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Longitudinal reflections of the recent political shifts in the prescription of opiates

Robert G. Bota, Andrei Novac, Aaron Kheriaty

UC Irvine Health Neuropsychiatric Center, Orange, CA, USA

The medical, ethical, and political history of treating pain with opiates, and balancing this against the risk of opiate abuse and addiction, has gone through various historical shifts and cycles.[1] The treatment of pain with opiates expanded in the U.S. during the years following World War II in response to the needs of injured soldiers. The 1980s saw a backlash in the U.S. in response to concerns that pain and disability claims were too subjective. These cycles are characterized by shifting attitudes in society and among physicians and healthcare professionals, often in reaction or response to either the under treatment of pain on the one hand, or the over-prescription of opiates with consequent abuse or death by overdose on the other hand. Such shifts are often followed in subsequent years by a counter-reaction in the *other direction.*

This pendulum continues to swing, and the task of finding the right balance of pain control and addiction or abuse avoidance has proven to be a major clinical, ethical, and social challenge in medicine. The central ethical and medical challenge is balancing the risks of the overmedicated against the risks of the undertreated; or to put it another way, the challenge involves balancing the benefits of denying opiates to addicts against the benefits of providing opiates to those in pain. What clinical criteria can we use to identify those who require pain treatment, while excluding those who stand to be harmed by opiate prescriptions?

These difficulties are exacerbated by the complex and multidimensional nature of pain, including especially the fact that, in the last analysis, the assessment of the nature and severity of pain still relies (and likely always will rely) on subjective reporting from the patient who suffers, or who claims to suffer, from pain. Both the patient in true pain, who in some cases may have minimal or no objectively observable findings to corroborate or account for the pain, can give the same self-report as the opiate-seeking individual who is not really suffering pain, but is instead seeking the drug for reasons of addiction, dependence, or abuse.

In our own day, opiate abuse has been on the rise in the United States for some time now; and rates of death by opiate overdose have increased in recent years.[2] This is in part due to earlier concerns dating back to the 1990s that pain patients were under-medicated. Surveys from that era revealed the fact that the majority of patients in hospitals did not receive adequate pain control. Elderly patients left to suffer with pain were viewed as victims of elder abuse. The case Bergman v. Eden helped to set the new paradigm in pain management.[3] In that case an 85-year-old man dying of cancer was sent home without adequate pain control. The jury found the doctor reckless for not relieving pain, and the case received widespread media coverage at that time.[4] Partly as a result of this campaign, monitoring pain in patients and awareness of this symptom increased. Health workers, focusing more on this problem, started to inquire more consistently about pain the patients would experience at different times in the day. Hospital rooms had the pain scale posted on the walls. Efforts were made to designate pain as the *5th vital sign*, though technically pain is a symptom (*i.e.*, subjectively reported phenomena), not a sign (*i.e.*, objectively observable or measurable phenomena). Gradually, pain control became one of the important criteria upon which the quality of care was assessed, increasing pressures to medicate reported pain with opiates.

The deontological Kantian approach to ethical criteria suggests that once a categorical imperative is in place (treating pain whenever it is presented or reported to be present),[5] it becomes a universalized practice, leaving no place for variation, circumstances, or individual judgments. Doctors are often faced with an ethical dilemma between *first do no harm*, and the relief of human suffering. Yet, in recent times, being a *good doctor/provider* is too often based on this single measure: pain relief. The problem of aggressively treating pain and ultimately the consequences of that policy, including abuse of pain medications, side effects, and ultimately overdoses and fatalities, got captured increasingly by the press. In the last few years, a new approach developed toward pain management that was driven by fear of using pain medication due to many factors, including growing levels of anxiety among health care providers over prescribing pain medications due to increasing fear of litigation toward healthcare organizations and physicians, thus creating a similarly distorted paradigm. In time, a wave of justified concern did turn the table and now safer approaches are implemented. The interdisciplinary approach and pain management clinics seem to have become *the new normal*.[6]

Different specialties may often view the issue of pain management differently, and be willing to assume different criteria in the assessment and provision of opiates. Surgeons, anesthesiologists, and pain specialists, naturally motivated to treat pain, and often judged and evaluated by patient satisfaction surveys, may be more concerned about the under-treatment of pain, and more willing to dispense opiates liberally. Better to medicate 10 addicts than to allow one person in pain to suffer unnecessarily. Psychiatrists, on the other hand, who deal more frequently with the harmful effects of opiate abuse and overdose, may be more wary, and may maintain heightened concerns about abuse and addiction. These different viewpoints, based upon different clinical experiences with distinct cohorts of patients, may be difficult to adjudicate form an abstract *neutral* position of supposed objectivity. This is among the reasons that an interdisciplinary approach to the evaluation and treatment of pain may offer the most prudent way to adjudicate and balance these various concerns and legitimate interests.

More than ever, physicians are being called upon to create treatment algorithms based on research data to provide ultimate transparency of care to patients. However, when it comes to major biological variables like chronic pain, caution has to be exerted to maintain adequate individualized care. At this time, there is still a concern that the pendulum swinging back to a more judicious distribution of pain medication would also result in some patients not receiving pain care at all, or receiving inadequate pain care. For this reason, an individualized approach utilizing combined treatment modalities (including non-opiate pharmaceuticals), is expected to become the norm. The new trends are pushing pharmaceutical companies to engage in more research and development on opiate formulations that have reduced abuse potential. As a consequence of often extreme trends in pain management

Correspondence: Robert G. Bota, UC Irvine Health Neuropsychiatric Center, 101 The City Drive South, Orange, CA 92868 , USA.
Tel.:+1.714.456.2056.
E-mail: rbota@uci.edu

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over the past two decades, the field of pain medicine has matured. Patients can now be provided with multi-disciplinary care that addresses an individual's psychiatric, social, and medical needs, which requires close cooperation between among physicians of varying specialties.[7] In most medical specialties, the team approach is deemed the most appropriate way to render the best outcomes.

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