

Short Note

The Misuse of ‘Stigmatization’ in Chronic Pain Patients

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“There is a great deal of human nature in people.” -Mark Twain (May 18, 1867)

Chronic pain has become a global and national epidemic, with approximately 100 million Americans believed to be affected [1]. Consequently, it is one of the most common reasons for seeking out primary care, accounting for up to 40% of clinic visits¹. As a result, it is estimated that approximately 600 billion dollars is spent per year on healthcare associated costs as well as lost productivity [2,3]. Management of pain following failure or incomplete alleviation of symptoms by conservative therapies has classically been dominated by the use of opioid analgesics [4,5]. This class of medication, known for its potent analgesic qualities, also carries the real risk of chemical dependence, abuse and lethal overdose, and terribly harmful both short and long-term side effects [6]. The prevalence of this public health concern has led to increased scrutiny regarding the evaluation and treatment of chronic pain with opioids¹. The general societal taboo of opioids stems from their potential for abuse, strict opioid prescribing oversight and regulation, and civil and criminal litigation against prescribing physicians, due to allegations of improper opioid prescribing habits [1]. This has subsequently created significant logistical and ethical dilemmas for physicians who manage chronic pain.

One of the resultant trends that have emerged from this backdrop has been the utilization of so-called pain contracts between many patients and physicians [7]. This entails an agreement where prior to the initiation of an opioid medication regimen for chronic pain, a signed agreement is created which mandates that a physician’s prescription for opioids be predicated on the adherence of the patient to not abuse or otherwise divert opioid medications. This agreement may set particular limits on the amount of opioids prescribed, so as to minimize this aforementioned abuse or diversion potential. Additionally, many physicians also utilize urine drug tests (UDTs) to ensure the patient is indeed adherent to the regimen and is not taking additional illicit drugs, nor diverting prescriptions. These contractual methods, used with the intention of ideally avoiding unscrupulous patient behavior and protecting prescribing physicians from legal or professional discipline, have been met with controversy. The use of UDTs in particular has been alleged

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by critics of pain contracts to be an unethical, stigmatizing practice that unfairly singles out chronic pain patients [8-10]. This article will attempt to briefly discuss several counterarguments to those who disapprove of pain contracts.

Although it is possible that a degree of stigmatization may occur as a result of pain contracts, a frightening and frankly eye-opening statistic still remains that upwards of 36,000 deaths a year in the U.S. are associated with opioid overdose [11]. Given the extreme, real, and known morbidity and mortality risks of opioids, a pragmatic and caring physician should seriously consider on what basis it would be ethically appropriate to prescribe a class of drug that is associated with approximately 100 deaths per day, without implementing a clinical strategy emphasizing the safest possible management of these patients. The goal of the prudent physician should be to treat the patient symptoms while minimizing the potential of diversion, over-dosage, or dangerous polypharmacy combinations with non-opioids such as muscle relaxants and benzodiazepines (the so-called “Holy Trinity”). The dangers of these medications do not end with the patient’s experience alone—they may involve dangerous and impaired behavior on the highway, at work, and at home, potentially exposing even children to easy access points for these drugs.

It is estimated that the incidence of drug abuse in patients receiving prescription opioids for chronic pain ranges from 18-41% [12]. Additionally, approximately 10% of patients with chronic pain use illegal street drugs [1]. Prescription opioid diversion is very frequent, with up to 70% of people who abuse prescription pain medication obtaining these medications from friends and relatives, a staggering figure. Physicians have classically relied on self-reporting by patients of their misuse of opioids; however, research over the last decade has shown this to be an unreliable monitoring method. Physicians who practice without the safeguards of a contractual agreement with their patients have also been indicted on the premise of “willful blindness,” exposing themselves to professional, civil, and criminal penalties and sanctions for trusting their patients to be forthright in their self-reporting [1]. Therefore, in order to protect themselves as well as their patients, many primary care and pain physicians have adopted these aforementioned

pain contracts that patients must sign prior to initiating therapy. This contract demonstrates both to the patient and any medical review board that responsible monitoring of the patients medical needs and use of these medications is in place [13]. In addition, UDT's are being utilized concurrently as a monitor for adherence to prescription medications, as well as a screen for illicit drug use [3]. Ideally, early identification of aberrant behaviors will lead to proper disclosure and subsequent treatment, and reduce potential patient or community harm³. UDT's can be extremely useful in a 'trust, but verify' practice guideline [5].

There are many critics of UDT as a strategy to help safely manage chronic pain patients, and many of their points, on the surface, may appear to be justified. Some issues include collection methods, variation in the interpretation of results, accuracy and validity of results, and overall effectiveness in preventing misuse¹⁴. However, in reality, while these tests are potentially vulnerable to patient manipulation, in only one manner would this lead to a dangerous misinterpretation by the physician; that is, if a patient is diverting these medications and takes a medication intentionally a day or two before testing to demonstrate compliance and obtain a new prescription to essentially continue criminal behavior. Besides the operational scenarios that may lead to the results being manipulated or inaccurate, there exists some criticism that asking for the tests themselves damage patient's self-esteem, weakens the physician-patient relationship, and identifies this particular patient group as prone to untrustworthy behavior -for example, stigmatizing them based on their clinical needs [8-10]. Patients experiencing chronic pain are already described as a marginalized population that endures persistent judgment from healthcare providers, caregivers, and others involved in their care [1]. If this idea of a testing strategy, used as a tool to document compliance as well as to identify and hopefully dissuade dangerous polypharmacy behavior stigmatizes a patients' perception of self, then where in the practice of medicine do we not practice this same 'stigmatization'? For example, we screen potential organ transplant recipients for sobriety for safety reasons. We screen pregnant women, who may absolutely deny risk factors for HIV, syphilis, or hepatitis, for safety reasons. We may deny bariatric patients their needed surgery, despite their denial of tobacco use, based on screening for a product that may be entirely second hand in its source for potential safety reasons. Despite patients presenting for care stating their insurance status, we always ask for proof of insurance at every visit. There exists a multitude of mandated job related screenings for all employees, including medical housestaff that could be interpreted as stigmatizing yet these have all demonstrated to be necessary. The identification of risky behavior is characteristic of every ED visit, with questions of recent drug and alcohol use included as a component of all medical intakes. With the knowledge of the implicit dangers associated with substantial narcotic usage, it would appear our concern with potential stigmatization of a patient by applying similar standards, as part of their care plan, is unfounded.

If a physician is to undertake the care of patients dealing with chronic pain, and in that role, be responsible for the supervision of significant amounts of prescribed narcotics, they must do so in a pragmatic and professional manner [15]. Pretending naiveté about the abuse potential of these prescriptions simply will not

play in either a medical nor legal review process. Chronic pain patients by definition likely have failed, or are failing, traditional, more conservative medical management. Symptom relief exists as the pre-emptive goal of medical management. The relationship of the physician and the patient suffering from pain involves a request for medication from the physician and in this somewhat scripted interaction, it is generally provided. It may be seen by some that the nature of the request and the possibility of the rejection of this request, essentially the rejection of the patient's description of self and their suffering, is the real source of stigmatization. One person with the power and authority to disavow another's needs is in itself, a somewhat disturbing place for a patient to find themselves during office visits. Herein lays the role of the thorough and empathetic physician. They should be attuned to this, perhaps unacknowledged, tension and accept the nature of these feelings of both their own and the patients. They should be able to, in a compassionate and professional manner, define the risks of the medications being prescribed. The need for a collaborative understanding of the importance of compliance and a mechanism to demonstrate that compliance exists, both internally and to potential outside reviewers, still needs to be emphasized. There obviously exists no consensus of what manner of testing, or monitoring, is best suited to patients on long term narcotic management. By making no efforts to develop scientifically based standards, we are serving no one well, and we should not be side-tracked in these efforts by misplaced concepts of stigmatization.

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