

## King of Pain: What Elvis's death tells us about media coverage of celebrities and the pain/addiction interface

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Media coverage of celebrities' problems with prescription medications creates an extra level of fear and reticence around classes of medications such as opioids. While patients should approach these medications seriously and with caution, the message sent by the media seems to be that addiction and abuse are unavoidable conclusions with this modality. In this editorial, we highlight the much publicized death of Elvis Presley as an example and discuss the ramifications media slant can have for both professionals and the lay public with regards to pain management.

Elvis Presley died of a drug overdose while sitting on the toilet. This indignity is nothing compared to the gradual and inevitable tarnishing of his image, portrayed as he was in later life and death as a fat, slovenly drug addict. Elvis was the "King of Rock and Roll," but he was also the King of Pain. Born on January 8, 1935, in Tupelo, Mississippi, Elvis Aaron Presley would have turned 72 this year; in death he can enlighten us about how the media portrays the interface of pain and addiction in celebrities who have had difficulties in this spectrum. We as pain practitioners need to think about how we can counter these portrayals.

Whatever else he was, Elvis was a chronic pain patient.<sup>1,2</sup> He suffered for years from debilitating stomach pain resulting from Crohn's disease. He was prescribed chronic steroids for this inflammatory disease, and this was the only treatment that offered him some relief. Elvis gained a significant amount of weight from the steroids. He broke bones because of them. He got jumpy and couldn't sleep. In order to continue to give his fans what they wanted in spite of these side effects, he took pain and anxiety medications. Elvis died just trying to be Elvis.

Brookoff<sup>1</sup> has argued that much of America's perception of Elvis is based not on his suffering but his drug addiction; in analyzing the actual medical facts of the case and then comparing them to the typical perception, Brookoff says, we obtain a commentary as much on how our society feels about people who take controlled substances and are overweight as on the realities of Elvis's

situation. So we will focus, then, for the rest of this piece on the problematic media portrayals of celebrities' pain and addiction and the dilemmas they create for those of us working in pain management. Finally, we will propose a solution.

It is clear that a great deal of fear exists regarding the use of opioids among patients, their caregivers, and their families.<sup>3-5</sup> While clearly not the sole source of opiophobia in society, Elvis's and other celebrities' highly publicized experiences with pain medications are bound to exacerbate an already wary view of pain treatment. Our pain patients (with both malignant and nonmalignant pain) are constantly asking if they are going to be turned into addicts. They think, "It happened to [insert celebrity name], and it could happen to me." Thus, a frequent question becomes, "Are we all liable to become enslaved by these powerful medications and end up in rehab?" It is at this moment that we are challenged to teach patients about addiction risk.<sup>6</sup> The benefit for us is that we can use this discussion as a jumping point for explaining to patients why we do the things we do to manage risks with opioids, such as opioid agreements and urine toxicology screens, and to explain to them that the celebrities they read about are likely not treated with such traditional limits.<sup>7</sup>

We must teach our patients that Elvis is the exception, not the rule. Elvis had a history of drug and alcohol abuse. His mother may have died of complications of alcoholism. His early life was complicated by his father's bootlegging and jail time. He lost his twin at birth and lived with chronic feelings of emptiness.<sup>8</sup> Combine those risk factors with his wealth, celebrity lifestyle, and status, which clearly opened the door for special treatment and relatively free availability of drugs, and we have a recipe for disaster.

In short, the trappings of fame can encourage an early downfall in individuals prone to substance abuse or misuse when they experience pain. As an introduction of risk management strategies, we can explain how it might sometimes be the case that when famous people have

pain, faulty assumptions get made that because they are successful, they can 1) take pain medications without risk; 2) continue to travel around the world while taking medications, unmonitored by physicians, psychologists, or other professionals; and 3) receive renewals on their prescriptions whenever they need or want them, with prescriptions often being written by multiple doctors.

We need to explain to our patients that while some people can benefit from such a loose approach, most people can not. Therefore, this is not the way in which most of us practice pain management. We can also explain that all pain management should be a carefully monitored team approach, with prescriptions coming from a single physician.<sup>9,10</sup>

Celebrities with pain who take pain medications in a more responsible fashion—and do well—don't make the news. Their pain management remains a private matter between them and their physicians. The now extinct "Many Faces of Pain" program of several years back was an effort to have some of this group of celebrities lecture on their pain and how their lives were enhanced by effective, safe opioid therapy. The program had a tremendous impact on the general public (as the first author personally witnessed when working with Lynda Carter in such a program in Lexington, Kentucky).<sup>11</sup> It would be good to see programs like it again.

The general public, of which our patients are a subset, gets fed a steady diet of rhetoric about the "dangers" of these "powerful" medications. Patients must be taught that the risk of addiction lies not in the medications but in a complex interaction between medications and people.<sup>12</sup> This interaction defies simplistic solutions such as avoiding pain medicines altogether. We need to educate professionals and patients so that they can have open discussions about the risks and benefits of these medications and so doctors can tailor therapy to every individual patient. To make this happen, we need to provide professionals with enough time and reimbursement to implement complex treatments for their complex patients, so they don't have to try to squeeze this group into less structured treatment settings. In an upcoming paper, Acosta and Haller<sup>13</sup> show that even patients who are actively abusing drugs can benefit from opioids under highly structured conditions with psychotherapeutic, motivational, and monitoring strategies as part of the package. The pain community must not be glib about these results; it is not just that they benefited (i.e., had good pain relief, curbed their use of nonprescription opioids, and even displayed a trend toward diminished use of other illicit drugs and alcohol) but that their risks were identified and managed in a highly labor-intensive fashion, complete with motivational therapies, behavioral management, and compliance monitoring.

Our patients must be encouraged to discuss their personal and family drug use histories with physicians openly so that their care can be planned. We have to build

their trust so that they do not fear that the potentially beneficial medications they need will be withheld because of their honest admissions. We must also be prepared to make the necessary referrals or provide psychological help and monitoring if needed.

Elvis, if he were alive, might say to doctors, "Don't be cruel; prescribe these medications for pain patients." But it is not only cruel to withhold them; it can be cruel to prescribe them and not take steps to assess addiction risk in each patient or implement safeguards when necessary. Elvis died trying to be Elvis. No other pain patient should die for simply trying to live his or her life.

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