Putting patient at the center of pain management: Fighting opioid crisis

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Physicians, medical organizations and public health experts around the nation all have shared reasons why the opioid overdose epidemic must be top of mind in the medical world, and it comes down to one focus—the patient. A panel of experts recently gave recommendations that lead the way to making patient-focused pain management possible.

Reducing the stigma of chronic pain

One important aspect of the efforts to combat the opioid epidemic is reducing stigma so that patients with chronic pain do not lose access to the care that they need.

“What is our role as physicians in this current problem?” asked John A. Renner, MD, president of the American Academy of Addiction Psychiatry and professor of psychiatry at Boston University School of Medicine, speaking to physician leaders at the AMA State Legislative Strategy Conference earlier this month during a session on the opioid crisis.

“This epidemic is not going to be contained until we change practice within medicine,” Dr. Renner said. “Medicine does not shrink from treating these chronic conditions.”

There are many things that physicians can do now to begin those changes, he added. “Before prescribing opiates for either acute or chronic pain, the clinician must screen every patient for a history of substance use disorders and for co-occurring psychiatric disorders. A review of the PDMP should be part of every routine assessment.”

“Recognize that patients with any history of alcoholism or substance use disorder are at higher risk for abuse, and they should be managed very carefully,” Dr. Renner said. “This means avoiding prescribing opiates if there are other medications that may be more effective, carefully prescribing … opiates if that is necessary, [and] it means monitoring the patient carefully, to look at how the
treatment is progressing.”

However, this does not mean withholding opiates from patients with acute pain, he said.

Dr. Renner cited a case where a patient with a history of addiction needed surgery. The surgeon gave the patient a four-day supply of opioids but also carefully monitored the patient during those four days and the time following to make sure the patient’s pain was managed sufficiently.

“Sometimes prescribing [opioid-based] medication is the best way to prevent relapse,” Dr. Renner said. In other cases, “we need to work with primary care physicians as well as pain management specialists to develop alternatives for handling chronic pain without relying on opiates.”

“There is a moral imperative to treat pain,” said Myra Christopher, the Kathleen M. Foley chair for pain and palliative care at the Center for Practical Bioethics. “Those who are in the healing professions have ethical and moral obligations to do so.”

“That does not mean that there is a moral imperative, an ethical duty or obligation to prescribe opioids,” she added. “It means there is a moral imperative to address this issue [of chronic pain].” One solution, Christopher suggested, is to increase training in pain management.

“If you ask any medical school applicant why they want to go to medical school, “they will say ‘I want to alleviate, or I want to treat pain and suffering,’” Christopher said. “That notion is really the foundation of what it means to be a healing profession.” However, although comprehensive management for chronic pain is necessary for many patients, most physicians have inadequate training on this approach.

**Actions physicians can take to end the overdose crisis**

In conjunction with patient-focused chronic pain management, physicians also need to be vigilant in taking steps to prevent overdose and treat patients who are living with substance use disorder.

“Where do we start when there are 44 people dying from opioid-related overdoses every day?” said Patrice A. Harris, MD, chair-elect of the AMA Board of Trustees, who also chairs the AMA Task Force to Reduce Prescription Opioid Abuse, during her opening remarks.

“This public health crisis related to opioid misuse and heroin addiction results in nearly 30,000 deaths annually and challenges us as physicians to amplify our current efforts and actions,” Dr. Harris said. “We use the word ‘actions’ deliberately [because] we must take concrete actions that will help end this crisis.”
The task force focuses on five recommendations for all physicians from “inside the profession,” Dr. Harris said. “These recommendations come from physicians who treat acute pain, chronic pain and patients who have substance use disorder. We must also look inwardly …. As physicians, we run toward the health crisis, not away from it.”

**Action No. 1:** Physicians should “voluntarily register for and use [their] state prescription drug monitoring programs (PDMP),” Dr. Harris said.

One example of a successful PDMP comes from the Ohio State Medical Association (OSMA). Also speaking on the panel with Christopher and Dr. Harris, Michael Bourn, DO, medical director of pain and palliative services at Doctor’s Hospital in Columbus, Ohio, described the success of his state’s PDMP for physician leaders.

The Ohio Automated Rx Reporting System (OARRS) is a tool to track the dispensing and personal furnishing of controlled prescription drugs to patients. OARRS is designed to monitor this information for suspected abuse or diversion and can give a prescriber or pharmacist critical information regarding a patient’s controlled substance prescription history to identify high-risk patients who could benefit from early intervention.

In 2010 there were about 5,000 Ohio prescribers with a voluntary OARRS account, but that number has increased to over 36,000 presently and counting. Between 2007 and 2014 the number of OARRS reports requested increased 5,900 percent, signifying its expanded use throughout the state in just seven years. In that same seven year period, Ohio experienced an approximately 50 percent decrease in “doctor shoppers” throughout the state and saw a significant drop in the number of patients seeking multiple prescriptions.

**Action No. 2:** “Focus on education,” Dr. Harris said. “Encourage yourselves and encourage your colleagues to ask themselves: When was the last time you took CME that was focused on opioid prescribing, to learn how to effectively use your state’s PDMP and to learn how to recognize the signs of abuse?”

**Actions Nos. 3 and 4:** “The third and fourth recommendations have to do with the stigma of pain,” Dr. Harris said. It’s important to reduce the stigma that surrounds pain patients in order for those with chronic pain to receive the care and the prescriptions they need to live happier, healthier lives, Dr. Harris said. It is also important to reduce the stigma of substance use disorder and increase access to treatment so patients feel comfortable in seeking that treatment.

**Action No. 5:** “Consider co-prescribing naloxone and support broad Good Samaritan protections,” Dr. Harris said. Last year access to naloxone—the life-saving medication that can reverse the effects of an opioid overdose by restoring breathing and preventing death—was increased substantially through new products and availability. “At the end of the day, remember what is most important—our patients.”


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