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Letter to the Editor

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A Pain Medicine Physician's Perspective on Iatrogenic Polypharmacy

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I read a recent article in *AMA Journal of Ethics*, "When Should Iatrogenic Polypharmacy Be Considered a Disease? (1)," with great interest. The article analyzes how patients end up with an extensive list of daily medications, often prescribed by specialists who do not communicate with one another.

"Polyprescription is a practice involving individuals and social institutions. There are a few factors that make it a clinically and ethically troubling phenomenon that requires further attention by bioethicists and philosophers of medicine. One of the ways that polypharmacy occurs is that some patients receive prescriptions solely from specialists practicing in isolation from a patients' other clinicians, perhaps during hospitalizations."

As an anesthesiologist subspecialized in Pain Medicine who works in private practice, I can relate to this. Although I consider myself an interventionalist first and foremost, with a desire to alleviate and reduce my patient's chronic pain through interventional procedures, I take pride in the fact that I work with my patients to create a personal, multimodal analgesic treatment regimen. I often refer to the multimodal plan as creating multiple spokes on a wheel. These spokes comprise of physical therapy, pharmacologic treatment, radiologic imaging and interventional procedures, amongst others.

Although pharmacologic treatment is only one "spoke" on this wheel, it is one that I often will utilise as I strongly believe that it ultimately does help my patients. A pain medicine physician's pharmacologic armamentarium typically comprises antineuropathics, anti-inflammatories, muscle relaxants, anti-depressants and on occasion opioids. Except opioids, which I consider myself more conservative and far less likely to prescribe and more likely to wean down, I believe that there is a place for those other categories of medication to treat chronic pain. Prior to seeing every new patient, I ensure that I go through their entire medication list, and although I may be cognizant that some are on a high number of medications prior to seeing me, they often leave my office with more medications than they came in with.

Although I ensure that the new medications I am prescribing do not interact with their present medications or the known side effects of the new medications will be tolerable in my patients, I must admit I have not withheld prescribing a medication just because my patient may already be taking a large number. As a specialist in private practice, it is true that I am isolated away from the patient's primary care physician or other specialty providers, which is of course quite different than if this patient was being seen in a large, tertiary, academic teaching institution where majority of specialists and primary providers are all together on one larger hospital or campus.

In addition, if I feel that a certain medication will help my patient's chronic pain, I would prefer to prescribe that drug because I believe it will help. We need more research to discern the effect of a large number of medications certain patients, particularly elderly ones, take on a daily basis. A pain medicine specialist's job is to focus upon their chronic pain and pain generators, but it is important to weigh the benefit of prescribing an additional medication that may improve

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that specific aspect of their chronic pain for that patient against adding yet another medication to several others that may possibly negatively impact the patient overall moving forward.

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