Statement by Richard Payne, MD
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Committee on Health, Education, Labor and Pensions
United States Senate
Hearing on OxyContin®: Balancing Risks and Benefits
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I thank you for the opportunity to speak with the Committee. My name is Richard Payne. I am a physician with expertise in pain management and palliative care, practicing at Memorial Sloan-Kettering Cancer Center in New York City. In my capacity as Chief, Pain and Palliative Care Service I see patients, teach medical students and post-graduate physicians-in-training, and direct a program of pain and palliative care research. I have also had the privilege to serve on The Agency for Health Care Policy and Research (AHCPR) committees charged with writing clinical practice guidelines for acute pain and I co-chaired the cancer pain management panel. I have been a consultant to the Institute of Medicine and the National Cancer Policy Board to advise these agencies on the deficiencies of care provided to Americans at the end of life, particularly on the disparities in pain management and palliative care at the end of life care experienced by minority patients. Over the course of my career, I have received honoraria and research funding from the NIH, private foundations, and the pharmaceutical industry, including Purdue Parma, to give lectures and seminars, serve on advisory boards, conduct research studies and provide expert legal testimony. Although I am president-elect of the American Pain Society, my appearance here today reflects my own personal views and not necessarily the views of the American Pain Society.

I wish to emphasize, in the strongest possible terms, the need to maintain balance in our drug regulatory policy so as to improve the availability of essential opioid medications for the treatment of pain while meeting our responsibility to control drug diversion and illicit use of opioids. This point was emphasized in a recent press conference (October 23, 2001) at which time, a position statement, *"Promoting Pain Relief and Preventing Abuse of Pain Medications: A Critical Balancing Act"* was released from 21 health care organizations and the Drug Enforcement Administration. Mr. Asa Hutchinson, Administrator, Drug Enforcement Administration (DEA) spoke at the press conference and acknowledged that the achievement of a balanced approach to drug regulations was an important objective of DEA policy.

I appeal for balance in drug policy because I am keenly aware of the negative consequences for the care of patients suffering from pain if the consequences of controlled substance regulation further restrict access to

essential pain medications. I take this position for several reasons, which are based on my own research work and experiences from 25 years in clinical practice. I wish to make several points:

- For many patients, opioid analgesics (e.g., morphine, oxycodone, fentanyl patches, methadone) are the most effective way to treat pain, and often the only treatment option that provides significant pain relief.

  My clinical experience is quite consistent with the evidence-based clinical practice guidelines for the management of pain, which emphasize the need for the availability of multiple pain medications to clinicians, so as to enhance our ability to select the right drug for the right patients. It is now very clear that with respect to the use of opioids to manage pain, one drug does not fit all. In my cancer center, up to 15-20% of our patients require an opioid drug other than morphine to provide the best pain relief with the minimum number and intensity of side effects. A study from Sloan-Kettering reported that 80% of patients required one switch of opioid medications; 44% of patients required two or more switches and 20% of patients required three or more switches of medication to manage their pain in the most optimal manner. Even though opioids derive for the same general chemical family, there are important clinical differences in the ways in which patients respond to specific drugs—patient A may not tolerate morphine, but will tolerate oxycodone, while patient B may be just the opposite. Therefore, it is essential to have many opioid medications available for clinicians--morphine, oxycodone, fentanyl, and methadone--to provide the appropriate clinical flexibility that allows optimization of therapy and individualization of the treatment of patients.

- OxyContin ®, a controlled-release formulation of oxycodone, is as effective as any other opioid for the treatment of pain, and has a similar profile of adverse effects, including abuse liability, as other opioids. The well publicized cases of OxyContin® abuse are, in my opinion, related to the fact that it is so much more widely prescribed—and therefore more available to those with criminal intent--than other opioids. There is little data that oxycodone per se has any inherently increased abuse liability compared to morphine or other opioids. The reason that OxyContin® is so widely prescribed relates, in part, to the fact that it is an effective alternative medication for patients that do not tolerate oral morphine, and for whom fentanyl patches or methadone are not good choices because of particular clinical circumstances. Generally, it is much easier to adjust the dose of OxyContin® to respond to the clinical needs of the patient, in comparison to the other available long-acting pain medications, such as methadone or transdermal fentanyl (patches). In my clinical practice, these factors

have as much to do with the relative popularity of OxyContin® for the treatment of pain, as do any marketing details by the pharmaceutical industry.

- Undertreatment of pain is a serious problem for all Americans, and, like other aspects of medical care, patients from minority and poor communities suffer from disparities in health care outcomes and are at greater risk for undertreatment than the general population. At least ten recent studies have documented disparities in pain management for minority patients. For example, as reported in the New England Journal of Medicine several years ago, although 46% of patients suffering with cancer-related pain were undertreated, members of minority groups have at least a three fold increased risk of undertreatment. Similar racial and ethnically based disparities in pain treatment have been observed in emergency room treatments for trauma and in post-surgical pain management.

  Poor pain assessment skills and--contrary to the current opinions noted in the media-- an exaggerated fear of addiction by health care providers, are important reasons documented to drive this undertreatment, particularly in minority patients. Another important factor driving racial and ethnically-based disparities in pain management is caused by a substantial problem with lack of availability of essential opioid medications in poor and minority neighborhoods. For example, a recent study published in the New England Journal of Medicine (April 6, 2000) reported that 72% of pharmacies in white neighborhoods of New York City stocked opioid drugs, whereas only 25% of pharmacies in poor and non-white neighborhoods stocked opioids for the treatment of pain. We have documented that this relative unavailability of opioids in poor and minority neighborhoods produces serious hardships and increased suffering, especially for patients, families and doctors managing terminal illnesses outside of the hospital. Drug regulations that further limit access to opioids will particularly impact on these very vulnerable patients.

In summary, I wish to restate that we must pursue policies that make pain management services and essential pain medications equally available to all Americans. I join many of my colleagues in pledging to work on strategies that ensure the availability of essential opioid medications for pain while incorporating ways to prevent their illicit diversion and abuse.

I thank the committee for hearing my statement.