



## THE PAINFUL DILEMMA

The use of narcotics  
for treatment of chronic pain  
A report prepared by the  
SACRAMENTO-EL DORADO MEDICAL  
SOCIETY  
November 1990

### Introduction

Millions of Americans suffer from pain. Among the most tragic victims are those whose lives are consumed by chronic, intractable pain.

Although narcotics can frequently help, they are typically avoided or given at inadequate levels. A number of factors are involved, including the fear of patient addiction and the threat of disciplinary action for over-prescribing. In addition, pain is difficult for the patient to describe and the physician to evaluate.

Whatever the reason, the result is often unnecessary suffering. Evidence is steadily accumulating that persons with intractable pain do not respond to narcotics in the same way as do street addicts. Their motivations are different, and so are their psychological reactions and tolerances to the drugs. The pain patient can be treated with narcotics with little risk of developing the self-destructive behavior characteristic of addiction--even though dosages may sometimes far exceed the "normal."

The public needs to know that more can and should be done for those people with chronic pain.

### THE PAINFUL DILEMMA

Albert Schweitzer once said:

*"We must all die. But if I can save him from days of torture, that is what I feel is my great and ever new privilege. Pain is a more terrible lord of mankind than even death itself"*

Everybody has suffered from pain--especially the intense acute pain that flares up when a toe is stubbed or a finger burned. That pain soon goes away. But at least 20 million Americans suffer from chronic pain that lasts for weeks or months--or may never go away. Most of its victims are the middle-aged and the elderly.

The most common form is low back pain, which arises from osteoarthritis or other causes, and is estimated to afflict 15

percent of the population. Cancer patients often suffer severe pain as their condition worsens. Burn victims may have excruciating pain during recovery. Chronic pain includes tension and migraine headaches. Individuals with arthritis often suffer from chronic pain.

In fact, chronic pain is one of the nation's most costly health problems. The price tag each year comes to nearly \$50 billion for medical costs, lost income, lost productivity, compensation payments and legal costs.

To the individual, the impact can be devastating both personally and professionally. Severe pain can impair sleep and appetite, and it can trigger anxiety, frustration and depression. Over time, pain can lower self-esteem and bring on significant psychological problems. Pain can destroy the will to live.

As common as it is, pain can be extremely elusive. The patient may have difficulty describing it, and the physician often cannot substantiate it. An individual in acute pain may scream and writhe in agony; but the person with chronic pain often appears outwardly normal, with few visible signs.

Although much remains to be learned about the mechanism of pain, we know individuals have different levels of tolerance to pain. There are also differences in individual sensitivity to drugs, and in how drugs are metabolized. Studies indicate that pain relief from opiates varies by age, race, cultural differences, type of pain and location of pain.

Because the effectiveness of pain medication varies greatly from person to person, a patient's need for a high dose is not necessarily a sign of addiction.

### Treatment of pain

A Variety of methods are used to treat chronic pain. They may include acupuncture, biofeedback and other relaxation techniques, physical therapy, psychotherapy, hypnosis, behavior modification, nerve block by injection and transcutaneous electrical nerve stimulation (TENS). Surgery can alter the perception of pain, modify conduction of pain along pathways of the central nervous system, or, as a last resort, block pain by cutting nerve bundles. Non-steroidal anti-inflammatory agents, antidepressants and anticonvulsants are among the medications that can be used.

Despite the variety of treatments available, a substantial number of pain patients are not helped. Even some of those "successfully" treated must learn to live with pain.

Narcotics are extremely effective for pain relief, but their long-term use has been avoided because of the potential for addiction. Included are "opiates" like morphine and codeine, which are derived from opium, and "opioids" like heroin and methadone, which are synthetic or semi-synthetic compounds with similar properties.

Opiate therapy is now generally used for burn victims and terminal cancer patients, and for shorter periods for hospital patients who have undergone surgery. The standard prescription is PRN (pro re nata, or "as needed"). In effect the order means medication is to be given only after pain returns.

However, by the time the pain is treated, it may be so severe that a larger dose, with greater side effects, is needed. Under-treatment can occur when surgery patients have a longer course of recovery than normal, and for young patients.

### Regulatory efforts

Narcotic analgesics are noted not only for their ability to relieve pain--but also for their widespread abuse.

Attempts to curtail drug abuse have led to a wide range of law enforcement activities. One of the most visible in the medical setting is the system of triplicate prescriptions required for a number of drugs. One copy of a prescription is retained by the physician, a second sent to the pharmacist, and the third to the Drug Enforcement Agency. Triplicate prescriptions are frequently used to identify physicians who may be over-prescribing.

Over-prescribing of narcotics, stimulants and other drugs accounts for almost 20 percent of the disciplinary actions taken by the Medical Board of California (or MBC, formerly the Board of Medical Quality Assurance).

In 1982, the physician who was then the MBC's medical consultant declared in an interview sent out to all licensed physicians in California:

*"We have two kinds of doctors who get into trouble [for over-prescribing narcotics] – "script doctors" and – "well intentioned doctors." The "well-intentioned" doctor may appear as a "nice guy," but he is really naive or, in some cases, not keeping up with present day prescribing standards. The "script doctor" is one who usually knows he is breaking the law and writes prescriptions for controlled substances purely for profit. "*

He gave no indication that prescribing high amounts of narcotics over the long term might be acceptable.

### The traditional view

The interview reflected the traditional view that long-term narcotics use by anyone inevitably leads to addiction: the body learns to tolerate the drugs, and demands ever escalating doses; abuse begins as a search for euphoria, and eventually conditioned reflexes cause an irresistible craving for the

narcotic. This escapist-conditioning explanation dominated medical thinking and public health policy for three decades and is still widely held.

For example, a June, 1990, issue of the Mayo Clinic's Medical Essay newsletter warns:

"Opiates can cause drowsiness, nausea, constipation and mood changes. In addition, extended use of opiates can lead to tolerance -- the body becomes accustomed to certain amounts of the drug and no longer responds as well to it. Because of the inevitable addiction that accompanies chronic opiate use, their use in treating pain should be extremely limited."

There are problems with that point of view. Some so-called "chippers" who abuse drugs occasionally do not become addicted. Many veterans of the Vietnam War used narcotics extensively while overseas, but abruptly discontinued use after returning home without subsequent re-addiction

It was discovered that long-term addicts could be maintained with methadone at a high, though stable, dose. Individuals could then function with minimal side effects.

Experience with cancer patients led to a major change in thinking. Except for an initial increase in dose, there was little evidence of growing tolerance to narcotics.

"The cancer patient has thus served as a model to demonstrate that opioids can be used on a chronic basis in patients with pain, and this insight has given a greater insight into the clinical pharmacology effects of these drugs," writes neurologist Kathleen Foley in a 1990 monograph on pain management. "For example, chronic use of opioids in the cancer patient has demonstrated that physical dependence occurs, but psychological dependence or 'addiction' is rare, if not nonexistent."

Many addicts claim to have been hooked by medical care, and older studies indicated perhaps 10 percent of addicts started off that way. However, a major study in 1980 showed abuse developed in only 4 of 11,882 patients given opiates while hospitalized; in only one instance was the abuse considered major.

In recent years, self-infusion pumps have been introduced which allow patients after surgery to give themselves limited doses of narcotics to control pain. There were fears the process would create a new population of drug addicts. Instead, the amount of narcotics used by patients has been the same or less than under the old PRN method.

### Emerging concepts

It now seems clear there is a major difference between addicts seeking euphoria and individuals seeking relief from pain. The traditional perception is that the reactions of street addicts are

simply a more extreme expression of what happens to chronic pain patients.

However, drug addicts behave as if obtaining and using drugs are primary drives--akin to eating, sleeping or sex. They take drugs to get high and are frequently lost to themselves, their families and society.

In contrast, the person with chronic pain takes drugs to return to normal and to get on with life. Narcotics allow individuals with pain to interact with their families and to return to work. Pain patients overcome most of the side effects of the narcotics.

The pain patient's entire behavior is aimed at getting relief from pain, just as the addict's efforts are aimed at obtaining drugs. Unlike an addict, the typical pain patient experiences little or no euphoria from narcotics. Except for an initial increase in dosage, there is little indication of increasing tolerance. Withdrawing from drugs is a major hurdle for addicts, but for the pain patient withdrawal is typically uncomplicated.

Why the different reaction to opiates? Chronic pain signals travel to the brain by a different nerve pathway than do sudden or "phasic" pain signals. One prominent researcher believes the chronic pathway develops relatively little tolerance to morphine, so does not demand constantly escalating doses.

### **New definitions of abuse**

Along with recent medical developments have come redefinitions of the key terms of drug abuse. All long-term users of narcotics become physically dependent: if drugs are suddenly discontinued, their bodies react with sweating, aches, nausea or other withdrawal symptoms. That physical dependence was once virtually synonymous with addiction, but is no longer.

The American Society of Addiction Medicine now defines addiction as the abuse of any psychoactive substance with compulsion and loss of control despite adverse consequences.

Similarly, an American Medical Association Task Force describes addiction as a chronic disorder characterized by "the compulsive use of a substance resulting in physical, psychological or social harm to the user and continued use despite the harm." "Psychological dependence," which emphasizes the compulsive use of drugs, is now often used interchangeably with the term addiction.

Under the older definition, anyone who became physically dependent could be viewed as an "addict"--including the pain patient on narcotics. The newer definition distinguishes between the pain patient trying to put a life back together and the self-destructive addict trying to achieve euphoria.

### **Physicians and pain patients**

Despite the changing perceptions of pain and addiction, physicians are generally ambivalent about the use of

narcotics. Most physicians were trained under older concepts of drug addiction--as are many current medical students. Pain experts today still disagree about the proper use of narcotics.

Even a supposedly safe practice--giving narcotics to terminal cancer patients--has its own quandaries. It is sometimes criticized for placing medical care nearer to euthanasia. In a highly publicized case in early 1990, the morphine-related deaths of two terminally ill patients in the Minneapolis area were ruled by the coroner to be homicides.

There is constant pressure for more discipline of physicians. A recent example is a draft report of the U.S. Department of Health and Human Services, which says data strongly suggest, "the universe of potentially actionable events far exceeds the number of disciplinary actions actually imposed by the [state] boards."

Physicians are also aware of the ongoing disciplinary actions against doctors for over-prescribing drugs, usually narcotics.

As a consequence, many physicians simply limit the amount of narcotics they will prescribe for any one pain patient. Some physicians even shy away from using any triplicate forms. The forms are a paperwork nuisance and a red flag of danger. Not having them is also a convenient excuse for not treating pain patients.

Few doctors welcome patients who complain of chronic pain. Pain patients often appear normal, so the physician cannot be sure of the extent or validity of the complaints. The patients are often difficult, manipulative or depressed. High levels of medication to relieve pain invite disciplinary problems for the physician.

Most physicians prescribe narcotics only for chronic pain patients they have treated for a number of years. Patients receiving such medication face a major problem if they move to a new area or their physician retires. New physicians will be extremely reluctant to treat them.

### **Political developments**

The environment in which physicians and patients now find themselves was captured by the theme of the October, 1989, meeting of the American Pain Society, "Relieving Pain in a Regulated Environment--a Medical Dilemma for the 90's." The meeting focused on the difficulties in treatment caused by the ongoing war on drugs.

The Texas Legislature confronted the problem in 1989 by enacting a law which defined "intractable pain," added to state law language from federal law recognizing the legitimate medical use of dangerous drugs, and restricted discipline of physicians for treating chronic intractable pain.

The California Legislature acted in 1989 as well, passing Senator Leroy Greene's SB 711 to set down new requirements before the Board of Medical Quality Assurance (now known as the Medical Board of California or MBC) could discipline a physician for over-prescribing. The Board would have to consider the

physical and mental condition of the patient, whether the patient had intractable pain, whether there was evidence of drug addiction or abuse, and whether the medication caused physical or psychological harm to the patient.

However, the bill was vetoed at the Medical Board's urging. The governor said he shared the board's concern the law would reduce its ability to discipline physicians: "By requiring that the Board's investigations take into account certain specific characteristics of the patient, particularly where the patient may not be willing to cooperate for fear of losing a supply of drugs, the bill places a significant new burden of proof on the Board in its efforts to discipline physicians who are excessive providers."

The Governor also pointed to the war on drugs: "I believe at a time when illicit access and use of drugs is a major problem for our citizens, this bill's provisions are a step in the wrong direction."

In 1990, Senator Greene took a different, successful tack with SB 1802. The bill said physicians could not be disciplined for prescribing controlled substances to control "intractable pain." The Medical Board found the bill more acceptable than the previous measure, but still thought there was no problem and no need for legislation.

SB 1802 defined "intractable pain" as "a pain state in which the cause of the pain cannot be removed or otherwise treated and which in the generally accepted course of medical practice no relief or cure of the cause of the pain is possible or none has been found after reasonable efforts including, but not limited to, evaluation by one or more physicians and surgeons specializing in the treatment of the area, system, or organ of the body perceived as the source of the pain."

The bill was signed into law by the Governor on September 30, 1990.

### Looking ahead

Hopefully, measures like the Greene bill will allow physicians to better treat the patient disabled by chronic pain. One key provision of that law requires consultation with other experts.

In addition, physicians should consider long-term narcotics only after other reasonable attempts at pain relief have failed. Patients should be seen and prescriptions given at regular intervals. Physicians must be wary of the patient with a history of drug abuse, the patient who does not have some initial relief with relatively low doses of pain medication, or the patient who hoards drugs or shows uncontrolled escalation of drug use.

Pain patients should be made aware of the risk of long-term narcotic use. But those who need narcotics should understand that physical dependence does not inevitably lead to addiction. The odds are decidedly against addiction in the self-destructive sense.

The medical community, regulatory bodies and the public need to know that more can and should be done for treatment of chronic pain. The emerging evidence indicates we can safely offer patients more for pain than to "learn to live with it."

## GLOSSARY

acute pain. Short-term pain. It usually means the immediate pain triggered by injury, or "phasic" pain.

addict. A person physically dependent on one or more drugs, and whose long-term use has produced tolerance and loss of control over intake.

addiction. 'Me abuse of any psychoactive substance with compulsion and loss of control despite adverse consequences.

chippers. Slang for individuals who abuse drugs periodically for recreational purposes.

chronic pain. Long-term pain lasting weeks, months or years.

intractable pain. Pain for which no generally accepted medical care has provided relief. The legal definition enacted in 1990 by SB 1802 is more extensive.

Medical Board of California. The state agency which licenses physicians. It was formerly known as the Board of Medical Quality Assurance and, earlier, the Board of Medical Examiners.

narcotics. Opium derivatives and synthetic and semi-synthetic drugs with similar properties. The legal term for narcotics also includes marijuana and cocaine.

opiates. Drugs isolated from opium such as morphine and codeine.

opioids. Synthetic and semi-synthetic drugs similar to the opiates; heroin and methadone are the best known, but over 60 compounds are prescribed by physicians.

opium. The brown gum formed by drying the white juice from the unripened fruit of the poppy, *Papaver somniferum*. Opium has been in use for over 2000 years. 'Me growth of poppies for opium began in Greece and Mesopotamia, and slowly spread eastward; Turkey and India are now major producers.

physical dependence. Physiological adaptation to a drug, there is usually some tolerance to its effects and a dependent individual suffers from withdrawal during prolonged abstinence.

psychological dependence. The emotional craving of a drug for its desired effect or to avoid negative effects associated with its absence; it is often equated to addiction.

tolerance. Physiological adaptation to drugs so that greater quantities are needed to achieve the same effect tonic pain. The long-lasting, often ill-defined pain that develops subsequent to an injury.

triplicate prescriptions. Prescriptions for so-called Schedule II drugs, which must be prepared in three copies: one for the physician, one for the pharmacist, and one for the Drug Enforcement Agency.

withdrawal syndrome. A predictable group of signs and symptoms affecting the central nervous system after abrupt discontinuation of rapidly decreased dosage of a drug.

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