Pain Medicine

Pain Medicine 2013; 14: 617–620
Wiley Periodicals, Inc.

PROFESSIONALISM AND COMMENTARY

Ethics Forum

A Pendulum Swings Awry: Seeking the Middle Ground on Opioid Prescribing for Chronic Non-Cancer Pain

Perhaps at no time in history has the field of pain medicine experienced a crisis as overwhelming as the current one regarding the prescription of opioid analgesics for noncancer pain. Physicians and observers [1,2] have noted the dramatic swing from the overprescription of opioid analgesics in the 1990s and the early years of this millennium to a rash of new state efforts to eradicate opioid prescription through the implementation of legal restrictions, sanctions, arrests, prosecution, and in some cases, frank intimidation of physicians who still consider opioid analgesics to constitute a critical element of their pain management armamentaria.

In this initial installment of the revived Ethics Forum, we call on two luminaries in the field of pain medicine to weigh in on this crisis. Dr. Gary Franklin, a researcher on the efficacy and abuse of chronic opioid therapy, was a leading proponent and pioneer of the now infamous "Washington State Opioid Law"—legislation that set the tone for the changes that have occurred over the past several years [3–5]. Here, Dr. Franklin provides his perspective on the recent restrictions on opioid prescribing as being necessary measures to protect both patients and the field of pain medicine. Dr. John Peppin provides a different viewpoint on the issue. Dr. Peppin, a pain management practitioner and bioethicist, has continued to argue that if used properly and cautiously, opioids should remain an open option for pain management physicians and their patients [6,7]. Following their brief presentations of their positions, we attempt to identify a position of rapprochement that will hopefully serve as a guide to clinicians who wish to simultaneously mitigate patient suffering while protecting individual patients as well as society as a whole—and accordingly practice in as effective, safe, and ethical manner as possible.

MICHAEL E. SCHATMAN, PhD, CPE,* and
BETH D. DARNALL, PhD†
*Foundation for Ethics in Pain Care, Bellevue, Washington; †Division of Pain Medicine, Department of Anesthesiology, Perioperative and Pain Medicine, Stanford University, Palo Alto, California, USA

References

1 Loeser JD. Five crises in pain management. Pain Clin Updates 2012;20:1–4.

2 Von Korff MR. Opioids for chronic noncancer pain: As the pendulum swings, who should set prescribing standards for primary care? Ann Fam Med 2012;10:302–3.

3 Franklin GM, Mai J, Wickizer T, et al. Opioid dosing trends and mortality in Washington State workers' compensation, 1996–2002. Am J Ind Med 2005;48:91–9.

4 Franklin GM, Rahman EA, Turner JA, et al. Opioid use for chronic low back pain: A prospective, population-based study among injured workers in Washington state, 2002–2005. Clin J Pain 2009;25:743–51.

5 Franklin GM, Mai J, Turner J, et al. Bending the prescription opioid dosing and mortality curves: Impact of the Washington State opioid dosing guideline. Am J Ind Med 2012;55:325–31.

6 Peppin JF, Kim G, Burke J, Kirsh KL. A partial review of the appropriate use of opioid analgesics in the treatment of chronic pain: Toward a model of good practice and rational pharmacotherapy. Crit Rev Phys Rehabil Med 2009;21:25–65.

7 Peppin JF, Passik SD, Couto JE, et al. Recommendations for urine drug monitoring as a component of opioid therapy in the treatment of chronic pain. Pain Med 2012;13:886–96.

Primum Non Nocere

Every year, on the Jewish Day of Atonement, Yom Kippur, a part of the liturgy recited is a brief paragraph of single phrases separated by periods; each phrase is an admission of a prior years potential wrongdoing, and one pounds their chest with a fist with the recantation of each phrase, such as "we have framed falsehood," ". . . and have caused others to err." A similar set of phrases pertinent to what has transpired over the past 15 years related to the treatment of chronic pain with opioids might be

"Death. Overdose hospitalization. Overdose ED visits. Falls and fractures in the elderly. Infertility. Neonatal abstinence syndrome. Dependence. Addiction. Life-long disability. Loss of family and community."

I am not going to question the initial motives of pain experts who believed that if opioids could comfort those at the end of life with horrible diseases, perhaps the same could be said for comforting those in chronic pain. The problem is that this precept was based on insufficient scientific evidence that such treatment would be safe and effective. The balance scale now appears to be heavily weighted: little to no evidence of long-term efficacy, particularly for clinically meaningful improvement in function [1], and terrible and potentially enduring harm. For drugs synthesized to be only a few atoms different than heroin, what did thought leaders in the field of pain think would happen?

In Washington State (WA), we have begun to make a dent, but only a dent, in a state that started out in the highest tertile of fatality rates [2]. This likely has occurred because of broad agreement among our academic and pain leaders that if you want to prescribe opioids for chronic pain, do so with all the best practices and universal precautions that, used prudently, *might* help avert disaster [3]. Our state guidelines include every publicly available, validated brief instrument any prescriber might need to successfully prescribe opioids should they choose that treatment path. This would include documenting pain and function, and opioid dose in morphine equivalents (MED), at every visit. Not doing so is akin to flying blind. The crucial but much maligned dosing threshold only says that if you have escalated doses to 120 mg/day MED and if the patient has not substantially improved in pain and function, take a deep breath and either hold the line or ask for some help. This is a new "set point" for prescribers to keep in mind, not a line in the sand. In one recent randomized trial, dose escalation was not associated with improvement in pain and function, and misuse/noncompliance occurred in 27% of patients [4].

Primary care prescribers with greater availability of tools and resources may be less likely to abandon their patients with chronic pain altogether [5,6]. State Prescription Drug Monitoring Programs will also help improve care delivery tremendously, but these programs are underused, underfunded, and do not allow interoperability across states and all health care systems [7]. Payers need to step up to the plate and pay for more effective, mostly nonpharmacological treatments for chronic pain. Multidisciplinary pain services, cognitive behavioral therapy, and graded exercise are all proven effective in the treatment of subacute or chronic low back pain [8] but are rarely used and often not covered. We are experimenting, in WA workers' compensation, with a medical home model with incentives for the prevention and more effective treatment and care coordination of chronic pain in injured workers [9]. In WA, we still have a huge hole to dig out of. How big is your State's hole? It is time to stop wailing, and to get down to business.

Conflict of Interest: Dr. Franklin has no conflicts of interest to report.

GARY M. FRANKLIN, MD, MPH*†‡§
*Departments of *Environmental and Occupational Health Sciences, †Neurology, and ‡Health Services, University of Washington, Seattle;*
§Washington State Department of Labor and Industries, Olympia, Washington, USA

References

1 Manchikanti L, Vallejo R, Manchikanti KN, et al. Effectiveness of long term opioid therapy for chronic, non-cancer pain. Pain Physician 2011;14:E133–56.

2 Franklin GM, Mai J, Turner J, et al. Bending the prescription opioid dosing and mortality curves: Impact of the Washington State opioid dosing guideline. Am J Ind Med 2012;55:325–31.

3 WA Agency Medical Director's Group. Interagency guideline on opioid dosing for chronic, non-cancer pain: An educational aid to improve care and safety with opioid therapy. June, 2010. Available at: http://www.agencymeddirectors.wa.gov/guidelines.asp (accessed 14 February 2013).

4 Naliboff BD, Wu SM, Schieffer B, et al. A randomized trial of 2 prescription strategies for opioid treatment of chronic nonmalignant pain. J Pain 2011;12:288–96.

5 Leverence RR, Williams RL, Potter M, et al. Chronic non-cancer pain: A siren for primary care—A report from the Primary Care Multiethnic Network (PRIME Net). J Am Board Fam Med 2011;24:551–61.

6 Franklin GM, Fulton-Kehoe D, Turner JA, et al. Primary care opioid prescribing practices for chronic pain in a rapidly changing regulatory landscape in Washington State. J Am Board Fam Med 2013. (in press).

7 Deyo RA, Irvine JA, Millet LM, et al. Measures such as interstate cooperation would improve the efficacy of programs to track controlled drug prescriptions. Health Aff (Millwood) 2013;32. Available at: http://content.healthaffairs.org/content/early/2013/02/13/hlthaff.2012.0945 (accessed 15 February 2013).

8 Chou R, Hufman LH; American Pain Society; American College of Physicians. Nonpharmacologic therapies for acute and chronic low back pain: A review of the evidence for an American Pain Society/American College of Physicians clinical practice guideline. Ann Intern Med 2008;148:492–504.

9 Wickizer TM, Franklin G, Fulton-Kehoe D, et al. Improving quality, preventing disability, and reducing costs in workers' compensation healthcare: A population-based intervention study. Med Care 2011;49:1105–11.