GUEST Editorial

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The Unfortunate Turn of Events in Pain Management

This is the third of a 12-part series: This year we're focusing on the phenomenal progress that the medical community has made in the 30 years of Federal Practitioner's *existence. This month we'll feature editorials written by 2 of our Editorial Advisory Association members, reminding us how much has changed in their particular medical field over the past 30 years. This month's focus is pain management.*

An old adage holds that where you sit determines where you stand on a particular issue. This old maxim is illustrated incredibly well this month by the diametrically opposed perspectives of our 2 Guest Editors. Each one is attempting to summarize generations' worth of developments in pain management. But one author is quite optimistic; the other relentlessly pessimistic. Chris Pasero, our expert in pain management nursing, presents a consistently upbeat picture of progressively increasing nursing sophistication in the assessment and management of pain. But our physician pain expert, Dr. Cuevas-Trisan, limns a much, much darker portrait of out-of-control abuse and overuse of opioids. Each perspective is true and legitimate, even as they are totally at odds with each other. Please read both editorials very carefully and marvel at how 2 virtually opposite yin and yang perspectives can be completely valid at the same time.

James V. Felicetta, MD, Editor-in-Chief

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The history of mankind is plagued with events that began as noble endeavors but down the line produced unintended consequences. Several events over the last few decades have produced similarly negative consequences in the contemporary management of chronic pain. The establishment of "pain as the 5th vital sign," although noble in its intentions, was fundamentally flawed, given the lack of an objective measure for it. We are currently paying for this mistake when it comes to the management of chronic noncancer pain. The noble intention of highlighting the importance of assessing pain on a regular basis has largely contributed to the opioid overuse and abuse epidemic that has become a serious public health crisis in this country.

Opioids are remarkably effective medications for the management of acute pain. However, when it comes to long-term, chronic use, the story is totally different. In our daily practices, we are constantly reminded of the problems associated with their chronic use: tolerance leading to dose escalation, hypogonadism, inactivity with decline in function, hyperalgesia, dependence, and abuse. There is no convincing evidence of their effectiveness when used over an extended period of time (years), yet this has become so common that it is almost considered the standard practice. Even some of the greatest advocates of liberalizing opioid prescribing have drastically altered their initial views on the subject. Over the last few years, the pendulum clearly swung too far, and it is time to bring it back to a more moderate position.

The lay public and, most unfortunately, the medical establishment have confused pain management with opioid prescribing. Painkillers are responsible for more American deaths than heroin and cocaine combined.[1] Since 2008, drug-induced deaths have outpaced deaths due to motor vehicle accidents. Prescription drugs account for nearly three-quarters (over 15,000) of all drug overdose deaths in the U.S., a figure that has quadrupled since 1999.[1] If you think these numbers are concerning, think again. Hydrocodone, a Schedule III opioid, is the most prescribed drug in the U.S., surpassing the most prescribed cholesterol-lowering agent (simvastatin), the 2 most commonly prescribed antihypertensive medications (lisinopril and amlodipine), and other very common prescription drugs, including levothyroxine, omeprazole, metformin, and amoxicillin, to name a few. In 2011, there were 131 million prescriptions written for a brand-name combination product of hydrocodone and acetaminophen, and in 2009, 99% of the hydrocodone produced worldwide was consumed in the U.S. This trend is similar, with only slight variations, for Schedule II opioids, such as oxycodone and fentanyl. This is particularly alarming considering that the U.S. population comprises approximately 4.5% of the world's population.[2,3]

I submit to you that we must

never feel compelled to prescribe opioids when facing a chronic nonmalignant pain condition, particularly one with no clear underlying etiology. We should instead feel compelled to fully and thoroughly evaluate the problem, do our very best to identify its etiology in order to have the best chance of providing definitive treatment, and more important, focus on maximizing the patient's function. When dealing with chronic noncancer pain, opioids should be the last treatment option and should always be started as a trial with clear functional goals and an unequivocal understanding that doses will not be indiscriminately increased. A great deal of patient education along with compliance monitoring measures, including tracking patient aberrant behaviors and drug screens, should be established and executed.

Another flawed measurement instrument, the patient satisfaction survey, has also unintentionally driven us into a deeper hole. Patient satisfaction surveys, virtually nonexistent a couple of decades ago, have become a major component of all medical practices. Different forms of these have even made their way as important outcome measures in many research protocols. This is, by most accounts, a noble idea: It provides patients a voice, and many times a choice, and the driving force to improve health care. But when it comes to chronic nonmalignant pain management, it has yielded additional unintended consequences: patient dissatisfaction with a provider's decision to not prescribe opioids (or worse yet, to not prescribe the patient's opioids of choice, including specific brand names or the desired dose), often resulting in bitter complaints from the patient even when the provider has precisely chosen the most prudent course of treatment. Nonetheless, these patients' complaints may be used to evaluate a provider's performance, potentially affecting the provider's rating in an organization with potentially negative impact on perceived competence and the provider's bottom line.

Many providers, when faced with this possibility, opt to follow the path of least resistance: yield to the patient's demands instead of engaging in a lengthy and oftentimes contentious argument with the patient that results in potentially negative consequences (poor rating in evaluations, leading to negative perception of their skills and professionalism; longer time spent with the patient and inability to see other patients; an unpleasant argument that may erode the physician-patient relationship of trust, etc). These consequences may have a negative economic impact for the provider, but there are other serious consequences in following the path of least resistance. As medical providers, we have taken the oath to do the right thing for the patient. I would say that we should be selfless, but I need to be more realistic as we all have to juggle multiple roles and pressures personally as well as professionally. However, the societal impact of the current opioid overuse epidemic is too large and broad to ignore. It certainly affects our patients and our practices, but also everyone around us, including our communities and potentially even our loved ones. Many of these drugs end up in the hands of teenagers and young adults, as it is widely known that for school-aged children, prescription drugs are easier to obtain than cigarettes and alcohol.

I encourage all medical providers to do the right thing! This starts with patient education but needs to be contemplated with staff education and the will to work harder in order to instill positive changes. It may seem to get old at times, repeating over and over again the same thing, but it must be done. I always tell my colleagues in our pain management practice that if we do not receive complaints from patients and only get eloquent compliments, I begin to think that we are not doing our job. Call me a skeptic, but the consequences are too devastating to be complaisant. I also call on decision makers and supervisors to be critical when patients complain about their provider regarding pain management issues; look and evaluate the whole picture rather than to immediately validate the patient's complaints regarding pain management issues as true at face value. After all, some of those complaints could possibly be indicators of good providers. ●

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