Let's Get Serious About Relieving Chronic Pain

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See also:

The Big Chill - Inserting the DEA into End-of-Life Care - Quill and Meier; NEJM; 345(1); 2006

Patients with debilitating pain from chronic illness, accidents, surgery or advanced cancer have long had problems getting adequate medication to control their pain and make life worth living.

Now the federal government, and especially the Drug Enforcement Administration, is working overtime to make it even harder for doctors to manage serious pain, including that of dying patients trying to exit this world gracefully.

In an article in the current New England Journal of Medicine titled "The Big Chill: Inserting the D.E.A. into End-of-Life Care," two specialists in palliative care, Dr. Timothy E. Quill and Dr. Diane E. Meier, state that despite some physicians' commitment to treat pain and despite the effectiveness of opioid drugs like OxyContin and morphine, "abundant evidence suggests that patients' fears of undertreatment of distressing symptoms are justified."

They continue, "Although a lack of proper training and overblown fears of addiction contribute to such undertreatment, physicians' fears of regulatory oversight and disciplinary action remain a central stumbling block."

Obstacles to Relief In addition to a case before the United States Supreme Court, Gonzales v. Oregon, that threatens to undermine Oregon's Death With Dignity Act, the D.E.A. has recently increased raids on doctors' offices, confiscating files and arresting doctors on charges of overprescribing narcotics to patients who are addicts or drug dealers.

Most of these physicians are compassionate people trying to help suffering patients but are sometimes fooled by clever addicts, drug dealers or undercover agents who fake their pain.

Should the court rule against Oregon, the D.E.A. could turn to all physicians whose patients die while getting prescribed opioids or barbiturates, even if the drugs were administered only to relieve intractable pain, not to hasten death.

Yes, there are bad apples among members of the medical profession. There are some doctors who charge for medical exams that they never do and provide phony patients with prescriptions for narcotics to feed their habits or sell on the street.

But should all physicians be subject to intense scrutiny by the D.E.A. and risk arrest and prosecution, leaving legitimate patients to suffer intensely or scramble to find other doctors willing to risk taking them on? Doctors have no certain way to measure patients' pain other than to ask them. Patients should be asked to rate their pain, say, on a scale of 1 to 10, with 10 being the most intense they can imagine. "Model Guidelines for the Use of Controlled Substances for the Treatment of Pain" were established in 1998, and every physician who prescribes narcotics should know them by now. These guidelines emphasize that documentation is critical to proper pain management.

With patients who are prescribed strong painkillers, doctors first are supposed to obtain a medical history, perform a physical examination, ask about addictive behaviors and whether other treatment options have been tried, and fully record what they find.

Prescriptions for controlled substances like narcotics cannot be refilled automatically. When a patient asks for a new one, a well-documented follow-up visit is necessary. The doctor should ask about the kinds and amounts of painkillers being taking, side effects, performance of daily activities and aberrant drug-related behaviors.

Dr. Jennifer P. Schneider, a pain management and addiction medicine specialist in Tucson, gives this example: "Back pain today is 4/10, walks the dog 15 minutes daily, constipation is controlled with Senokot-S, patient is on schedule with his meds." She advises physicians, "If a patient lies about his medical problems and turns out to be a drug abuser, at least you've documented that you were acting in good faith."

A Fear of Prosecution The growing number of arrests of pain management specialists is exacting high costs for patients, physicians and medical insurers. Some doctors order costly but unnecessary diagnostic tests so they can show the D.E.A. a reason for prescribing strong pain medication.

Many doctors are simply unwilling to prescribe narcotics, no matter how much a patient suffers. Ignorance, as well as a fear of the D.E.A., plays a role. For example, the surgeon who performed my double-knee replacement a year ago told me, in reference to OxyContin, a synthetic opioid: "I don't like to prescribe these drugs. Patients have too hard a time getting off them."

Well, sir, if you never prescribe them, then chances are you never learned how to help patients stop them. Many doctors and patients fail to understand the difference between physical dependence and addiction. An addict uses a drug to get high, becomes tolerant and needs ever-increasing amounts to maintain that high. Patients taking narcotics for pain don't get high; they get relief from their pain, and when larger doses are needed, it is usually because their pain has become more intense, as often happens in patients with advanced cancer or degenerative diseases. Physical dependence occurs in almost everyone who takes a narcotic for two weeks or more. The body becomes adapted to the presence of narcotics (that is, becomes physically dependent on them). A patient cannot go off them abruptly without suffering serious withdrawal.

A Gentle Weaning Process I asked Dr. Schneider how to go off narcotics safely. She suggested cutting back 10 milligrams every three days (the exact amount would depend on the dose a patient is on). If at any point in the weaning process my pain became more intense, I was to go back to the last dose, wait a week, then try to resume the weaning.

As I neared the end, the cutback was five milligrams every three days. Then the dose was down to nothing, and no withdrawal symptoms, either. Having heard only about those who, like Betty Ford, got hooked on painkillers, many patients are afraid of becoming addicted if narcotics are prescribed. But it is the rare patient who becomes addicted, and it is nearly always someone with a history of addiction, typically to alcohol. Even with dying patients, the families and physicians often shy away from narcotics for fear of addiction, as if it mattered whether someone near the end of life - in desperate pain or extreme agitation - became addicted to the morphine that could provide almost instant relief.

Proper pain management for dying patients can facilitate important communication between patients and their loved ones and provide what most people would call "a good death."

"Pain is a common symptom in patients nearing the end of life," with up to "77 percent of patients suffering unrelieved, pronounced pain during the last year of life," Dr. Timothy J. Moynihan wrote in The Mayo Clinic Proceedings in 2003.

In their current article, Dr. Quill of the University of Rochester School of Medicine and Dr. Meier of Mount Sinai School of Medicine stated, "Allowing D.E.A. agents, trained only to combat criminal substance abuse and diversion, to dictate to physicians what constitutes acceptable medical practice for seriously ill and dying persons" may make doctors increasingly reluctant to prescribe needed medications and "end up abandoning patients and their families in their moment of greatest need."

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