This issue’s Forensic Pain Medicine section juxtaposes several complimentary perspectives on the use of opioids in medical practice. Three academic U.S. medical organizations devoted to understanding the issue of opioids and chronic pain, the American Academy of Pain Medicine (AAPM), the American Pain Society (APS), and the American Society of Addiction Medicine (ASAM), have created and officially adopted a consensus document, Public Policy Statement on the Rights and Responsibilities of Health Care Professionals in the use of Opioids for the Treatment of Pain [1]. This statement poignantly compliments two other papers in this issue’s Forensic Pain Medicine Section that present important information about the regulation of opioids in medical practice at both the state and federal levels.

The Statement clarifies the rights and responsibilities of practitioners who prescribe opioids for pain relief, even with comorbid addiction disorder. The Statement supplements earlier consensus documents, Definitions Related to the Use of Opioids for the Treatment of Pain [2], and The Use of Opioids for the Treatment of Chronic Pain [3], which have been cited widely in the literature and disseminated to patients, clinicians, and policymakers alike. The Statement’s readily apparent clinical salience for dilemmas faced daily by physicians treating pain rests on its coherent integration of knowledge and concepts from clinical pain medicine, forensic pain medicine, and ethics.

The aura created by the investigatory role of the Drug Enforcement Administration (DEA) often obscures its intention to support the appropriate use of opioids for chronic pain. The letters exchanged between Dr. Covington, Dr. Heit, and Patricia Goode of the DEA clarify explicitly, in writing, the DEA’s views and policies. This exchange is timely and fortunate, and its authors deserve our gratitude for their creativity. Most physicians consider that the DEA’s communications about opioids, taken collectively over the last few years, present the penultimate “mixed message,” perpetuating uncertainty, anxiety, and doubt. Recent policy announcements by the DEA and other federal offices about interdicting prescription drug abuse only aggravate the situation because the epidemiologic studies used by the DEA to support the development of policies and procedures have serious methodological flaws. These mistakes cripple the DEA’s credibility, generally, among medical professionals and, specifically, among pain medicine specialists. This publicity unwittingly (it seems) coincided with the prosecution of several high-profile cases in which medications for pain management were blamed for causing addiction in patients who already had addiction disorder and never received quality pain or addiction treatment.

The use of opioids for chronic pain has been promoted to community physicians by lecturers supported by pharmaceutical companies. Unfortunately, much more training is required in how to use opioids safely and wisely for chronic pain. It is no surprise that community physicians are loathe to use these medications—they are caught between the suffering of their patients and their fears of retribution. Even when use is legitimate, they fear the arbitrariness of apparently careless science and bureaucratic policy that might threaten their careers and livelihood. The DEA letters clearly answer our questions about DEA policies and procedures, and should reassure those wishing to practice safe and effective pain medicine using opioids about federal intentions.

Scott Fishman and colleagues turn their attention to the state level in a paper that systematically reviews the outcomes of state prescription drug-monitoring programs in the United States [4]. Outcomes include the effectiveness in reducing prescription drug abuse, intended benefits of monitoring programs to society, and unintended consequences such as switching to unmonitored drugs and discouraging appropriate pain treatment. The use of data to drive policy change is encouraging. The considerable variability among states, where monitoring is flawed and the state medical board practice of oversight at times appears to be almost capricious, is discouraging. We hope that Fishman’s group, perhaps working with the AAPM, will maintain a current database to serve as a resource for the membership and the public at large. These data and their consequences cry out for local organizations, such as AAPM state
chapters, to monitor these problems closely and advocate for positive change. New, reliable electronic systems, by improving the physician’s and pharmacist’s security when providing opioids for pain, will enhance the privacy of patients and the sanctity of the doctor-patient relationship. These systems have the potential of freeing clinical decision making from the biases of doubt, distrust, and fear that plague our practices today. Our patients and the public will benefit.

References

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