S1E2 – Opioid

Transcript

Zach: [00:00:02] So have you ever seen that kind of thing firsthand?

Woman: [00:00:05] I mean, I still know people that go overboard on it and, you know, they sell it or whatever. Like, I mean, I don't know, they're getting 20, 30 bucks a pill. I'd be a millionaire by now if I sold mine. But I've never have. And I'm always accountable; so is my physician. And it's to protect both of us, really. There are other people like me that are taking them responsibly, that are terrified that these are going to be ripped out from under them and they're going to have nothing to replace it with and they're not going to have their pain managed because of the fentanyl crisis. I'm not happy about the fact that I have to take opiates, but there is a responsible way that it can be done.

Narrator: [00:00:57] Canadian Patient Safety Institute presents *Patient*, a nonfiction medical podcast about the people trying to fix modern health care from the inside out. My name is Jordan Blueman [ph].

Voices: [00:01:23] The magnitude of the opioid abuse crisis all across the country… because of the opioid epidemic…opioid epidemic.

Narrator: [00:01:33] So this is a story in two parts. One is of a national epidemic. It's a story of 19 million prescriptions, 2500 deaths in a country that ranks second globally for per capita opioid use. The other is of a person whose experiences illustrate just why that epidemic is so hard to solve. Opioid use turns harmful for a lot of people, some numbers are going as high as one in four. That's why we've heard a lot of a certain type of story, a story that invites the unhelpful binary of prohibition. If these things are so harmful, why don't we stop prescribing them all together? So the second part of our story is going to try to answer why there are no simple answers. We're going to try and avoid making value judgments about the use of opioids, instead focusing on the systems surrounding their use. How do we make those systems better? How do we reduce harm? But first, what are these things?

Zach: [00:02:31] My name is Zach Dumont and I am a pharmacist. I'm a hospital pharmacist and I work with the Regina Qu'Appelle Health Region as the clinical support pharmacist. They're available in oral; they're available in injectable; some of them are available in topical or transdermal formulations like fentanyl, where you're using a patch; you can give some in the cheek, you know, as a little lozenge in the cheek; you can give some sublingually. So there's some appeal at just how adaptable to different routes that you would be administering this, that

these drugs are. It's the fact that we can use this tool in multiple different ways. And we used to think that there was no ceiling dose, necessarily; we could just keep going up if pain got worse. That generally brought some appeal and some favouritism over other analgesics.

Narrator: [00:03:36] Opioids are a class of substance, primarily used as a painkiller or analgesic, which is that term that you would have just heard Zach use. Some types of opioid drugs that you've maybe heard of include codeine, morphine, OxyContin, Percocet, and notably heroin and fentanyl.

Zach: [00:03:55] I think we know more about it now and recognize how detrimental, I guess, that mindset has been for patients.

Narrator: [00:04:06] If you want to understand any of those startling numbers – 19 million prescriptions in Canada alone last year – you need to get what Zach is talking about when he refers to opioids as a tool. It's easy to see how, from the perspective of a medical practitioner trying to manage acute pain, opioids have some very, very appealing qualities. Which is where the problems start.

Zach: [00:04:28] They don't necessarily or that we didn't think they necessarily had much end organ damage, is one of the ways that we refer to it. So for that reason, as long as a patient could tolerate it – from a sedation standpoint or getting fatigued, drowsy, lower levels of consciousness – as long as they could tolerate it from that sense, as long as they could tolerate it from a breathing perspective – because they can at some point cause respiratory depression as well – then you could just keep going up in the dose.

Narrator: [00:05:01] Opioids are useful because if you up the dose slowly, you can give people a lot. Meaning you can treat really, really severe pain without immediate severe side effects.

Zach: [00:05:12] And as long as you followed a pattern like that, you could just essentially keep going up. At least that's what we used to think.

Narrator: [00:05:19] Which is true, until we started looking for other kinds of side effects.

Zach: [00:05:24] Obviously, the higher you go in the doses, potentially the more dependent your body gets on the medication as well. Going up that high, there's lots of room and lots of time that usually passes and lots of time for you to get used to it, to have it around your house, lots of time for you to adapt to the side effects associated with the medication, and more chance for

abuse misuse. And those are just, I think, the tip of the iceberg with some of the issues with opioids.

Narrator: [00:06:02] The tip of the iceberg.

Donna: [00:06:08] I've been sick since 1995. On and off.

Narrator: [00:06:12] That's Donna. She's been prescribed opioids.

Donna: [00:06:15] Well, yeah, my son was a preemie, two months, early due to medical error. And then I ended up getting, I don't know, sick after that and had multiple surgeries. And for some reason, I ended up getting osteomyelitis constantly on and off. And I've had that ever since. And since then, I've also developed other conditions. I had a nonmalignant tumour in my right rib that I had for three years that doctors missed for three years. So my rib kept breaking for three years and they didn't know why. Nothing showed up on scans or anything like that, at least the ones they did. And eventually I ended up where a thoracic surgeon decided he was just going to go in and clean up the ends of the break and it would heal. But once he got in there, it turned out to be massive, major surgery. So they had to remove that rib. And I've been to multiple, multiple pain clinics, had many other treatments tried, and nothing has worked. And every clinic or every pain clinic I went to all ended up with opiates.

Narrator: [00:07:58] But there's a problem here. Looping back to the fact that our goal in this whole episode is to start thinking about how we can reduce opioid harm in the health care system, if we accept that opioids are prescribed at the rate they're prescribed solely because they're a useful drug for treating pain because they're somehow essential, we're missing a part of the puzzle. Or rather, we're making an assumption that this problem, the opioid epidemic we're facing right now, it's happening everywhere.

Matthew: [00:08:31] My name is Matthew Young. I'm a senior research and policy analyst at the Canadian Center on Substance Use and Addiction.

Narrator: [00:08:37] We spoke with Matthew to get his insights on the opioid epidemic from the perspective of someone with nearly a decade's experience researching specifically substance abuse harms in Canada. But before we got into any of that, he brought up a really interesting point.

Matthew: [00:08:53] Speak with a pain physician from somewhere in Europe.

Narrator: [00:08:56] What's going on in Europe?

Matthew: [00:08:57] Well, because they've not really had an opioid crisis in Europe. And you know, and a large part of it is due to just that they have other… I mean, from my colleagues that I've spoken to from Europe, pain management is taught to pain physicians in Europe to employ a lot of other non-pharmaceutical interventions. I'm not a physician; I'm a drug use epidemiologist. But one of the things that is coming to mind is a lot of the premise of your question is that these are essential medications. And while I would agree with that in many ways, it's just the question isn't whether or not they're essential medications, but how essential are they?

Narrator: [00:09:36] Wait, wait, wait. Are we asking the wrong questions here? We began this episode with this narrative that there's an opioid epidemic in large part because of how often we prescribe these medications to people, but that we prescribe those medications that much because there's really no alternative; there's something essential about those drugs. But is that the whole truth? To make sense of this and it needs making sense of we need a broader sense of why these drugs are so popular in the first place. We need to answer the question, "Why is North America so enamoured with opioids?"

Matthew: [00:10:15] Well, I mean, this would be my personal opinion. I think for a period of time, opioids were marketed as a safe, very low-risk way of managing pain, even in people who are suffering from chronic pain; and it turns out that that wasn't the case.

Narrator: [00:10:33] Which brings us to the lawsuits. Matthew was careful to qualify that we needed to double-check this, which we did. But over the last decade, several opioid manufacturers have been the subject of, let's call it several lawsuits.

Matthew: [00:10:49] Where they admitted to downplaying the risk of dependency associated with opioid drugs.

Narrator: [00:10:58] The point of this isn't to cast blame on the pharmaceutical companies and walk away, though you could probably be forgiven for wanting to do that. The point is that the amount of opioid prescriptions that get handed out isn't fixed. It's not a given. It isn't X number of people in pain equals Y number of prescriptions to treat that pain. It's influenced by a whole bunch of factors, including the relationship between our health care system and pharmaceutical companies, factors that we can influence. And I emphasize "our" because the proof of this is in the fact that a lot of very culturally similar countries don't have opioid epidemics on the same scale. Britain doesn't really have this problem on the same scale that we do, which is really

good news if you think about it, because it means that the problem theoretically has a solution. The question now is what does that look like and how do we get there without leaving the patients using opioids right now even further behind?

Donna: [00:12:03] Because I was taking them long term and it sort of started coming out where – I mean, I'm talking several years ago – where people were abusing them and so on and so forth. I was nervous about it.

Man: [00:12:18] We do know that a great many people have become dependent on these substances and absolutely, you know. Have people used them and have people gotten relief and have they been an important tool? Absolutely. But we also know that we are in the middle of an opioid crisis right now.

Donna: [00:12:37] Like, I don't think my doctor is in any way doing anything wrong by prescribing these for me because this is what pain clinics in three different hospitals that prescribed or recommended or whatever you want to call it. And of course, they give you the warnings, too, right, by taking them long term or whatever at the same time. So at least I got that.

Man: [00:13:01] Opioid poisonings resulted in an average of six hospitalizations a day in 2016-2017. This is 17% increase from the daily hospitalization rate in 2014-2015. And one of the things, too, is that among some of the hospitalization data, you know, like, the highest rates are among seniors.

Donna: [00:13:21] And then after I thought about it more and I thought about, you know, all this stuff going on… and I mean, even before it got really bad with the fentanyl crisis and whatnot, I wanted some kind of protection.

Man: [00:13:38] So I think it just needs to be really taken seriously.

Donna: [00:13:41] I'm accountable. If, for some reason, I can't explain why I don't have them or why I need more earlier than I normally would or whatever, then I will never be able to have them again.

Man: [00:13:55] Does that mean that it's impossible to find somebody who's used them long term and not suffered as many harms? Like, I mean, yeah, you're going to find people like that. But I mean, when you're talking about things on a public health basis, I think it's pretty clear, the numbers are pretty clear, that we have a lot of people who are experiencing harms from opioids.

Narrator: [00:14:22] *Patient* is brought to you by the Canadian Patient Safety Institute. Established by Health Canada in 2003, the Canadian Patient Safety Institute works with governments, health organizations, leaders, and health care providers to inspire extraordinary improvement in patient safety and quality. To learn more about CPSI, visit PatientSafetyInstitute.ca.

[0:14:50] We know that the things that we've done in the past to try and improve the opioid epidemic haven't necessarily helped in the way we've intended. So we traditionally tried to decrease the supply of opioids with the goal of preventing new people from starting to use them. But in doing so, the biggest impact we seemed to have was to those who were already seeking out opioids, those that were already using them. What we essentially did was cut off access to people using opioids, forcing them to unregulated options.

Man: [00:15:16] One of the main reasons for opioid hospitalizations that's increased the most was, you know, accidental opioid poisonings. And this is probably largely due to the injection of counterfeit pharmaceuticals being sold in the illicit market. Around the time when OxyContin was taken off the market and Oxy Neo was introduced, we started seeing the appearance of counterfeit oxycodone tablets containing fentanyl. Since that time, you know, the network that I work with called the Canadian Community Epidemiology Network on drug use found that in between 2009 and 2014, there were at least 655 deaths in Canada where fentanyl was determined to be a cause or contributing cause. And fentanyl is just one of a number of what we call novel synthetic opioids that have appeared in counterfeit pharmaceuticals that have been detected. Opioids that have appeared are oftentimes products that were originally developed as possible analgesic drugs, but were never brought to market. You know, these were probably discovered by organized crime or people wanting to make a quick buck who'd just gone through and looked at old patents or old journal articles published on some of these substances and then just, you know, ordered them from a lab overseas, brought them into the country, and pressed them into pills or powders, and sold them on the street as counterfeit OxyContin tablets or other counterfeit drugs to people who were looking to buy these on the illicit marketplace.

Narrator: [00:17:04] And this is all why in maybe just the last year or so, we've kind of, on a public health level, switched to asking this new question.

Man: [00:17:12] Well, how can we prevent the people who are opioid-dependent from experiencing harms? And, you know, the most severe harm is, of course, death.

Narrator: [00:17:21] Which is where you get harm reduction programs and supervised consumption sites and naloxone distribution, which is kind of like an antidote to an opioid overdose.

Man: [00:17:29] So those are the kinds of things. And, you know, and there's also an increased attention to treatment. And so those are good. Those are good. And I think we need to kind of start looking now is what is the extent to which new people are becoming opioid dependent.

Narrator: [00:17:45] Preventing new people from becoming opioid dependent. Well, that's kind of what this whole thing is building to. Because unless you're a policymaker or a health care practitioner, the most immediate thing that you can do is to stay safe. It's to, you know, the next time you're a patient, understand the medications are being prescribed and why you're being prescribed them. Because as we've learned, that's how opioid dependency tends to start. I think that people understanding this problem, its causes, and its scope, is important for us to move forward in solving it on a societal level. But if we want to stay safe on an individual level, we've got to start there with questions. So let's put ourselves in the shoes of a patient and start asking some.

Chris: [00:18:35] My name is Chris Power, and I have the privilege to serve as the CEO of the Canadian Patient Safety Institute. So our work is really about preventing harm, but when harm happens, responding to it and then learning from it. Where the opioid crisis has really raised its head is the number of people across the country who have been prescribed opioids. That's the biggest crisis, I think. So people are dying of fentanyl overdose and that's horrible and we need to be paying attention to that. But I think one of the bigger things we need to be paying attention to is who are physicians prescribing to get on opioids to even start with, and really start to focus in on that. And so the work that we have been doing at Canadian Patient Safety Institute with others, our focus is on providing information to the public and to patients about alternatives to opioid treatment. So before you even be prescribed opioids, what are some alternatives for you to be thinking about? Because once you're on them, it's very difficult to come off them. And so we see that dependence that's happening across the country. So that's really been our focus. Safe use of opioids, safe disposal of them when you're finished them if you're on a short-term one, and options to opioid treatment. So really focusing more on the patient safety side, the knowledge transfer, arming patients and family members and the public with the information they need to have before they ever go down this path.

Narrator: [00:20:12] How does someone sitting in their doctor's office start going about getting that information?

Chris: [00:20:17] Well, I think better dialogue is huge. I think for physicians or whoever's prescribing, but physicians primarily are prescribing opioids, to have the conversation with the patients and their families , if families are there, about what are the side effects, what are the long-term effects of taking opioids, what are some of the options that you can have?

Narrator: [00:20:37] And then there are the five questions.

Chris: [00:20:41] The five questions are something we are incredibly proud of because they came about very organically. This came with actually a member of our board who had a very personal incident happen with her father as she was trying to help him navigate through the health system. He had many chronic conditions and many, many medications, and she was a pharmacist herself. But working with the Institute for Safe Medication Practices, with pharmacy associations, and most importantly, with our patients, saying, “What are those crucial questions we need every single person who is given medications to be able to ask of their health care provider to keep them safe so that they understand what they're getting?" And so through that work and through this group of people who came together, the five questions that every patient should ask about their medications – and family members, that we should all have in our back pocket, every single one of us – came to be. And so they are, you know, “What changes? Have any medications been added, stopped or changed and why? And should we continue? What medications do I need to keep taking and why?” Then the question, “What's the proper use? How do I take my medications and for how long?” Then the monitoring question of, “How will I know if my medication is working and what side effects do I watch for?” And then the whole follow-up, “Do I need any more tests? And when do I book my next visit?” So those five questions have been translated into many, many different languages, are being used all around the world. We're thrilled about that because questions do save lives. We know that.

[0:22:25] And, you know, in Canadian health care, we still have a huge deference to physicians and to nurses and to our pharmacists. We don't feel that we should be asking questions or we don't even think about asking questions, but it's so critically important for us to understand. We as individuals, we so desperately need to know what the medications are for, what their side effects are, why we're taking them, how long we should be taking them, because medications are the number one harm that happens to patients, when medications are missed, when the wrong medication is given, when there are side effects that people don't know about. So it's really critical for us to be asking those questions. And we think these five questions are easy ones for people. We can have them on a little sheet of paper. You can have them in your wallet, wherever you are, so that when you're having any interaction, you ask these questions and help keep yourself safe.

Narrator: [00:23:23] You can find those five questions that you should ask about your medication at PatientSafetyInstitute.ca. The opioid epidemic is one of the health care questions of our age, and it's a sprawling topic, so suffice it to say, we know we didn't cover anywhere close to everything in this episode. There are things in the history of the problem that we weren't able to dig into, things like the idea of pain is the fifth vital sign, and the sort of mid-80s paranoia that swept North America that we were under-treating pain that really helped create the current conditions that we're living in right now. And there are things today. We spoke a bit about prevention, but we didn't get to talk much about how people struggling with opioid addiction right now can get help and some of the really promising work that's being done to make that recovery process work better. It's this idea that we can help treat opioid addiction by treating related issues like depression. And we don't really get to talk about how the world of opioid addiction medications like methadone and naltrexone works. If you want more information on the history of this problem and the future of how we are kind of looking to solve it today, I highly recommend the opioid episode of the podcast Sawbones. If you haven't listened to it, it's fantastic.

[0:24:31] We need to be treating this like the chronic disease that it is, with the same commitment that we see in governments funding dialysis for renal failure. The point is that if this felt dire because of the tone and the music, there is hope, hope that we can solve this problem while still preserving the humanity of the people who need these drugs and the people who need a way out.

Donna: [00:24:55] There are days – I'm not going to lie… I mean, right now is a rough go for me because I've had a really bad setback. I've had these seizures. I broke my wrist. I've had just, you know, a reoccurrence of things and it just hasn't been good, so I had to take a step back and just kind of try and get healthy again.

Narrator: [00:25:20] And what is life without these drugs? What does that look like for you?

Donna: [00:25:24] I'd be in bed 24-7.

Narrator: [00:25:31] This season of *Patient* is produced by the Canadian Patient Safety Institute. For more information on projects people like Zach, Matthew, and Chris are all working on to improve patient safety, visit PatientSafetyInstitute.ca. *Patient* is produced by Scott Winder, Cecilia Bloxham, Carla Horan and myself, Jordan Blume. Thanks for listening.