The History of Medical Consumerism, Pain Management, and Prescription Opioids

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Abstract
Over the last few decades, pain treatment and the practice of pain management in the United States have changed dramatically. There are a number of historical forces that have contributed to these changes, but one particularly powerful one has been the tendency of the American patient and healthcare system toward medical consumerism. Since the late 1960s, this trend of medical consumerism has manifested itself in part through patients’ increasing activism and engagement in care, and through market-oriented health policy reforms, including the rise of managed care and the liberalization of medical advertising. These forces have had a particular influence on pain management practices, both positive and negative. Positive effects include an increased attention to patients’ experiences of pain, while negative effects include a decreased ability of patients and their physicians to implement comprehensive and holistic pain management interventions and an corresponding increased reliance on opioid analgesics. The results of this paper suggest that, in order to adequately address the current opioid crisis, these historical forces need to be recognized and addressed.

Biography
John Giardina is a graduate student in the Decision Sciences track of the Harvard PhD Program in Health Policy. His research interests include the measurement of patient preferences and the use of shared-decision making principles to help patients and their physicians make optimal health decisions.

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1. Introduction

Since the 1970s, there have been seismic changes in the way the US medical system diagnoses and treats pain.¹ The underlying desires of patients, however, have remained quite similar: patients want treatments to end pain or avoid the return of pain. In interactions with their healthcare providers about pain management, patients express remarkably consistent experiences that often revolve around access to pain medication, especially opioid analgesics.² Despite this persistent underlying context, there have been significant changes in the way patients and physicians work together (or do not work together) to treat pain.

The changes in this relationship mirror broad, underlying changes that have occurred in the American health system as a whole since the 1970s. In particular, this paper will trace two major trends in medicine since the 1970s and their influence on the use of opioid analgesics for chronic non-malignant pain (CNMP). First, a movement towards patient empowerment and engagement in the 1960s and 1970s and the backlash against managed care in the 1990s encouraged patients to be more involved in their own care, including being more active in seeking pain relief. Second, market-oriented health policy reforms since the 1970s and 1980s, including an increased focus on cost control and the liberalization of medical advertisements, led to a perception among physicians that they needed to be more accommodating and efficient in their interactions with patients. In conjunction with many other trends in the practice of pain management over this time-period,³ these two forces encouraged patient-physician interactions

² Compare, for example, “I couldn’t stand the pain anymore” (1977) to “I’m scared that this big pain is going to come back” (2014). Both of these quotes involve patients trying to convince their provider to give them opioid analgesics. Shizuko Y. Fagerhaugh and Anselm L. Strauss, Politics of Pain Management : Staff-Patient Interaction (Menlo Park, Calif.: Addison-Wesley Pub. Co., Health Sciences Division, 1977); A. Y. Esquibel and J. Borkan, "Doctors and Patients in Pain: Conflict and Collaboration in Opioid Prescription in Primary Care," Pain 155, no. 12 (2014).
³ Other trends influencing the patient-physician around pain management include: guidelines and standards of care that emphasized pain relief (e.g., “pain as the fifth vital sign”); beliefs that opioid analgesics used in a medical setting did not pose a significant risk of addiction; and changes in approaches to palliative
that (1) focused on treating the immediate symptoms of pain and (2) lacked a holistic long-term approach to treating pain. In general, this type of interaction led to an increased use of opioid analgesics, which is often cited as a root of the opioid epidemic today. An analysis of these changes from a historical perspective provides an opportunity to gain insight into how the shifting political and social structure of the health system as a whole affects the use of opioid analgesics, and how current strategies to combat the overuse of opioid analgesics may or may not work based on past history.

1.1. Background

From a theoretical standpoint, the optimal decision about whether or not to use an opioid analgesic should balance the benefits of significant pain relief against the potential risks of dependence and substance use disorder. To make this type of decision, however, a significant amount of information needs to be synthesized: the needs and preferences of the patient, along with their risk factors for substance use disorders (e.g., family history of substance use disorders), must be combined with a physician’s clinical knowledge about the likelihood of different outcomes among the possible treatment options. Obviously, such an analysis can be quite difficult, if not impossible; it requires patients to clearly communicate their preferences and circumstances to their physician, and it requires physicians to fully comprehend the needs of the patient, review the best available clinical evidence, and then provide a recommendation that is in the best interests of the patient. There are multiple standards of care for pain management but, because of the


inherently subjective nature of pain, these standards almost invariably suggest that the optimal
decision must be made in the particular context of any given patient.\(^5\)

Because the selection of an optimal treatment decision for pain management rests largely
on how well the patient and their physician communicate, the patient-physician relationship is
clearly one of most important aspects of clinical pain management. Because of this, there is a
substantial amount of clinical research that attempts to design interventions that can improve the
patient-physician relationship around pain management and lead to improved outcomes. For
example, interventions such as decisions aids (based on the concept of shared-decision making)
attempt to help patients and their physicians communicate and integrate information about
preferences and risks in order to arrive at an optimal decision.\(^6\)

This type of approach, however, focuses only on the immediate circumstances of a patient
and their physician, and neglects the broader historical forces that structure the relationship. There
is a large body of literature that traces the development of the medical profession and hospitals in
the US;\(^7\) a major implication of this work is that these institutions were rarely developed with the
sole purpose of improving people’s health. Instead, a wide array of forces, including economic
incentives, political interests, and social and cultural pressures, have combined to create the
American healthcare system. Throughout US history, patients have recognized the fact that,

\(^5\) The Joint Commission, "Pain Management,"
https://www.jointcommission.org/topics/pain_management.aspx; R. Chou et al., "Clinical Guidelines for the
Use of Chronic Opioid Therapy in Chronic Noncancer Pain," \Journal of Pain\ 10, no. 2 (2009); American Pain Society,

\(^6\) C. D. Spies et al., "Preferences for Shared Decision Making in Chronic Pain Patients Compared with
Patients During a Premedication Visit," \Acta Anaesthesiol Scand\ 50, no. 8 (2006); Daniela Simon et al.,
"Effectiveness of a Web-Based, Individually Tailored Decision Aid for Depression or Acute Low Back Pain: A
Randomized Controlled Trial," \Patient Education and Counseling\ 87, no. 3 (2012).

\(^7\) For example, see Paul Starr, \The Social Transformation of American Medicine\, Updated edition. ed.
(New York: Basic Books, 2017); C. E. Rosenberg, \The Care of Strangers: The Rise of America’s Hospital
System,\ 2 ed. (Baltimore, MD: Johns Hopkins University Press, 1995); W. Richard Scott, \Institutional Change
and Healthcare Organizations : From Professional Dominance to Managed Care\ (Chicago: University of
however well-intentioned their own doctor is, the incentives that physicians face are often contrary to the best interests of the patient; patients have therefore approached their interactions with physicians with at least some level of mistrust. This mistrust manifests in the methods patients use to ensure that their care is actually in their best interest; these critical methods and approaches to seeking medical care comprise what this paper will refer to as “medical consumerism.”

Tomes defines medical consumerism as a medical version of the consumer rights movement that seeks to secure “the rights to be safe, to be informed, to make choices, and to be heard.” She demonstrates that throughout the history of the US healthcare system, patients have been continually practicing medical consumerism, but that it has appeared in many different forms, ranging from a free-market approach to supporting significant government intervention. For the purposes of this paper, the focus will be on the type of consumerism that developed from the 1960s to the 1990s, which included an increased focus on both patients’ rights and engagement, and on market-oriented reforms. This time period coincided with a significant shift in pain management practices and the use of opioid analgesics for CNMP in the US, and this paper will discuss how those trends in medical consumerism impacted and interacted with these changes in pain management.

1.2. Argument Outline and Structure

The remainder of the paper will be organized as follows: section 2 will briefly sketch a general history of medical consumerism from the 1960s to 1990s, relying heavily on Tomes, and highlighting the patient rights movement, increases in patient engagement and activism, and

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9 Ibid., 5.
10 Ibid.
market-oriented reforms like managed care and liberalized advertising regulations. Section 3 will use historical documents to expand on this history of patients’ rights and engagement in the context of pain management practices through the use of two case studies: one on the growth of patient support groups for chronic pain and another on the development of the concept of pseudoaddiction. Section 4 will similarly situate market-oriented reforms in the context of pain management and opioid use by exploring how managed care and the liberalization of medical advertisements affected the patient-physician relationship. Section 5 will analyze how the two trends of patients’ rights and engagement and market-oriented reforms contributed to the liberalization of opioid analgesic use, and section 6 will conclude with a discussion of how this history could inform policy responses to current issues in pain management and opioid use.

2. Medical Consumerism from the 1960s to 1990s

The significant cultural and social transformations that began in the mid-1960s had profound effects on the healthcare system in the US. The introduction of Medicare and Medicaid in 1965 transformed the role of government in health care and began to solidify the assumption that Americans had a right to healthcare. In the academic realm, researchers were developing the field of bioethics, which presented new approaches to the morality of the healthcare system, both in terms of access to care and how patients interacted with their healthcare provider.

Along with these trends, the long-standing forces of medical consumerism reemerged in conjunction with the radical politics of the era. This new type of medical consumerism interacted with and was influenced by the federal Medicare and Medicaid programs and the emerging

12 Tomes, Remaking the American Patient: How Madison Avenue and Modern Medicine Turned Patients into Consumers.
theories from bioethics researchers, but the root causes of this movement were found more in the activists and individual patients advocating for a greater recognition of the rights of patients to have access to and be active participants in their healthcare.\textsuperscript{16} Tomes notes that these trends were grouped under titles such as the “patients’ rights movement, medical consumerism, or simply the ‘big change’,”\textsuperscript{17} but for the purposes of this paper it will be referred to as the “patient empowerment movement,” since the trends went beyond simply securing rights to medical care or consent, but instead represented a more fundamental shift in the way patients were involved with their care.

This movement pushed for a broad array of reforms, including increased access to healthcare for minorities and disadvantaged populations, major changes to physicians’ approach to women’s health, and improved oversight and regulation of physicians and pharmaceutical manufacturers.\textsuperscript{18} A visible example of this was the push for a Patients’ Bill of Rights, which was most prominently advanced by the National Welfare Rights Organization. It was argued that such a document would, among other things, force physicians, hospitals, and the healthcare system to recognize patients’ autonomy and guarantee them the right to be informed about their care.\textsuperscript{19} This campaign resulted in the adoption of a non-enforceable patients’ bills of rights by the Joint Council for the Accreditation of Hospitals and the American Hospital Association.\textsuperscript{20} While some commentators at the time argued that these actions were ultimately ineffectual and possibly harmful,\textsuperscript{21} the debate around the Patients’ Bill of Rights had persistent effects on how patients view their relationship with the healthcare system, and spurred legislative action at the state level.\textsuperscript{22}

\begin{itemize}
  \item \textsuperscript{16} Ibid., 287.
  \item \textsuperscript{17} Ibid.
  \item \textsuperscript{18} Ibid.
  \item \textsuperscript{19} Ibid., 270.
  \item \textsuperscript{20} Ibid.
  \item \textsuperscript{21} Jonsen, \textit{The Birth of Bioethics}, 368.
  \item \textsuperscript{22} Tomes, \textit{Remaking the American Patient : How Madison Avenue and Modern Medicine Turned Patients into Consumers}, 273-4.
\end{itemize}
More broadly, even though this activist component of the patient empowerment movement started as part of the political Left, the ideas underlying the movement moved relatively quickly into the mainstream by the 1970s.\textsuperscript{23}

Beyond an activism focused on securing patient rights and autonomy, however, the patient empowerment movement also changed the practical way patients become involved in their own care. Particularly, there was a focus on patients’ becoming more active in improving their health. For example, the 1970s saw the creation of community-led health centers that provided more patient-centered care and the creation of “shoppers’ guides” that would publicly list rates charged by hospitals.\textsuperscript{24} The key point to recognize for this paper is that there was a concerted and organized movement to ensure that patient had both the confidence and ability to make informed choices about their care, which represented a shift from the previous paternalistic approach to medicine that was often prevalent under previous incarnations of medical consumerism.

Moving from the mid-1970s into the 1980s, the patient empowerment movement certainly still continued, but the policy focus at the state and federal level began to shift to the issues of rising healthcare costs. The implementation of Medicare and Medicaid and a poor economy made healthcare costs a significant budget issue, and researchers and policymakers attempted to identify reforms that could slow the growth. It was during this time period that leading American health economist Victor Fuchs published a book titled \textit{Who Shall Live?}, and the RAND Corporation began conducting a major study to determine how the pricing of health insurance affected the utilization of healthcare.\textsuperscript{25} Similarly, on the policy side, government officials attempted to find ways to make physicians and patients more responsive to the cost of care through market-oriented

\textsuperscript{23} Ibid.
\textsuperscript{24} Ibid., 260-62, 80-1.
reforms. A thorough description of these reforms are not within the scope of this paper, so two examples, with particular relevance to changes in the practice of pain management, will be discussed here.

First, President Nixon promoted the formation of Health Maintenance Organizations (HMOs), an early form of managed care. The idea behind managed care is that the payor (e.g., the HMO) can both bargain with physicians over prices, and control over what types of care and procedures the patient can access (either through pricing or direct review of requests); the result, at least initially, was decreased costs from patients enrolled in HMOs. To a certain extent, these reforms could be thought of as positive step forward for medical consumerism, since this market-oriented approach explicitly framed the patient in a consumer role.

By the 1990s, however, there was a backlash from patients and policymakers against some of the cost-control measures, especially managed care (even though a relatively small fraction of the population was covered by managed care plans at that point). Articles in the popular press highlighted extreme iatrogenic injuries caused by managed care, and patients generally demonstrated a decline in trust for the medical system as a whole. The policy responses to this backlash often focused on system-wide reforms to reduce medical errors and improve quality, as exemplified by the two Institute of Medicine reports To Err is Human and Crossing the Quality

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29 Ibid., 330.
32 Blendon et al., "Understanding the Managed Care Backlash."; B. H. Gray, "Trust and Trustworthy Care in the Managed Care Era," ibid.16, no. 1 (1997).
These two reports set the stage for an increased institutional focus on patient satisfaction and outcome measures in the 2000s, which are still powerful forces in the healthcare system today.

The second example of market-oriented reforms that will be included in this paper is the liberalization of medical advertisements, including both advertisement for medical services and pharmaceuticals. It is important to note that in the 1960s, there much of the restrictions on advertising was voluntary and not government mandated. Instead, physicians objected to both direct-to-consumer advertising (DTCA) and the advertisement of medical services, including physician practices. A 1982 lawsuit against the American Medical Association (AMA) by the Federal Trade Commission (AMA), however, forced the AMA to drop its prohibition on physician advertising, and the Federal Drug Administration under President Reagan began relaxing the oversight of DTCA. Again, these market-oriented changes were often presented from a consumerist perspective, since if patients were more informed when making decisions about their care through the information provided through advertisements, they would be empowered to shop for the lowest prices. These changes, however, also had consequences for the patient-physician relationship, which will be discussed in section 4.

3. Pain Management in the Patient Empowerment Movement

The increased focus on patients’ rights and engagement influenced many types of patient care, but were particularly important in the context of pain management, since the evaluation of pain relies

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36 Ibid., 331.

37 Ibid., 374-7.
so heavily on the patients themselves. Most visibly, the changing norms were reflected in the way the popular press discussed the issue of pain management. For example, in 1978 *The New York Times* published an article that discussed new approaches to pain treatment, and suggested that the increased focus on pain by physicians and the medical system was caused by the trend to treat patients “as a person rather than a collection of organs and symptoms,” which seems to be a reference to the goals of the patient empowerment movement to treat patients as people with dignity and autonomy.\(^{38}\)

Another example in *The New York Times* is an article from 1986 that, while covering a consensus statement from the National Institutes of Health on guidelines for pain management, quoted a doctor as saying patients should “raise hell” if they feel they are not getting adequate pain treatment, emphasizing that patients must act as their own advocate to get the care they need, a common refrain in the patient empowerment movement.\(^{39}\) Additionally, published in the same issue as that article, was a short piece from the *Associated Press* about a women in Los Angeles who was suing her physicians to stop them from withholding morphine for pain treatment; she believed they were withholding this treatment as a “quasi-punitive action” because they resented her involvement in decisions about her care.\(^{40}\)

Clearly, these types of articles reflect the influence that ideas from the patient empowerment movement had on the discussion of issues surrounding pain management. The examples, however, do not clearly demonstrate the extent which patients’ and physicians’ practical approaches to pain actually adopted and incorporated the principles of that movement. To explore this direct effect, this paper will discuss chronic pain support groups and the diagnosis

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\(^{39}\) Philip M. Boffey, "Pain Victims' Care Faulted by Panel: Experts Say Chronic Sufferers Get Too Much Medication and Others Too Little," ibid., May 22, 1986.

of pseudoaddiction as case studies of the ways both patients and physicians began to emphasize patient dignity, rights, and autonomy in the practice of pain management.

3.1. Case Study: Chronic Pain Support Groups as Patient Empowerment in Care

Previous literature has explored peer support groups in the context of activism of patients around mental health issues, which was one notable part of the patient empowerment movement. Researchers have noted that this activism often placed an emphasis on the creation of peer support groups that were distinct from the healthcare system, as places where patients would be able to share their experiences and advice and recognize that people with serious mental illness were still able to lead successful lives. The patients who created and led these groups believed that this type support system was a key part of their care, even though it was not led by physicians or medical institutions. A similar trend towards peer support appeared in the context of chronic pain, and although previous literature has yet to place it explicitly in the context of the patient empowerment movement, it seems that it also represents a clear example of the way the ideas of patients’ rights and engagement were incorporated into the methods and approaches patients used to treat their pain.

From a review of popular press sources seems to trace the formation of chronic pain support groups in the US to a network called the American Chronic Pain Association (ACPA), which was founded in Pennsylvania in 1980. These support groups did not focus on treating pain in a medical context, but provided a forum to validate patients’ subjective experiences around

42 Davidson et al., "Peer Support among Individuals with Severe Mental Illness: A Review of the Evidence."
pain. For instance, in a Letter to the Editor of the *St. Petersburg Times*, the leader of a local ACPA support group noted that patients with chronic pain “are all too often treated as though they are merely chronic complainers” and that the support group provided an opportunity for patients to “know that they are not alone, they are not crazy and they are not powerless.”

In the context of pain, this validation acted not only to reassure the patient that their subjective experience was real, but to also encourage them to seek ways to reduce the effects that pain had on their life and functionality. A column by a physician about a regional ACPA support group in Florida noted that the group meetings often consisted of patients sharing relaxation techniques and exercises, and a *New York Times* article on the support groups that patients valued advice they received at the meeting about how to conduct the activities of daily living. Additionally, these groups seem to have been relatively popular during the 1980s and 1990s. A 1986 article on pain in *The Trenton Evening Times* list four different chronic pain support groups in that area, and the 1993 *New York Times* article reported that the ACPA had 660 chapters.

While these descriptions of the chronic pain support groups do not discuss the way these patients interacted with their physicians, it seems reasonable to assume that if these patients were attending meetings where they were reminded that they were not “faking” their pain and that they were empowered to seek relief from their pain, then they would be more active in their interactions with their physicians in requesting treatment for pain. Indeed, Tomes sees a similar effect from aspects of the broader patient empowerment movement, such as the growth of community clinics in the 1970s that emphasized self-help approaches (e.g., nutrition, stress-relief) and engagement for patients traditionally ignored by the medical system, similar to the chronic

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45 "Letter to the Editor."
46 David H. Baras, "Woman Forms Group to Help Patients with Chronic Pain," ibid., July 16.
47 Stern, "Solace for Victims of Chronic Pain."
48 Lichtenstein, "Pain: Getting a Grip on It."
49 Stern, "Solace for Victims of Chronic Pain."
pain support groups.\textsuperscript{50} She notes that even while many of these clinics closed after a few years, they “encouraged a broader trend within medicine...to treat patients with respect.” As will be discussed in section 5, it seems that the trends encouraged by the chronic pain support groups, especially respect for the subjective experience of pain and an emphasis on patient engagement in treatment, combined with other forces to shift the patient-physician relationship and the clinical approach to pain management.

3.2. Case Study: Pseudoaddiction in the Context of Patient Empowerment

While patients were becoming more willing to acknowledge their pain, physicians were also becoming more willing to treat it. Pain management practices among physicians changed significantly from the 1970s to the 1990s,\textsuperscript{51} the same time period in which patients became more active in the treatment of their pain and in medical care more broadly, but it would be difficult to localize the cause of these changes to physicians’ simply placing an increased focus on respecting patients’ autonomy and right to choose their care.

Instead, it seems that the effect of the patient empowerment movement likely had a more indirect effect on the specific methods and standards that physicians used to treat pain, with physicians changing the way they practiced pain management without adopting some of the more radical demands of the patient empowerment movement. Some researchers have, for instance, argued that the recognition of a right to pain treatment encouraged the use of pain as the “fifth vital sign,” which was a practice popularized by the American Pain Society in the 1990s.\textsuperscript{52} Around this time, physicians also began applying a diagnosis called pseudoaddiction to patients with pain in an attempt to differentiate patients seeking opioid analgesics to treat significant pain from those

\textsuperscript{50} Tomes, \textit{Remaking the American Patient: How Madison Avenue and Modern Medicine Turned Patients into Consumers}, 261-3.

\textsuperscript{51} Meldrum, "A Capsule History of Pain Management."

with an opioid use disorder. This phenomenon presents an interesting case study in the way physicians adopted some of the language from the patient empowerment movement to a more traditional medical context, and how that affected the way physicians and patients interacted regarding pain management and opioid analgesic use.

In 1989, Weismann and Haddox published a case study on a young leukemia patient with pneumonia and significant pain. The patient was hospitalized and was being treated with multiple types of opioid analgesics; when the patient began requesting increased dosages unrelated to any objective causes, the patient’s nurses and physicians became concerned that he was becoming addicted to the opioid medications. When the team consulted with specialists in cancer pain management, they were told that there was a real cause for the pain (i.e., pneumonia) and that they should work with the patient to establish a care plan that was more flexible and better met his care management needs.

The initial reaction of the medical team to the patient’s request for increased dosages of pain medication was characteristic of the way nurses and physicians had traditionally approached pain treatment in an acute care setting. For example, a study from 1977 on the interactions between hospital staff and patients around pain management suggested that nurses viewed reducing the levels of analgesic use as “an essential part of their job,” and would often assume that patients seeking increased dosages were in fact addicted. There are clearly issues with this approach, as the authors of the 1977 study rightfully noted; if a patient is in pain, it is reasonable to assume that they (1) will seek better treatment for that pain and (2) be in significant distress if they do not receive that improved treatment. Thus, the act seeking that increased dosages of

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analgesics or presenting severe distress should not necessarily be held as evidence that they have an opioid use disorder.\textsuperscript{55}

Weismann and Haddox formalized this conclusion, which seems perhaps relatively obvious, into the diagnosis of pseudoaddiction.\textsuperscript{56} They noted that the behaviors of patients with inadequate pain control, such as increasingly desperate attempts to seek increased dosages of pain medication, mirrored the behaviors of patients with opioid abuse disorder, but concluded that those patients did not actually have an opioid abuse disorder. Instead, they referred to the patients who exhibited these behaviors as experiencing pseudoaddiction: addiction-like behaviors from patients with under-treated pain. Unlike patients who were suffering from “real” addiction, they recommended that the optimal treatment for patients with pseudoaddiction was to adequately treat their pain with increased levels of opioid analgesics.

Although this new diagnosis was presented in the context of a single case study, within a few years it was adopted by many physicians and pain management guides.\textsuperscript{57} In these instances, however, the concept of pseudoaddiction was often applied outside of its original context. It is important to note that, in the case presented by Weismann and Haddox the patient was (1) suffering from pain caused by an acute illness (pneumonia), (2) was being treated in an inpatient setting, and (3) presented cancer as a co-morbidity. All these attributes of the case should have limited the external validity of the conclusions drawn by Weismann and Haddox, but most physicians referencing pseudoaddiction applied it beyond the original context. At least one pain

\textsuperscript{55} Ibid., 124-5.

\textsuperscript{56} Weissman and Haddox, "Opioid Pseudoaddiction—an Iatrogenic Syndrome."

management guide did limit the consideration of pseudoaddiction to cancer patients, but many, such as *The Massachusetts General Hospital Handbook of Pain Management* explicitly discussed the concept of pseudoaddiction in the context of chronic non-malignant pain. Weismann even published a letter in the *Journal of Pain and Symptom Management* responding to another article that he said incorporated elements such as family concerns about prescription drug use into the concept of pseudoaddiction.

While some physicians pushed back against the use of pseudoaddiction as a diagnosis, it seems to have been broadly adopted by many physicians focused on treating pain during the 1990s and early 2000s. It is unclear, however, what the concept added to the conception and treatment of pain, beyond providing a formalized medical way of believing and trusting patients who are requesting additional opioid analgesics. Some researchers have viewed pseudoaddiction as a way to separate “good” pain patients from “bad” addicts, especially along racial and socioeconomic lines, and there seems to be some indication that this actually occurred. But, from a more basic perspective, pseudoaddiction can be seen as a way to incorporate the validation of patients’ subjective experience of pain, which is a hallmark of the chronic pain support groups.

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59 Ballantyne et al., *The Massachusetts General Hospital Handbook of Pain Management*, 436. Interestingly, the pain management center at MGH received a $3 million donation from Purdue Pharma around the same time this handbook was published, and was slated to be renamed the Purdue Pharma Pain Center in 2005. It is unclear, however, if that name change ever actually took place. Raja Mishra, "Deal May Tie Massachusetts General Hospital to Furor on Pain Pill," *The Boston Globe*, March 14 2002.
60 D. E. Weissman, "Understanding Pseudoaddiction," *J Pain Symptom Manage* 9, no. 2 (1994). In some sense, this extension of the concept of pseudoaddiction beyond its original setting is analogous to the way the infamous Porter and Jick letter was used to argue that the use of opioids for pain management carried little risk of addiction. Both articles were limited studies conducted in an acute care setting, which were then interpreted to imply that opioid analgesics should be used more broadly in general. Jane Porter and Hershel Jick, "Addiction Rare in Patients Treated with Narcotics," *New England Journal of Medicine* 302, no. 2 (1980); Pamela T.M. Leung et al., "A 1980 Letter on the Risk of Opioid Addiction," ibid.376, no. 22 (2017).
61 Charles Chabal et al., "Opiate Abuse or Undertreatment?" *The Clinical Journal of Pain* 14, no. 1 (1998). This letter refers to pseudoaddiction as “yet another clinical label without specific therapeutic, predictive, or diagnostic value.”
62 Greene and Chambers, "Pseudoaddiction: Fact or Fiction? An Investigation of the Medical Literature."
discussed above, into a formal medical diagnosis. Incorporating patient experience in this way seems to subvert the original intention of the support groups (and the patient empowerment movement more broadly), since it still requires a physician to actually assign the diagnosis. Additionally, while the focus of the support groups was on acknowledging the patient as a full person and supporting them in achieving the goals of their life through multiple treatment and coping modalities, the primary treatment for a diagnosis of pseudoaddiction was to increase the dosage of opioid analgesics. While this approach may have been appropriate in the original acute care context of the diagnosis, it certainly was not sufficient to treat CNMP, which can obviously have many different causes and potential treatments. The implications of the use of the pseudoaddiction diagnosis and this reductive treatment approach for the patient-physician relationship and pain management practices will be discussed further in section 5.

4. Pain Management in the Context of Market-Oriented Reforms

As explored in section 2, the rise of the patient empowerment movement occurred in concert with an increased policy focus on cost-control. Together, these forces led to market-oriented health policy reforms that had a goal of increasing both patient choice and access to information, market competition, which in theory would lead to improved patient welfare and lower overall costs. This section will explore effects of managed care and liberalized advertisement practices as two examples of the way market-oriented reforms influenced pain management practices.

4.1. Managed Care and Pain Management Practices

The whole idea behind HMOs, and managed care more generally, is to place incentives on the payor, physician, and patient to use healthcare services more efficiently. To do this, however, managed care organizations often placed restrictions around the types of services patients could

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63 Tomes, Remaking the American Patient : How Madison Avenue and Modern Medicine Turned Patients into Consumers, 347.
receive, including pain management services. Although no specific studies from the 1980s or 1990s on managed care practices around pain management could be found, a 2003 study did demonstrate that the use of a successful interdisciplinary pain management program was limited because of managed care practices; the physical therapy aspect of the program had been “carved out” by the managed care provider, so that patients could not access the comprehensive program. A review of the issue from 2011 also supported this finding, noting that carve-outs and provider-networks (another tool used by managed care providers to limit costs and utilization) made it difficult for patients to gain access to a complete the suite of services needed to be treated in a interdisciplinary pain treatment program.

Clearly, in this context, managed care had detrimental affects on the ability of patients and their physicians to use the most effective pain treatment tools. It is important to remember, however, that during the 1980s and 1990s, most patients and physicians were not under managed care plans and would not have been subject to carve-outs or provider networks. Instead, it is likely that the most significant effects of managed care on pain management practices were indirect, through its effect on physicians conception of their role in the healthcare system and on patient trust.

A 1998 study surveyed physicians about the effect of managed care on the relationship with their patients and found, among other results, that most physicians felt managed care: did not leave them enough time to spend with their patients; decreased their ability to prioritize the needs of their patients; and often resulted in an adversarial relationship with their patient.

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65 M. M. Jeffery et al., in Multidisciplinary Pain Programs for Chronic Noncancer Pain, Ahrq Comparative Effectiveness Technical Briefs (Rockville (MD): 2011).
1995 *JAMA* commentary, physicians wrote that, although managed care could be beneficial if implemented appropriately, it had the potential to “undermine…the ideal physician-patient relationship.” This sentiment was repeated in a 1999 commentary, where physicians emphasized the need to make sure primary care physicians were care coordinators and not gatekeepers assigned to enforce the restrictions set up by managed care.

Clearly, physicians were worried that the rise of managed care could negatively impact their relationship with patients by both reducing the amount of time they were able to spend with them and setting up a relationship where they would be required to restrict the access patients had to other healthcare services, including pain management specialists or physical therapy. Even though many physicians were not directly affected by managed care during the 1990s, the general perception of a deteriorating patient-physician relationship caused by managed care likely reflected real anxieties about the state of that relationship in general, across all patients and physicians. Combining this with the general decline in patient mistrust resulting from the managed care backlash, as discussed in section 2, it would seem that managed care resulted, on average, in a decline in the amount patients and their physicians were able to communicate effectively about their health, including decisions about pain management.

4.2. Advertising and Pain Management Practices

As outlined in section 2, the restrictions around medical advertising were significantly liberalized during the 1980s. The change that usually receives the most attention was the reduction in FDA oversight of DTCA. But aggressive pain medications like opioid analgesics do not seem to have

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been directly marketed to consumers. Instead, the main effect of DTCA on pain management practices was probably the encouragement of a general attitude among consumers that medication was a primary form of medical treatment for any ailment.\footnote{Overdosed America: The Broken Promise of American Medicine.}

The change in medical advertisement that had the most direct effect on pain management practices was likely the ending of the AMA’s prohibition against physician advertisement. As Tomes notes, this change led to an “arms race,” with physicians and hospitals seeking to advertising that they were using the latest technologies and procedures.\footnote{Tomes, Remaking the American Patient : How Madison Avenue and Modern Medicine Turned Patients into Consumers, 333.} This change was justified as increasing the amount of information available to patients but, with the arms race mentality and the fact that some of the more unscrupulous providers made unrealistic promises in their advertisements, patients were not actually provided with the ability to make better choices.\footnote{Ibid., 335-6.}

Instead, in the case of pain management, this type of advertisement likely served to create false expectations about the ability of medical providers to relieve pain. Consider, for example, the newspaper advertisement in Figure 1, from 1981. This advertisement for pain treatment at St. Vincent’s Hospital in New York City describes a single success story of a patient undergoing successful pain management. This format allows the hospital to claim expertise and success in a area without explicitly stating any empirical evidence about how often their providers are able to relieve chronic pain. It is important to note that the advertisement qualifies the success of the patient, saying that the patient will always have at least some pain. Still it is easy to imagine a prospective patient seeing this advertisement and developing an expectation that medical treatment can provide significant, long-lasting relief from chronic pain. Of course, with a comprehensive treatment plan developed through a robust patient-physician relationship, this kind
of success is certainly possible. As the next section will discuss, however, when these types of expectations are combined with the other forces described in this paper, there will likely be a detrimental effect on the patient-physician relationship surrounding pain management.

5. Medical Consumerism and Changes in Pain Management Practices

The forces of the patient empowerment movement and the market-oriented reforms discussed in this paper clearly had a major impact on the patient-physician relationship surrounding pain management. To see how these forces combined to actively change pain management practices, it will be helpful to consider a hypothetical patient seeking pain treatment at some point during the 1980s or 1990s, and illustrate how these forces could interact to impact the way a patient works with their physician to treat their pain.

Suppose a patient has chronic low back pain and is seeking medical treatment to relieve their pain. Having internalized the underlying ideas of the patient empowerment movement, they are ready to be an active participant in their care, and will likely reject or avoid any physician who suggests that their pain is not real (perhaps with the encouragement of a chronic pain support group). The patient is also primed by medical advertisements for hospitals and pain centers to believe that medical care offers them a good chance at significant pain relief. Once they visit a physician, however, it becomes clear that the physician feels rushed and preoccupied by other tasks (possibly by the pressures of managed care and a changing insurance market). The patient’s insurance may not cover a comprehensive, interdisciplinary pain treatment program so the physician, in an attempt to get the patient the relief they need, prescribes an opioid analgesic that they believe carries a low risk of the patient developing opioid use disorder. It is even possible that the physician is influenced by an advertisement like the one in Figure 2, which emphasizes both the substantial benefits that the drug can provide to their patient and the minimal time amount of time the physician needs to devote to treating the patient. Then, once the patient begins a long-
term opioid regimen, the physician is likely to give the patient increased dosages if the patient continues to suffer from severe pain, relying on concepts like pseudoaddiction. This cycle could continue, with opioid analgesics as the primary treatment modality, without a patient and their physician having an opportunity to construct a long-term, holistic plan to treat their pain.

It is hopefully easy to see how this type of story would be plausible, given the historical trends and forces described in this paper. It is also hopefully easy to see how opioid analgesics could be used too frequently, especially given that it is known now that those drugs are much more addictive than was commonly assumed during the 1980s and 1990s. Of course, there are a multitude of other forces that contributed to these changes in pain management practice, including aggressive marketing of opioid analgesics by pharmaceutical companies, incorrect use of research on the safety of opioids, and prior changes in the use of opioids in palliative care. Still, it should be clear that elements of medical consumerism, including the patient empowerment movement and market-oriented reforms, acted as forceful historical trends to influence the way patients and their physicians interacted around pain management and utilized opioid analgesics.

6. Conclusions and Lessons for the Current Opioid Crisis

This paper attempted to demonstrate that the broad, historical forces of medical consumerism have had a significant impact on the way patients and physicians work together to treat chronic non-malignant pain. It is also argued that these forces played a role in increasing the use of opioid analgesics to treat CNMP, suggesting that an understanding of these forces could help identify ways to approach the current opioid epidemic (which is often linked with the increased use of opioids for CNMP). The most important lesson is thus perhaps that the patient-physician relationship is vital to ensuring successful pain management, and that the opioid crisis cannot be

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73 Tompkins, Hobelmann, and Compton, "Providing Chronic Pain Management in the "Fifth Vital Sign" Era: Historical and Treatment Perspectives on a Modern-Day Medical Dilemma."
solved by simply cutting-off access to opioid medications or implementing small clinical interventions to divert patients from opioid use.

Instead, as the patient empowerment movement has shown, patients are not likely to be satisfied with an approach that rejects opioids, which for all their faults successfully treat the symptoms of pain, without presenting a viable alternative. In this context, there is clearly a need to find comprehensive pain treatment strategies that both recognize the subjective experiences of patients with chronic pain and allow patients to participate in their daily lives. At the same time, it is important to recognize that market-oriented health policy reforms have historically promised patients more pain relief than might be feasible, and have limited the ability of patients to spend the necessary amount of time with their physicians to implement a comprehensive pain treatment program. It is only by addressing these underlying historical trends that the use of opioid analgesics can be reduced in a way that both accommodates the needs of patients with debilitating chronic pain, and addresses the devastating effects of the opioid epidemic.
To Conquer Pain

Joe is a burly outdoorsman who never knew an ache or discomfort in all his 47 years — until the morning he fell off a ladder from two and a half stories up. The fall broke a bone in his lower back and damaged his spinal cord.

He spent six months in the hospital and endured numerous operations. Even though he regained his strength and the full use of his arms and legs, his doctors told him he would be crippled for the rest of his life. Not by paralysis, but by pain.

Chronic pain. Searing, tooth-clenching, immobilizing, incurable torment. Pain that doesn’t let up for an instant and never will. Ever.

For four years, Joe endured a living hell, isolated from the world by his pain. It kept him from working, from socializing, from sharing in even the simplest joys of daily life. All his doctors could do was prescribe narcotics to dull the agony. But the narcotic side effects were every bit as debilitating as the pain.

Then Joe was referred to the Chronic Pain Institute at St. Vincent’s Medical Center. He learned that even though there is no cure for chronic pain, there are ways to lead a fuller, more normal life in spite of it.

Joe was evaluated by the Institute’s multi-disciplinary team of physicians, including an internist, a neurologist, a neurosurgeon, an orthopedist and a psychiatrist. The team treats the whole patient, coordinating every medical resource available to teach the patient how to focus on living instead of on pain.

The treatment: Joe received combined counseling, physical therapy, medication, biofeedback and vocational retraining. The results are very promising.

Joe no longer requires narcotics, and, for the first time since his accident, is taking an interest in life and the world around him. He has even gone back to work. Once again, he can take pleasure in family, friends and himself.

Joe knows that his pain will never leave. He knows there will be setbacks in his struggle against it. But he also knows that he can fight back. With help from the team at the Institute, pain will never again deprive him of the richness of life.

As Joe’s wife told the St. Vincent’s patient coordinator, “Thank God for all of you. You have given me back my husband.”

The art of medicine, the love of humanity.

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Figure 1. 1986 Newspaper Advertisement for St. Vincent’s Hospital in New York City. 74

Figure 2. 1992 Vicodin advertisement from a medical journal.²⁵

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