



My Wits About Me Patient Education and the Effective Use of Opiates

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"Among the remedies which it has pleased Almighty God to give man to relieve his sufferings; none is so universal and so efficacious as opium."

Thomas Sydenham, English physician
(1624–1689)

Managing symptoms at end of life can be one of the more challenging and rewarding aspects of medical care. Pain management in particular can be made difficult from an unlikely source. Surrounded by myth, misconception, and cultural bias, opiates remain the mainstay of treatment. Frequently, patients themselves may be the most formidable barrier to their effective use. Presentation of a reality-based case serves as the basis for exploring some of these attitudes and beliefs that may be a stumbling block to opiate use in effective pain management.

The inhibiting fear associated with prescribing drugs classified as "narcotic" is illustrated through 10 common misconceptions regarding their use and is characterized by the term *Opiophobia*. Not all the misconceptions originate from patients, but also from family members, cultural and regulatory agency norms, and even physicians themselves. A brief discussion follows each of such flawed concepts as "morphine use indicates death is imminent," "enduring pain enhances character," hospitalization is required for effective pain management," and "opiate use always leads to addiction." Regarding the hot button issue of addiction, a glossary is provided to help in distinguishing nonaddiction etiologies that explain the frequent need for dosing increases.

The formal recognition of hospice and palliative medicine as a certified sub-specialty confirms the notion that it is the duty of physicians to provide optimal care through the dying process. Undoubtedly, evidence-based guidelines will lead to new standards of practice improving end-of-life care. This article adds perspective to past practices and opens the door to adding perspective to new ones.

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The representative couple referred to in this vignette as Fred and Audrey could not be more in love. Fred, a former US Navy

pilot, and his blonde beauty could not wait to be in each other's arms, and it is no surprise that it fueled their passion for dancing all these years. In fact, through most of the nearly 20 years that I cared for them, every Saturday night was "Swing Night." I can only imagine how effortlessly they glided

and twirled across the floor as I had seen so many of that "Greatest Generation" do as I grew up. In fact, it was not until Audrey's Alzheimer disease was quite advanced that Fred stopped taking her to the dance hall. He was quite the stalwart in his commitment to Audrey. He was totally devoted to her care. They never had children, and their closest relative was a niece who lived 2000 miles away. Fred was there for Audrey 24/7. As her condition deteriorated, he learned to do it all—cook for her, feed her, clothe her, walk her, and diaper her. He knew he was her only world, and she was his. I often wondered if he would be totally devastated after her death, or if there would be a sense of relief and some motivation for him to move on. Only he was more surprised than I to realize it would be Audrey living on without him.

Fred had been ignoring his symptoms of abdominal pain, weakness, and weight loss, chalking them up to the stress of dealing with Audrey's progressive decline. How could he possibly get sick when Audrey needed him so badly? He was finally coaxed into updating some blood tests as it had been some time since he had scheduled a visit for himself. His pallor and weight loss suggested that more than stress was at work.

Fred was found to have metastatic liver disease and an unidentified primary tumor. His decline was very rapid, and it seemed sudden that I found myself seeing him in my role as a hospice clinician. The hospice nurse had reported that Fred had increasing severe pain and had been steadfastly refusing to take any of the "dope" that had been prescribed in spite of his obvious suffering. "I can't be doped up. Who is going to take care of Audrey? I gotta keep my wits about me."

Opiophobia

Few modalities used in standard medical practice can rival the legacy that opium and its derivatives has built since its first mention as an analgesic by Theophrastus in the third century BC.¹ The history that has accompanied the cultivation, trade, uses, and the legal, political, and profitability status of the unripe seed pod of the poppy plant, *Papaver somniferum*, is a significant part of world history. It has

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been romanticized and vilified, from Broadway plays to outright wars, from billions in illegal trade to bloody murders—all of it tied to its distribution and control. It is no surprise that with such a notorious history, many myths and preconceived notions have developed around opium, not only in the United States, but also in most all other cultures.

Morphine is a daughter of opium, and in the eyes of many, she cannot escape the sins of her mother. It is a purified derivative of opium and commonly indicated for analgesia in a variety of circumstances, not the least of which is suffering frequently associated with symptoms accompanying end-stage disease. Despite its checkered past, morphine sulfate has the efficacy, safety, side effect, and cost profile that is at least comparable to those of other high-quality pharmaceuticals used routinely in medical practice. All available drugs classified as opiates generally share these characteristics. Reference resources reviewed for this article are consistent in their recommendation for morphine as a standard in pain and symptom management.

Although several barriers (eg, fear of governmental regulatory policies, physician education and experience) to appropriate opiate use in chronic and progressive pain syndromes of end-stage disease may complicate efforts to provide quality end-of-life care, it is the reluctance of patients and caregivers that is most likely to be encountered with regularity. Success in improving patient and caregiver compliance has been shown to improve quality of living for those with a life-limiting prognosis.² An effective way to improve compliance is for physicians to upgrade their own education and understanding and to use their communication skills to identify and dispel patient and caregiver fears based on the mythical history of these drugs.

Ten Common Misconceptions About Pain and Opiate Use at End of Life

■ **“Once you start taking morphine, the end is always near.”**—As opiates, particularly morphine, are commonly used in end-of-life care, many patients and families who make the association take it as a powerful symbol that hope is



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lost. They need to be made aware that morphine does not initiate the final phase of life or lead directly to death. For patients with life-limiting illness and chronic pain, morphine can provide the type of comfort that may permit improvement in activity (eg, deep breathing, ambulation, or tolerance for sitting upright), nutritional intake, and social interaction, all of which may delay complications and lengthen their lives with improved quality.

■ **“Enduring pain and suffering can enhance one’s character.”**—Before the advent of scientific research to explain the physical processes of pain and modern analgesic interventions, the explanation

for the existence of pain was strongly attached to the spiritual realm. For example, in the Judeo-Christian tradition, pain is a consequence of man’s disobedience to God in the Garden of Eden. Every religion and school of philosophy has confronted the problem of pain. Coping with such discomfort through a belief system (eg, “I will earn a higher place in the after-life”) was the only mechanism available for centuries. While suffering in the spiritual realm can and does exist, treatment of the physical element can lessen distractions from reflection, meditation, prayer, and participation in religious rites and traditions, helping to ease existential concern and anguish.



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■ **“People have to be in a hospital in order to receive effective pain management.”**—Compared with the average acute care hospital, it is much more efficient and safer to provide effective pain management in a home setting. No competition for the attention of nurses or caregivers exists, and administration of medication can more accurately follow dosage schedules or be customized around patient need or preference. Having one or just a few caregivers offers an advantage for noticing nuances or more substantial changes that may reflect problems with dosing, efficacy, or side effects, and for reporting them in a timely manner so that appropriate interventions can be instituted. Technologic advancements make multiple modalities of pain control available in the home setting, (eg, peripherally inserted central catheter [PICC] lines, continuous infusion pumps, transcutaneous electrical nerve stimulation [TENS] units).

■ **“To get good pain relief, you have to take injections.”**—Until the mid-1970s, it was believed that morphine was not an effective analgesic when given by mouth, and it became standard practice to administer it by injection. Since then, effective oral preparations, both long-acting, (up to 12 hours) and immediate-release,

rectal suppositories, and transdermal preparations have been developed. Oral morphine in high-concentration, low-volume preparations can be used and are effective even when the patient does not have an intact swallowing mechanism by installing a dose for mucosal absorption sublingually or in the buccal space between cheek and gum.

■ **“Pain medications always cause heavy sedation.”**—Most patients in chronic pain have been deprived of sleep and rest as a consequence, and relief is often met with a period of well-needed rest. In most patients, any sedative effects begin to wane in the first 72 hours, allowing a return to baseline mental status. Short-term memory can be compromised in some individuals, and they should be encouraged or helped to keep a log or journal for important instructions or information. Persistent sedation may be due to drug interactions with concurrent medications, especially anxiolytics and sleep aids, which may no longer be necessary if uncontrolled pain was the cause for those needs.

■ **“It is best to save the stronger pain relievers until the very end.”**—The objective is to bring the pain under continuous control from the outset so that each day could be the best one possible

for the patient, and the highest quality of life can be realized for the duration of the patient’s life. Partially or occasionally controlled pain tends to increase in severity, leading to two mistaken assumptions:

(1) Patients mistakenly fear that the pain is so severe that it can never be controlled; anxiety may accompany this assumption, possibly increasing the severity of suffering and complicating further management through diminished trust.

(2) Physicians mistakenly believing that the patient is becoming addicted or developing tolerance to the analgesic; this could lead to further reservation in providing effective dosages in the case of presuming addiction, or overtreatment’s producing intolerable adverse effects in the case of presuming tolerance.

■ **“Some types of pain cannot be relieved.”**—Solely relying on opiates for pain control can have limitations, and neuropathic pain may be a classic example. However, “multimodality” or combined approaches, including adjuvant medications such as neuroleptics, chemotherapy, radiation therapy, nerve block, or ablation techniques, cannot be overlooked, and in nearly all circumstances are effective. Addressing psy-

chological, spiritual, and social aspects of the patient's suffering through intervention of professionals from those disciplines can also act as an effective adjunct to physical pain control.

■ **"Patients often develop tolerance to pain medications like morphine."**—Tolerance is certainly a phenomenon related to opiates; however, dosage levels effective for continuous control of pain in cases of life-limiting progressive diseases rarely need to be increased because of tolerance, but rather for increased pain associated with the progression of the disease process.

■ **"Once you start administering pain medicines, you always have to increase the dose."**—In many instances, once pain is under control and the dose of opioid holds at a steady level for several days, the opioid dose can be lowered gradually to a point that meets the patient's needs. The ability to lower the effective dose once control has been established seems paradoxical and is associated with severe chronic pain. In theory, it may be a phenomenon associated with relief of the emotional and psychological influences that may accompany fear that the pain will be permanent for the remainder of the patient's life.

■ **"Pain medications always lead to addiction."**—^{3,4}There is no empirically based evidence that opioids, when prescribed on a regular basis in a dose necessary to relieve pain, lead to addiction.

Tolerance, Addiction, or Something In-Between

The last misconception permeates the culture of both physicians and society in general, and as such, it can be the toughest misconception to overcome. It is not unusual for some physicians to underprescribe or for family and caretakers to take it upon themselves to hold doses or discard prescribed opiates for the sake of fears surrounding addiction and the legality of their activity. Understanding and explaining the nature of opioids and the frequent need for titration and at end of life may provide the confidence and trust necessary to ensure compliance and offer quality for the remainder of a patient's life.

The following definitions^{5,6} may be useful to clarify patients' status and allow

for better understanding of their needs and the rationale for changes that may be necessary.

Tolerance: A state of adaptation in which exposure to a drug induces changes that result in a diminution of one or more of the drug's effects over time.

Pseudotolerance: The need to increase dosage that is *not* due to tolerance, but due to other factors such as disease progression, new disease, increased physical activity, lack of compliance, change in medication formulation, drug interaction, addiction, and deviant behavior. When a once-fixed opioid dose is no longer effective, the foregoing listed conditions should be reviewed to exclude pseudotolerance.

Physical dependence: A state of biological adaptation that is manifested by a specific withdrawal syndrome that occurs after abrupt cessation of pharmacotherapy, rapid dose reduction (which decreases blood levels of the drug), and/or administration of an antagonist.

Addiction: a primary chronic neurobiologic disease, with genetic, psychosocial, and environmental factors influencing its development and manifestations. Addiction is characterized by behaviors that include one or more of the following: impaired control over drug use, compulsive use, continued use despite harm, craving, and a high rate of recidivism.

Pseudoadddiction: a term that has been used to describe patient behaviors that may occur when a patient is undertreated for pain. Patients with unrelieved pain may become focused on obtaining medications, may "clock watch," and otherwise seem inappropriately drug seeking." Even behaviors such as illicit drug use and deception can occur in the patient's efforts to obtain relief. Pseudoadddiction can be distinguished from true addiction in that the behaviors resolve when pain is effectively treated.^{5,6}

Comment

Fred's motivation to remain in severe pain was indeed admirable but totally unnecessary and even counterproductive to his goal: to remain in control of his helpless wife's well-being. When he realized how much the pain distracted from

his ability to concentrate, how much physical and emotional energy had to be invested to fight it, and that it might even make him less effective for Audrey's well-being, he accepted recommendations to control his pain.

We kept a journal to document our discussions and his wishes so memory would be less of a concern. He rested and slept better noting more energy. When his niece visited him, he was able to interact and convey his wishes and affections unencumbered by physical suffering. The arrangements Fred made for Audrey with the help of his niece were satisfactory, and his niece was more than willing to lovingly take over wherever he left off, taking Audrey close to her home.

Fred remained the dutiful husband that he needed to be until the day he died, and his life ended in peace. It was the best possible ending to a tragic situation. Dr Sydenham and I were pleased.

References

1. Fulop-Miller R. *Triumph Over Pain*. London, England: Hamish-Hamilton Ltd; 1938.
2. Syrjala KL, Roth-Romer S. Non-pharmacologic management of pain. In: *Principles and Practice of Palliative Care and Supportive Oncology*. 2nd ed. Philadelphia, Pa: Lippincott, Williams and Wilkins; 2002.
3. Lamers WM Jr. A brief history of pain. In: Doka KA, ed. *Pain Management at the End of Life: Bridging the Gap Between Knowledge and Practice*. Washington, DC: Hospice Foundation of America; 2006:17-38.
4. Rich BA. The ethical dimensions of pain and suffering. In: Doka KA, ed. *Pain Management at the End of Life: Bridging the Gap Between Knowledge and Practice*. Washington, DC: Hospice Foundation of America; 2006:245-260.
5. American Academy of Pain Medicine, American Pain Society, American Society of Addiction Medicine. Definitions related to the use of opioids for the treatment of pain. 2001. Available at: <http://www.ampainsoc.org/advocacy/opioids2.htm>. Accessed June 26, 2007.
6. Pappagallo M. The concept of pseudotolerance to opioids. *Journal of Pharmaceutical Care in Pain & Symptom Control*. 1998;6:95-98.