

## PAIN MANAGEMENT IN 2020

# Pendulum Paradox versus Discernment

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I find myself writing this month's President's Page while attending the annual AMA National Advocacy Conference in Washington, DC. It was actually one year ago that I attended the same conference and a series of discussions led by some of the highest level physicians and leaders in US health care. The message was reasonably simple and straightforward, whether it was coming from the then AMA President, or even from the Director of the US Department of Health and Human Services. To paraphrase the perspective on the approach to the opioid crisis, and inherently, to pain management, the message was, "while the potential for harm, and even death, is real, when it comes to opioids, and while there needs to be greater responsibility when it comes to prescribing, the intent was not to swing to the extreme we now find ourselves in." That extreme is where "recommendations and guidance" were translated into direct restrictions on prescribing, imposed on physicians and patients, by insurers, pharmacies, and various groups. Despite the message of "this was never our intent," I'm here to tell you, that in the day-to-day practice of caring for patients in need of pain alleviation, not much has changed in the last year. In fact, we are about to embark on mandated changes to our daily practice in Medicine, via required participation in reviewing the Prescription Monitoring Program (PMP), before prescribing every opioid, benzodiazepine, barbiturate, and Soma. Our very own DCMS colleague, Dr. C.M. Schade, is leading the statewide task force charged with providing guidance to how the implementation of PMP monitoring will be carried out. He has provided us insight, in last month's journal, about this. So as to not steal his thunder, my focus will not be on the PMP itself, but more so on the way in which we got to where we are. How we have arrived at this quandary, I contend, is by acquiescing to the Pendulum Paradox, while abandoning discernment.

Before getting into a discussion of the challenges we face in one of the cornerstones of medicine – the alleviation of suffering – I must first acknowledge bias. Without fail, we are asked to disclose bias prior to engaging in CME-related lectures, and for participants, we are asked to indicate whether bias was noted. Although the intention is to vet out financial, or industry, bias, I find the question somewhat "silly," we all carry our own biases, and we would be naïve to think we do not. I am reminded of the Catholic theologian, Anthony de Mello's, unique perspective on the notion of bias, when he would routinely state that, "I'm an ass, you're an ass, we're all asses." In some ways, almost no matter how you slice it, we've all been asses, when it comes to the opioid crisis...both extremes of it. So, if I have bias, what is it? It's quite simple. As a Palliative Medicine physician, one of my primary goals for my patients is to safely and effectively manage their troubling symptoms, so as to afford maintenance of functional status, and in so doing, a greater quality of life. The caveat with my palliative care patients, as opposed to my general internal medicine patients, is that the palliative care patients have medical conditions that are affecting their quality of life, and to a predictable degree, their longevity. This reality that life is short and quality is poor was what led, not just to the birth of the field that I am privileged to practice in – Palliative Medicine – but also medicine's push to more effectively address the pain that our patients are struggling with. And that was it. "Improve pain control." Nothing more, nothing less. But it wasn't that simple, was it? It wasn't that simple because rather than practicing clinical discernment (what some may refer to as common sense), we did what we are prone to do in our society, we jumped on the pendulum and allowed it to swing us in the direction of "opioids are the first and only answer in alleviating pain," whether it be a hospice patient, or a 23-year-old with a high ankle sprain. In acknowledging bias, was I, as an individual,

part of the problem? You bet ya'!

In what ways was I, and many of us, responsible for both sides of the opioid/pain management crisis? Was it heeding the shortcomings noted in the 1995 SUPPORT study that revealed that patients remained in severe pain, in the last three days of their lives, in major American teaching hospitals? Was it providing countless lectures on the safety of opioids when used for pain or dyspnea control in life-limiting settings? Was it basing these safety claims on numerous studies published from the mid-'80s to mid-'90s in oncology and burn patients, two groups with inherently high physiologic pain drives at a timeframe of opioid management that



did not include higher potency opioids, such as fentanyl? Was it advocating that in the setting of life-limiting illness, if long-acting opioids were incorporated, the total amount of opioid utilized, over a 24-hour period could actually be lower, as the patient was no longer having to “chase” their pain? Was it advocacy of a multimodal approach to pain management, at the same time we decry polypharmacy? I contend that the answer is not necessarily any of the above, and all of them. The “fault” is that we collectively abandoned discernment. Despite opening and closing lectures with statements that “this is to be applied to life-limiting illness settings, and not traditional ambulatory care, or ER settings,” the message either wasn’t clear enough, or it just wasn’t heard. It is also possible that the message was clear, and was heard, but inherent force of “guidelines” subdued discernment.

On the topic of the use of guidelines juxtaposed against discernment, we invest years, pumping volumes of information into our learners: medical students, residents, and fellows. Even in established clinical practice, we rely heavily on guidelines based on safety and improved clinical outcomes. As an aside, by no means do I intend to infer that guidelines, protocols, or checklists are in some way “bad,” or not

useful. They are a necessary and important part of safe, effective medical practice... when coupled with clinical discernment. When coupled with looking at and listening to the patient sitting before us, with incorporating all of their unique nuances that they present, and then overlaying the guidance embedded in said guidelines, to make clinical decisions relevant to them. With the immense breadth of medical knowledge we ask our learners and ourselves to master, one could easily “Google or Medscape it,” if need be. But the last time I checked, there’s no platform or app for “common sensing it.”

Another shortfall for which we must accept responsibility is our negligence to communicate clearly. One of the most glaring examples of this, in my opinion, is the relaxed nature with which we interchange “opioid” with “narcotic.” For

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clarity, opioids are a class of prescribed medications that act as agonists on the various opioid receptors in the human body. They are derived from naturally occurring opioid agonist found in the poppy plant, with the most primitive form being opium. Collectively they are one of our oldest pharmacologic agents, with the Sumerians utilizing opioid derivatives for pain relief some 5,000 years ago. In the purest of definitions, narcotics are “drugs or other substances affecting mood or behavior and sold for nonmedical purposes, especially an illegal one.” Although it is true that if a prescribed opioid is used for “nonmedical purposes,” it becomes a narcotic, it is simply not accurate to use “narcotic” in place of “opioid” when discussing the broad medical and social implications. To put it another way, “although many narcotics may be opioids, not all opioids are narcotics.” As physicians, we prescribe opioids, not narcotics.

Speaking of communication pitfalls, namely “influence,” there is another glaring reality with which we must come to terms. Specifically, our responsibility when it comes to discernment of guidance coming from the pharmaceutical industry. Just as above, when I acknowledged the use of guidelines and protocols, I also acknowledge the value that the pharmaceutical industry provides to the care that we afford our patients. Namely, the development of new and novel therapies to address “what ails us.” However, remember de Mello’s contention, “we’re all asses.” One just needs to review any of the recent news headlines to read about major pharmaceutical corporations “misleading” physicians, and the general public, to more greatly adopt the utilization of opioids, as first-line therapy for all chronic pain syndromes, as well as short-lived pain syndromes, regardless of the unique clinical circumstances. In other words, “pain is pain, to heck with discernment.” However, it wasn’t drug reps or pharma administrators who were writing the scripts that led to the opioid/narcotic crisis we are living through. Even after separating out the “bad actors” and pill mills, still plenty of physicians acquiesced to the influence of “pain management recommendations” that were coming directly from the pharmaceutical industry. I am reminded of numerous conversations I have had with colleagues, over the years, about the issues surrounding engagement of the pharmaceutical industry, or not, whether it be for samples, lunches, etc. The common theme I would hear, and what I too would often tell myself, is that “we went to college for 4 years, medical



school for 4 years, residency training for anywhere from 3-7 years, we are skilled at discerning scientific literature...certainly, the 5-minute elevator speech delivered by a pharmaceutical rep couldn't possibly influence me." Multibillion dollar lawsuit settlements seem to call this contention into question. Even we, ourselves, whether it be our professional societies, or as individuals, contend "it wasn't our fault... we were told to do so."

While grousing may serve a certain emotional benefit, by allowing us to vent, what good does it do if we don't also offer perspective on how to change the underlying issue causing stress? To that end, I propose the following, several-step process to combat the propensity to "ride the pendulum" and instead "use our collective common sense." The first step is to actually uphold discernment with the same emphasis and value that we apply to acquiring the medical knowledge and acumen we hold so dear. It entails fostering what I believe most medical school applicants inherently have in their skill set, common sense. To avoid the pendulum paradox, and to be clear, this should not be at the sacrifice of sound clinical guidelines and checklists. It is only

to say with every guideline, at every level of training and practice, a strong, clear acknowledgement should be made "for the right patient, at the right time, in the right clinical situation." The next step to foster a healthier balance of discernment is to acknowledge our own biases, both internal and external. Let's not fool ourselves, we are all driven by self-interest. It is no more right or wrong that, as a physician, I am driven to alleviate suffering, than a corporation, that happens to produce a pharmaceutical product, is driven to make a profit. At face value, I contend that these drives are either ethically neutral, to admirable/expected. The moral dilemma arises when these two aforementioned goals intersect with the reality of caring for patients, and the drive for profit, and

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becomes an impediment to our goal of affording care, or alleviating suffering. In other words, it is the discernment of dynamic of which we need to be more aware. In acknowledging our bias, we must also acknowledge our fallibility in being human, and thus, open to influence. The last step brings me back to the beginning of this article, and that is participation in advocacy. It was the voices of patients and physicians, through special interest groups, specialty societies, county medical societies, state medical societies, and ultimately up to the AMA, that were the impetus in stepping back from prior recommendations, and attempts made to correct the message, and the pendulum. Where there may be concern that, "I just don't have the time to engage in the degree of hands-on advocacy that others do," I would simply say that is completely understandable, but there is strength in numbers. As we embark upon the Capitol hallways of Austin, or Washington, the fact that we are representing "thousands to tens of thousands" of physicians carries weight in our effort to maintain discernment and common sense, at the heart of our practice, and avoid the dizzying effects of the pendulum paradox. **DMJ**



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We appreciate you!*

# National Doctors' Day

**MARCH 30<sup>th</sup>**

