Inadequate pain treatment and over reliance on medications for pain management, as well as lack of support for and knowledge of biopsychosocial pain self-management treatments are serious public health problems. This curriculum is designed to provide an overview of the efforts of pain advocates in Oregon in advancing pain management and addressing the under-treatment of both acute and chronic pain throughout the State. It is also designed to increase awareness regarding some of the major challenges healthcare providers face in providing effective pain management.

It is recognized that the issues surrounding the treatment of pain are complex, and cannot be adequately addressed in this one-hour introductory presentation. It is anticipated that relevant issues will be more extensively addressed in the six hour continuing education curriculum requirement.

This introduction to the pain management domain in Oregon qualifies as a portion of your selected continuing education requirement in pain management.

We thank you for your time. The goal of this information is to offer insight into the importance of pain management for all Oregonians.
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The Oregon Pain Management Commission (OPMC)

"The management of pain is a cornerstone of the compassionate practice of medicine. The knowledge exists to ameliorate pain in most of our patients. We now require the will to do so."  

-- Schecter, Berde, Yaster, 2003

In 2001, the Oregon Legislature mandated the creation of a commission to focus on the issue of pain in Oregon. The OPMC is a 19 member advisory commission within the Oregon Health Authority. Its members are an interdisciplinary group of physicians, physician assistants, naturopaths, chiropractors, dentists, pharmacists, nurses, psychologists, acupuncturists, physical therapists, occupational therapists, patient advocates, healthcare consumers and other interested individuals. In addition, two members from the Oregon Legislature—a member of the Senate and a member of the House of Representatives—serve as non-voting (ex officio) members.

Among the tasks of this commission was to develop requirements for pain management education for Oregon physicians and other licensees of the regulatory boards.

This commission has mandated a requirement of one hour of Oregon specific pain education, and six additional hours of continuing education on the issue of pain management or palliative care. This is a one-time requirement of the licensees of the regulatory boards, and must be completed prior to license renewal. In comparison, the state of California has a 12 hour requirement, with no specific required content.

This presentation fulfills the requirement of the one hour of Oregon-specific pain education. At your next license renewal, you will be required to certify that you have viewed this presentation and that you have received an additional six hours of pain medicine or palliative care-related continuing education hours.

The Oregon Pain Management Commission's Vision

Attention and resources devoted to pain management in Oregon are as available, effective, and guided by current science as services for other common disease states of similar prevalence and health impact. Oregonians should be satisfied with the availability and quality of their pain management resources.

Although there are many challenges to achieving adequate pain management for all Oregonians, the Oregon Pain Management Commission has a vision for pain care in Oregon.

This vision is intended to reflect the desires and concerns of the people of Oregon, not simply the opinions of a commission. These desires are in-line with the right to pain management as declared by The Joint Commission and the belief that everyone deserves treatment of their pain, as well as the recommendations of authoritative bodies involved in this important issue.

We believe that this vision for adequate pain management in Oregon can be realized if there is sufficient collaboration and communication between regulatory agencies, healthcare providers, insurers, and patients.
OPMC Responsibilities

- **Improve/coordinate regulatory and legal communication for patients and providers**
  In 2003, the OPMC endorsed Senate Bill 436 which removed the requirement in the Oregon Intractable Pain Treatment Act that a patient seek a second opinion on an intractable pain diagnosis, and clarified that healthcare providers will not be subject to disciplinary action from regulatory agencies for prescribing medication with the goal of controlling a patient's pain for the duration of the pain. However, it should be noted that the Oregon Medical Board strongly recommends a second opinion.

- **Advance a pain management practice program**
  One of the primary responsibilities of the OPMC is to create a pain management practice program. This presentation is part of this practice program. The Commission also developed the requirement that clinicians perform 7 hours of continuing education specific to pain management.

- **Develop and disseminate recommendations for improving pain management in Oregon**
  In addition the OPMC is studying ways to improve pain management services in Oregon through research, policy analysis, and model projects. Examples of OPMC efforts include the following: the OPMC developed and published a “Medical Use of Marijuana Position Statement” on the commission’s online website; the OPMC published online and mailed to Oregon primary care providers an analysis of Washington State opioid legislation with OPMC recommendations for chronic pain treatment in Oregon; the OPMC conducted an online exploratory survey of chronic pain issues of Oregonians.

- **Represent concerns of patients**
  Finally, the OPMC strives to represent the concerns of patients in Oregon on issues of pain management to the Governor and Legislative Assembly.

Key Pain Concepts and Definitions

Identifying and defining some key concepts in pain management helps ensure that patients and providers understand these terms correctly, can communicate appropriately, and will assure the best possible outcomes in pain treatment.

**Pain**

*An unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage.*

--International Association for the Study of Pain, 2012

Pain can be classified mechanistically as **Adaptive** (nociceptive, inflammatory) serving to protect against injury and promote healing or as **Maladaptive** (neuropathic or functional), not appearing to be related to a noxious stimuli or healing of tissue.

- **Nociceptive pain** is from pain receptor stimulation. It may be somatic pain from activation of receptors in the musculoskeletal system or visceral pain which arises from receptors in the viscera.

- **Neuropathic pain** is pain due to changes in the peripheral or central nervous system.

- **Idiopathic pain** is pain without a known cause and is not a diagnosis of psychogenic pain.
In the past pain was described on the basis of a timeline, intervals and evidence of healing. Definitions of pain simply referred to it as a physical symptom of illness or injury based on a stimulus response mechanism. Medical treatment focused on pharmacological management of physical symptoms. All pain was managed as acute. Persistent untreatable pain was believed to be psychosomatic in a pejorative sense; patients were not believed or were thought to be malingering for some gain.

**Acute Pain**

- A response to injury or illness
- Time limited
- Usually responsive to treatment
- Inadequate treatment delays recovery

The Federation of State Medical Boards (2004), a non-profit organization of 70 regulatory boards from across the country, defines acute pain as, "The normal, predicted physiological response to an adverse chemical, thermal, or mechanical stimulus..." Acute pain is generally time limited and is responsive to anti-inflammatory and opioid medications as well as other approaches. Inadequate treatment may delay full recovery and increase healthcare costs.

Acute pain may be due to trauma, or an acute medical or orthopedic problem. Postoperative pain, acute exacerbations of pain associated with chronic medical problems (e.g., cancer), and pain associated with medical procedures are also considered to be acute pain.

The treatment of acute pain should be as effective as possible to prevent the formation of prolonged or unusually severe pain episodes that can have negative psychological and physical effects.

**Impact of Acute Pain**

- Prolonged hospital stays
- Delayed recovery
- Increased healthcare costs
- Inadequately treated acute pain can lead to the development of chronic pain

The importance of effectively treating acute pain and providing greater comfort with the use of new medications and techniques must be emphasized. This is especially true given the research which indicates that the failure to effectively treat acute pain can lead to prolonged hospital stays and delayed recovery, both of which ultimately drive up healthcare costs and adversely affect medical and social outcomes.

**Chronic Pain**

"A state in which pain persists beyond the usual course of an acute disease or healing of an injury, or that may or may not be associated with an acute or chronic pathologic process that causes continuous or intermittent pain over months or years."

--- The Federation of State Medical Boards, 2004

- A 2011 Institute of Medicine report indicated that chronic pain affects at least 100 million American adults—more than those affected by heart disease, cancer, and diabetes combined.

--- Relieving Pain in American: A Blueprint for Transforming, Prevention, Care, Education, and Research, 2011: Institute of Medicine (IOM)
A 2009 Mayday Fund report noted that studies suggest chronic pain may affect 20 percent of all children. The Wisconsin Task Force on Pain Management defines chronic pain as persistent pain, which can be either continuous or recurrent and of sufficient duration and intensity to adversely affect a patient's well being, level of function, and quality of life.

"Healthcare providers, insurers, and the public need to understand that although pain is universal, it is experienced uniquely by each person, and care — which often requires a combination of therapies and coping techniques — must be tailored. Pain is more than a physical symptom and is not always resolved by curing the underlying condition. Persistent pain can cause changes in the nervous system and become a distinct chronic disease."

--Relieving Pain in American: A Blueprint for Transforming, Prevention, Care, Education, and Research, 2011: Institute of Medicine (IOM)

The International Association for the Study of Pain (IASP) called for recognition of chronic pain as different from acute pain, but early models of chronic pain were time based. Increased emphasis is now placed on the body's inability to re-establish homeostasis, stating that the nervous system may become damaged by the original injury in such a way as to be unable to restore itself to normal function. Changes in the central nervous system, secondary to injury may prolong and maintain pain after the expected period of healing.

"It is not the duration of pain that distinguishes acute from chronic pain, but more importantly, the inability of the body to restore its physiological function to normal homeostatic levels."


New paradigms in research identify chronic pain as Central Sensitivity syndromes with genetic and environmental factors. Instead of focusing on an original injury, it is believed that there may be a building up of factors which become triggered unrelated to an injury.

**Psychosocial Aspects of Chronic Pain**

- **Loss of vocational, recreational, and familial activities alter self-image**
  Chronic pain is distinct from acute pain in that there are long-term changes in quality of life, occupational activities, and self-image that may predispose patients to depression, persistent grief over these losses, and substance abuse problems.

- **Depression, post-traumatic stress disorder, grief, and other complicating factors**
  Mental health providers, including psychologists, psychiatrists, medical social workers, Psychiatric/Mental Health Nurse Practitioners, and counselors can help provide ongoing evaluations and support during chronic pain treatment.
• **Need for psychological evaluations and support**
  Clear communication between mental health providers and other care providers improves patient advocacy efforts and attention to psychological aspects of chronic pain. Cognitive behavioral treatment, biofeedback and mindfulness treatments can be incorporated in a patient’s treatment plan to encourage and support the patient’s self-management of chronic pain.

**Impact of Chronic Pain**

• **The economic and social impacts of chronic pain are thought to be greater than for any other single disease entity.**
  Chronic pain is a major public health problem because it affects millions of individuals, their families, and the healthcare system. Chronic pain negatively affects lifestyle, function, self-efficacy, independence and psychosocial well being. It also causes loss of meaningful occupation, may disrupt family, work, and social relationships.

  The economic impact of pain is significant. A 2011 Institute of Medicine report indicated chronic pain costs the nation up to $635 billion each year in medical treatment and lost productivity.

  "--Relieving Pain in American: A Blueprint for Transforming, Prevention, Care, Education, and Research, 2011: Institute of Medicine (IOM)"

**Inadequate Pain Treatment Can Lead To:**

• **Lost productivity**
• **Excessive healthcare expenditures**
• **Needless suffering**
• **Domestic and occupational problems**
• **Increased thoughts and risk of suicide**

**Fostering a Cultural Transformation:**

• “Pain represents a national challenge. A cultural transformation is necessary to better prevent, assess, treat, and understand pain of all types. Government agencies, healthcare providers, healthcare professional associations, educators, and public and private funders of health care should take the lead in this transformation. Patient advocacy groups also should engage their diverse constituencies. To reach the vast multitude of people with various types of pain, the nation must adopt a population-level prevention and management strategy.”

  "--Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research, 2011: Institute of Medicine"
Impact at End of Life

- **Pain in terminally ill individuals should always be adequately relieved.** Pain management in terminally ill individuals involves different concerns; keeping the patient comfortable and the family satisfied with pain control measures are primary goals. Withholding pain medications because of fears of overuse, physical dependency, or disciplinary concerns are inappropriate in this setting.

- **Other concerns that need to be addressed include:** patient fear of addiction; fear of sacrificing alertness for pain control; assumption that morphine is the “last ditch drug” reserved for the very end of life; and the need to address emotional, spiritual, and psychological issues (suffering) that may accompany pain and the end of life process.

### Pain Assessment

Accurate assessment of the type of pain will allow more accurate selection of appropriate medications and treatment. Pain may be multi-factorial and may require multiple interdisciplinary approaches to treatment.

Assessment of pain should include a focus on *the person in pain* and the impact of pain on a person’s present and future level of function, not just the pain. It may require the use of multidimensional assessment tools in evaluating pain.

“Pain results from a combination of biological, psychological and social factors and often requires comprehensive approaches to prevention and management.”

--- Relieving Pain in American: A Blueprint for Transforming, Prevention, Care, Education, and Research, 2011: Institute of Medicine (IOM)

The International Association for the Study of Pain (IASP) curriculum guidelines recommend that an assessment should:

- Recognize the difference between acute and chronic and the implications for the assessment and management of the patient.

- Account for the multi-dimensional nature of pain by including appropriate assessment measures for primary domains including sensory, affective, cognitive, physiological and behavioral.

- Recognize strengths and limitations of commonly used measures for different pain dimensions e.g. self report, physical performance measures such as Functional Capacity Evaluations, physiological/autonomic response measures, etc.

- Include modification of pain assessment strategies to match inherent variability associated with the patient’s clinical presentation.

- Assess individual factors, sociocultural characteristics of pain, clinical characteristics of pain, pain type and state, and vulnerable populations.

- Understand the need to refer to relevant health professionals as appropriate and in a timely manner.

- Assess impact on daily and quality of life.
• Utilize assessment appropriate to client’s communication problems related to age, language or physical or cognitive processing.

• Utilize behavioral and psychological measures of pain.

• Utilize standardized baseline and repeat measures of pain related to interference with function and quality of life.

• Include recognition of the importance of assessments which involve the limbic forebrain:
  o Emotions
  o Cognitive Aspects of pain

Pain Assessment should also include:

• A general history and physical exam to evaluate the individual’s general condition, musculoskeletal and neurologic systems and the site of pain.

• Evaluation of the individual’s self-report of pain and evaluation of the individual's behaviors or gestures suggestive of pain.

• Evaluation of subjective reported factors (location, onset/duration of pain, quality of pain with word descriptors, intensity of pain, variations/rhythms of pain, aggravating and alleviating factors of pain, associated symptoms, and potential pathology causation of pain).

• Evaluation of current therapeutic pain relief measures in use.

• A functional assessment that evaluates an individual’s prior level of function, pain-related changes or effect upon level of function, and impact on activities of daily living.

• A psychosocial assessment that evaluates impact of pain on quality of life, meaning of pain in relation to an individual's age, roles, skills and within the individual's cultural context or ethnicity. This evaluation should consider any history of: depression; psychopathology; sexual, physical or emotional abuse; chemical or alcohol dependency.

**Pain Management Goals**

• Pain reduction
• Improved functioning
• Improved quality of life

• Treatment goals should be SMART (Specific, Measurable, Achievable, Realistic, Time based).

• Appropriate consultations, referrals, diagnostic tests, accurate record keeping and documentation, treatment plan development in collaboration with the patient, and timely follow-up are the cornerstones of good pain management practices.

• If treatment goals are not easily achieved or the primary healthcare provider does not have adequate time to devote to pain management, consultation from, or referral to, a pain management specialist is in the patient’s best interest. An interdisciplinary approach is recommended and is required for optimal treatment. The primary healthcare provider may then continue to give the best continuity of overall care for the patient.
Key Concepts — Pain Management

- **Differentiation of acute and chronic pain**
  The Institute of Medicine recommends differentiation of acute and chronic pain and use of appropriate assessment tools. It also recommends that patient education should include lifestyle management: nutrition; appropriate exercise; stress management; sleep hygiene; evaluation of exposure to inflammatory agents; and review of ergonomic factors.

- **Considered routine part of medical practice**
  There are several key concepts regarding pain management that the OPMC believes are important. First, pain management should be considered a routine part of medical practice and be given the same attention and resources as other medical conditions.

- **Most care at primary care level**
  The OPMC believes that the majority of pain care should occur at the community level in the primary care setting utilizing the spectrum of other disciplines as indicated. Specialty evaluation and treatment should follow the same patterns established for other medical conditions.

- **Interdisciplinary approach**
  Often an interdisciplinary team approach is best, utilizing the expertise of physicians, nurses, physical therapists, chiropractors, acupuncturists, surgeons, naturopaths, psychologists, researchers, and pain centers as indicated by the clinical situation. Thus the OPMC advocates for a team approach using a combination of appropriate evidence-based practices that include pharmacologic, non-pharmacologic (such as cognitive behavioral therapy), surgical/procedural approaches, physical therapy and occupational therapy. Complementary and alternative approaches like acupuncture, chiropractic/osteopathic treatment, nutritional therapy and naturopathy have their place in the management of acute and chronic pain, depending on the needs and responses of the patient.

- **Vulnerable populations**
  The OPMC recognizes the potential for inadequate pain management in vulnerable populations such as children, the elderly, the cognitively impaired, individuals with prior or current substance abuse problems, and ethnic minorities. The OPMC emphasizes the need to protect such individuals by educating providers on proper pain assessment and treatment options.

  - Providers of pain management should be aware of common causes of pain within specific populations, be aware of behavioral signs of pain in those unable to communicate verbally, and be aware of medication and treatment guidelines specific to special populations. It is also important for providers to use assessment tools designed for use with special populations in order to overcome barriers to effective pain management.

- **Regulatory agencies, care providers, and patient advocates need to understand each other’s concerns in order to work together efficiently and appropriately towards the best interests of pain patients.**
  The OPMC acknowledges the challenges faced by regulatory agencies in protecting the public from abuse of controlled substances while simultaneously ensuring these same medications are available for appropriate use in treating pain.

  The OPMC recognizes that it will take concerted action from all stakeholders in order to accomplish the goals set forth in the Vision. The OPMC views each stakeholder as being part of the final solution. To facilitate positive progress, however, there needs to be
ongoing cooperation between regulatory agencies--such as state licensing boards, and pain advocate entities like the OPMC.

- **Policy clarification and education will foster improved pain management.** There is an urgent and basic need to provide ongoing education for healthcare providers on the policies that govern pain management and to clarify the Oregon Medical Board’s philosophy and intent on the use of opioids in treating pain. Effective provider education should help reduce or eliminate fears of regulatory scrutiny as a primary barrier to appropriate pain medication prescribing practices. It is also important for all healthcare professionals to be aware of the pain management philosophy of their licensing boards.

**Pharmacologic Options in Pain Management**

There are several pharmacologic options available for the prescribing physician when treating acute and chronic pain.

- Anti-inflammatory analgesics
- Opioid analgesics
- Antidepressant therapy
- Muscle relaxants
- Pain perception modifiers (e.g. anticonvulsants)

Ongoing medication evaluations to judge patient response, to adjust dosages, and to explore other options are keys to effective pain management.

**Appropriate Standards of Care for Use of Opioids in Pain Management**

- Providers should understand State and Federal Regulations.
- Providers should understand safe prescribing guidelines for treatment of pain/chronic pain.
- For patients with an inadequate functional response to low risk treatments, a trial of opioids can be pursued for those persons where the benefits may outweigh the risks.
- Providers should develop an opioid therapy treatment plan when using these medications.
- Providers should practice the “one prescriber or one practice” strategy of writing opioid prescriptions.
- Providers should use risk assessment tools and include an “Exit Strategy” in the treatment plan. For resources, see: [http://www.agencymeddirectors.wa.gov/Files/OpioidGdline.pdf](http://www.agencymeddirectors.wa.gov/Files/OpioidGdline.pdf)
- Providers should use random urine drug screens and pill counts in the treatment plan.
- Providers should refer clients to Addiction Medicine and Mental Health when warranted.
• Providers should utilize the Oregon Prescription Drug Monitoring Program (PDMP) to assess for aberrant behaviors.
  o The PDMP is a tool to help healthcare providers and pharmacists provide patients better care in managing their prescriptions.
  o Pharmacies submit prescription data to the PDMP system for all Schedules II, III and IV controlled substances dispensed to Oregon residents. The protected health information is collected and stored securely.
  o Only Oregon-licensed healthcare providers and pharmacists may be authorized for an account to access information from the PDMP system. By law, their access is limited to patients under their care.
  o The PDMP program was started to support the appropriate use of prescription drugs.
  o For more information, browse the website: http://www.orpdmp.com/

Tolerance, Physical Dependence, Addiction

• Distinct definitions
  The confusion and misconceptions of tolerance, physical dependence, and addiction contribute to the problem of poor pain management. The American Pain Society and American Academy of Pain Medicine have defined these terms and advocated for their use so that providers understand the distinctions between the terms.

Tolerance

"...is a state of adaptation in which exposure to a drug induces changes that result in a diminution of one or more of the drug's effects over time."

-- American Academy of Pain Medicine, American Pain Society, American Society of Addiction Medicine, 2001

• The American Academy of Pain Medicine (AAPM), the American Pain Society (APS), and the American Society of Addiction Medicine (ASAM) define tolerance as "a loss of drug effectiveness due to physical adaptation over a period of use."

• Significant tolerance to opioids can develop rapidly during sustained or prolonged analgesic treatment and should be accounted for in the dosing and prescribing process. Adjustment of opioid doses for tolerance for pain management at end of life is appropriate if consistent with the patient's goals. Whether adjusting opioid doses for tolerance for chronic pain is an effective and safe strategy is unclear.

Physical Dependence

"...is a state of adaptation that is manifested by a drug class specific withdrawal syndrome that can be produced by abrupt cessation, rapid dose reduction, decreasing blood level of the drug and/or administration of an antagonist."

-- American Academy of Pain Medicine, American Pain Society, American Society of Addiction Medicine, 2001
Physical dependence is not addiction. A withdrawal syndrome is to be expected after prolonged opioid therapy if there is sudden severe dose reduction or treatment cessation. The presence of a physical withdrawal syndrome does not in itself establish the diagnosis of addiction.

**Addiction**

“Addiction is a primary, chronic disease of brain reward, motivation, memory and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors.

Addiction is characterized by:

- Inability to consistently Abstain
- Impairment in Behavioral control
- Craving; or increased “hunger” for drugs or rewarding experiences
- Diminished recognition of significant problems with one’s behaviors and interpersonal relationships
- A dysfunctional Emotional response

Like other chronic diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death.”

--American Society of Addiction Medicine, 2011

**Universal Precautions in Pain Medicine**

The 10 steps of universal precautions in pain medicine include the following:

- Make a diagnosis with appropriate differential:
  - Identify treatable causes for pain and direct therapy to the pain generator.
  - In the absence of specific findings, treat symptoms.
  - Address co-morbid conditions, including substance abuse and psychiatric disorders.

- Psychological assessment including risk of addictive disorders:
  - Inquiry into personal and family history of substance abuse should not diminish a patient’s complaint of pain.
  - Perform patient-centered urine drug testing.

- Informed consent:
  - Discuss the proposed treatment plan including benefits, risks, and tolerance, dependence, and addiction at the patient’s level of understanding.

- Treatment agreement:
  - Expectations and obligations of patient and clinician should be understood.
  - Agreement plus consent forms the basis of the therapeutic trial.

- Pre- and post-intervention assessment of pain level and function:
  - Used to assess the success of medication and support continuation of therapy.

- Appropriate trial of opioid therapy with or without adjunctive medication:
Pharmacologic regimens should be individualized and based on clinical findings.

- Reassessment of pain score and level of function:
  - Regular assessment documents rationale to continue or modify treatment.

- Regularly assess the “Four A’s” of pain medicine:
  - Analgesia, activity, adverse effects, and aberrant behavior.

- Periodically review pain diagnosis and comorbid conditions, including addictive disorders:
  - Treatment for each condition must be coordinated for positive outcomes.

- Documentation:
  - Complete recording of the initial evaluation and follow-up sessions, combined with an appropriate physician/patient relationship, reduces medico-legal exposure and risk of regulatory sanction.


### Interventional Pain Management Options

- **Nerve blocks**
- **Implanted nerve stimulators**
- **Intra-spinal delivery systems**
- **Neuroablative procedures**

Healthcare providers may utilize a number of non-pharmacologic interventions to reduce pain, including nerve ablations or blocks and other procedures designed to interrupt or reduce the pain signals.

Interventional treatments can be utilized with pharmacologic and other treatments and may help reduce medication use and side effects. The more invasive interventional procedures (stimulators, pumps) require a high level of scrutiny to identify individuals who may benefit. Indiscriminate use of these modalities frequently results in poor outcomes.

### The Role of Medicinal Cannabinoids in Oregon Pain Management

Cannabinoids form a system in parallel with that of the endogenous opioids (endorphins/enkephalins) in modulating pain.

- New randomized, controlled trial results are beginning to suggest a role for marijuana in neuropathic pain. -- Abrams, UCSF, 2007; Meng, UCSF, 2007; Papanastassiou, UCSD, 2007
- Marijuana has been smoked for its medicinal properties for centuries. Preclinical, clinical, and anecdotal reports suggest numerous potential medical uses for marijuana. Although the indications for some conditions (e.g., HIV wasting and chemotherapy-induced nausea and vomiting) have been well documented, less information is available about other potential medical uses. Additional research is needed to clarify marijuana's therapeutic properties and determine standard and optimal doses and routes of delivery.

Unfortunately, research expansion has been hindered by a complicated federal approval process, limited availability of research-grade marijuana, and the debate over legalization. Marijuana’s categorization as a Schedule I controlled substance raises significant concerns for researchers, physicians, and patients. --American College of Physicians. Supporting Research into the Therapeutic Role of Marijuana. Philadelphia: American College of Physicians; 2008: Position Paper.

http://www.acponline.org/advocacy/where_we_stand/other_issues/medmarijuana.pdf
Oregon Medical Marijuana Act

Passed as Ballot Initiative in November 1998

- Mandates the Department of Human Services registration system. See: http://public.health.oregon.gov/DiseasesConditions/ChronicDisease/medicalmarijuanaprogram/Pages/index.aspx
- Provides legal protection for qualified patients (includes severe pain, persistent muscle spasms, cancer, etc.).
- Requires MD written statement listing a qualifying condition. Chart notes must state: “Medical marijuana may mitigate the condition or symptoms of that condition.”
- All attending physician documentation must be signed and dated by an MD or DO licensed to practice medicine in the state of Oregon.
- Physician documentation must have been signed and dated within 90 days of Oregon Medical Marijuana Program receipt.
- Applications are renewed annually.

The OPMC recognizes the benefit of medicinal marijuana and encourages continued dialogue and research for improved patient outcomes. See OPMC Position Statement on medical marijuana use: http://www.oregon.gov/oha/OHPR/pmc/docs/mmpositionstatement.pdf

The OPMC encourages providers to check with the Oregon Medical Board or the provider’s appropriate licensing board to review the board’s position on medical marijuana use.

Pain Management Team

Each member of the pain treatment team understands the anatomical and physiological basis of pain perception, the psychological factors that modify the pain experience, and the basic principles of pain management. Each team member should also understand modifiable lifestyle factors, self-management techniques and refer patients to appropriate disciplines.

- Effective management of severe and/or chronic pain usually involves more than one healthcare provider over the course of treatment, and clear communication between these providers is extremely important.
- The individual with pain is educated by pain management staff so that the patient can participate as fully as possible in decision making and in self-management of pain.
- All team members need to be advised of any changes or developments by the involved specialists and other providers.
- Family members may be part of the pain management team in the administration of medication and other aspects of pain care. Strict adherence to HIPAA privacy policies and other ethical boundaries and risks, including the risks of medication diversion, should be kept in mind when involving family members.
Modifiable Life Factors that Affect Each Other and Pain

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<td>Function and Occupation</td>
<td>Cognition/Attention</td>
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<td>Neuroplasticity</td>
<td>Happiness/Enjoyment</td>
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<td>Strength/Endurance</td>
<td>Self Efficacy/meaning/Purpose</td>
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<tr>
<td>Mobility</td>
<td>Sense of Safety/Sense of Place</td>
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<td>Sleep/Rest/Fatigue</td>
<td>Self Image/Shame</td>
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<td>Appetite/Digestion</td>
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Social Factors

- Caregiver Burden
- Roles and Responsibilities
- Social Support/Isolation
- Transportation

Spiritual Factors

- Suffering
- Meaning of Pain
- Faith/Religiosity
- Hope/Despair

Primary Care Management

- **Primary care providers are often the most appropriate leader of the pain treatment team.**
  The primary care provider is a key part of any pain treatment team. Much of the treatment of chronic pain can and should, with adequate resources, occur in the primary care setting.

- **Gatekeepers need to be involved and notified of treatment/condition changes.**
  Primary care providers are often held accountable financially and otherwise for referrals, pharmacy costs, specialty care and other aspects in the continuum of care, and as such, need to be advised of any changes or developments by the involved specialists and ancillary care providers as much as possible.

- Collaborative care models of chronic pain where the primary care clinician works collaboratively with behavioral specialists can result in improved outcomes for chronic pain management.
  --Steve Dobscha, et al, Collaborative Care for chronic pain in primary care: a cluster randomized trial, JAMA 2009; 301 (12): 1242-1252

- The Institute of Medicine, the World Health Organization, and the IASP recommend referral of all chronic pain patients to a lifestyle health educator. They also recommend that physicians follow the model used for other chronic disease states such as diabetes, heart conditions and arthritis.
Pain Management Specialists

Specialize in the diagnosis and treatment of the entire range of painful disorders. Because of the vast scope of the field, pain management is an inter-disciplinary subspecialty. The expertise of several disciplines is brought together in an effort to provide the maximum benefit to each patient.

- While healthcare providers from a wide variety of specialties may be called upon to treat acute or chronic pain, appropriate pain management is such an involved science that it is often considered a subspecialty.
- Pain management specialists provide a consultation and referral resource for all healthcare providers who are having difficulty achieving the desired pain control or who need advice on a particular patient.

Nurses and Pain Management

- **Nurses are the members of the multidisciplinary team who spend the most time with the patient.** *(McCaffery et al., 2000)*
- **The nurse's role involves patient education, pain assessment, analgesic interventions, assessment of the patient's response to pain management interventions, documentation and patient advocacy.** *(Campbell et al., 2006)*
- Nurses are involved in pharmacologic treatment, exploring side-effect experiences and effectiveness of pain relief from analgesia and communicating this information to other team members.
- Nurses assist with interventional techniques by preparing patients physically and emotionally, and assuring comfort and safety.
- Nurses frequently utilize non-drug interventions to improve coping and reduce focus on pain, such as ice, heat, massage, distraction, music, and imagery.
- Nurses are frequently the “front line” educators of patients, assuring that individuals understand the treatment and care they receive and how individuals can best participate in self-management of pain. Nurses are the “advocates” for patients and families navigating the complex and confusing details of their pain management plan.
- Nurses are increasingly found in a variety of roles and settings with the common goal of improving pain management practices and relieving the suffering of people with pain.
- Nurse practitioners and some clinical nurse specialists are able to assess and treat pain and prescribe all pain medicines including Controlled Substances.
Dentists and Pain Management

- The multidimensional nature of orofacial pain requires an interdisciplinary approach to assessment and management. All healthcare professionals need to serve as advocates for the person in pain and ensure that pain management is based on evidence-based standards and guidelines and ethical principles.

- Traditionally, dentistry has focused on the prevention, diagnosis and management of intraoral and orofacial pain.

- Dentists need to be knowledgeable about (orofacial) pain mechanisms, the epidemiology of pain, barriers to effective pain control, the variety of orofacial pain conditions, and variables which influence the patients' perception of and response to pain. They should be trained to apply valid and reliable methods of clinical pain assessment and to adequately master the range of available methods for the alleviation of orofacial pain.
  -- International Association for the Study of Pain, 2012

- Patients presenting to a dentist with pain most commonly complain of a tooth or teeth as the cause, but oral pain may originate in any orofacial tissue or structure including surrounding mucosa, periodontium, bone, muscles, blood vessels, lymph nodes, paranasal sinuses, salivary glands, or temporomandibular joints.

- Most oral pain is acute in nature and the best management strategy is urgent referral and definitive treatment of the source.

- When definitive treatment of the pain source is delayed or the patient suffers chronic or post-operative pain, analgesic and/or anti-inflammatory drugs to reduce or eliminate the sensation of pain may be indicated.

- Clinical studies have shown that non-steroidal anti-inflammatory drugs (NSAIDs) are effective for reducing acute dental pain and inflammation and are generally regarded as the analgesics of first choice in dentistry. Opioids may be indicated in cases of moderate to severe pain but should be considered as adjunctive analgesics. (Hargreaves, et al, 2005)

- When prescribing opioids for management of patients with acute or chronic pain, dentists should be aware of their role and responsibility for preventing prescription opioid abuse. According to data from the Office of Drug Safety, Food and Drug Administration, dentists prescribe twelve percent of immediate-release opioids, second only to family physicians. (Denisco, et al, 2011)

- The American Dental Association (ADA) Statement on the Use of Opioids in the Treatment of Dental Pain includes the following guidance for practicing dentists:
  - The ADA encourages continuing education about the appropriate use of opioid pain medications in order to promote both responsible prescribing practices and limit instances of abuse and diversion.
  - Dentists who prescribe opioids for treatment of dental pain are encouraged to be mindful of and have respect for their inherent abuse potential.
  - Dentists who prescribe opioids for treatment of dental pain are also encouraged to periodically review their compliance with Drug Enforcement Administration recommendations and regulations.
Dentists are encouraged to recognize their responsibility for ensuring that prescription pain medications are available to the patients who need them, for preventing these drugs from becoming a source of harm or abuse and for understanding the special issues in pain management for patients already opiate dependent.

- Dentists may also be involved in the treatment of patients with a variety of chronic pain conditions. These patients may present with orofacial pain symptoms and have other complications or be on medications that will have implications for their oral health and dental management. Consultation and co-management with the patient's primary care provider or pain management specialist may be appropriate to achieve the best outcomes.

**Non-Pharmacologic Pain Treatment Options**

- **Physical therapy, Occupational therapy, massage, body/energy work**
- **Acupuncture**
- **Chiropractic, Naturopathic care**
- **Prolotherapy**
- **Behavioral medicine, mental health treatment, biofeedback**
- **Lifestyle health and wellness educators**
- **Transcutaneous Electrical Nerve Stimulation (TENS) Units**
- **Laser**
- **Heat and Cold Application**
- **Hydrotherapy**
- **Personal trainers**

Ancillary or adjuvant treatment options for chronic pain can generally be used concomitantly with other medical therapy and are considered first line therapies due to the assumption these are lower risk treatments than pharmacologic and interventional treatments.

- Nurses and case managers may also be an integral and important part of an effective acute or chronic pain treatment team.

**Physical Therapy**

Physical therapists apply the latest research to help people get back in motion. Physical therapists receive a graduate degree—either a masters or a clinical doctorate—from an accredited physical therapist education program.

As a member of the pain management team, the physical therapist examines the musculoskeletal and neuromuscular systems' causes of pain and implements a plan of care based on his/her evaluation, which includes:

- Training the individual in proper posture and movement patterns for everyday life which often requires ergonomic modifications to the environment.
- Use of manual therapy, exercise, and thermal or electrical modalities to reduce pain, inflammation, limitations of mobility, and promote efficient body mechanics.
• Neuromuscular reeducation, coordination, balance training, strengthening and flexibility exercises to develop skills to help the individual progress to an independent and active life and prevent recurrence of pain and limitation.

• Recognition of fear avoidance behavior and the need for multidisciplinary intervention as part of a treatment program that addresses these barriers for individuals with chronic pain.

Physical therapists also provide public education on how to avoid pain and disability throughout one’s life span through habits of good posture and body mechanics, safety of exercise regimens, and healthy activity choices.

Physical Therapy and Other Body Work

• PT and OT are widely available.
• Massage therapy can help relax muscles and reduce pain perception.
• Energy healing and other body work techniques, including Pilates, yoga, etc. may be helpful.

• Physical therapists are widely used and available for addressing pain with hands-on-techniques and for instructing patients in establishing a home exercise program (HEP).
• Occupational therapy helps people function at the highest possible level, concentrating on what's important to them to rebuild their health, independence and self-esteem.
• Licensed massage practitioners are trained in soft-tissue manipulation for muscle/fascial release. Myofascial trigger point and other techniques have been shown to be effective for pain reduction in certain conditions.
• Energy healing and instructions in self-disciplines such as Pilates and yoga can improve general sense of well being and induce needed relaxation responses in chronic pain patients.

Exercise Physiologists

Clinical Exercise Physiologists (CEPs) are trained healthcare professionals who work in a variety of clinical and non-clinical settings.

• They are trained to use principles of exercise science to rehabilitate, maintain and enhance physical performance, fitness, health, functional ability and quality of life.
• They are trained in exercise assessment, training and rehabilitation, lifestyle management services, education and support to individuals with cardiovascular and pulmonary disease, osteoporosis, diabetes, pain, and a variety of other health problems.
• These services are typically delivered in cardiovascular/pulmonary rehabilitation programs and wellness programs at hospitals, physicians’ offices, private clinics and/or medical fitness centers.
• CEPs are competent to provide exercise-related consulting for research, public health, and other clinical and non-clinical services and programs.
Occupational Therapy

Occupational Therapists work with people with chronic pain to help them learn to manage the physical and psychological effects of pain and to lead more active and productive lives.

Occupational therapists:

- Identify specific activities or behaviors that aggravate pain and suggest alternatives.
- Teach methods for decreasing the frequency and duration of painful episodes.
- Implement therapy interventions that may decrease dependence on or use of pain medications.
- Facilitate the development of better function for daily activities at work and home.
- Collaborate with the client's team of healthcare professionals to determine the best course of treatment and intervention.
- Recommend and teach the client how to use adaptive equipment to decrease pain while performing tasks of daily living.

Massage Therapy and Other Body Work

- **Massage therapy can help relieve direct and referred pain and reduce pain perception.**
- **Energy healing and other body work techniques may be helpful.**

- Licensed massage therapists are trained in soft-tissue manipulation for therapeutic purposes. Myofascial trigger point massage and other techniques have been shown to be effective for pain reduction in certain conditions.
- Myofascial massage can help both direct and referred pain by relaxing muscles, easing soft tissue compression to relieve nerve entrapment, and reducing neuromuscular tension, all of which can reduce pain perception.
- Relaxation massage is also therapeutic. This type of massage can utilize aromatherapy, music therapy, and soothing techniques while manipulating soft tissue or working with energy. It can restore mind-body balance and activate the parasympathetic relaxation response which can reduce the perception of pain.

Acupuncture

- **Acupuncture has been demonstrated in clinical trials to be effective in treating acute and chronic pain with wide ranges of etiology.**
- **Acupuncture treats a wide variety of pain types with low incidence of adverse effects, as well as treating the causes of pain.**
- **It may be used in conjunction with pain medications and other treatments.**
  

- The National Institutes of Health has stated that acupuncture is effective in treating pain. *(NIH Consensus Statement, Vol. 15, #5, 1997)*
Acupuncture treatments are widely used in Oregon, and licensed acupuncturists have strict licensing requirements and board oversight on quality of care. Many hospitals now have licensed acupuncturists on staff.

Many insurance providers cover acupuncture for pain treatment. Oregon law makes acupuncture treatment the right of any insured individual who has been in a motor vehicle accident.

Under Oregon law, the practice of acupuncture also includes traditional and modern techniques of Oriental diagnosis and evaluation, Oriental massage, exercise and related therapeutic methods, use of Oriental herbs, vitamins, minerals, and dietary advice.

Chiropractic and Naturopathic Care

- Chiropractor adjustments may aid in musculoskeletal mobilization to reduce pain and improve function.
- Naturopathic physicians address pain with a holistic approach that includes botanicals, nutrition, and nutraceutical supplements.
- Chiropractic and naturopathic physicians have their own licensing boards, requirements and regulatory oversight. Chiropractic manipulation may be helpful in addressing chronic or acute postural or other musculoskeletal problems.
- Naturopathic medicine utilizes a variety of nutritional and botanical approaches to improve overall patient health and treat the source of pain.

Chiropractic Patient Care in Oregon

Chiropractic is an established modality for acute and chronic spinal pain and chronic headache

--- Bigos, AHCPR Publication No. 95-0642 1994; Giles, Spine 2003; Evans, Spine 2003

A Doctor of Chiropractic (D.C.) makes a differential diagnosis with information gathered during a physical examination. The chiropractic physician may order lab tests, radiological studies such as MRI, along with specialized diagnostic methods to identify etiologies and lifestyles which contribute to spinal subluxation, poor health, and chronic pain. (Etiologies identified may include drug reactions, alcohol abuse, type II diabetes, degenerative discopathy, COPD, autoimmune disease, and other systemic conditions.)

Chiropractic patients may receive spinal adjustments and/or alternative drugless therapies that assist the innate capabilities of the body to relieve pain, restore health and prevent disease:

- therapeutic & postural exercises
- OTC nutrition & herbs
- energetic mind/body techniques
- physiotherapy modalities
- biofeedback & relaxation training
- microcurrent & TENS

Oregon law permits chiropractors to write orders for a physical therapist or for referral to a medical specialist.
Naturopathic Care

- **Naturopathic physicians address pain with a holistic orientation that includes botanical medicine, dietary therapy, nutraceuticals, mind/body medicine, and pharmacological approaches as appropriate.**
- **Naturopathic medicine proposes that there is a natural healing power in the body that when activated establishes, maintains and restores health.**
- Naturopathic physicians have their own licensing board, requirements and regulatory oversight.
- Naturopathic medicine utilizes a variety of nutritional, botanical, and physical approaches to improve overall patient health and treat the source of pain.
- Practitioners work toward a goal of supporting healing power through nutrition, lifestyle counseling, dietary supplements, medicinal plants, rehabilitative exercise, homeopathy, injection therapy and physical medicine.

Behavioral Medicine

- **Addresses the psychological aspects of pain.**
- **Identifies disorders that contribute to pain and undermine treatment.**
- Psychologists, psychiatrists, individuals with a Masters Degree in Social Work (MSWs), and other mental health therapists may be effective and often indispensable parts of the pain treatment team.
- Behavioral medicine providers can assist in identifying and treating aspects of the patient's condition that may be difficult to detect without extensive one-on-one interviews and interaction. This includes conditions such as depression or unresolved grief.
- Psychiatric and personality disorders and addictions, which can complicate the evaluation and treatment of pain, can be properly identified and addressed by mental health specialists.

Other Useful Techniques/Therapy

<table>
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<tr>
<th>Alexander's technique</th>
<th>Meditation</th>
<th>Reiki</th>
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<tr>
<td>Aromatherapy</td>
<td>Mind-body techniques</td>
<td>Rolfing</td>
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<tr>
<td>Biofeedback</td>
<td>Movement therapy</td>
<td>Tai-Chi</td>
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<td>Craniosacral work</td>
<td>Music therapy</td>
<td>Trager approach</td>
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<td>Energy work</td>
<td>Myofascial work</td>
<td>Visualization</td>
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<tr>
<td>Feldenkrais method</td>
<td>Pilates</td>
<td>Yoga</td>
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<td>Guided imagery</td>
<td>Qi-gong</td>
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- A variety of other techniques can be useful in reducing pain, inducing relaxation response, improving function, general sense of well-being and overall quality of life for people with chronic pain.
Healthcare Professional Pain Management Issues

- **Negative attitudes and erroneous beliefs**
  Negative attitudes, beliefs, and behaviors of clinicians towards patients with pain and pain management in general can contribute to the under-treatment or mistreatment of pain.

- **Lack of knowledge and proper training**
  Investigators from the Johns Hopkins University Pain Curriculum Development Team examined curricula at 117 medical schools in the United States and Canada during 2009 and 2010. The authors performed a systemic review analyzing curricular emphasis on topics such as pediatric and geriatric pain, neuropathic pain, cancer pain, pain neurobiology and pharmacological pain management.

  The authors concluded: “Taken as a whole, these data bring to light glaring discrepancies between the prevalence of pain in society and the time dedicated to educating future physicians about pain in medical school. Given that the twin dangers of pain undertreatment and the abuse of pain-active medications are among our society’s deepest public health concerns, pain medicine does not receive the attention that it deserves in medical education. There are inarguable links between the undertreatment and the maltreatment of pain and the lackluster state of pain education in pain medicine. It is likely that unless opinion leaders and the next generation of physicians become aware both of the importance of conscientious pain management and the dangerous deficits in pain education, the crisis in pain care and resultant deaths from opioid abuse will only spiral upwards. A more organized and formal delivery of pain education is likely to be a principal catalyst in the sea change required to rectify the current shortcomings of pain care.”

Healthcare Professional Communication with Clients and Other Providers

- Active communication is required with all professionals caring for the client, including the exchange of past and current medical records.

- Communication should emphasize the development of a partnership where decreased pain and improved function are valued by the client and the physician.

- Communication should emphasize written protocols and procedures for clear understanding and continuity of care.

- Material Risk Notices and Pain Agreements—formally known as “pain contracts”—should be used for clear understanding and for continuity of care.

- All interactions should emphasize appropriate and professional boundaries between clinicians, staff and the client.

- Interactions should be based on direct and truthful communication.

- Good listening and interviewing skills should be developed and practiced in communication.
• Physicians should not be coerced into providing analgesics they do not believe are helping the client.

• Physicians should not fear repercussions to their professional licenses for developing individualized treatment plans, including the use of medications.

**Healthcare Professional Ethical Obligations**

• Healthcare professionals must understand the importance of individual cultures, basic human rights, and do a constant review of current practices.

• Professionals have a duty to prevent harm (nonmalficence), to be aware of pain risk for injury to dignity and self efficacy and to understand principles of “justice for all” in pain prevention, assessment, and treatment.

• Professionals should be aware of physical, bureaucratic, psychological, informational, political, and economic power of professionals over clients and families and determine if behaviors, concepts, and treatment recommendations are favorable to needs of clients, families, or clinicians.

• Professionals must understand the moral importance of informed consent in clinical treatment and research.

• Professionals must be aware of techniques to involve clients and family in the pain assessment and treatment process.

**Psychosocial Barriers**

• **Poor clinician-patient communication**  
  Patient characteristics, such as age, gender, language, cognitive abilities, ethnicity, coexisting physical or psychological illness, and cultural traditions can all serve as potential barriers to effective pain management.

• **Reluctance to report pain**  
  Patients may be reluctant to report pain to their provider because of low expectations of obtaining relief, stoicism, fears, or concerns about what the pain may mean (such as worsening illness), side effects, or addiction.

• **Financial barriers--lack of insurance, cost of medications**  
  Other factors contributing to the under treatment of pain are a lack of health insurance coverage and the high costs of medications. Both of these may result in the patient not reporting pain or not complying with a treatment plan.

  All of these factors can negatively impact the provision of pain management by making provider-patient communication problematic and by limiting the reporting of pain and/or utilization of appropriate services.

  --*The Joint Commission, 2001*
Federal-Controlled Substance Act

- USC § 801(1) and USC § 130.04(a)
- Outlines essential and legitimate medical purpose of controlled substances
- Does not delineate selection or quantity prescribed
- Does not address provider’s medical judgment

-- Good, 1998

- The Controlled Substance Act (CSA) outlines the essential and legitimate medical purpose of controlled substances and their role in maintaining the health and general welfare of the public.
- The CSA does not address medical treatment issues such as the specific selection of controlled substances, the quantity prescribed, or the appropriateness of the provider’s medical judgment.

Oregon's Pain Management Acts and Policies

- 1995: Oregon Medical Board’s (OMB) Statement of Philosophy
  In 1995, the OMB released a statement of philosophy on pain management in acute conditions as well as terminal illness: Use effective pain control for all patients... the standard of care allows neither under-treatment nor overtreatment.
  -- Oregon Medical Board, 1995

- 1997: SB 1071
  In 1997, Oregon Senate Bill 1071 established the Pain and Symptom Management Task Force. The Task Force studied the problem and made recommendations focused on:

  - the problems Oregonians faced in obtaining relief from pain
  - the nature of pain and symptom management practices, and
  - resources and remedies available for pain and symptom management

Oregon Medical Board Revisions of Statement of Philosophy

1999 — the OMB urged the use of effective pain control for all patients, good medical record keeping, legitimate prescribing and dispensing (no false prescriptions), as well as recommending a Material Risk Notice (pain management contract between physician and patient) and a narcotics agreement (patient agrees to use one doctor and one pharmacy).

2003 — OMB eliminated the requirement for evaluation by a specialist prior to treatment with opioids, but still recommended a second opinion as part of good medical practice.


2013 — OMB amended its Pain Management Statement of Philosophy. The OMB discussed Pain Management in terms of acute pain, chronic pain and in terminal illness. For chronic pain management, the OMB stated: “Pain management must be evidence-based and individualized to the patient. Oregon statute protects providers from disciplinary action by the Board when prescribing or administering controlled substances as part of a treatment plan for pain with the goal of controlling the patient’s pain for the duration of the pain. However, prescribing controlled substances without a legitimate medical purpose is prohibited.”

National Organizations Positions and Purposes

- **The Joint Commission**
  At the organizational level, the Joint Commission (JC) states that patients may experience pain and unrelieved pain has adverse physical and psychological effects.
  
  JC also supports the right of patients to pain management. By doing so, the JC mandates that accredited organizations must ensure that pain is recognized and addressed appropriately by assessing for pain, educating all relevant providers about assessing and managing pain, and educating patients and families, when appropriate, about their roles in managing pain and the potential limitations and side effects of pain treatments.

- **American Pain Society**
  The American Pain Society's stated goals are to advance the treatment of people in pain by ensuring access to treatment, removing regulatory barriers, and educating practitioners and policy makers in all settings about advances and economics of effective pain treatment. [http://www.americanpainsociety.org/](http://www.americanpainsociety.org/)

- **American Academy of Pain Medicine**
  The American Academy of Pain Medicine (AAPM) is a medical society representing physicians practicing in the field of Pain Medicine. The Academy is involved in education, training, advocacy, and research in the specialty of Pain Medicine. ([http://www.painmed.org/](http://www.painmed.org/))

Conclusion

**The Oregon Pain Management Commission advocates for the following:**

- Promote collaborative models of pain management between primary care clinicians and sources of pain treatment expertise.

- Promote services to assist clients with self-management of chronic pain with community programs such as “Living Well with Chronic Conditions,” etc. [http://public.health.oregon.gov/DiseasesConditions/ChronicDisease/livingwell/Pages/Index.aspx](http://public.health.oregon.gov/DiseasesConditions/ChronicDisease/livingwell/Pages/Index.aspx)

- Identify barriers to non-pharmacologic treatments for chronic pain that promote a bio-psycho-social treatment approach to chronic pain with the goal of improved patient well-being and self-management of pain.

- Promote the use of and reimbursement for non-pharmacologic multi-modality interdisciplinary services for chronic pain.
Recommendations

- **Interdisciplinary Treatment**
- **Discussions on opioid analgesics**
- **Mobilization of all stakeholders**
- **Prioritization of pain management**
- **Formal pain curriculum**

An interdisciplinary approach is recommended and is required for optimal pain management. Encourage discussions/forums on the use of opioid analgesics in treating pain. Continued efforts to address misuse, abuse and diversion of controlled substances without interfering with appropriate medical use should be supported. The advocacy of the judicious use of opioid analgesics in treating pain must be consistent with the state of clinical experience, scientific knowledge and professional consensus.

It is important to mobilize all stakeholders involved in pain management. This includes the providers, the patients, the regulatory agencies, and the policymakers. Without mobilization of all concerned parties, pain management advocacy efforts will be limited.

There should be a prioritization of pain management within each healthcare discipline. Each licensing board should address pain management as an important issue and in doing so collaborate with the OPMC in designing education guidelines for all providers throughout Oregon.

Advocacy efforts should continue to strive for obtaining a pain specific curriculum in medical schools and other healthcare provider training programs.

**Thank you!**

Thank you for your time in learning more about pain management in Oregon, the barriers to providing care, and what is needed to ensure that all Oregonians have access to the best possible pain treatment available to them.

[Continue to registration page]

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