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Why are our patients still in pain? Fifty million Americans have chronic pain categorized as disabling, and an estimated $150 billion per year is used for diagnoses and treatment, lost wages, and decreased productivity associated with chronic pain. Although pharmacologic advances have introduced new combinations of narcotic analgesics during the past several years, many primary care physicians remain reluctant to prescribe medications with sufficient potency and at dosing frequency to adequately treat nonmalignant chronic pain in the ambulatory care setting. The factors that contribute to this reluctance are multifaceted.

Back to Basics

What is pain management? The American Academy of Pain Management defines pain management as “the systematic study of clinical and basic science and its application for the reduction of pain and suffering: the blending of tools, techniques and principles taken from the discrete healing art disciplines and reformulated as a holistic application for the reduction of pain and suffering; and a newly emerging discipline emphasizing an interdisciplinary approach with the goal of reduction of pain and suffering.” It is essential to emphasize the goal of pain management in the context of nonmalignant chronic pain. According to the preceding definition, the goal of pain management of patients with nonmalignant chronic pain is not the elimination of pain, but rather the reduction of pain and resultant increased functioning.

At the onset of chronic pain treatment, clinicians have a responsibility to educate patients to accept the goal of treatment: reduction of pain. Many patients incorrectly assume the goal of chronic pain therapy to be the elimination of all pain symptoms. Although this would be favorable for both patients and physicians, it is often anatomically or physiologically impossible. Patients should regard achieving a level of pain control that allows them to function in the activities of daily living (eg, employment, family and social activities) with minimal adverse drug side effects as a successful outcome. Understanding that a certain level of pain or discomfort may persist even with medication, patients may become more tolerant during the course of treatment and allow their bodies time to respond to the healing process.

World Health Organization Guidelines for Opioid Use

The World Health Organization has established a protocol for the pharmacologic management of chronic pain. Initially, patients should be treated with nonnarcotic medications (eg, nonsteroidal antiinflammatory drugs [NSAIDs], aspirin, acetaminophen), as well as skeletal muscle relaxers, serotonin medications, and osteopathic manipulative medicine. Should these fail to provide symptom relief, the physician should begin use of United States Drug Enforcement Agency scheduled controlled substances (eg, codeine or hydrocodone with acetaminophen, Darvocet, and narcotic agonists: Talwin, Nubain, and Stadol). As a final option, stronger scheduled and controlled substances can be implemented (eg, morphine sulfate, hydromorphone, fentanyl, levorphanol, methadone). Physicians in the following study were more comfortable prescribing codeine/acetaminophen combinations than sustained-release morphine.

To Treat or Not to Treat

Studies have shown that strong opioids have been beneficial in treating patients with chronic nonmalignant pain. However, few detailed guidelines for care have been established for practitioners. Although primary care physicians may wish to provide adequate treatment for patients with chronic pain, many fear prescribing narcotic analgesics primarily because of the risks of drug dependence and increasing tolerance.

Using clinical vignettes and questions, the University of California, San Francisco, Stanford Collaborative Research Network study conducted a survey of physicians’ prescribing habits. In this study, chronic nonmalignant pain was described as any pain condition not associated with malignancy or other terminal diagnosis and persisting for more than 6 months. Of the 161 physician respondents, most were concerned with the development of physical dependence on drugs. The concern for dependence correlated with a decreased tendency to pre-
describe opioids for patients with chronic pain. Other predictors of physicians’ willingness to prescribe opioids were how recently medical school training was completed, level of satisfaction working with patients who have chronic pain disorders, level of fear of reprimand from licensing boards, and fewer total patients per month.¹

**Barriers to Care—Assessment and Expectations**

In addition to clinicians’ fear of drug dependence and tolerance, many physicians find assessing a patient’s pain a considerable challenge. A patient’s report of pain is subjective and difficult to verify, unless the patient presents with a pain that is reproducible. Therefore, patient reporting may be deemed unreliable. The true level of pain intensity may not be adequately appraised, and consequently, treatment may be inadequate.⁶

Most family physicians are capable of treating patients for chronic pain. However, patients with chronic pain disorders that are difficult to manage, as well as patients with histories of substance abuse or dependence, should be managed by physicians adequately trained in pain management and practicing at pain management facilities.⁷ Most other patients with chronic pain can be managed by osteopathic physicians, though many osteopathic physicians choose an approach that is too conservative, leaving patients with legitimate chronic pain without relief of symptoms. One may ask who should decide what is legitimate chronic pain? Legitimate chronic pain can be characterized as pain resulting from a known anatomic or physiologic dysfunction. Guidelines, charts, and questionnaires can be used to assess quality, quantity, duration, and location of pain.

Physicians’ expectations of a patient’s level of pain may also contribute to how aggressively that patient is treated. Physicians expect extreme quantities of posttrauma pain (eg, surgical procedures, motor vehicle accidents, visceral pain syndromes such as hepatic capsule disease, biliary disease, gastrointestinal disorders). Acute pain is generally treated adequately because physicians have evidence that there is a cause for pain. However, after a certain window of time, physicians may determine that the pain the patient is having should be resolved and may then adopt a more conservative approach to pain management. Is it the physician’s ethical responsibility to gradually decrease the dose of medication for patients taking habit-forming medications regardless of resultant pain? Or is it the physician’s duty to ensure pain relief and the return of sufficient daily functioning?

**Patients Take Action**

Most physicians would agree that many patients will take matters into their own hands when they perceive that they are not receiving adequate care for pain from their physicians. In addition, if pain is not adequately controlled in elderly patients, families may pursue legal remedies. A family invoked the elder abuse law in the Bergman versus Eden Medical Center, resulting in a $1.5 million judgment. Although physicians have a responsibility to encourage their patients toward personal responsibility for their condition, they do not want patients to seek harmful or illegal means of pain relief. The undertreatment of pain by physicians may have provoked the Compassionate Use Act of 1996 in California. The act was written “to ensure that seriously ill Californians have the right to obtain and use marijuana for medical purposes where that medical use is deemed appropriate and has been recommended by a physician who has determined that the person’s health would benefit from the use of marijuana in treatment of cancer, anorexia, acquired immunodeficiency syndrome, chronic pain, spasticity, glaucoma, arthritis, migraine, or any other illness for which marijuana provides relief.” The act also states that “no physician shall be punished or denied any right or privilege for having recommended marijuana to a patient for medical purposes.”⁸

Before prescribing narcotics, many physicians find it beneficial to enter into a written contract with the patient. The contract provides a point of reference should a patient begin to exhibit signs of drug misuse. In the contract, the patient agrees that he or she will only receive the medication from one physician, will be given a prescription at designated time intervals only, will not be given duplicate prescriptions should a prescription be lost, and may not call for refills.⁸ If it is discovered that the patient has violated any of the components of the contract, he or she will be immediately released from the physician’s care and referred to a drug dependency program.

Patients who are abusing prescription narcotics often have similar characteristics. A new patient may present with a history of back pain or chronic headache. The patient may ask for a specific medication by name, stating that it is the only drug that relieves the pain. The patient may appear nervous or agitated during the medical interview, potentially a sign of early drug withdrawal. The most commonly abused prescription narcotics are morphine, dilaudid, percocet, and fiorinal.³

**Chronic Pain—Prove It**

For many years, chronic pain conditions (eg, fibromyalgia) were considered psychologic problems because there were no radiography, laboratory tests, or other tangible means to diagnose these types of chronic disorders. The osteopathic approach to a patient with such a disorder includes analgesics, muscle relaxants, mood-altering medications, and the unique approach of hands-on manipulation of myofascial structures and osseous dysfunction, as well as addressing the psychologic component of the chronic pain.

Patients with fibromyalgia are likely to be female, between 20 and 50 years of age and present with diffuse pain, tenderness of bony prominences on palpation, disruption in sleep, and lack of physical exercise. The patient may also complain of anxiety and depression, sensitivity to extremes in temperature, frequent episodes of gastrointestinal dysfunction, headaches, and numbness or swelling of extremities. It is
reported that more symptoms of depression are seen in patients with fibromyalgia, compared with a control group that had chronic pain associated with rheumatoid arthritis and a group that was asymptomatic.9

Many patients with fibromyalgia undergo complete physical and laboratory examinations that are negative for degenerative and rheumatologic disorders. On palpation, some patients have a small increase in segmental mobility while others do not. Often, testing for range of motion in patients with fibromyalgia indicates that it is not decreased.9

Treatment for patients with fibromyalgia focuses on the relief of symptoms. Tricyclic antidepressants are used, as well as benzodiazepines, NSAIDs, and corticosteroids. In addition to the pharmacotherapeutic approach to fibromyalgia treatment, myofascial manipulation in conjunction with a stretching program frequently improves symptoms.9 Psychologic counseling services should also be used if this aspect of the syndrome is present.

Comment
In a personal correspondence from John Ashcroft, US Office of the Attorney General, Washington, DC, to Louis J. Radnothy, DO, President of the American College of Osteopathic Family Physicians, dated November 6, 2001, Ashcroft wrote, ‘I want the nation’s doctors to know that [as matters relate to patients’ comfort and relief] they will have no reason to fear that prescription of controlled substances to control pain will lead to increased scrutiny by the DEA, even when high doses of painkilling drugs are necessary and even when dosages needed to control pain may increase the risk of death.”

As osteopathic physicians, we recognize that there is more to pain than merely anatomic and physiologic dysfunction. Social and environmental factors also contribute to the quality, quantity, and duration of many chronic pain episodes. As holistic physicians, it is our duty to address all of these components as we attempt to alleviate chronic pain.

Osteopathic physicians would agree that the cornerstone principle of osteopathic medicine is enrolled in the Latin phrase Primum non nocere (first, do no harm). One must ask whether we are doing patients harm by allowing them to remain in chronic pain? Conversely, are we doing patients harm by supporting a dependence on pain-relieving medication that allows normal functions of daily life? There is a delicate balance that each osteopathic physician must find in the context of his or her practice of medicine.

Seven Steps for Helping Patients Cope With Chronic Pain
- Reestablish a sense of value. Many patients with nonmalignant chronic pain are elderly or are disabled by their pain. It is important to help them recognize their value to society despite their disability. Encourage a sense of importance that is not based on their level of productivity, but on character qualities, such as kindness, honesty, and loyalty.
- Encourage spirituality. In recent years, multiple research studies have shown that patients who include prayer or meditation in their daily lives have better recovery rates.
- Encourage patients to take responsibility for their look. Although patients may not be responsible for their chronic pain, they are responsible for the perspective they maintain about their circumstances. Encourage your patients to find new perspectives in their difficult situation.
- Listen to your patients. Patients who express their fears, experiences, and hopes may decrease the perception of pain symptoms.
- Encourage attending support groups. Patients with common pain symptoms may benefit from each other’s coping strategies.
- Encourage self-inventory. It has been demonstrated that people who harbor anger are more likely to have increased physiologic dysfunction, which may include aggravating chronic pain. Make amends in those relationships that have problems.
- Take one day at a time. Encourage patients to recognize that recovery is a process that requires time. Setting realistic goals, and celebrating small accomplishments will help during the recovery process.

References