

Opioids in End-of-Life Care: Promises and Problems

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Introduction

On the surface, it would seem that appropriate utilization of opioid analgesics to relieve suffering at the end of life is a “no-brainer.” Concerns about addiction, diversion, tolerance, and other side effects might impede the use of these powerful medications in chronic nonmalignant pain, but certainly terminal pain and suffering must override these concerns. Tragically, nothing could be further from the truth.

For years, the American Alliance of State Cancer Pain Initiatives has presented convincing data showing that the undertreatment of cancer pain at the end of life is a public health crisis.¹ What an interesting and descriptive phrase, “public health crisis!” Why not tragedy, shame, or outrage? A public health crisis implies the scope of the problem is huge, that it is of concern to us all, and that effective preventive therapies and treatment strategies are available, but are simply not being utilized.

A quick look at the numbers is alarming. More than half a million people will die of cancer each year in this country. About two thirds of patients with advanced cancer have significant pain. Numerous studies confirm that almost half of these patients have unrelieved pain. Clearly these numbers are of public health crisis proportions. But even more poignantly, most experts in pain management would quickly agree that more than 95% cancer pains could be effectively treated with the right medication at the right dose at the right time.

Unfortunately it isn't just cancer pain at the end of life that is under-treated. The well-known and often quoted Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments, SUPPORT, clearly showed that more than half of very sick hospitalized patients were in serious pain during their final days.² Unrelieved pain is incapacitating—interfering with the ability to eat, sleep, interact with others, and achieve a satisfactory quality of life.³ Nothing could be more diametrically opposed to our fundamental promise as physicians, to cure sometimes and to relieve suffering always.

How can we all do a better job and keep the promise? It seems simple enough. Terminally ill patients present with complaints of severe pain and healthcare providers respond by diagnosing and treating with appropriate analgesic medication. So simple that hospice, palliative care programs, and others have applied a set of ABC's to pain management at the end of life (See Table 1). Perhaps thorough reflection on this “simple” process will demonstrate both the barriers and potential solutions to adequate pain relief at the end of life.

Table 1.
ABC's of Pain Management

ASK	about pain regularly; ASSESS systematically.
BELIEVE	the patient and family in their reports of pain and what relieves it.
CHOOSE	pain control options appropriate for the patient, family, and setting.
DELIVER	interventions in a timely, logical, and coordinated fashion.
EMPOWER	patients and their families; ENABLE them to control their course to the greatest extent possible.

Ask and Assess

All too often it seems we fail to ask patients with serious illness about pain. Paradoxically, healthcare providers are expecting patients to complain, while patients are waiting for their provider to ask.⁴ A long list of potential reasons cancer patients may not complain about increasing pain can be easily generated. Pain may well have sinister implications, including spread of disease, failure of therapy, lack of further therapies, and imminent death. Pain may interfere with the doctor-patient relationship. Patients in pain may feel burdensome to their doctor if they complain of pain not adequately managed, even fear their pain may distract physicians from the business of curing their cancer.

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After all, patients fundamentally like and respect their doctors and want the same in return. They may not want to be considered weak, whiney, drug-seeking, ungrateful, or even a therapeutic failure to their physician.

Physicians share some of these same concerns that lead to a failure to ask. In addition, pain evaluation and management are not well taught in most medical schools and residency programs. One recent survey reported the average amount of time spent on teaching pain management in American medical schools is one hour; with just four hours for nurses.⁵ Failure to ask may also reflect insecurity about what to do with poorly controlled pain and fears of regulatory scrutiny when prescribing controlled substances. Weber and Huber showed that oncologists in a busy clinic setting documented pain severity and opioid dose only 25% of the time in patients known to have significant pain (see Table 2).⁶

Table 2.
Documentation of Severe Pain, Opioid Doses, and Opioid-related Side Effects *adapted from Weber and Huber⁶*

Finding	Frequency Documented
Pain Severity	24.6%
Opioid Dose	26.9
“Rescue” Dose	4.8
Bowel movements	1.6
Laxative Rx	4.2

Asking is a great place to start, but a more formal pain assessment and regular utilization of a pain assessment tool have been shown to improve pain management. While one might argue that various tools are too long, complicated, time-consuming, or subjective, studies repeatedly show that choosing and consistently using one is far better than using none.⁷ Most pain scales and tools are actually quite simple, often done by the patient, and easy to incorporate into regular visits. Even patients with mild-to-moderate dementia can respond to at least one of these simple tools.⁸ The simplest of tools are scales. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) now “recommends” the regular use of pain scales to assess pain severity and relief. The two most common scales are either verbal (none, mild, moderate, severe, or excruciating) or numerical (0-10 where 0 indicates no pain and 10 the worst pain you can imagine).⁹

In some settings and with some patients, particularly at initial assessment, more detailed tools like the two listed below are helpful. Neither of these tools is new and both have been validated in a variety of settings and many different countries. Many more are available and their use is encouraged.

The Memorial Pain Assessment Card (MPAC)

The MPAC¹⁰ uses a 10-cm Visual Analogue Scale to rate not only pain but also relief and mood. A Visual Analogue Scale (VAS) is a simple 10cm line labeled 0 (none) at one end and 10 (severe) at the other. The patient marks the point on the scale that best indicates the severity of the symptom. A VAS can be used to assess any symptom including pain, nausea, dyspnea, anxiety, depression etc. The patient’s response to the card also indicates global symptom distress.

The Wisconsin Brief Pain Inventory (BPI)

The BPI¹¹ comes in both a long and short form. The long form lends itself to initial pain assessment and the short form to follow-up. Both forms establish pain at its recent worst, least, average, and now using a 0-10 scale. They provide descriptive language about the quality of the pain as well as a body diagram to locate and separate pains. The BPI also asks patients to grade their overall pain relief efforts and quantify interference with mood, sleep, and relationships.

One element that has received recent media attention is incorporating pain as the “fifth vital sign.” In reality, this may become the standard of care. The United States Department of Veterans Affairs (VA) has initiated an ambitious program to include pain as the fifth vital sign in not only all of its medical facilities, but all patient encounters. A positive pain score then triggers further assessment, prompt intervention, and follow-up evaluation.¹²

Believe

Patients and their families often note that no one seems to believe in their complaint of pain. Physicians are often stuck in a medical model of care that demands a specific diagnosis before treatment. Treatment may be delayed until proof is found by diagnostic testing or even further delayed if our tests fail to confirm a clear etiology of the pain, e.g., a positive bone

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scan. Hospice nurses often express considerable frustration that patients with diseases like lung cancer, at high risk for painful metastases, often do not receive adequate pain medications until testing proves the existence of disease spread. With proof in hand, most physicians are then more than willing to prescribe whatever is necessary.

It is abundantly clear that many physicians are very concerned about prescribing opioid medication without “proof” of definitive disease. It is appropriate to be concerned; there are patients trying to scam us. Diversion, abuse, and misuse happen, but fears and

concerns about these possibilities should not prevent appropriate prescription of pain medications for patients who need them. This is easy enough to say, but with all the media attention and legal activity surrounding opioid diversion and misuse, fear of regulatory scrutiny, and even legal prosecution, often thwarts adequate pain management.

Few physicians will forget the picture of a Florida physician that appeared in papers all across the country with the caption, "Doctor is sentenced in Oxycontin deaths." Careful review of the article clearly showed that this was a "dishonest doctor" dispensing oxycontin for profit. Unfortunately few people get beyond the headlines. Within just the last year, an equally alarming legal advertisement appeared in the *Winston-Salem Journal* that read, "OXYCONTIN: If you have been prescribed Oxycontin for more than six (6) months for something other than cancer, call...(telephone number)...Prescription users only."

It is precisely for these reasons that the Drug Enforcement Administration (DEA) and 21 health organizations felt compelled to issue a Joint Statement Promoting Pain Relief and Preventing Abuse of Pain Medications: A Critical Balancing Act (see page 234).¹³ This joint statement clearly reassures us that,

"Preventing drug abuse is an important societal goal, but there is consensus, by law enforcement agencies, healthcare practitioners, and patient advocates alike, that it should not hinder patients' ability to receive the care they need and deserve."

This consensus agreement goes on to enumerate the following facts.

- Undertreatment of pain is a serious problem in this country.
- For many patients opioid analgesics are the most effective and often the only treatment that provides significant relief.
- Opioids are controlled substances and necessarily regulated.
- Drug abusers obtain these medications by diversion.
- Abuse is a serious problem, but focusing only on abuse could erroneously lead to the conclusion that these medicines should be avoided when indicated—generating a sense of fear rather than respect for their legitimate properties.
- Awareness of both use and abuse will enable all of us to make proper and wise decisions regarding the treatment of pain."¹³

Similarly, state medical boards have issued statements to reassure healthcare professionals that they need not fear sanctions for adequate symptom management of seriously ill patients. In fact, just the opposite is true; physicians have been sanctioned for *undertreatment* of pain at the end of life. The North Carolina Boards of Medicine, Nursing, and Pharmacy issued a Joint Statement on Pain Management in End-of-Life Care, adopted on October 21, 1999 that serves as a model for other states.¹⁴ This statement in part reads,

"The Medical Board will assume opioid use in such patients is appropriate if the responsible physician is familiar with and abides by acceptable medical guidelines regarding such use, is knowledgeable about effective and compassionate pain relief, and maintains an appropriate medical record that details a pain management plan."

The physician's fiduciary responsibility to treat pain at the end-of-life is abundantly clear. These statements serve as excellent guidelines to proceed with effective pain management. As long as physicians carefully follow the tenets of appropriate prescribing within an established doctor/patient relationship, we needn't fear regulatory or legal consequences.

Choose

A pain specialist once shared that effective pain management at the end of life was really quite simple. It comes down to using aspirin and/or opioids. There are a myriad of other potential interventions available including adjuvant medication, surgery, radiation, chemotherapy, central nervous system anesthesia, and even complementary modalities. For the vast majority of patients, pharmacologic therapy with aspirin and/or opioids will do the job. Of course aspirin means the broader class of nonsteroidal anti-inflammatory drugs (NSAIDs). And opioids means a thorough understanding of a number of appropriate opioids used at the right dose, in the right dosing form, at the right time, and by the right route. While NSAIDs have a role in pain management at the end of life, for the large numbers of patients with moderate-to-severe pain, opioids are the mainstay of pharmacologic therapy.

There is little doubt that the most important barriers to effective pain management at the end of life are poor assessment and inadequate utilization of opioid medication.³ "Inadequate utilization" does not assign blame, but refers to a major problem with education and attitude about opioid medications. This is not just a patient or physician problem, it is everyone's problem—nurse, pharmacist, family, friend, pastor, or volunteer. We all share inadequate education and inappropriate attitudes about opioid medication.

Pain and palliative care specialists speak frequently about morphine myths. These are generally held ideas about opioids that have grown to mythic proportion without much substantial proof as to their existence. These misconceptions interfere with the appropriate utilization of opioids and include undue concerns about addiction, tolerance, and uncontrollable side effects like euphoria, vomiting, constipation, sedation and respiratory depression. Numerous studies have shown that the more firmly held the myth, the more noncompliant the patient will be with their pain regimen.¹⁵ Patients who fear addiction resulting from simply utilizing opioids are unlikely to take them as prescribed. Likewise patients who are afraid that tolerance will develop if they start taking opioids early in the course of their disease, rather than "saving" them for when their pain gets "really bad," are unlikely to take medication appropriately. Healthcare providers must assume that these issues are on the minds of most patients as they write an initial prescription for an opioid medication and ensure appropriate education to explore and dispel the myths.

Perhaps more surprising is how these same myths affect physician attitudes about pain and opioids. A remarkable study done here in North Carolina¹⁶ confirmed the findings of others and demonstrated widespread misconceptions among physicians

about pain and opioid medications. In one study,¹⁷ 51% of physicians felt that tolerance to opioids was a significant problem and limited their ability to control pain. Most experts would agree that most of the time tolerance is not a clinical issue. Increasing pain means an increase in cancer-related disease processes and can be relieved by increasing opioid doses and/or other measures. On the other hand, 39% of physicians felt that intolerance to adverse effects of opioids made it difficult to control pain. Interestingly, most patients become tolerant of common side effects of opioids (except for constipation), but not to their analgesic effects. An alarming 20% of these physicians felt addiction was a problem for cancer patients treated with opioids and 19% felt poorly controlled pain was inevitable in advanced cancer.

While a detailed review of specific pharmacologic treatment strategies and recommendations is beyond the scope of this article, many monographs and guidelines are readily available. The American Pain Society has recently published the fifth edition of a remarkable pocket-sized set of guidelines for both acute and cancer pain,¹⁸ which can be ordered at <http://www.ampainsoc.org/pub/principle.htm>. The American Academy of Hospice and Palliative Medicine also publishes a pocket guide to palliative care with up-to-date recommendations covering both pain and a wide range of other end-of-life care issues.¹⁹ The American Geriatrics Society has recently reissued guidelines for pain management in older persons.²⁰ All of these resources are clear that opioids may well be both the safest and most effective treatment strategy for persons with serious pain at the end of life. All physicians should be familiar with basic opioid pharmacology, dosing strategies, and the role of common adjuvant medications. In addition, physicians must be knowledgeable about resources and pain consultants available in their communities when pain becomes difficult to control.

Unfortunately, in a distinct minority of patients, pain isn't nearly as difficult to control as the patient and/or their family. Some patients abuse their opioids, and some families divert patients' medications. Physicians must be thoughtful, careful practitioners willing to confront these possibilities and engage the assistance of specialists who commonly deal with these challenging circumstances. Pain clinics often employ effective strategies, like contracting, to deal with these circumstances.²¹ Engaging local DEA authorities may even become necessary to ensure both patient and public protection. *Tolerance* may truly be the issue in patients with a history of opioid abuse. These patients are often *tolerant* of opioid medication, *intolerant* of both physical and emotional pain, and clearly try the *tolerance* of their healthcare providers.

Deliver

Pain interventions should be delivered in a timely, logical, and coordinated fashion. A thorough understanding of the

pharmacology of opioids and other medications is essential for good pain management at the end of life. For example, many physicians dose oral opioids every four hours as needed for pain. However, for patients in pain crisis a more aggressive strategy is indicated. Since oral opioids reach maximum serum concentration within an hour, peak effects and peak side effects also occur in that time frame. As long as adverse effects of sedation or respiratory depression aren't observed, additional medication, including breakthrough doses, can be administered every one to two hours.

Similarly aggressive parenteral dosing strategies exist for patients in pain crisis presenting for inpatient care. One such successful strategy describes a dose doubling every thirty minutes.²² In this study, cancer pain patients already on opioids as outpatients presented for emergent admission with intense pain sustained for at least six hours and escalating over days. Appropriate to their outpatient opioid dose, patients received 10-20 mg of morphine intravenously over 15 minutes. If inadequate relief and no adverse effects were observed 15 minutes later, the dose was doubled and the process repeated every 30 minutes. Satisfactory pain control without adverse events was achieved in a mean time frame of 90 minutes for all patients.

In a similar study, cancer pain patients were treated with one milligram of morphine per minute for 10 minutes, which could be repeated after five minutes if there was no relief.²³ The goal in this study was also similar; to achieve adequate relief (< 5 pain score) not necessarily with complete relief, but without excess sedation or respiratory depression. In this study, the maximum dose was 30 milligrams over 45 minutes. None of their patients required this high a dose. Once relief was achieved, an hourly dose was calculated at approximately one-third to one-fourth of the loading dose.

Both of these studies depend on a clear understanding of opioid pharmacology. Both were also done in an inpatient setting, with experienced personnel, aware of, and prepared for adverse consequences. Nevertheless, innovative or "best-practice" models like this should be carefully reviewed, adapted and adopted in settings where poor pain control is likely to be encountered and effective pain management expected by patient, family, and providers.

A broader view of delivering interventions in a timely, logical and coordinated fashion suggests taking a harder look at what patients and their families need to achieve pain control. A recent review²⁴ suggests seven areas of difficulty in putting a pain regimen into practice. The primary difficulty is the cost of medication, but also of major concern are accessing information about the medication, tailoring the prescription to meet individual needs, and managing side effects like constipation. Anticipating these concerns is highly likely, and addressing them with all patients will clearly improve pain management. If opioid cost is an issue, methadone must be an option. While methadone has complex dosing problems and should only be

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prescribed by those thoroughly familiar with them, oral methadone costs only about a penny per milligram. Topical fentanyl patches for severe pain at 150mcg/hour applied every 72 hours may cost as much as \$30/day, whereas an equianalgesic dose of methadone may cost as little as 45 cents/day. In addition, methadone has very specific analgesic properties that make it a more potent and effective opioid for complex, chronic cancer pain. Recent reviews of methadone²⁵ are essential reading for any practitioner providing care for patients with significant pain at the end of life. Indeed, methadone is probably the ideal opioid in end-of-life care.²⁶

Empower and Enable

Unrelieved pain is incapacitating, interfering with the ability to eat, sleep, interact with others, and achieve a satisfactory quality of life.³ Healthcare providers need to empower patients and their families and enable them to control their course to the greatest extent possible. Information is power. Resources abound to provide patients and their families with information with which they can better manage pain at the end of life. From drug companies²⁷ to end-of-life care advocacy groups,¹ print and Internet resources are readily available. Hospices cover every square inch of North Carolina and probably the entire continental United States. Palliative care services exist in many hospitals and all regions of the country. Both are committed to effective pain management. Use your local hospice and consult your palliative care service.

JCAHO standards, at least the pain control standards, are terrific guidelines and are the rules we must live by in many settings. As much as we often rebel against “have to” standards, these are worth embracing and implementing. Most guidelines and standards “suggest” that institutions should promise excellent pain control, express it clearly in statements of patient’s rights and responsibilities, and put mechanisms in place to live up to the promise. One such statement reads,

“As a patient at Rockford Memorial Hospital, you can expect:

- Information about pain and pain relief measures.
- A concerned staff committed to pain prevention.
- Health professionals who respond quickly to reports of pain.
- State-of-the-art pain management.
- Dedicated pain relief specialists.
- Pain expressions will be believed.

As a patient at Rockford Memorial Hospital, we expect that you will:

- Ask your doctor or nurse what to expect.
- Discuss pain relief options with your doctors and nurses.
- Work with you doctor and nurse to make a pain relief plan.
- Ask for pain relief drugs when pain first begins.
- Help the doctor and nurse measure your pain.
- Tell the doctor or nurse about any pain that will not go away.
- Not worry about getting “hooked” on pain medication.”²⁸

This may not be the exact statement our institutions choose, but it is a great place to start. Individual and organizational commitment to pain relief is truly powerful. Education, attitude, passion, and compassion will overcome all of the barriers to adequate pain relief at the end of life, fulfilling our promise as concerned healthcare providers. **NCMJ**

“Paradoxically, healthcare providers are expecting patients to complain, while patients are waiting for their provider to ask.”

REFERENCES

- 1 American Alliance of State Cancer Pain Initiatives website. www.aacpi.org.
- 2 SUPPORT Principal Investigators. A controlled trial to improve care for seriously ill hospitalized patients: The Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatment (Support). *JAMA* 1995;274:1591-98.
- 3 Cherry NL. Cancer pain: principles of assessment and syndromes. In: Berger AM, Portenoy RK, Weissman DE, eds. Principles and practice of palliative care and supportive oncology. 2nd ed. Philadelphia, PA: Lippincott, Williams and Wilkins, 2002:3.
- 4 Yates PM. Barriers to effective cancer pain management: a survey of hospitalized patient. *J Pain Symptom Manage* 2002;23:393-405.
- 5 Rich BA. Pain management: legal risks and ethical responsibilities. *J Pharm Care in Pain Symptom Control* 1997;5(1):5-20.
- 6 Weber M and Huber C. Documentation of severe pain, opioid doses, and opioid-related side effects in outpatients with cancer: a retrospective study. *J Pain Symptom Manage* 1999;17:49-54.
- 7 Jensen MP. The validity and reliability of pain measures in adults with cancer. *J of Pain* 2003;4(1):2-21. Ferrell B. Pain assessment in dementia. *J Am Ger Soc* 1993;41:SA 25.
- 8 Phillips DM. JCAHO pain management standards are unveiled. Joint Commission on Accreditation of Healthcare Organizations. *JAMA* 2000;284:428-429.
- 9 Fishman B et al. The Memorial Pain Assessment Card. A valid instrument for the evaluation of cancer pain. *Cancer* 1987;60(5):1151-58.
- 10 Daut RL et al. Development of the Wisconsin Brief Pain Questionnaire to assess pain in cancer and other diseases. *Pain* 1983;17(2):197-210.
- 11 US Department of Veterans Affairs. Pain assessment: The fifth vital sign. Veterans Health Administration, Acute Care Strategic Healthcare Group, Geriatric Extended Care Strategic Healthcare Group. Washington, DC 1999.
- 12 Pain and Policies Study Group, University of Wisconsin Comprehensive Cancer Center website. www.medsch.wisc.edu/painpolicy/.
- 13 North Carolina Medical Board website. www.ncmedboard.org/endoflife.htm.
- 14 Ferrell BR, Juarez G. Cancer pain education for patients and the public. *J Pain Symptom Manage* 2002;23:329-336.
- 15 Levin ML, Berry JI, Leiter J. Management of pain in terminally ill patients: physician reports of knowledge, attitudes, and behavior. *J Pain Symptom Manage* 1998;15:27-40.
- 16 VonRoenn JH, Cleeland CS, Gonin R, Hatfield AK, Pandya DJ. Physician attitudes and practice in cancer pain management: a survey from the Eastern Cooperative Oncology Group. *Ann Intern Med* 1993;119:121-126.
- 17 American Pain Society. Principles of analgesic use in the treatment of acute pain and cancer pain. Glenview, IL: APS 2003.
- 18 American Academy of Hospice and Palliative Care. Pocket guide to hospice/palliative medicine. Glenview, IL: AAHPM 2003.
- 19 American Geriatrics Society Panel on Persistent Pain in Older Persons. The management of persistent pain in older persons. *JAGS* 2002;50 (SUPPL):5203-5224.
- 20 Fishman SM, Mahajan G, Jung SW, Wilsey BL. The trilateral opioid contract: bridging the pain clinic and the primary care physician through the opioid contract. *J Pain Symptom Manage* 2002;24:335-344.
- 21 Hagen NA, Elwood t, Ernst S. Cancer pain emergencies: a protocol for management. *J Pain Symptom Manage* 1997;14:45-50.
- 22 Davis MP. Acute pain in advanced cancer: an opioid dosing strategy and illustration. *American J Hospice & Palliative Care* 2004;21(1):47-50.
- 23 Schumacher KL et al. Putting cancer pain strategies into practice at home. *J Pain Symptom Manage* 2002;23:369-382.
- 24 Davis MP, Walsh D. Methadone for relief of cancer pain: a review of pharmacokinetics, pharmacodynamics, drug interactions and protocols of administration. *Support Care Cancer* 2001;9:73-83.
- 25 Cleary JF, Foley D. Methadone: the ideal long-acting opioid. *AAHPM Bulletin* 2002;2(2):6-7.
- 26 Partners Against Pain website. Purdue Pharma, Stamford CT 2004. www.partnersagainstpain.org.
- 27 Gordon DB, Dahl JL, Stevenson KK. Building an institutional commitment to pain management. Madison, WI: WCPI, 1996: section C.

**A JOINT STATEMENT FROM 21 HEALTH ORGANIZATIONS
AND THE DRUG ENFORCEMENT ADMINISTRATION**

Promoting Pain Relief and Preventing Abuse of Pain Medications: A Critical Balancing Act

As representatives of the health care community and law enforcement, we are working together to prevent abuse of prescription pain medications while ensuring that they remain available for patients in need.

Both healthcare professionals, and law enforcement and regulatory personnel, share a responsibility for ensuring that prescription pain medications are available to the patients who need them and for preventing these drugs from becoming a source of harm or abuse. We all must ensure that accurate information about both the legitimate use and the abuse of prescription pain medications is made available. The roles of both health professionals and law enforcement personnel in maintaining this essential balance between patient care and diversion prevention are critical.

Preventing drug abuse is an important societal goal, but there is consensus, by law enforcement agencies, health care practitioners, and patient advocates alike, that it should not hinder patients' ability to receive the care they need and deserve.

This consensus statement is necessary based on the following facts:

- ◆ Undertreatment of pain is a serious problem in the United States, including pain among patients with chronic conditions and those who are critically ill or near death. Effective pain management is an integral and important aspect of quality medical care, and pain should be treated aggressively.
- ◆ For many patients, opioid analgesics – when used as recommended by established pain management guidelines – are the most effective way to treat their pain, and often the only treatment option that provides significant relief.
- ◆ Because opioids are one of several types of controlled substances that have potential for abuse, they are carefully regulated by the Drug Enforcement Administration and other state agencies. For example, a physician must be licensed by State medical authorities and registered with the DEA before prescribing a controlled substance.
- ◆ In spite of regulatory controls, drug abusers obtain these and other prescription medications by diverting them from legitimate channels in several ways, including fraud, theft, forged prescriptions, and via unscrupulous health professionals.
- ◆ Drug abuse is a serious problem. Those who legally manufacture, distribute, prescribe and dispense controlled substances must be mindful of and have respect for their inherent abuse potential. Focusing only on the abuse potential of a drug, however, could erroneously lead to the conclusion that these medications should be avoided when medically indicated – generating a sense of fear rather than respect for their legitimate properties.
- ◆ Helping doctors, nurses, pharmacists, other healthcare professionals, law enforcement personnel and the general public become more aware of both the use and abuse of pain medications will enable all of us to make proper and wise decisions regarding the treatment of pain.

American Academy of Family Physicians

American Academy of Hospice and Palliative Medicine

American Academy of Pain Medicine

American Alliance of Cancer Pain Initiatives

American Cancer Society

American Medical Association

American Pain Foundation

American Pain Society

American Pharmaceutical Association

American Society of Anesthesiologists

American Society of Law, Medicine & Ethics

American Society of Pain Management Nurses

American Society of Regional Anesthesia and Pain Medicine

Community-State Partnerships to Improve End-of-Life Care

Drug Enforcement Administration

Last Acts

Midwest Bioethics Center

National Academy of Elder Law Attorneys

National Hospice and Palliative Care Organization

Oncology Nursing Society

Partnership for Caring, Inc.

University of Wisconsin Pain & Policy Studies Group