We thank the authors of these commentaries for their thoughtful comments. Each responded to our article in a different way, bringing to bear their backgrounds and experience. Each offers analysis, comments, and suggestions for addressing one issue with respect to treating patients with chronic pain: how to deal with physicians’ concerns that they will be subject to government action for prescribing opioids to addicts or diverters who appear to be patients in pain. Our background and experience as physicians caring for patients with chronic pain has affected the way we think about this problem. We, as other doctors, dread the thought of being investigated, indicted, or tried even if found innocent of wrongdoing at any stage of the process. This concern about legal action has consequences in that it inhibits doctors from prescribing adequate amounts of opioids for bona fide patients in pain.

We are ambivalent about imposing many of the procedures on our patients who are generally recommended to detect abuse or diversion of opioids. Our patients are people who have suffered episodes of rejection, humiliation, and depression in the course of their illnesses and treatment. Mandating procedures such as written contracts and routine urine testing for controlled substances adds to the humiliation and modifies the doctor–patient relationship. Does requiring chronic pain patients to continually prove they are not abusing or diverting drugs affect the doctor–patient relationship? We are concerned about the affective as well as sensory component of the pain experience. Do these mandated procedures impair our ability to treat the affective component of patients’ pain? We need to learn whether they do and, if so, how these procedures change our treatment effectiveness.

Frequently, recommended psychiatric consultations have been unhelpful. Many psychiatrists are either not interested in the problems of chronic pain or lack the training to enable them to deal effectively with our patients. In addition, psychotherapy is expensive for our patients, many of whom are disabled and have limited resources to pay for psychiatric care. Requests for psychiatric consultations have been interpreted by some patients as rejection and humiliation as well. These consultations have added to their distress rather than contributed to their benefit.

The perception of the risk of government action against a physician for “overprescribing” opioids or prescribing unknowingly to an addict or diverter has kept some patients with chronic pain from receiving adequate treatment. We have tried to learn about the reality of this risk and make these facts known to the medical community in our article about doctors being deceived by patients, as well as in earlier ones [1–4].

We acknowledge that drug abuse is a major problem for our society, and that diversion and misuse of prescribed opioids contributes to this problem. We do not know what fraction of the total national drug abuse problem is due to diversion of opioids prescribed for pain. We do not know how much benefit is achieved by the actions physicians have been told to take to minimize the risk of diversion or misuse. We do know that these actions can have negative effects on patients in pain. We hope to contribute by making facts known and having thoughtful, fact-based discussions of the problem such as presented by the authors of these commentaries. These discussions may help society develop the best compromises between effective and humane ways to treat people with chronic or recurrent pain and the most effective way to combat the problem of drug abuse in the United States. We certainly do not know the answers. Perhaps if a larger fraction of the money spent on combating drug abuse were spent on obtaining answers to questions like these, our society would be able to develop better compromises to limit drug abuse with less harm to people with chronic or recurrent painful illnesses.

Marcus M. Reidenberg, MD,* and Beth Jung, EdD, MD, MPH
*Professor of Pharmacology, Medicine, and Public Health Head, Division of Clinical Pharmacology
Weill Cornell Medical College
New York, New York, USA

© American Academy of Pain Medicine 1526-2375/07/$15.00/447 447–448
doi:10.1111/j.1526-4637.2007.00340.x
References


