

## COMMENTARY

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# Universal Precautions in Pain Medicine: A Rational Approach to the Treatment of Chronic Pain

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### ABSTRACT

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The heightened interest in pain management is making the need for appropriate boundary setting within the clinician–patient relationship even more apparent. Unfortunately, it is impossible to determine before hand, with any degree of certainty, who will become problematic users of prescription medications. With this in mind, a parallel is drawn between the chronic pain management paradigm and our past experience with problems identifying the “at-risk” individuals from an infectious disease model.

By recognizing the need to carefully assess all patients, in a biopsychosocial model, including past and present aberrant behaviors when they exist, and by applying careful and reasonably set limits in the clinician–patient relationship, it is possible to triage chronic pain patients into three categories according to risk.

This article describes a “universal precautions” approach to the assessment and ongoing management of the chronic pain patient and offers a triage scheme for estimating risk that includes recommendations for management and referral. By taking a thorough and respectful approach to patient assessment and management within chronic pain treatment, stigma can be reduced, patient care improved, and overall risk contained.

*Key Words.* Pain; Addiction; Universal Precautions; Prescription; Abuse; Misuse; Urine Drug Testing

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### Introduction

The term “universal precautions” as it applies to infectious disease came out of the realization that it was impossible for a health care professional to reliably assess risk of infectivity during an initial assessment of a patient [1,2]. Lifestyle,

past history, and even aberrant behavior defined as noncompliance with an agreed upon treatment plan were unreliable indicators that led to patient stigmatization and increased health care professional risk. It was only after research into the prevalence of such diseases as hepatitis B, hepatitis C, and HIV that we realized that the safest and most reasonable approach to take was to apply an appropriate minimum level of precaution to *all* patients to reduce the risk of transmission of potentially life-threatening infectious disease to health care professionals. Fear was replaced by

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knowledge, and with knowledge came the practice we know as universal precautions in infectious disease.

Because the fear of addiction is one of the barriers to opioid pain management, the result can be under- or nontreatment of moderate to severe pain [3]. Unfortunately, there are no signs pathognomonic of substance use disorders. Addiction is a “brain disease” [4] in which the diagnosis is most often made prospectively over time by monitoring the patient’s behavior and the ability to stay within a mutually agreed upon treatment plan. In view of the fact there is no definite test or physical sign that will predict which patient will do well on a therapeutic trial of opioids for pain, it makes sense to take a universal precautions approach to all pain patients, especially those who are considered for a therapeutic trial of opioids, to improve their quality of life. In order to assist health care professionals to meet the challenge of chronic pain management, we propose adopting a minimum level of care applicable to all patients presenting with chronic pain.

Pain is a common complaint presenting to the clinicians office and is an enormous public health problem [5,6]. Approximately 50–70 million people in the United States are undertreated or not treated for painful conditions [7]. Currently available data suggest that 3–16% of the American population have addictive disorders [8]. Therefore, based on these statistics, as many as 5–7 million patients with the disease of addiction also have pain. In fact, when studying pain in certain subsets of the general population, the incidence may be considerably greater as has been found in the Methadone Maintenance Treatment population [9]. The goal of pain treatment is to decrease pain and improve function while monitoring for any adverse side effects [10]. If this goal is not achieved by non-opioid and adjunctive analgesics, opioids may be indicated.

However, drug addiction is a chronic relapsing disorder that involves multiple factors. The most common triggers for relapse are states of stress; drug availability; and re-exposure to environmental cues (sight, sounds, smells) previously associated with taking drugs [11]. Inadequate treatment or no treatment of pain is a powerful stressor and consequently may trigger relapse to addiction. It stands to reason that if the patient is in recovery and the pain is undertreated or not treated at all, they may turn to the street for licit or illicit drugs, or may use legal drugs such as alcohol to numb the pain.

### **Pain and Addiction Continuum**

Emerging research is helping to place pain and addictive disorders on a continuum rather than on the traditional dichotomy of recent years [12–15]. It is clear to a growing number of clinicians that pain patients can, and sometimes do have concurrent addictive disorders that decidedly complicate the management of an already challenging patient population [16–19]. It is possible for pain and addiction to exist as comorbid conditions such as the case of the alcoholic with peripheral neuropathic pain. However, the chronic pain patient who suffers from the disease of opioid addiction may be somewhat different. In this situation, the opioids used to treat the chronic pain may be identified as either “the problem,” “the solution,” or a mix of both depending upon the frame of reference used (Addiction Medicine, Pain Management, or Pain and Chemical Dependency Specialties).

For example, with careful monitoring and tightly set limits, the patient recovering from the disease of opioid addiction may, quite appropriately, be prescribed an opioid class of medication for the treatment of either acute or even chronic pain [20,21]. As long as this therapeutic regimen is “doing more for the patient than to the patient,” that is, improving rather than worsening their quality of life, one can say that the balance between pain and addiction is positive. In this context, a continuum rather than a comorbid model may be more appropriate.

There is no evidence to suggest that the presence of pain is protective against the expression of an underlying addictive disorder. Similarly, there is no evidence that addiction prevents the development of chronic pain. Part of this confusion comes from the difficulty the clinician has in screening patients for having, or being at risk of having addictive disorders. Several issues contribute to this problem. First, there is inadequate undergraduate training in addiction medicine or pain management [22–24]. Health care professionals cannot diagnose illnesses of which they have little or no understanding. Second, there is often a personal bias that makes it difficult for practitioners to explore issues around their patient’s use of drugs including alcohol. Stereotyping leads to suboptimal care both in those incorrectly identified as likely or unlikely to have substance use disorders. By continuing to approach pain and addiction as a dichotomy, both the practitioner and the often complex

patient population that they serve will be disadvantaged.

### **Substance Use Assessment in the Pain Patient**

Beyond the expected inquiry into the presenting complaint of pain, every patient should be asked about their present and past use of both licit and illicit drugs, including alcohol and over-the-counter preparations [25]. While there is no simple relationship between past drug use problems and aberrant behavior in chronic pain management, the possibility of such risk should be discussed with the patient in advance of initiation of therapy especially with medications that may lead to physical dependency and possible misuse. It is important to reassure patients that these questions should not be interpreted as an attempt to diminish their complaints of pain. When it is clear to the patient that answering these questions honestly will lead to an improvement in, rather than a denial of care, a respectful inquiry into past and present drug and alcohol use will not be met with objection. To the contrary, persons with problematic use of drugs including alcohol may be aware of the extent of their problem and be looking for a solution. In this context, the application of a universal precautions approach to all patient assessments allows for the formulation of individualized treatment plans based on mutual trust and honesty. By consistently applying this basic set of principles, patient care is improved, stigma is reduced, and overall risk is contained.

Questions related to illicit drug use can pose problems for patients if the perception is that disclosing previous use will result in denial of care. A history of illicit drug use is a potentially complicating factor in chronic pain management; it is not a contraindication [25]. However, active untreated addiction may be an absolute contraindication to the ongoing prescription of controlled substances including opioids. While acute pain can be treated in a patient with an underlying active addictive disorder, in the authors' opinion, the successful treatment of a complaint of chronic pain in the face of an active untreated addiction is unlikely. In order to satisfactorily treat either condition, the patient must be willing to accept assessment and treatment of both. Thus, the diagnosis of a concurrent addictive disorder, where it exists, is vital to the successful treatment of chronic pain.

An unwillingness to follow through with recommended specialist referrals, preference for immediate release opioids where alternatives exist,

or a "philosophical" opposition to urine drug testing should be considered as red flags requiring further investigation before initiation or continuation of prescription of medications with high misuse liability. In the current medicolegal climate, both the prescriber and patient must accept the reality that initiation or continuation of controlled substances in the face of illicit drug use is contraindicated. Failure to inquire into, or document illicit drug use or problematic use of licit drugs is not consistent with optimal pain management. Beyond this point, the question remains whether to continue prescribing opioids in the face of social drinking.

Drinking no more than two standard drinks, defined as 12 ounces of beer, 5 ounces of wine, or 1.5 ounces of 80 proof liquor [26] in 24 hours to a maximum of 14 drinks per week for men and nine drinks per week for women, has been termed "low-risk." However, this recommendation can vary in the context of patients' other coexisting medical conditions such as with the use of prescription drugs including "pain killers" [26]. Thus it is left to the treating health care professional and patient to determine the role that social drinking may play in the context of their individual chronic pain management regimen. Clearly, the safest level of alcohol use, especially within the context of concurrent prescription drug use, is zero. The issue of continued prescription of controlled substances in the context of the use of prescribed benzodiazepines obtained from another prescriber is also worth examining. In some cases, the concurrent use of opioids and sedatives may be quite appropriate while in other cases, this is clearly problematic. Risk can often be reduced by clear and documented communication with all prescribing health care professionals. Otherwise, the very real possibility exists for loss of control of prescription monitoring by multiple prescribers, increasing the risk of adverse drug-drug interactions.

### **Universal Precautions in Pain Medicine**

The following universal precautions are recommended as a guide to start a discussion within the pain management and addictions communities. They are not proposed as complete but rather as a good starting point for those treating chronic pain. As with universal precautions in infectious diseases [1], by applying the following recommendations, patient care is improved, stigma is reduced, and overall risk is contained.

## *The Ten Steps of Universal Precautions in Pain Medicine*

**1. Make a Diagnosis with Appropriate Differential**  
Treatable causes for pain should be identified, where they exist, and therapy directed to the pain generator. In the absence of specific objective findings, the symptoms can, and should be treated. Any comorbid conditions, including substance use disorders and other psychiatric illness, must also be addressed.

### **2. Psychological Assessment Including Risk of Addictive Disorders**

A complete inquiry into past personal and family history of substance misuse is essential to adequately assess any patient. A sensitive and respectful assessment of risk should not be seen in any way as diminishing a patient's complaint of pain. Patient-centered urine drug testing (UDT) should be discussed with all patients regardless of what medications they are currently taking. In those patients where an opioid trial is considered, where the response to therapy is inadequate, and periodically while on chronic opioids, UDT can be an effective tool to assist in therapeutic decision making [10,25]. Those found to be using illicit or unprescribed licit drugs should be offered further assessment for possible substance use disorders. Those refusing such assessment should be considered unsuitable for pain management using controlled substances.

### **3. Informed Consent**

The health care professional must discuss with, and answer any questions, the patient may have about the proposed treatment plan including anticipated benefits and foreseeable risks. The specific issues of addiction, physical dependence, and tolerance should be explored at a level appropriate to the patient's level of understanding [2].

### **4. Treatment Agreement**

Whether in writing or verbally agreed, expectations and obligations of both the patient and the treating practitioner need to be clearly understood. The treatment agreement, combined with informed consent, forms the basis of the therapeutic trial. A carefully worded treatment agreement will help to clarify appropriately set boundary limits, making possible early identification and intervention around aberrant behavior [27,28].

### **5. Pre- and Post-Intervention Assessment of Pain Level and Function**

It must be emphasized that any treatment plan begins with a trial of therapy. This is particularly

true when controlled substances are contemplated or are used. Without a documented assessment of pre-intervention pain scores and level of function, it will be difficult to assess success in any medication trial. The ongoing assessment and documentation of successfully met clinical goals will support the continuation of any mode of therapy. Failure to meet these goals will necessitate reevaluation and possible change in the treatment plan.

### **6. Appropriate Trial of Opioid Therapy +/- Adjunctive Medication**

Although opioids should not routinely be thought of as treatment of first choice, they must also not be considered as agents of last resort. Pharmacologic regimens must be individualized based on subjective, as well as objective, clinical findings. The appropriate combination of agents, including opioids and adjunctive medications, may be seen as "Rational Pharmacotherapy" and provide a stable therapeutic platform from which to base treatment changes.

### **7. Reassessment of Pain Score and Level of Function**

Regular reassessment of the patient, combined with corroborative support from family or other knowledgeable third parties, will help document the rationale to continue or modify the current therapeutic trial.

### **8. Regularly Assess the "Four A's" of Pain Medicine**

Routine assessment of analgesia, activity, adverse effects, and aberrant behavior will help to direct therapy and support pharmacologic options taken [29]. It may also be useful to document a fifth "A": affect [30].

### **9. Periodically Review Pain Diagnosis and Comorbid Conditions, Including Addictive Disorders**

Underlying illnesses evolve. Diagnostic tests change with time. In the pain and addiction continuum, it is not uncommon for a patient to move from a dominance of one disorder to the other. As a result, treatment focus may need to change over the course of time. If an addictive disorder predominates, aggressive treatment of an underlying pain problem will likely fail if not coordinated with treatment for the concurrent addictive disorder.

### **10. Documentation**

Careful and complete recording of the initial evaluation and at each follow up is both medicolegally indicated and in the best interest of all parties. Thorough documentation, combined with an

appropriate doctor–patient relationship, will reduce medicolegal exposure and risk of regulatory sanction. Remember, if you do not document it, it did not happen.

### Patient Triage

One of the goals in the initial assessment of a pain patient is to obtain a reasonable assessment of risk of a concurrent substance use disorder or psychopathology. In this context, patients can be stratified into three basic groups. The following text will offer the reader a practical framework to help determine which patients they may safely manage in the primary care setting, those which should be comanaged with specialist support, and those that should be referred on for management of their chronic pain condition in a specialist setting.

#### Group I—Primary Care Patients

This group has no past or current history of substance use disorders. They have a noncontributory family history with respect to substance use disorders and lack major or untreated psychopathology. This group clearly represents the majority of patients who will present to the primary care practitioner.

#### Group II—Primary Care Patients with Specialist Support

In this group, there may be a past history of a treated substance use disorder or a significant family history of problematic drug use. They may also have a past or concurrent psychiatric disorder. These patients, however, are not actively addicted but do represent increased risk which may be managed in consultation with appropriate specialist support. This consultation may be formal and ongoing (comanaged) or simply with the option for referral back for reassessment should the need arise.

#### Group III—Specialty Pain Management

This group of patients represents the most complex cases to manage because of an active substance use disorder or major, untreated psychopathology. These patients are actively addicted and pose significant risk to both themselves and to the practitioners, who often lack the resources or experience to manage them.

It is important to remember that Groups II and III can be dynamic; Group II can become Group III with relapse to active addiction, while Group III patients can move to Group II with

appropriate treatment. In some cases, as more information becomes available to the practitioner, the patient who was originally thought to be low risk (Group I) may become Group II or even Group III. It is important to continually reassess risk over time.

### Conclusion

By adopting a universal precautions approach to the management of all chronic pain patients, regardless of pharmacologic status, stigma is reduced, patient care is improved, and overall risk is contained. Careful application of this approach will greatly assist in the identification and interpretation of aberrant behavior and, where they exist, the diagnosis of underlying addictive disorders. In those found to have, or be at risk of having complicating addictive disorders, treatment plans can be adjusted on a patient-by-patient basis. Adopting a universal precautions approach to the management of chronic pain will be an important step in raising the standard of care in this often complex patient population.

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