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# Do No Harm: Navigating Pain, Opioids, and Risk in Serious Illness

*2025 VEN Palliative Care Spring Series*

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**No financial disclosures to make**

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# By the end of this talk, we hope you will...

- Describe safe and appropriate pain management strategies in people with serious illness at risk for or with concurrent substance use disorder
- Distinguish substance use disorder from the under-treatment of pain in people with serious illness
- Define routine and universal risk assessment for substance use disorder when considering treatment with opioids

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# **Part 1: Where we are with Serious Illness and Pain Management**



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# Scale 1-5: How likely are you to prescribe an opioid for the patients below

## Albert Thomas

- 67 year old who has metastatic prostate cancer (to bones), back pain from cancer
- Pain is 12/10 and impacts his ability to do household chores, play with his grand children, and perform at local community theatre
- History of alcohol use disorder; Lives with wife
- Family history of substance use
- Takes Tylenol and steroids

## Betty Thomas

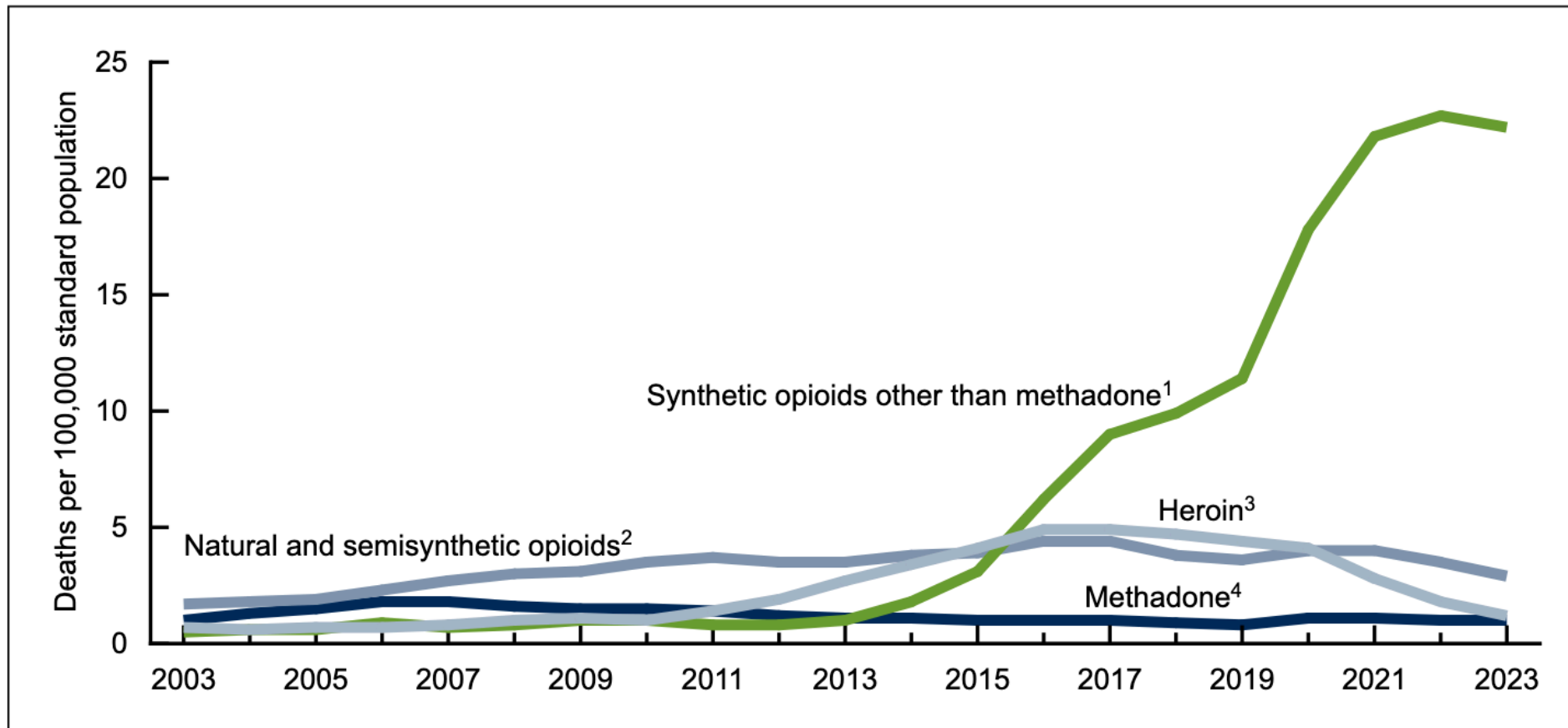
- 81 year old who has metastatic breast cancer (to bones), back pain from cancer
- Pain is 3/10 and impacts her ability to take care of her ADLs and keeps her up at night when she is laying on her back
- History of anxiety;
- Takes duloxetine, Tylenol and steroids

## Carl Thomas

- 48 year old who has metastatic pancreatic cancer (to liver), abdominal pain from cancer
- Pain is 8/10 and impacts his ability to perform ADLs and get to appointments
- History of opioid use disorder;
- Lives at a shelter
- Takes Tylenol and steroids

# We are still seeing the opioid epidemic

Figure 4. Age-adjusted rate of drug overdose deaths involving opioids, by type of opioid: United States, 2003–2023



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# There are other risks to taking opioids

- Falls
- Depression
- Motor Vehicle Accidents
- Increase in Opioid Use disorder (3-26% of patients in primary care settings)
- Stigma and isolation
- Long-term harms (hypogonadism, decreased bone density, immunocompromise)

**Yet, patients with serious illness now have undertreated pain because of fears of substance use disorder**



*Enzinger et al. J Clin Oncology. 2021.*



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# **We continue to see racial and gender disparities in pain management**

50% of trainees held one or more false beliefs about black patients

29% of sickle cell patients rated interactions with health care teams as “most negative” or “bad”

Female patients are less likely to be prescribed pain-relief medications compared to males



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**For those that treat  
serious illness, we  
are seeing more  
patients with  
complicated pain**





<https://www.fredhutch.org>

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**Opioids may be the best medication for a patient**

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Goal is for all patients to improve function and quality of life, using the safest, lowest effective pain regimen



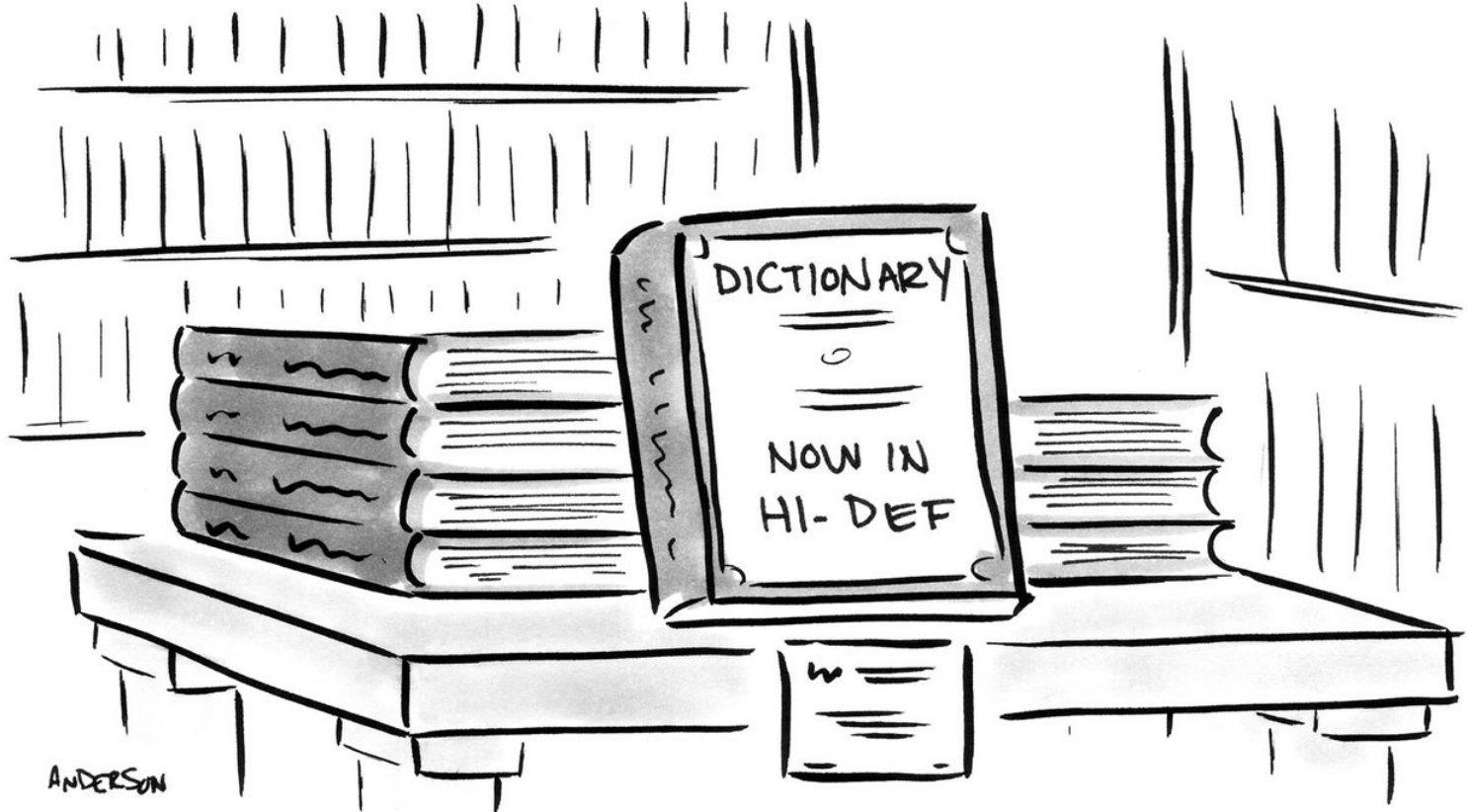
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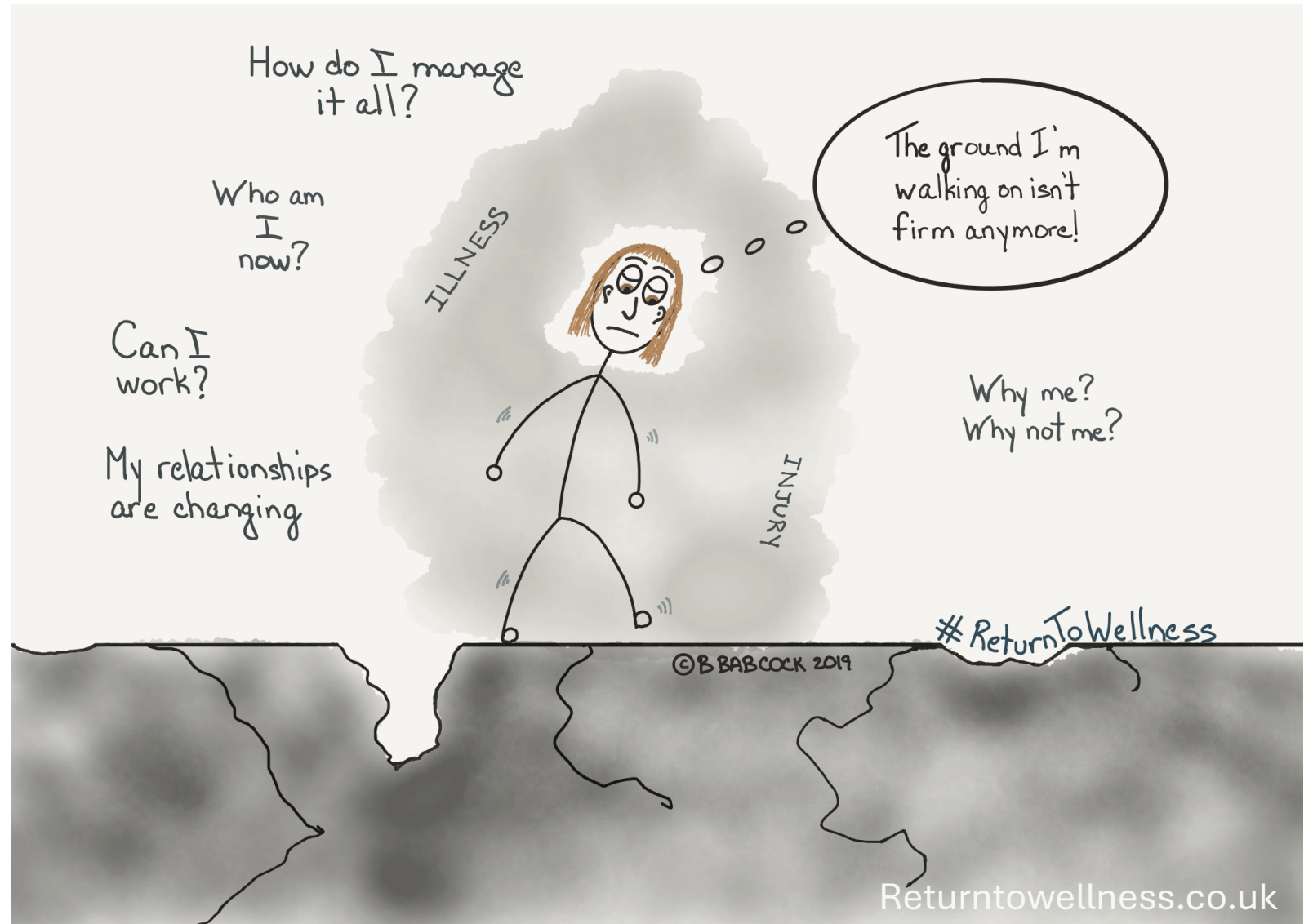
# Some definitions to keep in mind

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# Serious Illness

- Health condition that carries a high risk of mortality and impacts a person's daily function or their quality of life





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# Opioid Misuse vs. Opioid Use Disorder

Misuse: taking opioids in a way other than prescribed

Use Disorder: a chronic relapsing, and remitting disease; subset of substance use disorder



# Pseudo addiction

- Concerning behaviors that suggest to the clinician of the possibility of unsafe opioid use but diminish or resolve after a better analgesic plan is adopted

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**How can we  
find the right  
balance?**



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# **Part 2: Five Steps to Navigate Pain and Serious Illness**

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# Approach treatment in 5 Steps

1. Assessment

2. Build Relationships

3. Use Non-Opioid Therapies

4. If Non-Opioid Therapies are Ineffective

5. De-prescribe

## Take a thorough history

- Pain Assessment (OPQRSTU)
- Pain Management History
- Psychiatric History
- Elicit history- medical, social, family
- Elicit substance use history
- Sleep History



## Use assessment tools

- PHQ-Q for Depression/Anxiety
- Risk assessment tools such as opioid risk tool (ORT)

Over the last 2 weeks, how often have you been bothered by the following problems? <i>(circle one per question)</i>		Not at all	Several Days	More than half the days	Nearly every day
1	Feeling nervous, anxious, or on edge	0	1	2	3
2	Not being able to stop or control worrying	0	1	2	3
3	Little interest or pleasure in doing things	0	1	2	3
4	Feeling down, depressed, or hopeless	0	1	2	3

# 1. Assessment

## Opioid Risk Tool (ORT)

- Validated
- Length & Time: 5 items, <1 minutes
- Target: Adults
- Assess: risk of aberrant behaviors
- Administered by: Self-report

Mark each box that applies	Female	Male
<b>Family history of substance use disorder</b>		
Alcohol	1	3
Illegal drugs	2	3
Rx drugs	4	4
<b>Personal history of substance use disorder</b>		
Alcohol	3	3
Illegal drugs	4	4
Rx drugs	5	5
<b>Age between 16-45 years</b>	1	1
<b>History of preadolescent sexual abuse</b>	3	0
<b>Psychological disease</b>		
ADD, OCD, bipolar, schizophrenia	2	2
Depression	1	1
<b>Scoring totals</b>		

## 2. Build Relationships





## 2. Build Relationships

# Connect with communication skills

Curiosity

Non-judging or non-stigmatizing language

- Person-first language
- Neutral statements
- Avoid blaming

Patience

Partnership

Continuity

NEJM Group. Racial Disparities. 2021

Kung, L. CAPC. 2025.

Treatment improvement protocol. SAMHSA. 2020



## 2. Build Relationships

# Set Smart Goals

- Align with patient
- Feasible pain relief
- Measurable for next visit

**S M A R T**

By the next week, able to walk the dog 3 times without an acute pain episode

SPECIFIC

MEASURABLE

ACHIEVABLE

RELEVANT

TIME-BASED



## 2. Build Relationships



# Check in about your bias

- Would I be treating this patient differently if they were?
- Explore their bad experiences?

## First step strategies for less severe pain

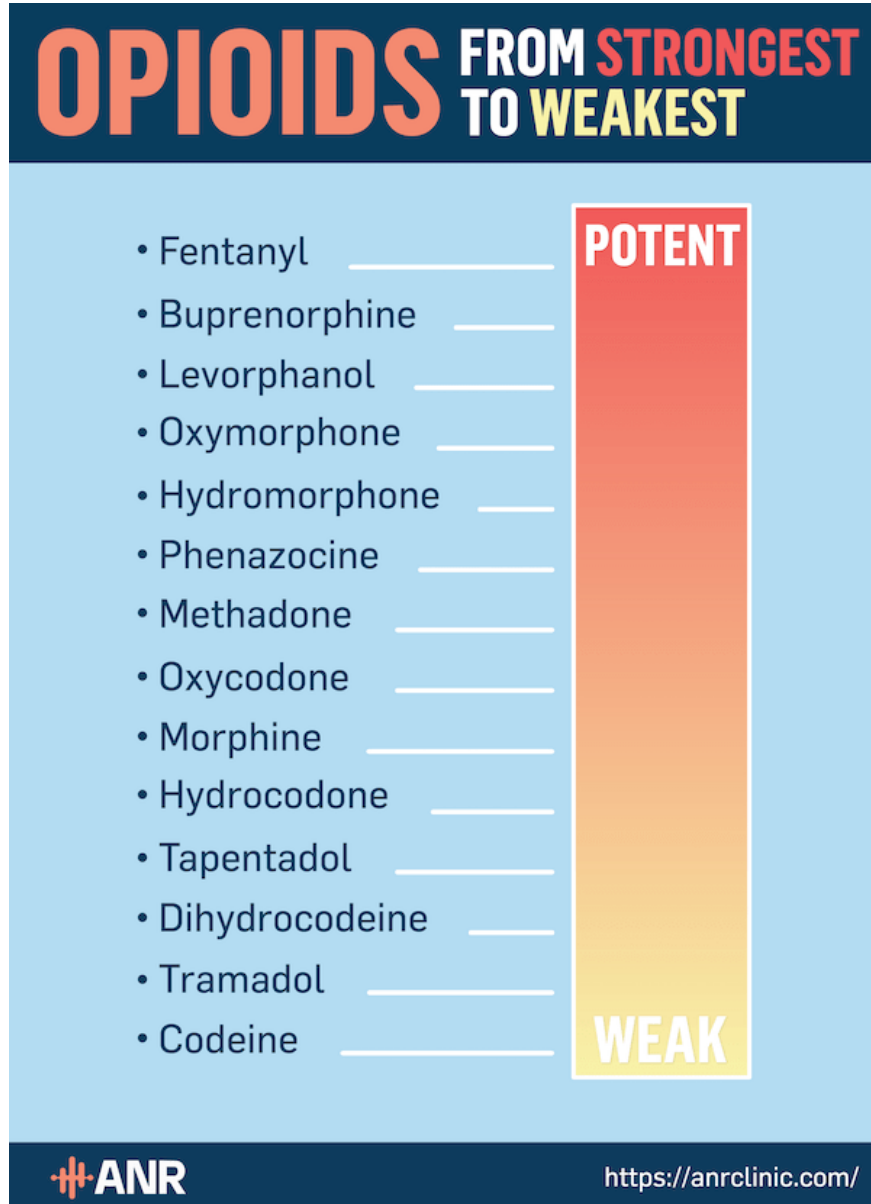
- Non-Pharm

- Adaptive Coping Strategies
- Cognitive Behavioral Therapy
- Physical Therapy
- Acupuncture
- Reiki
- Music Therapy
- Yoga

- Pharm

- NSAIDs
- Tylenol
- Steroids
- Antidepressants
- Gabapentinoids
- Interventional Pain
- Treating underlying cause

## 4. If Non-Opioid Therapies are Ineffective



**Consider Opioids  
when non-opioids  
are ineffective or  
pain is too severe**

## 4. If Non-Opioid Therapies are Ineffective

# Factors to consider when prescribing opioids

Medical History

Social History

Family History

Substance Use History

Caregiver Support

Function

Impact of prior pain management

Opioid Use risk

## 4. If Non-Opioid Therapies are Ineffective

# There are also many barriers that may make opioids more difficult to prescribe

- Insurance
- Access
- Low health literacy
- Over-reliance on pain scales
- Inadequate knowledge for providers
- Bias or stereotyping
- Lack of cultural sensitivity



## 4. If Non-Opioid Therapies are Ineffective

# For opioid naïve patients: start low, safe, and frequent

### Low

- Oxycodone oral 2.5-5mg
- Morphine oral 5-7.5mg
- Hydromorphone oral 1-2mg

### Safe

- Prescribe a bowel regimen
- Locked box
- Naloxone

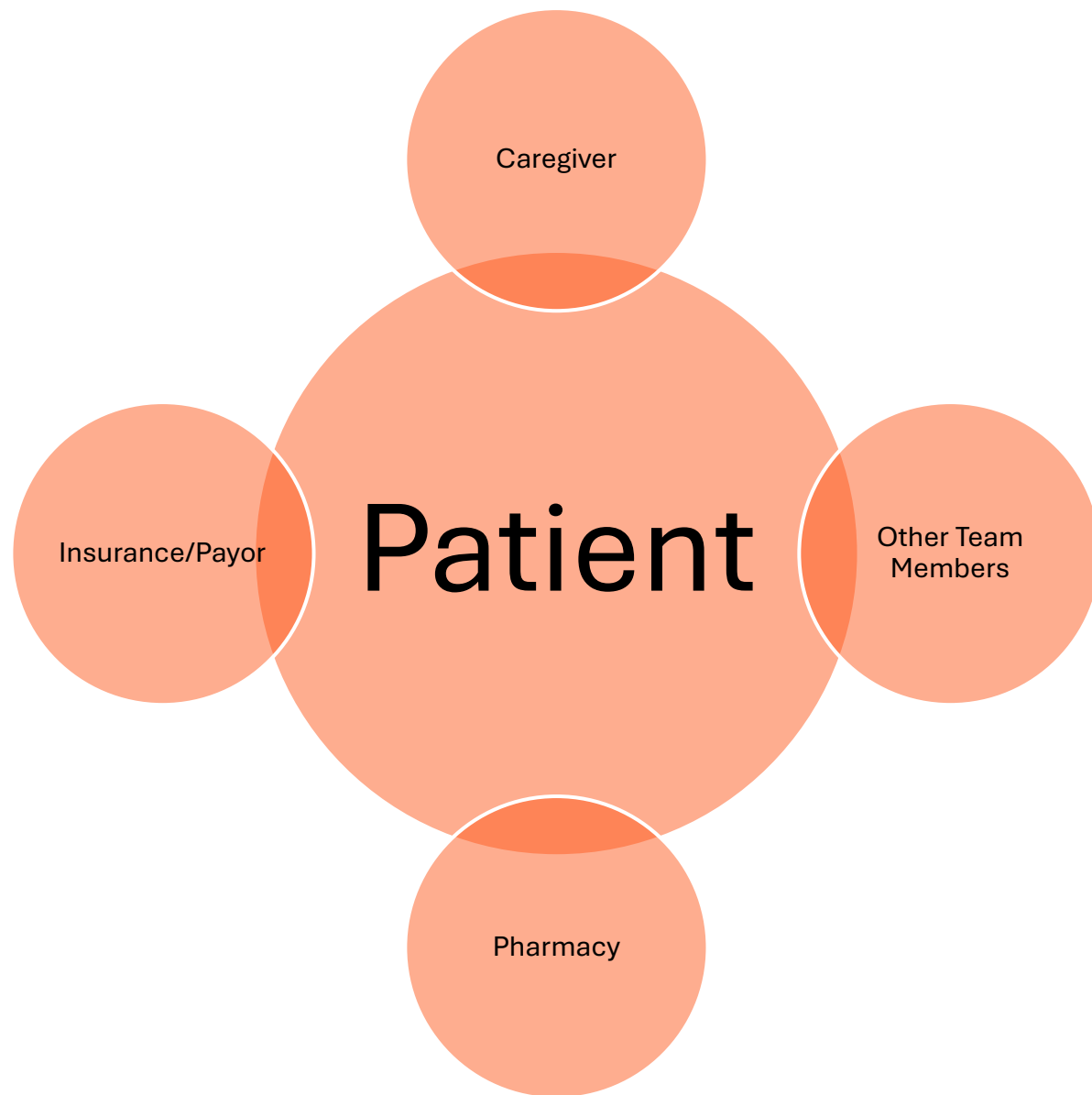
### Frequent Follow-ups

- 3 day-7 days



## 4. If Non-Opioid Therapies are Ineffective

**Ensure that all the stakeholders have been informed/consulted**



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## 4. If Non-Opioid Therapies are Ineffective

Regular Visits

Opioid Treatment Agreement

Clear Documentation

Prescription Drug Monitoring Program

Naloxone Training and Provision

**Utilize  
universal  
precautions**

## 4. If Non-Opioid Therapies are Ineffective

# Treatment agreements can improve communication but not outcomes

### Informed consent

- regarding opioid benefits, expected outcomes and potential harms

### Patient i

### Achievat

### Patients'

**SHARED DECISION MAKING =  
medically context + patient's goals**

- Patients have the right to pain control, but not to a particular pain medication or route of administration.

### Patients' responsibilities:

- Single prescriber
- Single pharmacy



## 4. If Non-Opioid Therapies are Ineffective

# Document the 4 As in your note

Analgesia: pain relief

ADLs: impact on function

Adverse effects: side effects

Aberrant behaviors: red flag behaviors



## 4. If Non-Opioid Therapies are Ineffective

# Use urine screen when necessary (particularly for patients with substance use disorder)

- The safest approach for drug screening.
- Screens can be costly and may not be covered by payers, but the utility of objective data outweighs these obstacles.
- Since screens can be difficult to interpret, choose the simplest screen.
- Screen on initiation of opioid analgesics and at random intervals - typically every 3 or 4 visits
- Be prepared for what you will do if its positive

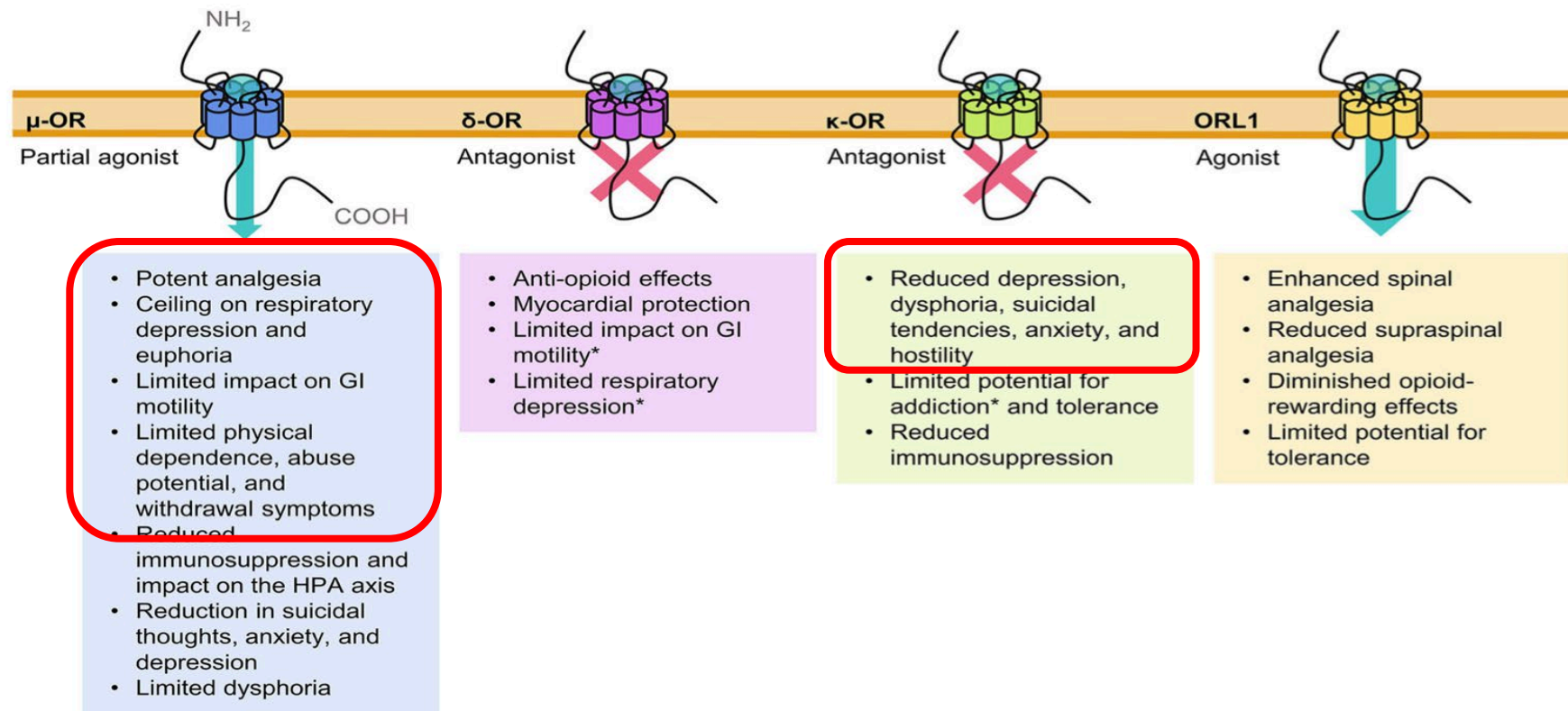
#### 4. If Non-Opioid Therapies are Ineffective



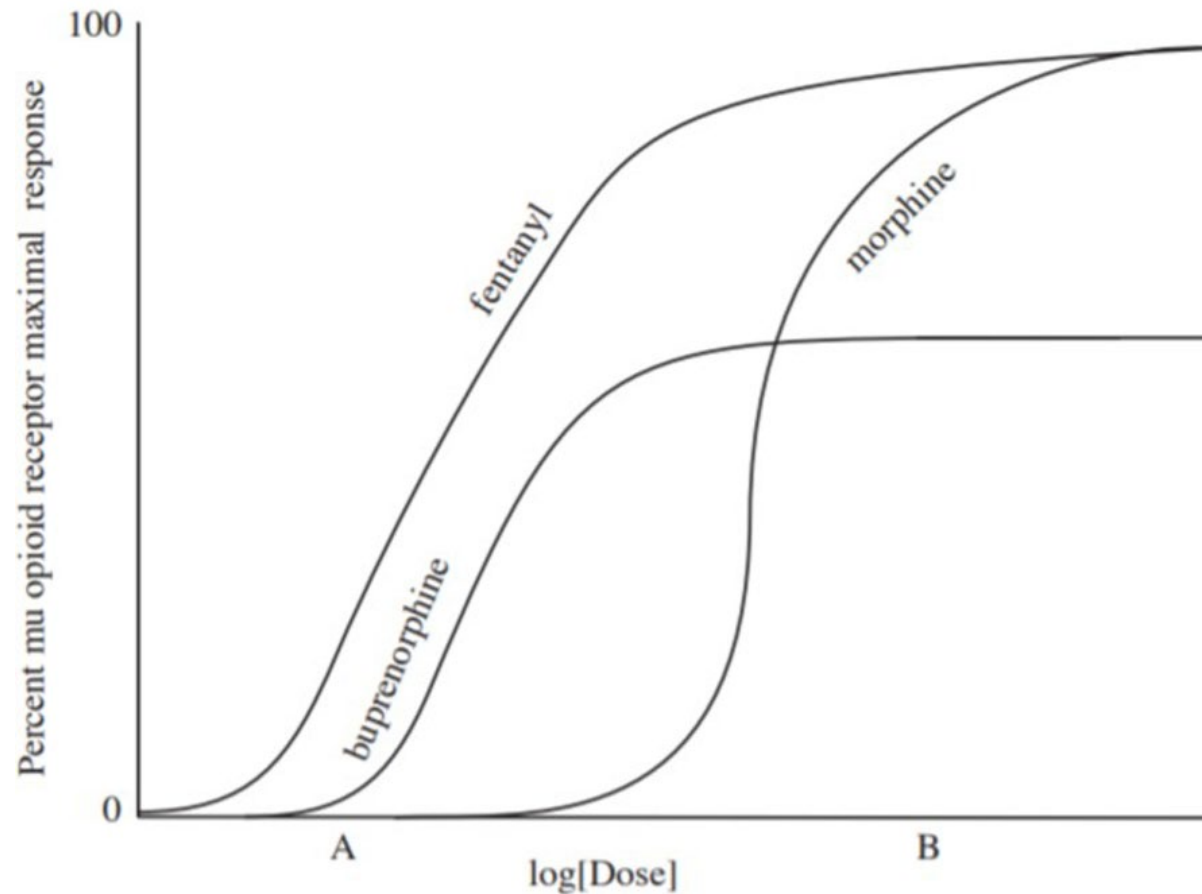
**Buprenorphine may be an effective strategy for serious pain and experience addiction**

## 4. If Non-Opioid Therapies are Ineffective

# Buprenorphine acts on unique receptor sites



## 4. If Non-Opioid Therapies are Ineffective



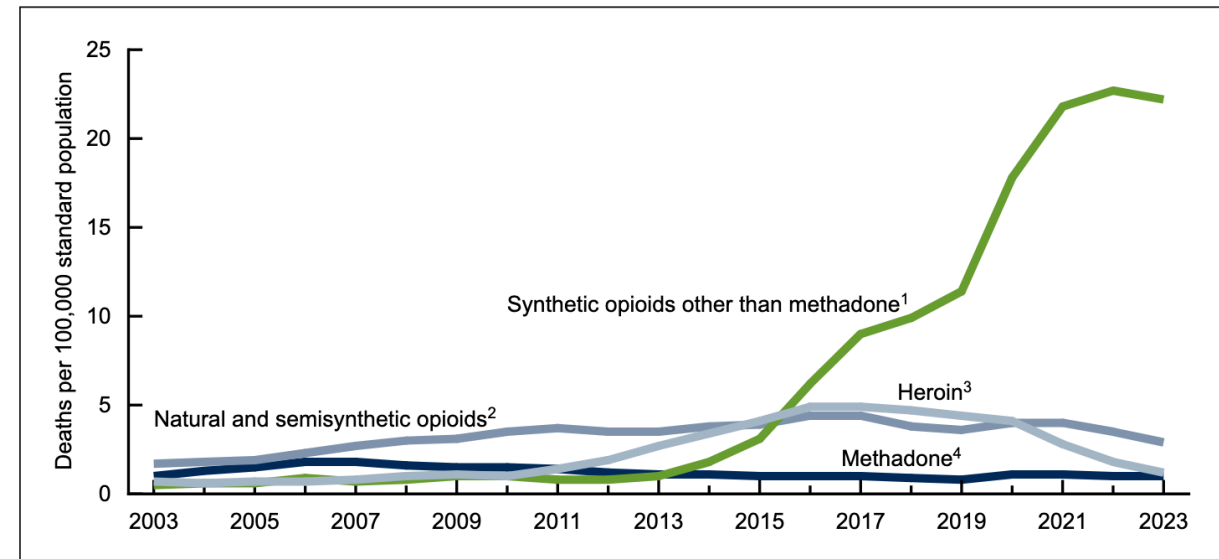
**Buprenorphine  
has a ceiling effect  
for toxicity**

## 4. If Non-Opioid Therapies are Ineffective

# Methadone offers a complex alternative

- Beneficial for opioid insensitive or opioid refractory pain
- NMDA antagonism suggests a mechanism for treating neuropathic pain
- Also used for SUD, but the dosing is different
- Delayed onset of relief and toxicity (2 hours)

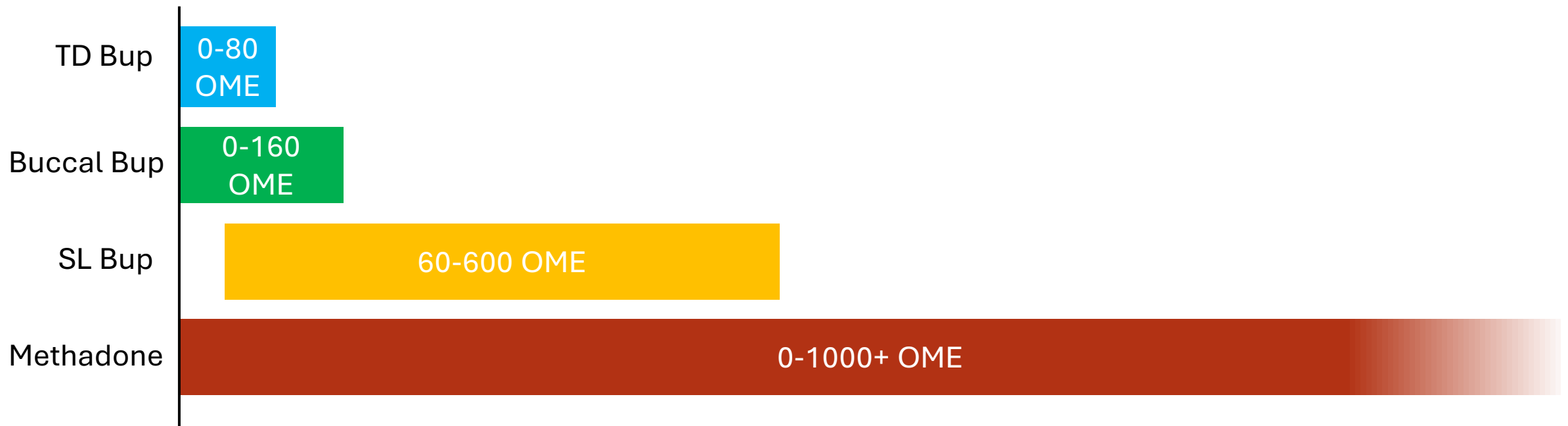
Figure 4. Age-adjusted rate of drug overdose deaths involving opioids, by type of opioid: United States, 2003–2023



## 4. If Non-Opioid Therapies are Ineffective

# Methadone is more likely to be effective with the highest levels of opioid tolerance

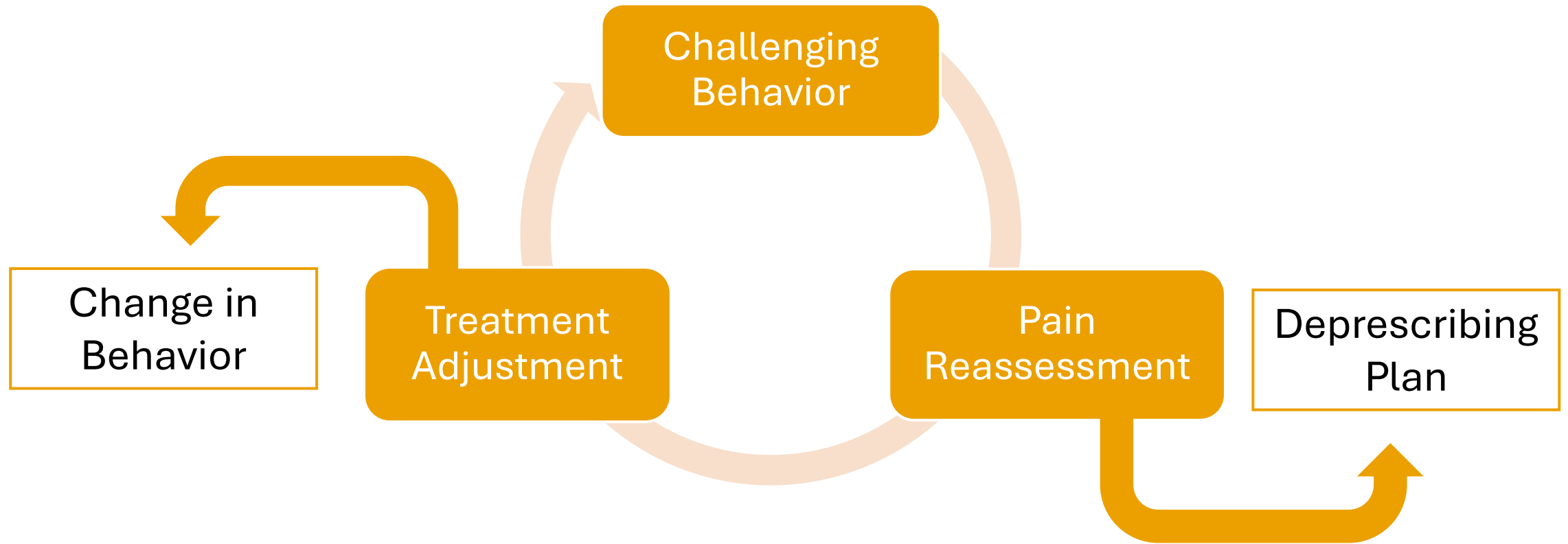
Approximate Oral Morphine Equivalent Range (OME) where you can anticipate analgesia



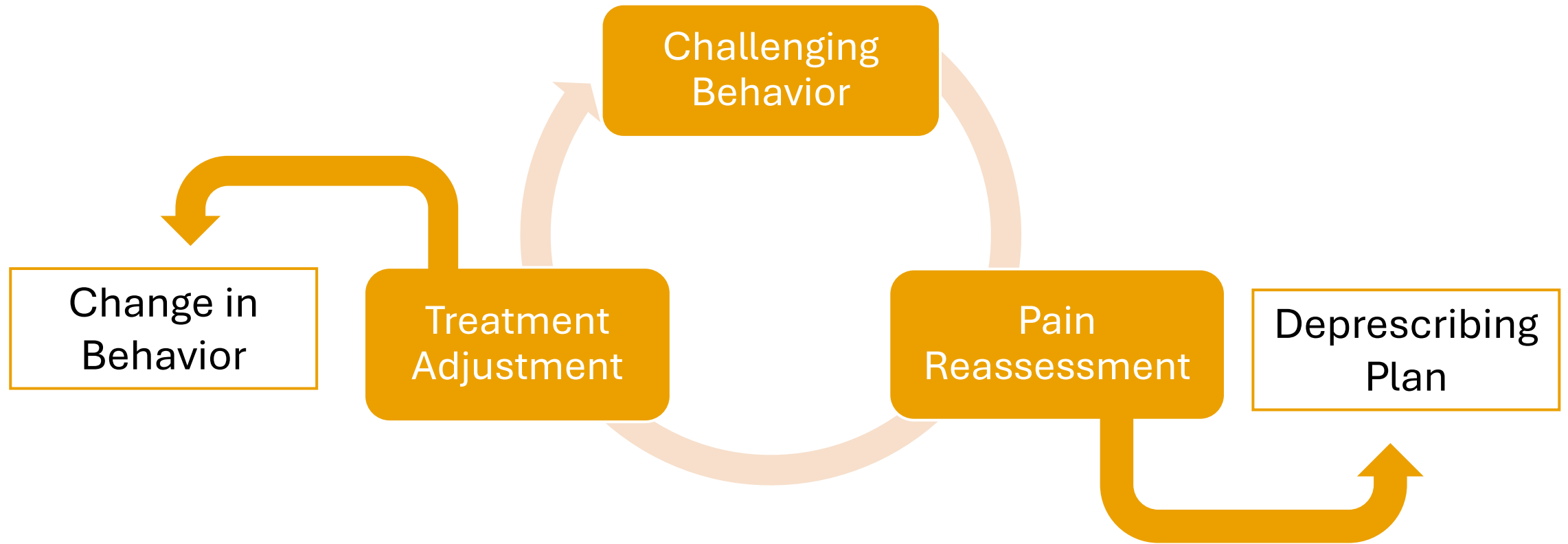
## 4. If Non-Opioid Therapies are Ineffective

	<b>Methadone</b>	<b>Buprenorphine</b>
Half-life	Long and variable (6h-6d)	but slow disassociation (72 hrs)
Analgesic window	6-12 hrs	6-24 hrs
Safety profile	Many drug-drug interactions, higher overdose risk Greater risk of arrhythmia	Fewer serious adverse events (OR ~0.7 compared to methadone)
Formulations	Liquid, tablets, intravenous	Sublingual, buccal, transdermal, intramuscular depot, intravenous
Special Populations	Neuropathic Pain Very High Opioid Tolerance Safe for renal disease Caution hepatic dysfunction	Active SUD or highest risk for SUD Safe for renal disease Caution hepatic dysfunction

# Addiction or Pseudoaddiction



# Addiction **AND** Pseudoaddiction





## 5. De-prescribe

# Deprescribe when risks outweigh benefits

Lack of improvement or impact and clinically on function, quality of life or other life goals with pain medications

Person is experiencing serious or intolerable opioid-related adverse effects domains

New diagnosis/med change that may interfere with opioids

# Recommendations for Deprescribing Opioids

Deprescribing plan at the point of opioid initiation

Gradual taper

Tailor the deprescribing plan based on the patient

Frequent monitoring and review

Implement interdisciplinary or multidisciplinary care



**Let's put  
this  
together**

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# Key Takeaways for pain management for **all patients** with serious illness and opioids

Use thorough assessments to determine cause of pain and appropriate medications

Build relationships through clear communication and trust

Use SMART goals over treatment agreements

Work with adjuvant medication and non-pharm methodologies to address pain

Communicate with the entire health team and document

De-prescribe

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# Key takeaways for pain management for patients with SUD, serious illness and opioids

Utilize buprenorphine or methadone

Work with interprofessional teams

Use urine screening

See patients frequently with continuity

Support SUD treatment and recovery

Work with specialists (addiction, palliative care)



# Questions

