to national averages until the question of heroin, where nearly two-thirds of the students answered that they took heroin regularly (2 times or more every week). I was fortunate that both the high schools I attended were not nearly as devastated by this drug, however I will say that prescription drug abuse was rampant, including opiates.

Drug abuse has become a topic of interest to me (I hope to dedicate a large part of my future practice to addiction medicine) and when I entered my undergraduate education I found myself in a research facility working with drugs of abuse on animal models, and worked as a psych-tech at an inpatient drug facility. This opportunity gave me a first-hand intimate knowledge of the epidemic. When our patients, who came from across the United States, were asked about their drugs of choice, the undeniable answer was opioids (both prescription and heroin). In my unofficial surveying over the year, never had any of the patients recovering from heroin use ever start with heroin.

Sad stories involving heroin always involved the humble beginnings with prescription medications. At times it was stories of having a surgery or medical procedure which provided them their first bottle of pills. Some would have a memorable introduction at a high school or college party and never look back. And others had been prescribed opiates for debilitating pain and were never been able to stop, even when the pain had subsided, as a new pang of withdrawal symptoms accompanied the bookends of their now finely tuned intake schedule. These pills were obtained through a limitless number of locations – from medicine cabinets of family members who are no longer taking them, to stolen morphine patches of grandmothers with cancer, the opportunities were endless.

As doctors we are trained to help, we are trained to heal, we are trained and indeed have a duty to do whatever we can to ease the pain of disease and work to fight sickness within our patients. I fear however in our overzealous efforts to temper pain, we have found ourselves causing the disease of addiction. While this has never been the intent, it is a sad reality that we must be aware of.

One of the consistent and troubling patterns I found with my patients at the inpatient facility was an all too common story… Upon the first hint of a prescribing physician realizing a patient may have a dependence issue, ties were cut and patients were encouraged to find treatment options somewhere else. For our patients at the rehab facility, this was often times the breaking point between functional addiction and an all-encompassing disease which would eventually affect their social, occupational and personal lives.

At the time, I did recognize many of the reasons why a physician would do this and I feel I understand even more now as a student of medicine. Within our current litigious

(continued on page 14)

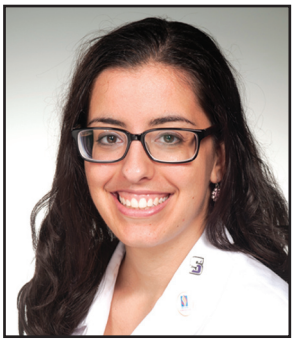
A STUDENT'S VOICE — PCOM

Elisa Giusto, OMS-IV and Olivia Hurwitz, OMS-IV

As we move through our clerkship years, we have the opportunity to work with many types of patients, physicians and students, which can be as beneficial to our education as the medicine we learn. This exposure allows us to understand the different styles of practicing medicine, as well as different attitudes that can either help or harm patients as much as any medical procedure. Unfortunately, treating patients with drug addictions can make students, physicians and other health care providers act in ways that can be very harmful to patients seeking (or not seeking) recovery. This problem can be seen both systemically, at the level of governmental and non-governmental organizations, and individually, through health care professionals interacting directly with patients.

The U.S. Drug Enforcement Administration reported that there were 4,642 drug fatalities in Pennsylvania in 2016, a 37 percent increase from 2015. Prescription or illegal opioids, such as heroin, were the cause of 85 percent of these deaths. Governor Wolf's administration is addressing the crisis by creating 51 locations in a "Center of Excellence" network to connect people to addiction treatment programs. Unfortunately, chronic understaffing and underfunding at the Department of Drug and Alcohol Programs is stalling the state's ability to fight the opioid epidemic. Auditor General Eugene DePasquale released a report last year recommending a licensing fee on drug treatment centers to help bring money into the agency. Meanwhile, the Department of Corrections monitors just one of its seven addiction treatment program for effectiveness, but this information is limited to mapping the rate of recidivism over time, and not necessarily the client's response to the programs themselves. The auditor general's report recommended evaluating all of its programs, including the agency's medication-assisted treatment programs, with an established routine evaluation. The report also recommended that the Department of Health write regulations to ensure Pennsylvania physicians safely prescribe buprenorphine-related medications, as such regulations were previously lacking. Although these recommendations are well-intentioned, it will be interesting to see if any of them are able to become reality, and whether they will end up acting as yet another barrier to patient care. These are just some examples of why drug recovery programs, and the patients themselves, end up getting overlooked by federal and state-level systems, even those which are supposedly put in place to help them.

Perhaps the more problematic barrier to patient care, as evidenced throughout our clinical clerkships, however, is on an individual level, by how physicians or other health care professionals interact with patients who are addicted to drugs. Most people assume that the worst way to act towards patients with drug or alcohol addictions is to be judgmental — to blame them for not being able to quit, to condemn them for using substances in the first place, to stereotype them as criminals or liars. These are, of course, inappropriate attitudes to hold towards these patients. However, while spending time on the inpatient detox unit during a psychiatry rotation in West Philadelphia, it quickly became apparent that the most harmful attitude towards patients who are addicted to drugs is not judgment, rather it is pity. To victimize these patients with a simpering "they are just a product of their circumstances" and a "poor you" attitude is to deny their agency and diminish their personhood. It gives them nothing, and only serves to take away the very self-determination that is vital to surviving the recovery process. This is not to say that it is wrong to acknowledge that some people's lives have been more difficult than others', but if we treat all patients addicted to drugs as though only bad luck, and not personal choice, is what got them there, how can we expect them to hold themselves to a higher standard? Treating patients effectively and empathetically may sometimes require a physician to foster in those patients a sense of resilience, not to pity them, but to reinforce in them the idea that they once were strong enough to be clean and sober, and that they can be strong enough to get there again.



Elisa Giusto
PCOM OMS-IV

Olivia Hurwitz
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Source:

APA: Pennsylvania told to improve addiction program evaluation. *U.S. News & World Report*, July 13, 2017. *https://www.usnews.com/news/best-states/pennsylvania/articles/2017-07-13/pennsylvania-isnt-evaluating-addiction-programs-audit-says*

ABOUT THE AUTHORS

Amy L. Davis, DO

The Honorable Josh Shapiro

Amy L. Davis, DO, MS, FACP, FAAHPM, is the author of "*Evaluating the Whole Person when Deciding on Opioid Inclusion.*" She is a board certified subspecialist in hospice and palliative medicine with a private palliative care practice in the Philadelphia area. She is also a clinical assistant professor at Drexel University School of Medicine. Dr. Davis graduated from the Philadelphia College of Osteopathic Medicine with DO and Master of Science (Neuroanatomy) degrees. She completed an internship at the University of Medicine and Dentistry of New Jersey – School of Osteopathic Medicine/ Kennedy Health System, an internal medicine residency at Pennsylvania Hospital and a palliative medicine fellowship at the Mount Sinai Medical Center in New York. A fellow of the American College of Physicians and the American Academy of Hospice and Palliative Medicine (AAHPM), Dr. Davis is serves on several national and regional committees of organizations focused on improving and providing quality medical care and on substance abuse in the setting of serious illness.

The Honorable Josh Shapiro, author of "*Doctors Critical in the Fight Against Opioids,*" is Pennsylvania's Attorney General, the Commonwealth's top lawyer and chief law enforcement officer. Sworn into office in January 2017, directing an aggressive fight against the heroin and opioid epidemic, including treatment for those suffering from addiction, is amongst his top priorities. Attorney General Shapiro previously served as chairman of the Pennsylvania Commission on Crime and Deliquency, chairman of the Montgomery County Board of Commissioners and a State Representative for Pennsylvania's 153rd House District. A graduate of the University of Rochester and Georgetown University Law Center, he is a member of the Pennsylvania Bar Association.

Index to Advertisers

Attention Writers...

***The Journal of the POMA* is seeking professional articles from *YOU*!**

The December 2017 issue will focus on the future of medicine and the role professional organizations, especially POMA, will play in helping physicians and patients navigate the ever-changing world of health care.

Submissions welcome from POMA members and the public!

E-mail entries to the *JPOMA* Editor c/o *bdill@poma.org*.

Guest Column
Evaluating the Whole Person when Deciding on Opioid Inclusion

by Amy L. Davis, DO

While early data cannot be directly compared with more recent figures because of collection differences, the Substance Abuse and Mental Health Services Administration's (SAMHSA) National Survey Reports suggest there was a 2.2-fold increase in overdose deaths from all drugs from 2002 to 2015, when more than 52,000 people died.[1] The number of people dying from heroin and illicit fentanyl continues to skyrocket throughout the United States. However, the number of such deaths from prescription opioids has generally stabilized since 2011 with 17,536 deaths in 2015.[1] Widely suggested reasons for this include improved prescriber education, decreased prescription opioid availability, and their subsequent increased cost. Heroin is now considerably cheaper to purchase in a growing number of communities than, for example, oxycodone.[2] Unfortunately, heroin tends to also be more lethal.

Drug-related aberrant behaviors can be viewed as falling into two categories: those related to medical or nonmedical use. Pseudoaddiction[3] can occur when pain treatment results in insufficient relief, causing the person to have escalating analgesic demands that are not adequately addressed and subsequent behavioral changes to convince others of the pain's severity. A bilateral crisis of mistrust becomes established. The aberrant behaviors cease with adequate analgesia, but the person's loss of trust in prescribers may linger. Another example in the medical use category is chemical coping.[4] This is characterized by a pattern of maladaptive coping through drug use or the belief that medications fix everything. People with this tendency often feel stress physically, such as with headaches, gastrointestinal symptoms, and/or "total body pain." They may use the medications to treat both their physical and nonphysical pain and in ways outside of the prescriber's recommendations. However, they do not have an addiction. "Chemical copers" have difficulty differentiating physical from nonphysical pain but are suffering regardless. There is a growing paradigm shift viewing people requesting pharmaceutical-based pain treatment as "comfort seekers" rather than as "drug seekers;" this is almost always a more accurate description of their goal.

Substance use disorders (SUDs) are physical conditions characterized by the continued use of a substance despite detrimental effects, compulsive use or behaviors to obtain it, and a pre-occupation with its use for nonmedical purposes. Because these behavioral components are more prominent than their physical causes and our culture puts a stigma on mental illness, those who admit they are suffering from this condition (or had in the past) often become isolated and judged negatively by society. Healthcare professionals and laypeople alike should view SUDs as physical illnesses requiring individualized evidence-based care, not character weaknesses; no one chooses to have a SUD. Diversion also falls into the nonmedical use category and may or may not stem from an underlying SUD.

Chronically uncontrolled, physical pain can negatively affect hormonal balance, renal function, mental processes and neurotransmitter balance, immunity, and other body systems.[5] The whole person, individualized approach, utilizing multimodality therapies with the highest expected benefits and the lowest risks expected for that person, is most effective in managing physical and nonphysical pain. There are a variety of validated screening surveys to assess someone's risk for aberrant behaviors, developing or having a SUD, or diversion, and most are available for free. While there is limited literature demonstrating efficacy, other tools, such as using a restricted medication bilateral agreement, urinary drug testing, and/or pill counting as part of a broader ongoing discussion with the person likely also have clinical utility. These

should be chosen based on the individual's unique situation and may change with evolving circumstances. Open communication is quintessential.

This type of whole person approach can also easily be applied to those requiring restricted medication for symptom management in the setting of concurrent serious illness (palliative care). Fewer treatment options may be available due to physiologic changes, prognosis, rapid escalation of symptom intensity, drug-drug interactions between non-opioid alternatives and disease-directed drugs, and other related issues. Nonetheless, consideration of non-restricted medications, as adjuvants or alternatives, and a multimodality care plan maximize benefits while minimizing risk and negative effects. Consultation with a palliative care specialist can be helpful in complex cases, regardless of the person's goals of care. Caregivers and loved ones should also be considered when assessing risk, especially when someone has significant debility or reliance on others. Tools too should be individualized. For example, if someone lacks understanding or would be harmed by participation in a restricted medication agreement discussion, substitution with the caregiver(s) should be considered. Just as serious illness affects people among all socioeconomic strata, communities, educational backgrounds, and other cultural divisions, SUDs too have no such boundaries. When these become concurrent issues, specialist consultation and even ongoing inclusion on the healthcare team should be considered to maximize symptom management and function and minimize suffering.

Aberrant behaviors demonstrated by people with pain should be viewed as "red flags" that require additional assessment to determine the etiology, and SUD should not be assumed. Viewing those seeking pharmaceutical-based pain treatment as "comfort seekers" is an important paradigm shift. While concurrent serious illness adds complexity, the individualized, whole person multimodality approach can be adapted to the needs of palliative care patients. Legislation of medical care needs to be cognizant of the diverse needs among those treated with opioids and other restricted medications and allow prescribers the flexibility needed to individualize treatment based on their expertise.

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Guest Column
Doctors Critical in the Fight Against Opioids

by Pennsylvania Attorney General Josh Shapiro

In 2016, over 4,600 Pennsylvanians suffered fatal overdoses, a 37 percent increase from the year before. Overdose is now the number one accidental killer in Pennsylvania. This epidemic, which claims the lives of 13 Pennsylvanians every day, is driven by opioids, including prescription pain medications, heroin, and synthetic drugs like fentanyl.

As Pennsylvania's chief law enforcement official, the opioid crisis is my top priority, but I know that we cannot simply arrest our way out of this crisis. We need a multidisciplinary approach that leverages the work of law enforcement, the medical profession, treatment providers, insurers, community groups and citizens across the Commonwealth.

First, we need to go after the dealers who traffic this poison into our communities. Since I took office, we have arrested 3 dealers a day and we are working with our partners at the federal, state and local level to halt the supply of heroin, fentanyl and other opioids on the street.

Second, we need insurance companies to do their part to reduce the sheer volume of prescription opioids in our communities. Four out of five heroin users start with prescription opioids, and most Americans cannot afford a prescription unless their insurance covers it. Insurers act as important gatekeepers to the supply of opioids. As a result, earlier this year, I announced a 10-point plan laying out the steps insurers should take to reduce the flow of opioids, increase access to addiction treatment and shift the focus to alternative pain treatments to reverse the rising tide of addiction.

Third, the makers of opioids manufacture far too many of these highly-addictive drugs. The United States consumes 80 percent of the world's opioid supply despite having only five percent of the world's population. That is why I am working with Attorneys General from across the country to investigate opioid manufacturers to determine if their marketing and sales practices have violated the law and helped fuel this crisis.

Fourth, the public must help reduce the opioid supply. There are also tons — literally tons — of opioid medications just sitting around in our homes, waiting to be abused. In fact, over 70 percent of people who misuse prescription opioids get them not from doctors or drug dealers, but from friends and relatives who have leftover pills in their medicine cabinets. Properly disposing of unused opioid medications will keep them from harming others later on. My office works with the DEA to set up medication drop boxes across the state where people can dispose of their old, unwanted medications. And they work: Pennsylvanians disposed of over 51 tons of medications at these sites in just the last two years. For those who do not live near a drop box, my office recently distributed over 300,000 medication deactivation bags to pharmacies across the state so people can safely get rid of medication in their own homes.

Ultimately, to stem this crisis we need to reduce supply by attacking the problem at the point of prescription. Doctors and health care providers play a critical role in determining how many opioids are available for misuse. Right now, our nation's doctors prescribe an extremely high number of opioids for pain treatment. Even though Americans report the same overall pain levels as they did in 1999, the rate of opioid prescriptions has quadrupled since then. In 2015, doctors wrote 300 million pain prescriptions, enough to keep every American medicated around the clock for three straight weeks.

Unfortunately, there are some doctors, nurses and other medical professionals who are themselves in the throes of addiction, or who use their position to divert opioids from their intended, legal use and siphon them off into the black market for their own profit.

While this is a small minority, drug diversion is a growing concern for law enforcement — one my office takes very seriously. We have doubled the number of diversion arrests so far this year compared with last year. No one should be profiting off of the pain, suffering and death of others — not manufacturers, not insurers, not doctors.

The vast majority of doctors, though, are simply trying to do what is best for their patients. But prescribing opioids has become the default for pain management. The medical community is making great strides in educating doctors about the very serious risks of opioids, updated prescribing guidelines and alternative pain treatments. I am working closely with the Pennsylvania Medical Society to develop new ways to reach doctors to provide them with information and help change prescribing habits.

It is going to take an all-hands-on-deck approach to defeat the opioid crisis. Doctors are on the front lines of this battle just as much as law enforcement. I hope that we can continue to work together and grow our partnerships so that we can more effectively combat this crisis.

LECOM STUDENT'S VOICE *(continued from page 8)*

society, a physician who has "made an addict" and then continued to feed that addiction puts themselves at serious risk. The easiest and most decisive way to mitigate that risk is to drop said patient and clearly document the reasons why. Not only was this beneficial from a legal perspective, but it also saves staff and medical personnel from arguably one of the more difficult clinical presentations within the world of medicine. Patients with the disease addiction are very difficult to work with – the lying, deceit, manipulation, tempers and more are all real facets involved with curing this disease.

That being said I implore the readers of this article to not give up. When your patient presents and you suspect addiction, be forthright and bold, tell them your suspicion and the reasons why, ask them, and in that same conversation let them know that you are there for them and that you are willing to work with them. Begin a plan for a taper, maybe get buprenorphine training. Many of these patients look up to you as their physician, and you may be one of the few constants in their life. Cutting yourself out of their life may just be severing one of the few fibers keeping the patchwork stitches of their life together. I do not write this to encourage physicians to become enablers, but I do request that you look at these patients as having a disease that can be cured and to look at yourself as having the skills to be a part of the solution.

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CME Quiz

Name _____

AOA # _____

1. The number of deaths from prescription opioids has generally stabilized since 2011.
   True False

2. The majority of people who misuse prescription opioids get them from their physician(s).
   True False

3. Overdose is the number one accidental killer in Pennsylvania.
   True False

4. In the past two years, Pennsylvanians used medication drop boxes to dispose of how much old, unwanted medications:
   a. over 1 ton
   b. over 25 tons
   c. over 50 tons
   d. over 75 tons
   e. over 100 tons

To apply for CME credit, *answer the following questions and return the completed page to the POMA Central Office, 1330 Eisenhower Boulevard, Harrisburg, PA 17111-2395. Upon receipt of the quiz, we will forward passing scores to the AOA CME Department. You will receive 0.5 Category 2B AOA CME credits.*

Answers to Last Issue's CME Quiz

1. True
2. b
3. b
4. c
5. d

(Questions appeared in the June 2017 Journal.)

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