BRITISH BROADCASTING CORPORATION RADIO 4

TRANSCRIPT OF “FILE ON 4” – “OPIOIDS – A PAINFUL PRESCRIPTION?”

CURRENT AFFAIRS GROUP

TRANSMISSION:	Tuesday 14th May 2019	2000 – 2040
REPEAT:	Sunday 19th May 2019	1700 - 1740

REPORTER:	Anna Cavell
PRODUCER:	Alys Harte
EDITOR:	Gail Champion

PROGRAMME NUMBER: 19VQ6232LH0

"FILE ON 4"

Transmission:	Tuesday 14th March 2019
Repeat:	Sunday 19th March 2019
Producer:	Alys Harte
Reporter:	Anna Cavell
Editor:	Gail Champion

MUSIC

SHARON: I think when my daughter said I looked like a junkie, that hurt, but it didn't hurt enough for me to stop taking the drugs. When my husband thought I was dying and he cried because I was so thin, that hurt, but still didn't stop me taking drugs.

CAVELL: Sharon was dependent on pills. At her lowest point, she says she was barely able to function.

SHARON: I didn't have a quality of life. I got up and took drugs in the morning and then I went back to bed. I woke up at lunchtime, I took more drugs, I went back to bed. I woke up again, took my night time drugs and slept all the way through - and that was my life.

CAVELL: How long did this go on for?

SHARON: Seven years.

CAVELL: Seven years of just waking up to take more drugs and going back to sleep?

SHARON: Yes.

CAVELL: But she wasn't getting her fix from a dealer. She was being prescribed high dose opioids by her GP. We're calling her Sharon, but that isn't her real name. She was living and working in rural Yorkshire as a housing officer when she got into a car accident, which left her with a serious neck injury - and constant pain.

SHARON: I used to cry going to sleep and I used to cry waking up. I felt like somebody was constantly prodding me with an arrow.

CAVELL: And how were you feeling emotionally?

SHARON: Drained and about as low as you can go, I think. It's not nice to not be able to do anything for your family. I've got a disabled son. I was failing to care for him. That made me feel inadequate. The best thing I can say is inadequate – at the worst I felt like I wanted to die, I really did.

CAVELL: A few years ago her daughter Jade got married. Sharon was present, but she can hardly remember it, so strong was the medication she was taking. When Jade shows her mum a photo of herself at her wedding, Sharon's shocked by her appearance.

SHARON: [Gasps] Oh my goodness. Gosh.

JADE: Look at you. Look at that, you've got a bruise on your head from where you've fallen.

SHARON: Yeah, I have. Oh dear.

JADE: On my wedding. You lasted a couple of hours and you needed to go. You know, you didn't even get to enjoy all that time. You know, I'm glad you came …

SHARON: So am I, but I didn't realise I looked so bad.

JADE: I cherish it, but you were, look at you, you don't even … look there, Mum. Look at your eyes.

CAVELL: In the photos Sharon's hardly recognisable from the person I meet. In it, she's painfully thin, and later tells me that she weighed just 6 stone. Her daughter and the other people in the picture are smiling, but Sharon's impassive and glassy eyed.

SHARON: I think you should delete that.

JADE: No, I'm not deleting it. That's the only moment I've got from, you know, the only pictures I've got from that day.

SHARON: Yeah. I don't even look very happy, do I?

JADE: You don't - and I were getting married!

SHARON: I know. Ah, sorry.

JADE: No, don't be sorry, I'm glad you came. I know, it was just you missed all this. It's a bit sad to look at.

SHARON: Yeah, it is. It's very sad to look at.

CAVELL: GPs in England prescribed almost 24 million opioids in 2017 - the equivalent of 2,700 packets every hour. Opioids are very good painkillers for acute pain, like a broken bone, and they're effective for pain at the end of life. But there's little evidence that they're helpful for long term pain.

ACTUALITY OF CAR DOOR CLOSING

CAVELL: Do you know this city well?

RICHIE: I do, yeah. I'm from Bradford, born and bred. It can be gorgeous in some places, but it's got its problems.

CAVELL: What kinds of problems?

RICHIE: I think deprivation, mainly. There's a lot of poverty, a lot of drugs, a lot of crime. But, you know, a lot of the people are amazing as well, so it's a shame really.

CAVELL: Michael Richie's a drugs worker at The Bridge Project, a treatment centre in Bradford in the north of England. He's been doing this job for more than 20 years, but recently he's specialised in dependence on prescription medicines, and opioids in particular.

RICHIE: I see the more complex cases primarily from near sort of large council estates or in the middle of council estates round Bradford. I'm from a council estate myself, so I'm not belittling anyone, but that's where a lot of these problems can start from really.

ACTUALITY AS CAR ENGINE STOPS

CAVELL: A few years ago, Michael's organisation was approached by some GP practices in Bradford. They asked him to work with patients of theirs who've been taking strong opioids for many years and needed to stop.

RICHIE: I've worked with people that have been on opioids and other medications for 40, 42 years, you know, it's just sort of controlled their lives really and sort of ruined their lives as well. They just seem to be left. You know, I'm not blaming GPs, I know they're busy, but people just get parked on this very strong medication and they just get left and it just has a really negative effect on their lives.

CAVELL: When Michael met Sharon, she'd just moved to Bradford and her new GP had been shocked by the amount of medication she was taking. Her doctor referred her to Michael.

RICHIE: We worked it out on the calculator, it worked out round about equivalent of about 1000 milligrams of morphine a day, which, you know, probably enough to kill an elephant, it's a heck of a lot. You know, the recommended therapeutic dose is about 120, and after that you don't really get many benefits, so over the years she'd just gone up and up and up and her body just got more tolerant, however her mental health and her physical health became worse.

CAVELL: It's probable that Sharon's original doctor had been trying to help her, but the drugs had terrible side effects and they didn't relieve her pain. Once a patient is dependent on opioids, especially at a very high dose, it's hard for them to stop taking them.

ACTUALITY AT TRAINING SESSION

STANNARD: Understanding the evidence for treatments for pain, we're doing some masterclasses which I would encourage you to think about coming, whatever discipline you come from, medical or non-medical, about managing ….

CAVELL: Dr Cathy Stannard is a consultant in chronic pain in Gloucestershire. When I went to meet her she was running a training session for GPs at a large surgery in the area.

STANNARD: I used to run high dose opioid clinics for years with a massive multi-disciplinary team and often couldn't get people off opioids, so it's not easy, there's no simple way to do this.

CAVELL: One of Dr Stannard's missions is to educate doctors that they're not likely to help patients with chronic pain by prescribing them opioids.

STANNARD: Most of the drugs we use will help a very small proportion of people. If they didn't help anybody, we would stop prescribing them, but the harsh reality is that almost any medicine that we prescribe is not going to help more than one out of ten that people that we prescribe it to.

CAVELL: One out of ten could be helped by medication? That seems incredibly low. Are there any other drugs that you could compare that to that are so ineffective?

STANNARD: It's a really good question, and in general prescribing practice, for something that is so widely prescribed, I can't think of another class of drugs that are less effective.

CAVELL: Research published in the British Medical Journal has attempted to put a price on the cost to the NHS of over prescribing. The estimate is that about £100 million every year could be being wasted by GPs overprescribing opioids for chronic musculoskeletal pain - things like back pain and sports injuries. In the course of Dr Stannard's career, the understanding about how to safely prescribe opioids has changed dramatically.

STANNARD: When I started pain in 1987, the general wisdom was that opioids should not be used for chronic pain because they don't work very well. From the mid-1990s onwards, there was a trickle - which became more of a stream - of publications which we now know were supported by the pharmaceutical industry, that suggested opioids could be effective in some of the long term pain conditions that we were struggling with. I think one has to remember the context that then, as now, we didn't have access to anything that was highly effective, so when anything new comes along, the medical community was keen to embrace it. One of the greatest advantages that we should celebrate in the way that medicine has moved forwards is in our understanding of where we can be misled by, say, scientific information, and I think we have a very good ability now to understand how clinical trials and published evidence can lead us down a wrong path. And when we look at the conduct of those clinical trials and, in particular, how they relate to how medicines are used in real life, we realise that they really didn't give us any useful information at all. In fact, they probably misled us.

CAVELL: In America, it's been established that doctors and patients were misled – and with catastrophic consequences.

EXTRACTS FROM AMERICAN TV SHOWS

MAN: Opioids are now the biggest drug epidemic in American history ….

WOMAN: The number of deaths from opioid abuse have skyrocketed over the last 15 years ...

WOMAN 2: ... killing tens of thousands of Americans every year ...

MAN 2: … that's more deaths than from car accidents and from guns.

ACTUALITY IN CAR

PANARA: Okay, here we go.

CAVELL: Carol Panara is driving through the outskirts of Philadelphia. She knows this place, she was born here.

PANARA: Well, my mother was born and raised in North Philadelphia, like around 7th and Brown. She would just be shaking her head, my father would be the one having an absolute breakdown. Just … I think he would be so disappointed and so saddened and so upset to see what has happened in this city.

CAVELL: In recent years, her birth town's been ravaged by the opioid crisis. It has the highest opioid death rate of any big US city, with more than a thousand deaths a year, which is nearly four times its homicide rate.

PANARA: Even for the people who aren't, who haven't died from opioids, the ones who are suffering, who really have no life, no quality of life, think of what some of those people could have become and could have done with their lives. It's really, it's a tragedy.

CAVELL: But Carol Panara isn't an observer to the opioid crisis. In 2008, she started working as a sales rep for the company, Purdue Pharma, manufacturer of the opioid OxyContin. She was working for a different pharma company when she heard that Purdue was paying its sales reps huge bonuses.

PANARA: At that time I heard they were making between $40,000 and $60,000 a quarter, which would mean between around $150,000 to even up to like $240, $250,000 a year in bonus, which sounds incredible and too good to be true, but apparently in some areas of the country, that was the case. And so when I had the opportunity to interview with them, I kind of had that in the back of my mind that this might be a very lucrative, you know a good opportunity for me.

CAVELL: Purdue says it's standard industry practice to provide incentives for sales reps.

MUSIC

CAVELL: When Carol Panara joined Purdue, she discovered that her new employer had a controversial marketing tactic. Purdue claimed that OxyContin, and opioids in general, carried a low risk of addiction. Purdue's been the subject of a number of lawsuits in the US, some of which are still ongoing. In 2007, the year before Carol Panara joined, they'd pleaded guilty to misleading doctors, regulators and patients about the risk of addiction to OxyContin. To resolve criminal and civil charges relating to the drug's misbranding, the parent company of Purdue agreed to pay $600 million in fines and other payments. It was one of the largest pharmaceutical settlements in US history. Here's a clip from one of their promotional videos from the 1990s, when OxyContin was just coming on to the market.

EXTRACT FROM VIDEO

PRESENTER: Some patients might be afraid of taking opioids because they're perceived as too strong or addictive. But that is far from actual fact. Less than 1% …

CAVELL: But even after making the landmark payout, Carol Panara says she and her colleagues were encouraged to emphasise a concept known as pseudo addiction.

PANARA: The company gave us a marketing piece that addressed the definition of physical dependence, of tolerance, of addiction. There was also a paragraph on it that addressed what they called pseudo addiction - the definition by the company, by Purdue, was that patients who exhibit drug-seeking behaviours may not always be true addicts. The whole idea was that if the patient is exhibiting this type of behaviour, it may not be someone who's an addict, it maybe someone who is pseudo addicted, which means that the answer is you just need to increase the dosing strength and do a better job of relieving their pain.

CAVELL: So you were trained by your employer to downplay this potential addiction risk?

PANARA: Not in so many words, because we were trained to always refer back to the package insert that had the black box warning that said 'Any opioid has a potential risk for addiction', so you always wanted to kind of cover your butt by referring back to that.

CAVELL: But this concept of pseudo addiction is something that Purdue told you to caution doctors about?

PANARA: Right.

CAVELL: They invented that?

PANARA: Yes.

CAVELL: And, looking back, is there another term that you would give to that?

PANARA: [Laughs] I don't know if I'd be allowed to say that on the radio, but I think, I think it was just BS.

CAVELL: 'BS' is Carol's polite way of saying bullshit. [MUSIC] Purdue promoted this concept – pseudo addiction - telling doctors that what might look like addiction could actually be unrelieved pain. And the answer for that ? More opioids. In response, Purdue points out that this concept was accepted by the US Food and Drug Administration, and they claim that back in the 1980s, pain experts advocated that opioids could be used to help patients suffering chronic pain. They add that the high rate of drug overdoses in America is driven primarily by illegal opioids like heroin, and it vigorously denies that its actions led to the current crisis. Purdue's also keen to point out that it's invested in initiatives to address the opioid problem in the US, and that it works with others to find solutions and to help save lives. This month the company settled out of court with the state of Oklahoma. They'd brought a case against Purdue, alleging that the company had ignited America's opioid crisis with aggressive marketing and deceptive claims about OxyContin - an accusation which Purdue denies. They didn't face a public trial, but rather the company agreed to pay $270 million to fund addiction research and treatment in the state. The company told us that it both recognises and is deeply concerned about the impact the opioid crisis is having on individuals, families and communities in the US. Purdue still faces around 1,600 additional cases to answer.

KOLODNY: What Purdue Pharma did, and ultimately other opioid manufacturers, was to reframe very good reasons for being cautious with opioids. They reframed them as barriers to compassionate pain care.

CAVELL: Dr Andrew Kolodny is the Director of Opioid Policy Research at Brandeis University in Massachusetts. He's also a prominent critic of Purdue, having testified against them at hearings at the US Senate and in the House of Representatives.

KOLODNY: During the first six years of the release of OxyContin, Purdue Pharma sponsored 20,000 continuing medical education programmes across the United States, in which the chief messages were that opioids are under-prescribed because of an overblown fear of addiction, that the risk of getting a patient addicted is extremely low, and that this was safe and effective for long term usage. Of course, none of this was true, and as we responded to this brilliant marketing disguised as education and the prescribing took off, it led to a public health catastrophe. The physicians who were leading the parade, the term is 'key opinion leader', they were working for Purdue Pharma and other opioid manufacturers on their speakers bureaus, taking quite a bit of money from them, but the messaging was so effective that ultimately we were at a point where many of the doctors who were giving these lectures to other doctors were not getting paid, but had just simply fallen for this and had been duped by these messages, because it became the conventional wisdom.

CAVELL: In a statement, Purdue says it didn't exert undue influence over key opinion leaders, and with regard to those medical education programmes, they said they did sponsor them, but that they didn't control the content. They also say that Dr Kolodny stands to benefit financially by working with plaintiffs' firms in court actions against them. Finally, Purdue told File on 4 that OxyContin never exceeded 4% of total opioid prescriptions in America. They also said that the opioid crisis is a complex societal problem that involves a number of different stakeholders. The US opioid crisis - declared by President Trump a public health emergency - is well documented. But did the pharmaceutical industry use the same tactics in the UK, and did they have any effect? Dr Cathy Stannard again.

STANNARD: For me, I hadn't been to the States before and everybody said, 'It's fantastic going to New York, it's like being on a film set and you have to see it, you have to experience it,' so that was for me very exciting.

CAVELL: In the early 2000s, Napp Pharmaceuticals, which is the UK company related to Purdue Pharma, flew groups of the UK's doctors specialising in pain to New York, where they also met the key opinion leaders referred to by Dr Kolodny.

STANNARD: When we got to New York, we stayed in a lovely hotel. It was not a hotel that I would have ever with my family have stayed in before. It was quite a remarkable experience - a room with a large footprint, in central Midtown. We had quite a lot of downtime so that we could go down to Times Square or look around and do stuff of our own. There was a programme of entertainment laid on, so if you wanted, you could go to a Broadway show, we could eat out in nice restaurants and so on, and we had a trip to the headquarters of the sponsoring pharmaceutical company, where we met their Medical Director.

CAVELL: So this was an all-expenses paid holiday, in effect, to New York, where you got to meet the rock stars of your profession?

STANNARD: Yeah, I guess you could, you could put it like that. It was advertised to us as an educational package and the idea of meeting the international thought leaders was a great hook for me.

CAVELL: It was very common for conferences to be sponsored by the pharma industry. Dr Stannard says of course she understood how these things worked and she knew who was paying for it. But what she says she didn't know was that some pharma companies monitored the prescribing rates of individual doctors, and deliberately targeted those they thought they could influence.

ACTUALITY IN OFFICE

CAVELL: Trips like the one Dr Stannard went on were referenced in a 2007 editorial in the British Pain Society newsletter. Dr Ed Charlton, who was the organisation's president at the time, flagged up the conflict of interest this kind of hospitality creates for doctors. And I have a copy of that here. He writes about a series of trips to New York in particular. He addresses doctors: 'What you may not have known was that the company' – though he doesn't say which – 'monitored your prescribing habits before and after the trip' and 'a majority started prescribing more of the product.' He goes on: the prescribing increase was presented to an annual conference by what he describes as a 'jubilant marketing manager'; the key message being 'increased profit'. It's this - the possible hidden true purpose of such trips - that Dr Stannard finds particularly unpalatable.

STANNARD: I feel very ashamed of that. I had become so aware of the pervasive influence of the pharmaceutical company and companies promoting medical interventions that I do feel duped, that at the time I went on a trip that was going to facilitate me having connections with people that I otherwise wouldn't meet up with, and in fact, it was, I was just a guinea pig to promote prescribing of a class of drug.

CAVELL: In a statement Napp told us they've always supported the exchange of ideas and best practice between clinicians. They added that the objective of the specific 'educational activity' with pain specialists, some twenty years ago, was to foster clinical debate and understanding. However, they didn't respond to our specific points about monitoring the prescribing activity of individual doctors before and after that trip to New York.

STANNARD: I think what is maybe not even appreciated now, but possibly more than it was then, is that these educational initiatives were run by the marketing departments of the pharmaceutical companies. In retrospect, what seems particularly cynical is that these promotional events were continuing at a time when the concerns about opioids and the public health impact of widespread opioid prescribing was being brought to the fore.

CAVELL: Certainly the dependence on opioids here is nowhere near on the same scale as in the US. But prescribing rates though have rocketed and now data from the Centre for Evidence Based Medicine at Oxford University indicates that the extent of this is far greater than had been previously understood. Ben Goldacre is a doctor, academic and author. I spoke to him at his office in Oxford.

GOLDACRE: So we published a paper in Lancet Psychiatry at the tail end of last year looking at trends and variation in opioid prescribing across the whole of England for the last 18 years, and the most striking finding there was the spectacular increase that had previously been missed. If you just count up the number of pills that have been handed out, then the increase in prescribing is only about 34%. But if you account for the fact that people are prescribing higher strength opioids, then the increase is actually 127%. And previous research had completely missed that spectacular increase, because they didn't account for the fact that opioids that are being prescribed today are much, much stronger.

CAVELL: That increase of 34% took prescriptions to over 760 per 1000 patients. So the UK's become dependent on more, and ever stronger, opioid medication. The Royal College of GPs told us doctors are highly trained and prescribe in line with current guidelines. They discuss the risk and benefits with patients and that the mantra is to prescribe opioids at the lowest possible dose for the shortest possible time. They say the lack of alternatives and the fact that there's no easy cure for chronic pain leaves both doctors and patients frustrated.

ACTUALITY AT TRAINING SESSION

CAVELL: In Gloucester, doctors and pharmacists at Dr Stannard's training session discuss this. They say their patients have an expectation that this type of pain can be cured with drugs – and that's something that's difficult to deal with.

PHARMACIST: We are a medical practice, we are not pick and mix at the cinema. You know, for too long I think we've allowed the patient choice to overrule medical common sense in certain patients, and if they come in and they say, 'I want that one, I want two of those, I want some of that as well,' we just go, 'Yes, here you are.' And that attitude needs to change, and so we have to tackle that. We can't keep saying 'Oh, they don't want to, they're not happy to.' It's us that are writing the prescriptions, we cannot just keep writing those prescriptions.

CONSULTANT: And what we've got to remember is that actually by giving in, we are doing them harm. They won't see that, but we are doing them harm.

GP: These often seem to happen at the end of an exhausting day, these kind of consultations and it's just so easy when you're emotionally at your ebb to just say …

PHARMACIST: That can be a good tactic as well, patients who are drug seeking will choose the new doctor, they will choose the most difficult clinic time, they may go in for different doctors every time, so, you know, most of these patients we are talking about are not addicts, but there is a small hard core who are deliberately trying to get drugs from you.

CAVELL: Experts agree that people experiencing chronic pain are often extremely vulnerable. But we've discovered another group of vulnerable patients which manufacturers saw as a potentially lucrative market for opioids: dementia patients. We've discovered evidence that a pharmaceutical company marketed these drugs in a way which was judged to be misleading and which even gave rise to safety concerns.

REGNARD: Something to say very importantly at the outset is that opioids, so these are strong analgesics like morphine and buprenorphine and fentanyl, yes, they are powerful drugs, but they're not inherently dangerous - it's how you use them that matters.

CAVELL: Dr Claud Regnard spent his career working in palliative care and with dementia patients. He said it can be particularly difficult to establish when some dementia patients are experiencing pain.

REGNARD: There are many dementia patients who are still able to communicate, tell you where a pain is or what's causing their distress. But equally there are number where the dementia has progressed, where either speech has been affected, behaviour's been affected and their ability to even say that they have pain, let alone say where it is or what it's like, has really largely gone.

CAVELL: Is it possible to know in a dementia patient who has trouble communicating whether or not they are in pain?

REGNARD: Well, that is a very sensible question. The answer is no.

CAVELL: So the diagnosis and treatment of pain in these patients is extremely complex. In 2014, Napp Pharmaceuticals got into trouble with the regulator of the pharma industry - the Prescription Medicines Code of Practice Authority, or PMCPA - for marketing its stick on opioid patches, called BuTrans patches, to patients with dementia. The company must have seen a potentially lucrative new market in this cohort, because they took out a full page ad in the British Medical Journal, set up a website and printed leaflets promoting their patches for use in patients with dementia. The problem was, and the reason

CAVELL cont: that they were censured, the evidence to support their claim wasn't sufficiently robust. They based their marketing material on one small clinical trial that was measuring agitation in dementia patients - not pain relief. To someone who has cared for dementia patients, the idea of promoting these patches in this way – and among such a vulnerable group of people - was horrifying.
What was wrong with what they were suggesting? Because it sounds like a nice, easy solution, doesn't it, rather than having to take lots of pills, to be able to just put a patch on somebody?

REGNARD: Doesn't it just? Absolutely. You can see why it's a tempting solution. The concept of using a patch in agitated dementia is a quick and dirty solution. It may be quick and it may be convenient and apparently simple, but it can be very dirty. If they are giving side effects such as increasing agitation, increasing confusion, causing drowsiness - perhaps worse - then it is certainly dirty.

CAVELL: The panel did indeed note that side effects could be increased confusion, agitation and anxiety. The panel was:

READER IN STUDIO: Particularly concerned about the safety of using BuTrans in its vulnerable patient group, given that if they could not verbalise pain, they were unable to express and communicate side effects.

READER 2 IN STUDIO: Promoting a medicine in a patient group in whom there was no robust evidence of efficacy was an extremely serious matter.

READER 3 IN STUDIO: The panel was extremely concerned about the material which, in its view, did not promote the rational use of BuTrans.

CAVELL: Despite how seriously the PMCPA clearly took this case, the only consequence for Napp was that they were made to withdraw the material. Napp told us that for patients struggling to take oral medication, an analgesic patch offers a helpful alternative to manage their pain. Nevertheless, they said they respected the decision and withdrew the materials in question immediately. They also ended their promotional activities related to dementia patients in pain.

MUSIC

CAVELL: The Association of the British Pharmaceutical Industry has tightened up the rules around what doctors can accept from Pharma, so something like that New York trip couldn't happen now. However, we found very recent examples of potentially problematic content in a national newspaper. In the UK, it's not permitted to market prescription medicines directly to the public. In March this year, the printed edition of the Guardian carried what it has called an advertorial supplement.

ACTUALITY WITH NEWSPAPER

CAVELL: So I have a copy of it here and it does look very similar to the Guardian, it's the same size. The articles in it are all about pain and, at first glance, they look like they've been written by pain experts; they all have those little photos beside their names like they do in newspapers. But when you look closer, the name of the true author is there in much smaller text, and if you google that name, you'll find that they work for the PR company who produced this supplement. But this is the part that stands out – there's a two page spread on the use of opioids for chronic pain. The content of the article itself is very well balanced, but the headline says, 'Opioids could help you manage your pain', and the bottom third of the page is an advertisement for Ethypharm, an opioid manufacturer.

When I contacted MediaPlanet, the PR company that produced the supplement, they told me that Ethypharm, and a number of other companies in the pain business, bought advertising space. However, they told me that the content was produced independently by MediaPlanet themselves and the advertisers were not permitted to review it before it was published. They also insisted that the layout was distinct from the Guardian and that it was clearly marked as having been produced by MediaPlanet. That wasn't the reaction of Dr Ben Goldacre at Oxford University though, himself a former contributor to the Guardian.

Can I draw your attention to something that fell out of a well-known newspaper?

GOLDACRE: Yes.

CAVELL: What does this look like to you?

GOLDACRE: [LAUGHS] Which newspaper is this?

CAVELL: I want you to guess.

GOLDACRE: Is it The Guardian?

CAVELL: Yes.

GOLDACRE: Wow.

CAVELL: What does it appear as to you?

GOLDACRE: Oh wow, is this not a news story? Holy hell. Oh wow. Same font, same layout, that, that is extraordinary. So where on the page does it say …. Oh, thank you, an independent supplement by MediaPlanet.

CAVELL: Now if you weren't a media professional, do you think you would have spotted that this wasn't Guardian editorial when it, when you turned the page and came across it?

GOLDACRE: No, this just looks like a completely normal news or opinion piece. 'Opioids could help you manage your pain' - that is truly extraordinary.

CAVELL: The Guardian told us that the supplement was advertorial and that its content was the responsibility of MediaPlanet. However, they did say that that particular article and its layout fell below the standard they would expect, and that they would not run the advertorial supplement in that form again.

So does this break the rules? I wanted to find out, so I contacted the regulatory body responsible - the PMCPA - to ask them if this constituted marketing of prescription medicines to the public. The short answer is, they couldn't tell me. They said the only way for me to find out was to lodge an official complaint, where it would fall to me to prove if - or how - any rules had been broken, but that ultimately it would take months.

CAVELL cont: A review by Public Health England into prescription drug addiction is ongoing and the Minister for Health recently announced that opioids must contain prominent warnings about addiction to protect people from 'the darker side of painkillers'. In Bradford, Sharon is mending the damage opioids caused to her family and, in particular, her relationship with her daughter.

SHARON: I thought my GP was my hero. He was trying to save me from pain. She didn't think that at all. She ended up stopping talking to me for a whole year, I missed out on my grandchildren for a whole year and because I wouldn't agree that I was taking too much medication, because I didn't think I was.

CAVELL: She says she's learning to live with her pain rather than resorting to pills.

SHARON: If I do get pain, and if it's, if it's unbearable pain, then I've got a supply which I'm allowed by my doctor to take if necessary. But it's here and there now - it's more there than here. I very rarely have to take them. I very rarely want to take them. I'd rather bear the pain than take the morphine.

CAVELL: A shift in cultural attitudes towards chronic pain has meant that sufferers expect to be able to find a cure, when sadly many experts say there may not be one. The legacy of recent years is that pharmaceutical companies and their marketing departments have been able to use this to their advantage - telling doctors and patients that they have the answer. [MUSIC] For pain expert, Dr Cathy Stannard, the challenge we now face is to somehow turn that situation around and consider the possibility that patients may need to look to many different solutions to the problem - not just a magic pill.

STANNARD: Many, many people live with long term pain and it's incredibly distressing and disabling. We have, as a society, become used to there being a treatment for things that are unpleasant. I think the difficulty with pain is it's very multi-factorial and framing it as simply a medical condition that has to be treated with a specific medical intervention is very dangerous.