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How Can We Improve Opioid Prescribing for Chronic Pain? A Survey of Prescribers in the Trenches

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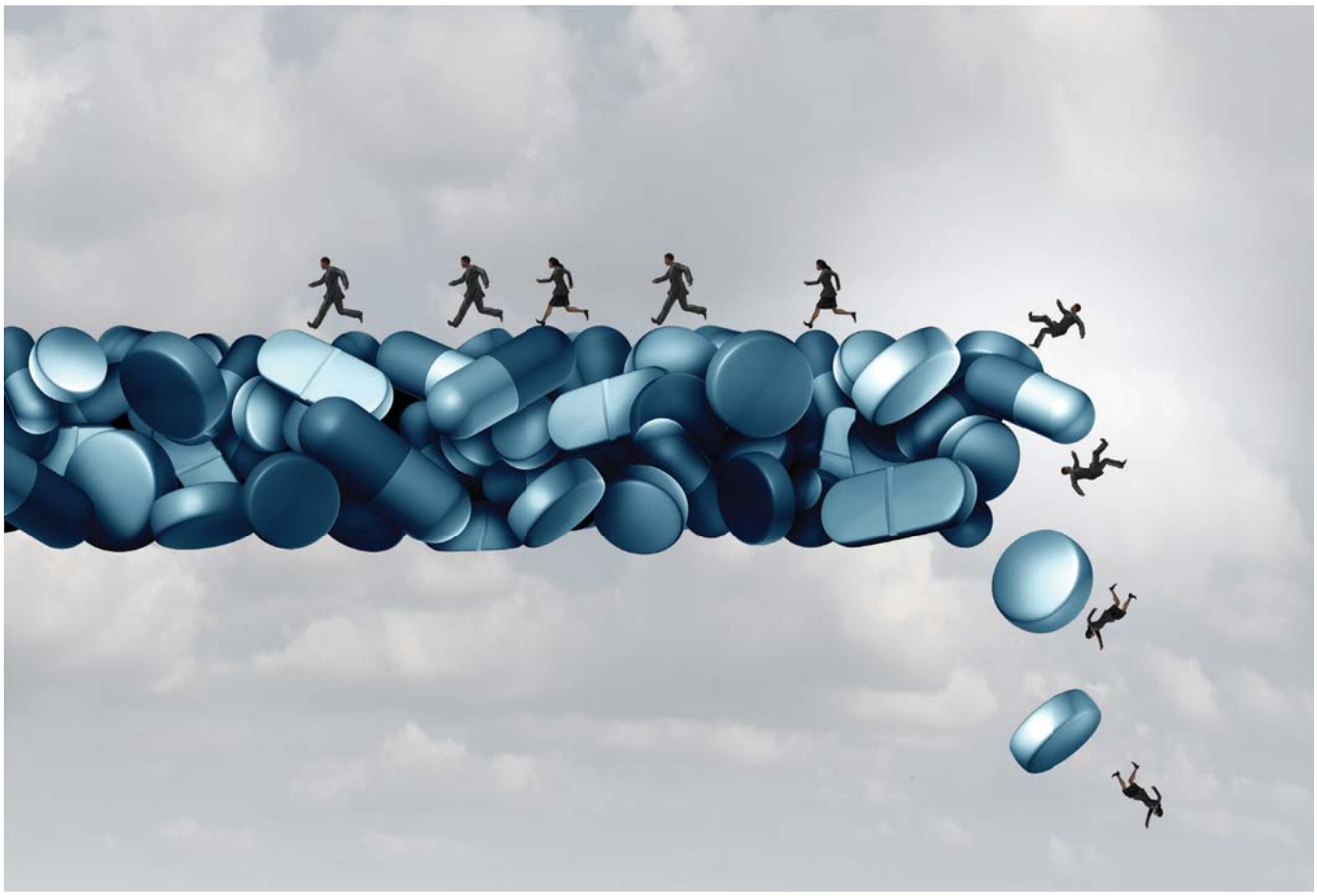

There is a need for better education for practitioners who are well meaning but who lack adequate knowledge of the intricacies required to safely and effectively treat pain patients. Best-care practice includes risk assessment, psychosocial evaluation, appropriate use of opioids, documentation, benefits of multiple modalities, and knowledge of the rules and regulations that are required to protect not only patients but also the public. This paper presents a summary of the most common errors of opioid prescribing, according to a survey of practitioners. We invite readers to take the survey and compare their answers to the participants' responses.

METHODS

The study population consisted of 395 prescribers who took a 21-CME remedial and proactive prescribing course, "Opioids, Pain, and Addiction," between 2013 and 2016. Most were primary care providers, and the remainder were psychiatrists, interventional pain specialists, physiatrists, orthopedic surgeons, emergency room doctors, physician assistants, nurse practitioners, and other clinicians.

On a **pretest survey** consisting of a list of statements regarding their prescribing of controlled substances (CSs), attendees checked whether each statement applied to them never, seldom, sometimes, frequently, or always. This report includes the pretest results of six true or desirable statements that were too often believed to be false or bad practice, and 14 false or undesirable statements with which too many agreed.

PRETEST SURVEY AND RESULTS

DESIRABLE ACTIONS

The statements below describe practices that should be a standard part of evaluation and treatment of chronic pain and the responses from the survey participants.

1. On the initial visit, when a new patient's complaint is long-standing chronic pain, I have the patient sign releases for the records from previous treating physicians.
Response: 15% never or rarely, 8% sometimes, 77% frequently or always
Previous medical records should be a standard part of the initial evaluation. They can provide details about the patient's history, diagnostic testing, and response to specific previous drug doses and procedures, and may also provide valuable information about the patient's reliability, or reason for the change of provider. A patient's refusal to facilitate obtaining old records is considered a red flag and should trigger the provider to ask, "Is there something to hide?"

2. I ask patients who are being seen for chronic pain their pain level at every visit.
Response: 31% never or rarely, 25% sometimes, 44% frequently or always
A major goal of the follow-up visit is to assess the outcome of treatment by evaluating the "four A's" (1): Analgesia, Activities of daily living, Adverse effects, Aberrant drug-related behaviors (ran out early, meds were stolen, etc.), plus a fifth A, Affect. At the top of the list is the patient's assessment of their pain!

3. In male patients on chronic opioids, I routinely order a serum testosterone level early on.
Response: 65% never or rarely, 19% sometimes, 16% frequently or always
Opioids impact the hypothalamic-pituitary axis, resulting in subnormal testosterone levels in most men (2-4). Testosterone replacement for hypogonadism is now believed NOT to increase the risk of prostate cancer (5,6). It's good practice to check serum testosterone levels (total and free testosterone) in men being prescribed chronic opioids and consider testosterone replacement if the level is subnormal.

4. I phone the lab or ask a knowledgeable colleague for clarification of a urine drug test (UDT) result that I don't understand.
Response: 24% never or rarely, 9% sometimes, 67% frequently or always
Practitioners who order urine drug tests have an ethical obligation to act on the results, which of course requires an understanding of the results. At times this is not simple, because several commonly used opioids have metabolites that routinely appear in the urine. In addition, routine enzyme immunoassays screen for classes of opioids rather than individual ones and will usually not detect semi-synthetic or synthetic opioids (such as fentanyl, oxycodone, buprenorphine, or methadone).
It is important for the clinician to look into any unexpected result whose explanation is not clear. Patients are sometimes unfairly discharged because of the purported drug misuse; on the other hand, the appearance of other unexpected drugs in the urine may be a clear indication of misuse, which does require action on the part of the prescriber.

5a. I document in the record actions I took as a result of any unexpected result on a UDT.
Response: 26% never or rarely, 8% sometimes, 66% frequently or always

5b. If a patient violates part of the opioid agreement he/she signed, I document in the chart what action I took.
Response: 23% never or rarely, 6% sometimes, 71% frequently or always
When treating chronic pain, the clinician needs to document his/her thinking and decision-making, and note any potential red flags. Not only is this in the best interest of the patient, but it also protects the prescriber from claims of negligence.

UNDESIRABLE ACTIONS

The statements below describe practices that are not desirable or beliefs that are not true, or that are warranted only at times followed by the responses from the survey participants.

1. When a patient tells me that one opioid works better for him than another, I consider it likely that he's a drug abuser looking for his drug of choice.
Response: 20% never or rarely, 38% sometimes, 42% frequently or always
There are legitimate reasons why patients may prefer one opioid to another. For example, in some patients the histamine-producing effect of morphine (but not oxycodone) produces itching; others may poorly metabolize codeine (to morphine) and thus find it ineffective.

2. I am comfortable prescribing opioids only to patients who are able to manage them safely, i.e., who are of normal intelligence, do not have organic brain syndrome, and do not have significant psychiatric illness.
Response: 21% never or rarely, 10% sometimes, 69% frequently or always
Patients who have ongoing pain and who are also cognitively impaired, who have dementia, or who have psychiatric disorders affecting their judgment still deserve to be treated effectively for their pain. The key is to identify another responsible relative or caregiver with whom to discuss the patient's medications. If, however, the patient has an active addiction disorder, referral for addiction evaluation and treatment is needed before it is safe to continue prescribing opioids.

3. I am comfortable prescribing opioids only if I can objectively identify the patient's pain generator (source of pain).
Response: 28% never or rarely, 14% sometimes, 58% frequently or always
For the most common type of chronic pain seen by physicians—chronic back pain—the specific pain generator can be found in only about 15% of cases (7). In other common types of chronic pain, including headaches and fibromyalgia, one can rarely find the pain generator.
If a specific pain generator is not apparent, or surgery is not an option, then the pain itself needs to be treated, with the goal of decreasing the pain and improving the patient's function. A comprehensive approach is optimal, keeping in mind that opioids are often the most effective analgesics, and there is no reason to exclude them because the specific pain generator is uncertain.

4. When I maintain chronic pain patients on opioids, I write in the chart that they are opioid dependent.
Response: 51% never or rarely, 17% sometimes, 32% frequently or always

5. I anticipate that my patient will become addicted to the opioid that I am prescribing for him/her for chronic pain.
Response: 37% never or rarely, 23% sometimes, 40% frequently or always
Calling a patient "opioid dependent" is still likely to be construed as "opioid addict." Although the current *Diagnostic and Statistical Manual of Mental Disorders* uses the classification "opioid use disorder" instead of "addiction," (8,) clinicians may still be accustomed to DSM-4, which used the term "opioid dependent" to mean addicted to opioids (9). Almost all patients who are on more than minimal doses of opioids for more than a couple of weeks are physically dependent; only a small percent of patients become addicted as a result of being put on an opioid.

Physical dependence is a property of opioids (and several other drug classes, such as corticosteroids). Its impact is that abrupt cessation produces a specific set of withdrawal symptoms, which are preventable by tapering the drug rather than simply stopping it. This is a different phenomenon than addiction, which can be viewed as a type of psychological dependence. The **key characteristics of opioid use disorder** (that is, addiction) (8) are:

- Loss of control (i.e., compulsive use)
- Continuation despite significant adverse consequences
- Obsession or preoccupation with obtaining, using, and recovering from the effects of the substance

The best way to make it clear in the chart whether you are referring to the patient's physical dependence or addiction is to avoid altogether using the term "opioid dependence" and instead always specify if your intention is to document "physical dependence" or "addiction/substance use disorder."

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6. When a patient on a chronic CS no longer needs the medication, I document in the chart how I "detoxed" the patient.
Response: 38% never or rarely, 12% sometimes, 50% frequently or always
The term "detoxification," or "detox," defined by the DEA as getting a drug addict off of their drug, is permitted only with an "X waiver," which permits treating drug addicts with controlled drugs (10). Physicians without the X waiver are permitted to taper or wean patients off opioids that were prescribed for chronic pain, but not to detoxify addicts. When a practitioner writes in a patient's chart that he "detoxed" that patient, he is, according to the DEA, identifying that patient as an addict, and he can treat that patient with an opioid only under an X waiver.

7. I advise patients who are on chronic opioids that they should not drive.
Response: 30% never or rarely, 27% sometimes, 43% frequently or always
Most practitioners automatically advise patients on opioids not to drive, but studies support driving after a week or two of maintaining a stable schedule II drug dose (11). After that, psychomotor and cognitive performance are indistinguishable from that in drivers who do not use opioids. (12-14). Even so, there are risks.

8. When a family member phones, I decline to continue the call if the patient has not already signed a release for me to talk with his or her family member.
Response: 22% never or rarely, 9% sometimes, 69% frequently or always
HIPAA rules regarding phone calls from a patient's relatives or friends are misunderstood by most clinicians. HIPAA rules require that we not provide any information in the absence of written consent, but they do not prevent us from *listening* (15). Family members who tried unsuccessfully to provide relevant information to the clinician are a major source of medical board complaints and lawsuits if a bad outcome occurs.

9. I obtain a urine drug test (UDT) at every visit from patients on opioids for chronic pain.
Response: 55% never or rarely, 22% sometimes, 23% frequently or always
Obtaining regular UDTs is now considered standard of care for patients on chronic opioids and is one of the CDC's recent guidelines (16). Those guidelines, however, do not specify how often to order a UDT. Too many clinicians believe that getting a UDT on every visit is the most effective way of monitoring a patient's compliance. But, an *unexpected* UDT is likely to provide a lot more information than a routine one and is more cost-effective.

10. I renew a CS prescription only as part of an office appointment.
Response: 14% never or rarely, 16% sometimes, 70% frequently or always
For long-term, stable patients, there is often no medical reason for them to be seen every month for their chronic pain. Yet most insurance companies will approve a prescription for only 30 days. The DEA allows issuing multiple prescriptions for up to a 90-day supply of a schedule II-controlled substance (17). Often a visit every two months will suffice for a stable patient. At the office

visit, the patient can be provided with two sets of prescriptions, one set to be kept in a safe place by the patient and filled the following month.

11. If a patient on opioids reports sedation or constipation, I attempt to reduce the dose.
Response: 17% never or rarely, 22% sometimes, 61% frequently or always
Sedation and constipation are common side effects of opioids. Sedation is usually transitory; constipation, on the other hand, persists. The ongoing use of a bowel stimulant or a combination bowel stimulant plus stool softener may provide relief. Persistent sedation can be treated with modafinil or methylphenidate.

Choosing to deal with opioid side effects by reducing the opioid dose is likely to increase pain and decrease function. Maintaining an effective analgesic opioid dose allows the patient to continue with decreased pain and improved quality of life and function.

12. If a patient breaks a rule to which he has agreed in his opioid agreement, I discharge him.
Response: 32% never or rarely,
22% sometimes,
46% frequently or always
This may be the most efficient approach by the clinician, but it is not necessarily in the patient's best interest. A more ethical response is to have a discussion with the patient about why this happened; there may be legitimate reasons. The only times when a single bad behavior requires you to immediately stop prescribing are 1.) when you learn that the patient has diverted a prescribed medication,
2.) when continuing to prescribe presents an imminent risk to the patient and/or others, and 3.) when there is active addiction.

13. I anticipate that I will have to gradually increase the patient's opioid dose because of development of tolerance to the drug.
Response: 35% never or rarely, 27% sometimes,
38% frequently or always)
Tolerance is defined as a need for increasing doses to get the same effect. Who develops tolerance and to which effect is very individualized. Development of tolerance to the analgesic effect of opioids remains controversial. Most clinicians and patients believe that tolerance to pain relief will develop, although it may occur over months rather than days. A minority of clinicians, however—those who have actually provided long-term opioid treatment to some of their pain patients—have found that many patients can be maintained on the same dose, whether high or low, for years, unless their disease worsens or there is a new source of pain. This was demonstrated, for example, in a study of long-term opioid dosing in 197 patients maintained on opioids for a mean of 4 years 8 months. (18).

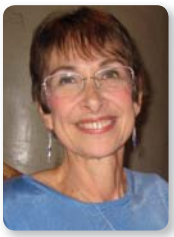
14. If I have a nurse practitioner or PA working with me, I am willing to pre-sign blank prescriptions to facilitate their prescribing opioids.
Response: 96% never or rarely, 2% sometimes, 2% frequently or always
All prescribers of controlled substances should know it is against DEA regulations (19) to pre-sign a blank prescription.

LIMITATIONS

This paper does not purport to be comprehensive in that it did not discuss areas in which most respondents are doing well. This includes initial urine drug testing, use of risk assessment tools such as the Opioid Risk Tool (20), and regularly accessing online the state's Prescription Monitoring Program. Also, this paper did not provide data on clinicians' beliefs about team-based care when treating chronic pain because this is only now beginning to be understood. There is a great need for not only familiarity with appropriate opioid treatment but also about the need for behavioral health and physical therapy integration into a holistic treatment plan which recognizes the complexity of pain (21). Finally, the participants were a mixed group, including some who were mandated by their state licensing board to take a prescribing course because of inadequate understanding of opioids and opioid treatment.

CONCLUSIONS

This study shows that a large proportion of clinicians who treat chronic pain with medications misunderstand significant aspects such as the characteristics of opioids, appropriate treatment, relationship to addiction, appropriate risk assessment, documentation requirements, and the need for ongoing communication with patients. There is still an ongoing need for education of physicians and other clinicians who treat chronic pain. The best time for this would be early in the clinician's career, but this education is still not being regularly provided. ■



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