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Center for Drug Evaluation and Research (HFD-21)  
ATTN: Kimberly Topper  
Food and Drug Administration  
5600 Fishers Lane  
Rockville, MD 20857

Ladies and Gentlemen:

My understanding is that the FDA is going to have a meeting to discuss medical use of opiate analgesics in various patient populations, including patients with chronic pain of nonmalignant etiology.

I am one of the few physicians in the central portion of Washington state to treat people with chronic pain. I am well aware of the concerns of the FDA with regard to medication diversion and abuse. In addition, however, as a physician, I am concerned with trying to provide appropriate medical care to patients who are truly suffering.

Pain is a terrible master. I have several patients in my practice who, when they came to me, were sufficiently emotionally distraught by their pain that they literally wanted to die. With control of their pain using opiates, sometimes in huge doses, the quality of their lives has been improved to the point that they now enjoy living, and they want to be around for their families.

I have a number of patients who, as a result of their treatment with opiate pain relievers, are able to work, and remain productive citizens. For them, without medication, they would be basically confined to their homes and completely nonproductive.

At the same time, one has to be honest in recognizing that, within this population there are people who abuse their medications. This abuse can either be from the patient himself, or from a family member. One of the more tragic episodes, which I remember from my residency in Battle Creek, Michigan, was a case in which a woman had cancer, was in intractable pain, and her husband would steal her medication and abuse it.

Physicians, as a general rule, have been reluctant to provide narcotics to people in chronic pain, particularly nonmalignant pain, precisely for this reason: They do not wish to have to deal with the questions of abuse and diversion. Regretively, this is a serious lack in medical education throughout the country; it was a lack when I went to school many years ago, and, to my knowledge, the situation has not improved much. Because of this, most physicians simply avoid the issue by refusing to give medications to anyone on other than a short-term basis for a time limited problem. As a result, we have a tremendous number of people in this country with chronic pain who are not effectively treated; the quality of their life is poor, and this quality could be dramatically improved if physicians are willing to treat their chronic pain. From my standpoint, we have this situation in which there is a simple treatment that is easily available to any physician, failing to treat such a problem is a crime.

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This is not to say, however, that diversion, abuse, and misuse are not problems. These are problems, and they are serious ones. However, I think that these problems could be managed without placing additional constraints on those few physicians who are, in fact, willing to treat the chronic pain of their own patients.

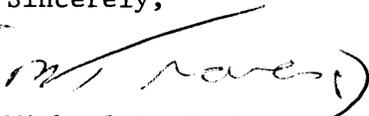
The solution might, I would suggest, include such things as a national data base on individual patients who receive narcotics, which would be available only to hospitals, clinics, and, (if necessary for prosecution) to legal authorities as well. There is such a system available in Canada; it has worked well in Canada. In the United States, because of concerns about privacy, such a system has not been established.

A second step which would, I think, go a long way toward controlling misuse and abuse would be for there to be a general rule that one physician, and only one physician, will provide narcotics except in an acute emergency situation. Even in that emergency situation, it would seem to me that there needs to be an attempt to contact the physician who is the primary care provider. There should also be some sanctions so that patients who claim a primary care provider who is not, in fact, really their physician (and who, as a result, obtain narcotics through false pretenses) should be legally sanctioned. This is a fairly common problem. Right now, I am dealing with one woman who claims to be my patient, whom I have not seen in over two years, who has been terminated from my practice, and who has seen multiple providers in emergency rooms throughout the state of Washington, obtaining narcotics, in part on the grounds that I am somehow her physician. This is morally and ethically wrong, and it needs to be sanctioned legally.

I think there are probably other ways as well, that one can, at least in part, solve the horrible problem of narcotics misuse, abuse, and diversion. I do not, in any way, have all of the answers. I do, however, feel that the proper way to do this is not by placing additional constraints on physicians. In fact, the very reason why physicians are so unwilling to treat chronic pain is because of the fact that medical authorities, in general, have given a much higher priority to the problems associated with abuse and diversion than they have to the problems of their patients who are sick, in pain, and perhaps dying. I do not think that this is fair, just, or moral.

I appreciate your willingness to listen.

Sincerely,



Michael D. R. Travers, M. D.

MDRT/mej