RAPID RESPONSE

Managing the continuum between pain and dependency in general practice

Advocacy for improved management of pain has contributed to the escalation of prescription opioid analgesic (POA) use in the West over the last two decades. In the USA, the most commonly prescribed class of medication is now the opioids [1]. While they are essential for acute or terminal pain, there is limited evidence for their safety or efficacy in chronic non-malignant pain (CNMP) [2], and population studies indicate that POAs do not seem to improve key outcomes such as: pain relief, quality of life or functional capacity [3]. POA safety and efficacy studies have excluded those with past opioid use disorders, yet half of those with this diagnosis will move onto chronic opioid therapy (COT) [4].

This commentary [5] calls for increased scrutiny for those with CNMP and follows similar calls by medical indemnity insurers and Departments of Health. The class of drug responsible for most medication-related notifications is now opioids, second only to vaccinations. Such medico-legal incidents may leave doctors exposed to civil, criminal and disciplinary proceedings, including punitive damages, such as removal of prescribing rights or deregistration [6].

Such calls for increased clinical diligence for general practitioners (GPs), to do with a major part (19.6%) of all their encounters [7], are likely to fall on deaf ears. GPs are already feeling over-burdened with workload, time and financial pressures. This is particularly so in rural Australia where workforce shortages have resulted in salaries being offered (Hamzeh N, 2010, personal communication) guaranteeing over double the average rural salary [8]. To help cover these labour costs requires an intense focus on time management. Public funding for general practice offers equal payment for consultations of between 5 and 19 min. Mindful of this, the chairman of the Australian Medical Association Council of General Practice, Brian Morton, has commented ‘Medicare rewards quick throughput’ [9]. A recent opinion piece in a free GP newspaper advised supervisors of GP registrars to teach that it is ‘entirely reasonable’ to simply provide a script if requested, and to leave any personal or preventative matters to the annual check-up. ‘Anything beyond that is a waste of time and money’ [10].

Currently COT surveillance is problematic, with a detection rate of only 13.9% of misusers in pain management centres [11]. Screening for dependency can be experienced by GPs as imposing judgment, threatening the therapeutic relationship and disruptive to the normal patterns of work and cooperation [12]. GPs may fear finding an addiction, which many are unprepared to treat [1]. Because of these time and financial pressures, the difficulty of detecting problematic opioid use and the lack of prescriber confidence in treating addiction GPs are left on the horns of a dilemma.

So, what should GPs do?

GPs need to explain COT is no panacea, with an improvement in pain and function levels found in only 26% and 16% of cases, respectively [13]. These modest benefits of COT need to be balanced against the risks such as sleep apnoea [14], opioid-induced hyperalgesia, unintentional fatal or non-fatal overdoses [15], diversion and addiction. The prevalence of addiction in COT has been estimated in various studies as 0–7.7% in cancer patients and 0–50% in non-cancer patients [16].

General practitioners have been called to implement universal precautions (UPs) [2,17]. The concept of UPs was developed after the advent of HIV/AIDS in order to reduce the risk of the transmission of infection. They described minimum standards of care for all patients, regardless of their perceived or confirmed infectious status. Introducing UPs for CNMP would systematise attention to the dimension of dependency in the use of COT. Rather than reserving harm minimisation strategies for those with confirmed POA abuse, doctors would systematically be assessing pain and addictive disorders along a continuum [17]. They would prepare for an exit strategy at initiation of a POA trial. They would manage the nuances of any adverse drug-related behaviours (ADRMs) as routinely as they currently manage cardiac risk factors. This would normalise flexibility in the degree of supervision and structuring for all opioid treatments. Pain is frequently part of the presentation of opioid dependency and withdrawal. Deciding on a management approach becomes more challenging when a commonly agreed definition of pain notes, ‘if people regard their experience as pain and if they report it in the same ways as pain caused by tissue
damage, it should be accepted as pain’ [18]. To reflect this overlap the Specialties of Pain and Addiction may be moving towards a Dual Diagnosis or bi-disciplinary approach. The American Medical Association recently convened the first National Pain Medicine Summit [19]. This group agreed that the field of Pain Medicine incorporated the understanding and management of pain in substance abuse populations and also, addiction medicine including drug testing.

Advantages of UPs could include improved practice morale and security [20] and decreased ADRBs [21]. By tracking ADRBs, GPs may avoid the distress where a pain patient becomes recognised as an abuser. Potential disadvantages of UPs include the risk pain patients may feel stigmatised and then forego COT and the requirement to increase funding and attention by policy-makers [22].

Currently in Australia, POA policies are a patchwork of archaic, uncoordinated and non-evidence-based regulations differing across each National and State Department of Health. In New South Wales, for example, computerised POA prescriptions have to include the complete text, hand-written, twice [23]. National standardisation of policy regarding the prescription of POAs could facilitate better practice [24].

The Australian Pharmaceutical Benefits Scheme, which subsidises most prescription medications, may have potential roles apart from those described in the editorial. It could:

- Require consumers to attend one doctor and one pharmacist [25].
- Require prescribers to sight identification at initiation of COT to deter fraud.
- Require prescribers to periodically document ADRB assessments, replacing the current once-off requirement for a second doctor to authorise COT after 1 year.
- Provide subsidies for opiate sparing medications such as Pregabalin or Duloxetine.

The Australian Government Department of Health and Ageing also should:

- Improve the accessibility and quality of information available to doctors concerned about patients going from doctor to doctor to acquire POAs.
- Foster UPs through its various payments to general practice.
- Better fund research encompassing pain and addictions [2].

Conclusion

While trying to improve the management of pain, GPs should aim to minimise the harms from POAs [5]. Current intuitive approaches are not effective and a systematic approach of UPs is recommended. However, it is not realistic for GPs, or their employers, to implement such an approach, given the pressure on them to improve their time management. Thus, exhortations to GPs to increase their workload to improve outcomes will be in vain until policy-makers commit funding and support to this intersection of pain and addictions.

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References


