CHAPTER 6

Pain Management Considerations

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INTRODUCTION

Patients with substance use disorder (SUD) who have acute or chronic pain present unique management challenges to the healthcare team. There are competing ethical principles that can confuse and confound prescribers and pharmacists alike. The obligation to relieve suffering can be in clear conflict with the necessity to do no harm in the patient with substance misuse who has acute and chronic pain. Also, competing practice pressures can make this dual diagnosis of SUD and pain especially difficult. The healthcare system emphasis on screening for and assessing pain complaints in the period between 1995 and 2015 and on patient satisfaction ratings are a form of pressure toward providing opioids.[1,2] At the same time, legal liability for prescribing and dispensing prescriptions that are misused provide pressure against providing those same prescriptions.[3] The result is a healthcare team in general and prescribers and pharmacists in particular feeling very uncomfortable as they are pushed and pulled from many directions.

KEEPING THE BASIC ETHICAL PRIORITIES STRAIGHT

The ethical and clinical dilemmas surrounding pain management and SUD are and will always be challenging, but can be made much more manageable if several basic principles of the practice of medicine are kept in mind.[4] Healthcare practitioners must recognize and adhere to the basic underlying premise of the healthcare relationship—*first, do no harm*. With this established as the basic essential lens through which to evaluate all patient management decisions, one can begin to unravel the complex issues involved in the patient with SUD with pain conditions. Another essential ethical principle is the duty to relieve suffering, but this is secondary to the avoidance of doing harm.

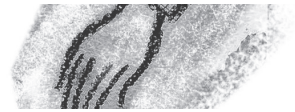
When efforts to relieve suffering (pain in this case) begin to significantly increase the risk of doing harm, the healthcare team must

- Step back

- Reassess the patient and the plan
- Change the plan to minimize risk to the patient, the family, and the community

PRACTICE POINT

Relieving suffering is a core ethical obligation, but doing no harm is even more essential.



How does this pre-eminent requirement to try to avoid doing harm apply to managing pain complaints in the patient with SUD? At the most basic level, it applies to the assessment of potential risks versus potential benefits of providing opioids to patients with SUDs who have acute or chronic pain.[5] All prescribing and dispensing decisions come down to an assessment of the risks and benefits of that medication in that specific patient. In other terminology, the benefit risk ratio is analogous to the strength of the clinical indications versus the severity of any contraindications. It is essential to apply these principles to patients with SUDs, who have opioids as a current or prior drug of choice, and who have acute or chronic pain prior to making opioid prescribing decisions.

THE HIGH-RISK BRAIN

As indicated in previous chapters, patients with clinically significant SUDs have brains which do not deal well with substances that trigger acute, supraphysiologic surges of dopamine from the mid-brain to the fore-brain. These "brain reward" or "euphoria-producing" substances include all drugs of abuse and all controlled prescription medications.[6] ***As a consequence, it is***

- Clinically risky (or relatively contraindicated) to provide any controlled medications to patients with SUDs
- Even more risky (more strongly contraindicated) to provide controlled medications on a longitudinal basis to patients with substance misuse
- Riskiest (most strongly contraindicated) to provide long-term controlled medications from the same class as a patient's current or past SUD

PRACTICE POINT

Controlled medications are high-risk medications, and patients with past or current SUD are high-risk patients.