The real crisis of chronic pain

Thank you for publishing the healthy debate[1] in the May issue of *Canadian Family Physician* surrounding the article by Dhalla and colleagues on prescribing of opioid analgesics by family physicians and related mortality.[2]

Where Dhalla et al see stridency[3] we see passion, on the part of all the clinician writers,[1] to improve patient safety, function, and quality of life. We believe that an important change in how governments, health care providers, and chronic pain sufferers themselves perceive and manage chronic noncancer pain (CNCP) is necessary to improve the real crisis of poorly treated pain.

One recent positive step forward deserves mention. On April 29, 2011, the College of Family Physicians of Canada (CFPC) approved the formation of a CNCP group in the Section of Family Physicians with Special Interests or Focused Practices, which will reach out to all primary care physicians and trainees to improve competence in CNCP management. Universal precautions in opiate prescribing and the Canadian opioid guidelines will be an important part of this initiative.

From their apparent higher moral ground, Dhalla and colleagues[3] trot out that old trope that we on the "pro-opiate" side of the issue are controlled by our contacts with the pharmaceutical industry. Instead of defending their science, they turn to personal attack. Further, they imply that we, rather than Health Canada, are responsible for the quality of pharmaceutical research.

In his letter, Dr Kahan states that "high prescribers … were influenced by an intense and sustained pharmaceutical marketing campaign."[4] This unsubstantiated statement deserves some actual research. Plato recognized that "knowledge is true opinion." One of our first orders of business as leaders of the CFPC's CNCP group in the Section of Family Physicians with Special Interests or Focused Practices will be to survey our College's members on the sources of their chronic pain knowledge.

We also remind Dr Dhalla and colleagues that the Canadian Pain Society content is accredited by both the CFPC and the Royal College of Physicians and Surgeons of Canada, as are most continuing medical education events by other medical organizations, which, barring government subsidies, are also sponsored by pharmaceutical companies.

True solutions to the complex problem of harms related to opioid prescribing for pain require the availability of other biopsychosocial treatment options rather than a simplistic focus on reducing opioid prescribing by family physicians.

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Competing interests
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with. **Dr Dubin** has also received advisory board and consultant fees from Boehringer Ingelheim, Purdue Pharma, Eli Lilly, and Pfizer. **Dr Jovey** has consulted for or been a member of speakers' bureaus for AstraZeneca, Bayer, Biovail, Boehringer Ingelheim, Eli Lilly, Janssen-Ortho, GlaxoSmithKline, King Pharmaceuticals, Merck Frosst, Mundipharma Australia, Nycomed, Pfizer, Paladin, Purdue Pharma, Sanofi-Aventis, Valeant, and Wyeth.

References

1. Letters. *Can Fam Physician* 2011;57:530-9.
2. Dhalla IA, Mamdani MM, Gomes T, Juurlink DN. Clustering of opioid prescribing and opioid-related mortality among family physicians in Ontario. *Can Fam Physician* 2011;57:e92-6. Available from: **www.cfp.ca/content/57/3/e92.full.pdf+html**. Accessed 2011 Apr 1.
3. Dhalla IA, Mamdani MM, Gomes T, Juurlink DN. Response [Letters]. *Can Fam Physician* 2011;57:537-9.
4. Kahan MM. The opioid crisis in North America [Letters]. *Can Fam Physician* 2011;57:536.

You can't measure pain

I am fascinated by the range of sincere opinions when it comes to the question of treating chronic noncancer pain with opioids.[1] But in all the discussions one little fact was consistently overlooked, a fact that was stated most clearly by Eldon Tunks 30 years ago: you can't measure pain. It was true then, and it is equally true now. This might have something to do with the absence of any solid, objective evidence that the effectiveness of opioid treatment outweighs the known and easily quantifiable risk.

Because pain itself can't be measured, the temptation has been to set up surrogates, all of which suffer from the same logical flaw: to establish correlations with pain intensity and pain relief, you have to be able to measure pain. Of course, if we could measure pain none of these surrogates would be necessary. Numerical and analogue scales? We have all asked the "on a scale of 1 to 10" question and received the answer "12." People who rate their chronic pain anything higher than a 5 have obviously never passed a kidney stone, or had a dentist hit a nerve.

Even so, the only person who can judge the effectiveness of pain relief is the person who feels the pain—and in come the factors of personality, pain tolerance, primary and secondary gain, and the sheer impossibility of comparing present pain with past pain, or with hypothetical pain. If we can't measure pain, then we can't measure the effectiveness of pain treatment in terms of objective evidence; and basing opioid treatment on unquantifiable self-report, in the presence of considerable risk of abuse, addiction, and even death, might not be the smartest strategy either.

But what would criticism be without a constructive suggestion? So here's one: As the evidence of risk points predominantly to oxycodone, rather than to opioids as a class, can we find the will to outlaw what is quite possibly the most addictive substance that it has been our collective misfortune to encounter?

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Competing interests
None declared

Reference
1. Letters. *Can Fam Physician* 2011;57:530-9.