



American Society of
Anesthesiologists™

Central Line
Episode Number 25
Episode Title – The Opioid Crisis
Recorded September, 2020

(SOUNDBITE OF MUSIC)

VOICEOVER:

Welcome to ASA's Central Line, the official podcast of the American Society of Anesthesiologists, edited by Dr. Adam Striker.

DR. ADAM STRIKER:

Hi, welcome to Central Line. I'm Dr. Adam Striker your host and editor. Today we're going to talk about a very important topic, opioid addiction. I have the honor of welcoming three guests to today's show, starting with a doctor and mother whose story will move you. Welcome to the show, Dr. Milas.

DR. BONNIE MILAS:

Hi, my name is Bonnie Milas. I'm an, a Professor of Anesthesiology at the University of Pennsylvania. Um, my area of expertise is, uh, cardiac surgery. I, uh, tragically have lost two adult sons to the, uh, opioid epidemic due to overdose. Um, I have no remaining children. I am deeply committed to reducing stigma associated uh, opioid with use disorder and saving lives resulting from opioid overdoses.

DR. STRIKER:

Dr. Milas, obviously you've given so much to this cause already, and we, it's just incredibly brave that you've joined us today to share with us your story, your insights, and so thank you so much for joining.

And we also have, joining with us today, Dr. Dagal.

DR. ARMAND DAGAL:

Hi there. My name is Arman Dagal and I, I am a Professor of Anesthesiology at University of Washington. Um, I work at the, um, Harborview Medical Center, um, which

is a Level 1 Trauma Center in, uh, Washington state, and I'm also a member of the Committee on Trauma and Emergency Preparedness with the ASA.

DR. STRIKER:

Finally, welcome Dr. Szokol.

DR. JOSEPH SZOKOL:

Hi, I'm Joe Szokol, I'm the Harris Family Foundation Chairman of Anesthesiology at NorthShore University HealthSystem based in Chicago, Illinois. I'm a clinical professor at the University of Chicago and am the ASA Chief Health Policy Officer.

DR. STRIKER:

Excellent. Thank you all so much. We appreciate you all being here to talk to us today. I want to start today by talking about your personal stories, so our listeners understand how deeply you've been impacted by the opioid problem. Especially you, of course, Dr. Milas. Can you tell our listeners a little more about your story?

DR. MILAS:

Sure, um, you know, I had already mentioned that I have lost, uh, tragically, both of my sons. Um, as an anesthesiologist, I think we have a unique opportunity in society to change the trajectory of the still ongoing opioid crisis to save lives and educate. You know, we as a group, we administer opioids. We know what, uh, an opioid overdose looks like. We also are well-versed at delivering Narcan and treating overdose and additionally we are experts at airways and rescue breathing. I think that this is a great opportunity for anesthesiologists to lead the charge to save lives lost to opioids.

DR. STRIKER:

And Dr. Dagal, you took very different route having been involved with an effort to save the lives of gunshot victims. Can you tell us a bit about how that led you to your role in advocating for better solutions for the opioid crisis?

DR. DAGAL:

Um, after the Sandy Hook Elementary, um, shooting that resulted in loss of life due to bleeding, the Stop the Bleed campaign has been initiated. And this campaign sort of spearheaded by the American College of Surgeons and Committee of Trauma, and they

have trained physicians to educate public how to apply tourniquet and stop loss of life due to hemorrhaging shock. Um, so, I've been involved with that education process. I am one of the instructors, um, and as part of the Committee on Trauma and Emergency Preparedness, we certify, most of our members are also educators. And we thought, we have a position and we have a opportunity to simulate the success of the Stop the Bleed campaign and perhaps due to similar public education and membership awareness around the opioid epidemic and that involves use of Narcan, um, and education of this, this (sic) maneuver, um, to public, such as schools, in our local communities as well as during our annual meeting and so on.

DR. STRIKER:

And Dr. Szokol, give us a little bit about how you came to this topic.

DR. SZOKOL:

So I really come to this topic, from a, a policy point of view recognizing this is a, a tremendous public health crisis. It's made worse during the COVID epidemic, and it's, it's something that the ASA is very committed to helping to solve this issue and educate the public and, and improve patients' lives.

DR. STRIKER:

One of the many challenges with addiction is that it's very secretive and I'm wondering, Dr. Milas, if you talk a little bit about your own childrens' opioid addiction. Are there signs people should look out for? Are there specific things you really want people to know, like other parents and doctors?

DR. MILAS:

Certainly I would agree with you that, um, addiction does start in secrecy and oftentimes remains there because of the shame and the stigma associated with it. Our children did not come to us saying, you know, mom and dad we're struggling. Instead it came by us as parents observing their behavior and being very attuned to inspecting things in their environment particularly, say in their bedroom. You know, I would often hear, say when I was uh, out to dinner with friends, that comments would be made like, I would always know if my child started to use drugs, uh, you know, people who don't know that their children are using it's because they're not paying close attention. But I can tell you as an anesthesiologist, it was even with my level skill, it was difficult to detect. Because they started off doing things like, say, smoking pot or taking pills, and these were readily available in our local community. They're readily available in school. You could

purchase, uh, Xannies or Xanax, uh, OCs, OxyContin. It was available and it started off very slow, very insidiously. So again, very hard to detect, but if you really were watching their behavior, you would become attuned to the fact that their moods would be sometimes erratic. Um, certainly, you could look at their pupils and see that they were either pinpoint or they were enlarged. But in particular, a behavior that we noticed was this, kind of a, what they would refer to as dipping out and this would be somebody who will be falling asleep when they shouldn't be. They would be standing in front of the refrigerator looking for something to eat and they would be leaning forward falling asleep holding onto the handles to keep them upright. Or they would be leaning forward into their dinner plate, to the point where most of us if your head kept falling, falling and falling, if you weren't impaired, you would jerk yourself upright and you'd shake it off. But this would be to the point where you know, the face is falling into their dinner plate.

And obviously, this came from using pills that were diverted locally into society, but it became very expensive. As for most people to continue with that, paying \$40, \$60, \$80 for a, an OxyContin that corresponded to the milligram dose. So then, most individuals would escalate to heroin, which is very cheap. You can buy a small bag of heroin for \$6. You can purchase a bundle of ten obviously for \$60 the same amount that you could buy one pill of OxyContin. So, the finances of it is frequently what drives people on to use intravenous heroin.

DR. STRIKER:

Can you talk a little bit about how a typical opioid addiction begins, or is there no typical?

DR. MILAS:

Well, I, you know, I would say that everyone's pathway into, uh, opioid addiction and is probably different as to how they get there. But I think it would be safe to say it is atypical to go straight to using IV heroin. Often times, it is during adolescence or young adulthood that they are exposing their still developing brain, which is of course a very dangerous time, um, and although they make a willing choice to use, everyone's propensity for addiction is somewhat different. And whether the first or second use they experience an intense, um, amplified response that rapidly progresses to addiction, they then get to the point where the willingness to use and the willingness to stop is obliterated. They do not have the ability to control their use, and you know, I think many people in society, stigma comes from the belief that an individual willingly chooses and can therefore willingly stop anytime they want. But that is clearly not the case and that does not hold true with the signs of addiction of what we know.

DR. STRIKER:

Let's dig a little deeper into the science of this, into the science of opioid addiction? I'm wondering if you can tell us what happens to the brain and the body when someone becomes dependent, and how does that dependency translate into behaviors?

DR. MILAS:

Well, once an individual's brain becomes opioid addicted, they need, they require higher and higher amounts of that chemical, that drug, in their system in order to feel the same endorphin high, or the good feelings of that chemical. Um, that's what we refer to as tolerance. If they do not use, then they will start to have symptoms of withdrawal, typical things like becoming agitated, becoming very anxious. They start developing physical symptoms, gooseflesh. They feel nauseous. They, uh, may start to vomit, have diarrhea, so physical symptoms that, uh, along with emotional distress, so they continue to use to avoid those negative symptoms and also to bring on that feeling of contentment, of warmth, the feeling that they are, are okay. Um, and that, that continued need to use, is again a financial burden. So that leads to the very negative behaviors of doing things like lying your family members, stealing, and can also lead to criminal behavior. And in fact, just the ongoing use of a controlled substance is illegal in and of itself. And again, I believe that that contributes to stigma, the negative impression and the shame that is put on the individual who's using because of those negative behaviors.

DR. STRIKER:

Can I ask you, Dr. Dagal, how has Dr. Milas' experience and experiences of so many other families like hers, changed your practice? I mean, is there something that you do differently with this very painful knowledge in hand, something you want, or think other anesthesiologist and other physicians, who are listening should do as well?

DR. DAGAL:

So, um, in 2010, there was about 38,000 people died, and gone up to, doubled to 72,000 in 2017. Uh, at 2017 this, uh, issue has been recognized as an epidemic and our Surgeon General, Dr. Adams, initiated 5-step action plan to combat epidemic. And these were including, um, improving (sic) and rehabilitation, increasing access to life-saving opioid overdose reversal drugs such as Naloxone, expanding public health surveillance of opioid use, pain and addiction research, and finally promoting pain management programs and practices among caregivers.

Since 2017, towards 2018 due to these initiatives we start to see some drop in (sic) to 67,000 deaths, uh, occurred in that year. But the following year, 2019, according to the latest numbers the death rate increased again significantly almost to 71,000 people dying as a result of an overdose.

And, you know, I have been dealing with trauma, uh, all my professional life and, um, and looking trauma numbers and deaths due to trauma and, um, according to the latest numbers, opioid overdoses are exceeding the car crash related deaths in the United States currently. This has become really significant issue for all of us as physicians to help to combat.

Uh, as I mentioned I, I sort of do perioperative care improvement in, in my institution. We developed pathways of delivery. In those pathway, we develop special multimodal analgesia structure to use help opioid use reduction while we are providing appropriate pain management care for the patients to satisfy them and get through the, you know, good recovery phase. So, all this initiatives and, uh, opioid epidemic issues made us more aware of the importance of education and restricted use of opioids and limited prescription practices and Naloxone co-prescription when you are prescribing opioids or discharging patients.

So, these are the things that we took, uh as a initiative in our hospital as physicians and we are spending good amount of time to understand and meet the expectations, define them, and provide appropriate care.

DR. MILAS:

From my end, uh, in my practice personally, I usually take a few minutes as we're rolling into the operating room away from family members. I'm with the patient, I'm close to their ear, we're putting on the non-invasive monitors, and I have a very honest discussion with them. Because of my personal experience, I know that, uh, substance use disorders are pervasive in the community. So I talk to them and I give them the freedom to tell me, uh, about their use habits, so, um, in kind of a, a non-threatening manner. I ask them quite frankly tell me what you take at home to help you relax. And, um, I give them a list of medications. Do you take, uh, Xanax, Ativan? Do you drink alcohol? Two drinks a night? I listen to their responses. Then I take them further deep into this discussion and I ask, many of my patients need to take pain medication for back pain or neck pain. Do you have a need to take medication such as tramadol and I go through a whole list of medication oxycodone, OxyContin, uh, Percocets. I listen to their response. Then I asked them whether they use recreational drugs. Do you smoke pot? Um, do you, um, use cocaine? Do you use, uh, intravenous drugs such as heroin? And I tell them that, you know, I'm the individual who is responsible for a safe anesthetic

and for making sure that they're comfortable and this is why I'm asking these questions. So based on their response, I come up with a, um, plan for intraoperative and post-operative pain relief. Additionally, if they have a need I can make a referral. We have CRS's which are Certified Recovery Specialists who will visit the patient in the hospital after surgery and they will engage them in getting a recovery plan ready for them. So, um, you know, I find that, uh, just a bit of empathy and discussion very honestly, people have shared some incredible things with me and we've been able to get them on the right path. And certainly to keep them comfortable during and after surgery.

DR. STRIKER:

Do you have anything to add, Dr. Szokol?.

DR. SZOKOL:

I was gonna talk about the, you know, what happens with patients having surgery, and it used to be, uh, we would, they would get a, a very large amount of opiates to take home to treat their post operative pain, especially for orthopedic surgery, and we recognized that a, a portion of those patients then may become addicted to opiates and as Dr. Dagal said, you know, anesthesiologists and surgeons are looking at other pharmacological ways, not using opiates, to help treat postoperative pain. So that's been an important shift in sort our mentality and medicine.

DR. STRIKER:

Excellent. And anesthesiologists, obviously, as you're saying, play such a critical role in pain management and the prescription of pain medication either before or following surgery. So I'd like to hear a little bit about other modalities beyond opioids for managing pain.

DR. SZOKOL:

So there are really two ways to look at this, it's the non opiate pain medications, acetaminophen, nonsteroidal medication and also the, uh, growing emphasis on doing regional anesthetic blocks to help patients with post-operative pain and giving them a, a period when they, their pain is really subdued because of the block and not needing opiates to treat that pain.

DR. STRIKER:

Are certain opioids more closely linked with addiction? Have they changed over time? And specifically, I'm kind of wondering if there are increased risks presented by the newer synthetic drugs?

DR. MILAS:

Well, I can comment on the fact that certainly any, uh, opioid that has a very quick onset and quick offset, it has a tendency for higher abuse potential. Um, but otherwise, I would say, you know, my addiction medicine specialists would probably be better able, uh, to comment on that. But I would like to make comments about Fentanyl. Fentanyl is a synthetic opioid. It does have that same profile of quick onset, quick offset. Um, but what is being purchased on the street, and what is particularly dangerous, is the non-pharmaceutical Fentanyl, which is typically, uh, the raw materials are brought in from, uh, outside the United States, from predominantly China. The drugs themselves are then manufactured, often in Mexico and then brought across the border. This information comes to me from a DEA agent who recently spoke in the Philadelphia area.

But Fentanyl, uh, the danger is twofold. One that it is being often times pressed into tablets and sold on street as, say, counterfeit Xanax or cocaine. So the individual thinks that they're using one drug and they're actually using Fentanyl. They are, uh, uninitiated and they rapidly overdose, leading to potentially, to an overdose death.

Um, it's being mixed, because it is cheap. It's not dependent on a poppy or an opium source. It's synthetic, so therefore it's very cheap for a dealer to mix it in with heroin. So, uh, again, someone thinks they're using heroin, but it's actually Fentanyl, um, so again, rapidly increasing the risk of overdose.

DR. STRIKER:

Let's shift gears here and talk about a very different drug. I want to talk about Naloxone. What is it? And how does it work?

DR. MILAS:

Naloxone, it is the antidote to an opioid overdose. There is no other known use for this medication. It is commonly sold in the pharmacy or you get it at a, uh, health clinic as the nasal spray Narcan. It works by competitive, uh, inhibition at the mu receptor, which is the opioid receptor. It displaces and occupies the receptor, such that it is able to restore consciousness and respirations or breathing in an individual who has overdosed. It takes approximately two to three minutes work. Um, you know, harkening

back to the Fentanyl epidemic that we're experiencing, Fentanyl is considerably more potent, somewhere between 50 to 100 times more potent, and in being so, it takes often times two, three, four doses of Narcan to reverse the overdose. And knowing that Narcan takes two to three minutes to work, then you can imagine that that time is adding up. So, two to three minutes for each dose and it takes multiple doses particularly with Fentanyl that if the individual, the victim, is not breathing that they will rapidly progress to either permanent brain injury or their heart is going to stop and it leads to death.

Um, with over 50% of overdoses occurring in the home, if think it is imperative that we have families who are at high risk of overdose, that, that they either have somebody with opioid use disorder in the home or they have an opioid prescription in the home, that they have the education and the Narcan, they know how to rescue breathe. That should be readily available in the home. Arman was mentioning the, uh, Stop the Bleed campaign. You'll find the trauma packs next to the AED in public location. I would like to see Narcan on the wall right next to that AED box just like the Stop the Bleed. That should be readily available in the public.

DR. STRIKER:

I do want to spend a little bit of time on solutions like what you just referenced. Have there been efforts across the country from anesthesiologists and others that are really working? Are there some bright spots you guys can talk about?

DR. MILAS:

Sure I think, you know, uh, probably Arman and, uh, Joe can speak to some of the, uh, efforts going on nationally. But what I can comment on is, um, with the COVID epidemic, uh, telemedicine has really exploded. That has allowed, uh, those individuals to have the ability to virtually connect with people who are struggling in order to help them get into treatment. It's also helpful to initiate, to start MAT, which is Medication Assisted Treatment for those individuals who do not want to use heroin, who do not want to use opioids, that we can get them connected with using buprenorphine.

Um, other things that are being developed and are actually in place right now, are, is the concept of the warm handoff. So, when an individual overdoses the EMS squads and also, um, emergency departments, have individuals who will visit the victim who has overdosed and ask them, are you ready to stop using? Do you want help? And they assist in getting them into recovery rapidly even to the point where, potentially, putting them in a cab and going with them to a treatment center for an assessment. So those are things, that again, are in place and are expanding.

DR. STRIKER:

Dr. Dagal, I'd love to ask you a little bit about federal and state regulations. How have they, regulations, around prescriptions and distribution of opioids changed?

DR.DAGAL:

Yes, so, um, before going to, uh, going into answering that question, I just want to emphasize what Dr. Milas mentioned. There are three action items (sic) people when they face an opioid overdose patient needs to be taken. So these are almost required simultaneous action with the help of others in and, and around us when we observe such a patient, or loved one. Um, these are getting the, uh, emergency services alerted, providing breaths and administration of Naloxone. Uh, these are really critical steps into helping to bring somebody back while the help is arriving, the emergency services. Our, uh, out of hospital providers are now, both in law enforcement as well as the paramedic programs, have done an enormous amount of work to recognize and help with this opioid overdose patients.

As, well, um, there is a national initiative for limited opioid prescription. So, uh, we limit the number of days, the number of doses the patient will be discharged from the hospital to take home with. Again, uh, there are a lot of educational materials provided to the patients as part of this, uh, action plan, what to do with the medication and how to manage pain, as well as what to do with the medication they end up not using. If someone goes, or you know, searches on the Internet to where is the opioid disposal stations are, many of the pharmacies and other locations are (sic) public to get rid of their medication without an identification or anything. They can go safely with medications they don't use so that eliminates the accidental use the opioid by the family members.

Um, in addition to that, I think state level, they're a lot of actions being taken, too. First of all, identify, uh, the uh, the size of the problem as well as initiatives like, uh, State Medical Directors have written, um, uh, standing orders for uh, Naloxone to be available without prescription, uh, for individuals so we can go and get Naloxone from any pharmacy, uh, without requiring special prescription. And, um, then they're lit, lot of educational and, uh, informative events going on. There are websites for each state, how they're tackling the opioid issue and if you visit our state, um, information board, and we will see what initiatives are taking place.

DR. STRIKER:

What are you seeing in Philadelphia, Dr. Milas?

DR. MILAS:

I personally am involved in my local community, which is a suburb of Philadelphia. Um, my local Bucks County Drug and Alcohol Commission, and of course, there's Alcohol Commissions across the United States. Um, I am involved with teaching, um, Naloxone rescue. So, very basic discussions with the community members about how do you recognize an opioid overdose, and the steps that they need to go through in order to get help, um, as quickly as possible. I impress upon them that if you find your loved one down and collapsed, overdose, that they become an immediate responder. They are the only help that's available until help arrives. And I really drive home that issue.

So I teach them, you call 911, you leave your cell phone out, keep it on speaker phone, and then that way you can use your hands and help the victim while you're speaking to the dispatcher and it also gives you a, essentially a timestamp, so that you know, when you gave the dose of, of Narcan, and you know, when to give the next one. But, uh, again, the importance of having Narcan immediately available in the home and, uh, also how to rescue breathe. We teach them how to rescue breathe and, uh, the importance of if they don't know their family member's HIV or hepatitis status, to wear gloves. They can use a face shield. I teach them how to use a face shield or a face mask and then yes, if necessary, if, um, they suspect that the individual, uh, does not have a heartbeat, where to put your hands and how to do chest compressions.

These are all important things that are measures that we can best get these individuals to survive, intact, without brain injury. And again, to get them to accept recovery and to heal.

DR. STRIKER:

So let's talk a little bit about the ASA. What is the ASA doing about this?

DR. SZOKOL:

Part of it is having podcasts such as this, and having, uh, Drs. Milas and Dagal speak at the uh, Annual Meeting about this issue. There is something called the RX Summit, uh, which they're going to have a presentation that, talking about this issue. And, um, having the Committee on Trauma and Emergency Preparedness really promoting this and, and trying to get to the local level and a big part of this, as mentioned before, is education. And going to schools going to churches, uh, working with Public Health Departments to get this information out with pamphlets and flyers and then the other one is really, the, to get the ability to get people to get the ready access to nasal

Naloxone cuz that, you know, rescue breathing is important, but again, nasal Naloxone is really the gold standard for treatment of opioid overdose.

DR. STRIKER:

Dr. Milas, I wonder if you'd like to add anything on to that.

DR. MILAS:

Well, uh, again, I think public education is the key. You need to have, again, we need to pair the Naloxone or the Narcan with basic life support maneuvers. I think that that's where the ASA has the opportunity to really, uh, make dramatic impact in, uh, society. Um, and again, the message that I drive home with community members is, they understand I'm an anesthesiologist. I have a level of expertise, but I teach them and I make it the point, that you do not need to be a doctor or healthcare worker to save your loved one or a community member. You just need to have the drug available. You need to call 911 and you need just some basic skills. And quite honestly, you know, harkening to what Joe was saying, is, personally, I think that, uh, rescue maneuvers and how to help an individual, not just somebody who's overdosed, but just having basic life support skills, that that is essentially a part of being a good citizen. And it should be taught in high schools and probably even lower down in middle schools. That again, if you're not helping an overdose victim, well, you may be helping your grandmother who's had a heart attack.

So, again, the pairing of Narcan with basic rescue maneuvers is important in overdose, but I think it is even more widespread. Just basic skills, it's part of good citizenship.

DR. STRIKER:

What can our listeners do to make sure they are giving their patients as much help as, as they can?

DR. SZOKOL:

The one thing I would also say, so we can treat the opioid overdose victim with Narcan and rescue breathing. But, uh, as Dr. Milas was referring to earlier, it's important to follow up with patients and having adequate treatment centers and resources available for persons interested in getting over their addiction, and helping to achieve that. Cuz all we're going to do is keep repeating this cycle and trying to rescue people. We need to get to the root causes first.

DR. STRIKER:

Okay so consider yourself talking to the 54,000 ASA members. What do you want them to do?

DR. DAGAL:

This is a grassroots movement. And, um, we want every member of the ASA to take action. And if they have any ideas or any, um, thoughts about how to participate, or what to do, reach out to us.

DR. MILAS:

I, I would say first and foremost is, um, to recognize the pain and the difficulties that all families that are dealing with opioid use disorder, what they are going through. And you know, from a personal standpoint, I want you to consider, really think about, what it's like when, say for instance, I would get up in the middle of the night for whatever reason and the first thing that I would do, is I would open my son's door, make sure that he was breathing, make sure that he wasn't face down on the bathroom floor overdosing. That many families across the United States, that's what they live with every day. And, I, I'd really like you to take that to heart, to internalize that, and recognize that that suffering is ongoing. It is a pervasive societal problem right now. And what you can do, is again, as a community member, to really embrace the call to arms that we're really asking for you to think about doing right now, is to have conversations out in your communities and also to be public educators. To really know that you can make a difference, and it doesn't take very much in terms of effort.

DR. STRIKER:

What role does stigma play in all of this?

DR. MILAS:

Uh, you know, I've spoken about the issue of stigma. I think that's that is perhaps the biggest barrier in society that prevents individuals from seeking treatment because they are ashamed and it also limits the family from beginning to heal. They don't necessarily want to present for treatment, the family, and the individual. So, uh, again, I think that as healthcare providers, as anesthesiologists, that we can as individuals, um, if we can start having conversations in public spaces like at PTA meetings, on the soccer fields, uh, when you're out to dinner with friends, is to lean into their conversations and you

can, uh, dispel, uh, untruths. You can educate people, just very informally. It really doesn't take, uh, much time or energy to do that and, to again, to educate others.

People like myself and there are other anesthesiologists who have also suffered losses. If we share our stories that we can humanize opioid addiction. That it's not just, uh, a marginalized individual that's affected. It is all of us. It is all of our loved ones, your neighbors that are affected. And, uh, by removing barriers to treatment, or by just improving attitudes in society, that that will allow us to treat opioid use disorder and substance use disorder, and in fact any mental health disorder, with empathy. And it will also allow us start treating it as if it is any other medical disorder, with the same research dollars and the same passion behind it.

DR. STRIKER:

That was beautifully said Dr. Milas. I think that is perfect place to leave it. I want to thank all three of you for joining us today, for your information that you've shared, um, Dr. Milas, for your personal story, especially. We appreciate your time, and it was a real pleasure. I'm sure our listeners learned a lot as well. Thank you.

DR. SZOKOL:

Thank you, everybody.

DR MILAS:

Thanks for having us.

DR. SZOKOL:

Appreciate it, thank you.

DR. STRIKER:

Thanks for joining us for another episode of Central Line. Please join us again next time.

(MUSIC)

VOICEOVER:

American Society of **Anesthesiologists**[®]

September is Pain Awareness Month. Unfortunately, pain is the most common cause of disability in the US today. Pain personally affects one in three people and causes more disability than cancer and heart disease combined. Untreated pain can be even more debilitating during times such as the COVID-19 pandemic. If you have patients with pain that won't go away, help them find relief with tips found at www.asa.org/hq/pain.

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