ETHICS SECTION

Introduction

Editorial: The Suppression of Evidence-Basis in Pain Medicine and the Physician-Driven Quest to Re-establish It

Evidence-basis in chronic pain management in the United States has tragically fallen by the wayside over recent decades, resulting in the pernicious convergence of deterioration of care received by suffering patients with excessive profiteering by a number of the myriad stakeholders in the “business” of pain medicine [1]. As this special series on the transformation of the “profession” of pain medicine to the “business” of pain medicine has focused, for the most part, on the deleterious impact of non-medical stakeholders such as the insurance and pharmaceutical industries [2,3], later contributions will place more of an emphasis on the unfortunate and all-too-frequent contribution of physician self-interest on the delegitimization of the discipline [4].

Rather than placing the blame on any single stakeholder, those of us concerned with dissention between profession and business in pain medicine should consider that the system as a whole has become progressively more dysfunctional [5–7], and that irrespective of the rectitude of individual clinicians, it may not necessarily be tenable to practice pain medicine in an ideally virtuous manner within the context of a system that seemingly rejects virtue [6]. Although some may consider evidence-based practice as consonant with virtuous practice [8,9], others [10,11] have warned that evidence-based pain medicine can potentially be biased and accordingly may have a deleterious impact on the well-being of persons with pain.

Irrespective of one’s views of evidence-based medicine, it can be argued that any appliance of pain medicine that is in clear contradiction to empirically established evidence with the primary goal of generating increased profitability is malfeasant at best, and, in certain instances, may even constitute fraudulent practice. Although it has been noted that the development of solid evidence bases for pain treatments is fraught with challenges [12], methodologically robust systematic reviews have indicated the clear ineffectiveness of certain treatments that continue to be utilized—even when the side effects and likely iatrogenic complications can be devastating. For example, despite the availability of myriad reviews establishing the contraindication of prescribing strong opioids to patients for pain associated with fibromyalgia [13–20], many physicians continue to treat this syndrome with this class of medications [21,22]. In such instances, pharmaceutical companies benefit, even if the patient does not. Other pain management approaches enjoy only very limited evidence-bases, but are widely utilized by physicians irrespective. Accusations of remuneration as the potential motivation for practicing in this manner are routinely made, and have been addressed in the pain management literature as well [23,24].

In this issue, Drs. Danielle Perret and Chuck Rosen [25] not only elucidate the scope of the problem of practicing pain medicine without respect to the evidence-bases, but offer a physician-driven solution to this unfortunate trend. The authors begin their article by expressing their concerns regarding the status of interventional pain medicine, suggesting that it may not be as reliant upon an evidence-basis as would be optimal. Concerns regarding an absence of a widely accepted standard of care in interventional pain medicine have certainly been expressed over recent years [26,27], although Perret and Rosen [25] address issues of profit motive more aggressively than has been done in the past. Despite the fact that the second author (CR) is an orthopedist, the authors are comfortable moving to an examination of the lack of evidence for the efficacy of many routinely performed orthopedic procedures, noting that the technophilic approaches that have become standard are extremely expensive given their lack of an adequate evidence-basis. Astutely, the authors suggest that technological “advancement” (teknē) in the absence of practical wisdom (phronēsis) cannot suffice in orthopedic surgery, as is true in all areas of pain management. Although the need to balance technology and practical wisdom in other disciplines in pain management has been discussed previously [28], the authors’ willingness to acknowledge this shortcoming within their own craft is commendable. Perret and Rosen [25] dedicate a formidable portion of their article to pain physicians’ overreliance upon opioid analgesics as a primary treatment, irrespective of chronic opioid therapy’s lack of a sufficient evidence-basis. The authors are inclusive in their succinct discussion of chronic opioid therapy, addressing issues including the history of trends in the prescription of opioids, side effects, and the growing body of literature on problems of potential safety and iatrogenesis—both to the individual and to society as a whole. The existing guidelines on chronic opioid therapy are, appropriately, criticized as not being particularly evidence-based, and ethical issues
associated with the use of high potency, ultra short acting opioids for which there is no evidence of efficacy as monotherapies in the treatment of chronic pain are raised. The authors briefly address ethical concerns regarding conflicts of interest in chronic pain management, which will be covered in far greater detail in future articles in this series in Pain Medicine by Drs. Schofferman and Gallagher [29,30].

Given its current challenges, merely criticizing the "business" of pain medicine is facile, and has not been established as a vehicle for changing the manner in which it is practiced or improving outcomes. What sets Perret and Rosen’s [25] article apart from other analyses of the problems that plague our field of practice is that they describe physician-driven efforts that have been made to solve many of the challenges with which our discipline is faced. The authors discuss the Physician Payment Sunshine Act, which will hopefully result in financial transparency through requiring public disclosure of all payments to physicians by industry when it is implemented in 2013. The second author (CR) has developed considerable notoriety as the co-founder and current President of the Association for Medical Ethics, an organization dedicated to reducing the influence of industry on the practice of medicine through the promotion of full financial disclosure by industries potentially influencing medical practice and research [31]. Dr. Rosen has testified before Congress regarding problems with unhealthy relationships between physicians, their institutions, and industry, and was instrumental in the successful effort to pass the Physician Payment Sunshine Act. Through his willingness to testify before Congress, he temporarily put his own career at risk. In subordinating his own needs for those of patients and the medical community as a whole. Dr. Rosen has exemplified virtue ethics as articulated by Aristotle [32], Plato [33], Pellegrino [34], and, ultimately, in pain medicine, Giordano [35].

We appreciate the considerable time and effort that Drs. Perret and Rosen dedicated to writing this article for the special series on the unfortunate devolution of the "profession" of pain medicine to the "business" of pain medicine. Their courageous, pioneering work has recently inspired the development of another provider-driven organization dedicated to the amelioration of the adverse impact of special interest groups specifically in pain medicine, the not-for-profit Foundation for Ethics in Pain Care (http://www.painethics.org). Hopefully, over time, pain medicine will become an entity that honors its expanding evidence bases as opposed to allowing special interests to exert undue influence over the manner in which the discipline is practiced. While groups such as the American Academy of Pain Medicine, the American Pain Foundation, the American Pain Society, the National Pain Foundation, and the Pain Care Coalition have sought to bring about meaningful change through their successful efforts to achieve legislative reform to improve third-party reimbursemens for integrated treatment, to increase funding for clinical pain research, and provide more effective education and training in pain management, the discipline still has a long way to go. Through the work of Drs. Perret and Rosen and those that follow them, perhaps pain care providers, rather than pain societies and legislators, will be at the forefront of the movement to make pain medicine “right” again.

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References


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