Statement by Dr. Bob Twillman

I regret that I cannot be there with you today, but unfortunately, airplane mechanical problems have caused me to be unable to attend.

I am grateful though, that Lynn Hart has agreed to provide you with the slide set I was planning to use, and to read this brief statement that I hope communicates the key messages I planned to deliver this afternoon.

As you consider the significant problem represented by drug overdoses and the role that prescription pain relievers may play in that problem, it is vital that you simultaneously consider another problem—the problem of unrelieved pain. Chronic pain, in terms of the number of Americans who suffer from it, as well as in terms of its cost to our economy, is an enormous public health problem, involving more than 100 million American adults and costing us around $600 billion per year. Still, this is not a situation in which it is useful to compare the magnitudes of these two problems, but rather one in which we need to recognize that both are serious crises that warrant our attention.

As is true for healthcare providers with their individual patients, policy makers owe a moral duty to the citizens of New Mexico to find ways to effectively address both of these problems. It is unfortunate that the easy solution to one or the other of these crises inevitably leads to a worsening of the other. Instead, we have to contend with the complicated natures of both drug abuse and chronic pain, and the conundrum presented to us as we try to manage both.

I believe that, to find the right answers, we first must ask the right questions. I call your attention to a couple of my slides, in which I pose what I think are the complicated but correct questions.

First, why is it that CDC statistics indicate that New Mexico has the nation's highest rate of drug overdose fatalities, despite the fact that its rate of opioid pain reliever misuse is not significantly different from the national average and its rate of opioid pain reliever sales is significantly below the national average? To me, what this suggests is that it is not the *frequency* of the use or misuse of opioids that is of utmost concern, but the *pattern* of that misuse that is significant. Exactly what that pattern is, and how to address it, is, I believe, unknown. Finding out is part of our diagnostic work-up, if you will, of this problem, something that we need to complete before prescribing solutions.

Second, it is wrong to ask “should we use opioids to treat chronic pain?” Instead, the correct question to be asked is, “in which patients should we use opioids, at what doses, for how long, with which adjunctive treatments, and with what precautions?” The first, incorrect, question suggests that opioids are *never* indicated in the treatment of chronic pain because they do not help anyone. We know, however, that there are *some* people with chronic pain for whom opioids are a very important and effective part of their treatment plan. Without these medications, these individuals would be disabled, dysfunctional, and devoid of any kind of quality of life. We need to ensure that these vital medications are available for those who truly benefit from their use.

Third, it is wrong to ask “how can we reduce the supply of prescription opioids?”, but right to ask “how can we reduce the EXCESS supply of prescription opioids?” The history of efforts to control drug abuse in this country demonstrates that focusing solely on the overall supply of opioid pain relievers has no effect on overall drug abuse rates; and ongoing experiments with these techniques in Florida and elsewhere suggest that doing so harms people with chronic pain who need these medications. The challenge for us as a profession and as a society is to define the term “excess”.

I believe the way out of the conundrum in which we find ourselves vis-à-vis these two crises is to be found in providing the right treatment for both problems. One of my slides shows that, in 2007, New Mexico was #42 in the country in the per-capita number of people admitted for inpatient treatment of substance use disorders in which prescription opioids were the primary drug of abuse. Again, this is in the context of the nation’s highest rate of drug overdose deaths. It seems logical that the rate of treatment admissions should be commensurate with the size of the drug abuse problem; to that end, I believe the state needs to invest in additional resources to provide effective substance abuse treatment, and to train healthcare providers and others to better recognize these disorders in the people with whom they work.

With respect to pain management, I believe we need to recognize that opioids are only one part of a comprehensive treatment plan for chronic pain. In fact, for some people with chronic pain, opioids may not be necessary, and for others they may do far more harm than good. Excellent treatment of chronic pain requires that we pay attention to not only the biological components of the pain experience, but also to its emotional, social, and spiritual components. Practitioners who consider all of these factors in their evaluation and treatment of people with chronic pain are engaging in a practice we know as integrative pain management. An integrative model recognizes that opioids may be necessary for some, but they are rarely sufficient for most. Only when our practitioners are adequately trained to understand all these components of chronic pain, to assess their patients to determine the role each component plays in each patient’s experience, and to formulate and execute treatment plans that address all components, will we be able to make significant progress in battling chronic pain.

“Getting there” in terms of this model of integrative pain management will involve an investment, but one that should pay handsome dividends. It will require increasing the training of medical students while they are still in medical school—note that veterinary medicine students have been found to receive approximately 10 TIMES as many hours of education about pain control as medical students. It will require improved continuing education for providers who are already in practice—and the Medical Board should be congratulated for formulating rules that provide for this. It will require that providers who do something other than prescribe medication—those who engage people with chronic pain in psychotherapy, physical therapy, chiropractic treatment, acupuncture, or any of a number of other interventions—are present in an adequate supply, are accessible for referrals from traditional medical providers, and have adequate reimbursement to enable them to work effectively with these patients.

One final thought—as legislators, you know that increasing regulation of some practices can serve as a disincentive to those practices, and result in decreasing their availability. The same is true for regulating the practice of pain management. Several states have experimented with regulating pain management clinics as a means of closing the notorious “pill mills”. The experience, from the point of view of the person with pain, has been disastrous. The unintended consequence of increasing regulatory requirements for legitimate pain management clinics, as a means of better policing the already-illegal behavior of those running “pill mills”, has been primary care physicians ceasing to treat chronic pain, and the closure of many good and legitimate pain management practices. At a time when we clearly need to be encouraging the development of more comprehensive, integrative pain management clinics, imposing onerous regulations on them is not only unproductive, it is harmful. There are only 34 board-certified pain management specialists in New Mexico; 25 of them practice in either Albuquerque or Santa Fe. Providing good pain care to the citizens of the rest of this large state clearly cannot be accomplished by 9 expert providers. Thus, not only do we need to encourage more of these individuals to practice in New Mexico, we also need to find ways to bring the care given by the existing providers to patients throughout the state, through more efforts like Project ECHO.

I would like to call your attention to two of my final slides, which highlight two successful efforts to address drug overdoses. The Zero Unintentional Deaths campaign in Utah, and the Project Lazarus effort in North Carolina, both represent shining examples of programs that have been successful because they have focused on the right targets for intervention. Both have a very heavy component of public education and engagement, recognizing that no matter what the medical profession does, it is still in and around people’s homes where most abused drugs originate and where most people die of overdoses. I invite you to examine these programs closely and would be happy to put you in touch with their originators.

In closing, let me once again thank you for the opportunity to present my thoughts about how we find our way out of the mess we're in. I hope I have provided you with food for thought, and please know that I am more than happy to discuss these ideas, and others, as you consider how to resolve these two crises.