Frustrated Patients and Fearful Physicians

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We appreciate Drs. Ruan and Luo's response to our editorial, and agree with their observation that clinical attitudes about using opioids to treat pain have fluctuated in part due to changes in society's perceptions about pain and opioid medications.¹ The use of opioids to treat chronic pain in the 1990s was itself a major departure from prior clinical practice, as indicated by the passage of state laws that explicitly shielded physicians from prosecution for using controlled substances to treat intractable pain. As a result of this shift, during our own training in the mid-2000s, we were taught to use long-acting opioids, including methadone, as first-line agents for chronic pain.

However, the shift towards using opioids to treat chronic pain in the 1990s was also driven, in part, by pharmaceutical companies' illegal misbranding that downplayed the addictive potential of opioid medications.² In contrast, recent shifts away from using opioids to treat chronic pain reflect the emergence of high-quality evidence that certain prescribing practices, such as using high opioid doses and co-prescribing opioids and benzodiazepines, put patients at significantly increased risk of overdose and death, without a clear corresponding clinical benefit.³ There is a critical need for better evidence about which patients, if any, might reasonably benefit from taking low-dose opioids for chronic pain. However, based on current evidence, we think that physicians should be extremely cautious about starting patients on long-term opioid therapy.

We agree with the authors that physicians and policymakers should not conflate opioid prescribing and pain management. Despite their terrible consequences in terms of increased

opioid misuse and overdose, the pain-related public health campaigns in the mid-1990s correctly recognized that physicians have a moral and professional obligation to take pain seriously and to treat it competently and comprehensively. However, paying attention to pain is not the same as willingness to prescribe opioids. Treating pain does not obviate the need for careful discussions with patients about the risks and benefits of different treatment options, and severe pain does not justify the routine use of high-risk, marginally effective treatments. Although clinical practice may be starting to shift, opioids still inappropriately occupy a position of primacy in discussions about chronic pain. In our experience, most patients with severe chronic pain are best served by a multidisciplinary treatment approach that emphasizes functional improvement and de-emphasizes the importance of opioids.

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