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Topics in health care ethics
April 2005

Ethical Considerations in Opioid Therapy for Chronic Pain

Whether we think of it in terms of the obligation to relieve suffering as a traditional goal of medicine, or a professional ethical duty to treat all patients with compassion and dignity, or the recognition that unrelieved pain can compromise patients' ability to exercise their autonomy, health care professionals clearly have a responsibility to assess pain and provide the most effective relief attainable. That responsibility is recognized in accreditation standards,[1] recommendations for professional licensure,[2] and VA policy.[3,4]

Overcoming "Opiophobia"

Yet despite significant improvements in pain management in recent years, patients still encounter barriers to receiving effective treatment, especially patients with chronic pain. The most important is what some have called "opiophobia," health care professionals' reluctance to prescribe opioids for fear patients will become addicted and/or divert or misuse the medications.[5,6]

Practitioners must not let fear undermine good patient care, however. To make clinically and ethically sound decisions about opioid therapy, they must understand the differences among tolerance, dependence, substance abuse, addiction, and pseudoaddiction.[6,7]

Tolerance (neuroadaptation to the effects of opioids) and *physical dependence* can both be expected with use of opioids for chronic pain; neither, in itself, implies addiction.[5,7] *Substance abuse* refers to the use of any substance for nontherapeutic purposes or of medication for purposes other than those for which it was intended.[8]

Practitioners must be particularly alert to the difference between addiction and pseudoaddiction. *Addiction* is associated with a complex pattern of behavior that includes impaired control of drug use, craving, compulsive use, and continued use despite adverse physical, psychological, and social consequences.[5–8]

Pseudoaddiction is an iatrogenic condition that results when undertreatment of pain leads patients to behave in ways that seem to suggest addiction—e.g., apparent "drug-seeking" behavior, such as requests for increasing doses of medication.[7] Underlying illness and treatment itself can also lead to states, such as impaired cognition, that may be mistaken as indicators of substance abuse.[5] Great care must be taken not to stigmatize patients as "addicts" or "abusers" when in fact their aberrant behavior stems from such causes.[5,7,8]

Opioid Therapy For Chronic Pain

- *Use opioid therapy when other pain therapies are inadequate*
- *Determine the goal of therapy with the patient or surrogate*
- *Assure safety—do no harm. Optimize therapy through trial and titration based on assessment*
- *Obtain a comprehensive assessment of the patient before initiating therapy*
- *Regularly assess adverse effects, adherence to treatment plan, efficacy, and satisfaction*
- *Develop an opioid therapy agreement with the patient to define responsibilities and expectations of both the patient and provider*
- *Educate the patient about therapy, adverse effects, and withdrawal*
- *Apply multimodal adjunctive therapy as indicated by the patient and disease process*
- *Accurately document all prescriptions, agreements, and assessments*
- *Refer and/or consult with a pain clinic substance-use specialty when needed*
- *Discontinue opioid therapy when it is not indicated*

Adapted from VA/DoD Clinical Practice Guidelines[7]

Opioid Therapy for Chronic Pain

Patients whose chronic pain has not been relieved by other treatments should be carefully assessed as candidates for opioid therapy, with attention to their pain-related history and psychiatric or substance use history, as

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well as a complete pain assessment. Individuals with complex pain conditions (e.g., pain and substance use disorder or other psychiatric comorbidity) should be referred to a pain specialist for evaluation and treatment.[7,9]

Treating chronic pain in patients who *do* have a current diagnosis or history of abuse or addiction poses significant clinical challenges, and managing their use of medication may be logistically complex. Patients in "recovery" may especially be reluctant to accept opioid therapy for fear they will become addicted again. The ethical imperative is clear, however: like all other patients, patients with current or previous substance use or addiction are entitled to the most effective pain management attainable. No patient should be denied opioid therapy for chronic pain when that is otherwise clinically appropriate.[1,8]

Pain Management Agreements

One approach to managing opioid therapy for chronic pain is to establish a formal pain management agreement.[2,9,10] Opioid agreements can serve as tools for communication and informed consent, as well as frameworks for treatment. Such agreements should establish realistic expectations and set attainable goals for therapy, educate patients (and family caregivers) about the risks and benefits of opioid therapy, set out patients' and providers' roles, and describe how medication will be prescribed and dispensed. They should also spell out the terms and conditions for receiving opioid therapy, and the consequences for failing to adhere to agreed on conditions.

Opioid agreements should respect patients' autonomy and dignity. Care must be taken to assure that they are not framed in ways that are stigmatizing, or used in ways that patients (or caregivers) could perceive as manipulation or punishment for disvalued behavior. The goal is to help assure that patients receive safe, effective treatment for chronic pain.[4,9,10]

Pain Management Agreements

Opioid agreements should include discussion of:

- *Goals of therapy: to minimize suffering and improve functioning (physical and psychosocial)*
- *Education about opioids: side effects, dependence, addiction, withdrawal, safety concerns*
- *How medication will be prescribed (e.g., by designated provider or team) and dispensed (e.g., at scheduled appointments only)*
- *Conditions for using opioids responsibly, e.g. obligation to:*
  - *report side effects*
  - *report concurrent use of other medications (prescription or over-the-counter)*
  - *refrain from using alcohol or street drugs*
  - *refrain from sharing, selling, or trading medications*
  - *keep medication safe and report loss or theft*
  - *report increased pain*
  - *refrain from adjusting dose without consultation*
  - *accept monitoring and random drug screening*
- *Consequences of not adhering to the agreement*

References & Resources

1. JCAHO Standard RI.2.160.
2. Federation of State Medical Boards. *Model Policy for the Use of Controlled Substances for the Treatment of Pain*.
3. VHA Directive 2003-021. *Pain Management*.
4. New York/New Jersey Veterans Healthcare System. *VISN #3 Pain Management Agreement for Chronic Opioid (Narcotics) Therapy.*
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6. Emmanuel L. Ethics and pain management: An introductory overview. *Pain Medicine* 2001;2(2):112–16.
7. VA/DoD Clinical Practice Guideline for the Management of Opioid Therapy for Chronic Pain, *Key Points*.
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10. Fishman SM,Kreis PG. The opioid contract. *Clinical Journal of Pain* 2002;18(4 Suppl):S70–S75.

The Ethics Center gratefully acknowledges the assistance of VHA's National Pain Management Strategy Coordinating Committee.