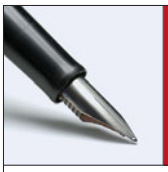

LETTER FROM THE EDITOR-IN-CHIEF

There Ain't No Shame in Pain

After years of lax oversight and insufficient skepticism from physicians, the United States is in an undeniable opioid epidemic, triggering seismic reforms and a regulatory frenzy. The scope of the problem is indeed staggering: Every 18 minutes, someone dies of opioid overdose, and half of those deaths involve prescription pills.

Oversupply and ease of access have been identified as the main culprits, and much of the prevention strategy revolves around physician prescribing. New guidelines have been advocated that limit the indications for narcotic analgesics. Prescription drug databases are now operating in the majority of states, and many states now require health-care providers to do database checks before prescribing opioids and other controlled substances. These efforts are already working. In my state of Ohio, reforms have made a significant dent, with 92 million fewer opioid doses prescribed in 2015 compared with 2012. With the Ohio Automated Rx Reporting System[1] in place since 2006, doctor shopping has decreased 71% in the state.[2]

As with all policies, however, there are winners and losers. Perhaps the patients most at risk are those living with chronic pain. One in 5 people will experience significant chronic pain in their lifetime.[3] Those who have chronic pain have always dealt with stigma. They are treated by many in the medical community with skepticism and often with frank discrimination. The reasons are as complex as the disease entities themselves, but one common theme seems to recur: The experience of pain is subjective, and its measurement is even more so. We have no test to objectively quantify pain, and there is tremendous variability in the sensation and disability associated with painful conditions. This variability has been linked to differences in pain thresholds, a vaguely defined and influenced metric. And this pain constitution has been strongly correlated to patients' psychological stamina and comorbidities.

The science, however, is very uncertain about causality. For example, anxiety is a common comorbidity in chronic pain, but no one would deny that pain itself induces anxiety and that the degree of anxiety is directly proportional to the intensity of pain. In addition, the chronicity of the pain and the stress response that follows trigger a cascade of neuroendocrinologic changes that can become permanent and further inhibit effective coping and recovery.

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Subjectivity and comorbidity cultivate equally subjective—and often inaccurate and biased—judgments and assumptions on the part of physicians. These judgments become labels, and then the labels become stereotypes, and before you know it, the entire staff is treating pain patients with scorn and dismissiveness. The frantic attention to reducing unnecessary opioid use will only increase animosity toward patients with chronic pain and is likely to encourage a simplistic approach that could lead to narrow, rigid treatment plans. In a noble effort to curtail "unnecessary" prescribing, we find ourselves trying to create objectivity and definition for a subjective and complex problem. I worry that we are creating an environment of contempt and shame, causing suffering and isolation for those in pain. Avoiding this unintended adverse effect will require as much attention and sensitivity as our effort to contain the epidemic itself.

Educating physicians about pain management cannot be limited to protocols and regulatory mandates. It is imperative that we do a better job understanding the complexities and variability of pain states and foster an environment of patience and empathy among clinical and reception staff. Some excellent tools and resources can be found at www.painedu.org and www.aachonline.org. ■

1.https://www.ohiopmp.gov/Portal/Default.aspx
2. https://www.ohiopmp.gov/Portal/State.aspx
3. Roll JM, Schraudner T, Murphy S, McPherson S. Prevalence of persistent pain in the U.S. adult population: new data from the 2010 national health interview survey. *J Pain*. 2014;15:979–984.

Lee A. Resnick, MD, FAAFP
Editor-in-Chief, *JUCM, The Journal of Urgent Care Medicine*