PERSPECTIVE

The painful truth about pain

A harrowing medical experience gave **Travis N. Rieder** more insight than he would have wished for into how people end up hooked on opioids.

On June 16, 2015, I woke up in agony. The day before, I had been in surgery for nearly nine hours, while three different teams of specialists tried to save my foot by carving muscle, fat, skin, artery and nerve out of my thigh and using it to patch together my shattered lower extremity. It was my fifth surgery following a motorcycle accident the month before, and it left me reeling with fiery, electric, boiling pain.

I begged nurses and doctors to increase my pain medication. When they moved too slowly for my liking, I stopped being quite as compliant a patient as I tend to be. I needed more drugs.

I now think of what happened that day as representing the central problem of pain medicine in the United States right now. It's often said that overprescribing is the root cause of our troubles with opioids. But people experiencing severe pain will be quick to tell you that fear of opioids now leads to underprescribing, and that they are left to deal with untreated pain. What I would eventually realize is that you find both going on all the time: some clinicians aggressively prescribe opioids without good evidence, whereas others withhold opioids out of fear. It is the worst of both worlds.

On that day in 2015, as my requests for more medication became more obnoxious, the intensive-care doctor tending to me regarded me with suspicion and disdain. She responded to my complaints with a curt comment that my request for more medication had been noted. And yet, when I managed to get my plastic surgeon to call a pain-management consultancy things went very differently. That team medicated me into oblivion, without careful counselling or follow-up — as a result, I formed a dependence on opioids. That dependence, and the withdrawal it eventually precipitated, would come to define my health-care experience, and eventually lead to my scholarly interest in the ethics of pain medicine.

This recognition that clinicians are both overprescribing opioids and undertreating pain is crucial, because it makes it clear that there will be no simple solution to the problem of prescription opioids. We cannot go from the claim that a surplus of prescription opioids helped to spark today's overdose crisis to the conclusion that we therefore must reduce prescribing. We need to reduce prescribing in the right ways: limit opioids when they really are surplus, but prescribe them when they are the appropriate treatment. This might sound obvious, but think for a moment about what it would take to follow this advice — what it would take, that is, to engage in responsible opioid prescribing.

First, the step that gets most attention: clinicians would need to initiate opioid therapy only when called for, and administer it in appropriate amounts and for an appropriate length of time. This should always have been the standard, but the fact is that we didn't have a good evidence base for much of the prescribing that has happened over the past two decades. Doctors were assured by pharmaceutical companies that opioids are safe enough to use for both chronic and acute pain, even when the discomfort is only moderate. We now know that opioids should not be the first-line treatment for chronic pain, and that other, safer therapies are more appropriate for less severe pain.

Our focus on this first point is obscuring how much more is required for responsible opioid prescribing. After all, many people like me will absolutely need opioids to get through severe, life-limiting pain; but that doesn't mean that doctors should be free to write prescriptions and then wash their hands of the patient. A key issue is the appropriate management and discontinuation of the medication.

Being exposed to opioids at all brings with it a risk of persistent use: about 6% of opioid-naive patients who receive a single day's prescription will still be on the medication a year later. That alone is a good reason not to take the decision to initiate opioid therapy lightly. But the longer a person has taken opioids, the more likely it is that they will still be taking them a year later: if a person receives more than eight days' worth of pills, that risk more than doubles; among those who receive more than a month's supply of opioids, nearly one in three will still be on opioids the following year (A. Shah *et al. MMWR Morb. Mortal Wkly Rep.* **66**, 265–269; 2017).

Having experienced withdrawal, these facts don't surprise me: after taking opioids for more than a few days, people might well experience symptoms of withdrawal on discontinuation; after more than a few weeks, those symptoms can be truly terrible. Prescribers need to prepare people for opioid therapy, counsel them on the goals of treatment and, crucially, have an exit strategy. This means that the prescriber will need to map out a tapering schedule and withdrawal-mitigation strategies.

How different would my situation have been had I been informed of the risks of opioids, counselled to reduce my dose as soon as possible, and then weaned off them at a pace no faster than a 10% dose reduction per week, pausing to collect myself whenever the withdrawal symptoms became too severe? Perhaps I would have been in so much pain that I wouldn't have listened to reason, and so would have taken too many pills for too long anyway. But I don't think so. When I had to undergo yet another surgery about seven months after the accident, my fear of withdrawal led me to be very cautious about my pain management, taking only a small number of low-dose opioids. I put up with a lot of pain in exchange for avoiding suffering down the road. What I needed during my first hospitalization was the information to let me make that same decision without having to learn, first-hand, to fear dependence.

Opioid therapy is complicated, but the behaviour of many clinicians in the United States is much too simplistic: either prescribe opioids aggressively, or treat patients with suspicion and withhold medication out of fear. Both practices are unjustifiable. As has been well documented, pain education is often an afterthought in medical schools; many medical students graduate without taking any courses on pain. To treat pain responsibly, we must recognize a simple, but apparently elusive, truth: pain medicine is hard. We have to stop pretending otherwise. ■

THERE WILL BE NO SIMPLE **SOLUTION** TO THE **PROBLEM** OF PRESCRIPTION **OPIOIDS.**

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